PUBLIC SECTOR ORGANIZATIONAL CAPACITY IN REFUGEE CRISIS MANAGEMENT: AN EMPIRICAL PERSPECTIVE ON HEALTHCARE ORGANIZATIONS IN THE CONTEXT OF THE ROHINGYA REFUGEE INFLUX IN BANGLADESH

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ACRONYMS AND ABBREVIATION

AFAD	Disaster and Emergency Management Authority
BBS	Bangladesh Burea of Statistics
BIDS	Bangldesh Institute of Development Studies
DESA	United Nations Department of Economic and Social Affairs
EU	European Union
GDI	Global Development Institute
IOM	International Organization for Migration
ICRC	International Committee of the Red Cross
MAJHI	Rohingya Community Leader in the Rohiongya camps
MOHFW	Ministry of Health and Family Welfare
MoDMR	Ministry of Disaster Management and Relief
NGO	Non-governmental Organization
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
ORRRC	Office of the Refugee Relief and Repatriation Commissioner
PMO	Prime Minister’s Office
PPP	Public–Private Partnership
SADAR	Twon Centre at the district or sub-district
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
UPAZILA	An administrative unit under a district (sub district)
UNO	Chief Executive Officer for a sub district (Upazila)

ABSTRACT

Literature shows that political crisis such as the refugee crisis threatens states and public sector organizations significantly. The number of refugees engulfed in this crisis has risen, reaching 70.8 million by 2019. The situation has further worsened after an outbreak of extreme violence in the Rakhine State of Myanmar on 25 August 2017. This triggered a large movement of refugees into Bangladesh. The massive influx has occurred rapidly into an area where the pre-influx situation was already delicate with substantial insecurity, a lack of sufficient water and sanitation, food insecurity, and generally inadequate facilities for health, education, etc. Basic services available prior to the influx became over-strained due to massive demands on the health systems and services. In 2018 the number of total arrivals of refugees became more than one million which is one-third of the total population of Cox's Bazar district. These huge vulnerable displaced people are totally dependent on the Government of Bangladesh and its international partners for health care services.

Against this backdrop, this study aims to identify the impact of the refugee crisis on public sector organizational capacity with particular reference to the public health sector in Bangladesh. Given its nature, the research follows qualitative methods to address the research objectives and questions. Data has been collected through semi structured interview and Focus Group Discussion (FGD). The evidence indicated that the refugee crisis has both negative and positive impacts on the organizational capacity from management and resources perspectives. The organizational capacity has been influenced by political, administrative, socio-psychological factors. Besides, the local community led response if well-coordinated and supported by active partnership can be effective even the responding organizations could not detect the signal properly well ahead of time. Informal trust-based management practice can be instrumental. Moreover, a national policy for health crisis management and community engagement along with a well training health professionals and local volunteers may be beneficial for public health sector organizational capacity. The study has implications from both academic and practioner's perspective.

DECLARATION

I declare that no portion of the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Mohammad Kamrul Hasan

July, 2021

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1. CHAPTER ONE: INTRODUCTION

1.1 Introduction and Background to the Study

The global trend of forcibly displacing people is alarming and on the rise. By the end of 2017, a total of 68.5 million individuals were forcibly displaced globally as a result of persecution, conflict, or generalized violence (UNHCR, 2017). An estimated 16.2 million people were newly displaced in 2017 (UNHCR, 2017) which means the number of new displacements was equal to an average of 44,400 people being forced to flee their homes every day in 2017. The multi-dimensional impact of such crisis touches not only the host countries but also those that they pass through.

There are few theoretical assumptions about the refugees and their movement. The concept of refugees were examined as ‘New vs Traditional’ (Paludan, 74) where ‘New Refugees’ has vast difference with their host both from culturally and racially. The movements usually take place from less-developed countries and the refugees are likely to get less support groups in their country of resettlement. On the contrary, the ‘Traditional Refugees’ have cultural and ethnic similarities with the host community and they usually move from countries in similar stages of development (George, 2010). In such situation, the refugees likely to be welcomed by host community. Moreover, the movements of refugees are viewed as ‘anticipatory movement’ and ‘acute movement’ (Kunz, 1981) where anticipatory refugees can manage an organized movement by detecting the crisis early. It has less negative impact on their family and resources. On the other hand, acute refugee movements are sudden and often forced to leave their homeland on a short notice. As a result, they are usually unprepared and sometimes traumatized (Kunz 1981). This kind of refugees require more support in every aspects.

It is observed that globally the acute movement is increasing along with cases of new refugees. However, the Rohingya crisis and the movement of refugees from Myanmar to Bangladesh is a case of traditional refugees within the context of acute movement.

In the statistical and theoretical context, Bangladesh has been a long-term victim of the crisis. Since 1784, when the first wave of Rohingya refugees fled from Arakan (a province of Myanmar, then Burma) to the area of Cox's Bazar in Bangladesh, as Burmese King Bodawpaya

invaded and annexed Arakan to the then Kingdom of Ava in central Burma, the country has been experiencing this crisis as a host (Ullah, 2011). Apart from the 1942 refugee influx, there were two major influxes of Rohingya people in 1978 and during the warring period from 1991 to 1992 to escape the Myanmar government-backed systematic genocide and ethnic cleansing program (Ullah, 2011). More than 270,000 Rohingya refugees crossed the border from Myanmar into Bangladesh between 1991 and 1992. According to the most recent Inter-Sector Coordination Group (ISCG) report, an estimated 745,000 Rohingya have sought refuge in Bangladesh since August 25, 2017, when violence triggered a mass migration from Rakhine State (ISCG, 2018). Adding this figure to the approximately 300,000 Rohingyas who were already in temporary settlements or mixed with host communities across Bangladesh, the total Rohingya population has risen to around one million (ISCG, 2018).

With the backdrop of such a huge Rohingya influx, the government of Bangladesh initially responded positively despite having no national legislation governing the management of refugee affairs. However, there was a dedicated refugee coordination and response unit, namely the office of the Refugee Relief and Repatriation Commissioner in the refugee-prone Cox's Bazar district since 1992. But since August 2017, the large unexpected movement of Rohingya has created a scarcity of resources resulting in a critical humanitarian emergency that exceeded the coping capacity of local communities and systems (ISGC, 2017)

It is understandable that dealing with severe crises is an important responsibility of governments and public sector officials. Crises are usually unpredictable, necessitate a quick response, and frequently elicit a great deal of criticism and debate (Boin, 2013). Planning and preparing for the unexpected and unknown, dealing with ambiguity, and responding to urgency while dealing with citizens' expectations puts bureaucratic public administration to the test (Boin et al., 2013; Taleb, 2007).

The sudden and massive influx of Rohingya in a short period of time created a crisis that had to be dealt with in the first instance by public sector organizations at the local level. One of the most important aspects of managing a crisis such as a refugee crisis is providing health services to the affected population. In the face of the Rohingya refugee crisis, the District Health Service Office (commonly known as the Civil Surgeon's Office) coordinates health service delivery under the direction of the Director General of Health Service (DGHS). As of June 2018,

a total of 107 partner organizations, including UN organizations and non-governmental organizations, were working on the health issue (DGHS, 2020).

According to the World Health Organization (WHO), there are approximately 170 basic health units, 33 primary health care centers, and ten secondary health care facilities for Rohingya refugees in operation. This means that 1 in 7,647 people still require basic health care and 1 in 39,394 people require primary health care (DGHS, 2020). In government-run facilities, approximately 290 hospital beds are available to those in need (WHO, 2018). Despite these efforts, there are capacity issues (ISCG, 2018). The majority of Rohingya refugees, according to the UNHCR (2018), have access to a health facility within a 30-minute walking distance. However, the services provided by health care facilities differ. According to the midterm review of the Joint Response Plan for Rohingya refugees, 76 percent of the population has access to birthing and delivery services, 57.7 percent has access to antenatal care, 27.4 percent has access to consultation services, and 13 percent has access to mental health care. However, 63 percent of Rohingya refugees have difficulty accessing health facilities at night, owing to closures (51.6 percent), difficult terrain (24.4 percent), distance and lack of transportation (18 percent), and security concerns (13.2 percent). Aside from that, water contamination is still a health risk, with Acute Watery Diarrhoea (AWD) being common in the camps. Poor nutritional status and crowded living conditions exacerbate health risks (WHO, 2018). On the other hand, the sector is still underfunded, with only 44.9 million USD allocated against a total requirement of 113 million USD, affecting service quality (Rahman, 2018).

In his study titled 'Crisis-induced Learning in Public Sector Organizations,' Deverell (2010) argued that organizations play an important role in crisis management. He goes on to argue that there are few theories about how organizations respond to crises, and that research tells us more about crises as events than about how these events are managed. In his submission, research on crisis management is focused on unusual, disastrous events and industrial accidents than how they are managed. As a result, the purpose of this research is to investigate the impact of the refugee crisis on the organizational capacity of the public sector in a specific context.

1.2 Statement of the Problem

Adverse circumstances such as the refugee crisis have an effect on the performance of both public and private organizations (Boin, 2009; Comfort, 2002; Whiteman & Cooper, 2011).

In recent years, the severity and nature of adversity has risen in terms of economic, political, environmental, and technological perspectives (Choucri, Mandick & Koepke, 2016; Toubiana & Zietsma, 2016; Laufer & Coombs, 2006; Perry & Quarantelli, 2005). According to the literature, political crises such as the refugee crisis pose a significant threat to states and public sector organizations. Since the cold war era, the number of refugees has been on the rise. According to UNHCR data, the number of refugees was 2.4 million in 1974 and had risen to 65.6 million by June 2017. This situation has been exacerbated by the Rohingya crisis, which has forced a large number of people to flee to Bangladesh since August 25, 2017, following an outbreak of extreme violence in Myanmar's Rakhine state.

The massive influx occurred quickly into an area where the pre-influx situation was already delicate, with multifaceted challenges (UNHCR, 2017). Due to massive demands on health systems and services, basic services available prior to the influx became overburdened (UNHCR, 2017). Literature indicates that health needs of migrants are poorly understood, communication between health care providers and migrant clients remains poor, and health systems are not currently prepared to adequately respond to this problem, as a result, health care requires appropriate focus and attention during such refugee crisis (Rechel et al., 2013).

Furthermore, Finney and Cunningham (2003) stated that strengthening mainstream health services to improve access and quality of care for refugees necessitates a combination of approaches such as developing expertise and cultural competence, funding, developing responsive policies and organizational culture, and developing cross-agency collaborations.

Based on the public health situation analysis published on October 10, 2017, WHO classified the Rohingya crisis as a level 3 emergency, in accordance with that theoretical understanding. According to the document, the health sector's ongoing challenges and needs place an undue burden on government health care facilities. Other challenges include health sector funding, health sector coordination, health sector response to service delivery planning, and disease surveillance (Rahman, 2017). Furthermore, ISCG (2018) suggests that the health sector remains severely underfunded, which has an impact on the quality of services provided. According to the report, adherence to the valid minimum package of primary health care services is inconsistent. Noncommunicable diseases, malaria, tuberculosis, and HIV/AIDS programming remain underfunded. ISCG (2018) also found significant gaps in health-care provision, such as

surgical capacity, medicine availability, and the availability of psychological specialists. It is assumed that in the event of a natural disaster, the gaps in surgical capacity will be a significant barrier to saving lives. Consequently, this crisis requires a greater capacity for rapid and predictable humanitarian response (Asia Pacific Refugee Rights Network, 2017).

The host government, with the assistance of international humanitarian organizations, handles the majority of refugee and forced migrant issues. As a result, the well-being of migrants is heavily dependent on the capacity of the public sector. When there is a crisis with broad ramifications for the public or citizens, all eyes turn to the government and the public sector (Drennan & McConnell, 2007). In this regard, the significance of national capability/capacity development cannot be overstated.

As previously stated, the magnitude of the influx of Rohingya refugees has placed enormous strain on all health-care organizations, raising public health concerns (WHO, 2018). In 2018, the total number of refugee arrivals surpassed one-third of Cox’s Bazar district's total population estimated around 2.5 million people (World Population Review, 2018). These vast numbers of vulnerable displaced people are completely reliant on the government of Bangladesh and its international partners for health-care services (WHO, 2018). Cox's Bazar has a modest health infrastructure, with no designated trauma care facilities (WHO, 2018). The district has one 250-bed district hospital, seven Upazila Health Complexes (subdistrict public hospitals), and 174 community health clinics, which are insufficient for the district's current population (MoHFW, 2018). Since August 2017, health facilities in Cox's Bazar and surrounding areas have reported a 150–200 percent increase in patients, far outstripping current capacity and resources (WHO, 2018). Furthermore, the literature indicates that the health system faces multifaceted challenges, such as lack of public health facilities, skilled workforce shortage, insufficient financial resource allocation, and political instability (Islam & Biswas, 2014).

Furthermore, the health sector suffers from lack of skilled and well-trained human resources, skilled trainers and equipment, quality training, unavailability of funds and logistics at the sub-national level, sluggish emergency preparedness response coordination at the sub-national level, and the lack of appropriate infrastructure (WHO, 2012; Bangladesh Health Facility Survey, 2014). The health care system, though run by either government or privately run

clinics, Bangladesh continues to lag behind in terms of providing health care services to both the poor and the wealthy (Ahmed et al., 2013).

Following from above, Bangladesh, as one of the world's most densely populated countries (1,077 people per square kilometres), has a health workforce shortage and an inequitable distribution of the health workforce. Furthermore, the ratio of health workforce (a doctor-to-nurse-to-technologist ratio of 1:0.4:0.24) is below standard compare to the WHO recommended ratio of 1:3:5 (WHO, 2014). The health professionals in the formal sector are concentrated in the urban areas, with regional variations. Retention and absenteeism are two major issues in rural areas (WHO, 2014), with the absence of key health human resources (physicians) often exacerbating the situation. In health facilities, there is severe shortage of drugs and other supplies. As a result, only 25% of the population has access to the government-funded health-care system (WHO, 2014). This illustrates human and resource capacity challenges in the public health sector. Against this backdrop, the purpose of this research is to identify the effects of the refugee crisis on public sector organizational capacity, as well as the nature of the response in the health sector.

1.3 Aim, Objectives and Research Questions

The main aim of the study is to explore, analyse and understand the link between crisis events and public sector organizational capacity with particular reference to the health sector. In order to explore the main aim, the following objectives and research questions have been set.

1.3.1 Research Objectives

a. To examine the impact of the refugee crisis on health sector organizations in order to better understand the public sector organizational capacity in crisis events;
b. To identify the capacity gaps in health service delivery in the context of the Rohingya Refugee influx in Bangladesh in order to prescribe better public sector organizational capacity development mechanism.

1.3.2. Research Questions

In order to address the above research objectives, the following questions have been identified:

1. What is the impact of the refugee crisis on the capacity of health service-providing organizations?
2. What are the key factors affecting health service capacity during refugee crisis?
3. How did the health sector respond to the Rohingya refugee crisis in Bangladesh?
4. How can the organizational capacity of health care services be strengthened in such a crisis?

Table 1: Aim, objectives and research questions of the study

Aim	Objectives	Questions
The main aim of the study is to explore, analyse and understand the link between crisis events and public sector organizational capacity with particular reference to the health sector	a. Examine the impact of the refugee crisis on the health sector in order to better understand the public sector organizational capacity in crisis events;	1. What is the impact of the refugee crisis on the capacity of health service-providing organizations? 2. What are the key factors affecting health service capacity during the refugee crisis and why?
	b. Identify the capacity gaps in health service delivery in the context of the Rohingya Refugee influx in Bangladesh in order to prescribe better public sector organizational capacity development mechanisms	1. How did the health sector respond to the Rohingya refugee crisis in Bangladesh? 2. How can the organizational capacity of health care services be strengthened in such crisis situations?

Source: Author’s Construct, 2021

1.4 Brief Theoretical Underpinning

This study is based on three major areas of related theories. They are organizational capacity in the public sector, crisis management and response, and the refugee crisis. The relationship between the three areas is described in the upcoming chapter on theoretical perspectives.

It is usually assumed that crisis challenge the smooth existence of a system. However, this may always not be the case. A crisis can lead to either positive or negative organizational outcomes (Mishra, 1996). A study conducted in 2010, on 97 organizations in Malatyas' Organized Industry Region (OIR) in Turkey claimed that crisis may have three positives and two broad negative impacts (Özdemir & Onur Balkan, 2010). While the positive effects include organizational change, potential revealing, and organizational learning, the negative effects include managerial issues and decreased effectiveness and productivity. In the context of refugee crisis, some researchers found that the refugee crisis has a positive impact on the consumption pattern of the local community (Alix-Garcia & Saah, 2008; Maystadt & Verwimp, 2009). Likewise, Gomes et al. (2010) asserted that the operation of the refugee camp in Kenya has improved the local economy. According to Esen and Ouş Binatl (2017), Syrian refugees have made significant contributions to Turkey in terms of entrepreneurial abilities as well as boosting the economy. Similarly, a study conducted by the European Social Network (2016) on 17 European countries have argued that the refugee crisis has a number of effects on public social services, including significant pressure on housing, specialized services for children, training, and information services. Likewise, in Denmark, Jensen et al. (2011) discovered that dealing with refugees or undocumented migrants has put strain on the health system as a result of inadequate funding, previous medical records and a sense of uncertainty about the future.

The sudden influx of Rohingya refugees has created an emergency crisis situation (WHO, 2017), particularly for public service providers in Cox's Bazar. Given the circumstances, it is reasonable to conclude that the Rohingya crisis may have a negative impact on service-providing organizations, particularly those in health-care. Nonetheless, this may also result in positive changes in the system.

It is predictable that public service providers are the primary responders to any refugee or forced migration-related crisis. Literature suggested that the public service delivery can be influenced by resources including organizational capacity, organizational culture, organizational structure and individual factors (Antwi & Analoui, 2008; Boyne, 2003). Organizational capacity can be seen from societal, inter-organizational, organizational, and individual perspectives (Mengesha & Common, 2007; Aijaz, 2010; Pallangyo & Rees, 2010; Watson & Khan, 2010) to help in service delivery. Concerning the Rohingya refugee crisis, public sector service delivery organizations are collaborating with non-state actors such as development partners and NGOs. As a result, the impact and capacity issues of public service providers must also be examined from this standpoint. Within this context, Anjula and Colin (2015) asserted that the problems of service delivery in developing countries are complex and multi-dimensional in nature. They therefore proposed a three-stage framework that focuses on public services (inputs), the wide range of risks and uncertainties associated with the service (impacts), and the implementation of special moderators (conditions and regulations) for efficient service provision. They came to the conclusion that these three factors played consistent role in achieving efficient and cost-effective service delivery. As a result, policy recommendations should not be aimed at a single factor or an aspect of the developing country's complex ecosystem but a multi-dimensional approach be considered. They therefore emphasized collaborative or coordinated approaches. These notwithstanding, there are some issues with the collaborative model. Lindsay and McQuaid (2008) have opined that lack of clear and specific goals, as well as different interpretations of the goals by various partners, can quickly lead to confusion, lack of coordination, and internal conflict. Besides the above findings, Osborne (2010) argued at the strategic level that, competing priorities and conflicts over control are the single most debilitating factor for effective partnerships. He also claimed that this could lead to organizational obstacles and rigidities, as well as increase operational costs. Using existing knowledge, the factors that influenced public sector capacity, which is related to the second research question, can be investigated. It is critical to investigate how organizations responded to the crisis in order to comprehend the factors.

Studies on crisis management and response are mostly focused on decision making, psychological issues, the role of leadership and teams, and identifying the cause and effect of crisis management. Scholars discovered that the effectiveness of a crisis response is dependent

on how the event is interpreted, the quality of decision making under high uncertainty, and the quality of response strategies (Jackson & Dutton, 1988; Maitlis & Sonenshein, 2010; Anderson, 1983; Smart & Vertinsky, 1977; Tjosvold, 1984; Bechky & Okhuysen, 2011; Kahn, Barton, & Fellows, 2013). Similarly, studies have shown that improving decision-making, role enactment, resources, and identifying and mobilizing capacities are all necessary for effective crisis response (Drabek, 1985; Stallings & Quarantelli, 1985; Webb, 2004; Neal & Phillips, 1995; Shepherd & Williams, 2014). Furthermore, Boin et al. (2010) argued that responding to a transboundary crisis requires distributed analytical capacity, surge potential, coordinated behaviour, and special authority arrangements. Using existing theories, the study examines how public health organizations responded in the face of the refugee influx. However, understanding public sector capacity in details is required before analyzing the response.

Fischbacher and Smith (2014) have argued that having too much or too little capacity can cause problems for organizations, so the right kind of capacity must be identified when dealing with crisis. This study also investigates the capacity requirements for service-providing organizations, particularly health-care organizations, in the context of a crisis such as the refugee crisis. As a result, service delivery organizations can be scrutinized through the theoretical lens of organizational capacity development. Capacity alone denotes an individual's or group's general ability to carry out their responsibilities and tasks (Hussein, 2006; Morgan et al., 2010). Capacity development has been an ill-defined term and practice (Morgan and Baser, 2007). In their study on Ghana, Antwi and Analoui (2008) concluded that three factors are critical in building capacity. These are: organizational culture, organizational structure, and individual level (Antwi and Analoui, 2008). As a result, capacity building can be implemented at any stage or level of an organization, from an individual to the entire organization. This enables capacity building to be more decisive in terms of its unit and levels of analysis (Jurie, 2000, Potter & Brough, 2004). Lusthaus, Anderson, and Murphy (1995) and Lusthaus et al. (2002), on the other hand, argued that organizational capacity can be viewed through the lens of its resources and management. The resources comprise of the staff, finance, infrastructure, and technology. The management component on the other hand includes process and procedure, leadership, and collaboration with other actors. The perspectives on capacity can be viewed through operational and adaptive lenses. According to the UN, all organizations must establish and maintain both

operational capacities that allow them to carry out their day-to-day activities efficiently and adaptive capacities that allow them to learn on the job on a continuous basis. The research findings on factors affecting health sector organizational capacity and capacity development of health sector organizations can be examined in terms of resources or from a management perspective, as well as operational or adaptive aspects. Potter and Brough (2004), on their part, argued that capacity building entails increasing the stock of people rather than managing what is already there. Capacity building, in general, can be defined as a process that occurs in addition to HRM within an organization. In accordance with the concept of health service delivery capacity, capacity was examined and understood from an organizational standpoint as processes as well as HRM.

Furthermore, the Rohingya crisis is an unexpected and sudden man-made crisis that has had a huge impact on Bangladesh from a social and economic standpoint, as well as on the public service delivery system. According to Farazmand (2009), routine crises are easier to prepare for, whereas sudden and chaotic crises with unfolding dynamics are extremely difficult, if not impossible, to read. Existing capacities may be adequate for routine tasks, but they are inadequate for dealing with complex and unexpected crises, and the challenges become even more daunting in countries hit by earthquakes, hurricanes, typhoons, or conflicts with large refugee populations. These issues are exacerbated when they occur on a regional or global scale, affecting multiple jurisdictions and national boundaries with a large population (Farazmand, 2009). In dealing with these capacity issues, Taleb (2007) argued that by taking the appropriate measures, the unpredictable situation can be avoided. Furthermore, Avinash (2008) asserted that unpredictable events can be avoided through various strategies such as hazard avoidance through event prediction or detection, hazard avoidance through operational procedure, and hazard avoidance through education and training. In line with the suggested prevention strategies, Farazmand (2009) proposed five capacity requirements at the onset of chaotic surprises and crises, which include a learning culture, training, information sharing, and the establishment of relevant institutions. Based on the aforementioned scholarly arguments, the capacity to respond to the Rohingya crisis situation can be further examined.

To summarize, the study's goal is to focus on public-sector organizational capacity issues, with a particular emphasis on health-care organizations affected by the Rohingya refugee crisis. The study's main argument is that a sudden refugee crisis, such as the Rohingya influx, has a significant positive or negative impact on service-providing organizations, and organizational capacity has been influenced by a variety of factors, with impacts on organizational capacity having a relationship with organizational response. According to existing research, crises have both positive and negative effects on organizations. The search revealed that there is very little literature focusing on the impact of the refugee crisis on the organizational capacity of the public sector. However, the study's main question is to see how the refugee crisis affects public health sector organizational capacity, which means that existing theories will guide the study and the study will contribute to the existing knowledge gap.

1.5 Significance of the Study

There are numerous studies on the refugee crisis that focus on different contexts and geographical locations. According to the literature, studies on the impact of voluntary migration and forced migration on refugees are easily accessible. However, there is a scarcity of literature on the impact of the refugee crisis on the host country's public sector organizational capacity (Boin et al., 2005). Furthermore, according to Boin and Lodge (2013), a major crisis has an impact on and constrains public administration. They also claimed that crisis management is a major government responsibility that is difficult to carry out (Boin et al. 2005; Boin &'t Hart 2003). They claimed that public administration academics have yet to thoroughly investigate the government's capacity to deal with major crises (Boin & Lodge, 2013).

Furthermore, Christensen and Lgreid (2016) asserted that organizational structure and coordination mechanisms within government arrangements are critical. As a result, it is necessary to investigate organizational structures and various arrangements for governance capacity, such as coordination capacity, as well as cultural features and processes related to input, throughput, and output legitimacy. According to Christensen et al. (2007), the future research agenda should focus on investigating the regulatory, delivery, and analytical capacity of public authorities for crisis management, as well as comparative studies of crisis management across countries, over time, and across different sectors.

Refugee crises and forced migration have become global crises, with public sector organizations providing the primary and major response. Schneider (2011) concluded that crisis management performance is determined by measuring the gap between organizational response and citizen demand or expectation. He assumed that the gap could be closed by either increasing capacity or decreasing expectations, or by a combination of the two. Furthermore, Christensen and Lgreid (2016) contended that crisis management performance differed depending on the type and nature of the crisis. Client expectations are unlikely to be reduced, rather with the passage of time it increases. Against this backdrop, the study will concentrate on the Rohingya refugee crisis, attempting to identify the impact on public services through the lens of the health sector's organizational capacity.

The study will contribute to the generation of academic knowledge in order to identify public service issues, with a focus on organizational capacity in a context similar to the Rohingya crisis. Despite the fact that only a few studies have been conducted on Rohingya refugees, empirical research on the impact of the refugee crisis on public service delivery capacity is almost non-existent, particularly in light of the new influx in 2017.

Refugee crisis trends show that the majority of refugee movements occur from underdeveloped or developing countries to developed countries. As a result, the literature demonstrated that the majority of the studies were conducted in the context of developed countries. Bangladesh, on the other hand, is a developing country that has long hosted refugees from another developing country. As a result, this study is being conducted in a different context in order to generate organizational capacity-related knowledge in the context of the refugee crisis. This knowledge could be useful in developing a model for public sector capacity in a similar context.

Furthermore, Farazmand (2009) argued that while routine crises are easier to manage, unexpected and chaotic crises with multiple dynamics are extremely difficult, if not impossible, to properly identify and respond to. He assumed that while routine capacities may be useful for routine tasks, they may not be appropriate for dealing with complex crises. In his opinion, the situation worsens in countries dealing with massive natural disasters or refugee crises. These issues are exacerbated when they occur on a regional or global scale (Farazmand, 2009). The

study's findings may be used to inform future strategy development processes for streamlining public service capacity, particularly health service capacity in managing refugee crisis.

Bangladesh has been recognized as one of the most successful disaster-management countries. More empirical knowledge, however, is required to be more efficient in managing the forced migration and refugee crisis. This study may also contribute to the policy formulation process for public service delivery organizations and institutions in this context.

Furthermore, the Rohingya refugee crisis is being managed by a number of actors, the majority of which are public sector organizations. As a result, a collaborative approach is in place, influenced by geopolitical factors in this region. Given this context, the study will contribute new academic knowledge from the perspectives of management and public administration.

1.6 Methodology: Brief Overview

The study focuses on public service-providing organizations to investigate the impact or effect of the Rohingya crisis in order to address the research objectives and questions. Field research and a review of the existing literature were used to answer these specific questions. There are two types of research in research practices: quantitative and qualitative (Morgan et al., 2003). Because of the nature of the research, it is conducted using qualitative methods. First, a multidisciplinary content analysis of the refugee crisis, crisis management, and public sector organizational capacity was conducted, followed by detailed fieldwork on organizations (health sector) involved in service delivery to the Rohingya refugees at the central and local level (Cox's Bazar district) of Bangladesh. During the examination, both primary and secondary sources are used. The majority of the primary data for this study is qualitative and was gathered through semi-structured interviews and Focus Group Discussions (FGD). Data was gathered from health professionals, representatives of government agencies that work closely with refugees, particularly those in the health sector, Development Partners, and non-governmental organizations (NGOs). In the case of secondary sources, however, data was gathered through document review. Inductive thematic analysis was used to analyze the data.

To summarize, this study follows a qualitative pattern in that it investigates an existing social phenomenon in its natural setting (the local and public services of the Rohingya crisis in Bangladesh) by attempting to interpret the meanings that individuals attribute to this phenomenon through interviews and documented sources (Creswell, 2014; Yin, 2010). As a result, rather than focusing on a single source, this study collects data from multiple sources (Creswell, 2014; Marshall and Rossman, 2011). However, a detailed elaboration of the methodology is provided in chapter three.

1.7 Limitation

Given the pressing need to investigate the factors influencing public sector organizational capacity in the context of the refugee crisis, gathering primary data from the field is difficult. To begin, service providers work at the local level in the south-eastern part of Bangladesh (Cox's Bazar), and refugee camps are located in difficult-to-reach areas further east of the Cox's Bazar district, with relevant personnel or bureaucrats preoccupied with the current crisis. As a result, conducting interviews was difficult. However, I was able to reduce the difficulty by utilizing my civil service network. Second, there is little literature on the Rohingya refugee crisis in Bangladesh in terms of public sector organizational capacity. One of the main limitations of my research will be the lack of prior research on the topic. However, through extensive reading of journal articles, books, and conference materials, as well as advice from my supervisors, I was able to overcome this challenge.

1.8 Outline of the Thesis

This study consists of eight chapters. *Chapter One* presents a background to the thesis, the problem statement, research aim, objectives and questions as well as the significance of the study. A brief indication of the theories and a concise version of methodologies were used, and the chapter concludes by affirming the possible limitations. *Chapter Two* covers the theoretical overview and a critical assessment of the relevant literature on Public Sector organizational capacity with particular reference to the health sector and the crisis management and response

aspects of public health sector organizations in the context of Rohingya refugee influx into Bangladesh

In Chapter Three, a detailed discussion of the research design and methodology, as well as the study's context, are presented. Under research question one, Chapter Four highlights the data on the impact of the refugee crisis on organizational capacity. The findings about the influential factors are presented in Chapter Five. Chapter Six contains data on the health sector's response and the potential for capacity development. The seventh chapter contains key findings as well as a discussion and analysis of the findings. The thesis's final chapter (Chapter Eight), contains a series of concluding remarks and policy formulation and implementation recommendations.

2. CHAPTER TWO: THEORITICAL OVERVIEW

2.1 Introduction

The chapter provides existing knowledge in three major areas related to the aim, objectives, and research questions, laying the theoretical foundation for the research. The areas are the refugee crisis, crisis management, and organizational capacity in the public sector. This chapter will thus provide a clear overview and foundation to support and assist the thesis's research objectives and questions. This chapter will then be divided into three sections that will discuss the relevant recent literature as well as the limitations of the literature in order to identify the gap and the contribution of this study to knowledge.

The primary goal of the literature review is to gather existing information and knowledge about the thesis's three main themes, with a focus on interrelationships, linkages, and gaps. It is expected that the literature search will be able to explain the issues related to the objectives and questions that have been established. It is also assumed that the literature review will be able to provide knowledge in order to examine the research queries in the context of academic knowledge availability and non-availability. This serves as a guide to achieve the research's overall objectives.

2.2 Refugee Crisis across the Globe: Trend and Effect

Since the Cold War, the refugee crisis and forcible migration have been on the rise due to a variety of factors such as political and ethnic conflict. According to UNHCR, the number of refugees increased from 2.4 million in 1974 to 10.5 million in 1984. By 1996, the figure had nearly tripled (Barnett, 2002). By June 2017, the figure had risen to 65.6 million (Edwards, 2017). The refugee crisis appears to be a growing concern for both nation-states and the global community.

Table-2: No of refugees in Recent Years

End-year	Total
2011	35,440,100
2012	35,848,000
2013	42,865,300
2014	54,945,400
2015	63,907,700
2016	67,749,800
2017	71,439,500
2018	74,791,900
2019	86,531,700
2020	91,920,400

Source: UNHCR, 2020.

In this regard, Bangladesh is not an outlier. The Rohingya refugees have become a significant burden on this small but densely populated country. Table 3 below provides a statistical overview of Rohingya refugee settlement in 2018.

Table 3 : Distribution of Rohingya refugees in various settings

Location	Total Population	Location	Total Population
Rohingya in Camps and settlements		**Rohingya in Host communities**	
Kutupalong Expansion Site	610,251	Cox's Bazar Sadar and Ramu	6,628
Kutupalong RC	16,251	Teknaf	5,332
Camp 14, 15, 16	98,529	Ukhia	2,920
Camp 21 (Chakmarkul)	12,823		
Camp 22 (Unchiprang)	21,685		
Camp 23 (Shamlapur)	13,049		
Camp 24 (Leda)	35,583		
Camp 25 (Ali Khali)	9,501		
Camp 26 (Nayapara)	47,961		
Camp 27 (Jadimura)	14,822		
Nayapara RC 23,601	23,601		
Sub-total	**904,056**	**Sub Total**	**14880**
Total Rohingyas	**9,18,936**		

Source: ISCG, 2018

According to existing literature, this forced migration of people has a variety of consequences for host countries and communities. The issues will be discussed from various perspectives in the following subsection.

2.2.1 Impact of Refugee Crisis on the Host Country: Different Schools of Thought

According to the literature, the refugee crisis has a significant impact on host countries. In terms of impact, the scholars are divided into three groups. One group believes it has a negative impact, another believes it has a positive impact, and yet another believes it has both a negative and positive impact.

Kreibaum (2016) asserted that, refugee camps have a positive impact on the local community when the legal framework allows the refugees to work and move freely. Similarly, Kibreab (1985) argued that refugees can help to boost growth. Furthermore, some scholars have stated that the refugee crisis in low and middle-income countries can accelerate the standard of living as financial resources from donor countries increase (Baez, 2011 & Jacobsen, 2002). additionally, other researchers have claimed that the refugee crisis has a positive impact on the local community's consumption pattern (Alix-Garcia & Saah, 2008; Maystadt & Verwimp, 2009). Correspondingly, Gomes et al. (2010) have opined that the operation of refugee camps in Kenya has boosted the local economy. Syrian refugees, according to Esen and Ouş Binatl (2017), have made significant contributions to Turkey in terms of entrepreneurial skills and economic development. They discovered that in 2015, 1,599 new companies were established, as compared to only 157 in 2012, and that the share of Syrian enterprises in total foreign partnerships reached 26% in 2015.

Some thinkers, on the other hand, argue that the refugee crisis has both positive and negative consequences. According to Shellito (2016), the refugee crisis can increase local consumption and long-term investment while also increasing local conflict and other social problems. In the same vein, Kouni (2018) demonstrated that the refugee crisis affects different groups of countries differently. He contended that refugees have a direct and positive impact on high-income and lower-middle-income countries. And it has a negative impact on the rest of the countries in the group. Furthermore, a study on Myanmar refugees in Thailand concluded that the refugee crisis

increased the likelihood of high insurgency and militancy in the local community. It also placed a significant strain on the health-care system (Brees, 2010). He further claimed that the refugee population has a positive impact on export earnings.

Some academics have argued that the refugee crisis has only a negative impact on the host countries (Orhan & Senyücel Gündoar, 2015; çduygu, 2015; Esen & Ouş Binatl, 2017). They claimed (based on a study conducted on Syrian refugees in Turkey) that the refugee crisis caused inflation, unemployment, and housing problems in the local community. In addition to the economic and social consequences, refugee movements have a negative impact on natural resources. According to Müller et al. (2016), the refugee movement degraded the land, reduced agricultural product production, and contaminated fresh water. Further, Berti (2015) asserted that refugee crisis pose a threat to internal security. He content that it causes friction between the host and the guest. Arguing from the context of the Rohingya influx, Alam (2018) has indicated that the refugee movement has negatively impacted local tourism and created opportunities for internal conflict between refugees and the local community. She further claimed that the crisis is having a significant negative impact on the local environment, such as degrading land, water, and air quality.

Regardless of the nature of the effects, crisis have a specific impact on specific sectors. According to the literature, research on migration and refugees has primarily focused on economic and social aspects such as labour market, the effect on remittances, social integration, and so on (Rodriguez & Castaeda, 2014). Based on existing literature, the following subsections will discuss the impact of refugees on various sectors.

2.2.2. The Economic Impact of the Refugee Crisis

A growing body of literature has investigated the effects of forced migration on labour markets in host countries (Ruiz & Vargas- Silva 2015; Braun, Sebastian & Omar Mahmoud, Toman 2014; Akgündüz,, Van den Berg, & Hassink, 2015; Orhan & Senyücel Gündoar, 2015) or its impact on economic outcomes and integration of displaced persons (Alix-Garcia, & Saah, 2010; Bauer et al., 2013; Braun & Dwenger 2017; Falck et al. 2012; Fiala, 2015; Sarvimäki However, there are some positive outcomes.

Based on their research in Tanzania, Ruiz and Vargas-Silva (2015) argued that a forced migration shock has multiple effects on Tanzanian labour market outcomes. This includes the likelihood of working for someone outside the household as well as the characteristics of the jobs they hold. On the contrary, Braun and Mahmoud (2014) demonstrated, using data from a study conducted in Germany, that a modest level of inflow may have little or no effect on the native labour market. Similarly, Akgündüz et al. (2015) claimed in a study on Syrian refugees in Turkey that the refugee crisis has no effect on native employment rates in various skill groups. The Syrian Refugee Crisis, on the other hand, has had a significant impact on the Turkish labour market, according to Orhan and Senyücel Gündoar (2015). They claimed that the influx of refugees has a negative impact on employment in the local communities.

According to Alix-Garcia et al. (2010), the impact of refugee inflows from Burundi and Rwanda in 1993 and 1994 on host populations in western Tanzania resulted in an increase in non-aid food items. They also claimed that refugee inflows have a positive effect on household income in areas near refugee camps while having a negative effect on wealth in urban areas. Similarly, Akgündüz et al. (2015a) claimed in a study on Syrian refugees in Turkey that the refugee crisis has increased the cost of food and lodging, thus increasing inflation. Similarly, Bauer et al (2013) demonstrated in a study of displaced Germans from east Europe during and after WWII that displacement had significant and overwhelmingly negative long-run economic consequences for the displaced. On the contrary, Esen and Ouş Binatl (2017) argued that the influx of Syrian refugees has increased foreign investment in Turkey. Similarly, some scholars discovered in Africa (Zambia, Uganda, South Africa, and Rwanda) that refugee movement has increased trade between refugees and host communities (Bakewell, 2000; Polzer, 2004; Betts et al., 2014; Taylor et al., 2016; Alloush et al. 2017).

The economic impact of the refugees notwithstanding, to fully understand the refugee situation, other aspect like social and environmental impact needs to be considered.

2.2.3. Social, Environmental and Psychological Impact of Refugee Crisis

Although the literature indicates that the refugee crisis has both positive and negative consequences, the social and environmental consequences appear to be overwhelmingly

negative. (Black, 1994; Ferris, 1993; Ghimire, 1994; Hoerz, 1995; Jacobsen, 1994, 1997; Ketel, 1994; Leach, 1992; Myers, 1993; Sorenson, 1994; Crisp, 2000; Dick, 2002; Hampshire et al., 2008; Harrell-Bond, 1998; Jacobsen, 2000; Phillips, 2003; Rumbach, 2007; Sarpong, 2003; Vas Dev, 2002; Voutira & Harrell-Bond, 1995; Akokpari, 1998; IRIN, 2009; Norwegian Refugee Council, 2002; Porter et al., 2008). In terms of the impact on infrastructure, literature indicates that it has had a negative impact on infrastructure such as roads, bridges, airstrips, and school buildings (Makanya, 1994; Zolberg et al., 1989).

According to Codjoe et al (2013), a study conducted in Ghana following the influx of Liberian refugees, refugees have increased crime and the possibility of social disorder. It demonstrated that the refugee crisis has contributed to an increase in drunkenness, prostitution, drug/substance abuse, and arms trade, among other things. This study also claimed that refugees have a negative impact on the environment, citing increased solid and liquid waste disposal, deforestation, and pollution. However, because human emotion and sentiment are involved, this study was based on the perceptions of the host community and refugees, which may not always provide a concrete real picture.

Similarly, Rahman (2010) stated that the presence of Rohingya refugees in Bangladesh has contributed to an increase in antisocial activities such as commercial sexual exploitation, forged marriages, forged job proposals, and the prevalence of sexually transmitted infections (STI). Furthermore, some academics blamed the refugees for the degradation of the hills and surrounding areas (Uddin & Khan, 2007). Similarly, the study found that the refugee influx caused environmental destruction by destroying forested land and other vegetation that housed endangered animals, biodiversity, and ecosystems). Degradation of these critical ecological resources may have a cascading effect on the environment, biodiversity, wildlife habitat, and overall socioeconomic health of the region (Hassan et al., 2018). Furthermore, Berti (2015) asserted that the Syrian refugee crisis has created short-term domestic and regional political and security instability, which, if not addressed properly, will have a negative impact on human development in the long run. Aside from these, Rutinwa and Kamanga (2003) argued that the refugee crisis in Tanzania has overburdened the local administration, consuming 50% of their time to deal with refugee-related security issues. Besides dealing with the administration of refugee-related issues, particularly those concerning security, they also stated that the crisis is

having a negative impact on the host community's police and judiciary. The impact is not limited to the social periphery. Literature also provides information on the impact of a psychological perspective.

Brooks et al. (2015) argued that a crisis or disaster, such as the refugee crisis, has a negative impact on service providers or responders. He claimed that the respondents may experience psychological effects such as traumatic distress, emotional involvement, self-harm, and so on.

Existing knowledge indicates that the refugee crisis has an impact that extends beyond the sector focus, such as economic or social-political. The handling of crises is more or less based on basic service delivery, on which the crisis has some visible and invisible effect.

2.2.4. Impact of Refugee Crisis on Public Service Delivery

It is clear that the socioeconomic impact of refugees varies depending on a variety of factors such as time duration and the integration process. As a result, the long-term and short-term effects are mixed. In contrast, according to existing literature, the impact of refugees on public service delivery appears to be mostly negative. However, there is a scarcity of literature, particularly on service delivery issues.

According to a study conducted on Syrian refugees in Lebanon, primary health care facilities, as well as other services such as water, electricity, and sanitation, were overstressed during the crisis, hampering the regular service of the local community (Kelley, 2017). She also claimed that the failure of service delivery caused political unrest in some parts of the community. Similarly, a study conducted by European Social Network (2016) on 17 European countries discovered that the refugee crisis has several effects on public social services, including significant pressure on housing, specialized services for children, training, and information services. They also claimed that during the refugee crisis, the language barrier is a significant issue for service providers (Montero & Baltruks, 2016). Similarly, according to the ORSAM report, municipal services such as refuse collection, cleaning, public transportation, and water distribution were overburdened by the influx of Syrian refugees, resulting in a massive budgetary burden on local municipalities (Orhan & Senyücel Gündoar, 2015; çduygu, 2015; Esen Ouş Binatl, 2017). Furthermore, Francis (2015) argued that the massive refugee movement in Jordan

has harmed the quality and capacity of health and education services. According to him, the fiscal impact of Syrian refugees on Jordan in 2015 was around $2.1 billion.

Furthermore, some studies concentrate on refugee health-care issues. According to a qualitative study conducted on Syrian refugees in Greece in 2017, the major challenges in terms of health service delivery are a narrow model of health service delivery, an insufficient referral mechanism for social support and mental health services, a language and gender difference between the refugees and the health service providers, and insufficient space and privacy in the clinics (Farhat et al., 2018). Similarly, ToziJa and Memeti (2007) asserted that the language barrier and cultural differences in recognizing diseases and their symptoms pose a challenge to healthcare providers. Furthermore, a study conducted in Denmark by Jensen et al. (2011) discovered that dealing with refugees or undocumented migrants has put strain on the health system due to a lack of funding, as well as a lack of previous medical records and a sense of uncertainty regarding further referrals.

From a different angle, studies have shown that delaying an initial restriction on access to primary and secondary health care services for refugees may increase health expenditure because preventive care may reduce the likelihood of various severe consequences. As a result, massive initiatives are required to improve the health system's resilience and capacity (Etienne et al., 2016). Furthermore, a study on newly arrived refugee children in Australia identified ten elements for good practice in terms of health service delivery, which included comprehensive health screening; coordination of initial and ongoing health care; integration of physical, developmental, and psychological health care; consumer participation; and culturally and linguistically appropriate health care (Woodland et al., 2010). They contended that these elements can help improve refugee health care and close the gap between health needs and currently available services.

The studies focusing on the health sector, on the other hand, were more or less concerned with identifying the challenges and solutions to the health sector during the refugee crisis. There is still a need for knowledge on the impact on organizations in order to develop a theoretical understanding from the perspective of public sector organizations.

Scholars have viewed refugee issues from various perspectives, but the overall impact of the crisis may need to be considered when assessing the impact. However, the majority of the

literature focused on the social and economic aspects of the crisis, but there is a need to understand public sector organizational issues from a public administration perspective because these organizations are primarily and operationally responsible for responding during the real-time crisis. Before delving into public sector organizational issues, it is critical to understand the refugee influx as a crisis and from a crisis management standpoint.

2.3 Crisis, Crisis Management and Response: Public Sector Perspective

For the purposes of the study, the refugee influx in Bangladesh has been viewed as a crisis. As a result, the public sector's response to the influx must be understood and explained through the theoretical lens of crisis and crisis management. Accordingly, this section discusses the conceptual and dimensional aspects of the crisis, crisis response mechanisms, and the impact of the crisis on public sector organizations, as well as an overview of scholarly knowledge within the cross-disciplinary field of crisis management studies outlining the main focus of the various dimensions and definitions of key concepts. It also seeks to identify knowledge gaps in crisis situations.

2.3.1. Refugee Influx as a Crisis: Conceptual Understanding

The word "crisis" is commonly associated with negativity, but it derives from the Greek word "krisis," which means "judgment" or "choice of decision." Depending on the context, the term can be used in a variety of ways (Paraskevas, 2006).

Rosenthal, Charles, and t'Hart (1989) defined crisis in terms of human error and policy implications. They defined crisis as an event that poses a serious and unsuitable threat to the organization's environment, creates a high level of uncertainty, and necessitates immediate action. In a similar vein, some scholars defined crisis as "a low-probability, high-impact event that threatens the viability of the organization and is characterized by ambiguity of cause, effect, and means of resolution, as well as a belief that decisions must be made quickly" (Lagadec, 2007; Pearson & Clair, 1998). James et al. (2011) redefined the term by combining three elements from Pearson and Clair's definition. Their three components are the event's rarity, significance, and level of impact on stakeholders. These definitions are more suited to the crisis as an event's point of view. Some scholars, on the other hand, viewed the crisis as a process.

'Processes that are extended in space and time, where a "triggering event" is the result of a long period of incubation; that is, crises occur in phases' (Roux-Dufort, 2016; Turner, 1976; Shrivastava, 1995).

However, a crisis should not be viewed from a single point of view because this may overlook other important issues. On the one hand, the 'crisis as an event' school of thought focuses on the actors' reactions to a previously rare and unexpected event while ignoring the other factors. The process perspective, on the other hand, focuses on areas such as internal and external environments, processes, crisis evolution, and organizational response. To comprehend a crisis and provide a better response, a comprehensive examination of the actors' reactions and contextual factors, as well as the process, is required.

Scholars are also looking at crisis from a cross-sectoral and cross-border standpoint. According to Boin et al (2010), a crisis is transboundary when it crosses a political boundary (border, political jurisdiction, etc.), a functional boundary (sectoral jurisdiction), and time boundaries (Head; 2008; Ansell et al., 2010; Fimreite et al., 2014).

To summarize, an organizational crisis is a known but sudden and unexpected external event with transboundary dimensions that has a significant impact on the organizational capacity and its stakeholders. Whatever the nature of the crisis, it has definite consequences for organizations, both public and private. This study, on the other hand, will concentrate on public-sector organizations, with a particular emphasis on health-care organizations. Some scholars also argued that because there is no agreement on the definition of the term crisis, management research on the crisis has been limited (Boin, 2004; Perry & Quarantelli, 2005).

2.3.2 Effect of a Crisis on Organization

A crisis, regardless of its nature or scope, has traditionally been viewed as a negative event for an organization. Some academics believe that a crisis is disastrous for both organizations and individuals (Mitroff, 1988). Some of them contended that a crisis results in the loss of human lives, money, and reputation (Lalonde, 2007a; Mitroff, 2002; Nathan, 2000; Newkirk, 2001; Pearson & Mitroff, 1993). Similarly, Mitroff, Pearson, and Pauchant (1992) asserted that a crisis "affects a system but also has a threatening effect on its basic assumptions, subjective sense of self, and 'existential core.'" Furthermore, some other thinkers have stated that a crisis can have a

severe impact on human resources in terms of emotional, physical, and behavioral aspects (Barnett & Pratt, 2000; Mitroff, 1988).

Though scholars claim that crises have negative effects on systems, organizations, and individuals, the nature and pattern of those effects may differ depending on whether the crisis is external or internal, natural or induced by humans.

Contrary to popular belief, a group of academics believes that crises are not always negative or bad. A crisis, according to Mishra (1996), can have either positive or negative organizational outcomes. According to a study conducted in 2010 on 97 organizations in Turkey's Malatyas Organized Industry Region (OIR), the crisis may have three positives and two broad impacts (zdemir & Onur Balkan, 2010). They contended that the positive impacts are organizational change, potential revealing, and organizational learning, while the negative impacts are managerial issues and decreased effectiveness and productivity.

In contrast to the two-dimensional belief, some scholars claim that the crisis effect is dependent on management skill. They argued that if a crisis is not managed efficiently, it can lead to decision-making problems, mistrust among managers, staff, and stakeholders, and panic among organizational staff (Kovoor-Misra, 2001), and that if it is not managed efficiently, it can ‘'reveal organizational problems, gain skills for change adaptation, developing new strategies and to gain competitive advantage and helps questioning usual management understanding" (Tutar, 2001)”

However, whether the effects are positive or negative depends on the context of both the crisis and the organizations. Existing literature focuses primarily on natural disasters and catastrophic incidents. As a result, specific knowledge on the impact of human-caused and transboundary crises such as refugee influxes must be identified through additional research. The global crisis management and response scenario must be reviewed in order to understand and address the crisis's impact on organizations.

2.3.3 Crisis Management and Response: Global Evidence and Lessons

Catastrophes, disasters affecting public health, security, and so on, are increasingly putting nation states and public sector organizations to the test (Deverell, 2010). Terrorist attacks on the World Trade Center in 2001 and Mumbai in 2008, Hurricane Katrina, the 2004 Southeast Asian Tsunami, and SARS in 2002 are examples of major crises. As a result, major crisis management researchers limited their empirical research to such disasters (Deverell, 2010a).

According to the literature, studies on the topic are mostly focused on some areas such as decision making, psychological issues, the role of leadership and teams, and identifying the cause and effect of crisis management amongst others.

The initial public-sector studies focus on the decision-making of political leaders and bureaucrats in relation to US foreign policy (Paige, 1968; Allison, 1971; Hermann, 1972, George, 1980; Hermann, 1963; Jervis, 1976; Khong, 1992). Some researchers concentrated on psychological aspects of crisis management, as well as the decision-making process (Kaufman & Kaufman, 1998; Stern, 1999; Hermann, 1979; Staw et al, 1981; Svedin, 2009).

Aside from these, some theory on crisis management was developed as a result of natural disasters (Fritz, 1961; Quarantelli, 1978; Britton, 1988; Rodriguez, Quarantelli & Dynes, 2006). Additionally, a large number of studies on industrial accidents/incidents have also been conducted (Shrivastava, 1987; Pauchant & Mitroff, 1992; Roux-Dufort, 2007).

On the contrary, some scholars have emphasized the importance of focusing on non-dramatic social science events in order to develop a new theory (Seeger et al, 2003). However, available literature demonstrates that there are few studies on crisis management from an organizational standpoint (Roux-Dufort, 2007). It should also be noted that existing studies on organizations deal with planning, resilience, and preparedness (Pauchant & Mitroff, 1992; Rosenthal et al, 2001; Pearson, Roux-Dufort & Clair, 2007). Besides these, some scholars also conducted research on organizations from the crisis management perspective. Dekker and Hansen (2004), for example, conducted a study on Sweden and the Netherlands and discovered that politicization plays little or no role in organizational learning during crisis in Sweden and the opposite situation in the Netherlands. Similarly, Hensen (2007) argued that during crises, the hard work of policy entrepreneurs, have a positive effect on post-crisis policy change. Some

studies looked at how crisis management affects the implications for learning from crisis events (Birkland, 1997; 2006; Boin et al, 2005; ‘t Hart & Boin, 2001; Carley & Harrald, 1997; Boin et al, 2008).

Recent organizational studies on crisis management have focused on coordination, cooperation, the leadership role, and teamwork. Coordination, according to some scholars, has been identified as both a failure and a solution factor in crisis management (Boin & Bynander 2015; Rhinard et al. 2013). Similarly, some studies asserted that coordination is an unavoidable requirement when dealing with a crisis (Kettl, 2003; Brattberg, 2012; Boin & Bynander, 2015a). Furthermore, Ansell et al. (2010) argued that coordination is more important in complex and transboundary crises. In another study, Christensen et al. (2015) found no discernible direct relationship between crisis management structures, coordination arrangements, and processes in a study of six European countries. They also claimed that coordination quality is not directly related to organizational structure and that organizational culture plays a larger role in crisis management than coordination.

Leadership and crisis management have been the focus of some scholars (Simpson, Clegg & Cunha, 2013; Roux-Dufort & Lalonde, 2013; Van Wart & Kapucu, 2011; Brockner & James, 2008; James et al., 2011). Some studies asserted that leadership styles matter in effective organizational response (Bundy & Pfarrer, 2015; Stam, Van Knippenberg, Wisse & Pieterse, 2016). Leadership ability to detect the crisis signals and make proactive actions are effective means of addressing the crisis (Rerup, 2009). In addition to that Roux-Dufort (2009) argued that ignorance of the leaders about the organization’s vulnerability resulted in major dysfunctions. On the contrary, Bundy and Pfarrer (2015) argued that in crisis management, effectiveness of leadership depends on factors like nature and stage of the crisis. In the same fashion, Coombs and Holladay (2001) claimed that leadership reaction to crisis is sometimes influenced by the extent of the preparation and this eventually affects the nature of the crisis response.

In addition to that some scholars also focused on the appropriate leadership style for effective crisis response as they claimed that in hierarchical culture, transformational leadership is more effective than transactional and directive leadership for both external and internal crisis response (Bowers et al., 2017)

Studies on crisis teams have primarily focused on the nature and techniques of the crisis management team in dealing with the crisis (Mitroff & Pearson, 1993; Sapriel, 2003; Pearson & Sommer, 2011). According to some researchers, the effectiveness of a crisis response is determined by the quality and nature of the training provided to members of the crisis management team (Undre et al., 2007; Young, 1998). Others have argued that the collective and shared understanding of the team members influences crisis response quality (Rentsch & Klimoski, 2001; Smith-Jentsch, Campbell, Milanovich, & Reynolds, 2001). Similarly, some studies have discovered that the composition of a team influences effective management (Kaplan, Laport, & Waller, 2013).

Furthermore, numerous studies on crisis management from a strategic standpoint have been conducted (Ulmer, 2001; Boin et al, 2005; Brockner & Hayes James, 2008). On the other hand, there is a scarcity of research on operational units in organizations with a focus on crisis response. However, studies on safety cultures, such as High-Reliability Organization (HRO) theory and Normal Accident Theory, cover operational units in particular with regard to responsiveness to threats, risks, and common incidents (Roberts, 1990; Dufort & Metais, 1998). However, research on the operation unit's response to crises is limited (Roe & Schulman, 2008; Flin, 1996; Klein, 1993; Weick, 1993).

More importantly, there has been very little research on the perspective of health sector organizations. Having said that, there are few studies that focus on crisis management in the health sector. For instance, Lin (2013) argued, based on a study conducted in Taiwan, that hospital business uncertainty has a positive correlation with the improvement of the crisis management system. He also asserted that the organizational culture in public hospitals is not conducive to the effective operation of the crisis management system. This notwithstanding, evidence of effective crisis response is required for the study. As a result, the following section will concentrate on crisis response issues, with a particular emphasis on public sector organizations.

2.3.4 Crisis Management Process and Response

Various scholars have approached crisis management and response mechanisms from various angles. However, for the purposes of this research, organizational crisis management and

response will be the primary focus. Organizational crisis management is defined as “a systematic effort by the organization's personnel and other relevant stakeholders to minimize crises or effectively manage those that do occur” (Pearson & Clair, 1998).

Different scholars have classified the crisis management process into phases. Comfort (1988) distinguished four stages: mitigation, preparedness, response, and recovery. Similarly, other studies have identified a variety of crisis response steps such as a) signal detection (b) preparation/prevention (i.e., planning) (c) containment/damage control (d) business recovery, and (e) learning (James &Wooten, 2010; Pearson & Mitroff, 1993; Schneider, 1992; Waller, Lei & Pratten, 2014). This model has been updated to incorporate a new component called "redesign" (Mitroff, 2005; Hutchins & Wang's, 2008). On a different note, some scholars have divided the crisis management process into five segments based on the critical challenges namely: “sense making, decision making, meaning making, terminating, and learning” (Boin, ‘t Hart, Stern, & Sundelius, 2005).

It has been discovered that the effectiveness of the crisis response is dependent on the interpretation of the event, the quality of decision making under high uncertainty, and the quality of response strategies (Jackson & Dutton, 1988; Maitlis & Sonenshein, 2010; Anderson, 1983; Smart & Vertinsky, 1977; Tjosvold, 1984; Bechky & Okhuysen, 2011; Kahn, Barton, & Fellows, 2013). Similarly, research has shown that effective crisis response necessitates improved decision-making, role enactment, resource identification, and mobilization capacity (Drabek, 1985; Stallings & Quarantelli, 1985; Webb, 2004; Neal & Phillips, 1995; Shepherd & Williams, 2014). Furthermore, according to Boin et al. (2010), responding to a transboundary crisis necessitates distributed analytical capacity, surge potential, coordinated behavior, and special authority arrangements.

Although studies of crisis management in public administration using organizational theory are uncommon, there are a few notable studies (Christensen et al, 2016). Petak (1985) in his study on emergency management argued that crisis response is complex in nature and an effective response requires social, administrative, political, legal, technical and economic factors to be considered with importance.

In his study on the 9/11 terrorist attack, Hammond (2007) claimed that state and local governments failed in terms of prediction, policy implementation, capability, and management.

He also contended that such a "crisis management effort" entails various trade-offs and that government should be organized differently. Similarly, studies conducted in the United States following Hurricane Katrina discovered that crisis response can be ineffective when there is a lack of preparation, a lack of emergency management knowledge among public officials, overcentralized decision making, poor communication, and coordination (Farazmand, 2007; Waugh, 2006). Furthermore, according to a study on the Nepal earthquake, proactive and well-defined policy guidelines for crisis management, as well as a proper capacity assessment of the national responding agencies, play a positive role (Shrestha & Pathranarakul, 2018). According to the study, effective communication with relevant stakeholders, including inter-agency communication, has a positive relationship with response.

According to studies, three types of strategic capacity are required to deal with hyper change and unexpected situations in crisis management solutions. They advocated for an adaptive strategy, a service delivery performance strategy, and a development and advancement strategy. The adaptive strategy is comprised of two components: proper responsiveness and reactiveness to perform efficiently and effectively in a changing environment, and pro-activeness, which involves anticipatory internal organizational change to prepare the organization for any unexpected situation (Farazmand, 2009; Argyris, 2004; Stacey, 2001). Similarly, some other scholars asserted that effective crisis and emergency management necessitates serious preventive planning and preparation, institutionalized response systems with a strong central command structure, a well-coordinated network of response and recovery systems, a specialized crisis management team alongside decentralized field commands armed with flexibility, and the presence of a specialized crisis management team. Aside from that, Roberts et al. (2016) suggest that from the perspective of refugee health, effective response is difficult. Language barriers, poverty, a lack of health insurance coverage, unfamiliarity with the health care system, different understandings of illness and treatment, distrust between staff and patients, and a lack of access to the refugee's medical history must all be overcome in order for an effective response to be implemented.

In some publications, the terms crisis response and resilience are used interchangeably. Some researchers concentrate on resilience factors. According to Gittell et al. (2006), one important factor that has a negative impact on resilience is a lack of redundant resources.

Similarly, studies have shown that a lack of infrastructure reduces an organization's resilience (Vogus & Sutcliffe, 2007; Dominelli, 2013). Ebi (2011) has asserted that excessive centralization undermines effective local responses to health risks.

Several studies, on the other hand, have discovered that the number of slack resources is the key to organizational resilience (Weick, 1993; Bruneau et al., 2003). In addition, Vogus and Sutcliffe (2007) argued that, beside slack resources, how financial, cognitive, and relational resources are distributed and utilized is important in promoting resilience. Similarly, Bruneau et al. (2003) asserted that there must be consistency between resource allocation, prioritization capacity, and problem identification. He also claimed that decentralization promotes resilience (Bruneau et al., 2003a). Furthermore, Sciulli et al. (2015) argued, based on a study of local councils in Italy, that financial resources, external relations management with other public entities, and stakeholder management have a positive relationship with resilience during the crisis. They also claimed that bureaucracy and poor urban planning undermine organizational resilience.

Furthermore, Farzmand (2009) proposed five capacity requirements in the face of chaotic surprises and crisis. They are organizing specialized training for key political leaders, developing a cooperative culture of learning and relearning organizations and organizational learning, offering specific study programs on crisis management in universities, organizing regular seminars and workshops for administrators and politicians to disseminate cutting-edge crisis management information, and establishing advanced interdisciplinary teams.

To summarize, the literature on crisis response suggested that developing an effective crisis response requires both soft capacities (decision making, leadership, psychological), as well as hard capacities (resources, infrastructure). In a theoretical sense, an effective response addresses both organizational management and resource capacity. However, the existing literature lacks sufficient evidence on the health sector's response to a crisis such as the refugee crisis. Furthermore, understanding organizational capacity from a public sector perspective is required to capture the organizational response in a crisis situation. As a result, the following section will highlight the capacity of public sector organizations from various dimensions and perspectives.

2.4 Capacity and Capacity Development: Public Sector Organizational Perspective

The study's primary goal is to investigate the impact of the refugee crisis on organizational capacity. As a result, the ideas and concepts of capacity and organizational capacity must be understood from a variety of perspectives in order to explain the impact and factors influencing organizational capacity during crisis events such as refugee influx. The first subsection will address the conceptual clarity of a few terms. The subsections that follow will concentrate on the existing literature on organizational capacity from various perspectives.

2.4.1 Understanding the Term Capacity: Difference from Other Related Terms

The term "capacity" has been used in a variety of academic journals, including Public Administration Review, Public Administration and Development and Organizational Science (Christensen & Gazley, 2008). However, there are few terminologies that are synonymous with capacity, which are frequently used in management and public administration literature namely: capability and competence. As a result, the distinction between the terms must be clearly understood. Despite the fact that the two terms are related and sometimes overlap, they have been defined separately. According to the Cambridge Dictionary, capacity refers to "the amount that something can hold or produce," while capability refers to "the amount that something can hold or produce." Capability is defined as "having the skill, ability, or strength to do something" (Cambridge, 2008). Competence refers to the ability or knowledge to perform a task well enough to meet a basic standard. Scholars define these terms in a variety of ways. The ability to perform appropriate tasks effectively, efficiently, and sustainably is defined as capacity (Grindle & Hilderbrand, 1995). According to Morgan and Hussein, capacity is an individual's or group's general ability to carry out responsibilities and tasks (Hussein, 2006; Morgan, 2006). Yu-Lee (2002) conceptualized capacity as an organization's ability to perform its job in a similar way. Christensen and Gazley (2008) contended that capacity and ability have very similar definitions. Capacity, according to Jurie, is "the inherent endowment possessed by individuals or organizations to achieve their fullest potential" (Jurie, 2000).

Capability, on the other hand, is defined as an individual's or a group's knowledge, skills, and attitudes (Hussein, 2006). It can also be defined as specific abilities that must be gathered in

order to reach the overall capacity. Kaplan (2000), on the other hand, stated that capability would denote the action taken on capacity in order to realize the potential. Capability, according to Jurie, is "the action taken on the capacity for realizing this potential" (Jurie, 2000a). Kaplan and Julie summarized that capacity and capability are inextricably linked.

Competence, on the other hand, has been defined as skills held by individuals within the government who structure parts of the cooperative capabilities and capacity (Morgan & Baser, 2007). According to Wojtczak (2002), from a medical standpoint, competence is a holistic integration of understandings, abilities, and professional judgments. Concurrently, Hope (2009) stated that competence or competency is a component of capacity development and that the two terms are linked.

In essence, capacity, capability, and competence are all related to an individual's or organization's ability to complete tasks in order to achieve the ultimate goals. It is up to the author to highlight the terms in order to express the ability to achieve its goals. Scholars, on the other hand, have explained capacity in organizations, namely organizational capacity, in a variety of ways. The following section will look into issues concerning organizational capacity.

2.4.2 Organizational Capacity: Scholastic Understanding

Regarding the conceptual understanding of organizational capacity, there are several schools of thought. According to Lusthaus, Anderson, and Murphy (1995) and Lusthaus et al. (2002), capacity includes the organization's resources, knowledge, and processes used to achieve its goals. Organizational capacity, on the other hand, includes staffing, physical infrastructure, technology, and financial resources; strategic leadership, program and process management; and networks and links with other organizations and groups. They go on to argue that an organization's personnel, facilities, technology, and funding constitute its resource base and its procedures and processes for managing its resources and programs as well as its external relationships make up its management capacity. They further assert that overall organizational capacity is nothing but the combination of resources and management capacities.

According to some other scholars, organizational capacity includes both tangible and intangible, or quantitative and qualitative dimensions, so it includes not only the number of

personnel but also their technical skills, as well as the strength or quality of organizational leadership (Glickman & Servon, 1998; Chaskin, 2001; Eisinger, 2002; Sowa et al., 2004). Capacity, on the other hand, is sometimes defined as a purely internal organizational quality that includes both human and capital resources, and other times as a concept with both internal and external dimensions (Brinkerhoff, 2005; Forbes & Lynn, 2006). Other scholars, in addition to these, have viewed capacity as a matter of resource acquisition and funding (Kushner & Poole, 1996; Brooks, 2002). Some academics have taken a different approach to the term. For example, Chaskin (2001) defines capacity as "any quality that can hinder or encourage the achievement of organizational objectives." In a separate dimension, organizational capacity is defined as the sum of manager and system quality (Ingraham et al., 2003). In a similar vein, Christensen and Gazley (2008) provided a framework for organizational capacity, stating that capacity is a function of (1) organizational infrastructure, (2) human resources, (3) financial resources and management systems, and (4) external political and market characteristics.

To summarize, it is understandable that organizational capacity deals with an organization's software and hardware, which includes both man and machine. From the system theory perspective, it can be viewed as the desired output produced by utilizing inputs in an efficient manner.

The study's objectives were limited to organizations in the public sector. As a result, the public sector's organizational capacity must be investigated as part of the organizational capacity literature. In line with this, the following subsections will discuss various aspects of organizational capacity from the perspective of the public sector.

2.4.3 Public Sector Organizational Capacity: What Do We Know?

According to existing literature, capacity focus varies depending on the nature of the organization. As a result, organizational capacity can be viewed from the perspective of the public and non-profit sectors, as opposed to profit-making or business organizations.

Organizational capacity in the public sector refers to a government's ability to organize, develop, direct, and control its financial, human, physical, and information resources (Ingraham et al., 2003). Painter (2000) highlighted in this context that effective or good capacity can be divided into three aspects: state, policy, and administrative, implying that the first two capacities

involve not only the government but also social and economic power. And administrative capacity is the effective management of human and physical resources required for effective government outputs. Grindle and Hilderbrand (1995) defined public service capacity in a similar context as the combination of professional knowledge and a delivery system with "the ability to perform appropriate tasks effectively, efficiently, and sustainably." Huque et al. (2013), on their part, classified public service capacity into three levels. The first is individual level capacity, which is made up of individual skill and knowledge. Second, there is the issue of institutional capacity. They defined institution as a specific organization or arrangement that serves as a framework for combining individual capacities in order to achieve the goals. The third is the capacity of the entire society, in which all segments of citizens who contribute to various values are brought together through networking and cohesion.

Again, Ingraham et al. (2003) suggest that the quality, characteristics of management systems, leadership, and results focus are important components of organizational capacity in the governmental context. According to Eisinger (2002), the critical elements of capacity are resources, effective leadership, skilled and sufficient staff, institutionalization, and external linkages. Bryan (2011), on his part, identified six dimensions of capacity. He asserted that the key dimensions of organizational capacity are human resources, financial resources, information technology, knowledge, stakeholder commitment, and collaboration.

Capacity, on the other hand, refers to a set of management practices and processes that assist a non-profit organization in achieving its mission (Letts et al., 1999; Eisinger, 2002). Because the concept of organizational capacity encompasses a wide range of dimensions, Bryan (2011) identified and classified different approaches of scholars into three perspectives which are resources, capabilities, and outcomes.

Table 4: Perspective and concept of capacity

Perspective	Concept
Resources	Capacity is understood as inputs into a production process that result in the basic ability of an organization to do its work; Attracting resources from the environment (including human, financial, technical, knowledge resources); Resources can be characterized as both tangible and intangible (Honadle, 1981; Wernerfelt, 1984; Barney, 1991; Frederickson & London 2000; Ingraham, Joyce et al., 2003; Christensen & Gazley 2008).
Capabilities	Capacity is understood as the ability of organizations to absorb and mobilize resources in specific ways that produce an organizational capability; Basic know-how of the Organization; Transforms resources into Organizational output; Understood in Public Management literature as management capacity (Honadle, 1981; Teece, Pisano, et al., 1997; Ingraham, Joyce et al. 2003; Helfat, Finkelstein, et al. 2007; Harvey, Skelcher, et al. 2010).
Outcomes	Capacity is understood as those organizational resources and capabilities that are related to organizational effectiveness; Output-based understanding of capacity; The assumption is that organizations can assess their capacity by looking at what organizational attributes positively impact organizational Performance (Ingraham, Joyce et al. 2003; Bryson 2004; Sowa, Selden et al.2004; Laurence J. O'Toole and Meier 2010)

Source: Extracted from Bryan, 2011.

Organizational Capacity: Resources Perspective

Many organizational theorists have emphasized the significance of acquiring resources from the environment in order to improve organizational capacity. Open system organizational theories, in particular, emphasize the importance of being able to attract and obtain a variety of resources from the environment in order to survive as an organization (Bryan, 2011). Furthermore, from a strategic management standpoint, resources play an important role in an organization's life cycle. Some academics regard resources as inputs into an organization's production process (Honadle, 1981; Ingraham, Joyce, et al. 2003; Helfat, Finkelstein, et al. 2007; Christensen & Gazley 2008).

These resources, however, are divided into two dimensions. They consist of both tangible and intangible resources. Tangible resources, such as financial, physical, and technological resources, can be quantified. Leadership, skill, reputation, external linkage with other organizations are examples of intangible resources and are unmeasurable.

For public sector organizations, the resource view of capacity is more important because an organization cannot achieve its goals without adequate resources. It is not enough to simply amass resources. These resources must be effectively managed and utilized.

Organizational Capacity: Capabilities Perspective

Scholars assess organizational capacity based on its ability to use its resources. Some academics define organizational capacity as the ability to effectively absorb and manage resources (Honadle, 1981; Teece, Pisano, et al. 1997; Ingraham, Joyce, et al. 2003). Dees et al. (2007) define organizational capabilities as the ability to transform inputs into outputs and to sum up both tangible and intangible resources for achieving ultimate goals. According to Helfat et al., 2007, organizational capability is the ability to perform a coordinated set of tasks while utilizing organizational resources for the purpose of the end result. In the public administration, literature organizational capabilities can be understood as looking at the organization as a black box (management capacity) where inputs are transformed into outputs (Ingraham, Joyce et al. 2003).

From the literature, it is clear that the resources alone do not constitute capacity. To make a complete package of capacity it is important to have the right kind of ability to absorb and mobilize resources in specific manners.

Organizational Capacity: Competency Perspective

Organization scholars have been eager to see organizations, regardless of their nature, become more effective and efficient. As a result, capability and resources aren't the only pieces of the capacity puzzle. Organizations needed competency to produce efficient and effective results. A large number of academics have emphasized competency as an important aspect of organizational capacity. According to Bryson (2004), competency is an organization's ability, a set of actions, and strategy to perform well on its key success factors. Others, on the other hand, have argued that capacity is a measure of potential effectiveness (Ingraham, Joyce, et al. 2003;

Sowa, Selden, et al. 2004; Laurence J. O'Toole & Meier 2010). Furthermore, according to O'Toole and Meier (2010), capacity is the organization's potential for actions but not the actions that are currently in place.

This capacity perspective is concerned with determining how and in what ways organizational effectiveness can be influenced by structures, operating processes, and managers. However, it appears that the outcome measurements are complex in nature and may differ from one organization to the other.

2.4.4 Public Sector Organizational Capacity: Categorization Based on Literature

A review of the literature reveals that organizational capacity is a multifaceted issue. Various scholars classified organizational capacity based on a variety of factors. Scholars have identified various capacity structures that include a wide range of categories (Frederickson and London 2000; Eisinger 2002; Ingraham, Joyce, et al. 2003).

Based on a review of the literature, organizational capacity can be classified into the following types:

Table 5: Types of Organizational Capacity

Type	Focus	Components
Management	Ability to effectively utilize the available infrastructure and resources	Leadership, strategies, skill, etc
Infrastructure	Organization's administrative and operational capacity	All basic systems and process and procedure like Human Resources Management system, financial management system, information management system, etc.
Adaptive	Ability to learn and utilize the learning	Leadership commitment, the scope of experimentation, knowledge transfer and integration
Absorptive	Ability to absorb new knowledge with their structures and processes	Knowledge acquisition, knowledge assimilation, and knowledge codification
Collaboration	Ability to make effective linkage and relationship with the external environment and organizations for better performance	Access to more financial and non-financial resources, Increased reputation and credibility

Source: Author's construct, 2021

Management Capacity

Management capacity is defined by public management scholars as an organization's management's ability to use all other capacity and available resources to achieve organizational goals (Ingraham, Joyce, et al. 2003; Andrews & Boyne, 2010; Krueathep, Riccucci, et al. 2010; Laurence J. O'Toole & Meier 2010). According to Ingraham, Joyce, et al. (2003), organizational management can positively influence performance by providing proper and visionary leadership, aligning and integrating management systems, and implementing an effective performance management system. Similarly, Lusthaus et al. (2002) asserted that the management component includes process and procedure, leadership, and network management.

Some academics have conducted empirical research on management capacity. According to O'Toole and Meier (2010), management capacity can help organizations adjust to environmental shocks and minimize negative effects on organizational outputs.

Andrews and Boyne (2010) provide a more robust model that links managerial capacity with leadership and performance by incorporating multiple capacity measures for management systems such as capital management, information technology management, human resource management, and financial management.

Other researchers have focused on managerial characteristics to better understand management capacity. In their study on the determinants of network formation in local governments, Krueathep et al. (2010) framed management capacity as a function of managerial experiences, responsibilities, and attitudes.

To summarize, it can be argued that existing scholarship on management capacity has placed a greater emphasis on internal management skill. However, in the age of collaborative governance, efficient management of external interactions is just as important as efficient management of internal interactions because organizational performance is heavily reliant on interactions with other external organizations.

Organizational Infrastructure Capacity

Organizational infrastructure is a critical component in establishing capacity (Bryan, 2011). This type of capacity is also known as administrative and operational capacity. Some academics refer to it as a resource management capability (Burgess, 1975). Human resources

management system, financial management system, property management system, and IT management system are all examples of infrastructure capacity. According to Ingraham, Joyce, et al. (2003), support services such as human resources, information technology, and financial management services, as well as administrative processes, form the foundation of public organizations.

In a study, Eisinger (2002) discovered that paid staff and the presence of administrative routines such as record computerization contributed positively to organizational effectiveness. Furthermore, Frederickson and London (2000) found that operational support, such as staffing, is important in organizational performance in their study on community development organizations.

Adaptive Capacity

One of the major areas of concern for organizational thinkers has been organizational knowledge and learning. According to some scholars, an organization's ability to learn and apply that learning in existing organizational processes is a core capability that can improve organizational performance (Hult & Ferrell 1997; Jerez-Gomez, Cespedes-Lorente, et al. 2005; Ekboir, Dutrenit, et al. 2009). Adaptive capacity is a component of the organization's knowledge and learning capacity.

The ability of an organization to learn and respond to a changing environment is referred to as adaptive capacity. Armitage (2005) defines adaptive capacity as the ability to experiment with and foster innovative solutions to complex problems. Similarly, Jerez-Gomez et al., (2005) argued that adaptive capacity is an organization's resource for creating, disseminating, and integrating knowledge for improved performance. Capacity, on the other hand, is viewed as a combination of various elements such as managerial commitment, a systems perspective, openness to experimentation, and knowledge transfer and integration (Ferrell & Hult, 1997, Jerez-Gomez et al, 2005).

Leadership with a high level of commitment is essential for adaptive organizations. Aside from this, experimentation flexibility is essential, as is knowledge sharing through training, seminars, or dialogue.

According to the literature, adaptive capacity is more prone to business organization due to its identified characteristics. However, it can be stated that public sector organizations can have adaptive capacity by demonstrating more and more success and failure factors, as well as sharing experience among organizations and even departments within an organization.

Absorptive Capacity

Almost identical to the concept of adaptive capacity, absorptive capacity is concerned with how an organization absorbs new knowledge through its structures and processes (Bryan, 2011). According to some scholars, it is the ability of an organization's existing routines and processes to improve, adjust, and apply new knowledge (Cohen and Levinthal 1990; Lane and Lubatkin 1998; Van den Bosch, Volberda et al. 1999; Zahra and George 2002; Zollo and Winter 2002; Harvey, Skelcher et al. 2010). In a similar vein, Zahra and George (2002) defined this type of capacity as a set of ongoing organizational processes and systems through which an organization acquires, assimilates, transforms, and utilizes knowledge. Furthermore, Harvey et al. (2010) defined absorptive capacity as an organization's internal knowledge process ability to effectively align its competencies in response to changing environmental conditions. Furthermore, several scholars have identified absorptive capacity as an active capability (Zollo & Winter 2002; Harvey, Skelcher, et al. 2010) that provides critical information to managers who can modify the organizational resource base for organizational learning.

Based on literature, absorptive capacity can be characterized by some organizational processes which are knowledge acquisition process, knowledge assimilation process, and knowledge codification process (Cohen & Levinthal, 1990; Zahra & George, 2002; Zollo & Winter, 2002).

To summarize, the literature on absorptive capacity has focused on internal processes and routines, whereas public sector organizations are now operating in network approaches with multi-sector partners, implying that networked or partnership processes must be considered for a comprehensive conceptualization of absorptive capacity.

Collaborative Capacity

In an era of increasingly complex organizational issues, even public-sector organizations are collaborating with other public-sector or non-profit organizations. Even government agencies are now forming public-private partnerships. As a result, public and non-profit scholars have increasingly focused their attention on the dynamics of collaborative processes, including capacity issues (Sandfort, 1999; Bardach, 2001; Foster-Fishman, Berkowitz et al. 2001; Page 2003; Page, 2004; Bryson, Crosby et al. 2006; Thomson, Perry et al. 2007; Weber, Lovrich et al. 2007; Ansell & Gash 2008; Getha-Taylor, 2008; Sowa, 2008; Weber & Khademian 2008; Nowell, 2009; Sowa ,2009; Nowell, 2010).

This collaborative capability can be examined from three different angles. Individual perspective, organizational perspective, and inter-organizational perspective are the three types. According to Getha-Taylor (2008), managers with high levels of interpersonal understanding, as well as those who actively encourage teamwork and cooperation, are more successful in collaborative efforts. Other scholars emphasized the importance of individual public managers' collaborative competency in order to improve collaboration (Foster-Fishman, Berkowitz, et al. 2001; Getha-Taylor 2008; Weber & Khademian, 2008). However, for the purposes of this research, organizational and inter-organizational collaboration will be highlighted. Some literature emphasized how participation and involvement in collaborative efforts can affect an organization's capacity (Sandfort 1999; Hardy, Phillips, et al. 2003; Arya and Lin 2007; Sandfort and Milward 2008; Sowa 2009). Other scholars, on the other hand, have focused on motivational issues in terms of organizational collaboration (Bryson, Crosby, et al. 2006; Ansell and Gash 2008; Sowa, 2009). They contended that collaboration is beneficial to organizations. Similarly, Sandfort and Milward (2008) contend that collaboration can benefit service delivery organizations by providing access to more resources and expanding client services. Literature has demonstrated that there are some key factors that enhance organizational collaboration and these are access to increased financial resources, increased non-financial organizational resources, and increased credibility and reputation (Hardy, Phillips, et al. 2003; Arya & Lin 2007; Sandfort & Milward 2008; Sowa, 2009).

Existing literature concentrated on the dimensions and factors that influence collaborative capacity. However, knowledge of collaborative capacity development in a crisis and challenging situation must be thoroughly researched and comprehended.

2.4.5 Organizational Capacity from Public Health Sector Perspective

Organizational capability is a multifaceted concept. Capacity can be viewed from various angles, even from different sectors. According to the literature, organizational capacity can be viewed through the lens of the public health sector. According to WHO (2001), "capacity of a health professional, a team, an organization, or a health system is the ability to perform the defined functions effectively, efficiently, and sustainably, so that the functions contribute to the team's, organization's, and health system's mission, policies, and strategic objectives." The WHO perspective appears to be more focused on competency. Similarly, Goodman et al. (1998) argued that capacity in the health sector is the ability to carry out the organizations' stated objectives. Organizational capacity in the health system, on the other hand, refers to the structure, processes, and management system that enable a specific health-related organization to perform effectively and adapt to a changing environment (Lafond et al., 2002). It includes an organization's human, physical, and knowledge resources, as well as the processes used to convert these resources into services. Furthermore, Potter and Brough (2004) viewed health sector organizational capacity as a pyramid in which system, structure, and role form the foundation for the effective and gradual use of staff, infrastructure, skills, and tools. They emphasized nine dimensions of capacity for organizations in the health sector. These dimensions are presented below:

1. Performance capacity: The organization's ability to produce an effective final output;
2. Personal capacity: an organization with the right kind of skilled and motivated manpower;
3. Workload capacity: enough staff and practical job description;
4. Supervisory capacity: robust monitoring system with effective incentives and sanctions provision;
5. Facility capacity: appropriate kind of hospital and training institutions;
6. Support service capacity: effective laboratories, administrative, research facilities required for the organization;

7. Systems capacity: effective internal external management process;

8. Structural capacity: effective decision-making system; and

9. Role capacity: well-described role and effective authority at different levels with the sector.

However, in terms of jurisdiction and overlapping in the same cases, the dimensions appear to be too narrow. System capacity and structural capacity, for example, are more or less overlapping and difficult to distinguish.

Furthermore, some other scholars define organizational capacity in the health sector using different constructs (Meyer et al., 2012; Mays et al., 2009; Handler et al., 2001). They contended that there are eight organizational capacity constructs for public health. They are as follows:

i. Fiscal and economic resources: budget, sources of revenue, funding mechanism, etc.

ii. Workforce and human resources: number of employees, skill, training, motivation, compensation, etc.

iii. Physical infrastructure: office, equipment, communication tools, transportation, etc.

iv. Inter-organizational relationship: Breadth/diversity of partners, density and strength of relationships, Status of relationship, the direction of benefit or degree of reciprocity, collaboration, etc.

v. Data and informational resources: E-mail/Internet access, IT support, data, and information sources.

vi. System boundaries and size: geopolitical jurisdiction, the structure within the broader system (e.g., federal, state, local), community attributes

vii. Governance and decision-making structure: governance structure, centralization/decentralization, the local board of health, type of jurisdiction, standard operating procedures

viii. Organizational culture: planning and development, strategy/strategic plan, fit (goals, norms, needs), leadership, Adaptation, innovation, human resources management.

Health sector capacity and service delivery in a crisis situation has been viewed differently by some scholars. A study conducted on Syrian refugees in Lebanon identified four major factors that enabled health sector capacity to respond (Ammar et al, 2016). The factors are (i) networking with stakeholders (ii) diversification of the health system that provided for adequate

infrastructure and health human resources (iii) a comprehensive communicable disease response and (iv) the integration of refugees into the health system. Similarly, a qualitative study conducted on Syrian refugees in Greece in 2017 claimed that the major challenges in terms of health service delivery are narrow model of health service delivery, inadequate referral mechanism for social support and mental health service, language and gender difference between the refugees and the health service providers and insufficient space and lack of privacy in the clinics (Farhat et al., 2018).

On the other hand, research indicates that some academics are more concerned about surge capacity during a crisis. Surge Capacity, as defined by Hick et al. (2009), is the ability to manage a sudden, unexpected increase in patient number. According to them, there are four critical factors for surge capacity and these are the system, the space, the staff, and the supplies. The factors can be measured on three levels: conventional capacity, contingency capacity, and crisis capacity (Hick et al., 2009). They described three types of surge response. They are facility-based surge capacity and community-based surge capacity, which refers to the establishment of off-site treatment facilities as well as the development of a unified coordination command mechanism to manage the operations of various agencies and health care facilities. Likewise, Barbera and Macintyre (2002) asserted a six-tier response system. The tiers are facility-based surge capacity, coalition building among health care providers, jurisdictional incident management system development, regional incident management system development, and state and federal incident management system development.

Additionally, Traub et al. (2007) have argued, based on an Australian study, that surge capacity for hospitals is a symbol of the ability to deliver emergency care to both critical and non-critical mass casualties at the same time and is a symbol of the capability to deliver emergency care in a disaster situation. However, plethora of literature on public health sector capacity is concerned with capacity dimensions, types, elements, and challenges. Consequently, the factors affecting the capacity of health-care organizations during crisis are limited, as is information about the impact of crisis events on public-health-care organizations. As this study is conducted on health service providers in Bangladesh with a focus on the Rohingya influx, the overall health sector capacity in Bangladesh is assessed. In line with this, the following subsections will provide some background information on the health sector in Bangladesh.

2.4.6 Health Sector Capacity in Bangladesh

Research shows that, the health sector in Bangladesh has faced a number of challenges. Health care in Bangladesh is provided by either government-run hospitals or privately run clinics. Bangladesh continues to lag behind in providing health care services to both the poor and the wealthy (Mahmud, 2011). The dominant form of provision in developing countries is frequently a network of formal and informal private facilities and practitioners. It is estimated that in developing countries, private physicians account for 55% of the total number, while in Asia, the figure rises to 60% (Hanson & Berman, 1998).

According to the most recent Bangladesh Health Facility Survey (BHFS) 2014, basic diagnostic capacity in health facilities is low in most cases, while a small fraction provides high-end services. Only one out of every ten facilities have provision for the most common blood test (haemoglobin); other tests are even more scarce in all facilities. Advanced diagnostic tests are limited and no-good value for resources invested (maximum four percent). Only around twenty-five percent of health facilities in Bangladesh have some basic equipment, such as stethoscopes, thermometers, blood pressure apparatus, an adult weighing scales, and child or infant weighing scales. However, the most critical challenge faced by the health sector in Bangladesh is an acute shortage of skilled human resources resulting in health tourism by the affluent.

Sixty-two percent of physician positions are filled at district and Upazila facilities, whereas less than one-fourth of the sanctioned positions at union level facilities are currently filled (BHFS, 2014). Only four in ten facilities that offer child curative care have all four basic types of primary care equipment such as scales, measuring boards, thermometers, and stethoscopes (BHFS,2014). Among facilities that offer Antenatal Care (ANC) services, twelve percent can test for haemoglobin, nineteen percent for urine protein, and eighteen percent for urine glucose.

Bangladesh has one of the world's largest deltas, covering an area of 147,570 square kilometers. According to the Bangladesh Bureau of Statistics (BBS) Statistics Pocketbook, the country has a population of approximately 158.9 million as of July 2015 (BBS, 2016), making it one of the world's most densely populated countries (1,077 per sq.km). The projected population for 2016 was 160.221 million people (Projected population in a scenario as described in "Population Projection of Bangladesh, Dynamics, and Trends: 2011-2061", BBS, available at

www.bbs.gov.bd). According to the Bangladesh health system review (WHO, 2015), Bangladesh's health workforce is characterized by "shortage, inappropriate skill mix, and inequitable distribution." The country currently has 64,434 registered doctors, 6,034 dentists, 30,516 nurses, and 27,000 nurse-midwives. Furthermore, the health workforce is skewed toward doctors, with a doctor-to-nurse-to-technologist ratio of 1:0.4:0.24, compared to the WHO-recommended ratio of 1:3:5. The involvement of the health workforce in the private sector has grown over time, with an estimated 62 percent of medical doctors working in the private sector in 2013. The formal health workforce (doctors, dentists, nurses) is mostly concentrated in cities, with regional variations. In rural areas, two major issues are retention and absenteeism (WHO, 2014). Absence of key health human resources (physicians) frequently exacerbates the situation. In health complexes, there is also a severe shortage of drugs, supplies, other medical facilities. As a result, only 25% of the population has access to a publicly funded health-care system (WHO, 2014).

Under the above scenario, Rohingya Crisis becomes additional pressure for the health sector organization operating in Cox's Bazar district**.** Since August 2017 the health facilities in Cox's Bazar and surrounding areas have reported a 150–200% increase in patients, overwhelming the current capacity and resources (WHO, 2018). The Inter-Sector Coordination Group (ISCG, 2018) has argued that the health sector remains seriously under-funded and this has affected the provision of quality service. Further, adherence to the valid minimum package of primary health services remains inconsistent. Programming for non-communicable diseases, malaria, TB, and HIV/AIDS remains lean. Again, the ISCG argued that partners working in this area are struggling to scale up twenty-four hours service which is critical for emergencies. It also found important gaps in health service provision like surgical capacity, availability of medicine, and psychological specialists. It therefore concludes that the gaps in surgical capacities might create a significant barrier to saving lives in the event of natural disasters.

The literature focuses on the overall challenges under the circumstances, but does not address the capacity issues of health sector organizations. As a result, in the case of public sector organizational issues with reference to the health sector, understanding is required for developing capacity-related knowledge in a similar context.

2.5 Capacity Development: Health Sector Perspective

Scholars have approached the concept of capacity development in a variety of ways. In general, capacity building refers to a process or activity that improves a person's, organization's, or entity's ability to "carry out stated objectives" (Lafond et al, 2002). Scholars have asserted that, capacity development should concentrate on management technology, leadership skills, organizational change, decision making, diversity management, cultural competence, program monitoring and accountability, financial management, personnel administration, and supervision (Dolan, 2002; Fong & Gibbs, 1995; Gutierrez, Kruzich, Jones, & Coronado, 2000; Hyde, 1998; Perlmutter, 1988). They emphasized the significance of capacity development over its measurement.

However, for the purposes of this research, we will focus on capacity development in the health sector. According to Lafond et al. (2002), health system capacity is a complicated concept. Several characteristics of capacity building in the health sector have been identified in studies conducted around the world.

According to Lusthau et al. (1995), capacity building is a continuous process of improvement at the individual, organizational, and institutional levels in order to provide better or improved health services. Capacity building has also been defined as a process of improving functions at the individual, organizational, or institutional levels with the assistance of an outside group or entity (Taschereau, 1998). These academics regard capacity development activities as an internal process. On the other hand, the term is sometimes used to refer to an external intervention rather than internal processes aimed at improving specific skills such as supervisory abilities and financial management skills (Kotellos et al., 1998; Lusthaus et al., 1995). External assistance, according to them, takes the form of technical assistance, training courses, and financial assistance. In a broader sense, some scholars proposed three levels of capacity building in the health sector, namely the system, organizational, and human resource or health program personnel (Brechin et al., 1998; Fort, 1999; Kotellos et al., 1998; Lusthaus et al., 1995; Paul, 1995). Others have added community level capacity development to the three identified earlier (Lafond et al. 2002). Nonetheless, most of the capacity development measures in the health sector are concentrated within the organizational and personal levels (Lafond et al., 2002). Other

scholars, however, have claimed that capacity building can be implemented through four main approaches, which include (a) a top-down organizational approach through policy change (b) a bottom-up organizational approach through training or skill development (c) a partnerships approach that involves strengthening relationships between organizations; and (d) a community organizing approach (Crisp et al., 2000; McLaughlin et al., 1997).

There are limited resources available to identify customized capacity development issues in the context of refugee crisis. However, Kherallah et al. (2012) discovered that during the Syrian refugee crisis, data management capacity, governance capacity such as transparency, coordination capacity, and human resource management capacity must be developed. WHO (2012) suggested the following capacity development areas during disaster and crisis: a) service delivery, b) health workers, c) health information, d) medical products, technology, and vaccines, e) health finance, and f) governance and leadership.

To summarize, the literature on health sector capacity development appears to be generic in nature. Learning to customize knowledge of capacity development for health sector organizations in the context of refugee influxes is still an area that needs to be explored further. Existing knowledge, on the other hand, can aid in the development of a capacity development framework for the purposes of the study. However, some specific theoretical lenses is important to discuss in order to validate the findings.

2.6 Some Additional Theoretical Perspectives for Discussion and Analysis

In addition to the literature reviewed above, certain additional thematic areas have been discussed in the discussion and analysis chapter (i.e chapter seven) in order to compare the findings of this research.

In this regard further theoretical discussion has been focused on the impacts of the crisis on various aspects of the organizational capacity and factors that influence the organizational capacity during crisis such as aspects of coordination, communication, decision making, leadership, learning, personnel management along with influence of media and socio-psychological issues.

The coordination aspects during crisis can be discussed from 'fast–response' organizations perspective. Some literature indicated that coordination in fast moving and emergency situation are highly evolving and cannot only be predetermined or set or for that matter top-down. Both expertize based (top-down) and dialogic (bottom-up) approach is needed (Faraj & Xiao, 2006). However, this study was confined to disaster events as crisis events. Similarly, scholars suggested that a pre-planned coordination mechanism may help to work effectively along with emergent approach of coordination (Boin & Bynander, 2015).

Some scholars claimed that decision making in a crisis context is not a simply organizational decision making process (Hale et al, 2006). Scholars indicated that normative decision making is less effective in comparison with naturalistic decision making practice which is mostly based on individual judgement and negotiation (Hale et al., 2006; Mintzberg et al., 1976). In contrast Nutt (2000) claimed that crisis decision requires expert opinion based on analysis. Some scholars also emphasized on team instead of the individual when it comes to decision making (Coombs, 1999; Pearson & Clair, 1998; Witt & Morgan, 2002). However, most of the studies are based on either natural disaster or massive accidents which can be taken as reference for the man-made crisis such as refugee crisis.

In all circumstances leadership qualities are vital in managing crisis and the crisis also has influences the leadership patterns and the success and failure largely varies on the types of the organizational culture and context (Bowers et al., 2017). Some scholars argued that transformational leadership is more successful in hierarchal culture and transactional pattern is ineffective (Bowers et al., 2017). Some other scholars claimed that three kinds of leadership behaviours which are task-oriented, people-oriented, and organization-oriented (Van Wart, 2003, 2008; Silvia & McGuire, 2010). During crisis, leaders in their networks focus more on people-oriented behaviours and less on task-oriented behaviours (Silvia & McGuire, 2010; Morse, 2010)

From learning perspective, crisis sometimes instigates learning and sometimes inhibits the scope for learning (Roux-Dufort, 2000). However, some scholars claimed that crisis triggers learning (Birkland, 2006). Besides, Deverell (2010) opined that innovation and learning occur during severe crisis management periods when time and uncertainty are limited. On the other hand, some other scholars observed that a crisis event has no or a limited relationship with

learning and whether a crisis event triggers any learning process is yet to be determined (Smith & Elliott, 2007; Boin, McConnell, & 't Hart, 2008; Roux-Dufort, 2000; Nohrstedt, 2007; Boin, ‘t Hart, Stern, & Sundelius, 2005).

Besides the impacts on the organizational capacity the existing theories suggested that the organizational capacity can be influenced by various factors. Izard (2009) argued that the emotion and thinking are fundamentally connected and emotions such as fear or rage can facilitate cognitive operations. Similarly, scholars claimed that motivational states such as threat can be useful for affective crisis responses (Smith & Kirby, 2001). Again, existing knowledge suggested that media can be supportive to crisis management (Pan & Meng’s, 2016). On the contrary scholars claimed that media mostly concentrated on negative aspects highlighting the failure of government agencies while disregarding responsive efforts (Cortias-Rovira et al., 2014; Veil, 2012).

The findings of the study have been discussed in the light of the abovementioned theories along with other relevant thematic areas

2.7 Developing a Conceptual Framework: Utilizing the Existing Knowledge

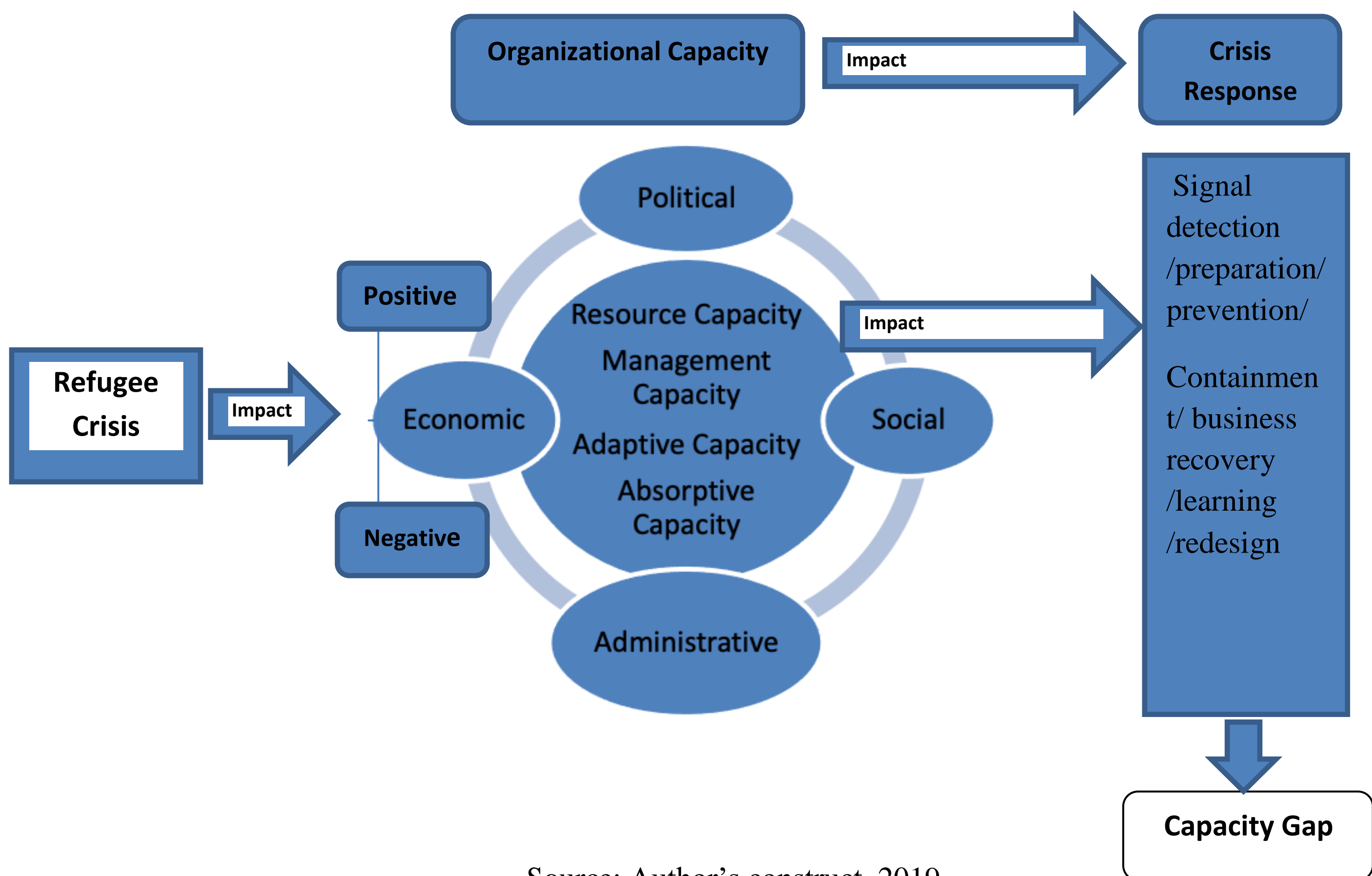
The study's main goal is to investigate, analyze, and comprehend the relationship between crisis events and public sector organizational capacity, with a focus on the health sector. For the purposes of the study, the Rohingya influx has been designated as a crisis event.

The literature reviewed so far suggest that, the refugee crisis has both positive and negative effects on the host community. However, there is a knowledge gap regarding the effects on the organizational capacity of the public sector. This research will attempt to make a contribution in this area. As a result, the initial hypothesis for developing a conceptual framework is that the Rohingya influx has a positive, negative, or mixed impact on the capacity of health-care organizations. According to the literature, organizational capacity in the public sector is mostly viewed as management and resource capacity from an operational standpoint, and adaptive and absorptive capacity from a learning and adjustment standpoint. As a result, the study will investigate the impact of the refugee influx on the aforementioned capacity

dimensions of health-care organizations. It is also assumed that social, economic, administrative, or political factors have had an impact on organizational capacity.

Secondly, how the health sector organizations respond in stages of signal detection, preparation, prevention, containment, business recovery, learning and redesign (James & Wooten, 2010; Waller, Lei & Pratten, 2014; Mitroff, 2005; Hutchins & Wang's, 2008) in the context of refugee influx has been identified by this study. By analyzing the response process the research investigation will identify the capacity gap and subsequently recommend capacity development areas in the process.

Figure 1: Conceptual Framework



Source: Author's construct, 2019

2.8 Summary of the Chapter

This chapter is important to the overall research because it provides the research conceptual framework and literature-based propositions. The three main themes related to objectives and research questions were identified and critically reviewed in this literature review. The themes are the refugee crisis, crisis management, and organizational capacity in the public sector. It has provided a theoretical foundation for the study by integrating these themes.

According to the research objectives and questions, these three themes are strongly interrelated, and it is almost impossible to explain and examine one theme without the influence of the other. It is evident from the literature review related to the refugee crisis that the literature regarding the impact of the refugee crisis on the host country with special focus to a particular area in the public sector is limited. However, the existing literature on refugee crisis nearest to the study focused on impact from various dimensions like social, economic, psychological, service delivery aspects. The literature suggests that the impact on the host country has both positive and negative impact. Evidence shows that the positive impact is mostly concentrated in the areas of the labour market and the local economy. However, there is a tendency of a negative effect of the refugee crisis on almost all aspects. Public sector organizations are the main and key responders in dealing with the refugee crisis. Therefore, organizational issues of the public sector as key service providers are important. But the literature review reveals the knowledge gap in these particular areas. As a result, the first research question will hopefully be able to address the identified knowledge gap.

The crisis management theme has been centred on defining refugee influx as a crisis and exploring the existing evidence of crisis management in various context and typology. The section also focused on the crisis management process and response mechanisms. It also touches upon issues like the effect of the crisis on organizations. The literature suggests that most of the exploration spin around significant disasters, accidents or incidents. The major focus in the context of public administration and management has been given on finding the cause and consequence of crisis with particular attention to leadership, decision making, coordination, and cooperation. The literature on the effects of crisis has provided a guideline to define the effects of refugee influx on the health sector. The review regarding crisis response suggests that the

knowledge so far concentrates on issues like steps and processes in crisis response and its effectiveness. The literature will help the study to shape its research question three.

Exploring the issues of public sector organizational capacity is the main goal of the study. Therefore, the literature review in this area tries to emphasize the conceptual issues related to organizational capacity from various perspectives. In addition to that capacity dimensions based on empirical evidence has been highlighted. The capacity issues have also been examined within the lens of the health sector. The review suggested that the organizational capacity is being viewed from various angles but public sector organizational capacity is confined to basic capacities like management and resources capacity and learning and adjustment capacity like adaptive or absorptive capacity. It is evident from the existing knowledge that the impact on any public sector organizational capacity can be examined by these above-mentioned capacity dimensions. The first and second research questions can be explored and shaped by creating indicators based on these capacity dimensions. The capacity gap can be analysed and identified based on the capacity development knowledge though they are not directly related to the context. However, this may also help to create new knowledge in the context of refugee influx with particular reference to the health sector. Based on the literature a conceptual framework has been developed to align with the research objectives and questions. It is expected that the framework will further guide the study.

The literature review, considering its primary objectives, suggested that the existing knowledge in the academic world mostly focused on identifying the impacts of refugees on the society, community, environment, economy and political system of the host country from host county perspective. And from refugee perspective, the research is mainly concentrated on the social and psychological impacts of forcible migration on the refugees. However, very few researches have been conducted to see the impacts on the service providing organizations specially, public sector organizations let alone public health sector organizations. These findings suggested that there should be a knowledge vacuum which can be provided by this research.

Now, it is important to have the required data to fit into the framework and answer the queries of the study. Thus, the following chapter will detail with the research design and methodology

3. CHAPTER THREE: RESEARCH METHODOLOGY AND CONTEXT OF THE STUDY

3.0 Introduction

The study's main goal is to investigate and comprehend the relationship between the refugee crisis and public sector organizational capacity in the health sector. There are two objectives that correspond to the goal, and under each objective, there are two research questions that correspond to the goal. Given the nature of the study, the chapter explains the research path based on appropriate philosophical understanding from an ontological, epistemological, and methodological standpoint. The chapter also goes over the mechanism for data collection and analysis based on the identified philosophical standing. The chapter goes on to discuss the research approach to theory construction. The study takes a subjective stance based on nominalist ontology, interpretive epistemology, and an inductive approach. This philosophical foundation enabled the researcher examine the research objectives and questions.

The impact of the refugee crisis on the organizational capacity of public-sector health-care organizations can be perceived socially by adopting contextual meaning derived by the target people and the researcher. The impact and the factors that contribute to it are all defined by various inter-subjective perceptions and characteristics, and this chapter justifies the process used is this research. In line with this study's positioning, the chapter presented a methodology outlining the key methods of data collection. This included interviews, that is, semi-structured interviews and Focus Group Discussions (FGDs), and documentary reviews. It also served as the foundation for evaluating the contribution to knowledge.

3.1 Philosophical Foundation of the Research

In research, researchers usually try to explore or identify the answers to specific questions on a specific topic or area, and then add academic knowledge. To do so, a point of view must be established from the outset. This point of view is necessary because it describes the researcher's role and helps others understand the specific angles from which the research was conducted (Johnson & Christensen, 2010). This has paved the way for an accurate assessment of the research. It also assists the researcher in identifying methods and techniques that are more

appropriate for the study. In general, the research is guided primarily by two philosophical perspectives, namely ontological and epistemological perspectives.

3.1.1 Ontological Perspective

Ontology is concerned with reality and determining what exists in reality (Ritchie et al., 2013). Fixing an ontological position at the start of a research is critical because it helps shape the research design. The social science is dominated by two major ontological positions, namely "realism" and "idealism." Idealism is the belief that claims phenomena in social settings can be explained using human concepts (Burell & Morgan 1979). Similarly, Ritchie et al. (2013) stated that reality is nothing more than a phenomenon's socially shaped, human mind dependent meaning. Realism, on the other hand, contends that phenomena in social settings are independent of human perception and belief (Ritchie et al., 2013). Burell and Morgan (1979) state that "the individual is seen as being born into and living within a social world, which has its own reality." It is not something that the individual creates; rather, it exists “out there:” ontologically, it exists before the existence and consciousness of any single human being.” Because the issues under consideration are socially constructed and not independent of human conception, the Idealist ontology is appropriate for the study. The major queries under the study can best be identified by observing the social context, social actors and individuals involved.

3.1.2 Epistemological Perspective

The epistemological philosophy in social studies can be viewed primarily through the lenses of interpretivism and positivism, as well as realism and pragmatism (Saunders et al, 2009). The term 'interpretivism' implies that findings or situations can be interpreted rather than simply observed; as a result, researchers should consider various interpretations of an observed situation (Harzing & Pinnington, 2011). According to Saunders et al. (2007), interpretivism is a philosophy that helps researchers identify differences between humans as social actors. Interpretivists are also known as 'feeling' researchers because they interpret their social actor's roles based on the meaning assigned to these roles, and they interpret others' roles based on their own set of meanings (Saunders et al., 2007). Furthermore, interpretivists believe that there is

little difference between facts and opinions because the findings are influenced by the researchers' values.

Positivism implies that there is a reality that can be identified and evaluated in a situation in which the researcher, the research, and the research instruments are distinct entities that cannot influence one another (Ryan, 2006). Furthermore, Positivists argue that the research topic is an independent area whose properties should be measured objectively rather than subjectively explained (Easterby-Smith et al., 2012). Positivist researchers, according to Wicks and Freeman (1998) are objective observers who can capture reality and facts without human biases using scientific methods.

According to Saunders *et al.* (2009) "pragmatism supports that the research questions are the most important elements of a research and based on them researchers have to investigate what is most valuable to their research without taking into consideration other factors that might have slightly influenced their research". 'Realism' on the other hand holds that reality is unlikely to be described, and thus the researcher observes the truth from a dependent point of view (Sumner & Tribe, 2008).

Epistemologically, this study requires an active involvement of the researcher's own critical knowledge and perception in the process and so the active involvement of the researcher is critical. As a result, the researcher cannot be divorced from the research and reduced to the role of an unbiased observer. Moreover, the findings and the contribution of the knowledge mostly dependent on the critical analysis and explanation of the researcher.

3.2 Research Approach:

Existing literature and theories can be used in research primarily in two ways. The approaches are commonly referred to as inductive and deductive. These approaches are developed in accordance with the researcher's philosophy. The positivists prefer the deductive approach, whereas the interpretivists prefer the inductive approach (Teddlie & Tashakkori, 2009).

Researchers use the deductive approach to develop research propositions and test them through a review of existing literature (Ang, 2014). According to Collis and Hussey (2003), in deductive research, a theory is first developed and then tested using existing literature, and it is best suited for natural sciences. Furthermore, Bryman (2004) defines deductive research as "an approach to the relationship between theory and research in which the latter is conducted with reference to hypotheses and ideas inferred from the former."

In contrast, in the inductive approach, researchers begin with data collection and then develop theory based on data analysis (Saunders et al., 2009). In line with this, Thomas (2006) argued that inductive research develops a theory based on data collection and analysis. Additionally, Cohen et al. (2011) state that an 'inductive' research approach supports a cause-effect relationship between the research variables. Besides, the inductive approach is used to identify a specific issue of interest within its social context, which is related to theory generation (Rocco et al., 2003). Furthermore, in the inductive approach, the researcher first collects information from various sources, which is then developed into themes, broad patterns, and, finally, theories (Bahari, 2010).

The study's goal is to identify the impact of the refugee crisis on public health sector organizational capacity, as well as the factors influencing the process. The study relies on primary data to investigate the answers to the questions. Based on the findings and analysis of the data, a theoretical framework would be developed. As a result, the study takes an inductive approach with a focus on qualitative methodology.

3.2.1 Qualitative Research Approach

As it is difficult to quantify people's perceptions and beliefs; qualitative techniques are used to assess these issues. The qualitative methodology can provide detailed textual explanations of how people perceive a research issue. Furthermore, qualitative methods can delve into less obvious issues and factors involved in the research (Mack et al., 2005). Similarly, qualitative methods are effective in comprehending processes, complexities of situations, participant norms and culture, and the context in which the research is conducted (Bawole, 2013). Furthermore, researchers claimed that this method can produce significant results with smaller samples (Maxwell 2005; Denzin et al. 2006; Brown 2010).

The qualitative method, on the other hand, is not without criticism. Some academics believe that these methods are vulnerable in terms of dependability, validity, objectivity, and transparency (Grix 2004; Denzin et al., 2006; Tracy, 2010). Another criticism is that qualitative methods are overshadowed by the researchers' personal values and interpretations. Ulin et al. (2005), on the other hand, argued that qualitative methods have several quality standards, including confirmability, credibility, transferability, and dependability. Similarly, triangulation, structural corroboration, and referential adequacy have been used to ensure quality assurance (Eisner, 1997).

This study intends to investigate an issue which exists in a natural setting. According to Creswell (2003) qualitative research enquire into the problems within their natural settings. The study aims to conduct research in the environment within which the public sector health service providing organizations operate. Besides, the study intends to identify the impacts of refugee crisis on organizational capacity of public health sector organizations including the influential factors effecting the organizational capacity which call for a qualitative data collection technique as it requires deep enquiry into the nuances of the nature of impacts. The study aims to implore evidence from key senior and local level government officials, NGO and Development partner (DP) officials whose size is small. Identifying and extracting meaningful conclusion from a small sample is only possible in qualitative research (Crouch & McKenzie, 2006; Gerring, 2007). The research studies a complex element as it tries to identify the impact as well as the factors effecting the organizational capacity. It is evident that dealing with complexities and explaining the complexities is the strength of the qualitative research. On the contrary, Gummesson and Cassell (2006) claims that qualitative methods are not enough for explaining complexities. Moreover, some scholars argued that the use of qualitative method has become more and more prominent in the evidence-based policy making (Denyer & Tranfield 2006). Additionally, scholars claimed that knowledge creation should consider social context within which data are generated and is flexible rather than depending on non-flexible and remote methods (Denzin & Lincoln, 2005). Again, a qualitative method is appropriate as the study requires a detailed insight of complex issues of refugee crisis, public sector organizational capacity and crisis response which can only be collected by interviewing participants and allowing them to respond in their own way (Creswell, 2007; Yin, 2010)

3.3 Research Strategy

According to scholar's qualitative research can be conducted using several strategies which includes case study, grounded theory, phenomenology, ethnography, biographical, historical and participatory strategies (Denzin & Lincoln, 2011; Yin, 2010; Creswell, 2009). This researcher selects a single case-study research strategy because it allows for in-depth exploration of a real-life existing issue in its natural context (Yin, 2012; Farquhar, 2012; Woodside, 2010). A case study research is appropriate when the study is not under the direct influence of the researcher and when a real-life context is the issue of enquiry (Yin, 2009). The case study strategy, therefore, facilitate an organized analysis of real-life issues through data collection and analyses with a view to generate knowledge, recommend alternative solutions and offer suggestions (Lethbridge et al., 2002). According to some scholars, case study as a strategy is gaining recognition in organization and management research due to its own rigorous characteristics which relies on interviewing, observing and document review (Denzin & Lincoln, 2011; Yin, 2009; Hartley, 1994). Moreover, case study is a system where a holistic view of a case can been seen in addition to the specific phenomenon and may include data from different sources by utilizing single or multiple methods (Punch, 2005; Creswell, 2013).

3.4 Sampling

The organizations which are involved in dealing with Rohingya refugees especially with health issues were approached during the study. The organizations include local level and central level public sector organizations, NGOs and DPs operating in the health sector for Rohingyas. A List of the organizations have been described in table 6 :

Table 6: List of Organizations covered for data collection

Name of the Organizations	Location
Civil Surgeon Office	Cox’s Bazar, Chattagram, Bandarban
250-bed district hospital	Cox's Bazar
Upazilla (sub-district) Health Complex	Tekhnaf, Ukhia, Ramu, Chakaria of Cox’s Bazar
Office of the Refugee Relief and Repartition Commissioner	Cox's Bazar
Office of the Deputy Commissioner	Cox’s Bazar
Office of the Upazilla Nirbahi Officer (Sub district executive officer),	Tekhnaf and Ukhia
Ministry of Health and Family Welfare;	Dhaka
Ministry of Disaster Management and Relief;	Dhaka
Director General of Health Services (DGHS)	Dhaka
Divisional Health Office	Chattagram

Source: Author’s Construct, 2021

However, data has been gathered from concerned development partners (DP) and NGOs in addition to public sector organizations. Currently, 13 different organizations are collaborating to ensure health service delivery. Among the organizations from The DP’s community are World Health Organization (WHO) (who is leading the health sector for Rohingyas), UNHCR and IOM. Among the International NGOs are the Save the Children and Muslim Aid and among the national NGOs is Bangladesh Rural Advancement Committee (BRAC). The list of DP and NGOs are listed below:

a. WHO;
b. UNHCR;
c. IOM;
d. BRAC (NGO)
e. Muslim Aid (INGO) and
f. Save the Children (INGO).

In the case of individual respondents, the initial inclusion criteria were that the respondent be an official of one of the sampled organizations. The second criterion for inclusion was that an official of a certain stature be involved in the Rohingya issue and be able to provide quality information about the researched issue. The respondents should be officials who have

been working in the above-mentioned areas since the Rohingya influx begun. However, if any officials who were in key positions in the targeted organizations during the influx but are no longer there due to transfer or posting, they would also been interviewed. Table 7 below shows the list of interviewees

Table 7: List of Interviewees

Name of the organization	Designation /stature	No of Interviewee	Comments
Civil Surgeon Office, Cox's Bazar	Civil Surgeon	01	
	Ex Civil Surgeon	01	
	Medical officer	01	
Civil Surgeon Office, Chattagram and Bandarban	Civil Surgeon	02	
Office of the Deputy Commissioner, Cox's Bazar	Additional Deputy Commissioner	02	
	Deputy Director Local Government (DDLG)	01	
Cox's Bazar 250 bed (Sadar) Hospital	Deputy Director	01	
	Ex deputy director	01	
	Assistant Director	01	
Upazilla Health Complexes	Upazilla Health and Family Planning Officer (UHFPO)	06	Current and ex UHFPO of Ukhia and Tekhnaf (sub districts directly faced the influx); UHFPO of Ramu and Chakaria (other two sub-districts under Cox's Bazar district which are not directly affected by the influx).
Office of the Refugee Rehabilitation and Repatriation Commissioner (RRRC)	Additional Refugee Rehabilitation and Repatriation Commissioner	01	
	Camp in charge	03	

Name of the organization	Designation /stature	No of Interviewee	Comments
	Assistant Health coordinator	01	
Rohingya Coordination Cell (Ministry of Health and Family Welfare), Cox's Bazar	Chief coordinator	01	
	Field coordinator, Operations	01	
Director General of Health Services (DGHS)	Additional Director General	01	
	Director, Diseases control	01	
	Assistant Director, Communicable Diseases control	01	
	Deputy Program manager, Hospital service management	01	
	Deputy Program manager, Upazilla Health System	01	
Divisional Health Office, Chittagong	Director	01	
Ministry of Health and Family Welfare	Additional Secretary	01	
	Joint Secretary	01	
Ministry of Disaster Management and Relief	Joint Secretary	01	
	Deputy Secretary	01	
Prime Minister's Office	Director	01	
DP and NGO			

Name of the organization	Designation /stature	No of Interviewee	Comments
WHO	Representative working at Cox's Bazar	01	
UNHCR	Representative working at Cox's Bazar	01	
IoM	Representative working at Cox's Bazar	01	
Save the Children		01	
Muslim Aid	Country representative	01	
BRAC	Head of programme, Advocacy for social change	01	
Total		41	

Source: Author's Construct, 2021

3.4.1 Sampling Methods

In research there are two broad category of sampling methods. One is known as probability sampling and the other one is non-probability sampling. In qualitative research and case studies usually non probability sampling is suitable as it focusses on small samples to examine a real-life issue and not to make statistical interpretations in relation to the wider population (Yin, 2003). There are various types of non-probability sampling methods. They are quota sampling, snowball sampling, convenience sampling and purposive sampling. According to Davis (2005) "quota sampling is a technique where participants are selected based on predetermined characteristics so that the total sample will have the same distribution of characteristics as the wider population". In Snowball sampling new and additional cases are identified and encouraged to take part in a study using few identified and accessible cases and thus increase the number of participants (Breweton & Millward, 2001). Convenience sampling is

selecting cases or participants who are readily and easily available. But this approach may not be able to produce quality data. Purposive Sampling is a technique where cases or participants are selected consciously because they are assumed to be conversant or well informed about the phenomena under investigation (Maxwell, 1996). Similarly, some scholars define purposive sampling as choosing participants who are able to serve certain purpose consistent with the objectives and aims of the research under study (Collingridge & Gantt, 2008; Abrams, 2010).

Participants in this study were chosen based on their experience and knowledge of the issue under investigation. The sampling of respondents at the local and central levels, as well as DPs and NGOs, was determined based on their position and experience with issues relating to the impact of the refugee crisis on the organizational capacity of the public health sector. This study's sampling, as a qualitative study, did not focus on representativeness, but rather on the ability to provide diverse insights and in-depth understanding of the issue (Abrams, 2010). As a result, the participants were identified based on their position and involvement in dealing with the problem. This judgement was made before the going to the fieldwork

From the foregoing, it can be deduced that this research adopted the purposive sampling method to identify the target participants.

3.5 Data Collection

This study relied on both secondary and primary data. Primary data was collected using semi-structured interviews and FGD, while extensive review of documents was used to collect secondary data.

3.5.1 Interview

According to the literature, researchers frequently use interviews as a data collection tool in qualitative studies (Myers & Newman, 2007). Similarly, scholars asserted that interviews are mechanisms capable of producing high-quality illustrations of the interviewee's perception and opinion on the issue under consideration (Mack et al., 2005). An interview is defined as the collection of data from a person or a group of people on a specific topic through the use of specific questions or in the form of opinions or comments. Because this was a qualitative study, it relied on this data collection strategy. According to the literature, there are three types of interviews: structured, semi-structured, and unstructured.

Structured interviews are carried out using a structured questionnaire by trained interviewers in a standardize way (Pope & Mays 2006). The interviewees have to respond mostly within the fix choice. This kind of interview may not be able to capture all the ground reality about the topic beyond predetermined and existing theoretical framework.

Unstructured interview or loosely structured interview means interviewing on a topic without any predetermined questions or frame. This kind of interview largely depends on the interviewee's spontaneous behaviour. According to Punch (1998) unstructured interview is a process of understanding the complex behaviour of people without imposing any prior categorization. In an unstructured interview the interviewer generates questions based on the response or narration of the interviewees. However, this type of interview may not be useful when the researcher has basic understanding about the issue and wants to explore some particular aspect of the issue (Zhang & Wildemuth, 2009). In addition to that unstructured interviews are time-consuming and hard to manage due to lack of identified periphery of queries. This kind of technique is usually used when the issue is almost unknown or significant depth is required (Gill et al, 2008).

In a semi structured interview, the participants are asked questions which were determined previously and are mostly open ended. The participants are given scope to input their own ideas which they feel significant alongside responding to the specific questions. This approach is important as it helps to explore significant issues and ideas which may not be taken into account during the design phase of a research (Gill et al, 2008). Besides, it is also suitable to grab the perception and opinion on complicated social phenomena. Additionally, a standardized interview schedule can be avoided by engaging diverse kind of sample.

Semi-structured in-depth interviews are the most widely used interview format in qualitative research and this can be used for both individual and groups (Bernard, 2017; DiCicco-Bloom & Crabtree, 2006; Rubin & Rubin, 2011). According to Rubin and Rubin (2011) individual, in-depth interviews help to explore social and personal issues in detail. In spite of having different kinds of qualitative research interview methods, semi-structured and in-depth interviews have been chosen for use during this study because they are able to provide detailed and quality information about individual experiences. Rubin and Rubin (2011) noted that in-depth interviews

can be used to understand complex social issues related to health care. Apart from interview in order to grab group views FGD was also adapted as data collection tool.

3.5.2 Focus Group Discussion (FGD)

Apart from the interviews, the study employed Focus Group Discussion (FGD) to elicit further information relevant to the research questions. FGD is a guided, monitored and recorded group discussion on a particular topic. Krueger (2014) noted that focus groups are not just getting a group of people to talk rather, it a special type of group in terms of purpose, composition, size and procedure. Besides, Morgan (1996) argued that FGD is a technique where data is collected from an interaction between the researcher and a number of respondents. In other words, focus groups are similar to group interview but in this kind of technique, the researcher instead of asking each person to respond to a question, people are encouraged to interact with each other on their opinions and responses. This method helps to identify not only what respondents think about an issue but also how they think and why they think so (Morgan, 1998). This method helps to collect diversified thoughts from respondents on a topic and sometimes allow validation of already collected data. Additionally, according to Hennink (2014) FGD generate different types of data through group interactions which may not be possible to generate through individual interview. Similarly, Mack et al. (2005) claimed that FGDs are appropriate for collecting group opinions and identifying variety within a population. This technique is suitable for both exploratory and explanatory research dealing with research application like 'to explore', 'to explain', 'to evaluate', 'to design', 'to understand context', etc.

Two focus group discussions (FGDs) were held for the purposes of the study. Six health professionals from government health facilities and health management units, as well as DPs and NGOs, took part in the first FGD. Eight participants from the public health sector, district administration, the Office of the Refugee Rehabilitation and Repatriation Commissioner, Upazilla administration, DP, and NGO attended the second FGDs.

Each FGD was carried out by the researcher with the help of a tape recorder. The researcher asked for permission before recording every discussion. Each FGD was initiated by an introductory session including describing the aims and objectives of the fieldwork. A set of structured and open-ended questions was used during the FGDs. However, FGD is not without

practical challenges. Gathering the target participant during the discussion was quite difficult. And it was even more difficult to conduct the discussion session. Ensuring the participation of every participant was a challenge. In order to address this problem, the researcher had to interfere time and again in the form of moderation.

Despite the fact that this data collection technique has both advantages and disadvantages, it was chosen for this study because it helps to disseminate some topics of interest and collect diverse knowledge and information from specific types of participants.

3.5.3 Documentary Review

In qualitative research, document review is as important as any other data collection tool. Some scholars contended that documentary review is simply a process in which documents are reviewed and interpreted by the researcher in order to find existing data that is relevant and meaningful to a research issue (Bowen, 2009). When it comes to data triangulation, documentary review and analysis are critical, as they help increase credibility (Bowen, 2009). Despite the fact that the volume of specific documents related to the study was limited, documents related to the Rohingya response, such as the sectoral joint response plan developed by the sector lead, meeting minutes, and monitoring reports, served as important data sources in addition to the interviews and FGDs. Furthermore, the websites of the relevant central and local level organizations, as well as the DPs and NGOs involved, were accessed.

The detailed mapping of the data collection mechanism is presented in table 8 below:

Table 8: Summary of the Methodology

Objectives	Questions	Data collection method	Target Group
Examine the impact of the refugee crisis on health sector organizations in order	a. What is the impact of the refugee crisis on the capacity of health service-	Secondary sources: Documentary Review Primary Source: Semi-Structured	Civil Servants from local health service-providing organizations (civil surgeon, head of the

Objectives	Questions	Data collection method	Target Group
to better understand the public sector organizational capacity in crisis events;	providing organizations?	Interviews; FGD.	hospital, deputy head of the hospital, Upazila Health and Family welfare officer) local district administration, the local government body, office of the Refugee Relief and Repatriation Commissioner. Key officials from the Ministry of Disaster Management and Relief, Ministry of Health and Family Welfare; Frontline officials working in development partners and NGOs
	b. What are the key factors affecting health service capacity during the refugee crisis and why?	Secondary sources: Documentary Analysis Primary Source: Semi-Structured Interviews; FGD;	Civil Servants from local health service-providing organizations (civil surgeon, head of the hospital, deputy head of the hospital, Upazila Health and Family welfare officer) and

Objectives	Questions	Data collection method	Target Group
			Ministry of Health and Family Welfare. Frontline officials working in development partners and NGOs
2. Identify the capacity gaps in health service delivery in the context of the Rohingya Refugee influx in Bangladesh in order to prescribe better public sector organizational capacity development knowledge	a. How did health sector organizations respond to the Rohingya refugee crisis in Bangladesh?	Secondary sources: Documentary Analysis Primary Source: Interviews; FGD	Civil Servants from local health service-providing organizations (civil surgeon, head of the hospital, deputy head of the hospital, Upazila Health and Family welfare officer), local district administration, the local government body, office of the Refugee Relief and Repatriation Commissioner. Key officials from the Ministry of Disaster Management and Relief, Ministry of Health and Family Welfare; Frontline officials working in development

Objectives	Questions	Data collection method	Target Group
			partners and NGOs
	b. How can the organizational capacity of health care services be strengthened in such a crisis?	Primary Source: Semi –structured Interviews; FGD	Civil Servants from local health service-providing organizations (civil surgeon, head of the hospital, deputy head of the hospital, Upazila Health and Family welfare officer), local district administration, the local government body, office of the Refugee Relief and Repatriation Commissioner. Key officials from the Ministry of Disaster Management and Relief, Ministry of Health and Family Welfare; Frontline officials working in development

Objectives	Questions	Data collection method	Target Group
			partners and NGOs

Source: Author’s Construct, 2021

3.5.4 Transcription of Interviews:

Ensuring quality during data collection and processing is an important part of the total quality assurance process of a qualitative research. Interview transcription is part of the whole process. According to some scholars’ interview or data transcription is a crucial part of a qualitative research (Oliver et al., 2005; Witcher, 2010).

Transcription can be classified into two broad types which includes natural and de-natural transcription (Bawole, 2013). Natural transcription means the exact reproduction of an interview with every utterance including stutters, pauses, etc. De-naturalism, is a transcription approach whereby all the idiosyncratic elements of speech are avoided (Oliver et al. 2005). Besides Powers (2005) argued that transcription is a written document, is not a mirror of the original and it should capture those aspect of the recoding which is relevant to the thesis or future reference. To ensure the integrity and relevance of the data, transcription was performed using a de-natural approach. Nonetheless, because the interviews were tape-recorded, the files were used whenever the original orientation was required. To summarize, the study used a hybrid of the two orientations, naturalism and de-naturalism (Oliver et al., 2005). When it came to storing and transcribing the interviews, a coding system was used. The data was transcribed using the “question and answer” format. The following section explain how the collected data was analyzed systematically.

3.6 Data Analysis: Theoretical and Practical Aspects

Data analysis is a process through which raw data is transformed into a meaningful story in line with the queries of the study. Some scholars viewed the analysis as a process of reducing huge amount of data into some kind of story or interpretation (Lecompte & Schensul, 1999). Similarly, according to Patton (1987) data analysis is organizing, summarizing and categorizing the data and developing some kind of pattern or themes. However, the qualitative data analysis is the combination of description, connections, and classification of data collected through various methods (Dey, 2003).

There exist various methods for qualitative data analysis. The deployment of a specific method largely depends on the nature of the study. Merriam (1998) defined ethnographic and phenomenological analysis as a technique for dealing with qualitative data. The goal of ethnographic analysis is to identify the categories associated with a culture's socioeconomic context and demography. It is best suited for ethnographic research. Phenomenological analysis focuses on the participants' assumptions and perceptions of a phenomenon under investigation. It also emphasized the importance of examining participants' life-worlds and personal experiences (Smith, et al, 1999). This type of analysis method is commonly used in psychological and clinical research. Bernard (2000) also proposed a few approaches to qualitative data analysis, such as hermeneutics or interpretive analysis, narrative analysis, discourse analysis, and content analysis. In interpretive analysis, the analyst must constantly interpret the words in the data to gain a thorough understanding and direction (Merriam, 1998). The interactions of the research subjects must be closely monitored and analyzed during discourse analysis. Given the nature and objectives of the study, the approaches mentioned above do not appear to be perfectly appropriate for this study. As a result, a thorough examination of the various options for data analysis has been conducted. Based on the review, the collected data is analysed using cross tabulation, triangulation, and thematic analysis (inductive and deductive) which seems to have broader scope for analysis from multi-dimensional perspectives. Furthermore, this approach allows for greater flexibility in interpreting the data (Guest et al., 2012), and expediting the in-depth analysis of the data in order to find meaningful answers to the research questions (Ryan & Bernard, 2000).

3.6.1 Thematic Analysis

Identifying important and thought-provoking patterns from collected data is the key aim of a thematic analysis. The patterns are commonly considered as themes based on which the main queries of a research are being addressed (Maguire & Delahunt, 2017; Braun & Clarke, 2006). The thematic analysis is not only summarizing the data but also make some sense out of it. Thematic analysis is a flexible method one can deploy to analyse findings in multi-disciplinary ways. The researchers have the option to analyse the whole data set as well as some portion of it. It can portray both the straight meaning of the findings and the dormant or latent meaning of the data (Braun & Clarke, 2006).

Despite having a number of advantages, this method is not without criticisms. Some scholars claimed that the approach's high level of flexibility could lead to discrepancies between developed themes and actual study findings (Holloway & Todres, 2003). Furthermore, some scholars argued that thematic analysis is not a separate method, but rather a simple tool that can be used in data analysis (Boyatzis, 1998; Holloway & Todres, 2003; Ryan & Bernard, 2000).

Braun and Clarke's six-step approach to data analysis was used in the study (2006). The method begins with extensive reading or listening (audio records) to become acquainted with the data. The second stage focuses on creating codes that identify labels for data features based on the research questions. The researcher should then focus on developing or searching themes that are made up of some important pattern responses in relation to the study queries. Once the themes have been identified, the quality of the codes and data set must be checked. During this stage, the researcher can revise, discard, or add new themes. The fifth step is to define or name the themes so that they can be identified as distinct and covering distinct issues. In the final segment of the approach, the researchers must write a report that can tell a compelling story based on the data analysis.

Data analysis can be seen as an iterative process from various segments. Following the fieldwork, the recoded interviews were listened to several times each day in accordance with the concept of thematic analysis. This practice aided in the codification and later identification of the major themes from the collected data. It also aided in better preparing for the next interview session. Tracy (2013) stated in a similar vein that it is critical to visit and revisit the recoded data

and transcription on a regular basis in order to gain emerging insights from the data and gradually polish the focus and understanding on the emerging phenomenon of the study.

The transcripts were read repeatedly during the transcription stage in order to develop codes and, later, themes for the analyses. During the fieldwork, a couple of themes emerged from the data that were noted to help with the analyses. At this point, a number of key themes were identified in accordance with the research objectives and questions. These themes were chosen as the basis for data analysis. As soon as the themes were identified, the researcher focused on the data gathered from various sources to determine the responses that corresponded to each theme. Dominant themes identified during this stage were preserved, reformed, or set aside for future development. But, at this stage it seemed too early to make changes in the themes.

The major data management work in the third stage of data analysis was the coding of interview transcripts into two main themes that corresponded to the two research objectives. The two research objectives also corresponded to the four main research questions. The identified data in the form of responses was initially coded as Q1, Q2, Q3, and Q4 to correspond with research questions one through four. Second, coding was developed within the established broader codes and centered on the earlier developed main themes. The number of codes assigned to each research objective was determined after several readings and listening of the data.

Following Tracy (2013), both metaphor analysis as well as the exemplar and vignettes approach were applied to analyse the research questions. In this context, metaphors analysis refers to defining or labelling data themes in symbolic word or words. Exemplars are key frequent concerns that characterize a theme, and vignettes are isolated and distinct issues that, when combined, can demonstrate a point (Tracy, 2013). Care was taken to use these variables to consolidate the overarching points (Tracy, 2013).

In line with the notion of the thematic analysis the data analysis was done following an integrated approach (Bradley et al., 2007). In this case the framework approach described by Catherine et al (2000) was adopted. This framework consist of five steps which includes familiarization of data, creating of the thematic framework, categorization of the data in line with the theme, registering and reorganising data through abstraction and synthesis and mapping and interpretation (Catherine et al. 2000).

In addition to this inductive process, some themes were developed from the existing literature using the deductive approach (Bradley et al. 2007). It is worth mentioning that the themes were arrived at through a continuous and iterative reading and listening process with a thoughtful consideration in order to bring in more transparency in the analysis (Emanuel et al., 2004). Nonetheless, the data was analysed manually. The rationale behind this manual approach is being described in the following subsection.

3.6.2 Manual Analysis Instead of Software based Analysis

Initially, the researcher intended to use the qualitative software Nvivo for data analysis, but due to a few limitations of the software, the researcher decided to go with a manual approach. The study data are not well structured, which is required by the software. Furthermore, the software is only useful for organizing data into patterns; it does not perform data analyses or interpretation. In this manner, the researcher deemed it unfavorable in terms of cost and time investment. Furthermore, Welsh (2002) claimed that the software is incapable of performing the vigorous retrievals that researchers expect from it. Therefore, a manual approach was adopted instead of using the software-based approach.

3.6.3 Maintenance of Quality

A research must meet a minimum quality standard in order to pique the interest of academia and be accepted as having contributed knowledge to their field. In qualitative research, the terms quality and validity are frequently used interchangeably. Validity is sometimes confused with credibility (Creswell & Miller, 2000). Various scholars viewed the quality of qualitative research through various lenses. According to Cho and Trent (2006), quality can be ensured in the research process by employing specific techniques, methods, and/or strategies. Similarly, Tracy (2010) asserted that several factors such as worthy topic, significant contribution, ethics, rigor, credibility, and meaningful coherence can ensure the quality of a study. Others have emphasized triangulation, structural corroboration, and referential adequacy as important quality assurance components (Eisner, 1997). Furthermore, some judge the quality of a study based on the consistency of the research approach and topic (Silverman, 2005) as well as the appropriateness of the research questions (Creswell, 2003). Dixon-Woods et al (2004) argued in a similar vein that the quality of a qualitative research can be judged based on the

clarity of its research questions, the appropriateness of the questions as qualitative enquiry, the appropriateness of the data collection and analysis technique against the research questions, and the clarity of the sampling and data collection and analysis process, as well as the contribution. Furthermore, gathering data from knowledgeable informants who have different perspectives on the issue under investigation is an important quality assurance measure (Eisenhardt & Graebner, 2007).

The researcher placed a high value on the research process and methods. In addition, appropriate philosophical and methodological dimensions and techniques are used. In addition, the researcher conducted interviews with the most relevant individuals who have extensive knowledge and information about the issue under investigation. And who has a certain level of authority in the sample organizations.

3.7 Assessing Original Contribution to Knowledge

The award of the PhD largely dependent on the original contribution of knowledge. The contribution to knowledge has been viewed from various perspectives by various scholars. According to Morris (2011) contribution to knowledge may be production of new data, the restructuring of old knowledge and a combination of both. Some scholars argued that adding value to the existing knowledge includes generation of theory, creation of new concept, illustration of specific implications; and rich insight (Walsham 1995; Eisenhardt & Graebner 2007). On the other hand, Phillips and Pugh (2010) opined that the contribution to knowledge cannot be confined only to mean an enormous breakthrough within a subject area. They contend that the original contribution to knowledge can be assessed based on certain criteria such as carrying out a unique empirical work, making a new synthesis, using known materials with a new interpretation, adopting a certain technique and applying it in a new area, bringing new evidence to accept or reject an old issue, being cross-disciplinary and using different methodologies, focusing on new areas in a discipline. Similarly, Tracy (2013) claimed that contribution to knowledge can also be possible by extending, transforming, or complicating a theory or practice in new and rational ways. Tracy (2013) further argues that the contribution to existing knowledge can also be possible if the research findings can prompt curiosity of the

research community to carry out further investigation. Based on the scholastic views and frameworks, the study's contribution to knowledge is outlined in chapter 8.

3.8 Ethical Consideration

This study has been conducted following all ethical rules applicable in the University of Manchester. Ethical approval was sought and obtained from the Faculty Ethics Committee. Anonymity of the participants were maintained as per the university rules and data has been managed under the relevant data protection rules of the University.

3.9 Context of the Study

The research was carried out in Bangladesh, with the public health sector being taken into account in the context of the Rohingya influx. As a result, basic information about Bangladesh, as well as the nature and structure of the public health sector, must be understood in order to have a clear understanding of the study. To provide context for the study, this subsection focuses on Bangladesh's demographic and geographical information, the structure and system of the public health sector, the categorization of organizations, and their management practices.

3.9.1 The Country Context of Bangladesh

Bangladesh is located in South Asia, surrounded on three sides by India and Myanmar, with the southern border shared with the Bay of Bengal. Bangladesh is a former British colony that gained independence from colonial rule as part of East Pakistan in 1947 and eventually obtained full independence as Bangladesh in 1971, following a nine-month liberation war with Pakistan. Bangladesh is a republic practicing parliamentary democracy. Since 1991, the country has enjoyed democracy with few military interventions. The President is the head of state, while the Prime Minister is the head of government. The President appoints the Prime Minister based on the outcome of the general election (BBS, 2019). The country, which covers an area of 147,570 square kilometres, is divided into sixty-four districts under eight administrative divisions. A divisional commissioner, a civil servant appointed by the government, leads the division. The Deputy Commissioner (DC) is the chief executive of a district (commonly referred to as a Zilla) and a member of the Bangladesh Civil Service. Each district is divided into a number of sub-districts (commonly known as Upazilas), each of which is led by a civil servant

locally known as Upazila Nirbahi Officer (UNO). The local government system is divided into three tiers. At the grassroot level is the Union Parishad, at the sub district level is the Upazila Parishad, and at the district level is the Zila Parishad. There exist two kinds of urban local government: Pourashava (Municipality) and the City Corporation. While the former operates in the town, the later exists in the big cities. The local governments except the Zilla Parishad are elected bodies.

From administrative points of view, there exists three-tier system in public sector management practice. The national level consisting of the ministries and divisions which deals with the policy and policy decisions. The second tier consists of the line departments attached to the ministries and divisions that are mainly responsible for general administration, coordination among the grassroot or local level organizations and policy implementation. The third tier consists of the grassroot organizations providing direct service to the citizens at the local level (Sarker et, al., 2017; Ahmed, 2002).

With a total population of 164.6 million (BBS, 2019), the country is one of the most densely populated in the world, with a population density of 1239.5 people per square kilometer (World Bank, 2020). With a literacy rate of 73.9 percent (BBS, 2019), the country has a demographic dividend because 63.5 percent of its population are economically active (BBS, 2018).

Having recently graduated from LDC, the country now has the world's 35th largest economy in terms of nominal GDP. In 2018-19, the service sector contributed 52.26 percent of GDP, followed by industry (35.14 percent), and agriculture contributed 13.6 percent (MoF, 2020). However, approximately 40.6 percent of the population is still employed in agriculture (MoF, 2020). The main export earnings are primarily from ready-made garments, jute and jute goods, pharmaceuticals, and so on. Foreign remittances are a significant source of income for the country because approximately 13 million Bangladeshis work outside the country (karim et, al., 2020). Bangladesh has traditionally had a deficit budget, but the contribution of foreign aid has dwindled over the years. The budget's spending is divided into two major categories. The revenue budget covers operational and recurring costs, whereas the development budget covers the costs of development work carried out under the Annual Development Program (ADP). According to the national budget for 2020-21, the main sectors for public expenditure are public

administration, education and technology, transportation, and communication. Despite high economic growth in recent years, the country has experienced 5.5-5.6 percent inflation in recent years, as well as an unemployment rate of more than 4 percent (BBS, 2020).

Bangladesh's ethnic and cultural homogeneity is well known around the world. The overall population is made up of approximately 98 percent Bengalis, with the remainder being non-Bengali Muslims and indigenous tribal peoples (James & Robert ,1989).

In terms of religion, approximately 83 percent of the total population are Muslims, and the country ranks third in the world in terms of Islamic population. The rest of the population is primarily Hindu, Christian, or Buddhist. Despite a deep belief in Islam, the majority of the population does not support religious fundamentalism; rather, they see Islam as primarily a matter of customary practice (James & Robert, 1989). They prefer to live in joint families because family and kinship ties are at the heart of their social lives. However, in recent years, the concept of nuclear family has gained popularity in urban areas.

Although the country has a strong socio-cultural structure and an expanding economy, it faces some governance challenges. Corruption control, as well as the institutionalization of democratic governance, is a critical issue to address (Khan & Islam, 2015). Furthermore, it is one of the most vulnerable countries in terms of global climate change (World Bank 2010, 2014; Rahman, 2018), with four percent of the population at risk of natural disaster (BBS, 2019). Furthermore, for decades, the public sector's performance in terms of effective public service delivery has been heavily criticized (Khan, 2003).

3.9.2 Health Sector in Bangladesh

Bangladesh's health-care system is made up of both public and private health-care organizations. The public healthcare organizations are active in both the rural and urban areas. However, majority of the private health-care organizations are based in the cities. Individual doctors' private medical practices, on the other hand, are common across the country. There is an informal and traditional health care system as well and this based on herbal medication. According to studies, roughly two-thirds of the population use traditional medicine (Saha et al., 2017; Haque et al., 2014).

Bangladesh is perceived to be struggling to provide quality health care to both the poor and the wealthy (Mahmood, 2012). According to some studies, the country's health-care system is plagued by governance, accessibility, and affordability issues (Muhammad et al., 2016). Aside these challenges, one of the key concerns for the health sector is the adequate supply of human resources. The current doctor-patient ratio in Bangladesh is only 5.26 to 10,000, which is among the lowest even in South Asian countries (Mohiuddin, 2020; Alam, 2019). It is estimated that 34% of all health-care positions are unfilled, and the hospital bed-to-patient ratio is 1: 1667 (Fahim et al, 2019). According to the Bangladesh Health Facility Survey (BFHS), only 30% of rural health facilities have basic medical equipment such as stethoscopes, blood pressure machines, weighing scales, amongst others (Molla, 2019). Furthermore, the doctor-to-nurse-to-medical-technician ratio is 1:0.4:0.24 (WHO, 2015), which is significantly lower than the international standard (WHO recommended ratio is 1:3:5).

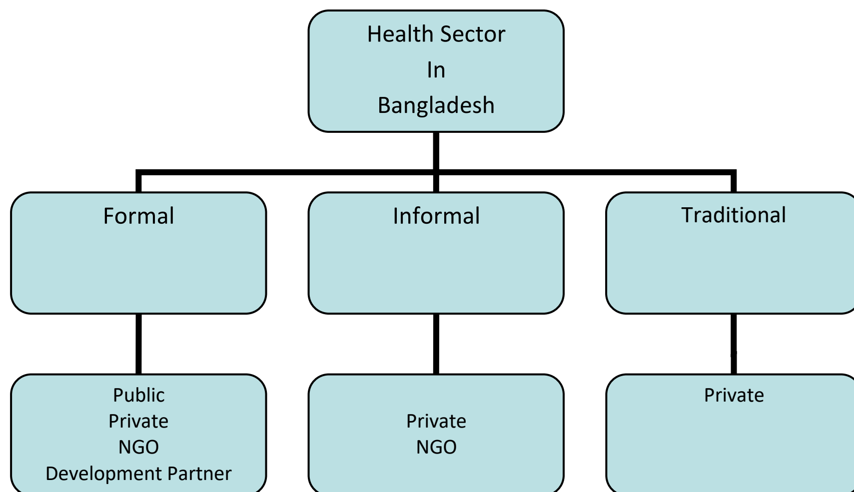
In terms of health-care financing, private out-of-pocket (OOP) spending dominates, with the public sector accounting for only 25% of total health-care spending (Islam et al., 2015; Saksena et al., 2010). In comparison to neighbouring countries, OOP payments as a percentage of private health expenditure is extremely high (approximately 92.9 percent) (Molla & Chi, 2017; Majumder, 2011). According to the data, Bangladesh spends little money (as a percentage of GDP) on health care in comparison to global standards, and this expenditure has been increasing marginally over the last decades despite the fact that the overall economy grew by nearly 7.5 percent per year (Islam et al, 2015). However, in recent years, the allocation for health has increased, with the government allocating 5.63 percent of the total budget for the health sector in 2019-20 (which is 1.02 percent of GDP) (MoF, 2020).

However, in rural areas, retention and absenteeism are two major issues (WHO, 2014). Absenteeism of key health human resources of key health personnel (physicians) frequently exacerbates the situation. In health facilities, there is also a severe shortage of drugs and other essential supplies. As a result, only 25% of the population has access to a publicly funded health-care system (WHO, 2014).

In contrast to the various challenges, the achievement in the health sector is also noteworthy. The average life expectancy has risen to 72.8 years, infant mortality has fallen to 31/1000 (less than five years) and 24/1000 (less than one year), and maternal mortality has fallen

to 1.72/1000 (MoF, 2020). Furthermore, through immunizations, the country has done exceptionally well in controlling communicable diseases. This accomplishment is possible through the combined efforts of the general public, NGOs, and DPs. The overall scenario of the health sector in Bangladesh can viewed in figure 2:

Figure 2: Health sector structure in Bangladesh



Source: Author's Construct, 2021

3.9.3. Public Health Sector Structure in Bangladesh

Bangladesh's public health service is divided into three phases: primary health care, secondary health care, and tertiary health care. Primary health care is provided by village community clinics and union health posts at the union level (Union is the lowest tier of the local government which comprised of few villages). Secondary health care services are provided at the sub-district level by Upazilla Health Facilities and at the district level by district hospitals or general hospitals. Tertiary health care is provided by medical colleges and specialized hospitals. Majority of the hospitals at the Upazilla level have 31 or 50 beds. Hospitals at the district level typically have 100 or 250 beds (DGHS, 2019). According to DGHS (2020) the total statistics of the health facilities are displayed in table 9 below:

Table 9: Statistics of Health Facilities in Bangladesh

Items	Number
Total number of primary-level facilities (excepts community clinics)	2003
Community Clinics	13000
Total number of secondary and tertiary level facilities	255
Number of Hospital beds under DGHS	54660
Number of registered private hospitals and clinics	5,321
No. of hospital beds in private hospitals registered by the DGHS	91,537

Source: DGHS, 2020

There exists shortage of human resources (HR) in the public health sector as a good number of posts are vacant. The statistics below provides an idea of the overall HR scenario under the government facilities:

Table 10: Public health sector HR scenario

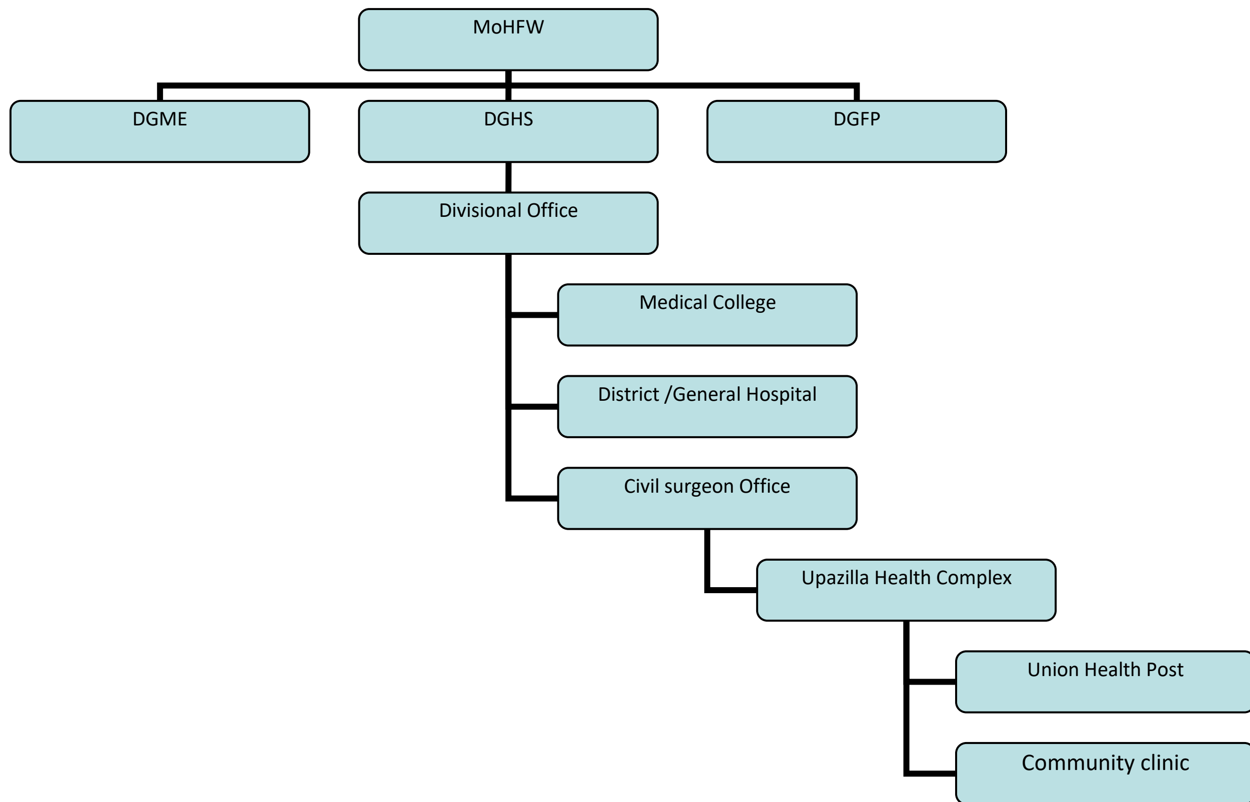
Items	Currently working	Total sanctioned Posts
Total Personnel under DGHS	78,619	105,254
Doctors	25,594	27,002
Medical Technologists	5,208	8,146
Sub-Assistant Community Medical Officers (SACMOs)	3,709	5,337
Health Assistants (HA)	15,020	20,908

Source: DGHS, 2020

The Ministry of Health and Family Welfare (MoHFW) is the main policy making organization which is responsible for the overall health sector of the country. The main duties of the ministry are to formulate national policy guidelines for the overall health sector in Bangladesh. There are three directorates that are in-charge of implementing policies and programs. The Directorate of Health Services is in-charge of health-care issues throughout the country under the supervision of the Director General of Health Services (DGHS). The Directorate of Medical Education (DGME) is in-charge of the country's health and medical education issues and the responsibility of family planning issues is delegated to the Directorate of Family Planning (DGFP). Each directorate has attached organizations working at the national level as well as subordinate and line organizations operating at various level. However, the

DGHS has its line organizations at the divisional, districts, subdistrict (Upazilla) and union levels. The overall framework of the public health sector can be seen as follows in figure 3:

Figure 3: Public health sector organizational structure in Bangladesh



Source: Author's Construct, 2020

3.9.4 Understanding the Nature and Role of the Public Health Sector Organizations

Depending on their role and nature, public health organizations can be divided into two major categories. Hospitals, clinics, health posts, and health complexes are examples of organizations that provide direct health care services to citizens. Some organizations do not provide direct service to citizens, but rather act as coordinators and provide support to organizations that do, such as the civil surgeon office, divisional health office, DGHS, and so on. For the purposes of the study, organizations that provide direct services to citizens are referred to as Direct Service Providing Organizations (DSO), whereas coordinating organizations are referred to as Coordinating Organizations (CO). Some COs operate at the central level such as DGHS and some of them work at the local level (district level) like civil surgeon office. Based

on their locations the COs can be divided into two subcategories which is local level CO and central level CO.

The DSOs which were situated at the main two sub districts (Ukhia and Tekhnaf) where the main influx took place and where most of the refugee camps were established have been defined as DSOs operating at the crisis zone. These DSOs are mainly primary and secondary health care provider. Besides the district level hospitals under the category of DSO is also defined as DSO operating at the crisis zone. The framework of the health sector organizations operating in the Cox's Bazar district can be described as below in table 11:

Table 11: Framework of public health sector organizations based on locus and focus

DSO		**CO**	
Operating in Crisis Zone	Operating in non-Crisis Zone	Central Level	Local Level
Cox's Bazar District Hospitals	Other Hospitals except Cox's Bazar District Hospitals	MoHFW; DGHS	Divisional health Office; Civil Surgeon office, Cox's Bazar
Upazilla Health Complex at Ukhia and Teknaf	Upazilla Health Complex except Ukhia and Teknaf		
Union health posts and community clinics at Ukhia and Teknaf	Union health posts except Ukhia and Teknaf		

Source: Author's Construct, 2021

Based on the nature of the jobs, the duties of the leading health professionals working in DSOs can be divided into two major types. Typically, the heads of DSOs are health professionals. A DSO chief must serve as both the unit's leading physician and its chief manager. As a result, they must manage the unit administratively as well as practice medicine. A health professional's role as a doctor in DSO is defined as "Clinical," whereas staffing or managing the unit is defined as "Non-Clinical."

3.9.5 Context of Cox's Bazar District

Cox's Bazar district is the border district situated at the south eastern part of Bangladesh. It is the main tourist destination in Bangladesh. The district is under Chattagram administrative division and surrounded by Chattagram district on the north, Bandarban district, and Myanmar on the east, Bay of Bengal on the west and South. The area of the district is 2,491.86 square kilometers. The district is divided into eight sub districts (Upazilla) and 71 unions (lower local

government units). According to the last population census, the total population of the Cox's Bazar is 2,289,990 (BBS, 2019). Two main refugee prone subdistricts through which the major influx took place and the most refugee camps are located, are Ukhiya and Teknaf. The population of Ukhiya and Teknaf are 234,726 and 299,253 respectively (DGHS, 2017). The refugee populations are settled in these two sub districts. Table 12 below portrays the population distribution in the area.

Table 12: Refugee population distribution according to camps /areas

Upazila	Union	Location	Population
Teknaf	Baharchhara	Camp 23 (Shamlapur)	10,499
		Communities	28,098
	Nhilla	Camp 24 (Leda)	25,992
		Camp 25 (Ali Khali)	7,604
		Camp 26 (Nayapara)	40,314
		Camp 27 (Jadimura)	14,970
		Nayapara RC	22,333
		Communities	49,927
	Sabrang	*Communities*	44,553
	Teknaf	*Communities*	41,977
	Teknaf Paurashava	*Communities*	29,069
	Whykong	Camp 21 (Chakmarkul)	16,466
		Camp 22 (Unchiprang)	21,213
		Communities	60,014
Ukhia	Haldia Palong	*Communities*	50,968
	Jalia Palong	*Communities*	48,478
	Palong Khali	Camp 14	32,026
		Camp 15	49,672
		Camp 16	20,762
		Kutupalong Expansion Site	582,135
		Communities	31,880
	Raja Palong	Kutupalong RC	16,711
		Communities	59,695
	Ratna Palong	*Communities*	28,410
		TOTAL	1,333,766

Source: OCHA, 2020

The total number of sanctioned government health sector positions in Cox's bazar is 1191 (DGHS, 2020), with 439 currently vacant. There are 187 open positions among the 346 sanctioned positions for physicians and dental surgeons (DGHS, 2020). The district's overall public health facilities scenario can be viewed in table 13 below:

Table 13: Public health sector infrastructure in Cox's Bazar

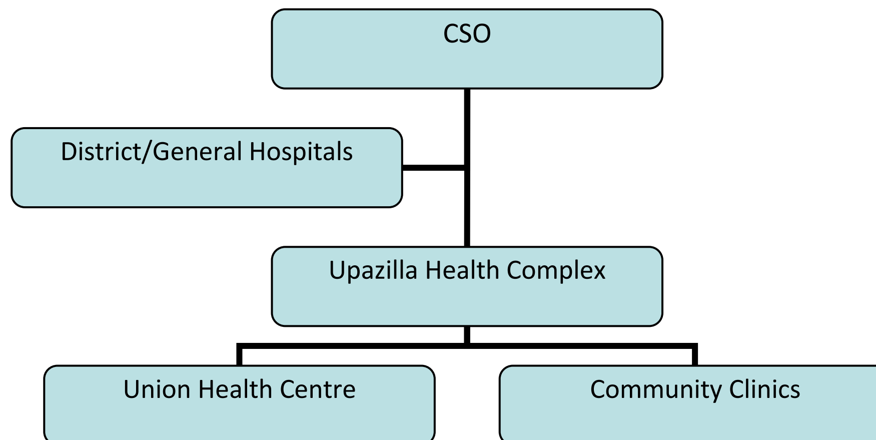
Description of the facilities	Number
Hospital Beds	572
Union Health Centre	58
Community Clinics	187

Source: DGHS, 2020

The data suggested that the ratio of government physicians per ten thousand populations in Cox's bazar is 0.81 compare to national average of 5.26 (Mohiuddin, 2020; Alam, 2019) while the ratio of patient in government hospital bed is 4003: 1 which is far below the national average of 1667: 1 (Fahim et al, 2019).

The management of the public health sector in Cox's Bazar is coordinated by the Civil Surgeon Office (CSO). The Civil Surgeon (CS) of Cox's Bazar is the led person who coordinates the public health sector organizations in the districts. Although the 250-bed hospital and the medical college has separate administration, overall general coordination of the health sector organizations in the district is run by the CSO. The structure of the public health sector organizations in Cox's Bazar can displayed in figure 4 below:

Figure 4: structure of the public health sector organizations in Cox's Bazar



Source: Author's construct, 2020

3.10 Summary of the Chapter

This chapter highlights and discuss both the philosophical and methodological perspectives of the research along with the context of the study. The study is guided by subjective ontology, anti-positivist epistemology and idiographic methodology. In the process the study adopts an interpretive paradigm along with an inductive research approach. This philosophical and methodological standpoint provides the researcher a scope to examine and interpret the findings from both the researcher's and subject's perspective. The impact of the refugee crisis on the public health sector organizational capacity and the driving and restraining factors are economic, social and political phenomena which cannot be clearly understood without taking into account the contextual meanings derived from the interpretation by both the actors and the researchers. In line with the research orientation the study relied on semi-structured interviews, documentary reviews, and focus group discussions as the key data collecting tools. This chapter also focused on the framework for assessing the contribution of knowledge.

It is also important to understand the context of the study alongside the methodological architecture. This chapter also described the country as well as the Cox's Bazar district where the crisis took place. The structure of the public health sector organizations along with its nature of duties is also presented. The public health organizations have been identified as DSOs and the COs. The roles of the health professionals have been clarified based on the nature of their responsibilities. This contextual understanding paves the way in designing and conducting the research.

CHAPTER FOUR

IMPLICATIONS OF ROHINGYA CRISIS ON PUBLIC SECTOR HEALTHCARE ORGANIZATIONS

4.0 Introduction

Data was collected from the field using the methodology described in the previous chapter. This chapter describes the data in accordance with the first research objective and question. The chapter begins by examining the impact of the refugee crisis on the organizational capacity of health-care organizations, which is addressed by the first research question. The study's data revealed that management, resources, absorptive, and adaptive perspectives have both positive and negative impacts. The data analysis yields eight themes. Quality of service, disease control, change in convention and practice, resource allocation, environmental degradation, illegal drugs and public health, health infrastructure, unholy practice, and professional knowledge are among the themes addressed in this chapter. It is worth noting that, in addition to the dominant themes, there were other hints that were not significant enough to be considered as separate themes. However, there were exceptions to the rule, so the themes only represent general situations. Alongside dominant negative impacts, the crisis also brought in some positive effects in the organizational capacity.

4.1 Positive Impact of Refugee Crisis on Public Health Service Providing Organizations

Evidence suggests that the Rohingya influx has had some positive consequences on public health organizations. Most the respondents indicated that there were some favourable impacts. The impacts are divided into two categories namely those related to health-care infrastructure and expertise or professional knowledge.

4.1.1 Professional Knowledge

The Rohingya crisis appears to have a good influence on public health service providers in terms of obtaining professional skills and knowledge. Most of the respondents who worked in health-related institutions indicated that the Rohingya minority brought in infectious diseases (such as, Diphtheria, Cholera and Measles) that were virtually non-existent in Bangladesh. This is also evident in the Rohingya camps with their outbreaks especially diphtheria and cholera. There was also the chance of these diseases spreading to the host communities. However, most of the

respondents stated that the health system handled the crisis well and lessened the infections. Documents prepared by numerous development partners as well as newspaper pieces supported this evidence. The respondents also indicated that doctors in the public health system though not well equipped to deal with outmoded diseases as it had been eradicated since the 1980s, they were able to manage the situation. The health practitioners learned how to manage these diseases from international experts working with development partners. Though no formal training, the doctors received emergency medical training to manage the situation. This consequently equipped them with the necessary skills that hitherto they did not possess. The was further supported by the statement of one of the heads of the sub district leading hospitals who indicated that:

> *"Our last diphtheria patient was in 1986 and most pharmaceutical companies in Bangladesh stopped producing medicine for diphtheria in late 1990s. When we found diphtheria cases in the camps, we were anxious for two reasons, firstly we did not have a treatment plan readily available and secondly, there was a risk of spreading the diseases in the host community. We had to work with international doctors for a treatment plan [Transcript# ID101_012]."*

The international experts who were dispatched to assist with the Rohingya issue were important in passing on their knowledge to the local health professionals. Apart from that, data revealed that there was a cholera outbreak in the camps, necessitating the government's rapid implementation of a massive cholera vaccine campaign. This large-scale immunization program in such a short period of time was unparalleled in Bangladesh's history. One of the directors working in the health directorate made a statement that was worth mentioning. He asserts:

> *"We have to complete 9 lac oral cholera vaccination campaign within two months. We haven't done work of such magnitude in our history. Moreover, we have to deal with the Rohingyas who have no health awareness. But we have learnt to deal with such humongous operations [Transcript# ID101_026]."*

From the foregoing, the respondents believed they had learnt how to deal with medical emergencies. The health-care sector had never been exposed to such a big and intense issue before, so they were confronted with a new predicament which they were able to handle with ease. In addition, those in charge of the issues were given various capacity building trainings in

order to better prepare them to deal with other crisis situations. One of the medical officers who worked in a sub district government hospital had this to say:

> *"It was like a tidal wave of injured people pouring in continually, with a wide range of injuries. We were on the verge of collapsing. But, through time, we've created our own strategies for dealing with the problem. And I believe we now know how to deal with such a situation [Transcript# ID101_014]."*

In addition to the crisis handling knowledge the health professionals also admitted that they are now aware of how to work in partnerships**.** The respondents opined that they have practically seen how to work with international partners and how to work complimentarily with each other. They have also mentioned that working with the local community is also a learning curve for them as they are now aware of how to utilize the local resources in an organized way. One of the officials working in the RRRC disclosed. He had this to say:

> *"It was important to have international experts work with our health professionals they did not have the practical experience to deal with other situations. It was next to impossible to deal with the crisis effectively if we didn't have quick response from the international community. And it was a great opportunity for me especially as I have learned many important procedures which I might not learned if I didn't work with them [Transcript# ID101_029]."*

The evidence pointed that a good number of studies have been conducted on the Rohingya population focusing various diseases and risk of outbreak of some communicable diseases. Some health professionals mentioned that new knowledge has been created on various issues related to diseases and diseases control. One of the NGO representatives mentioned

> *"The crisis has somehow opened up windows for more fields of study. Development partners are showing interest in investing in research and even the government is investing huge sums of money into research which is not very common [Transcript# ID101_032]."*

The data collected through this interview has also been corroborated by the interviews conducted with the officials working in the health directorate. And the evidence is also supported by the documents produced by various development partners.

4.1.2 Health Infrastructure

The data gathered on the ground revealed that the Cox's bazar's overall health infrastructure was insufficient, even for the host population. Prior to the migration of the Rohingya, several vital medical equipment and testing facilities were in short supply. According to the findings of the interviews and focus groups, the Rohingya crisis has accelerated the infrastructure improvement process in public health institutions. With the aid of development partners and foreign communities, the number of beds at the sub-district public hospital has been raised. Medical equipment and other technical amenities of the public hospital have been built by the international community. Field hospitals have been established by the international communities which ultimately reduce the pressure of the public health sector facilities. Initially some of the health facilities were only opened for the Rohingya population but later these facilities were made accessible to the host communities. The head of the public health facilities in one of the sub districts asserted that:

> *"We didn't have an x-ray machine in our hospital. The patient needed to go to the district headquarters or private clinics for a very minor x-ray. We didn't have full operational theatre (OT) initially as we were lacking both the equipment and experts. But now, we can at least save lives which is mentally satisfying. This could not have been possible without the Rohingya crisis [Transcript# ID101_008]."*

The evidence has been further strengthened by an assertion by another medical officer working in one of the public hospitals, he opined:

> *"If you came to this hospital in 2018, you couldn't stay in this hospital for more than 30 minutes as there was an intolerable odour and waste everywhere. You couldn't also walk freely as there were patients everywhere even on the floors and corridors. The situation has changed drastically since*

the development partners and international communities came forward after the Rohingya crisis started [Transcript# ID101_005]."

The data showed that during the Rohingya crisis, the development partners and international communities alongside local NGOs came forward to assist the government in terms of fulfilling the capacity gap in terms of human resources and equipment. The statement of one of the representatives working in one of the prominent development partners is worth mentioning here, she indicated that:

"ICRC established an international standard emergency department in the Cox's Bazar district hospital. I believe such standard emergency departments is very rare in Bangladesh. If you go to Ukhiya and Tekhnaf hospital you will see very good medical waste management system which is also rear here. These are contribution of the crisis [Transcript# ID101_015]"

Though the primary goal of the assistance was to ensure the Rohingya minority's health, the host community also benefited in the long term. Since the commencement of the Rohingya immigration, the overall health facilities in Cox's Bazar district have improved tremendously. All the respondents believe the improvement is linked to the Rohingya influx. Furthermore, the road and communication infrastructure has also seen an upliftment. This has also helped the health-care sector's organizational capability by ensuring that patients and logistics are transported smoothly and on time.

4.2 Negative Impact of Rohingya crisis on the Health Service Providing Organizations

According to the literature, crises, whether internal, external, or transboundary, have both negative and positive consequences for organizations, regardless of their nature, i.e., public or private. Similarly, the study discovered that the Rohingya crisis has both negative and positive impact on the organizational capacity of health-care providers. Based on the interviews, majority of the identified impacts on health-care organizations are negative in nature. The following subsection presents some of the effects discovered during the field research.

4.2.1 Quality of Service

In response to the question about impact, the majority of respondents stated that the crisis has directly or indirectly hampered health service delivery to the local community (camp areas and

other parts of the country) in terms of both quality and quantity. In this context one of the ex-deputy director of the Cox's Bazar district main hospital (250 bed hospital) mentioned that:

> *"There were 200% -300% more patient than usual. As a result, we could not provide quality and enough time to our host patients and even sometimes the local patients had to go back without any doctor's consultation after waiting long hours. In normal time we had around 170-180% occupancy rate in the sadar hospital. And we had only 70-75% of the human resources compare to our sanction posts. This was the case for all hospitals and health facilities in the Cox's Bazar district [Transcript# ID101_019]."*

According to reports from the government and development partners, prior to the crisis, the health sector facility was not even adequate for the host community. Official statistics indicate the ratio of government doctors per 10,000 population in Bangladesh was 1.29, while the country also trailed in the nurses-patient ratio, which was only 3.06 (both public and private) per 10,000 population (MoHFW, 2019). The situation in Cox's Bazar is comparatively worse. Prior to the Rohingya crisis, the bed occupancy rate in district level hospitals was 145-150 percent but the situation in Ukhyia and Teknaf was even worse ((MoHFW, 2019). The health facilities were already overcrowded prior to the influx, which was exacerbated once the influx began in August 2017. Furthermore, there was a shortage of health professionals in the Cox's Bazar's health facilities. The following field data can provide a more accurate picture of the situation in the Cox's Bazar district.

Table 14: Vacant post of doctors in Cox's Bazar

Name of the Sub district	Percentage of the Vacant post of doctors (entry level)
Cox's Bazar Sadar	81.8%
Chakaria	75%
Kutubdia	75%
Ramu	73.3%
Ukhiya	44.4%
Tekhnaf	48.1%

Source: DGHS, 2020

Respondents also stated that because dealing with large numbers of refugee patients was a priority, they were sometimes unable to follow existing standard processes or SoPs, which caused technical issues. One of the resident medical officers working in a sub district hospital opined:

> *"We have standard referral system but sometimes due to huge pressure we could not maintain it. Some patients needed to be sent to the district hospital but we had to release them as we didn't have spare ambulance. We had to request that they go to the district hospital by their own arrangement. At times our medical assistants have to undertake major emergency procedures which according to our SoPs must be done by an MBBS doctor [Transcript# ID101_011]."*

The findings were further strengthened by the statement of one of the representatives of UNHCR. He asserted:

> *"The situation was so acute to control that we have to forget our post or positions when it came to dealing with the patients in critical conditions. I being a manager had to get myself involved in treating the injured patients as I was a doctor by education. This was the situation for all organizations be it public sector or private sector or NGOs [Transcript# ID101_021]."*

On average, health professionals had to work 15/16 hours per day. As a result, they were unable to spend time with their families for months, exacerbating the deplorable health professionals' mental and physical stress. This had occasionally hampered careful disease diagnosis. One of the respondents working in the Cox's Bazar Sadar Hospital avers:

> *"My wife was pregnant, and she was living in an apartment alone in Chittagong which is only 150 miles away from my workplace, but I could not go to see her for more than three months. Sometimes I became so stressed mentally that I forgot to mention the appropriate name of the medicine. And sometimes I forget to mention dosages in the prescription [Transcript# ID101_009]"*

Most of the respondents opined that the influx has in some way or other hampered their daily life which has direct and indirect correlation with the quality of service delivered.

The Civil Surgeon Office (CSO) was also preoccupied with the crisis that it spent majority of its time coordinating with crisis-response DSOs and other partner organizations. During the first months of the crisis, CSO support for medications and logistics for non-crisis zone areas were almost non-existent. Apart from Rohingya-related issues, official correspondence was non-responsive on almost all issues. The medium of communication to the Civil Surgeon (CS) was the use of cell phones. As a result, DSOs operating in non-crisis zones were forced to make decisions at the local level based on their professional knowledge and discretionary authority. In this regard one of the health professionals working in a healthcare facility in a non-crisis zone stated that:

> *'We were literally alone as there was no timely response from the CSO. We had to take our own decisions. We had to wait for a long time to get hold of the CS over mobile phone and this was the only means of communication with him. We had to manage the health facility locally applying our interpersonal and leadership skills as there was both scarcity of logistics and directives [Transcript# ID101_007].*

4.2.2 Disease Control

The findings from the field indicate that the Rohingya people were infected with communicable diseases such as diphtheria, cholera, and measles. Sporadically, these diseases spread on a small-scale in the Rohingya settlement camps. It also had the high tendency of spreading to the host community. As a result, the government was forced to deploy additional resources, both human and financial to mitigate or control the outbreak. The government was required to carry out an oral cholera vaccination campaign in the camps, as well as establish isolation centres for Diphtheria patients. Additionally, government had to monitor the situation 24/7. In this regard one of the health professionals mentioned that:

> *"It was a real shock when we found diphtheria patients in the camps because we haven't come across this disease for more than 25 years. At the same time, it was alarming as the interactions of the refugee community and the host*

community was not that restricted. As a result, we were anxious about the possible outbreak in the host community. We even didn't have medicine for diphtheria control at that time. We have to deploy additional doctors and scientist from diseases control units to thoroughly investigate the real scenario. We had to establish isolation centres and also channel our efforts on dealing with the outbreak [Transcript# ID101_006]."

This rare disease had a massive impact on the capacity of health-care organizations in terms of resources and management. In February 2018, it was estimated that 38 children died from diphtheria, and over 5800 suspected cases were discovered (WHO, 2018). According to reports from development partners, an estimated 250,000 children under the age of eight required immediate vaccination, while approximately two and a half million children under the age of five required nutritious food supplements to prevent malnutrition. On the other hand, approximately two million forty thousand children of various ages were required to receive the measles-rubella (MR) vaccine (UNICEF, 2017).

Furthermore, there was small-scale cholera outbreak in the Rohingya camps at Ukhia (a sub district). In addition, the government was required to provide oral **Lactobacillus casei vaccines** (lac) within a very short period of time. The camps located near the existing host communities were linked by canals. As a result, the host community was at risk of an outbreak of a water-borne disease such as cholera. In this case, an all-out effort was made to address the issue. However, the Rohingya refugees were almost completely unaware of the fundamental concepts of vaccination, and they initially questioned the vaccine's purpose. As a result, the government was forced to conduct an awareness campaign among the refugee population in order to familiarize themselves with such a vaccine and vaccination program. To deal with such a situation, additional health professionals and medical technicians were dispatched on an emergency basis from various parts of the country. The statement of one of the health professionals working in the disease control unit helps to clarify the situation. He asserts:

"We are really worried about the possible outbreak of cholera and diphtheria in Cox's Bazar. We have to send relevant health professions to the spot immediately. So, the regular service delivery at various parts of the country suffered a setback.

The Rohingyas were reluctant to take the vaccine. We have to allocate resources for carrying out awareness campaign to make them familiar to such system [Transcript# ID101_027]".

Disease control in Cox's Bazar was one of the primary responsibilities of health sector organizations during the initial stage of the influx, in addition to regular health services. According to DGHS data, 354982 cholera vaccines, 236696 measles and rubella vaccines, 1056505 oral polio vaccine, and vitamin A capsules were distributed to the Rohingya community by the end of December 2017. Carrying out such a drive and campaign in the Rohingya camps necessitated the deployment of additional health professionals from other parts of the country. On the other hand, as per data from DGHS around 61.7% entry level post of doctors was vacant. Considering the level of vacancy, it is evident that this drive has hampered the service delivery of other parts of the country. One of the officers' in-charge of the refugee camps had this to say in support of the above:

"The camp administration had to deploy all its effort along with the health professionals to make the Rohingyas aware about the benefits of the vaccine. We had to train their own people to make them understand that the vaccine is not harmful. We had to concentrate in this campaign setting aside other works. Our regular administrative works were hampered as Diphtheria control was our top priority [Transcript# ID101_031]."

The evidence from the field also suggested that besides the communicable diseases, the Rohingya community had some unknown non-communicable diseases like hepatitis, high blood pressure and pregnancy, etc. The health sector had to deal with these issues in addition to other threat of communicable disease. One of the public sector health managers working in the coordination cell at the Cox's Bazar said:

"Every day around 50-70 babies are born in the Rohingya community. Of which around 20 to 30 babies are born in the health facilities. In most of the cases, there was some kind of maternal or neo-natal complication. The gynae unit in the local hospitals were too busy to deal with the flow of new patients

every day that the host patients sometimes had to go to private health care facilities [Transcript# ID101_018].”

The data from the interview was backed up by reports from the development partners. According to UNICEF (2018), 60 babies were born on the average every day during the first nine months of the crisis. The same report alludes that between August 2017 and May 2018, a total of 16000 children were born in the Rohingya camps. According to government reports from the ministry of health and family welfare, 45,890 women tested positive for pregnancy as of 2020, with 303,686 pregnant women receiving iron and folic acid therapy. Moreover, the data from the field also indicated that the health sector has to devote time and resources in dealing with non-communicable diseases as well. The following table 15 relates this fact:

Table 15: Service provided by Cox’s Bazar public health facilities (2015-2018)

Year	No of average patient consulted /month for Non-communicable diseases	Increase (%)
2015	3338.14	-
2016	3508.16	5.09
2017	4947.18	41.01
2018	5280.16	6.73

Source: Author’s construct based on the data from MOHFW, 2020

4.2.3 Change in Convention and Practice

Almost all respondents stated that, aside from treating refugee patients, other important regular and routine tasks were disrupted by the massive workload caused by the Rohingya influx. The health service organizations perform a variety of tasks such as routine vaccination programs, preparing reports for central organizations, monitoring development activities, representing in various coordination and development bodies, and so on. However, the results revealed that health professionals were unable to devote time to such work during the first months of the influx. The result also indicated that the development program's implementation rate was hampered, which was supported by a ministry-level report on the implementation of the Annual

Development Program (ADP). During the first months of the crisis, regular personnel management activities such as recruitment, promotion, training, and even departmental proceedings were unable to take place. This has heightened internal organizational tensions. This could have a negative impact on employee motivation. In this regard, one of the leading health-care managers in the Cox's Bazar district stated that:

> *"It was really an unusual time, we sometimes forgot to submit our own salary bill in time. We were absent in almost all district level routine meetings. Once or twice, we received 'show cause' letter from our superior organizations for non-compliance as we could not send regular reports on time [Transcript# ID101_013]"*

The findings were supported by the information gathered from the officials working in the local administration and coordination bodies. In this regard the statement of one of the officials working in the district administration is worth mentioning:

> *"There was no work except the work related to the Rohingyas. Most of the development works were either suspended or slowed down. We had to cancel most of our regular and routine meetings due to non-availability of key committee members. The health facilities were over crowded by the refugees therefore the host patients were forced to go to private health facilities. But we could not conduct our monitoring drive to ensure quality of service in the private health facilities due to lack of adequate personnel who were too busy handing the Rohingya settlers [Transcript# ID101_025]."*

Therefore, the crisis hampered the quality of health service from legal point of view. And it was spread over the whole health sector in the district beyond the periphery of public health sector only.

Some respondent mentioned that the routine vaccination campaign for the host community was not maintained as routine during the refugee influx time. And the implementation of some of the projects which were jointly ran with other organizations were also hampered. The situation has been explained by one of the respondents working with an NGO as:

"It happened that there were no health professionals available to carry out the vitamin A vaccination campaign as result we had to bring in health professionals from the private sector. And there was no discipline in carrying out other activities apart from treating the injured and traumatize patients who were coming from Myanmar [Transcript# ID101_030]."

Furthermore, the data revealed that with the onset of the crisis, the regular and customary management practice had changed. The coordination between the CO and DSOs working in the crisis zone, as well as the cooperation among the crisis response organizations, has grown increasingly prominent and innovative. Other regular and normal coordination, such as coordination with non-crisis zone DSOs and internal coordination, has grown sloppy. It was also clear that the communication style had shifted to one that was more informal and, in most cases, vocal. In comparison to the typical procedure, decision-making has also taken on a different shape. The decisions were primarily made locally, especially by local level COs and DSOs operating in the crisis zone, based on intuition, professional knowledge, and judgment. During normal times, the statistics revealed that decisions were generally made on the basis of data and from the top. Managers in the local CO and the DSOs operating in the crisis zone appeared to be transformed into leaders as a result of the crisis. Instead of being task-oriented and authoritarian, managers had become more relational and transformative. According to the statistics, this change was critical in inspiring the organizations' staff as well as bringing novel approach to the crisis response. In this context, one of the medical officers working in the crisis zone has observed that:

"The situation during the initial days of the crisis was really new. Sometimes, we just made a mobile conference call with the relevant officials in case of coordination. Our supervisors did not ask for a formal letter for anything which was unprecedented. In most of the cases we had to take decision by ourselves and we had to manage everything locally. But I must admit that the senior officials were always sympathetic to us. Whenever, they called us they wanted to know our personal condition at the very first instance. I haven't seen such caring attitude in my career [Transcript# ID101_010]."

4.2.4 Allocation of Resources

Most of the respondents believed that the crisis had put a strain on the health-care resources available to other parts of the country since a large chunk of money had to be diverted to the Rohingya crisis-prone areas. As a result, some facilities had to make changes to their budgets or wait for funds to become available. The respondents also stated that in the early months, almost all of the resources provided for the Cox's Bazar region were used to deal with the issue. Moreover, in the first two months, health professionals were dispatched from various areas of the Cox's Bazar districts. Later, health specialists from other sections of the country were dispatched. As a result, the region's wage budget, as well as travel and daily allowances, needed to be boosted. The interview revealed that extra equipment and vehicles were required for the Rohingya operations, which also cost a lot of money. One of the top health-care executives spoke out in support of the outcome, saying:

> *"We were not ready to accumulate additional expenses which were really unexpected. Therefore, in the initial months we could not provide the demanded allowances on time. The doctors and staffs had to wait for more than two months to get their travel and daily allowances paid. We had to write to the health directorate several times to allocate additional travel and daily allowances to cater for the additional deployment of health professionals during the Rohingya influx time [Transcript# ID101_016]".*

To deal with the increasing influx of patients, medical teams were organized. These medical teams were made up of doctors who were stationed in various sections of the country. Making travel and lodging arrangements for the deployed health experts require more resources. The medications allocated needed to be increased about fivefold. As a result, there were shortage of medicine in other sections of the district as additional medicine had to be moved to the three major hospitals that were primarily dealing with Rohingya refugees during the early months of the inflow. Against this backdrop, one of the health professionals working in the one of the major hospitals mentioned that:

"Our medicine store was always almost empty as we could not store medicines because of the high demand. And almost every two days we have to rush to district headquarters to collect additional medicine. Sometimes we had to request NGOs to supply essential medicines as the supply from government side was not able to cope with the unexpected demand [Transcript# ID101_008]".

The findings also revealed that development partners and NGOs have become increasingly important in meeting the enormous demand for resources, whether human resources, equipment, or finances. Furthermore, the government had to allocate additional human resources to the Cox's Bazar district in order to manage the public health situation in both the host and Rohingya communities. Till date, the allocation of such resources is continued. This is expressed in the Civil Surgeon sayings as quoted below:

"Government is keen to handle the situation here in Cox's Bazar. This year government has given 80 entry level doctors to be posted at various health facilities in Cox's Bazar. This is big a chunk as compared to the national average. Now, the health facilities have fully equipped ambulances which is an exceptional case if you compare it to other districts [Transcript# ID101_001]."

The data collected from the Ministry of Health and Family Welfare fall in line with the result which showed in table 16 below:

Table 16: Health Professionals and equipment deployed at Cox's Bazar

Resources	Number
Doctors	293
Nurse	186
SACMO	224
Community Health Worker	1259
Ambulance	45

Source: MoHFW, 2020

4.2.5 Unholy Practice

The findings from the field revealed that the crisis inadvertently encouraged some unholy practices in the health administration's management issues. Around 20% of respondents said that there was some sort of corruption in the deployment of health personnel. They stated that because a large number of doctors were needed in the Rohingya camps, the directorate of health was forced to delegate health professionals from all over the nation. The task in the Rohingya camp was also extremely difficult and stressful. Furthermore, there were issues with their lodging and transport arrangements. Given the circumstances, some health practitioners attempted to avoid such tasks. To prevent being assigned to the Rohingya camps, health professionals began lobbying at political and administrative levels. They also mentioned bribery concerns. Some respondents also noted that some health professionals fabricate medical reports in order to avoid deputation. The remark of one of the health sector managers working in the health directorate backed this assertion. In this context he said:

> *"We are tired of listening to the requests from high officials and political leaderships. Always requesting us to cancel the deputation order of some health professionals. Sometimes, the request comes from ministers who are high level officials. In such situations, we are in dilemma as we are under pressure to urgently deploy health professionals in one instance and at the same time, we are under pressure to cancel some names from the deputation list [Transcript# ID101_022]"*

Another manager working at the divisional level corroborates this by indicating that:

> *"At the time, I had to meet a number of health professionals personally as they came to request me to withdraw their names for the deputation list. Their personal requests were mostly followed by a phone call from high officials or political leaders or professional associations. There is a rumour that an unholy practice was operational at that time [Transcript# ID101_024]."*

Other respondents also mentioned that deploying the health professionals caused some management issues, which they likened to some sort of unethical practice. The management

process and decision-making were under duress as a result of this practice and this resulted in ineffective management.

Simultaneously, the respondents stated that a group of local businesspeople backed by the local political class attempted to seize control of the health-care supply chain, including patient food and even laundry services. This is expressed in the statement of one of the ex-civil surgeons. He had this to say:

> *"It seemed to me that they took the crisis as an opportunity. During the crisis in one of our hospitals, we have tried to introduce one innovative practice to reduce the cost of laundry service but a group resisted the process by engaging their political power with a fear that this might limit their scope as suppliers. Again, during the crisis, we had to supply additional food for the patients as there were more patients than the capacity. We had to manage it locally from some suppliers on credit but they offered higher prices as compared to the prevailing market price and we had to pay it [Transcript# ID101_033]."*

It was also discovered that a group of individuals attempted to use the catastrophe to change their fate overnight. Though the problem has been under control over time, it has faded away as a result of the government authority's putting in place structured mechanisms for procurement.

4.2.6 Environmental Degradation, Illegal Drug and Public Health Threat

Respondents indicated that the huge influx has caused significant level of environmental degradation. The data suggested that deforestation, hill cutting, clearing of vegetation from the watershed areas along with air pollution has become a serious concern for the Cox's Bazar district. The evidence from the field confirmed that the settlement was unplanned and certainly destroyed the biodiversity of the area. A total of 4300 acres of hills including forest has been destroyed due to temporary shelters in Ukhia and Teknaf (UNDP, 2018). It was also found that almost half of the forest land has been encroached upon and nearly 6800 tonnes of fuelwood is collected each month for cooking. The water bodies and cannels have become contaminated due to overuse and open defecation. The situation can be further understood by the statement of one of the medical officers working in one of the sub district health complexes. He avers:

"I could smell diesel and patrol every time I went to the roadside. No doubt the level of air pollution has risen as my asthma has worsened during that time so as the case of others. I have noticed an upsurge in lung diseases in this area as we see more patients with severe cough and asthma in the OPD [Transcript# ID101_028]".

Data collected on the ground indicate pollution levels in these locations have grown as a result of increasing vehicle traffic and smoke produced by Rohingya settlers burning firewood. It is also evident that environmental degradation has both direct and indirect impact on public health, as air and water pollution are known to exacerbate health problems.

Some of the respondents indicated that the uncontrolled influx has further increased the presence of illegal drug, commonly known as Yaba. Yaba is a Thai word which means crazy medicine. The drug is manufactured in Myanmar (this is Thai broader) which has been a channel through which this illicit trade is smuggled to Bangladesh over a long time now. After fleeing the genocide in Rakhine state, most of the felt obligated to smuggle Yaba to protect their safety or to make some money in this situation. Furthermore, some were obliged to travel to the border with local smugglers in order to acquire drugs from entering immigrants. As a result, it was clear that some Rohingyas were going to Myanmar on a regular basis at night to receive narcotic packages. They also returned with other refugees making it difficult for the authorities to track those who were entering Bangladesh and what they were carrying along.

According to a response of one sub district chief executive on the local newspaper's allegations, a large number of Rohingyas have been transporting and selling Yaba. Between August 2017 and August 2018, roughly 600 Rohingyas were arrested for either selling or carrying Yaba. In the 12 months after the migration began, the authorities have recovered more than 10 million Yaba tablets from Rohingyas and other local drug dealers.

The findings indicated that the usage of illegal drugs such as Yaba had a major influence on public health. The use of drugs has exacerbated the complications of other diseases in users and has sparked the emergence of new disorders. It has some indirect effects as well, as it is linked to an increase in gender-based violence and malnutrition. One of the ex-civil surgeons made the following statement which is worth mentioning here. He opined:

"The occupancy rate in the special clinics for the addicts are always more than 100%. As doctors, we are finding more and more patients who are in one way or other involved in some kind of addiction. The situation has become more vulnerable with the advent of the refugees [Transcript# ID101_017]."

4.3 Summary of the Chapter

The main purpose of the chapter was to identify and explore the major impact of the Rohingya crisis on the organizational capacity of the public health sector organizations. Beginning with an introduction, the chapter presented the findings from the field. The impact is divided into two major categories based on their nature and extent. The negative impact has been categorized into six themes which includes quality of service, disease control, change in convention and practice, resources allocation, environmental degradation, illegal drug and public health, and unholy practice. The chapter also discussed three themes constituting the positive impact which are professional knowledge, health infrastructure and local development. The findings have shown some interesting contradictions as the respondents mentioned that the crisis has hampered the quality of services to the host community and at the same time it has also widened opportunities in terms of improved health infrastructure. However, in order to further understand the impact, it is important to examine the influential factors behind them. Therefore, the next chapter focuses on the factors involved in explaining the impact of the crisis.

CHAPTER FIVE

KEY FACTORS INFLUENCING THE CAPACITY OF PUBLIC HEALTHCARE ORGANIZATIONS IN THE CONTEXT OF ROHINGYA CRISIS

5.0 Introduction

Describing and exploring the nature and dimensions of impact of Rohingya crisis on the capacity of the public health sector organizations was focus of the previous chapter. Hence, it is important to understand the actors and factors which influenced the organizational capacity. In line with that this chapter focuses on the factors that affect the organizational capacity of the health sector organizations in order to visualize the result of the second research question. The findings support the assumption that political, administrative and socio-psychological factors played important roles. The identified data has been divided into twelve themes which includes political commitment, effective monitoring, sense of kindness and affection, religious affinity, culture and tradition, international pressure, Islamophobia, media presence, active partnership, presence of a specialized organization, too much intervention and unfamiliarity of basic health service. However, some of the factors acted as driving forces and the others tried to restrain the capacity of the health sector organizations. Nonetheless, the data showed that there were several factors that were indirect in nature yet had an impact on organizational capacity.

In order to thoroughly examine the impacts of the crisis on organizational capacity, we need to understand the driving, restraining factors and actors behind it. It will help us to attain the first objective of the study. Again, the restraining factors are important to understand in order to identify the capacity gaps in the health sector organizations which is the second objective of the research.

5.1 Driving Factors

The findings revealed that several factors had a positive impact on organizational capacity, implying that they directly or indirectly accelerated the capacity of health-care organizations. In the case of the Rohingya refugee crisis, variables such as political commitment, effective monitoring, feelings of warmth and affection, religious affinity, culture and tradition, media

presence, active partnership, and the presence of specialized organizations aided the crisis response. These are discussed below.

5.1.1 Political Commitment

Responses from the field indicated that, the level of political commitment, particularly at the highest political level, played a major role in engaging public sector organizations to respond positively towards the Rohingya crisis. The visit of the Prime Minister at an early stage of the influx, according to the majority of respondents, was a strong signal for public sector employees. One of the former civil surgeons of Cox's Bazar district mentioned that:

> *"I was present at that meeting where the Prime Minster gave her speech in September 2017. I become emotional when the honourable prime minister said that the Rohingyas were our guest and we should share our food with them. I can still remember that moment when the prime minister reminded us about our history of liberation. Almost everyone become emotional. And we could understand the message of the government clearly. This visit was a turning point and we realized that there will be no mercy if there is any negligence in the Rohingya response activity [Transcript# ID101_002]."*

Most of the respondent also suggested that the involvement of the Prime minister's office at the initial stage alerted the public sector organizations about the crisis. The Prime minister's office provided an initial guideline and made the ministry of Disaster Management and Relief as the coordinator at the national level. The ministry of Health and Family Welfare was also assigned as the national lead for health issues. One of the officials working in the Health and Family Welfare Ministry stated that:

> *"We were in a dilemma as to what to do in the early days of the refugee movement until a high-level meeting convened at the Prime Minister's Office and presided over by the Principal Secretary. The meeting's decisions acted as our operating guidelines in the initial months. The Principal Secretary's*

command was very clear and we as civil servant understood the gravity of the situation [Transcript# ID101_020].”

In order to better coordinate the health situation in the Rohingya-affected areas, the Ministry of Health and Family Welfare developed a coordination cell and deployed it in the Cox's Bazar district. According to the responders, such rapid deployment was a symbol of the ministry's eagerness and dedication. Evidence from the field revealed that the Rohingya crisis has risen to the top of the Directorate of Health Services' priority list since the Prime Minister's meeting. This is supported by the statement of one of the directors of the health directorate. He avers that:

> *“Our director general had to rush to Cox’s Bazar immediately and he had to stay there for two weeks. He could not even attend the funeral of his mother. Our senior officials had to stay in Cox’s Bazar according to emergency duty roster. All kind of leaves for the health professionals working in the public sector were cancelled [Transcript# ID101_023].”*

The intention of the top political leadership has been communicated all the way down to the grass roots level via administrative channels. The government's strong commitment had prompted government staff to devote themselves to the Rohingya operations. The results were also bolstered by a remark made by one of the development partners' representatives, who stated that:

> “*The role of government doctors working in the field levels are not beyond criticism. They were blamed for absenteeism, insincerity, amongst others. To be honest, I have also personally observed some of these situations. However, in case of this Rohingya crisis, I must admit that they have done their level best. And in some occasions, they have done beyond their capacity. The effort is praiseworthy. And I have seen this kind of tremendous effort since the honourable Prime Minister visited us in early September, 2017 [Transcript# ID101_034]*.”

The data suggested that, all representatives of NGOs and other development partners stated that the commitment displayed from the highest political level appeared serious, as evidenced by the effort of the government officials working on the operation.

5.1.2 Effective Monitoring

In addition, proper and effective performance was supported by tight monitoring at all levels. Majority of the respondents indicated that their respective higher officers were extremely alert during the Rohingya issue. It was evident that the officers had to send regular reports relating to the Rohingya refugees. A control room was established up at the health directorate to monitor the situation 24 hours a day, seven days a week. One of the medical officers working in one of the hospitals opined that:

> *"Sending four to five reports every day was a real burden for us. The DG office and the ministry was so keen on getting the report on time that they sometimes knocked at our doors before the stipulated time. They required up-to-date reports at four o'clock when the deadline was five o'clock. Anytime we called the control room, there was someone to respond to our call even around midnight [Transcript# ID101_004]."*

Almost every week, high-ranking ministry officials visited the sites. Aside from these, representatives from the international community visited the camps and hospitals on a regular basis. The local administration and the RRRC headquarters also kept a close eye on things. The head of one of the sub district hospitals remarked during the course of the interview that:

> *"Almost every day, we had visitors. Sometimes, we were not aware of visits until we receive a copy of the inspection report. We were tired of visitors, but we were keen on keeping everything in good order to avoid any negative remarks from our superiors [Transcript# ID101_003]."*

It was clear that physical visits by superior authorities and regular reporting played a role in getting things done correctly. To coordinate and closely monitor the situation, the Ministry of

Health and Family Welfare (MoHFW) established a coordination cell in the Cox's Bazar district, where the ex-secretary of the MoHFW was appointed as the chief coordinator, and he and his entire team were based in Cox's Bazar. During the interview session, the civil Surgeon of Cox's Bazar mentioned that:

> "*I haven't seen our superior authority at the directorate so serious. We were being watched so meticulously that it seemed to me that we were working under CCTV surveillance. They had literally shifted the head office from the centre to the periphery. This had facilitated a positive crisis response and efficient management at the field level [Transcript# ID101_001].*"

The result from the field also supported the same findings as the respondents of other departments also mentioned that same scenario while describing the situation at the initial phases of the crisis. The statement of one of the Additional Deputy Commissioner (ADC) working in the district administration during the interview is worth mentioning, as he noted:

> *"It was like a flood of VIPs. Cox's Bazar was the main tourist destination, always busy because of the frequency of visits by the VIPs. This was unprecedented at the initial days of the Rohingya crisis. All the government rest houses including the Circuit rest house were full. We had to negotiate with the private hotels to accommodate some government officials and the dignitaries from various embassies and donor agencies. Almost all the officers of the district administration were busy with either VIP protocol or relief work. We had to postpone other schedules like our regular meetings, hearings at the courts, inspections, etc. [Transcript# ID101_034]."*

The situation was the same for the development partners and the NGOs operating in the Rohingya crisis areas.

5.1.3 Sense of Kindness and Affection

The findings from the field also revealed one crucial characteristics of the health sector employees as demonstrating a sense of friendliness and affection. Almost all of the respondents in the health sector stated that a large number of Rohingya refugees had been shot, burned, or

physically attacked. As a result, as medical professionals, they could not help but treat them. They did not have a time schedule, but they said they never got tired working overtime just to treat the injured refugees. In the course of the interviews, one of the medical officers who worked in the frontline during the initial days of Rohingya crisis reiterates this as follows:

> *"I haven't seen such a situation in my life. I sometimes forgot to take my lunch because it was not possible for me to go for lunch leaving an emergency and injured patient unattended. This was the case for most doctors working in the hospital. We had to work 14-15 hours a day. I was mentally attached to them that I could ignore my tiredness [Transcript# ID101_009]."*

Oher respondents who were not health professionals also indicated that the situation of the Rohingya refugee was so inhumane that they sometimes became emotional and saw their work as a humanitarian activity rather than an official duty. One of the officials working with RRRC mentioned:

> *"As a civil servant, I have participated in various crisis management and emergency situations but this particular situation was unprecedented. I had to be in the border areas (the entry points of the refugees) 7 days a week. I couldn't stand the plight of the Rohingyas. Majority of them were either harmed or physically assaulted in one form or the other. I couldn't stand it when I saw the injured children. I had to take some injured patients from the transit points to the hospitals on many occasions. It wasn't my obligation, but as a human being, I couldn't stand unmindful but help them [Transcript# ID101_035]."*

The findings were further echoed as one of the DP representatives mentioned that:

> *"I have been working with the development partners and INGOs for 12 years. I haven't seen such sincere work from public sector employees. I saw some of them buying unavailable medicines from the private market for the Rohingya children. I had also seen in one of the camps, the in-charge buying food from his pocket to distribute to the Rohingya children [Transcript# ID101_036]."*

The sense of kindness and sincerity was just unimaginable, it was a daily affair and seen as one of the influential factors demonstrated by officials helping to mitigate the effects of the crisis during the initial phases. And this factor prevailed irrespective of the sector the official was coming from (either public or private) organization.

5.1.4 Religious Affinity

The findings from the field suggested that a good number of the respondent viewed the crisis from religious perspectives. The data showed that most of the officials worked during the crisis opined that the genocide and oppression, was as a result of the religious identity of the Rohingyas. The perception of the respondents also indicated that the acceptance of such a huge number of refugees would not have been possible if they were not Muslims. One of the medical officers working in the sub district health complex reiterates this point during the interview session:

> *"Such a massacre would not have happened if the Rohingyas were not Muslims. It seemed like an agenda to depopulate the Muslim community and they had no one to stand beside them. They are our brothers and sisters. Can you imagine, the perpetrators had raped our Muslim sisters in order to give birth to non-Muslim children. I am not a practicing Muslim but I cannot still fathom what happened to our Muslim compatriots. I would have done the same work if they were not Muslims [Transcript# ID102_009]."*

Results from the interviews and FGDs suggested that religious feelings were significantly more active among lower-level staff employees. In normal times, respondents indicated that there was a common tradition of insincerity among staff employees. However, the data indicated that the staff members were genuine and spontaneous during the crisis response period. They were all personally motivated to help their folks in need. According to respondents working in the public health sector, the sense of kindness, as well as the sense of Islamic religious affiliation, was a factor. One of the chiefs of a sub district hospital remarked in the following words:

> *"I was surprised to see the sincere effort of my staff. I didn't see any complain from them though they worked for long hours. Rather I have seen some of my*

staff distribute meat during Eid festival with the patients staying in their hospitals. I had a personal reservation about the distribution of food among the patients as I was worried that the food may cause further problems. But they did not listen to me instead they said that they could not eat the meat without their Muslim brothers who could not observe the Eid due to the situation they found themselves in [Transcript# ID102_008]."

Though Bangladesh is not an Islamic country by constitution, majority of its population are Muslims. It is evident that people in Bangladesh in general are sentimental from religious point of view. No matter their practice, Islam is their day-to-day life and they become sentimental when religious issue occurs. The results of the interview and FGDs suggested that the respondents had the same kind of sentiment. Though the sentiment was not obvious in the formal sector, it appeared to be in the back of their minds. It was evident from the field that the camp managers and other officials had personally participated to the developing and management of prayer areas in the camps. One of the camps in-charge stated as follows:

"I was surprised when I found that the very lower-level staffs with very low salaries contributed significant amount of money to establish a mosque for the Rohingyas. Colleagues who were not Muslims also contributed wholeheartedly towards this purpose. When I went to the mosque to pray with the Rohingyas, I could not resist my emotion when the Rohingya brothers were crying while praying. Daily, I pray to the Almighty to make their lives normal again. I can't explain these feeling in words, but it comes out from my heart. And so is the case with everyone working here with us [Transcript# ID101_037]."

The findings also suggested that the officials and their family members gave Zakat (a system in Islam where Muslims distributed their extra money under certain rules to the poor and needy among them, in this case the Rohingyas). It was found that the Rohingya women were also supplied with the veils (covering dress for the women) purchased by the donations made by officials and staff members working in one of the district level offices. The data also indicated that huge religious organizations came forward with huge funds and relief materials. They also

established mobile medical teams in the affected areas during the early days of the crisis. One of the deputy commissioners working with the district administration had this to say:

> *"I had to travel to the affected areas daily. We were very busy managing the flow of relief materials from various parts of the country. I saw a good number of religious people wearing religious dresses every day at the affected areas. They were from various religious organizations or members of mosque management committee. These people have contributed generously especially in areas of food and medicine. In the mosque that I always go to pray, I have seen the management committee appealing for funds for the Rohingyas [Transcript# ID102_017]."*

These issues were raised and discussed in the FGDs, and the results revealed that workers' genuine involvement was influenced by their religious sentiments. Respondents averred that the availability of resources to the Rohingyas was related to these sentiments. According to the data, respondents of the DPs also found this kind of mindset among civil workers and NGOs.

5.1.5 Culture and Tradition

The culture and traditions of the local area, as well as the country as a whole, appeared to have a part in the crisis management. Bangladeshi culture is known for its hospitality. These characteristics can be found in almost all persons whether affluent or poor. The evidence from the interviews and FGDs indicated that the indigenous people are known for their hospitality and are more religious than the rest of the country. It was also discovered that there was a long history of kinship and relationships between the Muslim communities in Rakhain, Myanmar, and Cox's Bazar, Bangladesh. The kinship is more prevalent in boarder regions such as Teknaf and Ukhia. Respondents also indicated that intercommunity marriage had been popular for a long time because of the cultures and languages of Rakhain, Teknaf, and Ukhia. It was also discovered in the field that there were a large number of wealthy Rohingyas who had purchased property and houses in Teknaf and Ukhia with the assistance of relatives living in various regions of Cox's Bazar. One of the medical officers working in the Teknaf health complex during interviews had this to say:

"I have heard that the Rohingyas have strong kinship with the local people, but was not recognizable before the crisis. Daily I see some local faces here, some of them are local elites visiting/attending to the injured Rohingyas. I can still remember, one day one of our staffs who is a local, rushed to me, requesting me to save the life of one of the burnt/injured Rohingya. I was initially surprised by his reaction but later I found out that the injured person was his brother-in-law. The crisis seemed to be local family crisis rather than the crisis of the Rohingya community [Transcript# ID102_F007]."

The locals clearly accommodated the distressed Rohingyas in their yards, back yards, and even their own homes. Respondents also stated that a large number of Rohingyas were housed by relatives, hence the total number of registered Rohingyas in the 34 camps was never included. Because of the similarities in physique and language, it was extremely difficult to distinguish between the Rohingyas fand the native population. The response from one of the local chief executives echoed this sentiment as he observed that:

"Alongside political and administrative pressure, we could feel the pressure from the local community as well. The local community hosted the Rohingyas as their own family members in the initials days which helped the overall management in a positive way. But they also started to put pressure on us for better management of the Rohingyas. Daily I receive a good number of complains about poor service delivery at various service delivery points. These complaints were lodged by the local people and sometimes local elites.

The bond between the Rohingyas and the local people was both traditional and historical, and based on the religious and cultural similarities. The findings were also supported by the respondents from NGOs and DPs as one of the representatives of a key development partner mentioned that:

"I have been working in this region for more than 5 years in various capacities and have seen the strong tie between the Rohingyas and the local people. In Teknaf during the festival seasons, the markets were full of Rohingya buyers.

Even I have seen them using the mobile SIM which were registered in Bangladesh. During festivals like Eid, I see a good number of people from Myanmar visiting Tekhnaf and Ukhia and vice versa [Transcript# ID102_F011]."

The kinship between the two communities was significant. It was also discovered that business and trade relationships were significant among the two communities. And border authorities of both countries were well aware of the mutual circulation of persons for a variety of reasons. It was also clear from the field that border forces on both sides were flexible during festival periods since they were briefed of the mutual bonding of the two communities' people.

5.1.6 Active Media Presence

Active presence of the media has a played significant role in the crisis management activities. The data from the study suggested that the media played an important role in the Rohingya crisis. The media played a watchdog role in disseminating the real situation of the crisis to the global community. The findings indicated that the crisis attracted huge international media coverage beside the local one. The respondents mentioned that usually the media tried to find out the loopholes of how the crisis was managed instead of covering the good works done by the authority. Therefore, the officials were concerned about the huge presence of the media especially the international media. These notwithstanding, other respondents also portrayed a different scenario about the media. They indicated that the media played very effective role by portraying not only the problematic areas but also the good works and real pictures of the crisis. The ex-Civil Surgeon during the interview session had this to say:

"I have a personal aversion to journalists because of a bad encounter I had with them earlier on. We were very busy throughout this crisis, but I advised my colleagues to be very careful and methodical in dealing with the problem because the media was very active. Surprisingly, my interaction with the media this time was positive. I've seen them print and broadcast positive and constructive news alongside the flaws and gaps in the crisis management situation. Nonetheless, the knowledge about our flaws has occasionally aided

us in resolving the problem on an expedient basis, as media coverage has facilitated remedial operations at all levels, whether local or central [Transcript# ID102_F007].”

At the central level especially at the health directorate and ministry level the media reports and publication were treated with high importance. The ministry level officials and the officials at the Prime Minister’s Office were concerned about the reports as these reports were connected to the reputation of the government and the country as a whole. The respondents observed that they were more concerned about the presence of the media and their reportage especially the international Media. This made them put in extra efforts in developing policies and plans regarding the Rohingya crisis. They had taken some measures based on media reports. In this connection the statement of one of the officials working in the Ministry of Health and Family Welfare is significant as he observed:

“During the early days of the crisis, one of my duties was to go through all the media reports (both print media and the international news). The essence was to find out whether there was any significant news about the Rohingya crisis. If there were, we took immediate action against any negative reportage concerning health care. The Prime Minister’s Office was also monitoring such news. I must admit the presence of the media somehow made us more careful in dealing with the issue as compared to any other issue we had previously handled [Transcript# ID102_F003].”

The field data further suggested that the huge presence of the media played a significant role in the overall crisis management irrespective of the sector or area. An official working at the district administration during the interview session mentioned that:

“We were literally being watched by the media every day. So, the authorities easily became aware of any kind of mismanagement or corruption. The media report sometimes attracted immediate actions from the authorities. This would not have been possible without the media [Transcript# ID102_F006].”

The news about the insufficiency of medical equipment and health professionals necessitated the deployment of health professionals and equipment during the crisis. It was also found out that the international coverage also facilitated the inflow of needed funds in some cases.

5.1.7 Active Partnership

A formal and active partnership between the government, development partners, and NGOs seemed to be a critical aspect of the organizational capacity of health sector organizations. Furthermore, the active role and involvement of the local population played an important role in the crisis management and response efforts. Regardless of the nature of the crisis, it was clear from the literature that the engagement of international development partners aided the crisis management operation. The field results confirmed the importance of the relationship in the context of the Rohingya issue. The respondents confirmed that the development partners, in collaboration with the NGOs intervened in real time. Furthermore, the statistics showed that there was a substantial supply gap of human resources and adequate medical equipment at the start of the crisis. The government attempted to fill the gap with its own resources, but due to limited resources, the government was unable to keep up with the tremendous demand. Some international and national NGOs, as well as some foreign communities, responded rapidly and effectively as partners in development. In order to deal with the crisis, the development partners sent their own health professionals to the government hospitals. They also provided medical equipment to government hospitals. Additionally, they arranged training for the relevant health professionals. The NGOs also played a supporting role in filling the essential gaps, mostly in terms of human resources. In this regard, one of the heads of a sub district health complex stated as follows:

> *"We had to work 24/7 in the emergency departments, deploying three or four doctors in each shift in the early months of the influx. There is no emergency department in the public hospital in Bangladesh where you will find more than one doctor at a time in each shift. We could only do this because some development partners and NGOs deployed their own doctors with us. [Transcript# ID102_F002]."*

In addition to providing health professionals to help with the crisis, the development partners also contributed with infrastructure development in various government facilities. They complemented the 31-bed government hospital by building 48-bed facilities in Tekhnaf health complex. Some of the development partners also established laboratory facilities. One of the medical officers had this to say:

> *"Initially, we didn't have an X-ray machine. Now, we have digital X-ray machines as well as an expert radiologist working in the hospital. This was only possible because one of the international organizations stepped in. We didn't have storage facilities in the hospital and so we couldn't preserve some medicines. Now we have a separate and standard medical storage facility which was made possible by one of the development partners [Transcript# ID102_F005]."*

The development partners stablished field hospitals and primary health care centres. They also established specialized clinics for various diseases. These initiatives helped to decrease the pressure on the government health facilities. Data from DGHS suggested that the health sector is coordinated under the leadership of the Civil Surgeon's Office in Cox's Bazar. The World Health Organization (WHO) is leading the sector on behalf of the development partners for better emergency responses. There are 100 active partners operating in the health sector among which 62 are development partners, 59 are National NGOs and 8 are UN agencies (DGHS, 2019). The health sector has been operating in three tiers which includes the District, sub-district (Upazila) and union levels. The health sector is being managed by six working groups led by various UN agencies. Sexual and Reproductive Health (SRH) group is chaired by UNFPA, the Community Health (CH) group is chaired by UNHCR and co-chaired by CPI, Epidemiology and Case Management (ECM) group is led by WHO, Mental Health and Psychosocial Support (MHPSS) is coordinated by IOM and UNHCR and the Emergency preparedness response (EPR) working group is headed by WHO. As at December 2019, a total of 129 health posts, 32 primary health care centres were operated by these health sector development partners. Among which primary health

care centres are providing 24/7 services (DGHS, 2019). The involvement of the partners filled the capacity gap of the public health facilities. One of the deputy directors working in a hospital in Cox's Bazar stated as follows:

> *"We had shortage of equipment and health professionals in the hospitals. But since the Rohingya crisis started, we are now witnessing effective moves. Some demands were fulfilled by the government and the rest of the gap has been addressed by various international communities and the development partners. In the hospital, we now have many wards for the Rohingyas with all kinds of modern amenities. Besides, the Rohingya patients, the hosts patients are also benefitting [Transcript# ID102_F010]."*

The findings indicated that the effort from all collaborators was sincere and quick. The government, development partners and the NGOs are working efficiently towards fulfilling a common goal. The coordination and leadership from the government's side is seen as effective as the participation of the other partners. In this direction, one of the representatives of the leading development partners had this to say:

> *"I have seen government officials ignoring or finding only faults of the initiatives run by NGOs or development partners. And we were also busy with finding faults with them. To be honest, this time round within this crisis, I have observed a harmonious co-existence and real cooperation of the government and other partners [Transcript# ID102_F004]."*

It was evident from the data collected from the DGHS that the partners actively engaged in vaccination programs along with the other conventional activities. The data suggested that between July and October 2019, the following number of vaccines has been provided to the Rohingya people:

Table 17: Scenario of vaccination among the Rohingya population

Name of the Vaccine	Number administered
BCG	24 529
Pentavalent vaccine (Penta 1 and 3)	31094
Measles Rubella vaccine (MR1 and MR2)	26062
Tetanus Diphtheria.	9046

Source: author's construct based on the data collected from DGHS, 2020

5.1.8 Presence of a Specialized Organization

According to the respondents, excellent collaboration among the multiple departments was critical in dealing with the issue. The outcome demonstrated that collaboration within government operational departments, as well as coordination between government organizations and development partners, was very effective. The data indicated that the presence of devoted and specialized groups such as RRRC was one of the primary elements in coping with such an unprecedented scenario effectively. Due to the earlier movements of the Rohingyas in the Cox's Bazar district, the government of Bangladesh established an organization namely Office of the Refugee Rehabilitation and Repatriation Commissioner (RRRC) in 1992 to deal with refugees. This organization under the Ministry of Disaster Management and Relief. It is operated with the financial and technical support from UNHCR and WFP. The organization has been dealing with all kinds of humanitarian and basic service deliveries in the registered Rohingya camps since its inception. As a result, a kind of specialization was present in Cox's Bazar district long before the current influx of this refugees took place. The respondents opined that RRRC was experienced in dealing with the Rohingya refugees because they had the technical know-how to deal with this influx. It was also perceived that the active coordination could have been a real problem if RRRC was not there. There was a pre-existing coordination mechanism headed by RRRC even before the crisis. Therefore, the coordinated actions were very quick and effective. One of the representatives of a development partners mentioned as this as noted below:

> *"The District Administration is busy with various kinds of activities. I have also noticed a kind of professional tag-of-war between various government*

departments when it comes to who leads a particular programme. RRRC was an ideal kind of organization in such situation because they had a previous experience and specialization in dealing with this kind of crisis. If the RRRC was not present, it could have delayed the actual crisis management operation in the field [Transcript# ID101_031].

The organizational structure of RRRC also played an important role as it was headed by one of the additional secretaries of the government and consisted of a group of high and middle ranking government officials. Therefore, it seemed effective because of the existing strict hierarchy of authority considering how other officials were working at the district level. The head of the RRRC was the highest-ranking government official working in Cox's Bazar. As a result, it was easier for him to coordinate and instruct the other government departments operating in the district. It was evident from the administrative culture of Bangladesh that strict hierarchical order was an important factor in coordination and management of the situation.

5.2 Indirect Factors

It was evident from the study that some factors though not directly related with the health sector capacity, were very important to understanding the environment within which the public health sector operated. According to the respondents these factors are significant in order to describe the real situation and these factors also influenced the crisis management drives indirectly. Though the factors were indirect, they had remote connections with the crisis. These factors can be categorized into three different themes which includes, huge international pressure, trust and mistrust on international players and Islam-o-phobia.

5.2.1 Huge International Pressure

Since the inception of the Rohingya crisis, the international community including the Islamic countries put huge pressure on the Government of Bangladesh to keep her borders open for the Rohingyas and also make arrangements for their settlement. It was evident from the response of the central level officials dealing with the crisis that the international community including the UN bodies and Islamic countries created diplomatic pressure in the initial days of the influx

without considering the capacity of Bangladesh to deal with such huge crisis. One of the officials working in the Prime Minister's Office had this to say:

> *"We received many official letters from various international organizations and individual countries as well as a long queue of requests from various diplomatic missions calling on the honourable Prime Minister to do something proactive regarding the Rohingya issue. In some instances, I was surprised by these requests because some of the organizations and individual representatives of various countries seemed like imposing their wish over the management of the Rohingya crisis settlement on Bangladesh without considering our demands and rights. This pressure sometimes compelled the Bangladeshi government to make some impromptu decisions without assessing the capacity of the Bangladeshi public service [Transcript# ID102_F006]."*

The statement is being supported by the other findings from the field. It was pointed out by the local officials that at the onset of the crisis, the government took rapid and unassessed decisions, making some of the decisions inappropriate given the circumstances. It was later found out that the actions were based on the suggestions coming from various international communities. These suggestions were not even discussed in any local or central government level meetings of the concerned organizations. The continuous pressure compelled the government to carry out some initiatives which was not possible due to lack of organizational capacity or the geographical and cultural context of the situation. One of the directors working at the DGHS mentioned that:

> *"The pressure by the international community was so intense at the initial stages that we were a bit annoyed with them. They always came and met the Director General. They gave instructions as if we had created the crisis and it is our sole responsibility to manage the Rohingyas. We tried to convince them about our own initiatives and limitations. But every time they tried to impose their instructions without any fruitful assistance in terms of funds, equipment*

or HR. Initially this created significant problems in our crisis management operations [Transcript# ID102_027].”

This same pressure was also felt by the officials working in the various donor agencies. They had to quickly mobilize resources to help management the Rohingya crisis. However, in most cases, they did not have sufficient funds or the necessary amenities to deal with the crisis. Due to the huge pressure from the headquarters or regional headquarters, they also started to put continuous pressure on the government to adequately support the Rohingyas. One of the officials working with one of the leading development partners mentioned that:

“We were in dilemma as to what to do at the beginning of the crisis. It was unexpected and we did not have ample time to plan effectively. We started panicking because of huge pressure and continuous demands from our regional headquarters. We were also asked to put pressure on the government organizations to ensure full support for the Rohingyas. To me, the GOB in most of the situations had perform creditably well as per our desires. We were also unfamiliar with the Rohingya crisis. As a result, our actions at the very beginning were not accurate enough to deal with the situation [Transcript# ID102_013].”

It was evident from the data that the delegates from various countries and international organizations frequently visited the crisis prone areas at the initial stages of the influx. The respondents working at the local level mentioned that as these individuals came, they regularly gave instructions and suggestions, but this was not backed by the right kind of logistics or technical knowhow. According to them, there was also a huge pressure to handle the consistent inflow of the representatives of the international community. As the government was careful about the comments of the international community, the local level officials had to deal with them with great care and sincerity. In this context one of the medical officers working in a government facility had this to say:

“Delegates from the international community have become an extra burden on us. They sometimes talk as if we were subordinates, and they were our

supervisors. They sometimes lodge complaints about our service delivery processes but when we ask them to fulfil their part of the bargain in terms of funding or equipment, we don't receive any significant positive response from them. This was the scenario in the initial stages of the crisis. The situation has since changed positively [Transcript# ID102_014]."

The findings suggested that the international community was keen on putting pressure on Bangladesh to ensure incessant quality service delivery to the Rohingyas. But on the other hand, it seems they were not active enough in providing a long term and permanent solution to the crisis. The respondents opined that the international community including the UN was not showing strong commitment especially when it came imposing sanctions on Myanmar. Bangladesh being a developing country with huge population, it becomes difficult for the government to deal with extra millions of people. This has consequently put negative pressure on the management of the host community in all sector including the health.

5.2.2 Islamophobia

The perception and belief of the respondents suggested that the crisis originated because the Rohingyas were a minority group and belonged to the Muslim community and the Myanmar authority wanted to get rid of Muslims from their territory. At the same time, some respondents were also concerned with the possible upsurge of a terrorist group with the support of the Islamic fundamentalist groups. They are also afraid of such possible outcome from the Rohingya settlers. They indicated that this kind of possibility made their intervention more methodical. They had to keep close contact with the local administration and the law enforcing agencies on a regular basis in order to prevent such attempts. They had to follow certain guidelines as to what to do or not to do in order to minimize the risk of becoming such an organized armed group. The findings also suggested that the international community was also very much concerned about this issue. They opined that the deployment of the armed forces to assist the civil administration in this region was not only for assisting the administration in dealing with the rehabilitation work but also to keep an eye and mitigate such risks. One of the local level health professionals reiterated this assertation in the following words:

> *"Sometimes we had to change our own mode of operation and distribution system as the security agencies and local administration disagreed with us due to security reasons. We could not distribute some of the reliefs provided by some organizations which had suspicious movement as per the opinion of the security agencies. We had to also say no to some of the health professionals who were deployed at the camp sites as they were provided by some organizations which have not been cleared by the security agencies [Transcript# ID102_011]."*

The security measures and the presence of the security agencies in and around the Rohingya camps and surrounding areas supported the notion found during the field study. One of the officials working at the local administration had this to say:

> *"We had to monitor the areas 24/7. We had to be vigilant not only on the Rohingyas but also on the inward movements of the relief workers to scrutinize their motives and origin of their organizations. This people have lost their near and dear ones and their belongings back in their country. The situation can be a fertile ground for possible radicalization. That's why we are taking extra measures. And the authority is thinking of fencing the camp areas to make it more secure [Transcript# ID102_015]."*

Evidence suggested that the government has to arrange additional security deployment including additional presence of the intelligence agencies in order to prevent the upsurge of any kind of armed movement with the assistance of the international or local terrorist organizations. Various reports found during the field study reassured that the Jamaat-ul-Mujahideen, an Islamic organisation operating in Bangladesh has been trying to organize and build links with the refugees living in various camps situated in Ukhia and Teknaf. According to some news reports in December 2018 some suspected members of the Jamaat-ul-Mujahideen were arrested by the security agencies with the allegation of some suspicious activities related to the Rohingyas. Moreover, some reports also indicated that in addition to the organizations like ISIS and Al Qaeda, some radical groups operating in South East Asia are trying to make linkages with Rohingyas in different ways which includes the news about training of hundreds of extremists

from regional countries who are planning to conduct terrorist operations in Myanmar or in Bangladesh.

5.3 Restraining factors

The result from the field data indicated that some factors directly or indirectly acted as restraining forces. These factors are not new but inbuilt in the public administration system of Bangladesh. As per the data, there were too many visits by dignitaries and this interrupted the pace of the operation. In addition, the unfamiliarity of the basic health care needs of the Rohingyas also played role in slowing down the pace of the crisis management. Moreover, the stakeholder consultation before taking decision was very minimal during the crisis.

5.3.1 Too many cooks spoil the broth

It was evident from the field that there was strong monitoring from both the central and local level. The respondents believed the monitoring had a positive role in dealing the crisis. However, other respondents also indicated that the frequent visits by dignitaries and high-level officials not directly involved in the health sector impeded the smooth operation of the crisis management. It is further believed based on the responses from the local administration indicated that the many visits by the VIPs in the initial days of the crisis hampered the substantive workflow. They opined that they had to spend much time observing protocols to the VIPs. A good number of the officials had to be deployed providing protocols to the VIPs. According to them, these officials could have been positioned in the actual crisis management. One of the health professionals working in the district level health coordination office confirms this by saying:

> *"I could understand the concern of the headquarters, but I am not sure about the visits of so many officials. Sometimes, the senior officials without any contextual knowledge of the situation tried to interfere with the work process, and this hampers our work. I could understand that they wanted to justify their visits by doing something. Even people with no relevance, frequently came to inspect the crisis operations. Managing their transport, accommodation and food become a headache for us [Transcript# ID102_F021]."*

Cox's Bazar happens to be the main domestic tourist destination in Bangladesh. This therefore served as a point of attraction to the officials irrespective of departments or work schedules. As a standard procedure, visits by senior officials is a common practice during any kind of emergency or important event. But the data showed that the frequency of these official visits was unprecedented given the limited time frame. One of the officials working in the district administration had this to say:

> *"This was like a flow of high officials and dignitaries. Some of the officials were coming with families. To be honest, some of them just visited the camp site for justifying their official tour. It seemed to me that they actually came here for a vacation. The political leaders were also coming in good numbers which was a big challenge for us as they always wanted due hospitality and protocol. Managing such demands became a real burden. I have not seen any real contribution towards the crisis management [Transcript# ID102_017]."*

The time spent for a visiting official seemed significant. But it was opined by the respondents that the real contribution in reality is insignificant.

5.3.2. Unfamiliarity about Basic Health Care Service

The data from the field indicated that the Rohingya community as a whole was deprived from basic health services. They are not familiar with the basic health care services. The Rohingya community did not know about the immunization services and mostly dependent on the indigenous type of treatment to get rid of most of their illness. It is evident that herbal medicine was the most popular medication among the Rohingyas. They also relied on the religious or spiritual system of medication. The modern health care system was totally unknown to the Rohingyas. As a result, they were reluctant and suspicious about the treatment and the medication process. The unfamiliarity and mistrust on the health care system slowed down some of the health-related initiatives in the Rohingya camps. The result from the field suggested that the health professionals needed to deploy their valuable time in building awareness among the Rohingyas. One of the officials involved in the camp management work indicated during the interview that:

"When the health sector came up with the Cholera and Diphtheria vaccination programme, I was surprised that the Rohingya community were unwilling to take the vaccines. Due to my own curiosity, I tried to explore the reasons. Belatedly, I got to know that there were rumours that if they took the vaccines, it will make them impotent and consequently lead to their early demise. They haven't seen or heard about these vaccines and so I wouldn't blame them because they lack these facilities in their home country [Transcript# ID102_023]."

The lack of knowledge and the very low rate of education among the Rohingyas made the situation difficult for the health sector professionals to take effective preventive measures. During the Diphtheria outbreak for instance, the health professionals had to spend much time to create awareness about the necessities of the isolation camps especially for the infected and suspected patients. The parents of the Diphtheria infected patients were initially unwilling to go for vaccine. They assumed that their children might die if they were given these vaccines. One of the medical professionals working in the camps had this to say:

"We were afraid of possible outbreak of Diphtheria in the camps and even among the host communities. We also realized the Rohingyas were not aware and concerned about the need and importance of isolating suspected or already infected patients. In addition to that they were suspicious about the vaccination and medication. With the help of the local administration, we spend a good amount of time to bring back their trust. You would be surprised to know that in one of the camps, the in-charge had to take the cholera vaccine in front of huge number of Rohingyas in order to show that the vaccine is risk free [Transcript# ID102_022]."

5.4 Summary of the Chapter

The chapter identified and described three different set of factors which influenced the public health sector organizational capacity during the Rohingya crisis. The driving factors facilitated the organizational capacity of the health sector. Some of the factors acted as pseudo issues in the

crisis management process while others restrained the smooth operations of the health sector organizations.

The political commitment along with the administrative monitoring seemed to have a significant role in facilitating the organizational capacity. It is evident that the political stand of the government was strong enough to enhance administrative commitment. It was also evident that no economic factor positively influenced the organizational capacity during the crisis. Coordination and active partnership among government organizations, and between the government organizations and the other actors like development partners and NGOs also played a significant positive role in the health sector. Further, the presence of the media seemed to be instrumental during the crisis situation. Then, the socio-psychological factors like religious affinity and sense of kindness also seemed very significant in facilitating the activities of the health system. It was also identified that culture and tradition can play some positive roles. Not all, the presence of a dedicated government organization with strict hierarchical authority to deal with refugee issues was also very beneficial.

International and regional issues also had some role to play. Though this had nothing to do with the health sector organizational capacity directly. However, issues like too much international pressure and Islam-o-phobia remoted and indirectly influenced the operational activities mostly at the macro level.

Further evidence revealed that too much inspections and visits by the senior officials and dignitaries hampered the pace of the crisis management. It revealed that effective monitoring is instrumental but visits of the high officials without specific purpose can be a restraining factor. The level of basic health facilities and health education and awareness seemed to have significant role in carrying out health crisis management.

CHAPTER SIX

ORGANIZATIONAL RESPONSE AND SCOPE FOR CAPACITY DEVELOPMENT OF PUBLIC HEALTHCARE ORGANIZATIONS IN THE BACKDROP OF ROHINGYA CRISIS

6.0 Introduction

The effect of the Rohingya crisis on the health service providing organizations and the major driving and restraining factors which influenced their capacity has already been discussed in the previous chapters. Now, it's time to explore the evidence related to the nature of response of the organizations along with the possible ways to further strengthen the capacity of the health sector in the context of Rohingya crisis. The chapter also explores the result of the third and fourth research questions. Beginning with the nature of the organizational response, the chapter subsequently portray the scope for strengthening the capacity of health sector organizations in order to deal with such crisis. The findings related to organizational response is divided into seven different themes, which are signal detection, community led response, prompt engagement of international community, partnership approach, trust-based management, key stakeholder engagement and dedicated human resources. In terms of recommendations for the health sector organizations, which answers research question, the results are categorized into five themes, namely, coordination, health infrastructure, partnership approach, integrating ICT, specific training and policy intervention. The findings are subsequently discussed below.

6.1 Nature of Response

The Rohingya crisis in Myanmar and their influx in Bangladesh has a long history. The movement started before Bangladesh obtained independence. The significant influx started in 1978. Afterwards, several movements took place in 1991-92 and 2016. Nonetheless, the influx of 2017 was unprecedented in the history of Bangladesh. Cox's Bazar local administration had previous experienced some of these movements in different phases during the 1970s and 1990s. However, the whole system was not expecting such huge movement within a very short period of time. As a result, the government machinery was not initially ready to deal with the crisis. The

result from the field suggested that the response had taken a certain pattern which can be characterised as follows:

6.1.1 Signal Detection

As part of the crisis response, detecting the signal was very important. The data from the field indicated that the government noticed some initial movement through its Union (administrative unit) level health posts. But the authorities were not imagining the severity of the situation at the beginning. The local authority assumed that this was similar with other previous movements and so did not take it seriously, although they sent reports to their superior authority as a routine work. The situation aggravated so fast that the preparation from the government side could not keep pace with it. One of the chief executives of one of the sub districts mentioned this during the interview session as follows:

> *"We were familiar with the movement of the Rohingyas and to be honest we were not concern about the scattered movement initially. But we were vigilant. I sent a report to my superiors but the situation turned so fast that I assumed the report did not reach the appropriate authorities before the influx escalated [Transcript# ID101_0016]."*

There was no formal warning from the international community or organizations about the crisis. The lack of forecasting put the local public sector organizations and the local community in an unprecedented pressure. About seven lac Rohingyas crossed the border within the first three months which means 7500 - 8000 people per day. Dealing with such massive population along with the host community without prior preparation and warning was a huge challenge. A representative of one of the development partners had this to say:

> *"We had heard from the news that some Rohingyas are crossing the borders. We thought it was business as usual. We did not have any early warning from our superior office. As a result, we were not worried about the situation. But the surge of the Rohingyas was so huge and fast that we*

were confused as to what to do. This was also true for the public sector organizations [Transcript# ID102_027].”

It is evident from the results that the crisis took place suddenly without any major warnings. The response was made based on the situational analysis without any prior planning. The response from the central government also supported the evidence collected obtained from the respondents. One of the officials working at the Ministry of Disaster Management and Relief stated that:

“The Rohingya influx was a bolt from the blue. We were busy handling various natural disasters at that time of the year and there was no indication this crisis could actually strike. We had to take some time to explain the situation to the Prime Minister’s Office. Nonetheless, we were fortunate enough that the local administration and local community started responding to the crisis from the onset without wasting time [Transcript# ID102_033].”

The result from the field indicated that the early crisis detection was not possible due to lack of early warning signals. The local authority was not all that concerned at the initial stages as they were used to the occasional Rohingya movements in the past.

6.1.2 Local Community Led Response

The host community had a long historical relationship with the Rohingyas and this was evident in the data collected during the study. The influx was so sudden and huge that the local authority could not predict the severity of the crisis. However, the local community because of their personal and family relationships with the Rohingyas, knew the magnitude of the situation at Rakhine. Initially the Rohingyas came through various corridors, some even crossed the Naf River into Bangladesh. Those who had close relatives in various parts of Cox’s Bazar went straight to their homes. Others gathered near bus terminals and marketplaces. The host community started dealing with the situation with their own resources initially. Some vacated their rooms to accommodate the stranded Rohingyas from Rakhine, while other Bangladeshi families gave their yards and back yards to the Rohingyas. The evidence suggested that the local people mobilized resources from the local community including food, cloths, medicine, safe

water and baby food to the Rohingyas. They started feeding them and also arranged health facilities for them. Though the arrangement was not well coordinated, it was a good step for the people in real need. One of the medical officers of one of the sub district health complexes mentioned as follows:

> *"The local people supplied foods and sometimes medicine for the Rohingyas. I can remember during the first few days, we had to mobilise medical teams locally to treat the Rohingyas. We run out of essential medicines and even fresh water at the time. However, the local organizations including the youth organizations mobilized funds from the local community to arrange for food and other essentials. I saw the young people in the community cooking food for onward distribution to the Rohingyas [Transcript# ID102_009]."*

The local administration was a bit confused as to what to do at the initial stage. Though they were at the scene undertaking emergency works, it seemed they were not fully engaged until they got the green signal from the government. In the interim, the response was carried out by the local community with their own resources and coordinated by the local administration. One of the chief executives of one of the sub districts reiterated this as follows:

> *"We were surprised by the huge movement for which we were not ready. The resources at the local level were limited as a result we had to rely on the local resources. In fact, the local host community deserve the credit for coming forward to support. It seemed that we were in a war and the local community dedicated themselves for the salvation of the Rohingyas. They shared everything they had including food with the Rohingyas [Transcript# ID102_025]"*

Evidence from the field suggested that the local community was active in the initial response in a variety of ways. They assisted the Rohingyas by providing temporary shelter and food. They also assisted them in obtaining treatment from the local medical facilities. Within two to three days following the influx, relief and support from various private and community-led organizations including the local community was mobilized for the Rohingyas. The data suggested that there was a flow of relief from various sections of the country, primarily organized by community organizations and local NGOs. To coordinate the relief efforts, the local administration was forced to send

public personnel. Later, the armed forces were called in to distribute and deliver the aid.
One of the Officials working with the RRRC had this to say:

> *"Managing the relief was a challenge in the first weeks of the crisis. The flow of the relief was so intense that there was a huge traffic jam daily on the Cox'Bazar-Ukhia road. The government had to deploy mid-level civil servants to coordinate those reliefs. A good number of organizations also set up medical camps with their own health professionals and medicine without the help of the government [Transcript# ID102_F021]."*

The response from the development partners also indicated that the sincere participation of the local community was a key factor in aiding the crisis response operation. Others also opined that the community engagement complimented the initiatives of the government and the development partners.

6.1.3 Prompt Engagement of International Community

The results from the field suggested that the international community's response was prompt and quick. The response effort encompassed over 100 partners, including 62 foreign partners, 59 national NGOs, and 8 UN agencies. WHO assumed leadership in the health sector on behalf of the partner organizations. Among the international community, the UNHCR and IOM were the first two significant organizations to respond at the outset. However, in the case of health care services, the Red Cross and Red Crescent were the two groups that reacted swiftly. Within two months of the crisis IOM provided around 800000 liters of drinking water. Besides, they also deployed health care teams and distributed personal hygiene kits. Moreover, IOM constructed nearly 700 latrines and 100 mobile toilets for the refugees. They further set up child delivery facilities and a patient stabilization unit at the camps. Additionally, UNHCR provided 1500 tons of emergency survival kits along with basic equipment for building settlement.

Within a month after the onset of the crisis, WHO, with the assistance of other partners, initiated a vaccination drive to combat diseases like polio and measles. For instance, WHO dispatched a team of epidemiologists and an extra 40 personnel. Again, in accordance with the response strategy, WHO with the cooperation of the Government of Bangladesh, implemented an Early Warning, Alert, and Response System (EWARS) across the Rohingya camps in December 2017, less than three months after the crisis began. This technique aided in the discovery of any

outbreaks as well as disease surveillance. Furthermore, within the first month of the crisis, the World Food Programme (WFP) also provided food relief to about four lac Rohingyas, with a 631 metric ton food supply delivered on September 15, 2017 (UN, 2017). Turkey, as an individual country, provided food for 6000 Rohingya per day for five months, beginning September 2017. An officer on the RRRC avers that:

> *"We were really lucky that the international community especially the UN bodies were quick to take part in the crisis response work. Usually, the UN bodies and the development partners took a long time to really operationalize their policy decisions on the ground. But I must admit that this time it was praiseworthy. It is true that some of the UN bodies were already here in the existing camps with ongoing projects, which might help them to be on the field within a short notice. The organizations like UNHCR, IOM launched emergency response activities faster than the local administration [Transcript# ID102_F029]."*

Evidence suggested that 12 individual countries came up with emergency support within the first three months of the crisis. The data from field can be visualized in table 18 as follows:

Table 18: Emergency support as of February 2018

Country	Emergency support as of February 2018
Turkey	1. Rice: 34.98 MT 2. Pulses: 5.964 MT 3. Oil: 5696 litres 4. Salt: 2.000 MT 5. Sugar: 6.362 MT
Indonesia	1. Rice: 2,029.98 MT 2. Sugar: 1.032 MT 3. Blanket: 13600 pieces 4. Tent: 100 pieces
Morocco	1. Rice: 7.960 MT 2. Blanket: 1000 pieces 3. Milk: 4320 kg 4. Medicine: 20 cartoons
Azerbaijan	1. Oil: 20,017 liters 2. Sugar: 20.018 MT 3. Milk: 10,008 kg
Malaysia	1. Rice: 30.025 MT 2. Pulses: 2.480 MT 3. Oil: 3464 liters 4. Salt: 2.125 MT 5. Sugar: 1.226 MT 6. Blanket: 309 bags 7. Tent: 685 pieces
India	1. Rice: 278 MT 2. Pulses: 55.84 MT 3. Oil: 62,940 liters 4. Salt: 55.64 MT 5. Sugar: 55.64 MT 6. Milk: 5564 kg
Singapore	1. Blanket: 24 bags 2. Tent: 90 pieces 3. Medicine: 64 cartoons
Iran	1. Blanket: 485 bags 2. Tent: 300 pieces 3. Medicine: 139 cartoons
Italy	1. Rice: 10,000 MT 2. Pulses: 3.125 MT 3. Oil: 3600 liters 4. Salt: 2,500 MT 5. Sugar: 1.75 MT 6. Medicine: 54 cartoons
Saudi Arabia	1. Blanket: 650 cartoons 2. Mattress: 264 cartoons 3. Tent: 550 pieces 4. Food basket: 100 cartoons 5. Flour: 100 bags 6. Rice: 100 bags

Source: Data collected from Ministry of Disaster Management and Relief, 2020

Four broad international organizations were engaged in the Rohingya crisis management. These included the UN organizations, international NGOs, development partners other than the UN bodies and individual countries. Some UN organizations, as well as some NGOs, were present in the Cox's Bazar district, where they were carrying out projects in the former Rohingya refugee camps. After the big influx began in August 2017, the remaining groups joined the crisis response and management operation.

In comparison to other development partners and international NGOs, the response from UN entities and individual governments was faster. Following the crisis, it was clear that NGOs needed to prepare themselves in terms of both planning and finance. They needed to raise funds from a variety of funding agencies and donors. However, national-level NGOs appeared to be more responsive than the multinational ones.

In terms of contribution from individual countries at the very initial stage, the response from the Muslim countries were noteworthy. Among the 12 contributing countries, 8 were from Muslim dominated countries. The statement of one of the camps in-charge is significant in this regard as he stated:

> *"The Turkish and Malaysian governments have demonstrated a difference by establishing field hospitals and health posts within the shortest period of time. The Government of Saudi Arabia also contributed towards developing the capacity of the Cox's Bazar Sadar (main hospital) after the Rohingya crisis took place. The Turkish food supply was made available for the Rohingyas even before the international organizations mandated such actions. It may sound biased, but this is the fact that we have witnessed [Transcript# ID102_031]."*

6.1.4 Effective Partnership among the National and International Actors Despite Comparatively Low Funding

Aside from the international community's prompt response, the crisis response appeared to be the outcome of a successful collaboration among many actors. According to the statistics, the first Joint Response Plan (JRP) for the Rohingyas was developed at the beginning of 2018, less than six months after the crisis began. The Cox's Bazar district was established as an Inter Sectoral Coordination Group (ISCG) to coordinate the

Rohingya crisis response operation. The IOM and UNHCR hosted the group. There are 29 partners who worked in the health sector. The report showed that international donors had already contributed USD 361.9 million through the JRP. Furthermore, less than a year after the crisis, international financial organizations such as the World Bank and the Asian Development Bank (ADB) committed USD 480 million and USD 200 million, respectively. The distribution of funds as of September 2018 is shown in table 19 below:

Table 19: Distribution of funds as of September 2018

Sector	Available fund
Shelter	34.4 million USD
Food Security	108.3 million USD
Site Management	56.3 million USD
Health	***26.6 million USD***
WASH	94.7 million USD
Education	13.3 million USD
Protection	29.6 million USD
Nutrition	25.2 million USD
CWC	4.2 million USD
Coordination	2.5 million USD
Logistics	1.9 million USD
Emergency Telecom	844.8 K USD

Source: Data collected from Development Partners 2020

It was clear that the government's financial contribution was insignificant in comparison to the contributions of the other partners, but the government became a significant partner as a host by providing vast lands for camp settlement, deploying additional human resources in dealing with the crisis, deploying all government service-providing agencies, and facilitating the inflow of refugees. The statement of one of the representatives of one of the UN organizations is worth mentioning:

> *"The support from the government is really fascinating. The government is demanding support from us and we are trying to fulfil it. Similarly, the*

government is proving us with all kinds of cooperation and support as needed. Unlike previously, they are regularly asking us whether we need any kind of support from them. We provide direct funding but the government contributes indirectly by providing manpower, establishment and facilities. To be honest, we are experiencing the flavour of true partnership in dealing with the crisis [Transcript# ID102_035].”

Similarly, the government of Bangladesh and NGOs are making direct contributions. According to data from the field, the government's commitment as direct finance, in addition to other contributions, over the first five months of the crisis is BDT sixty lac. During the same timeframe, 111 NGOs contributed around USD 6.5 million (MoDMR, 2020).

In order to coordinate and rationalize the contribution of the NGOs, an umbrella platform for the NGOs was established in July 2018. The purpose of the platform was to rationalize the crisis response activities among the partners. It also created an opportunity for the local and international NGOs to express their views and ideas as well as their voice regarding the ongoing operation. The result from the field indicated that the partners were complimenting each other when it came to managing the crisis. One of the officials working with RRRC had this to say:

“We could only manage the crisis because we, the government, DPs, NGOs and the local community worked hand in hand. In the health sector, the scenario is even better. The government provided the existing infrastructure and facilities, the partners provided the necessary human resources and vice-versa. When there were available human resources from the government’s side, the partners complimented it with the necessary logistics and equipment. The state and non-state actors played complimentary role. It was an excellent example of effective cooperation among the government and non-governmental partnership [Transcript# ID102_018].”

According to the data from the field and the respondents' perceptions, the weight of the partnership is equal in terms of intention, despite the disparity in contribution in terms of funding. The partnership can therefore be viewed as follows in figure 5 :

Figure -5: Share of the partnership

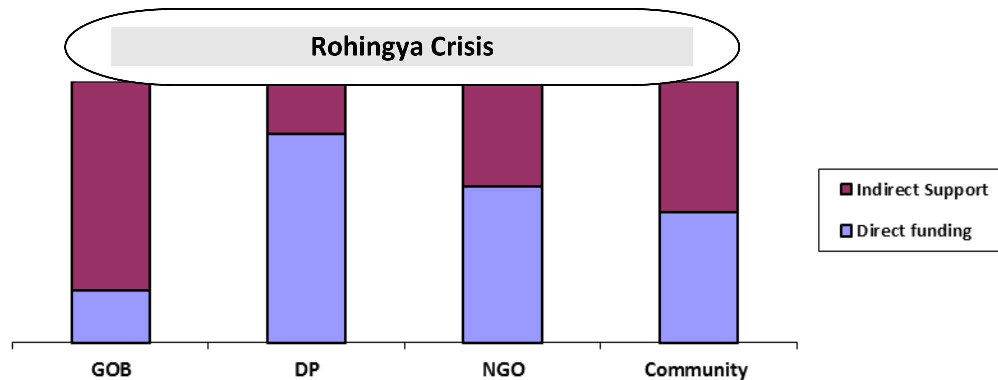


Figure: Author Construct, 2021

At the beginning of the crisis, it was suspected that there was a huge number of deaths due to the outbreak of various diseases and natural calamities. The data indicated that the number of deaths was insignificant compared to the previous assumptions. The data from WHO claimed that 199 deaths had been reported in the first three months of the crisis. Out of this number, 28% resulted from acute respiratory infections and 10% were from injuries (WHO, 2017). It was suggested that the crisis reaction and management could be termed as successful. Despite the fact that the health sector received the lowest funding from the Joint Response Plan, receiving just about 23% of the needed funds, the effective intervention, coordination, and proper resource utilization made the endeavour successful to date. However, the insufficient funding negatively impacted the crisis management operations, as partners continued to struggle to provide services for noncommunicable life-threatening diseases, as well as some other services such as mental and psychosocial support, sexual and reproductive health services.

Aside from collaboration between national and international actors, collaboration between national actors also drew the attention of respondents. Majority of the respondents believed that the national actors played an effective role as partners. At the onset of the crisis, the civil administration, service providers, and the local community were at the forefront of the crisis management. Following that, the crisis response operation was accompanied by development partners and NGOs. When the situation became uncontrollable, the armed forces were called in to supervise the relief efforts. The combined operation was supervised by the Ministry of

Disaster Management and Relief and monitored by the Prime Minister's Office. The other partners of the crisis response activity in the health sector are illustrated in figure 6 below:

Figure 6: Share of Public Sector Organizations in crisis response

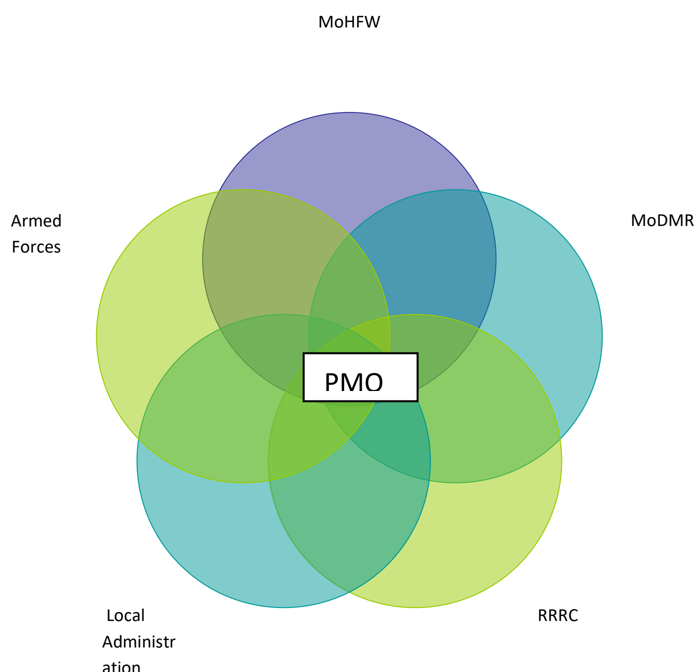


Figure: Author's Construct, 2021

6.1.5 Informal and Trust Based Management

The hallmarks of formal communication and decision making in Bangladesh's public sector organizations are bureaucratic procedures and channels. Decisions are made in accordance with a predetermined procedure. This procedure is typically time-consuming, which is not suitable for crisis response. However, there were some mechanisms put in place to deal with disasters and emergencies. The nature of the Rohingya crisis did not meet the threshold for declaring the

situation a disaster and so, the SoPs for disaster management were not fully adhered to. However, the situation was a sudden disaster for both the local administration and the government. The judgments and actions required to be made as soon as possible. The data made it clear that the local government needed to make informal and out-of-the-box judgments and actions. Most of the decisions that were carried out on the field were as a result of verbal discussions. Following the successful execution of the judgments on the ground, the formal procedures were subsequently completed. In critical circumstances, post-facto permissions were obtained in order to meet legal responsibilities. In this direction, one leading public health sector manager mentioned as follows:

> *"If we followed the formal process, who know what would happen. I had to constitute medical teams immediately. I didn't have time to take approval from the top. I just made phone calls to my senior officials to inform them about the situation and what I was doing. If I needed medicines and human resources, I had to make a local request for them to deploy health professionals from other sub districts, this is not possible during normal times. In this instance, nobody questioned me for this. Rather my senior officials authorized my decisions. I remember, calling the divisional and DG office for various support like additional medicine, logistics and HR on daily affairs. And most of the time, I got what I needed without any written communications [Transcript# ID101_003]."*

The data suggested that the communication and the decision-making process had become informal and verbal replacing the formal and written processes. The demands and the requests from the field in most of the time were accepted by the superior authority without any further cross checking or investigation. The requirements placed by the field officials in most cases were proved to be accurate. Therefore, a kind of trust-based relationship was established and practiced during the initial months of the crisis.

In most cases, the decision-making process also became informal in nature considering the regular practice. It was evident from the field that the selection of the lands for the camps and the

arrangements for building the shelter for the Rohingyas were made instantly and informally superseding the regular government procurement processes. The respondents indicated that without such quick and informal decision-making, it might take more than six months to establish camps with shelters. One of the officials of the Ministry of Disaster Management and Relief (MoDMR) during the interview session had this to say:

> *"I can still remember this scenario; the ministry called a meeting with the relevant development partners and the other stakeholders to decide what could be done in terms of building shelter for the Rohingyas within the shortest possible time. The secretary was chairing the meeting. One of the consultants of one of the development partners mentioned that they would need a minimum of three months to plan and design the shelters. After a long discussion, the secretary suggested that, we should provide the Rohingya families with tarpaulin, rope and bamboo with a basic measurement so that they can build their own shelter. He further requested the development partners to come up with the funds so that these materials could be purchased immediately. The development partners agreed and within two days provided the funds. As a result, the shelters were built within a shorter period [Transcript# ID102_036]."*

Usually, the civil servants are sceptic to risk and wants to avoid any kind of uncertainty. In this backdrop the data indicated that the leadership at that time also played important role. The civil servants at the decision-making position were able to take instant decisions without thinking about the risk of failure. The selection of the camp land is a typical example of informal decision-making during crisis. The land belonged to the Forest Department of Bangladesh and if you wanted to acquire any forest land you had to go through certain administrative processes before approval which is time consuming. In this case, the secretary of the Ministry of Disaster Management and Relief went on a visit to the area to assess the extent of the crisis in the early days of the crisis. While in Ukhia and Tekhnaf, he instantly selected the land in the presence of the district administration officials. Based on this selection, work on the establishment of the

camp commenced within three days. The process of acquiring the land was done long after the camp was established.

The channel of communication between the government departments also changed during this period. Initially, the relationship between these departments in the field was not cooperative as there seemed to exist a kind of rivalry on the superiority and importance of the departments in the field. The district administration is supposed to coordinate and lead all activities at the district level, but due to the lack of mutual understanding on superiority, there existed a kind of disrespect and tendency of avoidance among the departments operating in the field. This situation was not an exception in the Cox's Bazar district. However, the findings suggested that the departments were working harmoniously during the crisis. The findings indicated that the mutual relationship during the period was based on a sense of cooperation and trust. One of the health professionals working in one of the Rohingya camps revealed this during the interview session by observing that:

> *"We had unprecedented support from other departments. Especially the cooperation and support from the district administration was amazing. Usually there exists some kind of mistrust and superiority complex between us but the situation changed with the advent of the crisis. I had to communicate with them on a daily bases and I found it was very cooperative and sincere this time round [Transcript# ID102_026]."*

The relationship between the government departments and development partners and government departments and the NGOs also became informal and trust based in nature. Respondents from both the government and development partners opined that there was less formal paperwork and strict adherence to procedures during the crisis especially at the initial stages. The health sector led by the Civil Surgeon of the Cox's Bazar district spearheaded the operation. The findings indicated that most of the requirements and instructions to the development partners and NGOs were verbal. It was also evident from the findings that the verbal and informal communications were treated as official instructions by the development partners and the NGOs. One of the representatives of one of the partner NGOs had this to say:

> *"There was no time for formal procedure, the government was on our shoulders. We had to comply with the verbal communication from the*

government departments. We had to support them in good faith. our own internal process had to also change. Our head office sometimes took action based on email communications and telephone request. It was a trust-based management from bottom to top [Transcript# ID101_019].”

6.1.6 Engagement of Key Stakeholder: Involving the Rohingyas in Crisis Management

The host community, as well as the Rohingyas contributed to the crisis response. The findings suggested that the crisis management authority created an opportunity for the Rohingyas to engage in the response process. The Rohingyas were hired to build their own homes using materials provided by the Bangladeshi Government and development partners. The government and the camp authority select Rohingya community leaders (known as "Majhi") for improved coordination and communication between the crisis management authority and the Rohingya community. This community leaders began to serve as the community's spokes persons. The community leaders received a variety of training to help them deal with coordination and communication challenges. According to the findings, these community leaders became the link between the camp authorities and the Rohingya population in the camps. The involvement of community leaders has shown to be helpful on several occasions. For instance, during the Diphtheria and Cholera vaccination campaign, there was confusion among the Rohingya communities concerning the program's objectives and potential outcomes. This miscommunication arose as a result of their lack of knowledge about basic health service delivery, which is linked to their previous health service delivery culture. The health sector, with the assistance of the camp administration, enlisted the cooperation of these community leaders to help reduce the confusion in the Rohingya community. These community leaders were therefore instrumental in raising awareness among the Rohingya community about the benefits of the vaccination campaign. Majority of the respondents indicated that this massive campaign could not have been carried out in such a short period of time without the help of the community leaders. One of the public sector health professionals working in the camp mentioned this in the following statements:

“The Rohingyas were not ready to take the vaccine while the cholera outbreak was on the rise. We had pressure from the top to put a hold on the outbreak. The situation was horrible. Then the local administration and camp

administration along with the health professional started an awareness campaign. Initially, the Rohingyas doubted what was told them in the campaign. But fortunately, it started to work effectively as soon as the 'Majhi' were engaged with the campaign. Some Majhis have to take the vaccine in front of the huge Rohingas community to prove it was safe. I am sure without them we could not do much [Transcript# ID102_F004]."

Managing people in camps is a daunting task for the managers. The authorities also had resources constraints and this made it difficult to identify and address all the problems in the camp. The Community leaders (Majhis) played a pivotal role in this direction. It is evident that most of the community leaders were keen to put forward the problems of their communities in the appropriate forum. Such actions helped the camp authorities in addressing the problems properly. The community leaders were also found to be the source of early warnings in case of any outbreak of diseases or other problems. They are also played a significant role in maintaining internal law and order in the camps. One of the camps in charge had this to say:

"Maintaining law and order in the camps along with coordinating other activities was one of our key tasks as camp managers. However, we were only two government officials who had to do everything. Yes, we had support from some development partners and NGOs, yet it was still a huge responsibility. If we had not engaged the services of the Majhis (from the Rohingyas), it would have bene really difficult to manage everything in its true sense. Though there were some allegations against some of the majhis, but in general, they assisted us in the overall management of the camps [Transcript# ID102_031]."

Apart from engaging the community leaders the authority also involved a good number of volunteers from the Rohingyas. These volunteers were given training on various issues like first aid, firefighting, cyclone preparedness, etc. These volunteers also assisted camp management in distributing relief, maintaining law and order, and coordinating natural disasters. According to the findings, these volunteers were very helpful throughout the awareness campaigns, including health-related issues. Occasionally, the volunteers were proactive in addressing potential difficulties within the camps. One of the RRRC officials working as one of the assistant camps in-charge mentioned as follows:

> *"The team of volunteers were really effective when it came to providing services on a massive scale. The police force could sufficiently maintain law and order. As a result, sometimes, we had to depend on the volunteers and the community leaders. In instances, they proved more effective than the regular force [Transcript# ID102_F016]."*

It is obvious from the field that engaging the Rohingyas in parts of the everyday tasks, as well as assuring their participation in camp management through the use of 'Majhi' and volunteers, has sped up the crisis management operations in the camps.

The respondents stated that involving the Rohingyas in the crisis management process had a positive impact on the Rohingyas' trust in the management actors and processes. This has enhanced the trust of the international community, especially potential donors. The findings also indicated that carrying out any large-scale program, particularly in the health sector, has become easier since the inclusion of Rohingya community leaders and volunteers in the management process. Respondents also believed that the sense of belonging of Rohingya community leaders and volunteers in the crisis operation boosted the productivity and efficiency of policy execution in camp settings. The statement of one of the NGO representatives is worth mentioning in this context as he said:

> *"It was difficult for us to make the people understand the benefits of any program as we did not know their culture, tradition and values. Since the inclusion of the Majhi and local volunteers, it has become less complicated and less time consuming for us to implement any program. They are, in many ways taking our responsibilities as their own [Transcript# ID102_F017]."*

The evidence suggested that the participation of the Rohingyas in the management process seemed to be effective in the response operation. According to the findings, the crisis response seemed to be effective apart from the early signal detection. There was no clue as to the magnitude of the crisis even before the real crisis began in late August 2017. However, the public sector, especially the health sector seemed to be effective in dealing with the other parts of the response. The response was initially a community led response. The sincere participation of the local people proved to be very effective at the initial stages of the crisis. The flow of the local response was successfully taking over

by the government at a later stage. The quick involvement of the international community along with development partners was also found to be a significant factor. The NGOs regardless of their origin played an important role in the response process. The findings indicated that the change in the management practice of the public sector organizations especially the health sector organization acted as driver in the crisis management process. However, the most significant role played was the effective coordination and active engagement by the government with the development partners, NGOs, and the local population. This active collaboration was discovered to be critical in the response process.

6.2 Main Capacity Focus for Health Sector Organizations in Addressing Crisis like Rohingya Influx

In line with research question four, the respondents were asked to provide recommendations about the areas which needed significant overhaul in order to deal effectively with such crisis. The data from the field study indicated that the suggestions are not necessarily new or innovative in nature but generic. In some cases, the result is similar with the previous research findings which was conducted in this ground. However, based on the nature and significance of the response, the findings are categorized into six thematic areas which includes coordination, partnership approach, trust building, Integrating ICT in the Health Management System, specific training, and policy intervention.

6.2.1 Effective Coordination is an Important Precondition

The data collected from the field suggested that effective coordination between the government and non-government actors along with coordination among the government departments and organizations is one of the most important areas in dealing with Rohingya crisis. The respondents opined that real coordination in practice was significant. The respondents indicated that the coordination on the ground really played a pivotal role in managing the Rohingya crisis. One of the directors working in the Directorate of Health Services mentioned that:

> *"Manging a health crisis is a combined effort of all partners. If we did not get the support from the local administration in transporting our medication and health professionals on time and we did not also get the vaccine and*

necessary medicine from the international partners, we would not have been able to do anything. I haven't seen such a complimentary role of all the actors before in my career, it was really amazing [Transcript# ID102_021]."

The synchronization of coordinating activities at all the levels was found to be critical. Irrespective of the nature of job or sector, the respondents indicated that the coordination at the policy level as well as at the operational level was well organized and effective in dealing with the Rohingya issue. The statistics showed that uncoordinated programs from multiple departments within the health directorate were putting strain on field level organizations. As a result, field-level health sector organizations were overwhelmed by the large number of projects implemented by the health directorate without regard to the capabilities of the field-level organizations. The findings also revealed that these activities were interfering with the actual crisis response activity. However, in a later stage, such activities were harmonized in consultation with field level organizations.

Further, it was also realized that the coordination at the organization level as well as at the individual level also played significant role. Based on the data it was evident that the coordination framework in the case of the Rohingya crisis was multi-disciplinary in nature which can be described in figure 7:

Figure 7: Coordination Mechanism

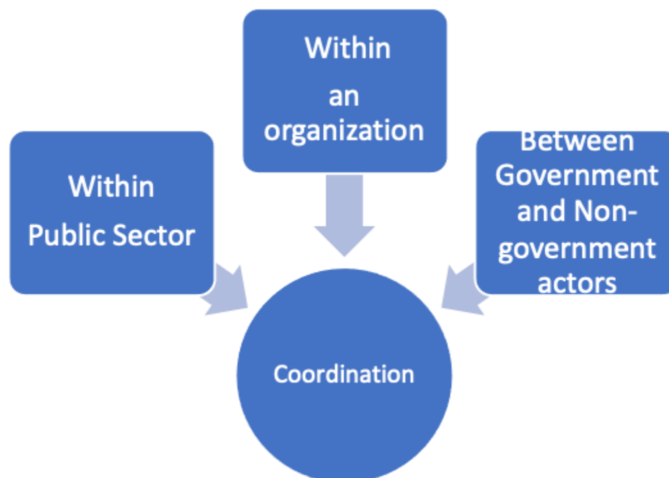


Figure: Author's construct, 2021

The findings demonstrated that coordination across government agencies at the central and field levels became effective as a result of top-level political and bureaucratic commitment. The magnitude of the government's commitment was adequately communicated on the ground. This notion is shared by all respondents in the public sector. Despite the fact that the data revealed that there were some abnormalities in the early stages, the public sector organizations were able to bring things back into shape. The findings also revealed that efficient coordination in the field was occasionally aided by officials' individual leadership capacity. One officer from the district administration had this to say in this context:

> *"The contribution of the then Upazilla health and family welfare officer at Ukhia was really remarkable. He had good relationship with everybody including the local political leadership. He had some kind of quality to manage everything. We could not refuse his request. Even sometimes the local chief executive officer (UNO) put pressure on us to fulfil his requirements. We were lucky that we had few officials of his quality working in this district during the initial stage of the crisis [Transcript# ID102_F019].*

In view of the fact that two registered Rohingya camps existed long before the present migration, the data suggested that there was an established coordination system between the government and the development partners in Cox's Bazar. According to the findings, this existing link worked as a catalyst for good cooperation between government health sector entities and several UN organizations.

It was clear from the results that a dedicated Refugee management body, such as RRRC, played an important role in bringing improved coordination among the actors. RRRC has been in place since 1992 and has the organizational capacity and structure to guarantee improved cooperation in refugee management. Regardless of the type of their organization, the respondents all agreed that the RRRC was an important aspect of the coordination system. One of the officials working with one of the development partners mentioned as follows:

"The RRRC's very existence was noteworthy. Aside from its routine duties, it served as a coordinator at various times and in varied situations. The RRRC's stance made inter-organizational coordination easier and faster. It also served as a monitor, putting pressure on the operating actors to improve upon the collaboration [Transcript# ID102_029]"

The findings suggested that coordination within the public sector, i.e., collaboration between public sector entities at the central and field levels, was enhanced. Coordination between government and non-government actors, including foreign actors, was also a driving force behind such crisis response and management operations. The findings further revealed that interpersonal coordination and organizational coordination ensured effective crisis management. Furthermore, the results revealed that synchronization of cooperation between central level organizations and field level organizations was crucial in dealing with such crises.

6.2.2 Active and Effective Partnership Matters

The findings from the field study revealed that the complementary roles of government and non-government actors, as well as the local community, played a crucial role in responding to the Rohingya crisis, particularly in the early stages.

The findings demonstrated the timely and effective collaboration of public health sector institutions with non-government actors, including the international and local communities, was critical in the early stages of the crisis. The findings further revealed a shortfall in management and resource capabilities at public health sector entities. However, this shortfall was addressed by the Non-governmental players, particularly the foreign community and development partners. The public sector further expanded this collaboration by deploying its own people, resources, infrastructure and facilities.

The international community and development partners deployed health professionals in the public health sector facilities and in the other facilities developed in the camps for the Rohingyas. They also developed medical infrastructure by providing essential equipment in the public health sector facilities. For instance, the international community developed new fully-fledged health facilities in the camps. The NGOs provided mobile health services to the Rohingyas. They also provided the necessary logistic support where they were required. The

necessary medicine and vaccine were equally provided by the international community and development partners in order to fill the gap in the public sector.

The parties spoke on a regular basis in terms of knowledge and idea sharing. In terms of decision-making and implementation, they took a consultative approach. The outcome demonstrated that the partners respected and trusted one another. There was also a great mutual understanding of the values of each partner's contribution. They were therefore found to be working toward a common goal. The statement of an officials working with a development partner is worth mentioning in this context as he stated:

> *"Usually, working with the public sector is challenging. There used to exist a clear difference between them and us. However, this time, I believe we have been able to break the line. We literally forgot about which sector we belonged. As we had a common goal and everybody believed in it, we could feel the real test of actual partnership. We had mutual respect and trust. We tried to cooperate with each other sincerely and with all our efforts [Transcript# ID102_F021]."*

The evidence showed that the health sector capacity at large had improved due to the effective participation of the partners. The managerial capacity has benefited from a sufficient supply of health experts as well as information sharing. Formal capacity development programs, such as training, have also had a good impact in the health sector. The provision of equipment, drugs, and direct funding has been found to be useful in strengthening the health sector's resource capacity.

It was also discovered on the ground that the cooperation was not limited to the supply of funds and materials. Mutual trust and psychological reliance on one another were also visible during the Rohingya crisis response effort. And this has helped to build the confidence of public health experts, which has indirectly increased managerial capability.

The study revealed the contribution of other government departments such as the Local Administration, Roads and Highways Department, Local Government institutions, law enforcement agencies, and the armed forces to be tremendous. The Municipal administration helped to ensure effective supply chain for health personnel, emergency medicine, and equipment. The local government also helped by facilitating the establishment of mobile medical

camps and other health amenities. Further, the government institutions contributed significantly in raising awareness among the Rohingyas during major health emergencies, like the outbreak of Diphtheria and cholera.

It could therefore be said that there was effective partnership among the operating organizations and individuals working with the collaborating organizations in responding to the Rohingya crisis. The partnership in this case can be shown in figure 8:

Figure 8: Structure of partnership

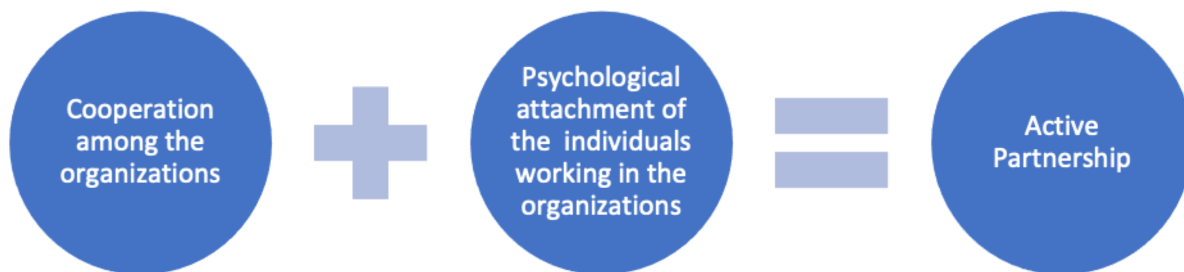


Figure: Author's construct, 2021

6.2.3 Building Trust with the Service Recipients

Building trust with the Rohingyas appeared to be too critical in the early stages of the crisis. The findings revealed that the Rohingyas were unfamiliar with the various fundamental health services, including the treatment process and medication, due to a lack of understanding of basic health service delivery and a lack of formal education. In the majority of cases, the Rohingyas relied on herbal or traditional practices in Myanmar. A good number of them also relied heavily on the religious process of treatment like taking water purified by some religious leaders or people through recitation of some verses from the religious books. The findings suggested that most of the Rohingyas haven't seen some of the modern health service in their entire life.

Additionally, the data indicated that the Rohingyas were very suspicious of some of the modern treatment and medication especially the various vaccines. They were therefore reluctant to take the cholera and the Diphtheria vaccines during the outbreaks due to these suspicions. There was the rumour that the vaccine was life threatening for them and their children. As a result, the outbreak control program was hampered and delayed for some time. Given the situation, the health sector had to develop a kind of trust with the Rohingyas through mass awareness programs. The awareness program was able to build the trust and facilitated the smooth and speedy health service delivery to the Rohingya community at the later stage. One of the camps in-charge stated as follows:

> *"We were confused as to why the Rohingyas were unwilling to take medication and vaccine. Later we came to know that they were not familiar with this kind of vaccine and they thought this might be a conspiracy by us to kill them and their children. We had to carry out huge awareness campaign utilizing their community leaders and volunteers. Even I had to take the vaccine in front of the huge Rohingyas in order to convince them. However, the campaign helped us to build trust with them which later facilitated in carrying out health as well as other sectoral programs [Transcript# ID102_F022]."*

It is clear from the data and related documents that irrespective of the sector, be it site management, education, food or shelter, mutual trust between the service provider and the Rohingyas was very instrumental. It was also evident that this trust issue also played significant role in carrying out other programs including demographic and personal data collection process. In this context one of the health professionals working in public health sector facility mentioned as follows:

> *"The Rohingyas seemed to be very sceptical about the treatment and medication at the initial stage. We had to spend extra time educating them about the medication. It was time consuming and this interrupted our speed in terms of service delivery. However, the situation became better after the awareness campaign and their*

participation ensured the successful implementation of the programs. Now, they seem to have much trust on us on our advice [Transcript# ID102_F031].”

This trust has boosted the capabilities of health-care institutions in various ways including administrative and resources.

6.2.4 Special Training can be Instrumental

The findings on the field showed that training for health workers is essential. Trainings for public-sector health professionals are typically traditional and generic in character. The respondents indicated that such special trainings for crisis situations was non-existent in the curriculum of standard training programs. However, the health professionals opined that training in areas such as mass casualty management, health emergency management, crisis response and management, successful cooperation, and stakeholder involvement can be advantageous. A leading health professional working at a sub district level had this to say:

“I was not given any training on mass emergency management and crisis response in our student life as well as in our professional career. Neither did we have the experience of managing such medical emergency nor do we have the theoretical knowledge about it. We could have done better if we had such training [Transcript# ID101_005].”

The findings revealed that adaptability across diverse workforces working in the public health sector is a key component of emergency response. It is critical to have the necessary knowledge and skills to deal with a changing environment. Through capacity building programs and training, this skills and knowledge can be harnessed. It was also discovered that the capacity of the supporting personnel, in addition to the major health experts, was required. In this context one of the Ex Civil Surgeon mentioned as follows:

“*We could not handle such huge flow of emergency patients as we didn’t have sufficient health professionals. In order to address the huge demand, I had to deploy other staff in the process. I gave them a short orientation on the basics in an emergency room. I did not deploy them in the core treatment though. Rather, I engaged them to assist the core health professionals. I could not have managed the situation without their participation” [Transcript# ID102_F033].*

As a result, providing training to extra workers in addition to the existing staff appears to be helpful. Aside from that, the results indicated that having some redundancy in the system for backup during an emergency is also necessary, as people of the workforce may be affected by the disaster as individuals.

Furthermore, data showed that various trainings were provided by development partners and UN organizations during the Rohingya crisis. Diphtheria and cholera control trainings were shown to have been effective. Respondents in the health sector felt that the series of training and orientation provided on the ground was beneficial in dealing with the health crisis during the Rohingya influx. In this regard one of the deputy directors working in the main hospital situated in Cox's Bazar mentioned that:

> *"We were not trained on Diphtheria and so was the case for most of the doctors working in the public sector. We were really tensed about the possible management of Diphtheria. The training and knowledge sharing by the international experts was a real game changer. Currently, we have a group of trained health professionals with the appropriate skills to handle this situation [Transcript# ID102_009]."*

Furthermore, training for health professionals as well as support employees was critical. Training in non-medical issues relating to medical and health crisis management, as well as adaptability, is equally important in developing a proficient workforce for coping with health crises. During the early stages of the crisis, a large number of volunteers from the host community assisted. According to the data, local volunteers played a significant part in the crisis response process. Despite the fact that they were not professionally trained, they were useful in carrying out support and logistical tasks. Most crucially, the locals and the Rohingyas speak nearly identical languages. As a result, these local volunteers played an important role by serving as interpreters for the Rohingyas. The findings also revealed that some health-care organizations gave basic orientation to volunteers. According to the respondents, trained volunteers demonstrated more efficiency, which eventually improved organizational capacity in several health-care organizations. One of the medical officers working in one of the health complexes stated as follows:

"The host community was at the forefront of the initial crisis response operation. They participated everywhere even in our hospitals. One youth organization provided us about 20 volunteers who worked with us for more than two months. They mainly did the administrative and logistic support works but they sometimes acted as interpreters for the Rohingya patients. They become organized and motivated once we gave them some basic orientation about the hospital management or emergency room management. In my view we should develop a group of volunteers in every district as part of the preparation process in dealing with emergencies [Transcript# ID102_F027]."

The findings from the field also revealed the need for health workers with extensive knowledge and skills in public health. Majority of the health professionals working in the research sector lacked academic or professional expertise on public health. Respondents mostly focused on topics typically addressed in public health school modules. As a result, it appeared that more health workers with academic or professional knowledge and ability in public health would be vital in dealing with such a crisis. Hence, the training on mass casualty management, health crisis management, public health, crisis response along with effective partnership and coordination for the health professionals can be effectively organized to develop the organizational capacity of the health sector in dealing with situations like the refugee crisis. The framework can be described as follows in figure 9 :

Figure 9: Framework for Training

Source: Author's construct, 2021

6.2.5 Need for a Country Contextual Health Crisis Management Guidelines

Respondents expressed a desire for a detailed guidance for dealing with such a health catastrophe. The health personnel were forced to deal with the health crisis from the first day of the Rohingya immigration because the bulk of them had been injured or traumatized. They appeared to have expertise dealing with small-scale health crises, most of which were caused by natural disasters such as cyclones or floods. However, the statistics indicated that the health experts were unfamiliar with such a large-scale health problem. As a result, the officials entered the crisis response activity without any prior experience. They were initially overwhelmed by the influx of patients and were perplexed regarding the overall handling of the situation. They contacted the health directorate for specific guidelines, but they also failed to provide any detailed guidelines, they were only told to work on an ad hoc basis. One of the key health specialists working in the health complex during the initial stage of the influx made the following statements:

> *"We had managed emergency situations before and thought we would be able to manage this as well. But I was wrong, I could not estimate the severity of this health crisis. No one in our hospital has ever seen such huge upsurge of patients in their career. It was like a war situation. We had no clear idea on how to manage the patients and we had no clear instructions from our superiors. We were just instructed by our district boss to help save the lives of the Rohingyas by all means. We didn't even know whether we could make use of the local resources including the host community and volunteers [Transcript# ID102_004]."*

It was later discovered that the health sector personnel made local decisions based on the scenario in consultation with the district level officials. In cases of therapy and patient care, the public-sector health practitioners relied on national-level customary recommendations. Some of them also adhered to the catastrophic emergency response criteria developed by the Government of Bangladesh. However, in November 2017, the

World Health Organization created a bundle of basic services called the ‘Minimum Package of Essential Health Services for Primary Healthcare Facilities in FDMN Camps' within a short period of time. This package was developed using the DGHSs' Essential Package of Services (ESP). The government of Bangladesh updated this guideline, and the public health sector began implementing it in January 2018. These rules were only intended for primary health care facilities. As a result, there was still the need for an all-encompassing rule. In order to address this issue, the Bangladeshi government subsequently issued a thorough patient management guideline in June 2018. The findings revealed that, these principles improved the organization and efficiency of the crisis response process. With the introduction of these specific recommendations, public health administrators were able to eliminate the ambiguity of possible treatment plans and referral systems. Almost all respondents working in the public health sector agreed that this standard operating system based on the recommendations had been developed. They also proposed that this could be used in other scenarios with similar characteristics. One of the ex-Civil Surgeons indicated this in the course of the interview, he said:

> *“I strongly believe a comprehensive guideline for health crisis management is essential. This time, we have been able to manage the situation using our individual leadership and management qualities. Fortunately, we had a group of efficient health sector managers at the time of the crisis. There are some guidelines now for patient management and essential service but I still belief this in not enough. We need a comprehensive national level guideline which should cover both clinical and non-clinical issues [Transcript# ID101_002].”*

The respondent proposed documenting the entire crisis response operation in consultation with the officials who were working during the crisis's earliest stage. They believe that capturing the experience is critical because they were on the ground and had an active part during the crisis.

A systematic documentation may aid in identifying potential issues for the health sector in similar circumstances. Based on detailed information about successful leadership, decision making, coordination, or partnership approaches, this may also be useful in identifying effective organizational techniques to dealing with similar type's health crises the future. Similarly, this can also be used to determine the factors that failed in the crisis management situation. This could therefore be used as a comprehensive SoP in dealing with similar crises. One of health professionals working with the district (Sadar) hospital in Cox's Bazar had this to say:

> *"Everyone who worked during the crisis is a valuable resource. This team will not be available at all times. Some of them are already on retirement. So, a quick action is needed for documenting their experiences. Based on the inputs from them, an effective handbook can be developed which could be used as a reference point in similar crisis [Transcript# ID102_F028]"*

As a result, a comprehensive guideline may aid in the ongoing development of organizational capacity in the public health sector, with a particular emphasis on management, resources, adaptive, and absorptive ability.

6.2.6 Integrating ICT in the Health Management System

The use of ICT in public sector administration has grown in popularity around the world, particularly in developing countries. According to the data from the field, the usage of ICT-based tools during the crisis resulted in beneficial outcomes. At the onset of the crisis, the health sector relied entirely on the manual system of management in all aspects, which is the standard management practice of public health sector organizations at the local level in Cox's Bazar. This significantly slowed the decision-making process. Some prompt responses in impacted communities are hampered as a result. For instance, the World Health Organization would have been able to implement an early warning system, known as the Early Warning, Alert, and Response System (EWARS), if there was an internet platform. An entire scenario of a given area can be examined and analysed using this platform based on inputs from numerous entry points. This technique can also forecast signs for potential disease epidemics in a certain area. Since the system's inception, decision-making in a given situation has become timely and effective. This

approach also aided in making the necessary preparations ahead of time. According to the findings, this has contributed enormously in dealing with the Cholera outbreak in the Rohingya camps. A leading health professional working in the camp mentioned this as follows:

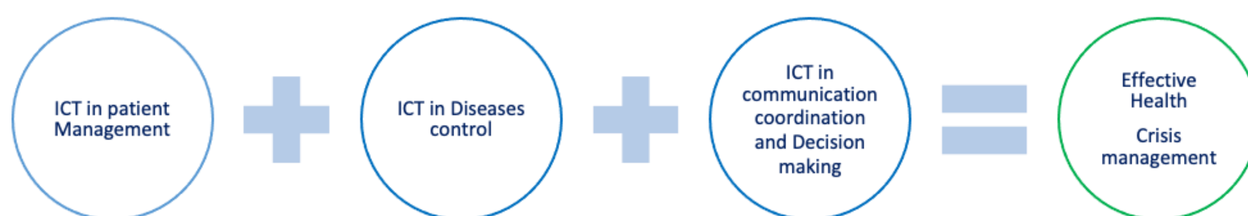
> *"To forecast an upcoming disease outbreak is even more important than its control in a situation like ours. The Rohingya camps were full and people were living in congested conditions so, any kind of outbreak could be a disaster. Moreover, the settlements of the host community were very near to the camps. Given the situation, the EWARS has contributed significantly in preventing and managing possible outbreaks in the camps since its inception [Transcript# ID102_016]".*

The respondents also opined that during the Rohingya crisis they attended various coordination and planning meetings. As a result, they sometimes had to travel from one place to another which was very time consuming. These meetings were significant, but it also interrupted their day-to-day activities. They felt a need for an alternative solution against physical attendance in every meeting. In their opinions, virtual meetings using digital platforms could be a possible alternative. However, access to uninterrupted internet facilities especially at the remote camp site might be a challenge. This notwithstanding, the utilization of more and more virtual communications and coordination mechanisms could facilitate prompt decision-making as well as ensure more working hours in actual crisis response operation on the ground. The statement of one of the medical officers working at one of the sub district public hospital is worth mentioning here, he opined:

> *"At the beginning, before the construction of the new roads, it took around four hours to reach the district headquarter. So, if we had to attend any meeting, we had to compromise our regular work for that day. It was really difficult to spare a doctor for a whole day at the peak of the crisis. But we had to attend several meetings almost every week. I understand that these meetings were important but it really interrupted our service delivery. Virtual meetings could be helpful, but you know, the irregular power supply coupled with the quality of our internet network here is a big challenge to us in this part of the country [Transcript# ID102_F034]."*

Although evidence suggested that incorporating ICT into the crisis management process was beneficial and accelerated health management during the Rohingya crisis, the respondents recognized a gap in terms of incorporating ICT into the management process. However, based on the study's findings, the relevant infrastructure is not supportive of an uninterrupted virtual management system due to its geographical location. The framework of ICT integration in such crisis can be viewed in figure 10 below:

Figure -10: Framework for ICT Intregration



Source: Author's Construct, 2021

Evidence suggested that the integration of ICT was made available mostly in early warning and disease control mechanisms, but the use of ICT in non-clinical domains such as communication, coordination, and decision making were not largely formal. However, there were some informal communications which were largely done at the individual level through personal initiative. As a result, the use of ICT can be beneficial in a variety of components such as patient management from a clinical standpoint, disease control, and overall communication and coordination from a non-clinical standpoint. The findings therefore revealed that incorporating ICT into the entire management process appeared more favourable in terms of increasing organizational capacity from both management and resource perspectives. Nonetheless, a conducive infrastructure like consistent supply of electricity and uninterrupted internet network are pre-conditions for a successful integration.

6.2.7 Need for a specific Policy

Results from the field suggested that Bangladesh has no national policy on refugee issues. This has been debated in a variety of forums on several occasions. The beginning of the Rohingya crisis in 2017 escalated this debate. The findings also revealed that there is no national policy to deal with health crises. A specialized contingency plan is also lacking. However, during such situations, Bangladesh relies heavily on disaster emergency contingency plans. Due to the lack of a comprehensive plan, health sector professionals and members of support groups are not sufficiently informed about their respective roles and responsibilities in dealing with such health emergencies. The results suggested that the organizations were unsure about their duties and potential interventions in the early phases of the crisis. This dilemma seemed to be prevalent both at the central and field level. One of the public sector health managers working at the sub district level had this to say:

> *"We started treating the Rohingya patients from the very first day of the influx from our professional and ethical points of view but we didn't know what to do in situation like this. We tried to get instructions from our superiors but they told us to wait for clear instructions. My hospital was overwhelmed with the huge numbers. Initially, we were asked to take minimum service charge from the patients. Subsequently, we were instructed not to take any service charge from them. In fact, the Directorate of Health was not sure about the possible management [Transcript# ID102_013]."*

The respondents also opined that lack of specific action plan and policy guidelines hampered the initial interventions in the field and at the central level. The local health managers were also not sure about the engagement of the local community and the private actors in the management process. Some of the local public sector health managers were not enthusiastic about the integration of local and private resources as there was no specific instructions from the government. They wanted to avoid the risk non-compliance from the government. But the huge surge of patients put pressure on the existing infrastructure in terms of management and resources. As a result, most of the health sector managers could not manage their facilities without assistance from the local and private actors. In this context, one of the statements of a leading health manager working at the sub-district level was significant, he observed:

"From one side I had huge pressure to treat the Rohingya patients, on the other hand I had no idea or guidelines about clinical and non-clinical management process. Local people and voluntary organizations came forward with some kind of assistance, but I was not sure about any standard procedure as to how to utilize them. I was not sure whether the government would allow this kind of engagement. I waited for three days, but no clear instructions were given, so I had to take my own decision as the situation was getting worse. I had no choice but to accept the assistance from the host community and other private and voluntary actors [Transcript# ID102_006]."

It is evident that a comprehensive policy is a prerequisite for effective management of the crisis. However, the lack of policy seemed to have negative impact on timely decision-making and coordination. As a result, the lack of policy direction impacted the overall organizational capacity from both management and resources perspective. Nonetheless, the result from the field suggested that individual leadership quality of the health sector managers played a significant role in minimizing the gap or the absence of a guideline.

Hence, the need for a national level policy in dealing with massive scale health crisis is important and it should be prepared based on the economic, social and geographical context of the country. It was found that a specific policy on refugee is also needed for effective management of such crisis. The possible policy framework can be described as follows in figure 11:

Figure 11: Recommended Policy Framework

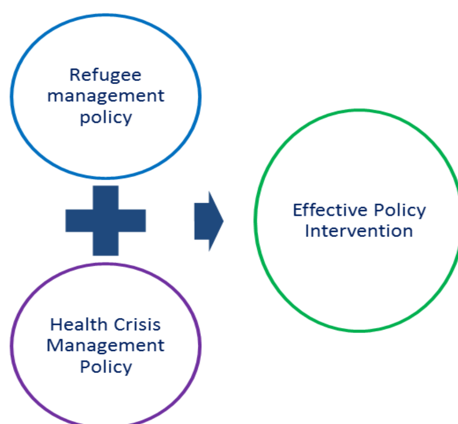


Figure: Author's Construct, 2021

The combination of these two policies can be a policy driver for enhancing organizational capacity. However, the health crisis management policy should include both clinical and non-clinical (coordination, partnership approach, stakeholder engagement, decision making, etc.) in other to make the management issues more effective.

The findings from the field study suggested that a combination of several elements can be beneficial in increasing the organizational capacity of public health sector organizations. Coordination from three different viewpoints appeared to be advantageous for health sector organizational capability, including coordination among participatory public sector organizations, coordination between government and non-government players, and coordination within the organization. An effective partnership was discovered to include a combination of active cooperation and complementary role playing by participating government and non-government organizations, as well as the psychological attachment of the persons working in those organizations. The findings further revealed that mutual trust between the service provider and the service recipients is also required. The training seemed to be useful and effective. However, the findings revealed that training for support workers and volunteers is just as crucial as training for primary health care providers. Training on both clinical and non-clinical issues is equally important. Incorporating ICT into the crisis management process proved to be a driving force in terms of enhancing overall organizational capability from both a management and a resource perspective. Furthermore, thorough policy guidelines for health crisis management and overall refugee management are required.

6.3 Chapter Summary

The findings of research questions three and four were highlighted in the chapter. The focus of this chapter has been on the actual reaction to the crisis, as well as issues linked to organizational capacity shortages and capacity development of health sector institutions. The crisis response can be defined as a collaborative effort of the local community, government, development partners, non-governmental organizations, and the international community. The local community spearheaded the first reaction, which was eventually supported by other partners. In the management process, the partnership method, combined with the coordination system, appeared to be effective. However, there was an early signal detection gap that impeded early planning

and preparedness efforts. The findings suggested there were certain gaps in coping with the crisis, such as a lack of capacity development efforts or training on health crisis management from both clinical and non-clinical perspectives. The necessity for a comprehensive policy guideline in terms of managing huge health crises and overall refugee management appeared to be critical. However, the drafting of a standard operating procedure based on the experience of the crisis operation team members was also deemed important. The results further showed that creating trust with service receivers can be a significant motivator for increasing organizational capacity. However, ICT integration has also proven to be advantageous to health-care companies.

CHAPTER SEVEN: KEY RESEARCH FINDINGS AND ANALYSIS

7.0 Introduction

This chapter focuses on the discussion and analysis of the key findings generated from the data collected against research questions. The previous empirical chapters (four, five and six) displayed the facts and figures gathered from the field and also provided certain kind of analysis. However, the collected data required certain level of synthesis and interpretation. Along with synthesizing, this chapter emphasizes a connection between the findings and the existing academic knowledge. Additionally, this chapter tries to provide the basis regarding the contribution of knowledge discussed in the following chapter. The chapter is divided into four segments. The first one emphasizes the nature and the characteristics of the implications of the refugee crisis on the public sector organizational capacity in line with the theories of public sector organizational capacity and crisis management as outlined in chapter four. The second part focuses on the dimensions of the factors affecting the organizational capacity in the light of the theories of organizational capacity highlighting the new insights found by this study. The third section highlights the relationship between the actual crisis response and required capacity against the crisis response and management theories. The last section documents the linkages and interconnectedness of the four research questions and the findings from the study. Each segment starts with key finding generated from the data collected in line with research questions.

7.1 Impacts of Rohingya Crisis on Public Health Sector Organizational Capacity

Chapter four presented the responses to research question one. The data, after rigorous examination and interpretation, leads to certain key findings. The findings suggested that the Rohingya crisis had implications on both direct service delivery organizations (DSO) and the coordinating organizations (CO). However, the nature and scope of the implications differ depending on the type of organization. The findings also revealed that the consequences differ depending on whether the organization operates in a crisis or non-crisis zone. Before proceeding to a more in-depth examination, let’s focus on the summary of the impacts on various types of organizations in the context of its locations.

Table 20: Summary of the impacts on organizational capacity

Coordination
Refugee crisis enhances the inter-organization coordination capacity of both the DSOs and the COs operating in crisis zone; COs and DSOs lost the regular and routine coordination capacity at the advent of crisis; The bottom-up coordination patterns become prominent and effective in the organizations operating in the crisis zone subsequently.
Communication
Inter-organizational communication (within the sector or outside the sector) had become informal and trust based in nature in the local CO and DSOs operating in the crisis zone; The refugee crisis didn't have any significant effect on the communication pattern of the organizations operating in the non-crisis zones
Decision Making
The decision making at the crisis zone had become more situational, based on the cognitive ability, intuition, judgement and professional knowledge of the individual health sector managers instead of usual process based decision-making; The decision-making became more formalized and process based at central level CO; The crisis didn't affect the decision-making process of the organizations operating in non-crisis zone.
Leadership
Leadership role at the crisis zone (in CO and DSO) had become more prone towards relationship orientation instead of task orientation; The leadership pattern had become more transformative and transactional rather authoritative and directive; Crisis had no significant impact on the leadership role and pattern in the organizations operating in the non-crisis zone.

Personnel Management System
The recruitment, skill development, career advancement and internal justice mechanisms had been negatively affected at the DSOs and local level CO; It had negative impact on employee motivation; The crisis hampered the organizational good governance principles; Scope for corruption and unholy practice increased at both DSOs and COs
Financial Resources
The crisis triggered changes in the financial management and resources allocation and utilization practice especially in the coordinating organizations; Facilitated innovative practice in DSOs operating in the crisis zone;
Infrastructure
Triggered infrastructure development at the crisis zone; Development was mostly ad-hoc without sustainability plan; Triggered discrimination at the DSOs operating in the non-crisis zone.
Learning /Professional Knowledge
The crisis facilitated professional development about clinical and nonclinical procedure along with crisis response mechanism both at the DSOs and CO level

Source: Author's Construct, 2021

Crisis situations, regardless of their classification, usually have an impact on the public sector institutions that deal with them. The severity of the impact is determined largely by the type and characteristics of the crisis. According to the literature, a large number of scholars believe that refugee crises usually put negative pressure on the host country's organizations (Orhan & Senyücel Gündoar, 2015; çduygu, 2015; Esen & Ouş Binatl, 2017), while others believe that the crisis brings positive changes and necessary breakthroughs in the process (Alix-Garcia & Saah, 2008; Maystadt & Verwimp, 2009; Gomes, 2010; Kreibaum 2016). Few of them argued that the refugee crisis brings forward both positive and negative impacts on the participating organizations of the host country (Kouni, 2018; Shellito, 2016; Brees, 2010). Though most previous research focused on the overall effects rather than stressing on the organizational capacity element specifically, the study conducted in a similar vein found that the Rohingya crisis had both negative and positive effects on the capacity of public health organizations.

Despite the fact that the results showed that the existence of negative impacts outweighed the presence of beneficial effects. However, the dimensions of the beneficial improvements in Bangladesh are equally enormous. The implications must be considered in the context of various organizational types.

7.1.1 Perspectives from Coordinating Organizations (CO) and Direct Service Delivery Organizations (DSO)

The findings indicated that the impact of the Rohingya crisis was not always similar in nature on Coordinating Organizations (CO) and Direct Service Delivery Organizations (DSO). The components of organizational capacity such as coordination, communication, decision making, leadership, personnel management, financial resources and professional knowledge have been affected differently in these two organizational types.

7.1.1.1 Fusion of Failure and Success in Coordination

The result indicated that the coordinating organizations at the local level somehow coped with the unexpectedly raising demands from the direct service providing organizations operating with the Rohingyas. But the CO were more vulnerable in dealing with the DSOs operating in the non-crisis prone areas as the CO had to channel almost all the resources to the crisis prone areas. Again, the CO played an effective inter-organizational role with the partners operating in the crisis management. The co-existence of the success and failure indicated that the political commitment and administrative pressure from the central level COs to ensure smooth crisis response compelled the local CO to become more active in the Rohingya issues and less vigilant in other issues. Hence, the findings suggested that the overall coordination capacity has been negatively affected with a success in crisis coordination.

The result of the study in terms of coordinating the real crisis showed some kind of inconsistency with some of the scholastic views of emergent coordination theories which suggested that coordination as a set on integrated actions has become difficult during unexpected situations and sometimes lead to lack of cohesive approach, misunderstanding and equivocality (Bechky, 2003; Carlile, 2004; Bechky, 2006; Jarzabkowski et al., 2012; Brown et, al. 2015).

Additionally, the result does not also fall in line with some of the findings which claimed that coordinating crisis response is very difficult when the crisis situation is ambiguous, there is time pressure and the actors are operating in distant locations even though there exists a structure system defining roles and actions (Wolbers et al, 2013).

On the other hand, the coordination practice in the COs under study can be explained and fall in line with some other studies which argued that officials dealing with rapidly changing and uncertain situations need to act beyond organizational boundaries by applying certain techniques such as finding innovative solutions to arising problems by circumnavigating the rule bound actions in line with the routine protocols. These actions include informal and temporary practices (Kobayashi et al., 2005; Wolbers et al, 2018).

Additionally, some scholars claimed that the bottom-up or 'emergent' perspective of coordination is more spontaneous in dealing with crisis situations (Boin & Bynander, 2015). The Rohingya crisis coordination showed symbols of both the top-down perspective and bottom-up or 'emergent' perspective of coordination. As a result, it becomes difficult to differentiate which type was more effective; rather, it is rational to argue that the combination of both models played an important role.

The implications of the Rohingya crisis seemed more intense on the direct service proving organizations (DSOs) as compared to its coordinating bodies. The DSOs had to coordinate within the organization as well as needed to maintain inter-organizational coordination with other organizations operating in the field including the development partners, NGOs and the local administration. It was also found that these DSOs had to deal with the central level organizations directly during the initial period of the crisis. The findings indicated that the DSOs were more successful in inter organizational coordination compared to the internal coordination. The pressure on the DSOs was enormous during the initial stages of the influx and there was scarcity of resources which includes the human resources as well as financial and material resources. As a result, integrating and accumulating resources from other supporting organizations was one of the main activities of the DSOs at that time. And the managers of the DSOs didn't have much time to perform the internal coordination work. Though, the

responsibility of the inter organizations coordination laid with the Coordinating Organizations (CO), DSOs had to perform a key role in securing necessary supports from the partnering organizations. The significant demand and supply gaps in resources compelled the DSOs to participate directly in inter-organizational coordination. The findings indicated that these organizations were not engaged in any inter-organizational coordination activities prior to the start of the crisis. As a result of this experience, the DSOs became acquainted with the coordination activity, which may be advantageous in improving the organizational coordination capacity of these grass-roots health service-providing organizations. As a result, it was discovered that while the crisis impacted internal coordination, it also helped in improve inter-organizational collaboration among DSOs operating in Rohingya crisis-affected areas.

The outcome is similar to the ideas of some researchers who believe that in uncertain and tough crises, players frequently emphasize collaboration in order to uncover feasible solutions (Okhuysen & Bechky, 2009). Similarly, this finding is consistent with Faraj and Xiao's (2006) hypothesis that officials who have never worked together or even met before demonstrate coordinated and complementary attitudes under pressure. Bottom-up coordination is more spontaneous in the case of DSOs, supporting the hypothesis of Boin and Bynander (2015) that during an emergency, bottom-up coordination is more prevalent.

To summarize, the crisis appeared to have a favorable effect on inter-organizational cooperation in both Coordinating Organizations (CO) and Direct Service Delivery Organizations (DSO). Internal coordination in DSOs appeared to have been significantly harmed. The study also revealed that in these organizations, the scenario of coordination in normal time is practically inverse, implying that internal coordination was always superior to inter-organizational collaboration. Bottom-up coordination was shown to be successful in DSOs, whilst top-down and bottom-up coordination were found to be successful in CO activities. These notwithstanding, the evidence did not support one viable approach of coordination in COs.

7.1.1.2 Shifting from Formal Communication to Informal Trust Based Communication

In Bangladesh, most communication in the public health system is formal. Communication between organizations is very formal, taking the form of written official letters. Internal communication within an organization is also formal, but informal communication is also

present to some extent. The findings suggested that the Rohingya crisis has brought about certain changes in the communication style of health service providing organizations, both in Coordinating Organizations (CO) and Direct Service Delivery Organizations (DSO). The communication of the health service providing organizations can be viewed from three dimensions which includes:

--Internal communication within an organization,

--Inter - organizational communication within health sector,

--Inter - organizational communication with other partner organizations beyond health sector.

At the outset of the influx, the COs of the Cox' Bazar district had to establish contact with central level officials such as the divisional office and the directorate. As the directorate was required to interact with the Ministry. At this level, communication was completely formalized by sending official letters. However, due to the massive workload created by the unprecedented surge of Rohingyas with medical problems and health concerns, contact between the CO in Cox's Bazar and the CO at the divisional level and the directorate became informal in character within a few days. Bottom-up communication from the CO of Cox's Bazar for extra resources was made informally through telephone calls. Top-down communications from central level institutions such as the directorate and ministry, on the other hand, were largely formal in nature and carried out through official letters. Initially, communications between CO and DSOs were largely verbal and casual in character. However, some crucial verbal statements, such as financial resource allocations, were later formalized by issuing retrospective official letters. Similarly, communication with other partners was formal in nature and entirely relied on written documents. However, as the severity of the crisis increased, communication with other partners, especially development partners, became more informal and primarily verbal. The scenario at the crisis-affected areas where DSOs operated were not exempted. The organization's communications devolved into a completely informal system relying on verbal instructions and rules. This appeared to be at polar ends with the communication approach used during normal times.

The findings therefore suggested that the crisis has compelled organizations operating in crisis-prone areas to adopt informal communication styles, regardless of their nature. Informal communication did not appear to impede the crisis operation; rather, it appeared to hasten the

prompt response. Thus, it can be argued that highly formalized communication was turned into an informal framework, implying a considerable shift in corporate culture from evidence-based communication to trust-based communication.

According to some researchers, informal communication is useful in unexpected and sudden situations (Kraut et al., 1990). However, these experts asserted that the actors' proximity is a necessary condition in this scenario. In this situation, informal communication can be useful in uncertain situations, but closeness is not required. However, Daft and Lengel (1986) suggested that informal communication is required for better management in uncertain situations, which supports the study's argument.

7.1.1.3 A Shift from Processed Based Decision Making to Intuitive and Judgement Based Decision Making at the Periphery

Decision-making in Bangladesh's public health sector organizations are sometimes characterized by bureaucratic procrastination, with an emphasis on formal consultation in special committees or regular committees. For major cross-cutting issues and policy choices, a committee-based method is used. Aside from that, decisions are made in organizations by individual job holders using their discretionary authority at various hierarchical levels. However, evidence from the field revealed that critical and inter-organizational decisions are typically made through consultations in meetings, even though managers have individual decision-making ability. The results from the field espoused that the crisis had influenced the decision-making patterns of the health service providing organizations including the Coordinating Organizations (CO) and Direct Service Delivery Organizations (DSO).

The Office of the Civil Surgeon is the primary coordinating institution in the health sector in a district. At the start of the crisis, the Rohingyas were arriving at numerous border sites with critical medical issues that necessitated immediate medical attention. As the local DSOs were unaware of their responsibility in this circumstance, they began communicating with the Civil Surgeon's office for guidance. The findings indicated that the Civil Surgeon immediately spoke with the divisional office and the directorate of health, however the health directorate did not issue clear directions immediately. Meanwhile, the situation was fast deteriorating as a result of the large and irregular influx of the Rohingyas with major and minor injuries. To curb the

situation, the Civil Surgeon had to take a decision using his discretionary powers. This expediated action by deploying additional resources, such as health personnel and medicine, from other parts of the Cox's Bazar district to the affected areas. Aside from this, the Civil Surgeon was required to also make decisions concerning local resource mobilization, as to whether they should involve local volunteers at the sub-district health facilities. The outcome demonstrated that these judgments were made depending on the situation rather than following any set and customary processes.

However, the findings from the field suggested that there was very little variation in the decision-making process and style among COs at the central level, such as the ministry or directorate of health services. The Rohingya issue appeared to bring about some adjustments that were virtually diametrically opposed to the change in the COs working at the perimeter. The central level COs' decisions were primarily based on consensus reached in meetings specially constituted to deal with the Rohingya situation. As a result, decisions at the center were heavily focused on processes. Nonetheless, it was evident that the decision-making process was faster when it had to do with the Rohingya crisis, but the average decision-making time for other issues became lengthy than usual. As a result, the overall management process of the health service became stagnant in the initial days of the Rohingya crisis.

Evidence from the field indicated that officials working at DSOs, particularly the head of the unit, were required to make substantial local choices using their discretionary authority and professional knowledge, which went beyond what was typical practice at the time. Decisions such as supplying food to additional patients at hospitals without government consent can be an important example of decision-making procedures in DSOs during the early days of the crisis. The impact of the migration was so severe that officials were forced to compromise with official processes. It is vital to emphasize that this divergence from standard procedure may have jeopardized the professional careers of the officials. The officials were aware of the potential ramifications as government employees, but the gravity of the situation prompted them to go above and beyond the standard procedure. This notwithstanding, the supervisory authority did not obstruct local decision-making, but rather facilitated it. It is possible to claim that the intensity of the crisis prompted changes in decision-making patterns at both the federal and local

levels. This shift in practice was made possible by a high level of political and administrative commitment.

Decisions in COs and DSOs are primarily situational and based on the cognitive ability, intuition, judgment, and professional knowledge of individual health sector managers. The rule-bound process, which largely adhered to the gradual and logical qualities, was jettisoned, and initial judgments were mostly made locally, with or without the orders of superior authorities. The use of discretionary authority was prevalent. During the crisis, the pattern of making critical and inter-organizational decisions shown a considerable departure from the rule-bound practice, and the decisions were determined to be rapid in character.

The findings are consistent with some of the scholarly perspectives of the contingency paradigm of decision making, which say that amid high levels of urgency and uncertainty, managers cannot simply follow normal operating procedures, but must instead rely on intuition and judgment (Thompson, 1967; Mintzberg et al, 1976; Nutt, 1984; Hale et al., 2006; Daft, 2007). Furthermore, the findings are consistent with some scholarly claims that during a crisis, management must be flexible in decision-making by exercising discretionary powers within the existing regulatory environment (Christensen et al., 2016; Meyer, 2016), and organizations operating under external constraints and affected by events beyond their control have few options (Boyne et al., 2001; Andrews et al., 2005). However, this outcome contradicts the argument of some experts who claimed that during crisis, superior authority become more vigilant while government workers on the ground are comparatively slow and rigid in decision making. During crisis, these two circumstances typically lead to central level, top-down decision making (Monten & Bennett, 2010; Krebs, 2009).

7.1.1.4 Change from Authoritative Managers to Transformative Leaders in the Local Context

Bangladesh's administrative culture is traditional rather than modern, with a relatively high degree of power distance, a limited tolerance for uncertainty, and a reliance on traditional sources of information (Jamil, 2002). According to the perceived culture, leadership in the public sector is more autocratic in nature. However, the study's findings suggested that the leadership style had something to do with the Rohingya problem, particularly in the local context. Some of

the leaders have clearly made a substantial difference in the crisis response effort. When compared to COs operating amid the crisis, the role of leaders was more significant at DSOs.

The data revealed that the health sector managers working in the COs were reactive in nature and usually followed the rules prior to the onset of the crisis. It was also clear that they were hesitant to make any significant changes to the existing system and were more concerned with task orientation rather than employee relations. They were used to give directives to coworkers and subordinate organizations based on the prescriptions of superior organizations. The health managers' existence was primarily limited to endorsing the superior authorities' orders and allocations. Managers' roles were limited to uncovering flaws in subordinate offices in the name of monitoring. According to most of the respondents, the superior subordinate relationship was intended to be more controlling rather than improving. The attitude of the Civil Surgeon office, the main CO in the district, was not an exception at the start of the crisis, which was deemed to be demotivating by respondents working at local DSOs. However, as the severity of the crisis increased, health-care managers were forced to take on important individual roles in addition to their regular duties. The unexpected influx of Rohingyas has boosted administrative and managerial activities, which have sometimes had to be carried out locally without the approval of superiors. The use of professional knowledge, intuition, or personal judgment in the distribution or rearrangement of resources seems to be prevalent during the crisis, particularly in the early days of the influx. The Civil Surgeon's role has evolved into one that is more consultative and relational in nature. According to the data, the Civil Surgeon has granted subordinate officials more leeway in making local decisions. The Civil Surgeon (CS) appeared to be more concerned with the subordinate officials' comfort and problems. During the normal period, that is, before the crisis, the scenario was different. The CS's leadership style has evolved into a new pattern that is more in line with the qualities of transformative leadership. The findings suggested that a shift in the CS's attitude influenced subordinate authorities during the challenging early days of the Rohingya crisis. According to the respondents, this strategy pushed health managers working in DSOs to adopt innovative activities that were ultimately beneficial in dealing with the problem.

The scenario in crisis-affected DSOs followed a similar pattern. The massive influx compelled them to take more and more immediate actions without the approval of superior

authority, and they needed to improve interpersonal relations with other public sector actors, particularly the local administration. Some health managers had to rely on their personal magnetism to organize local resources. Health managers in DSOs were discovered to be more relational than administrators in health institutions. This can be explained by the fact that without a caring attitude, it may be difficult to motivate workers who were delivering extra service under stressful conditions. The data also revealed that interpersonal skill and leadership quality made a substantial difference in terms of identifying early signals, predicting the outcomes of their decisions, and obtaining resources. Despite differences in effective situation management, practically all health managers in DSOs were found to be more intuitive and judgmental rather than rule bound and instruction abiding. According to the findings, health managers relied more on professional expertise and individual cognitive abilities.

To summarize, the findings revealed that the crisis prompted certain adjustments in the leadership methods of both COs and DSOs. However, the changes in the DSOs functions at the epicenter of the crisis are more visible when compared to other organizations. Individual managers who were largely rule-bound and directive in nature in typical situations exhibited certain features that resembled the democratic and transformational patterns. As a result, the leadership strategy during the crisis was discovered to be a mix of transformational and transactional leadership patterns.

The findings confirm experts' claims that the transformational, ethical, and transactional leadership approaches are more effective in crisis response and employee motivation in public sector organizations (Bowers et al., 2017; Meyer et al., 2019; Morse, 2010; Silvia & McGuire, 2010; Hanbury et al., 2004; Van Wart, 2003; Rainey, 2003). The findings contradict the argument that public sector managers in Bangladesh have little or no managerial discretion, which has a negative correlation with adaptive approaches or innovation (Siddiquee, 2003), and transformational leaders are expected to be less effective in organizations because these traits are not highly legitimized in the public sector (Alimo-Metcalfe & Alban-Metcalfe, 2006; Currie & Locket, 2007). Again, the findings suggest the necessity for innovative operational strategies to deal with uncommon events (Christensen et al., 2016; Head & Alford, 2015; Webb & Chevreau, 2006).

7.1.1.5 Interrupted Personnel Management System

The activities associated with recruiting, selection, placement, training, career promotion, and performance management are an important component of the entire personnel management system. Planning, acquisition, development, and sanction are the four primary responsibilities of a human management system (Klingner et al., 2015). According to the study's findings, the crisis has affected several components of the human management system. However, the regional impact appeared to be more intense than the national level.

Aside from doctors and nurses, support staff roles in district and sub-district health sector organizations are typically employed and overseen by the local CO, such as the Civil Surgeon Office. The results showed that at least two due recruitment processes were either postponed or delayed during the first six months of the crisis due to massive workloads associated with the Rohingya problem. As a result, the local health facilities, especially the COs, have suffered from a lack of fresh support employees with new knowledge.

Meetings of the departmental promotion committee (DPC) could not be scheduled during the first eleven months of the crisis, causing the local support staff's career advancement to be hampered. The delay resulted in financial loss for the incumbents, which appeared to have a detrimental impact on motivation at a time when they were already overburdened by the massive task of the crisis response. Furthermore, numerous health professionals were unable to attend departmental examinations, which were required for advancement to higher positions.

Regular training, including mandated training, for health workers working in the Cox' Bazar district had been severely affected because there was no way for them to leave their job during the high demand circumstances. The statistics revealed that the career promotion path for some of the newly appointed health professionals had been hampered because training was required for permanent employment.

COs used to rely on departmental proceedings, an internal justice system, to deal with any type of inappropriate behavior by staff members, including misconduct and misappropriation. This approach entails conducting an investigation, taking depositions from the accused, and rendering a decision based on the facts. Surprisingly, the study discovered that

the crisis had an impact on the departmental procedure system because the designated officials were too preoccupied with the crisis response. The majority of the departmental proceeding hearings have been reported to have been postponed since the beginning of the Rohingya crisis. This therefore, hampered the timely disposal of the cases which negatively affected the governance system in these organizations.

There was an established placement policy for health professionals at the central level. The study indicated that the policy was vigorously implemented by the health directorate before the crisis. However, the crisis compelled the directorate to go above and beyond the established protocol in order to deploy a large number of health experts in crisis-prone locations.

Health professionals were unwilling to be placed in crisis-prone locations, and they began to use any means possible to prevent this placement. According to the responses, during the first few months, management in the health service directorate had to deal with a slew of unpleasant situations, ranging from political and bureaucratic pressure to bribery. Respondents felt that a form of unholy practice surrounding the deployment of health experts was even established from the start of the crisis. This has impeded the governance process at the COs that operate at the central level.

The findings suggested that the impact is particularly severe on COs and DSOs operating at the crisis's edge. The crisis had affected almost every aspect of human resource management. Though the central level health sector organizations were not adversely affected, the vibe of the local effect is indirectly impacting the national personnel management system.

The findings support the premise that additional labor, either recruited or deployed from other accessible sources, must be put in place to deal with a crisis, in addition to coordinating existing workers (Ansell et al., 2010; Meyer, 2016). Furthermore, some academic theories contend that crisis conditions have a negative impact on HRM practices like as recruitment, training, and employee motivation (Eckhard et al., 2020). However, the data contradict that there was no strong evidence of poor motivation among health personnel during the Rohingya crisis.

7.1.1.6 Rearrangement of Direct and Indirect Financial Resources within the National Budget Causing Resources Constraints in other Parts of the Country

Bangladesh's budgetary allocation is broken into two primary sections. One section is known as the revenue budget, and it manages all expenditures for public employees' salaries and benefits, as well as other recurring expenditures. The remainder is known as the development budget, and it is utilized for all types of development activity under an Annual Development Programme, abbreviated as ADP. The revenue budget allocates funds for health at the district and sub-district levels based on the number of hospital beds (for food and drugs) and employees in facilities (for salaries and other allowances). However, population size, demographics, and epidemiological issues are not taken into account (Islam, 2015).

Prior to the crisis, the Cox' Bazar district health facilities faced a number of issues, including a severe scarcity of staff resources. In the backdrop of the aforementioned issues, Cox's Bazar's health industry was severely impacted in August 2017. The occupancy rate of health facilities surprisingly jumped, reaching nearly double the national average. As a result, in order to deal with the sudden and fast developing health problem, the health sector's expenses have been boosted. Given Bangladesh's national health landscape, the total number of health professionals deployed in the Rohingya crisis response is almost equal to the total workforce of any two large districts. The government was forced to set up a separate coordination center in Cox's Bazar. Along with the wage, the government is required to give additional travel and daily allowances. However, because the health professionals were deployed on an ad hoc basis from various regions of the country, their salaries and benefits were withdrawn from their original posting location. As a result, the host community faced discrimination because they were not serving the individuals for whom they were paying. As district budgets are restricted, the government was forced to shift more cash from national allocations, putting financial limits on other health sector groups functioning in other parts of the country. As a result, the data suggested that the crisis sparked an internal reorganization of financial resources within the national budget allocation, with increased resources being channeled towards the Rohingya crisis-prone district of Cox's Bazar. This internal system has aided the response to the crisis, but

it also hampered the quality of service and timely implementation of health initiatives and schemes in other parts of the country.

The findings suggested that this arrangement resulted in resource restrictions in other sub-districts of the Cox's Bazar district (apart from the main two sub-districts where the main Rohingya camps are located). The findings indicated that the health budget for the Cox's Bazar district as a whole had been significantly funded, but distribution was not fairly done, consequently, the districts who did not live in the crisis-prone areas felt they were being discriminated. The non-crisis prone districts and their and the officials working there felt they have been deprived of what is due them.

The findings support some scholars' claims that the large refugee crisis has harmed the quality and capacity of some public services such as health and education (Francis, 2015). This finding is also similar to Kelley (2017)'s argument that the host community's basic facilities are impaired as a result of the large flow of migrants.

It is vital to note that the highest level of governmental commitment prompted public health sector institutions to make changes in financial allocation and management practices in order to help the Rohingya crisis response. Given the restrictive bureaucratic system, the reforms and innovation in management practice that were sparked by the crisis appeared to be significant. It can therefore be argued that the rigid bureaucratic system can be changed in the advent of crisis if there is strong political commitment.

7.1.1.7 Filling the Infrastructure Gap at Some Pockets in Disguise of Crisis Response

Even for the host communities, the infrastructure capacity of the health institutions was unquestionably insufficient. In this context, health-care facilities were exposed to an additional one million Rohingyas. The attention of the government, as well as the world community, including UN bodies, was attracted to Cox's Bazar as a result of this massive action. During the crisis response process, the authority was made aware of organizational capacity deficits from both a management and a resource viewpoint, prompting certain capacity development activities led by the government but primarily funded by development partners. However, the government also invested its own funds in the expansion of health-care infrastructure, which was made

possible by the crisis. Though the infrastructural development is still insufficient to serve the host community on its own, it can be viewed as a step forward.

Infrastructure growth in other sectors, such as roads and highways, has indirectly helped to increasing the capacity of the health sector. According to the findings, the Rohingya issue has accelerated the development of connecting roads between the district headquarters and the two main crisis-prone sub-districts. The commuting time has lowered dramatically as a result of road improvements, which has indirectly contributed to increased health-care capacity for both the host and guest communities.

Since 2017, considerable infrastructure development in the health sector has been focused mostly on dealing with the Rohingya problem. However, because the nature of some of the development activities is permanent, the host community automatically benefits in the long run. Thus, from a resource standpoint, the crisis appeared to help infrastructural development in the Cox's Bazar district. However, in order to be sustainable, additional infrastructure must be incorporated in the official organogram of the units. According to the current method, no maintenance can be performed unless it is included in the official organogram.

It is worth noting that the development is more visible in organizations located near the Rohingya settlement. At the same time, infrastructure development in other parts of the district appeared to be stalled since the start of the crisis. As a result, while the benefits of the ad hoc development process are trickling down to the host community, it is also causing discrimination in other parts of the district. As a result, the development may not be long-term in order to bring about significant capacity changes in the broader health sector organization. This development can be classified as cosmetic development on a fragile infrastructure.

The findings somewhat agree with some scholarly perspectives that indicate that crises have a favorable impact on issues such as organizational development, potential revealing, and organizational learning (Zdemir and Onur Balkan, 2010). According to the study, the nature of infrastructure development can be associated with organizational development, although there is no significant evidence of organizational transformation in this setting. Furthermore, the findings are consistent with the claims of other researchers who suggested that under an integrated health system, the resources devoted for providing services to refugees have a major positive influence on the local health system and transportation infrastructure (Damme ,1999).

7.1.1.8 A Learning Platform for Professional Knowledge

Despite the fact that regular and normal internal training has been disrupted by the crisis, research suggests that the potential to obtain professional knowledge from foreign and private sector health specialists has grown since the inception of the crisis. With the emergence of different outdated diseases among the Rohingyas, various partners, particularly international ones, stepped in with relevant experts and treatment strategies. For more than 15 years, diseases such as diphtheria and cholera were almost nonexistent in Bangladesh, according to data. In particular, there hasn't been a single incidence of Diphtheria in Bangladesh since the late 1980s. As a result, new generations of health professionals in both the public and private sectors were under-trained in this field. For more than a decade, Bangladesh had ceased production of diphtheria medication. However, under these conditions, there was Diphtheria outbreak in the Rohingya communities in late 2017. The density of the Rohingya population in the camps, as well as the host community's proximity to the Rohingya settlements, made the situation more dangerous for both the Rohingyas and the host community. The intervention of the WHO and other development partners in this environment was exceptional. WHO and other partners gathered appropriate resources, including specialists, vaccines, and medicines throughout the world. They also organized information transfer programs, such as training for national health professionals. Aside from that, they created and published guidelines for the identification and clinical management of suspected cases, as well as contact tracing (DGHS, 2018). The findings suggested that these measures were fruitful, and that without such intervention and knowledge transfer, the situation may have been substantially worse. However, the results show that such interventions, particularly knowledge transfer initiatives, have significantly contributed to a reduction in the death rate among the Rohingyas and in the host community. Local health workers' knowledge in dealing with Cholera and emergency medical response was strengthened. Furthermore, unique trainings were provided to local health professionals, the majority of which are on-the-job training.

The data also revealed that international experts were involved in the drafting of guidelines and SoPs for the Rohingya health issue. As Bangladesh is a disaster-prone country,

these rules would be useful in the future for similar types of health crises. The local actors involved in the drafting process have acquired some expertise that can be used to develop similar policy guidelines for Bangladesh or even at the regional level. Furthermore, health specialists working in the public sector have never seen a medical or health emergency of this magnitude. As a result, they were unfamiliar with crisis response or management techniques. Furthermore, it was obvious from the statistics that majority of the health professionals had little exposure to relevant training. The crisis therefore provided an opportunity in disguise for health professionals to learn from their own experiences about what went well and what went wrong in terms of crisis response. As a result, it has generated opportunities for 'learning by doing'.

However, the findings also indicate a lack of initiatives to scale up the learned knowledge by spreading it among other health professionals operating in different parts of the country. It is also important to note that the government has been deploying public health professionals in the Rohingya response work in turns (for one or two months), so a large number of health professionals are familiar with the treatment plan and the technical know-how to deal with medical emergencies. Nevertheless, it is equally critical to chronicle the health-care response based on the experiences of front-line workers during the early days of the inflow. Having said that, it is clear from the study that the crisis has aided in the acquisition of new professional knowledge, which can be valuable in boosting the health sector's capability from a management standpoint.

The findings showed some similarities with some of the scholars who advocated that sometimes crisis provide opportunities for learning, change, and administrative adaptation (Andrews et al., 2013; Birkland, 2006). Besides, Deverell (2010), opined that innovation and learning occur during severe crisis management periods when time and uncertainty are limited. On the other hand, the findings contradict the claims of some other scholars who observed that a crisis event has no or a limited relationship with learning and that whether a crisis event triggers any learning process is yet to be determined (Smith & Elliott, 2007; Boin, McConnell, & 't Hart, 2008; Roux-Dufort, 2000; Nohrstedt, 2007; Boin, 't Hart, Stern, & Sundelius, 2005).

To summarize, the findings suggested that the Rohingya influx has moderate to significant influence on the capacity of the health sector organizations. The result indicated that the crisis has both negative and positive impact on the organizational capacity. However, the crisis has shown more negative impact compared to the positive ones. Most importantly, the crisis has pushed some changes in practices which are connected to organizational capacity. The nature and the intensity of the impact varies according to the nature and the location of the organizations. The Direct Service Delivery Organizations (DSO) like hospitals and the Coordinating Organizations (CO) like Civil Surgeon Office has shown different kinds of results in terms of effects. The result also differed based on whether it is a central level organization or local level. The findings suggested that the Rohingya crisis has shown different impacts on various perspectives of organizational capacity. Some of the impacts are negative in nature and some of them seems positive. The impacts seem to fall under two major perspectives of organizational capacity which are described in table 21

Table 21: Summary of the impacts from Organizational Capacity perspective

Perspective of Organizational Capacity	Specific aspects
Management capacity	Coordination
	Communication
	Decision making
	Leadership
	Personnel Management
Resources Capacity	Financial Management
	Infrastructure
	Learning/ professional Knowledge

Source: Author's construct, 2021

7.2 Influential Factors for Health Sector Organizational Capacity

The facts and the figures about the influential factors behind the organizational capacity in the context of Rohingya crisis was presented in chapter five. According to the nature of the influence, the factors were divided into three major categories and these were, the driving factors, the indirect factor and restraining factor. The data presented in the chapter five needs to

be interpreted and discussed in the context of existing knowledge. The findings suggested that fourteen factors played role under the three broad categories. The factors that facilitated the crisis response operation as well as the overall capacity are viewed as driving factors. Besides, some factors which are mostly international in nature, also played a role but had no direct relationship with the health sector organizations at the micro level was found to be significant in order to understand the overall phenomena from the macro perspective. These factors are discussed under the indirect categorization. The restraining factors are those which interrupted the crisis response rather facilitating it. The key findings can be described as follows in table 22:

Table 22: Key findings under research question two

Research Question	**Factors**
What are the key factors affecting health service capacity during the refugee crisis and why?	**Driving Factors**
	Political:
	Political commitment at the highest political level is one of the most important facilitators for organizational capacity in such crisis
	Administrative:
	Effective monitoring and coordination among the actors can enhance the organizational capacity;
	Presence of a specialized and dedicated public sector organization with cross cutting and convening authority for dealing with the crisis issue can positively assist the organizational capacity
	Economic:
	Active partnership among the state and non-state actors at the organizational level as well as individual level is a strong driver;
	Socio-psychological:
	sense of kindness and affection, religious affinity and similarity of culture and tradition can boost motivation at the individual level;
	Media:
	Media can contribute in improving the organizational capacity in crisis

Research Question	Factors
	situation by playing dual role both as watchdog and means of attracting quick attention;
	Indirect Factor
	Regional and Global: International pressure and guidance without knowing the context of the crisis can sometimes hamper real crisis response; Non-cooperation of international players based on the regional and global geopolitics can negatively affect the quick decision making at the macro level (central level COs); Regional or global concern like Islamophobia can slow down the pace of the crisis response; Lack of trust among the actors is detrimental for organizational capacity in a crisis situation
	Restraining Factors
	Administrative: Unplanned and too many unnecessary inspections and visits by political, administrative and international delegates can cause unnecessary delay in the actual crisis operation, can hamper quality of decisions and actions; **Social:** Level of health awareness of the service recipients has positive correlation with organizational capacity.

Source: Author's Construct, 2021

7.2.1 National level Political Commitment Reflected at the Local Level

Evidence from the study indicated that the national level political commitment was one of the most critical aspects in the crisis response drive. The presence of a large national level political leadership at the crisis zone, including a visit by the Honorable Prime Minister within the first

three weeks of the crisis's genesis, demonstrates the level of devotion even more. The political commitment at the central level can be seen from a variety of viewpoints, including the historical perspective and the leadership image perspective. Bangladesh's ruling party (Bangladesh Awami League) is the same party that led the country's liberation war in 1971. During the conflict, a large number of Bangladeshis were forced to flee to neighboring India, and the party was forced to establish a government in exile. A large number of party leaders, including the present Prime Minister, were forced to flee to India as refugees. As a result, from a historical standpoint, the refugee crisis became an emotional phenomenon. In this environment, the ruling party leadership, including the present Prime Minister, has a sympathetic spot for any refugee forced to flee due to genocide or mass murdering. According to the second school of thought, the ruling party was strongly criticized both nationally and internationally for restricting the possibility for democratic practice in the country. The critics claimed that the ruling party was seeking international recognition by welcoming the large Rohingya population and keeping the border open. It is quite difficult to infer what the key causes for the strong commitment were within the boundaries of the investigation. However, the level of political commitment was discovered to be extremely high, and it was effectively disseminated to the local level. The central political commitment supplemented the involvement of the ruling party's local political entities at the local level. The participation of the local ruling party in the crisis response appeared to have a favorable effect on the crisis response. Even political party leaders who were always loud about local people's rights and equity were found to stay silent when resources from their own area were transferred to the crisis zone to aid the Rohingyas. Local political leadership was also shown to be helpful in mobilizing local resources such as volunteers and financial support. The political leadership's strong dedication also played a significant role in launching timely and all-out administrative drives during the early days of the crisis. The actions of the Ministry of Health and Family Welfare and the DGHS were aided by the minister's personal intervention in accordance with Prime Minister's Office directions. It was also discovered that political commitment from political parties other than the ruling party was beneficial. Despite some initial blame games between the ruling party and the other political parties, they later worked together in a fashion

that is typically seen after a national tragedy. And the political leadership's dedication is especially noteworthy given Bangladesh's lack of a refugee policy.

7.2.2 Socio – Psychological Factors Matter

The findings suggested that various elements such as sense of compassion, religious affinity, family closeness, and culture and tradition were significant and had a part in the crisis response process. The variables discovered to be significant behind the health sector's organizational capabilities.

In most cases, the Rohingyas were forced to flee to Bangladesh on foot, with no or very few goods. They were traumatized and, in the majority of cases, had burn or bullet injuries. They had to walk a great distance from Myanmar's Rakhine state to the border with Bangladesh. They were also suffering from starvation and emotional trauma. They were extremely vulnerable and defenseless as a result of their whole situation. Out of 716915 Rohingyas (relocated since 25 August 2017) 52% was female and 48% was male (UNHCR, 2020). According to the data from UNHCR (2020) among the total population there was 52% children, 3% older person and 1% disabled. Beside this the data also indicated that the Rohingyas were extremely vulnerable.

The inhuman conditions of the Rohingyas have triggered the humanitarian aspects of the human beings, and health professionals working in the region became more emotionally engaged to the situation. They began to regard their responsibilities as humanitarian rather than merely professional. They worked extra hours without asking for financial or administrative compensation. Responses from the field suggested that they did not even complain to anybody about their overstressed conditions but rather were satisfied to deliver real services to the Rohingyas. On the other hand, they get dissatisfied if they were unable to provide appropriate assistance to them. The health professionals went above and beyond their professional boundaries by participating in local resource mobilization operations to assist Rohingya patients, which was unprecedented.

At the very onset, the local community and the crisis response officials assumed that the Rohingyas were persecuted because they were Muslims. They believed that the Buddhist who constituted majority of Myanmar's population were the actors behind the genocide. As a result, a sense of communality prevailed among the host community and the officials working in the area. People at this part of Bangladesh are considered more religious as compared to the other parts of the country. This may be due to the fact that this part is a disaster-prone area and it also has a low literacy rate. The findings suggested that, from religious perspectives some of the health professionals saw their role in the crisis response as a religious obligation. This feeling seemed to expedite the motivation of the health professionals. Instead of claiming overtime, some of them spent their own money for the Rohingyas. They were found to share food during religious festivals with the Rohingyas as part of their sense of religious affinity. It was evident that the religious perspective contributed positively in mobilizing the local resources. This religious affinity also worked behind the scenes to encourage the participation of the local girls as volunteers to serve the Rohingya female patients. These local volunteers helped to enhance the capacity of the local health facilities during the initial days of the crisis. The evidence suggested that there was a sense of Muslim brotherhood among the health sector employees and supporting staff and subsequently kept their motivation and morale high. This contributed positively from the organizational capacity perspective. This specific finding contradicts claims by some scholars that a common religion may not be significant in crisis response situation and may not be able to supersede political, social, and cultural divisions (Palmer, 2011).

Historically, there was a relationship between the people of Rakhine and the local people of Cox's Bazar. These two communities had both trade relationship and kinship ties for a long time. It is believed that a good number of the Rohingyas had marital relationship with the people of Tekhnaf and Ukhia in the Cox's Bazar district. There is also a rumor that some Rohingyas possessed parcels of land in Cox's Bazar with the support of their relatives living there. From these, it is evident that the Rohingyas had cultural, dialectal and religious affinity with the people of Cox's Bazar and most importantly, the situation of the Rohingyas had always been unstable and shaky in Rakhine. In this backdrop, the Rohingyas might have been motivated to strive for alternative safe homes in Cox's Bazar. The findings indicated that the local community put a

kind of pressure on the local health facilities to ensure better service quality for the Rohingyas. This kind of local monitoring was there not only from the sense of kindness and religious affinity but also from kinship ties with the Rohingyas. The evidence further suggested that the local pressure was more intense especially for those who had kinship ties with the Rohingyas. This kind of family attachment positively contributed to the health sector as it motivated the local community to further extend support to the local health facilities through volunteering, financial and mental support. They therefore acted as local watchdogs and simultaneously contributed in enhancing the management and resources capacity of the health service providing organizations.

These socio-psychological elements appeared to have a greater influence on DSOs working in crisis zones, as well as an indirect impact on the local CO. The sole component shown to be influential in increasing the motivation of employees working at the central level COs was a sense of brotherliness. This had a substantial impact on the crisis management officials working in other government agencies as well and that played a complementary role in health service delivery.

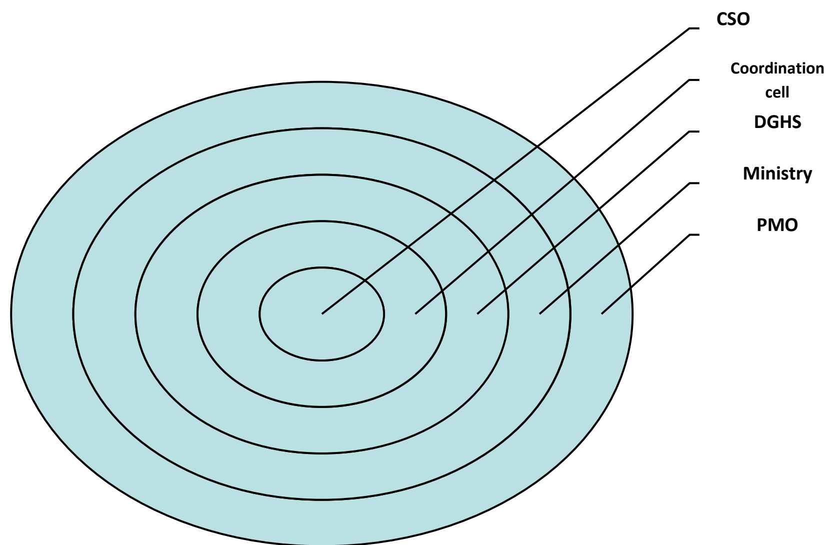
The findings are consistent with the claims of some scholars who argue that emotion and thinking are fundamentally connected and that emotions such as fear or rage can promote effortful cognitive operations (Izard, 2009). Furthermore, Smith and Kirby (2001) asserted that motivational states such as threat can be useful for affective crisis responses. However, the data revealed that socio-psychological elements such as kindness, religious affinity, or kinship can contribute to public sector organizational ability in specific contexts such as the Rohingya crisis.

7.2.3 Effective Inter-organizational Coordination under Stringent Monitoring and Existence of Special Organizational Structure

Bureaucracy in Bangladesh has been blamed for the relatively low performance in implementation and monitoring. The health sector is not exception in this regard. However, the findings indicated a different scenario with the Rohingya crisis management. The public sector organizations from top to bottom found to be very sincere and active. The central level COs such as the ministry and directorate were very keen in decision-making as well as implementation. Five layers of monitoring system was put in place to constantly examine the health situation of

the Rohingyas. A committee at the Prime Minister's Office (PMO) was formed to monitor the situation from the national level. Committees were formed at the ministry and DGHS level. Moreover, a separate and dedicated coordination cell was also formed the Cox's Bazar district in addition to the monitoring committee at the CSO level. Additionally, at least one high level official from DHGS and the ministry was always present at the district during the first three months of the crisis. They monitored the situation in order to expedite the crisis response operation. Though the official coordinator of the health sector for Rohingya crisis is the Civil Surgeon Office (CSO), the parallel organizational set-up like coordination cell provided necessary assistance during the time of real need in terms of human resources and logistic. Such initiatives contributed positively in the crisis response during the initial days. These initiatives helped to take local level decisions and actions quickly. It was initially assumed that the creation of a parallel coordination cell may create problems such as overlapping in crisis response but the interpersonal communications skills of the officials of CSO and the cell and an excellent term of reference (ToR) for coordination helped to avoid possible overlapping and misunderstanding. The monitoring structure of the Rohingya health crisis response can be better understood from figure 12:

Figure 12: Monitoring Structure



Source: Author's Construct, 2021

This stringent monitoring system was developed to avoid any kind of failure in the crisis management. The bureaucrats were fully aware about the level of political commitment in the crisis response and as a result, they did not hesitate to take risk in bringing innovative ideas. In the same spirit, they were found to be comparatively flexible in management practice including decision-making, communication, financial management and procurement. However, such intensive monitoring and flexible management was only practiced in the crisis prone district and not in the other parts of the country. Hence, the organizational capacity of the crisis zone was enhanced but beyond the crisis-prone areas, the organizational capacity either experienced no change or very limited changes. Again, it was evident that some of the management practices were replicated country wide.

Furthermore, inter-organizational coordination can be considered from three perspectives: coordination within the health sector, coordination with other public sector organizations, and coordination with non-state organizations such as development partners, NGOs, and commercial enterprises. Evidence showed that overall coordination between the Local CO and DSOs operating in the crisis zone was effective. Coordination with local COs and DSOs, as well as other public sector institutions, was also effective.

It was considered that the government's priority, particularly during the first three months after the influx began, was to respond to the Rohingya problem. The health sector organizations and other government agencies that were performing complementary roles were aware of the significance of the crisis management operation. Given the government's strong commitment, coordination operations were prioritized in all government ministries involved in the process, both at the central and local levels. As a result, the crisis response coordination was deemed effective. Other records and reports back up these findings. The timely communication of government agencies with UN agencies and other development partners, as well as their prompt response, made the crisis coordination very efficient. As a result, the required resources were available to deal with the problem on time. Even though the resources were insufficient, the front-liners were able to launch the crisis operation in a timely manner. The evidence revealed that the actual mortality rate and severity of the disease breakout scenarios were far lower than anticipated at the outset. This suggests that the coordination and response were effective in terms

of the crisis management. Nonetheless, the coordination activities beyond the crisis response seemed less effective and time-consuming as compared to the usual situation.

The role of a specialized organization like the RRRC must be explored in conjunction with the refugee crisis response process. Given that Bangladesh lacked a distinct legal tool for refugees, it is intriguing to establish a dedicated institution to deal with refugee issues. The organization's structure and mandate demonstrated its overarching and convening authority over refugee concerns. The organization is directed by an Additional Secretary, a senior (Grade -2) central government official, and is made up of additional mid-level officials delegated from the central bureaucracy. The organization's involvement was discovered to be extremely apparent and effective in resolving cross-cutting and inter-organizational issues that had become convoluted and contradictory among the collaborating organizations. It was discovered that the convening authority of the organization, particularly the head of the unit, was highly helpful in making choices when the collaborating organizations were unable to reach a consensus. Aside from its coordination role, the organization assisted health-care organizations by playing a complementary role in creating health-awareness, immunization, and disease-control activities. This organization also played an important role in bringing about the rationalization of health service delivery among development partners and non-governmental organizations. The RRRC officials' interpersonal communication skills were crucial in the overall coordinating task. According to the findings of the study, officials from other departments respected and trusted the organization's leaders. The aforesaid view is also supported by the professional track record and the perception of coworkers.

It is also important to indicate that the inter-organizational cooperation was able to succeed due to an active partnership strategy. More than a hundred partners collaborated formally under the supervision of Cox's Bazar's CSO. The WHO took the dominant position outside the government. However, the local community also played the essential role of an informal collaborator. The collaborating organizations actively and truly played their roles in a way that allowed them to complement one another. The physical infrastructure, as well as other resources, were given by public sector institutions. The worldwide community gave the requisite cash and resources. National-level NGOs provided logistics and human resources. In addition to their role in mobilizing local resources during the initial days of the crisis, the local community

participated in volunteering. The partners collaborated for a common objective and a mutually beneficial purpose, they shared their resources to deliver services collaboratively, and there was a high level of trust among the personnel working in the partnering organizations. Their interactions were routine in nature, with the goal of sharing and discussing matters of mutual interest. The partnership approach in this case seems to have more similarities with the Consortium model and the Multi-Agency working model (Sheehy, 2017). However, the interaction pattern also falls within the Network model style of partnership. As a result, the partnership approach was found to be a combination of Network, Consortium and Multi-Agency model instead of following a single model. Different partners had different intrinsic and extrinsic motives behind their active participation. It can therefore be argued that the political commitment of the governmental organizations, international mandate of the UN bodies, humanitarian and in some cases religious affinity for international community and fund-raising motives of the NGOs acted as important motivating factors behind the active participation in the crisis management process. Nonetheless, the local community seemed to have no direct benefits other than the already mentioned socio-psychological factors. Having said that, it can be argued that the partnership seemed not to only exist at the organizational level but also existed at the individual level. This individual level relationship may have contributed in developing an active partnership among the participating organizations.

On the other hand, the findings also suggested that excessive visit by the central level officials, the political leadership and dignitaries in the name of vigilance as oppose to the effective and substantive monitoring interrupted the crisis management activities in the first six months of the crisis. Being the main tourist destination in Bangladesh, an official visit to Cox's Bazar is always a lucrative official assignment to the government officials irrespective of their departments. As the crisis management operation at the Cox's Bazar was the topmost priority for the service providing ministries or departments, they tried to reinforce their organizational strength. As part of the process, they increased their official visits with the view of strengthening the monitoring at the grassroots. Due to the high political commitment by the Prime Minister (PM), members of the cabinet were also keen to visit the sight in order to highlight it to the PM. It was reported that during such official visits, most of the officials were accompanied by their family members. At the onset of the crisis, the main focus was providing health service, food and

shelter. Hence, the officials of the health service providing organizations visited the site most. The main aim of visiting the site was to monitor the conditions in order to identify the challenges and consequently provide the necessary supports. However, in most of the visits, the officials failed to fulfill their main objectives of the visit. In some instances, they were found to be irrational and naïve in dealing with such crisis. Additionally, providing vehicles and other logistic support to the monitoring officials became an extra burden to the local level organizations. The evidence therefore indicated that most of the visits were unnecessary because they disrupted the capacity of the organizations contrary to their claim of embarking on effective monitoring.

Coordination, particularly inter-organizational coordination, backed by active partnership and a multi-level monitoring system, as well as a dedicated refugee coordination unit supported by personal traits and professional skills of individuals involved in the crisis response, played a significant role in supporting the health sector organization's capacity. At the same time, it appeared that too frequent monitoring visits in the name of monitoring were having a negative impact on the organizations. As a result, it might be claimed that qualitative aspects of monitoring are more significant than quantitative ones.

The findings are consistent with some scholarly perspectives that emphasize the role and importance of coordination in the success and failure of crisis management (Boin & Bynander, 2015; Rhinard et al. 2013; Kettl, 2003; Brattberg, 2012; Boin & Bynander 2015a), particularly when dealing with complex and transboundary crises (Ansell et al, 2010). On the contrary, it undermines the claim that there is no link between crisis management and coordination arrangements (Christensen et al., 2015). Despite the fact that the study did not focus on the success of the crisis management effort, the findings suggested that it was an important aspect that influenced the crisis management process. Other research, on the other hand, stressed the overall coordination element of crisis management, but the findings of this study indicated a specific type of coordination (inter-organizational) as an essential factor influencing health sector organizational capability. Furthermore, the data support the concept that continuous monitoring of the internal and external environments can reduce the likelihood of negative outcomes by lowering the challenges (Kuzmanova, 2016). Nonetheless, this study also concluded that the qualitative part of monitoring is more significant than the quantitative aspect. Furthermore, the

findings in terms of partnership corroboration, supports Glasby and Dickinson's (2009) assertion that effective partnership should focus not only at the organizational level but also at the individual and policy level. Similarly, the study supports the concept that interpersonal and informal individual relationships are just as important as formal and organizational relationships in order for a partnership to be effective (Forti & Singh, 2019).

Apart from visible administrative factors, the presence of huge national and international electronic and press media needs to be discussed from critical lenses.

7.2.4 Presence of Media as Prospect as well as Pressure

The media had covered the tumultuous situation in Rakhine state from its beginnings, therefore the Rohingyas were in the news even before the surge in August 2017. As a result, during the early stages of the movement, the large influx was at the centre of national and international media coverage. With the intensification of the problem, it garnered more media attention, particularly from the international arena. The government took the media reports, particularly the international ones, very seriously. The public-sector officials were concerned about the media's attentiveness and presence, particularly when it came to any issues.

In Bangladesh, the relationship between the media and public sector institutions was marked by mutual contempt and mistrust. Among public sector officials, there is a scepticism toward the press and media. However, with the increasing presence of the media in every aspects of life over the previous decade, the situation has gradually improved. The media is currently regarded as a significant tool in highlighting concerns and programs. Given this context, the media's presence since the crisis's origin can be discussed from two perspectives: the "watchdog" perspective and the "means for gaining attention" perspective.

The Watchdog views suggested that the public health sector officials were very much concerned about the media as the government was serious about their reportage. The presence of the national and international media was huge on the ground especially in the early days of the crisis. In this context, the officials were much more careful about any kind of mismanagement, corruption or operational gaps. This kind of extra vigilance contributed in ensuring more flawless crisis response and management operations. The officials tried to act immediately on issues which were brought into light by the journalists. As a result, it has favourably contributed to the crisis management process, which may be regarded as an important aspect of

organizational capability. This component was important in both local and national organizations. However, the contribution of these elements appeared more obvious in local level organizations than in central level organizations.

Under the “means for gaining attention” approach, officials attempted to draw public attention to issues that demanded prompt national and international action. This kind of policies appeared to have elicited immediate action. As a result, the media has occasionally aided in the revitalization of the capacity of health-care organizations functioning in crisis zones. This viewpoint, however, was largely observable at the local level.

The findings support Pan and Meng's (2016) assertion that a mutual and cooperative connection between the media and the government can assist effective crisis management. However, this contradicts some other findings which indicated that the news media mostly concentrated on negative aspects highlighting the failure of government agencies while disregarding responsive efforts (Cortias-Rovira et al., 2014; Veil, 2012). The study did discover, however, that the media can be viewed as a performance facilitator during a crisis, particularly a health crisis in a refugee setting.

7.2.5 Role of Global and Region Issues at the Macro Level

Some international and regional elements, particularly connected to geopolitics and regional security, have been identified as significant at the macro level, with an indirect impact on the whole crisis management operation. These considerations, however, appeared to have only a minor impact on the overall health sector management of the Rohingyas. Despite the fact that there is no direct link with the organizational capacity of the health sector at the local level, it appeared to be essential at the policy level.

The United Nation along with the major international forum like EU was very much concerned with putting continuous pressure on Bangladesh in order to keep the border open for the fleeing Rohingyas. They had been very keen on maintaining regular diplomatic communications with the government since the inception of the influx. Besides, individual Islamic countries such as Turkey, Malaysia, and Saudi Arabia had requested the government to accept the Rohingyas and made temporary arrangements for food, shelter and heath care. The

government could not avoid such multi-dimensional global pressure and had to comply with their requests and temporary plan. In order to maintain a good diplomatic relationship with the international community, the government sometimes had to take actions as per the prescriptions of the global community without accessing the reality on the ground and the actual capacity of the public sector organizations. This quick decisions and actions sometimes create operational challenges as these were not customized based on the context. It was also evident that the real support in terms of resources did not arrive concurrently with the execution plan, rather the support arrived a bit late. Meanwhile, the local health service started with the crisis response based on their locally made temporary arrangements. This local plan was based on the local context and available capacity. At that point, top down and imposed plans seemed to contradict with some of the locally made plans. Thus, shifting from one kind of management practice to another took some valuable time during the crisis management process. Although Bangladesh did not have a specific legal instrument for the Refugees, its compliance and respect to other international conventions like the Geneva Convention might compel Bangladesh to comply with the international pressure and requests.

Besides, it is believed that one of the causes behind the ethnic cleansing against the Rohingyas was to force them to flee from some specific location at the Rakhine where Myanmar was planning to build huge economic zones. It is also believed that the powerful countries in the region had planned to invest huge amount of money in these economic zones. Hence, the regional powers had economic and geo-political interest in the area. In this context, the behaviour of some of the neighbouring and friendly countries had become ambiguous as they were simultaneously sending reliefs and other emergency supports to the Rohingyas and taking stand in favour of Myanmar in the global forum like UN. Existing literature also suggested that the political economy of Rakhine state instigated the displacement of the Rohingyas to another place in order to facilitate the investment of the regional powers in different economic projects of Myanmar in Rakhine state and at the same time the international community, particularly the UN was unable to intervene effectively towards a robust resolution crisis (Rahman & Akon, 2019). This therefore created a kind of confusion as to trust or mistrust the global community. It is further believed that without the support of these regional powers, it would have been impossible to resolve the Rohingya crisis. Therefore, there is a prevailing perception in the policy arena that

this crisis may take a long time to settle. This perception seemed to be crucial in shaping the policy decisions and actions. As a result, it can be argued that this geo-political factor may have a role to play in determining the nature of the interventions of the public service organizations including the health sector. Additionally, this kind of perception may have negative effect in terms of the engagement of public officials in the management process.

Furthermore, terrorism and religious fundamentalism have become an increasing global problem. Bangladesh is no different in this regard, despite the fact that the country is in a less perilous position for organized religious terrorism due to a lack of popular backing. However, the government is highly concerned about the situation and does not want it to become a breeding ground for terrorist organizations, particularly religious fundamentalists. The Rohingyas are predominantly Muslims who were forced to flee their nation due to ethnic cleansing and genocide. They had to endure many forms of injustice and violence. Due to the mental trauma, this type of circumstances may elicit a sense of vengeance. In this context of their vulnerability, this can be a breeding ground for international terrorist organisations, particularly religion-based groups, to recruit new members and organize them. If the terrorist organizations are effective, they will pose a national as well as a regional threat. Existing information suggests that the Rohingya problem is more than just a humanitarian issue for an oppressed population; it is also a concern since it has aspects for the emergence of Jihadist and basic terrorist organisations (Wolf, 2017; Bashar, 2017; Rahman, 2010). Furthermore, Bangladesh's present administration has adopted a zero-tolerance policy towards any terrorist activity (Riaz, 2016; Bashar, 2017). In this context, every intervention in the camps and for the Rohingyas required extra prudence and had to be carried out in a more organized manner. All groups were required to adhere to particular criteria regarding what to do and what not to do in order to reduce the likelihood of the formation of any such armed group. The problem had also piqued the interest of the international community. As a result, one of the primary reasons for the deployment of armed forces in this region is to aid the administration in dealing with rehabilitation work while simultaneously keeping an eye on and mitigating such risk. Though there was a sense of warmth and religious kinship among those working on the crisis response, they were also concerned about an increase in radicalism among the Rohingyas. This has indirectly influenced management practice and personal motivating issues. As a result, the management and resource components of capacity

have had an indirect impact on both local and central level COs, as well as local level DSOs. The findings confirm the claims of some researchers that islamophobia has a variety of effects on refugees, including affecting host community reactions to the prospect of resettlement, inciting acts of discrimination, and this is reflected in national and local anti-refugee legislation (Amos 2017; Gorman & Culcasi, 2021; Goyette, 2016; Hubbard, 2005). However, in most of the cases these studies have concentrated on industrialized and non-Muslim countries.

7.2.6 Demand Side Awareness Matter

The health-care system in Myanmar's Rakhine state was accused of lacking proper access and contemporary medical facilities. As a result, the Rohingyas were deprived of essential modern health services. Most of them were unfamiliar with basic health care services, such as immunization, safe child delivery, and current preventive treatment procedures, due to a lack of exposure to modern and basic health delivery systems. It was clear that the Rohingyas relied largely on traditional treatment systems and herbal medicine, as well as religious or spiritual systems of medicine. Several health-related indicators support the hypothesis, demonstrating that the maternal mortality ratio among the Rohingyas was more than double the Myanmar norm, and the crude death rate was nearly double when compared to the acute phase of a complex disaster (Mahmood et.al., 2017). The research also revealed that acute malnutrition among the Rohingyas had already reached the level at which the World Health Organization generally designates as complex emergency (Sollom & Parmar, 2010). Furthermore, some experts argued that the Rohingyas had inadequate health literacy and limited access to qualified health care professionals, with over 80 percent of the Rohingyas relying on traditional village doctors or herbal medical practitioners (Rahman et al, 2010). In addition, lack of education played a role in the development of some superstitious beliefs, such as the use of modern medicine and treatment was irreligious. In this context, the Rohingyas were hesitant and sceptical of the therapy and pharmaceutical process that was offered to them at the start of the crisis. Furthermore, due to different rumours regarding the side effects of medication and immunization, the Rohingyas were hesitant to receive health treatments wholeheartedly. It was also probable that a lack of faith or trust in the health-care system contributed to this attitude. However, considering the situation of the Rohingyas, it can be argued that the lack of health literacy and the unfamiliarity about modern health system seemed to have contributed to this current situation.

This kind of mistrust and reluctance had interrupted some of the health service schemes (massive vaccination for Diphtheria and Cholera, family planning initiatives, etc.) at the onset of the crisis. The health sector was under pressure to control the outbreak of the communicable diseases so that it does not spread to the host community and simultaneously ensure all-out participation of the Rohingyas. The health sector had to take the partnership approach with other public sector organizations such as the RRRC and district administration in order to deal with the situation. Hence, they had to launch separate mass awareness campaign with the support of the mentioned organizations simultaneously with the ongoing vaccination program. This slowed down the pace of the health schemes and put additional pressure in terms of human and financial resources.

To summarize the findings indicated that the influential factors fall under seven broad streams which include political, administrative, economic, socio-psychological, media, social and global governance. However, the findings also suggested that the economic factors played role in the form of partnership in the context of the Rohingya crisis. Therefore, the findings deviated from the original conceptual framework which argued that the organizational capacity can be influenced by political, administrative, economic and social factors. It is evident that the political and socio-psychological factors mainly influenced the administrative factors. However, the presence of the media was also important and seemed to have positively impacted the situation. The international and regional issues seemed to have role at the macro level but the impact was indirect in nature. Moreover, the socio-psychological factors seemed to have notable influence on the organizational capacity which may create new windows for viewing the public sector organizational capacity from health sector perspective in crisis situation. Additionally, the impact of the international and regional issues, though indirect in nature, on the public sector organizational capacity seemed to bring in new dimensions in the context of public administration in crisis management. The overall influential dimensions can be viewed as follows in table 23:

Table 23: Factor Influencing Organizational Capacity

Broader Area	Specific Factors	
	Positive Impact	**Negative Impact**
Political	Political commitment	
Socio-Psychological	Sense of kindness; Religious affinity; Sense of kinship.	
Economic	Active partnership	
Social		Demand side awareness
Administrative	Inter-organizational coordination; Stringent monitoring; Existence of a dedicated organization for Refugee	Too much unnecessary oversight and intervention
Global Governance		International pressure; Non-cooperation and trust and mistrust of international players; Islamophobia;
Other	Active Presence of Media	

Source: Author's Construct, 2021

7.3 Examining the Art of Public Health Sector Response

To comprehend the nature and characteristics of the actual crisis response in accordance with research question three, it is necessary to discuss the findings under themes such as signal detection, community-led response, prompt engagement of the international community, partnership approach, trust-based management, key stakeholder engagement, and dedicated human resources. The key findings as far as the response is concern can be described in table 24 as follows:

Table 24: Key findings in line with the research question three

Research Question	Key Findings
How did health sector organizations respond to the Rohingya refugee crisis in Bangladesh?	The health sector organizations had to perform two crisis response steps (preparation and containment) simultaneously as the signal detection couldn't be possible
	Combined response consisted of local community, state and non-state actors including the international community was very effective
	Informal and trust-based management can be an effective management approach in such crisis.
	Active and timely partnership not only at the organizational level but also at the individual level is instrumental
	Involvement of the refugees in the crisis response process expedited the organizational capacity
	Learning by doing, knowledge sharing, and transfer of technology are important to expedite the response

Source: Author's Construct, 2021

The crisis response activities can be compared to the crisis response steps such as signal detection, preparation, containment/damage control, business recovery, learning, and redesign (James & Wooten, 2010; Pearson & Mitroff, 1993; Schneider, 1992; Waller, Lei, & Pratten, 2014, Mitroff, 2005; Hutchins & Wang's, 2008).

The magnitude and severity of the refugee crisis were unprecedented. As a result, health-care institutions were unable to take the essential precautions by identifying the early signals. It was clear that the organizations had to work on both preparation and containment at the same time. During the containment stage, the response was initially led by local DSOs, with assistance from the local CO and the local community. Later, the local CO dispatched additional health experts to the crisis zones and reshuffling other administrative jurisdictions. This was followed by the dispatch of central level COs from various parts of the country. The UN bodies already operating in the existing refugee camps in Cox' Bazar then joined the response. This stage seemed to be the most stressful and pressurizing situation for the public health service providing organizations. The international communities, as well as NGOs, gradually began to join the

operation. However, initially, the local and international partners focused on issues such as food and shelter, followed by health assistance. Individual countries responded faster than other international institutions. The response was mainly based on three major interventions which include the management of the emergency patients, management of communicable diseases, management of pregnant women and neo natal children. However, the initial focus was confined to management of the emergency patients due to the quantity of the emergency patients among the Rohingyas. The instruments for the three different interventions are shown in table 25 below:

Table 25: Framework for crisis response

Area of Intervention	Procedure	Main Organizations involved
Management of the emergency patients	Emergency treatment and surgery, medication	Mobile medical teams; Health Posts; Upazilla Health Complexes; District Hospital (DSOs operating in crisis zones)
Management of communicable diseases	Field research; Medication; Isolation; Vaccination	Health Posts; Upazilla Health Complexes; District Hospital (DSOs operating in crisis zones) Local CO; Central level Cos
Management of routine patients including the pregnant women and children	Safe delivery arrangement; Medication; Immunization	Health Posts; Upazilla Health Complexes; District Hospital (DSOs operating in crisis zones)

Source: Author's Construct, 2021

The engagement of the international community from both UN bodies and the other development partners along with the individual countries was quicker than expected by the government. Four UN bodies (WHO, UNHCR, WFP, IOM) started operations within two weeks of the crisis. The early deployment was possible because they were already engaged in various activities in the existing Rohingya Camps situated at the Cox's Bazar district. However, international humanitarian organizations such as the Red Cross and Red Crescent were comparatively quicker in taking part in the crisis operation. About twelve countries also responded within the first one month of the crisis of which eight were Muslim countries. The sense of religious affinity might have played a role behind their quick response. At the initial stage, the support from the

individual countries were confined to supplying medicine. At the time, the government administered total health care with the assistance of some UN agencies and local NGOs. Over time, the international community provided assistance in practically every field, including the deployment of health professionals, the provision of equipment and medicine and direct funding. The involvement of such an international community in such a short period of time might be considered as a result of the government of Bangladesh's early intervention. It can be argued that diplomatic moves from Bangladesh side was effective in attracting the attention of the international community. At the same time the role of the international and national media was also important in this context.

There was an active partnership among the participating organizations. The public sector organizations, the international community and the local community played a complimentary role to one another since the beginning of the crisis. As a result of this active partnership, a Joint Response Plan (JRP) was formulated within four months of the crisis. Inter sector Coordination Group (ISCG) was also established within ninety days of the crisis. The operations of the partners were streamlined by dividing the health sector into six distinct intervention areas. The partners' roles were determined based on the need and strength of the organizations. A single platform for NGOs was also established to rationalize their roles and operations. The health crisis management system was therefore a well-coordinated effort based on an active collaborative approach.

The whole response management system was shifted from a very rigid natural style to an informal pattern. Decision making, as well as internal and inter-organizational communication, became more informal as a result of mutual trust. Local level leadership in health sector organizations also had an important impact, as evidenced by good decision making and interpersonal communication skills. The crisis response also fostered professional learning by facilitating knowledge sharing between professionals at the national and international levels. At the same time, the scenario provided an opportunity for local health experts to learn by doing. As a result, local health professionals became familiar with issues like health crisis management and emergency patient management in a large-scale catastrophe. This has aided the organizational capability of health-care organizations. Though there were permanent improvements or reform in

the health sector as a result of the learning they had received, some modifications in management practice, both clinical and non-clinical, have been replicated in other parts of the country.

The emphasis of the preparation and containment phase can be characterized by early community engagement, prompt international community engagement, well-coordinated actions and active partnership at the organizational and individual levels, informal and trust-based management, and involvement of key stakeholders (Rohingyas). During the learning phase, professional knowledge was strengthened through information sharing and learning by doing. As part of the designing phase, there is no notable indication of reform or change.

This finding supports the argument that the organizations which adapt more flexible, informal and creative approach (combination of private, public and nonprofit characteristics) in their internal management processes and follow the participatory approach with the local community, are more effective in crisis response (Eckhard et. al., 2021). On the other hand, the response opposes some of the principles of surprise management, which claim that during the crisis response, all conventional and expected management practices are discarded, and management practices begin to shift continually with flexibility and adaptability (Farazmand, 2009a). However, the findings confirm Farazmand's (2009a) claim that the unexpected events facilitated relevant capacity growth.

7.4 Scope for Right Kind of Capacity Development

It was evident from the study that the health sector was suffering from lack of capacity to ensure quality service even to the host community. Given the situation, the crisis put huge extra pressure on the public health service organizations especially on the DSOs operating in the crisis zones. However, the capacity of the COs was also severely challenged by the Rohingya influx. It was evident from the study that the vibe of the crisis was experienced by the entire health sector though indirectly.

Evidence indicated that the lack of adequate health infrastructure and funds along with lack of appropriate professional knowledge about emergency health crisis management as well as lack of national level policy guidelines to deal with such crisis were the main capacity challenges. Furthermore, there were no procedures in place to include the local community or other stakeholders in the crisis response in the event of a health-care crisis. Again, the majority of health professionals working in the public health sector have no academic or professional

experience of non-clinical public health management. Furthermore, because health-care organizations have had little encounters with other public-sector organizations, they are not accustomed to inter-organizational coordination or partnership. The key findings concerning the capacity gap and capacity development of the health sector can be viewed in the Table 26 below:

Table 26: Key findings under research question four

Research question	Key Findings
How can the organizational capacity of health care services be strengthened in such a crisis?	Formulation of a national level policy guidelines for emergency health crisis management is necessary; National level policy to deal with refugees as a whole is important for high-risk countries; A distinct policy to engage community during health crisis can be effective
	Well trained group of volunteers both at the national and local level can play significant role in enhancing the organizational capacity; A dedicated organization to deal with refugee issues in countries with high risk can be instrumental
	Developing trust among the service recipient can help to enhance the performance of the health sector organizations
	Training on health crisis management and response for all health sector professionals including the support staffs is essential; Scope for continuous knowledge sharing at the regional and global level can be mutually beneficial
	Allocation of special emergency fund at the local level can be beneficial in tackling sudden health emergencies

Source: Author's Construct, 2021

Nonetheless, the findings suggested that one of the key factors behind the crisis response was coordination and partnership. This was possible because of the political and administrative level commitment as well as the socio-psychological factors mentioned in the previous chapters. Integrating the local community in the process played a significant role in coping with the crisis at the initial days.

Building trust of the service recipients has also found to be a positive driving factor. It was made possible by engaging the Rohingyas and their representatives in the crisis response operations. Moreover, specific kind of on-the-job trainings was also instrumental in the health crisis management. These trainings were effective in the management of the communicable

diseases and its outbreak. The integration of the ICT in health management system especially in early detection of any upcoming outbreaks proved to be effective. The combination of the application of ICT and training helped to reduce the chance of any disease outbreak. The capacity gaps have been addressed through various interventions which includes direct and indirect intervention. The overall capacity framework can be viewed in the table 27 below

Table 27: Overall capacity framework

Capacity Gaps	**Management Technique During Crisis**	**Capacity Needs**
Lack of Health Infrastructure and funds	Partnership with international community and national non-state actors; Redirecting of financial resources from other allocation within the national budget; Deploying additional HR and equipment from other facilities	Health infrastructure development with a focus on emergency patient management; Allocation of special fund for any saddened emergency situation at the local level; Incorporating ICT in patient management, diseases control and personnel management
Lack of professional knowledge about emergency health crisis management	Knowledge transfer from international experts; On the job trainings; Special trainings; Learning by doing	Institutionalize the learning of emergency health crisis management through incorporating relevant courses in academic curriculum of the medical students; Providing mandatory training on the emergency health crisis management to the public health sector professionals and the support staffs; Creating a scope for academic and professionals' degrees on public health management for the public health professionals; Creating a scope for regular knowledge sharing with international experts;
Absence of national policy guidelines as to deal with the health crisis management and integration of stakeholders	Applying individual professional knowledge and judgment; Local level innovation	Formulation of a national level policy guidelines for emergency health crisis management; Establish a group of volunteers both at the national and local level under a national level policy

Capacity Gaps	Management Technique During Crisis	Capacity Needs
Lack of Coordination and partnership approach in public health sector	Political and administrative commitment at the top; Socio-psychological aspects of the individual health professionals	Develop a national level guideline for coordination under any health crisis management; National level policy to deal with refugees as a whole; Establish a dedicated organization to deal with refugee issues in countries with high risk

Source: Author's Construct, 2021

The findings support the scholastic views which advocates that institutional, organizational as well as individual level capacity initiatives through policy change, skill development and management practice change along with community organizing is important for health sector capacity development (comfort et al., 2010; Lafond et al., 2002; Crisp et al., 2000; Brechin et al., 1998; Fort, 1999; Kotellos et al., 1998; McLaughlin *et al*., 1997; Lusthaus et al., 1995; Paul, 1995). These studies were undertaken in a variety of circumstances that had similarities with the current study but not directly related to the refugee issue. Similarly, the conclusions of a study done on the refugee crisis shared some similarities with the findings of this study, which indicated that coordination ability and human resource management capacity needed to be improved for crisis management (Kherallah et al., 2012). However, this research was carried out in a refugee environment, with a focus on the public health sector.

7.5 Interrelations among Impact, Factors and Response

Although, the impacts of the Rohingya crisis on health sector organizations are independent variables, some factors have influenced the organizational and individual changes due to the impact. The response approach has definitely been influenced by the identified factors. It is important to discuss the possible interrelationship in order to better understand the capacity issues from organizational perspectives.

The change in the management practices including the inter-organizational coordination, informal and trust-based communication and local level decision making were possible due to two interrelated issues:

a) Huge political level commitment at the central level; and

b) Administrative support at the central and local level.

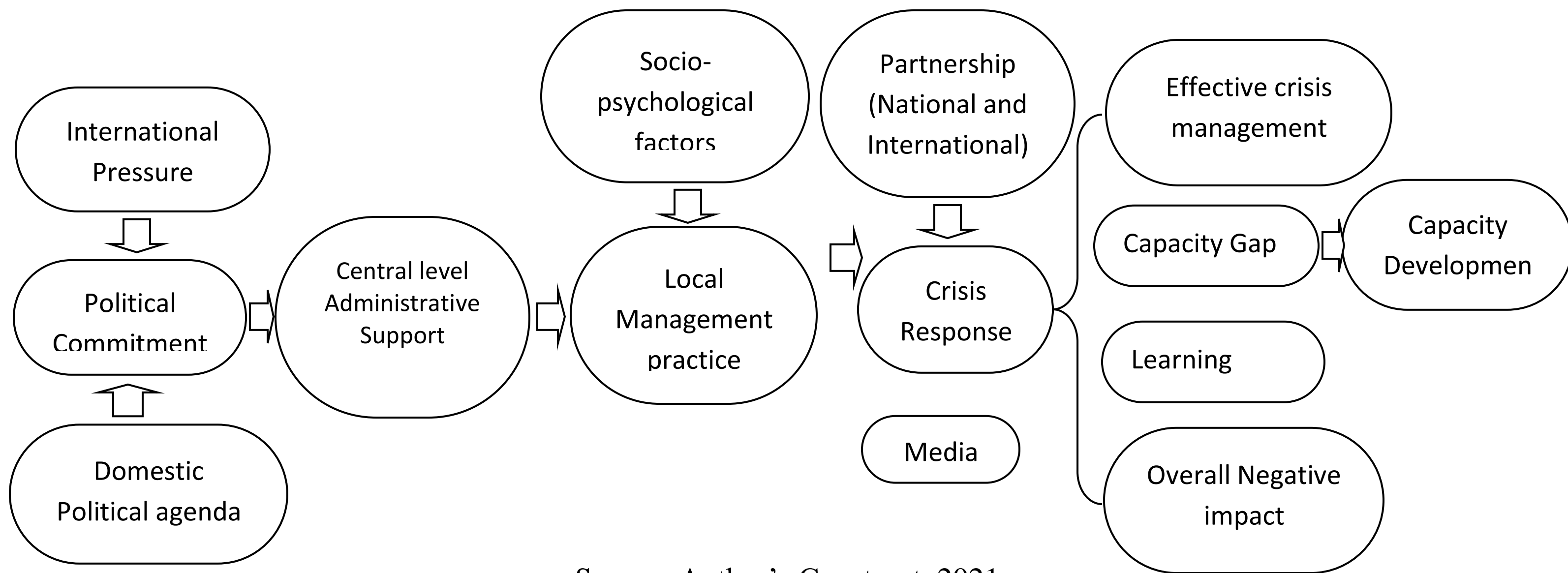
The political commitment pushed the bureaucracy to complete the task at whatever cost. As the central level COs did not have appropriate ideas to cope with such a big and sudden issue, the bureaucrats gave ample latitude to the local authorities to get the job done. They aimed to reduce the risk of procrastination thereby relying on the immediate actions of local level officials. Consequently, local health managers were free to vary their SoP. As a result of a strong political level message being delivered through all levels of government, inter-organizational coordination had become effective. Furthermore, the rapid engagement and partnership strategy of non-state actors, particularly international communities, was critical in inter-organizational coordination. However, coordination on non-Rohingya issues had been ineffective for a while due to lack of institutionalization of a stringent monitoring system for the entire health sector, which was triggered by a lack of management and resource capacity of health sector organizations, particularly COs at the central and local levels.

The health sector leadership was prominent during the crisis response. The health managers took innovative approaches as they had the flexibility as well as the professional skill and were emotionally attached to the crisis response operation. Moreover, in the initial days when the political level commitment was not clear, the management practices and the overall response seemed to have been influenced by the socio-psychological factors such as sense of kindness, religious affinity and kinship ties. On the other hand, the political level commitment had been influenced by international pressure as well as the ruling party's national and worldwide political agenda. It was also affected by the present ruling party's historical and emotional attachment to the refugee problem. The early community-led response was aided primarily by socio-psychological variables such as kindness, religious affiliation, and kinship, which were later reinforced by political commitment at the national and local levels.

The role of the media can be viewed from two perspectives. It had played a role in creating international opinion and expedited the response operation by minimizing the scope of mismanagement and misappropriation as well as bringing the necessary issues to the attention of the appropriate authority. The interrelationship of the three major aspects of the study which

includes the impact and the change, factors and the response can be viewed in the figure 13 displayed below:

Figure 13: Interrelationship of the three major aspects of the study



Source: Author's Construct, 2021

The political commitment was mainly facilitated by the international pressure and domestic political agenda. The political commitment shaped the actions of the central bureaucracy and the local level response was influenced by the socio-psychological factors and the commitment of the central level bureaucracy. The response was also facilitated by the active partnership of the international and national non-state actors. The media played independent and conducive role in responding the crisis. The health sector organizations seemed to be successful in terms of the crisis response, but the impact of the crisis negatively affected the overall health sector. However, in the process the capacity gap was identified and development work has been initiated at the local level. Additionally, the health sector had benefited from the knowledge sharing of the international experts and the on-the-job-trainings.

7.6 Summary of the Chapter

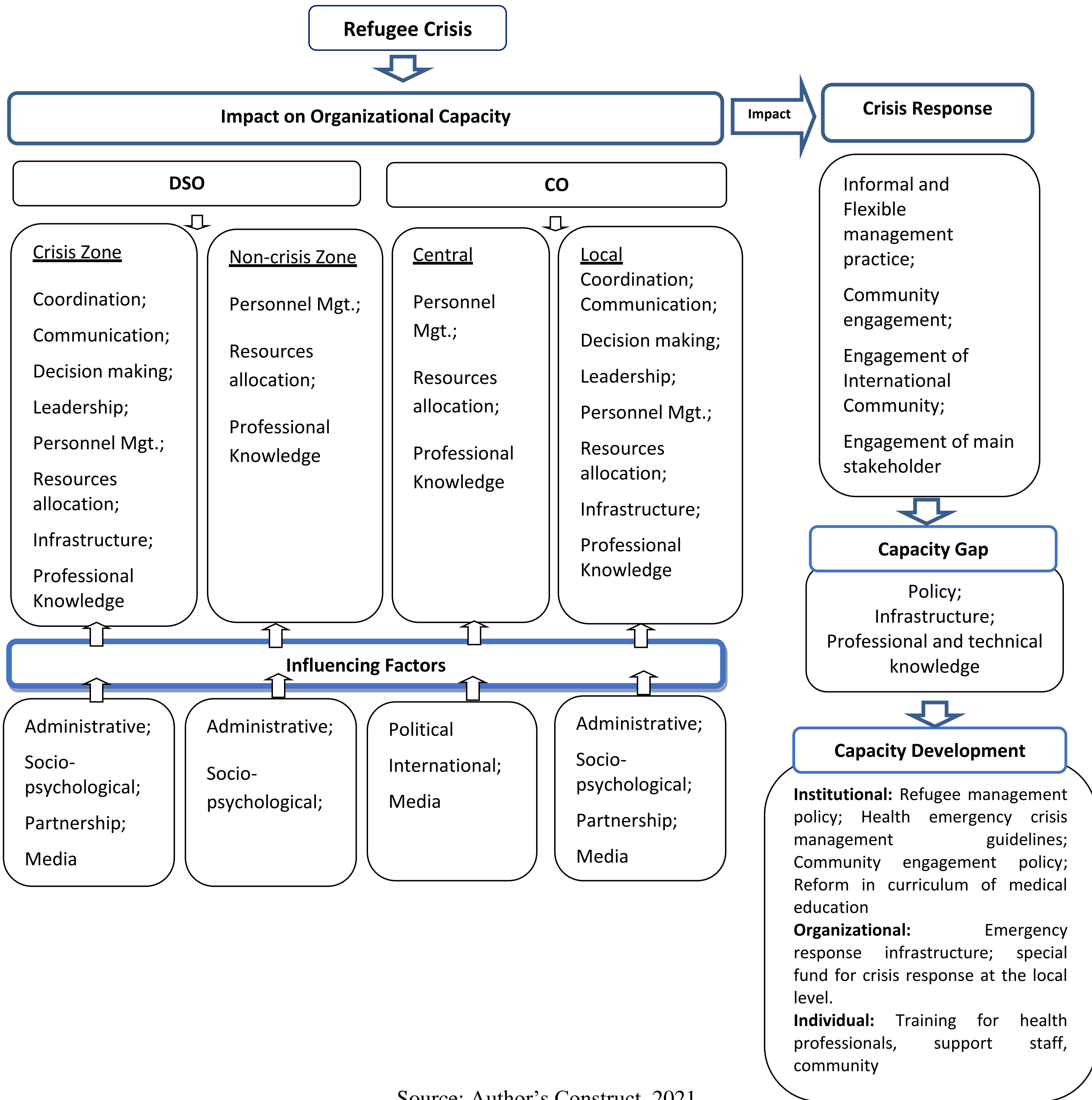
The chapter discussed and interpreted the findings gathered under the study's four research topics. The findings have been summarized and examined in the context of the study as well as in the existing literature, focusing on three primary theoretical aspects: organizational capability, crisis management and response, and refugee crisis. The connectivity and interplay of the study's four key emphasis areas has also been discussed. The discussion and interpretation revealed that the findings differed from the previously constructed conceptual framework, which was based on existing literature.

Organizations in the health sector have been impacted from both managerial and resource perspectives. The crisis prompted more adjustments in the management perspective than in the resource perspective. The findings indicated that the impact on health-care organizations varies based on their locus and purpose. The impact on Direct Service Delivery Organizations (DSO) is greater than that on Coordinating Organizations (CO). At the local level DSOs functioning in the crisis zone, management practices have grown more informal and flexible. DSOs operating in non-crisis zones have witnessed nothing or very limited adjustments. The crisis had impacted coordination, communication, decision making, leadership, and personnel management practices. In instances, the crisis had resulted in unethical practices in central personnel management and a lack of governance in local level DSOs as a result of delays in the internal justice system. The organizational crisis management capacity of local health sector organizations functioning in the crisis zones had been positively impacted, but the overall health sector appears to have been negatively impacted.

As per the conceptual framework, political, administrative, social, and economic elements had influenced organizational capacity, but the findings show that economic considerations had little or very little influence on organizational capacity. Furthermore, socio-psychological elements had significant influence on organizational capability. The political and administrative factors appeared to be inextricably linked. The role of international and regional issues is equally important, even though not indirectly related. In the context of such crisis, the role of the media cannot be overemphasized in terms of organizational capacity. However, from the organizational perspective, political commitment and socio-psychological elements played the most crucial roles. Notwithstanding, the active participation of non-state actors (international

community, NGOs, and local host community) as well as the presence of international and national media appeared to play significant external roles. The crisis response was initially led by the local community and local health sector organizations. Due to the unexpected nature of the crisis, the health sector organizations were unable to detect the signal in order to prepare. Therefore, the health sector organizations had to prepare and simultaneously work to contain the situation. The response seemed to be effective due to the initial community engagement, quick engagement of the international community, well-coordinated actions, and active partnership at the organizational and individual level, informal and trust-based management and involvement of the main stakeholders (Rohingyas). In responding to the crisis, capacity gaps were identified and considered. The gaps encompass organizational, individual as well as policy aspects of the health sector. Nevertheless, the crisis enhanced the professional and technical knowledge of the health professionals through knowledge sharing and on-the-job-training. Additionally, the crisis response in the context of a resource constrained environment had facilitated the scope for learning by doing. The framework of the thesis based on the result can be viewed in figure 14 below as follows

Figure 14: Revised conceptual framework based on result



Source: Author's Construct, 2021

CHAPTER EIGHT: SUMMARY OF FINDINGS AND CONCLUSIONS

8.0 Introduction

This is the final chapter, which contains the research summary and conclusion. A recap of the previous chapters is discussed at the outset, demonstrating their extent and coverage. The subsection that follows provides a summary of the key findings in relation to the research objectives and questions. This is followed by a discussion of the study's contribution to knowledge. A reflection on the study's potential policy implications is also presented, along with a policy recommendation. This study, like any other, has limitations, which are given in this chapter along with a recommendation for more research specifying the scope. Furthermore, it shows the researcher's reflection on the complete PhD journey, which covers the researcher's history, professional development and experiences obtained during the PhD study, as well as publications and conferences attended.

8.1 A Brief Overview of the Thesis

The thesis is divided into eight chapters that highlight the research background, theoretical underpinnings, methods and context of the study, findings, analysis, conclusions, and recommendations for future research. This section summarizes these chapters and highlights the important points of concern.

The first chapter discusses the research background and research problem, as well as the scope, aims, objectives, and research questions. It also emphasizes the study's significance within the context of academic knowledge creation.

The second chapter focuses on the research's theoretical perspectives by incorporating the relevant conceptual and theoretical frameworks. This work is conceptually related to three important theoretical areas: organizational capacity, crisis response and management, and refugee crises. This chapter demonstrated a variety of conceptual understandings, including capacity, capability, organizational capacity, public sector organizational capacity, and public health sector organizational capacity. It emphasizes the effects of the refugee crisis on host countries, public service delivery, and organizational capability in the public sector. It further provides a conceptual knowledge of crisis response and management, as well as the impact of the

crisis on organizations. It also examines capacity development approaches for the research context. Following a thorough review of the literature, this chapter contends that a good number of studies on the refugee crisis are available, with most of them focusing on the impact on the host community, the impact on service delivery, the human rights condition of the refugees, and the challenges of the refugees. Again, studies on crisis response and management are available from a success or failure or effectiveness perspectives. However, there has been relatively little research on the impact of the crisis on the organizational capacity of the public sector. Furthermore, little research is being conducted in the context of the Rohingya refugee crisis, particularly with regard to public health sector organizational capabilities. As a result, rather than clinging to specific theories, the chapter developed a conceptual framework based on the literature.

The third chapter sets out the research design and the methodology along with the philosophical perspective of the study. This chapter also discusses the research context from both macro and micro perspectives. Based on the nature of the study, this research is guided by subjective ontology, anti-positivist epistemology and idiographic methodology. This study therefore adopts an interpretive paradigm along with an inductive research approach. In congruence with the research orientation, the study followed a qualitative research method. Semi-structured interviews and focus group discussion (FGD) as well as documentary reviews were utilized as key data collection tools. The collected data were transcribed and categorized under various themes. Further, a framework for determining the contribution of the study to knowledge was also discussed.

The chapter four presents the data collected under the first research question which sought to explore the impact of the Rohingya crisis on the capacity of the public health sector organizations. The findings were categorized into eight themes of which the negative impact was visualized through themes such as quality of service, disease control, change in convention and practice, resources allocation, environmental degradation, illegal drug and public health and unholy practice. The positive impacts on the other hand were professional knowledge and health infrastructure.

Chapter five exhibits the result of research question two which identifies the factors that influenced the organizational capacity of the public health sector organizations. The findings

suggested that three types of factors influenced organizational capacity. These are characterized by political commitment, effective monitoring, sense of kindness and affection, religious affinity, culture and tradition, media presence, active partnership and the presence of a specialized organization. It also identified some indirect or pseudo factors which included international pressure and islamophobia. Some factors such as too much intervention and unfamiliarity of basic health service seemed to have negative influence on the health sector organizations. The main factors fall under the three broader perspectives which are political, administrative and socio-psychological.

The sixth chapter exhibited the results of the study in line with research question three and four. The main quest of the chapter was to demonstrate the response of the public health sector organizations during the crisis and capacity need. The data suggested that health sector organizations were unable to detect the signals ahead of the actual crisis and as a result they had to combine two steps (preparation and containment /business recovery) of the crisis response and acted simultaneously. The learning process was stimulated by knowledge sharing and technology transfer. However, “learning by doing” acted a significant role in the organizational learning curve. The data indicated that the response was led by the local community and the local health care organizations in the initial stages. However, the findings suggested that the response was a summation of active partnership among the state and non-state actors including the international community, inter-organizational coordination among the participating organizations within the health sector and beyond, engagement of the local community and the service recipients in the response process. The study reiterated that a comprehensive policy guideline in terms of massive health crisis management and overall refugee management was important. Training on health crisis management from both clinical and non-clinical perspectives for the health professionals alongside the support staff was equally necessary. Furthermore, forming a network of national and local health crisis volunteers appeared beneficial. The findings suggested that creating trust with service receivers was beneficial to organizational capability. Furthermore, incorporating ICT into both clinical and non-clinical activities improved the performance of the health-care organizations.

Chapter Seven focuses on interpretation by synthesizing the findings from the study's four research objectives and connecting them to applicable theories of organizational capacity,

crisis response, and management, as well as the refugee crisis. The chapter strengthens the connection between the study's two main goals and simplifies the interconnection from a theoretical perspective.

The main concern of the last chapter is to summarise the entire study. It also highlights the contribution of the study to knowledge. Moreover, it provides a summary of the major findings along with recommendations and limitations of the study.

8.2 Summary of the Key Findings

The entire study sought to answer four research questions. The summary of the findings is presented below in table 28:

Table 28: Summary of key findings

Research Question	Major Findings
1. What is the impact of the refugee crisis on the capacity of health service-providing organizations?	**Coordination** -Inter-organizational coordination at the crisis zone became informal and speedier **Decision Making** -Process based decision-making pattern transformed into cognitive ability, intuition, judgement based style at the crisis zone; -Decision-making at the central level became more process based. **Communication** -Organizational communication transformed into informal and trust based from formal pattern **Leadership** -Leadership pattern changed from authoritative and directive to transformational and transactional style at the crisis zone

Research Question	Major Findings
	Personnel Management - Overall personnel management system has been negatively effected in the crisis zone; - Scope for corruption increased at the central level. **Financial Management** -Bring in changes and innovation in the management practices **Infrastructure** **-**Local health sector infrastructure improved without sustainable planning. **Learning** -The crisis helps to develop local professional knowledge.
2. What are the key factors affecting health service capacity during the refugee crisis and why?	**Driving Factors** Political: Political commitment of the government; Administrative: Effective monitoring; Effective Coordination; Presence of a specialized organization, Economic: Active partnership Socio-psychological: Sense of kindness and affection; Religious affinity; Culture and tradition Other factors: Media presence; **Indirect Factors**

Research Question	Major Findings
	Regional and Global: International pressure; Non-cooperation of international players; Islam-o- phobia; Trust and mistrust **Restraining Factors** Administrative: Too much unnecessary intervention; Social: Unfamiliarity and lack of health awareness on basic health service.
3. How did health sector organizations respond to the Rohingya refugee crisis in Bangladesh?	▪ Active partnership and effective coordination matters along with local community engagement ; ▪ Informal and trust-based management expedited the crisis response; ▪ Engagement of service recipient in the response process was instrumental; ▪ Learning by doing, knowledge sharing, and transfer of technology were important in expediting the response.
4. How can the organizational capacity of health care services be strengthened in such a crisis?	**Institutional** ▪ A national level policy guideline for emergency health crisis management is necessary; ▪ National level policy to deal with refugees as a whole is important for high-risk countries; ▪ Scope for community engagement during health crisis can be effective; ▪ Establishment of a health crisis volunteers group at the national and local level can help. **Organizational** ▪ A dedicated organization to deal with refugee issues

Research Question	Major Findings
	in countries with high-risk can be instrumental; ▪ Scope for continuous knowledge sharing at the regional and global level can be mutually beneficial; ▪ Allocation of special emergency fund at the local level can be beneficial to tackle sudden health emergencies; ▪ Arrangement of mandatory training programs on health crisis management for health professionals and the support staff is necessary; ▪ Introduction of ICT in both clinical and non-clinical management process can be fruitful **Individual** - Building trust between the service provider and the service recipients is very important

Source: Author's Construct, 2021

8.3 Implication of the Study

The findings suggested that the impact of the refugee crisis on the organizational capacity of public health sector organizations, as well as the factors influencing organizational capacity, is of greater concern to policymakers, public sector organizations, and the global community. The consequences can be divided into two major categories: academic implications and practical implications.

8.3.1 Implication from Academic Perspective

The result indicated that the refugee crisis had visible effects on the management and resources capacity of the public health sector organizations. The impacts varied based on the focus and locus of the organizations. The findings indicated that the refugee crisis had impact on the coordination, decision making, communication, leadership, financial management as well as personnel management system of the public sector organizations. Moreover, performance of any

organization depended significantly on the management practice and personnel management system. As a result, the findings can be utilized as a reference point for additional academic endeavor. The findings also suggested that corrupt practices and bad governance is likely to increase with the advent of such crisis. These evidences can be important in reshaping the knowledge of Public Administration and Management when looking at public sector capacity in similar context and situation. Moreover, the findings bring to the fore significant influencing factors for public sector organizational capacity which indicated that not only political and administrative factor but also socio-psychological factors are important. Hence, further research initiatives could be commissioned to identify additional knowledge in this respect. Additionally, the findings suggested that community led crisis response and the engagement of key stakeholders can yield effective and positive results. Therefore, academic investigations can explore further knowledge in defining new crisis response mechanisms in the public sector.

8.3.2 Implication from Practitioners Perspective

Organizational capacity, as well as individual capacity, is critical for all types of organizations. Organizations in the public sector must be prepared to deal with any type of national or transboundary catastrophe before it occurs. As a result, crisis management competence for public sector organizations is critical. The inter-organizational coordination and collaboration strategy should serve as a learning opportunity for organizations in the public health sector. Similarly, evidence on the actual response (what worked and what didn't) and the capacity requirements can be a useful starting point for organizational development. Furthermore, the study emphasizes the role of informal non-state actors, including the local community, in crisis response, and how this community engagement might be regulated by enacting community engagement legislation. It was also discovered that trained health crisis response volunteer groups can help with the response. As a result, a clear and detailed key stakeholder engagement guideline might be useful in dealing with comparable natural disasters.

The study indicated that health crisis and emergency management training is essential from both a clinical and non-clinical perspective, and this training should be made mandatory for all health sector professionals as well as support employees. For wider coverage, relevant modules should be introduced into medical education. At the central level, a permanent arrangement for information sharing with overseas experts can also be formed.

The study revealed that Bangladesh has no particular policy for refugee management. Standing Orders and Directives (SoD) of disaster management, which were originally established for natural disasters, have primarily dealt with crisis situations. Though Bangladesh is internationally acknowledged for its capacity to manage natural disasters, the necessity for a specialized crisis management policy such as the case of the Rohingya catastrophe is critical. Furthermore, the study's investigation revealed a need for a detailed health crisis response and management policy. Based on the available SoD for disaster management and the experience of the Rohingya crisis response, a special policy on health crisis management should be developed. The study reveals some of the relevant aspects for public sector organizational capacity that should be considered when developing crisis response and capacity development policies in Bangladesh and other similar countries.

From a global perspective, the findings revealed that active collaboration between national and international players, as well as effective coordination, was critical to crisis response. The nature and characteristics of such collaboration and coordination can be instructive. At the same time, the findings, taking into account regional and global factors related to the crisis itself or the location where the crisis occurred is instrumental in shaping global responses to refugee-related crises. Furthermore, studies about socio-psychological aspects may be useful in determining the appropriate type of response measures to take in the field.

8.4 Contribution of the Research to Knowledge

Existing literature have indicated paucity of academic empirical study that has integrated public sector organizational capabilities with reference to the health sector and the refugee crisis. Most of refugee related studies conducted globally have either concentrated on impact on host community from economic, social, environmental or on service delivery perspectives. For instance, some studies focus on economic impact of the host community (Braun & Dwenger, 2017; Esen & Oğuş Binatlı, 2017; Kreibaum, 2016; Taylor et al., 2016; Fiala, 2015; Betts et al., 2014; Bauer et al., 2013; Falck et al., 2012; Baez, 2011; Gomes et al.,2010; Brees, 2010; Sarvimäki et al. 2009; Jacobsen, 2002). Other studies emphasize on the labour market of the host country (Ruiz & Vargas- Silva 2015; Akgündüz et al., 2015; Orhan & Senyücel Gündoğar, 2015; Braun et al., 2014). Further, some scholars also highlighted the consumption pattern (Shellito,

2016; Alix-Garcia & Saah, 2008; Maystadt & Verwimp, 2009) and social and environmental impact of the host community (Rodriguez & Castañeda, 2014; Codjoe et al., 2013; Crisp 2000; Hampshire et al. 2008; Porter et al. 2008; Rumbach 2007; Phillips, 2003; Sarpong 2003; Dick 2002; Jacobsen, 2000). A good number of studies have been conducted from the service delivery perspective of the host country (Farhat et al., 2018; Kelley, 2017; Francis, 2015), from budgetary constraint perspective (Esen Oğuş Binatlı, 2017; Orhan & Senyücel Gündoğar, 2015; İçduygu, 2015; Jensen et al., 2011) and from language barrier perspective (Montero & Baltruks, 2016; ToziJa & Memeti, 2007). Few studies were also conducted from health sector capacity perspective (Farhat et al., 2018; Etienne et al., 2016; Woodland et al., 2010).

The studies on Rohingya crisis are mostly focused either on socio-economic, environmental and political impact of the host country or health and mental wellbeing along with gender-based violence and human rights condition of the refugee community. For instance, a good number of studies have been conducted from environmental perspective (Hammer & Ahmed 2020; Rashid et al., 2020; Quader et al., 2021; Ahmed et al, 2019; Mukul et al., 2019; Hassan et al., 2018; Imtiaz, 2018), from political perspective (Simon, 2020; Rey, 2019; Bashar, 2018; Guhathakurta, 2017) and economic perspective (Ahmad & Naeem, 2020; Choudury & Fazlulkader, 2019; Filipski et al., 2019; Dey, 2018). Some studies were also carried out from health and mental wellbeing of the refugee population perspective (Persson et al., 2021; Anon, 2020; Ullah et al., 2020; Rahman et al., 2020; Majeed, 2019; Tay et al., 2019; Chan et al., 2018; Riley et al., 2017). Besides, these studies are limited in their scope and none of them touch upon the organizational capacity of the public sector organizations in the context of the Rohingya refugee crisis. Additionally, there is very limited academic empirical study which tried to identify the impact of Rohingya crisis on the public health sector organizational capacity and the influential factors behind the organizational capacity.

Moreover, the empirical researches of the crisis response and crisis management in broader perspective mainly highlighted on either natural and environmental disasters or catastrophic accidents and events. For instance, some scholars focused on natural disasters (Shrestha & Pathranarakul, 2018; Boin and ‘t Hart, 2010; Farzmand, 2009; Farazmand, 2007; Rodriguez et al., 2007; Birkland, 2006; Waugh, 2006; Lagadec, 2004; Britton, 1988; Quarantelli, 1978; Fritz, 1961), whereas some emphasize on man-made accidents and incidents (Sciulli et al,

2015; Olmeda, 2008; Roux-Dufort, 2007; Hammond, 2007; Deverell & Stern, 2006; Parker & Stern, 2002; Shrivastava, 1987; Pauchant & Mitroff, 1992).

Besides, the studies from organizational perspective mostly focused either on the effectiveness and process of the crisis management or implications on images and reputation of the organizations. To be more specific the effectiveness and process regime mainly concentrated on coordination, communication, role of leadership, decision making, resilience and team effort. For instance, some studies were on crisis coordination (Boin & Bynander 2015; Christensen et al., 2015; Rhinard *et al.* 2013; Brattberg 2012; Ansell *et al.,* 2010; Kettl 2003) and resilience perspective (Dominelli, 2013; Smith & Fischbacher, 2009; Smith & Elliott, 2007; Lalonde, 2007; Vogus & Sutcliffe, 2007; Wildavsky, 1988). Some scholars highlighted leadership role (Bowers et al., 2017; Van Knippenberg et al., 2016; Bundy & Pfarrer, 2015; Simpson et al., 2013; Roux-Dufort & Lalonde, 2013; James et al., 2011; Van Wart & Kapucu, 2011; Roux-Dufort,2009; Rerup, 2009; Brockner &James, 2008; Coombs & Holladay, 2001) and the crisis team (Kaplan et al., 2013; Pearson & Sommer, 2011; Undre et al., 2007; Sapriel, 2003; Rentsch & Klimoski, 2001; Smith-Jentsch et al., 2001; Young, 1998; Mitroff & Pearson, 1993). A good number focused on decision making (Shepherd & Williams, 2014; Barton, & Fellows, 2013; Bechky & Okhuysen, 2011; Maitlis & Sonenshein, 2010; Webb, 2004; Neal & Phillips, 1995; Jackson & Dutton, 1988; Drabek, 1985; Stallings & Quarantelli, 1985; Anderson, 1983) and crisis communication (Liu et al., 2011; Coombs, 2010; Ulmer et al., 2007; Seeger, 2006; Argenti, 2002; Coombs & Holladay, 1996) along with reputation and image (Page, 2019; Christensen & Lægreid, 2015 ; Claeys & Cauberghe, 2015; Weber et al, 2011; Romenti, 2010; Coombs, 2007; Coombs & Holladay, 2006; Coombs & Schmidt, 2000). Given the existing literature, this study is an improvement as it emphasizes the impact of the crisis on the management and resources capacity of public health sector organizations in the context of a transboundary crisis. This study also highlighted the influential factors which are important for organizational capacity of the public sector organizations in man-made crisis like refugee crisis.

Additionally, the existing literature on public health sector is mostly centered around few themes such as service delivery, patient satisfaction and reform and management. For instance, those focusing on patient satisfaction include (Hussain et al., 2019; javed et al., 2019; Gacevic et

al, 2018; kwateng et al., 2017; Xesfingi & Vozikis, 2016; Hazilah, 2012; Atinga, 2011; Owusu-frimpong et al., 2010; Andaleeb et al., 2007) and service delivery (Rawal et al., 2019; Ngan et al., 2018; Mehran et al., 2016; Mosadeghrad, 2014; Traub et al., 2007; Bhat, 2005; King et al., 2004; Gong-Guy et al., 1991). A few highlighted-on reform and management (Barretta & Ruggiero, 2018; Jammoul, 2016; Lethbridge, 2014; Meyer et al., 2012; Oliver, 2008; Hurley et al., 2004; Hebson et al., 2003; Handler et al., 2001). Against this backdrop, this study is unique in that it brings to the fore the public health sector organizational capacity issues and factors.
Furthermore, this study was undertaken in the context of Bangladesh and the Rohingya crisis, where most studies on the public health sector focus on issues relating to access or satisfaction with health care or challenges with service delivery (Rahman, 2020; Kader, 2020; Adams et al., 2018; Ahmed et al., 2017; Muhammad et al., 2016; Islam & Biswas, 2014; Sen, 2013; Rahman et al., 2008; Andaleeb et al., 2007; Aldana et al., 2001; Vaughan et al., 2000).

Another noteworthy contribution of this study is the relevance of the subject matter for public sector management in Bangladesh and in similar context as a good number of reports and empirical researches exist on public sector reform, capacity development and service delivery but very limited resources are available with particular reference to public sector organizational capacity. Besides, this study also highlights influential public sector organizational capacity factors in the context of refugee crisis which can be significant in formulating further capacity development initiatives. In addition, this study contributes significantly to existing literature on public administration in Bangladesh from crisis response and management perspective as there is abundance of literature in disaster management whereas very limited knowledge is available in crisis response and management.

Moreover, the study combines the issues of public sector organizational capacity, crisis management and refugee crisis together which also gives it a unique interdisciplinary nature from academic perspective.

8.5 Limitation of the Study

This study, like many other studies, has limitations. One of the limitations was the study's narrow scope. The Rohingya refugee crisis was handled by a large number of public sector organizations involved in varied service delivery, and because it was a collaborative effort, the obstacles and

issues are difficult to isolate for organizations functioning in a specific sector. Nonetheless, this study only looked at organizations in the public health sector. Furthermore, public sector personnel in the crisis zone were too preoccupied with their assigned tasks, and as a result, it was difficult for them to spear time for interviews or FDGs. A good number of interviews had to reschedule for more than once. Some of the relevant officials (who were working during the initial months of the crisis) have been transferred to other parts of the country hence, the researcher had to travel a long distance in order to interview them.

Furthermore, one of the study's major drawbacks was the lack of time and funds. A significant timescale is required to capture the actual events under any investigation. However, the study's fieldwork was limited to six months, and the thesis was written over a three-year period. The lack of adequate financial assistance could not also be overlooked, especially given the research area's location and the considerable traffic commuting to various geographical sites. The study's limitations open up new avenues for future investigation, as noted in the subsection that follows.

8.6 Implications for Further Research

This thesis highlights some results that require further investigation and validations to provide further robust contribution to both theory and practice. Although, this study contributes in examining the impact of the refugee crisis on the organizational capacity of the public health sector organizations along with the key influential factors in the context of Bangladesh and relates this to what may happen in other developing world context, it is important to carry out more studies in unveiling the nature of the impacts, factors and their implications for other public sector organizations.

The nature and structure of public sector organizations in developed and developing countries varies so as the relationship with the local community and the other non-sate actors, therefore, more studies are required in the context of the developing countries in order to have a comparative view of the impacts and the influential factors. Although this study is conducted in the developing world context, similar studies can provide important insights if conducted in locations having different demographic and cultural configurations.

Moreover, the study focuses on the organizational capacity aspects of the health sector organizations. More specific researches can be conducted to identify the impact on the motivation or coordination or communication or decision making of the public sector organizations. In view of this, much is still not known within both developed and the developing country contexts.

8.7 Reflections on the PhD Process

8.7.1. Researcher's Background

This is an interpretative research where the background of the researcher is an important element (Angen, 2000), as the researcher's perception plays significant role in the interpretation. Therefore, interpretive researchers are required to disclose their background which may influence the research (Bawole, 2013). In line with that I feel obligated to disclose my background.

The researcher is a Bangladeshi belonging to the middle-class society and resident in Dhaka, the capital city. He had all his education in Bangladesh with a bachelors' and master's degrees in Public Administration from the University of Dhaka. He had another master's degree in Public Policy and Governance from the North South University under a scholarship of the Norwegian government. Being a member of Civil Service for the past fifteen years, he has held several posts in Bangladesh's federal and municipal governments. In addition, he had collaborated with various development partners. The entire experience of the public sector and development partners played a significant role in selecting this topic for investigation. In this study, analysis and discussion are based on interviews, focus groups, and documentary reviews, although interpretations and reflections are influenced by the researcher's background, experience, and research approach.

8.7.2 Professional and Academic Development

The PhD journey in the University of Manchester has opened up an enormous opportunity for my professional development and widened my experience. During the three years stay with the university, I came across several research groups and interacted with diversified scholars. Additionally, I had the opportunity to teach on the MSc programme which strengthened my

exposure to academic world. I have also taken part in various training programmes organized by the University.

In addition to the professional trainings, I had the opportunity to attend several international conferences as a presenter as well as a participant. These conferences include American Society of Public Administration (ASPA) Conference 2020 and 2021, 20th Nordic Migration Research Conference 2021 organized by the University of Helsinki. The accepted papers are now awaiting publications. Moreover, my academic writing skill has been improved since embarking on the PhD journey. A number of manuscripts are to be completed in the next couple of months based on the outputs of my PhD thesis.These manuscripts are targeting the top tier peer reviewed journals in public administration, organizational studies and crisis management. Some of the salient thematic areas are:

- Examining the impact of crisis events on the organizational capacity of Public Sector Organization: A critical analysis of the Rohingya crisis in the context of Bangladesh;
- Factor affecting Public Sector Organizational Capacity in Refugee crisis: A case on Rohingya crisis with particular reference to health sector;
- Exploring the impact of Covid-19 crisis on the organizational capacity of the public sector organizations: A study of fieldwork administrator in Bangladesh;

8.8 Challenges

The PhD journey was not without challenges. During my first year, I had to go through some health conditions for which I had to get myself admitted in the hospital. However, the most challenging situation started during the 2nd year of my study with the outbreak of the Covid-19 Pandemic across the world. For more than one year, we had to stay at home due to the nationwide lockdown. In the interim, the Covid-19 had infected my family members and I. As a result, I had to spend about half of my PhD time emotionally traumatized. It also prevented me from participating in several relevant scholarly endeavors, such as international conferences.

8.9 Final Remarks

The study's main aim was to explore, analyse and understand the link between crisis events and public sector organizational capacity with particular reference to the health sector. To fulfil the conditions of this aim, the study examined the impact of the refugee crisis on health sector organizations in order to better understand the public-sector organizational capacity in crisis situations and identify the capacity gaps in order to prescribe better public sector organizational capacity development knowledge. In finding indicated that the Rohingya crisis impacted the public health sector's organizational capacity in terms of both management capacity and resources capacity. The findings revealed that the impact had both negative and positive consequences. The result suggested that the coordination, especially inter-organizational coordination, organizational communication, decisional making process, leadership patterns, personnel management practice along with the financial management practice in the public health sector organizations have been directly affected by the Rohingya crisis. However, the nature of the impact varied based on the locus and the focus of the organizations. At the crisis zone, management practices became more informal and trust based, whereas at the non-crisis zones, there was no significant change. Nonetheless, at the central level, the management practice sometimes became more formalized than usual. Therefore, the crisis seemed to have quite opposite reactions in the central and local level organizations.

The findings revealed that organizational capacity in the public health sector was influenced by a variety of factors, which could be classified under political, administrative, and socio-psychological factors. However, regional and global variables, as well as the presence of the media, appeared to have had a substantial impact on public sector organizations. Some indicators, such as political commitment, stringent monitoring, effective coordination, active partnership, a sense of goodwill, religious connection, kinship, and the presence of the media all played an important role in driving organizational capacity. On the other hand, some regional and global issues like islamophobia and international pressure played significant indirect role. Initially, the conceptual framework assumed that the administrative, political, social and economic factors were the significant but the findings revealed that the economic factors had very limited direct influence on organizational capacity and instead only the socio-psychological factors played important role.

In terms of crisis response, the results indicated that a combined response involving local communities, state and non-state actors, as well as the international community, can be effective if there is prompt and active partnership, as well as good coordination. The study also found that informal and trust-based management can speed up crisis response, and that involving service recipients in the response process can be beneficial. Additionally, learning by doing, knowledge exchange, and technology transfer are critical in expediting the response. The findings also revealed that institutional, organizational, and individual capacity gaps existed. As a result, at the national level, initiatives such as emergency health crisis management, refugee management, community participation, and crisis volunteers' groups are critical. Furthermore, a specialized institution to deal with refugee concerns in high-risk nations, as well as opportunities for continuous knowledge sharing at the regional and global levels, can be advantageous. Furthermore, allocating a particular emergency fund at the local level can be beneficial. Additionally, arrangements for mandatory training program on health crisis management for health professionals and the support staffs alongside introduction of ICT in both clinical and non-clinical management process would enhance their capacities.

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LIST OF APPENDICS

INTERVIEW QUESTIONS

Research Objectives	Research Questions	Interview Questions	Target Participants
1. Examine the impact of the refugee crisis on health sector organizations in order to better understand the public sector organizational capacity in crisis events	1. What is the impact of the refugee crisis on the capacity of health service-providing organizations?	How long have you been working in this position?	Civil servants, NGO and DP officials
		How do you describe the Rohingya influx as a crisis?	Civil servants, NGO and DP officials
		What do you think about the overall impact or effect of sudden Rohingya influx on health service organizations?	Civil servants, NGO and DP officials
		In your opinion how does the organizational capacity affected by the Rohingya crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation

Research Objectives	Research Questions	Interview Questions	Target Participants
			Commission (RRRC)]
		What is the impact of Rohingya influx on organizational management capacity?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]
		What is the impact of Rohingya influx on organizational resources capacity?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]
		How do you explain the influence of Rohingya crisis on organizational adjustment and learning process?	Civil servants working in heath service proving organizations

Research Objectives	Research Questions	Interview Questions	Target Participants
			at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]
		In your opinion how do you describe the positive impact of such crisis on health service organizations?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]
	2. What are the key factors affecting health service capacity during the refugee crisis	In your view what are the major factors affecting your organizational capacity during Rohingya crisis?	Civil servants, NGO and DP officials
		How do you describe influential political and administrative issues in dealing with Rohingya crisis ?	Civil servants, NGO and DP officials

Research Objectives	Research Questions	Interview Questions	Target Participants
	and why?		
		What do you think about the influence of social and economic factors in the context of health sector organizational capacity?	Civil servants, NGO and DP officials
2. Identify the capacity gaps in health service delivery in the context of the Rohingya Refugee influx in Bangladesh in order to prescribe better public sector	3. How did health sector organizations respond to the Rohingya refugee crisis in Bangladesh?	In your opinion how does the health sector organization respond to the Rohingya crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation

Research Objectives	Research Questions	Interview Questions	Target Participants
organizational capacity development knowledge.			Commission (RRRC)], NGO and DP officials
		Can you please explain how does the organization deal with the crisis at the beginning?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
		How do you describe the organizational planning process in the context of Rohingya crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants

Research Objectives	**Research Questions**	**Interview Questions**	**Target Participants**
			working directly with Rohingya crisis management [Ministry of health and family welfare]
		In your opinion how does your organization adjust with the crisis situation?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]
		How do you explain the organizational learning from such situation?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health and family welfare]

Research Objectives	Research Questions	Interview Questions	Target Participants
		In your opinion what are the major organizational resources that were effective in managing Rohingya crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
	4. How can the organizational capacity of health care services be strengthened in such a crisis?	In your opinion what are the organizational weak areas for manging such crisis that was revealed during the Rohingya crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of

Research Objectives	Research Questions	Interview Questions	Target Participants
			disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
		How do you describe the major organizational strong areas in dealing such crisis?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
		What do you think about the organizational weak areas that need to	Civil servants working in heath service

Research Objectives	Research Questions	Interview Questions	Target Participants
		be strengthened?	proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
		How can the organizational strong areas be further strengthened?	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration,

Research Objectives	Research Questions	Interview Questions	Target Participants
			Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials
		Do you have any special recommendation for developing the capacity of the health sector organization	Civil servants working in heath service proving organizations at the Cox's Bazar district, civil servants working directly with Rohingya crisis management [Ministry of health , Ministry of disaster management and relief, local administration, Refugee Rehabilitation and repatriation Commission (RRRC)], NGO and DP officials