HUMAN RESOURCE MANAGEMENT CHALLENGES AND RESPONSE STRATEGIES IN SRI LANKAN HOSPITALS AMIDST A DUAL CRISIS CONTEXT.

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ABSTRACT

The recent global pandemic has wreaked social, political, and economic havoc worldwide. In particular, the health care (HC) sectors across the globe were vastly disrupted. In Sri Lanka, the impact of the pandemic was compounded by an economic recession which, to date, still plagues the country. This dual crisis has hit the country's HC sector harder than any other sector.

The purpose of this study is to draw upon contextually based human resource management (HRM), HRM process, organisational justice, and crisis management (CM) literature to explain the HRM challenges imposed and how, in response to these crises, HRM policy and practices in hospitals change, at intended, implemented and employee perceived levels. The HRM preparedness is explored. Further, the study examined whether the HRM changes have been absorbed into routine HRM.

Taking a qualitative approach, a multiple case study design was employed across four hospitals with varying characteristics. Eighty three semi-structured interviews were conducted with hospital managers and employees, reflecting a broader representation of the healthcare worker (HCW) population. Data analyses included thematic analysis assisted with NVivo. This thesis makes a distinctive theoretical contribution to the HRM field, by aligning HRM and CM perspectives to construct a framework for HRM delivery in crisis contexts. The framework links the HRM response in crisis contexts to implementation practices and outcomes of wellbeing of HCWs and quality of care. Importantly, the study examined the Crisis induced Human Resource Practices (CIHRP), through the lens of employee perceptions of fairness. Further it adds to the literature, addressing context based - empirical findings from a developing country, navigating a dual crisis. The findings will be useful to HRM practitioners, designing policy to withstand future HRM crises in local hospitals.

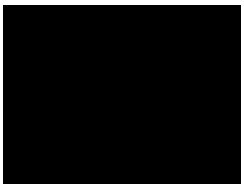
Keywords: HRM, CM, HRM response, Sri Lanka, hospitals

DECLARATION OF AUTHENTICITY

"I, Samadi Madiwala, declare that the PhD thesis entitled "Human Resource Management Challenges and Response Strategies in Sri Lankan Hospitals amidst a Dual Crisis Context" is no more than 80,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

"I have conducted my research in alignment with the Australian Code for the Responsible Conduct of Research and Victoria University's Higher Degree by Research Policy and Procedures.

"All research procedures reported in the thesis were approved by the Victoria University Human Research Ethics Committee. (Approval Number HRE20-128, date 09/03/2021)."

Signature: 

Date: 29 August 2024

DEDICATION

To my parents, who raised me and gave me education to be who I am today, thank you for your unconditional love and prayers.

To my husband, who supported me in this doctoral journey, thank you for your unwavering support.

To my two sons Manuth and Okith, you have been my joy and happy pills always, thank you for making my stressful days brighter and enjoyable.

I dedicate this work to all the health care heroes,
who selflessly battled against COVID-19,
saved lives,
and
made the world a safer place to live.

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LIST OF RESEARCH PUBLICATIONS

The following research publications and presentations were based on this PhD thesis.

Conference Presentations with abstract publications

1. Samadi, M. (2024). Managers' Experiences on Work Arrangement Strategies in Hospitals amidst a Dual Crisis. *The 30th Kuala Lumpur International Business, Economics and Law Conference, Infrastructure University, Malaysia* (Virtual).

2. Samadi, M. (2023). Human Resource Management Challenges and Response Strategies in Hospitals amidst a Dual Crisis in a Developing Country. *The 11th International Conference on Business, Management and Governance (ICBMG 2023), University of Western Australia, Perth, Australia.*

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Best Presentation Awards

1. Samadi, M. (2023). Human Resource Management Challenges and Response Strategies in Hospitals amidst a Dual Crisis in a Developing Country. *The 11th International Conference on Business, Management and Governance (ICBMG 2023), University of Western Australia, Perth, Australia*.

2. Samadi, M. (2023). Managing Human Resources in Hospitals amidst a Dual Crisis in a Developing Country. *ISILC HDR Symposium, Victoria University, Melbourne, Australia.*

Upcoming Conference Presentations

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LIST OF ABBREVIATIONS

AGM - Assistant General Manager

AO - Admin Officer

CA - Chief Accountant

CBHRT - Contextually based Human Resource Theory

CD - Communicable Disease

CIHRP - Crisis induced Human Resource Practices

CM- Crisis Management

CNO - Chief Nursing Officer

CRHRP - Crisis related HR Practices

CTF- COVID-19 Treatment Facility

EAP- Employee Assistance Programs

HC- Health Care

HCW- Health Care Worker

HD - Hospital Director

ICC - Intermediate Care Centers

ICU - Intensive Care Unit

ID - Infectious Diseases

LM - Line Manager

MH- Ministry of Health

MO - Medical Officer

MOH- Medical Officer of Health

MS- Minor Staff

MST- Medical Superintend

N/O - Nursing Officer

RQ - Research Question

SM - Senior Manager

SQ - Sub Question

WIC - Ward in-charge

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Chapter One: Introduction

1.1. Introduction

This chapter presents the aims and context of the current study. The related CBHRT (Paauwe, 2004), HRM process (Wright & Nishii, 2013), CM (Frandsen & Johansen, 2011; Jaques, 2007; Johansen et al., 2012) and organizational justice (Colquitt, 2001, 2012; Colquitt et al., 2005), literature is introduced, and the research questions are identified. The key contribution of the study is presented in terms of theoretical and practical aspects. The research design is briefly described. The chapter concludes with an outline of the thesis which presents an overview of the eight chapters.

1.2. Aims and Context of the Study

On 11 March 2020, the World Health Organization (WHO) declared the global COVID-19 outbreak a public health emergency of international concern (Abdulah et al., 2021; Chen et al., 2020). Since then, the way people live, and work has changed across the world. Some of the challenges faced by organisations include workplace health and safety concerns, lockdowns and other forms of movement restrictions, and supply chain disruptions. The world realized that this was a human crisis, and HRM leaders had to facilitate high levels of employee resilience while contribute the successful navigation of their organizations out of the crisis (Collings, Nyberg, et al., 2021).

Hospitals, as part of essential services, play a major role in times of natural or man- made disasters and emergencies. The Health Care (HC) sector is highly labour-intensive (Schopman et al., 2017), and HCWs are confronted with emotionally demanding work conditions (Demerouti et al., 2000; Kim & Wang, 2018; Shamika et al., 2019). With the rapid spread of the virus, HC systems reported an acute shortage of physical and human resources in caring for the surge of patients (Abdulah et al., 2021). These conditions added additional physical and psychological pressures on HCWs (Abdulah et al., 2021; Chen et al., 2020; Fernandez et al., 2020).

At the same time, hospitals were arguably unprepared for a crisis of this magnitude. For example, Gupta et al. (2021) examined the health workforce surge capacity during COVID-19 and recommended actions to policy makers to develop protocols for reallocating resources and

shifting tasks, training for in-service workers and engagement of a standby volunteer pool. Kuhlmann et al. (2021) highlight a lack of evidence on HC workforce planning during infectious diseases outbreaks. Elaborating further on protection and preparedness of human resources, they identify knowledge gaps in areas like psychological factors, burnout, gender considerations and specially information on low- and middle-income countries. It is reasonable to assume that developing countries would have been hit harder by such a devastating global pandemic.

Sri Lanka a low-middle-income country (AGDFAT, 2021), with around 21.9 million population (CBSL, 2020a), provides a specific study context as the country navigates through a dual crisis- a devastating economic crisis followed by the global pandemic. The island nation has a universal HC system, which is dominated by the public sector (WHOROSEA, 2021). Sri Lankan hospitals have suffered various disaster experience including the Asian Tsunami in 2004, ethnic conflicts including a 30-year civil war and occasional political violence (AGDFAT, 2021; Munasinghe et al., 2021).

Over the course of the pandemic, hospitals have been instructed to adhere to various government guidelines and circulars (S. L. MHIMS, 2020a), which include measures to be undertaken in areas of operational setups and staff management. Similarly there have been different measures imposed by authorities in the economic crisis context, which hospitals had to adhere when responding to that crisis.

1.3. Statement of Problem and Rationale of the Study

COVID-19 pandemic revealed the changes made to work arrangements in almost every workplace. Although remote working became the new normal at a greater pace, such strategies do not apply for certain types of jobs in certain sectors like HC. As such, hospitals would have brought about distinct strategies in their battle against the pandemic.

Empirical research on pandemic induced HRM strategies in developing countries are notably low. In Sri Lanka, the pandemic impact was compounded by an economic recession. As such, in this dual crisis context, being in the essential services sector, hospitals would have encountered various HRM challenges, and their manner of response is not very well known. On the other hand, employee perceptions on such response strategies can serve as an important input in evaluating the effectiveness of those strategies and designing strategies for future crises.

This study is designed based on the CBHRT (Paauwe, 2004), HRM process (Wright & Nishii, 2013), CM (Frandsen & Johansen, 2011; Jaques, 2007; Johansen et al., 2012; Oscarsson, 2022) and organizational justice (Colquitt, 2001, 2012; Colquitt et al., 2005) literature. A conceptual framework (figure 4.1) was developed, on which the research questions of the study were drawn. A brief introduction to these theoretical perspectives are presented below.

The CBHRT (Paauwe, 2004) advocates that three domains namely the competitive mechanisms, institutional mechanisms and the organizational mechanisms can shape HRM decisions of an organization. This perspective has been developed based on prominent theoretical arguments drawn from the institutional theory (DiMaggio & Powell, 1983), Harvard model of HRM (Beer et al., 1985) and contingency and configurational modes of HRM (Delery & Doty, 1996).

Wright and Nishii (2013), present the "Process model of SHRM" to explain links between intended, actual, and-perceived HRM practices, and identify distinctions in the content and process along the multiple levels. This model links HRM practices to organizational performance through employee reactions, based on the premise that the goal of intended HRM practices is to lead positive employee reactions towards organizational performance. This model has been used by scholars in multi - level research (eg. Makhecha et al., 2018; Piening et al., 2014; Van De Voorde & Beijer, 2015). In the current study the HRM changes took place in hospitals will be examined along intended (designed HRM practices to response crisis), actual (implemented) and employee perceived (as experienced by employees) levels. Along this line of thinking, van Mierlo et al. (2018) advocate that the process of HRM implementation is recursive and as such the actors influence changes to the designed practices so as to ensure the practices match with the needs. Based on feedback and reviews, practices can be either attracted to routine practices or redesigned in a way that match with the organization's needs. This recursive process is aligned with the Structuration theory (Giddens, 1984).

Crises are dynamic processes (Jaques, 2007) that can be mitigated if the organisation has the knowledge to handle those in a strategic and proactive mean (Johansen et al., 2012). The practice perspective focuses on how practitioners respond to changes in various situations such as crises, and how they integrate and absorb those responses into their everyday work.

Organisational justice is the overall perception an employee has of what is fair and unfair in the workplace (Colquitt, 2001, 2012; Colquitt et al., 2005). The current study is designed to identify employee justice perceptions towards HRM practices and changes they encountered in their workstations given the crisis contexts. Organizational justice consists of four

dimensions, namely: procedural justice (which is concerned with the process of implementing HRM), distributive justice (that is associated to HRM outcomes and reward distribution), informational justice (i.e., the degree to which employees were provided with information adequate, relevant and consistent information) and interpersonal justice (i.e., the degree to which employees are treated with dignity and respect) (Colquitt, 2001). In this study, the HRM response in the dual crisis are examined through the lens of fairness as perceived by employees.

1.4. Methodology

The context of this study, an unprecedented global health crisis and an economic recession in an under-researched area like the Sri Lankan hospitals sector warrants a qualitative approach.Managing a well-motivated, skilled and deployed HC workforce has been identified as an essential factor for success in health system delivery (Buchan, 2004b; Veld et al., 2010a). Thus, to understand how hospitals dealt with people management under dismal, challenging and hazardous operational pressures, and to understand employees' experience of HRM interventions response, a qualitative approach is found to be suitable. Qualitative methods are appropriate for learning lived experiences (Liamputtong, 2013).

Literature calls for more qualitative methods that utilize multiple sources in HRM studies (Lengnick-Hall et al., 2009; Sanders et al., 2013; Truss, 2001). Scholars call for the need to incorporate employee perceptions in evaluating HRM effects (e.g.Alfes et al., 2013; Collings, Nyberg, et al., 2021; Guest, 2011; Kooij et al., 2013; Truss, 2001). In the pandemic context, Kim et al. (2022) anticipate that HR process research is ideal for examining how employees perceive, understand, and attribute the HRM in their organizations. Adding to this, the authors claim that HR process research has rarely considered extra-organizational phenomena such as the COVID-19 pandemic. This study underpins the HRM process perspective, and a multiple-case study design is proposed for this research project.

A multiple-case study design (R.K. Yin, 2014) was employed, across four hospitals in Sri Lanka. Sri Lankan HC system is dominated by the public sector (WHO, 2018). This study was carried out in three public hospitals and one private hospital. Data was collected through semi-structured interviews with multiple groups of respondents; hospital management, LMs and HCWs.

Purposive sampling strategies were used, and the respondents were approached through the gatekeepers (top management/ director of hospital). No set formula is applied in qualitative

research for determining the sample size (Liamputtong, 2013). As indicated by Teddlie and Tashakkori (2009), there are no universally accepted rules for determining the sample size in qualitative studies and often the size depends on number of factors such as what the researcher wants to know and what will have credibility. Data saturation is the general rule used for purposive sampling, which occurs when no new information is resulted from adding of more units, that can be used in theme development (Teddlie & Tashakkori, 2009). Thus, sample size was driven by data saturation. Interview guides were used at the interviews to ensure consistency. However, considerations were given to a participant- led approach where necessary, given the unprecedented context and the need for grasping in-depth information. Interviews were conducted in Sinhala language and data were audio recorded, transcribed, and then translated.

Data was analyzed using thematic analysis (Braun & Clarke, 2006). The process involved familiarizing with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (Braun & Clarke, 2006). NVivo software was used to assist data analysis. Ethics approval has been obtained from the Victoria University Human Research Ethics Committee (HRE20-128) and ethical considerations were addressed in different stages including data collection, analysis and storage.

1.5. Research Questions

This study intends to answer five research questions as follows.

RQ 01: What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

RQ 02: What HRM strategies have the hospitals designed to respond to these crises?

RQ 03: What were the barriers and enablers of implementing the designed HRM strategies?

RQ 04: What are employees' experiences and perceptions of fairness towards these HRM responses?

RQ 05: How effective were the HRM strategies?

1.6. Contribution to Knowledge and Statement of Significance

This study's theoretical contribution is to fill in gaps in HRM and CM literature, given that dearth of studies around pandemic and in general in the domain of HRM is still lacking from the Asian context. This study brings together the HRM process perspective, organisational

justice literature and CM literature and thus, incorporates multi-level perspectives in the HRM process in crisis contexts.

As argued by scholars, HRM research has been dominated by private sector studies and scant attention has been given to the public sector (Brown, 2004; Brunetto et al., 2011; Knies et al., 2015; Knies et al., 2017). Considering this research gap, this study incorporates findings from both the public and private sector. On the other hand scholars argue that small and medium sized firms are not well empirically researched in the HRM domain (Panayotopoulou et al., 2003; Welbourne & Andrews, 1996). The hospitals studied in the current research are of different sizes when it comes to the number of employees and bed capacity.

Literature identifies a limitation of prior studies, that have analyzed the effects of HRM practices on organizational outcomes, based on single views of senior HRM professionals and calls for involving employee perceptions for a better understanding (Alfes et al., 2013; Kooij et al., 2013; Truss, 2001). Scholars recommend applying qualitative methods with multiple sources to study the HRM phenomena (Lengnick-Hall et al., 2009; Truss, 2001), Given the crisis context, Collings, Nyberg, et al. (2021) propose to identify employee experience on HRM response for examining the effectiveness of such response, while Kuhlmann et al. (2021) discovered a lack of information on health care (HC) sector workforce preparedness for the infectious diseases outbreaks from low and middle-income countries. According to Buchan (2004b) literature lacks HRM – performance research in the HC sector. As further argued by Kim et al. (2022) HR process research has rarely considered extra-organizational phenomena over intra-organizational phenomena. They further highlight that HR process research within the COVID-19 crisis can bring important insights into literature. This study is a response to such suggestions for future research and an attempt to address the said limitations in prior studies.

The findings of this study may be useful to policy makers and HRM practitioners in decision making, especially in preparing the organizations and their human resources to respond to disruptions induced by crises like COVID-19. Recommendations made by the study may inform the case study hospitals in the effective and high-impact management of their workforce.

1.7. Thesis Outline

This thesis consists of eight chapters. The following section provides a summary of the contents of each chapter.

1. Chapter One: Introduction

This chapter presents the aim and context of the current study, particularly the dual crisis. The related HRM process (Wright & Nishii, 2013), CM (Frandsen & Johansen, 2011; Jaques, 2007; Johansen et al., 2012; Oscarsson, 2022) and organizational justice (Colquitt, 2001, 2012; Colquitt et al., 2005), literature is introduced, and the research questions are identified. The key contribution of the study is presented in terms of theoretical and practical aspects. The research design is briefly described. The chapter concludes with an outline of the thesis which presents an overview of the -Eight chapters.

2. Chapter Two: Literature Review Part One

Chapter Two and Chapter Three are organized to present the literature and theoretical aspects pertaining to the current study. This study aims at exploring the hospitals' HRM response in the context of a dual crisis. ,

3. Chapter Three: Literature Review Part Two

This chapter explores the main two theoretical perspectives that guide the study, HRM and CM. The CBHRT, process- based model of HRM and the literature around the recursive nature of the HRM process perspective is reviewed. The organizational CM literature is then discussed, and the literature around the dimensions of organizational justice is examined. This chapter concludes with an identification of gaps in literature, pertaining to the literature reviewed in both Chapters Two and Three.

4. Chapter Four: Conceptual Framework

Based on the reviewed literature, the conceptual framework is constructed in the forth chapter. Research questions are developed with related propositions and sub questions. A discussion on variables in the conceptual framework is also presented. The conceptual framework contributes to informing the discussion of the study findings presented in the final chapter.

5. Chapter Five: Methodology

Chapter Five discusses the research design and methods used in the study. The research paradigms are introduced and the paradigm underpinning the current study is identified. Researcher's self-interests are discussed under researcher's positioning as a reflexivity strategy. The current study employs a multiple- case study design. A justification of using a case study approach is presented. The methodology used for the study is discussed in detail

including sampling strategy, data collection, data analysis and strategies adopted for enhancing rigor of the study. The ethical considerations of the study and implementation of such practices in the current study are described.

6. Chapter Six: Findings

This chapter discusses the case study findings. The first case study findings are presented in detail, followed by a summary of findings related to other three cases. The impact of the dual crisis on the respective case study hospital and the preparedness aspects are presented. The designed HRM response is identified, and the implementation is explored. HCWs' experience about these HRM implementation, and their perspectives of fairness towards these HRM responses are identified. The effectiveness of the HRM response is examined and the lessons learnt are discussed.

7. Chapter Seven: Analysis

This chapter provides an analysis of the findings presented in Chapter Six. The study propositions are examined based on the findings, which informs the discussion and conclusion presented in the final chapter.

8. Chapter Eight: Discussion and Conclusion

Chapter Eight discusses the findings with the underlying theoretical perspectives. The research questions and the conceptual framework are revisited. The practical implications of the study are described, the limitations of the study are identified, and areas of future research are proposed. The chapter presents a conclusion to the overall study and the thesis.

1.8. Summary

This chapter presented an overview of the current research study. The aims and the context of the study was introduced. The research questions were identified, and the methodology of the study was explained. Then the contribution of the study and the significance was described. Finally, an overview of the chapter organization was presented.

Chapter Two: Literature Review - Part One

2.1. Introduction

The aim and significance of the current study and an outline of the thesis were presented in the previous chapter. Chapter Two and Chapter Three present an overview of literature that underpins the current research. In this chapter, the context of the study is identified as Sri Lanka's HC sector within the COVID-19 pandemic and the economic crisis contexts. Then, the concept of surge capacity and dimensions of hospital preparedness are discussed. Continuing the literature review, the literature around HRM and CM is examined in the next chapter, and the gaps in the reviewed literature are identified.

2.2. The Context of the Study: Sri Lankan HC Sector, Disaster Experience and Recent Two Crises

2.2.1. Sri Lanka – an Overview

Sri Lanka is an island nation in the Indian Ocean and a South Asian country. With over 3000 years of a rich history, the country formerly known as Ceylon was under Portuguese and Dutch rule after the sixteenth century, followed by the British (Mirza & Ensign, 2021). The island nation gained its independence in 1948. The tropical country is a famous tourist destination, and its major exports include apparel, tea (known as *Ceylon Tea*), spices- mainly cinnamon (global monopoly for *True Cinnamon*), rubber and coconut based products (SLEDB, 2023). The population counts for around 22.1 million (CBSL, 2021) and exhibits a heterogeneity in terms of religion and ethnicity. The major ethnic group is represented by Sinhalese (74.9%) while the Sri Lankan Tamils, Sri Lankan Moors, Indian Tamils and others represent 11.2%, 9.3%, 4.1% and 0.5% of the population respectively (CBSL, 2020b). The Buddhists majority counts for 70.1% of the population, followed by Hindus (12.6%), Islamic (9.7%) and Christian and Roman Catholics (7.6%) (CBSL, 2020b).

Sri Lanka is a low-middle–income country (AGDFAT, 2021; WB, 2018) and the GDP per capita is counted for USD 4013.7 as of 2021 (WB, 2023). The life expectancy at birth (2021) is 76.4 years (UNDP, 2023). Sri Lanka was ranked 73rd in the Human Development Index in 2021 (UNDP, 2023), leading other countries in the South Asian region. The labour force is

largely represented by men (65%), where 35% is women (DCSSL, 2023). The Hofstede national culture dimensions identifies Sri Lanka as a collective society with a low score of 35 for the individualism dimension (Hofstede, 2022). Sri Lankan society comprised of individuals who belong to 'in groups' that maintain closer and long-term commitment to the member groups. Research shows the support of extended family as a leading factor in maintaining work-family balance in the Sri Lankan society (Wanninayake et al., 2024).

2.2.2. Sri Lankan HC Sector

Sri Lanka has a universal HC system, where in 2019, the government expenditure on public health was 1.6% of the GDP (CBSL, 2020a), which was 1.3% in 2022 (CBSL, 2022). The health indicators are comparably higher from that of other countries in the region and some countries in the western world (CMA, 2020; Jones, 2015). The number of patients per doctor was 1054, while 18.4 nurses per 10,000 persons was recorded in 2022 (CBSL, 2022). The country has a free education system, by which medical and paramedical professionals are been trained through medical faculties across all regions of the country (CMA, 2020). Nurses represent the highest proportion in the global HC workforce (Fernandez et al., 2020). Similarly in Sri Lanka, highest proportion of the HC workforce is represented by nurses (WHO, 2018). Sri Lanka has a policy of recruiting and then training nurses, leading to 100% absorption of trained nurses into the public HC system (WHO, 2018), while post-graduate training and education is available for doctors and paramedical workforce.

In Sri Lanka, the HC service provision includes both allopathic and indigenous medical system, provided by the public and private sector (WHOROSEA, 2021), and is dominated by the western allopathic system of medicine (Wickramasinghe & Fernando, 2022). Allopathic systems were initially introduced in the country by Portuguese and the Dutch, in order to provide care only to the military and colonial staff then (WHOROSEA, 2021). In 1858 during the British colonial period, the present HC system was initiated. Western trained Sri Lankans were assigned to provide medical care in hospital settings and dispensaries and the Colombo medical school was founded in 1870 (Jones, 2015). As the traditional, indigenous systems of medicine was also predominant in the country at that time, a board of indigenous medicine, a hospital and a training college have been established in the colonial era (Jones, 2015). The indigenous medicine systems consist of *Ayurveda* from north India, *Siddha* from southern India, the Arabic *Unani* system and the traditional *Deshiya Chikitsa* (Sri Lankan medical care

or commonly referred to as Sinhala Wedakama (Samarakoon et al., 2021)) also known as *Sinhala medicine* (WHOROSEA, 2021). Researchers claim that patient characteristics information and morbidities data are relatively hard to find within the traditional systems due to lack of systematic record keeping (WHOROSEA, 2021).

The HC sector is dominated by the public sector who provides 95% of inpatient care and 50% of outpatient care services while only a limited inpatient care is provided by the private sector (WHOROSEA, 2021). Public sector employs nearly 140,000 HC workers (HCWs) where more than 58% are skilled professionals including medical officers (doctors), nurses, midwives, and paramedics. As recorded by the Ministry of Health Sri Lanka, there are 1,103 public hospitals across the country as of year 2020. There are public Ayurveda hospitals across regions, although not expanded as much as the allopathic services network (Wickramasinghe & Fernando, 2022). The public hospitals are categorized into four types namely, provincial (teaching), district general, district base and divisional (primary care units) (WHO, 2017). Additionally, the Sri Lankan preventive care is provided through Medical Officer of Health (MOH) units across the country (Adikari et al., 2020; WHO, 2017). MOH units function at the grassroots level of the public health system on areas including communicable, non-communicable diseases (CDs), maternal and child health, elderly care, occupational and school health (Adikari et al., 2020).

Private sector provides outpatient care and specialists services mostly through government medical officers who work part time in the private hospitals (WHO, 2017; WHOROSEA, 2021). There are around 5,000 medical officers - part time and over 4,500 full time nurses working in the private hospital setting (WHOROSEA, 2021). Private hospitals are required to obtain a registration from the Private Health Services Regulatory Council under the Ministry of Health according to the Private Medical Institutions (Registration) Act No. 21 of 2006. Private hospitals mostly located in metropolitan areas, provide services at a cost with modern equipment and facilities (WHO, 2017), and cater economically sound cohort of the population (Wickramasinghe & Fernando, 2022). In addition to the allopathic medical services, private sector also provides Ayurveda and traditional Sri Lankan medical care (Wickramasinghe & Fernando, 2022).

2.2.3. Sri Lanka's Disaster Experience

Sri Lanka's GDP indicated a decline over the years since 2017 (WB, 2018, 2023). Despite these slowdowns, the country's economic growth is accounted for an average of 5.8% since 2010, as the nation strived towards reconstruction and growth, aftermath of the 30 year civil war ended in 2009 (WB, 2018). This war was a battle between the Sri Lankan government and the Liberation Tigers of Tamil Eelam (LTTE) insurgent group, as the LTTE urged to establish a separate state for the Tamil minority (Anandakugan, 2020). The fear of terrorism remerged with the bomb blasts occurred on the Easter Sunday in 2019. Several bomb attacks went inside churches during Easter services in three cities, while other bombings went inside four hotels including three luxury hotels. The death poll counted nearly 290, while hundreds of people injured (CNN, 2019). This disaster has caused a 2.3 % reduction in GDP growth in 2019, while the growth averaged to 3.1% between 2017 and 2019 (WB, 2021a). Currently the country is overwhelmed due to an economic crisis, accelerated by the effects of the COVID-19 pandemic.

In addition to the man-made disasters, Sri Lanka's vulnerability to natural disasters is considerably high given its geographical location, where the frequent natural disasters reported include floods, landslides, cyclones, droughts, windstorms and coastal erosion (Farley et al., 2017; Munasinghe et al., 2021). The Global Climate Risk Index, ranked Sri Lanka as the second most affected country by the weather-related losses in 2017 (Wickramasinghe, 2019). The nation encountered the worst natural disaster in its history, the Asian Tsunami in 2004 (AGDFAT, 2021; Munasinghe et al., 2021; Ruddock et al., 2010), which resulted in over 30,000 deaths, and significant damages to its coastal infrastructure (WB, 2005), while around half a million people were internally displaced (WHO, 2016). Resulted in over 100 deaths and over 400,000 people displacements, Sri Lanka experienced a flood and landslide disaster in May 2016 (WHO, 2016). Country's natural disasters have affected 6,777 persons causing 07 injuries and one death across the country as of 08th May 2023 (daily situation report DMC, 2023).

Further to such man-made and natural disasters, Sri Lanka periodically faces epidemics of CDs, causing morbidity and mortality, such as leptospirosis and dengue (Wickramaarachchi et al., 2020). The country has been able to successfully mitigate other CDs including polio, malaria, lymphatic filariasis, neonatal tetanus and vertical transmission of HIV (Adikari et al., 2020). There have been few Swine flu (H1N1) outbreaks reported in 2009-2010 period and dengue epidemics in 2004 and 2017 (Wickramasinghe & Fernando, 2022). Sri Lanka seems to have escaped major viral epidemic respiratory illnesses such as severe acute respiratory syndrome

(SARS 2002-2003) and Middle East respiratory syndrome (MERS 2015) (Wickramaarachchi et al., 2020), until the COVID-19 began to spread in the country in 2020.

The terms epidemic and pandemic refer to CD outbreaks based and usually differs on the scale of the outbreak (Healthline, 2020). Epidemic can be an unexpected surge of disease cases in a specific geographical area while, when an epidemic has spread across different parts of the world, it is called a pandemic (CUMSPH, 2021; Healthline, 2020; MW). Additionally, when a disease outbreak persists at a consistent level, limited to a specific region, it is endemic (CUMSPH, 2021; MW). For instance, malaria is considered endemic in certain countries and regions (CUMSPH, 2021).

Sri Lanka's strong public HC network has been identified as a critical success factor in preventing disease outbreaks (WHO, 2016). A study reported various measures taken by a leading hospital in Sri Lanka to successfully responding the dengue epidemic in 2017 (Rathnayake et al., 2018). To enhance physical and human capacity, additional physical resources and staff have been deployed and special activities have been undertaken to provide orientation to new staff, ensure safety and health of the staff and to enhance staff morale.

Hospitals, as part of essential services, play a major role in times of natural or man-made disasters and emergencies. Sri Lanka's HC system and hospitals have had enormous disaster experience, including the civil war and the Asian Tsunami (Munasinghe et al., 2021). Such mass casualty events can impose great challenges to routine hospital operations, overwhelming resources, space, and workforce in hospitals (Persoff et al., 2018). Research shows a limited disaster preparedness in Sri Lankan hospitals (Farley et al., 2017; Munasinghe et al., 2021). However, there appears significant strategic interventions for strengthening the HC sector emergency preparedness and response capacity, initiated aftermath of the Asian Tsunami disaster. During this disaster, 97 HC institutions have been destroyed completely or partially, severely hindering the provision of HC services (WHO, 2016). This situation has been exacerbated due to the loss of 35 HCWs while many other HCWs were injured and suffered from mental health issues (Munasinghe et al., 2021).

In strengthening the disaster and emergency preparedness, an act for providing a legal basis for disaster risk management in the country has been passed in 2005 and key institutions such as the disaster preparedness and response division have been established. Further to these, national, provincial and district level HC emergency units have been established to coordinate the HC emergency response throughout the country. Emergency response training programs

have been incorporated into health academic curricular, while emergency planning programs have been established in hospitals (WHO, 2016). In 2014, an initiative has been launched across hospitals to make sure that hospitals remain fully operational during an emergency, while drills have been conducted in 56 hospitals to assess their preparedness plans. The HC sector's preparedness to chemical, biological, radio and nuclear threats has been strengthened, through HC staff training programs and ensuring the provision of medical supplies and specialist equipment to hospitals (WHO, 2016). The *hospital preparedness and the surge capacity* are vital components in addressing HC needs ahead of any disaster or emergency, specifically if mass casualties are expected. These two components are further discussed in section 2.3.

The COVID-19 global pandemic impacted the global HC systems and arguably most of the institutions were unprepared for an emergency of such magnitude. Studies in this pandemic context are limited from developing countries, particularly from South Asia (Munasinghe et al., 2021; Saeed et al., 2021; Wanninayake et al., 2022). Managing a pandemic can be more tough, within a developing country context (Saeed et al., 2021). The current study explores the Sri Lankan hospitals responses to the global pandemic health crisis and the devastating economic crisis in the country. Economic crisis in Sri Lanka, was visible in many aspects like shortages of fuel and basic commodities including medicine that resulted in public unrest and diminishing living standards of citizens. Following sections provide an overview of the COVID-19 pandemic experience and the economic crisis experience in Sri Lanka. Given the pandemic's impact extended in a global scale, pandemic experience in the global context and the implications to HRM and to the HC sector are first examined.

2.2.4. COVID-19 Pandemic

2.2.4.1. Global Experience and Implications for HRM

The global COVID-19 pandemic, caused by the severe acute respiratory syndrome coronavirus 2 (Sars-CoV-2) (Wade et al., 2022) has led to unprecedented alterations in both social and working environments across the globe; the way people live, and work has changed across the world (Keen et al., 2022). On 11th March 2020, the global COVID-19 outbreak, was declared as a public health emergency of international concern, by the WHO (Abdulah et al., 2021; Chen et al., 2020). According to the Johns Hopkins Coronavirus Resource Centre, as of 3rd March

2023, there were approximately 657 million COVID-19 infections, and around 6.9 million deaths worldwide (JHCRC, 2023).

This pandemic provided organizations around the world with an exogenous shock, given the uncertainty and the magnitude of the pandemic (Carmine et al., 2021). An earlier survey on the crisis preparedness level of business firms ahead of the COVID-19 pandemic has found that almost half of the survey respondent business firms' CM plans were not specifically addressing infectious outbreaks (IPR, 2020). Frandsen and Johansen (2023) claim that organizations had to simultaneously navigate a health crisis (restrictions and instructions of the health authorities and the government) and a business crisis (due to the consequences of the public and political handling of the health crisis) in this pandemic context. Some of the challenges faced by organisations include workplace health and safety concerns, lockdowns and other forms of movement restrictions, and supply chain disruptions. The pandemic triggered organizational tensions where managers tackled with competing priorities; either focused on 1) their people or 2) profit and service delivery (Branicki et al., 2022). HR managers were expected to improve the coping capabilities of employees and successfully navigate organizations out of the crisis (Collings, Nyberg, et al., 2021). Organizations had to leverage between dual needs; ensuring employee safety and keeping organizations economically sustainable, where HR mangers were expected to address resulting HR issues (Branicki et al., 2022).

Many countries initiated mitigation strategies during early stages of the pandemic (Kwon & Kim, 2022) while Walker et al. (2020) observed that such suppression strategies were earlier implemented in lower-income countries among others. As stay-at-home orders (Alqadhib et al., 2022), border closures and lockdowns came into effect, organizations worldwide started to experience a catastrophic impact. Global supply chains were dramatically disrupted (Verbeke, 2020), businesses could not survive due to restrictions, while a significant decline in overall world gross domestic production was reported in 2020 (Alqadhib et al., 2022). In April 2020, around 68% of the world's total workforce, including 81% of employers, were living in countries with recommended or required workplace closures (ILO, 2020b). In most places, firms have had to determine whether to lay-off or stand-down staff, decide on whether to cut down staff benefits while planning how to carry on these tasks within a short time (Newman et al., 2021). Voluntary furloughs were offered to employees in specific industries due to low demand to the product or service (Nyfoudi et al., 2024). Due to supply chain disruptions, production employees in low-wage countries were reported to suffer from loss of work, poor health, safety, housing and transport facilities (Carmine et al., 2021). Amidst supply

disruptions, countries tend to buy from local suppliers, signalling signs of deglobalization (Carmine et al., 2021; Marwah & Ramanayake, 2021). Despite these disruptions, some entrepreneurs and businesses thrived as demand for particular products including protective equipment and HC products was boomed, while many other firms enjoyed diversification of their businesses through digital platforms (Verbeke, 2020). Automobile plants manufactured ventilators, clothing manufacturers turned to produce surgical garments while beverage companies engaged in hand sanitizer production (Deloitte, 2021). Scandinavian Airlines launched a program to retrain their laid-off cabin crew who already had a medical training and emergency response experience, and then sent those crew members to hospitals to support HCWs (Deloitte, 2021).

Government-imposed mandatory lockdowns, social distancing policies, suspension of selected work activities, isolation periods, and procedures coupled with loss of income and anxiety of virus transmission had negative implications for both mental and physical wellbeing of workers and the community. Mandatory domesticity stimulated working from practices where employees faced unexpected barriers with caring for dependents while working from home (Wanninayake et al., 2024). Research shows that this pandemic lead to anxiety, distress, depression, sleep disturbance and even suicidality among the general public (Sher, 2020), while workers experienced job insecurity, extended periods of isolation and uncertainty of the future that have had impacts on their psychological wellbeing (Giorgi et al., 2020). Scholars refer to this pandemic as a massive global unemployment crisis, given the increasing number of job losses induced by the pandemic (Blustein et al., 2020). Employee layoffs and resulting downsizing can have negative influence over both employees and the organization. These include stress and anxiety among both victims and survivors of job loss, reduction in institutional knowledge, destruction of core elements of the organization, and shattered bonds between the organization and employees (Aycan & Kabasakal 2006).

Einwiller et al. (2021) assert the importance of cognitive and emotional support of management towards employees during crisis contexts. This pandemic is a human crisis (Caligiuri et al., 2020). Thus, HR managers play a central role as key supporting actors (Tursunbayeva et al., 2022). This pandemic highlighted the role of Chief HR officers, similar to the situation where the 2007-2009 financial crisis highlighted the role of Chief Financial officers (Economist, 2020). The pandemic was challenging to HR managers, as they were required to adjust their employees to altered working conditions and / or enacting new workplace policies and procedures that were designed to ensure limited human contact (Carnevale & Hatak, 2020).

The pandemic has led HRM transforms in different areas like working models (remote or flexible working), employee recruitment, training and motivation (Kilic-Kirilmaz, 2021). HRM response to COVID-19 can be seen primarily in areas like jobs and work continuity, physical health and wellbeing, mental health and well-being, resilience, family support and dealing with uncertainty, remote work and flexible work (Tursunbayeva et al., 2022). As Deloitte (2021) reports, employee wellbeing has remained a major concern among employers, while one of the priorities were to keep employees physically and mentally healthy and safe, as for instance, at Delta Air Lines, workers who were recognized as at high risk for the virus, were provided leave with pay and medical benefits. Zacher and Rudolph (2021) claimed that crisis and risk management along with resilience as key predictors of HCW health and well-being amidst the recent pandemic. A discussion on employee wellbeing in relation to HRM is presented in section 3.2.5.2.

Due to social distancing measures imposed by governments and authorities, people were encouraged to work from home (Desilver, 2020). Wang et al. (2021), assert that, remote working became the new normal at a greater pace, although most of the organizations and employees were not prepared to support such practice and had limited prior experience of working remotely. However, some jobs are difficult or impractical to perform outside the standard worksite (Pinsonneault & Boisvert, 2001; Wang et al., 2021). Remote working is seen as appropriate for only certain types of jobs: jobs with very routine tasks, with well-defined objectives and require little need for access to equipment, materials, and services that are available only at the central office (Pinsonneault & Boisvert, 2001). In 2020, a survey estimated that only 37% of jobs in the USA can be performed entirely from home and revealed that this amount is relatively lower in developing and emerging market countries (Dingel & Neiman, 2020). Organizations where remote working was practiced, managers have had to plan for ways to support employees in their performance, engagement, creativity, and wellbeing related matters, while supporting employees to manage their impeding personal factors and carer responsibilities (Newman et al., 2021). An increase in the demand for free-lancers and temporary workers in the coming years was predicted, compared to the pre-pandemic period and organizations with traditional employment forms will be affected harder, given the challenges around work, workforce, and workplace (Minbaeva, 2021). Thus, examining the disruptions of this pandemic would be helpful in figuring out the shape of future of work where work, time, task, and place will not combine together (Minbaeva, 2021).

2.2.4.2. Implications for HC Sector

Organizations in some industries that treated as non-essential, were forced to shut down or limit their business transactions as a prevention measure during the pandemic (Carnevale & Hatak, 2020). On the other hand, essential services including hospitals were struggling to function with limited resources both physical and human. Hospitals as part of essential services, play a major role in times of natural or man- made disasters and emergencies, while HCWs were vital at the frontline in the pandemic battle (Erdem & Lucey, 2021). The HC sector which is highly labour-intensive (Schopman et al., 2017), was one of the most affected sectors worldwide, by the COVID-19 pandemic (Tursunbayeva et al., 2022). Melman et al. (2021) assert that the COVID-19 pandemic has transformed the global HC systems.

With the rapid spread of the virus and the dramatic intensification of number of suspected and confirmed cases, HC systems reported an acute shortage of physical and HRs in providing patient care (Abdulah et al., 2021; Melman et al., 2021). As the crisis unfold, HC organizations, even the stable and robust ones reported to become overwhelmed. The threat of exposure to the virus limited the capacity of hospitals in providing optimum patient care. Surge in cases created further issues linked to pressures on capacity, overwhelmed systems and disruptions to essential health services (Kwon & Kim, 2022). Every infected HCW has been seen as a further gap in the COVID-19 battle (ILO, 2020a). Thousands and hundreds of HCWs, were infected and lost their lives during the pandemic (Erdem & Lucey, 2021). Resulting inadequate health system capacity and adverse health effects including risk of infection, added additional physical and psychological pressures on HCWs (Abdulah et al., 2021; Chen et al., 2020; Fernandez et al., 2020), who confront with inherently emotionally demanding work conditions (Demerouti et al., 2000; Kim & Wang, 2018).

Psychological issues associated with health emergencies, might include anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disorders and those issues found to be more likely to have impact on HCWs (Giorgi et al., 2020). The sources of mental burden may include overwhelming workload, depletion of personal protection equipment (PPE), feeling of being inadequately supported and feeling of vulnerability and concerns about health of self, family and others (Vindegaard & Benros, 2020). HCWs engaged in the diagnosis, treatment, and care of patients, were exposed to a higher risk than the average of infection to the virus. Hazards that put the HCWs at risk included, but were not limited to pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma and physical and

psychological violence (WHO, 2020). Further, they encountered moral dilemmas and different unfamiliar practice environment.

These mental issues, can have a significant impact on the frontline HCWs (Giorgi et al., 2020). However, as relatively a less emphasis has been given by researchers in examining experiences of HCWs outside critical care during this pandemic context (Halcomb et al., 2020), there exists a research gap in understanding experiences and examining impact of the pandemic on non-critical care HCWs. Such millions of HCWs who provided essential supportive services, mostly engaged in low-prestige and low-wage jobs remain under researched particularly in this pandemic context (Sharma et al., 2022). As mentioned earlier, frontline HCWs were relatively at higher risk than the average. However, given the magnitude of this pandemic, HCWs engaged in supportive services might have also been significantly affected by the COVID-19. For instance, Sharma et al. (2022) reported physical and social dilemmas experienced by hospital janitors in India.

As Koh et al. (2005) asset, it is a major responsibility of HC institutions to ensure safety of HCWs and provide them with assistance to manage the stress and fear during an epidemic. During this turbulent time of the pandemic, HC authorities and hospitals would have taken measures in maintaining high quality care for patients while ensuring safety and health of the workforce. Hospital HR managers reported to have encountered many challenges dealing with the shortage of HRs, employee burnout, the need to acquire new knowledge and skills, employees' health and safety and the reward system within this pandemic context (Asadi et al., 2022). At the beginning of the COVID-19 pandemic, the WHO set up operational guidance for health services that countries need to consider to 1) reorganize and maintain access to high quality essential health services and 2) specific measures to protect occupational safety and health of HCWs (WHO, 2020). For instance, as Chen et al. (2020) have outlined different measures undertaken by a leading hospital in China responding to the COVID-19 outbreak, included setting a 24 hour fever clinic, multiple patient screening wards, recruitment of volunteer medical staff and psychological intervention for responding psychological pressures on staff. In accordance with this psychological intervention, staff have been provided with a place for rest where they could isolate temporarily from their families, food and daily living goods, leisure activities and regular support from psychological counsellors. These measures can be seen as means to accomplish the above mentioned two considerations, as advocated by the WHO.

Scholars assert that there appears to be a dearth of research of HRM in HC organizations within the context of COVID-19 (Tursunbayeva et al., 2022). Thus, possible areas of research would

be the challenges of HRM in times of crisis, how have HC organizations overcome those challenges, which HRM strategies, processes and practices in these organizations have been affected by COVID-19 and how have tools and methodologies for different HRM evolved during COVID-19 (Tursunbayeva et al., 2022).

2.2.4.3. COVID-19 Pandemic- Sri Lankan Experience

Sri Lanka has been able to successfully combat the COVID-19 pandemic in its early stages (Amaratunga et al., 2020; Hettiarachchi et al., 2021; Jayasena & Chinthaka, 2020; Widanapathirana et al., 2020) leading its regional counterparts (TRTWORLD, 2020) and some other most developing countries (CMA, 2020). Stringent measures were taken by the government to contain the pandemic (WB, 2021b) while the country's public HC system has been identified as a major contributor in controlling the disease spread (Arambepola et al., 2021; CMA, 2020). However, the country later encountered a health crisis due to subsequent waves of the virus spread (Fowsar et al., 2021).

The first COVID-19 case in Sri Lanka was reported on 27th January 2020, which was a Chinese tourist (Epidemiology Unit, 2022), while the first local patient was reported on 11th March 2020 (Ediriweera et al., 2020; Wickramasinghe & Fernando, 2022). There appears a slow increase of daily number of cases, since then few spikes reported later due to clusters from a Navy base, quarantine centres and a rehabilitation centre, while the daily case numbers were ranged between 0–30 until October 2020 (Wickramasinghe & Fernando, 2022). Huge surges in confirmed cases and associated deaths have been reported in late 2020 until end of 2022. The total number of cases counted for 672,031 and 16,830 deaths have been reported as of 1st March 2023 (Epidemiology Unit, 2023; JHCRC, 2023).

In containing the pandemic, the Sri Lankan government has adopted a strong national level risk governance framework where actions were designed and delegated well in advance, before the outbreak started to spread in the South Asian region (Amaratunga et al., 2020). The island's authorities started to take actions to contain the potential disaster, just at the time of the novel coronavirus in Wuhan was announced (CMA, 2020). According to the Epidemiology Unit of the Ministry of Health, Sri Lanka, case surges have been tracked across three waves as follows. 1st wave from January to early-October 2020 with 3,396 cases and 13 deaths, 2nd wave from October 2020 to April 2021 with 92, 341 cases and 591 deaths while the 3rd wave from mid-April 2021 to November 2022 with 575,945 cases and 16,199 deaths (EUMOH, 2022). The

second wave hit the country harder than the first, where the numbers increased 10–20 times higher (Wickramasinghe & Fernando, 2022). The death rate of Sri Lanka is considerably lower than the global rate, as per the Sri Lanka Health Promotion Bureau.

The service of military forces and the national intelligence service were utilized mainly to control the spread of virus among public, while specialized aviation and border control expert teams were also established (Wickramasinghe & Fernando, 2022). Same as most other countries, measures were enacted to limit public gathering including a strong lockdown type curfew. Such stringent measures have been imposed by the government to contain the pandemic (WB, 2021b). Sri Lanka was one of the first countries that launched rescue missions to evacuate their citizens in Wuhan, and the 33 Sri Lankan families evacuated and were quarantined in a unique quarantine military facility (CMA, 2020). In 2020, Sri Lanka was ranked as the 10th on the Global Response to Infectious Diseases (GRID) index, by the Institute of Certified Management Accountants, Australia (Amaratunga et al., 2020; CMA, 2020). This index has been developed based on a research study that examined the response and leadership in countries within the early stages of the pandemic. Sri Lanka has been ranked on this place, alongside countries including Hong Kong, UAE, Japan and Taiwan. As per the rankings, Sri Lanka lead the South Asian countries where India was placed on the 38th and that of Bangladesh was 80. As acknowledged by the CMA (2020), having a free public health system and the free education system has been the major enabler of the Sri Lankan effective pandemic response.
Similar to other countries, Sri Lankan HC system played a major role in COVID-19 pandemic response (Widanapathirana et al., 2020). It was expected that the vigilant and widespread HC system in the country was ready to take up the challenge of the pandemic (Wickramasinghe & Fernando, 2022). Health and medical services were managed by the Ministry of Health where circulars and guidelines for hospitals have been issued time to time, to instruct the hospitals' response to the pandemic, such as, Hospital preparedness guidelines, Guidance for treating patients with COVID-19, Rational use of PPEs, Guidelines for intermediate care centers (ICC), to name a few (EUMOHSL, 2023). A three-tier approach was initiated to address the hospital emergency preparedness and response plan of all the public hospitals, including 1) declaration of designated COVID-19 treatment facilities, 2) declaration of isolation hospitals and 3) identification of centres with intensive care unit (ICU)/ high dependency unit (HDU) facilities (S. L. MHIMS, 2020b). The hospital preparedness guidelines included various measures to be undertaken by hospitals that covers operational setups and staff related elements. Some of the measures include establishment of "COVID-19 Operational Cell" for facilitating collective

decision making at the hospital level, establishment of designated interim section/ ward for COVID-19 suspected patients, safe transferring of patients to COVID-19 designated/isolation hospital and ensuring safety of HC personnel. Adding to this, some essential steps needed to be taken to ensure safety and wellbeing of the staff including provision of PPE and transport facilities, continuous education programs, psychological support and ensuring adequate number of staff by recruiting additional personnel within the hospital.

In the MOH units, various programs have been implemented to contain the pandemic at the grass root level including public awareness and education. Additionally MOH officers including public health inspectors (PHIs) were assigned in surveillance measures, contact tracing, overseeing quarantine and public health measures, laboratory testing, case management and maintaining routine public health services (Adikari et al., 2020). COVID-19 treatment facilities across the country have been strengthened and a vaccination program was deployed throughout the country (WB, 2021b).

There appears to be a productive pandemic response in the country. However, the facilities to treat COVID-19 patients appears to be limited (Wickramaarachchi et al., 2020). Shortages in hospital resources including hospital beds and medical equipment were reported during the time that the country hit by COVID-19 case surges caused by new variants (Jayawardena, 2021; Munasinghe et al., 2022). The ICC to treat the COVID-19 positive patients were established to optimize the hospital capacity (MHIMS, 2020). The health services have been expanded across the private sector and the indigenous medical sector. Private hospitals were given authority to establish ICC and to conduct PCR (Polymerase Chain Reaction) testings. Indigenous medicine and the related traditional precautionary practices seemed to be in use against the spread of COVID-19 virus. Use of indigenous medicine for boosting the immunity, has been promoted by the Ministry of Indigenous Medicine, for the infected and those who are at risk of infection (TM, 2020) while a project has been initiated in September 2021, to distribute caskets of indigenous medicine to every household (NEWSLK, 2021). The Ayurveda hospitals have been converted into COVID-19 treatment facilities in May 2021 (CP, 2021).

Adding to the above, there have been various measures imposed by the government to contain the virus spread and to ensure the safety of the people at work environments. As per the circular no 2020/01 (MPA, 2020) government officers have been instructed to maintain high safety standards. Further, calling of pregnant and breast-feeding women to work has been instructed to avoid as possible. Usually, government workers are required to wear the designated uniforms

if any or be in the suitable attire at work (e.g. saree or *Kandian saree* for staff grade females and shirt and tie for staff grade males). Within the pandemic context, this requirement has been exempted as the attire and accessories may serve as a medium of virus transfer.

As seen by Wickramasinghe and Fernando (2022), there have been major contributions from various factors including the country's HC structure, strategic use of forces and other government entities, media support, traditional social practices (indigenous medicine practices and precautions), the public responsiveness, and the geographic location of the country (located closer to the equator) towards the control of the pandemic and management of the disease in Sri Lanka. As Wickramasinghe and Fernando (2022) explored, people in Sri Lanka exhibited various social beliefs and practices in mitigating the spread of the disease. Traditionally, Sri Lankans practice 14 days of isolation during a CD spread. Thus, the quarantine was not a new concept for Sri Lankans, despite the fear over the severity of the virus. It is generally accepted among Sri Lankan society that, herbs, and spices such as coriander, ginger and garlic can be used for boosting immunity. Further, the rituals carried out in religious places including the Buddhist temples enhanced the spiritual wellbeing of the people during these distressed, turbulent times.

2.2.5. Economic Crisis in Sri Lanka

Sri Lanka has been facing this debilitating economic crisis since 2019, which is seen as the worst economic crisis since its independence in 1948. The surge in COVID-19 cases and mobility restrictions slowed down the recovery of the country's economy, which was already been hit by various disaster shocks caused by natural hazards, a political crisis, and terror attacks (ADB, 2022). Studies reveal that the country's main income sources were severely hit by the pandemic (Marwah & Ramanayake, 2021) Swift measures enacted by the government to contain the pandemic, had adverse impacts on tourism, construction, and transport sectors. Collapsing global demand impacted the textile industry, while job losses and drops in earnings disrupted private consumption (WB, 2021a).

Specifically, at the time the COVID-19 pandemic hit, Sri Lanka was struggling to recover from the forfeiture caused by the Easter Sunday blasting occurred in April 2019 (Wickramasinghe & Fernando, 2022). Sri Lankan tourism sector has been hit harder by the COVID-19 pandemic and the Russia-Ukraine war, throwing the country into an economic downfall (Lancet, 2022b). The tourism industry which contributes more than 10% to the country's GDP has been disabled

in generating earnings as usual, since the 2019 bomb blast. This situation has been exacerbated by the impacts of the pandemic.

There appears to be several other interconnected factors that caused this economic crisis (AGDFAT, 2021; Madurapperuma, 2022). Sri Lanka's external performance was threatened by drops in its export earnings, remittances, and income from tourism. In return, Sri Lankan Rupee was depreciated rapidly against world major currencies (Deyshappriya, 2020). Further to the income loss, the government initiation of organic farming policy dramatically caused to a decline in crops (Madurapperuma, 2022). Import restrictions were imposed by the government in a way to reduce the use of foreign reserves. In return, this has caused price increases in basic food items (AGDFAT, 2021). Tax cuts lead to increased borrowings that has caused to raise the country's debt, for which to be paid the government has utilized its foreign exchange reserves (Madurapperuma, 2022).

Sri Lanka's weak political and fiscal mismanagement has been identified as a major cause to the economic crisis (Pathiraja & Tombesi, 2023; WB, 2021a). As reported, many experts blame politically driven economics policies has led to this crisis, although the government has pointed out that the pandemic and the Easter Sunday attack have impacted the loss of foreign currency income through the drops in tourism industry (BBC, 2023). The country was ranked as the 101st most corrupted country among the 180 countries evaluated by the Transparency International, in 2022 (TI, 2022). This ranking is a widely used global corruption ranking in the world and it incorporates experts' and business- peoples' perceptions to measure how each country's public sector is corrupted. The high corruption rankings of the country appear to be persisted across the years.

There have been frequent power cuts and restrictions over selling fuel to non-essential services (BBC, 2023). The high inflation levels, shortage of medical supplies, skyrocketing price hikes and shortages in essential commodities has caused public unrest and severe decline in living standards. The inflation rate has dramatically risen from 14.2% to 69.2% through January to September in 2022 (CBSL, 2023). Due to fuel shortages public transport including medical vehicles have been disrupted where schools were closed and people have been asked to work from home in a way of conserving supplies (BBC, 2023). Specially, the administrators of state-owned institutions have been instructed via circulars to restrict the calling of officers to work and on initiating strategies at workplaces for saving electricity and fuel to manage government expenses (Circular no: 10/2022 MPA, 2022g). Given the fuel shortages and transport issues, public officers were allowed to stay home on Fridays and instructed to engage in farming or home gardening activities in a way of preparing for the potential food shortage (Circular no:

15/2022 MPA, 2022d). This was further stretched by restricting government officers coming to work for two weeks in June 2022 and the authorities were instructed to manage the work via working from home interventions and adjustments in work shifts (Circular No: 16/2022 MPA, 2022f). Authorities have been instructed to use a newly introduced computerized system for processing staff leave requests and other program approvals across government officials, instead of paper based approvals in a way of minimizing printing and paper costs (Circular no: 14/ 2022 MPA, 2022c).

Government reduced the retirement age of public sector employees to 60 (Circular no: 19/2022 MPA, 2022e) with immediate effect among many other measures to reduce state sector capital expenditure. Prior to this, the retirement age has been increased to 65 (Circular no: 02/2022 MPA, 2022a) by the previous finance minister to reduce the expenditure on pensions payments. Opposite to cuts in taxes prior to the crisis, the government initiated tax changes as a way of expanding government revenue (BBC, 2023; ECONOMYNEXT, 2022; SLIR, 2023). The Inland Revenue (Amendment) Act No 45 of 2022 was imposed from December 2022. There has been a hike in personal income tax rates for up to 36% and at the same time corporate income tax rates have been increased from 14% (concessionary) to 30% including the HC services (KPMG, 2022). The relief from taxable personal income has been reduced from 3 million LKR to 1.2 million LKR with effect from 01.01.2023 (SLIR, 2023) Changes in income tax rates has resulted in public servants unrest (Jayasinghe, 2023).

2.2.5.1. Implications for HC Sector

An economic crisis can have significant effects on the HC system of a country. Taking into account economic recessions happened in Zimbabwe, Venezuela and the countries of the former Soviet Union, Claborn (2020) examined the severe impacts on the public health system of these countries. These include health infrastructures collapses, HCW turnover and emigrations and re-emerging of CD. In Sri Lanka, due to insufficient funds to finance disease surveillance and management programs, there is a risk of re-emergence epidemics such as dengue that can overwhelm the HC system (Lancet, 2022b). Overcrowding on public services including the transport systems (due to fuel shortages) and hospitals may weaken the ID containment including the COVID-19 (Bandara & Alwis, 2022).

Due to high inflation, public would have to compromise their expenditure on food over other necessary consumables including medicine. As such, in Sri Lanka it has been reported that many do not have sufficient money to afford three meals a day. This may increase malnutrition

levels among public and indirectly pose a burden to the HC system. In this crisis scenario chronic illness patients have reported with significant reductions in their medication intake according to a recent study (Jayawardena et al., 2023).

Sri Lankan HC sector has been experiencing various challenges due to the shortages of drugs and medical devices, which have then lead to disruptions in routine surgeries and clinical practices (Bandara & Alwis, 2022; Matthias & Jayasinghe, 2022). In 2022, the United Nations News reported that the HC system in Sri Lanka was about to collapse due to the limited power supply and shortages in medicine and equipment, where patients have been asked to supply hospitals with medical equipment to be used for the treatments (UN, 2022). An editorial published in the Lancet (2022b) claimed that fuel shortages have caused problems in emergency transport of patients and HCWs as well as the supply of medical equipment. Given the unaffordability of daily transport to work, nurses have started to continue work for extra shifts. Prices of medication has increased by 40% by April 2022. The medication costs have become unaffordable to the public. The authors assert that the rising costs of medication would increase the number of patients coming to public hospitals rather going for treatments at private hospitals, posing an additional burden to public hospitals (Lancet, 2022b). On the other hand, private hospitals may struggle with income losses due to limited number of patients seeking medical services at a cost within such an economically hard context.

Sri Lankan HC professionals have been active in protests (Matthias & Jayasinghe, 2022), to inform and force the authorities to bring about viable solutions to the issues in their hospitals, ahead of the economic crisis. Doctors have claimed they had difficulties in treating patients with the power cuts and had to use torch light and lanterns to provide treatments, in rural areas where patients with snakebites regularly may seek treatment even at night (Zaheena & Rathindra, 2022). Hospitals staff in a teaching hospital have been instructed to limit surgeries due to shortage of a drug used for anaesthetising, while some hospitals have suspended routine surgeries. In many hospitals Caesarean surgeries have been delayed due to the shortage of anaesthetic drugs, while some types of tests have being suspended as the reagents are out of stocks (Wijerathna, 2023). Doctors claim that most surgeries that should be done before certain diseases become incurable have being delayed while there was a probability of suspending kidney transplants, and non-emergency surgeries (Wijerathna, 2023). With the shortage of foreign currency, most medication including the essential ones have reached out of stock levels, as the country used to import most of the medicines it consumes (Lancet, 2022b). According to a panel of health experts of the Sri Lanka Medical Association (SLMA), about 160 essential medicines out of about 300, were out of stocks, at the national medical supply division (the

central medicine storage) of the country in April 2023 (Hettiarachchi, 2023). The National hospital had limited their laboratory investigations (Zaheena & Rathindra, 2022). HC staff have been told to reuse medical supplies like endotracheal tubes where possible, by cleaning and sterilising instead of discarding the tubes (Zaheena & Rathindra, 2022). Lifesaving medical supplies and drugs were in severe shortage and the SLMA has estimated that this may result in a catastrophic number of deaths, which is likely to be in excess of the combined death toll of the past disasters of COVID, Tsunami and the civil war (Zaheena & Rathindra, 2022). At the time of this writing there have been a health crisis across the country due to the supply of substandard medicines to hospitals resulting protests carried out by HCWs (Crisis24, 2023).

The World Food Program estimates that 3 out of every 10 households experience food insecurity, while this can cause to malnutrition and hypertension (Bandara & Alwis, 2022; Lancet, 2022b). Surviving within such a context can be more stressful and may result in mental health issues, depression, and suicidality (Bandara & Alwis, 2022; Lancet, 2022a, 2022b).

As reported by BBC in July 2022, general workplaces in Sri Lanka have seemed vastly affected by the crises due to staff shortages given disrupted commuting with fuel shortages resulting failures in staff show up. Supply chain disruptions and sales declines as customers refusing to spend on non-essentials reported to provide with further challenges (BBC, 2022).

HCWs as victims of these crises (Wijesinghe et al., 2023) have been reported with burnout and affected by additional burdens given the issues in their working environment (Bandara & Alwis, 2022). As revealed earlier in section 2.3, even before the pandemic, Sri Lankan nurses have been working with intensified pressures in their work environments (Wanninayake et al., 2022). Research shows that HCW burnout and stress is common issue in Sri Lankan HC sector (Desapriya, 2022), while scholars have examined that this situation has been exacerbated and continued to worsen aftermath of the pandemic (Desapriya et al., 2023; Wijesinghe et al., 2023).

The reforms in public administration systems including changes to retirement age (MPA, 2022e) and schemes for leave the country on no-pay leave (MPA, 2022b) has caused shortages in manpower in the HC sector (Wijerathna, 2023). Specifically, the government with its short-term expectation to increase the foreign currency income, facilitates public sector migration allowing leave for five years. This scheme seemingly weakening the public sector including the hospitals.

Many HCWs have migrated to foreign countries (Bandara & Alwis, 2022). About 500 doctors from the public sector have migrated within the first eight months of 2022 as per the Sri Lanka's

Foreign Employment Bureau, while 10 out of 40 nephrologists have left the country by October 2022 (Rasoldeen, 2022). Due to health professionals increasingly leaving the country, many hospitals have experienced inability to continue routine services and some services have been closed such as specialist wards (e.g. a hospital's pediatric ward closed down as all pediatricians attached to the ward have migrated ADADERANA, 2023). Overall, a huge increase in departures for foreign employment has been reported in 2021 which counted to 121,795, from 53, 711 in 2020, despite an increase in national labour force from 8.467 million in 2020 to 8.553 million in 2021 (CBSL, 2021). This situation might have created severe challenges to HR managers in the HC sector and the other organizations in general, as they lose their workforce, within such a devastating economic crisis context.

2.2.5.2. Implications for HRM

Economic fluctuations occurred during the collapse in Soviet Union in 1991, Asian financial crisis in 1997 and the global financial crisis in 2008 have compelled workforce downsizing and HRM functions restoring in many firms (Bae et al., 2003; Carvalho & Areal, 2016; Kim et al., 2022). In many developed economies, work related pressure has been intensified due to productivity freezes aftermath of the 2008 financial crisis while employee wellbeing has been affected by resulting job insecurity (Guest, 2017). Scholars assert that catastrophic economic changes such as a financial crisis may compel organizations to abandon pre-established routines and HR practices (Bae et al., 2003; Carvalho & Areal, 2016; Kim et al., 2022), reconsider HR policies and practices (Ererdi et al., 2022), dramatically develop HRM practices (Druker et al., 1996) and reorganize the HR function (Gunnigle et al., 2013). Such responses may include job redesign (Markovits et al., 2014) and strategic adjustments such as redundancies (Naudé et al., 2012), resulting in changes to working conditions, employee duties and what employees expect form their employers (Markovits et al., 2014), make working conditions harder (Psychogios et al., 2014) and create hostile workplaces (Psychogios et al., 2019) A survey found that HR managers perceive that the impact of economic crisis on their businesses are greater than that of other types of crises (Thumiki et al., 2019).

Firms would experience a labour surplus resulting from declined product demand as a consequence of a financial crisis, while the weak financial conditions may create pressures to cut down costs including the cost of labour (Zagelmeyer & Gollan, 2012). As a result, HRM would need to initiate adjustment policies. A study in Oman, found that changes in HRM practices amidst an economic crisis included suspension of employee benefits and reductions

in employee recreation expenses while introducing more non-monetary employee motivation tools (Thumiki et al., 2019). Gunnigle et al. (2013) claimed of four standard economic propositions on the impact of an economic crises on HR practices in terms of staffing, pay and benefits, industrial relations, and role of the HR function. 1) Staffing levels may be adjusted to the decreased demand. As such there would be a decline in recruitment and selection, while firms adopt more cheaply staffing patterns like shortened work times, casual and temporary labour, lay-offs and unpaid leave. 2) As firms seek possible labour cost reductions, there would be drops in pay and benefits. 3) In terms of industrial relations, firms may exploit the bargaining power of trade unions which can be weaker in such an economically difficult scenario. Thus, the managers would make changes to work practices and working conditions through concession bargaining or unilateral management decisions. 4) The strategic importance of HR practices may diminish as the management may prioritize financial and operational concerns given the economic crisis context.

Although the demand of a business firm may diminish during an economic crisis, the demand of a not-for-profit (NFP) organization (such as a government hospital, a community service) may substantially increase as more clients seek and demand support services. For an example, patients may seek free or low-cost health services during an economic crisis rather looking for such services at a cost, as earlier discussed. This resulted in patient surges at public and NFP medical facilities. On the other hand, NFPs may face budget constraints from limited funding and higher expenditures. For instance during the 2008 economic crisis, NFPs in the USA had encountered increased demand and diminishing resources, specifically as the funding through charitable giving was dramatically declined (Raffo et al., 2016). To respond the high demand for services, NFPs have considered diversifying their revenue sources to finance human capacity expansions, engaged heavily with volunteers, and shifted roles towards fundraising while practicing staff reductions, recruitments postponing, cuts in pay and salary freezes.

As observed by Ererdi et al. (2022), the hard HRM practices associated with tackling the effects of economic collapses include pay cuts, pay freezes, reductions in the workforce, recruitment halts, reductions in training budgets, re-negotiations of contractual agreements, decrease in individual performance goals and plans and voluntary departure plans, while the soft HRM practices may include flattening hierarchy levels and informal coordination, knowledge sharing and information sharing schemes (specific to the effect of and response plans to the crisis), training on new skillsets and highly individualized results-based motivation. It is expected that organizations that operate with relational exchange norms would tend to use

cost-cutting strategies in other areas, rather than applying HRM related cost-cutting policies in times of financial crisis (Aycan & Kabasakal, 2006).

Above discussions elaborated on the two recent crises in the Sri Lankan context. The implications of the COVID-19 pandemic and economic crisis in general for both the HC sector and for HRM were discussed. Both natural and economic collapses can have significant impact on organizations particularly to the workforce and HRM, where preparedness can lessen the severity of such challenges. Following section is a discussion about the concepts of *hospital preparedness and surge capacity*.

2.3. Hospital Preparedness and Surge Capacity

Hospitals confront various environmental challenges that demand reforms in structural change, cost controlling, the introduction of market mechanisms and consumer choice. (Veld et al., 2010a). Health systems' performance and ability to respond appropriately to the challenges they face is highly affected by the availability of skilled, adequate and properly located HCWs whose working in an environment that is motivating and engaging (WHO, 2023). As such, a motivated, skilled, and deployed workforce is an essential component in achieving HC delivery success (Buchan, 2004a; Veld et al., 2010a). However, HRM delivery in hospitals is a complex process worldwide (Townsend & Wilkinson, 2010), and this can be more challenging during a crisis situation. As previously acknowledged, the COVID-19 pandemic brought about unprecedented challenges to the HC sectors across the globe (Tursunbayeva et al., 2022), and the hospitals were arguably unprepared for a crisis of this magnitude.

As elaborated by Watson et al. (2013), the term "surge" implies unanticipated escalations in health system demand caused by exceptional events (such as natural hazard–induced disasters and pandemics), while surge capacity stands for the ability to respond to a sudden boost in the demands of patient care. As Hasan et al. (2022) elaborate, when the clinical needs and/or patient volumes exceed a hospital's service limits a medical surge occurs. During a mass casualty, the emergency departments (EDs) become the epicentre of hospital HC delivery. Hospitals may compromise the quality and safety of patient care during mass casualty events if they are not well prepared to expand their surge capacity. Massive inflow of patients, over crowdedness, and intensified admissions would disrupt the care flow if the hospitals have not pre planned the ways to expand their surge capacity. In disasters and in sudden and dramatic patient surge conditions, the ability to increase a hospital's capability has been seen as a major issue and thus addressed thoroughly in hospital preparedness (Dowlati et al., 2021). Barbisch and Koenig

(2006) urged the requirement of having a systems approach that integrate hospitals capability to prepare and respond. In their words, " It is not simply beds or ventilators, but appropriately trained personnel (staff), comprehensive supplies and equipment (stuff), facilities (structure), and, of imperative importance, integrated policies and procedures (systems) to develop optimized sustainable surge capacity" (Barbisch & Koenig, 2006, p. 1099). Sustainable funding mechanisms in health systems has been identified as critical in ensuring hospital preparedness to successfully face emergencies and crises like COVID-19 (Kwon & Kim, 2022; Munasinghe et al., 2023).

WHO's Hospital Emergency Response Checklist (WHO, 2011) is a tool that can be useful in designing interventions to enhance hospital surge capacity as a component of international good practice. This checklist follows the academic literature's emphasis on the "four S's" of surge capacity: *staff, stuff, structure, and systems* (Watson et al., 2013). In a similar vein, Munasinghe et al. (2021) describe that the global literature classifies hospital preparedness and response in terms of this "four S's concept. In contrast some authors refer to only three components namely staff, stuff and structure, where structure consists of both management infrastructure (systems) and physical space (Dowlati et al., 2021). Gupta et al. (2021) claim that the capacity strain of health systems during disease outbreaks can be considered in terms of preparedness for hospital space, personnel, physical equipment, and governance (planning and coordination).

WHO guidelines for hospital emergency response in general (e.g.WHO, 2011) and specifically in crisis preparedness for influenza pandemics (e.g.WHO, 2006) thoroughly emphasize the HR component in different areas including staffing (deploying additional staff such as staff from other hospitals, retired medical staff, medical students, military medical officers and volunteers), training in patient handling and triage (the process of categorizing and prioritizing patients so that the best care can be provided to as many patients as possible with the available resources), decontamination and infection control, safety (provide personal protective equipment, medicine and vaccines) and psychological wellbeing and support systems (employee support programs, counselling, support for families, child care etc.). Adequate training for HCWs in infectious diseases has been considered as a key element in preparedness and prevention of COVID-19, by WHO (Żółtowska et al., 2021). Therrien et al. (2017) claim that high rates of staff absenteeism has been identified as a greater challenge on system capacity in times of crisis. Rosenbäck et al. (2022) examined in a study that hospitals have utilized staff from internally (other wards) and externally (volunteers) in managing surge in COVID-19

patients in specialist units. Further, expanding working hours and extending shifts have been associated with surge capacity through expanded staffing.

Referring to health system requirements and responses during the COVID-19 pandemic and other global respiratory disease outbreaks, Gupta et al. (2021) argue that limited attention has been given to explicitly address HR requirements in response plans. They recommended actions to policy makers to develop protocols for reallocating resources and shifting tasks, training for in-service workers and engagement of a standby volunteer pool. Kuhlmann et al. (2021) highlight a lack of evidence on HC workforce planning during infectious diseases outbreaks. Elaborating further on protection and preparedness of HRs, they identify knowledge gaps in areas like psychological factors, burnout, gender considerations and specially information on low and middle-income countries. As Wanninayake et al. (2022) examined, nurses in Sri Lanka were experiencing intensified work pressures because of staff shortages, overcrowded hospital wards, long working hours, limited career development opportunities, lack of medical supplies and low pay even before the COVID-19 pandemic.

In general, scholars argue that it is essential to involve HR managers in preparing emergency plans (Ererdi et al., 2022; Goodman & Mann, 2008). This will ensure that HRM aspects are carefully addressed beforehand a crisis. However, researchers show that vital employees were not been involved in developing emergency plans (in locales) and those plans had failed to adequately address post disaster HR issues such as compensation, retention, recruitment, and task re-orientation (Goodman & Mann, 2008; Mann, 2014).

The above discussions herald that HCWs are a vital component of hospital surge capacity. As Veld, Paauwe and Boselie (2010) assert, managing HCWs by means of HRM is a key to hospital success. Thus, HRM function will have an important role to play with regards to optimizing system capacity of a hospital in terms of manpower requirements. System capacity is associated with the concept of resilience. The concept of resilience in a hospital setting interprets, a system's ability to adapt to an unexpected surge in demand during a crisis and afterwards and to quickly recover from it (Rosenbäck et al., 2022; Therrien et al., 2017). The concept of resilience is elaborated later in section 3.2.10.

2.4. Summary

The current study aims to explore the hospitals' HRM response to the recent two crises in Sri Lanka. So far in this chapter, the Sri Lankan context, the two crises and the concepts of hospital

preparedness and surge capacity were discussed. The main two theoretical perspectives of this study, HRM and CM are explored and the gaps in the reviewed literature are presented in the next chapter.

Chapter Three: Literature Review - Part Two

3.1. Introduction

The Sri Lanka's HC sector within the COVID-19 pandemic and the economic crisis contexts were examined and the concepts of surge capacity and hospital preparedness were discussed in the previous chapter. This chapter explores literature and theoretical aspects pertaining to both HRM and CM. The literature around the HRM process perspective is reviewed and the dimensions of organizational justice are discussed. Then, the literature around organizational CM is examined. This chapter presents gaps in the reviewed literature pertaining to both Chapters Two and Three.

3.2. Human Resource Management

HRs are an integral part of any organization's success. HR is seen as an expense that is one of an organization's largest and the most complex one to control, but is also seen as major ingredients that affect performance of the organization (Combs et al., 2006). As organizations strive to compete and survive, effective utilization of the available resources is critical, no exception for people within. Both inside and outside academia, different terms are used to refer to people of an organization. These include and but not limited to employees, labor, personnel, and HR. HRM seeks to strategically integrate the interests of organization and employees and it is in a key position to affect customers, business results and shareholder value (Nankervis et al., 2016). HRM involves the productive use of employees to achieve organizations' strategic business objectives and at the same time ensuring the fulfillment of employee individual needs (Nankervis et al. 2016; Stone 2014). Many HRM tasks can be administrative, but involves planning and links to strategy (Mann, 2014). HRM includes major functions such as HR planning, recruiting, and selecting, training and development, performance evaluation, compensation management and managing employee and industrial relations. As Armstrong (2021) sees, all aspects of employing, managing and developing employees in organizations are the many concerns of HRM.

HRM has been emerged as a response to economic and industrial changes, where Scientific Management was highly influential to the emergence of HR function, as admitted by Ulrich and Dulebohn (2015). Scientific Management theorists originated job analysis to management

practice which represented a primary HR administrative activity. Job analysis was seen as the basis for employee selection and training and for evaluating jobs for compensation. Further Scientific Management promoted performance-based pay and the need to assign specialized and trained personnel to manage different functions. Along this way, Scientific Management theorists contributed to formalizing of general management and HR function (Ulrich & Dulebohn, 2015).

The concept of HRM was originated in the 1980s, replacing the term personnel management (PM) (Armstrong, 2021). Guest (1987) in his foundational study distinguished a new, HR approach to what was previously PM. PM integrated HR policies and practices with organization's business strategy, however it placed a similar value on people as on other assets (Stone, 2017). As elaborated by Paauwe (2008), this novel approach of HRM, emphasized its strategic contribution and alignment to business, LM involvement and focusing on HRM outcomes such as commitment, flexibility and quality. The employees were referred to as HR. The concept of HRM valued employees as a resource and considered employee satisfaction and involvement as critical factors for organizational success. Stone (2017) asserts that PM was more consistent with the hard approach of HRM, which placed an emphasis on strategy implementation. The soft HRM approach recognizes the need for the integration of HR policies and practices with the organization's strategic objectives, but places emphasis on employee development, collaboration, participation, trust and informed choice (Stone, 2017).

3.2.1. Approaches to HRM

Scholars acknowledge two broad approaches to HRM as soft and hard (Cregan et al., 2021; Druker et al., 1996; Truss et al., 1997). The soft approach considers employees as the greatest asset (Druker et al., 1996). HRs are the key to organizational success, through their creativity, commitment and skills. HRs add value to the organization and therefore, must be managed carefully. In contrast, the hard approach treats HRs like any other factor of production with the emphasis of minimizing costs of labor and flexible employment while the word "people" is often used as a substitute to the word "employee".

The hard and soft versions of HRM are based on opposing views of human nature and managerial control strategies; tight strategic control vs control through commitment. (Truss et al., 1997). The soft HRM is concerned with human relations movement and associated with goals of flexibility and adaptability. In contrast, hard HRM is associated with a quantitative, calculative and business strategic aspects of managing people. Druker et al. (1996) suggest that

soft approaches of high commitment and high development would be productive in value-added industries, while hard approaches would be appropriate in mass-production industries, where minimizing of labor costs and flexible employment are strategic tools of obtaining competitive advantage.

Another definition of different approaches to HRM presented by Bae and Lawler (2000), considers on high involvement HRM strategy vs a control strategy, which the former refers to emphasizing the significance of employees as a source of organization's competitive advantage. Although Bae and Lawler (2000) describe that high involvement HRM strategy positively relates to organizational performance, some studies conclude that there is a gap in terms of measuring high involvement (soft) HRM practices and subjective organizational performance (Moideenkutty, 2011).

Pfeffer (1994) advocated of two distinct approaches to shaping employee behavior and attitudes at work namely, "control or commitment". The former is referred to as "cost reducers" and the latter as "commitment maximizers". On one hand, the controlling approach aims at reducing direct labor costs and improving efficiency. Employee compliance is ensured with rules and procedures while employee rewards are based on some measurable criteria. On the other hand, the commitment approach shapes desired behavior and attitudes of employees by imitating psychological links between organizational and employee goals. The focus here is to develop committed employees who will use their discretion or choice to perform their tasks that would align with the goals of the organization (Arthur 1994).

3.2.2. HRM Systems

HRM is delivered by the HR system in an organization that is comprised of HR strategy, HR policies and HR practices that fit together and act together to achieve a purpose (Armstrong, 2021). HR strategy defines the direction that HR expects to take in its main activity areas. HR policies embark on what HR is there to do and set out guidelines on applying and implementing specific aspects of HRM while HR practices are the activities carried out to manage and develop people and manage employment relationship (Armstrong, 2021). HRM policy choices may be influenced by different factors and required to fit into various elements as far as the systems approach is concerned.

3.2.2.1. Harvard Model of HRM

The Harvard model, a widely used HRM model, admits that HR practices involve a systems approach that takes into account the stakeholder interests and situational factors when designing and establishing HRM policy choices (Beer et al., 1985; Bondarouk & Brewster, 2016). In a nutshell, the model proposes that both the situational factors and stakeholder interests can affect HRM policy choices that in turn affect HR outcomes, and long-term consequences (Beer et al., 1985; Brunetto et al., 2011). Changes in situational factors can have influences over stakeholder interests. Stakeholders may include the management, employee groups, government, the community and unions. These parties' values, input and perspectives must be considered when designing HRM policies. Accordingly, it is vital that employee interests are considered when making HRM policy choices (Brunetto et al., 2011).

The situational factors in this model refer to both the internal (workforce characteristics, business strategy, management philosophy) and external environment (labor market, unions, technology, laws, regulations, societal values). HRM policy choices determine the approach that management will influence work systems, reward systems, the flow of HR functions and employees. Resulting HR outcomes are represented by the 4Cs: commitment, congruence, competence, and cost-effectiveness. These HR outcomes will then influence the long-term consequences of organizational effectiveness, individual wellbeing, and societal wellbeing.

A collaborative approach is apparent in the model which acknowledges the employees as stakeholders (Gooderham et al., 2008). In a study examining the impact of supervision change on HR outcomes, Brunetto et al. (2011) used the Harvard model to conceptualize the said impact. This study revealed that HRM policy choices need to focus on employees' perceptions of well-being and admitted that ignoring stakeholder interest can have a negative impact on HR outcomes. This logic is consistent with the concepts of Institutional Theory that focuses on the deeper and more resilient aspects of social structures (rules, norms and routines) that are legitimized by the environment and which guide social behavior (DiMaggio & Powell, 1983; Scott, 1987). The specific context of an organization has an effect on shaping of its HR practices (Paauwe, 2004; Veld et al., 2010a).

3.2.2.2. Institutional Theory

Organizations respond to the dynamics in the business environment, as well as to institutional pressures and thereby adapt their formal structures and routines to conform to institutional

norms in order to be perceived as legitimate (Nijssen & Paauwe, 2012). According to Bondarouk and Brewster (2016), for example, the role of government and regulations are identified as important factors that influence HRM policies and practices. With reference to the institutional theory, DiMaggio and Powell (1983) described the isomorphism, which refers to that organizations in a given field or an industry try to become homogeneous over time. Coercive isomorphism, mimetic isomorphism and normative isomorphism are three different mechanisms of institutional isomorphic change, where the first refers to when a particular organization is directly or indirectly pressures to confirm to the demands of parties on which the pressured organization depends. The parties might include the state or funders. When an organization mimics other organizations that are successful or more legitimate in response to technological or environmental uncertainty, mimetic isomorphism occurs. For an example, as DiMaggio and Powell (1983) state, hospitals tend to upgrade the services and patient care in accordance with what the competitors introduce to ensure their competitive stance. Normative isomorphism can be derived from professional norms and standards which guide the work of professional employees which would shape the organizational behavior (DiMaggio & Powell, 1983).

3.2.2.3. Contextually Based Human Resource Theory

Incorporating the perspectives of institutional theory (DiMaggio & Powell, 1983), Harvard model (Beer et al., 1985) and contingency and configurational mode of HRM (Delery & Doty, 1996), Paauwe (2004) presented the Contextually Based Human Resource Theory (CBHRT). Paauwe's theoretical framework (Paauwe, 2004, p. 91) illustrates three domains that have implications on HRM policy and practice decisions, namely the competitive mechanisms, institutional mechanisms and the configuration (organizational). The first two domains refer to environmental dimensions namely to *the product- market combinations and the appropriate technology* (the PMT dimension) and *the socio-political, cultural, and legal context* (the SCL dimension), that can shape the HRM of an organization, subject to the degree of leeway. The PMT dimension represents the tough economic rationality of competition and resembles the concept of competitive isomorphism. The demands of this domain are expressed in terms of criteria such as efficiency, effectiveness, flexibility, quality, innovativeness, and speed.

The second dimension, the SCL dimension, resembles the institutional isomorphism indicating that existing values, norms, and their institutionalization have an impact on designing of HRM policies and practices. Widely shared societal values such as legitimacy and fairness are seen

as the demands of this domain. Here fairness is referred to as a fair balance in the exchange relationship between an organization and individuals (both internal and external stakeholders) while legitimacy refers to the acceptance of an organization in the wider society.

Given the two dimensions discussed above, when an organization designs its HRM policies, there appears a tension between economic rationality (added value - related to the PMT dimension) and relational rationality (moral values - related to the SCL dimension). The economic vs relational expectations seem to be in consistent with the hard and soft approaches to HRM (Druker et al., 1996; Truss et al., 1997) and control vs commitment systems (Pfeffer, 1994), as elaborated earlier in section 3.2.1.

In addition to the PMT and SCL dimensions, the configuration influences the shaping and structuring of HRM policies and practices, as depicted in the CBHRT model (Paauwe, 2004). The configurations may appear as the outcome of past choices of strategy and the engendered organizational culture. Related to the configuration, the third domain is named as the organizational, administrative, and cultural heritage. This heritage (structures, methods, competences, and values that originated in the past) can have impact in future structuring including HRM. Delery and Doty (1996) advocated a unique fit between HRM policies and practices and other organizational characteristics (e.g. organizational structure, technical system, culture) as they refer to the configurational approach.

Paauwe (2004) admit that the HRM decisions can be shaped by different actors in the organization (SM, LM, HR department and employees) resulting in *dominant coalition*. The actors may adopt to the influences of the external and organizational forces (PMT, SCL and configuration), subject to the leeway and thereby determine HRM policy decisions, based on alternative strategic choices (Child, 1972). The dominant coalition is involved in shaping and selecting HRM policies and practices for which different fits are available.

The strategic fit can be seen as the fit between the organization's HRM strategies and the business or competitive strategy (PMT dimension). Next, the organizational fit is the fit between HRM strategies/ practices and other systems within the organization (administrative and cultural heritage). The environmental fit is the fit between HRM strategies and the organization's environment (SCL dimension). Internal fit is the fit between HRM practices as coherent and consistent bundles. Further exploration of fit and flexibility of HR practices are discussed later in section 3.2.4.1.

The CBHRT links the resource-based view (in achieving firm-specific advantages through its HRs; a portfolio of core skills and routines, coherence across those skills, and unique know-how) to institutional theory and proposes that firms can achieve competitive advantage through uniqueness by optimally blending environmental forces with internal HRs and capabilities. The environmental forces can be both an opportunity and a constraint. Thus, responding to those forces with internal HR capabilities is aimed at generating HRM outcomes that contribute to the firm performance. The HRM-firm performance link is discussed in detail under section 3.2.5.

Researchers have used the CBHRT model widely in context based HRM studies (e.g. Buttiens & Hondeghem, 2015; Farndale & Paauwe, 2007; Fernando & Bandara, 2020; Veld et al., 2010b). Based on a qualitative study using this model, Blom et al. (2021) conclude that similarities in HRM among firms are strongly shaped by external factors, while the differences in HRM are strongly shaped by internal factors.

3.2.3. HRM Practices and Bundles of HR Practices

HRM scholars have two major views: content vs process view. The content view emphasizes what is it in HRM (i.e.: HR practices) while the process view looks at the ways that HRM is delivered. This section explores how scholars attempted to categorize HR practices. The HRM process view is discussed under section 3.2.6.

Pfeffer (1994), claimed about high performance HR practices while Delaney and Huselid (1996) identified seven 'progressive' HRM practices. Later, Pfeffer described seven practices of successful firms including, employment security, selective hiring of new personnel, self-managed teams and decentralization of decision making, comparatively high compensation contingent on organizational performance, extensive training, reduced status distinctions and barriers, extensive sharing of financial and performance information throughout the organization (Pfeffer 1998). Stavrou and Brewster (2005) identified fifteen bundles of HR practices including, training, share-options, evaluation of HR, profit-sharing, group-bonus and merit -pay.

There appear various classifications of HR practices and scholars have started to look at bundles of HR practices rather than focusing on individual practices. According to Gooderham et al. (2008), the two generic bundles of HR practices; control or calculative type of HRM practices and collaborative or commitment type of HRM practices. Control oriented HRM

practices include practices such as performance-based pay. Collaborative or commitment HRM practices are intended to foster a mutuality of interest between employer and employee. Calculative practices refer to hard or transaction- based practices that emphasize tangible exchanges between the firm and the employer while collaborative practices refer to soft or commitment-based practices that emphasize employee engagement. Thus, these two generic bundles are consistent with the widely adopted soft and hard approach of HRM (Gooderham et al., 2008) and can be referred to the two distinct approaches (control vs commitment) advocated by Pfeffer (1994).

Kooij et al. (2013) identified two bundles of HR practices intended towards "development" and "maintenance". Maintenance HR practices related to protection, safety and responsibility which assist workers to maintain their current levels of functioning (such as performance appraisal), and development HR practices are related to advancement, growth and accomplishment which assist workers in achieving higher levels of functioning (such as training). Further, they concluded that a third bundle of HR practices termed "job enrichment" bundle was found in practice. Collins and Smith (2006) distinguished between transaction-based and commitment-based HR practices. Transaction-based HR practices emphasize individual, short-term exchange relationships where the commitment-based HR practices focus on mutual, long-term exchange relationships.

It is apparent that different types of classification of HR bundles exist. The distinction between different bundles of HR practices is vague to some extent. It can be noted that there seems to be no accepted theory to classify different HR practices into different bundles (Boselie et al., 2005; Kooij et al., 2013) and according to Kooij et al. (2013), some HR practices may fit in multiple bundles. For instance, Kuvaas (2008) and Zaleska and de Menezes (2007) have differently classified HR practices into developmental bundles. Defining the perception of developmental HR practices as the degree to which employees perceive that their developmental needs are being supported by the organization's HR practices, Kuvaas (2008) has operationalized developmental HR practices as career development, training opportunities and performance appraisal. In contrast, Zaleska and de Menezes (2007) have operationalized training, development opportunities and career management as developmental HR practices. Having considered this Kooij et al. (2013) suggest that there is a need to examine the HR practices as experienced by employees.

3.2.4. Strategic Human Resource Management

As mentioned earlier, people are the key resource of any organization. Managing people is of strategic importance to organizational success (Barney, 1991). Storey (1989) states that the term HRM implies the idea that employees are an asset that should be enhanced and utilized to the maximum capacity, rather than merely a variable cost to be minimized. This idea suggests a matter of strategic interest. As Wright and Ulrich (2017) advocate, it is vital to manage people strategically by positioning the skills and behaviors of the workforce with the organization's strategic needs, and such effort has been referred to as Strategic Human Resource Management (SHRM).

As Ulrich et al. (2013) examined, six domains of HR competence can be identified in terms of what HR should focus on and how HR should focus on that area through specific HR roles. The six domains describe the HR roles as Strategic positioner, Credible activist, Capability builder, Change champion, HR innovator and integrator and Technology proponent. Stone (2014) describes eight multiple roles of HR manger namely, HR functional expert, employee advocate, agent for change and cultural transformation, talent manager, organization ambassador, board and senior executive resource and legal advisor. Stone et al. (2015) discussed about the forces towards a change in roles and processes of HRM while focusing on technology advancements' impact on HR role.

Ulrich and Dulebohn (2015) argue on HR's transformation waves, moving beyond traditional roles of HR. Evolution of HRM roles over time has been introduced in the form of four waves, where the last two waves consider on a strategic role and adjusting to the context. Waves 01 and 02 describe the administration aspects and practices of HRM. Moving further, wave 3 considers that HRM creates value as what HRM does inside the company is aligned to expectations outside the company. Historically HRM is treated as a tool to ensure employee welfare; mostly the focus is limited within the company. But the strategic role implies the need to align the outside context, and wave 4 proposes an inside/outside approach, in which HRM needs to move from reacting to organizational challenge to more fully participating in developing strategy and adding value.

The SHRM field is relatively young compared to other disciplines (Wright & McMahan, 1992; Wright et al., 2018) and what it focuses on is the role of HR in improving firm performance or competitive advantage (Wright & Snell, 1998). Scholars assert that HRs are a critical source

of competitive advantage (Gooderham et al., 2008), while Bennett et al. (1998) see the integration of HR function with strategic decision making as a central aspect of SHRM. As Armstrong (2021) states, SHRM is based on the primary suggestion that for the success of the organization, a strategic role is played by HR. The focus of SHRM is to make certain that an organization's goals are accomplished through its HR by integrating HR strategies with the business strategy. HRM objectives are linked with organizational objectives which includes employees and customers (Nankervis et al., 2016). HRM objectives and plans can be linked to strategic organizational objectives including, cost containment, customer service, effectiveness, social responsibility and integrity (Stone, 2017).

There are various definitions to SHRM and a best known one, by Wright and McMahan (1992, p. 298) refers to SHRM as " the pattern of planned human resource deployments and activities intended to enable an organization to achieve its goals." Kaufman (2015, p. 404) defines SHRM as "the choice, alignment and integration of an organization's HRM system, so its human capital resources most effectively contribute to strategic business objectives". Armstrong (2021, p. 1) defines SHRM as "the process of making decisions on the intentions of the organization, concerning people." As far as the above definitions are concerned, the purpose of SHRM can be seen as deploying HR in a way that assures the achievement of the organization's objectives. Further, as Wright and McMahan (1992) stated, SHRM adopts a systems view to examine the effects of a bundle of HR practices. SHRM studies differ from traditional HRM studies with functional views (Jiang et al., 2013).

3.2.4.1. Fit and Flexibility in SHRM

According to the definition presented by Wright and McMahan (1992), SHRM refers to HR deployments and activities that are being planned to assist the organization in its endeavors towards achieving organizational goals. Two types of fit are emphasized here, namely the vertical fit and horizontal fit (Wright & Snell, 1998). As Schuler and Jackson (1987) state, vertical fit involves the aligning of HRM practices to the strategic management process. Horizontal fit denotes the integration among different HRM practices and also the congruence of HR practices with other functions (Baird & Meshoulam, 1988). Vertical fit implies the directing of HRs toward the primary initiatives of the organization, while horizontal fit is necessary for efficiently allocating HRs (Wright & Snell, 1998). Organizations that achieve fit, found to be more efficient and effective (Baird & Meshoulam, 1988).

Scholars also advocate that given a complex and dynamic environment, firms require flexibility to adapt to diverse and changing requirements, and thus, SHRM is concerned primarily with strengthening the firm's capabilities to adjust to changing environmental contingencies (Wright & Snell, 1998). Chakravarthy (1982) admits that adaptation or fitting to the conditions of a firm's changing environment as the purpose of strategic management. Flexibility refers to a firm's abilities to respond to dynamic environmental demands and that enables a firm to modify its existing practices in response to the changes in the environment (Wright & Snell, 1998). HRM flexibility is the capacity of HRM to facilitate the firm's ability to adapt effectively to the demands and changes of its external environment and to the changes and demands of the firm itself (Milliman et al., 1991).

Scholars propose that fit and flexibility are independent concepts, yet both are essential for organizational effectiveness (Wright & Snell, 1998), as firms require flexibility to respond to changes, by continually adapting to achieve a fit between the firm and its environment (Chakravarthy, 1982), both externally and internally (Milliman et al., 1991).

3.2.4.2. SHRM and Strategic People Management

Given the dynamic contexts, a growing concern towards adopting a revised approach to SHRM is evident. For instance Zhang-Zhang et al. (2022), claim that SHRM is viewed as inconsistent to cater the requirements of a VUCA world and the concept of Strategic People Management (SPM) has been put forward, replacing SHRM. VUCA is a managerial acronym which stands for volatility, uncertainty, complexity and ambiguity (Bennett & Lemoine, 2014). An interesting avenue of investigating the applicability of SHRM in such dynamic contexts, would be to explore how organizations adopt their HRM practices within the context of the COVID-19 pandemic, which is perhaps the most widespread outbreaks that has continued to destabilize the entire global system in the recent past.

The concept of SPM appears to be originated from the concept of people management. This can be discussed in the light of criticisms around referring to people as resources. As Armstrong (2021) stresses, a wrong message is conveyed by the term 'HR' that 'employees are a factor of production, that is exploited by the business.' Oxtoby and Coster (1992) criticized the use of the term resources to refer to people and claimed that the term reduces people to the same value category as other factors of production (Armstrong, 2021). Continuing on the same theme, Zhang-Zhang et al. (2022) distinguish between HRM and people management, under different

aspects. The management philosophy of people management is "people are central as a value adding source" while that of HRM is "exploitation and exploration of human beings as resources and assets for the success of financial results" (Zhang-Zhang et al., 2022, p. 590). Key actors in people management include stakeholders, leaders, frontline managers in addition to the HR professionals and employees associated with the HRM. Most importantly Zhang-Zhang et al. (2022) claim that people management is applicable to highly dynamic contexts while HRM is only applicable to relatively stable contexts in which strategy planning is feasible. Thus, there are more important aspects to consider in distinguishing the two concepts, not merely the difference in terms used.

Although there appears to be much debate around the terminology used to refer to people and managing people in organizations, Armstrong (2021) asserts that HRM still remains the most commonly used term. In a similar vein, Zhang-Zhang et al. (2022), claim that HRM is the term widely used in academic research, although there is a growing interest in using the term people management in practice. As such, the term HRM is used throughout this writing, while the above-mentioned debates and criticisms are being acknowledged.

3.2.5. HRM- Performance Link

HR practices play a major role in aligning human effort, creativity and involvement towards achieving organizational objectives. Lee et al. (2010) claim that HR practices had a significant impact on employee productivity, while Gould-Williams (2003) found that high performance HR practices are powerful predictors of trust and organizational performance.

A positive relationship between HR practices and organizational performance is evident from extant literature (Appelbaum, 2000; Boselie et al., 2005; Combs et al., 2006; Ferris et al., 1999; Gooderham et al., 2008; Huselid, 1995; Pfeffer, 1994; Stavrou & Brewster, 2005; Van De Voorde et al., 2012). However, in which ways HRM enhances performance have not been clearly identified by empirical research (Combs et al., 2006). Many HRM researchers attempted to understand the HRM performance linkage, however, fail to explain the mechanisms and processes by which HRM practices link to performance. HRM scholars refer to the "black box" of HRM – performance link (Asta & Zivile, 2010; Boxall et al., 2011; Guest, 2011; Messersmith et al., 2011; Truss et al., 2013), with regards to explaining the mechanisms and processes link HRM and performance. The black box can be a largely unexpected facet, remaining void or a gap (Asta & Zivile, 2010).

Guest (2011), stressed that more research is needed that explain the causal chain link HRM to organisational performance, especially since previous studies have demonstrated association rather than causation. There appears a growing interest among scholars who carried out some prospective empirical research to detect the said mechanisms. For an example, Kooij et al. (2013), investigated that HR practices enhance performance through increased discretionary effort by providing opportunities to participate and by enhancing skills and motivation of employees. As Peccei et al. (2012) elaborate, majority of research on HRM – performance link propose the idea that the HRM effect on organizational performance mainly goes through employees, where employee psychological, attitudinal and behavioral work outcomes including employee well-being play a key role in understanding the HR practices impact on organizational performance. However, in general, literature lacks empirical evidence on how HRM links to performance.

Addition to this backdrop, prior studies, have analyzed the effects of HRM practices on organizational outcomes, based on single views of senior HRM professionals and fail to incorporate employee perceptions for a better understanding (Alfes et al., 2013; Kooij et al., 2013; Truss, 2001). Scholars recommend utilizing multiple sources to study the HRM phenomena (Lengnick-Hall et al., 2009; Truss, 2001). In their recent article, Heffernan et al. (2022) claim that HRM-performance research has gradually moved to incorporate employee perspectives. Jiang et al. (2013) stated that much of previous research on HRM- performance link, such as the study of Huselid (1995) has adopted a unit level of analysis to examine the relationship between HR practices and organizational performance indicators.

Theoretical perspectives that explain the HRM-performance link at the unit level include the behavioral perspective (Jackson et al., 1989), resource-based view of the firm (Barney, 1991) and social exchange perspective (Blau, 1986). *The behavioral perspective* suggests that firms require different role behaviors for different strategies they adopt and assumes that personnel practices are been used by employers as a way of eliciting and controlling the attitudes and behaviors of employees. As seen by Wright and McMahan (1992), this perspective assumes employee behavior as the mediating factor between strategy and performance of the firm. In another way, as Jiang et al. (2013) assert, the behavioral perspective of SHRM suggests that investments in HR systems will result in employee favorable attitudes and behaviors.

The resource-based view of competitive advantage as noted by Barney (1991), assumes that if properly managed, internal resources of an organization have a high potential in gaining

competitive advantage. Adopting this perspective, Wright and McMahan (1992) found that the HR practices have a direct impact on the level of human capital. This is apparent in the CBHRT discussed above in section 3.2.2.3.

Social exchange perspective entails indefinite obligations, followed by positive sentiments toward and evaluations of others and engender feelings of personal exchange obligation, gratitude and trust (Blau, 1986). When employees view HR practices as expressing appreciation and recognition, signaling that the employees are considered vital for firm survival and success, employees develop reciprocal obligations and tend to remain within the firm and perform at a higher level (Takeuchi et al., 2007). As Gouldner (1960) described, reciprocity is a type of moral norm that morally oblige individuals to offer benefits to those who have offered them benefits. The 'norm of reciprocity is a concrete and special mechanism involved in the maintenance of any stable social system." (Gouldner, 1960, p. 174). However, the degree to which reciprocity principles are applied vary across people and cultures (Cropanzano & Mitchell, 2005).

Taking into account both the resource-based view and social exchange perspective, Takeuchi et al. (2007) examined the high-performance work systems (HPWS) and assert that such HPWS stimulate collective human capital and encourage high levels of social exchange. High performance HR bundles are identified as important to the enhancement of organizational performance (Christopher & Ken, 2006; Ferris et al., 1999). Confirming that both the human capital and social exchange positively related to firm performance, they argue that the HPWS - firm performance relationship is mediated by the level of collective human capital and the degree of social exchange. As identified by Takeuchi et al. (2007), HPWS consist of a collection of separate but interconnected HR practices designed to strengthen employee skills and efforts. (through rigorous and selective staffing, comprehensive training, competitive compensation and extensive benefits (Huselid, 1995)).

3.2.5.1. HRM Outcomes

To explore how HRM affect performance, Guest (1997) argues that it is essential to measure HRM outcomes. In section 3.2. HRM outcomes were identified as commitment, flexibility and quality, under the novel approach of HRM emphasized by Paauwe (2008). HRM practices lead to HRM outcomes at employee level in terms of *quality* (develop high skills and abilities through careful selection, socialization, and high investment in training), *commitment* (enhance motivation through job security, promotions and performance-related pay) and *flexibility* (an

appropriate role structure and role perception through extensive communication and feedback, employee involvement, team working, job design and flexible job descriptions) (Guest, 1997). Performance at the individual level depends on high motivation, possession of the necessary skills and abilities and an appropriate role and understanding of that role. These HRM outcomes (commitment, quality, and flexibility) affect behavioral outcomes. These include employee motivation, cooperation, involvement, and organizational citizenship. These behavioral outcomes lead to performance outcomes (high productivity, quality and innovation and low absenteeism, labor turnover, conflicts, and customer complaints) and finally to financial outcomes (profits and return on investment).

Huselid (1995) concluded that based on his empirical study, the impact of HPWS on financial performance (accounting profits and firm value) is influenced by employee turnover (average annual rate) and productivity (sales per employee). Following this seminal study, much of HRM performance research has attempted to examine the relationship between HRM and financial performance using measurements such as accounting profits, productivity and customer satisfaction (Paauwe et al., 2012). As Jiang et al. (2012) emphasized in their meta-analysis, *organizational outcomes* can be measured through voluntary turnover, operational and financial outcomes, where overall productivity, quality, service, innovation, and overall operational performance can be considered as *operational outcomes*, and return on assets, return on equity, market return, sales growth, and overall financial performance can be used as *financial outcomes*.

These types of measures are relevant and publicly available for private companies. However, public sector organizations' performance indicators are not generally financial in areas like HC and education. Given this unavailability of performance related financial information, researchers have not paid a considerable attention in investigating HRM and performance relationship in the public sector (Paauwe et al., 2012). Further, extant literature lacks evidence on the HRM and performance relationship in the hospital context although the relationship has been examined in the profit sector (Combs et al., 2006; Veld et al., 2010a). As Veld et al. (2010a) assert, how and why HRM matters in the HC context have not been properly identified by researchers. Thus, there appears a gap in literature relevant to HRM performance relationship in the public sector and specifically in the HC setting.

3.2.5.2. Employee Wellbeing in HRM- Performance Link

SHRM scholars including Kaye (1999), argue that when organizations strive to increase performance, employee welfare might be of less interest, thus result in employee dissatisfaction. Prior HRM performance research has mainly emphasized the link between HR practices and organizational performance, and relatively a low attention has been given to employee wellbeing as an outcome of the HRM interventions (Guest, 2017). Scholars admit that it is of similar important to focus on the HRM effects on employee-centred outcomes, as on organizational performance (Van De Voorde et al., 2012) and the role of HRM function to look after the employees is emphasized (Guest, 2017).Consequently, scholars have attempted to focus on employee outcomes in the domain of HRM- performance research, in terms of the influence of HRM on work attitudes (such as commitment and satisfaction) and little emphasis is given to examine the consequences of HRM on employee health (Van De Voorde et al., 2016).

In general terms wellbeing consists of a person's psychological, physical and social functioning (Grant et al., 2007). Employee work-related wellbeing is the overall quality of an individual's subjective experience and functioning at work (Grant et al., 2007; Peccei et al., 2012). As Cynthia D Fisher (2014) admits, there need to present three major components when conceptualizing and measuring wellbeing at work. Those include 1) subjective wellbeing: job satisfaction and similar positive attitudes, positive affect, and negative affect, 2) eudemonic wellbeing: engagement, meaning, growth, intrinsic motivation and calling, 3) social wellbeing: quality connections, satisfaction with co-workers, high-quality exchange relationships with leaders, social support, etc.

In another way, Peccei et al. (2012) show that wellbeing at work can be identified under two dimensions. First dimension referred to as happiness wellbeing and related elements include job satisfaction and organizational commitment. The other dimension is related to employee physical and psychological health at work and can include job-related anxiety, stress, burnout and exhaustion. Adding to this, Van De Voorde et al. (2012), assert that employee well-being can be represented by happiness, relationship, and health. The first two are consistent with the mutual gains perspective (Peccei & Van De Voorde, 2019), while the latter functions as a conflicting outcome. Mutual gains or conflicting outcomes refer to the two competing perspectives to describe the role of employee wellbeing in HRM-performance relationship. The mutual gains perspective assumes that employee wellbeing at work would be a mechanism that provides resources and support for employees, and employees are expected to reciprocate their efforts towards organisational goals. (Van De Voorde et al., 2012).

HPWS may lead to work intensification that can result in employee burnout, while altering the nature and context of work can have significant impact on employee wellbeing (Guest, 2017). In this regard, scholars assert the significance of satisfying employee psychological needs. Satisfied psychological needs results in enhanced self-motivation, mental health and wellbeing (Ryan & Deci, 2000). Researchers emphasize that such psychological needs and processes are relatively significant within specific domains such as HC and education (Ryan & Deci, 2000).

Employee wellbeing related HR practices can enhance organizational performance through employee attitudes, motivation, and behaviour (Guest, 2017). Employee attitudes are reflected in work engagement and organizational commitment (Guest, 2017; Schaufeli et al., 2009) while motivation is reflected in employees' higher energy level and willingness to collaborate and engage in organizational citizenship behaviour (OCB) (Guest, 2017; Ryan & Deci, 2000; Wright, 2003). Well established cognitive presence at work and lower levels of absence and turnover rates reflect the behavioural outcomes that enhance innovation and higher levels of service quality (Guest, 2017).

Another approach to discuss employee wellbeing is the job demands–resources (JDR) model (Bakker & Demerouti, 2007; Van De Voorde et al., 2016). Balanced demands of work (e.g., workload, emotional demands, and work–non-work conflict) and the available resources (sufficient job autonomy, social support, development opportunities and feedback) result in low burnout and stress and high levels of work engagement. Extant empirical findings that referred the JDR model confirm that, when the necessary resources are provided through appropriate HR practices, physical discomfort can be diminished, while employee well-being and individual performance can be enhanced (Bakker & Demerouti, 2007; Schaufeli et al., 2009; Van De Voorde et al., 2016).

3.2.6. HRM Process Research

Most of earlier HRM and performance research was focused at the organizational level and assume that all employees receive the same HRM treatment (Veld et al., 2010a). Differences may exist between intended HR practices and the actual practices and employee perceptions (Nishii & Wright, 2008) across different sections of the organizations specifically in large and complex organizations (Veld et al., 2010a). Scholars then have demonstrated an interest in adopting a multilevel theoretical perspective to examine the mediating mechanisms in the black box (Jiang et al., 2017; Jiang et al., 2013). They have attempted to explain how HRM systems and practices need to be deployed in order to trigger desirable employee behaviours and

attitudes and at the same time to understand how these HRM systems are experienced by employees (Jiang et al., 2013).

One such multi-level model – commonly known as the HR systems strength theory – has been put forward by Bowen and Ostroff (2004). Bowen and Ostroff (2004) distinguish between the HRM content (i.e. the collection of HR practices that an organization has adopted to achieve particular objectives) and the HRM process (that is concerned with the signalling effect of HRM practices). This resulted in a shift of HRM researcher attention from what HRM consists of to how does HRM affect performance, as a function and a system. As elaborated by Sanders et al. (2014), Bowen and Ostroff (2004) assert that HRM practices is a way of communication from the employer to the employee. HR practices are signals (Haggerty & Wright, 2010) that managers relay to employees. HRM practices are seen as a system that motivate employees to adopt intended attitudes and behaviours that ultimately contribute firm performance. The HR process is the way that HR policies and practices are communicated to employees (Xiaobei et al., 2011). HR practices can have a motivating impact on employees if they have been properly implemented and they transmit positive HRM messages. For instance, LMs who provide employees with time to access mental wellbeing programs or counselling, signal to employees that they value and care about employee well-being. However, if the LMs fail to provide this opportunity to every employee, employees might perceive a sense of inequality or breach of fairness. Employees perceive the HRM practices based on the HRM messages transmitted to them. To direct and guide employee behaviour, organizations establish principles for employees and constantly adjust behaviour by sending informal and formal signals, where HRM has been seen as the primary channel through which those signals are transmitted. However, the interpretation of the signals by employees are subject to various factors including personality, interest, and focus. Employees may differently interpret the same practices (Jiang et al., 2017; Katou et al., 2014). In a strong situation, signals are correctly interpreted, employees are likely to share a common perception of work environment and behave in similar ways to support organizational objectives (Haggerty & Wright, 2010; Jiang et al., 2017).

Drawing on attribution theory (discussed below in section 3.2.8), Bowen and Ostroff (2004) identified key features that enable messages to be received and interpreted uniformly among employees. The strength of a HRM system is based on meta-features that are distinctiveness (understandability, visibility, legitimacy of authority and relevance), consistency (instrumentality and consistent HRM messages) and consensus (agreement among HRM decision makers and fairness) (Bowen & Ostroff, 2004). Accordingly, distinctive, consistent

and consensual HRM systems "send signals to employees that allow them to understand the desired and appropriate responses and form a collective sense of what is expected" (Bowen & Ostroff, 2004, p. 204). Employees may engage in numerous cycles of sense-making processes (e.g., information acquisition, interpretation, sharing, and verification) and consistent HR messages enable them to reach a shared understanding of the HR system (Jiang et al., 2017)

3.2.7. Process Model of SHRM

Continuing on this theme, Wright and Nishii (2013), present the "Process model of SHRM" to explain links between *intended*, *actual*, and *perceived* HRM practices, and identify distinctions in the content and process along the multiple levels. This model links HRM practices to organizational performance through employee reactions, based on the premise that the goal of intended HRM practices is to lead positive employee reactions towards organizational performance. This model has been referred by scholars in multi - level research, linking HRM practices to firm performance (eg. Makhecha et al., 2018; Piening et al., 2014; Van De Voorde & Beijer, 2015).

The "intended HRM practices", as described by Wright and Nishii (2013) "represent the outcome of the development of an HR strategy that seeks to design an HRM system or practice that the firm's decision makers believe will effectively elicit the employee responses desired" (p. 102). Accordingly, intended practices refer to the premise that organizational decision makers proactively analyse a particular situation, and determine that a certain set of HRM practices will effectively bring out desirable employee attitudes and behaviours. However, Wright and Nishii (2013) recognize that LMs may not be implementing HRM practices as intended by the organizations, thereby resulting in the next level – "actual HRM practices".

Next, "perceived HRM practices" indicate that employees perceive and interpret the actual HRM practices subjectively. Each employee processes the information in a way that stimulates "employee reactions" which can be in the form of affective, cognitive, or behavioural. Affective reactions include aspects of job satisfaction and organizational commitment while increased knowledge and skills refer to cognitive reactions. Behavioural reactions refer to task related behaviour (behaviour prescribed as part of the job), counterproductive behaviour, and discretionary behaviour. Based on the level of *coordination* across employee reactions, those reactions can be positively linked to "organizational performance". Organizational

performance is elaborated as employee outcomes (absenteeism and turnover) and organizational outcomes (productivity, quality, and customer satisfaction).

Each level of the process model of SHRM, is linked to the next level with respective linkages namely, *implementation, communication, moderation, and coordination.* Variations have been identified across the levels. First, a gap between intended and implemented HR practices - commonly referred to as the "rhetoric vs reality of HRM" – has been revealed by numerous studies (Druker et al., 1996; Nishii & Wright, 2008; Piening et al., 2014; Truss, 2001; Truss et al., 1997). Khilji and Wang (2006) refer to lack of management commitment in developing a culture and structure to ensure consistency in HR implementation, as weak implementation. Examining a sample from the banking industry, they found a substantial difference between what is intended and implemented HRM. Kuvaas (2008) states that the rhetoric and actual practices formulated by HR mangers and endorsed by senior managers (SM) appear not to be consistent with what is experienced by the employees. Piening et al. (2014) state that implementation gap/failure results when an HR practice is used with less frequency, less consistency or less assiduously than intended. As elaborated by the authors, this gap is moderated by the ability to leverage necessary organizational resources. Adding to this Makhecha et al. (2018), state that implementers adapt HRM practices to suit their units' needs, objectives and structures such as operational pressures and short term business targets. The distinction between reality and rhetoric can have adverse effects on the consistency between the intended – perceived levels and ultimately the employee reactions. To elicit desirable perceptions of HR practices and reactions from employees, a higher degree of consistency between intended and implemented HR practices is vital (Khilji & Wang, 2006; Piening et al., 2014).

Second, a gap between actual and perceived HRM practices has been highlighted in the literature. Wright and Nishii (2013) highlight the importance of HRM meta-features to build a strong HRM system, as convinced by Bowen and Ostroff (2004). The strength of the HR system is described as a way of assisting employees to create a shared sense of what behaviour is expected, supported, and rewarded by the management. Accordingly, effective implementation of an HR system is based on employees' perceptions of the system's distinctiveness, consistency, and consensus. Despite the importance of meta-features of HRM systems, Wright and Nishii (2013) address that individual schemas and social context can have influence on how they perceive the HRM messages. For example, individuals' perceptions of job characteristics may be partly determined by how co-workers describe those. When new

practices are introduced, employees seek information through their social ties to understand the goal of the new practices.

Third, a variance between perceived HRM practices and employee reactions is described using the concept of *moderation*. This concept is based on the theoretical premise that impact of one variable on another varies depending upon the level of a third variable (such as individual differences). Elaborating on this, Wright and Nishii (2013) describe that attitudinal, motivational and individual differences, psychological contract and different attributions on HR practices can moderate the impact of perceived HRM practices on employee reactions. Considering the same, Nishii et al. (2008) earlier convinced that, based on the attributions employees make about management's purpose in implementing the actual HR practices, employees respond to the HR practices attitudinally and behaviourally.

An earlier study in the construction industry by Druker et al. (1996) revealed that, with the changes in economic environment, HRM practices have been dramatically developed and a difference between what the employees expect and what managers practice (in terms of hard and soft HRM). Actual HR practices as perceived by the employees may differ from intended HR practices as a function of the way that HR practices are implemented (Nishii & Wright, 2008). Research shows that employee attributions on HR practices predict their commitment. Individuals' attributions can form collective attributions when shared among the members which then can explain group-level outcomes (Martinko et al., 2011). The next section presents an overview of the HR attribution literature.

3.2.8. Attribution Literature

Based on a review on attribution theories in the domain of HRM, Hewett et al. (2018) observed that the use of attribution theories in the HRM field has accelerated since 2000. They recognize HR system strength (HRSS) (Bowen & Ostroff, 2004) and HR attributions (HRA) theory (Nishii et al., 2008) as two key theories with attribution creeds, which have revitalized attention in this area of research. As Hewett et al. (2018, p. 88) put in, "there has been a resurgence in the interest of the role of attribution theories in explaining the so called 'black box' between HR and performance."

HR attributions are defined as causal explanations that employees make about managements' motivations for using HR practices (Nishii et al., 2008). Managerial decisions can be influenced

by organizations' strategy, environmental pressures, and the management's employee-oriented philosophy (Child, 1972; Lepak et al., 2007; Nishii et al., 2008). Employee behaviour may depend on the attributions they make about the management intentions and motives underlying the HR practices they experience. Suggesting that the intent behind HR practices can be classified as either internal or external, Nishii et al. (2008), present a typology of attributions, where they distinguish between internal and external attributions.

3.2.8.1. Types of HR Attributions

Internal attributions consist of both HR attributions relevant to the business or strategic goals and employee-oriented philosophies underlying HR practices. Employees perceive that actions/ HR practices are adopted as a function of management's intentions towards business orientation or employee orientation. In contrast to the internal attributions where actions are taken due to factors for which the management is accountable and which over the management's control, external attributions refer to the perception that certain actions/HR practices are a result of adopting to external forces/ constraints, but not due to management's voluntary intentions. The HRSS literature (Bowen & Ostroff, 2004), shows that HRM messages are seen as a tool that help employees to create a shared sense of what behaviour is expected, supported, and rewarded by the management. Along this way Nishii et al. (2008) proposed that individual level attitudes are shared with members of the unit, whereas the unit-level attitudes influence unit level behaviour and outcomes.

According to the 'theory of correspondent inferences' (Jones & Davis, 1965), an individual may develop either an internal attribution (a correspondent attribution) or an external attribution (a non-correspondent attribution) when ascribing the cause to a behaviour or event (Monahan et al., 2023). For instance, as described by Monahan et al. (2023) when assessing the motive behind publishing a warning on a cigarette pack, a consumer might develop an external attribution, assuming that the producer included the warning as obliged by legal mandates. Otherwise, he or she may create an internal attribution suggesting that the producer is honest and concerned for consumer well-being. In a pandemic scenario, employees may assess a particular HR practice change or initiation of a new practice (such as flexible working practices or social distancing measures) based on an internal attribution if the management valued employee welfare and safety. In contrast, employees might consider the motive behind such practice is just to ensure compliance with guidelines imposed by authorities, which is an external attribution.

Acknowledging that satisfaction, commitment and OCB have identified as desired employee responses to HR practices by previous research, Nishii et al. (2008) focused on the relationship between HR attributions and satisfaction and commitment. Their study found that employees had different attributions in response to the same HR practices, and those attributions were differentially related to satisfaction and commitment. Showing, that internal attributions can have either positive or negative implications for employees, which eventually shape their attitudinal responses, they distinguish between *commitment-focused attributions* and *control-focused attributions*.

The first type of attributions refers to when employees perceive the intended goals of HR practices are to improve employee well-being and quality of work, while the latter refers to when employees perceive that the HR practices are aimed at cost reduction and employee exploitation (Chen & Wang, 2014). In contrast, some scholars have referred to employee attributions as strategic orientation vs employee orientation of HR practices (eg. Gao & Haworth, 2019; Piening et al., 2014). Similarly, Van De Voorde and Beijer (2015) referred to HR well-being attributions and HR performance attributions in relation to HPWS practices.

Citing Jones and Davis (1965), Nishii et al. (2008) claim that behaviours perceived as beneficial to a perceiver will create favourable attributions, while unfavourable attributions can be the result of a behaviour that is perceived to have adverse effects to the perceiver. Drawing on the social exchange principles (Gouldner, 1960), as Nishii et al. (2008) suggest, commitment-focused attributions are likely to stimulate a felt obligation to reciprocate in positive and beneficial ways. In contrast, control-focused (cost reduction and employee exploiting) attributions can lead to dissatisfaction and lower commitment when employees perceive that HR practices are with lower concerns for employees over cost minimizing and control targets.

Examining the signalling impact of enacted HPWS on HR attributions, Van De Voorde and Beijer (2015) revealed that higher levels of HR well-being attributions are associated with more commitment and less strain while higher levels of HR performance attributions are associated with higher levels of experienced strain. Generally commitment-focused attributions are positively related to desirable outcomes and control-focused attributions related to undesirable outcomes (Beijer et al., 2019). Such outcomes include OCB (Nishii et al., 2008), turnover intentions and task performance (Chen & Wang, 2014), commitment and job strain (Van De Voorde & Beijer, 2015).

3.2.8.2. The Influence of Social Context on HR Attributions

Individual attributions can be shared with unit members and eventually could influence unit-level attitudes, and performance outcomes. The social context can influence employee attributions as they form or adapt their own perceptions (Beijer et al., 2019; Hewett et al., 2018; Nishii et al., 2008; Pollock et al., 2000). Drawing on the social information processing (SIP) theory (Salancik & Pfeffer, 1978), Beijer et al. (2019) claim that employee attribution processes can be influenced by the information provided by LM and the co-workers. LM while implementing the HR practices are expected to help employees understand and interpret the reasons and motives behind specific HR practices. They do this by providing employees with information that is identified as HR signals (Nishii & Paluch, 2018). Four HR implementation leader behaviours that facilitate a strong HR system have been put forward by Nishii and Paluch (2018). These include verbal articulation of the intended meanings and expectations, role modelling the desired behaviours, reinforcing preferred behaviours, and assessing followers' interpretations of the provided meanings so that further adjustments can be made in the meaning-making process. These would result in cohesive climate perceptions that will lead to a strong HR system (Nishii & Paluch, 2018).

Next, same as the LM, co-workers' perceptions of HR practices, can shape an employee's attributions of HR practices as they make sense of why particular HR practices are being used (Beijer et al., 2019; Chen et al., 2013). As reviewed by Chen et al. (2013), earlier studies based on SIP theory have suggested that people rely on cues to validate their understanding of the reality, to form impressions of the problems and to regulate their behaviour when they encounter new or unclear problems, given that usually their information gathering capacity and processing ability is limited. In a workplace context, co-workers are a good source that provide such cues through their clear enough statements and behaviours (Burkhardt, 1994) while employees would test and confirm their perceptions by comparing their attitudes and actions against these clues (Chen et al., 2013). In addition, co-workers make their information more salient and can affect employee perceptions (Beijer et al., 2019). Thus, when co-workers express a particular explanation of why HR practices are used, this information becomes more salient and can affect the employee's HR attribution. Thus, co-workers may influence a focal employee's OCB (Bommer et al., 2003), as well as retaliation (Jones & Skarlicki, 2005) and aggressive, undermining behaviours (Beijer et al., 2019).

In addition, Jiang et al. (2017) assert that employees may gather information through their own observations on how HR practices are applied to co-workers and share their views back with the co-workers enabling this process of information exchange to shape and alter HR attributions of both employees. This can be linked to third party fairness dimension relevant to organizational justice literature which is discussed under section 3.3. Co-workers represent the immediate social environment of employees, and employees will make use of information provided by these co-workers to make sense of why HR practices are in use.

Hewett et al. (2018) claim that only a few research has empirically tested the study by Nishii et al. (2008) to confirm the proposition that commitment-focused attributions lead to positive outcomes while control-focused attributions are associated with negative outcomes. Importantly, Hewett et al. (2018), argue that researchers need to consider the role of external attributions as existing studies have not looked at the role of external attributions, in examining the relationship between attributions and outcomes. The crisis context in Sri Lanka would pave possible ways to examine such internal, external and commitment vs control attributions related to HRM. One important aim of the current study is to explore what are employees' and LMs' perceived HRM response, across the dual crisis contexts in Sri Lanka. The following section (3.2.10) is devoted to HRM in crisis contexts and includes a discussion on employee attributions in such crisis contexts.

3.2.9. HRM Implementation and the Recursive Nature of HRM Process

Moving back to HR process research, this section discusses about HR process's recursive nature as argued by van Mierlo et al. (2018). Scholars in general agree that HRM implementation involve a process. For instance, Khilji and Wang (2006) see the HRM implementation as the translation of intended practices into actual practices, while Nishii et al. (2008) see the HRM implementation as actual and perceived HRM practices. Moreover, as discussed above, Wright and Nishii (2013) claim that HRM process involves intended, implemented and perceived HRM practices.

In contrast, with the preposition that HR process involves a continuous interplay, van Mierlo et al. (2018) argue that the HR process is recursive. According to their view, HR practices, organisational actors (like LM and employees) and the context of the organization mutually influences each other in a recursive process and gradually reach HRM implementation success, at a stable phase. Wright and Nishii (2013) suggested that the gap between intended, actual and

perceived HRM should be kept to a minimum, to achieve successful HRM implementation. Based on the structuration perspective (Giddens, 1984), van Mierlo et al. (2018) demonstrate that once an HRM message is sent, the recursive process begins. The process emerges bottom-up from message recipients in a way that sends feedback to the message senders. This influences the HRM practice. Such a recursive process may be evident in a changing context such as a crisis. Scholars acknowledge that ad-hoc, one-off decisions and continuous adjustments are made to cope up with crisis situations in organizations (Oscarsson, 2022; Simon, 2015).

3.2.10. HRM in Crisis Contexts

Changes in the environment external to organizations can have significant impact on HRM practices in the way in which the managers respond to such changes (Gunnigle et al., 2013). A crisis such as an economic recession is part of the external economic, political and societal environment within which HRM operates and can be an important strategic concern of a firm as the dynamism and volatility of the crisis create a high degree of uncertainty that can influence the design of the firm's HR architecture (Zagelmeyer & Gollan, 2012). Extra-organizational phenomena also referred to as environmental disruptions, are the changes happen outside the organizations that can have serious impact on existing arrangements within and across organizations (Kim et al., 2022).

Mann (2014) assert that ensuring organizational success is vital especially during times of crisis, unlike in any other circumstance. Most organizations might adopt a controlling orientation rather a flexible HRM orientation ahead of external environment changes (Panayotopoulou et al., 2003). However, employees tend to expect the organizations' crisis response to be more flexible towards employee protection (Aycan & Kabasakal, 2006). Simon (2015) admit that in crisis prone situations, a democratic management style was more appropriate. Thus, organizations may confront which aspects to prioritize when dealing with a crisis. As Deloitte (2020) highlights successful organizations navigate crises through quick response followed by recovery initiatives in which HRM recovery strategies can come along five critical actions: Reflect, Recommit, Re-engage, Rethink, and Reboot.

As Carmine et al. (2021) elaborate, exogenous changes can trigger organizational tensions between 1) exploration and exploitation, 2) cooperation and competition or 3) control and collaboration. Based on the organizational paradox literature, they show that tensions can be both multi-level and multi-faceted and can impact organizational actors across the hierarchy

(from CEO to frontline staff), while tensions involve cognitive, emotional, and material responses. Thus, environmental disruptions, are a challenging managerial concern, that seemed to have exerted multifaceted influence over the HRM function. Implications of such disruptions (COVID-19 pandemic and economic crises) for HRM in general, were discussed in sections 2.2.4.1 and 2.2.5.2 respectively.

Crisis induced HR practices (Antwi et al., 2024) aka Crisis related HR practices (CRHRP) are different from other HR configurations given that such practices are supposedly initiated as a consequence of crises (Nyfoudi et al., 2024). As such, organizations introduce new HR initiatives or reconfigure existing practices. A recent classification of CRHRP (Nyfoudi et al., 2024) distinguishes between solidary, utilitarian and opportunistic CRHRP. Solidary CRHRP are designed to prevent or minimize workplace adversity for all employees, while utilitarian CRHRP aimed at preventing or minimizing adversity for the majority but not for all. Examples for the former include reskilling, job rotations, secondments, redeployments and communications. Utilitarian CRHRP can include downsizing, restructuring, redundancies, salary freezing, and cuts in wages and work hours. Any of these CRHRP can be classified as opportunistic if those are being implemented by managers based on their self-interests, given the high levels of uncertainty and limited knowledge (Nyfoudi et al., 2024).

Unlike other functions of a firm, HRM has the comparative advantage of working at the interface between many critical domains. These include a firm's people, its processes and structures and the environment within which the firm and its human beings operate (Zagelmeyer & Gollan, 2012). Thus, HRM would be able to respond to changes in external environment at both strategic and operational levels. Organizations with strategic HR capacity have a competency that would make the organization resilient during challenging times (Lengnick-Hall et al., 2011). The resource-based view of the firm suggests that in times of uncertainty, organizations with a core competence that enable benefits in the new environment will be more successful than those that do not possess such competence (Raffo et al., 2016). The resource-based view of HRM was discussed earlier in section 3.2.5.

As Lengnick-Hall et al. (2011) distinguish, some authors define organizational resilience simply as the ability to rebound from unexpected, stressful, adverse situations and to pick up where they left, while some define it as a concept that is not only restoration but also the development of new capabilities to keep pace with and even create new opportunities. Thus, resilience can be seen as a firm's ability to engross threatening disruptive surprises, to create

situation-specific responses and at the same time engage in transformative activities to capitalize on such surprises (Lengnick-Hall et al., 2011). Resilience includes a system's ability to continuously learn from past experiences of CM and improve the ability to manage future crises (Rosenbäck et al., 2022).

Employees often bear a high degree of uncertainty in a changing context, that may result in more varying perceptions and reactions towards HR practices introduced or adopted by the management (Chen & Wang, 2014). Employees expect that their organization would protect them in times of crisis (Aycan & Kabasakal, 2006). Xie et al. (2022) propose that within the COVID-19 pandemic context, employees' perceived threat to health can encourage higher levels of preventive behaviours to reduce exposure to the virus. In contrast, they predict that individuals would not practice and promote among others, such preventive behaviours if they perceive their jobs are insecure given the uncertain context. As discussed earlier in section 2.2.4.1., employee layoff was one of the major HR implications in some industries, where authors refer to the pandemic as an unemployment crisis. These cut downs in employee numbers may have been perceived by employees as internal HR attributions where the managers decide to lay off employees to reduce costs, but neglect to ensure employee wellbeing as they lose their way of living. In contrast, employees may perceive the motive behind employee layoffs is due to external forces such as government-imposed regulations to limit or shut down certain businesses. Along this line of thinking, it is assumed that employees act positively with CM response related HR practices, if employees perceive those practices as supportive and designed to drive employee safety and wellbeing.

Based on a study in a financial crisis context, Aycan and Kabasakal (2006) found that employees have perceived cost cutting HR practices adopted by the firm as unfair. Employees had primarily questioned the criteria on which HRM decisions were based (e.g., performance, seniority, need, tenure, age). The researchers claim that whatever criteria were used, employees had perceived cost cutting HRM practices as unfair and what they had expected from their employer was employee protection rather than exploitation. This type of expectation can be more likely the same in a collective culture, where employers are expected to look after their employees, as the organizations value concepts such as familism and paternalism (Aycan & Kabasakal, 2006).

The investigation of HRM practices under contexts of uncertainty has been seen as limited (Agarwal, 2021; Sanyal & Sett, 2011) including HR process research. Kim et al. (2022) argue

that literature lacks HR process research that considers extra-organizational phenomena in comparison to intra-organizational phenomena. Such research would need to examine the influence of extra-organizational phenomena on how employees perceive, understand, and attribute HR in their organization. They highlight that HR process research within the COVID-19 crisis can bring important insights into literature. Given the COVID-19 context, Collings, McMackin, et al. (2021) propose to identify employee experience on HRM response for examining the effectiveness of such response. The current study will fill these gaps by exploring HRM implementation in Sri Lankan hospitals as a response to such extra-organizational phenomenon (that is the dual crisis context), by considering the HR practices along intended, implemented and employee perceived levels. This study therefore contributes to an area where there is a dearth of research.

In contrast, to a natural disaster a health crisis is sustained over a longer period and the frequency of occurrence is less. As a health crisis can spread through populations, such crisis is difficult to manage solely by government interventions. Typically, individuals tend to place part of the responsibility on themselves and come together to form comradeship in responding to such a health crisis (Wheeler et al., 2022). Obviously HCWs, would accept such responsibility given that they value helping others (Shields & Ward, 2001; Veld et al., 2010a) and would perceive their work calling (Cynthia D Fisher, 2014). When considering the dual crisis context in Sri Lanka, the health crisis can be seen as a context where these HCWs and generally other individuals tend to assume accountability for playing a role in overcoming the crisis, whereas the context of economic crisis would not fit into the same assessment (public may blame politicians and government as causing inflation or economic crises). Narrowing this theme, this study aims to examine the perceptions (employee and LM) of fairness of HRM response in times of these two different crisis contexts and identify whether the drivers of these perceptions are stable across these two contexts or whether the drivers of these perceptions are context dependent in hospital settings. The next section is a discussion around organizational justice (fairness) literature.

3.3. Organizational Justice

Organisational justice is the overall perception an employee has of what is fair and unfair in the workplace (Colquitt, 2001, 2012; Colquitt et al., 2005). Organizational justice literature attempts to explain and describe the role of fairness as a workplace consideration (Greenberg, 1990). As such, organizational justice relates to perceived fairness concerns within the

workplace. Thus, organizational justice can be seen as employees' evaluations of fair treatment (Tepper, 2001), which built on the belief that perceived inequality lead to employee demotivation (Zeidan & Itani, 2020). The terms justice and fairness have been used interchangeably in organizational justice literature (Cugueró-Escofet & Fortin, 2014; Konovsky, 2000).

In an organizational context, a process of social exchange occurs between the employee and the employer based on reciprocity (Blau, 1986), where the perceived organizational treatment that employees experience, determines the outcomes of their behaviour toward the organization. If employees are treated by the organization in the manner they expect, they reciprocate favourably, resulting in positive outcomes towards the organization (Otto & Mamatoglu, 2015; Takeuchi et al., 2007). Employee expectations of just and fair treatment from the organizations, and the organization's ability to meet those expectations, will have implications for employee work-related attitudes and behaviour. Employees' perceptions of fairness affect their work-related attitudes, behaviours and workplace outcomes such as task performance, job satisfaction, organizational commitment and OCB (Cohen-Charash & Spector, 2001; Colquitt et al., 2001; Du et al., 2012; Folger & Cropanzano, 1998; Tan, 2014; Tepper, 2001) .

Organizational justice research mainly considered employee perceptions and responses to organizational decisions and have distinguished between the fairness of outcomes, procedures, interpersonal treatment, and information (Cugueró-Escofet & Fortin, 2014). Organizational justice has been differentiated among four dimensions namely; distributive justice (justice of outcomes), procedural justice (decision making process) interpersonal justice (personal treatment) and informational justice (whether sufficient and timely information was provided) (Colquitt, 2001, 2012; Colquitt et al., 2005; Cugueró-Escofet & Fortin, 2014).

As viewed by Colquitt (2012), scholars have solely considered about *distributive justice* in the earlier stages of justice literature. Distributive justice links with the equity theory (Adams, 1965), and accordingly, individuals judge the fairness of an outcome by comparing their perceived input or contribution with the outcome, and then compare their input-outcome ratio against comparable others (Colquitt, 2001, 2012; Greenberg, 1990). Equity rule advocates that reward and resources need to be distributed in accordance with recipients' contributions (Colquitt, 2001). In an HRM standpoint, distributive justice is associated to HRM outcomes and reward distribution.

Scholars then have started to refer to a two-factor model (Kals & Jiranek, 2012), with the introduction of a second dimension to organizational justice; *procedural justice*, after series of studies on the decision making fairness (Colquitt, 2012). As elaborated by Greenberg (1990), procedural justice conceptualizations focus on the fairness of the process used to achieve the outcomes, while distributive justice conceptualizations focused on the fairness of the content or the outcome itself. Procedural justice is concerned with the fairness of methods used by managers to arrive at a decision. Procedural fairness is achieved if a procedure is consistent, not personally biased and represents important subgroups (Leventhal, 1980). Employee emphasis here is on the process rather than the outcome (Colquitt, 2001). Procedural justice shape employee reactions to distributive justice (Du et al., 2012). As Konovsky (2000) put in, if employees perceive the procedure implemented during decision making related to outcome as fair, they might not act negatively even they are dissatisfied about the actual resource distribution/ outcome. At an HRM stance, procedural justice can be considered as the fairness associated with the process of implementing HRM.

Both distributive and procedural justice perceptions are highly correlated with attitudinal constructs of organizational commitment and satisfaction (Aycan & Kabasakal, 2006). Scholars McFarlin and Sweeney (1992) admit that among these two justice perspectives, distributive justice was the important predictor of personal outcomes, including well-being and job satisfaction while procedural justice was the predictor for organizational outcomes such as organizational commitment.

The organizational justice dimensions have been later added with a third dimension; *interactional justice*, that referred to individuals' concerns about the quality of interpersonal treatment they experience during the enactment of organizational procedures (Bies, 2001). Interpersonal justice relates to respectful and decent interpersonal behaviour associated with an outcome (Kals & Jiranek, 2012). This dimension of organizational justice relates to the argument that individuals are not only sensitive to procedures and outcomes, but also to the quality of interpersonal treatment they receive during the enactment of procedures (Mikula et al., 1990). Interactional justice refers to the extent to which individuals view decision makers and authorities as fair (Jones & Skarlicki, 2005). Interactional justice has been considered as an important variable in understanding employee commitment, trust in management and OCB behaviour (Bies, 2001).

The interactional dimension has been expanded with two dimensions namely *informational justice* and *interpersonal justice*. Greenberg (1993) proposed the importance of social

determinants of justice and assert that informational justice refers to social determinants of procedural justice (providing knowledge about procedures that demonstrates concerns for people), while interpersonal justice refers to social aspects of distributive justice (showing concerns for individuals regarding the distributive outcomes). Informational justice is the degree to which employees were provided with information that are adequate, relevant, and consistent while, interpersonal justice is the degree to which employees are treated with dignity and respect (Colquitt, 2001). In relation to the interactional justice, Bies (2001) describe four categories of profanities, namely derogatory judgments, deception, invasion of privacy and disrespect. In a justice context, these four profanities refer respectively to 1) truthfulness and accuracy of statements and judgements about a person, 2) correspondence between a person's words and actions, 3) legitimacy of disclosing one's personal information to another and 4) signs and symbols conveying respect for the worth of the individual.

In addition to these dimensions, employees may perceive fairness from a third-party perspective, that they can observe and understand how the co-workers are been treated within the organization. This type of fairness is referred to as *third-party fairness* (Johansson et al., 2007; Kray & Allan Lind, 2002). When formulating their justice judgments, employees may observe and consider the fairness experiences of others (co- workers) (Kray & Allan Lind, 2002). Thus, perceptions of third-party fairness may shape employee reactions. As Kray and Allan Lind (2002) highlighted, studies show that employees who observed but did not actually experience an injustice (mistreatment to another employee), had a negative reaction to some unfair procedures. Third parties' responses to employee mistreatment of an organization or its agents (supervisors), can have a significant effect on the organization. As such, their reactions may lead to foster justice norms and ethical climate in the organization (Skarlicki & Kulik, 2004).

Scholars assert that the justice literature is mainly based on empirical data from the United States while there are only a few studies conducted in different cultural settings (Aycan & Kabasakal, 2006). As far as the Asian cultures are concerned, organizations generally respect the traditional value of familism with a strong emphasis on paternalism. Paternalistic relationships support a shared norm of taking care of employees' well-being. (Aycan & Kabasakal, 2006).

3.3.1. Justice and Fairness in Crisis Contexts

External environments are complex such as in a pandemic context, where firms might consider the survival of the business as their priority, rather than other aspects, including HR. As mentioned earlier, organizations would adopt a controlling orientation rather a flexible HRM orientation in response to external environment changes (Panayotopoulou et al., 2003). When organizations strive to increase performance, employee welfare might be of less interest (Guest, 2017; Kaye, 1999), causing employee dissatisfaction. Based on a study in a hospital setting Bartram et al. (2007), argue that specifically at difficult times, HRM is seen as an administrative function that is vulnerable to financial controls, unless the HRM's facilitating and enabling role is linked with the hospitals' performance management activities. This situation might be more realistic when a crisis exists. On the other hand, organizations might have to adjust to the external environment forces which may have negative impacts on their workforce (causing to external attribution).

As described earlier in section 2.2.4.1, during the COVID-19 pandemic, some workers had to adjust to unfamiliar work settings (such as work from home), some had to be trained and practice different workplace procedures (such as social distancing and hygiene practices), while some had lost their jobs. More importantly people got infected may be due to unsafe work settings and some lost their lives. During financial crisis scenarios, as elaborated in section 2.2.5.2., firms had implemented pay cuts, holds to employee benefits and employee lay-offs. Job insecurity and uncertainty about salary and benefits fall under distributive injustice, can create anxiety among employees and serve as a threat to employee psychological well-being, while disrespectful treatment to employees seen as procedural injustice can be a threat to their attitudes towards the organization (Aycan & Kabasakal, 2006).

Bapuji et al. (2020) in their influential editorial commentary, argue that the pandemic has led to a greater deal of societal inequalities and claim that the COVID-19 crisis has affected different job holders in different means. They categorize jobs into four: elite jobs, frontline jobs, outsourced jobs and gig economy jobs. During the crisis elite job holders had the chance to work from home with the minimum exposure to the virus. Frontline jobs in sectors not deemed essential, experienced full or partial job losses while the virus exposure risk was higher. Conversely essential frontline workers faced a higher virus exposure. Interestingly, the scholars claim that job holders in medical profession had often work with higher protective measures than other sectors within the frontline category like transport, grocery stores and

pharmacies. Outsourced job holders suffered with job losses while gig economy job holders experienced relatively unaffected.

Bapuji et al. (2020) further discuss the class inequalities highlighted within the covid-19 pandemic. Accordingly in many countries, Individuals with an Asian appearance reported racism as the very first outbreak occurred in China. Foreigners in general, experienced racism in countries where the virus found to be imported from another country. With reference to the HC sector, the authors further assert that gender inequalities in frontline jobs, highlighting the presence of females. Importantly they note that in UK, the first 10 lost their lives among the doctors assigned for COVID-19 patient treatments were from Black ethnic minorities. Adding to this, Agarwal (2021) has examined that employee lay-off schemes in the tourism industry in India were reported to be based on caste, within this pandemic context. These instances of inequalities, call policy makers and managers attention towards justice and fairness in employment policies and staffing within their workplaces.

Perhaps, essential workers including HC professionals would have experienced various difficulties, during the pandemic, in contrast to the workers who were able to work from home and afford living. Arguably, essential workers do not have the luxury of choosing between flexible working arrangements such as working from home. Thus, it is hard to agree with and accept our general understanding of considering "remote working as the new normal" within the context of COVID-19. This heralds a discussion for examining what challenges that organizations faced onsite where remote working was not an option, what practices were introduced or adjusted to cope up with such challenges imposed by the pandemic, and what are the employee perceptions of fairness/ justice on such practices.

Thus, this context provides an important research avenue to examine to what extent organizations were fair in their crisis response, what were their priorities and motives (business survival/ performance vs employee well-being). Given the situation in the country, as previously explained, Sri Lankan hospitals present a unique context to study the underwent changes as they recently encountered back-to-back crisis situations due to the pandemic and economic fluctuations. Thus, examining employee perceptions of fairness in these crisis contexts would add to both organizational justice, CM and HRM literatures.

3.4. Crisis Management

3.4.1. What is a Crisis?

A core characteristic of a crisis is uncertainty (Boin et al., 2020). The word uncertainty became the catchword that the society witnessed in recent times, as the recent global pandemic unfold. The pandemic revealed that only certainty seems to be lots of uncertainty and attempting to predict the future is a difficult task (David Green in Ulrich & Gherson, 2023a).

A crisis is a "situation faced by an individual, group or organisation which they are unable to cope with by the use of normal routine procedures and in which stress is created by sudden change" (Simon, 2015, p. 86). A crisis can be seen as an unexpected event that causes a significant threat to economies, organizations, and individuals (Newman et al., 2021). Although often considered as a threat for many involved in it, a crisis can also be seen as a new opportunity that opens up new possibilities and stimulates innovatory ideas (Simon, 2015). Well prepared organizations would manage crises well with less damage, and would also benefit in turning crises into opportunities (Olaniran et al., 2012).

Organizations confront with high levels of uncertainty caused by grand challenges beyond national, economic, or social borders (Eisenhardt et al., 2016; Ferraro et al., 2015). In other words, a crisis is an event or experience of the organizational life that is unforeseen, unexpected, and inevitable. Crises differ due to their severity and scale (Wheeler et al., 2022). Abrupt changes in the environment in terms of markets, products or suppliers may have the potential to create problems for an organization, making it more vulnerable to crisis (Simon, 2015). Most experienced forms include natural disasters and health crises (Wheeler et al., 2022). A crisis is not the same as a disaster. A disaster is an episodic event that can cause great harm while a crisis occurs over extended periods of high threat to a system's structure, values or norms (Wheeler et al., 2022). Williams et al. (2017) identified global economic recession, climatic episodes, natural catastrophes, industrial accidents, distressing product recalls, information technology and data security breaches, disruptive social media trends and terrorism risks as challenging threats that organizations have recently encountered.

As Frandsen and Johansen (2020b) noted, the society that we live in is a "crisis society", referring to the point that, most visible and mediatized crisis events have happened back-to-back in the recent past, including The World Trade Centre terrorist attack in 2001, Indian Tsunami crisis in 2004 and the global financial crisis in 2008. Most recent health crises are the

Spanish flu, the HIV/AIDS pandemic, and the COVID-19 pandemic (Wheeler et al., 2022). Of note, the COVID-19 pandemic crisis has shaken the entire globe, recalling the need for careful preparedness and resilience. As Boin et al. (2020) claimed, most governments were not well prepared to deal with this health crisis. Some well-known organizational crisis incidents include Exxon Valdez oil spill in Alaska, Bhopal Gas Tragedy in India (Mitroff & Alpaslan, 2003) BP mining slippage in Papua New Guinea (Heenetigala & Lokuwaduge, 2013) and Johnson and Johnson product recalls (Olaniran et al., 2012).

CM can be discussed in multidisciplinary approaches. If all public efforts to protect the citizens, their lives and values against fire, natural disasters and epidemics are understood as CM, the history of such practice began perhaps even thousand years ago. Slaves served as firefighters in ancient Rome, where the need to have a fire department seems to come from (Frandsen & Johansen, 2020a). CM can be categorized into three sub fields, namely public CM, political CM and corporate CM (Frandsen & Johansen, 2020a; Frandsen & Johansen, 2023). The first, public CM focuses on the safety of citizens during the crisis stage and deals with reacting to the crisis and crisis communication to reduce the risk and harm to citizens. Next, political CM focuses of maintaining and gaining political power aftermath of a crisis and may include activities like official commissions of inquiries (Frandsen & Johansen, 2023). Politicians and government actors try to escape blame for the occurrence of the crisis and defend their policies. They generate framing contests to interpret events, their causes, the responsibilities and lessons in ways that suit their political purposes and future policy directions, thus causing crisis exploitation (Boin et al., 2009). The other CM component, corporate CM focuses on corporate reputation and involves precautions to avoid crises typically beforehand a crisis occurrence (Frandsen & Johansen, 2020a; Frandsen & Johansen, 2023).

In a business management perspective Shaw (2004) describes a crisis as a major event that has potentially negative results on a business and its employees, products, services, financial condition, and reputation during and aftermath of the event. The history of CM and crisis communication began in the business world only a few decades ago, where the first book "Crisis management: planning for the inevitable" by American consultant Steven Fink published in 1986. Pioneers in CM first appeared during 1960s and 1970s. As acknowledged by scholars such as Williams et al. (2017), some of the earlier crisis research and theorizing has stemmed from the work of Hermann (1963), who defined an organizational crisis along three dimensions, as follows. "An organizational crisis (1) threatens high-priority values of the organization, (2) presents a restricted amount of time in which a response can be made, and (3)

is unexpected or unanticipated by the organization."(Hermann, 1963, p. 64). A well-known definition, by Pearson and Clair (1998, p. 66) describes an organizational crisis as " a low-probability, high impact situation, that is perceived by critical stakeholders to threaten the viability of the organization and that is subjectively experienced by these individuals as personally and socially threatening." They further assert that ambiguity of cause, effect and means of resolution of the organizational crisis will lead to weakening expectations or loss of shared meaning, as well as to the shattering of commonly held beliefs and values and individuals.

3.4.2. Crisis Preparedness

Crisis preparation is the initial phase to effective CM. Hutchins et al. (2008) examined that employees working for organizations with crisis plans had greater confidence in their ability to respond to a crisis event. Crises might be unavoidable, even with a good organizational preparedness (Mitroff, 1994). Jaques (2007) asserts that crises are dynamic processes while Johansen et al. (2012) show that crisis can be mitigated if the organisation has the knowledge to handle those in a strategic and proactive mean. Thus, no organization can completely prevent organizational crisis from occurring. In this vein, one can argue that organizations cannot completely prepare for crises and more likely respond reactively once a crisis occurs. According to Mitroff (1994), CM enables faster recovery along with a learning experience, although CM would not necessarily enable the prevention of crisis occurrence. Shaw (2004, p. ix) defines CM as "the coordination of efforts to control a crisis event consistent with strategic goals of an organization." He asserts that CM covers broader responsibilities of pre-event mitigation, prevention and preparedness and post event restoration and transition. As seen by Engström et al. (2020) CM generally involves exceptional policies and may adjust constraints on decision making. Best organizations act according to a systematic way in their preparations to deal with potential crises where detection of early signs of crises plays an important role (Mitroff, 1994).

Frandsen and Johansen (2020b) consider CM as an organizational practice, not as a function. They further claim that CM is used with great frequency and naturalism in today's businesses, where the question is not if the organization will be hit by a crisis, but when it will be hit. Rather than in any other circumstance, perseverance of organizational success is critical during times of crisis (Mann, 2014). Thus, risk assessment and diagnosing crisis exposures are seen as vital areas of CM (Coombs & Laufer 2018). Crisis preparedness has to be an integral part

of an organizational strategy and as such, proactive CM is essential for the survival of organizations (Mitroff & Radke, 2020).

Adding to this as Mitroff and Radke (2020) assert, every crisis can be seen as a learning opportunity that enable early preparations. They claim that a crisis can certainly precede to another next one and argue that a crisis never appears in isolation. In evidence, the COVID-19 pandemic, threatening the entire global system, has exacerbated, and spawned not only a health crisis, but accompanied economic recessions in many parts of the world (Engström et al., 2020; Le & Phi, 2021), such as the case in Sri Lanka. In addition to these multiple yet intersecting crises imposed by the Corona virus, there appears multiple crises induced by diverse factors including climate change, natural disasters and civil unrest (conflict between Russia and Ukraine). Engström et al. (2020) examined the possibility of policy changes that can address both the COVID-19 crisis and the climate crisis, in terms of employment, pandemic induced lay-offs and emissions. They found that climate policies such that supporting large scale labour intensive green infrastructure projects, assisted in economic recovery but failed to provide sufficient employment to alleviate the effects of the pandemic.

3.4.3. Crisis Response

Same as risk assessment and diagnosing crisis exposures (Coombs & Laufer, 2018), strategic leadership is another important aspect for effective CM (Taneja et al., 2014), where the quality of decision making influenced by qualities and abilities of managers (Simon, 2015). Not only the leadership, but the involvement of the employees is vital in managing a crisis. It is of great importance that all members are fully motivated by the strategic vision of an organization in order to face the many challenges of a crisis (Simon, 2015). Bringing inward the strategy and the mobilisation of the workforce are essential aspects to cope up with corporate crises, while the size, resource base, structure, procedures of planning and control can have strong influence over the management and their views on the vulnerability of crisis situations (Simon, 2015).

When dealing in a crisis environment, management mostly take their decisions based on intuition and past experience rather on rationality (Simon, 2015). As Simon (2015) asserts, mangers become preoccupied with the decisions made on a day to day, one-off basis, and tend to lose the strategic dimension in their decision making in crisis contexts. Top managers prioritize financial and operational concerns during financially turbulent times, diminishing the strategic importance of the HR function and HR concerns (Gunnigle et al., 2013). In their study

on HRM implications of MNCs in Ireland during the global financial crisis (2008), Gunnigle et al. (2013) found that HR played the role of a delivery agent of management practice changes, notably cost reduction and productivity enhancement. The findings revealed that most restructuring activities of these firms were related to HR domain, such as downsizing, working time reductions, lay-offs, concession bargaining for trade unions and changes in reward systems and working conditions.

3.4.4. Beyond Crisis Response

As advocated by Marker (2020) a designated team and leadership is needed for effective CM, where they will work through the phases of identifying risk identification, development and documentation of response plans, practicing those plans, implementing the plan when needed, and reviewing the results. Thus, going beyond detecting of warning signs as an enabler for preparations to control potential damage, revising preparedness and response plans according to the learning experience can be seen as vital tasks in a CM effort. CM is considered as the foundation for renewal and prevention of future crises (Taneja et al., 2014).

Smith (1990) assert that aftermath of a crisis, firms often try to legitimize their operational procedures and management styles by searching for scapegoats. Thus, this phase is seen as a crisis of legitimation. Other scholars have referred to this as gaining or restoring reputation. This situation can be more visible with an organizational crisis such as a product recall or mass casualty industrial accident. The goal here is to restore external confidence and deal with government interventions in the firm's crisis process as the government authorities seek both to secure legitimacy and to take preventative measures.

The intervention of government and authorities during a global or local crisis other than an (internal) organizational crisis is not well covered in the organizational CM literature. As previously explained, the COVID-19 pandemic provided with the organizations simultaneously a health crisis and a business crisis imposed by external parties including governments (Frandsen & Johansen, 2023), while at the same time prioritizing their strategic orientation across employee wellbeing and service delivery or more generally the survival of the business (Branicki et al., 2022). Thus, there appears a gap in the organizational CM literature, as most studies consider CM as an internal management activity that concerns crises within the organizations. On the other hand, in general most CM models do not provide practical strategies to deal with specific crises and fail to incorporate contextual factors such as external forces (government restrictions and support) and internal characteristics (firm size and

resources) (Le & Phi, 2021).(cf. Evans & Elphick, 2005; Olaniran & Williams, 2001). Many CM models are seen as more general and descriptive while some cannot be put into operation (Evans & Elphick, 2005). Thus, there appears a need to develop an integrated CM model that incorporate both external and internal contextual factors, specifically applicable for crises that can emerge either from internal or external factors.

3.4.5. The Event and Process Perspectives of Crisis

Williams et al. (2017) argue that existing literature lacks an agreed definition of the term crisis and there appears two broad conceptualizations of crisis. Accordingly, crisis has been seen as an event and as a process. The event- based perspective, considers basically on examining the aftermath of a crisis, while in contrast, the process perspective emphasizes that crises develop overtime and sometimes in phases and form a discontinuation in normal functioning. As reviewed by Williams et al. (2017), the majority of introductory literature on crisis and CM, provide for a process definition of crisis. For instance Shrivastava (1995) asserted, that crises are processes extended in time and space and argued that crises are not events. Pearson and Clair (1998) view CM as a systematic process of deterring or handling a crisis to sustain or resume general business operations and diminish any loss to stakeholders.

Mitroff (1994) assert that CM involves five different phases namely, 1) signal detection, 2) probing and preparation, 3) damage containment, 4) recovery and 5) learning. Along this theme, Mitroff's CM model (2005), introduces the redesign phase, which links learning and signal detection phases. Thus, CM is presented as a process that begins with detection of signals and moves to preparation phase which then leads to business recovery phase through damage containment phase. Then a review of the process is suggested at the learning phase which then stimulates the redesign of the process. As viewed by Hutchins and Wang (2008), this CM model emphasizes the importance of feedback that can bring new knowledge that can potentially affect the entire system.

Defining CM as a set of interrelated factors designed to battle crises and to lessen the actual damage imposed by a crisis, Coombs and Laufer (2018) assert that CM involves prevention, preparation, response and revision along three phases namely, the pre-crisis phase (prevention and preparation), the crisis phase (response), and the post-crisis phase (learning and revision). They claim that there is a lack of research that examine the post crisis phase. These three phases

have earlier been emphasized by scholars including Johansen et al. (2012) and Frandsen and Johansen (2011).

Coombs and Laufer (2018) call for research in a global perspective, highlighting the need to explore specific under researched aspects. They instil - cross country comparison of these research across the three phases of CM: pre-crisis, crisis, and post- crisis. Importantly, the concept of uncertainty avoidance has been seen as an important factor in risk assessment and they call for researchers to examine the link between uncertainty avoidance and CM in relation to the pre-crisis phase. According to Hofstede (2022), uncertainty avoidance refers to how the society deals with unknown circumstances of the future and the level to which members feel endangered due to such situations and have formed beliefs and institutions that help prevent such unknown circumstances.

Further, examining the role of corporate reputation in a global crisis has been identified as one of the possible areas of investigation aligned to the crisis phase. Thus, the impact of reputation on CM in different cultural contexts have been identified as a potential research area. Focusing on the learning component, Coombs and Laufer (2018) suggest that it would be vital studying what factors enable organizational change aftermath of a crisis and to examine whether certain countries are more responsive to post-crisis reviews than others.

3.4.6. The Practice Perspective of Crisis

Acknowledging both the event and process perspectives, Williams et al. (2017, p. 739) define crisis as "a process of weakening or degeneration that can culminate in a disruption event to the actor's (i.e., individual, organization, and/or community) normal functioning". Accordingly, CM can be seen as an actor's attempt to bring a disrupted system back into alignment to achieve normal functioning and the actors may involve in such an attempt at any stage of a crisis (Williams et al., 2017). Along this line of thought, they demonstrate that ad hoc organizing efforts unavoidably emerge in the aftermath of disasters or crises and propose an important, potential research avenue for those who emphasize normative approaches to disasters, to better integrate such ad hoc efforts. Goodman and Mann (2008) in their study, explored that emergency plans had incur adjustments at the response phase. This heralds a discussion to examine whether the learning and associated revisions and redesigns are ongoing across different phases of crisis, and not limited to the review stage. Along this way, a recent research study by Oscarsson (2022) argues that crisis can be seen as a day to day practice in contrast to the event and process perspectives. As mentioned above in the section 3.4.1,

Frandsen and Johansen (2020b) have also advocated the potential of considering CM as an organizational practice, not as a function.

As Oscarsson (2022) stresses, previous research commonly consider CM as a normative approach and recognize CM as a specialized integrative practice with particular meanings, materials and competencies. To elaborate, 1) the meanings to CM include readiness and awareness, 2) materials can be the plans, documents, and supply stocks while 3) the competencies for CM are enhanced through exercises and drills. In contrast to the normative approach, the practice perspective seems to be based on the idea that CM goes beyond such specialized meanings, materials and competencies and the peripheral CM needs to be recognized in routine organizational practices. This approach recognizes CM as dispersed practices and view CM as a formal and active state of readiness. In other words, CM is not only something placed in documented plans and drills, but also something interconnected with many organizational practices that bear resources used when coping with a crisis. Accordingly, this perspective focuses on CM as "the elasticity of work practices as built-in capacities to uphold daily routines"(Oscarsson, 2022).

Along this view, as Oscarsson (2022) argues, the practice perspective of CM, highlights the everyday aspects of CM, or the most practical details of work through which practitioners solve problems to continue with the core activities during a crisis. In that sense, it is possible to see CM as something ad hoc, based on resources from routine work practices. Thus, arguing that this approach to CM can enhance the understanding of details typically considered insignificant to deserve attention and explanatory value in the CM literature, the attention is shifted from considering CM as a highly specialized field to everyday activities that bear in them elements of CM. The practice perspective draws the focus on how practitioners respond to changes in various situations, and how they integrate and absorb those into their everyday work using resources and skills such as localized knowledge and professional practices. Further, this approach can help to recognize in what ways, the organizational members with little or no formal competence in CM cope with a crisis.

As suggested by Oscarsson (2022), drawing on this perspective, CM research can bring new insights to knowledge, by exploring what has been implemented when facing a crisis, the practices and tools employed and with what intentions and their joint episodes of activity. Based on such observations, contextual findings can be brought into discussion which emphasize practice rather than organizing and management principles. It is important to

understand how the core activities are being maintained during a crisis, rather than an evaluation of how well plans are implemented and used. Thus, the practice perspective of CM can allow researchers to elaborate on what is CM, based on how, in what ways and by whom it is practiced. Frandsen and Johansen (2020a) advocate adopting a qualitative research design to examine such CM practices. They assert that qualitative inquiry is appropriate to find out if, how, where, when and why organizations use preparedness practices. Scholars agree that qualitative enquiry is suitable in examining crisis situations including health emergencies and outbreaks (Teti et al., 2020).

The current study aims at exploring HRM practices adopted in hospitals in a developing country, which exposed to a dual crisis (COVID-19 and the economic crisis). As derived from the above literature review, this research would be taking the practice based perspective of CM (Oscarsson, 2022). The changes in practices designed to cope up with the crisis as well as to sustain routine hospital activities will be examined in detail, taking a qualitative approach.

3.5. Gaps in Literature

As discussed in section 2.3., there is lack of evidence relevant to health system preparedness and their responses during infectious diseases such as the recent pandemic (Gupta et al., 2021; Kuhlmann et al., 2021). Knowledge gaps have been identified in psychological factors, burnout, gender considerations and specially evidence from developing countries. The current study explores the preparedness of hospitals in dealing with the two crises in a developing country context.

Many contexts based HRM studies have based on the CBHRT model, as elaborated under the section 3.2.2.3. (e.g. Buttiens & Hondeghem, 2015; Farndale & Paauwe, 2007; Fernando & Bandara, 2020; Veld et al., 2010b). However, the application of this model within a (dual) crisis context was not discovered according to the best knowledge of the researcher. Thus, this research would attempt to apply the model in such an unattended context.

In section 3.2.10., it was identified that research on HRM practices under contexts of uncertainty are limited (Agarwal, 2021; Sanyal & Sett, 2011) including HR process research (Kim et al., 2022). It is vital to review experiences and challenges of HR managers within the post-pandemic era to determine lessons learnt, changes made and thereby prepare for upcoming crises (Dave, 2023; Hamouche, 2023) including changes to remote working and associated employee wellbeing issues (Straus et al., 2023). More research is demanded to examine

employee perceptions and their HR attributions as a clear understanding of the employee experiences can be useful in examining the effectiveness of HR response (Collings, McMackin, et al., 2021). This study, by employing the HR process perspective will fill these gaps as it explores HRM implementation in Sri Lankan hospitals along intended, implemented and employee perceived levels.

As far as employee perceptions and their HR attributions are concerned, those can be discussed under the domain of organizational justice and fairness. It was identified under the section 3.3., that organizational justice literature is dominated by empirical data from the United States and a dearth of research exists from other cultures including Asia (Aycan & Kabasakal, 2006). In the Asian context, organizations prioritize familism and paternalism, that supports a shared norm of taking care of employees' well-being (Aycan & Kabasakal, 2006). As earlier discussed, organizations confront many challenges among firm survival/ productivity and employee wellbeing as they navigate crises. This study would bring important insights to justice literature as well as CM literature around employee fairness perceptions on the organizational crisis responses.

As elaborated in section 3.4.6., the practice perspective can be identified as one most recent advancement in CM theory (Oscarsson, 2022). Adopting this perspective will assist to understand how the core activities are being maintained during a crisis, while exploring in what ways the crises were managed acknowledging the ad-hoc solutions (Oscarsson, 2022). This study will add to literature by exploring the applicability of such ad-hoc solutions to routine practices and/or to CM plans/ preparedness through learning and review endeavours with evidence from a second crisis (economic) that follows the initial crisis (pandemic).

Scholars acknowledge the central role of HR in pandemic response (Collings, Nyberg, et al., 2021), while extant literature reveals an interest in investigating HR practices adopted in times of crisis. However, there is limited research on how such HR practices are implemented by managers and their impact on employees (Newman et al., 2021).

The existing, yet limited HRM research around the COVID-19 pandemic in the Sri Lankan context, have primarily investigated the HR practices through an HR practitioners' viewpoint, and are limited to the private sector. (e.g. Adikaram & Naotunna, 2023; Adikaram, Naotunna, et al., 2021; Adikaram, Priyankara, et al., 2021; PwC, 2020; Weerarathna et al., 2022), while some studies remain conceptual (e.g. Opatha, 2020) . These studies have failed to explore the employee experiences on HRM responses. Wanninayake et al. (2024) examined wellbeing issues and coping strategies related to working from home. HRM responses in essential

services sectors including HC are not well examined. Overall, crisis induced human resource practices (CIHRP) in the public sector have not been adequately explored.

Researchers have not attempted to study the HRM in hospital settings within the pandemic context. However, HCW experiences amidst the COVID-19 pandemic has been explored in some studies (Sundarapperuma et al., 2023; Udayanga et al., 2022). For instance, Wanninayake et al. (2022) studied nurses' experience of job demands–resources (JDRs) within the pandemic context. Adding to this, Wijesinghe et al. (2023) examined the psychological issues experienced by frontline HCWs in public hospitals, within the post pandemic context. A recent study by Munasinghe et al. (2023) examined the hospital preparedness experiences of frontline HCWs in public hospital context. The experiences of non-critical HCWs have not been examined in these studies. As revealed in section 2.2.4.2., similarly, researchers in other countries, have not paid considerable attention in examining experiences of non- critical care HCWs within this pandemic context (Halcomb et al., 2020). Thus, a research gap exists.

The hospital-based studies in Sri Lanka have basically explored the HCW experiences within the public and private hospitals and not attempted to critically explore the hospitals' response in a management perspective within the HRM domain. Further, none of these studies have examined the indigenous (Ayurveda) hospitals. There appears a gap in literature around the HRM response in Sri Lankan hospitals as experienced by both managers and HCWs. The need to investigate the phenomena across public, private and Ayurveda sectors was also apparent. The experiences of HCWs associated with crisis scenarios, can suppose lessons for managing future crises including outbreaks and pandemics (Koh et al., 2005).

Considering the above, the current study attempts to discover the crisis response strategies across the two recent crisis contexts adopting the practice perspective of CM.

3.6. Summary

The current study aims to explore the hospitals' HRM response in the context of a dual crises in Sri Lanka (COVID-19 and the economic crises). An overview of literature that underpins the current study: HRM (CBHRT, HRM- performance link and HRM process perspective), employee attribution, organizational justice and CM was presented in this chapter based on empirical findings and conceptualizations.

It was revealed that empirical research focusing on HRM in crisis contexts is scarce. The importance of examining HRM implementation utilizing different actors and adopting the

HRM process perspective for such investigation has been advocated by various scholars. Although research confirm that what is planned for HRM would not be the same when it is implemented and as perceived by the employees, investigating these gaps and variations and employees' perceptions of fairness towards HRM practices during crisis context has not been well addressed in the extant literature. In addition, little empirical research has examined HRM delivery in hospitals in general, and specifically in developing, non-western contexts. It was also revealed that researchers have not well explored non- critical care HCW experiences within the pandemic context. From an organizational CM point of view, scholars argue that much of the literature remains conceptual. The literature review pointed out that what is needed to explore is how CM is practiced and absorbed in routine organizational practices, as responding to a crisis can involve ad-hoc decisions in addition to pre-planned responses. Scholars call for research to explore what effects to HRM tools and methods (practices, decisions and policies etc.) experienced by organizations, what changes were made and how those tools and methods evolved during the pandemic.

As such, the current research study is an attempt to address the gaps that exist in these areas of research. A discussion on the links between these variables, the proposed conceptual framework, research questions and the research propositions that are being investigated form the content of the next chapter, Chapter Four.

Chapter Four: Conceptual Framework

4.1. Introduction

The context of the current study and the theoretical aspects that underpin the study were discussed in the previous two chapters. This chapter will discuss a conceptual framework for exploring the HRM response of hospitals amidst crisis contexts.

4.2. Conceptual Framework for HRM Response in Hospitals amidst Crisis Contexts

The literature review chapter indicated several implications for HRM in crisis contexts as well as the importance of HRM function in contributing organizational efforts in navigating crises. The current study is an exploration of HRM (practices) response amidst crisis contexts. Gaps in the literature relevant to the study phenomena was examined in section 3.5.

A substantial body of empirical research confirms the link between HR practices and performance. Authors later took the approach studying HR practices as bundles and as such, there exists plenty of research around HPWS- performance link. However, the search for the mechanisms that link these two (HR practices and performance) remains a priority of HRM research. CBHRT suggests that various environmental factors influence HRM decisions that design HRM practices and that HRM practices lead to performance through HRM outcomes. The process model of SHRM emphasizes the deviations between rhetoric and reality in HRM delivery while the need to devote substantial effort in understanding how employees perceive the HR practices and form their behaviors that influence their attitudes and thereby shape the performance.

Employees may perceive HRM delivery as either wellbeing oriented or performance oriented as advocated by scholars referring to HR attribution literature. Further, scholars suggest that the process of HRM to be considered as recursive rather than linear, given that HRM signals can be taken a bottom-up approach where various actors (not only managers) can provide feedback in a way that HRM practices can be evaluated for further adjustments or to be confirmed and standardized as routine HRM practices. However, applying these HRM delivery mechanisms in crisis contexts has been not well addressed and scholars suggest the importance of investigating HRM implementation within such contexts using HRM process research and call for research that study employee perceptions in such contexts. As such, this study takes an initial step in that research direction by attempting to explore the HRM response in a dual crisis

context along design, implementation, and employee perceived levels. With reference to the employee perceived HRM practices, employees' perceptions of fairness towards the HRM response will be explored.

Apart from the HRM literature, this thesis is developed based on the organizational CM literature. The practice perspective of CM advocates the importance of examining the ways and mechanisms that CM is practiced, what changes are being made to routine practices and to what extent such changes are aligned to routine practices of an organization that strives to navigate a crisis.

The conceptual framework of this study is based on different concepts: the contextually based HR theory/ CBHRT (Paauwe, 2004), process model of SHRM (Wright & Nishii, 2013), organizational justice literature (Colquitt, 2001, 2012; Colquitt et al., 2005) and the literature around CM with special reference to the practice perspective of CM (Oscarsson, 2022). This framework is depicted in figure 4.1 below and it brings HRM and CM disciplines together, provides a unifying framework to guide the inquiries of this study related to HRM response in hospitals dealing with crisis contexts. The elements of the conceptual framework are briefly discussed below.

a) HRM- performance link

HRM- performance link is explored through an inputs-process-outputs relationship where,

- *HRM response design is seen as the inputs*. This element refers to top management decision towards designing HRM interventions in response to crisis events.
- *Implemented and employee perceived HRM response belong to the process component*. Implementation refers to practicing the response decisions at ward level, while employee perceived HRM response refers to what employees feel about the changes made by the hospital in response to the crises.
- *Employee fairness*: As elaborated in section 3.2.10, employee fairness concerns towards managerial decisions is an important factor in crisis contexts. This conceptual framework, integrates employee perceptions in general, allowing it to be used in a similar study. As discussed in the literature review chapter, and highlighted in the section 3.5, there's a research gap to identify employee perceptions in relation to HRM process perspective. In response, this study will take a fairness perspective to study the employee perspectives on HRM response, during this dial crisis context. The RQ4 was developed to uncover employees' experiences

in general and perceptions of fairness towards these HRM responses. A broader justification can be found under the section 4.2.5.3.

- *Outcomes* as the HCW wellbeing and quality of care (as described below).
- *Feedback* in between the HRM process, as indicated in the framework aligns with the recursive nature of HRM process.

b) Outcomes of the HRM response

Employee wellbeing and quality of care (as vital in a hospital setting) are set as the two outcomes of the HRM response. As elaborated in section 2.2.4.2., patient care and HCW wellbeing were the two main concerns of hospitals in the COVID-19 pandemic. This framework is particularly capturing hospital performance within the crisis contexts. Therefore, these two performance outcomes were integrated into the framework. Literature review of this research study, revealed that providing patient care with possible means while maintaining HCW wellbeing were the two main priorities during the pandemic. As such, these two aspects were selected among others, to be integrated in the framework. Although those two outcomes are not equivalent or interchangeable, those two concepts are highly interdependent. As exemplified in the framework itself, employee wellbeing is an important factor for maintaining a high quality patient care.

c) Crisis context

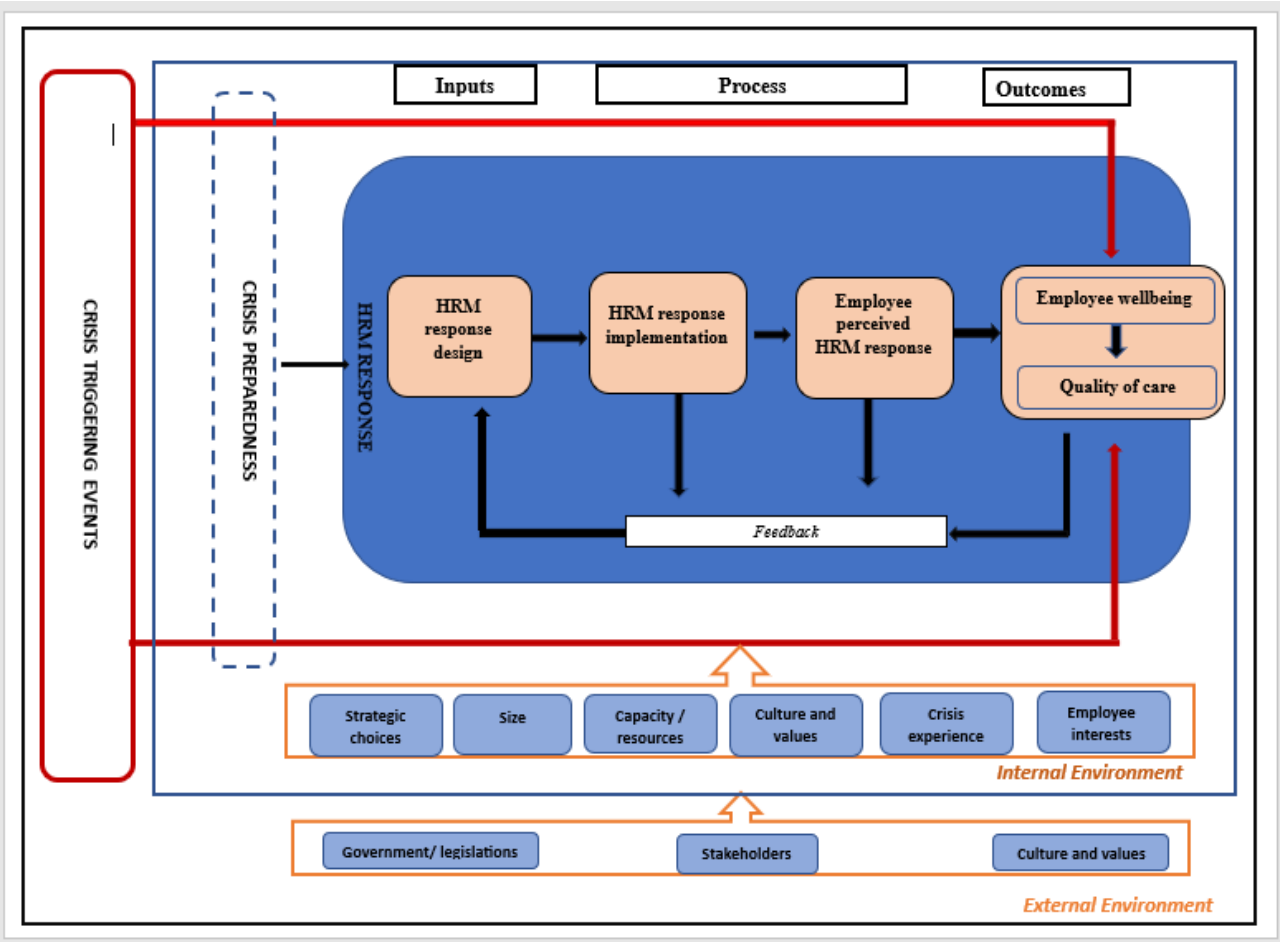
Linking the HRM perspectives with the CM perspectives, the crisis triggering events' influence over the two outcomes is illustrated in the framework.

d) Crisis preparedness

The crisis preparedness is seen as an enabling factor to buffer the crisis influences on hospital performance. It is expected that to better implement the HRM crisis response, decisions need to be taken after carefully considering both external and internal environmental factors as well the crisis preparedness (such as emergency/ risk management plans).

e) **Impact of the environment** - both internal and external environment influence is integrated in the framework.

Figure 4.1. Conceptual Framework for HRM Response in Hospitals amidst Crisis Contexts



4.2.1. Research Questions

The objective of this study is to address the identified research gaps and calls for research within HRM process and CM domains, by collecting and analyzing data from (both managers and employees in) four hospitals in Sri Lanka as they navigate through a dual crisis context. The key questions attempted to answer by the study are related to the HRM response strategies designed and implemented in Sri Lankan hospitals to address challenges imposed by the two crises, employee fairness perceptions of those HRM responses, and the usefulness of learning experiences of HRM response in future preparedness. These are explored through five research questions, as follows.

RQ 01: What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

RQ 02: What HRM strategies have the hospitals designed to respond to these crises?

RQ 03: What were the barriers and enablers of implementing the designed HRM strategies?

RQ 04: What are employees' experiences and perceptions of fairness towards these HRM responses?

RQ 05: How effective were the HRM responses and to what extent the practices been absorbed into routine practices?

Below is a discussion on variables illustrated in the conceptual framework, which guides the research study.

4.2.2. The Influence of Environmental Factors on HRM

The CBHRT supposes that an HR policy needs to be chosen after considering several dimensions in the (institutional) environment and the influence of stakeholders of an organization (Buttiens & Hondeghem, 2015). According to the CBHRT, external, competitive mechanisms, institutional mechanisms, and the internal configuration (organizational) can shape the HRM of an organization. HRM is aimed at generating HRM outcomes that contribute to the firm's performance. Both external forces and internal factors can affect the design of HR practices of an organization. Selected internal and external environmental factors are illustrated in the framework that is linked to the HRM response.

The CBHRT further emphasizes that firms may establish or adjust their HR practices subject to the leeway. As such it is implied that although external stakeholders including authorities can have direct influence over a firm's HRM decisions, the firm would be shaping their HRM practices considering the freedom to adopt according to other factors like internal work culture and values. Adding to this, the literature review revealed that external forces result in similarities of HR practices across organizations while internal factors lead to differences in HR practices. Along this line of thinking, it was discussed that the influence of a financial crisis can vary among public (NFP) and private firms.

Hospitals in this study vary in their sector (public vs private and Western medicine vs Ayurveda medicine), size, specialty (infectious diseases/ teaching hospital) and location. The influence of these factors on HRM response design is expected to vary across these hospitals.

Two propositions are formed here based on the above discussion on the influence of environmental factors on HRM.

Proposition 01: Environmental forces can influence HRM decision making during a crisis context. (These forces can include crisis triggering events; discussed below in section 4.2.3.)

Proposition 02: These influences can be differently experienced across hospitals with varying characteristics such as their sector (public vs private and Western allopathic vs Indigenous/ Ayurveda), customer base, CM experience, resource capacity (size, ability to expand, access to funding etc.) and specialty (expertise in infectious diseases) etc.

Further to those, socio-cultural environment and the enterprise environment can have influence on the internal work culture and HRM practices (Aycan et al., 2000). Individuals in societies that value collectivist norms, maintain closer and long-term commitment to the member groups (Hofstede, 2022). Compared to other cultures, organizations in Asian cultures, generally respect the traditional value of familism and paternalistic relationships that emphasize a shared norm of taking care of employees' well-being (Aycan & Kabasakal, 2006). Thus, the design and implementation of HR practices in general and specifically when responding to a crisis can be shaped by such cultural values and member expectations.

Along this line of thinking, probably the Ayurveda hospital in this study would possess distinct features backed by indigenous values and traditions. Indigenous firms respect the local mythology, and their management approaches are shaped by indigenous knowledge entrenched in ancient religious and philosophical creeds (Gopinath, 1998; Malik et al., 2021; Marsden, 1991). Studies suggest that indigenous firms adopt a unique indigenous approach to managing their employees and mostly extend support to their employees (Malik et al., 2021; Saini & Budhwar, 2008). Malik et al. (2021) studied the performance management systems between a Western medicine and an Ayurveda medicine pharmaceutical firm in India and discovered distinct differences within. Contrast to the western medicine firm which had a control-oriented, highly structured performance management approach, the Ayurveda firm had a performance management approach that reflected Ayurveda philosophy of focusing on the holistic well-being of the employees and community members from local villages to grow and proposer in harmony with nature sustainably. The performance reviews were real time, in contrast to the ongoing time-based performance reviews at the western medicine pharmaceutical firm.

4.2.3. The Influence of Crisis Triggering Events

Organizations may treat a crisis as a threat or an opportunity (Simon, 2015). Crisis triggering events can emerge in the external environment or within the internal environment of an organization (Smith, 1990). If not properly addressed, these triggering events can pose threats and internal operational crises, (Smith, 1990). Pandemics and economic recessions are external crisis triggering events that can create crises internally, while crisis triggering events such as product recalls and industrial accidents can trigger internal crises. The literature review presented that the COVID-19 pandemic has imposed different threats to organizations where scholars identified various crises resulting from the pandemic. These include unemployment crises and business crises in addition to the health crises.

Scholars have admitted that most managerial decisions during a crisis can be based on the past crisis experience (Simon, 2015) and factors such as sector, scale, market penetration and coverage can mediate the impact of external changes such as economic crises on a firm (Gunnigle et al., 2013). As Simon (2015) asserts, the size, resource base, structure, procedures of planning and control can have strong influence over the CM of an organization. For instance, the literature review revealed that while most sectors suffered from the many challenges of the COVID-19 pandemic some sectors like pharmaceutical suppliers and online businesses flourished. Even in the hospital settings, hospitals upgraded their telehealth facilities and mobile pharmaceutical services amidst the challenges imposed by the pandemic, excelling on new business opportunities (e.g. Shaown, 2021).

As revealed in the literature review, private hospitals and public hospitals can have different implications during crisis situations. For instance, in an economically turbulent situation patients may largely seek treatment from a public hospital given their unaffordability of medical bills, resulting overcrowded public hospitals. Conversely, there would be sales drops in private hospitals. Both situations can have negative impacts on HRM (employee workload, salary, and other benefits). Such differences on the impact of the two crises across different hospitals will be compared in this multiple-case study. Previous research proved that similarities in HRM among firms are strongly shaped by external factors, and the differences in HRM are strongly shaped by internal factors (Blom et al., 2021). These discussions herald a proposition that the impact of the two crises considered in this study (pandemic and the economic crisis) on the Sri Lankan hospitals, can be different across hospitals with varying characteristics.

Proposition 03: The influences of the crisis on hospitals are distinct across the two crisis situations.

4.2.4. Influence of Crisis Preparedness towards HRM Response

Literature suggests that responding to a crisis can be very difficult without proper crisis preparedness, while a study showed that employees working for organizations with crisis plans had greater confidence in their ability to respond to a crisis event (Hutchins et al., 2008). It was revealed in the literature review that organizations would manage crises well with less damage, and would also benefit in turning crises into opportunities if they are well prepared (Olaniran et al., 2012).

The conceptual framework illustrates that crisis preparedness can buffer the impact of a crisis on the hospitals' outcomes. In a hospital setting, the surge capacity and hospital preparedness are vital components in managing crises including mass casualty events as argued in the previous research (Barbisch & Koenig, 2006). WHO's Hospital Emergency Response Checklist (WHO, 2011) emphasises the "four S's" of surge capacity: *staff, stuff, structure, and systems* (Watson et al., 2013). The capacity / resources have been indicated in the current framework, aligned to the internal environmental factors that can influence the crisis/ HRM response. Based on the above, the next proposition is developed as follows.

Proposition 04: Hospitals with crisis preparedness/ risk management plans and provisions for surge capacity find less challenges with coping up and responding to crises.

Linking the propositions (01-04) on the impact of environmental forces on hospitals within crisis contexts and the importance of crisis preparedness, the first research question is formed as follows.

RQ 01: What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

Sub questions (SQ) under the RQ 01 are as follows.

01. What challenges did the hospitals encounter during the pandemic and how were those challenges different from what they experienced during the economic crisis?
02. How did the crisis influence employee wellbeing and quality of care (outcomes as elaborated below in section 4.2.5.4)?

03. What were the environmental influences (threats and opportunities) over the hospitals and the impact of those on their HRM (government/ WHO / legislations/ protocols/ suppliers/ society/ culture and beliefs)?
04. What were the internal influences (strengths and weaknesses) e.g. previous experience with disasters or emergencies, management intentions (strategic choice vs employee wellbeing), internal work culture and values, hospital size, capacity and resource availability etc.?
05. Were there any crisis preparedness in place and to what extent were they useful/ applicable as an actual crisis response

4.2.5. HRM Response to Crisis Contexts

The next research questions are drawn from the theoretical underpinnings of HRM process perspective. The main theoretical perspective used in this framework is the HRM-performance link and it is built upon the process of HRM delivery (Wright & Nishii, 2013) ranging from inputs (intended HRM design) to outcomes (employee wellbeing and quality of care), through the implementation process (both implemented practices and employee perceived practices). HRM practices affect HRM outcomes (commitment, quality, and flexibility) that affect employee behavioral outcomes, which lead to performance outcomes.

One important factor to consider in this research study is the crisis context. As discussed in the literature review, crisis events have implications on both a firm's survival/ performance and employee wellbeing. As such, based on that notion, this study researches the influence of the crises on these two outcomes (emphasizing employee wellbeing and quality of care as major concerns of a hospital setting) and to what changes in HRM practices have been applied to manage such impact. Accordingly, the following two propositions are developed.

Proposition 05: Crisis contexts can bring challenges to employee (HCW) wellbeing.

Proposition 06: Crisis contexts can be a challenge for hospital survival and performance.

Proposition 07: Changes to HRM practices are designed and implemented to respond to such challenges.

4.2.5.1. HRM Response Design

An organizations' strategy, environmental pressures, and the management's employee-oriented philosophy can influence its decisions (Child, 1972; Lepak et al., 2007; Nishii et al., 2008). The CBHRT suggests that when an organization designs its HRM policies, there appears a tension between economic rationality and relational rationality (moral values). Scholars have admitted that when firms attempt to enhance performance employee wellbeing might be of less interest. An organization's strategic orientation (performance vs employee wellbeing motives) drives and is reflected through, its HR practices.

In general scholars agree that HRM decisions can be control or commitment oriented. Based on the widely used hard and soft HRM dichotomy, also consistent with commitment vs control HRM practices, scholars claim that high commitment HRM practices promote employee participation and drive employee efforts towards organizational goal achievement while control HRM practices emphasize approaches of cost minimization towards goal accomplishment through standardized efforts. Scholars assert that control oriented HRM is applicable to mass manufacturing firms while service firms would benefit from commitment oriented HRM approaches. It is important to explore which one of these two approaches when dealing with a crisis. Scholars admit that democratic management styles (more likely commitment oriented HRM) are more productive when dealing with crises. However, the literature review revealed that contradictions exist between what is implemented (more control oriented) by the organizations and what is expected by the employees (wellbeing oriented) during crisis contexts. Firms tend to take performance-oriented decisions when coping with a crisis, rather employee wellbeing-oriented decisions. Conversely, employees have had expectations towards their employers to have more flexibility in HRM practices aimed at their safety and wellbeing. This would be relatively an important HRM consideration in a collective society and paternalistic work culture such as the case in Sri Lanka.

As discussed in the literature review chapter, during the pandemic, firms have had to tackle both employee wellbeing and firm performance/survival challenges. Employee wellbeing has been seen as a vital priority in many firms. WHO emphasized the importance of providing high quality care while ensuring HCW wellbeing. But to what extent HRM practitioners in hospitals adopted their CM towards these two outcomes are not known.

It was discussed in the literature review that different HRM practices have been implemented by firms in response to crisis situations, including changes to staffing, recruitment (freezes in

economic crises), compensation etc. In HPWS literature and high commitment management research, scholars have identified HRM practices that are effective in successful organizations including selective staffing, team working, compensation contingent on performance, extensive training, employment security, communication and information sharing, participative decision making etc.

The motives behind the HR practices can be different. For instance, extensive training has been seen as an investment component that incurs a cost to the firm but develops its competitiveness through a skilled workforce (Goldstein & Gilliam, 1990), which can be seen within the performance enhancement lens. At the same time, scholars admit that training and development can signal employees that their employer has high employee concern levels (Rhoades & Eisenberger, 2002).

This qualitative inquiry is designed to investigate what HRM practices have been involved in responding to the two crises in the selected hospitals. During semi-structured interviews conducted for data collection, questions were open for participant voice. Interview questions were designed to investigate changes to 1) staffing, 2) training, 3) rewards, welfare and employee assistance, and 4) employee participation practices.

Based on this discussion, the following propositions are drawn.

Proposition 08: Hospitals' crisis responses are performance- oriented.

Proposition 09: Hospitals' crisis responses are employee well-being oriented.

The second research question is developed to examine these propositions.

RQ 02: What HRM strategies have the hospitals designed to respond to these crises?

SQs developed to answer the RQ 02 are as follows.

01. What staffing practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing?
02. What training practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?
03. What rewards, welfare and employee assistance practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

04. What employee participation practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

4.2.5.2. HRM Response Implementation

Next, intended practices might be different from what is implemented due to various reasons. Researchers referring to the HRM process model, have found that, LM have encountered barriers (such as operational pressures) in implementing the intended practices same as the design (Makhecha et al., 2018). This might be frequent in a crisis situation, as also admitted by the practice perspective of CM (Oscarsson, 2022), when managers have to implement ad hoc solutions to problems that arise during a crisis (Simon, 2015). Decisions are often made on a day to day, one-off basis, while HR managers facilitate overall CM initiatives (Simon, 2015). A proposition is drawn from these theoretical perspectives.

Proposition 10: Hospital managers may incur changes to planned practices during the implementation stage.

The next research question is developed to explore whether the intended HRM designs were implemented as the same or if not, what changes have occurred, what barriers and enablers the LMs experienced during the implementation stage.

RQ 03: What were the barriers and enablers of implementing the designed HRM strategies?

SQs drawn to answer the RQ 03 are as follows.

01. What staffing practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?
02. What training practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?
03. What rewards, welfare and employee assistance practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

04. What employee participation practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

4.2.5.3. Employee Perceived HRM Response

Next stage of the HRM process, is the perceived HR practices. As discussed under HR attribution literature (Hewett et al., 2018; Nishii et al., 2008) and organizational justice literature (Colquitt, 2001, 2012; Colquitt et al., 2005), employee behaviour may depend on the attributions they make about the management intentions and motives underlying the HR practices they experience. Scholars suggest that employees perceive the changes in HR practices and the related motives can be either external (due to legislation; for instance, implementing social distancing measures at workplace during the pandemic due to government guidelines) or management interests/ internal (of either caring or exploiting employees). Previous research suggests that when employees perceive the HR practices to be wellbeing oriented, they create a sense of reciprocity and tend to perform well unlike in a situation when they perceive the HR practices to be more performance oriented. However, employee attributions towards HR practices within crisis contexts have not been well addressed in the literature.

Proposition 11: Employees perceive the motives of HR practices as external in a crisis.

Proposition 12: Employees perceive the motives of HR practices as internal (wellbeing vs performance) in a crisis.

The role of fairness as a workplace consideration is discussed under organizational justice literature (Greenberg, 1990). Organizational justice relates to perceived fairness concerns of employees as they evaluate the fairness of treatment within the workplace (Tepper, 2001), Previous research suggests that perceived inequality lead to employee demotivation (Zeidan & Itani, 2020). Unlike other situations, employees may expect wellbeing-oriented treatment of employer within a crisis scenario. However, literature indicates that employers prioritize performance-oriented practices in such crisis contexts. Thus, it is questionable, whether the employees perceive their employer's HR response as fair during a crisis context. Employees may have multiple views of fairness depending on their own experience and how they evaluate fair treatment towards their co-workers (Johansson et al., 2007; Kray & Allan Lind, 2002).

The above propositions around employee attributions and fairness towards their (de) motivation might not be applicable as same in a hospital setting. As elaborated in section 3.2.10 in the literature review chapter, HCWs, would accept additional workload with minimum facilities or benefits with a sense of responsibility given that they value helping others (Shields & Ward, 2001; Veld et al., 2010a) and perceiving their "calling for work" (Cynthia D Fisher, 2014; Sharma et al., 2022).

Proposition 13: HCWs may perceive performance-oriented changes in HRM in crisis contexts as fair.

In a similar vein, scholars suggest that individuals perceive and value part of the responsibility on themselves and form comradeship in responding to widespread adversities such as a health crisis (Wheeler et al., 2022). However, this would not be applicable in an economic crisis scenario in which generally public do not feel accountable for the recession. The context of this study would provide different perspectives towards HCWs' fairness and wellbeing attributions as feelings of employee accountability might be different across the two crises.

Proposition 14: HCWs' perceptions of fairness can be varied across the two crises (pandemic and economic crisis).

It is interesting to examine the employee perceptions of HRM response, the drivers of these perceptions and to identify whether their perceptions are stable or not, across the two crisis contexts. The following research question is formed based on the above discussion.

RQ 04: What are employees' experiences and perceptions of fairness towards these HRM responses?

SQs drawn to answer the RQ 04 are as follows.

01. What staffing practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those staffing practices perceived as fair by HCWs?
02. What training practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those training practices perceived as fair by HCWs?
03. What rewards, welfare and employee assistance practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or

what motives are perceived by the HCWs? Were those practices perceived as fair by HCWs?

04. What employee participation practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those employee participation practices perceived as fair by HCWs?

The above research questions (RQ 02-04) are in line with the calls for research in HRM domain to explore the HRM perceptions using multiple stakeholders including employees. (Alfes et al., 2013; Kooij et al., 2013; Truss, 2001). As elaborated in the literature review, scholars have urged the importance of HRM process research and exploring employee experienced HR practices in crisis contexts (Kim et al., 2022).

4.2.5.4. Outcomes of the HRM Response

As described earlier and as depicted in the conceptual framework, employee wellbeing and the quality of care are the two outcomes of the HRM response considered in this study. The effectiveness of the HR response can be explored as experienced by the participants (both top managers, LM and the employees). As mentioned earlier, in a crisis there might be gaps between what was designed and what was implemented. Thus, the intended outcomes might not be achieved completely as expected and there might be adjustments to what was planned.

Proposition 15: Perceived outcomes of the HRM response can be different from intended outcomes within a crisis context.

The HR response's impact to employee wellbeing and the level of quality of care can be identified through participant views. Although patients can be the main source of identifying the level of care they received, this study is not exploring the phenomena with patient feedback. However, hospital managers and HCWs can provide their views and perceptions on quality of care and patient satisfaction.

When hospitals strive to enhance quality of care, consideration to ensure employee wellbeing might be diminished. At the same time, if hospitals have failed to ensure patient care in a standard manner, HCWs might experience feelings of distress due to inability to provide proper care. Changes to work settings and work contexts which can be apparent in a crisis context can be negatively related to employee wellbeing (Guest, 2017). Conversely, when employees feel

satisfied and experience that their wellbeing is assured, their performance boosts. Existing literature admits that employee wellbeing related HR practices enhance employee wellbeing and organizational performance through employee attitudes, motivation, and behaviour. It was revealed in the literature review that employee wellbeing is positively related to performance (Guest, 2017). Reflecting these relationships, the conceptual framework illustrates that HRM response affects both outcomes: employee wellbeing and quality of care and while wellbeing can impact the quality of care. Studies referred to the JDR model confirm that, employee physical discomfort can be diminished, when the necessary resources are provided through appropriate HR practices and such practices positively related to employee well-being and individual performance (Bakker & Demerouti, 2007; Schaufeli et al., 2009; Van De Voorde et al., 2016).

Proposition 16: Changes in HRM practices can boost or decrease employee wellbeing.

Proposition 17: Changes in HRM practices can boost quality of care.

Proposition 18: HCWs perform better when they perceive wellbeing oriented HRM practice changes.

Particularly in a hospital setting, the aspect of prosocial orientation of employee wellbeing related to work calling (employee consider helping others as a major purpose of the job) (Cynthia D Fisher, 2014) can be of high relevance. Research showed that during the pandemic, HCWs have experienced low levels of wellbeing due to job related factors as well as factors beyond workplaces. These include work-family issues, social discrimination etc. (Abdulah et al., 2021; Bapuji et al., 2020). It is questionable whether these wellbeing concerns have also been noticed and addressed by the hospitals related to their crisis response. These types of important HR concerns are expected to be explored when questioning about the effectiveness of the HRM response in achieving both employee wellbeing and performance outcomes. Therefore, the next research question of this study is to explore, the effectiveness of the HRM response in terms of achieving intended outcomes and how far were the HRM practices related to ensure employee wellbeing and quality of care.

4.2.5.5. Feedback and Changes in HRM Response

The last research question is linked to the practice perspective of CM (Oscarsson, 2022) and to the recursive nature of the HRM process (van Mierlo et al., 2018). Research suggest that crises

bring important learning opportunities, while the lessons can shape the organizational practices, future crisis response as well as the level of preparedness. Literature calls for studies that examine the factors enable organizational change aftermath of crises and highlights the importance of examining level of responsiveness to post-crisis reviews (Coombs & Laufer, 2018).

Feedback in the HRM process can be sought at implementation level (LM) and through employee voice as well as by examining the effectiveness of outcomes. Literature suggests that this feedback can be used to determine whether the HRM practices need modifications, or if not to determine the suitability to continue as its original design (van Mierlo et al., 2018). This can happen both at design and implementation stages.

Proposition 19: Ongoing changes to HRM practices can be made in a crisis context based on feedback from implementation, employee experience and outcome stages.

The dual crisis context in Sri Lanka is ideal to examine whether the hospitals have had redesigned their HR responses during the various phases of the COVID-19 pandemic, and at the same time to identify whether any learnings associated with the pandemic HR response have been utilized in designing the HR response to the economic crisis. At the same time, it would be possible to see to what extent the changes in HRM practices have been absorbed to routine HRM practices.

Proposition 20: Learnings based on reviews of HRM practice changes can be used to determine whether to absorb those changes into routine HRM practices and/or to revisit and refine the crisis preparedness/ HRM response plans.

Along this line of thinking, the final research question is formed as follows.

RQ 05: How effective were the HRM strategies?

SQs to answer the RQ 05 have been drawn as follows.

01. What were the outcomes of HRM response?
02. Do managers and HCWs experienced any influence of employee wellbeing on employee performance and thereby on quality of care?
03. Have the HRM strategies been adjusted during and across the crises?
04. Were those changes based on review and feedback from managers and HCWs?
05. To what extent the HRM response strategies have been absorbed into routine practices and overall crisis preparedness?

4.3. Summary

This chapter introduced the proposed conceptual framework of the current study based on related theoretical perspectives discussed in the previous chapter. Five research questions of the study were identified based on relevant propositions drawn from the theoretical underpinnings. The methodology of the thesis is discussed in the next chapter.

Chapter Five: Methodology

5.1. Introduction

The previous chapter outlined the conceptual framework and the research questions were discussed. This chapter discusses the research design and methods used in the study. The epistemological approach for this study has been identified, followed by an introduction to the general research paradigms. As a reflexivity strategy, the researcher's self-interests are discussed under the researcher's positioning. A multiple-case study design is employed in the current study, and the methodology is discussed in detail. The context of the study and a rationale for selecting the case study hospitals are presented. The sampling strategy and techniques used for data collection are described. Thematic analysis was used for data analysis. Strategies used for enhancing the rigour of the study are presented. Finally, the ethical consideration of the study is described.

5.2. Research Paradigms

Researchers operate within a paradigm. Paradigm is a whole system of thinking that consists of basic assumptions, questions to be answered, the research techniques to be used in a research (Neuman, 2013). Lincoln and Guba (1985) state that paradigms represent a distillation of what we think about the world and our actions including actions as inquirers in the world, cannot occur without reference to those paradigms. According to Brown and Dueñas (2020), paradigm is a set of common beliefs and agreements shared between scientists about how problems should be understood and addressed. The nature of knowledge in any research is explored and detailed with respect to the research paradigm.

There have been many categorizations of research paradigms and there appears to be considerable debate around these classifications. Morehouse (2012) categorizes research paradigms into two: positivist approach and naturalistic approach. In contrast to positivist approach, the naturalistic approach requires the researcher to become a part of the research. Lincoln et al. (2011) claim that social sciences turn towards more interpretive, post-modern, and critical practices and theorizing. They provide a comprehensive analysis of five research paradigms: positivism, post-positivism, critical, constructivism or interpretivist and participatory or postmodern. Positivism indicates an objectivist epistemology and widely employs quantitative methods. Post-positivism's epistemology is modified objectivist and

modified experimental methods (including qualitative methods) are employed. Critical theory and constructivism indicate a subjectivist epistemology and constructivism deals with co-created findings. A dialectical methodology is employed in both paradigms. Participatory/ postmodern paradigm indicates a critical subjectivity epistemology and the methodology used include participation in collaborative action inquiry (Lincoln et al., 2011, p. 100). Postmodernism view that realities can only be understood within particular contexts where realities are constructed within. The focus of research moves from a large-scale to small scale qualitative research (Liamputtong, 2013).

Three major research paradigms have been put forward by Teddlie and Tashakkori (2009) as follows.

1. Positivist: researchers believe that the reality is out there and researchers employ quantitative methods.
2. Constructivist: The reality is believed to be socially constructed and preferred methods are qualitative.
3. Pragmatist: the truth is what works and proves itself good for definitive reasons and is subject to de-negotiate and debate. Mixed methods are employed.

This research study lies within the constructivist paradigm.

5.2.1. Ontology, Epistemology and Methodology

Ontology stands for the nature of reality. This research aims to understand participants' experiences of HRM implementation within a dual crisis context. As such, the researcher believes that there can be multiple realities and many interpretations can be made in an inquiry.

Epistemology is the nature of knowledge. In other words, epistemology refers to how can the inquirer know about the reality or what is the nature of relationship between the inquirer and the reality. In this study, the researcher's view of nature of knowledge is subjective.

Methodology consists of the set of theoretical concepts and methods applied to answering the research questions. This research study lies within a constructivist paradigm. As such, the researcher believes in multiple realities and subjectivist knowledge. Qualitative methods are used to find answers to the RQs.

5.2.2. Researcher Positioning

In a qualitative study, it is impossible for the researcher to be objectively detached from the research as the researcher is an integral part of the study (Liamputtong, 2013). For instance, the researcher becomes the research instrument during the data analysis, and makes judgements about coding, building themes, and contextualizing the data (Nowell et al., 2017). Thus, the quality of the qualitative research may be impacted by the researcher's social position, personal perspectives, experiences and beliefs (Liamputtong, 2013; Marshall & Rossman, 2011). Researcher reflexivity has been seen as a major strategy for quality control of qualitative studies. This refers to as the researcher's self-appraisal in the research, in view of knowledge production as independent of the researcher producing it (Berger, 2015).

According to Creswell (2016), researcher positioning is often referred to as reflexivity. "Reflexivity is the engagement by researchers in self-understanding about the background they bring to a research study and how it shapes their interpretations….".(Creswell, 2016, p. 222). Researcher reflexivity has become an essential characteristic in qualitative research (Berger, 2015; Liamputtong, 2013). A qualitative researcher should therefore mention about the researcher's biases, values and experiences the researcher brings to a study. Creswell (2016) advocates to do so, by 1) explaining the researcher's experiences with the phenomena being explored, by imparting past experiences through work, schooling, family dynamics etc. and by 2) discussing how the past experiences shape the interpretation. The scholar further asserts that, it is vital to detail past experience with the phenomena and to be self-conscious about how those experiences may potentially have shaped the findings, interpretations and conclusions presented in the study.

The researcher acknowledges that her personal background might have impacted the interest in researching the HRM practices in the Sri Lankan HC sector and her experience, beliefs and personal perspectives would influence the data collection and interpretation. As argued by scholars, it is expected that a critical self-reflection of the researcher can be useful as a mean of enhancing the quality of the research. The following section is a self-reflection of the researcher's background and experiences.

The researcher of this research has no professional experience in the Sri Lankan health sector, despite her exposure to the health sector, being a spouse to a paramedic HC worker in Sri Lanka. However, when the pandemic hit Sri Lanka, the researcher was not residing in the country and only had the chance to hear about issues in hospitals and about a few HCW

experiences through her network. Further, during this time there was a big exposure of hospital staff in public media for enhancing public awareness for acknowledging and respecting the service of HC workers, which was anew in her country. These external, yet important information triggered her interest to conduct research, within the context of this pandemic, and she was eager to first, have a look at how the hospitals have managed the staff and second, to explore the experiences of staff within this context. Following the pandemic, the economic recession triggered a dual crisis scenario in the country which had significant influences in the health sector. These informal experiences would shape and influence the data collection, sense making, judgements and interpretation of data in any possible means. With this awareness, the researcher employed strategies to ensure rigour of this research, which are described in section 5.3.7.

5.3. Methodology

5.3.1. Qualitative Research Methods

Positioning in the constructivist paradigm, this study employs a qualitative research methodology. Qualitative research can enable the researcher to learn something truly new, that quantitative research can almost never do (Press, 2005). Qualitative research focuses on context (Marshall & Rossman, 2011). A qualitative researcher is concerned with presenting a description of the phenomenon of interest by capturing the experience of participants (Denzin & Lincoln, 2011) and the qualitative methods are appropriate to learn lived experiences (Liamputtong, 2013).

As elaborated in the literature review chapter, there is a dearth of research around health sector, in low and middle-income countries (Kuhlmann et al., 2021). Scholars recommend studying the employee experiences in the context of COVID-19 (Collings, Nyberg, et al., 2021). Furthermore, scholars stress the need for more research in the HRM domain, that involve employee perceptions in evaluating HRM effects on firm performance (Alfes et al., 2013; Guest, 2011; Kooij et al., 2013; Truss, 2001). There exists criticism that prior research in the HRM field tend to analyze the effects of HRM practices on organizational outcomes, based on single views of senior HRM professionals (Alfes et al., 2013; Kooij et al., 2013; Truss, 2001). Of note, Buchan (2004b) asserts that there is lack of evidence- based research on HRM-performance link in the HC sector, while scholars argue that qualitative research in HC sector has gained growing interest (Hoff & Witt, 2000; Liamputtong, 2013; Murray, 2010; Sofaer, 2002; Weiner et al., 2011).

According to the above information, the current study's context and objectives warrants a qualitative research approach.

5.3.2. The Research Design – the Case Study Approach

There are different types of approaches to qualitative research design. This research study is designed to understand HRM implementation in crisis contexts by collecting participants' experiences of crisis challenges and HRM responses strategies in different hospitals. Therefore the case study design was chosen. This is also aligned with the recommendations made by scholars including van Mierlo et al. (2018) and Woodrow and Guest (2014) to use case study approach when designing HRM implementation research.

A case study can be defined based on the scope of the study (Yin, 2014). A case study is" an empirical enquiry, that investigates a contemporary phenomenon in depth and within its real-world context, …." (Robert K. Yin, 2014, p. 16). Neuman (2013, p. 42) describes a case study research as "research that is an in-depth examination of an extensive amount of information about very few units or cases for one period or across multiple periods of time". A case study may contain a single case or more than a single case. Latter is referred to as multiple-case study (Creswell, 2016: Yin, 2014).

Creswell (2016) describes four steps to conduct a case study. First the case needed to be clearly identified by the researcher. "A case could be a concrete entity such as a group, an individual, an organization, a community, a decision process or a specific project" (Creswell, 2016, p. 265). Next the researcher needs to describe the case of interest that is expected to provide insight into an issue or a problem. Then data can be collected from multiple sources to provide a broader perspective about the issue or the problem within the case. Last step is to develop a detailed description of the case which is the end product of the case study. The description of the case needs to be followed by themes emerging from the collected data and generalizations or assertions about the studied case. An in-depth analysis of the issue being studied needs to be emerged at the end.

This research is conducted across four hospital in Sri Lanka and thus can be categorized as a multiple-case study.

5.3.3. Selection of Case Study Hospitals

When selecting cases for a multiple-case study, the replication logic needs to be applied, and each case must be carefully selected to ensure that the case "either predicts similar results

(literal replication) or predicts contrasting results but for anticipatable reasons (theoretical replication)" (Robert K. Yin, 2014, p. 57). According to Yin (2014), a few cases (2-3) would be designed to pursue literal replications and a few other cases for theoretical replications. The rationale for selecting multiple case study design, needs to be derived from the researcher's understanding of these replications. As stated by Yin (2014), selecting two or more cases that the researcher believes to pursue literal replications, would be the simplest multiple-case study design.

The rationale for determining the number of cases for this study was first derived from the prediction that inclusion of cases with different characteristics (public and private, Western and Ayurveda medicine, expertise in infectious diseases and previous crisis/ emergency experience) would derive contrasting results. This type of prediction refers to theoretical replication, for which there needs to be more than 3 cases included in the study (Yin, 2014). Due to practical issues in accessing to hospitals and project time constraints, this study was designed with 4 case study hospitals with varying characteristics as follows.

Table 5.1: Case study hospital details

Case	**Sector**	**Type**	**Bed capacity and no of staff**	**location**	**Expertise or previous crisis experience**
A	Public	Western Allopathic	200 beds 170 nurses 70 doctors	Metropolitan	Specialized in infectious diseases
B	Private	Western Allopathic	50 beds 70 nurses	Regional	-
C	Public	Ayurveda	76 beds 45 HCWs	Regional	-
D	Public	Western Allopathic	2060 beds 1085 nurses 340 doctors	Regional	Disaster experience during 30 year Civil war

Once the candidature proposal approval has been secured for the research project, the ethics application was submitted to the university ethics committee with three potential hospitals with access to conduct the study. To obtain access, the researcher located email and telephone contact details from her network and also directly from the hospital websites. Initial method of contact was through email to six hospitals. However, these were left unanswered. As a next strategy, telephone communications were used. HR Managers from 8 hospitals expressed their

interest in participating, but later some withdrew their interest for various reasons, including resource and time poverty and concerns with virtual data collection processes. Only 3 hospitals (including Cases A and B) agreed to participate.

Ethics approval was secured before the commencement of data collection. Data collection was initially commenced through telephone interviews in two hospitals including case A. Gatekeepers in these two hospitals highlighted the practical problems with access to email communications and online modes among hospital staff. Further, data collection progress was pressed due to various issues including daily power cuts in Sri Lanka at that time and participants' cultural hesitance for online communication modes. Due to a refusal of access to the third case study hospital after 9 interviews have been conducted, search for alternative hospitals was initiated. Based on the recommendations of the second milestone review of the study (Mid Candidature Review), it was decided to expand the number of cases and to gain access to an Ayurveda hospital. Further, as online data collection did not seem appealing, the researcher decided to travel to Sri Lanka and conduct face to face interviews. By the time, access to cases A and B was secured. After a significant effort of approval and formal discussions with couple of other hospitals, the researcher was able to secure access to Hospital C (Ayurveda) and Hospital D (public).

5.3.4. Sampling

A sample is "a small set of cases a researcher selects from a large pool and generalizes the population (Neuman, 2013, p. 246)". Morehouse (2012) identifies the purposive sampling strategy as the preferred manner for qualitative studies, where researcher seeks maximum variation rather than a random sample. Purposive sampling method is appropriate if the researcher aims to have a mobilized sample and this method helps selecting unique cases that are specially informative (Neuman, 2013). The sample is selected on purpose in a systematic way (Morehouse, 2012). Purposive sampling is suitable when the subjects have all experienced the phenomenon of the study (here, the two crises) and when the research is exploratory (Cresswell, 2005; Hutchins et al., 2008).

Snowball sampling allows researchers to identify " cases of interest from people who know people, who know what cases are information rich" (Marshall & Rossman, 2011, p. 111). This research utilized purposive sampling and snowball sampling techniques. In this study, few participants were approached through the key informants and when the interviews progress, snowball sampling was applied to reach additional respondents.

The sample size was determined based on data saturation and access. There are no universally accepted rules for determining the sample size in qualitative studies and often the size depends on number of factors such as what the researcher wants to know and what will have credibility (Liamputtong, 2013; Teddlie & Tashakkori, 2009). As described by Mariampolski (2001), to make meaningful comparisons between groups or individual participants, a sufficient number of respondents should be interviewed. Acknowledging the difficulty in determining at which point 'enough' respondents are being interviewed, the scholar explained that approximations of the saturation point include when the investigator has reached redundancy after hearing the same thing from repeated respondents. Such redundancy is referred to as data saturation, signals that data collection may cease (Faulkner & Trotter, 2017; Guest et al., 2006).

Data saturation is considered as the suitable approach to determine the sample size in qualitative studies (Guest et al., 2006; Morse, 2000; Saunders & Townsend, 2016). "Data saturation entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy. In other words, saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added" (Bowen, 2008, p. 140).

In this study recruiting participants was initially started through the gate keepers of each case study. In Case A, the Chief Nursing officer agreed to publish the invitation to participants (Appendix 1) within the hospital to promote the awareness among staff. In hospital B, the assistant HR manager assisted with promoting the research invite among all staff through the department heads.

In Hospital C, the Medical Superintend introduced the researcher to staff during an informal gathering (a tea party). Cases B and C had few employees when compared to other two cases. In hospital D, the researcher had to make direct contacts with department heads for recruiting participants, given it was a large scale hospital. At the beginning of each case, there have been few nominated participants through the key informants and further participants were located through 1) reaching out to participants and through 2) snowball sampling. Having participants from three categories (SM, LM and HCWs) and including participants from different sections in every hospital was a main consideration when adding participants to the sample. The sample size was determined based on the data saturation.

5.3.5. Data Collection

According to Mann and Stewart (2000), qualitative research generally involve interviewing, observations and document analysis while interviews are the most commonly used method. Interviewing is the most widespread method among those qualitative data collection methods (Creswell & Poth, 2016; Keen et al., 2022), particularly in organization and workplace studies (Saunders & Townsend, 2016) .

Doing a qualitative study using interviews involves selecting a number of respondents and discover their perceptions, attitudes and behaviours regarding a specific idea, matter or situation (Sbalchiero, 2018). When personal perspectives of participants are expected to reveal and when they are not likely to share their perspectives in a group setting, One-on-one interviews can be the best option, where the interviewer can access to the participants body language, inflections to voice and establish a personal connection with the participant that may enhance their willingness to be open in the discussions in these interviews (Creswell, 2016). Telephone interviews have been identified as an ideal method when participants are located at a different place from the interviewer (Creswell, 2016), and is a possible mean to extend access to participants (Mann & Stewart, 2000).

For this research study, data was gathered from three participant groups: SM, LM and HCWs. Interview guides (Appendices 2, 3 and 4) were designed for three participants groups to grasp potential information to answer the research questions. Creswell (2016), asserts the need to using an interview protocol during an interview. It is a tool that lists the interview questions and used for recording some of the interviewer's thoughts as the interviews proceed. Interview guides of this study were designed with the guidance of a member of the supervisory team and the questions were open to themes including;

1) Dual crisis experience to self, hospital, and workers

2) Hospital preparedness to the crises

3) HR responses, changes to practices (staffing, training, rewards and employee assistance programs, employee participation) and the level of implementation

4) Perspectives of fairness towards the HR response

5) Effectiveness of the changes, impact on employee wellbeing and patient care/ satisfaction, 6) Lessons learnt, level of absorption of the changes into routine practices and implications for future.

In addition to the main questions, probing and follow up questions were raised and the researcher made sure to allocate time for introduction and follow the closing instructions as Creswell (2016) described. Once the interviews were scheduled, during each interview audio equipment setups were carefully monitored (Creswell, 2016). During each interview a short time was devoted to building rapport and appreciating the willingness of interviewees in participating the interviews. This helped enhancing trustworthiness and participant willingness to open up (Creswell, 2016). This was accompanied by the consent form which was signed by the participants before the interviews.

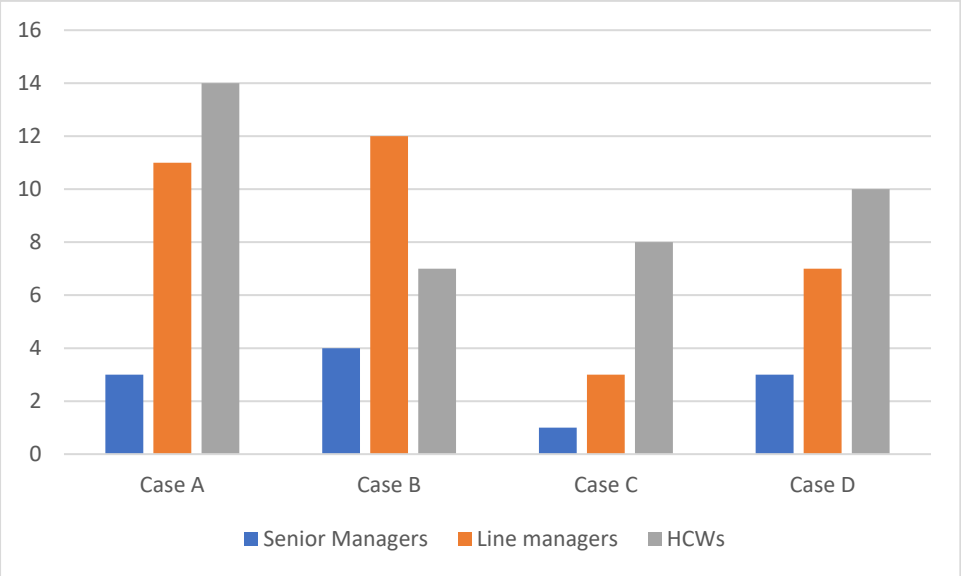
The interviews were semi-structured, and allowed the interviewees to talk freely about the subject in question, which may have generated more information than if the questions had been fully structured. Responses were followed up using probes and prompts to help participants to elaborate on specific information. Interviews ranged in duration between 30 to 60 minutes. Interviews were conducted in Sinhala language and were audio recorded using digital recording device and a backup recording was mostly took place using the Zoom application. After each interview a follow-up was done to check the quality of the recordings and then the recordings were saved in the R-drive folder. Participants of 2 interviews refused to be audio recorded and as such the researcher took notes of the discussions.

English is the working language in Sri Lanka. Thus, participants are expected to be fluent in reading and understanding English. For instance, to be eligible for entering into Sri Lankan Public sector Pupil Nursing Training course, candidates must have obtained a Credit pass in English language at the General Certificate of Education- Ordinary Level Examination. (Sri Lanka Nursing Service Minute - The Gazette of the Democratic Socialist Republic of Sri Lanka No 1837/8). Information to Participants forms and consent forms were provided in English (Appendices 5 and 6). The researcher chose to conduct interviews in Sinhala language, because of her belief that use of native language can be helpful for respondents to express their ideas comfortably. 83 interviews among the three types of participants were conducted in total across the four hospitals. The details are presented in the table 5.2 and illustrated in figure 5.1.

Table 5.2. Summary of interview data collection

	SM	LM	HCWs	Total
Case A	3	11	14	28
Case B	4	12	7	23
Case C	1	3	8	12
Case D	3	7	10	20
Total	11	33	39	**83**

Figure 5.1. Interviews conducted among SM, LM and HCWs



Out of the 83 interviews, there were 65 face to face interviews. 11 of those interviews were group interviews. Group interviews were organized when participants from a same category were present and willing to be interviewed together.

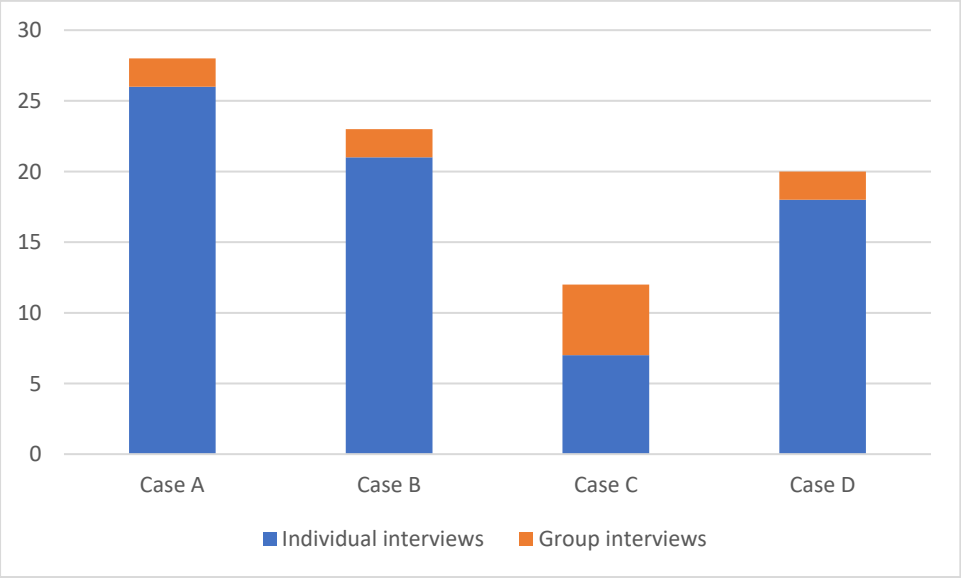
When conducting group interviews, a participant lead approach was used, which allowed the respondents freedom of choice to be in a group discussion. Also, time was allocated carefully so that everyone had an equal opportunity to comment/ present their ideas and views on the discussion points.

The details can be presented as follows.

Table 5.3. Details of group interview participants

Group	Hospital	Number of Participants	Category
1	A	2	Nursing Managers
2	A	2	Nurses (one ward)
3	B	4	Nurses
4	B	3	Nurses
5	C	5	Office staff
6	C	2	Receptionists
7	C	2	Pharmacists
8	C	2	Male attendants
9	C	3	Female attendants
10	D	2	Nurses (infectious control division)
11	D	3	Nurses (one ward)

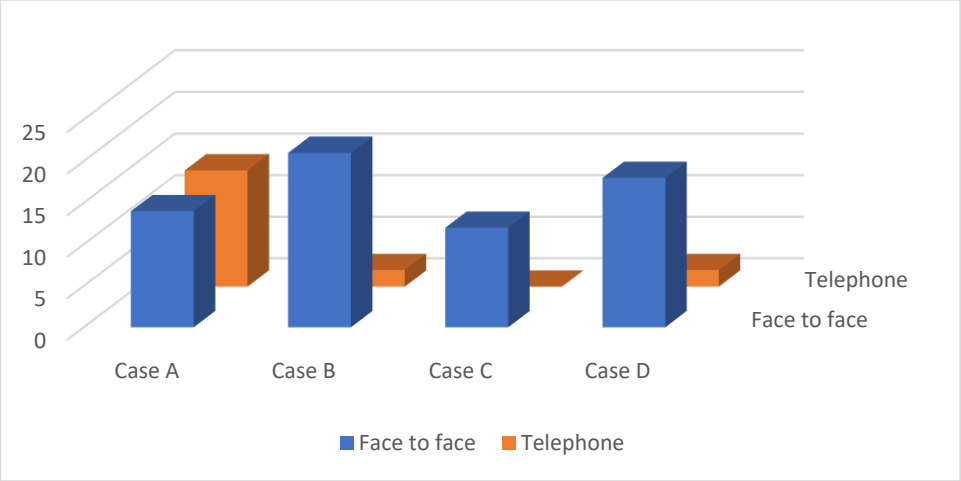
Figure 5.2. Interviews conducted: individual vs group interviews



For individual interviews, the researcher always allowed the participants to decide the time and place for each interview. A few interviews were carried out over the phone, as per the participants' preference which enabled them to talk freely, with no influence by other participants and out from disturbances at workplace settings. .Below is a summary interviews conducted through the telephone.

13 interviews in hospital A were conducted prior to the field based data collection. Later, 5 telephone interviews were conducted as per the availability of participants. These include 1 from hospital A, 2 from hospital B and 2 from hospital D.

Figure 5.3: Interviews conducted through face to face and telephone mode



Unlikely in face to face interviews, the researcher was unable to reveal the participant facial expressions and body language. But voice and intonation were still available, allowing her to get partial exposure to their feelings and emotions. Researcher took notes about such incidents where participants talked with emotions. Each interview was ended up with a brief thanking to appreciate the participants for sharing their experience in the study. Sri Lankans live in a collective culture (Hofstede, 2022), and these types of verbal appreciation is always expected by individuals upon such generous, volunteer contribution.

In addition to the data collected through interviews, relevant documentary evidence was sought. Government websites such as the Ministry of Health and Epidemiology Unit of Sri Lanka, WHO publications and relevant online information (news feeds and web posts) were referred.

5.3.6. Data Analysis

5.3.6.1. Qualitative Data Analysis Methods

There are different types of data analysis methods for qualitative research including, content analysis, discourse analysis, thematic analysis, grounded theory and interpretive

phenomenological analysis (Braun & Clarke, 2021; Finlay, 2021). Braun and Clarke (2021) claim that researcher can consider a range of options for research method, and it is vital to make sure that the method used is in alignment with the purpose, theoretical assumptions and questions of the research. Considering this, they explain a concept of methodological integrity which stands for the idea that research designs and procedures need to be selected in a way that support the research goals, the research problems/questions, that respect the researcher's paradigms or epistemological assumptions, and are tailored for fundamental characteristics of the subject matter and the investigators. Thematic analysis (TA) is the preferred method used in this study.

5.3.6.2. Thematic Analysis

TA is a widely used qualitative analytic method (Braun & Clarke, 2006; Nowell et al., 2017) and it is a method for identifying, analysing, and reporting patterns within data. Finlay (2021) claims that TA is a method of identifying patterns as well as meanings within data. It has been identified as a method with more accessible form of analysis that early career researchers can gain advantages of (Nowell et al., 2017). TA is suitable when a researcher tries to understand and analyse participant experiences or views across a data set (Kiger & Varpio, 2020).

TA has been identified as a family of methods and as such, there is no standardised TA (Braun & Clarke, 2023). TA type can be scientific or artful, while the type needs to be aligned with the researcher's epistemological positioning (Finlay, 2021). As Braun and Clarke (2021) describe, there can be three different types of TA methods namely; Coding reliability approaches, Reflexive approaches and Codebook approaches.

1. **Coding Reliability Approaches**

These approaches involve a process of identifying evidence within data for themes that have been developed early. Themes are understood as topic summaries, overviews of common answers of participants. This approach requires the coding to be centred around a coding frame or codebook and involve multiple coders work independently. Researcher subjectivity is minimized with the use of multiple coders, measuring the agreement between coders and agree on final codes through consensus.

2. **Reflexive Approaches**

These methods involve developing themes from codes. Themes are conceptualized as patterns of shared meaning. Coding process is unstructured and inherently subjective as themes are generated by the researcher. This process requires a researcher to reflect on their assumptions and how these might shape and restrict their coding. The method includes six recursive phases: familiarisation, coding, generating initial themes, reviewing and developing themes, refining, defining and naming themes and writing up.

3. **Codebook Approaches**

These approaches align the reflexive values with coding reliability TA; structured coding approach of early theme development and conceptualizing themes as topic summaries. These approaches typically used in research projects where a team of researchers code different parts of the data set.

In addition to the above, there are other two approaches; Framework method (Gale et al., 2013) and Template analysis (King, 1998). In template analysis researchers agree on and use predefined codes when conducting the analysis. Most recent publication by Braun and Clarke (2023) introduces another approach named Thematic Coding.

Coding reliability approaches are seen as the use of qualitative tools but techniques related to positivist research values; emphasize objective while aims at generalizable, reliable and replicable knowledge. Reflexive TA is seen as the use of tools and techniques within qualitative values. Researcher subjectivity is considered as a resource. Importantly, this approach acknowledges that generated meaning and knowledge is contextual (Braun & Clarke, 2021, 2023).

This research is driven by believes and assumptions within a constructivist paradigm. Thus, the reflexive TA approach deemed suitable for the data analysis.

Audio recorded data and the two interview (not recorded) notes were translated by the researcher. A random sample of translations were verified for accuracy and transparency, by one of the supervisors whose native language is Sinhalese.

According to Gauthier and Wallace (2022), when moving through the six phases of thematic analysis as presented by Braun and and Clarke (2006), researchers progress through three conceptual stages of work: familiarization, interpretation, and reflection. These involve practical tasks like data cleaning and filtering and coding among others. Researchers may involve data cleaning during thematic analysis, as original conversations may include

information that are not necessarily relevant for the researcher. These may include general discussions around the topic of discussion, pauses in responses, punctuations, changes in respondents' pace and voice. Braun and and Clarke (2006) advise researchers conducting thematic analysis, to be mindful about the meaning of transcriptions as compared to the original voice recordings during data familiarizing and transcribing, in relation to preserving the original meaning of the responses. This is critical when data is being transcribed by another person not by the researcher. When the researcher collects data, given prior knowledge about what has been collected during interviews, data cleaning task can be done effectively.

During data analysis of the current research, the researcher involved in data cleaning, during translations. To ensure the credibility of the contents included in transcriptions, a sample of transcriptions were checked by a member of the research supervisory team in comparison to the voice recordings, as mentioned in section 5.3.7. Changes were made based on negotiations. This enhanced the quality of data cleaning and transcription tasks.

Transcribed data were coded using the NVivo software. Inductive coding approach was used to codes development. This approach is data- driven and allows researchers to spontaneously create original codes the first time data are reviewed (Saldana, 2021). In Vivo codes were included in subcategories and categories before themes were developed. Codes and themes were developed separately for each case. A randomly selected sample of transcripts were coded by a member of the supervisory team as a strategy of maintaining minimum researcher subjectivity. Use of multiple coders was employed to determine the level of agreement between coders and to agree on final codes through consensus (Braun & Clarke, 2021).

5.3.7. Rigour of the Study

To enhance the rigour, qualitative researchers can use different strategies and techniques. Scholars discuss different concepts that support the rigour in qualitative research, such as data truthfulness and trustworthiness (Ahmed, 2024). These include credibility, transferability, dependability, and confirmability.

According to Nowell et al. (2017), there are different ways to establish trustworthiness during phases of thematic analysis. Usually, researchers apply prolonged engagement with data, and data triangulation. In this research, all the interviews were conducted and the recordings were translated by the researcher. This involved prolonged engagement with data which facilitated

data familiarization. As part of the data analysis, data triangulation was carried out as data gathered from three participant groups in each case and through different sources including interviews and documentary evidence. Research was also carried out to include data available in internet sources such as news websites, reports, research articles and MH circulars and health authority publications. Referring multiple sources of evidence and data triangulation can enhance the construct validity of a case study research study (Yin, 2014).

Case study research has limitations with generalizability and such issues can be addressed when multiple cases are involved, by which the exploration of a given same phenomena is carried out through different number of cases (Silverman, 2010). A theoretically guided selection of the case studies are recommended (Silverman, 2010: Yin, 2014). The case selection for the study was carefully done to include hospitals with varying characteristics such as sector (public and private), western and indigenous medicine, ID expertise, previous disaster experience, hospital size and location.

Yin (2014) convinced to maintain a case study database to assure the reliability of case study research. All interview data, and documents were saved in the university R-drive with secure access only to the research team. It is also recommended that data collection needs to be systematic and open for review anytime during the data collection phase (Yin, 2014). Researcher maintained ongoing communication with the supervisory team during online and field data collection, while interview data was stored in the R-drive, immediately after a set of interviews have been completed. Likewise, supervisors' advice was obtained to overcome challenges in the field while collecting data, and also to improve the quality and content of ongoing data collection.

This study used purposive sampling. As described in section, 5.3.4, data collection in each case was started with a few nominated participants who were approached through the key informants. Only a few respondents contacted the researcher following up the invitation to research participants. Further participants were located through 1) reaching out to participants by the researcher while on site and through 2) snowball sampling.

Snowball sampling can present several disadvantages as far as the trustworthiness is concerned. One main disadvantage among others is the selection bias, as a result of relying on a sample that was extended through respondent recommendations. To address the issues with snowball sampling, the respondent selection was administered through selection criteria (having pandemic experience in the hospital). In addition, having participants from three categories

(SM, LM and HCWs) and including participants from different sections in every hospital was a main consideration when adding participants to the sample. The sample size was determined based on the data saturation. Extending the data collection up until the data saturation point, ended up with a large number of interviews (n= 83). The researcher observations and documentations referred for the study assisted to complete a more balanced data collection (data triangulation). As, such the researcher committed towards, not solely relying on snowball sampling.

As previously stated, data translations and coding were verified with the supervisory team to ensure the transparency and accuracy. Checking for accuracy in translations is helpful in confirming that participants' ideas and statements are accurately reflected in the English translations. Translating is critical as far as the representation, alteration of meaning, and language and cultural competence are considered (Gawlewicz, 2019). Use of multiple translators in the research team is a recommended strategy for ensuring the consistency of cultural, social and linguistic meaning of the original data when being translated (Gawlewicz, 2019; Regmi et al., 2010; Yunus et al., 2022). A sample of translated transcripts done by the researcher were checked with respective audio recordings by a supervisory team member who is a Sri Lankan, for accuracy and true meaning. Changes were made as required based on negotiations (Regmi et al., 2010).

Similarly, during data analysis, the multiple coding approach (Braun & Clarke, 2021) was employed as a way of ensuring the reliability of researcher's interpretations and data analysis. Yin (2014) recommends auditing of data analysis for ensuring reliability of a research study. The data analysis was driven by codes and themes development. A random sample of transcripts were coded by a supervisory team member and emerging themes were discussed with the researcher. This process added a great value to the coding process to ensure the reliability of the data analysis. Similar codes and themes were observed across the two independent coding efforts. The researcher preferred the manual coding approach, to ensure data analysis accuracy and the opportunity to involve in data cleaning. Having multiple coders allowed more accuracy in interpretation of data, coding and development of themes. Discussions and negotiations between the research team members were preferred to a software based coding and analysing of the data. Storing and coding were assisted by NVivo software but was not used to cross check the TA.

To ensure trustworthiness of a researcher's findings and interpretations, it is vital that the pragmatic orientations and assumptions are clearly outlined (Kiger & Varpio, 2020). Braun and Clarke (2023) recommend 10 activities for researchers to better use TA. Among those it has been emphasized to determine the underlying research values and philosophical assumptions to locate the use of TA theoretically. Further, it is advised to ensure the methodological procedures coherently link with research values and chosen TA approach. When using reflexive TA, it is vital to link personal reflexivity to the analytic practice. Providing a clear overview of the themes/thematic structure is also recommended. Themes emerged during data analysis were clearly mentioned and discussed in detail in the Findings Chapter.

Validity

There are different strategies in determining the validity of a qualitative study (Lub, 2015). These include triangulation, researcher reflexivity, member checking, prolonged engagement in the field, thick description etc. A constructivist researcher assumes more pluralistic, interpretive, and contextualized perspectives of reality. Procedures for validity therefore look for an alternative vocabulary for validity labels, such as, transferability instead of 'external validity' (Lub, 2015).

Strategies for validity of the current study include prolonged engagement in the field. The researcher spent around 10 days in each case study hospital during data collection. In addition to conducting interviews, this time was utilized for observations, familiarizing to the organization culture and work practices, building rapport and involve in formal discussions with hospital staff. These shaped the quality of interpretation of the data.

Next, the researcher attempted possible participants for member checking. Reviewing draft case studies by key informants is recommended for ensuring validity of case study research (Yin, 2014). Due to the contextual influences, contacting participants through email was not possible. Attempts were made to contact them through their mobile phones. However, this process had some practical issues including reserving a time with every participant for a telephone discussion. Few attempts were successful and data interpretations were cross checked with the participants over the phone. All participants were agreed with their respective data and researcher interpretations, while majority of them urge their requests for privacy and anonymity.

Each case study is presented with a thick description. Thick description is to describe in detail the study settings, participants and themes (Lub, 2015). Each case study hospital is described and a summary of participant details is presented. Further the findings of the first case study is discussed in detail, followed by a summarized discussion of other three cases. A detailed comparison of all four cases is also presented for further clarification.

Next, reflexivity is to make researcher's own values and beliefs explicit in the report. This has been included as part of the Methodology chapter (Lub, 2015), explaining to what extent the researcher's values and experiences might have influenced the results.

5.4. Ethical Considerations

Before commencing the research project, ethical clearance was sought from the Victoria University Human Research Ethics Committee. An application was lodged, and the approval was secured on 09.03.2021, with the application ID: HRE20-128 (Appendix 7). The application was revised in two turns and the recommendations were applied to the research project accordingly. These revisions enhanced the ethical aspects of the research project.

The participation of the research was entirely voluntary, and the participants were informed that they can withdraw their participation at any time of the study. A verbal reminder was given at the start of each interview, regarding the participants' consent to record the interviews and their ability to withdraw from the study.

Secondly, the researcher made contacts with "Sri Lanka Sumithrayo" a leading voluntary counselling service based in Colombo with its regional service centres. The availability of the service was sought for any event a participant requires emotional support. It was assumed that, participants may come across with trauma during an interview, while recalling their experience around the pandemic and the economic crisis. The counselling service is available via telephone, email or by visiting the centre. The researcher already discussed the possibilities with the service and their phone number kept handy during each interview. The information confirming the services availability for such emotional support for the participants can be seen in Appendix 8.

Data were audio recorded (except 2 interviews) and were saved in university R-drive with secure access to the research team. The participant anonymity is secured throughout the research process. Pseudonyms were used for documentation and reporting purposes.

5.5. Summary

The qualitative research methodology adopted in the study, was discussed throughout this chapter. The current study was guided within the constructivist paradigm. A multiple- case study design was employed across 4 hospitals in Sri Lanka. Purposeful sampling techniques were utilized to recruit respondents. Semi-structured interviews were conducted. Relevant documents and information in public domain were also gathered. Data was analysed using thematic analysis. The next chapter discusses the case study findings.

Chapter Six: Findings

6.1. Introduction

Chapter five presented the methodology of the research study. This chapter outlines the findings of the study, organized into two parts. Part One outlines findings from the first case - Hospital A, and Part Two briefs the findings from other three cases. To present the findings in a precise and intelligible manner, within the given word limit, a thorough description of case A is provided, followed by a summary comparing the findings of the issues from the other three cases with Case A. A total of 83 interviews were conducted in the study, which included participants from SM, LM and HCW categories in each hospital, resulted in a large amount of data.

The first case was selected for an in-depth discussion due to various reasons. It is the national ID specialized hospital in the country. According to the government pandemic management plan, as also described in the literature review chapter, section 2.2.4.3, there was a three tier approach in assigning hospitals for COVID-19 treatment. Being one of the first three designated COVID-19 treatment hospitals, along with its expertise in ID, Hospital A warrants a rich case with experiences of early challenges of the pandemic and an adaptive nature in their response strategies.

Within this context, the challenges experienced by other cases were time sensitive and their role in the pandemic response was different in many ways. For instance, Hospital B, did not engage in COVID-19 treatments in the early stages of the pandemic, but operated two ICC later on. A group of Hospital D staff, received special training at Hospital A, in preparation for the surge in patients expected later on. As such, they started their COVID-19 treatment facility sometime after the first phase of the pandemic. The Ayurveda Hospital was allowed to treat COVID- 19 patients only during the latter phase of the pandemic, while up until then their main role was to promote traditional curative and preventive medicines for CDs. The staff prepared caskets and herbal drinks that were distributed among communities in the area and beyond.

Likewise, during the economic crisis, public hospitals experienced a surge in patient numbers while the private hospitals, including Hospital B, struggled with financial restrictions as a result of their diminishing sales. There were differences in the level of impact of cost of living to staff and to hospital management, based on each hospital's location. Hospital A is located in

Colombo, the main commercial city of the country while other three hospitals are located in regional, semi-rural areas.

Across the four cases, interviews with SMs were targeted to gather information on the hospital profile and were mainly focused on HRM challenges, environmental forces, crisis preparedness, designed HRM strategies and the outcomes. LMs were asked about the implementation of the HRM strategies, enablers and barriers for implementation and outcomes while interviews with HCWs were focused on their experiences of crises, preparedness and perceptions of fairness regarding the HRM strategies. The effectiveness of the HRM response in terms of quality of care and wellbeing of HCWs have also been questioned among the interviewees. Different themes yielded from the data analysis, are outlined in this chapter.

6.2. Part One: Hospital A

6.2.1. Hospital A - Organizational Profile

Established around 1940s during the British colonization, Hospital A is a public, national hospital in Sri Lanka and is the pioneer hospital specialized for Infectious diseases (ID). The vision and mission statements are as follows.

Vision*: To be the centre of excellence in managing infectious diseases by providing high quality specialized care.*

Mission*: To provide comprehensive care for infectious diseases by a well-trained, dedicated team of HC staff while ensuring safe and satisfaction for all, to provide quality care for other medical needs of the local community and being the leading centre for training and research in infectious diseases.*

(Source: Hospital A website)

According to several respondents, Colombo district has been selected to locate the hospital due to proximity to the Colombo harbor and the airport. These are the two hotspots through which any ID can be transmitted into the country, through incoming passengers. Further the highest geographical location in the Colombo district has been utilized to build the hospital. This is a strategy of minimizing the spread of infections of airborne diseases into the country, through a natural process. The contaminated air at the hospital is expected to be naturally released to air at a higher point of location.

The building structure and layout of hospital wards have also been carefully designed with isolation facilities and plenty of room for proper ventilation. A SM claimed that,

"*… good ventilation is assured, with small, single-storied wards, with long corridors…. there is a big distance in between wards…that reduces the possibility of spreading any viruses across wards through air*."

With a 200-bed capacity, the hospital is led by the hospital director (HD). There are around 450 employees including 170 Nursing officers (N/O), 10 consultants and 60 doctors. There was no organizational chart that is properly documented. However, the hospital seems to have a well-organized flow of responsibility. Both clinical and administrative functions are overseen by the HD and the deputy director. Consultants oversee the doctors. Nurses are managed through ward in-charges (WIC) and overseen by the Chief N/O (CNO). Health Services Assistants, often referred to as the Minor staff (MS) are managed through the overseers and also overseen by the CNO. Clerical staff is managed through the administrative officer (AO). The procurement and accounts are overseen by the chief accountant (CA). Paramedical staff is attached to various units including the laboratory, pharmacy, X-ray department and physiotherapy unit. There is also a blood bank and a dental unit.

Scholars admit that small and new organizations have no specific department for HRM (Welbourne & Andrews, 1996). Studies show that there exist less sophisticated or no HR functions in small and medium scale organizations (Nyfoudi et al., 2024; Psychogios et al., 2019). A study revealed that, in many Sri Lankan organizations, HRM functions are managed by individuals who are not HR professionals (Opatha, 2019). As a state owned hospital, there is no HRM department in Hospital A. Administrative matters are handled by the CNO and HD. In general, primary HRM functions including recruitments, promotions and transfers are handled by the Ministry of Health (MH). Guidelines and circulars sent by the MH are being communicated among the staff and been implemented through the CNO and AO. As such, any new implementation usually needs prior approval from the MH. Hospital operations are funded through the MH by government treasury.

As the CNO highlighted,

"When we receive a (ministry) circular through the director, we communicate that to ward-in-charges to implement that accordingly. Then we advise on the implementation, and we must provide the necessary facilities to implement the things and we supervise if the things are being implemented in the hospital".

The Medical Officer (MO) Planning described that,

"We have an annual action plan. We plan training needs and building (construction) needs such as constructions of wards, staff quarters etc each year and get ministry approval and monitor the work as planned throughout the year".

6.2.2. Interviewees' Profile

The sample consists of 3 SMs, 11 LMs and 14 HCWs. 75% of the participants were female and 25% were male. 14 were aged between 30-40 years (50%), 1 was between 40-50 years, while 10 were aged over 50 years (mostly the SMs and LMs). 3 were below 30 years. Participants' working experience in this hospital were ranged from 2 to 33 years at the time of data collection. Details of respondents of Hospital A is presented in appendix 9.

Section 6.2.3 to 6.2.7 will provide answers to the 5 research questions (RQ) based on Hospital A data analysis. Each section refers to sub questions (SQ) for respective research question as presented in chapter 3.

6.2.3. RQ 01
What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

6.2.3.1. SQ 1
What challenges did the hospital encounter during the pandemic and how were those challenges different from what they experienced during the economic crisis?

<u>Pandemic context</u>

As previously mentioned, Hospital A was one of the three hospitals in the country that was designated for COVID-19 treatment during the start of the pandemic (Ediriweera et al., 2020). A majority of the respondents including the CNO mentioned that this added to their responsibilities, as the national hospital specialized in ID. Such responsibility was apparent in the vision and mission statements.

Exceeded surge capacity

A majority of respondents claimed that during the pandemic, the hospital was overwhelmed, operating at its maximum capacity with high numbers of critical patients.

A doctor mentioned that,

"*In the early days, no patients were sent to other hospitals, all the patients were in hospital A, so there was a little pressure then*."

In a similar vein a nurse claimed that,

"*..other wards and special units in our hospital were converted to COVID units, so they expanded patient care but with the existing number of staff*.."

A doctor recalled his experience mentioning that,

"*…. there was a sudden boost in patients... I had to work overnight without rest…..the hospital was full*."

According to the overseer, there have been staff availability and safety issues among MS.

"*.. Workers had issues with more workload and the risk of exposing to the virus*."

Resources availability issues

As also reflected in the above quotes, there were challenges in allocating staff and other resources during the pandemic. It was apparent that the long held curfews and lockdowns exacerbated these challenges. The hospital managers also encountered funding issues as the hospital is government hospital.

According to HCWs there was a lack of facilities. For example, one nurse said,

"*We didn't have enough PPEs at the beginning, so we used polythene coveralls. We had some in our stocks that were about to expire. We initially used them*…"

The laboratory in-charge officer mentioned that,

" *..we had to send PCR tests to outside as we didn't have facilities in the hospital. We had to stop other routine tests due to safety issues, we had only primary Biological safety levels*."

<u>Economic crisis context</u>

In the economic crisis the hospital had challenges in dealing with staff absenteeism due to difficulties in transportation issues. Fuel shortages and breakdowns in public transportation system resulted huge challenges. In addition to that there were drug shortages and lack of facilities that caused problems in patient care.

One LM noted that,

" *….transport issues caused many absenteeism issues*..."

MO planning mentioned that,

"… *We ran out of drugs, we tried local purchasing with a brand substitution ….*"

The hospital has faced lots of funding issues. The chief accountant stated that,

"*We have had no enough money received from the treasury….Suppliers are being aggressive to us, they yell at us when the payments are being delayed…. This behavior of the suppliers caused stress among my staff....*"

It is apparent that in contrast to the pandemic context, the hospital had faced funding issues to deal with resource shortages in the economic crisis context. During the pandemic they have had plenty of donations to supplement the funding needs.

Located in the heart of Colombo, the staff compelled to live with a relatively higher cost of living, experienced many difficulties and resulting financial stress.

Many other challenges are being discussed throughout the chapter.

6.2.3.2. SQ 2

How did the crisis influence employee wellbeing and quality of care?

<u>Pandemic context</u>

Vulnerability to virus

Pandemic context led to employee wellbeing issues in many ways. During the early stages of the pandemic, nobody knew the severity of the virus and many respondents admitted that such doubt lead to stress and burnout. This feeling was exacerbated due to the fear of transmitting the virus to their family members and society.

As one LM highlighted,

" *..the major impact was on the staff, during early stage of the pandemic staff had a considerable fear of the virus. First, we got to know a disease was spreading in China, by that time our members assumed that if this spreads in Sri Lanka, then the patients will be sending to the Hospital A and that made them feeling afraid, as we didn't know much about the disease*…"

A doctor recalled his experience as follows.

" … *This hospital treats patients with ID, COVID was something similar, but the bad thing was the fear of transmitting it to our families. ……*"

Similarly, another WIC claimed that,

"…during the earlier times, some staff (nurses) did not report to work because of fear of the virus, so as the MS…"

Transport issues, new/ unfamiliar working practices and stress

Due to lockdown staff were unable to travel as usual. There have been staff shortages. New work practices were introduced including wearing complete protective gears (PPE). These has impacted wellbeing issues among staff.

One SM described that,

".. *Staff couldn't travel as usual. …we needed more staff than usual …"*

".. Once the duty within a ward is completed wearing the complete PPE kit, staff members felt exhausted, and weak. Some were about to faint….."

The overseer mentioned similar issues among the MS.

"….it was difficult for them to keep wearing the PPE kits for a long time… Some workers fainted while working. "

Wearing PPEs have been also negatively impacted patient care quality.

One doctor told that,

"*We had difficulties in working with the PPE on, with the gloves on, we were unable to check patients' pulse. We couldn't properly listen through the stethoscope. ICU doctors complained that they couldn't insert the tubes properly to the patients while wearing the PPEs. As we lose our sensation (wearing double gloves), it is hard to examine pulse and blood pressure of patients.* "

Such wellbeing issues will be further discussed later in the chapter under RQ 04.

Economic crisis context

Stress and burnout

Due to transportation issues, inflation and living costs, hospital staff claimed they experienced high stress. Managers noted that staff had low energy levels and diminishing morale levels due to financial stress.

The CNO mentioned that,

"*Nurses have started to do the basics of the job. No enthusiasm, no feeling of belongingness and decrease in capacity …. … They seem distressed, just finish the basics of patient care and spend the rest of the time on the phone as a way of relief, earlier they were more engaged, after completing the job they used to help in other duties like housekeeping*..."

The Deputy CNO also added,

"*During COVID period they had a strong commitment….Worked as a family, but with the economic crisis it is hard to get them involved, they use mobile phones as a way of relieving of stress. No team work... They don't find time for others*."

Employee turnover

Further, there have been many cases of skilled labour turnover in both clinical and MS categories. The overseer talked about the MS. She claimed that,

"*... Some are leaving the country… The salary is not sufficient to survive, some found casual jobs and left the job at the hospital*…."

A doctor admitted that,

"*We have big issues with staffing. Some doctors are leaving the country without even informing properly. Next month there will be more resignations."*

Shortage in drugs and facilities

Importantly, almost every clinical HCW related the shortages in drugs and other facilities to patient care and highlighted that they feel unfortunate of themselves for not being able to provide a proper patient care.

6.2.3.3. SQ 3

What were the environmental influences (threats and opportunities) over the hospital and the impact of those on their HRM (government/ WHO / legislations/ protocols/ suppliers/ society/ culture and beliefs)?

<u>Pandemic context</u>

Government regulations

As mentioned earlier, the government nominated this hospital as one of the three designated hospitals for treating COVID-19 patients at the very beginning of the pandemic. On the other

hand government announced hospitals as an essential service which meant that it was mandatory for HCWs to report to work.

Additionally, respondents showed that the frequent changes in government circulars and guidelines highly influenced the HRM practices in the hospital. Such interventions in general, were identified in the literature review chapter.

Government requested managers to call employees to work in alternate teams. Thus, this hospital initiated a team based system for their staffing. This was in line with the government and ministry circulars. Aligned to that government instructed hospitals to implement a special leave system that enabled the alternate teams to get days off while the other team was at work. This was rotated among the teams. Similarly, a special leave system for pregnant staff was introduced.

The CNO recalled that,

"*There were different circulars for leave matters, we had a special leave provision for pregnant workers*."

Lockdowns have been a major influence in workforce planning and providing facilities to staff. Respondents claim that they had issues with travelling to work. Staff had issues with accommodation and buying essential stuff including food. Hospitals had to facilitate access by staff to these facilities in order to maintain staff wellbeing and continuous patient care.

As one SM claimed,

"…. *due to the lockdown, the employees were required to work longer shifts. There was limited (no) public transport facilities….The contractor who ran the hospital canteen did not operate and we had to shut down the canteen. There was no place for the employees to buy food or grocery*."

One facility was the special bus service operated by the government to assist government servants to report to work. However, HCWs claimed deficiencies in that service.

A nurse mentioned that,

"*In hospitals the shift times are different from office hours. Most of the time, we couldn't catch the bus service, it was designed to office staff…*

Another nurse mentioned that,

"..Some days we had to work extra hours due to heavy work load…but bus service wasn't available…."

Discrimination from the society

Access to the services was made more challenging due to reluctance of vendors and transport providers to provide services to hospital staff.

A WIC recalled that,

"Some days we didn't have food, we were discriminated by the shopkeepers, the shopkeepers refused to sell goods to us, …Taxi drivers did not provide rides to our hospital... We faced lots of social harassment from outsiders."

Similarly, the Overseer described her experience as follows.

"Sometimes I experienced when I go to grocery shops, people refused me when they hear that I work in hospital A".

Due to limited transport facilities, there emerged the new challenge of providing staff accommodation. On the other hand, a majority of staff had lost their usual accommodation given the reluctance of landlords to provide accommodation to hospital staff.

The Overseer commented,

"Some of the workers had no accommodation facilities, because the landlords had asked them to leave due to the fear of infection".

Another doctor recalled her experience with accommodation and day care providers as follows.

"I have two kids ….The day care centres were not happy that kids of the hospital staff being sent there …. I had to withdraw my kids from the day care centre. We then had to leave the house that we were on rent. ....."

Family members and close contacts of staff

A majority of the respondents claimed that their family members were supportive and assisted them to report to work. Few had issues with family members intervening to stop them going to work due to the fear of virus. However, there have been a massive support with house work and child care given by family members, and enabling the HCWs to work.

Two nurses claimed that they had sent her children to their parents during the start and peak of the pandemic, while a majority of female nurses said that their husbands were very supportive. One manager and another LM told of the assistance from family friends in managing other family members while they had continuous work at the hospital.

For an example, one ward in-charge nurse mentioned that,

"*Our duty was enriched with sacrifices of our families. I think they are a big part of our service*"

This kind of support can be a result of the collectivism nature of the society. However, in other countries HCWs had many challenges between work and parenting during the pandemic. For an example in South Australia, HCWs have not had the chance to come to work due to lack of childcare facilities, amidst overwhelmed HC systems (Panagiotaros, 2023).

External service providers

There had been challenges in maintaining routine services that were outsourced such as cleaning and security services. At times, the managers have had to allocate the MS on such additional duties. Registered contractors have refused to provide services and this has heightened the challenges of staff facilities including hospital quarters and construction tasks.

The MO Planning claimed that,

" *Our contractors refrained from coming to the hospital…. We used to have our engineering consultancy agency to help with the constructions before pandemic. But during the pandemic, they withdrew their services…"*

According to the CA,

"*Due to the lockdown…, the contractor who ran the hospital canteen did not operate and we had to shut down the canteen…*"

Access to funding and supplies

The CNO, MO planning and the CA mentioned that there have been major delays in funding from the government at the start of the pandemic which caused interruptions to hospital operations and uplifting facilities to staff. Other supplies provided through the ministry were also delayed during the lockdowns.

The MO planning highlighted that,

"*We have only a limited number of registered suppliers through the ministry, we had the authority to contact these suppliers only…. that was a limitation. These suppliers did not have enough stocks to cater our needs.. at the peak times we needed more stuff."*

The hospital had alternatively obtained donations through their philanthropists and interestingly, general public had started helping with materials and grocery rations.

"We had to look for donations. Because as per the procedure we had to strictly go with only the registered companies, they didn't have enough stocks to supply, and we were not allowed to purchase from anyone who is ready to supply ….."

According to the CA,

"We received lots of funding through donations. Mostly we received PPEs….. Later people donated the staff with groceries and stuff. It was normal that donors send stuff for the patients as community service or sharing happiness on their special occasions like birthdays. But during pandemic, they started to pay their gratitude to the staff as well."

Culture and values

Sri Lanka is a multi -religious country. Buddhist temples and other religious places carried out prayers and preaching programs that have helped HCWs to maintain their spiritual wellbeing during the pandemic context. In addition to this, media launched appreciation programs for HCWs and spread news of a new concept called "*Suwa Wiruwo*" (health heroes) among general public. Other people assisted the hospital through donations as discussed above. These influenced the HCW mental wellbeing with feelings of belongingness and appreciation from the society.

According to the overseer,

"….*We believe in Pinkam and well wishing chanting (Seth Pirith). … such chanting protects us from dangers.*"

The Deputy CNO claimed that,

" *Our community is always helping minded, you know… they have helped the needy during seasonal floods every year, as such, this was a huge disaster, people helped hospitals with groceries, companies donated money to purchase machines, some donated PPEs. The Army and forces contributed their labour to build the staff quarters and temporary buildings for treating patients…these encouraged our staff. We felt supported*.."

As the CNO mentioned,

" *at the beginning our staff started to feel distressed, they thought it was like working in a prison, no idea of when this will finish and had no connections with their families…..Earlier society didn't accept us, but later they realized the HCW commitments, they assisted us through many ways. Including donations and prayers and well-wishing rituals (Seth Pirith*)..*Those blessings protected us from infections we believe*."

A ward in-charge said,

"*I was involved in TV programs … was able to share my experience and instruct public to prevent virus spread. My voice- cut was published on national TV and YouTube. I was featured in the newspaper; my family was very happy, so I was very excited…..*"

Economic crisis context

During the economic crisis context, the involvement of the society had not remained the same. Donations had dropped significantly and the managers mentioned that they have had a pool of consistent donors sometime after the pandemic, but during the economic crisis a majority of them were unwilling or unable to assist given the financial difficulties.

At the same time, additional numbers of patients were coming to the hospital. Doctors mentioned that, usually this hospital treats low and middle income level people and it was unusual to find that people with higher income levels were coming to this hospitals. It appeared that changes to social status were also influencing the hospital capacity to enhance patient satisfaction. Patients who have used to be private hospital patients expected a same level of quality service and facilities in public hospitals. Due to this crisis, the minimum levels of quality services were being maintained with utmost difficulty. Patients have felt dissatisfied and sometimes have reacted aggressive with hospital staff according to many HCWs in this hospital.

Adding to that, HCWs have experienced aggressive behaviour of the stakeholders (vendors, suppliers) and general public as well.

A nurse manager mentioned that,

"*Our people treated us as health heroes during pandemic, it was just a fake recognition I think, when we (HCWs) were given priority in limited fuel supply queues, people were really*

aggressive, and they didn't allow us to get the service in a priority line. This caused delays and long waits in queues…..where was their gratitude?"

6.2.3.4. SQ 4

What were the internal influences (strengths and weaknesses) e.g. previous experience with disasters or emergencies, management intentions (strategic choice vs employee interests), internal work culture and values, hospital size, capacity and resource availability etc.?

Previous disasters/ emergency experience

This hospital has plenty of experience in dealing with ID including seasonal Dengue disease. A majority of respondents showed that they had successfully faced such epidemic situations and that experience has been a major strength in dealing with the recent pandemic. A few had experience with some other CDs as well. Aligned to these, the hospital has been organizing routine emergency drills as a preparedness initiative which will be elaborated in section 6.2.3.5.

As the CNO recalled,

"In 2003 we faced the SAAS epidemic and H1N1 in 2009. In between we had few other unidentified diseases .... "

A nurse mentioned that,

"..... We have had huge patient load during Dengue peaks, so we had a kind of familiar situations with surge in patients. ....."

A doctor has had crisis experience while he was working in another hospital back in 2019. He admitted that his previous experience was helpful for him to deal with the pandemic situation as well as managing his team.

"*When I was working in Batticaloa, there was a bomb blast in a church in 2019, that was Easter Sunday combined blast, All the HCWs were called to handle the emergency, that was a mass casualty incident.. I had a good experience in handling such a situation*…"

Management intentions (strategic choice vs employee wellbeing)

Managers admitted that they had considered both patient care and employee wellbeing when developing strategies during both crisis scenarios. The intention has been to ensure safety and wellbeing of the staff as a way of ensuring continuous patient care.

The CNO claimed that,

"*We had to give maximum patient care because we were the specialized hospital during the pandemic. But since this was a quite new and dangerous situation, our staff was feeling a bit not completely ready for the battle…. We had to think and plan for the two extremes. Our idea was to always keep our staff safe and look after them, if they are not ready and not able to work we wouldn't be able to give a good patient care."*

The overseer admitted that,

" We never let issues in patient care due to staff unavailability. I think the hospital leadership wanted to balance both patient care and employee wellbeing. There were many strategies we used to make it a safe place for the staff and of course we had to encourage them and even I had individually talked to my workers to let them know that we are always with them. We wanted to make no disturbances to patient care as well guarantee the staff was working happily and safe."

Internal work culture and values

A good leadership and team working culture which shaped the HRM response during the two crisis scenarios. Almost every HCW and the managers claimed that the team working culture shaped and assisted the hospital crisis responses both during the pandemic and the economic crisis.

Additionally, a majority of HCWs and managers agreed that there has been good leadership and also closer relationships among managers and HCWs. These have fostered familism within the hospital culture. Such a well-established working culture has enhanced employee morale and positively influenced the HRM strategies implementation to address the crises.

A doctor admitted that,

"*Our director is an all-rounder. …. He doesn't care about the level of the employee…is open to talk with everybody… he knows everybody's profile and issues. That kind of a leadership is important to this hospital.*"

A nurse claimed that,

"*During the outbreak, staff was discriminated by the public. The director, tried his best to support the staff, he found donations and supplied meals to the staff during the curfew times … Because of the commitment and his leadership, we always encouraged and feel happy to work.*"

A minor-staff member said that,

" *All managers including the director are very close to us, even we are MS, we do not feel any difference, We respect them but same time we can work as a team and like a family in the hospital*."

The Deputy CNO mentioned that this family concept has been helpful in sharing employee concerns during the pandemic. Further, it has been useful for assisting with employee issues ahead of the financial crisis.

" *I consulted my nurses how to deal with financial difficulties, I suggest them few tips as a mother, they usually respect and accept our suggestions, because of our family concept*.."

Religiosity is a significant factor that shapes the attitudes, values and the way of behaviour of individuals (Eid & El-Gohary, 2015; Mokhlis, 2009). The religious beliefs have shaped the internal work culture in this hospital. Religious activities have been in use in the hospital including the *Seth Pirith* chanting, as discussed earlier.

Hospital size, Capacity and resource availability

The hospital is a medium sized hospital (bed capacity 200). In responding the surge in patients during both crises the hospital functioned in limited surge capacity which is a reflection of the hospital size. It was identified that there was teamwork culture and close relationships among the SMs and all employee categories.

The hospital was designated as a main focal point during the pandemic. However, its capacity was basically 200 beds with a considerably limited staff. There were only two wards with isolation facilities. Ahead of the surge in patients, other wards were quickly converted to COVID-19 treatment wards and a few temporary buildings were constructed. Staff accommodation, resting facilities, medical equipment and laboratory facilities proved insufficient.

As one N/O stated,

"*We didn't have sufficient rest room facilities while we worked for continuous shifts, we had been instructed to take a bath after each ward round, but we had the same (few) number of washrooms and changing rooms…*"

Additional staff from other hospitals were brought in to manage the work. As such, the size of the hospital was a major factor that influenced the overall crisis response and the related HRM interventions during the pandemic.

However, within the context of the economic crisis, other issues emerged from the expansion of the hospital capacity to deal with surge in patients. These include drug shortages, HCW absenteeism ahead of transportation issues, limited patient transfers to other hospitals given fuel shortages, staff turnover, reductions in permitted over time hours, reduced staff morale and limited donations and much more. These challenges will be further elaborated later in the chapter.

6.2.3.5. SQ 5

Were there any crisis preparedness in place and to what extent were they useful/ applicable as an actual crisis response?

Emergency preparedness

It was revealed above that the majority of the respondents were prepared to battle the COVID-19 disease even before the virus started to spread in the country. Fifteen interviewees claimed that they were emotionally prepared for the pandemic as they had a pre-established set of responsibilities. Such responsibility seemed to have been stimulated by their managers given the fact that the hospital A is the focal treatment point for any kind of ID.

As one HCW noted,

"……due to my feeling of responsibility of being a staff member of the hospital, not specific to the COVID-19, but any kind of ID if however, entered the county and started to spread in here (country) we will be the first and only hospital designated for treating patients with infections. That mindset and preparedness backed by the responsibility has been already stimulated and stored within our minds by our top managers and superiors. That was something I knew already."

Another WIC pointed out,

"*We are a specialized hospital for such ID. So, this time it was not something surprising for us. As we have already had preparation for airborne diseases and hearing about COVID-19 was something not that a big thing…… I think the hospital was ready with the staff, we are ready to work. We wanted to get ready with the other required items (equipment).*"

ID training and drills

There have been regular training programs and annual drills around ID handling, patient care and safety procedures, carried out for all staff. Such training had attached to the hospital's

orientation program for newcomers. There have been a training and a drill organized in preparation for another suspected Ebola ID in 2019, just before the COVID-19 pandemic hit.

A LM claimed that,

"*Our CNO conducted training to prepare us for Ebola mid-early 2019. (This covered) PPE and patient management, care, blood testing procedures. She has a leadership with always preparedness, I respect her for that, based on her desire for being updated we were ready for COVID-19 up to some extent*."

As another N/O mentioned,

"The hospital has a policy of providing the newly recruited staff including the MS with a training of use of PPEs. So we had a basic idea of using PPEs."

The CNO claimed that,

"*… Ebola preparedness drill and training was planned just before the COVID-19 hit and that preparedness was a blessing in disguise. By that time, we had a kind of confidence because we already planned for Ebola that is severe than the COVID-19 virus….*"

Plans for resource allocation- Space and systems

It was reported that the building layout and ward setups were originally well established for treating ID. However, there had not been any written plan of how to manage a mass casualty in a pandemic situation. Five LMs claimed that the SMs know what procedures are to be implemented if such emergency occurs. Further this was already practiced during seasonal epidemic situations such as Dengue.

As the MO Planning describes,

"*…Yes, we have such planning. During that type of situation, we plan to transfer normal medical patients to nearby hospitals. Specially if it is an epidemic…*

We have our isolation unit, it is a two storied building, normally it is vacated for any ID patients. …. All other wards are used to treat medical patients. When there is a surge in patients with a CD the normal functioning of the hospital is adjusted. The patient admission is controlled at the OPD. If we realize that the capacity is not sufficient, the admitted medical patients will be transferred to the nearby hospital and then expand the admissions of the ID patients…."

She further claimed that,

"*… I have not seen anything in written, but this is what is being practiced, the procedure….”*

Similarly, another MO stated that,

"*…No, it was just a commonly known agreement of handling patients during a surge...*"

Resources preparedness- Stuff

It was reported above, that due to previous disaster experience and working with seasonal diseases, there had been considerable staff and resources preparedness at the beginning of the pandemic.

As a WIC elaborated,

“... We prepared our PPE stocks, somewhat extra and other necessary things including TCL, hand sanitizers. Instead of panicking about the disease we got ourselves ready with required resources…For Swine flu and H1N1 we had prepared with overall PPEs including coverall, overall, apron, leggings, shoe covers and face shields…"

However, a majority of the HCWs indicated that the level of preparedness in resources was insufficient when the volume of incoming patients was increased during the peak times of the pandemic.

A nurse articulated that,

"*…but our plan was not effective ... may be due to… ... overload of patients. Our plan was limited ..., we had very basic planning but may be not suit with such high volume of patients. Many new things were adopted once we realized the number of patients were increasing, such as wall oxygen system and ventilators. Once we completed with many resources it was almost the end of the pandemic, We did not plan properly*."

The laboratory manager highlighted that the hospital had limited capacity in PCR testing and was relying on external service providers. This has caused delays in proper patient care and waste of time.

Adding to this both CNOs admitted that, they had not predicted something like a lockdown and had not considered such conditions in the preparedness planning. This has been a major issue in responding to the pandemic with the additional burdens of transportation, supplies and facilities to staff.

Furthermore, during the economic crisis, hospital had faced shortages of resources due to the continuation of the crisis over a considerable period of time. In particular, the safety stocks of drugs and medical supplies were completely utilized and staff had faced many other issues.

A majority of nurses complained that, in addition to the daily work load which had already increased due to huge number of patients, they were assigned to manage the drugs stocks in their wards. They started to keep careful communication and records across wards in exchanging drugs. In the absence of drugs doctors started to prescribe alternative or substitute medicines that sometimes would not completely match the expected result. If drugs were not available, they had to ask the patients to buy it from outside, in which case the nurses had to deal with both their own and patients' emotional regulation.

A nurse mentioned that,

"*I know that the patient cannot afford to buy the medicine, but I had no option….She was coming to this hospital because it is said to be free, majority of patients are poor and innocent*…"

Another nurse added,

" *we as nurses sometimes help poor patients with daily essentials or if they need to pay for something like tests or special medicines, it is usual at times if the patients have no carer or with no income. But given this situation we cannot afford to help someone else. We live very hard, our lifestyle had changed. The situation is sad and working is not a pleasure now a days*…."

Nurses claimed that when they cannot perform the patient care due to lack of resources they feel distressed. Similarly, a pharmacist claimed that she had thoughts of empathy for patients and felt distressed for not being able to help them. She added,

"*Nowadays, I see patients waiting in the queues to collect the drugs and mostly they only get few drugs from what is prescribed. These people are poor and innocent, and I feel sympathetic for them, it makes me feel stressed, as I am kind of a part of the process*."

Further, the drugs shortage has added to their routine duties as they have had to use alternative ways of finding drugs and other medical supplies. There have been conflict among the LM and the staff. She mentioned,

" *.. I put as much as effort I could to find another hospital with drugs we ran out of. Then with utmost effort I confirm the collection requests with that hospital, but there are no vehicles to send to make the collection due to fuel shortage. …. My duty is only to find and process the order collection, and request a vehicle for collection, I have done my job with considerable amount of time and effort, but the end part is not completed that is a duty of the admin office, not mine, after considerable effort I wait for the collection to be done, when this is delayed I have to respond to the wards and ICU when they keep calling me about the drugs. When this is the result, I get angry. This has become a major issue in my day-to-day life. This is a huge pressure, I have decided to get a transfer soon and I have planned to make a complaint in writing, a long letter I will write. Even when I am back home after work, my mind is still stuck with work at the hospital... it comes into my dreams even that I have to anyhow find the drugs…"*

The impact of the financial burdens on employee wellbeing were discussed earlier in the chapter.

Building resilience: preparedness vs readiness- Staff

Despite preparedness in other dimensions (stuff, space and systems), a majority of the respondents claimed that they had doubts about the severity of the virus as it was something very new and the information was seen through news and social media reporting about the virus spread in other countries. This had been exaggerated due to the possible risk of transmitting the virus to family members as earlier discussed.

As a WIC explained,

" *At the time we had the first patient, nurses were afraid, some cried, they refused to work in that ward*…"

Given such a situation, SMs have used a strategic approach to lift up HCWs' morale highlighting the importance of the duty of HCWs in this health crisis. Sometime before the media started the concept of *health heroes,* the CNOs used to meet the HCWs and let them imagine the 30 year civil war and the army and forces who battled and saved the country. Reminding that and trying to align it to the upcoming health battle, they have tried to stimulate the call for work attitudes among the HCWs throughout the hospital.

The CNO explained as follows.

"*…. No other hospital specializes in this type of disease, other than our hospital….. the whole country is observing our service, and they expect that we would do the best to fight with this disease…. I had to encourage them…. I …, explained about the scenario of the 30 year civil war and the enormous effort and sacrifices that our army has extended in that, they did not ask general public to battle in the field, whether they had enough weapons or not. Likewise, if you are accepted to work in this hospital which is the specialized one, we as the staff are expected to accept the responsibility in this time of pandemic….*"

At the same time managers have worked as early adaptors and role models.

The deputy CNO mentioned,

" *… I worked at the ward together with nurses at the beginning, I accompanied them for patient care. I had to train them about safety procedures and PPE. I never let them feel that they are alone. We wanted to signal that the management is also on this mission with them. Imagine in a battler field the commander needs to lead the team. So when we were with them, they felt our support, so by that we were able to show that it is something that we can do together…*"

6.2.4. RQ 02
What HRM strategies have the hospitals designed to respond to these crises?

The HRM strategies designed by the SMs will be discussed under the RQ 02. The strategies were investigated and elaborated across 4 HR practices.

6.2.4.1. SQ 1

What staffing practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

<u>Pandemic context</u>

Extended shifts and Staffing alternate groups

According to the government circulars, hospital managers have had to decide on rescheduling work shifts among two groups of HCWs. This was earlier mentioned in section 5.4.3.This was done in consultation with the HCWs and the respective LMs.

Team one was at work for two weeks, while the other team was not reporting to work. The next two weeks were assigned to the other group while the first group were sent on leave. Normal 6 hour shifts had been extended to double shifts and even to continue to 24 hour shifts where

necessary. As noted above, delays in staff reporting to work were caused by loss of accommodation and transport facilities. Majority of HCWs who used to live in boarding places had lost their accommodation. Given these reasons, the hospital had to enhance accommodation facilities and at times provide transport facilities to HCWs.

However, the team schedules directing work duration times and leave were different from what was recommended. SMs mentioned that due to limited number of staff and the long distance travel from home for a majority of the HCWs, they had to allow extended shifts so that the HCWs would be given accumulated leave days. This procedure was mainly aimed at ensuring HCW safety and limiting the spread of the virus across all staff at a given time if any outbreak occurred within the hospital. In that sense the hospital aimed to ensure that majority of HCWs were safe and there by continue the patient care without any disturbance.

Facilities

Aligned to this initiative there were been major developments in hospital staff quarters. A few spots were added by renovating previously abandoned staff quarters, while two staff quarters were built with the assistance of the Army officers. Few other places outside the hospital were sourced to accommodate staff.

Adding to that the hospital decided to provide meals to all staff given the lockdown. As such, staff had facilitated with high nutritional food as advocated by the HD, aiming at boosting their immunity through healthy food.

As the CA admitted,

"…. *management decided that our staff need extra nutrition because they need to keep high immunity level and we change the meal with additional protein. … the hospital canteen did not operate ..... There was no place.. to buy food or groceries. So, it was necessary that we had to provide them with meals cooked in our kitchen, through funding from ministry and donations*".

It was indicated that meal preparation within the hospital for all staff was an essential task, given the lockdown and inability to find food venders as usual. MS were allocated to manage the added workload at the kitchen, as the overseer mentioned.

Staff rotation

At times the nurses had changes to their work stations according to the work load requirements in other wards. During the beginning of the pandemic, majority of nurses from other wards were sent to work temporarily in the isolation ward to get an exposure to the new patient care procedures. WICs found it effective to pick the staff who were accommodating within the hospital premises to cover additional shifts in their respective wards as well as in other wards, when necessary. MS were called to assist in supportive work in the wards.

A nurse recalled that,

"*During the peak anyhow we felt lack of staff, at times we talked to the top management nursing managers, and they helped us with sending staff from other units*."

Interim staffing practices

Internal staff

Once the pandemic started to appear challenging and a potential surge in patients was anticipated, management decided to cancel the specialty clinics (eg HIV AIDS) in the hospital and the respective staff were allocated to other wards. A nurse whose long term duty has been to conduct such clinics, admitted that being transferring to a patient ward, she found it unfamiliar and difficult and had to learn and adjust to manage work in a ward.

In providing services to regular patients of specialty clinics, staff were required to contact their patients through the phone on their respective clinic days. Observations were made through these conversations and medicine were packed at the hospital and sent to patients via post. A WIC commented that given social issues regarding patient confidentiality (in the case of HIV AIDS patients) there were added responsibilities to the duty, when using communication mechanisms and third parties such as the local mail services.

Volunteers

There were Army personnel assisted the hospital with many non-medical tasks such as construction of staff quarters and temporary buildings.

Staff from other hospitals

During the early stages of the pandemic, there was a decrease in patients coming to hospitals for non COVID-19 treatments. As such, staff from other hospitals were allocated for work at

the Hospital A on a temporary basis. For example, the CNO mentioned that, at the beginning few nurses were received from the National Hospital to work at hospital A for 14 days.

The AO added,

" *One major issue was staff shortage as we had lots of patients, nearby hospitals were not busy as usual, so we were able to receive additional staff from about 4-5 hospitals*."

However, there were issues in allocating these staff to relevant wards as they had no exposure to specific patient handling procedures which were in action at that time. As such, the managers trained them before sent to work. Further, ensuring their wellbeing and availability of facilities added to the managers' duties. According to the deputy CNO,

"*Managing these external staff was another added layer of issues, we had many challenges, and we had to give orientation and specific training …. Providing extra care .Finding out their needs and arrange accommodation and transport for them… had to keep them felt caring from the hospital as they are outsiders and we need to keep the hospitality. At times, I felt that I had to ignore needs of my own staff".*

As the overseer mentioned, there was a labour shortage even before the pandemic. During the pandemic, the hospital received MS from other hospitals.

"*We had deficiency in worker numbers, so we had to ask for extra staff from other hospitals. They sent the workers in 20/25 batches to work here for one- or two-months period, that's how we managed*"

She further added,

"*It was not enough that we were given extra staff, they sometimes did not fit with our patterns and the way we work here*."

The CA also commented on this.

"*Government officers were asked to stay home due to lockdown. We asked officers from local councils, that we can utilize them for at least to complete available office work like data entering. Then we got some of them. But they were working with lots of pressure due to the fear of virus transmission…. they were reluctant to move with our staff and just wanted to do the work and leave, they didn't want to take a tea break at least, wearing double masks and didn't want to take it off at least for drinking water……*"

Limited remote working

Despite the above staffing arrangements, office staff was allowed to work from home (WFH). However, according to the CA and the AO this was not effective. The hospital was not able to provide the staff with required devices given that it is a government hospital. Some worked from home utilizing their own mobile phones and network connection. This was not applicable with all staff and it was an on and off practice.

The CA mentioned that,

"*My staff had to use their personal mobiles and bear the cost of mobile data for processing such work*."

Changes to working practices

Triage

Almost every respondent agreed that their regular work practices were adjusted in the pandemic context. Frontline HCWs had been working on a triage system in receiving and diagnosing incoming patients. This was to ensure efficient use of time and resources as well as HCW safety. Nurses and WICs mentioned their experience was new, but they adapted to the new practices as they go.

Care in wards

During patient care, wards initiated a new system of three zones: red, green and yellow. Nursing stations were established (yellow zone) outside the wards and given the pre-established layout of the wards (with short walls, open wards) nurses were able to see the patients from the yellow zone. Green zone was the place which connected with the patients' zone (red) where the nurses were assisted with a team member usually called a "buddy" who provided equipment and other necessities including medication for performing the ward rounds. Both had to wear the full PPE kit and once the work was done there was a sanitizing activity using TCL. This system was established to minimize the spread of infections to other staff. Nurses highlighted that they started to pre-plan the activities that needs to be completed during the ward round and at times doctors performed some duties that were usually done by a nurse. They also indicated the difficulties of wearing the PPE for a long time in a humid environment. Further to this, wards used an intercom system to communicate with patients. A wall oxygen system had been installed that can be operated from the nursing station. In addition nurses and WICs had to learn to use new machines and equipment such as portable ventilators. Further, nurses learnt to

conduct PCR tests during this time. PCR tests was not covered in the nursing curriculum and was not in the duty list of nurses in the country.

One N/O claimed,

" *It was a new duty to take PCR tests. Usually doctors do that. Even we did not learn about it at the training school...*"

Additional care for patients

From patients' perspective, nurses admitted that they had to handle them with extra care. Patients were anxious and distressed given the fear of a new, deadly virus and feeling isolated from the society. Thus, patients' psychological wellbeing was also a top priority but a challenge while maintaining their own wellbeing. They had to ensure the supply of daily essentials. Usually those are supplied by the patients and family but given the lockdown, no bystanders and visitors were allowed and patients had no connections with their loved ones.

As a WIC mentioned,

" *…they had a feeling of being sent to a prison and some thought they will end their lives inside the hospital, we didn't have a vaccine by that time, what we had to do is keep them strong during their isolation period. We had to work really kind to them, we built their confidence."*

MS duties

The overseer and the MS member admitted their experiences on the routine work that has been gradually changed. MS had to work in the frontline, mostly cleaning and sanitising, handling incoming patients and transferring patients, assisting wards with supporting services and maintaining the huge work load in the hospital kitchen. Further, the overseer highlighted that the hospital mortuary was overwhelmed with 10-15 daily deaths and was hardly managed with only three workers. According to the overseer, there is a huge shortage of mortuary technicians across the country.

Laboratory services

Laboratory services had been extended with major infrastructure improvements and the staff at the lab had to learn how to use new machines while maintaining required safety procedures. Earlier PCR tests were not conducted in-house, as mentioned earlier, but with the new machines they had to work to the maximum capacity. Later they started to conduct tests for other hospitals as well.

Procurement

The CA highlighted that vendors gradually moved to online modes and accordingly the working practices of her staff had to change, but with minimum devices. As mentioned earlier, she commented that most of the time her staff used their own devices to get things done online.

Staff wellbeing

Both SMs and LMs commonly admitted that a big part of their work time was dedicated to looking after the employees given this turbulent time. To communicate with wards they initiated a "corridor meeting" system where SMs came and visited HCWs in each ward outside the wards (long corridors –hospital layout). The CA commented,

"*We the management organized "corridor meetings" ... as we couldn't organize common meetings for all. ... we used to talk with the staff adjunct to the nearby two wards at a time, just to share their needs and give our assurance to look after them…. encouraging them, give the message that the management is always with them and to motivate them. ... some staff members hadn't visit their family for about one month …. or so. They were psychologically unfit. This type of activities helped to enhance the team spirit."*

Communication

Overall staff had been instructed to maintain social distancing. In addition to that there was an increase in communication through social media including a WhatsApp group for the hospital members. The newly initiated corridor meetings have been an effective communication method.

Economic crisis

Due to transport issues and rising living costs it had been decided to allow HCWs to work on extended shifts and provide accommodation while they were continuing on multiple shifts. This allowed HCWs to reduce travelling and thereby reduce living costs. The staffing practices continued beyond the pandemic will be discussed in section 5.8.5.

6.2.4.2. SQ 2

What training practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

Safety training

The main target of training was to give all staff an awareness of patient handling and donning and doffing of PPE kits. This was planned to cover all staff including MS. In particular, nurses were assigned to work with the first patient who was admitted to the isolation ward, on a job rotation basis. It had been planned to give them an exposure before the peak so that the nurse are prepared for work during the surge in patients. Within wards, a new work system using the buddy and designated zones was initiated. During the early stages of the pandemic there had no surge in patients and only few wards provided COVID-19 treatment. Thus, this new system was introduced to the rest of the nursing staff through role plays.

Training on PCR tests

As mentioned earlier, nurses did not have a proper training for conducting the swab test on suspected patients. Only the doctors were performing the sample collections. But there was high demand for PCR tests as the number of patients increased, which automatically required nurses to involve in obtaining PCR samples work. Thus, nurses were given on the job training to do the sample collections.

As the laboratory facilities were expanded, few members of the laboratory were sent for a special training on PCR testing at the National Medical Research Institute which was the central body in the country who carried out PCR tests for hospitals at the beginning of the pandemic. Those who attended this training, trained the rest of the team while working back at the hospital.

ICU training

During the peak the ICU facilities were extended, adding a new ICU facility. However, there were not sufficient number of ICU trained nurses within the hospital. Staff from another hospital were involved to manage the added ICU duties. The CNO has requested additional ICU trained nurses from the ministry. The hospital then received a group of nurses (first appointment). As these newcomers had no ICU training, they were sent for an ICU training at the National Hospital before they were absorbed to the hospital ICUs. A previous study revealed that there is a significantly low percentage (approximately 11%) of ICU trained nurses in the Sri Lankan state hospital system (Haniffa et al., 2014).

Training for MS

Similarly, the overseer had arranged training for new MS at other hospitals. These included a new member at the mortuary. As claimed by the overseer, mostly minor staff appointments are

influenced by politicians and thus, they recruit people for MS duties without considering their qualifications or skills.

Operating new machines and equipment

It was mentioned earlier about the new machines and equipment added to the wards during the pandemic. Demonstrations were conducted by the suppliers to train the staff on how to operate the machines and equipment. A small number of staff were given chance to participate in such demonstrations and through them the knowledge was passed on to the rest at their wards.

Cost cutting and financial stress management

During the economic crisis, there had been training programs on how to deal with financial distress. Further, CNOs have initiated cost cutting and waste minimization activities. Those include minimum use of paper for documentation, keeping ongoing communication via WhatsApp that reduce paper based notices. Further, WICs instructed nurses to liaise with other wards and help exchange of drugs and medicine among wards where possible.

6.2.4.3. SQ 3

What rewards, welfare and EA practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

Welfare programs

As discussed earlier, with reference to staffing arrangements, there have been many welfare and employee assistance programs (EAPs) designed by the hospital. Those include the transport facilities, accommodation and meals as well as grocery and other consumables where HCWs were assisted with looking after their families during the lockdown. However, the management was unable to design any pay rise or special compensation for the HCWs for pandemic related work they had done. Some respondents mentioned that they received a one-off incentive payment during the early pandemic. Overtime payments had been arranged with special requests sent to the ministry as the team based duty system ended up with additional overtime hours that was above the maximum number of hours allowed per month. HCWs were given cumulative leave following the team based duty shifts. It was revealed that the managers designed such practices to keep the workforce motivated and to uplift their morale.

Educational and entertainment programs

In addition to this, there were meditation programs, religious activities and entertainment programs organized in the hospital. Motivational speeches were organized and were facilitated by experts. Involving staff and patients there have been musical programs. Music, religious and meditation activities are important parts of Sri Lankan lifestyle. Management initiated such activities inside the hospital so as to assist employee mental wellbeing. Involving patients in some programs, targeted at patient wellbeing. Through the government, an appreciation program was implemented in which HCWs given a holiday package in a hotel. Of note, all these activities have been initiated after the peak of the pandemic, given social distancing procedures and busy workload for everyone.

Limited EAPs during economic crisis

Due to financial difficulties, and inability of raising funds through the donors, managers claimed that the hospital had limitations of continuing or initiating EAPs. However, management continued to provide extended work shifts to assist the HCWs to save their travelling costs and thereby minimize living costs. However, due to government regulations maximum overtime hours had been controlled. This was contradictory as the hospital could not manage its work load without overtime. It was revealed that compulsory overtime is apparent in the Sri Lankan hospital sector, due to skilled worker shortages, as also examined by Wanninayake et al. (2022). To facilitate continuous work shifts, hospital has generously allocated additional space for accommodation for workers who usually travel to work, as the hospital quarters were already utilized up to the maximum capacity.

Allocation of additional shifts was a must, as demanded by the drops in employee numbers due to 1) early retirement (as per the changes government regulations) and 2) some HCWs left the job at the hospital (migration). On the other hand, government restricted new recruitments to public service including hospitals. It was also revealed that many MS have relocated to their home towns seeking casual jobs given their diminishing living standards in the urban settings.

6.2.4.4. SQ 4

What employee participation practice strategies were designed as a crisis response? What were the expected outcomes (performance/ quality of care/service continuity or HCW wellbeing)?

Decentralized decision making

Managers recognized the value of involving employees in decision making. For example the corridor meetings which were introduced in the section 6.2.1, enabled managers to listen to employee concerns, keep two way communication which resulted informed and decentralized decision making. This assisted to make sure work related issues are minimized and the quality of service to patients is maximized.

As per the government guidelines the managers had the COVID-19 cell – regular meetings with all department representatives throughout the pandemic time. This enabled the employees to raise their concerns, as well as suggest amendments to new work practices as they go ahead with unfamiliar work practices. Further to this, the initiation of the hospital WhatsApp group had been an effective platform where the employees were able to connect with the hospital community.

According to managers, these employee participation practices were aimed at enhancing employee commitment and there by ensure effective decision making.

Economic crisis

There were no specific employee participation programs designed during the economic crisis, despite the continued communication and exchange of information through the WhatsApp group. Managers admitted that they had regular contacts with LMs and attended to HCW issues so as to uplift HCWs' wellbeing. Their concern was that, due to the financial hardships there were limitations to how they could intervene. But, their requests for having additional work and accommodation facilities were generously processed by SMs.

6.2.5. RQ 03
What were the barriers and enablers of implementing the designed HRM strategies?

The following section discusses the implementation of practices introduced in the section 6.2.4. Information collected from LMs are considered in this section.

6.2.5.1. SQ 1

What staffing practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

Pandemic

Staff absenteeism

According to the WICs, designed staffing practices were implemented. The team working attitude and support from SMs were the enablers. They admitted that due to the team based system, they experienced a positive work culture where teams committed to fulfill the expected tasks up to their maximum capacity. However, as noted above, there were delays in staff reporting to work due to transport issues. These include daily travelers to work and staff returning to work after their special leave, travelling from far. These caused delays to shift handovers or staff absenteeism resulting other staff to bear additional work pressures.

At such instances, LMs had to ask the staff members at work to continue for the next shift or assign the duty to staff residing at hospital quarters. Mostly they chose unmarried staff members, as they had less family commitments and responsibilities, assuming that it would enable them to adjust to ad hoc work demands. Both staff members and LMs admitted that the team working spirit and commitment to work had been the enablers of accepting such additional work without delays. As a remedy to these travelling issues, hospital had to expand their accommodation facilities.

Unfamiliar work

As discussed earlier, hospital's pandemic management involved a process of converting wards into COVID-19 treatment facilities and allocating internal staff and staff from other hospitals as well. Staff claimed that they had to familiarize with new work practices and strict hygiene and social distancing practices. Unlike the nurses already being working in wards, staff from special wards have experienced an additional layer of unfamiliarity, in the COVID-19 wards. Working in special clinics had distracted them with managing work in a ward setting including patient care. A LM who was earlier attached to the HIV-AIDS clinic, claimed that she had to spend a significant time in adjusting to the management system applied in normal wards including staff rostering and related administrative work, as her clinic was converted to a ward. The overseer had similar thoughts about her staff as they have been assigned almost every supportive work, despite what they were specialized at. Importantly, they were allocated work in wards such as housekeeping and maintenance work which were not included in to their routine work load prior to the pandemic.

Difficulties in wearing PPEs

LMs mentioned that they identified that difficulties with HCWs wearing the PPEs for long hours made barriers for smooth implementation of designed work practices. At times, HCWs started to skip some items when donning and LMs had to carefully inspect if the correct

donning was being practiced. Further, there have been a few instances where the wards ran out of PPEs and LMs had to ask the HCWs to use the PPE kits up to the maximum duration, unlike the earlier times where they could change in to another set of the PPE kits during a single work shift. Additionally, LM claimed that they encountered quality issues with PPEs. Mostly PPE kits were in a standard size but were not fitting to all.

Violating social distancing procedures

Additionally, it has been sometimes hard to practice social distancing in their wards. Typically in Sri Lankan culture employees take lunch together with their work colleagues, mostly share the meals they bring from home and spend time together during tea breaks. As such, there are informal groups who usually take meals together. This practice has been a major barrier for implementing social distancing at the hospital.

Aligning interim staff to hospital culture

There have been issues when aligning work teams and staff coming from other hospitals during the peak of the pandemic. Outsiders were not familiar with the hospital's work culture. The CA admitted such issues, among the staff assigned to her office from external government offices, mainly due to risk of virus exposure. Those staff shown a preference not to mingle with the staff of the hospital.

Economic crisis

Surge in patients and staff shortages

There have been significant increase in patients during the economically turbulent time. But managing this has been challenging given short supply of power, medicine and availability issues of staff due to limited public transport and fuel shortages (as also discussed earlier). However, WICs and CNOs admitted that, there were staff coming to work walking a considerable distance which indicated their commitment to work.

Further to this, staff turnover and retirements have made drops in staff numbers. There has been a new scheme for government employees to take no-pay leave for Foreign Service and few members of staff had taken advantage of this. Few have left without proper notice including the MS. On the other hand government recruitments were restricted in the country resulting almost no new staff assigned to the hospital. These has caused staffing issues in wards and with other supportive services at the hospital. Overall, staff shortages together with high volume

patient numbers inclined compulsory overtime work. As mentioned earlier, allowing staff for continued/ extended shifts resulted in increase in their overtime hours.

Overtime restrictions

Allocating overtime work has been persuasive to enhance the surge capacity to cope up with operational requirements and at the same time to assist employees with an opportunity to continue multiple shifts. While implementation, managers faced barriers with financing the overtime hours above the maximum overtime hours, due to government restrictions. Despite such limitations, managers worked out with the ministry to obtain approval with special considerations. LMs claimed that, their involvement as the national hospital for ID and as the focal point for seasonal Dengue epidemic strengthened the eligibility for easy approval of additional overtime hours.

6.2.5.2. SQ 2

What training practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

Limited participation allowed

In relation to the training programs, a major issue was the inability to allow everyone to participate. For example, new equipment demonstrations were opened only to selected employees from some wards. The attendees had to pass the knowledge to others and LMs followed up this knowledge sharing process. There were a few complaints in some wards that when none of the members of the ward had participated a particular demonstration. At such instances, they had to contact and arrange a session at another ward, which was a hard ask given tight work schedules in every ward.

Scheduling trainings at external providers

When sending staff for outside training programs, such as the ICU training and PCR testing, there have been difficulties in scheduling those programs, due to delays in approvals, strict social distancing measures and other related arrangements.

<u>Economic crisis</u>

Limited funding

During the economic crisis two information sessions on financial management were conducted. Given funding issues, no further training was organized. The CNO mentioned that during pandemic, there were plenty of donations and donors themselves got involved in contacting the

hospital and processing donations of different types. It was also apparent that as a government hospital they have limited power to ask from donors for help. The CA claimed that later on they had to control contacting donors. By the end of the pandemic, there was a regular donor base. However, during the economic crisis those donors were less able to help the hospital and as the CNO highlighted there was a significant drop in inquires received from regular donors regarding making donations.

6.2.5.3. SQ 3

What rewards, welfare and EAP strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

Funding welfare practices

During the pandemic a majority of welfare and EAPs were financed through donations, given restrictions and practical issues in obtaining funds directly from the government. However, no rewards were added such as special allowances for pandemic service except for the government initiated hotel vacation package. The implementation of this scheme had been adjusted after consulting the ministry through the HD as initial proposal sent by the ministry did not cover all employee categories such as office staff. As such, access to this reward was expanded during the implementation stage.

The context of the economic crisis negatively impacted the continuation of EAPs and cultural celebrations such as Sri Lankan New Year and Vesak, due to funding issues. LMs admitted that usually such celebrations are partly funded by hospital administration together with donors or sponsors while a small contribution from staff volunteers are collected. It was clear that staff volunteers neglected to contribute these celebrations given their financial difficulties. A few celebrations were organized with tight budgets with limited event components (e.g. light/ no refreshments).

Hospital provided meals

Meals for admitted patients in wards and for the staff who work for continuous shifts are provided free of charge. The overseer indicated that there have been limitations to number of servings per meal and the content, due to rising costs. Streamlining these, they have started to prepare meals according to the headcount of patients admitted on a given day morning and only for staff who will run multiple shifts on the given day. As such, they have been able to minimize food waste. However, most days they come across with difficulties in providing meals to patients who admitted during the day. Ad-hoc staff adjustments also create additional meal

requirements but if those would have not included in the particular day's headcount, cause insufficient servings. As such, this system has seen as a bit ineffective. Given increased prices of groceries, kitchen staff have started to use vegetables, coconut and other spices from the hospital garden whenever possible. Hospital staff had been encouraged to assist with planting vegetables in the hospital garden.

6.2.5.4. SQ 4

What employee participation practice strategies were implemented as a crisis response? Were they the same as what was planned? What barriers or enablers encountered at implementation stage?

Eased communication

As elaborated in the section 6.2.4.4., there have been various employee participation practices. LMs claimed that SMs cultivated an open communication culture through these meetings and specially responding to employee suggestions. The WhatsApp group was another enabler to strengthen real-time communication across management and employee levels. The corridor meetings have been effective in raising employee voice.

Restrictions to implement employee suggestions

As previously explained, LMs have been openly communicating with HCWs and their suggestions have been incorporated into the pandemic response. But during the economic crisis, there have been financial restrictions that limited the activation of employee suggestions. Mainly HCWs were concerned about their travelling costs and looking for additional work which were both possible to achieve through extra over time work. However, given government restrictions, LMs had to minimize allocation of extra work hours although they had compassion over employees and were doing their best to listen and follow up their concerns.

6.2.6. RQ 04

What are employees' experiences and perceptions of fairness towards these HRM responses?

6.2.6.1. SQ 1

What staffing practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those staffing practices perceived as fair by HCWs?

HCW safety

HCWs confirmed the implementation of extended shifts using alternate work teams as the major change to their staffing practices. They mentioned that the managers aimed at their safety as a priority when making those changes and that was what they perceived as the motive behind those practices. LMs always encouraged them to follow safety guidelines, indicating that HCW safety is what matters. Some respondents claim that these were designed to ensure continuous care to patients.

External attribution

Some staff had the idea that the hospital did this change in response to a government directive. As such, employees had different perceptions of the motives behind such HRM practices.

Support for vulnerable employees

Majority of HCWs mentioned that the LMs attended to HCWs' requirements and special considerations while allocating work across teams. These include female workers with young children and employees with medical conditions. Thus, majority of the staff agreed that changes to staffing practices were fair and justice.

Adding to this, a doctor mentioned that there have been special working arrangements for her during her pregnancy. She had been assigned work at the laboratory, a shift from her usual ward work, as a way of minimizing contacts to patients. She has been asked to take extra leave if required. This was before the government announced a special leave system for pregnant workers. She admitted that such concerns over vulnerable employees, reflect the fairness of the management strategies and support for workers during the pandemic and such attribution enhanced her commitment to continue work despite many challenges.

Gender based fairness concerns

Male nurses had some concerns over duty allocation and distribution of accommodation facilities. They highlighted a gender based discrimination. However, they admitted that it is usual in the Sri Lankan society to give priority to females when it comes to protection and security matters and assigning light work. It is general that to assume that males can bear pain and emotions. Female workers who were working mothers, would receive exemptions in additional duties such as working extra shifts during an emergency or ad-hoc work requirements. These male nurses mentioned that in such situations they were selected over female workers. They complained that male employees were picked for continuous shifts but

had less priority for facilities including transport and accommodation as compared to their female counterparts. They highlighted that even during the economic crisis, male nurses had few chances to use hospital accommodation. They expect that given a context like a pandemic and also the economic crisis everybody feels the same burden and expect to be treated equally.

Further to this, they indicated that in Sri Lankan HC system, there is a norm of maintaining only 5% male nurses in the government nursing cohort. However, given cultural influences there are specific procedures that are preferably performed by male nurses (for male patients) and usually male nurses are assigned duties in male wards not in female wards (again due to gender and cultural norms). These cultural influences have been sometimes an extra issue for LMs, during the pandemic given the surge in patients.

Back office staff not prioritized

Similarly, the AO indicated that his staff had concerns over fairness as most of the time managers took decisions based on wards and other frontline HCWs. As such, they perceived that office staff lost the close attention from top management. There were thoughts of "not being considered" when designing staffing practices. They had to report to work as usual while there had been issues in working from home due to lack of provisions for devices and network connections. Being at the back office, there had no extra safety concerns and they had only used minimum PPE mostly the masks. Further, they had additional workload which were essential to support and facilitate new practices implemented during the pandemic such as registering and documentation of donations including PPE, food and daily essentials items and arranging transport facilities for staff etc.

Flexible working arrangement

During the economic crisis, management allowed the changes to routine shifts in a way that assist staff to reduce travelling and facilitate with accommodation support. Respondents had high fairness perspectives on that initiative. Their perceived motive behind these initiatives were clearly employee wellbeing. Adding to these both managers and HCWs indicated that mostly government employees' appointments have been influenced by government agendas and as a result majority of hospital staff are residing far from the hospital. As such, they would have suffered with travelling to work, unless the hospital arranged flexible work, allowing extended shifts and supported with hospital accommodation.

Unfair staffing procedure – government influence

For example, a particular government can decide how many new employees of unskilled labor will be appointed and basically those will be filled using residents from the president or minister's village and quotas to be filled were based on political interests (priority given to party supporters). Transfers and first appointments are also influenced by political connections.

Further, due to economic crisis, there had been freezes to MS recruitments. Given changes to pension schemes there had been a raise in early retirement in every employee category. Adding to this a considerable number of HCWs, both clinical and MS had left the hospital. Due to this experienced labor turnover, existing staff encountered additional job duties amidst the surge in patients.

There have been limited nursing recruitments made by the ministry during the pandemic. The nursing students were given online lessons with no practical training due to closure of educational institutes during the lockdown. Following the pandemic, the ministry started assigning these new staff to hospitals. However, the CNOs indicated that newcomers underperform due to the lack of proper practical training.

Employee wellbeing over government restrictions- the overtime payments

There has been a reduction in overtime hours that has caused issues in allocating work as usual. Pharmacist and a MS member claimed that they have a huge workload but with limited number of workers it was usual to work extra hours. But with the government restrictions their managers started to limit the working hours. Importantly this has caused reductions in their salary. They admitted that their managers cannot control this issue as they have had to follow government instructions. As such, the attribution of these respondents was mostly external.

However, they claimed that their concerns are being considered within the hospital and on a few occasions the hospital had obtained special approval from ministry to allow additional overtime hours and they have had compensated. As such, they perceived the hospital management interventions as fair, but not the government regulations regarding overtime restrictions.

6.2.6.2. SQ 2

What training practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those training practices perceived as fair by HCWs?

Safety training

A majority of respondents confirmed that PPE training, patient handling training sessions and role plays were very important. These trainings were practical and aligned to previous Ebola drill. What managers communicated to them as the aim of these trainings was to make sure that hospital staff were safe and if they are safe there can be continuous patient care. They have been told that they are the capable team who can eliminate this virus from the society.

On the job training- treating the first patient

Nurses gave positive feedback about the initial training at the isolation wards (rotation) when the first patient was admitted. There has been around one month until she was discharged and before the surge of patients occurred. Nurses had considerable time to get exposed to the new practices as the hospital converted wards gradually, one after one into COVID treatment.

Learn by doing- new duties

A MS member claimed that their routine work was significantly increased with new tasks that they were mostly learnt by doing those tasks. At times they have been involved in ward housekeeping as the outsourced cleaning staff were not coming to work. Working closer to patients has been a challenge, but they worked high commitment despite their vulnerability. He mentioned that he didn't consider whether such ad hoc practices were fair or not, but given the urgency and timely requirements they were ready to do any kind of task. He also mentioned that ward managers supplied required PPEs and safety instructions. He had perceived the motive behind such practices were continuing and maintaining a safe workplace. Given the changing nature of the knowledge about the virus and updates to procedures, he admitted that mostly there was a lot to know and they trained themselves while doing the jobs.

Limited participation opportunities

With regards to machine and equipment training, nurses had a few concerns regarding fairness in providing access to participate the demonstrations. As only selected members were given the training, there have been issues in passing the knowledge to other members. Sometimes, none of the members of a particular ward had participated and there have been delays in starting to use such machines in those wards.

Deficiencies in nursing student training

Further to this, nurses highlighted the issue with their nursing student curriculum as it has not covered specific training for swab testing procedures to do the CR tests. As such, they had to

face many issues in the pandemic context and had to train by doing. Adding to this, nurses mentioned that most of them just followed the instructions and were able to complete their tasks, but they did not have a complete understanding or idea about the basics of the procedure. For example one nurse mentioned that they do not know how to understand the readings of a PCR test. Their major concern was that without proper training they had to continue the sample collection, which was previously only done by doctors. But after this, nurses were compelled to do the collection and there resulted in an unfair distribution of designated work across doctors and nurses.

Cost cutting instructions

In the economic crisis context, LMs initiated informal information sessions on applying cost cutting practices. AO mentioned about power saving and limiting paper and printouts in the office. Nurses reported that they were given instructions by CNOs regarding maximum use of drugs, equipment and paper. They have been asked to sanitize and clean some medical equipment and reuse, some which were usually single use. Commonly, nurses perceived that such practices were aimed at hospital performance.

Financial stress management

HCWs had lower fairness perspectives regarding the participation opportunities for financial stress management workshops at the hospital. But they had understood the hardships with managers to finance multiple workshops. Nurses claimed that CNOs educate them with cost cutting initiatives to use in their personal living. CNOs have been role models to the staff, share their own tips to be used for example meal preparation (not a usual practice in the Sri Lankan society), energy saving cooking methods, extending EAPs including hospital accommodation (in the case of overcrowded accommodation spaces, male staff were allowed to share common areas in the hospital like rest rooms as temporary accommodation). Staff claimed that the motive behind such initiatives as employee wellbeing.

6.2.6.3. SQ 3

What rewards, welfare and EAP strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those practices perceived as fair by HCWs?

Less appreciation from government

A majority of HCWs claimed that their service was not appreciated properly by the government. They would have appreciated any incentive during the pandemic service.

However, they mentioned that the hospital looked after the employees and gave the maximum support to uplift their physical safety and mental wellbeing. Almost every HCW claimed that mental wellbeing programs were really helpful. The common perception of HCWs regarding welfare and EA program seems to be employee wellbeing. Few had thoughts of maintaining hospital services without interruption through a healthy and motivated workforce. Thus, it was clear that the motives of these EAPs had not been clearly communicated by the respective managers. Instead these strategies have signaled multiple motives to HCWs.

Limited access to EAPs

A major fairness concern was access to welfare and EAPs. HCWs mentioned that their mangers tried to give opportunity to everybody despite working shifts and work commitments. In doing so, SMs organized multiple programs. As such, the HCWs indicated that management genuinely attempted to make welfare to all.

Influencing expansion of access to all

Further to this, AO on behalf of his team (office staff) appreciated the HD's influence extended to the ministry to get access to his staff for the hotel vacation reward which originally did not include office staff as beneficiaries. HD and managers have claimed it is not fair enough. Then HD refused the package when it was first sent to the hospital and he requested access to all staff. After his intervention, the government extended spots for office staff. Employees have perceived fairness through this type of caring efforts of the management.

Hospital compassion towards HCWs' financial hardships

During the economic crisis context, the hospital had been flexible in adjusting continuous shifts and providing additional accommodation facilities to staff which to relieve HCW financial burdens. One major concern the doctors and nurses mentioned was that the majority of the workforce was residing in rural areas and few resided in boarding houses. This issue was also raised by other employee categories as detailed in section 6.2.4.1. As such, travelling and accommodation costs are an integral part of the government worker's lifestyle. They indicated that hospital has been very supportive in many ways and the motive behind such initiatives related to employee support and wellbeing.

However, they mentioned that there is nothing substantial that the managers can do in this kind of situation. They expect that government should solve the issues. Adding to that, a majority of HCWs appreciated the initiatives that the managers took to increase their overtime hours

beyond the government restrictions. According to the overseer and also the CA, the hospital had processed such requests and obtained approval several times for monthly salary payments.

6.2.6.4. SQ 4

What employee participation practice strategies were experienced as a crisis response? Were the motives of these changes communicated to HCWs and/ or what motives are perceived by the HCWs? Were those employee participation practices perceived as fair by HCWs?

New ways to promote employee voice

It was a common indication of almost every HCW, that there were open communication channels including the corridor meetings and they were able to present their work issues and suggestions to the managers and those have been considered in management decision making. Further, the WICs have been available for employee grievances. The majority of nurses agreed that work allocations were planned considering staff requirements and there has been flexibility over staff needs. Developments to work stations and working arrangements have been improved and changes have been made at ward level based on staff suggestions and feedback. They claimed that given there have been frequent changes to managing the patients in different phases of the pandemic, LMs frequently looked for staff ideas. They have attributed these type of employee participation as a way of maintaining a higher level of employee wellbeing.

Compassionate LMs

During the economic crisis, the majority of employees witnessed the difficulties that their LMs faced in meeting employee requests, suggestions and ideas. Given financial distress, staff sought additional work and LMs/ WICs liaised with the SMs to make adjustments to overtime restrictions based on staff requests. The nurses and MS member appreciated such intervention and was satisfied about the opportunities to raise their concerns.

Virtual communication –cost saving

Further they highlighted the use of WhatsApp group as an effective communication method that they connect with the managers and SMs. This had caused a drop in paper printed notices and letters to staff which is a great saving during a turbulent time with no paper supply and restricted power supply. They mentioned that even LMs arrange zoom meetings that enabled them to attend, without travelling to the hospital which was very useful in such a period with fuel shortages. Their motives behind such practices seems to be both hospital performance and employee wellbeing.

6.2.7. RQ 05
How effective were the HRM strategies?

6.2.7.1. SQ 1

What were the outcomes of HRM response?

Pandemic

Zero internally acquired virus infection to staff

SMs admitted their main concern during the pandemic response was to ensure the hospital staff safety from the virus. At the same time, the intention for providing a continuous service and maintaining quality of patient care were also apparent and managers admitted the importance of looking after employees in that turbulent context. All the three SMs admitted that there were zero virus infection acquired at work among the hospital staff. This has been a great indicator of the successful attainment of the intended outcome of the different HRM interventions. These include the team based staffing strategy, COVID-19 training and continuous updates to procedures and patient management activities that were based on government instructions, expert recommendations and employee and ward level suggestions. There have been a system to conduct PCR testing free of charge for staff attached to the team based work schedules in way preventing infections transmission from the hospital to community and from the community to the hospital.

Overwhelmed staff

Managers had mixed responses regarding the level of employee wellbeing as an outcome of HR interventions. Majority mentioned that due to heavy work load at peak times, staff felt overwhelmed. Shortages in staff has been an issue even before the pandemic. Managers had failed to address wellbeing issues arising due to heavy workload, despite many successful EAP interventions.

Patient satisfaction and positive feedback

The other main intended outcome has been the continuous patient care and patient satisfaction. SMs admitted that they were able to continue patient care through the high safety levels of HCWs that lead to zero virus transmission within the hospital. They had no delays to patient care as the hospital staff was managed in a way that ensured continuous staff availability. In addition to the medical and clinical care, the staff was directed to help patients with their mental wellbeing given patients'' anxiety to this new virus. Staff had worked hard and looked after

the patients with additional care. Thus, recovery rates had been satisfactory and hospital had received good feedback from patients unlikely during other situations. There were written feedback, appreciation letters and gifts including donations from patients who recovered. In common, patients have mentioned they received great care and the staff had been very supportive with their mental wellbeing during the isolated periods.

Economic crisis

Navigating resource scarcity

Cost cutting initiatives at ward level and across other areas of the hospital enhanced the efficiency and enabled the continuity of hospital operations despite very limited resources. However, limits with medicine and overcrowded wards and clinics created patient dissatisfaction and aggressive reactions. These show low levels of hospital performance as indicated in patient feedback. HCWs and managers claimed that patients reacted abnormally given deficiencies in hospital services.

Employee burnout

Utilization of EAPs (including staffing and accommodation arrangement), stress management workshops and CNOs' informal lessons on personal spending, HCWs found satisfactory level of support to cope up with their difficulties during the financial crisis. However, heavy workload and additional responsibilities including liaising with other departments to exchange goods and share drugs for patients have all contributed for HCW stress and burnout.

6.2.7.2. SQ 2

Do managers and HCWs experienced any influence of employee wellbeing on employee performance and thereby on quality of care?

Employee wellbeing issues were detailed earlier in section 6.2.3.2.

Wellbeing increased performance

HCWs claimed that during the pandemic the working conditions were safe despite issues with the PPE fit, occasional shortages in PPEs and staff absenteeism. The entertainment and meditation programs have been helpful for uplifting their mental and spiritual wellbeing. One nurse mentioned that visiting the temple and doing meditation has been a routine practice in her life which she missed during the peak of the pandemic. She was glad that the hospital organized meditation programs and motivational speeches in the hospital. The EAPs have

enhanced their performance. LM support and the employee voice mechanisms all have lead their commitment. All these supported high performance despite many challenges.

Positive patient feedback

Patient feedback enhanced the fulfilment of perceptions of the value of the work (C. D. Fisher, 2014) through the feeling of making a difference for others. Unlike other situations, the pandemic required additional care for patients. Positive feedback assisted the HCWs to reinforce their beliefs of fulfilling their duties to the full. As such, the HRM interventions aimed at employee wellbeing led to high quality patient care at the same time patient feedback cultivated motivation in HCWs to perform better and better.

Disruptions to patient care

During the economic crisis, managers noted that HCWs lost their commitment and energy levels due to financial burdens. As such their productivity and performance had deteriorated. On the other hand, lack of staff amidst high patient numbers led to an overwhelmed hospital. Drugs shortage has been a major cause of hospital staff dissatisfaction due to their inability to provide a proper care for the patients. These uncontrollable factors influenced lower levels of patient care. The HCWs felt compassionate and at times distressed because of feeling unhelpful for their patients.

6.2.7.3. SQ 3

Have the HRM strategies been adjusted during and across the crises?

Contradictions between preparedness and the demands of the crises

Pandemic

As mentioned in the previous section, managers had designed the HRM practices aimed at both safety of the hospital staff and their mental wellbeing. A majority of managers admitted that although their pre- preparations and drills were really a great advantage during the pandemic, there were major deficiencies given the novelty of the virus and unexpected isolation from the external society due to lockdowns. The introduction of new HR practices at the beginning of the pandemic has been subject to dramatic changes as the pandemic progressed. These changes were also subject to the government instructions during different phases of the pandemic. Managers indicated that preparedness plans were mostly helpful to initiate their response, but

timely decision making and ad-hoc adjustments were critical in managing workforce and operational demands across various phases of the pandemic.

Economic crisis

Takeaways from the pandemic response enabled managers to maintain employee wellbeing practices during the economic crisis. Extra care for HCWs was a critical concern during the pandemic. Thus, the staffing practices and accommodation facilities were continued as same. Some of the practices were not continued beyond the pandemic, because 1) most of the practices were tailored to the pandemic, and 2) were sponsored with donations.

As far as the economic crisis is concerned, managers mentioned that navigating the pandemic was a lot easier than the economic crisis. Their major concerns were about the financial resources. They claimed that they did not have any back up plans to cope up with a financial crisis. Usually as a hospital what they understood is to be prepared for an emergency that can increase the inflow of patients. As a government hospital, they completely rely on the government for essential funding while utilizing donations for additional funding needs. But while trying to cope up with this crisis, the hospital had to deal with increased number of patients, who at times seeking for a higher standard of care (used to be private hospital users), with a limited number of staff.

6.2.7.4. SQ 4

Were those changes based on review and feedback from managers and HCWs?

Employee suggestions

Communication between wards and the management enabled feedback and employee suggestions. A majority of HCWs and WICs claimed that there have been changes to work practices and safety procedures at ward level based on employee requests and suggestions, while on going adjustments have been done, based on the changes in government instructions. For example, amendments to the mandatory PPE requirements have been made based on reviews on virus severity, employee convenience and government regulations.

Employee suggestions during the economic crisis regarding extended shifts have been implemented at ward level.

Reviewing implementations

Staff meal breaks were organized in a way that HCWs had to adhere strict social distancing measures. Additional spaces were allocated for meal breaks and resting. These implementations were based on LM observations and complaints received form some HCWs regarding staff breaching social distancing practices. It was a new task for WICs to monitor social distancing practices of HCWs.

6.2.7.5. SQ 5

To what extent the HRM response strategies have been absorbed into routine practices and overall crisis preparedness?

Extended shifts as a continued practice

Following the pandemic context, hospital has identified the possibility of continuing newly introduced and modified HR strategies. Majority of the strategies were aligned to their existing emergency management policies. However, there have been major adjustments to the way that the hospital used to function. The hospital has learnt alternative ways to their staffing strategies and work practices. Among those, the extended staffing practices that have the potential to continue are the way that the work was assigned to minimize transport costs. Although, the team based staffing system and interim staffing practices seemed not useful after the pandemic, they have been integrated into preparedness planning for the future.

Justifying additional overtime payments

Addressing ministry restrictions on overtime hours, the managers obtained special approval from the ministry to allocate additional funds to pay the HCWs during the pandemic. Given the fact that the hospital was overwhelmed and the staff were assigned extra workloads to continue hospital service, and the national level importance of the hospital in seasonal epidemics, it was not a difficult task for the managers to get the special approvals for compensating additional overtime hours. However given the economic context, this has been a major challenge for the hospital managers as they struggle to assist their employees with extended shifts. As the hospital lacks staff in a few categories, including the MS, this has been a further burden for the LMs to get work done within the maximum time allocated. They have been able to convince the ministry to approve extra funding in this context, justifying the similar situations faced during the pandemic.

Long term benefits beyond the pandemic

Exposure and work experience in the pandemic turbulent time and developments in infrastructure have enhanced employee resilience. Almost every respondent claimed that the experience lead to heightened resilience and readiness for future disasters.

There have been major developments in hospital assets including staff quarters and additional temporary buildings. These have been useful in facilitating accommodation demands emerged due to the implementation of extended shifts during the economic crisis. Occasionally, office staff did WFH despite technical and devise issues. Delivery of medicine to patients was also continued. With the new machines and equipment (portable ventilators, expanded laboratory etc) added and staff has been trained how to operate them, the hospital services and capacity significantly increased. Thus, these enhanced the preparedness of the hospital for any future infectious disease crisis.

Financial restrictions

The employee mental wellbeing concerns have been highly prioritized and seen as major investment category during the pandemic. Continuing this, there have been attempts to maintain such meditation and motivation programs. However, in the economic crisis context, managers highlighted that the hospital could not afford multiple programs except the two financial stress management workshops. HCWs also highlighted the psychological dilemmas encountered with the feeling of being incompetent to provide a good patient care. Overall both managers and HCWs agree that the impact of the economic crisis has seen more critical than that of the pandemic.

Virtual communication

It was clear that online communication system (WhatsApp and Zoom meetings) were newly initiated during the pandemic and have been continued and practiced thereafter. LMs have almost stopped using printed notices. Instead they share soft copies or pictures of the notices via WhatsApp. Participants highlighted the advantages of practicing online communication in the economic crisis context (cost effectiveness).

6.3. Part Two: Hospitals B, C and D

6.3.1. Hospital profiles

6.3.1.1. Hospital B

Hospital B is owned by a leading private company in Sri Lanka, which excels across different businesses such as telecommunication, finance and HC services. There are six hospitals across the country. The company also owns an island wide laboratory services business. Their first hospital of was established in 1980 in Colombo. Hospital B is located in a semi-rural city in the Southern Province.

Established in 2007, Hospital B currently operates two units in separate locations in the same area. It has obtained several local and international level accreditation including the Australian Council on HC Standards International (ACHSI) in 2019. Services mainly include diagnostic, medical and surgical services. It is well sought for consultancy services specializing in Obstetrics, Gynaecology and Orthopaedics at a cost for such services and for those who seek comfortable and luxurious in-patient care services. As per the Assistant General Manager - HR, location of the hospital in this regional area was a strategic choice, as majority of private hospitals are located in the capital city Colombo.

The bed capacity is 50 and the HCWs include approximately 70 nurses who are permanent employees. Doctors and additional nursing staff is sought through locum method (public hospitals employees who work part-time private hospitals). Doctor channelling services are managed through mobile applications and telephone. Consultancy services are provided by specialist doctors and assisted with channelling nurses. There is a General Manager, a Medical Manager and an Operations Manager. The CNO looks after the nursing staff, while a doctor is handling the locum rosters. The hospital maintains its own in-house pharmacy and laboratory service. There is a kitchen that fulfils meal requirements for patients and staff. Some HRM functions are handled by the head office in Colombo assisted by HR information systems. HRM department of the hospital mainly handles recruitments, training, payroll, attendance and leave, performance appraisal, employee grievances and industrial relations matters.

6.3.1.2. Hospital C

This hospital is located in Uva Province, a regional part of Sri Lanka. It is a public Ayurveda hospital operated with 45 staff with a 76 bed capacity. Several treatments based on Ayurveda practices are provided with the leadership of a Medical Superintend (MST). Ayurveda is a traditional medicine system of India (das Neves & da Silva, 2024). Hospital C also provides *Deshiya Chikithsa* (local traditional medicine) in addition to Ayurveda treatments. Their

treatments are based on traditional methods that use natural ingredients (herbs), handmade medicines, processing medicine in earthenware, using firewood hearths, oil treatment and massaging. The location, like other rural areas are known for their rich heritage of indigenous medicine (Samaranayake et al., 2021), less congested, and richness of medicinal plants. According to the MST, indigenous medical practitioners usually transfer their knowledge from generation to generation, as a practice following their ancestors.

Same as the case in Hospital A, in this hospital majority of HRM functions are operated through the MH. As per the interviews and also confirmed by the MST, there is a staff shortage. Surprisingly, there was no single nurse working in this hospital. This is due to the lack of trained Ayurveda nurses in the country, backed by a persistent lack of interest of nursing students to select the Ayurveda stream. As such, nursing duties are covered by hospital attendant staff. Majority of doctors, including the MST had family ties to preceding indigenous medical practitioners. The patient base consists of patients from the area as well as patients coming from other parts of the country, as this hospital is a famous Ayurveda hospital in the country. As such, it has specialized wards and personalized care facilities at a cost in addition to its main free of charge medical services. It has achieved National Productivity Awards consecutively over the recent years.

6.3.1.3. Hospital D

Hospital D was first established as a small rural hospital in 1850 and was relocated to the current premises (semi-rural) with an extended bed capacity and other facilities. It is one of Sri Lanka's largest tertiary care hospitals and it is a leading teaching hospital attached to a University medical faculty. The hospital also runs a nursing training school. Located closer to the Northern provinces, this hospital has served as a critical care point during the civil war attacks over the 30 years. Thus, the hospital's emergency management system would be a well-established one. The current bed capacity is 2060 across 50 wards. There are 8 ICUs including the COVID-19 ICU. Total employee count is nearly 3000 of which 40% are nurses. Hospital; is managed through a HD. Medical units are managed through consultant physicians while nursing staff is handled through CNOs. There are couple of overseers to manage the MS. As a state owned hospital, the MH has direct influence on management of the hospital same as the Hospital A and C.

There are more than 76 medical specialist services such as Ophthalmology, Paediatric Cardiology and Neuro Physiology. Other services include laboratory, pharmacy and health

education unit. Supportive services include the transport, kitchen, laundry, maintenance and recording units.

6.3.2. Interviewee profiles of Hospital B, C and D

The number of interviews conducted in each case study were described in table 5.2., in the Methodology chapter. Twenty three, twelve and twenty interviews were conducted in Hospitals B, C and D respectively.

Sample at Hospital B consists of 4 SMs, 12 LMs and 11 HCWs. Sixty five percent of the participants were female and 35% were male. These included 2 group interviews with 5 nurses. Participants' working experience in this hospital were ranged from 4 to 15 years at the time of data collection. Details of respondents are presented in appendix 10.

In Hospital C, the interview sample included 22 participants. There were 5 group interviews out of the 12 interviews. Many participants were interested in talking as groups. Total 12 interviews included 1 with SMs, 3 with LMs and 8 with HCWs. 73% of the participants were female and 27% were male. Participants' working experience in Hospital C were ranged from 5 to 22 years at the time of data collection. Details of respondents are presented in appendix 11.

20 interviews in Hospital D included 22 participants. There were 2 group interviews. Interviews included 3 with SMs, 7 with LMs and 10 with HCWs. 60% of the participants were female and 40% were male. Participants' working experience in Hospital D were ranged from 5 to 31 years at the time of data collection. Details of respondents are presented in appendix 12.

The following sections 6.3.3 to 6.3.7 present findings to answer the five RQs from Hospitals B, C and D.

6.3.3. RQ 01
What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

6.3.3.1. Hospital B

<u>Pandemic</u>

As mentioned previously, Hospital B, a private hospital did not have the authority to treat COVID-19 patients during the first phases of the pandemic. Lockdowns and travel restrictions limited patients coming to the hospital. The management initiated telehealth services and a

mobile pharmacy service while managing medical services in the hospital with highest safety measures. A triage system was followed for incoming patients. Telehealth services had limited success due to technology related factors. A majority of consultants were older and had digital literacy issues. On the other hand, patients residing in this regional area, had issues with access to internet and network quality issues when obtaining the telehealth services. These added to customer service inquiries and follow up services. Mobile pharmacy service was highly successful with rising demands as the public pharmacies were overwhelmed. Demand for PCR testing was also increased, mostly due to the norm, that a negative PCR test result became the license to travel and/or to enter back to the society after being an infected case or a close contacts to a COVID-19 case. Private sector laboratory service providers had higher demands because the public laboratories could not handle the overwhelming test load. These assisted to keep hospital sales on average.

Once the government allowed, Hospital B managed ICC in two hotels. Patients who tested positive to the virus, who sought for a comfortable care at a cost, had chances to admit to ICC due to overwhelmed public hospitals. This increased the sales, and the hospital could finance employee benefits and wellbeing activities. An incentive payment was paid to those who work in ICC, and staff had the choice to voluntarily assume to work at ICC. To facilitate the additional staffing needs for ICC, locum nurses were recruited on casual basis.

When applying for the ACHSI accreditation, the hospital established an emergency management procedure that included training and drills for staff for hazard identification, communication, triage and response. Managers and HCWs indicated that the hospital's COVID-19 response was based on this emergency procedures. The hospital is located in the heart of the Southern part of the country which had a devastating disaster experience during the 2004 Tsunami. Some staff had emergency and disaster handling experience, as they were working at public hospitals in the area. Their emergency management exposure was helpful in preparing the hospital for pandemic response. Further to this, locum staff including consultants, nurses and paramedics brought their COVID-19 exposure and experience (working full time at public hospitals) to this hospital. Due to interim staffing practices adopted in many public hospitals, there was an increase in locum staff availability.

Economic crisis

There was a drop in patient numbers due to the financial recession. Hospital had slight increases to prices for their services. Drug and other supply shortages were unavoidable. Procurement

process was hard and there were cuts to employee benefits including meals and accommodation. Transport issues lead to absenteeism. Staff turnover in public hospitals impacted the locum rosters. Due to government restrictions to income taxes, consultants had less hours available for private practices within the tax deductable income threshold.

Managers claim that as a member of a large private company, the hospital had financial stability although there were drops in sales. The income from the ICC during the pandemic enhanced the group investments and returns. Annual bonus for employees is paid across all the different companies, even at times some companies were not progressing. At the time of data collection, despite the economic crisis in the country, Hospital B employees had received the annual increment to their basic salary. However, the hospital managers claimed that it is likely that a slight cut to the year-end bonus payments, due to financial difficulties.

6.3.3.2. Hospital C

Pandemic

Hospital C located in a regional area had few infected patients in the early pandemic. The patients usually sought immunity boosting medicine, as prevention of the virus infection. Traditional sanitizing methods were used in the hospital to prevent any potential outbreak (herbal smokes). There were disruptions to procurement due to lockdown and travelling across districts. The hospital has a management consultative committee which involves community representatives such as members of the village and religious leaders. Through that the MST initiated a program to seek herbs from donors who can supply herbs from their gardens. This was helpful as the hospital had to expand its casket distribution services beyond the hospital surroundings and nearby villages.

Generally Hospital C caters patients with preventative medicine and curative medicine for chronic and CDs. When it comes to CDs like measles and chicken pox, the 14 day isolation, infection control and immunity enhancement treatments which are associated with indigenous medicine system are common practices in the society. It is also common that people seek Ayurveda treatment for venom and snake bites and for Orthopaedic treatments for injuries and diseases of musculoskeletal system. As such, Hospital C had previous emergency experience in such treatment, but not encountered any mass casualty or disaster. Thus, their emergency experience and preparedness had no exposure for a sudden boost in patient numbers. According to the government procedures, the hospital initiated COVID-19 treatments during the later stage of the pandemic,

The staff had higher beliefs and attachment to indigenous medicine. A majority of the respondents indicated that they only use Ayurveda medicine for their medical concerns. They believe that Ayurveda treats for the causes of the medical condition and as such there is a high chance of getting completely cured. Additionally, they had family ties to indigenous medical practitioners. One doctor invented a hand sanitizer solution using natural ingredients, which was used in the hospital throughout the pandemic as one of the main safety practices.

Economic crisis

Living in an uncongested rural area, lead to less living cost pressures to the staff. Their life style seemed simple and relatively not expensive, when compared to urban living. Staff usually consume vegetables and fruits grown in their own gardens.

For example, the researcher had the chance to participate two tea parties at the hospital during the data collection. Those were organized to celebrate staff birthdays. The food served was Sri Lankan traditional food (milk rice with *Lunu miris* (see for more details Rathnayake, 2021) served with locally grown tea with *Kithul hakuru* (palm jiggery (see for more details Balachander, 2017)). The food were homemade, traditional and symbolizing auspicious and celebrative cause. Importantly, were different to what is usually served at a workplace tea party in Colombo, which would be more likely some type of short eats or snacks probably bought from a restaurant.

Staff at Hospital A, had less impact from power cuts and fuel shortages (LP gas) on their cooking needs as they use firewood. This was the same for hospital operations, given that they use firewood in medicine production processes. However, most of the staff had transportation issues, travelling from home to the hospital. This caused delays in shift handovers. Hospital had limited accommodation facilities and the MST released restrooms as temporary staff accommodation. Some found private accommodation near the hospital.

6.3.3.3. Hospital D

Pandemic

As this hospital is one of the largest hospitals in the country, making arrangements to provide care for both COVID-19 patients and other patients was a priority. Until the time it was given permission to treat COVID-19 patients, the management had a considerable time for preparations for its pandemic response. First, a group of medical staff including a consultant was sent for a specialized training in Colombo, on COVID-19 patient care and HCW safety practices. This training was held at Hospital A.

Next, screening for COVID-19 virus on incoming patients was conducted to minimize virus inflow to the hospital. There was no documented preparedness plan. As earlier pointed out, the hospital had emergency response experience, serving victims of the civil war. The triage system is not a new concept for the hospital. Managing a mass patient load across 50 wards, plus thousands of OPD patients was usually a complex process. Although there was a considerable drop in OPD patients, patient admissions into hospital wards remained as usual at the beginning of the pandemic. Serving multiple districts as a leading tertiary hospital, critical patient transfers from regional hospitals in those districts is a main form of patient inflow. Hospital is located in an agricultural area. Farming related accidents and snake bites are the main causes for patient admissions. The emergency treatment unit (ETU) serves as an epic centre.

To minimize disruptions to routine patient care, establishing a separate COVID-19 treatment facility (CTF) was a priority. A building located outside the hospital premises, which was used for health education purposes was chosen to be transformed into a CTF with wards and an ICU. A medical officer, in charge of the CTF was appointed and assisted with a consultant and a WIC nurse. However, assigning staff for this special unit was not an easy task with the existing limited workforce. LMs indicated that the hospital was operating with staff shortages both in frontline and MS cohorts, prior to the pandemic. The in- charge medical officer attempted to obtain additional staff through the MHIM. Failures in multiple attempts left with no options rather allocating staff from the hospital wards to work in the CTF. Staff were asked to voluntarily give consent to work. But surprisingly, less interest was expressed. Staff had thought “why only me”, given the large numbers of staff across the 50 wards. This resulted in, managers randomly selecting staff to work at the CTF. The ICU nurses claimed that, they were compelled to work at the CTF. But they acknowledged that there was strict safety procedures that minimized the risk of infection.

Economic crisis

Drug shortage was the major issue given that the hospital is a large tertiary hospital. Nurses claimed of added duties in managing the drugs exchanges across wards. Employee turnover has been another issue, where one specialized unit was temporarily closed due to the consultant who operated the unit, left the job at this hospital. Same as in other cases, staff transportation issues have caused smooth functioning of hospital operations.

Following section presents a summary of findings to RQ 02, 03, 04 and 05 explored in Hospitals B, C and D. A detailed clarification of findings to five RQs from the four case study hospitals are presented in appendices 13 to 17.

6.3.4. RQ 02
What HRM strategies have the hospitals designed to respond to these crises?

There were changes to staffing practices including extended shifts, staffing alternate groups, and staff rotation in the three hospitals. No interim staffing practices were implemented. Hospital B had the opportunity of sourcing additional staff through locum method.
To facilitate these staffing practices, hospitals initiated supporting practices such as accommodation, meals and transportation. Such practices were aimed at enhancing employee wellbeing.

Involvement of third part personnel were apparent in the three hospitals, Hospital B had to liaise with the hotel staff as they ran ICC in two hotels while the Ayurveda hospital had community support. In Hospital D, support from Army officers were significant same as Hospital A.

Communication with staff and managers were critical and meetings regularly held at both hospitals. However, in Hospital D there were difficulties in managing two way communication given its larger size despite proper COVID-19 management meetings that were held targeting the CTF.

In supporting changes to staffing practices it was a common feature that managers showcased their involvement and commitment. At Hospital B managers had the chance to retrain from coming to work as they were required only to report to work every other day. But to keep the team spirit and familism values, they started to report to work daily. Remote working was initiated in Hospital B with funded devices and internet connection. Continuation of remote working for office staff at Hospital D was unsuccessful due to network connection issues and confidentiality concerns.

During the economic crisis, extended shifts were continued and remote working for office staff were practiced but with limited success.

Training was mainly carried out for safety procedures. During the economic crisis major focus was on awareness on cost cutting practices.

Rewards and employee welfare practices were significant in Hospital B given their financial stability and high flexibility in obtaining necessary funds. Conversely, funding issues were apparent in the other two hospitals. In all three hospitals, there were limitations to employee rewards and welfare practices during the economic crisis context.

6.3.5. RQ 03
What were the barriers and enablers of implementing the designed HRM strategies?

Staff absenteeism due to transport issues was a common barrier in the hospitals while frequent changes to protocols and unfamiliar work systems were implementation challenges. Staff complains on difficulties of wearing PPEs was another major issue, but was less influential in Hospital C. Proper implementation of social distancing practices were difficult for managers because of cultural and social factors. Managers had implemented different strategies to enable the successful implementation of intended CIHRP.

Limited access to training programs was apparent in the hospitals due to operations pressures and heavy work load. Hospital B had the opportunity of acquire knowledge through their locum staff who work in other public hospitals. A special training for Hospital D staff was organized at Hospital A.

Funding challenges for HCW rewards and welfare activities were significant in public hospitals across both crises, while Hospital D had slight changes to their routine employee reward practices and welfare activities during the economic crisis. Staff turnover and migration imposed significant HCW shortages in public hospitals, while Hospital B had issues with locum staff availability due to income tax restrictions.

6.3.6. RQ 04
What are employees' experiences and perceptions of fairness towards these HRM responses?

In common public hospital HCWs had perceived the motives of CIHRP as employee safety, wellbeing and patient care as a second priority. Conversely, Hospital B staff had perceived the motives to be oriented towards patient care prior to employee wellbeing and safety.

There were significant fairness concerns among staff, appeared to be positive towards safety concerns. Negative fairness perspectives lied with the feelings of treated unequally such as the case in Hospital D, where management prioritized safety at the CTF, not the overall hospital. Further, there were unfair perceptions related to work allocation (compelled to work at CTF).

However, HCWs indicated that the issues arose during the economic crisis were out of control of their hospital managers and the liable party is the government. Thus, there appeared they involved with compromising with managers in dealing with work problems while managers acted with compassion.

6.3.7. RQ 05
How effective were the HRM strategies?

Hospitals experienced that the overall outcome of crisis response is in line with the intend outcomes. In terms of safety, a considerably lower level of internal virus acquisition was identified across the three hospitals. However, it was identified that employee wellbeing outcomes were somewhat not achieved due to unavoidable heavy workloads across the public hospitals. Such issues are directly linked with the staff shortage problems.

All hospitals experienced maintaining quality of care during the pandemic through utmost efforts and procedures. However, there have been patient distress and aggressive reactions within the economic crisis.

Major developments incurred in hospital B and D in terms of physical resources. Exposure to such a devastating health crisis enhanced staff knowledge, experience and resilience levels.

Based on revisions and reviews, many practices have been absorbed to daily routine work including extended shifts, accommodation, cost cutting practices etc.

6.4. Summary

This chapter presented the findings of the study. Findings of Hospital A were presented in detail. A summary of findings of the other three cases was also included. Detailed findings with a comparison across the four hospitals is included in the appendix section. The next chapter will analyse the study findings in light of the propositions developed in Chapter Four.

Chapter Seven: Analysis

7.1. Introduction

This chapter presents an analysis of the findings outlined in the previous chapter. The analysis is done with reference to theoretical perspectives and propositions of the study.

7.2. Re-examining the Research Questions

This study attempted to answer five RQs as follows.

RQ 01: What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

RQ 02: What HRM strategies have the hospitals designed to respond to these crises?

RQ 03: What were the barriers and enablers of implementing the designed HRM strategies?

RQ 04: What are employees' experiences and perceptions of fairness towards these HRM responses?

RQ 05: How effective were the HRM responses and to what extent the practices been absorbed into routine practices?

As outlined in Chapter Four, Research propositions were drawn from RQs. Following section is dedicated to discuss the findings for each RQ and to examine whether the propositions are confirmed or rejected.

7.2.1. RQ 01

What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

This RQ was drawn, linking the theoretical perspectives of Institutional theory, the CBHRT and CM particularly the crisis preparedness. Organizations face various challenges from the environment. Fit and flexibility are essential concepts for organizational effectiveness, which are independent concepts (Wright & Snell, 1998). Flexibility to respond to changes, adapting to achieve a fit between the firm and its environment is vital (Chakravarthy, 1982), both externally and internally (Milliman et al., 1991). Such flexibility was identified in the four case study hospitals, but with varying influences. In common, public hospitals had less

opportunities for directly changing their HRM practices, while the private hospital had more flexibility towards designing own HRM initiatives although it was a part of a group of companies.

In line with the Institutional theory (DiMaggio & Powell, 1983) and CBHRT perspectives (Paauwe, 2004), HRM challenges experienced by the four case study hospitals were shaped by institutional forces such as government bodies, MH and external stakeholders. Government's national pandemic response was highly influential for all four hospitals in the study. Next, the influence of competitive mechanisms, the second dimension of CBHRT model (Paauwe, 2004) were apparent in the Hospital B, pertaining to number of patients, sales volumes and emerging business opportunities such as ICC and mobile pharmacy services. The influence to Hospital B's business model adds insights to this analysis, as it is the only private hospital among the four cases. Such changes to business models in response to the pandemic in private hospitals were also evident in the literature (Shaown, 2021). Handling a considerable number of dead bodies, more than usual was a challenge (Corpuz, 2022) to Hospital B, and this involved intensified job demands to administrative employees of the hospital. They had to manage the operations in line with government guidelines, authorities, and religious parties for final rites, transportation to designated massive graveyard, despite dealing with patients' families with the grief of the loss of their loved ones.

The social and cultural influences were significant during the pandemic. Employee wellbeing issues were critical due to social discrimination, while psychological wellbeing practices were shaped by cultural factors such as religious beliefs. The configuration influences were identified across the four hospitals considering their organizational cultures and past crisis experience. Hospital A and D were battling with much confidence given their prior experience on emergency management, surge capacity and CM. Among those, the ID expertise which was apparent in Hospital A is worth noting. Serving as two national level hospitals, one as an ID expert and the other as a teaching hospital and at the same time with considerable emergency management and mass casualty experience, Hospital A and D provides vital contextual information into this analysis.

Pandemic imposed operational challenges to public hospitals given the rising COVID-19 infections. The pressure was greater to designated hospitals including Hospital A. As per the government pandemic management plan, private hospitals and Ayurveda hospitals entered the COVID-19 treatment mission at a later phase. Operational pressures in Hospital A, further

exacerbated by different stakeholders such as government regulations, MH requirements, suppliers and vendors. Lockdowns and curfews brought unexpected challenges. All these challenges lead to numerous HRM challenges. Among those staff availability, safety and health, wellbeing, work-life balance, stress and skilled labour concerns were much challenging.

Although the pandemic was an exogenous shock to all four hospitals, Hospital B exploited various opportunities in terms of operations and sourcing staff. Adding to those, public hospitals A and D also had major infrastructure developments that had influences on HRM. For instance, new ICUs and laboratory facilities demanded more skilled labour, created staffing and training needs. Likewise, added facilities such as staff accommodation enhanced employee wellbeing and satisfaction.

Economic crisis impact were differently experienced by the hospitals based on their sector and location. Public hospitals had high volumes of incoming patients, while the private hospital experienced diminishing sales. Drug shortages and staff turnover were among the major challenges to public hospitals. Relying on government regulations and strict funding mechanisms created further burdens to hospital procurement and operations in public hospitals. The impact was slightly lower in the Ayurveda hospital, as the management had community assistance and access to local sources of raw materials for producing medicine. The location of the hospital was a main factor that determined the financial burdens to staff. It was identified that rural life style patterns had influenced the cost of living pressures (Zimmerman et al., 2023) that reflected less employee wellbeing concerns for hospitals located in rural areas specially in the case of the Ayurveda Hospital.

Preparedness to the pandemic was different across the four hospitals. However, all hospitals had the privilege of observing early signs of a pandemic before the virus actually started to spread in the country. Such signal detection resulted in initiating preparedness plans before the pandemic hit the country. Hospital A's regular ID drills and pre- established emergency response plan (although not formally documented) indicated a significant preparedness when compared to other hospitals. At the same time, Hospital B had emergency response plans and drills attached to the accreditation standards. Overall, both the preparedness plans had not considered how to cope with a lockdown and a widely spread CD rather for an emergency of a small scale. Other studies highlighted the lack of hospital preparedness in Sri Lanka (Munasinghe et al., 2021). It is recommended that the hospitals initiate their preparedness

planning referring to WHO guidelines for hospital emergency response in general (e.g.WHO, 2011) and for influenza pandemics (e.g.WHO, 2006).

In terms of HRM response, these plans should consider staffing (deploying additional staff : staff from other hospitals, retired medical staff, medical students, military medical officers and volunteers), training in patient handling and triage, decontamination and infection control, safety (provide PPE, medicine and vaccines) and psychological wellbeing and support systems (employee support programs, counselling, support for families, child care etc.). The ID expertise with Hospital A was a major influencer in their pandemic response and it is recommended that there need to be multiple ID specialized hospitals across regions so as to strengthen the ability of the Sri Lankan HC sector to deal with future pandemics. The WHO admits that adequate training for HCWs in ID is a key for preparedness and prevention of COVID-19 (Żółtowska et al., 2021). Aligning interim staff and volunteers to the hospital system was a major challenge as identified in Hospital A. It is recommended that a selected pool of interim staff from other hospitals and a volunteer pool should be established in line with preparedness plans. There should be programs to engage such external HR and hospital HCWs, such as hospital visits to provide the outsiders an exposure to internal culture and systems and engagement opportunities such as social events, training etc. It is essential that these interim staff and volunteers are involved in safety drills and ID training programs.

Aligned with CBHRT (Paauwe, 2004) research, past studies confirmed that HRM similarities across different organizations are shaped by external factors and the differences in HRM are due to internal factors. According to the findings of this study, that perspective can be partly agreed. It was clear that differences were due to internal factors such as sector, size, level of training and preparedness, staff availability, expertise and previous crisis experience. However, the HRM responses to the external factors were not exactly the same among the four hospitals. The responses seemed to be designed based on the perceived challenges. Four hospitals faced different challenges during and beyond the pandemic and during the economic crisis. For instance, the financial burden on the Ayurveda hospital was less influential on HRM and hospital operations, when compared to the Hospital A which was based in a metropolitan area.

The following table indicates whether the research propositions related to RQ 01, are confirmed or not, based on the study findings.

Table 7.1. Research propositions- RQ 01

	Research propositions	**Confirmed or Rejected**
1	Environmental forces can influence HRM decision making during a crisis context.	Confirmed
2	These influences can be differently experienced across hospitals with varying characteristics such as their sector (public vs private and Western allopathic vs Indigenous/ Ayurveda), customer base, CM experience, resource capacity (size, ability to expand, access to funding etc.) and specialty (expertise in ID) etc	Confirmed
3	The influences of the crisis on hospitals are distinct across the two crisis situations.	Confirmed
		Patient surge issues for public hospitals during both crises
4	Hospitals with crisis preparedness/ risk management plans and provisions for surge capacity find less challenges with coping up and responding to crises.	Confirmed
		Lack of documented plans for CM in public hospitals

7.2.2. RQ 02

What HRM strategies have the hospitals designed to respond to these crises?

In this RQ, theoretical concepts pertaining to HRM flexibility, HRM process and the Recursive nature of HRM process are being examined. The analysis will manly done with special reference to the first step of the HRM process; *Intended HR practices* and the concept of CIHRPs are revisited in the Sri Lankan HC sector. Responding dynamic environmental changes, firms need flexibility. HRM strategies strengthens a firm's capabilities to adjust to such contingencies (Wright & Snell, 1998). The HRM flexibility (Milliman et al., 1991) identified in the case study hospitals was different across private and public sectors. More

flexibility was apparent in the private hospital in making changes to the HRM practices. The study identified CIHRP (Antwi et al., 2024; Nyfoudi et al., 2024), related to four HRM practices, reflected significant changes to existing staffing, training, employee wellbeing and employee participation practices. Changes to compensation practices were significant in the private hospital.

Staffing

There were alterations in shift allocation (extended shifts) and work load (work shared among staff to minimize exposure to patients), introduction of "alternate team" work system, utilizing interim staff (volunteers and staff from other hospitals) and working remotely with patients as possible. Working from home arrangements were initiated for office staff, but with limited success. There were arrangements to work remotely from patients with the use of telephone/ intercom communications, remotely controlled observations and telehealth. Such practices (working remotely but physically at workplace) are not well addressed in the literature, despite WFH becoming the buzz word during the pandemic and beyond. In the economic crisis context, the four hospitals encountered HCW shortages, as also observed in other studies (Wijerathna, 2023). These were encouraged due to changes to retirement age (MPA, 2022e) and schemes allowing public sector workers to leave the country on no-pay leave (MPA, 2022b).

Increased personal income tax rates for up to 36% (KPMG, 2022), affected the number of private practice hours that doctors would work on locum basis for private hospitals. This was identified as a major staffing issue in Hospital B. As a reflection of its business model, Hospital B highly relies upon locum staff. Majority of the permanent clinical staff were nurses and there were only a few permanent doctors (retired public hospital doctors). Having locum staff involved in hospital operations brought significant advantages including their expertise and exposure to new protocols and procedures already implemented at their employer hospitals. However, relying on the locum staff can be risky, which was apparent during the economic crisis.

Overall, the changes to staffing practices were aimed at continuing patient care, while ensuring HCW safety. Managers of Hospital B indicated their priority was to provide a quality care for patients and to make sure that it is get done through safe and supported workforce. As such, there appeared a slight difference in what motives drove changes in staffing practices among public and private hospitals.

Training

It was a common feature across the four hospitals that, training programs were designed to promote safety practices and patient handling protocols. At Hospital A, multiple training programs were organized in line with operational changes. When new machines like portable ventilators, new procedures like assigning PCR sampling to nurses and initiating PCR testing facilities with extended laboratory, relevant staff were provided with training. Special training was conducted for nurses, before assigning work at new ICU facilities. Hospital D connected with Hospital A for a specialized training in safety and patient handling protocols. It is worth noting that Hospital A not only prepared own staff quickly just before the pandemic hit, but also was a benchmark to other hospitals. Their response strategies were exposed to other hospitals including Hospital D through site visits and demonstrations. This can be identified as their vision and mission statements (section 6.2.1) being activated in real operations.

The study identified the lack of skilled labour in different categories across the four hospitals including the MS and ICU trained nurses. A major concern was identified in the Hospital C, which indicated a common issue in the Ayurveda sector, the lack of nurses. The majority of nurses are absorbed to the public sector mainly through government nurses training schools. Universities produce graduate nurses, but the number is relatively low. The study found that graduate nurses had additional trainings with a rich curriculum. Two nurses from Hospital A and Hospital D indicated that they had a specialized COVID-19 training for six months before they were graduated, which was in addition to their usual internship training. This has taken place during the first phase of the pandemic and such an initiative is highly time sensitive and proactive. On the other hand, nursing schools hold all the in house curriculum delivery, transferred to online mode and allowed trainees to complete the courses without proper internships, as identified in this study through nurse managers and newly recruited nurses. University graduate nurses had a proper idea about PCR testing procedures and their fundamentals, while other nurses found it difficult to involve in PCR testing given their lack of knowledge.

Thus, it would be better if the government nurses training curriculum can be revised and expanded with aspects like PCR testing. Further, there should be a proper mechanism like a quota to promote specialized nursed such as ICU trained, infectious control and Ayurveda

nurses. Additionally, nursing graduate programs at universities should be expanded so as to cater the shortage of nurses in the country.

Rewards, welfare and EAPs

Public hospitals had relied on government initiated rewards in terms of monetary benefits. Despite the high dependency on government and ministry procedures that prevent public hospitals' ability to finance any project including employee rewards and incentives, Hospital A was brave enough to work outside such procedures. They sourced funds through donations so as to facilitate non-monetary rewards to the staff. However, this attempt had no longer life given potential interruptions from the ministry. On the other hand, rewards and incentives were highly influential in the private hospital where HCWs both clinical and non-clinical were able to earn additional incentive payments as a result of working at the ICC. Similarly, nurses and laboratory staff were paid additional incentives for PCR tests. Such incentives attracted locum staff availability. The impact of the different business models and strategies across private and public sectors, are evident in these findings.

It was a common feature that all four hospitals initiated welfare and EAPs, such as hospital funded accommodation, transportation, meals and changes to communication modes. Musical programs and religious activities took place in Hospital A, were not only targeted employee wellbeing, but also that of their patients. Involving staff and patients for entertainment programs during a pandemic as a stress reliever was a unique practice which was hard to find in current literature. Western hospitals had full time chaplains assisting spiritual wellbeing of patients, but with limited availability and hardships during the pandemic (TIME, 2020). In leading hospitals in Sri Lanka there are spiritual services, but the continuation of those services during the pandemic is unknown. Managing patient wellbeing had intentions on providing a quality care and assist HCWs to cope with their wellbeing issues and indirectly make their job easy, as far as patient wellbeing concerns are considered.

Motives that drove EAP programs were to facilitate with daily living essentials to support the employees at work, strengthen their morale. Communication was strengthened to share work floor suggestions with managers and to maintain regular contacts and updates. Email and Teams communication were not a new concept at the private hospital, where as keeping contacts with employees via Zoom platform and WhatsApp group messages were newly initiated in the three public hospitals. However, in Hospital D, both managers and HCWs

admitted that there were less opportunities for majority of HCWs to involve in such decision making given the large number of employees, multiple units and the larger size of the hospital. Adding to that managers claimed that, overall management concern lies on the CTF which was separately functioned. Thus, other hospital operations were not prioritized, including employee wellbeing and safety issues. It is worth noting that a majority of nurses and LMs of that hospital perceived that working at the CTF is safer (in terms of safety procedures against the risk of infection) than working in the normal wards.

Employee participation practices

It was explored that employee participation programs were highly practiced through joint, two way consultative decision making. Corridor meetings at Hospital A and COVID -19 preparedness and response meetings in all hospitals were the main modes of uplifting participation of employees.

Changes in the economic crisis context

In the context of the economic crisis, CIHRP were apparent in staffing, training, employee wellbeing and compensation practices. Across the four hospitals, extended work shifts were effective in continuing hospital services amidst HCW commuting issues (breakdown of public transportation and nationwide fuel shortages).

Training on cost effective work practices and financial stress management workshops were conducted in Hospital A. Many cost effective practices were implemented in Hospital B that had direct impact on various jobs. For example, regular meetings at the head office that incurred managers travelling from Hospital A to Colombo, converted to online meetings as a way of cost cutting. Direct cuts to features available through software packages including the Outlook was experienced by majority of staff grade employees. Overall, training and development programs in all hospitals were restricted with funding issues.

Limited EAPs were continued given funding issues in public hospitals. Private hospital continued the accommodation, transportation and meal services to employees, but at a cost, which was provided free of charge before this crisis. Despite severe decreases in hospital sales, Hospital B continued to provide year-end financial and other rewards to their employees as a result of the group earnings and multi sector investments. Such financial stability was not

apparent with public sector hospitals and that is another avenue of research to explore in what ways the public sector institutions can strengthen their financial stability, not solely depend upon the government funding. In Hospital C, there were a few treatment facilities that were provided to patients at a cost. Such income generating means should be promoted along with public awareness of such extended facilities. There were a few highly trained staff with expertise in body massaging and other specialized treatments. Wellness or health tourism is an emerging trend in Sri Lanka's tourism industry, where Ayurveda medicine is an integral part (SLEDB, 2024). Hospitals like Hospital C would consider such opportunities for the financial stability of the hospital, staff development and contribute to the economy and the wider society.

Table 7.2. Research propositions- RQ 02

	Research propositions	**Confirmed or Rejected**
5	Crisis contexts can bring challenges to employee (HCW) wellbeing.	Confirmed
6	Crisis contexts can be a challenge for hospital survival and performance.	Confirmed
7	Changes to HRM practices are designed and implemented to respond to such challenges.	Confirmed
		Emerging practices and changes to existing ones
8	Hospitals' crisis responses are performance- oriented.	Confirmed
		Both orientations were identified.
9	Hospitals' crisis responses are employee well-being oriented.	Confirmed
		Both orientations were identified.

7.2.3. RQ 03
What were the barriers and enablers of implementing the designed HRM strategies?

The third RQ was drawn to explore the implementation of CIHRPs. The analysis is carried out in line with the HRM process (second part: *implemented/ actual HR practices*) and CBHRT perspectives. LMs experienced complex situations in prioritizing employee wellbeing concerns over operational pressures, in line with what scholars claimed related to the pandemic (Branicki et al., 2022) . Funding issues have been a major barrier in enhancing HCW wellbeing initiatives across both crises for public hospitals. However, the private hospital had managed to deal with their funding implications. It was identified that CIHRP have been subjected to slight changes during implementation given variations in pandemic demands (virus severity, fluctuations in patient numbers, easing of government regulations etc.) and feedback from ward managers and

HCWs. Such changes to intended HR practices during implementation was identified in previous studies (Druker et al., 1996; Khilji & Wang, 2006; Nishii & Wright, 2008; Piening et al., 2014; Truss, 2001; Truss et al., 1997). Religious and cultural implications on employee resilience was a major enabler for supporting the effective implementation of CIHRP. At the same time, cultural influences made barriers to implement social distancing measures.

Staffing

Access to internet in rural areas can be challenging (Lai & Widmar, 2021; Zimmerman et al., 2023). Although Hospital B purchased new devices such as laptops, tabs and dongles that facilitated office staff and managers to work from home, there were network issues that prevented successful implementation of remote working. In comparison, public hospitals did not have the luxury of facilitating staff with such devices. In Hospital A, managers were asked to report to work every other day. However, given familism concerns (Aycan & Kabasakal, 2006), managers rarely worked from home and reported work at the hospital premises. That was to be role models and to make the subordinate HCWs feel that they are all supported, belonged and management involvement in the battle. Moving to telehealth was a common feature in HC delivery globally. However, the consultants and retired doctors serving at Hospital B were not well supporting with the system being transferred to digital modes. This issue is aligned with what other studies have confirmed. Older generation face challenges in coping with digital advancements and the level of challenge vary across different generations (Lissitsa, 2024). On the other hand, patients had lack of access to digital modes and were requesting for face to face consultation. Thus, the hospital managed the staffing with a hybrid patient care. It is suggested that, considerations should be given on enhancing digital literacy and internet access for rural areas, in preparation for responding to future pandemics.

Public hospitals highly relied upon the MH guidelines, and those restricted their flexibility and ability respond quickly with staffing decisions. This was a common feature across the three public hospitals as they faced staff shortages and this was more influential with the lack of trained or specialized staff such as ICU nurses, PCR testing and MS including mortuary technicians. However, it was noted that Hospital A was competent in fulfilling their staffing needs, by convincing the government authorities on their expertise and being the specialized ID hospital and also being one of the three main COVID-19 treatment hospitals. Hospitals and the MH would benefit if a skill audit is conducted along with a HR planning for the public hospital system. Revisions to HC curriculum and expanding student intake to both medical colleges and nursing schools are highly essential. Further, the politically driven recruitments

should be banned so as to absorb skilled labour to MS positions. See CT (2016) for an example of such political influence in public sector recruitments. Hospital overseers claimed of difficulties in assigning specialized jobs (such as maintenance, mortuary technicians, cookery) to these unskilled MS. A national level involvement is required to ensure that relevant trainings are provided to such unskilled labour before they are being absorbed to the MS positions.

It was common that the three public hospitals faced issues with staff transportation and delays to report to work due to long distance travel incurred. This was caused by the political influences in public sector appointments. A concept like "working closer to home" needs to be implemented, where HCWs would be given opportunities to find employment closer to their residence and on the other hand developments in the transportation systems would be another solution to address the issue as advocated by practitioners like Daniels (2007). The private hospital had offered jobs to the local community and mostly the clinical staff were residing in the Southern region, although they would have preferably settled in Colombo as they have graduated and trained in Colombo. Further, there are frequent staff transfers from their other hospitals located in Colombo to their regional hospitals to give opportunities for staff from local areas, if they prefer to work closer to home. Such flexibility is recommended for the public sector so as to enhance continuation of hospital services, staff wellbeing, work- family balance, reduce transport costs and avoid transport disruptions in preparing for future crisis (lockdowns, public transport failure and fuel shortages). Hospitals' ability to respond an emergency is influenced by the availability of skilled, sufficient and appropriately located HCWs (WHO, 2023).

Further the public hospitals had restrictions in funding additional facilities related to extend staffing (food and accommodation). In contrast, private hospital had sufficient funding and financial freedom to invest in additional staff such as in the case of hiring more locum staff, use compensation (incentive payments) as a motivator for staff to work in ICC and provide additional facilities (food, accommodation, transport) free of charge. It was apparent that public hospitals tend to look for donors to assist with funding difficulties. However, there appeared interruptions from the MH for such initiatives. It would be better if hospitals and the MH keep a considerable amount of safety stocks and most importantly financial resources that can be easily allocated for initiating HRM responses during an emergency. Such interventions should be incorporated in preparedness plans. The ability to respond to such funding issues were relatively restricted in the public hospitals as compared to case B.

There were issues with unfamiliar work and frequent changes while a majority of respondents claimed of difficulties in wearing PPEs including thermal discomfort and feeling exhausted. PPEs should not be of one size fit (Brisbine et al., 2022) and user friendly. HCWs faced many difficulties with low quality, one size and not climate friendly PPE suits during the pandemic. Further, nurses claimed of barriers to proper patient care while in a PPE kits. These findings are consistent with similar studies in other countries (Davey et al., 2021; Hunt et al., 2023). There should be frequent breaks for HCWs while working in a pandemic.

As an intervention, public hospitals initiated to allow HCWs to wear scrubs instead of their usual uniform. After the pandemic there have been continued debate at hospital level, whether to continue that practice. A majority of respondents agreed that they feel comfortable when working with the scrub rather than the uniform. Nurse uniform is for instance not user friendly with the local tropical climate, however, nurse managers admit that it is not only the comfort, but the uniqueness and professional identity that a uniform can add to an employee. It is recommended that authorities should start negotiating with HCW unions to navigate the debates so as to ensure that work wear promote HCW wellbeing.

Training

In common, HCW access to training programs were limited due to operational pressures. As such, staff who obtained training had to train the other staff, while attending assigned jobs. However, organizing specialized training in collaboration with external parties (other hospitals) were carried out despite social distancing and travelling issues. One major drawback was given the novelty of the virus and the frequent changes to protocols, managers had to conduct multiple training programs and keeping up to date with MH circulars and guidelines and that was an added layer of responsibility. As such, a national level centralized training facility, providing hybrid programs would be appropriate to deal with a future pandemic.

Rewards, welfare and EAPs

Funding issues in public hospitals was a major barrier, while use of donations can be identified as a main enabler. Overall, team working and good leadership enabled employee wellbeing and coping of stress and burnout. As far as the compensation is considered, all the three public hospitals had to adhere government restrictions. The limited access to a particular reward/ incentive package offered to staff at Hospital A was revised and expanded with access to all

staff with the involvement of the management. Such interference is worth noting, despite strict government regulations which showcases the management commitment towards employee wellbeing lead by fairness and equality concerns.

One specific feature highlighted in the study relevant to compensation mechanisms in the private hospital was that there is a pay gap based on hospital location. Among the group's six hospitals, three are located in Colombo. Given the urban cost of living concerns, staff at every skill level in Colombo hospitals earn a higher wage compared to staff at rural hospitals. This feature is not apparent in the public sector and is something that needs to be considered in future advancements to public sector HR policies. Such initiative can also be linked to the working closer to home concept.

Employee participation practices

Use of online modes for contacting HCWs in the presence of social distancing and operational pressures was a main influencer. However digital access issues and generational skill differences were barriers for successful implementation. Pre-existing working cultures, strengthened by visionary and participatory leadership enhanced the two-way decision making. However, this was not a smooth process in Hospital D, due its larger size and perceived priority given to the CTF. The flexibility in working culture, leader- member interactions and the depth of networking were limited in Hospital D as compared to other three cases. This can be examined as a reflection of the hospital's larger size.

Changes in the economic crisis context

Some CIHRP initiated in the pandemic context was continued to address the challenges of the economic crisis, with financial difficulties. These include extended shifts and providing accommodation. However, implementation of cost cutting initiatives were hard for managers given the pre-established working practices and employee indirect resistance towards adhering to changes. Employee welfare practices were affected due to financial difficulties. But the private hospital tend to continue the same while balancing rising costs by providing the services at a cost to the HCWs. It is worth noting that the management involvement in challenging government restrictions on overtime payments in hospitals A and C. It would be something feasible for the hospitals to look for alternative low cost ways to extend participation such as by virtual programs.

Table 7.3. Research propositions- RQ 03

	Research propositions	Confirmed or Rejected
10	Hospital managers may incur changes to planned practices during the implementation stage.	Confirmed
		Changes incurred due to various reasons

7.2.4. RQ 04

What are employees' experiences and perceptions of fairness towards these HRM responses?

The RQ 04 explores the HCWs' experiences and perceptions of fairness towards CIHRPs. The analysis links with the third stage of with the HRM process (employee *perceived HR practices*) and CBHRT perspectives. Specifically, the organizational justice and fairness literature shed light to the revisiting of this question. The attribution and CM theories will also guide the discussion as there appears significant the contradictions between motives of management and expectations of employees when dealing with crisis situations. Fairness as a workplace consideration, discussed under organizational justice (Greenberg, 1990), refer to the perceived fairness concerns of employees on treatments within the workplace (Tepper, 2001). Perceived inequality can promote employee demotivation (Zeidan & Itani, 2020). Employee fairness concerns can develop based on their own experience and how they evaluate fair treatment towards their co-workers (Johansson et al., 2007; Kray & Allan Lind, 2002). Previous studies revealed that employees expect wellbeing oriented HRM responses from their organizations during crisis situations (Aycan & Kabasakal, 2006), while organizations may respond towards service continuity and firm survival (Panayotopoulou et al., 2003).

As suggested in this study's literature review and conceptualizations, HCW fairness concerns may take a different direction in a health crisis as they prioritize the calling for work concerns. HCWs, would accept additional workload with minimum facilities or benefits with a sense of responsibility given that they value helping others (Shields & Ward, 2001; Veld et al., 2010a) and perceiving their "calling for work" (Cynthia D Fisher, 2014; Sharma et al., 2022).

It was a major area to explore whether the employees perceived their employer's HR response as fair during a crisis context. In common, HCWs claimed that their priority was to be at work and fulfil their responsibilities in such a devastating health crisis. It is worth noting that they indicated a different fairness perceptions within the economic crisis context. Mostly they were

dissatisfied with the government response towards HCW wellbeing during financial recession and as such they had relatively fewer complaints towards their hospital management.

Both frontline and non-critical care HCWs, indicated that CIHRP assisted them to enhance their resilience and coping strategies. The employee wellbeing services provided by hospitals were successful in coping with their physical safety and fatigue concerns. Unique EAP programs held at Hospital A was highly appreciated by HCWs while religious activities, indigenous ID preventative practices and support form immediate supervisors and SMs were perceived as fair by a majority of HCWs. However, HCWs of Hospital D had significant fairness concerns towards their managers with regards to compelled staffing practices, less safety measures at hospital as they perceived the management prioritized safety measures at the CTF. This can be due to the barriers for smooth functioning and maintenance of fairness with a larger number of HCWs.

Some of the respondents claimed that operational pressures, insufficient physical and human resources lead to failures in patient care, which created psychological dilemmas among HCWs. Such issues had not been discussed and was less visible to their managers. Thus, managers failed to address those. It was revealed that HCWs have suffered from being incompetent for providing complete care for patients given the exhausted surge capacity across both crises. This was a common indicator among public hospitals' HCWs and can be referred to the concept of "calling for work" (Cynthia D Fisher, 2014; Sharma et al., 2022).

HCWs of public hospitals had lower levels of satisfaction with regards to appreciation and rewards. There were no incentives for HCWs who assigned work at COVID-19 wards. The effects were apparent to be more critical with Ayurveda hospital HCWs. In contrast, private hospital's HCWs had higher fairness concerns in terms of rewards and incentives. Therefore, it is suggested that the government and authorities should consider on financial benefits as well as non-monetary benefits to HCWs that can reflect the level of significance of difference job roles. Further, there should be a balance between all HC sectors including the Ayurveda hospitals.

Adding to those, non-critical care workers indicated an unfair distribution of protective equipment and wellbeing practices compared to frontline HCWs. Thus, it is recommended that employees should be properly educated regarding the level of exposure and the requirement of safety practices that can be varied across different jobs.

Male workers had negative fairness concerns on their workload allocations and access to wellbeing practices when compared to their female counterparts. This was backed by the cultural influences, males being the ideal worker and may be managers' misinterpretation of "Men don't cry" concept (Wanninayake et al., 2024). Thus, this is a specific finding explored through this research, that managers should consider emotional aspects of both genders when they make decisions. For the HCWs, it is suggested that although the culture with a high power distance traditionally prevent them from seeking opportunities to raise their voice against fairness concerns, they should still initiate negotiations ahead of perceived unfair distribution of work and rewards.

In common, HCWs indicated the importance of support from family and extended family to cope up with work-life balance considerations. Such considerations were also apparent in a recent research study (Wanninayake et al., 2024). Hospitals should promote ways of external support for HCWs during crisis scenarios. In many other countries HCWs retrained reporting to work during the pandemic due to caring responsibilities (e.g. Panagiotaros, 2023).

Signalling motives

It was clear that mostly LMs have failed to correctly pitch the motives of different HRM interventions and CIHRP to their subordinates. As such, there were differently perceived HRM response within and across hospitals. It is suggested that to be able to achieve intended performance though employee perceived HR practices, managers should clearly indicate the "Why" of every HRM intervention they initiate.

Mostly HCWs perceived external influences in explaining changes to their work roles , as also observed in recent literature (Cañibano & Avgoustaki, 2024). As suggested by Nyfoudi et al. (2024), this research study agrees to the perspective that different signallers within an organization can influence the signalling process differently. This was apparent in the public hospitals, where no clear signals were transmitted and HCWs seek information through their co-workers in interpreting the motives and purposes of HRM interventions.

Table 7.4. Research propositions- RQ 04

	Research propositions	**Confirmed or Rejected**
11	Employees perceive the motives of HR practices as external in a crisis.	Confirmed with some practices

		In the absence of clear signalling of motives, HCWs had differently perceived the same practice.
12	Employees perceive the motives of HR practices as internal (wellbeing vs performance) in a crisis.	Confirmed with some practices
13	HCWs may perceive performance-oriented changes in HRM in crisis contexts as fair.	Confirmed
14	HCWs' perceptions of fairness can be varied across the two crises (pandemic and economic crisis).	Confirmed
		Fairness concerns on government mismanagement (not really on hospital managers) during the economic crisis

7.2.5. RQ 05

How effective were the HRM responses and to what extent the practices been absorbed into routine practices?

Based on the literature review, figure 4.1 illustrated two outcomes in crisis response in HC settings. This was in line with the CM theory, particularly the practice perspective and the CBHRT and HRM process research. In essence these theoretical perspectives are examines in relation to the HRM performance link. Therefore, the final RQ of this study will be revisited based on all those theoretical perspectives As such,, the two indicators of HRM response success that are being observed are employee wellbeing and quality of care.

Pandemic context

Literature revealed that key predictors of HCW safety and health are CM and risk management along with employee resilience (Zacher & Rudolph, 2021). In Hospital A, there were zero internally acquired infections, while other hospitals were also maintained minimum levels of internal virus transmission to staff. A recent study indicated that infections of COVID-19 among HCWs was a significant effect on Sri Lanka's HC system (Rannan-Eliya et al., 2024). However, the source of virus infection has not been clearly examined. In their study across few hospitals in Sri Lanka, Munasinghe et al. (2023) identified that less virus infections to HCWs acquired at work. A study of Samaranayake et al. (2021) revealed that in another hospital in Sri Lanka majority of HCW infections were acquired from the community and only 23%

infections were acquired at the hospital. For a comparison, see Woodley (2020) who claimed that 86% and 22% of HCW infections in the state of Victoria, in Australia during second and first wave respectively, seemed to be acquired at work.

Managers claimed of significant improvements to patient care that resulted in higher recovery rates and lower deaths in each hospital, which was also reflected through a higher recovery rate of 97% - the country record (Epidemiology Unit, 2023).

Achieving these, incurred changes to what was originally intended, when implementing. Such changes were encouraged due to changes to protocols and ward level suggestions as described in section 6.2.3.

Economic crisis

A majority of CIHRP were tailored to respond the pandemic. But the experienced benefits and lessons learnt from those practices enabled the hospitals to move forward with limited support from external factors. Thus sharpen the competence on making use of available resources. This has been a major feature in responding to economic crisis. Specific practices have been absorbed to routine practices in line with the practice perspective of CM (Oscarsson, 2022).

Table 7.5. Research propositions- RQ 05

	Research propositions	**Confirmed or Rejected**
15	Perceived outcomes of the HRM response can be different from intended outcomes within a crisis context.	Confirmed
16	Changes in HRM practices can boost or decrease employee wellbeing.	Confirmed
17	Changes in HRM practices can boost quality of care.	Confirmed
18	HCWs perform better when they perceive wellbeing oriented HRM practice changes.	Confirmed
19	Ongoing changes to HRM practices can be made in a crisis context based on feedback from implementation, employee experience and outcome stages.	Confirmed
20	Learnings based on reviews of HRM practice changes can be used to determine whether to absorb those changes into routine HRM practices and/or to revisit and refine the crisis preparedness/ HRM response plans.	Confirmed

7.3. Summary

This chapter presented an analysis of the findings of the study, in light of the propositions developed in Chapter Four. The next chapter, Chapter Eight presents a discussion of the study with reference to theoretical perspectives and propositions. It also provides recommendations to practitioners, the theoretical and practical implications and limitations of the study and suggestions for future research.

Chapter Eight: Discussion and Conclusion

8.1. Introduction

This chapter presents a discussion based on the findings and the analysis outlined respectively in the previous two chapters. Following the discussion, recommendations for case study hospitals and policy makers are presented. Further, the theoretical and practical implications of the study are discussed. Limitations of the study are identified and suggestions for future research are presented with a conclusion to the study.

8.2 Theoretical Implications

Conceptual Framework

This study contributes to both HRM and CM literature by addressing several under-researched areas. The conceptual framework (figure 4.1) links both aspects to represent HRM interventions designed, implemented and perceived specifically in crisis context. This novel, yet integrated framework can be used to guide future studies that focus on HRM implementation in times of crisis.

Cases with varying characteristics

The study incorporates findings from both the public and private sectors. HRM research has been dominated by private sector studies and scant attention has been given to the public sector (Brown, 2004; Brunetto et al., 2011; Knies et al., 2015; Knies et al., 2017). Adding an indigenous hospital for the exploration of the phenomena enriched the scope and practical implications of the study.

Important findings:

Non-existence of HRM departments in the public hospitals

A main study finding is the non- existence of HRM departments in Sri Lankan public hospitals. Scholars argue that HRM functions are less sophisticated or may not exist in SMEs and new firms (Nyfoudi et al., 2024). However, the case with Sri Lankan public sector firms highlighted a different approach of managing people without a designated HRM department. The flexibility and freedom to address HRM issues without any delay was restricted across the three public hospitals in the study, as they relied highly upon MH guidelines, circulars and approvals. For instance, both hospitals experienced unexpected difficulties which intensified the pre-existing

staff shortage issues, when HCWs started to migrate partly due to the new government scheme that allowed public sector employees to obtain no-pay leave to find foreign employment as described in the literature review chapter. This scheme did not have any exceptions or restricting clauses for essential services including the HC sector. In the absence of a well-established HRM department and internal policies, hospitals were not able to raise any concerns regarding the impact on losing their key talents. As a whole this was something that hospital managers had to allow to happen, although they realized that HCW migration would bring further gaps to HCW cadres.

As described, literature indicates that small and new firms may not function a HRM department and standard HRM functions. This study identified that all three public hospitals which were of different sizes (A- medium, C-small and D-large) did not function a designated HRM department. It was clear in Hospitals A and C, there was a proper interaction within departments and among management and employees. HD and CNOs together with the CA of the Hospital A played a human centred and employee oriented role to manage operational pressures and employee welfare and wellbeing concerns. Similarly, the MST managed the crisis challenges with a closer collaboration with employees. Both hospitals' management had visibility to employee issues, sought employee feedback throughout the CM response. Thus, it is worth noting that the managers would have played a both operational and people management roles. Their CM response reflects managing those two aspects without the guidance and involvement of HR professionals. Thus, it is a greater strength.

Conversely, the larger hospital among the case study hospitals had limited opportunities to employee wellbeing concerns. Findings of the study clearly indicated the absence of proper communication mechanisms and room for employee suggestions, specially compelling HCWs to work in the CTF. As such, a larger hospital would require a designated HRM department with experienced HR managers to tackle with even the routine HR practices, which is more essential in critical situations such as crises.

It is recommended that the countries public administration authorities should consider about developing HRM skills and competencies within the HC sector. Further, there can be ways to absorb HRM graduates to public sector. In the absence of such opportunities, a majority of HRM graduates find employment in the public sector or seek for employment opportunities in foreign companies. The researcher, employed in a public university in Sri Lanka has witnessed the difficulties in their university system when dealing with HR matters, with the non-existence

of proper HRM skilled personnel in administrative positions. Further seeking for work integrated learning and internship opportunities for HRM undergraduates of their university is mostly connected to private sector employers.

An exploration of CIHRP

Recently scholars referred to CIHRP (Antwi et al., 2024; Nyfoudi et al., 2024) and the existing classifications lies based on the type of practices. This research study add to literature with empirical findings on different CIHRP along with driving motives and implementations gaps, in a developing country.

Extensions to theory- the recursive nature of HR process

This study was partly drawn upon the recursive nature of HR process (van Mierlo et al., 2018). This model is focused basically on internal actors who influence HRM implementation through reviews and suggestions. Extending the basic theoretical perspectives, this study argues that the feedback can be sourced not only from the internal actors of the organization but also form customers on their perceptions and suggestions for HRM improvements, as in the case of Hospital A, where the feedback was incorporated to HRM response (patient feedback, suggestions etc- e.g. musical programs). Similarly, in Hospital B, telehealth facilities were partly continued due to patient preference on face to face consultation. On the other hand, external influences should also be incorporated in the HRM process, as illustrated in the conceptual framework (figure 4.1), and as confirmed in the CBHRT research and also discussed through the findings of this study.

A different version of remote working

Another main finding of the study was the CIHRP reflected in HCWs assigned remote work, while physically present at the workplace, with less proximity to patients, as possible. For instance, in Hospital A, nursing stations were established external to the patient wards, where nurses were able to monitor the patients with a distance, communication facilitated through intercom phone connections, while oxygen supply was controlled remotely through the wall oxygen system. Such practices are not well addressed in the current remote working literature, despite the advancements in technology for patient care such as using robots for inspecting patients in isolation and changes to telehealth practices (CNA, 2020). As such, this study opens another avenue of research to explore various modes of remote working.

Hard and Soft HRM dichotomy – Public and private sector debate

One major objective of this study was to identify the difference between HRM responses across public and private sector hospitals. Recent studies argue that public-private HRM practices mainly differ due to hard and soft approaches (Knies et al., 2022). Further, such differences have been observed to be decreasing overtime. In contrast, this study identified significant differences in HRM responses and the challenges faced by public and private hospitals, in a developing country context. Adding to that, the phenomena was explored across a dual crisis context.

Fairness concerns

As far as the fairness perceptions were explored across four case study hospitals, this study revealed that HCWs had negative fairness perceptions on some CIHRP, although the managers assume that they have made all possible means to enhance employee wellbeing. The gender based fairness concerns is worth noting. As such, the study suggests that managers may had less attention on employee wellbeing concerns at times, given the crisis contexts and other operational pressures. This was highly visible in the Hospital D. Findings of the study are in line with the researcher's own conceptualization presented in section 3.2.6. (in the presence of weak signalling, HR practices can be negatively perceived by employees) and with an emerging argument which claims that, HR practices may not always positively affect an organization's outcomes but can also have a negative impact on both individual and organizational outcomes (Nyfoudi et al., 2024).

Addressing gaps in literature

As identified in section 3.5, this study attempted to fill significant gaps in the literature. Some of those gaps are summarized below.

- Lack of evidence relevant to HC preparedness and their responses during ID, specifically in developing countries (Gupta et al., 2021; Kuhlmann et al., 2021)
- Need to apply CBHRT model (e.g. Buttiens & Hondeghem, 2015; Farndale & Paauwe, 2007; Fernando & Bandara, 2020; Veld et al., 2010b), within a (dual) crisis context.
- Research on HRM practices under contexts of uncertainty are limited (Agarwal, 2021; Sanyal & Sett, 2011) including HR process research (Kim et al., 2022).

- Explore experiences and challenges of HR managers within the post-pandemic era to determine lessons learnt, changes made and thereby prepare for upcoming crises (Dave, 2023; Hamouche, 2023).
- More research is demanded on employee perceptions and their HR attributions in examining the effectiveness of HR response (Collings, McMackin, et al., 2021).
- Lack of organizational justice and fairness research from developing countries and from the Asian context (Aycan & Kabasakal, 2006).
- Studies needed to explore the practice perspective of CM (Oscarsson, 2022).
- Scholars not attempted to explore the pandemic influence and HRM responses in Sri Lankan HC sector, involving managers and both frontline and non-critical HCW, while less attention on extending the studies towards the economic crisis context.

Insights to Hospital Surge capacity and Psychological impact to HCWs

This study explored different surge capacity management approaches in the case study hospitals. Hospital B and D managed COVID-19 patients separately while continuing other operations. In contrast, Hospital A was fully converted into COVID-19 treatment facility.

As far as the psychological impact of HCWs were concerned, studies have considered the phenomena in line with the proximity to the COVID-19 epic centres or CTFs. Studies show that HCWs worked with COVID-19 patients had higher levels of virus exposure and related mental stress compared to HCWs worked at hospitals that had no CTFs (Chang et al., 2021). Adding to this, scholars admit that HCWs working further to COVID-19 epic centres had less psychosocial impact from the pandemic (Yáñez et al., 2020). Findings from this research study are against these assumptions as it was revealed that staff at Hospital A were battling with high resilience and the reported virus infection rate was zero. On the other hand, staff at Hospital D had safety concerns, due to the perceived safety risks outside the CTF. They experienced less safety measures applied outside the epic centre (CTF) and thus felt higher risk of virus exposure and related psychological concerns.

Studies found that frontline HCWs had relatively high psychological impact than second-level or non-critical care HCW in the COVID-19 pandemic context (Chang et al., 2021). The current study identified significant psychological impact on non-critical care workers such as laboratory technicians, overseers and pharmacists during the pandemic and beyond.

The study revealed that managers had to deal with both HCW and patient mental wellbeing during the pandemic. It is suggested that educational programs should be promoted for both HCW and patients to enhance the coping strategies (NCDMPH, 2020). Further, there should be interventions that focus on managers, that will assist them to enhance their coping strategies, emotional regulation, resilience and decision making skills. It was identified that low participation of HCWs in clinical counselling sessions and the need to educating them about availability of such services (NCDMPH, 2020).

8.3. Practical Implications

Throughout the discussion of RQs, based on the study findings and referring to literature, appropriate recommendations were made in section 7.2 and also in section 8.2. The findings of this study can be useful to policy makers and HRM practitioners in decision making, especially in designing CIHRP to address disruptions induced by crises. This study is an exploration of experiences of both managers and employees. Thus, the recommendations may inform the case study hospitals in the effective and high-impact management of their workforce especially during crises.

8.4. Limitations of the Study and Future Research

Data collection of this study was done in two time periods, with a gap incurred due to unexpected delays in data collection. There were barriers to successfully collect data using online means, as described earlier in the methodology chapter. This gap might have influenced the richness of data collected during face to face interviews. Researcher acknowledges that face to face data collection was more productive, as those interviews allowed the gathering of data in a more realistic manner, involving rapport that assist build trust, facial expressions of respondents that lead the researcher to collect good quality data through in-depth interviews.

The study was limited to four hospitals. Future research can be aimed at examining the phenomena across different number of hospitals applying quantitative methods, for more contrasting results. The phenomena can also be studied in another geographical or industrial context. In addition, future research can use the diary method to collect data rather based on recalling participant experiences. Additionally, joint interviews can be conducted with managers and HCWs that may bring insights into work dynamics, mutual and shared perceptions.

Future studies can use the conceptual framework to explore CIHRP in other organizations, beyond the HC sector, operating under diverging macro-institutional factors.

8.5. Conclusion

Throughout this chapter, a discussion to the research study was presented based on the research findings and the analysis. The theoretical implications of the study were discussed. The study led to various recommendations and suggestions for both policy makers and hospital HR managers. Limitations of the study were acknowledged with s suggestions for future research.

This study had its strengths and weaknesses. At the same time, it played a role of an eye opener for various aspects that can be used by policy makers and hospital mangers. HRM function is seen as a strategic partner in today's highly complex business world (Stone, 2014; Ulrich et al., 2013). At the same time it was revealed that HR managers played an administrative role during organizations' difficult times and they had to work hand in hand with other operational functions. In such situations, considerations on employee wellbeing might have diminished, as also revealed in some instances in the case study hospitals. Based on the study findings, the researcher recommends that organizations take a balanced orientation towards employee wellbeing and operational pressures when navigating crises. HR managers should be supported, encouraged and felt belonged so as to enrich them with appropriate coping strategies.

As the study identified, facing these massive crises had many positive outcomes, particularly in an HRM perspective. The exposure, lived experiences, failed preparedness plans, application of ad-hoc solutions, succession through failures, shared moments with tears and smiles must have added a remarkable on the job training to both managers and HCWs. The world is fast moving and we live in a society that is prone to crises (Frandsen & Johansen, 2020a). As such, the role of HR professional will incur many possible disruptions (Ulrich & Gherson, 2023b). Thus, lessons learnt from the HRM responses will be a great enabler, to prepare HRM professionals to deal with future challenges.

8.6. Summary

This chapter presented a discussion of the research study with reference to theoretical perspectives and propositions which drove the current study. Recommendations to case study hospitals and practitioners were also included in the discussion. Further, the theoretical and

practical implications and the limitations of the study were explored. The researcher concluded this chapter suggesting areas for future research pertaining to the fields of HRM and CM and indicating the importance of integrating learned lessons in this dual crisis context, for preparing hospitals to navigate successful in times of crises.

----- THE END------

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APPENDICES

Appendix 1: Invitation to Participants

Dear Sir/Madam,

I am a PhD candidate, conducting a research study entitled '**Human Resource Management changes in the Sri Lankan health sector- COVID-19 response**'. This research is being conducted as part of my PhD study at Victoria University, Melbourne, Australia under the supervision of Dr. Ancy Gamage.

I am conducting,

a) interviews with hospital managers and line managers (e.g. nursing managers), and
b) interviews or focus groups with doctors and nurses

to explore the intended changes in Human Resource Management (HRM) practices both at the implementation and employee perceived levels.

This research is not intended as an evaluation of the effectiveness of the hospital's services, but rather as an analysis of how the hospital dealt with people management in response to the COVID-19 pandemic.

Being healthcare professionals, you are in an ideal position to give me your valuable information from your own perspective and experience within the distinct context of COVID-19. Your participation will be a valuable addition to my research and the findings of this study will result in greater understanding of the phenomena and thereby benefit HRM practitioners in their future HRM planning.

Interviews will take around 60 minutes (online- ZOOM or via phone) to capture your thoughts and experience regarding the HRM changes brought about at your hospital. Your information will be kept strictly confidential. For data analysis, data will be de-identified to ensure your confidentiality and alias will be used to prevent your identification. Interviews will be recorded with the consent of the participants, to allow the researchers to transcribe and then analyse the data.

Your participation in this study is entirely voluntary and you may withdraw your participation at any time if you feel uncomfortable or distressed. Please find the attached information for participants form and consent form (separate forms for interviews and focus groups).

For any further information or if you have any questions , please contact me : sumiri.madiwalagamagedon@live.vu.edu.au or +61 477628459.

If you are willing to participate in this research, please email me a signed consent form.

Thank you for your kind cooperation.

Sincerely,

MGDS Samadi

PhD Candidate, Victoria University, Melbourne, Australia.

හිතවත් මහත්මයා/මහත්මිය,

මම '**ශ්‍රී ලංකාවේ සෞඛ්‍ය ක්ෂේත්‍රයේ මානව සම්පත් කළමනාකරණ වෙනස්කම්- COVID-19 ප්‍රතිචාරය**' / **Human Resource Management changes in the Sri Lankan health sector - COVID-19 response**' යන මාතෘකාව යටතේ පර්යේෂණ අධ්‍යයනයක් සිදු කරන උපාධි අපේක්ෂකයෙක්මි. ආචාර්ය ඇන්සි ගමගේ ගේ අධීක්ෂණය යටතේ ඕස්ට්‍රේලියාවේ මෙල්බර්න් හි වික්ටෝරියා විශ්ව විද්‍යාලයේ මගේ ආචාර්ය උපාධි අධ්‍යයනයේ කොටසක් ලෙස මෙම පර්යේෂණය සිදු කෙරේ.

මෙම පර්යේෂණය හරහා අපේක්ෂා කරන්නේ COVID-19 වසංගතයට ප්‍රතිචාර වශයෙන් රෝහල මානව සම්පත් කළමනාකරණ (Human Resource Management) කටයුතු සිදු කළ ආකාරය පිළිබඳ විශ්ලේෂණයක් සිදු කිරීමය.

රෝහල් කළමනාකරුවන් සහ රේඛීය කළමනාකරුවන් සමඟ සම්මුඛ සාකච්ඡා (උදා: හෙද කළමනාකරුවන්), සහ වෛද්‍යවරුන් සහ හෙදියන් සමඟ සම්මුඛ සාකච්ඡා හෝ කණ්ඩායම් සම්මුඛ සාකච්ඡා සිදු කිරීම අපේක්ෂා කෙරේ.

සෞඛ්‍ය සේවා වෘත්තිකයන් වන ඔබ, COVID-19 හි වෙනස් සන්දර්භය තුළ ඔබේම අත්දැකීම්වලින් වටිනා තොරතුරු ලබා දීමට සුදුසුම ස්ථානයක සිටී. ඔබගේ සහභාගීත්වය මගේ පර්යේෂණයට විශාල අගයක් එකතු කිරීමක් වනු ඇති අතර මෙම අධ්‍යයනයේ සොයාගැනීම් ප්‍රතිඵලයක් ලෙස COVID-19 සංසිද්ධි පිළිබඳ වැඩි අවබෝධයක් ලබා දෙන අතර එමගින් මානව සම්පත් කළමනාකරණ වෘත්තිකයන්ට ඔවුන්ගේ අනාගත මානව සම්පත් කළමනාකරණ කටයුතු සැලසුම් කිරීමේදී ප්‍රතිලාභ ලැබෙනු ඇත.

ඔබේ රෝහලේදී සිදු කරන ලද මානව සම්පත් කළමනාකරණ වෙනස්කම් සම්බන්ධයෙන් ඔබේ සිතුවිලි සහ අත්දැකීම් ග්‍රහණය කර ගැනීමට සම්මුඛ පරීක්ෂණ සඳහා ආසන්න වශයෙන් මිනිත්තු 60 කාලයක් (මාර්ගගත- ZOOM හෝ දුරකථනය හරහා) ගත වේ.

ඔබගේ තොරතුරු දැඩි ලෙස රහසිගතව තබා ගනු ඇත. දත්ත විශ්ලේෂණයේදී, ඔබේ රහස්‍යභාවය සහතික කිරීම සඳහා, ඔබේ හඳුනාගැනීම් වැළැක්වීමට අත්වර්ථ නම් භාවිත කරනු ඇත. පර්යේෂකයන්ට දත්ත පිටපත් කිරීමට සහ විශ්ලේෂණය කිරීම සඳහා, සහභාගිවන්නන්ගේ කැමැත්ත ඇතිව සම්මුඛ සාකච්ඡා පටිගත කරනු ලැබේ.

මෙම අධ්‍යයනයට ඔබේ සහභාගීත්වය සම්පූර්ණයෙන්ම ස්වේච්ඡාවෙන් සිදු වන අතර ඔබට අපහසුතාවයක් හෝ පීඩාවක් දැනේ නම් ඕනෑම වේලාවක ඔබට ඔබගේ සහභාගිත්වය ඉවත් කර ගත හැක.

වැඩිදුර තොරතුරු සඳහා හෝ ඔබට කිසියම් ප්‍රශ්නයක් ඇත්නම්, කරුණාකර පහත සම්බන්ධතා තොරතුරු භාවිතා කරන්න.
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ඔබ මෙම පර්යේෂණයට සහභාගී වීමට කැමති නම්, කරුණාකර කැමැත්ත සටහන් කරන පෝරමයක් (Consent Form) සම්පූර්ණ කර අත්සන් කරන්න.

ඔබගේ කාරුණික සහයෝගීතාවයට ස්තූතියි.

එම්ජී.ඩී.එස්.සමාධි

උපාධි අපේක්ෂක,

වික්ටෝරියා විශ්ව විද්‍යාලය, මෙල්බර්න්, ඕස්ට්‍රේලියාව.

Appendix 2: Interview Guides used for Interviews with Senior Management

QUESTIONS	SENIOR MANAGEMENT (INTERVIEW) - SCOPE
1. What is your role & background?	*Interviewee's personal background* *Hospital contextual information (organisational **strategy**, collect policies, organisational structure, history, etc.)*
2. What was your experience of COVID-19?	*Impact on organisation, on yourself, on your team* *Challenges the organisation has faced*
3. To what extent were you and your organisation prepared for this type of crisis? *PRE-CRISIS*	*Do you have a risk management plan in place* *Type of HRM policies and practices in place prior to COVID-19* *Individual preparedness (e.g. prior experience to trauma, Sri Lankan values)*
4. How did the organisation respond to the crisis? How effective was the response? *DURING CRISIS*	*Implementing new policies/ Change existing ones, Which ones? Who was involved in the redesign of policies? (e.g. remote work for admin staff, training, OHS)* *How did you communicate policies – level of support provided to employees* *Constraints in organisational responses* • *External constraints: supply chain/access to protective equipment; WHO/ government, healthcare policy makers, authorities, stakeholders* • *Internal constraints: labour shortages, employee burnout and infections, funding, etc* *What could have been done better?*

5. How fair was the organisational response and HRM practices?	*Procedural fairness* *Distributive fairness* *Interpersonal fairness*
6. Any positive coming out of the crisis? *POST-CRISIS*	*Opportunities, learnings, preparedness to future outbreaks*
7. Any other comment?	

Appendix 3: Interview Guides used for Interviews with Line Management

QUESTIONS	LINE MANAGEMENT (INTERVIEW) - SCOPE
1. What is your role & background?	*Interviewee's personal background*
2. What was your experience of COVID-19?	*Impact on organisation, on yourself, on your team* *Challenges the organisation has faced.*
3. To what extent were you and your organisation prepared for this type of crisis? *PRE-CRISIS*	*Type of HRM policies and practices in place prior to COVID-19* *Individual preparedness (e.g. prior experience to trauma, Sri Lankan values)*
4. How did the organisation respond to the crisis? How effective was the response? *DURING CRISIS*	*Implementing new policies/ Change existing ones. Which ones? (e.g. remote work for admin staff, training, OHS)* *How did you **implement** the policies, and challenges of implementation* - *Constraints: access to protective equipment, labour shortages, employee burnout and infections, bureaucratic processes* - *Level of support provided to employees*
5. How fair was the organisational response and HRM practices?	*How did employees experience policy changes/crisis? (e.g. employee resistance to or satisfaction of policy changes)* *Procedural fairness (e.g. workload, shift allocation)* *Distributive fairness (e.g. employee empowerment, rewards, equitable access to training)* *Interpersonal fairness*
6. Any positive coming out of the crisis? *POST-CRISIS*	*Opportunities, learnings, preparedness to future outbreaks*
7. Any other comment?	

Appendix 4: Interview Guides used for Interviews with Employees

QUESTIONS	EMPLOYEE FOCUS GROUP - SCOPE
1. What is your role & background?	*Interviewee's personal background*
2. What was your experience of COVID-19?	*Impact on organisation, on yourself, on your colleagues*
3. To what extent were you and your organisation prepared for this type of crisis? *PRE-CRISIS*	*Type of HRM policies and practices in place prior to COVID-19* *Individual preparedness (e.g. prior experience to trauma, Sri Lankan values)*
4. How did the organisation respond to the crisis? How effective was your manager in implementing HRM policies and overall organisational responses? *DURING CRISIS*	- *Constraints: access to protective equipment, labour shortages, employee burnout and infections, bureaucratic processes* - *Level of support provided to employees*
5. How fair was the organisational response and HRM practices?	*How did you experience policy changes/crisis? (e.g. resistance to or satisfaction of policy changes)* *Procedural fairness (e.g. workload, shift allocation)* *Distributive fairness (e.g. employee empowerment, rewards, equitable access to training)* *Interpersonal fairness (e.g. nurses vs doctors)* *Third-party justice perceptions*
6. Any positive coming out of the crisis? *POST-CRISIS*	*Opportunities, learnings, preparedness to future outbreaks*
7. Any other comment?	

Appendix 5: Information Sheet for Participants

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled 'Human Resource Management changes in the Sri Lankan health sector- COVID-19 response'.
This project is being conducted by a student researcher, M.G.D.S. Samadi as part of a PhD study at Victoria University under the supervision of Dr. Ancy Gamage from Victoria University Business School.

Project explanation

This research project aims to explore the work environment changes that have taken place in the Sri Lankan health sector, in response to the COVID-19 pandemic. More specifically, this project will examine the design and implementation of key human resource management (HRM) practices in Sri Lankan hospitals' response to the pandemic, as well as employees' experience of these practices. Thus, this project aims to,

1. identify the HRM practices that Sri Lankan hospitals have designed in response to COVID-19 pandemic.
2. explore to what extent have line managers implemented these HRM practices in line with hospitals' design intentions.
3. explore how do health care workers (doctors and nurses) experience these HRM practices, and how effective are these practices in eliciting desired employee behaviours and attitudes.

Healthcare sector is highly labour intensive, and it is important to explore how hospitals dealt with people management in response to the COVID-19 pandemic. This research will thus bring novel insights to the HRM literature, given the distinct context of COVID-19. Taking a multi-level view on the changes in HRM practices that have taken place in response to the pandemic, this research aims to explore the intended changes in HRM practices both at the implementation and employee perceived levels. Thus, the findings of this study will benefit HRM practitioners in their future HRM planning.

This research is not intended as an evaluation of the effectiveness of the hospital's services, but rather as an analysis of how the hospital dealt with people management in response to the COVID-19 pandemic.

What will I be asked to do?

You will be asked to participate in an interview which will take place (online- ZOOM or via phone) at a mutually agreed upon time and may last for about 60 minutes. The interviews will be recorded to allow the researcher to transcribe and then analyse the data. Your involvement in this research would be to provide answers to the questions the researcher will ask. Your participation in this study is entirely voluntary and you may withdraw your participation at any time if you feel uncomfortable or distressed.

What will I gain from participating?

You will contribute to new knowledge given the distinct and unprecedented context of the COVID-19 pandemic. The insights that the study can bring, might be useful in future HRM decisions and preparing for risk management.

How will the information I give be used?

All information collected in this study will only be made accessible to the research team. No one outside of the study will have access to the recordings and the recordings will be destroyed five years after the end of the study.

What are the potential risks of participating in this project?

The information that you provide will remain completely confidential and we respect your privacy. The potential risk of participating this project is minimal as we keep your information confidential. However, as we will be talking about your experiences around the COVID-19 pandemic, you may feel distressed or uncomfortable. In that case, you may reschedule the interview. We can also assist you in seeking confidential counselling service.

All recordings and information collected for this research will only be made accessible to the research team and will be kept at a secure location.

COVID-19 can spread easily in the community and it can have severe consequences. We will take any practical precautionary measure to reduce the risk of you been infected in COVID19 while in our facilities during your participation in the research, however, we cannot guarantee that you will not be infected. To minimise the risk we will ask you to notify us if you have been recently diagnosed (less than 14 days) with COVID-19, have been identified as a close-contact of someone with COVID-19, or have signs or symptoms suggestive of COVID-19. You will be phone screened for these criteria 24 hours prior to each in-person visits and will also complete the form again on arrival.

If you have been diagnosed with COVID19 you will not be allowed to participate in the study until you will be cleared of COVID-19 and your medical doctor will provide us a letter of approval.

How will this project be conducted?

Participants will be provided with an 'Informed Consent' form. If they are willing to participate in the research, they must sign and email this form to the researcher (student) before the interview can take place. All interviews will be recorded and transcribed.

Who is conducting the study?

Victoria University, Melbourne
Chief Investigator: Dr. Ancy Gamage (Ancy.Gamage@vu.edu.au)
External Supervisor: Dr. Dushan Jayawickrama (dushan@sjp.ac.lk)
Student Researcher: M.G.D.S.Samadi (sumiri.madiwalagamagedon@live.vu.edu.au)

Any queries about your participation in this project may be directed to the Chief Investigator listed above.
If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

Appendix 6: Consent Form for Participating in Interviews

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into the Human Resource Management changes in the Sri Lankan health sector, in response to the COVID-19 pandemic. This research study is conducted by M.G.D.S.Samadi, a doctoral student from the Victoria University Business School, Melbourne.

The research title is **'Human Resource Management changes in the Sri Lankan health sector -COVID-19 response'.**

The aims of the study are as follows:

1. Identify the HRM practices that Sri Lankan hospitals have designed in response to COVID-19 pandemic.
2. Explore to what extent have line managers implemented these HRM practices in line with hospitals' design intentions.
3. Explore how do health care workers (doctors and nurses) experience these HRM practices, and how effective are these practices in eliciting desired employee behaviours and attitudes.

This research project is under the supervision of Dr Ancy Gamage of the Victoria University Business School, Melbourne Australia. You are being asked to participate in this study because of your experience in the changes in Human resource management practices and changes in healthcare workers' work environment which have been taken place in response to the COVID-19 pandemic.

Your participation will involve taking part in an interview with the researcher. The interviews will take place (online- Zoom or through phone) at a mutually agreed upon time and may last for about 60 minutes. The discussions will be recorded to allow the researcher to transcribe and then analyse data. Your expected involvement would be to provide answers to the questions the researcher would ask during the interview. Your participation in this study is entirely voluntary and you may withdraw your participation at any time if you feel uncomfortable or distressed.

All recordings and information collected for this research will only be made accessible to the research team and will be kept at a secure location. No one outside of the study will have access to the recordings and the recordings will be destroyed five years after the end of the study. The results of this study may be published or presented at conferences.

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CERTIFICATION BY PARTICIPANT

I," ....."

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study 'Human Resource Management changes in the Sri Lankan health sector -COVID-19 response', being conducted at Victoria University by Dr.Ancy Gamage.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by M.G.D.S.Samadi and that I freely consent to participation involving the below mentioned procedures:

- An interview with M.G.D.S.Samadi.
- The session will be recorded, and the study results may be published or presented at conferences.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential by the researcher.

Please tick the box if you give consent to participate and to have the interview recorded. ☐

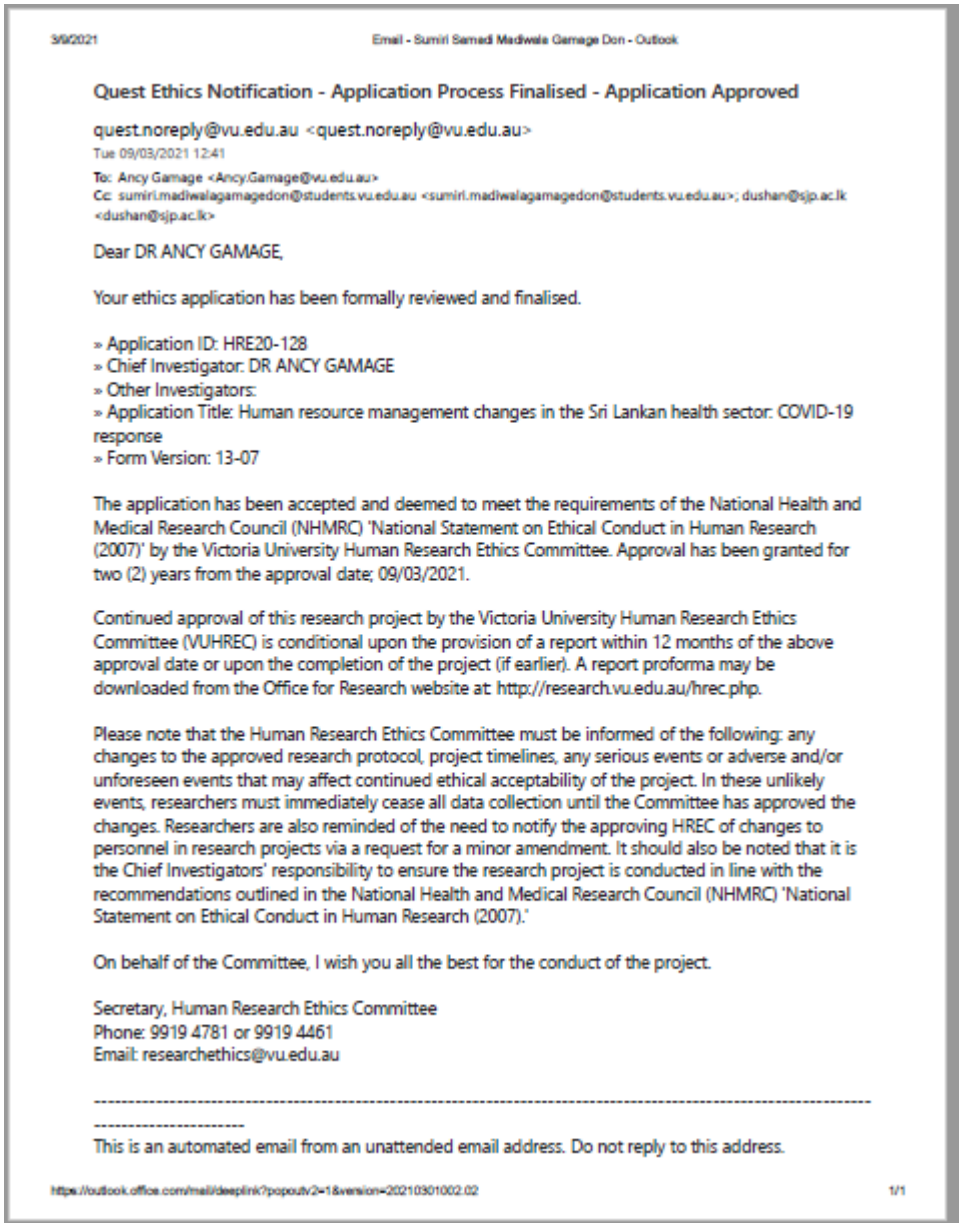
Signed: .....

Date: .....

Thank you in advance for participating in this study and we highly appreciate your support and cooperation extended by participating in this research. Any queries about your participation in this project may be directed to Dr.Ancy Gamage (Tel: +61 99195626 or Email Ancy.Gamage@vu.edu.au) and/or to Dr. Dushan Jayawickrama who is the external supervisor of this research project (Tel: +94 71 401 14 89 or Email dushan@sjp.ac.lk).

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001, email Researchethics@vu.edu.au or phone (03) 9919 4781 or 4461.

Appendix 7: Ethical Clearance (HRE20-128)



3/9/2021 Email - Sumiri Samadi Madiwala Gamage Don - Outlook

Quest Ethics Notification - Application Process Finalised - Application Approved

quest.noreply@vu.edu.au <quest.noreply@vu.edu.au>
Tue 09/03/2021 12:41

To: Ancy Gamage <Ancy.Gamage@vu.edu.au>
Cc: sumiri.madiwalagamagedon@students.vu.edu.au <sumiri.madiwalagamagedon@students.vu.edu.au>; dushan@sjp.ac.lk <dushan@sjp.ac.lk>

Dear DR ANCY GAMAGE,

Your ethics application has been formally reviewed and finalised.

» Application ID: HRE20-128
» Chief Investigator: DR ANCY GAMAGE
» Other Investigators:
» Application Title: Human resource management changes in the Sri Lankan health sector: COVID-19 response
» Form Version: 13-07

The application has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Victoria University Human Research Ethics Committee. Approval has been granted for two (2) years from the approval date; 09/03/2021.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date or upon the completion of the project (if earlier). A report proforma may be downloaded from the Office for Research website at: http://research.vu.edu.au/hrec.php.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment. It should also be noted that it is the Chief Investigators' responsibility to ensure the research project is conducted in line with the recommendations outlined in the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007).'

On behalf of the Committee, I wish you all the best for the conduct of the project.

Secretary, Human Research Ethics Committee
Phone: 9919 4781 or 9919 4461
Email: researchethics@vu.edu.au

This is an automated email from an unattended email address. Do not reply to this address.

https://outlook.office.com/mail/deeplink?popoutv2=1&version=20210301002.02 1/1

Appendix 8: Response from Counselling Service Provider

9/29/2020 Email - Sumiri Samadi Madiwala Gamage Don - Outlook

RE: Request for information on counselling services

sumithra@sumithrayo.org <sumithra@sumithrayo.org>
Tue 29/09/2020 19:27
To: Sumiri Samadi Madiwala Gamage Don <sumiri.madiwalagamagedon@live.vu.edu.au>

Dear Samadi,
Thank you for your email and interest in our services.
It's nice to hear about your research and we understand that you feel that some issues that require emotional support can arise based on the findings.
We are happy that you have a good understanding of the support systems available, that the community can reach out to when they are in distress. We appreciate your thoughts to go beyond your call of duty to broaden the awareness.
We are a voluntary organization which was started in 1974 and we have been serving the community for the last 46 years. We offer our service free of charge and our trained volunteers are available to support anyone who contacts us.
Our center is open every day from 9 am to 8 pm, 365 days (we are open on all days including Poya, Christmas, Mayday, Independence day etc.)
Our service can be obtained over the phone (0112 696666, 0112 683555, & 0112 692909.) or by visiting us at No. 60B, Horton Place, Colombo 07. We will be also available on emails through sumithra@sumithrayo.org
Anyone can walk in, call, or write to us at their convenience, and there is no need for any prior appointments. We assure confidentiality and anonymity of those who contact us and are happy to be of support at the time of their distress. Therefore, we believe that the best way to support the people you interview will be to disseminate our information to them. If you wish we could provide some leaflets in Sinhala, English, and Tamil.
Should you need any further clarifications please contact us via email or on the office line 0112 683981
We wish you all the success in your research and future endeavors.
Best Regards
Directors

From: Sumiri Samadi Madiwala Gamage Don [mailto:sumiri.madiwalagamagedon@live.vu.edu.au]
Sent: Monday, September 28, 2020 11:57 AM
To: sumithra@sumithrayo.org
Subject: Request for information on counselling services

Dear Sir/ Madam,
I am a lecturer from University of Ruhuna and am currently reading for my PhD at Victoria University, Melbourne, Australia.
I am planning to undertake a research on human resource management changes in Sri Lankan hospitals, in response of COVID-19.
I am organizing interviews and focus groups with the management and staff of selected hospitals.
Given the context of my study (the pandemic), there is a probability to traumatic risk for the respondents which can arise during the interviews.
Therefore, I understand that it would be better to seek for and keep readily available professional counselling support, to mitigate this risk for the respondents.

The purpose of my writing is to request information on the possibility of asking for counselling support from your organization, for such a situation. What arrangements can be made in place and can we obtain counselling support over the phone or online, please.

Please advise.

https://outlook.office.com/mail/inbox/id/AAQkADIyOWJlNzdlLTZmZGUtNGFhNy1hMmMwLTU4NTgwMTZlMmNmOAAQALslDylalbKGdeTRgDR6k... 1/2

9/29/2020 Email - Sumiri Samadi Madiwala Gamage Don - Outlook

Thank you.

MGDS Samadi
PhD Candidate, Victoria University.

Virus-free. www.avast.com

Appendix 9: Details of Respondents- Hospital A

	Pseudonym	Designation	Level	Experience (Years)	Gender	Age
1	Hiru	CA	SM	10	Female	50
2	Kumudu	N/O plus WIC duties	HCW	11	Female	37
3	Paba	MO planning	LM reporting to the HD	4	Female	35
4	Ashi	Doctor plus MO planning	LM reporting to the HD	3	Female	32
5	Bandula	WIC	LM reporting to the CNO	17	Male	57
6	Mala	Overseer	LM reporting to the HD	7	Female	54
7	Dinu	Pharmacist	HCW	3	Female	32
8	Gaya	CNO	SM	33	Female	58
9	Indu	WIC	LM	16	Female	53
10	Ivan	N/O	HCW	2	Male	32
11	Sithmi	N/O	HCW	5	Female	32
12	CNOs group	CNO	SMs	NA	NA	NA
13	Keheliya	Chief AO	LM reporting to the HD	28	Male	52
14	Usha	WIC/ICU	LM reporting to the CNO	5	Female	37
15	Maya	N/O	HCW	8	Female	34
16	Akshi	Chief laboratory Technician	LM reporting to the HD through the Microbiologist	4	Female	45
17	Two nurses	N/O	HCW	2	Female	28/29
18	Pradeep	Health Services Assistant (MS)	HCW	7	Male	34
19	Raju	N/O	HCW	5	Male	33

20	Rajna	WIC	LM reporting to the CNO	6	Female	55
21	Ahaz	Doctor	MO / LM	4	Male	32
22	Ruwani	N/O	HCW	4	Female	28
23	Sammi	N/O	HCW	7	Female	39
24	Shanthi	WIC	LM reporting to the CNO	28	Female	52
25	Thejan	N/O	HCW	6	Male	34
26	Wasana	Deputy CNO	SM	12	Female	55
27	Thejani	WIC	LM reporting to the CNO	26	Female	55
28	Gamage	N/O	HCW	5	Female	30

Appendix 10: Details of Respondents- Hospital B

	Pseudonym	Designation	Level	Experience (Years)	Gender	Age
1	Prabath	Medical officer in charge	LM	8	Male	43
2	Thushi	Dentist	HCW	15	Male	47
3	Nimali	Admin officer	LM	4	Female	38
4	Dasuni	Assistant Manager HR	SM	10	Female	37
5	Sandaru	Medical Manager	SM	13	Male	47
6	Dammi	Operations Manager	SM	12	Female	42
7	Chamara	Front office Manager	LM	8	Male	38
8	Samira	Procurement Manager	LM	5	Male	38
9	Iresha	Lab manager	LM	12	Female	41
10	Latha	Nursing Sister/ WIC	LM	12	Female	42
11	Imalia	Infections control nurse	LM	10	Female	45
12	Dinushi	HR executive	LM	4	Female	32
13	Darshana	Pharmacy in charge	LM	11	Male	38
14	Malith	IT manager	LM	5	Male	35
15	Kumu	CNO	SM	13	Female	48
16	Chathura	Assistant CNO	LM	7	Male	45
17	Nidarshi	Assistant CNO	LM	9	Female	42
18	Darshika	Housekeeping assistant	HCW	10	Female	37
19	Nayumi	Receptionist	HCW	5	Female	33
20	Nurses group 1	Nurses 3	HCW	NA	Female	NA
21	Nurses group 2	Nurses 2	HCW	NA	Female	NA
22	Kanthi	Security officer	HCW	12	Female	38
23	Jagath	Procurement officer	HCW	7	Male	35

Appendix 11: Details of Respondents- Hospital C

	Pseudonym	Designation	Level	Experience (Years)	Gender	Age
1	Priya	Medical Superintend	SM	10	Female	45
2	Pharmacists group	Pharmacist / Assistant pharmacist	HCW	NA	Female	NA
3	Mahinda	Doctor/ WIC	LM	5	Male	37
4	Office clerks group	Clerical and administrative support	HCW	NA	Female	NA
5	Samarawansha	Overseer	LM	22	Male	49
6	Widana	Doctor / WIC	LM	12	Female	42
7	Sarath	Therapist	HCW	10	Male	39
8	Sapumali	Therapist	HCW	5	Female	32
9	Receptionists group	Receptionist	HCW	NA	Female	NA
10	Attendants group	Attendants	HCW	NA	Female	NA
11	Attendants group 2	Attendants	HCW	NA	Male	NA
12	Mudali	Dispenser	HCW	7	Male	38

Appendix 12: Details of Respondents- Hospital D

	Pseudonym	Designation	Level	Experience (Years)	Gender	Age
1	Lasath	Medical officer in charge	SM	8	Male	39
2	Kumari	CNO	SM	18	Female	47
3	Galappathi	Consultant	SM	15	Male	45
4	Dayasiri	Nurse manager	LM	30	Male	57
5	Kamal	Nurse manager	LM	23	Male	52
6	Sumana	WIC nurse	LM	22	Female	56
7	Lasantha	Overseer	LM	18	Female	43
8	Gayan	Admin officer	LM	13	Male	38
9	Prasadi	Nurse manager-Education unit	LM	31	Female	46
10	Raani	Supervisor- cleaning	LM	8	Female	42
11	Gayantha	Medical laboratory technician	HCW	14	Male	38
12	Jayaani	Nurse	HCW	25	Female	49
13	Maali	Nurse	HCW	10	Female	40
14	Wasantha	Nurse	HCW	5	Male	32
15	Nurses group	Nurses- infection control unit	HCW	NA	Female	NA
16	Sithumini	Nurse	HCW	7	Female	35
17	Kapila	Nurse	HCW	9	Male	38
18	Nurses group	Nurses and WIC	LM and HCW	NA	Female	NA
19	Pramila	WIC -OPD	LM	12	Female	41
20	Damith	Transport supervisor	LM	13	Male	42

Appendix 13: Findings for RQ 01

RQ 01: What HRM challenges did the dual crises impose to Sri Lankan hospitals, and to what extent were Sri Lankan hospitals prepared for crises like these?

Themes	**Hospital A** Public ID Hospital **City (Colombo)** Size: Medium. 200 Beds **N=28**	**Hospital B** Private Hospital **Semi-rural (Southern Province)** Size: Small.50 Beds **N=23**	**Hospital C** Public Ayurveda Hospital **Regional (Uva Province)** Size: Small.76 Beds **N=12**	**Hospital D** Public Tertiary Hospital **Semi-rural (Northern Province)** Size: large.2060 Beds **N=20**
SQ 1	**Challenges encountered during the pandemic and the economic crisis**			
Pandemic Context				
Hospital's role in the pandemic response	One of the first three hospitals to treat COVID-19 patients.	Not allowed for COVID-19 treatments at the hospital. Established two ICC in hotels (Emerging business opportunities)	Distribution of immunity booster caskets- incurred field work. Later initiated COVID-19 treatment.	Assigned COVID-19 treatment during second half of the pandemic.
Surge Capacity issues	Exceeded Surge capacity	Less surge capacity issues.	Less surge capacity issues.	Avoid surge capacity issues through the separate CTF.
Resources availability	Limited resources: PPEs, buildings, staffing (ICU nurses and MS), equipment etc. Had funding issues. Use of donations.	Sufficient supply of resources No funding issues- financed through the head office and increased sales Locum staff availability increased due to alternate	Herbs and other plant based ingredients found through donors. Government funding and support mostly prioritized Western medicine hospitals. (lack of sufficient supply of PPEs)	Building upgraded to a CTF Managed with minimum staff Lack of ICU nurses.

		staffing practices in government hospitals.		
Lockdown	Limited supply of transport, accommodation and meals for staff Difficulties in obtaining supporting services (outsourced, suppliers, contractors) No visitors and bystanders allowed for patients	Do	Moderate	Do
Economic Crisis Context				
	High volume of patients Shortages/ absenteeism of HCWs due to transport issues and turnover Hospital operations disrupted by staff shortages, power cuts and fuel scarcity Drug shortages Overtime restrictions	Reduced patient numbers Transportation issues Procurement issues with Locum staff availability influenced by government income tax policies	Considerable increase in patients Shortages/ absenteeism of HCWs due to transport issues Moderate disruptions to operations due to power cuts and fuel scarcity Medical supply shortages Overtime restrictions	High volume of patients Shortages/ absenteeism of HCWs due to transport issues and turnover Hospital operations disrupted by staff shortages, power cuts and fuel scarcity Drug shortages Overtime restrictions
SQ 2	**Crisis influence on employee wellbeing and quality of care**			
Pandemic Context				
Employee wellbeing	High vulnerability to virus as one of the first three responding hospitals.	Moderate risk of virus infection.	Moderate risk of virus infection. Increased workload with limited staff	Moderate risk of virus infection.

	Fear of transmitting virus from hospital to family/community. Heavy work load and unfamiliar practices Feeling isolated	Minimized exposure to patients by having two separate ICC.		Minimized exposure to patients through separate CTF. Fear of transmitting virus from hospital to family/community.
	Transportation issues. Social discrimination. New/ unfamiliar working practices. Heavy workload and stress	Transport issues. New work practices.	Transport issues. Heavy workload.	Compelled to work at CTF. Priority for CTF in safety practices. Staff at other wards felt belittled.
Quality of care	Patients demanding extra care - psychological issues, isolation, novelty of the disease	Do	Do	Do
	Only COVID-19 patients	COVID-19 patients treated at ICC while managing other operations at the hospital	Community treatments / casket distribution involved work in the field while managing treatments and medicine preparations at hospital	COVID-19 patients treated at CTF while managing other operations at the hospital
	Overwhelmed wards	Had the ability to extend services through ICC	Moderate	Overwhelmed wards
Economic Crisis Context				
Employee wellbeing	Financial stress was high due to urban living standards	Moderate as less impact from inflation No impact on compensation, but had	Moderate due to less impact from inflation Restrictions on overtime work compensation	Ranged between high to moderate Restrictions on overtime work compensation

	Restrictions on overtime work compensation	cuts in free of charge benefits		
	Employee turnover -Yes. Clinical Staff (migration) MS (leaving the job)	Yes Locum staff (migration) Some permanent staff migrated due to partner migration. Drops in locum staff availability due to income tax restrictions	No Number of transfer requests increased (staff looking for workplace options closer to home)	Yes Clinical Staff (migration) Staff willingness to transfers
	Feeling incompetent for providing a complete patient care - due to shortage in drugs and other facilities	Moderate	Moderate	High- due to shortage in drugs and other facilities
Quality of care	Disrupted	Moderate impact	Moderate impact	Disrupted
SQ 3	**a) Environmental influences**			
Pandemic Context				
Government regulations	Government COVID-19 management plan	Do	Do	Do
Service providers	Declined to provide services Difficulties in procurement due to lockdown	Procurement difficulties due to lockdown	Procurement difficulties due to lockdown	Procurement difficulties due to lockdown
Opportunities	Improvement in staff ID training and resilience	Improvement in staff ID training and resilience	Enhanced networking with community	Improvement in staff ID training and resilience

	Increased staff cadre, infrastructure and other facilities	New business opportunities (telehealth, mobile pharmacy, ICC) Increased staff cadre, infrastructure and other facilities		Increased staff cadre, infrastructure and other facilities
Community, Culture and values	Social discrimination to staff	Moderate	Moderate	Social discrimination to staff
	Donations- high	NA	Donations- moderate	Donations-moderate
	Religious beliefs and practices enhance HCW resilience	NA	Indigenous medicine beliefs related to ID	Moderate
Economic crisis context				
Power cuts, fuel shortages	Strong impact from	Moderate impact	Moderate impact	High impact
Patients	Aggressive patients	Aggressive patients	Aggressive patients	Aggressive patients
Service providers	Strict conditions on credit	Lack of alternative suppliers	Strict conditions on credit	Strict conditions on credit
Donations	Limited	NA	Limited	Limited
SQ 3	**b) Impact on HRM**			
	Changes to staffing, training, employee wellbeing, compensation issues	Do	Do	Do
SQ 4	**Internal influences**			
Previous disasters / emergency experience	Yes-Managed patient surges during seasonal ID	Practiced emergency management drills due to ACHSI accreditation purposes.	Nil	Emergency and mass casualty experience with war victims

	Regular emergency management drills	Some staff had previous work experience with Tsunami disaster while working at other hospitals		
Management intentions (strategic choice vs employee wellbeing) *As perceived by managers*	Mixed: national level role in responding the pandemic was a priority through safe working practices while ensuring employee wellbeing	Sales, customer satisfaction and respond to market opportunities was the main purpose Employee wellbeing has been a priority as well	Mixed: Fulfil the role expected by authorities to respond the crisis , through safe and supportive work environment	Mixed: Fulfil the role expected by authorities to respond the crisis , through safe and supportive work environment
Internal work culture and values	Team working Strong leadership Decentralized decision making Staff attitudes aligned with national level role Strong beliefs on safety procedures Behaviors shaped by Religious thoughts	Leadership- decentralized decision making across the groups Customer service quality is the priority Reflections from other member companies in the group (including their hospitals in Colombo) Exposure to government procedures in public hospitals gained through Locum staff	Team working Leadership Staff attitudes aligned with indigenous medicine and religious thoughts	Issues with team working Weak leadership Difficulties in making decentralized decisions
Hospital size	Small- medium	Small-medium	Small-medium	Large
SQ 5	**Crisis preparedness and to what extent were applicable in crisis response**			
Preparedness plans	Agreed plan but not documented	Documented plan	Not considered	Agreed plan but not documented

			Consider responding based on prior experience	
- Emergency	Well established ETU with experienced staff	Well established ETU, but occasionally used	ETU usually functioning well	ETU well established, usually busy
- Mass casualty	Consider responding based on prior experience during seasonal epidemics	Well planned and mock practices	Not planned well/ not needed	Consider responding based on prior experience during the war
ID training and drills	Yes- usual	No	No	Yes- occasional
Resources preparedness				
- Stuff	Limited safety stocks Had confidence about being prioritized at the government medical supplies division that will enable quick restocking	Average Considerable level of assurance of obtaining funds from the group for as required for emergency response	NA	Limited safety stocks
- Staff	Expertise in ID Mentality and morale related with the national level role specially for ID Limitations in trained staff	Exposure from local public hospitals through locum staff	Expertise in traditional methods of infection control	Expertise in mass casualty handling- managers as veterans
Limitations in preparedness plans	Not considered ways to deal with a lockdown	Not considered ways to deal with a lockdown	-	Not considered ways to deal with a lockdown

Appendix 14: Findings for RQ 02

RQ 02: What HRM strategies have the hospitals designed to respond to these crises?

The planned HRM responses in the context of the pandemic and in the economic crisis are identified. Such responses are classified under four HRM practices and explored across various HCW categories.

Themes	**Hospital A** Public ID Hospital **City (Colombo)** Size: Medium. 200 Beds **N=28**	**Hospital B** Private Hospital **Semi-rural (Southern Province)** Size: Small.50 Beds **N=23**	**Hospital C** Public Ayurveda Hospital **Regional (Uva Province)** Size: Small.76 Beds **N=12**	**Hospital D** Public Tertiary Hospital **Semi-rural (Northern Province)** Size: large.2060 Beds **N=20**
SQ 1	**Staffing practices**			
Pandemic Context				
Extended shifts and Staffing alternate groups	Staff was grouped into two and one group was called to work at a turn (usually a fortnight) which incurred extended shifts and long work hours. Then the work is handed over to the alternate group and the first group is sent on leave (cumulative day offs related to the worked period with special leave as allocated by the MH) This was successfully applied in wards.	Extended shifts were used to manage the work as some staff were not able to report to work due to transportation issues during lockdown. Additional staff was required due to increased demand for PCR testing and ICC start up. Nursing vacancies were filled using locum staff.	Staffing alternate groups with continued work was used to maintain added workload in and outside hospital.	Staff at the hospital was not exposed to the staff at CTF to minimize virus transmission. This lead to staff shortages and extended shifts both at the hospital and the CTF.

	For MS and office staff there have been slight variations.			
- Facilities provided	Hospital provided meals, accommodation and transportation facilities to staff. Government facilitated transport service was not compatible.(Sometimes there were no set times for duty on and offs)	Do Incentive payment was paid for ICC nurses and other staff. Additional work hours were compensated with incentives for other staff.	Do	Meals and transport arrangements were provided by the hospital for staff at other wards and units. Meals, accommodation and resting facilities were provided to CTF staff. Government facilitated transport service was not compatible.
Staff rotation	During first phase, staff from each of the wards were assigned to work at the isolation ward on rotation. This gave them a training and exposure to work with patients before the actual surge in patients occurred. These related to overall hospital preparedness. Staff residing in accommodation at hospital premises were called for emergency duty and unexpected absences.	Permanent nursing staff were assigned duties at ICC where they had the opportunity to accept work voluntarily. Locum staff were used to balance work at the hospital in the absence of staff who sent to ICC.	Staff were rotated across in house and field work.	Staff rotation was used during staff absences and quarantine.
Interim staffing practices	Clinical staff from other hospitals were called to	NA	NA	NA

	assist handling the heavy workload during the first phase. MS from other hospitals and office staff from other hospitals and government institute were utilized to cover up duties throughout the pandemic. Army officers volunteered for building construction and infrastructure development work.	CNOs and managers were allowed to come to work every other day.		
Changes to working practices				
Clinical staff				
- Triage	Used for screening incoming patients.	Do- at the hospital NA- at the ICC.	Do	Do
- Additional care for patients	Aimed at patient psychological wellbeing. No bystanders allowed.	Do ICU facilities were extended at hospital	Do	DO
- Remote work	Established ways to - Communicate with the patients (intercom) - Remotely observing the patients (open wards- nursing station placed outside, covered with a glass door)	Nurses were on duty 24/7 as nurses were residing at the same hotel. Patients were allowed to make contact with the nurses through their mobile phones.	NA for clinical staff as most treatments are face to face, one on one. Applied for incoming patients at the reception and at the dispensary.	Applied in the CTF- patients were observed through glass covered walls and used the intercom to communicate. Limited wards rounds both at CTF and hospital wards.

	- Wall oxygen system, ventilators operated remotely at the nursing station. - Limited ward rounds with minimum staff exposed to patients (used the *Buddy system*).	Limited observation rounds led by a physician.		
- New practices and equipment	PPE donning and doffing Nurses learnt and conducted PCR sample collection New equipment used, training involved Frequent cleaning and sanitizing	PPE donning and doffing Frequent cleaning and sanitizing	PPE donning and doffing Frequent cleaning and sanitizing	PPE donning and doffing Nurses learnt and conducted PCR sample collection New equipment used, training involved Frequent cleaning and sanitizing
Laboratory services	Overwhelmed 24 hour services Extended with new machines Training involved	Overwhelmed 24 hour services	NA	Overwhelmed 24 hour services
MS duties	Overwhelmed, assisted with interim staff Added duties in mortuary, cleaning and sanitizing, cooking, patient transfers (ambulance)	Added to housekeeping staff duties with sanitizing, and meals at hospital Meals were obtained from hotels for ICC Laundry service was outsourced	Added with field work and preparation of medicine in house	Added duties in mortuary, cleaning and sanitizing, cooking, patient transfers (ambulance)
Procurement	Disrupted due to lockdown and staff had to put extra effort: - visit vendors to clear items	Do	Do	DO

	- liaise with the police for transporting items			
Admin staff	Liaise with authorities (police, local councils, central COVID-19 control / Disaster management centre, other government agencies) Keep updated on frequent changes to legislations and protocols	Had to develop new contacts with relevant authorities and this was a major change to the routine admin jobs, ability to perform and take actions quickly were limited due to added layers of approval and waiting for external party involvement- (E.g. managing deaths occurred at the hospital was a critical task compared to pre-COVID , bodies needed to be stored until arrangements made at cemeteries- mass graveyards, perform last rites at hospital (for Islam patients –same day rites), waiting and adapting to external party schedules (local authorities, transport, police, religious leaders) and managing	Same as A	Same as A

		patient family and cares with care		
Limited remote working- office staff	Office staff allowed to WFH. Devices or internet connection not sponsored by hospital- funding issues. Interrupted by network/ access to internet issues for staff who reside in rural areas.	Office staff allowed to WFH. Devices and internet connection sponsored by hospital. Interrupted by network/ access to internet issues.	NA	Office staff allowed to WFH. Devices or internet connection not sponsored by hospital- funding issues. Interrupted by network/ access to internet issues.
Third party personnel	Army as volunteers	Hotel staff in ICC for providing patient friendly/ sometimes doctor prescribed meals and housekeeping) Third party transport services for mobile pharmacy and staff transportation	Community leaders and volunteers	Army as volunteers
	Supporting practices related to changes in staffing			
Wellbeing for staff at work	Breaks and rest room facilities Washing facilities PPEs Allowed wearing scrub suits instead of uniforms (humid climate, additional physical work involved) Nutritious food Priority in obtaining vaccines	Breaks and rest room facilities Washing facilities PPEs Nutritious food Priority in obtaining vaccines	Breaks and rest room facilities Washing facilities PPEs Allowed wearing scrub suits instead of uniforms (humid climate, additional physical work involved) Immunity booster drinks Spread of indigenous thoughts	Breaks and rest room facilities Washing facilities PPEs Allowed wearing scrub suits instead of uniforms (humid climate, additional physical work involved)

	Spread of religious thoughts			
Communication on staffing	Corridor meetings – Ward level communication	COVID-19 preparedness meetings held regularly comprised with hospital managers, Microbiologist, CNO and ICN- decisions communicated through LMs	COVID-19 meetings held regularly - chaired by MST, communicated through LMs	COVID-19 preparedness meetings held regularly comprised with hospital managers, Microbiologist, CNO and ICN- decisions communicated through LMs
Leaders' involvement	To motivate staff : lead by example, used Army at the war as a reference, used religious taught	CNOs and managers work onsite as usual, although they were required to come to work every other day	To enhance staff morale: lead by example, used indigenous thoughts regarding assurance for non-succumbing to the ID	Was not clear in hospital wards Lead by example at CTF
	Expected outcomes - performance/ quality of care/service continuity or HCW wellbeing			
	Fulfil national level role expected Staff safety and wellbeing Patient care Practice government recommended guidelines/ circulars	Quality patient care Staff safety and wellbeing Practice government recommended guidelines/ circulars	Staff safety and wellbeing Quality patient care Practice government recommended guidelines/ circulars	Staff safety and wellbeing and patient care were seen as same priority Practice government recommended guidelines/ circulars
Economic Crisis Context				
Extended Shifts	Yes- both clinical, office and MS	Yes- both clinical, office and MS	Yes	Yes
Remote work for office staff	Yes - with limitations (network issues, funding issues for devices, confidentiality concerns)	Yes – with limitations (network interruptions)	NA	Yes- with limitations (network issues, funding issues for devices, confidentiality concerns)
	Expected outcomes			

	Cater work overload issues amidst staff shortages (absenteeism, turnover) Assist staff with travelling issues and living cost Patient care	Assist staff with travelling issues and living cost	Cater work overload issues amidst staff shortages (absenteeism, turnover) Assist staff with travelling issues and living cost Patient care	Do
SQ 2	**Training**			
Pandemic Context				
Safety training	In-house, for all staff	Do	Do	Initial training given for a group including few LMs organized at Hospital A Also covered patient handling and ward management procedures
PCR training	In-house, for nurses	NA	NA	In-house, for nurses
ICU training	At other national hospital, for nurses	NA- locum ICU trained staff	NA	NA
Training for MS	At other national hospitals	In-house	NA	NA
Operating new machines and equipment	In-house, demonstrations by suppliers/ vendors Staff training other staff	NA	NA	In-house, demonstrations by suppliers/ vendors Staff training other staff
	Expected outcomes			
	Safety of staff and patients Patient care	Patient care Safety of staff and patients	Safety for staff Patient care	Safety for staff Patient care
Economic crisis context				

Cost cutting practices	Short talks and briefs by CNOs during ward rounds- following up ministry / internal circulars Communicating cost cutting tips among staff Practices include: Minimum use/ reuse of paper Reuse surgical equipment Limited food waste/ controlled meals cooked Optimize usage of medicine and drugs across wards Controls to electricity use- limited photocopying Shift to posting notices on WhatsApp instead paper notices Gardening at hospital	LMs to provide instructions and support employees Practices include: promote e-billing and emailing medical reports to patients to minimize paper use Selection of basic packages for renewal of software subscriptions (eg: outlook, zoom) controls to vehicle allocation for transport needs (sync outgoing and incoming transport needs) Shifting physical meetings to online (instead of travelling to Colombo head office) Optimize procurement processes to minimize laps between order placements and receiving goods (ongoing price increases)	MST instruct and facilitate through LMS Practices include: Use of firewood for most of the treatments Prioritize for source medicine and other ingredients locally Quality checks for such ingredients Controls to vehicle allocation for transport needs Gardening at hospital	SMs instructions communicated through LMs, cultivated during ward rounds Reuse of surgical equipment Power saving in wards Optimize usage of medicine and drugs across wards SMs had plans/concerns on more cost cutting practices to other areas of the hospital. But initiation has not been an easy task given the large size of hospital.
Financial stress management workshops for employees	Two workshops organized at the hospital, conducted by external resource providers	No	MST guide and encourage employee peer learning of personal tips, during regular meetings	No

	CNOs share their tips and educate HCWs (impact of crisis when lining in Colombo)			
	Expected outcomes			
	Adhere to ministry circulars Cost cutting Minimize disruptions to patient care Employee resilience	Cost cutting Minimize disruptions to patient care	Cost cutting Employee resilience	Adhere to ministry circulars Cost cutting Minimize disruptions to patient care
SQ 3	**Rewards, welfare and EA practice**			
Pandemic Context				
Rewards	One-off incentive payment Media exposure Special approval for overtime payments	Special incentives for nurses at ICC Additional allowance for overtime work	NA – operations based on government funding only	One-off incentive payment
Welfare and EA	Grocery and rations to bring home Special care for infected family members of HCW *	Special rates for hospital services for HCW family members *	*	Special care for infected family members of HCW *
	Refer to “Supporting practices related to changes in staffing under SQ1” above*			
Educational and entertainment programs	Meditation programs Motivational talks Musical programs Religious/ well-wishing activities Hotel holiday package	NA	Religious/ well-wishing activities	Religious/ well-wishing activities

	Expected outcomes			
	Enhance HCW motivation and morale HCW resilience and wellbeing Sustain a quality patient care through a happy and safe workforce	Do Value HCW service and sacrifices	Enhance HCW motivation, morale, resilience and wellbeing	Enhance HCW motivation, morale, resilience and wellbeing
Economic crisis				
Rewards	Special approval for overtime payments- responding government restrictions on additional overtime No additional payments/ incentives	Permanent staff- Made annual salary increments in a different manner in 2022, to minimize wage gaps across some HCW categories and to uplift quality of life for all. The increment rate differs across different categories ranged from 40%. This is the highest rate paid ever before. Locum staff: consultants were given a chance to increase their fees Permanent staff: there was a group policy in determining basic pay for a given job	Allowed maximum possible overtime and payments No additional payments/ incentives	Do

		according to the location (Colombo staff earn higher salaries than regional based staff- cost of living concerns)		
EAPs	Additional spaces for employee accommodation Staffing arrangements with continuous shifts	Continued EAPs (accommodation, meals) but with a charge Transportation Confirm to employees about the upcoming annual bonus payment and distribution of free school book packs for HCW children, at the end of the year	Additional spaces for employee accommodation Staffing arrangements with continuous shifts	
	Expected outcomes			
	Employee wellbeing	Do	Do	Do
SQ 4	**Employee participation practices**			
Pandemic Context				
Decentralized decision making	Seek employee ideas during corridor meetings	LMs convey HCW suggestions and ideas at COVID-19 preparedness meetings	MST had open communication Having community members in meetings	LMs convey HCW suggestions and ideas at COVID-19 cells/meetings
Economic Crisis Context				

Decentralized decision making	Seek employee ideas and requirements through LMS Shift to online communication, use of WhatsApp and zoom meetings	Seek employee ideas and requirements through LMS	MST regular talks with HCWs, check for ward level and individual requests	LMs seek for HCW needs and concerns
	Expected outcomes			
	Enhance HCW commitment Effective decision making	Effective decision making	Maintain family like culture Effective decision making	Effective decision making

Appendix 15: Findings for RQ 03

RQ 03. What were the barriers and enablers of implementing the designed HRM strategies?

This section includes the responses from LMs based on their experiences on implementing HRM responses. The enabling factors as well as barriers for implementation were identified.

Themes		**Hospital A** Public ID Hospital **City (Colombo)** Size: Medium. 200 Beds **N=28**	**Hospital B** Private Hospital **Semi-rural (Southern Province)** Size: Small.50 Beds **N=23**	**Hospital C** Public Ayurveda Hospital **Regional (Uva Province)** Size: Small.76 Beds **N=12**	**Hospital D** Public Tertiary Hospital **Semi-rural (Northern Province)** Size: large.2060 Beds **N=20**
SQ 1	**Staffing**				
Pandemic Context					
Staff absenteeism	Barriers	Transport issues	Do	Occasionally	Do
	Enablers	Utilize staff at hospital quarters	Do	NA	Continue multiple shifts
Unfamiliar work	Barriers	Specified work procedures Changes to protocols Added duties	Changes to protocols Added duties	Mostly followed familiar ID treatments	Specified work procedures Changes to protocols Added duties
	Enablers	Staff rotation in isolation ward Team working	Start of ICC at a later time	Expertize	Training at Hospital A Separate CTF with a small team- easy to educate and observe
PPEs	Barriers	Humid climate-sweating Difficulty in breathing	Long work hours Inability of performing a	Same as Hospital A	Do

		Blurred vison through goggles Long work hours Not fitting to all sizes (eg: coveralls) Low quality- frequent replacement (eg: masks) Inability of performing a proper one to one care to patients (observations like pulse reading with double layer gloves)	proper one to one care to patients		
	Enablers	Scrub suits Use of buddy system and remote observations of patients with minimum required layers of PPEs	Fully air-conditioned hospital premises and ICC High quality PPEs	Scrub suits Use of minimum required layers of PPEs	Same as Hospital A
Social distancing procedures	Barriers	Social relationships at work A habit of sharing/ having meals (lunch, tea) together	Do	Do	Do
	Enablers	Locating new open spaces for having meals- WIC supervise Not allowing staff to have meal breaks together Additional rest rooms and washing facilities	Strict measures and supervision Not allowing staff to have meal breaks together	Do	Do

Aligning interim staff to hospital culture	Barriers	Being an epic centre in COVID-19 treatments ID as an integral part of work culture at hospital	NA	NA	NA
	Enablers	CNOs close supervision Priority in wellbeing measures	Working with locum staff has always been a practice Intensive payments		
New staff	Barriers	Inability to immediately fit them in vacant positions -Lack of training (online delivery for nursing training, unskilled MS) Government recruitment policies Generational differences	NA	NA	Same as Hospital A
	Enablers	Arrange trainings (ICU) In house orientation	Well established recruitment process		NA
Economic crisis					
Surge/ drops in patients	Barriers	Staff shortages (turnover, leave and retirement) Restrictions on maximum overtime hours	Less availability of locum staff	Same as Hospital A	Same as Hospital A
	Enablers	Extended shifts	Revised consultation fees		

			enabling increases to doctors payment		
SQ 02	**Training**				
Pandemic Context					
Participation to trainings/ demonstrations in house	Barriers	Limited due to busy work schedules	Do	NA	Same as Hospital A
	Enablers	Participants educate their respective teams			
Scheduling trainings at external providers	Barriers	Delays in approvals/ arrangements Strict social distancing measures.	NA	NA	Strict social distancing measures.
	Enablers	Priority given as an ID hospital	NA	NA	Priority given as a tertiary hospital
Economic crisis	Barriers	Limited funding	NA	NA	NA
SQ 03	**Rewards, Welfare and EAP**				
Pandemic Context					
Funding	Barriers	Government restriction Work ethics on approaching donors	NA	Government restriction	Government restriction
	Enablers	Donations Priority as the ID hospital	Increased sales and group financing	Internal work culture	Donations
Economic crisis					

Funding	Barriers	Decrease in donations Decrease in staff funding/contributions Pressures for cost cutting	Pressures for cost cutting	Pressures for cost cutting	Pressures for cost cutting
	Enablers	Compassionate management- utilize existing resources	Group financing	Same as Hospital A	NA
SQ 04	**Employee participation**				
Pandemic Context					
Communication	Barriers	Social distancing	Do	Do	Do Larger Size of hospital
	Enablers	Corridor meetings Introduce WhatsApp groups and Online meetings	COVID-19 preparedness meetings Already used email communication mode Online meetings	Small size of hospital	Continuing COVID-19 cell meetings Gradually introducing online mode
Economic Crisis					
Implementing employee suggestions	Barriers	Financial restrictions Government policies (restrictions to overtime)	Cost cutting pressures	Same as Hospital A	Do

Appendix 16: Findings for RQ 04

RQ 04: What are employees' experiences and perceptions of fairness towards these HRM responses?

In this section the motives of HRM responses as perceived by employees are presented. Their perceptions of fairness related to the HRM responses were also identified.

Themes		**Hospital A** Public ID Hospital **City (Colombo)** Size: Medium. 200 Beds **N=28**	**Hospital B** Private Hospital **Semi-rural (Southern Province)** Size: Small.50 Beds **N=23**	**Hospital C** Public Ayurveda Hospital **Regional (Uva Province)** Size: Small.76 Beds **N=12**	**Hospital D** Public Tertiary Hospital **Semi-rural (Northern Province)** Size: large.2060 Beds **N=20**
SQ 1	**Staffing**				
Pandemic Context	Perceived motives	HCW safety Work continuity Adhere to government regulations	Patient care HCW Safety	HCW Safety Work continuity Government procedures	Work continuity Safety of staff
	Fairness perceptions	Positive-Priority for vulnerable employees, supported facilities like transport, groceries Negative-Gender biased practices, office staff	Positive- flexible for HCW needs, supported with extra facilities and incentives, devices provided for WFH	Positive- priority for HCW wellbeing Negative-staff shortages (no nurses), limited supply of PPEs, feeling belittled	Positive- having separate CTF, staff not mingled with rest of the hospital, strict safety measures, supporting facilities provides

		felt belittled, no provisions for WFH for office staff			Negative- ICU nurses compelled to work at CTF Unexpected pressures from patients-patients from different parts of the country were sent to hospitals based on a central commanding unit operated across the country- such patients brought unfamiliar behaviors, norms and patient expectations (specially in the case of a batch of fishermen from Colombo Fish market), heavy workload at laboratories for PCR testing with no additional staff, Normal wards lack attention and safety measures- staff claimed working at the CTF was safer than working at the hospital, no provisions for WFH

Economic Context	Perceived motives	Employee wellbeing Adhere to government regulations	Staffing adjusted to Patient care needs	Staff wellbeing	Patient care
	Fairness perceptions	Positive- flexible staffing arrangements despite transport issues, allow additional overtime despite government restrictions Negative-added duties resulting from cost cutting practices, conflicts in coordinating work across departments (pharmacy and stores), aggressive patients and vendors, HCW unrest during delays in payments	Positive- flexible staffing Negative- aggressive patients, pressures to procurement staff - delays / supply chain issues	Positive-provide maximum overtime allowed Negative- unfair restrictions on overtime	Negative- mismanaged staffing arrangements, added duties to staff- nurses to manage medicine requirements, conflicts between department (eg: stores, transport and pharmacy)
SQ 2	**Training**				
Pandemic Context	Perceived motives	Staff safety Work continuity Awareness of new practices Respond to ad-hoc work pressures- new machines	Safety Patient care quality Awareness of new practices	Staff safety Work continuity	Staff safety Work continuity Awareness of new practices Respond to ad-hoc work pressures

	Fairness perceptions	Positive- on the job training- rotation for first patient's care Negative- limited access to trainings, nurses were compelled to perform PCR tests, overwhelmed with unfair distribution of work - PCR testing was not a nurses' job, lack of training	Positive- safety for all	Positive- staff safety	Positive- staff safety, exposure to practices at an epic center- at Hospital A Negative- priority for CTF
Economic Context	Perceived motives	Work continuity- hospital performance- cost cutting Employee wellbeing- financial stress management workshops	Cost cutting	Cost cutting	Cost cutting
	Fairness perceptions	Positive- feeling of compassionate management Negative- lack of funding and government support	Positive- respond to financial pressures	Same as Hospital A	Negative- not compassionate managers
SQ 3	**Rewards, Welfare and EAP**				
Pandemic Context	Perceived motives	Employee wellbeing Hospital performance	Do	Do	Do
	Fairness perceptions	Positive – intervene to pay for additional overtime payment, had	Positive- incentives,	Positive- MST working closer with HCWs, felt belonged	Positive- Managers commitment at CTF

		multiple EAP programs, access to office staff to the government intensive program Negative- insufficient appreciation from government, no incentive, limited access to EAPs	continuous supply of PPEs	Negative- insufficient government attention, limited PPE supply	Negative- not sufficient attention to staff at hospital, low visibility for non-front line workers (laboratory technicians, cleaning staff)
Economic Context	Perceived motives	Support employees Employee wellbeing	Support employees	Same as Hospital A	Not clear as employees felt lack of support from the managers
	Fairness perceptions	Positive- Compassionate managers, generous resource allocation for staff welfare provisions Negative- lack of attention from government, occasional reward programs to selected occupations (mostly doctors got increments on-time)	Positive- maintain same level of financial rewards to all, efforts on maintaining reward programs	Positive- Compassionate managers, generous allocation of existing resources for staff welfare, Negative- lack of attention from government, less priority compared to Allopathy hospitals	Negative- not committed mangers, LMs limited capacity to assist HCWs
SQ 4	**Employee participation**				
Pandemic Context	Perceived motives	Employee voice for better decision making Enhance employee wellbeing Patient care quality	Feedback on new practices Staff wellbeing Patient care quality	Same as Hospital A	Feedback at ward level

	Fairness perceptions	Positive	Positive	Positive	Negative- less room for raise voices, not considered for implementation
Economic Context	Perceived motives	Employee voice	Employee feedback	Employee voice	Feedback and requests at ward level
	Fairness perceptions	Positive- efforts to implement/ address employee ideas/ requests Cost effective communication practices	Positive- address employee requests	Positive- compassionate , efforts to address Negative- less attention, funding from government	Positive- LMs active listeners, compassionate Negative- less room to access SMs, not considered for decision making

Appendix 17: Findings for RQ 05

RQ 05: How effective were the HRM strategies?

The outcomes were identified under employee wellbeing and patient care quality as hospital performance indicators.

Themes		**Hospital A** Public ID Hospital **City (Colombo)** Size: Medium. 200 Beds **N=28**	**Hospital B** Private Hospital **Semi-rural (Southern Province)** Size: Small.50 Beds **N=23**	**Hospital C** Public Ayurveda Hospital **Regional (Uva Province)** Size: Small.76 Beds **N=12**	**Hospital D** Public Tertiary Hospital **Semi-rural (Northern Province)** Size: large.2060 Beds **N=20**
SQ 1		**Outcomes**			
Pandemic Context					
Intended outcomes		Fulfil national level role expected Staff safety and wellbeing Patient care Practice government recommended guidelines/ circulars	Quality patient care Staff safety and wellbeing Practice government recommended guidelines/ circulars	Staff safety and wellbeing Quality patient care Practice government recommended guidelines/ circulars	Staff safety and wellbeing and patient care were seen as same priority Practice government recommended guidelines/ circulars
Safety	-Virus infection to staff from work	Zero	Few outbreaks reported, most infections acquired outside work	Same as Hospital B	Number of outbreaks reported, staff acquired virus both from in and outside work
Physical wellbeing	Workload	Overwhelmed- huge patient load managed with limited staff	Satisfactorily managed- utilised locum staff	Overwhelmed- huge workload (including field work) managed with limited staff	Overwhelmed- wards and new CTF managed with existing staff

	Work life balance	Achieved through Flexible staffing arrangements	Same as Hospital A	Same as Hospital A	Difficult with limited staff- specially for laboratory and ICU staff
Psychological wellbeing	Stress and burnout	Managed	Managed	Managed	Managed to a certain level
	Employee resilience	Enhanced	do	do	do
Quality of care	Patient satisfaction	High	High	High	High in CTF Average - complaints from patients in wards
	Patient feedback	Positive	Positive	Positive	Positive in CTF Average - complaints from patients in wards
Development opportunities	Physical resources	Expanded- medical equipment, ICU facilities, temporary buildings last for few more years, accommodation, hospital services (laboratory, medicine delivery via post)	Expanded- medical equipment, mobile devices, accommodation, canteen facilities	NA	Expanded- CTF, ICU facilities
	Staff	Crisis response experience Training in other areas (PCR) Resilience Teamwork	Crisis response experience Resilience Teamwork	Crisis response experience Resilience Teamwork	Crisis response experience Training in ID Teamwork

	Networking	Donations	Links with supporting services (laundry- started outsourcing during pandemic given sanitizing concerns/ continue the service beyond the pandemic given quality and cost efficiency), external transport providers, government officials	Strengthen the links with community	Few donations
Performance	Patient recovery rate	Satisfactory	Do	Do	Do
	Legitimacy	Followed government circulars with few approved amendments	Followed government circulars	Do	Do
Economic crisis					
Employee wellbeing		Financial stress with limited overtime Managed up to some extent through workshops Limited welfare services Stress/ unsatisfied due to limitations to provide a good service to patients	Financial stress management opportunities - Continued to maintain welfare services Some services provided at a cost Slight changes to bonus payment	Slight financial stress with limited overtime Burnout of working continued shifts (employee chosen)	Financial stress with limited overtime Limited welfare services Stress/ unsatisfied due to limitations to provide a good service to patients Burnout of working continued shifts (employee chosen)

	Burnout of working continued shifts (employee chosen)			
Patient care	Average satisfaction -Limitations due to resource scarcity and staff shortages Difficult to cater High volume of patients	Average satisfaction-resource scarcity, changes to locum staff availability result in patients not having a chance to consult with preferred/ their usual doctors	Average satisfaction-resource scarcity- at times patients were asked to find herbs and medicine for a treatment as prescribed by doctors create delays High volume of patients	Mostly dissatisfied -Limitations due to resource scarcity and staff shortages Difficult to cater High volume of patients
SQ 2	**Impact on employee wellbeing and performance**			
Pandemic Context	Positive	Do	Do	Negative
Economic Crisis Context	Negative	Average	Average	Negative
SQ 3	**Need to adjust HRM practices**			
Pandemic Context	Yes, usually as the government regulations change Based on learnings Due to operational pressures and implementation barriers	Do	Do	Do
Economic Crisis Context	Occasionally	Do	Do	Do
SQ 4	**Review and employee feedback for improvements**			
Pandemic Context				

Reviewing implementations		Needed because of 1) The contradictions between preparedness and the demands of the crisis (e.g.- lockdowns, patient surges) 2) As government requirements changed Regularly in cross-functional meetings	Same as Hospital A Regularly in COVID-19 preparedness meetings	Needed because of frequent changes in government requirements Regularly in cross-functional meetings	Same as Hospital A Regularly in COVID-19 cell meetings
Employee suggestions		Yes	Yes	Yes	Yes/ but occasionally
Economic Crisis Context		According to government requirements Employee suggestions considered	Company/ groups level decisions taken into consideration	Same as Hospital A	Same as Hospital A
SQ 5		**Absorb CIHRP to routine HRM and link to crisis preparedness**			
Absorb CIHRP to routine HRM	**Staffing***	Extended shifts as a continued practice Team based staffing created closer ties among employees – this allows sharing work , covering duties when	Locum staff Telehealth facilities as needed/ patient preference.	Extended shifts as a continued practice Team based staffing created closer ties among employees – this allows sharing work , covering duties when someone is on leave etc	Extended shifts and staff rotation as a continued practice

		someone is on leave etc Additional overtime payments approvals			
	Extended facilities to staff	More accommodation facilities	More accommodation facilities Staff increments adjusted to minimize gaps in basic pays will be continued. Centralized meal services across the two hospital units under one kitchen during pandemic- continue the same	Extending accommodation spaces with existing capacity.	Extending accommodation spaces with existing capacity.
	Communication	WhatsApp and Zoom based communication during pandemic is continued Continue paper less communication	Due to financial restrictions there have been cuts to software updates and licencing such as for outlook. Staff adjusted to work with limited facilities. Email communication has always been a practice.	Paper less modes of communication. There is a very active WhatsApp group for staff communication.	Zoom meetings for managers. Hospital wide online communication is not practical given the size of the hospital.

Crisis preparedness (lessons learnt and implications for future crisis response planning)	Implementation of CIHRP as a great experience Identified high resilience, best performing employees during crisis response-considerations for succession planning across wards Understand the importance of considering macro factors in preparedness plans (such as a lockdown) Learning of managing stuff with limited resources, finding for alternatives (such as donors)	Implementation of CIHRP as a great experience Understand the importance of considering macro factors in preparedness plans (such as a lockdown, government authorities influence)	Implementation of CIHRP as a great experience	Readiness with a separate space (CTF) for ID treatment or any kind of patient surge Implementation of CIHRP as a great experience Identified high resilience, best performing employees during crisis response-considerations for succession planning across wards

*Due to staff shortages (as a result of trade union actions) many government hospitals currently utilize Army personnel as interim staff to assist with non-medical services.