

The Façade of Interprofessional and Union Collaboration in Rural Community Health Centers, South Africa

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ABSTRACT

Introduction

Collaborative relationships between health professionals and organized labor are essential for securing safe, effective, and sustainable healthcare delivery in rural community health centers (CHCs). However, challenges such as dysfunctional union representation, labor disputes, and poor communication undermine these partnerships, affecting service quality and staff well-being.

Purpose

This mixed-methods study aimed to explore the lived experiences of health professionals and trade unions regarding collaboration in rural and semi-rural CHCs in South Africa. It sought to identify barriers and enablers to positive collaboration, elucidate the role of unions, and develop evidence-based guidelines and a conceptual model to strengthen sustainable partnerships.

Methods

A sequential explanatory mixed-methods design was employed. Quantitative data were collected through surveys evaluating communication, leadership, conflict management, and discrimination among health professionals. These data were analyzed using descriptive statistics to summarize response patterns. Qualitative data were gathered through ten in-depth interviews and focus group discussions followed by manual thematic analysis focusing on union representation, commitment, and compliance with labor legislation. Data integration was performed using a meta-inference approach to guide model development.

Results

Findings revealed that unclear union representation, limited engagement of health professionals, and non-compliance with labor laws were key barriers to effective collaboration. Positive collaboration was facilitated by trust-based leadership, open communication, and inclusive training initiatives. The study culminated in the development of the Interprofessional Union Collaboration Partnership (IPCUP) model, which integrates Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, Interprofessional Competencies (IPEC), and contemporary Labor-Management Partnership practices.

Conclusion

Improving collaboration between health professionals and organized labor requires systemic interventions addressing communication breakdowns, leadership gaps, and weak policy enforcement. The IPCUP model provides a structured, evidence-based framework designed to rebuild trust, strengthen workplace safety, and promote sustainable collaboration to foster mutually secure and equity-driven rural CHCs.

INTRODUCTION

The primary healthcare (PHC) model in South Africa reflects the country's long-standing commitment to equity, access, and health promotion as part of its post-democratic transition since 1996. The National Department of Health (NDoH) introduced the PHC re-engineering strategy in 2011 to operationalize these principles through the District Health System (DHS), establishing 24-hour comprehensive community health centers (CHCs), 8-hour clinics, and specialized teams (Department of Health, 2011; National Department of Health [NDoH], 2020). The PHC re-engineering model represents a reformative initiative to strengthen healthcare delivery, particularly in historically disadvantaged communities, while fostering safe, harmonious working relationships in alignment with national legislative frameworks (NDoH, 2011). Comprehensive Health Centers are pivotal to the DHS, providing essential services to underserved rural and semi-rural populations (Wright et al., 2024).

Despite robust legislative frameworks and health policies designed to foster workplace safety and interprofessional collaboration, a critical gap remains. Specifically, there is limited understanding of how health professionals (HPs) and trade union representatives navigate collaborative dynamics and labor relations within under-resourced, historically disadvantaged rural CHCs. The fragmented relationships, unclear union functionality, and professional isolation continue to undermine safe, cooperative practice environments. Most existing research prioritizes clinical performance, service delivery, and patient outcomes, leaving a void regarding the systemic relational dynamics between healthcare workers and organized labor. This study assesses that gap by investigating health professionals and organized labour's lived experiences and structural challenges that hinder collaborative partnerships in CHCs, aiming to foster safe, sustainable, and equitable workspaces.

Primary healthcare environments, particularly 24-hour CHCs, are critical points of delivery where workplace conflict and relational disharmony commonly arise and require mediation (LeBan et al., 2021; Wright et al., 2024). Relational weaknesses are particularly pronounced in rural and semi-rural CHCs, where the roles and

responsibilities of organized labor, health professionals, and management are often poorly defined or poorly understood.

Crucially, the [National Health Insurance \(NHI\) Act \(No. 20 of 2023\)](#) recognizes health workers as the backbone of successful NHI implementation. The Act emphasizes PHC facilities as the core platform for safe, collaborative partnerships among critical health stakeholders ([Republic of South Africa, 2024](#)). Thus, the research problem is multi-layered, spanning systemic, institutional, and practice-related dimensions of healthcare worker safety and labor rights within CHC employment settings.

Healthcare professionals are expected to implement the [NHI Act 2023](#), enacted in May 2024. Public sector HPs are regulated by contractual and legal obligations to the NDoH as their employer, while concurrently holding membership in various professional bodies, associations, and trade unions based on their professional interests ([Maphumulo & Bhengu, 2020](#)).

However, health professionals report that organized labor is not consistently experienced in accordance with legislative mandates, with representation being far more effective in urban centers than in rural areas. This has created a skewed relationship in rural contexts. [Mausz et al. \(2022\)](#) highlight growing concerns regarding mental health challenges, negative attitudes, lack of visible and efficient organized labor, toxic relationships, workplace violence, and structural conflicts among HPs, management, and labor unions in rural CHCs. These issues lead to high turnover and volatile working relationships.

Union shop stewards are democratically elected by workers within their respective facilities. Their mandate is to defend workers' rights and educate members on trade union practices ([Labor Research Service \[LRS\], 2019](#)). Shop stewards are expected to be committed, disciplined, and knowledgeable advocates who balance the interests of management and workers. However, because HPs occupy dual roles as public employees and union members, dynamic interpersonal conflicts frequently emerge due to tensions between clinical/professional duties and collective employment rights ([Saridi et al., 2021](#)).

Health professionals in CHCs are governed by the [National Health Act \(No. 61 of 2003\)](#) and are entitled to union membership under institutional and policy frameworks ([Republic of South Africa, 2003](#)). The [Occupational Health and Safety Act \(OHSA\) \(No. 85 of 1993\)](#) and the [Labour Relations Act \(LRA\) \(No. 66 of 1995\)](#) serve as the primary legislation protecting employee safety and promoting constructive work environments ([Republic of South Africa, 1993, 1995](#)).

Trade unions such as the Democratic Nursing Organisation of South Africa (DENOSA), Health and Other Services Personnel Trade Union of South Africa (HOSPERSA), Public Servants Association (PSA), National Education, Health and Allied Workers' Union (NEHAWU), and South African Medical Association (SAMA) defend employment-related rights under these statutes. However, the LRA's protection of the right to participate in strikes can conflict with the employer's obligation under the National Health Act to maintain essential services at all times ([Republic of South Africa, 1995](#)).

The [World Health Organization \(WHO, 2022\)](#) emphasizes that protecting the health and safety of healthcare workers must remain a high institutional priority. The current "façade" of collaboration must be transformed into functional practice through active implementation, monitoring, and revision of policies protecting this scarce workforce ([WHO, 2022](#)). [Sakaria \(2022\)](#) indicates that workplace social justice includes worker dignity, equal opportunity, non-discrimination, and fair treatment in decision-making, which serves to balance power between employers and workers.

[Ugwu et al. \(2025\)](#) justify that, accordingly, health professionals, managers, and union representatives must coexist in collaborative partnerships to ensure that clinical settings operate as safe and secure workplaces. [Maake-Malatji \(2023\)](#) further stresses that achieving social justice in the workplace requires functional employer-employee mechanisms that respect the constitutional values of human dignity and equality.

The researcher identified a critical gap between the theoretical application of labor laws and the actual coordination of safety and labor frameworks in rural and

semi-rural CHCs. To cultivate a safe, collaborative interprofessional workspace, HPs need a clear understanding of their legislative obligations, political environments, and active participation rights under the [LRA \(Act No. 66 of 1995\)](#). Currently, insecure workplaces driven by unfair labor practices remain a serious issue. [Serapelwane and Manyedi \(2022\)](#) found that PHC workers frequently experience favoritism, discrimination, and poorly resourced working conditions, directly contravening constitutional, labor, and safety protections. Unfair treatment and on-the-job discrimination constitute unfair labor practices that degrade clinical performance and service quality ([Songstad et al., 2011](#)). These persistent tensions in rural CHCs highlight a deep-seated systemic misalignment, necessitating an in-depth investigation of union-professional dynamics to restore safety and workplace justice.

METHODS

Study Setting

The study was conducted across six rural and semi-rural CHCs operating 24-hour services in the Mpumalanga, North West, and Gauteng provinces of South Africa. These facilities provide comprehensive PHC services, including maternal and child health, chronic disease management, emergency care, and preventive medicine. Staffing complements consist of nurses, medical officers, and allied professionals (e.g., social workers, pharmacists, psychologists, nutritionists, physiotherapists, and occupational therapists).

Research Design and Population

This study adopted a sequential explanatory mixed-methods design, underpinned by a pragmatic paradigm, to comprehensively investigate the collaborative dynamics between health professionals and trade unions. The target population comprised N=69 health professionals employed across the six selected CHCs.

Sampling Strategy and Justification

- I. *Quantitative Phase:* Simple random sampling was utilized to minimize selection bias. Out of the target population of 69 eligible professionals, 42 respondents completed and returned structured questionnaires, yielding an acceptable 60.9% (rounded to 61%) response rate, considering the high

workload and operational constraints of under-resourced rural clinics (Karuga, 2024).

To enhance content validity, the survey instrument was pre-tested with 14 healthcare professionals from a comparable semi-rural CHC not included in the main study (Sajko, 2024). Cronbach's alpha was not computed for the main study's quantitative analysis because of the small sample size (n=42). According to Kennedy (2022), Cronbach's alpha estimates can be highly unstable and misleading when calculated on sample sizes below 50.

- II. *Qualitative Phase:* Convenience sampling was employed to select participants for the qualitative phase due to rotational shifts, unpredictable emergency workloads, and limited staff availability, which rendered probability-based sampling unfeasible. To mitigate selection bias and enhance external validity, a diverse group of 15 participants was selected across different facilities and provinces, ensuring rich, experience-based insights into interprofessional dynamics (Emerson, 2021; Lines et al., 2022). Combining random and purposive/convenience approaches facilitated statistical trends to be meaningfully contextualized by qualitative depth, in line with explanatory mixed-methods guidelines (Younas & Durante, 2023).

Data Collection Procedures and Instruments

Ethical clearance was granted by the UNISA Health Studies Higher Degrees Committee (HSHDC/687/2017), followed by approvals from provincial health departments and facility managers. Written, informed consent was obtained from all participants, and anonymity was strictly maintained.

Quantitative data were gathered using a five-point, self-administered Likert-scale questionnaire. The questionnaire consisted of six subsections:

- i. Participant demographics
- ii. Conceptualization of safety
- iii. Experiences of security in CHCs
- iv. Communication practices
- v. Leadership and management support

vi. Organized labor relations

The principal investigator was physically present at the facilities to resolve queries, provided contact numbers for night-shift staff, and collected completed questionnaires in sealed envelopes.

The qualitative phase involved focus group discussions (FGDs) and semi-structured in-depth interviews conducted by the principal investigator. FGDs were arranged in an oval seating format to facilitate open, non-hierarchical communication, while individual interviews were conducted in private consulting rooms. Discussions and interviews focused on union collaboration experiences, workplace safety, and partnership dynamics, with all sessions audio-recorded and complemented by field notes (Creswell & Creswell, 2017).

Data Analysis

- a. *Quantitative Data Analysis:* Quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26. Analysis included descriptive and inferential statistics (frequencies, percentages, means, and standard deviations). A professional statistician assisted in verifying the analytical models to minimize coding errors. Missing data were managed using pairwise deletion to preserve statistical power (Van Ginkel et al., 2020).
- b. *Qualitative Data Analysis:* Audio recordings were transcribed verbatim. The principal investigator conducted a manual thematic analysis following Braun and Clarke's (2021) six-phase reflexive framework (familiarization, initial code generation, searching for themes, reviewing themes, defining and naming themes, and producing the report). Manual coding was preferred over software (such as NVivo) due to the manageable data size and the need for close interpretive engagement with the participants' experiences.
- c. *Data Integration and Meta-Inferences:* In line with sequential explanatory mixed-methods design, quantitative and qualitative datasets were integrated during the interpretive phase using a meta-inference approach (Creswell & Plano Clark, 2023).

d. Quantitative results were compared and cross-verified with qualitative themes to identify convergence (where findings supported one another), divergence (where results differed), and expansion (where qualitative insights added depth to statistical trends).

Rigor and Trustworthiness

The validity of the study was supported by a thorough literature review, expert questionnaire review, pre-testing (n=14), and method triangulation (Forza & Sandrin, 2023). Trustworthiness in the qualitative phase was achieved by adhering to the criteria of credibility, transferability,

dependability, and confirmability (Ahmed, 2024). The principal investigator maintained a reflexive journal, and the research supervisor and an independent statistician audited the coding schemas, raw transcript extracts, and quantitative datasets to ensure analytic neutrality (Tuval-Mashiach, 2021).

RESULTS

Demographic Characteristics

The study analyzed data from 42 healthcare professionals across six CHCs in three South African provinces. Table 1 summarizes the demographic and union-related profile of the participants.

Table 1:
Demographic and Union Profile of Participants (n=42)

Demographic Category	Details / Affiliation	Frequency (n)	Percentage (%)
Age Group	25–64 years	42	100.0%
Union Status	Union Members	32	76.2%
	Unaffiliated	10	23.8%
Union Affiliation (n=32)	Public Servants Association (PSA)	14	43.8%
	National Education, Health & Allied Workers' Union (NEHAWU)	9	28.1%
	Democratic Nursing Organisation of South Africa (DENOSA)	7	21.9%
	Health & Other Services Personnel Trade Union (HOSPERSA)	2	6.2%

The sample shows a mature workforce with no representation of professionals under 25. While 76.2% of HPs are unionized, membership is highly fragmented across four distinct unions, which may weaken collective bargaining cohesion. Furthermore, a survey on legislation knowledge revealed that while 31% (n=9) reported basic awareness of the OHSA, awareness regarding the implementation of the LRA and quality assurance frameworks was extremely limited (3.4%; n=1), exposing a critical knowledge gap in labor rights.

Integrated Labor Experiences

The descriptive analysis of the 14 Likert-scale items assessing health professionals' perceptions of organized labor in rural CHCs reveals moderate to high levels of

agreement with most positive statements, albeit with notable variability. Items reflecting perceptions of union objectivity and participation in safety structures yielded the lowest scores (M=3.00–3.21), indicating skepticism about operational efficacy. In contrast, items on union-community partnerships (M=4.12) and frustration with absent unions (M=3.72) scored higher, suggesting a desire for stronger labor engagement.

The mean scores and standard deviations for health professionals' perceptions of union performance and safety collaboration are illustrated in Figure 1 and Figure 2.

Mean Agreement Scores (1 = Strongly Disagree, 5 = Strongly Agree)

Figure 1:

Graphical representation of mean agreement scores per organized labor statement.

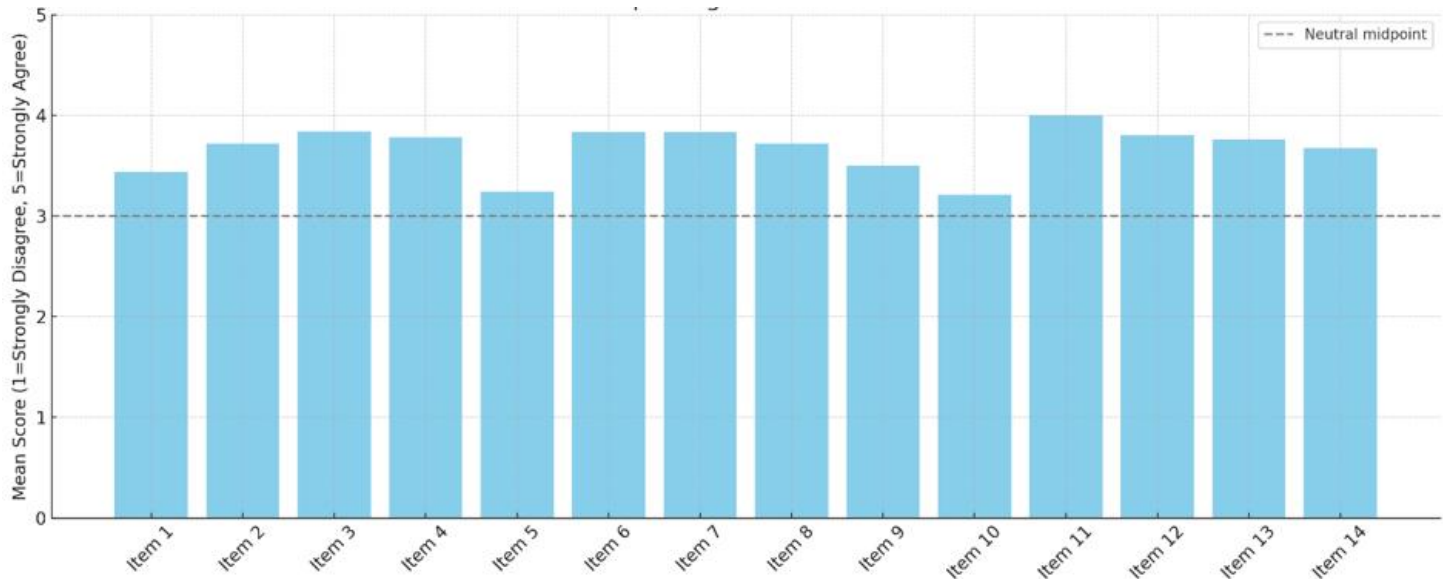
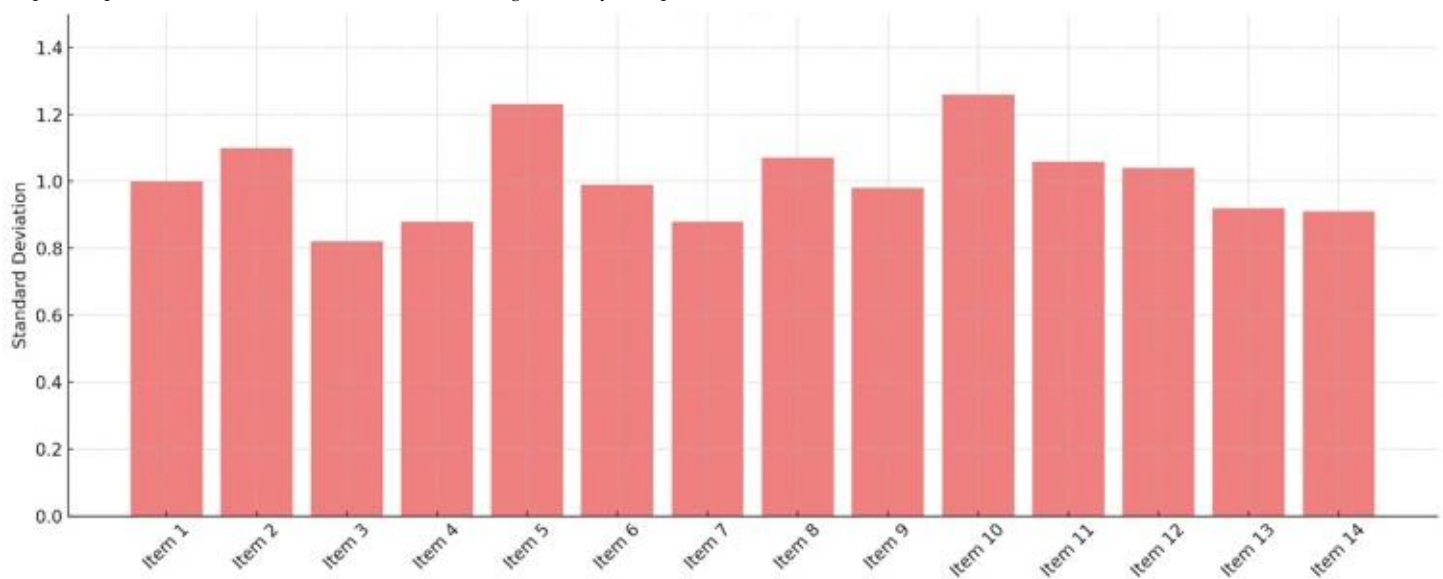


Figure 2:

Graphical representation of standard deviation scores showing variability in responses



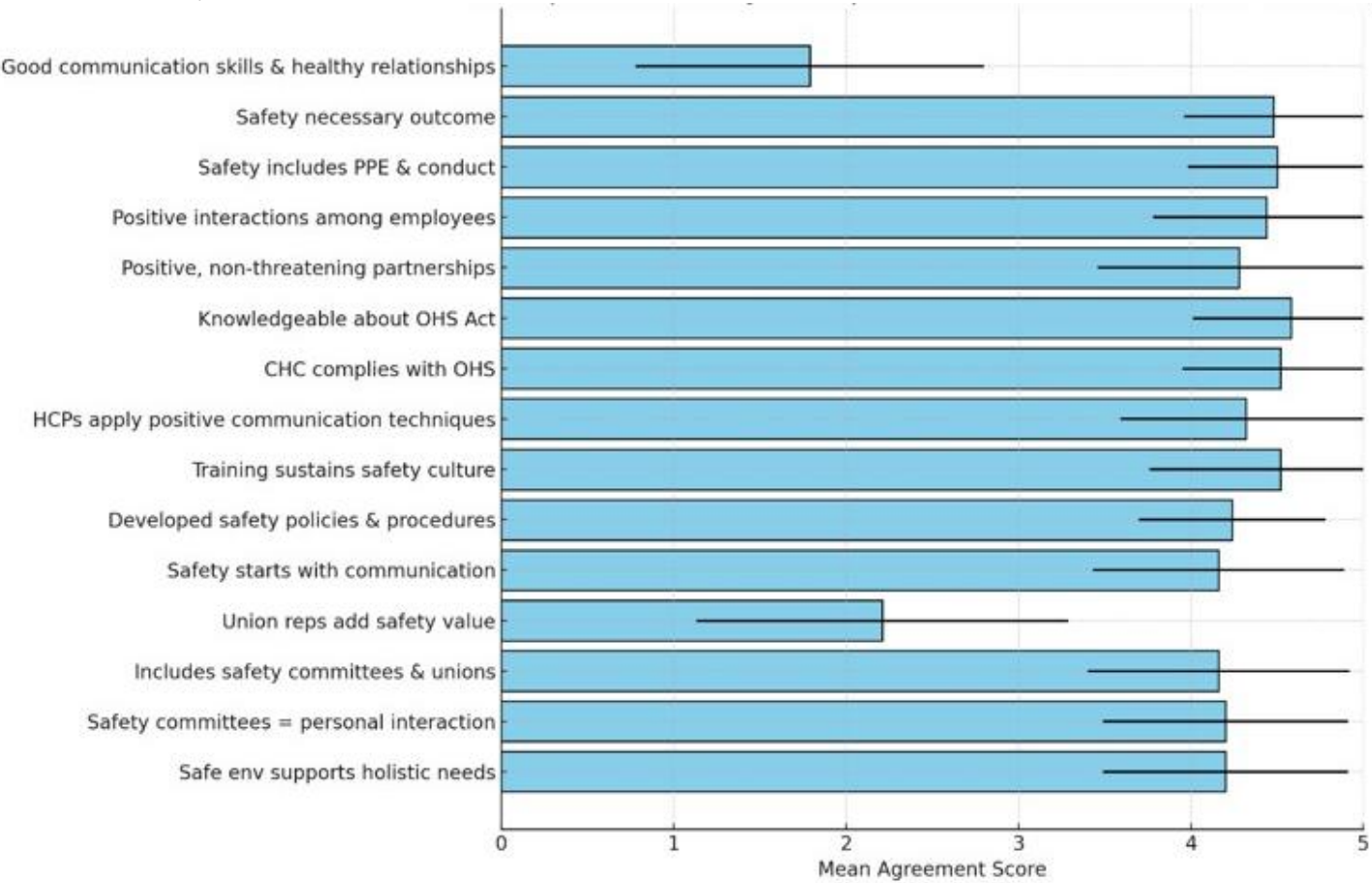
- i. **Key Findings from Figure 1 & 2:** The highest mean agreement ($M=4.12, SD=0.74$) was observed for **Item 11** ("Union working with community and politicians can contribute to a safe health facility"), suggesting a strong belief in external, multi-stakeholder partnerships to resolve workplace safety challenges. Similarly, **Item 2** ("The unavailability of a functional union has frustrated healthcare workers") scored highly ($M=3.72, SD=1.00$), confirming significant workplace frustration regarding union absence.
- ii. Conversely, internal union performance items, such as **Item 9** ("Union representatives are objective, help organize and attend all safety committees") and **Item 10** ("Union communicate and serve on joint labor-management committees"), yielded low agreement ($M=3.00, SD=1.02$ and $M=3.21, SD=1.26$, respectively), highlighting perceptions of union inactivity on key operational platforms. Standard deviations ranging from 0.82 to 1.26 reflect divided

opinions on internal union objectivity and committee engagement.

Participants demonstrated a robust theoretical understanding of workplace safety as a multidimensional construct (Figure 2).

Conceptualization of Safety

Figure 3:
Conceptualisation of Safety



- a) **Procedural and Relational Dimensions:** Nearly all respondents (96%) agreed that safety must be consistently maintained and measured, encompassing both physical protective equipment (PPE) and professional workplace conduct.

b) **Interpersonal Harmony:** 92% emphasized that positive employee interactions and non-threatening partnerships are critical to maintaining safety.

c) **Policy vs. Practice Disconnect:** While 96% reported awareness of the OHSA and affirmed that CHCs should comply with safety guidelines, qualitative data exposed severe implementation gaps, including infrastructure deficits, security breaches, and a lack of visible union intervention.
- d) **Union Value-Add Deficit:** Only 29% believed union representatives added practical value to facility safety, while 70% remained uncertain or disagreed, citing minimal union presence in safety structures.

e) **Holistic Needs:** 92% supported a holistic view of safety encompassing psychological, physical, and spiritual well-being, aligning with Maslow’s and Watson’s theoretical frameworks.

Integrated Meta-Inferences

The integration of quantitative statistics and qualitative narratives revealed severe systemic issues. [Table 2](#) summarizes the resulting meta-inferences.

Table 2:
Summary of Meta-Inferences, Quantitative Results, and Qualitative Insights

Theme	Quantitative Results (n=42)	Qualitative Insights (FGDs/Interviews)	Meta-Inference / Conclusion
Dysfunctional Union, HP, and Management Relations	67% (n=28) agree that poor communication and weak interpersonal relations exist between staff, management, and unions. 72% (n=30) agree that they are free to join unions, but find the local representatives inactive.	"Participation of unions is very minimal; representatives are not even well known." (GP-IDIA3) "No union-led forums on safety... if you are vocal, you become a target and your safety (especially emotional and psychological) is compromised." (MP-FGA2)	A profound breakdown in trust and communication exists between healthcare staff, facility management, and unions, creating a culture of fear and professional isolation.
Absent Organised Labour and Structures	41% (n=17) disagree and 29% (n=12) are uncertain that unions add value to facility safety structures. 66% (n=28) agree that an inactive union frustrates health professionals, impacting their safety and rights.	"Not active and some not represented at the CHC; no shop stewards." (NW-FGA2) "Shop-stewards offer no support whatsoever... they are not available." (MP-IDIA2)	Formal union representations exist on paper but are functionally absent or inactive at the facility level, leaving workers clinically and legally vulnerable.
Poor Commitment of Organised Labour	72% (n=30) disagree that unions actively advocate for staff interests. 69% (n=29) disagree that labor representatives perform their roles without fear or favor.	"Lack of commitment from organized labor. Not effective role; they are passive to absent." (MP-FGB31) "Union reps not available... they only focus on formal issues of workplace neglect, not the social wellbeing of members." (GP-IDIB2)	Unions are perceived as passive, reactive, and highly selective in their advocacy, failing to offer balanced, objective support to frontline workers.

DISCUSSION

Dysfunctional Labor Relations and Collaboration Breakdown

The results expose a severe gap between the legal rights of healthcare workers and the functional support they receive in rural South African CHCs. While unionization rates are theoretically high (76.2%), actual collaboration is characterized by fragmentation, role ambiguity, and operational passivity. Over half of the participants expressed dissatisfaction with workplace conflict resolution, aligning with literature detailing the erosion of worker trust when union visibility is low ([Rayner & Lewis, 2020](#)).

Workplace conflict—driven by poor communication and weak collaboration—was confirmed by 78.6% of respondents. This indicates a systemic failure of local bargaining structures. Healthcare professionals voiced deep skepticism regarding union objectivity, echoing global research on the challenges of workplace unionism in fragmented environments ([Alamgir & Banerjee, 2019](#); [Louche et al., 2020](#)). Qualitative insights confirmed that when safety and professional integrity are threatened, workers often face isolation and fear of managerial

retaliation, with little to no union advocacy ([WHO, 2022](#)). This "labor fragmentation" undermines collective action and compromises team cohesion in highly demanding primary care settings ([Farrenkopf & Lee, 2019](#)).

Safety, Vulnerability, and Union Invisibility

A stark contrast emerged between high policy awareness and physical workplace safety. Although 96% of participants understood the OSHA and agreed that safety is a holistic right, they reported persistent infrastructural deficits and exposure to criminal threats without active union protection ([Brown & Stark, 2022](#)). In under-resourced rural clinics, implementation gaps and poor safety enforcement are common ([Goodluck et al., 2025](#)).

The finding that only 29% of participants believed unions add value to safety committees underscores a deep credibility crisis. As [Rayner and Lewis \(2020\)](#) argue, passive leadership and poorly defined roles severely degrade union efficacy. Despite this, 92% of participants endorsed a humanistic, holistic definition of workplace safety that includes physical, psychological, and spiritual care, confirming the relevance of Maslow's Hierarchy of Needs and Jean Watson's Theory of Human Caring in healthcare management ([Karadencheva, 2025](#)).

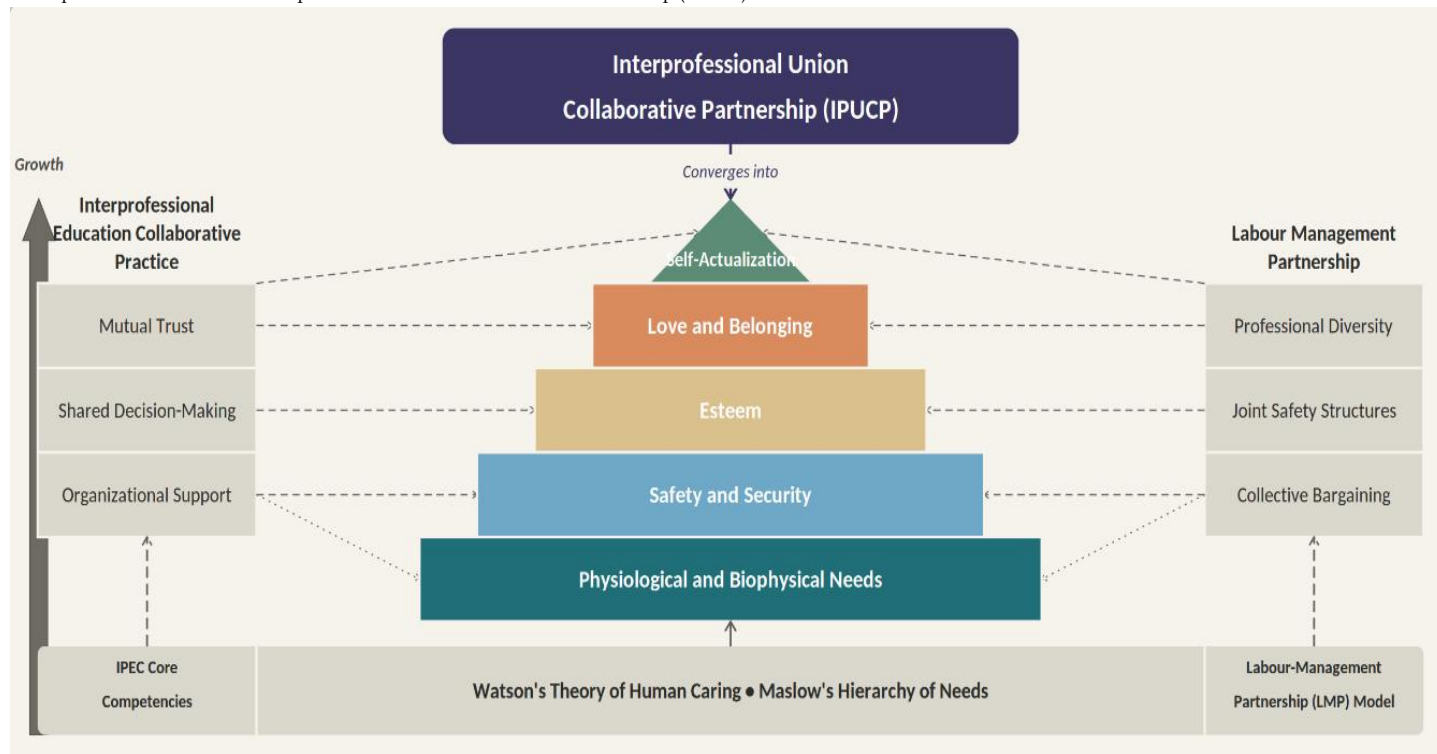
From Disillusionment to Partnership: The IPCUP Model

The persistent "façade" of collaboration—where formal committees and union designations exist on paper but fail to function in practice (Brown & Stark, 2022)—demands a shift from symbolic compliance to active, shared

governance. To bridge this gap, this study proposes the Interprofessional Union Collaboration Partnership (IPCUP) model (illustrated in Figure 4).

Figure 4:

Conceptual framework of the Interprofessional Union Collaboration Partnership (IPCUP) model



Theoretical Foundations: Watson's Caring Theory & Labor-Management Partnership (LMP)

The IPCUP model integrates Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, Interprofessional Education Collaborative (IPEC) competencies, and Labor-Management Partnership (LMP) principles into a unified, systems-based framework. The model emphasizes that professional self-actualization and high-quality clinical care cannot occur without establishing basic physiological, physical, and emotional safety at the foundational levels. It provides a structured roadmap for establishing transparent, bi-directional communication, joint labor-management safety committees, and co-owned accountability platforms to rebuild trust in rural CHCs (Bhaumik et al., 2020).

Limitations and Future Research

This study was limited by its sample size (n=42) across six CHCs, which may restrict the generalizability of the quantitative findings to larger urban facilities. Furthermore, the sensitive nature of discussing union politics and management relationships may have caused some participants to withhold information due to fear of professional reprisal. Future research should expand to include larger sample sizes, across multiple provinces, and incorporate the direct perspectives of facility managers, provincial administrators, and high-level union leaders to validate and scale the IPCUP model.

CONCLUSION

This study exposes the disconnect between the theoretical framework and the practical reality of interprofessional and union collaboration in South Africa's rural CHCs. While formal labor representation and safety policies exist on paper, the lived experiences of healthcare professionals

reveal fragmented leadership, passive union advocacy, and symbolic compliance.

To transition from a "façade" of collaboration to functional partnership, stakeholders must implement structured, rights-based accountability frameworks. The proposed Interprofessional Union Collaboration Partnership (IPUCP) model offers a theory-informed, context-sensitive pathway to rebuild organizational trust, protect employee safety, and secure equitable health delivery across rural primary healthcare systems.

Use of Artificial Intelligence (AI) Declaration: No artificial intelligence tools were used in the generation, primary analysis, or interpretation of the experimental raw data presented in this study.

Authors' Contributions: Kgongwana, T. H.: Conceptualization, Methodology, Investigation (data collection), Formal analysis, Visualization (model formulation), Writing – original draft, Writing – review & editing. J. M. Mathibe-Neke: Supervision, Writing – review & editing.

Data Availability Statement: All data generated or analyzed during this study are included in this published article [and its supplementary information files]. Additional supporting data are available from the corresponding author upon reasonable request, subject to institutional policies.

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Ethical Approval: Ethical clearance was granted by the University of South Africa Health Studies Higher Degrees Committee (Ref: HSHDC/687/2017) and approved by the respective provincial health research committees.

Informed Consent: All participants provided written informed consent prior to inclusion.

Conflicts of Interest: The authors declare that they have no conflicts of interest.

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