HEALTH PROFESSIONALS AND TRADE UNION COLLABORATIVE PARTNERSHIPS: PROSPECTS FOR A MUTUALLY SECURE WORKPLACE WITHIN COMPREHENSIVE HEALTH CENTRES

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I declare that the above thesis is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

I further declare that I submitted the thesis to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at the University of South Africa for another qualification or at any other higher education institution.



30 November 2025

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ABSTRACT

Healthcare delivery in South Africa's rural and semi-rural comprehensive health centres (CHCs) remains challenged by persistent resource constraints, high staff turnover, and fragile interprofessional and labour relations. Although trade unions have historically advocated for workers' rights, their limited visibility and functionality in these settings may weaken collaboration, safety culture and mutual trust among health professionals.

This study explored the experiences of health professionals and trade union representatives regarding collaboration and secure workplace relations within rural and semi-rural CHCs. It further developed and validated the Interprofessional Union and Collaborative Partnership (IPUCP) model and implementation guidelines. The model integrates Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Interprofessional Education Collaborative (IPEC) framework and the Labour-Management Partnership (LMP) model.

A sequential explanatory mixed-methods design was employed to ensure both breadth and depth of understanding. In Phase 1 (quantitative), six rural and semi-rural CHCs were purposively selected, two each from Gauteng, Mpumalanga and Northwest provinces. Within these selected CHCs, a total-population approach was followed by inviting all eligible and available health professionals to complete the questionnaire. Sixty-nine questionnaires were distributed and 42 usable questionnaires were returned, yielding a response rate of 61%. A self-administered five-point Likert-scale questionnaire measured leadership, communication, workplace safety, collaboration and union functionality.

Quantitative data were analysed using the Statistical Package for the Social Sciences (SPSS), version 26.0, and reliability was confirmed through a Cronbach's alpha of 0.70.

In Phase 2 (qualitative), participants from Phase 1 who consented to further engagement were purposively selected as participants for three focus group discussions and ten in-depth interviews. Audio data were transcribed verbatim and analysed thematically using Braun and Clarke's (2021) six-phase framework. Integration of both datasets was achieved through narrative weaving, joint displays and meta-inference matrices to illustrate convergence, divergence and expansion, enabling a comprehensive interpretation of findings.

The integrated results revealed systemic constraints, including resource and infrastructure shortages, weak communication structures, limited union participation and inadequate leadership support. Findings further emphasised inclusive capacity building, caring leadership, role clarity, mutual respect and the need for visible and functional union representation to promote collaborative and psychologically safe environments. Workplace security in rural and semi-rural CHCs was found to be aligned to three interdependent pillars: physical and infection-control safety, relational and psychological safety, and procedural-justice safety.

The validated IPUCP model and accompanying implementation guidelines offer a contextual framework to strengthen interprofessional collaboration, enhance trust and reinforce labour-management partnerships in rural and semi-rural CHCs. The study concludes that sustainable collaboration requires supportive leadership, shared accountability, visible organised labour and the integration of caring and humanistic values into everyday workplace practices.

Key concepts

Communication; community health centres, health professionals, interprofessional collaboration; interprofessional union collaborative partnership model, labour unions, rural comprehensive health centres; safety.

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DEDICATION

I dedicate this extensive work posthumously to my son, Khutso. We had committed ourselves to contribute significantly to society through our respective disciplinary fields of interest and specialisation.

KHUTSO, MAY YOUR SOUL REST IN PEACE!!

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ABBREVIATIONS AND ACRONYMS USED IN THE STUDY

ACEIS	Academic Collaborative on Equality and Inclusivity in Surgery
CHCs	Community Health Centres
COID	Compensation for Occupational Injuries and Diseases
CPD	Continuous Professional Development
DENOSA	Democratic Nursing Organisation of South Africa
DHCS	District Healthcare System
DHS	District Health System
NDoH	National Department of Health
FGD	Focus Group Discussion
GP	Gauteng Province
HPs	Health Professionals
HOSPERSA	Health and Other Services Personnel Labour Union of South Africa
HP	Health Professionals
HPCSA	Health Professionals Council of South Africa
IDI	In-Depth Interview
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
IPCP	Interprofessional Collaboration Practice
IPEC	Interprofessional Education Collaboration
IPECP	Interprofessional Education and Collaborative Practice
IPUCP	Interprofessional Union and Collaborative Partnership
MP	Mpumalanga Province
NCS	National Core Standards
NEHAWU	National Education and Health Association Workers Union
NHA	National Health Act
NIMART	Nurse Initiated Management of Antiretroviral Therapy
NIOSH	National Institute for Occupational Safety and Health
NLMP	Nurse Labour-management Partnership
OECD	Organisation for Economic Co-operation and Development
OHSC	Office of Health Standards Compliance
OHS	Occupational Health and Safety
PHC	Primary Healthcare
PPE	Personal Protective Equipment
PPE	Positive Practice Environment
PSA	Public Servants Association

QA	Quality Assurance
rPHC	Re-engineering of Primary Healthcare
SANC	South African Nursing Council
SAMA	South African Medical Association
SDG	Sustainable Developmental Goals
SPSS	Statistical Package for the Social Sciences
UHC	Universal Health Coverage
Unisa	University of South Africa
WHO	World Health Organization
YNIU	Young Nurses Indaba Union

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Chapter 1 presents the research problem and its context, the research objective, objectives and questions, significance of the study, definition of key concepts, theoretical foundations, overview of the research methodology and research design, scope of the study, as well as the structure of the thesis and summary. Furthermore, the chapter signals the study's culminating contribution, namely the development of the Interprofessional Union and Collaborative Partnership (IPUCP) model and its implementation guidelines.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

World Health Organization (WHO) (2021a:8) refers to the International Labour Organization (ILO) report that health workforce in rural and remote areas experience poor work retention, resource deficits. Further WHO (2021a:8) highlights that workplaces are infested with poor, indecent working conditions and violation of human rights, whilst trade unions are available. The WHO report was relevant to this study because it provided background, encouraging the researcher to reflect on rural health services in South Africa (WHO 2021a:9). The WHO report was relevant to this study because it provided a global background on rural health service challenges, thereby enabling the researcher to contextualise similar workforce, access and service-delivery concerns within rural health services in South Africa (WHO 2021a:9). These global findings are significant for the present inquiry as they establish that unsafe working conditions and weak union protection in rural health systems are not an isolated or context-specific anomaly, but a recognised international pattern (WHO 2021a:9). At a regional level, this pattern is echoed across Sub-Saharan Africa, where health facility safety remains an under-researched area and health systems continue to experience compromised working conditions as also supported by (Assegaai & Schneider 2021:31). Evidence from Nigeria, shows that mutual distrust, tension and factionalism among health workers have repeatedly disrupted service delivery (Idowu 2023a:11).

Primary healthcare (PHC) is a central pathway for achieving universal health coverage (UHC) particularly when PHC systems are supported by effective health system governance (Khatri, Endalamaw, Erku, Wolka, Nigatu, Zewdie & Assefa 2025:7). Khatri et al (2025:9) in a scoping review on health system governance and PHC delivery for UHC, indicate that fragmented evidence needed to be synthesised to understand how governance contributes to PHC performance, including the successes, weaknesses, strategies and barriers affecting service delivery. Endalamaw, Erku, Khatri, Nigati, Wolka, Zewdie and Asseffa (2023:9-10), in a scoping review of 134 studies, found substantial variation in PHC performances across countries, and identified persistent barriers related to access, workforce capacity, quality of care and service continuity across countries including Sweden, Ghana, Nigeria, the United Kingdom, the United Arab Emirates, South Africa, Poland, Brazil and China.

These international findings are relevant to the South African context, where the 2030 Human Resources for Health Strategy identifies inequity, inefficiency and workforce planning gaps as continuing barriers to effective health service delivery (DoH 2020:24).

Mohamed, Peck and Senekal (2024:1-2, 5-8) study further asserts that interprofessional collaborative practice remains limited by siloed professional cultures, weak systems support, leadership and management challenges, communication barriers and resource limitations. In addition, community-based health workers continue to experience poor resourcing, insecure employment conditions and limited bargaining power, which strengthens the relevance of organised labour and workforce protection in rural health systems (Malatji, Griffiths & Goudge 2024:1-2; Ngene, Khaliq & Moodley 2023:90). Despite South Africa's constitutional and legislative protections for occupational health and safety and labour representation, it remains unclear whether these protections translate into functional, collaborative workplace practice within the country's own rural and semi-rural community health centres (Mackenzıe & Filiz 2023:1458). It is this gap between international evidence, national legislative intent, and facility-level reality that motivates the current study. This study was therefore undertaken to address this gap by exploring the experiences and perceptions of health professionals and organised labour in rural CHCs across Gauteng, Mpumalanga and Northwest provinces.

Since 1997, the South African health system has been dedicated to improving primary healthcare (PHC) in rural communities by establishing a district health system (DHS) that includes community health centres (CHCs) staffed by a wide range of health professionals. Organised labour is found to have difficulties in representing workers fairly and playing the advisory role in management to fairly protect workers' interest in rural health facilities due to several factors (Chen, Hou, Zhang & Li 2020:6). Limited research has examined collaboration between health professionals, management and organised labour as a strategy for creating secure and supportive workplaces. Yet these facilities are an important part of the South African health system and are central to achieving the Sustainable Development Goals (SDG) and implementing National Health Insurance (NHI).

Recent literature on rural workplace safety, PHC governance, interprofessional collaboration and labour protection supports the need to investigate how rural workplace conditions, labour-management relations and interprofessional collaboration influence workforce wellbeing and health-system performance (Mackenzie & Filiz 2023:1458; Malatji et al 2024:1-2; Mohamed et al 2024:1-2, 5-8; Wright, Jatrana & Lindsay 2024:1-2).

The recent literature on rural workplace safety, PHC governance, interprofessional collaboration and labour protection supports the need to investigate how rural workplace conditions, labour management relations and interprofessional collaboration influence workforce and health system performance (Mackenzie & Filiz 2023:1458; Malatji et al 2024:1-2; Mohamed et al 2024:1-2, 5-8; Wright et al 2024:1-2).

The World Health Organization (WHO) (2021a:9) emphasises that resilient health systems depend on adequately supported health workers, effective governance and safe working environments. Similarly, the WHO (2021b:16) links progress towards the Sustainable Development Goals to decent work, strong institutions and partnerships, which are essential to achieving equitable health outcomes. The WHO (2021a:9) emphasises that resilient health systems depend on adequately supported health workers, effective governance and safe working environments. Similarly, the WHO (2021b:16) links progress towards the Sustainable Development Goals to decent work, strong institutions and partnerships. As highlighted by (Owidhi 2019:15), a comparable advocacy gap has been identified in Kenya, where an assessment of the state of trade

unions found that unions need to advocate more assertively for occupational health and safety and labour rights, particularly on behalf of health professionals serving in rural areas. These priorities reinforce the importance of examining labour policies and collaborative workplace practices within rural South African CHCs.

Prosperi-Porta (2025:61-68) is of the opinion that the interprofessional and interorganisational role of health professionals in rural CHCs is an unexplored dynamic within the healthcare system. Sriram, Brophy, Sharma, Elias and Mishra (2023:6) assert that union representatives, play an important role in representing health worker interest in policy and workplace related processes, In the South African context, this representatives role is further supported by the Labour Relations Act of 1995, which promotes freedom of association, collective bargaining, workplace forums and far labour practices (South Africa 1995:1). Health professionals in their various categories constitute a vital backbone of both public and private healthcare sectors in most societies around the world (Department of Health [DoH] 2019b:24). In the context of this study, health professionals include nurses, medical officers, facility managers, radiographers, pharmacists, dietitians, physiotherapists, podiatrists, occupational therapist psychologist, social workers and dental therapists while performing their duties Furthermore, healthcare professionals (HCPs) in South Africa are regulated by their respective statutory professional councils. These include, the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC) and the South African Pharmacy Council (SAPC) (Health Professions Act 1974: ss 3(c); Nursing Act 2005: ss 3(e), 4(l), 30, 31; Pharmacy Act 1974: ss 2, 3, 13-14), depending on the professional category. These statutory bodies regulate professional registration, scope of practice, ethical conduct, professional standards and accountability. In addition, as employees, health professionals may belong to professional associations or trade unions according to their professional roles, employment conditions, needs and interests, as protected under the Labour Relations Act 66 of 1995. These structures influence professional accountability, ethical practice, labour representation and workplace advocacy within the healthcare system (Labour Relations Act No. 66 of 1995: ss 4-5).

Goossensen, Simons, Goossensen and Nies (2022:1-2) warn that the WHO (2010:2) advocates that interorganisational and interprofessional collaboration is increasingly appreciated as essential to maintaining and improving the quality of healthcare. The findings in the study of Davidson, Kelly and Ball (2022:2) outline barriers of

interprofessional collaboration and practice (IPCP) in PHC, namely: the lack of team structures, unavailable or off-site located allied health workers, lack to limited leadership, absence of common vision and goals, and poorly defined roles and responsibilities.

The rural CHCs in South Africa appear to be challenged by similar barriers, hence the need to explore the experiences of employees playing dual roles. Davidson et al (2022:2) share that IPCP has been extensively researched, as well as in rural primary care settings; it was suggested that it is more challenging to implement IPCP in PHC than in hospital settings. Health professionals play a variety of roles in health services, and the trade union is an organisation that serves the interests of workers with formal professional training; thus, they are interprofessional collaborators. The trade unions collaborate interdependently with professionals and managers and other stakeholders within the health facilities; thus, they are interorganisational collaborators. In the context of this study, rural CHCs must embrace IPCP that promotes people centeredness and quality work life for health professionals, and positive health outcomes. The purpose of IPCP is to enhance the achievement of improved health outcomes with less cost. This requires structures, diverse health professionals working as a team, transparent communication, clarified roles, and well-resourced safe facilities (Hewitt, McNiesh & Fink 2019:153).

Simons, Goossensen and Nies (2022:6) clarify that elements that can foster interorganisational and interdisciplinary collaboration are improving communication, teamwork, professional roles, collective activity, and coordination of care. Goossensen et al (2022:6) caution that to achieve these competencies, all health professionals require increased knowledge, improved collaboration, improved communication, enhanced clarity of roles and development of the process of collaboration.

Health professionals belong to various registered trade unions and face the challenge of mediating potential conflicts arising within the CHCs, while ensuring that their rights and benefits as both employees and as union members are to be managed equally (Sriram, Brophy, Sharma, Elias & Mishra 2023:4). For example, as employees of the NDoH, health professionals are regarded as providers of essential services. Consequently, their right to engage in protected labour action under the Labour Relations Act (No. 66 of 1995) may conflict with the obligations of its employer under the National Health Act (No. 61 of 2003).

Given the duality of their roles as NDoH employees and trade union members, dynamic interpersonal and professional relations emerge between health professionals and their labour organisations. Saridi Panagiotidou, Toska, Panagiotidou and Sarafis (2019:1) alert that there are dynamics that arise from the interaction between occupational or professional rights, on the one hand, and employment-related rights and conditions of service, on the other hand. In this regard, health professional representatives in their trade unions are obliged to ensure that they co-exist in an environment characterised by collaborative partnerships among the health professionals, nurse managers, and labour organisation representatives. This form of collaboration is essential to ensure that nurses experience centres (CHCs) as safe and secure workplaces (Farghaly, Abdallah, Abdelgawad & El-Sayed 2024:51).

This decline in the functionality of collaborative secure partnership between health professionals and organised labour must be uncovered, reviewed, and reformed by implementing monitoring and reviewing the legislation and any other policies to save the scarce population of health workers (WHO 2022:7). The rights of workers to safe and healthy workplaces have been under increased attack recently than at any time since the passage of the landmark Occupational Safety and Health Act in 1970. This is supported in a study by Serapelwane and Manyedi (2022:1) who discovered that health workers in PHC facilities experienced favouritism and discrimination, including poorly resourced workplaces that are against labour relations and occupational and health safety legislations (Serapelwane & Manyedi 2022:1). Management continues to find that their supervisory role is inadequate, and it remains a concern that discrimination practices and violations of the rights of HCPs continue in their presence. Therefore, limitations warrant further investigations, involving all role players, trade unions, managers, and health professionals.

A study conducted by Wirawan (2023:36) in Asia on the fight against nepotism and regional authorities, reflects that discrimination on the job is an unfair labour practice that negatively impacts the quality and provision of health services. Furthermore, it concerns that the dormant position and role of labour unions, which are meant to defend and protect health professionals in rural health facilities, to have safe workers, safe health facilities and positive health outcomes remain an ignored limitation. Both the results and recommendations of this study are of relevance to the NDoH and its policymakers regarding improvements in the plethora of areas and challenges uncovered and

discussed in this study. DENOSA and the Young Nurses Indaba Union (YNIU) in 2016 served a petition to the NDoH and the South African Nursing Council (SANC), demanding, amongst others, safe working conditions for health professionals in all health facilities. This development demonstrates that there is an ongoing demand from many stakeholders that challenges the DoH to improve its mission of establishing a safe workplace with secure relationships between health professionals and stakeholders.

Therefore, the NDoH, the health training institutions, DHS, the SANC and health professionals labour organisations such as DENOSA, the YNIU, South African Medical Association (SAMA), Public Servants Association (PSA), Health and Other Service Personnel Trade Union of South Africa (HOSPERSA) and National Education, Health and Allied Workers' Union (NEHAWU) will benefit from both the study's first-hand empirical data and recently acquired literature-based knowledge from the diverse perspectives of scholars, professionals and practitioners in the fields of organised labour, human resources, and nursing science and practice. Schminke and Fridell (2021:3) explored the role of the success and failure of organised labour unions with a focus on the lack of worker's voice, social dumping and limited resources in rural areas, as well as the management of the working environment, which is in line with this study.

1.2.1 Source of the research problem

The research problem relates to nature, the extent and implications of the challenges experienced by HCPs and their trade union representatives concerning the prospects or lack thereof, for collaborative secure CHCs. Therefore, the research problem in the current study is multi-faceted and spans the systemic, organisational, institutional and practice-related parameters of the workplace safety of HCPs, which are regulated by specific legal instruments and official government policy at the systemic level. In addition, the research problem also encompasses the organisational factors within the CHCs that could exacerbate the state of potential conflictual or disharmonious interpersonal and professional relations if the situation is not adequately addressed. Schot, Tummers and Noordegraaf (2020b:333) further clarify that the identified system-wide institutional problems are interrelated and not necessarily mutually exclusive. It was against this problematic background that the researcher, drawing on her professional experience within the primary healthcare sector, undertook this study to explore and interpret the nature of the problem in greater depth.

1.2.2 Background to the research problem

In this study, the background of the research problem is in the context of PHC. In 2010, the South African government undertook to implement the Primary Healthcare Re-Engineering Model (PHCRM), which is in alignment with the 2008 Ouagadougou Declaration on PHC during the thirtieth anniversary of the Alma Ata Declaration on PHC (Schneider, Daviaud, Besada, Rhode & Sanders 2020:363). The benefits of the PHCRM include access to healthcare, as well as system efficiencies and an enhanced referral pathway within the community healthcare model (Naidoo, Suleman & Bangalee 2024:3). A fully functional PHCRM has twenty-four-hour CHCs, a district hospital, ward-based outreach teams, PHC clinics, as well as the school health system linked to the municipality's healthcare services. Primary care had been shifted from the curative approach since 1997 and became legal status in the National Health Act (No. 61 of 2003) but still faces systemic challenges (Kalonji & Mahomed 2019:2).

On 15 May 2024, the government further committed to the implementation of universal health coverage (UHC) through the National Health Insurance Act (No. 20 of 2023) (DoH 2023:24). The purpose of National Health Insurance is to correct the inequitable distribution of healthcare that was created by the two-tier health system and to provide access to quality essential healthcare services to all citizens (Naidoo et al 2024:2). Accessibility and affordability of quality PHC are fundamental objectives of universal health UHC, however, many healthcare systems around the world struggle to fulfil this basic healthcare need (Waithaka, Kagwanja, Nzinga, Tsofa, Leli, Mataza, Nyaguara, Bejon, Gilson, Barasa & Molyneux 2020:1).

Furthermore, National Health Insurance Act (No. 20 of 2023) defines comprehensive healthcare services in the context of ensuring the continuum of “health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care across the different levels and sites of care within the health system according to the needs of users.” This supports the study’s use of comprehensive primary care as a key concept because rural and semi-rural CHCs are expected to address users’ needs through promotion, prevention, curative and rehabilitative (South Africa 2023:8).

Most importantly, it is worth stating that the National Health Insurance Act (No. 20 of 2023) also acknowledges the vital role of healthcare workers in implementing a successful National Health Insurance system by centralising and emphasising PHC facilities as the essential locale for enhancing safe collaborated partnerships among critical stakeholders (South Africa 2023:21). Thus, the fundamental tenets of the research problem presented in the following section are multi-layered, covering the systemic, institutional, and practice-related aspects of the' safety and labour rights of HCPs within CHCs as their places of employment.

1.3 RESEARCH PROBLEM

The research problem addressed in this study may be expressed in a single statement: in rural and semi-rural CHCs in South Africa, the absence of an integrated framework for collaborative partnership among health professionals, trade unions and facility management compromises workplace security, interprofessional cohesion and the quality of patient care. This problem statement serves as the central organising thread of the thesis.

The research problem is based on the nature, extent, and implications of the challenges experienced by health professionals and their trade union representatives in relation to collaborative workplace safety within the respective CHCs.

1.3.1 Research problem in the context of comprehensive health centres

In this study, the above-stated aspect of CHC is system-wide since these centres are found throughout the country as part of the government's PHC re-engineering model and the national health insurance as collective expressions of UHC. Therefore, the CHCs are viewed as the local and focal points within which conflict and disharmony thrive, and the need for mediation is critical (LeBan, Kok & Perry 2021:1).

Effective service delivery in rural and semi-rural CHCs remains vulnerable where workplace safety, infrastructure, organisational support and staff preparedness are weak. s and inadequate induction of inexperienced staff. These conditions are relevant to rural CHCs, where under-resourced facilities may expose health professionals to physical, psychological and organisational risks.

Effective service delivery in rural and semi-rural CHCs remains vulnerable where workplace safety infrastructure, r organisational support and staff preparedness are weak. Wright, Jatrana and Lindsay (2024:3299) show that health professionals in rural and remote primary health settings experience safety risks linked to unsafe infrastructure, poor organisational safety conditions and inadequate induction of inexperienced staff. These conditions are relevant to rural CHCs, where under resourced facilities may expose health professionals to physical, psychological and organisational risks. are increasing concerns about mental health challenges, negative attitudes, the lack of visible efficient organised labour, toxic relationships, workplace violence, and conflicts between, and among HCPs, management, labour union and community members. These issues require urgent interventions h particularly in rural areas. Mausz, Donnelly, Moll, Harms and Mcconnell (2022:14) further indicate that rural and semi-rural community health services often struggle to attract and retain health professionals, which intensifies service delivery pressures. In context of this study these pressures were reflected in concerns about mental health strain, negative workplace attitudes, weak visibility of organised labour, toxic relationships, workplace violence and conflict among health professionals, management, organised labour and community members. These challenges required targeted interventions that strengthen workplace safety, staff support and labor management collaboration.

1.3.2 Health professionals as part of the challenged collaboration partnership

HCPs are associated with this aspect of the research problem because they are role players in the workplace. Practice by health professionals exists within an environment of policies and regulations that aim at improving crucial aspects such as teamwork, safe workplaces, staffing levels and skill mix towards improved health outcomes, thus quality relationships and creations (Maben, Ball & Edmondson 2023:2-16). Therefore, it is of vital significance to recognise that the community of nurses, medical doctors, nurse managers, allied professionals, organised labour representatives and other HCPs becomes a catalyst for a productive workforce within the therapeutic CHC environment. To that effect, Kebe, Chiocchio, Bamvita and Fleury (2020:5) clarify that the value of health professionals who are committed to collaborative partnerships has substantial benefits in terms of high organisational support, mutual trust, participation in decision-making, knowledge sharing and knowledge integration, and professional diversity.

Despite the above, organisational challenges such as increasing workloads for nurses and HCPs in general have the potential to result in a negative work environment and culture, unhealthy work relations, burnout and less engaging employees who are passive and could compromise the efficacy of a health system (Gaspar, Botelho-Guedes, Cerqueira, Baban, Rus & Gaspar-Matos 2024:7). Some concerns have been raised about the shift system's concession for registered nurses to work on day and night shifts and some on certain days of the week (Banda, Simbota & Mula 2022:1). Additionally, there has been observable non-compliance with legally defined safety requirements in many comprehensive healthcare centres and institutions due to duplicate and conflicting compliance requirements in realm of policy and legislation, resulting in disillusionment and disgruntlement on the part of health professionals (Maphumulo & Bhengu 2020:1).

While compliance with, and implementation of the various legislative instruments is binding, noncompliance with quality standards in healthcare facilities is engendered by poor management practices, such as challenges with human, material, and financial resources (Mogakwe & Magobe 2020:1). As such, facilitating compliance with quality standards through effective management practice and allocating adequate resources required in healthcare would bring positive change. Concerns have also been raised regarding instances of nurses' professional misconduct of nurses by the Nursing Act (No. 50 of 1978, as amended in Act No. 33 of 2005), that it does not meet out penalties to other health professionals and their organised labour representatives as guilty parties who should also be included in the corrective programme by the respective misconduct committee (SANC 2014: chapter 4, section 38).

A further concern is that the SANC's misconduct committee does not provide clear procedures for an independent appeal process and structured collaboration with the health ombudsman (Matumba 2019:89; Reif 2020:60). There are concerns that continue to be raised repeatedly by the DoH, the SANC, as well as community members staging incessant service delivery protests due to PHC failures such as staff attitudes, unavailable medication, as well as limited skilled leadership and availability of all categories of health professionals as in line with the PHCR model. These service delivery grievances and protests are further triggered by reported issues such as nurses assaulting patients in healthcare facilities, missing inexplicably, and increasing litigation incidents against DoH. These negative experiences are not conducive to collaboration between health

professionals, quality implementation of health services and positive guaranteed health outcomes irrespective of a strong legal framework and policy environment (Todowede, Lewandowski, Kotera, Ashmore, Rennick-Egglestone, Byod, Moran, Oriasaeter, Repper, Robothan & Rowe 2023:13).

1.3.3 Research problem in the context of healthcare professionals' trade union environment

In this study, all the health professionals in one CHC elect a fellow colleague as a labour representative or shop stewards for members within one CHC, who are members of one trade organisation; there is always more than one trade union in one CHC. These health professionals who are union members and shop stewards from different unions will be working in one shared workspace about common health services; they are members of different trade unions and are different in their profession. The dynamic that health professionals are members of various trade unions and are all employees of the DoH might create a barrier towards a mutually secure partnership between health professionals who are to collectively establish a secure work environment to provide health services. It is therefore essential that the research problem embraces both the union and the health professionals concurrently.

Zungu, Yassi, Ramodike, Voyi, Lockhart, Jones, Kgalamono, Thunzi and Spiegel (2023:368) confirm that South African health employees of the NDoH are entitled to organised labour organisation membership through institutional and policy arrangements. To that effect, the SANC amplifies that: "Nurses have the right to a safe working environment which is compatible with efficient patient care equipped with at least the minimum physical, material and personnel requirements; as well as a working environment which is free of threats, intimidation and/or interference" (SANC 2016:2). Furthermore, the employment-related rights of healthcare and medical professionals have been duly recognised by organisations such as the Democratic Nursing Organisation of South Africa (DENOSA), the Health and Other Services Personnel Trade Union of South Africa (HOSPERSA), the Public Servant Association (PSA), the National Education and Health Association Workers Union (NEHAWU), and the South African Medical Association (SAMA) and Solidarity. Membership of these labour organisations is open to public and private HCPs.

It is incumbent for health professionals to fully understand the nature of their membership involvement, legislative obligations, political environment, as well as active participation within their respective labour organisations. Such understanding is critical for fostering safe, positive, and therapeutically collaborative interprofessional work environments and partnerships (Butcher, Gilchrist, Phillimore & Wanna 2019:1). The Labour Relations Act (No. 66 of 1995) aims at advancing labour peace, social justice, economic development, and the participation of employees in an organisational context. Moreover, Section 14(2) of the Labour Relations Act stipulates that any workplace that has at least ten members in the same labour union should have one labour union representative. For functionality, it is best to have two union representatives at the event, one is not available due to personal reasons or unforeseen circumstances; always have continuity and advocacy in the CHC. The health professionals at an operational level and management level have an equal right to be members of any legally recognised labour organisations of their choice.

The above-cited situation implies that in many instances, the numerical strength of CHC health professionals is not necessarily reflective of the representation criteria for a full union structure to be established in any CHC. Instead, such a structure is only established by all the clinics within a single region, where some may not even have an employee representative or shop-steward (Roczniewska, Tafvelin, Nielsen, Von Thiele Schwarz, Miech, Hasson, Edwards, Abildgaard & Sørensen 2024:1104). The implication is that the CHC staff is represented by shop stewards who may be unfamiliar with the clinical dynamics of the members.

As representatives, they are all still duty-bound by their mandatory responsibilities and roles to fully implement their professional pledges in terms of the Occupational Health and Safety Act (No. 85 of 1993). The Occupational Health and Safety Act stipulates the establishment of a safe and harmonious partnership and interpersonal working relations between nurse managers, nurses, and organised labour (nurse shop stewards). This collaborative alliance is collectively tasked with creating a safe and positive workplace culture that inculcates employee well-being and a reduction of health risks, as well as enforcement of accountability, collaboration, and partnership (Morrison, Pabico, Robertson & Bates 2022:23).

Despite the prescripts of the Occupational Health and Safety Act and the Labour Relations Act, there have been concerns about the effectiveness and implementation of social justice and judiciary advocacy in terms of the dignity of the worker, equal opportunities in the workplace, non-discrimination and fair treatment within the labour union organisational context (Venter 2019:31). Such concerns align with the view that various labour unions were not actively engaging with their members regarding their work-related concerns as legally required (Casey-Maslen & Heyns 2021:22).

Based on the researcher's articulation and presentation of the research problem in both its broader and more specific contexts, the study relied on its empirical evidence to determine the extent of prospects, if any, for the future of mutually secure or safe workplaces for HCPs in the context of comprehensive rural health centres.

1.4 PURPOSE OF THE STUDY

1.4.1 Research purpose

The purpose of the study is to explore the experiences and challenges of health professionals, labour union representatives and management regarding collaborative interprofessional relationships and secure safe workplaces in the context of community health centres and organised labour in South Africa and to develop evidence-based model and guidelines to promote positive and sustainable collaboration between managers, health professionals and shop stewards towards a safe working environment in the community health centre.

1.4.2 Research objectives

The aim of the study was achieved through the following research objectives:

- Explore the lived experiences of collaboration between health professionals and labour unions in rural CHCs.
- Identify barriers that limit positive collaboration between health professionals and trade unions for prospects of a secure CHC.
- Explain the role of trade unions in the prospects of a mutually secure relationship.

- Describe the elements that promote positive collaborative relationships between health professionals and trade unions in the comprehensive health centre.
- Explore measures to be employed in strengthening the collaboration between health professionals and trade unions for a prospect of secure CHCs.
- Develop an evidence-based model with implementation guidelines to promote positive and sustainable collaboration between health professionals and trade unions in rural CHCs.

1.4.3 Research questions

Emanating collectively from both the preceding research aim and objectives, the study focuses on answering the following research questions:

- What are the lived experiences of collaboration between health professionals and labour unions in rural CHCs?
- What are the barriers that limit positive collaboration between health professionals and trade unions for prospects of secure CHCs.
- What is the role of trade unions on the prospects of a mutually secure relationship in CHCs?
- Which perceptions of health professionals and trade unions' collaborative relationships are prospects for mutually secure CHCs?
- What are the possible measures to be employed in strengthening the collaboration between health professionals and trade unions, for a prospect of mutually secure CHCs?
- What evidence-based model with implementation guidelines to promote positive and sustainable collaboration between health professionals and trade unions in rural CHCs?

Table 1.1 Alignment of research objectives, research questions, methodological phases, and thesis chapters

Objective	Corresponding research question	Methodological phase and data source	Chapter(s) where addressed
Objective 1: To explore the lived experiences of collaboration between health professionals and trade unions towards a mutually secure workplace within comprehensive health centres.	RQ1: What are the lived experiences of collaboration between health professionals and trade unions towards a mutually secure workplace within comprehensive health centres?	Phase 2: Qualitative phase using focus group discussions and in-depth interviews; Phase 3: Integration of findings	Chapters 1, 2, 3, 5, 6, 8
Objective 2: To identify the barriers that limit positive collaboration between health professionals and trade unions within comprehensive health centres.	RQ2: What barriers limit positive collaboration between health professionals and trade unions within comprehensive health centres?	Phase 1: Quantitative survey; Phase 2: Qualitative phase; Phase 3: Integration of findings	Chapters 1, 2, 3, 4, 5, 6, 8
Objective 3: To explain the role of trade unions in relation to collaborative workplace practice and workplace security within comprehensive health centres.	RQ3: What role do trade unions play in collaborative workplace practice and workplace security within comprehensive health centres?	Phase 1: Quantitative survey; Phase 2: Qualitative phase; Phase 3: Integration of findings	Chapters 1, 2, 3, 4, 5, 6, 8
Objective 4: To describe the elements that promote positive collaborative relationships between health professionals and trade unions within comprehensive health centres.	RQ4: What elements promote positive collaborative relationships between health professionals and trade unions within comprehensive health centres?	Phase 1: Quantitative survey; Phase 2: Qualitative phase; Phase 3: Integration of findings	Chapters 1, 2, 3, 4, 5, 6, 8

Objective	Corresponding research question	Methodological phase and data source	Chapter(s) where addressed
Objective 5: To explore perceptions of collaborative relationships between health professionals and trade unions as prospects for a mutually secure workplace within comprehensive health centres.	RQ5: How are collaborative relationships between health professionals and trade unions perceived as prospects for a mutually secure workplace within comprehensive health centres?	Phase 2: Qualitative phase; Phase 3: Integration of findings	Chapters 1, 2, 3, 5, 6, 8
Objective 6: To develop the Interprofessional Union and Collaborative Partnership (IPUCP) model and implementation guidelines for a mutually secure workplace within comprehensive health centres.	RQ6: How can an evidence-based model and implementation guidelines be developed to strengthen collaborative partnership between health professionals and trade unions within comprehensive health centres?	Phase 3: Integration and meta-inferences; Phase 4: Model and guideline development and expert validation	Chapters 1, 2, 3, 6, 7, 8

(Source: Developed by the researcher from the study objectives, research questions and sequential explanatory mixed-methods design)

1.5 SIGNIFICANCE OF THE STUDY

There is limited empirical research on collaborative interprofessional and union secure relationships in rural CHCs, particularly in relation to workplace safety, interprofessional cohesion and service delivery. This study therefore contributes to knowledge in health sciences by addressing an underexplored area at the intersection of interprofessional practice, organised labour relations and primary healthcare. The evidence-based model developed provides a contextually grounded framework for strengthening collaboration between health professionals, managers and organised labour with the aim of improving workplace relations, enhancing safety and supporting the quality of rural facilities.

In disciplinary terms, the study is located within the health sciences under Classification of Educational Subject Matter (CESM) 09: Healthcare and Health Sciences. The inquiry draws on nursing science, primary healthcare, interprofessional practice and labour relations. Health sciences therefore remain the primary disciplinary location of the study because the study seeks to improve patient-care quality through workforce stability, interprofessional collaboration and workplace safety.

1.5.1 Disciplinary and epistemological significance or relevance

The new body of knowledge from this study will contribute to the strengthening of the PHC re-engineering programme in three provinces (North-West, Mpumalanga, and Gauteng), revision of labour policies, and review management framework in rural CHCs. It also challenges concerned researchers to make further advances based on any limitations identified in the study at the district level.

1.5.2 Institutional and organisational significance or relevance

This study is premised on the contribution it makes to the efficient, functional, and user-friendly health services provided during the collaboration of HCPs and trade unions in rural CHCs located in Gauteng, Mpumalanga, and Northwest provinces. The study also adds value for the identification of the relevant legislation, course content, and competencies of the HCPs placed in CHCs. Based on the study's findings and recommendations, nursing curriculum experts, political leaders, nursing managers, and organised labour will be able to strengthen the curriculum of health professionals to embrace interprofessional education and enable health and trade union policy makers and politicians, to review policies that can improve poor between health professionals and trade unions. These aspects impact health outcomes at the district level of care.

The study findings and recommendations will also contribute towards policy development for effective collaborative partnership models applicable at all levels of care to achieve a safe working environment and improved health outcomes in rural CHCs between health professionals, managers, and organised labour.

1.5.3 Socio-economic significance or relevance

The study does not necessarily entail direct or immediate socio-economic benefits. However, some of its outcomes and implications, if implemented, could translate into benefits that are of relevance to the social and economic improvement of all stakeholders within the milieu of rural CHCs. Litigations and high staff turnover incur huge financial costs to the DoH due to factors such as ward injuries to patients and medical negligence (Maphumulo & Bhengu 2019:2). Thus, the improvement of interpersonal safety compliance and standards, as well as collaborative partnerships among all relevant role players, necessarily translates into fewer litigation cases, which is a financial benefit to the NDoH. Therefore, the budget that the DoH spends annually on litigation could be redirected to other pressing healthcare needs in society (Sehlabaka 2023:24).

Such a re-orientation of DoH's budgetary allocation is an enabling factor in changing the healthcare system from becoming a reactive, litigation-prone institution with weakened capacity to fulfil its mandate.

1.6 DEFINITION OF KEY CONCEPTS

The key concepts or terms in this study are identified based on their thematic relevance and logical association with the research topic and its core related variables.

1.6.1 Collaboration and partnership

Collaboration relates to the nature and extent of the association, interaction, and practices between two or more people working together in partnership towards the attainment of shared or common goals and interests. The partners then coordinate their attitudes, behaviours towards a common goal and health outcomes, including agree implantation process (Castañer & Oliveira 2020:994).

Partnership is defined as a form of collaboration that can overcome conflict transfer, cross sectional learning and turn differences into synergies between parties that inspire prosperous relationships with shared communal responsibility around work related decision making (Potluka 2020:131). The synergistic relationship between collaboration and partnership has similarities and can coexist (Balcells-Balcells, Giné, Guàrdia-Olmos, Summers & Mas 2019:56). In this study, collaboration and partnership refer to the working

relationship between health professionals, managers and organised labour within rural and semi-rural CHCs. The concept is used to describe how these role-players communicate, share responsibility, manage workplace concerns and contribute to a mutually secure workplace

1.6.2 Health professionals

Health professionals are duly trained and experienced individuals in the provision of healthcare programmes, services, and activities at the designated health facilities in accordance with their training, experience, or considerations deemed to be relevant by their employer (Mabusela & Ramukumba 2021:1). Health professionals provide services for which they are duly trained in terms of regulations such as the Health Professions Act (No. 56 of 1974); the Pharmacy Act (No. 53 of 1974); the Nursing Act (No. 50 of 1978, as amended) and Nursing Act (No. 33 of 2005); the Dental Technicians Act (No. 19 of 1979); the Allied Health Professionals Act (No. 63 of 1982); as well as the National Health Act (No. 61 of 2003), as amended.

In the current study, the community of health professionals encompasses registered nurses across all categories and levels of training; tutors; dieticians, psychologists, medical doctors, counsellors, allied health professionals, as well as organised labour representatives. All the health professionals work in six CHCs in the DHS of the Gauteng Province, Mpumalanga Province, and North-West Province.

1.6.3 Union/organised labour

The Labour Relations Act (No. 66 of 1995) clarifies that organised labour is a constituted registered trade union in line with the prescripts of the Labour Relations Act and in a workplace with a majority of members. Section 14 of the Act provides for the election of trade union representatives by members of a representative trade union in the workplace, subject to the applicable organisational rights and representativity requirements (South Africa 1995: s14).

The number of health workers in rural health facilities because of the multiple trade unions available might compromise the nominations thus might find a health facility with no union members. For example, fifty employees belonging to one registered trade union may then

elect seven health professionals as union representatives in their shared workplace. Health facilities then, depending on the total number of memberships, may select the union representatives; therefore, some employees might not have union representatives within their health facility.

In the context of this study, the union members are shop stewards and are employed as health professionals who can be nominated by employees within the CHC to represent them and defend their working conditions. Based on the legal prescripts, therefore since the CHC staff complement is known to be less than fifty in total, the union representatives in CHCs might not be all available to represent their members who are employees because the recognition of each trade union is determined by the total number of workers affiliated to that trade union. Therefore, the workers will be compromised, and alternative means need to be found, and they must be informed as stipulated in the Labour Relations Act (No. 66 of 1995). The trade unions have multiple roles, but are independent, membership based and provide support to workers who are their members, hold discussions with supervisors, mangers on who represent the employer who has a responsibility to improve working conditions and solve conflict relations that render a working area unsafe.

1.6.4 Mutually secure workplace

A mutually secure workplace refers to a CHC work environment in which health professionals, managers and organised labour share responsibility for creating a workplace experienced as safe, stable, supportive and respectful. The concept is informed by secure workplace attachment, which refers to a positive relationship between workers and their workplace, where the work environment is experienced as familiar, safe, supportive and capable of providing stability and emotional comfort (Scrima, Mura, Nonnis, Rioux & Fornara 2025:7274-7275).

Marrelli (2023:13) defines safety as the absence of any form of hazards and risks that could potentially threaten or risk an individual's overall well-being. In this study, the aspect of safety is strictly focused on the well-being of groups of individuals within the healthcare profession and in their organisational workplace environments.

For analytical clarity, this thesis distinguishes between a safe workplace and a secure workplace, although the two concepts are closely related. In this study, safe refers primarily to the physical, environmental and infection-prevention dimensions of the working environment, including structurally sound infrastructure, controlled access, functional equipment, availability of infection-prevention resources and compliance with occupational health and safety requirements (South Africa 1993:6, 11-12). By contrast, secure refers primarily to the relational, psychological and labour-relations dimensions of the workplace, including trust, freedom from harassment and victimisation, fair grievance handling, meaningful union representation and psychological safety (Department of Public Service & Administration (DPSA) 2024:20; Dong, Altshuler, Ban, Wong, Mohammed, Tang & Kachur 2025:1, 5; South Africa 1995: s14; South Africa 2022:5).

A mutually secure workplace also includes the relational conditions under which workers feel valued, respected and able to contribute without fear. Gregory, McAllister and Albritton (2026:1) distinguish insecure striving, where employees feel they must succeed to be valued, from secure non-striving, where employees feel valued regardless of performance. This distinction is relevant to the present study because rural CHC staff may experience insecurity where relationships are shaped by fear, conflict, weak communication, poor support and pressure to perform under resource-constrained conditions.

In this research context, the community health centre (CHC) is a workplace for health professionals, managers and trade union representatives who mutually contribute overtly or covertly to a secure workplace. The CHC may expose or protect all role-players to danger, Role players may mutually develop a secure workplace based on how they relate with each other within the CHC feel safe with each other and their interactions are beneficial to each other.

1.6.5 Community health centre

A community health centre (CHC) refers to a primary healthcare facility located within the district health system and providing comprehensive healthcare services to individuals, families and communities. The National Health Insurance Act (No. 20 of 2023) defines comprehensive healthcare services as services that provide a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and

palliative care across different levels and sites of care according to the needs of users (South Africa 2023:8).

The comprehensive health centre (CHC) as a designated primary healthcare facility that is a component of the district health system (DHS) in South Africa. It is also worth stating that the CHC directly receives patients or clients from the community and refers them to the district hospital or higher levels of care where necessary.

In this study, the CHC is also characterised by a community base; hence, the delivery of high-quality, comprehensive, and culturally sensitive PHC services in rural or semi-rural areas. These services include pharmaceutical access, oral health, mental health, maternity, emergency services, nutrition, non-communicable diseases, physiotherapy, occupational and speech therapy, optometrist, dietician, podiatrist, and medical services.

1.6.6 Comprehensive primary care

Comprehensive primary care refers to primary healthcare that addresses the health needs of individuals, families and communities across the continuum of care. This includes health promotion, disease prevention, diagnosis, treatment, management, rehabilitation and palliative care according to the needs of users (South Africa 2023:8). Comprehensive primary care is therefore broader than episodic treatment because it includes preventive, promotive, curative, rehabilitative and palliative dimensions of care.

In this study, comprehensive primary care refers to the range of PHC services provided by the selected rural and semi-rural CHCs. These services require interprofessional collaboration because no single professional category can meet the full range of user needs alone. The concept is therefore relevant because effective comprehensive primary care depends on communication, role clarity, teamwork, leadership, resource availability and stable labour-management relations.

1.6.7 Interprofessional union and collaborative partnership (IPUCP)

The Interprofessional Union and Collaborative Partnership (IPUCP) is the integrated model developed in this study to promote positive and sustainable collaboration between

health professionals, managers and organised labour in rural and semi-rural CHCs. The model integrates Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Interprofessional Education Collaborative (IPEC) framework and the Labour-Management Partnership (LMP) model.

In this study, the IPUCP model provides a contextual framework for strengthening workplace security, interprofessional collaboration, labour-management engagement, communication, leadership, trust, staff well-being and shared accountability. The model is operationalised through implementation guidelines for rural and semi-rural CHCs and is presented in Chapter 7.

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

This study is grounded in a pragmatic paradigm, which supports the use of both quantitative and qualitative approaches to address a complex practice-based research problem. Pragmatism is appropriate because the collaboration between health professionals and trade unions in rural and semi-rural CHCs involves measurable workplace patterns as well as lived experiences, meanings and contextual realities (Dawadi, Shrestha & Giri 2021:27; Harrison, Reilly & Creswell 2020:475). The combination of the two approaches creates a more holistic understanding of the research problem by leveraging the strengths of both paradigms.

Based on the problem statement and the setting context the study adopted a pragmatic paradigm, the ontological, epistemological, axiological, and methodological assumptions have also shaped the researcher's perspectives concerning various aspects in the field of research.

1.7.1 Conceptual framework

This study is underpinned by an intertheoretical framework that integrates concepts from complementary theories relevant to human motivation, caring relationships, and collaborative partnership within healthcare and labour relations contexts (Creswell & Creswell 2023:231). Guided by a pragmatic philosophical foundation, the framework draws from four key theories: Watson's Theory of Human Caring, Maslow's Hierarchy of

Needs, the Labour-Management Partnership (LMP) model, and the Interprofessional Education and Collaborative Practice (IPECP) core competencies (Efron & Ravid 2019:4).

Collectively, these theories provide a multidimensional lens for understanding how health professionals and trade unions interact within rural and semi-rural CHCs.

- Watson's Theory of Human Caring highlights the ethical, emotional, and humanistic dimensions of collaboration, promoting trust, compassion, and psychosocial safety in the workplace (Ghanbari-Afra, Adib-Haibaghery & Dianati 2022:246).
- Maslow's Hierarchy of Needs explains how motivation, belonging, and self-actualisation drive teamwork and the creation of secure, enabling environments (Collins 2024 89-101).
- The LMP Model contributes an organisational perspective, emphasising shared governance, mutual respect, and joint problem-solving between management, health professionals, and trade unions (Huang, Fu, Wei, Gollan & Xu 2023:600).
- The IPEC Core competencies operationalise interprofessional collaboration through measurable behaviours in communication, role clarification, teamwork, and values/ethics for collaborative practice (Brashers, Haizlip & Owen 2020:123; Utley, Mathena & Gunaldo 2020:3).

Integrating these frameworks offers a holistic conceptual foundation through which the study examines interprofessional collaboration, union engagement, and workplace safety culture. This integration supports the development of the IPUCP model, an evidence-based framework and set of guidelines to promote sustainable, ethical, and secure partnerships among HCPs and organised labour in South Africa's CHCs.

1.7.2 Research paradigm

This study is anchored within the pragmatic paradigm, which provides the philosophical foundation for the sequential explanatory mixed-methods design adopted. Pragmatism assumes that the choice of method should be guided by the research problem rather than by commitment to a single philosophical tradition. It acknowledges that reality is contextual and dynamic, and that both objective and subjective experiences contribute to knowledge construction (Creswell & Creswell 2023:254; Feilzer 2024:20).

In this study, pragmatism is appropriate because the collaboration between health professionals and trade unions in rural and semi-rural CHCs takes place in a complex, socially constructed environment. The paradigm supports the integration of quantitative data, which captures measurable trends and relationships, with qualitative insights, which explore lived experiences and contextual meanings. This integration enhances the depth and practical relevance of findings. The pragmatic worldview therefore aligns with the purpose of this research, to produce evidence-based and contextually responsive knowledge that can inform policy, improve interprofessional collaboration, and strengthen union partnerships in the rural health system.

The pragmatic assumption is between health professionals and unions in rural and semi-rural CHCs, which are in a complex social environment. It includes the meta-theoretical, ontological, and epistemological aspects that will be described as follows:

1.7.2.1 Meta-theoretical assumptions

The researcher's view of the world and society is linked with meta-theoretical assumptions because the health professionals and trade unions are accountable, responsible, and resolute professionals who embrace holistic and humanistic cantered collaboration principles that may establish secure CHC (Greenhalgh 2020:67). The CHCs in rural and semirural CHC environments are unpredictable in their nature, the positivists paradigm is quantitative and the qualitative is constructive. The dual role of health professionals as employees and members of a trade union and representatives of employees allows them to create their own reality, thus defining the meaning of each situation through words when they interact with each other. The interprofessional collaboration and trade union's role complement the collaboration within a secure workplace of professionals who are caring, humane and responsive to Maslow's hierarchy of needs.

1.7.2.2 Ontological assumptions

Ontological assumptions are premised on understanding concerning the nature of reality (Dawadi et al 2021:28). It was based on this assumption that participants were involved through in-depth interviews and focus group discussions to enhance the understanding

of the nature of the investigated experiences between health professionals and trade union collaborative partnerships: prospects for a mutually secure workplace in CHCs. The recognition of reality as open to multiple interpretations and not fixed in a solid form aligns with pragmatism and is referred to as ontological assumption (Creswell & Creswell 2023:23).

In this study the ontological assumption is about the nature of knowledge concerning labour relations roles, workers' rights and secure relations as cited by Creswell and Cresswell (2023:12) as a social life where people interact or relate influences ontological interpretations. The legislative prescripts about the scope of work of health professionals and the legislative prescripts of labour law and secure workplace are pragmatically derived from real-life experiences in the CHC.

1.7.2.3 Epistemological assumptions

Epistemological assumptions are based on the development of knowledge (Harrison et al 2020:475). This was applied in this study's adoption of rural CHCs, which are natural environments with health professionals sharing their relevant experiences and knowledge generated through interviews and focus groups as well.

Pragmatism advocates relational processes which are deemed to be transformative, thus epistemological (Hothersall 2019:865). This study aimed to obtain information about the current situation of the collaboration between health professionals and trade unions regarding the mutually secure CHCs settings in South Africa. The epistemological assumption in this study refers to the application of knowledge of the scope of practice by different health professionals applied during collaborations of health services guided by known legislation on workers' rights, labour rights and secure workplaces. This is a phenomenon being directly investigated in this study, as the experiences are happening in the natural environment where they spend most of the time and express themselves to serve each other and other members of the community visiting the CHC.

1.7.2.4 Axiological assumptions

Additionally, the axiological assumptions emanate from the application of ethical considerations in research (Leavy 2022:14). This was applied using the researcher's

adherence to the University of South Africa's (UNISA's) requirements for research integrity through adherence to ethical principles throughout the study (Sempa, Patil, Matthewson, Kabelka, Yaghmaei, Coleman, Sohoni, Straetemans, Gopolakrishna, Wienia & Kombe 2024:221). Lastly, the various methods of data collection employed in this study were deemed suitable and relevant to answer the research questions in full.

1.7.2.5 Methodological assumptions

The development of the evidence-based model to enhance collaboration between health professionals and secure partnerships is based on findings from the sequential mixed-method approach. The model framework was developed by the researcher based on gaps identified in the existing evidence from the data analysis. The mechanisms needed to support collaboration and secure partnerships in CHCs will be derived from the conceptual framework's pragmatic elements that will become guidelines that are to be implemented in the CHCs. Interprofessional and interorganisational relationships are to yield positive, secure relationships. During Phase 1 and Phase 2 of the data collection and phase 3 comparative analysis phases in this study, it was assumed that the:

- Quantitative methodology yielded accurate, reliable numeric data that answers research objectives and questions.
- The self-administered questionnaires that were confirmed to be reliable and valid could yield the data that answered the research objectives and research questions and thus lead to prediction, explanations and understanding of the experiences of respondents.
- The findings from the quantitative data collection tool were linked to the qualitative methodological assumptions; thus, was further used as an inductive process that would yield accurate and reliable data through accurate, reliable narratives and verified answers to the research questions. They were formulated based on the research objectives and findings of the quantitative research.
- The three focus groups and ten in-depth interviews with semi-structured questions sought to answer the research objectives and questions. The narrated data from diverse health professionals was reliable and accurate through the verification process.

- The development of an evidence-based model was based on the evidence-based findings discovered in the study from six CHCs in three provinces, Gauteng, Mpumalanga, and Northwest.

1.8 OVERVIEW OF RESEARCH METHODOLOGY AND RESEARCH DESIGN

This study adopted a pragmatic philosophical perspective supported by a sequential explanatory design, integrating both quantitative and qualitative approaches. Pragmatism was appropriate for exploring the complex relationships between health professionals and organised labour within rural and semi-rural CHCs, as it allows the use of multiple data sources and analytical strategies to address the research questions (Creswell & Plano Clark 2023b:118; Feilzer 2024:20).

A sequential explanatory design was implemented, whereby quantitative data collection and analysis preceded qualitative inquiry.

- Phase 1: Quantitative: Numerical data were gathered to determine patterns and perceptions relating to interprofessional collaboration, leadership, communication, safety culture and union engagement.
- Phase 2: Qualitative: Semi-structured interviews and focus-group discussions followed to provide contextual depth and explain the quantitative results.

Findings from both phases were integrated to generate meta-inferences that informed development of the Interprofessional Union and Collaboration Partnership (IPUCP) model, consistent with sequential logic described by Peters and Fàbregues (2023:3).

Findings from both phases were integrated to generate meta-inferences that informed development of the Interprofessional Union and Collaboration Partnership (IPUCP) model, consistent with sequential mixed methods logic described by Peters and Fàbregues (2023:14). Peters and Fàbregues (2023:7) demonstrate how visual joint displays and iterative interpretation can systematically integrate qualitative and quantitative findings to support robust model development and theory building

The population comprised health professionals employed in six rural and semi-rural CHCs, two each in Gauteng, Mpumalanga and North-West Provinces. Participants

included professional nurses, medical officers, pharmacists, allied health professionals, and facility managers.

These CHCs operate as 24-hour district-based facilities within the PHC re-engineering model, providing a suitable environment for exploring collaboration and labour engagement. The National Health Act (No. 61 of 2003) provides the legislative foundation for such structured service delivery, outlining responsibilities for national and provincial health departments to ensure accessible, integrated health services (South Africa 2003: section 2). Furthermore, the *National Development Plan 2030* highlights PHC re-engineering and district health system revitalisation as strategic levers for achieving universal health coverage and health equity in underserved areas (South Africa 2012: chapter 10).

The six rural and semi-rural CHCs were purposively selected because they met the study context and inclusion criteria. Within these purposively selected CHCs, the quantitative phase followed a total-population approach, whereby all eligible and available health professionals were invited to complete the questionnaire.

During Phase 1, 69 questionnaires were distributed, and 42 valid responses were received and analysed.

During Phase 2, purposive sampling was used to select information-rich participants who could provide deeper insight into the quantitative findings and the lived realities of interprofessional collaboration, workplace relations and organised labour in the selected CHCs (Creswell & Plano Clark 2023b:119-120; Polit & Beck 2021:312). Three focus group discussions and ten in-depth interviews were conducted. Data collection continued until saturation was reached, when no new categories or insights emerged (Polit & Beck 2021:312).

Two complementary instruments were used (See Annexure F and G):

- Quantitative tool: A self-administered questionnaire containing five-point Likert-type items (1=Strongly Disagree to 5=Strongly Agree) measuring communication, leadership, supervision, conflict management and union visibility.

- Qualitative tools: A semi-structured interview guide for in depth interviews and the adapted semi-structured interview guide for use in focus group discussions, with minor modifications to facilitate group interaction and collective elicited narratives on collaboration dynamics, psychosocial safety and leadership experiences within CHCs (Nowell & Albrecht 2019:349).

Quantitative data were analysed using SPSS, version 26.0 for descriptive statistics (frequencies, percentages, means) and Cronbach's alpha to confirm internal reliability (Kim & Mallory 2022:212). Qualitative data were analysed thematically using an open-coding framework consistent with current approaches to thematic analysis (Braun & Clarke 2021:39). Integration of datasets during meta-inference enabled identification of convergence and divergence, shaping the final IPUCP model and implementation guidelines.

1.8.1 Ethical considerations

Ethical clearance was obtained from the University of South Africa Health Research Ethics Committee (Ref: HSCD/687/2017) (Annexure A) and the National Health Research Directorate (Ref: 2017_RP3_49) linked to the letters of permissions from the provincial research department of Gauteng, North-West and Mpumalanga (Annexures C, D and E). The study was conducted in accordance with the ethical principles of autonomy, beneficence, non-maleficence, and justice, led by the World Medical Association (WMA), whose Declaration of Helsinki sets the foundational principles for the protection of human subjects in research (Riva & Petrini 2024:2). Participants were informed of their rights, confidentiality was maintained, and all data were anonymised and securely stored.

1.9 SCOPE OF THE STUDY

In the conceptual or epistemological sense, the study is fundamentally premised on collaborative partnerships and safety in healthcare contexts, also known as therapeutic environments in CHCs. The scope of the study does not encompass collaborative partnerships and workplace safety in other therapeutic environments such as hospitals. The study's reach does not extend to workplaces in the private sector or any other public sector organisation.

Geographically, the study is confined to a total of six research rural and semi-rural CHCs sites in three provinces, namely, North-West Province, Mpumalanga Province and Gauteng Province. The study by Franklin and Gkiouleka (2021:14) agrees that data was collected from participants who represent diverse health professionals and are playing other roles as managers and or shop stewards.

The scope and demarcation of the study may be summarised under five headings:

- First, in methodological terms, the sequential explanatory mixed-methods design supported descriptive analysis, thick description, integration and model validation, but did not permit statistical generalisation.
- Second, in relation to population boundaries, the study was limited to regulated health professionals employed at the six selected CHCs with a minimum of six months' service.
- Third, in conceptual terms, the study focused on three interrelated concerns, namely workplace security, interprofessional collaboration and labour-management partnership.
- Fourth, the study examined workplace conditions, interprofessional dynamics and labour-management relations as interdependent sets of variables.
- Fifth, in geographical and temporal terms, the study was delimited to six rural and semi-rural CHCs in Gauteng, Northwest and Mpumalanga provinces. Data collection took place after ethical clearance, national registration, provincial gatekeeper permissions and pilot testing, with the empirical data collection occurring between late 2017 and January 2019, and model validation completed in 2025.

The findings should therefore be interpreted within the rural and semi-rural CHC context and should not be generalised uncritically to all healthcare settings.

1.10 STRUCTURE OF THE THESIS

The study is structured and organised into eight chapters as follows:

Chapter 1: Orientation to the study

The chapter presents an overview of the research project with particular focus on the study's background and context, the research problem, the delimitations of the study, the aim, objectives and key questions to be answered in this study; as well as the significance of the study, the definition of key concepts or terms, an overview of the research design and methodology, and the organisation of chapters of the entire study.

Chapter 2: Literature review

This chapter provides a context of multiple scholarly perspectives regarding the research topic. The chapter presents international, Sub-Saharan African, and South African contexts and perspectives regarding health professionals and labour union collaborative partnerships in CHCs.

Chapter 3: Research design and methodology

This chapter presents research design and methodology in more detail. In that regard, the chapter outlines the research paradigm, research approach, design, and methods, as well as the population and sampling parameters of the study. The chapter further discusses both the qualitative and quantitative data collection tools and processes and consequent data analysis processes and procedures. The latter is then followed by an outline of the study's trustworthiness measures and applicable ethical issues and considerations.

Chapter 4: Analysis and presentation of quantitative data

The chapter presents and discusses the quantitative data that was obtained during Phase 1 with the utilisation of the questionnaires with demographic data and subheadings aligned to research objectives. The data is analysed and interpreted in the context of the available literature sources for points of agreement and disagreement. The research problems, research aim, objectives, and questions also served as relevant reference points for evaluating the levels and extent of agreement and disagreement.

Chapter 5: Analysis, presentation and description of qualitative data

This chapter presents and discusses the qualitative data that was acquired during Phase 2 through focused group interviews and structured individual or face-to-face interviews with the respective participants. The chapter presents the participants' raw/verbatim statements or responses in a thematically coordinated manner in the context of the prevailing literature perspectives. The purpose is to compare the veracity of the elicited participant viewpoints. The research problems, research aims, objectives, and questions also served as relevant reference points for evaluating the levels and extent of agreement and disagreement from the participants' elicited responses.

Chapter 6: Integration of quantitative and qualitative data

This chapter presented a merged or convergent overview of both the quantitative (Phase 1) and qualitative (Phase 2) findings of the study that were acquired in both Chapter 5 and Chapter 6, respectively.

Chapter 7: Model development and validation

This chapter focuses on the IPUCP model and implementation guidelines developed by the researcher, in alignment with the final research objective, namely, to develop a model and guidelines to promote positive and sustainable collaboration between managers, health professionals and shop stewards towards collaborative partnerships and safe working environments in CHCs.

Chapter 8: Conclusions, limitations and recommendations

The main aspects of this chapter include overall research design and method summary and interpretation of the research findings, the conclusions and recommendations, the contributions of the study, limitations of the study, as well as the researcher's own concluding remarks.

1.11 SUMMARY

This chapter introduced the study with a particular emphasis on the background and context, the research problem, the delimitations of the study, the aim, objectives and key questions to be answered in this study, as well as the significance of the study, the definition of key concepts or terms, an overview of the research design and methodology, and the organisation of chapters of the entire study.

The next chapter addresses the literature reviewed for the pertinent issues emanating from the exploration and review of HCPs and labour union collaborative partnerships in respect of CHCs.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a critical review and synthesis of the literature relevant to secure interprofessional and union collaborative partnerships within CHCs. The review draws on international, Sub Saharan African and South African scholarship to examine the theoretical, legislative and empirical foundations that inform collaboration among health professionals, organised labour and management within the primary healthcare environment. Rather than presenting the literature as mere isolated bodies of knowledge, the chapter integrates current evidence, policies, legislative frameworks, models and contemporary practices to establish the context for the present study.

The chapter further examines the theoretical frameworks underpinning the study, the legislative and policy environment governing CHCs, stakeholder perspectives on collaborative partnerships, and the potential outcomes associated with secure interprofessional collaboration. It concludes by identifying what is currently known, highlighting areas that remain under investigated, and demonstrating the need for an integrated framework to strengthen collaborative partnerships within rural CHCs. This critical synthesis provides the conceptual and contextual foundation for the empirical phases of the study and the subsequent development of the Interprofessional Union and Collaborative Partnership (IPUCP) Model.

2.2 SOURCE OF LITERATURE

The literature reviewed in this chapter was obtained from a range of multidisciplinary electronic databases, publisher platforms and other authoritative information sources relevant to the study. These included Google Scholar, Sabinet, ScienceDirect, PubMed, Elsevier journals, institutional repositories, theses, books and grey literature that addressed interprofessional collaboration, organised labour, workplace safety and primary healthcare. In addition, authoritative websites, including those of the World Health Organization (WHO), the South African National Department of Health (NDoH) and other

statutory bodies, were consulted to access relevant legislation, policy frameworks, guidelines and official reports. Media reports, municipal archives documenting unrest within CHCs, and trade union publications were also reviewed to provide contextual insight into the challenges, emerging gaps and collaborative practices relevant to the present study. Collectively, these sources provided a comprehensive evidence base for examining the theoretical, legislative and empirical dimensions underpinning secure interprofessional and union collaborative partnerships within CHCs.

2.3 THEORETICAL FRAMEWORK

A theoretical framework provides the conceptual foundation upon which a study is developed by explaining the relationships among key concepts and guiding the interpretation of the research problem (Creswell & Plano Clark 2023a:112). It offers a structured lens through which existing knowledge may be examined, interpreted and synthesised, thereby strengthening the scholarly basis of the study. In the present study, the theoretical framework serves as the foundation for understanding secure interprofessional and union collaborative partnerships within CHCs and informs the development of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

The study is underpinned by four complementary theoretical perspectives, namely Maslow's Hierarchy of Needs Theory, Watson's Theory of Human Caring, the Labour Management Partnership (LMP) Framework, and the Interprofessional Education Collaborative Practice (IPECP) Framework. Although each framework contributes a distinct perspective, they are not applied in isolation. Rather, they collectively provide a comprehensive understanding of the individual, organisational and collaborative dimensions of secure partnerships within CHCs. Collectively, these theoretical perspectives provide the conceptual basis for examining the interaction between healthcare professionals, organised labour and management, while informing the interpretation of the study findings and the subsequent development of the IPUCP Model.

2.3.1 Maslow’s hierarchy of needs

Maslow's hierarchy provides a valuable conceptual lens for understanding the relationship between workplace conditions, motivation and professional performance

within healthcare settings. Although Maslow did not originally apply the hierarchy to health professional performance, contemporary organisational psychology literature demonstrates that the fulfilment of fundamental human needs promotes motivation, engagement, teamwork and innovation (Neher 1991:10; Ryan & Deci 2017:3; WHO 2020a:5). To illustrate the practical application of the theory within the context of rural CHCs, Table 2.1 below presents an analytical alignment between Maslow's five levels of need and selected health professional performance indicators. The table demonstrates how the fulfilment or deprivation of physiological, safety, belongingness, esteem and self-actualisation needs may influence motivation, participation in interprofessional collaboration, workplace security and the capacity of health professionals to contribute effectively to quality patient care.

Table 2.1 Correlation between Maslow's Hierarchy of needs and health professional performance indicators

Maslow's Need Level	Performance Indicator	Application to CHCs
Physiological	Access to essential resources	Availability of consulting rooms, clean water, rest areas, medical supplies and equipment (WHO 2020a).
Safety	Predictability and protection	Physical security, occupational health standards, effective communication and emergency procedures (Ryan & Deci 2017; WHO 2020b).
Belongingness	Team cohesion and inclusion	Multidisciplinary teamwork, mutual support, collaborative decision-making (Neher 1991; WHO 2020a).
Esteem	Recognition and professional respect	Opportunities for leadership, autonomy, acknowledgement and career progression (McLeod 2020).
Self-actualisation	Innovation and professional fulfilment	Environments that support growth, creativity, mentorship and patient-centred innovation (WHO 2020a).

(Source: Adapted from Maslow's Hierarchy of Needs (Maslow 1943; 1954) and supported by contemporary evidence linking workplace needs to performance and health-worker motivation (Neher 1991; Ryan & Deci 2017; WHO 2020a; WHO 2020b).

Table 2.1 demonstrates that Maslow's hierarchy extends beyond a general theory of human motivation by providing a practical framework for understanding how workplace conditions influence professional behaviour and collaborative practice within rural CHCs. The alignment between each level of need and corresponding performance indicators illustrates that the fulfilment of basic physiological and safety needs creates the conditions necessary for effective teamwork, organisational commitment and meaningful

participation in union and interprofessional activities. As higher order needs are progressively supported, health professionals are more likely to experience a sense of belonging, professional recognition and opportunities for growth, thereby strengthening collaboration, innovation and service delivery. Consequently, the hierarchy provides a valuable diagnostic framework for interpreting the experiences of health professionals and union representatives within the present study.

In conclusion, Maslow's Hierarchy of Needs provides a coherent theoretical foundation for examining the motivational and relational factors that influence collaboration within rural CHCs. The theory demonstrates that professional commitment, staff morale and collaborative practice are shaped by the extent to which both fundamental and higher order needs are fulfilled within the workplace. Accordingly, Maslow's hierarchy establishes the motivational foundation upon which the ethical, interpersonal and organisational dimensions of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model are developed. This theoretical perspective also provides a natural transition to Watson's Theory of Human Caring, which further extends the discussion by examining how caring relationships, professional values and human centred practice contribute to sustainable interprofessional collaboration.

2.3.2 Watson’s Theory of Human Caring

While Maslow's Hierarchy of Needs explains the motivational conditions that influence professional behaviour, Watson's Theory of Human Caring extends the discussion by providing the ethical and relational foundation upon which meaningful collaboration is built. In this study, Watson's theory is considered through its foundational and subsequent formulations, *Nursing: The Philosophy and Science of Caring* (1979:42), the revised edition (2008), and later scholarship that further developed caring science and professional practice (Watson 2009:23). Together, these works establish the carative factors, later refined into the clinical caritas processes, and the transpersonal caring relationship as the central concepts of the theory.

Watson's Theory of Human Caring is grounded in the view that care, compassion and respect for human dignity constitute the moral foundation of healthcare practice (Watson 2009:476). Rather than limiting caring to the delivery of clinical services, the theory conceptualises it as an ethical and relational commitment that shapes interactions among

health professionals, patients, managers and colleagues. Consequently, the theory offers an appropriate conceptual lens for understanding how respectful relationships, mutual trust and workplace culture contribute to effective interprofessional collaboration within CHCs.

Although originally developed within nursing, Watson's theory has gained wider application across healthcare disciplines because of its emphasis on empathy, authentic human connection and mutual respect (Aghaei, Vanaki & Mohammadi 2020:3). These principles are particularly relevant to rural CHCs, where heavy workloads, resource constraints and emotionally demanding working conditions frequently influence professional relationships. Watson's perspective also resonates with the African philosophy of Ubuntu, which emphasises interdependence, shared humanity and the principle that “a person becomes a person through other people” (Ewuoso & Hall 2019:101). While Ubuntu is not presented as an independent theoretical framework in this study, its values complement Watson's caring philosophy by reinforcing the ethical principles of compassion, dignity and mutual respect that underpin collaborative practice.

Within the present study, Watson's Theory of Human Caring provides the ethical and relational assumptions necessary for understanding collaboration in rural CHCs. Psychological safety may therefore be viewed as an organisational expression of caring, where respectful, supportive and non-punitive workplace environments enable health professionals to raise concerns, acknowledge uncertainty, participate openly in shared decision making and engage constructively with colleagues, managers and organised labour. This ethical orientation provides the foundation for the discussion that follows on the practical application of Watson's caring principles through the carative factors, transpersonal caring relationships and the development of a caring based safety culture within CHCs.

2.3.2.1 Carative factors and their relevance to comprehensive health centres

Central to Watson’s Theory of Human Caring are the carative factors, which were subsequently refined into the clinical caritas processes. These principles provide the ethical and relational foundation for compassionate healthcare practice by emphasising the development of helping-trusting relationships, the encouragement of emotional expression, collaborative problem solving within caring contexts, and the creation of

supportive and protective environments (Devi, Pradhan, Giri & Lepcha 2022:1464; Vujanić, Prlić & Lovrić 2020:3). Rather than viewing caring as the performance of clinical tasks alone, the theory positions caring as a professional value that guides respectful interactions among patients, colleagues, managers and other stakeholders, thereby strengthening trust, empathy and ethical responsibility within healthcare organisations.

Within rural CHCs, the application of the carative factors contributes to workplace environments in which psychological safety, mutual respect and interprofessional collaboration can flourish. Health professionals who perceive their working environment as supportive and respectful are more likely to participate openly in shared decision making, communicate constructively and engage in collaborative problem solving with colleagues, managers and organised labour. These caring principles are particularly relevant in resource constrained rural settings, where effective collaboration depends not only on clinical competence but also on trusting professional relationships that promote staff wellbeing, organisational cohesion and high-quality patient care.

2.3.2.2 Transpersonal caring in interprofessional relationships

A central principle of Watson's Theory of Human Caring is the concept of transpersonal caring, which emphasises authentic human to human relationships that extend beyond task orientated interactions. The theory recognises caring as a moral and relational process that acknowledges both the healthcare provider and the recipient as individuals with inherent dignity, shared humanity and equal moral worth (Doherty 2020:56). Contemporary scholarship further demonstrates that transpersonal caring is not confined to interactions between health professionals and patients but also shapes the quality of relationships among colleagues by fostering empathy, mutual respect and ethical accountability within interprofessional teams (Aghaei et al 2020:3). Consequently, transpersonal caring provides an important relational framework for strengthening communication, trust and collaborative practice within healthcare organisations.

Within CHCs, the application of transpersonal caring encourages health professionals, managers and organised labour representatives to engage with one another as collaborative partners working towards shared organisational and patient care goals. By promoting respectful dialogue, mutual understanding and appreciation of diverse professional roles, this approach contributes to reducing hierarchical barriers, minimising

workplace conflict and strengthening interprofessional relationships. In the context of the present study, transpersonal caring reinforces the ethical and relational principles underpinning the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model by demonstrating that sustainable collaboration depends not only on professional competence but also on caring relationships characterised by trust, respect and shared responsibility.

2.3.2.3 Caring as the foundation of a safety culture

Watson's Theory of Human Caring supports the view that caring and safety are mutually reinforcing rather than independent organisational values. A caring workplace culture promotes psychological safety, open communication and mutual accountability, all of which are recognised as essential components of effective teamwork and patient safety (Schot et al 2020a:333). When health professionals experience respect, compassion and supportive workplace relationships, they are more likely to report errors, support colleagues and consistently adhere to safe professional practices.

Within rural CHCs, where staff shortages, heavy workloads and resource constraints frequently challenge professional relationships, a caring based organisational culture contributes to strengthening morale, emotional wellbeing and collaborative engagement. Contemporary scholarship further demonstrates that caring for oneself and others is fundamental to sustaining emotional resilience and professional competence (Butler, Mercer, McClain Meeder, Horne & Dudley 2019:120), while the early integration of collaborative and caring practices within organisational systems and leadership structures helps reduce professional silos and promotes safer, more coordinated patient care (Delawala Haldar, Chatterjee & Mukherjee 2021:3).

Watson's theory has also been the subject of constructive scholarly critique. Although recent literature continues to affirm its value in promoting dignity, compassion, authentic human relationships and caring organisational cultures (King, Rossetti, Smith, Smyth, Moscatel, Raison, Gorman, Gallegos & Watson 2021:283), this study recognises that caring discourse should not be interpreted in isolation from the structural realities that influence workplace relationships. When applied uncritically, caring principles may inadvertently obscure organisational power imbalances or divert attention from systemic challenges requiring institutional intervention. For this reason, Watson's Theory of Human

Caring is adopted in the present study for its ethical and relational contribution, while the Labour Management Partnership Framework, discussed in Section 2.3.3, provides the complementary organisational and governance perspective needed to safeguard labour rights, organisational accountability and workforce protection. Table 2.2 below presents a summary of the main contributions of Watson's theory to this study.

Table 2.2 Summary of key contributions of Watson's theory to this study

Contribution	Application to the study
Moral and relational foundation	Provides a lens for understanding how empathy, dignity and respect shape interprofessional relationships
Carative factors	Guides emotional safety, compassion and mutual trust within CHCs
Transpersonal caring	Promotes authentic engagement between health professionals, management and unions
Caring-based safety culture	Connects emotional wellbeing with professional accountability, teamwork and workplace safety

Table 2.2 demonstrates that Watson's Theory of Human Caring contributes the ethical and relational dimension of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model. Rather than conceptualising collaboration as a purely transactional workplace activity, the theory positions collaborative practice as a caring, respectful and relationally accountable process involving health professionals, managers and organised labour. Within the integrated theoretical framework developed for this study, Maslow's Hierarchy of Needs explains the motivational conditions that support professional engagement, whereas Watson's Theory of Human Caring provides the ethical principles and interpersonal values required to translate those conditions into respectful and sustainable collaborative practice. The discussion therefore proceeds to the Labour Management Partnership Framework, which extends these motivational and relational foundations by examining the organisational structures and governance arrangements necessary to support long term collaborative partnerships within rural CHCs.

2.3.3 Labour-Management Partnership (LMP) model

The Labour-Management Partnership (LMP) Model provides a structured organisational framework for promoting collaboration between employees, management and organised labour within complex institutions such as public healthcare systems. Although its origins lie in industrial labour relations, the model has evolved to address the realities of

professional healthcare environments, where effective service delivery depends on balancing clinical responsibilities with labour rights, organisational accountability and collaborative decision making (Huang et al 2023:613). By emphasising shared governance, joint problem solving and mutual accountability, the LMP Model offers an appropriate framework for understanding how constructive relationships are established and sustained among health professionals, facility managers and trade union representatives.

Within the context of the present study, the LMP Model extends the theoretical foundations established by Maslow's Hierarchy of Needs and Watson's Theory of Human Caring by translating motivational and relational principles into practical organisational processes. Its focus on partnership, dialogue and collective responsibility provides a valuable lens for examining how workplace challenges may be addressed collaboratively within rural CHCs, where resource limitations, workforce pressures and organisational complexity frequently require cooperative engagement among multiple stakeholders. Consequently, the model provides the governance and partnership perspective upon which the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model is further developed.

2.3.3.1 Core principles of the LMP model

The LMP model is founded on four interrelated principles, namely shared accountability between labour and management, joint decision making on matters affecting employee welfare, transparent communication, and mutual recognition of the respective roles of management and organised labour (Huang et al 2023:569). Collectively, these principles promote collaborative governance by encouraging dialogue, trust and shared responsibility in organisational decision making. Within unionised CHCs, where professional autonomy, organisational policies and collective bargaining rights frequently intersect, the LMP Model provides a structured framework for fostering constructive engagement without diminishing either managerial authority or legitimate union representation.

In the present study, the discussion of the LMP Model is informed by the foundational Kaiser Permanente National Agreement of 1997 together with contemporary industrial relations scholarship and its more recent application within healthcare systems (Heery &

Williams 2020:201). This integrated perspective provides an appropriate conceptual basis for examining how collaborative partnerships between health professionals, managers and organised labour can strengthen workplace relationships, support shared governance and contribute to sustainable organisational performance within rural CHCs.

2.3.3.2 LMP as a catalyst for interprofessional collaboration

Interprofessional collaboration has generally been understood as cooperation among healthcare professionals working towards shared patient care goals. The Labour Management Partnership (LMP) Model broadens this perspective by recognising organised labour as a legitimate stakeholder in creating supportive, safe and collaborative practice environments. Through its emphasis on shared governance, open communication and joint problem solving, the model promotes constructive engagement between health professionals, managers and trade union representatives. Evidence indicates that effective implementation of LMP structures is associated with improved communication, reduced workplace conflict, more efficient dispute resolution and a transition from adversarial labour relations towards collaborative governance (Huang et al 2023:613; Vatn & Dahl 2022:186). These organisational attributes are particularly important within rural CHCs, where resource constraints, hierarchical structures and workplace safety concerns may impede effective teamwork and collaborative practice.

Contemporary research further demonstrates that the LMP Model contributes to psychological safety by creating organisational environments in which employees are encouraged to communicate openly without fear of reprisal (Rico & Cabrer Borrás 2021:1). In this respect, the model complements Watson's Theory of Human Caring by reinforcing ethical workplace relationships founded on trust, respect and shared responsibility, while also reflecting the principles of Ubuntu, which emphasise collective wellbeing, mutual humanity and collaborative engagement. Within the present study, these complementary perspectives strengthen the conceptual basis for understanding how partnership-based governance can enhance interprofessional collaboration and contribute to the development of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

2.3.3.3 Relevance to rural comprehensive health centres

Rural CHCs operate within socio-economically constrained environments, characterised by limited infrastructure, shortages of skilled personnel and heightened labour tensions during periods of service disruption. In such settings, conventional top-down management approaches frequently prove inadequate for addressing the complex organisational and workforce challenges confronting healthcare institutions. The Labour Management Partnership (LMP) Model provides a structured framework for fostering inclusive, values driven labour relations by encouraging management and organised labour to work collaboratively in addressing occupational safety concerns, workload pressures and staff grievances (Opele 2022:340). Contemporary health systems literature further reinforces the importance of organised labour as a legitimate partner in workforce governance rather than merely an external adversarial force.

A scoping review by Dierkes, Gigli, Dutchess and Martsolf (2024:64) found that nursing unions are associated with measurable nurse, patient and health system outcomes, although the available evidence remains uneven. Similarly, within the South African context, Malatji et al (2024:24) demonstrate that community level health workers continue to advocate for greater recognition, improved employment conditions and stronger labour representation, highlighting the need for structured labour management engagement within primary healthcare settings.

The successful implementation of the LMP Model nevertheless depends on the ability of health professionals, managers and organised labour representatives to build collaborative relationships through effective communication, emotional intelligence and constructive conflict resolution. Rico and Cabrer Borrás (2021:1) argue that, in the absence of these competencies, labour management partnership structures risk becoming symbolic rather than functional. Collectively, the literature demonstrates that the LMP Model provides an appropriate organisational framework for strengthening shared governance, communication and accountability within rural CHCs (Huang et al 2023:613; Rico & Cabrer Borrás 2021:5). Within the integrated theoretical framework of this study, Maslow's Hierarchy of Needs establishes the motivational foundation for collaboration, Watson's Theory of Human Caring provides its ethical and relational basis, while the LMP Model contributes the governance structures through which health professionals, managers and organised labour can share responsibility for improving

workplace conditions. These organisational principles inform the interpretation of participants' experiences and contribute directly to the development of the Interprofessional Union and Collaborative Partnership (IPUCP) Model presented in Chapter 7, while providing a natural transition to the Interprofessional Education Collaborative Practice Framework discussed in the following section.

2.3.4 Interprofessional education and collaborative practice (IPECP) framework

Interprofessional collaboration is widely recognised as a key strategy for improving healthcare quality, strengthening workforce cohesion and enhancing patient safety within primary healthcare systems. The Interprofessional Education and Collaborative Practice (IPECP) Framework provides a structured approach to understanding how health professionals from different disciplines learn with, from and about one another to improve collaborative practice and service delivery (Interprofessional Education Collaborative (IPEC) 2023:3; Seaton, Jones, Johnston & Francis 2021:224). This framework is particularly relevant to rural CHCs, where limited resources, increasing service demands and overlapping professional responsibilities require effective multidisciplinary collaboration.

The IPEC Core Competencies Version 3 identifies four interrelated domains that underpin collaborative practice, namely values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork (IPEC 2023:5). Collectively, these domains provide the behavioural competencies required to strengthen collaboration among health professionals, managers and organised labour. The values and ethics domain promotes mutual respect, cultural humility and a shared commitment to patient centred care, principles that closely align with Watson's Theory of Human Caring, where empathy, respect and moral responsibility are recognised as essential attributes of professional practice (Aghaei et al 2020:3).

The roles and responsibilities domain emphasises the importance of clearly defining professional boundaries, responsibilities and expectations in order to minimise role ambiguity and enhance coordinated decision making. This is particularly relevant within rural CHCs, where health professionals frequently undertake responsibilities beyond their formal scopes of practice because of workforce shortages and service demands. Greater role clarity reduces duplication of responsibilities, strengthens accountability and

promotes constructive collaboration among health professionals, managers and organised labour representatives, including those who simultaneously fulfil professional and union leadership roles (Joseph & Gaba 2020:269).

Interprofessional communication and teamwork constitute the operational foundation of collaborative practice. Effective communication promotes timely information sharing, respectful dialogue and responsiveness to professional, cultural and organisational differences, thereby reducing conflict and strengthening trust among healthcare professionals, managers and organised labour (Rico & Cabrer Borrás 2021:1). Likewise, effective teamwork enables shared decision making, collaborative problem solving and collective accountability while enhancing organisational resilience in the face of staff shortages, resource limitations and increasing community healthcare demands (Sherman & Pfeifle 2024:99).

Evidence from both international and South African studies reinforces the value of the IPECP Framework in strengthening collaborative practice. Community based interprofessional models have been shown to improve service accessibility, health literacy and care coordination when supported by clearly defined roles and shared goals (Ijiga, Enyejo, Odeyemi, Olajide, Olajide & Daniel 2024:90), while successful collaboration also depends on recognising and addressing unequal power relationships between health professionals, labour organisations and healthcare institutions (Fichtenberg, Delva, Minyard & Gottlieb 2024:568). Within the South African context, collaborative practice continues to be constrained by siloed professional cultures, leadership and management challenges, communication barriers, resource limitations and inconsistent organisational support (Mohamed et al 2024:1-2, 5-8). Furthermore, Müller, Archer and Couper (2024:1) demonstrate that rural multidisciplinary placements provide valuable opportunities for interprofessional learning despite the contextual and logistical constraints affecting rural healthcare settings.

Within the integrated theoretical framework developed for this study, the IPECP Framework contributes the behavioural competency dimension of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model. Whereas Maslow's Hierarchy of Needs explains the motivational conditions for collaboration, Watson's Theory of Human Caring provides the ethical and relational foundation, and the Labour Management Partnership Model establishes the organisational governance

structure, the IPECP Framework operationalises these perspectives by identifying the competencies required for values-based practice, role clarity, effective communication and teamwork. Consequently, the framework provides the practical mechanism through which collaborative relationships among health professionals, managers and organised labour may be translated into safe, accountable and sustainable practice within rural CHCs. The following section introduces Dickoff, James and Wiedenbach's Practice Theory as the operational framework through which these integrated theoretical foundations are translated into the components and implementation processes of the proposed model.

2.4 LEGISLATIVE AND POLICY FRAMEWORK GOVERNING COMPREHENSIVE HEALTH CENTRES

This section examines the legislative and policy framework that governs CHCs and provides the regulatory context for secure interprofessional collaborative partnerships involving health professionals, management and organised labour. It considers the South African legislative environment together with selected national and international policy commitments that promote safe workplaces, collaborative governance and quality primary healthcare. The discussion is further informed by the principles of primary healthcare articulated in the Alma Ata Declaration, which defines primary healthcare as essential healthcare that is universally accessible through practical, scientifically sound and socially acceptable approaches (WHO 1978/2023: para. 1), and reaffirmed in the Astana Declaration, which positions primary healthcare as central to achieving universal health coverage and equitable, people centred health services (WHO 2018: para. 2). Collectively, these legislative and policy frameworks provide the contextual foundation for interpreting collaboration, workforce governance and occupational safety within rural CHCs.

2.4.1 Primary healthcare re-engineering model (PHCReM)

South Africa’s Primary Healthcare Re Engineering Model (PHCReM) was established to strengthen the District Health System (DHS) through the reorganisation and integration of primary healthcare services, building on the principles of the 1995 District Health System policy (Maduna 2022:302). The DHS comprises a network of healthcare services delivered through different categories of health facilities to improve equitable access to quality healthcare and promote efficient allocation of health resources in accordance with

national health priorities (South Africa 2003). Within this integrated system, CHCs occupy a strategic position by providing a broad range of primary healthcare services while supporting referral pathways between primary healthcare clinics and district hospitals.

The PHC Re Engineering policy further introduced an integrated platform consisting of eight-hour clinics, twenty-four-hour community health centres, ward-based outreach teams and district clinical specialist teams to strengthen service delivery across the District Health System (NDoH 2011: section 3). This integrated approach seeks to improve access to essential healthcare services, strengthen disease prevention and health promotion, and enhance continuity of care, particularly for vulnerable communities (DoH 2019a:6). Recent evidence further indicates that the model improves patient management at primary healthcare level by promoting standardised service delivery and adherence to national treatment guidelines (Naidoo et al 2024:3-4). The organisational structure and service integration envisaged by the Primary Healthcare Re Engineering Model are illustrated in Figure 2.1, which depicts the position of CHCs within the District Health System and their relationships with other levels of healthcare delivery.

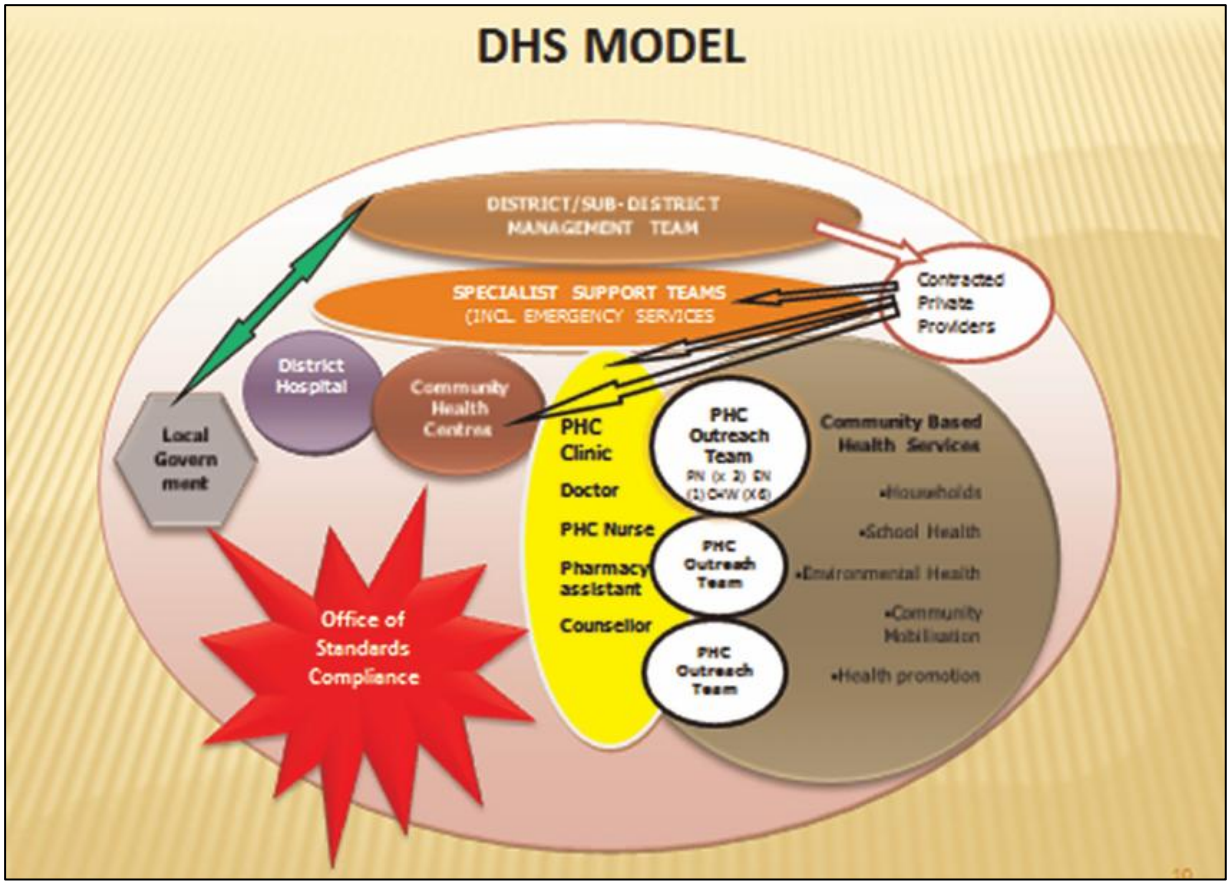


Figure 2.1 DHS model as a component of the primary health re-engineered model

(Mahomed & Asmall 2015:5)

Figure 2.1 illustrates the organisational structure of the re-engineered District Health System, demonstrating the relationships between district management, primary healthcare clinics, CHCs, district hospitals, contracted private providers and specialist support services (Mahomed & Asmall 2015:5). The figure highlights the central position of CHCs within the referral network, emphasising their role in coordinating healthcare delivery, integrating multidisciplinary services and supporting collaboration among healthcare professionals across different levels of care. As observed by Cowan, D'Ambruoso, Van Der Merwe, Witter, Byass, Ameh, Wagner and Twine (2021:2), strengthening the District Health System remains fundamental to promoting health, preventing disease and integrating primary healthcare services throughout Southern Africa.

The relevance of the PHC Re Engineering Model extends beyond service integration to workforce planning and organisational sustainability. South Africa's Human Resources for Health Strategy 2030 identifies persistent workforce inequities, maldistribution of healthcare professionals, planning deficiencies and weaknesses in organisational support systems as significant constraints to effective service delivery (DoH 2020:24). These challenges are particularly evident within rural and semi-rural CHCs, where staff shortages, increasing workloads and resource limitations frequently affect collaborative practice, employee wellbeing and workplace safety. Consequently, the PHC Re Engineering Model provides an important policy foundation for understanding the organisational environment within which the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model is intended to operate.

2.4.2 National health policies on health environment

In South Africa’s legislative and policy framework provides the statutory foundation for safe healthcare environments, collaborative labour management relations and quality primary healthcare service delivery within CHCs. Central to this framework are the National Health Act (No. 61 of 2003), which governs the organisation and delivery of health services, the Labour Relations Act (No. 66 of 1995), which promotes constructive labour management relations and fair workplace practices, and the Occupational Health and Safety Act (No. 85 of 1993), which establishes measures for protecting employees and maintaining safe working environments. Collectively, these statutes provide the legal

context within which health professionals, managers and organised labour collaborate to strengthen workplace safety, employee participation and the delivery of equitable, quality healthcare services, particularly within rural and semi- rural CHCs.

2.4.2.1 National Health Act (No. 61 of 2003) and secure health facilities

The National Health Act (No. 61 of 2003), as amended, provides the overarching legislative framework for the organisation, governance and quality of healthcare services in South Africa. A key mechanism established under the Act is the Office of Health Standards Compliance (OHSC), which is responsible for monitoring compliance with prescribed norms and standards across health establishments, including hospitals, clinics and CHCs. Through the development and implementation of national core standards, the OHSC promotes quality healthcare, patient safety and continuous improvement in health service delivery (Shenaaz 2023:931). Central to these standards are the promotion of quality clinical care and ethical practice, the reduction of preventable harm to healthcare users, and the effective management of adverse events affecting both patients and healthcare personnel.

The provisions of the National Health Act are directly relevant to the present study because they establish the institutional conditions necessary for safe, accountable and collaborative healthcare environments. Beyond regulating patient care, the Act recognises that effective leadership, corporate governance, operational management, infrastructure and public health systems collectively support the delivery of quality healthcare services. The powers vested in the OHSC to inspect health establishments, monitor compliance and investigate complaints further reinforce organisational accountability and continuous quality improvement. Consequently, the Act provides an important legislative foundation for understanding how patient safety, employee wellbeing, workplace governance and collaborative practice intersect within rural CHCs, thereby supporting the development of secure interprofessional and union partnerships envisaged by the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

2.4.2.2 Labour Relations Act (No. 66 of 1995)

The Labour Relations Act (No. 66 of 1995) provides the legislative framework for promoting fair labour practices, workplace democracy, social justice and labour peace

through constructive engagement between employers and employees. Within the healthcare sector, the Act affirms the rights of employees to union membership, consultation, participation in workplace decision making and collective engagement, while encouraging collaborative labour management relationships that contribute to safe and productive working environments. These principles are directly relevant to CHCs, where effective collaboration between health professionals, managers and organised labour is essential for maintaining both employee wellbeing and quality healthcare service delivery.

Furthermore, Sections 78 to 94 of Chapter 5 provide for the establishment of workplace forums as mechanisms for promoting consultation and cooperation between employers and organised labour. However, these provisions apply only to workplaces employing at least one thousand employees, creating a practical limitation for most rural CHCs, where staffing levels are considerably lower. This legislative gap is particularly relevant to the present study, which seeks to explore how collaborative workplace relationships are experienced and sustained within smaller healthcare facilities despite the absence of formal workplace forum structures.

The Labour Relations Act further promotes consultation on matters affecting employee welfare and workplace conditions through institutional mechanisms that support dialogue between employers and employee representatives. In particular, Section 19(1) provides for consultation between the employer and the health and safety committee, reinforcing the importance of collaborative governance in promoting safe workplaces. Contemporary evidence similarly highlights the value of stable workplace relationships in supporting an appropriate balance between professional responsibilities, employee wellbeing and personal life (Peiris, Sharma, Praveen, Bitton, Bresick, Coffman, Dodd, El-Jardali, Fadlallah, Flinkenflögel & Goodyear-Smith 2021: S6). Consequently, the Labour Relations Act provides an important legislative foundation for labour voice, workplace participation and collective engagement while also illustrating that statutory provisions alone are insufficient unless they are translated into meaningful participatory structures, effective communication and collaborative practice within rural CHCs.

2.4.2.3 Occupational Health Safety Act (No 85 of 1993)

The Occupational Health and Safety Act (No. 85 of 1993) provides the principal legislative framework for promoting and maintaining safe and healthy workplaces in South Africa.

The Act prescribes the respective responsibilities of employers, employees and organised labour in preventing occupational hazards and ensuring that workplaces remain safe and without risk to employees' health, as far as is reasonably practicable. Within the healthcare sector, these statutory obligations extend beyond physical safety to encompass effective communication, consultation and shared accountability among all workplace stakeholders. Rikhotso, Morodi and Masekameni (2021:1) observe that the legislation was enacted to ensure that employees across all sectors work under conditions that safeguard their health and wellbeing. The Act further requires employers to establish appropriate health and safety policies, communicate workplace risks, implement preventative measures and maintain systems for reporting occupational hazards and incidents. Consequently, communication becomes a fundamental mechanism through which health and safety policies, procedures and organisational responsibilities are translated into practice.

Within CHCs, the Occupational Health and Safety Act places significant responsibility on facility managers, under the leadership of district management, to create and sustain therapeutic and safe working environments. Effective implementation depends not only on compliance with legislative requirements but also on collaborative leadership, interprofessional cooperation and constructive engagement with organised labour. Accordingly, managers are expected to promote organisational cultures characterised by shared responsibility, open communication and mutual accountability while ensuring that health and safety policies are regularly communicated, implemented, monitored and reviewed. Equally important is the active participation of employees and trade unions in identifying workplace risks, supporting policy implementation and strengthening occupational health and safety programmes. These collaborative processes recognise that workplace safety is achieved through coordinated organisational effort rather than through managerial authority or individual compliance alone.

Despite this comprehensive legislative framework, challenges remain in translating statutory obligations into effective workplace practice. Rikhotso et al (2021:40) caution that employees are legally entitled to refuse dangerous work where occupational risks are not adequately addressed, while unions have increasingly exercised this right in response to unsafe working conditions. The authors further argue that shortcomings in employer compliance and inadequate investment in occupational health and safety continue to undermine effective implementation of the Act, thereby contributing to strained labour

management relationships (Rikhotso et al 2021:41). For the present study, the Occupational Health and Safety Act provides the strongest legislative foundation for understanding the interrelationship between workplace safety, communication, organisational accountability and union participation. It reinforces the premise that secure CHCs require integrated safety systems, collaborative governance and sustained partnerships among health professionals, managers and organised labour to promote safe, accountable and quality healthcare environments.

2.4.2.4 National Health Insurance Act (No. 2023)

The National Health Insurance Act (No. 20 of 2023) establishes a health financing system designed to pool public funds to ensure equitable access to quality, affordable healthcare services for all South Africans according to their health needs, irrespective of socioeconomic status (Naidoo et al 2024:1). The Act seeks to address longstanding inequalities within South Africa's dual public and private healthcare system by promoting universal health coverage and strengthening access to comprehensive primary healthcare services, including those delivered through CHCs (NHI 2023: ss 2, 4, 6, 10).

The National Health Insurance Act is directly relevant to the present study because the successful implementation of universal health coverage depends not only on sustainable financing but also on the effectiveness of the primary healthcare platform. In particular, CHCs require collaborative leadership, effective interprofessional communication, safe working environments and constructive labour management partnerships to deliver equitable, quality healthcare services. Consequently, the Act reinforces the importance of strengthening organisational capacity and collaborative practice within rural CHCs, thereby supporting the objectives of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

2.4.2.5 Compensation for Occupational Injuries and Diseases (COID) Act (No. 130 of 1993)

The Compensation for Occupational Injuries and Diseases (COID) Act (No. 130 of 1993) provides statutory protection for employees who sustain occupational injuries, diseases or death arising from the course of their employment. The Act replaced the Workmen's Compensation Act (No. 30 of 1941) and established a compensation system funded

through employer contributions to support employees or their dependants following work related injuries or occupational diseases. Within the healthcare sector, this legislation recognises that health professionals, like the patients they serve, are entitled to safe working environments and appropriate protection against occupational risks. The importance of these safeguards is underscored by evidence indicating that occupational hazards, compromised workplace safety and work-related diseases contribute substantially to morbidity and mortality among healthcare workers (Debelu Mengistu, Tolera, Aschalew & Deriba 2023:1).

The COID Act is directly relevant to the present study because it reinforces employer accountability for preventing occupational injuries, maintaining appropriate reporting systems and protecting employees who experience workplace related harm. Effective implementation requires commitment from management, employees and organised labour to promote safe working environments, prevent workplace incidents and strengthen occupational health and safety practices (Mujtaba, Kaifi & Lawrence 2023:7). Within rural CHCs, where resource limitations may heighten occupational risks, the Act strengthens the principle that employee safety is inseparable from service quality, organisational accountability and sustainable healthcare delivery. Consequently, it supports the study's argument that effective reporting mechanisms, labour participation and collaborative governance are essential components of secure and resilient CHCs.

2.4.3 Global policies and commitments on interprofessional practice and union partnership

This sub-section reviews selected global, international and African policy commitments that promote interprofessional collaboration, workforce protection and constructive labour-management partnerships within primary healthcare systems. It examines how this policy frameworks advance safe working environments, decent work, health equity and collaborative governance as essential components of sustainable healthcare delivery. Within the context of the present study, these commitments are particularly relevant because the challenges experienced in rural CHCs extend beyond local operational realities to reflect broader health system concerns relating to workforce shortages, occupational safety, interprofessional collaboration, labour participation and the long-term sustainability of primary healthcare services.

2.4.3.1 The SDG global policy position

The United Nations 2030 Agenda for Sustainable Development provides a comprehensive global policy framework for promoting health, social justice, decent work and sustainable partnerships across all sectors, including healthcare. Eisenmenger, Pichler, Krenmayr, Noll, Plank, Schalmann, Wandl and Gingrich (2020:1101-1102) recognise the Sustainable Development Goals (SDGs) as a transformative platform that encourages collaboration among governments, institutions and stakeholders to achieve equitable and sustainable development. Within the health sector, the WHO (2021b:16) further emphasises that the SDGs provide an important foundation for strengthening participation, collaborative governance and safe working environments, while encouraging health systems to invest in the resources necessary to achieve quality healthcare and workforce sustainability.

Several SDGs are directly aligned with the objectives of the present study. In particular, SDG 3 promotes good health and wellbeing, SDG 8 advances decent work and inclusive economic growth, SDG 10 seeks to reduce inequalities, SDG 16 promotes peace, justice and effective institutions, while SDG 17 emphasises partnerships for achieving sustainable development. Reynolds and Buffel (2020:352) similarly argue that these goals support the creation of collaborative, safe and therapeutic working environments through effective communication, professional cooperation and institutional accountability. Collectively, these policy commitments reinforce the importance of respectful workplace relationships, interprofessional collaboration and constructive labour management partnerships in strengthening primary healthcare services.

The implementation of these global commitments is further supported by workplace health and safety initiatives that encourage employers and employees to address physical, psychological and organisational risks while promoting employee wellbeing and community participation (National Institute for Occupational Safety and Health (NIOSH) 2019b: para. 7). Consistent with the principles underpinning the Occupational Health and Safety Act (No. 85 of 1993), these initiatives recognise that sustainable health systems depend on safe working environments, effective communication and collaborative engagement among all stakeholders. Consequently, the SDGs provide an important global policy foundation for the present study by demonstrating that health equity, decent work, institutional accountability and partnership are mutually reinforcing principles that support secure, collaborative and sustainable CHCs.

2.4.3.2 International context on interprofessional and union safe collaborative partnership

International health policy increasingly recognises that effective healthcare systems depend on a well-supported, competent and collaborative workforce. The World Health Organization's Global Human Resources for Health (HRH) Strategy seeks to strengthen national health systems by increasing the availability, competency and retention of health professionals while improving job satisfaction and workforce sustainability (Farrenkopf & Lee 2019:464). Similarly, Amoah, Anokye, Boakye, Acheampong, Budu-Ainooson, Okyere, Kumi-Boateng, Yeboah and Afriyie (2019:3) emphasise that effective regulatory systems are essential for ensuring the production, professional development and continued support of competent health professionals. Collectively, these international policy initiatives recognise that workforce planning, professional regulation and organisational support are fundamental to achieving safe, high-quality healthcare services.

International labour literature further demonstrates that collaborative workplace relationships are shaped by broader labour market and governance contexts. Muszyński (2020a:53) argues that workplace restructuring in several Central and Eastern European countries has exposed weaknesses in labour law enforcement, highlighting the need for continuous policy review and contextual adaptation rather than reliance on uniform regulatory approaches. The author further observes that the destandardisation of employment relationships has altered the traditional role of organised labour, creating complex power relationships between health professionals, managers and trade unions (Muszyński 2020b:77).

Similar challenges have been reported in countries such as the United States, Germany, the United Kingdom, the Netherlands, Norway and Israel, where changing labour market conditions have reduced the protective capacity traditionally associated with union membership (Muszyński 2020b:77). Nevertheless, Blanchflower, Bryson and Green (2021:275) note that union membership remains comparatively high within professional occupations because of the employment protection and collective bargaining benefits it offers, while Chiu, Villeneuve and Paul (2020:176) demonstrate that labour management relationships within the Canadian healthcare sector continue to reflect tensions associated with organisational authority and union representation.

International organisations have also increasingly invested in strengthening occupational safety and workforce protection within healthcare systems. The International Committee of the Red Cross has supported initiatives aimed at improving the safety and security of health professionals and healthcare facilities through collaboration with governments, professional associations and ministries of health, particularly within African countries (Chersich, Gray, Fairlie, Eichbaum, Mayhew, Allwood, English & Scorgie 2020:4-5). These initiatives acknowledge that shortages of human resources, inadequate protective equipment and organisational constraints continue to undermine safe healthcare delivery (Chersich et al 2020:4-5). Collectively, the international literature demonstrates that effective interprofessional and labour management collaboration depends on integrated workforce planning, supportive labour policies, occupational safety, organisational leadership and institutional accountability. These global experiences provide an important policy context for understanding the collaborative challenges encountered within African and South African CHCs and reinforce the rationale for the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

2.4.3.3 African context

Healthcare systems across Africa continue to face complex challenges that influence workforce stability, service delivery and collaborative practice. Evidence from Nigeria demonstrates that repeated disruptions to healthcare services have negatively affected the continuity and quality of care, while collaborative learning initiatives supported by organised labour have contributed to improved staff morale, productivity and organisational adaptability (Idowu 2023a:11). Nevertheless, persistent challenges, including mutual distrust, workplace tension, factionalism and competing organisational interests, continue to undermine effective labour management relationships. These findings highlight the importance of strengthening teamwork, trust and collaborative problem solving to promote resilient primary healthcare systems across the African continent. Furthermore, African healthcare practice is shaped by sociocultural values that emphasise interpersonal relationships, ethical conduct and respect for community beliefs and traditions, principles that remain fundamental to collaborative healthcare delivery (Okpaku 2019:291).

Across Africa, organised labour continues to play an evolving role in supporting workforce participation, organisational accountability and collaborative governance. Visser (2019:18, 47) argues that trade unions are undergoing significant transformation in response to changing workplace environments and technological developments, requiring renewed forms of partnership between employers, employees and organised labour. Similarly, participatory management approaches increasingly replace traditional hierarchical leadership by encouraging shared decision making and collaborative workplace governance (Schot et al 2020a:333). Through Labour Management Partnerships, health professionals, managers and organised labour collectively contribute to creating healthier workplaces, reducing occupational risks and strengthening accountability for employee wellbeing and quality healthcare delivery. These developments reinforce the need for continued leadership development, organisational capacity building and effective labour management collaboration within African healthcare systems.

Despite these advances, many African countries continue to experience significant constraints arising from resource shortages, political instability and, in some regions, civil conflict, all of which adversely affect the safety and sustainability of healthcare services (Assegaai & Schneider 2021:31; Nicolaides 2023:133). Within this context, the African philosophy of Ubuntu provides an important ethical foundation for fostering solidarity, mutual respect and cooperative teamwork among healthcare professionals, managers and organised labour (Assegaai & Schneider 2021:32). Ahmed, Kadaika and Schultz (2022:2404) further emphasise that sustainable workplace safety depends upon the collective commitment of all stakeholders to institutional policies, shared responsibilities and agreed organisational values, while recognising that unresolved workplace conflict undermines the creation of positive practice environments. These African perspectives reinforce the present study's argument that secure rural CHCs require collaborative leadership, ethical workplace relationships and sustained partnership among health professionals, managers and organised labour to strengthen both employee wellbeing and quality healthcare delivery.

2.4.3.4 South African context

The South African healthcare healthcare system continues to face significant challenges that influence the quality of primary healthcare services and the effectiveness of

interprofessional collaboration within CHCs. Contemporary evidence indicates that persistent workforce shortages, unequal distribution of health professionals, resource constraints and organisational weaknesses continue to affect the functioning of the primary healthcare platform (DoH 2020:24). These challenges are particularly evident in rural and semi-rural settings, where healthcare professionals are expected to deliver comprehensive services despite increasing workloads, infrastructure limitations and constrained institutional support. Consequently, strengthening collaborative practice, workforce capacity and organisational leadership has become a national priority for improving service delivery and achieving equitable healthcare outcomes.

Recent South African research further demonstrates that interprofessional collaborative practice remains constrained by siloed professional cultures, ineffective communication, leadership and management weaknesses, and limited organisational support (Mohamed et al 2024:1-2, 5-8). At the same time, labour representation continues to play an important role in advocating for improved working conditions, employee wellbeing and equitable participation within healthcare organisations. Malatji et al (2024:12) similarly report that many community level health workers continue to experience challenges relating to recognition, employment conditions and meaningful labour participation. These findings suggest that sustainable improvements in healthcare delivery require stronger collaboration between health professionals, managers and organised labour, supported by effective governance structures and context responsive leadership.

Taken together, the global, African and South African literature confirms that secure collaboration within rural CHCs cannot be adequately explained through a single theoretical perspective. Rather, the evidence consistently demonstrates that collaborative practice is influenced by motivational factors, ethical relationships, behavioural competencies and organisational governance. These contextual realities provide a strong justification for integrating complementary theoretical perspectives to explain the phenomenon under investigation. Accordingly, Table 2.3 presents a comparative analysis of the four theoretical frameworks that collectively inform the conceptual foundation of the proposed Interprofessional Union and Collaborative Partnership (IPUCP) Model.

Table 2.3 Comparative summary of the four theoretical frameworks underpinning the IPUCP model

Aspect	Maslow's Hierarchy of Needs	Watson's Theory of Human Caring	Interprofessional Collaborative Practice (IPC)	Labour-management Partnership (LMP)
Originator	Abraham Maslow (1943).	Jean Watson (1979, later refinements).	WHO (2010); IPEC (2016).	Harvard School of Public Health, Kaiser Permanente, and Unions (1997).
Discipline	Psychology/ Human Motivation.	Nursing/Caring Science.	Health Professions Education and Practice.	Industrial Relations/Health Systems.
Main Concept	Human needs are arranged in a hierarchy from basic to advanced.	Caring is essential to healing and meaningful human relationships.	Effective collaboration improves patient and provider outcomes.	Shared governance and decision-making between labour and management.
Structure	Five-level hierarchy: 1. Physiological 2. Safety 3. Love/Belonging 4. Esteem 5. Self-actualisation.	Non-hierarchical. Based on 10 Caritas Processes promoting transpersonal caring.	Based on four domains: Values, roles, communication, teams.	Based on principles of trust, mutual respect, and accountability.
Goal	Achieve self-actualisation through satisfaction of lower needs.	Promote holistic healing, dignity, and mutual respect.	Foster collaborative, team-based care and health system efficiency.	Improve workplace satisfaction, productivity, and service quality.
Application to Rural CHCs	Staff and unions must feel safe, valued, and included before effective collaboration can occur.	Encourages HCPs and leaders to treat each other with compassion, empathy, and respect.	Strengthens interprofessional teamwork in rural, resource-limited settings.	Provides a structured way to include unions in decisions affecting staff well-being.
Emphasis in Collaboration	Stresses fulfilling safety, esteem, and belonging needs to reduce conflict and promote teamwork.	Centres on interpersonal connectedness, creating emotionally safe and caring workspaces.	Emphasises shared decision-making, role clarity, and communication.	Emphasises co-ownership of decisions, problem-solving and joint training.
Relevance to the Model	Underpins the motivational and psychosocial needs driving sustainable	Provides the ethical and philosophical foundation for caring, equitable	Offers a practice framework to build teamwork competencies and collaboration	Anchors union inclusion in management and staff affairs, promoting

Aspect	Maslow's Hierarchy of Needs	Watson's Theory of Human Caring	Interprofessional Collaborative Practice (IPC)	Labour-management Partnership (LMP)
	collaboration.	labour-management relations.	culture.	democratic workplace practices.
Integration in Model	Supports development of trust-based policies and inclusive engagement practices.	Shapes the leadership ethos to embody caring and shared responsibility.	Guides to the competencies and processes in building functional interprofessional teams.	Ensures formalised, sustained partnership structures for collaboration.

The comparative analysis presented in Table 2.3 demonstrates that the four theoretical frameworks are complementary rather than competing perspectives. Maslow's Hierarchy of Needs explains the motivational and psychosocial conditions necessary for collaboration; Watson's Theory of Human Caring provides the ethical and relational foundation for respectful engagement; the Interprofessional Education and Collaborative Practice (IPECP) Framework identifies the behavioural competencies required for effective collaborative practice; and the Labour Management Partnership (LMP) Model provides the organisational governance structures that facilitate shared decision making, labour participation and workplace accountability. Collectively, these frameworks establish the conceptual foundation upon which the proposed IPUCP Model is developed, providing an integrated lens for understanding and strengthening secure interprofessional and union collaborative partnerships within rural community health centres.

2.5 INTERPROFESSIONAL AND UNION COLLABORATIVE PATNERSHIP (IPUCP): LITERATURE-DERIVED FRAMEWORK

Interprofessional collaboration is generally defined as the process through which two or more health professionals from different disciplines work collaboratively to improve healthcare delivery, strengthen teamwork and promote shared responsibility for patient outcomes (Schot et al 2020a:333). In the context of the present study, the Interprofessional and Union Collaborative Partnership (IPUCP) is conceptualised as a literature-derived framework that extends conventional interprofessional collaboration by explicitly incorporating organised labour participation into collaborative healthcare practice. The framework recognises that effective collaboration within CHCs depends not only on productive relationships among health professionals, but also on constructive

engagement between managers, organised labour and employees in creating safe, accountable and supportive workplaces. This perspective aligns with international health workforce and patient safety priorities that advocate collective responsibility, resilient health systems and positive practice environments as prerequisites for quality healthcare delivery (WHO 2019b:1-5; WHO 2021c:30-60; WHO 2022:10-25).

Within this chapter, the IPUCP framework is presented as a literature-derived conceptual framework rather than the final model developed by the study. Its primary purpose is to synthesise the evidence reviewed in Sections 2.3 and 2.4 into an integrated understanding of three interrelated pillars underpinning the study, namely interprofessional collaboration, organised labour participation and workplace security within rural CHCs. The reviewed literature consistently demonstrates that these dimensions are mutually reinforcing and cannot be addressed in isolation, as effective collaboration is shaped by leadership, communication, shared governance, professional relationships and organisational safety. Consequently, the IPUCP framework serves as the conceptual bridge between the theoretical foundations discussed earlier in the chapter and the empirically derived model presented in Chapter 7, integrating Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Labour Management Partnership (LMP) Model and the Interprofessional Education and Collaborative Practice (IPECP) Framework into a coherent foundation for analysing and strengthening collaborative practice in rural CHCs.

2.5.1 Core structural and organisational foundations of IPUCP

The structural foundation of the Interprofessional and Union Collaborative Partnership (IPUCP) framework is grounded in organisational approaches that promote collaborative governance, shared accountability and joint problem solving rather than traditional adversarial relationships. Central to this foundation is the Labour Management Partnership (LMP) Model, which encourages consultation, employee participation and shared decision making among health professionals, managers and organised labour to strengthen workplace safety and organisational performance (Hosono 2020:50; Spiegel, Zungu, Yassi, Lockhart, Wilson, Okpani, Jones & Sanabria 2023:2). Within this partnership approach, workplace challenges are addressed collectively on the premise that those directly involved in service delivery are best positioned to identify practical solutions. The Kaizen partnership pathway similarly reinforces this collaborative

philosophy by promoting continuous improvement, teamwork and a culture of safety as essential organisational practices (Hosono 2020:51).

The organisational structure of the IPUCP framework is further strengthened by the World Health Organization's Interprofessional Education and Collaborative Practice (IPECP) Framework, which provides the behavioural and operational competencies required for effective collaborative practice (Van Diggele, Roberts & Mellis 2020:5). Consistent with the IPECP framework, sustainable collaboration depends upon shared ethical values, clearly defined professional roles, effective communication, teamwork and collective responsibility for service delivery (Schot et al 2020a:333). These competencies require deliberate organisational planning, leadership support and continuous professional development to translate collaborative intentions into everyday practice (Van Diggele et al 2020:5). Accordingly, the IPUCP framework recognises that successful collaboration within rural CHCs cannot rely solely on individual goodwill, but requires formal governance structures, role clarity, accountable leadership and institutional mechanisms that facilitate meaningful engagement among health professionals, managers and organised labour, particularly within resource constrained healthcare environments.

2.5.2 Relational dynamics: Psychological readiness and therapeutic communication

While effective organisational structures provide the foundation for collaboration, their successful implementation ultimately depends on the quality of interpersonal relationships among those responsible for delivering healthcare services. Within the Interprofessional and Union Collaborative Partnership (IPUCP) framework, collaborative practice requires psychological readiness, mutual trust, ethical engagement and effective therapeutic communication to strengthen relationships between health professionals, managers and organised labour. These relational dimensions foster respect, shared understanding and constructive dialogue, thereby enabling collaborative decision making, conflict resolution and the creation of safe and supportive workplace environments within rural CHCs.

2.5.2.1 Role of intra- and interpersonal capacity

Effective interprofessional and union collaboration is fundamentally dependent on the intrapersonal and interpersonal capacities of those engaged in collaborative practice.

Intrapersonal communication refers to the internal processes through which individuals interpret their self-concept, beliefs, perceptions and expectations before interacting with others (Jankelová & Joniaková 2021:346). As such, meaningful professional relationships begin with self-awareness, self-regulation and reflective practice, which influence how health professionals communicate, negotiate and collaborate within multidisciplinary teams. In the context of the Interprofessional and Union Collaborative Partnership (IPUCP) framework, these internal capacities provide the psychological foundation for respectful engagement, shared decision making and constructive labour-management relationships.

The importance of these capacities becomes particularly evident within healthcare environments characterised by high workloads, organisational pressure and interpersonal conflict. Jankelová and Joniaková (2021:346) observe that unmanaged anger and emotional distress may impair judgement, hinder communication and contribute to adversarial workplace interactions. Consequently, health professionals, managers and union representatives require emotional intelligence, self-awareness and effective communication skills to promote objective problem solving and collaborative engagement. Rider (2023:4) further emphasises the importance of neutral leadership and purposeful dialogue in maintaining productive workplace relationships, while Al-Bsheish, Al-Bsheish, Manaf, Ismail and Nordin (2019:637) demonstrate that psychological empowerment positively influences workplace safety through employees' perceptions of management's commitment to safety. Accordingly, the IPUCP framework recognises intrapersonal and interpersonal capacity not merely as individual competencies, but as essential relational resources that strengthen teamwork, labour-management collaboration and the development of safe, supportive and accountable CHCs.

2.5.2.2 Communication, ethics and values

Effective communication is fundamental to therapeutic relationships, interprofessional collaboration and productive labour-management partnerships. Therapeutic communication integrates both verbal and non-verbal strategies to promote empathy, emotional safety, trust and mutual understanding among healthcare professionals, patients and other stakeholders (Open Resources for Nursing [Open RN] 2022:1-3). Keutchafo (2022:3) further demonstrates that non-verbal behaviours, including appropriate posture, attentive presence, eye contact and supportive body language,

strengthen interpersonal trust and improve collaborative interactions. These evidence-based communication approaches are particularly relevant within multidisciplinary healthcare settings, where respectful dialogue and effective information exchange underpin safe, coordinated and person-centred care.

Communication is inseparable from the ethical values that guide professional relationships and collaborative practice. Effective collaboration requires mutual respect, dignity, integrity and accountability, principles that are consistent with the values enshrined in the South African Constitution (Korzh & Tsodikova 2019:15). Similarly, Moudatsou, Stavropoulou, Philalithis and Koukouli (2020:26) emphasise that empathy, genuineness and unconditional positive regard strengthen therapeutic relationships by fostering trust, inclusivity and shared understanding. However, Henderson, Barker and Mak (2022:3) caution that linguistic diversity, cultural differences and resource limitations continue to present communication challenges within multilingual and rural healthcare settings, highlighting the importance of culturally responsive communication and ongoing professional development.

Within the Interprofessional and Union Collaborative Partnership (IPUCP) framework, communication is regarded as both a clinical competency and a labour-relations competency that supports collaborative governance, workplace safety and organisational effectiveness. In rural CHCs, ineffective communication may compromise patient care, weaken teamwork, undermine grievance management, hinder occupational safety reporting and erode trust between health professionals, managers and organised labour. Accordingly, the IPUCP framework positions ethical, respectful and culturally responsive communication as a core competency for strengthening collaborative practice, promoting constructive labour-management relationships and sustaining safe, accountable and high-quality healthcare environments.

2.5.3 Workplace milieu as an agent for collaboration

A positive practice environment (PPE) is widely recognised as a prerequisite for effective interprofessional collaboration, workforce wellbeing and quality healthcare delivery. Such environments promote professional growth, job satisfaction, organisational commitment and employee productivity while supporting collaborative relationships between health professionals, managers and organised labour (Dans & Lundmark 2019:8).

Organisational initiatives such as the Pathway to Excellence Programme further demonstrate that healthcare institutions can deliberately cultivate workplace cultures that promote excellence, professional engagement and sustained collaborative practice (Dans & Lundmark 2019:8).

The workplace milieu extends beyond organisational structures to include the physical, psychological and social conditions that influence the wellbeing and performance of healthcare professionals. Tulbentci and Arcan (2021:73) emphasise that healthcare facilities should function as healing environments that positively influence both employees and healthcare users. Similarly, Russell, Wakerman, Humphreys and Kuipers (2021:21) demonstrate that rural healthcare facilities that provide supportive learning and professional development opportunities are more successful in attracting and retaining health professionals. These organisational characteristics strengthen collaborative partnerships by reducing workplace stress, enhancing psychological resilience and creating conditions conducive to safe, respectful and effective teamwork.

Within the Interprofessional and Union Collaborative Partnership (IPUCP) framework, the workplace milieu is regarded as an active enabler of collaborative practice rather than merely the setting in which healthcare is delivered. Unsafe, poorly resourced or conflict-ridden work environments may erode trust, lower staff morale, intensify labour-management tensions and compromise patient care. Conversely, positive practice environments foster psychological safety, strengthen interprofessional teamwork, improve staff retention and encourage collaborative problem solving. Accordingly, the IPUCP framework recognises that sustainable collaboration within rural CHCs depends not only on individual competencies and organisational structures, but also on workplace environments that actively support safety, mutual respect and shared accountability.

2.6 STAKEHOLDER PERCEPTIONS OF INTERPROFESSIONAL AND UNION COLLABORATION

While the IPUCP framework provides a conceptual basis for understanding collaborative practice, its implementation within rural CHCs is ultimately shaped by the experiences and perceptions of the key stakeholders involved. The literature consistently demonstrates that effective collaboration depends not only on organisational structures and policy frameworks, but also on how employees, organised labour and management

perceive their respective roles, responsibilities and relationships within the workplace. Consequently, stakeholder perceptions provide valuable insight into the practical realities that either facilitate or impede collaborative practice.

Within the context of the present study, collaboration is understood as a dynamic process enacted through everyday communication, leadership, decision making, workplace culture and responses to organisational challenges and conflict. The interaction between health professionals, organised labour and management is further influenced by broader organisational, political and health system contexts that shape workplace relationships and collaborative governance. The following subsections therefore examine the perspectives of employees, organised labour and management to provide a comprehensive understanding of the factors that enable or constrain interprofessional and union collaboration within rural CHCs.

2.6.1 Employee perspective

From the employee's perspective, effective interprofessional and union collaboration is largely influenced by the quality of workplace relationships, communication and organisational support. Poor communication, unfair criticism, bullying, favouritism, discrimination, sexism and racial inequalities contribute to workplace conflict, reduce morale and compromise the quality of healthcare delivery (Saridi et al 2019:2). Such challenges are often exacerbated by high workloads, unclear organisational priorities and ineffective communication, creating environments in which collaboration and professional relationships become increasingly difficult to sustain (Saridi et al 2019:2).

Employees also require workplaces that satisfy their psychological, professional and social needs, consistent with Maslow's Hierarchy of Needs. Assegaai and Schneider (2021:32) report that employees who experience trust, belonging and organisational support demonstrate stronger organisational commitment, healthier workplace relationships, improved performance and greater staff retention. Similarly, Verdezoto, Ramos, Nunes and Fitzpatrick (2021:4) identify access to adequate resources, continuous professional development, effective communication and meaningful employee participation as important contributors to positive working conditions and reduced workplace conflict. These findings suggest that collaborative practice is

strengthened when employees perceive their work environment as fair, respectful, adequately resourced and psychologically safe.

Within the IPUCP framework, the employee perspective reinforces the view that successful collaboration depends upon more than formal organisational structures or policy directives. Employees are more likely to participate constructively in interprofessional teamwork and labour-management partnerships when they experience mutual respect, equitable treatment, supportive leadership and opportunities for meaningful engagement. Conversely, persistent communication failures, inadequate resources and discriminatory workplace practices may weaken trust, intensify conflict and undermine collaborative governance within rural CHCs. These perspectives further reinforce the relevance of Maslow's motivational theory, Watson's caring philosophy and the principles of psychological safety as essential foundations for sustainable collaborative practice.

2.6.2 Labour Union perspective

From the perspective of organised labour, trade unions are recognised as important stakeholders in promoting social justice, protecting employee rights and advancing safe, equitable and supportive workplaces. Kelly and Tham (2021:1) emphasise that labour unions play a fundamental role in safeguarding workers' interests, while Sriram et al (2023:6) argue that unions contribute to collaborative health systems by representing health professionals and influencing policy development at the interface between employers, governments and the healthcare workforce. Within the healthcare sector, organised labour therefore extends beyond grievance representation to include advocacy for workplace safety, professional dignity and quality service delivery.

Nevertheless, Sriram et al (2023:6) caution that collaborative labour-management partnerships may be undermined when labour relations become excessively politicised or adversarial, potentially affecting organisational stability and healthcare delivery. In South Africa, professional organisations such as the Democratic Nursing Organisation of South Africa (DENOSA) have consistently highlighted physical and verbal abuse against nurses as significant threats to workplace safety, while advocating stronger interprofessional collaboration, including partnerships with organisations such as the

South African Medical Association (SAMA), to strengthen healthcare services and protect health professionals (Chetty, Doherty & Essack 2020:3).

Within the Interprofessional and Union Collaborative Partnership (IPUCP) framework, organised labour is therefore conceptualised as an essential collaborative partner in strengthening communication, workplace safety, professional accountability and employee wellbeing. Effective labour participation enables constructive dialogue between employees and management, facilitates collaborative problem solving and contributes to healthier organisational cultures. Conversely, limited union participation, inconsistent representation or adversarial labour-management relationships may weaken trust, reduce opportunities for collaborative governance and compromise workplace safety. Recent South African evidence further reinforces this perspective, with Malatji et al (2024:22) demonstrating that community-based health workers continue to experience challenges relating to recognition, employment conditions and effective labour representation. Although their study focuses on community health workers, the findings underscore the broader importance of labour voice, employment security and meaningful stakeholder participation in strengthening collaborative practice within primary healthcare settings.

2.6.3 Management perspective

From the management perspective, effective interprofessional and union collaboration depends largely on leadership practices that promote trust, inclusion and shared responsibility. Leadership behaviours that encourage autonomy, participative decision making and collaborative problem solving have been shown to strengthen interprofessional teamwork and improve organisational performance (Timmermans, Van den Dungen, Van Stel, De Brouwer & Van Wijngaarden 2021:23-33). Likewise, managers who actively support staff wellbeing, job satisfaction and workplace safety contribute to the development of a positive organisational culture that reinforces quality healthcare delivery and sustainable collaborative partnerships (Al-Yateem, Rossiter & Devereux 2020:172-179). Dayekh, Naseridine, Dakroub and Olleik (2022:8) further identify management commitment and staff motivation as essential enablers for embedding collaborative partnership within organisational quality improvement initiatives.

Conversely, ineffective leadership characterised by poor communication, inconsistent decision making, bullying or disregard for professional boundaries may erode trust and intensify workplace conflict. Within rural CHCs, managers occupy a strategic position in coordinating health professionals, organised labour and institutional priorities while ensuring that risks are managed and staff receive appropriate support (Jule 2020:363). As organisational leaders, they are expected to model professional behaviour, encourage constructive communication and reinforce a culture of safety through positive leadership practices that promote a shared vision and collaborative working relationships (Jule 2020:364). Effective management therefore extends beyond administrative control to include psychological safety, transparent communication, equitable resource allocation and constructive engagement with organised labour.

Collectively, the perspectives of employees, organised labour and management demonstrate that interprofessional and union collaboration is both a relational and organisational process. Employees require safe, respectful and supportive workplaces; organised labour requires meaningful participation and recognition; and management requires the leadership capacity to coordinate people, resources and workplace relationships effectively. These complementary perspectives reinforce the central premise of the Interprofessional and Union Collaborative Partnership (IPUCP) framework that secure and sustainable rural CHCs are best achieved through integrated partnerships founded on trust, communication, shared accountability and collaborative governance.

2.7 POTENTIAL BENEFITS AND OUTCOMES OF SAFE INTERPROFESSIONAL COLLABORATIVE PARTNERSHIPS

The literature reviewed throughout this chapter indicates that safe interprofessional and union collaborative partnerships have the potential to improve individual, team and organisational performance within healthcare settings. Beyond strengthening professional relationships, collaborative partnerships contribute to safer workplaces, enhanced communication, improved workforce wellbeing and higher quality patient care. This section examines the principal benefits associated with collaborative partnership, together with the organisational conditions necessary to sustain these outcomes within rural CHCs.

2.7.1 Benefits and outcomes of safe interprofessional collaborative partnerships

The literature consistently demonstrates that safe interprofessional collaborative partnerships generate substantial benefits for health professionals, healthcare organisations and service users. Collaborative practice enhances professional satisfaction, strengthens teamwork and improves organisational performance by replacing fragmented ways of working with coordinated, team-based approaches (Winslow, Dunn & Calderon 2019:5-6). Similarly, Ahmed et al (2022:2405) report that supportive workplace relationships, appropriate resource allocation and positive organisational climates contribute to improved employee performance and workplace effectiveness. A safe therapeutic environment further promotes staff wellbeing, professional confidence and self-empowerment, while supportive relationships between health professionals and supervisors foster trust, organisational commitment and sustainable workplace partnerships (Luke & Carnelley 2019:1046; Margue, Peters & Van den Broek 2021:790).

Within rural CHCs, these benefits extend beyond improved interpersonal relationships to include stronger communication, reduced workplace conflict, enhanced psychological safety, more efficient utilisation of scarce resources, improved staff morale and greater continuity of care. Collaborative partnerships therefore address many of the operational challenges associated with rural healthcare, including workforce shortages, limited infrastructure and increasing service demands. As Rosa, Upvall and Essandoh (2021:1) argue, health professionals should be empowered to function as equal partners in achieving collaborative practice that advances both organisational objectives and the Sustainable Development Goals (SDGs).

At the individual level, collaborative partnerships promote confidence, belonging, motivation and psychological safety (Chang, Fu, Huang & Chen 2023:2567; Ryan & Deci 2017:3; Vu, Buléon, Le, Lua, Martin, Minehart & Macaire 2025:1.). At the team level, they strengthen role clarity, communication, trust and collaborative problem solving (IPEC 2023:15-19; Mohamed et al 2024:5-8), while at the organisational level they contribute to workplace stability, labour-management cooperation, patient safety and improved quality of care (Dierkes et al 2024:24; Huang et al 2023:613; Malatji et al 2024:1-2). Collectively, these outcomes provide a compelling rationale for the development of the

Interprofessional and Union Collaborative Partnership (IPUCP) Model proposed in this study.

2.7.2 Enabling conditions for sustainable collaborative partnerships

Although the literature consistently identifies numerous benefits associated with collaborative partnerships, it also demonstrates that these outcomes are unlikely to occur without deliberate organisational support. Sustainable collaboration requires supportive leadership, transparent communication, meaningful employee participation, recognition of organised labour, adequate human and material resources and shared accountability among all stakeholders (Fadlallah, El-Jardali, Hemadi & Akl 2021:17; Mohamed et al 2024:5-8). Similarly, Rico and Cabrer-Borrás (2021:1, 5) emphasise that collaborative structures must be supported by effective communication, mutual trust and organisational commitment if they are to function as intended.

For rural CHCs, these enabling conditions are particularly important because collaboration takes place within environments characterised by resource constraints, workforce shortages and complex organisational demands. Strengthening leadership capacity, fostering constructive labour-management relationships and creating psychologically safe workplaces are therefore essential for translating collaborative principles into everyday practice (DoH 2020:24; Malatji et al 2024:1-2). The literature consequently suggests that effective interprofessional and union collaboration depends not only on the willingness of individuals to work together, but also on organisational systems that actively support partnership, accountability and shared governance. These observations provide a logical transition to the following section, which examines the existing knowledge base and identifies the gaps that justify the present study.

2.8 WHAT IS KNOWN AND WHAT REMAINS UNDER-INVESTIGATED IN IUCP WITHIN RURAL COMPREHENSIVE HEALTH CENTRES

This section synthesises the evidence presented in Sections 2.3 to 2.7 by identifying the principal areas of established knowledge, examining the current evidence within the South African and Sub-Saharan African contexts, and highlighting the aspects of interprofessional and union collaborative partnerships that remain under-investigated in

rural CHCs. By consolidating the existing evidence, the section provides a clear basis for identifying the knowledge gap that informs the present study.

Rather than repeating the literature reviewed in the preceding sections, this synthesis draws together the major scholarly perspectives, identifies areas of convergence and unresolved questions, and demonstrates the need for further investigation. The review indicates that interprofessional collaboration, organised labour participation and workplace safety are closely interconnected within primary healthcare settings, yet limited evidence exists on how these dimensions interact within rural CHCs or how they may be integrated into a context-sensitive framework to strengthen collaborative practice, workplace security and service delivery. The present study addresses this gap through the development of the Interprofessional and Union Collaborative Partnership (IPUCP) Model and its accompanying implementation guidelines.

2.8.1 What is known in the international context

The international literature consistently demonstrates that effective interprofessional collaboration is underpinned by the integration of motivational, relational, organisational and behavioural factors. Evidence derived from Maslow's Hierarchy of Needs and its contemporary applications indicates that the fulfilment of physiological, safety, belonging and esteem needs contributes to trust, motivation, psychological wellbeing and collaborative teamwork, whereas unmet needs may undermine employee engagement and organisational performance (Karadencheva 2025:49; Maslow 1943:370-396; Maslow 1954:62-72; Ryan & Deci 2017:3; Taş 2024:141). These findings reinforce the importance of creating work environments that support both individual wellbeing and collaborative practice.

International scholarship further confirms that sustainable collaboration depends on ethical leadership, caring relationships, shared governance and clearly defined behavioural competencies. Watson's Theory of Human Caring emphasises empathy, respect and relational accountability as the ethical foundations of collaborative practice (Aghaei, Vanaki & Mohammadi 2020:3; Watson 2009:467). Complementing this perspective, the Labour-Management Partnership model demonstrates that shared decision-making, structured labour-management engagement and joint problem-solving strengthen organisational accountability and reduce adversarial workplace relationships

(Huang et al 2023:569, 613; Rico & Cabrer-Borrás 2021:1, 5). Similarly, the IPEC Core Competencies identify values and ethics, roles and responsibilities, interprofessional communication and teamwork as the essential competencies for effective collaborative practice across healthcare systems (IPEC 2023:15-19; Seaton, Jones, Johnston & Francis 2021:224; Sherman & Pfeifle 2024:98-99).

Collectively, the international evidence establishes that collaborative partnership is most effective when supported by psychological safety, ethical practice, organisational commitment, worker participation and structured teamwork. However, the literature also reveals that these dimensions are frequently examined in isolation, with limited attention given to their integration within a single collaborative framework or to the relationship between interprofessional practice and organised labour in resource-constrained primary healthcare settings. This limitation provides an important point of departure for the present study.

2.8.2 What is known in the South African and Sub-Saharan African contexts

The South African and Sub-Saharan African literature confirms that CHCs occupy a pivotal position within primary healthcare and the District Health System, supported by an extensive legislative and policy framework that promotes safe, equitable and collaborative health services. Key statutes, including the National Health Act (No. 61 of 2003), the Labour Relations Act (No. 66 of 1995), the Occupational Health and Safety Act (No. 85 of 1993) and the Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993), establish the statutory foundations for workplace safety, labour participation and organisational accountability. However, despite these enabling frameworks, evidence from the region indicates that interprofessional collaboration continues to be constrained by workforce shortages, inadequate infrastructure, resource limitations, leadership challenges and inconsistent implementation of collaborative practices (DoH 2020:24; Maduna 2022:302; Mahomed & Asmall 2015:5; Mohamed et al 2024:1-2, 5-8; Naidoo et al 2024:3-4).

Regional evidence further demonstrates that workforce recognition, employment conditions and meaningful labour participation remain fundamental to the effectiveness and sustainability of primary healthcare services. Studies show that health workers, particularly within community-based and rural settings, continue to experience limited

organisational support, insecure employment conditions and constrained opportunities for effective labour representation, all of which influence collaborative practice and service delivery (Malatji et al 2024:1-2). Collectively, the South African and Sub-Saharan African literature suggests that sustainable collaboration within rural CHCs depends not only on legislative compliance but also on strengthened leadership, effective communication, psychological safety, workforce support and structured partnership mechanisms that respond to local organisational and contextual realities.

2.8.3 What remains under-investigated

Although the international, South African and Sub-Saharan African literature provides substantial insight into interprofessional collaboration, workplace safety and labour-management relations, important gaps remain within the rural primary healthcare context. Existing studies have generally examined interprofessional collaboration, labour relations, workplace safety and workforce governance as related but separate areas of inquiry, with limited attention to how these dimensions interact within rural CHCs as an integrated organisational phenomenon (Dierkes et al 2024:64; Malatji et al 2024:1; Mohamed et al 2024:1-2, 5-8). Consequently, there remains insufficient understanding of how collaborative practice, organised labour participation and workplace security collectively influence the functioning of rural CHCs.

A further gap concerns the limited development of an integrated theoretical and operational framework that is specifically applicable to rural CHCs. While the literature supports the importance of motivational needs, ethical caring, shared governance and interprofessional competencies, these perspectives have seldom been synthesised into a single framework that integrates Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Labour-Management Partnership model and the IPECP framework within the South African primary healthcare context (Huang et al 2023:569, 613; IPEC 2023:15-19; Maslow 1943:370-396; Mohamed et al 2024:5-8; Watson 2009:467). Similarly, although recent South African scholarship has advanced interprofessional implementation guidelines in specialised areas such as primary healthcare rehabilitation, comparable guidance that explicitly incorporates workplace security, organised labour participation and collaborative governance within rural CHCs remains limited (Africa, Frantz & Mlenzana 2025:2-3).

The literature therefore suggests that the principal gap lies not in the absence of knowledge relating to interprofessional collaboration, organised labour or workplace safety individually, but in the absence of a context-sensitive, operational framework that meaningfully integrates these interdependent dimensions within rural CHCs. The present study addresses this gap through the development of the Interprofessional Union and Collaborative Partnership (IPUCP) Model and its accompanying implementation guidelines, thereby providing an evidence-informed framework for strengthening collaborative practice, workplace security and labour-management partnership in rural CHCs (Africa et al 2025:2-3; Malatji et al 2024:1-2; Mohamed et al 2024:1-2, 5-8).

2.9 SUMMARY

This chapter critically reviewed the literature relevant to the study by examining international, Sub-Saharan African and South African scholarship on interprofessional collaboration, organised labour participation and workplace security within CHCs. The review established that safe and effective collaboration among health professionals, managers and organised labour is fundamental to strengthening primary healthcare service delivery, particularly in rural and resource-constrained settings.

The chapter further demonstrated that collaboration is shaped by interrelated motivational, relational, organisational, behavioural and policy dimensions. These dimensions were examined through an integrated theoretical foundation comprising Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Labour-Management Partnership model and the Interprofessional Education and Collaborative Practice framework, while the relevant legislative and policy environment, including the National Health Act, Labour Relations Act, Occupational Health and Safety Act, National Health Insurance Act and Compensation for Occupational Injuries and Diseases Act, provided the statutory context for safe, collaborative and accountable practice.

The literature review further identified what is currently known internationally and within the South African and Sub-Saharan African contexts, while highlighting the continuing absence of an integrated, context-sensitive framework that brings together workplace security, interprofessional collaboration and organised labour partnership within rural CHCs. This identified gap provides the scholarly justification for the present study and informs the development of the Interprofessional Union and Collaborative Partnership

(IPUCP) Model and its implementation guidelines presented in later chapters. The chapter therefore establishes the conceptual, theoretical, empirical and policy foundation upon which the study is built and provides a logical transition to Chapter 3, which outlines the research methodology adopted to investigate the experiences of health professionals, managers and organised labour representatives and to generate the evidence required for the development of the proposed model.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research design method, population and study setting, sampling, the development and testing of the data-collection instruments, the data-collection process, data analysis, data integration, ethical considerations, and the measures taken to ensure reliability, validity and trustworthiness The intention is to demonstrate how the methodological choices were aligned with the research problem, the research aim, the objectives and the research questions, so as to resolve the research problem and answer the research questions in a credible and defensible manner.

3.2 RESEARCH DESIGN

A sequential explanatory mixed-methods design was employed, as guided Creswell & Plano Clark 2023a:76-117). Quantitative data were collected and analysed firs to describe patterns of interprofessional collaboration and workplace safety; qualitative data were then collected and analysed to explain and elaborate on the quantitative results. Final integration of both phases generated meta-inferences that are more comprehensive than either quantitative or qualitative phase alone (Creswell & Plano Clark 2023a:76-117). This design is appropriate when initial numerical findings require elaboration and when complex social processes are best understood by combining statistical trends with participants' accounts (Bryman 2006:106; Guetterman, Fetters & Creswell 2021b:5).

The study was guided by a pragmatic paradigm, which prioritises the use of methods that best address the research problem. Pragmatism acknowledges that interprofessional collaboration and labour–management relations are multidimensional and cannot be fully explored through a single approach (Creswell & Creswell 2023:10). By combining numerical evidence with explanatory narrative insights, this design allowed for a broader and more meaningful understanding of the phenomenon under investigation.

The sequential explanatory design enabled the researcher to identify measurable patterns through descriptive statistical analysis, and then to explore the meaning of those patterns through focus group discussions and in-depth interviews. This was appropriate for a study that sought not only to measure perceptions, but also to understand lived experiences, contextual realities and relational dynamics within rural and semi-rural CHC workplaces.

Figure 3.1 illustrates the flow of the design, where each phase is built on the preceding one. This structure ensured that statistical patterns identified in Phase 1 were meaningfully explained and contextualised through participants' narratives in Phase 2, before both strands were merged during integration to inform the final meta-inferences.

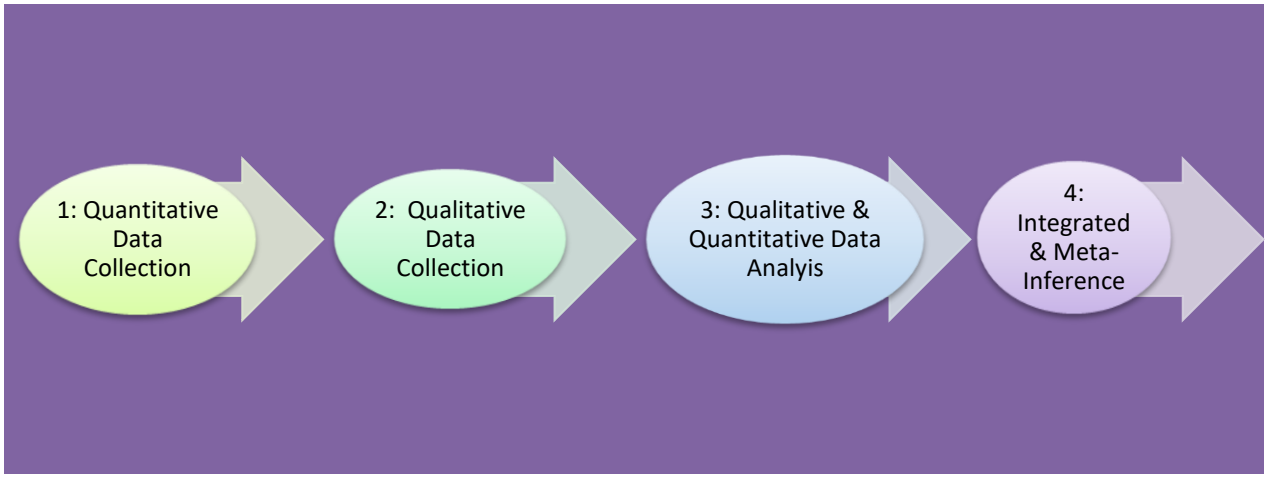


Figure 3.1 Sequential explanatory mixed-methods process

(Researcher's compilation adapted from Creswell 2020:86; Polit & Beck 2022:578)

Each phase is built on the preceding stage, enabling the researcher to identify measurable patterns and then deepen their meaning through qualitative exploration before drawing integrated meta-inferences. The quantitative findings provided the descriptive baseline, the qualitative findings explained and contextualized the numerical patterns, and the integrated interpretation informed the development of the Interprofessional Union Collaborative Partnership (IPUCP) Model and its implementation guidelines.

This sequence enabled the researcher to identify trends through descriptive statistics and then deepen their meaning through participants' narratives, resulting in a credible and comprehensive interpretation of the phenomenon.

3.3 RESEARCH METHOD

A mixed-methods approach was applied, consisting of two connected phases. Phase 1 involved the collection and analysis of quantitative data using a structured self-administered questionnaire (Annexure G) to generate descriptive statistical results. Phase 2 consisted of qualitative data collection through focus group discussions and in-depth interviews to elaborate on and explain the Phase 1 findings. The two strands were analysed separately and later integrated to strengthen interpretation and generate meta-inferences (Fetters 2019:213).

- **Phase 1: Quantitative strand**

The quantitative component followed a descriptive survey method to obtain numerical data on respondents' experiences of interprofessional collaboration and workplace safety. A five-point Likert-scale questionnaire (Annexure G) was distributed to 69 eligible respondents, of whom 42 returned completed questionnaires, yielding a response rate of 61 percent. The scale ranged from 1 (strongly disagree) to 5 (strongly agree). Data were analysed using the SPSS, version 26.0, to produce descriptive statistics, including frequencies, means and standard deviations.

- **Phase 2: Qualitative strand**

The qualitative component followed a descriptive and exploratory design aimed at explaining and elaborating on the quantitative findings (Polit & Beck 2021:237). Three focus group discussions and ten in-depth interviews were conducted using an interview guide (Annexure H). Participants were drawn from the Phase 1 respondents who met the inclusion criteria and were willing to participate. All interviews were audio-recorded with permission, and field notes were kept capturing contextual observations and non-verbal cues. Data were analysed thematically using the steps described by Braun, Clarke and Hayfield (2022:424). Contextual realities in rural CHCs, such as staff rotation, high patient loads and limited availability of health professionals, influenced the process and made individual interviews a more feasible strategy in some instances, which supported timely data saturation.

- **Rationale for the mixed-methods approach**

A mixed-methods approach was selected because workplace safety and interprofessional collaboration are multidimensional and cannot be fully understood through a single method. The quantitative findings provided measurable patterns, whereas the qualitative findings clarified the reasons behind those patterns. Using both strands enabled complementarity, triangulation and expansion of the results (Creswell & Plano Clark 2023c:36; Fetters 2019:213). The approach aligned with pragmatism and enhanced the depth, validity and usefulness (Fetters & Molina-Azorín 2020:281-294).

3.3.1 Sampling

Sampling refers to the process of selecting a portion of the population that will participate in a study in order to represent the views or experiences of the larger group (Polit & Beck 2022:250). In mixed-methods research, sampling is conducted in a manner that allows both the quantitative and qualitative strands to answer the research questions effectively and complement one another.

In this study, the sampling process was applied at three levels. First, six rural and semi-rural CHCs were purposively selected as study sites because they represented resource-constrained primary healthcare service-delivery environments relevant to the study focus. Secondly, within these purposively selected CHCs, the quantitative phase followed a total-population approach, whereby all eligible and available health professionals who met the inclusion criteria were invited to complete the questionnaire. Thirdly, the qualitative phase used purposive sampling to select participants with direct experience of interprofessional collaboration, workplace relations and organised labour in the selected CHCs.

This sampling logic was appropriate because the study did not seek statistical generalisation to all CHCs in South Africa. Instead, the quantitative phase sought to describe patterns among eligible health professionals in the selected CHCs, while the qualitative phase sought to explain and deepen the understanding of those patterns through participants lived experiences. Staff shortages, workload, rotational scheduling and service-delivery pressures affected participant availability and response rates; these

factors are therefore treated as contextual recruitment constraints rather than as the sampling strategy itself.

3.3.1.1 Population and study setting

The study population consisted of health professionals working in six rural CHCs across Gauteng, Mpumalanga, and the North-West provinces. In this thesis, the CHC refers to the district-based primary healthcare facility setting, while comprehensive primary healthcare (CPHC) refers to the scope of promotive, preventive, curative, rehabilitative and palliative services delivered through these centres. The study population consisted of health professionals working in six rural and semi-rural CHCs across the three provinces.

The CHCs collectively provide 24-hour maternity and emergency services, as well as non-communicable disease management, mental health, social work, pharmacy, dentistry, dietetics, psychology, immunisation, and dispensing services. These facilities are managed by registered nurses with clinical health assessment, treatment and care (R48) and nursing management qualifications. The additional radiography, termination of pregnancy, trauma specialist, and mental health services were available only at one semi-rural CHC in Gauteng Province. The AURUM a non-governmental organisation (NGO) supported TB/HIV services in line with the 90-90-90 targets were also available at one rural CHC in the three provinces. While core services were comparable across provinces, minor variations were noted in the service package offered at each CHC.

The population included health professionals, managers, and organised labour representatives who have worked more than six months in the CHC and were directly involved in interprofessional collaboration and workplace relations. These includes the professional nurses, medical officers, social workers, pharmacists, psychologists, radiographers, and facility managers. The professionals are also members of various recognised labour union representatives, such as DENOSA, NEHAWU, PSA, SAMU and HOSPERSA. These groups were selected because their interactions directly influence communication, collaborative practice, and workplace safety within CHCs (Taherdoost 2020:18). External non-governmental organisation staff, including AURUM Institute staff, were excluded unless they met the study criteria as health professionals working within the CHC context and relevant to the study focus. Administrative and general support staff

who were not directly involved in interprofessional or labour-related activities were excluded from the main study.

3.3.1.2 Sampling strategy

For methodological clarity, the sampling strategy is described separately in relation to the selection of study sites, the quantitative phase and the qualitative phase (Saharan, Kulhari, Jadhav, Pooja, Banerjee & Singh 2024:43). Selection of the six rural and semi-rural CHCs were purposeful because they met the inclusion criteria and represented resource-constrained primary healthcare service-delivery environments relevant to the study focus. These sites were not sampled as “comprehensive primary healthcare” itself; rather, they were selected as CHC workplace settings in which comprehensive primary healthcare services were delivered. Two CHCs were selected from each of the three provinces, namely Gauteng, Mpumalanga and North-West. The selection of these sites enabled the researcher to explore the phenomenon across more than one provincial context while retaining a focus on rural and semi-rural CHC workplace realities.

Sampling procedures were aligned with the sequential nature of the design, starting with quantitative then qualitative data collection.

- Phase 1 (Quantitative): A purposive non-probability approach was used to recruit participants who met the inclusion criteria and were available during the data collection period at the selected CHCs. A structured questionnaire was distributed to 69 potential respondents.
- Phase 2 (Qualitative): Convenience sampling was applied to select willing participants from the Phase 1 cohort for three focus group discussions and ten in-depth interviews; this approach is consistent with qualitative methodological guidance that prioritises information-rich participants (Polit & Beck 2021:312).

Inclusion criteria:

- Health professionals employed in the selected CHCs for at least six months.
- Direct involvement in clinical service delivery or labour–management interaction.
- Voluntary informed consent to participate.

Exclusion criteria:

- Administrative or support staff not involved in interprofessional or labour-related activities.
- Individuals who are part of the AURAM NGO and on extended leave during the data collection period.

This approach ensured methodological alignment between strands and enabled meaningful integration of results during interpretation.

3.3.1.3 Ethical issues related to sampling

Ethical principles informed the sampling process to protect participants' rights and uphold the integrity of the study. The principles of autonomy, beneficence, non-maleficence and justice were observed throughout recruitment. Participation was voluntary, and no individual was coerced or disadvantaged for choosing to participate or decline. Each prospective participant received an information sheet and informed consent form, outlining the purpose of the study, the expected level of involvement, potential risks and benefits, and the right to withdraw at any stage without negative consequences (Dhai & McQuoid-Mason 2019:64).

Formal approval to access participants was obtained from the Mpumalanga, Gauteng, and North-West Provincial Research Ethics Committees (Annexures B, B1, B2, B3 and B4) after the authorisation from the National Health Research Database (NHRD). Written permission from the respective provinces (Annexures C, D and E) for two CHCs from each provincial DoH. Furthermore, verbal authorisations from facility managers of the six selected CHCs were secured. This multilayered approach ensured that the sampling process complied with national, provincial, and district research governance requirements.

The researcher did not directly select participants, but rather invited all eligible individuals based on the inclusion criteria, ensuring fair and non-discriminatory recruitment while avoiding undue influence. Furthermore, personal identifiers were not captured during

sampling, thereby safeguarding confidentiality and anonymity and reducing workplace power imbalances.

3.3.1.4 Sample

The total quantitative sample size in this study for quantitative data consisted of 42 respondents who completed the questionnaire from the six selected CHCs across the three provinces. A total of 69 questionnaires were distributed, yielding a 61% response rate, which is considered acceptable for voluntary health research base on the validity assessment framework (Holtom, Baruch, Aguinis & Ballinger 2022:1580).

The level of return is acceptable for voluntary health-related survey research, as response rates above 50% are generally adequate for descriptive designs (Polit & Beck 2021:323), while survey norms range between 30–60%, with ≥60% regarded as strong (Baruch & Holton 2022:1139-1140). Recent evidence further confirms that response rates in this range fall within acceptable validity thresholds (Holtom, Baruch, Aguinis & Ballinger 2022:1560-1584). The achieved sample also complies with contemporary criteria for minimum sample adequacy in descriptive survey studies (Taherdoost 2017:237-239), supporting its suitability for preliminary statistical estimation.

- **Quantitative sample size**

For the quantitative phase, a total-population approach was followed, whereby all eligible health professionals in the selected CHCs who met the inclusion criteria and were accessible during the data-collection period were invited to complete the questionnaire. This approach was appropriate because the number of eligible health professionals in the selected rural and semi-rural CHCs was limited, and the purpose of the quantitative phase was descriptive rather than predictive or hypothesis-testing in nature (Creswell & Plano Clark 2023b:119-120; Polit & Beck 2021:348). A total of 69 questionnaires were distributed, and 42 completed questionnaires were included in the final analysis. The final quantitative sample size was therefore determined by the number of eligible respondents who voluntarily completed and returned usable questionnaires, and not by a convenience procedure. Participation was influenced by contextual realities such as staff shortages, increased workload and service-delivery demands. These factors affected availability and response rates but did not constitute

the sampling strategy. These operational realities, including rotational scheduling, probability sampling and formal power calculations were impractical.

For a descriptive survey, the sample was sufficient to meet the study purpose (Polit & Beck 2021:348) and to generate robust quantitative patterns that would inform and shape the subsequent qualitative phase, in keeping with the logic of a sequential explanatory mixed-methods design (Mele & Belardinelli 2019:335). The distribution of the final sample across the selected provinces and facilities is presented in Table 3.1.

Table 3.1 Quantitative sample size of (N=42) from three provinces

Province and comprehensive health centre	**Sample size (number of respondents)**
North-West Province	Total: (n=10)
Mpumalanga Province	Total: (n=18)
Gauteng Province	Total: (n=14)
Total: Three provinces	**(N=42 respondents)**

- **Qualitative sample size**

For the qualitative phase purposive sampling was used to select information-rich participants who could provide deeper insight into the quantitative findings and the lived realities of interprofessional collaboration, workplace relations and union-related experiences in the selected CHCs (Creswell & Plano Clark 2023b:119-120; Polit & Beck 2021:312). Three focus group discussions (FGDs) and ten in-depth interviews (IDIs) were conducted, and data saturation was reached when no new categories or insights emerged (Hennink & Kaiser 2022:2125; Polit & Beck 2021:312). The sampling of the participants was purposive convenient sampling.

To ensure confidentiality and clear traceability of data sources, all participants were assigned anonymised codes based on the province, the CHC, the data-collection method and the participant number. A single, consistent coding framework was applied to both the focus group discussions and the in-depth interviews; no parallel numbering system was used. Facility names, job titles and other identifying details were removed. Each code therefore represents the province, the corresponding CHC, the data-collection method and the participant number. For example, MP-FGB2 refers to focus group participant 2

from Mpumalanga (CHC B), and NW-FGA4 refers to focus group participant 4 from North-West (CHC A). This systematic coding ensured that quotations cited in the results could be clearly traced back to the relevant setting without compromising anonymity.

The discussions unpack the coding and anonymity framework for focus group discussions and in-depth interviews. To ensure confidentiality and clear traceability of data sources, all participants were assigned anonymised codes based on province, CHC, data-collection method, and participant number.

A single, consistent coding framework was applied to both the focus group discussions and the in-depth interviews; no parallel numbering system was used. Facility names, job titles and other identifying details were removed. Each code therefore represents the province, the corresponding CHC, the data-collection method and the participant number. For example, MP-FGB2 refers to focus group participant 2 from Mpumalanga (CHC B), and NW-FGA4 refers to focus group participant 4 from North-West (CHC A).

Table 3.2 presents the coding framework for focus group participants whereas Table 3.3 presents the framework for in-depth interview participants. This systematic coding ensured that quotations cited in the results could be clearly traced back to the relevant setting without compromising anonymity.

Table 3.2 Coding framework for focus group participants (N=16)

Province/CHC code	Participant categories	Assigned codes	Total participants
Mpumalanga (CHC B)	4 Nurses 1 Pharmacist assistant 1 Dietician	MP-FGB1-MP-FGB6	6
Northwest (CHC A)	3 Nurses 1 Social Worker 1 Pharmacist Assistant	NW-FGA1-NW-FGA5	5
Gauteng (CHC B)	4 Nurses 1 Social Worker	GP-FGB1-GP-FGB5	5
Grand Total			**16**

Table 3.2 outlines the anonymised coding system used for in-depth interview participants. Each code reflects the province and corresponding CHC, the method of data collection,

and participant sequence number. For example, MP-IDIA1 refers to Participant 1 from Mpumalanga (CHC A), and NW-IDIB1 to Participant 1 from Northwest (CHC B). This ensured confidentiality while retaining contextual meaning for analysis.

In mixed methods studies, sample adequacy is judged by both breaths, to allow quantitative description and depth to enable qualitative meaning-meaning (Creswell & Plano Clark 2023b:119). The anonymous coding framework enhanced credibility, dependability and authenticity by ensuring transparent traceability of data sources while preserving participant confidentiality (Polit & Beck 2021:361-362) Table 3.3 outlines the anonymised coding system used for in-depth interview participants. Each code reflects the province and corresponding CHC, the method of data collection, and participant sequence number. For example, MP-IDIA1 refers to Participant 1 from Mpumalanga (CHC A), and NW-IDIB1 to Participant 1 from Northwest (CHC B). This ensured confidentiality while retaining contextual meaning for analysis.

Table 3.3 Coding framework for in-depth interview participants (N=10)

Province/CHC code	Data collection method	Participant categories	Assigned codes	Total participants
Mpumalanga (CHC A)	In-Depth Interviews (IDI)	1 Facility Manager 1 Nurse 1 Medical Doctor	MP-IDIA1–MP-IDIA3	3
Northwest (CHC B)	In-Depth Interviews (IDI)	1 Social Worker	NW-IDIB1	1
Gauteng (CHC A)	In-Depth Interviews (IDI)	1 Radiographer 1 Facility Manager 1 Nurse	GP-IDIA1–GP-IDIA3	3
Gauteng (CHC B)	In-Depth Interviews (IDI)	2 Nurses 1 Facility Manager	GP-IDIB1–GP-IDIB3	3
Grand Total				**10**

Table 3.3 outlines the systematic in-depth interviews coding to ensure that quotations cited in the results could be clearly traced back to the relevant setting without compromising anonymity.

In mixed-methods studies, sample adequacy is determined by both sufficient representation for quantitative description and sufficient depth for qualitative meaning-making (Creswell & Plano Clark 2023b:119). The anonymous coding framework enhanced credibility, dependability and authenticity by ensuring the transparent

traceability of data sources while preserving participant confidentiality (Polit & Beck 2021:361-362). The final sample in this study was therefore adequate for descriptive statistical analysis, rigorous thematic exploration, and meaningful integration of the two phases.

3.3.2 Data collection

Data were collected in two sequential phases that aligned with the explanatory focus of the mixed-methods design. The quantitative phase was conducted first to obtain baseline patterns and measurable trends. The qualitative phase followed the preliminary analysis of the quantitative results, allowing participants to elaborate on and explain the findings. This approach ensured that the qualitative data strengthened the interpretation of the quantitative results and contributed to credible meta-inferences (Creswell & Plano Clark 2023b:117).

3.3.2.1 Data collection approaches and methods

Phase 1: Quantitative Strand: The quantitative component followed a descriptive survey method to obtain numerical data on respondents' experiences of interprofessional collaboration and workplace safety. This involved the administration of a structured self-administered questionnaire (Annexures F and G) to gather measurable data on interprofessional collaboration and workplace safety. The quantitative instrument was useful for identifying trends across a defined population and for producing data amenable to statistical analysis (LoBiondo-Wood & Haber 2022:134).

Responses in this regard were presented numerically in resonance with the mixed-methods research design approach of the study. This is helpful to the researcher's understanding of the respondents' collective thinking about the collaboration between health professionals and union secure partnership in CHCs.

Phase 2: Qualitative Strand (Annexure H): The qualitative component followed a descriptive and exploratory design aimed at explaining and elaborating on the quantitative findings (Polit & Beck 2021:237). This phase consisted of three focus group discussions and ten in-depth interviews. Qualitative methods enable the exploration of subjective

meanings, lived experiences, and contextual influences that cannot be fully captured through numerical findings (Polit & Beck 2021:312).

3.3.2.2 Development and testing of the data collection instrument

The development of the data collection instruments was informed by recognised best practices for academic research instrument design. Data collection tools must be aligned with the research questions, theoretical constructs, and research design to ensure methodological coherence (Creswell & Creswell 2023:181).

3.3.2.2.1 Quantitative instrument development

The structured questionnaire for Phase 1 (Annexures F and G) was developed from a synthesis of empirical literature, national policy directives, and global guidelines. The overall focus of the questionnaire was on the health professionals' perception regarding safety and measures to establish safety in their comprehensive health centre. The instrument consisted of six sections and was structured as follows:

- Section A: Biographical data
- Section B: Experiences regarding the safety
- Section C: The understanding of the different roles and responsibilities played by different role players in the healthcare facility
- Section D: Perceived impact they have in case of limited partnership
- Section E: Perceived barriers to acquire safety
- Section F: Cues to action on promoting sustainable safety in comprehensive health centre

Likert scale and column structure: Sections B through F contained the closed-ended items measured on a five-point Likert scale. The response structure was arranged in columns ranging from 1 (strongly disagree) to 5 (strongly agree), allowing respondents to indicate the direction and strength of their agreement or disagreement with each statement, or to select a midpoint where they were unsure. The five-point format was selected because it is widely validated, easy for respondents to interpret, and well suited to descriptive statistical analysis (Polit & Beck 2021:356).

The midpoint of the scale combined the “Uncertain” and “Do not know” options into a single response column. This combined column was provided so that respondents were not forced to agree or disagree with a statement when they were genuinely unsure, thereby reducing the risk of distorted or arbitrary responses. It is acknowledged, however, that “Uncertain” (indecision about a position) and “Do not know” (limited knowledge of the matter) represent two different cognitive positions. The decision to combine them is therefore disclosed as a methodological limitation in Section 8.7.2, where it is recommended that future studies separate the two options to allow finer-grained interpretation of the midpoint responses.

Pilot testing of the quantitative instrument: The quantitative instrument was pilot tested on a small, non-random sample (n=9) at a semi-rural CHC in the Gauteng Province which was not part of the six CHCs where data was collected. The pilot sample included health professional nurses, labour union representative, facility manager, and general support staff, the cleaner and security.

3.3.2.2.2 Outcome and challenges discovered

The pilot test confirmed the general clarity and feasibility of the instrument. However, significant challenges were identified which necessitated a refinement of the target population and instrument:

- Language discrepancies and comprehension: Support staff, including security and cleaners, reported difficulties understanding the terminology used in specific items related to interprofessional collaboration.
- Literature alignment: Further consultation confirmed that the primary constructs were most relevant and reliably measured within the professional healthcare group (nurses, doctors, allied health).
- Redundancy of role: Items pertaining to day-to-day interprofessional collaboration were deemed irrelevant or not directly applicable by the management/union roles and the support staff roles.

Based on the challenges discovered, the following actions were taken:

- Refinement of target population: The quantitative data collection was restricted to HP only clinical and the health professionals to mitigate the language and comprehension discrepancies.
- Qualitative scope retention: The qualitative phase retained the inclusion of union and management representatives to provide the necessary explanatory context and divergent viewpoints.
- Instrument adjustment: The wording of certain ambiguous items identified during the pilot was clarified for better neutrality.

3.3.2.2.3 Qualitative instrument development

The in-depth interview guide for Phase 2 (Annexure H) was similarly developed from the literature and informed by the emerging quantitative results to ensure alignment with the explanatory intent of the mixed-methods design. This instrument, used for both focus group discussions and in-depth interviews, was structured around a central, "grand tour" question followed by thematic probes:

Central question: “Tell me about the experiences you have with trade union collaborative partnerships to establish a mutually secure workplace in the CHCs.”

Probing questions are:

- “How can you describe your experiences in collaborating with other health professionals, shop stewards or union representatives, and management in this CHC?”
- “What is the relationship between management and unions in this CHC?”
- “What solutions do you suggest for enhancing collaborative secure partnerships?”

3.3.2.3 Characteristics of the data collection instruments

The data collection instruments were purposefully designed to support the sequential explanatory mixed-methods approach and ensure coherence between the quantitative and qualitative strands (Creswell & Creswell 2023:188).

- Quantitative instrument characteristics: The structured questionnaire consists of six distinct sections and uses a five-point Likert scale for core measurement items. This fixed-response structure ensures the data is quantifiable, comparable across participants, and highly amenable to efficient descriptive and compared across participants and supported systematic descriptive statistical analysis (Polit & Beck 2021:356).
- Qualitative instrument characteristics: The interview guide was structured to ensure both breadth using the central question and depth using the thematic probes, aligning with the exploratory purpose of Phase 2. The use of a single central question ensured that the data collection started broadly, allowing participants to define their experience, while the subsequent open-ended probing questions specifically targeted the core study variables.

3.3.2.4 Data collection process

Data collection was conducted in two separate phases over varying dates in 2018 from three provinces.

3.3.2.4.1 Quantitative data collection process

The facility manager facilitated access to eligible participants by inviting the participants to an initial information session in the facility boardroom, where the researcher was introduced. The researcher provided a written and subsequent verbal explanation of the study, using the information sheet and consent form. Participants were informed of their right to voluntary participation, withdrawal from the study, and refusal to be involved without any retributive measures (Sürücü & Maslakci 2020:2694).

The participants were allowed to complete the questionnaires in the boardroom. However, due to time constraints and workload, some participants requested to complete the questionnaire at their workstations or during breaks. The researcher maintained a questionnaire control record to track questionnaires distributed and returned. Returned questionnaires were checked for completeness and assigned unique study identification

codes. To uphold confidentiality and anonymity, the following procedure was strictly followed:

- The questionnaires were provided in self-sealing, unmarked envelopes.
- Participants were instructed not to record their names, employee number or other personals identifiers on the questionnaires.
- The researcher provided the to seal the envelope immediately upon completion.
- Participants sealed the envelopes immediately after completing the questionnaires.
- The researcher collected the sealed envelopes personally from the participants who completed them immediately while on site.
- For staff on night duty, sick leave, or those unable to submit immediately, arrangements were made with the CHC head administrator to receive the sealed opaque envelopes with unique coding written on each envelope.
- The administrator's role was restricted to the safekeeping of the sealed envelopes and was instructed to lock the sealed envelopes securely in a designated cabinet to ensure privacy and confidentiality.
- The researcher collected all outstanding completed questionnaires personally and directly from the head administrator in bulk on a subsequent visit, who kept them locked safely in a safe, verifying that all envelopes remained sealed.

These procedures supported the confidentiality and anonymity of participants and the secure custody and integrity of the completed questionnaires.

3.3.2.4.2 Qualitative data collection process

The qualitative phase was conducted using focus group discussions (FGDs) and in-depth interviews (IDIs) to explore and deepen the findings that emerged from the quantitative results, consistent with explanatory mixed-methods designs (Creswell & Plano Clark 2023a:186-189). Eligible participants who met the qualitative sampling criteria and provided informed consent were invited to participate. A two-track design was used: the focus group discussions provided a shared discussion space in which collective and contrasting views could be surfaced, while the individual in-depth interviews offered a confidential, one-to-one space for participants to share deeper or more sensitive experiences that they might not have been comfortable raising in a group.

- **Focus group discussions (FGDs)**

Three FGDs, each lasting approximately 1 to 2 hours, were conducted to explore shared meanings, contrast viewpoints, and observe interactional dynamics among professional nurses, doctors, allied health practitioners, and psychologists. FGDs were held in private rooms behind closed doors to ensure confidentiality and minimise workplace interruptions. Before each session, the researcher outlined ground rules that emphasised voluntary participation, respectful engagement, confidentiality, and avoidance of personal identifiers during discussion. To prevent more senior or more vocal members from dominating, the facilitator actively drew quieter participants into the discussion by direct, respectful invitation, and reminded the group that all views were equally valued. Participants who preferred not to disclose sensitive matters in the group were reassured that the individual in-depth interview offered a private alternative.

A semi-structured FGD guide ensured consistency across groups, while still allowing participants to raise emerging issues. Each discussion was audio-recorded with permission, and field notes were taken to document context, group dynamics, and non-verbal cues, supporting richer interpretation and analytic depth (Braun & Clarke 2023:42; Polit & Beck 2021:536).

- **In-depth interviews (IDIs)**

Ten IDIs, each lasting approximately 45 to 60 minutes, were conducted to obtain deeper, individual perspectives that participants might not have been comfortable sharing in a group context. Interviews were conducted in private rooms with closed doors to ensure uninterrupted discussion and confidentiality (Polit & Beck 2021:169-170). A semi-structured interview guide provided direction while allowing the researcher to probe for clarity and depth as themes emerged. With participant consent, all IDIs were audio-recorded, and field notes were kept capturing emotional tone and non-verbal cues, enriching the accuracy and meaning of the data (Braun & Clarke 2023:43).

- **Participant identification and data saturation**

To ensure anonymity, each participant was assigned a unique identification code, which was used on all audio files, transcripts, field notes, and analytic documentation (Polit & Beck 2021:169).

Data collection continued until data saturation was reached, defined as the point at which no new substantively new themes, categories, or insights emerged from the interviews (Hennink & Kaiser 2022:2125; Polit & Beck 2021:517). All qualitative data collection was conducted in private rooms at the respective CHCs to maintain confidentiality and minimise workplace disruptions.

3.3.2.5 Competency and role of the researcher

The competency and role of the researcher in the sequential explanatory mixed-methods data collection processes was reinforced by her experience of over ten years in healthcare services, education and training, as well as quality assurance in supporting the implementation of the DHS and rPHC model as an employee of the DoH.

While this extensive professional experience enhances the researcher's ability to interpret nuanced findings, it also presents a potential for bias due to prior association with the DoH authorities. To maintain objectivity and rigor, the principle of reflexivity was applied. The researcher acknowledged these prior roles and actively maintained a reflexive journal throughout the data collection and analysis phases to document any pre-existing assumptions or interpretations that could unduly influence the analysis. This process included bracketing of personal opinions during qualitative interviews and utilising peer debriefing with the supervisory panel to audit coding decisions, thereby mitigating the risk of prior professional affiliations compromising the neutrality and validity of the results.

3.3.2.6 Ethical considerations related to data collection

Ethical considerations in research-based studies relate to the principles, protocols, and the professional norms and standards that should be steadfastly upheld by the researcher to ensure fair and equal treatment of the participants during the entire course of data collection (Dawadi et al 2021:27; Lund 2022:1186).

3.3.2.6.1 Ethical clearance and permission to conduct the study

The researcher obtained ethical clearance from the Research Ethics (REC) Committee of the University of South Africa's Department of Health Studies (Annexure A). The researcher was granted permission by the NDoH to conduct the study at selected six rural and semi-rural CHCs in Gauteng, Mpumalanga and North-West provinces from the respective provincial health authorities (Annexures C, D and E).

To provide a transparent record and address the concern that approval dates and working titles required clarification, the chronological sequence of approvals was as follows:

- UNISA REC ethical clearance: reference HSCD/687/2017, April 2017.
- National Health Research Database (NHRD) registration: reference 2017_RP3_49, April 2017.
- Provincial gatekeeper permissions (North-West, Mpumalanga and Gauteng): granted between April and May 2017, each issued under the working title current at the date of issue.

Pilot testing at a semi-rural Gauteng CHC not included in the main study, followed by full data collection from 2017 to 2018. The substantive inquiry was interprofessional in focus throughout. The variation in working titles across the early approval documents reflects administrative wording current at each date of issue, and not any change to the study's design, aim, population or methodology. The original 2017 clearance and permission letters are retained unaltered as authentic, contemporaneous records.

3.3.2.6.2 Informed consent and voluntary participation

Informed consent and voluntary participation imply the participants' willingness to be involved in the study uncoerced following the researcher's full and transparent disclosure of the purpose of the study. Participants were informed about their rights to sign consent before commencing with the study and the assurance that a unique code allocation will be done to protect their anonymity. Participation was entirely voluntary: participants could

withdraw at any point, without giving a reason and without consequence; no inducement, pressure or obligation was placed on any individual; and withdrawal would not affect their employment, professional standing or relationship with the institution

3.3.2.6.3 Anonymity, privacy and confidentiality

The researcher did not ask for any of the participants' personal information. They were referred to by coded pseudonyms for the purpose of concealing their true identities, and their verbal responses and contributions to the study were not divulged to any third persons who were not directly linked to any aspect of this study. The researcher ensured that none of the statements and responses of the participants could be directly linked to them. In the focus group setting specifically, participants were advised at the outset that, while the researcher would maintain confidentiality, confidentiality between participants in a group could not be guaranteed. This guidance was protective and methodologically grounded as, Wa-Mbaleka (2019:33) cautions that confidentiality between participants in a group could not be fully guaranteed because the researcher cannot control what participants disclose outside the group. The in-depth interview was therefore available as a more confidential alternative for participants who wished to disclose sensitive experiences outside the group setting.

3.3.2.6.4 Avoidance of harm to participants

The researcher ensured that no invasive questions were asked that could evoke any emotional or psychological discomfort of the participants, who are themselves HCPs.

3.3.2.6.5 Safekeeping of data materials

Following the actual data collection, capturing and analysis process, the researcher kept all the hard copies and digital material obtained through the questionnaires, individual and focus group interviews safely. The digital material was stored on a laptop protected by a password and is only accessible to the researcher. All hard copies are safely stored in a steel cabinet with a combination-lock mechanism.

3.3.3 Data analysis

Data analysis was conducted sequentially, aligning with the sequential explanatory mixed-methods design.

3.3.3.1 Quantitative data analysis

Quantitative data was analysed using the SPSS, version 26.0 by an independent statistician (Annexure I). Before analysis the data set was screened for completeness and accuracy. Some respondents did not complete all sections of the questionnaire, the pairwise deletion method was applied enabling the inclusion of all valid data for each variable rather than discarding incomplete cases (Mirzaei, Carter, Patanwala & Schneider 2022:2312). The approach maximised sample size and is suitable for descriptive analysis where the aim is to summarise rather than infer population parameters (Polit & Beck 2021:312).

The internal consistency reliability of the questionnaire was assessed using Cronbach's alpha, which produced a coefficient of 0.70. According to Salleh, Sulaiman and Gloeckner (2023:260), a Cronbach's alpha value of 0.70 or higher demonstrates acceptable internal consistency for social-science research instruments. This confirmed that the items within each construct were sufficiently correlated to measure the same underlying dimension. Because the quantitative phase aimed primarily to describe rather than test causal relationships, inferential statistical significance tests (p-values) were not applied. This analytical decision aligns with the principles of a sequential explanatory mixed-methods design, where descriptive results provide an empirical foundation for the qualitative phase that follows (Creswell & Plano Clark 2023a:222). All statistical procedures adhered to the approved ethical and data-management protocols to maintain the integrity, confidentiality, and accuracy of findings (Cunha-Oliveira, Ioannidis & Oliveira 2024:1392).

3.3.3.2 Qualitative data analysis

Qualitative data, derived from the audio recordings of the FGDs and IDIs, was subjected to thematic analysis, following the six-phase approach using a reflexive analysis as outline by Braun and Clarke (2021:41-43).

This approach provided a structured yet flexible framework for identifying, analysing, and reporting recurring patterns of meaning within the data (Kiger & Varpio 2020:847; Nowell & Albrecht 2022:3). It was chosen for its suitability in capturing complex and contextually grounded experiences related to interprofessional collaboration and workplace safety within CHCs.

The process began with familiarisation, where the researcher listened repeatedly to the audio recordings and transcribed them verbatim. Reflective field notes were incorporated to capture non-verbal cues, tone, and contextual dynamics observed during interviews and discussions (Polit & Beck 2021:475). This immersion enabled a deeper understanding of participants' experiences and established a foundation for generating meaningful interpretations.

During initial coding, the researcher read each transcript line by line and manually identified meaningful units of data that addressed the research objectives. Each code represented a concept or experience shared by participants. Manual coding, supported by colour coding and margin notes, facilitated continuous engagement with the data and reflexivity throughout the process (Braun & Clarke 2021:94). Reflexive journaling was maintained to record analytic decisions and reflections, enhancing transparency and reducing interpretive bias.

The searching for themes stage involved clustering related codes to form potential themes that represented broader patterns of meaning across the dataset. The researcher compared codes within and between transcripts to identify consistencies and variations across professional groups (Creswell & Creswell 2023:198). Analytic memos were used to capture emerging insights and theoretical connections.

During reviewing of themes, each provisional theme was evaluated for internal coherence and consistency with the overall dataset. Some themes were refined, combined, or excluded based on evidentiary strength. To enhance credibility, an independent coder experienced in qualitative research was invited to review a subset of the coded data. Divergent interpretations were discussed until consensus was achieved (Nowell & Albrecht 2022:7).

Next, the researcher defined and named each theme, ensuring that each theme accurately reflected the underlying meaning and scope of participants' experiences (Braun & Clarke 2021:107). Detailed thematic descriptions were developed, and representative verbatim quotations were selected to illustrate key findings and preserve authenticity.

Finally, in the reporting phase, the refined themes were integrated into a literature-controlled narrative, linking findings to existing studies and theoretical frameworks. This ensured that the analysis was both contextually grounded and academically rigorous (Creswell & Creswell 2023:202; Kiger & Varpio 2020:848). An audit trail comprising coded transcripts, analytic memos, and theme development notes was maintained throughout the process to enhance transparency and confirmability (Nowell & Albrecht 2019:353). This iterative and reflexive approach ensured that the findings were grounded in participants lived realities while meeting methodological standards of trustworthiness and rigour.

3.3.3.3 Data integration

The integration of quantitative and qualitative data occurred during the interpretation and discussion phase, consistent with a sequential explanatory mixed-methods design. This approach allowed the researcher to move beyond the isolated reporting of numerical trends and thematic narratives, toward a *holistic synthesis* that generated deeper understanding of the collaborative relationships between health professionals and trade union representatives in CHCs (Creswell & Plano Clark 2023b:119-122).

The quantitative results from Phase 1 provided a descriptive and relational baseline, highlighting trends in perceptions of safety, communication, and professional collaboration. These findings guided the design of the qualitative phase (Phase 2), which sought to expand and explain the numerical patterns through lived experiences and contextual insights. Integration was then achieved through a structured interpretive process that examined the points of convergence, complementarity, expansion, and divergence between the two datasets (Doyle, Brady & Byrne 2019:343; Howell Smith, Babachuk, Stevens, Garrett, Wang & Guetterman 2020:204).

- **Convergence**

Convergence occurred when quantitative and qualitative findings confirmed each other, thereby reinforcing validity. For example, the high quantitative agreement that safety in the workplace includes professional conduct and interpersonal respect" was substantiated by qualitative narratives describing respectful teamwork and accountability among CHC professionals. This alignment demonstrated that the statistical and narrative evidence reflected a shared understanding of workplace safety (Creswell & Creswell 2023:219).

- **Complementarity**

Complementarity was achieved when the qualitative findings added depth, emotion, and context to the quantitative patterns. For instance, quantitative data showed moderate scores on "union involvement in safety promotion," while the qualitative data revealed emotional nuances such as mistrust and role confusion between union and management representatives. These insights complemented the statistical results by illuminating the *human factors* underpinning the numerical responses (Fetters & Molina-Azorin 2020:294).

- **Expansion**

Expansion occurred when the qualitative phase extended the scope of understanding beyond what was measured quantitatively. While the survey identified collaboration barriers (e.g., communication gaps, unclear safety policies), the qualitative findings expanded these results by revealing structural challenges such as bureaucratic delays and leadership power dynamics that were not captured by the questionnaire. This expansion enriched the study's explanatory power and demonstrated how multi-level influences shaped collaboration (Clark, Foster, Bryman & Sloan 2021:351).

- **Divergence**

Divergence was also recognised, where qualitative findings contradicted or challenged quantitative patterns, prompting critical reflection. For example, although most participants quantitatively agreed that "CHCs comply with Occupational Health and Safety standards," the qualitative data exposed inconsistencies in implementation and

reporting of safety procedures. This divergence illustrates how mixed methods integration can expose implementation gaps that are not captured in quantitative survey data alone, generating richer insights into policy–practice disconnects (Doyle, McCabe, Keogh & McCann 2020:343; Guetterman et al 2021b:5)

- **Meta-inferences and interpretation**

Through this multi-logic integration, the study generated meta-inferences that transcended individual datasets. The synthesis revealed that workplace collaboration and safety in CHCs are influenced by both measurable systems (policies, communication structures) and experiential factors (trust, professional identity, power relations). These integrated insights strengthened the explanatory validity and practical relevance of the findings, aligning with the pragmatist foundations underpinning the study (Creswell & Plano Clark 2023b:121).

The integration process therefore moved beyond juxtaposing results to meaning making across methods, producing a coherent and contextually grounded narrative of interprofessional collaboration within South African CHCs.

3.4 RIGOUR OF THE STUDY: VALIDITY AND RELIABILITY TRUSTWORTHINESS

The rigour of a mixed-methods study is established by demonstrating the quantitative validity and reliability and the qualitative trustworthiness of the findings (Polit & Beck 2021:197).

3.4.1 Quantitative rigour

3.4.1.1 Validity

Validity refers to the degree to which an instrument truly measures the construct it is intended to measure (Polit & Beck 2021:358).

- Content validity: This was ensured through the comprehensive development of the questionnaire, which was informed by an extensive literature review, national policy, documents and the objectives of the study This questionnaire was for relevance,

clarity, coverage, and appropriateness by an independent expert familiar with CHC settings and by the supervisor of the researcher. The questionnaire was further piloted before the main data collection to assess the clarity of the items, the wording of questions, the flow of the instrument, and the estimated time required for completion. Feedback from the expert review and pilot process was used to refine the wording, structure, and alignment of the questionnaire items before final administration.

- Construct coherence was supported through alignment of the questionnaire items with the study objectives, the theoretical constructs discussed in Chapter 2, supervisor review, expert input and pilot testing. Exploratory factor analysis was not appropriate because the pilot sample was small and the quantitative strand was descriptive rather than scale-development or hypothesis-testing in purpose (Polit & Beck 2021:360).
- Reliability was confirmed through the internal-consistency analysis reported in Section 3.3.3.1, where Cronbach's alpha of 0.70 demonstrated acceptable internal consistency (Salleh et al 2023:260).

To maintain the authenticity of narratives, participants' quotations were presented verbatim, reflecting their original meaning, tone, and context. Equal attention was given to voices from all provinces, diverse professional categories, and labour union affiliations to prevent bias reflexive journaling, peer debriefing, and supervisory consultation further enhanced transparency and minimised researcher bias, ensuring that the findings faithfully captured participants' realities and the contextual dynamics of rural CHCs.

3.4.2 Qualitative rigour

Trustworthiness was ensured using the criteria proposed by Lincoln and Guba (1985), namely credibility, transferability, dependability, confirmability and authenticity (Enworo 2023:372-384). This framework remains widely applied in contemporary qualitative research.

Although purposive. voluntary access to participants can introduce methodological vulnerability, this risk was mitigated through prolonged engagement in the field, triangulation of data sources, reflexive journaling, peer debriefing, and the use of a detailed audit trail. These rigorous and transparent procedures ensured that the

qualitative sample and resulting interpretations were thematically adequate and aligned with the study purpose (Creswell & Plano Clark 2023b:139)

3.4.2.1 Credibility

Credibility refers to confidence in the truth and authenticity of the findings (Bing 2024:60-83). Multiple strategies were applied to strengthen credibility:

- Prolonged engagement: The researcher spent extended time in the field approximately 6 to 9 hours per day across six CHCs to build rapport, understand contextual dynamics, and gain a realistic sense of participant experiences. This immersion reduced misinterpretation and enhanced contextual understanding.
- Triangulation: Credibility was strengthened through methodological triangulation, which involved comparing insights from FGDs and in-depth interviews (IDIs) and integrating them with the quantitative findings. In addition to spoken narratives, observational field notes and non-verbal cues were documented during FGDs and IDIs to capture contextual nuances, emotional expressions, and group dynamics that might not be evident in transcripts alone. This multi-source approach enabled the verification of convergence, clarification of divergence, and development of a more comprehensive understanding of the phenomenon, while reducing the risk of single-source bias (Enworo 2023:379; Polit & Beck 2021:255).

3.4.2.2 Transferability

Transferability was promoted through thick description, which included detailed accounts of the research setting, participant characteristics, and contextual conditions. By providing rich narrative detail, the researcher enabled readers and future scholars to make informed judgments about the extent to which the findings may be applicable to other settings with similar conditions (Polit & Beck 2021:432).

In this study data collection was conducted across six CHCs from late 2017 to the end of 2018. The extended data collection period was due to the geographical distance between sites, the researcher's full-time employment responsibilities, and the need to schedule data collection around service-delivery demands and participant availability. Three forms of data collection were undertaken, namely self-administered questionnaires, focus group

discussions, and in-depth interviews. To minimise disruption to patient care, data collection at each CHC was arranged during less busy working days and hours.

Credibility refers to the confidence and truthfulness of qualitative findings, including the extent to which the data and interpretations accurately represent participants' experiences (Stahl & King 2020:26). This was achieved through:

- Prolonged engagement**:** Prolonged engagement was achieved through repeated field visits to the six CHCs during the data collection period. The researcher spent approximately six to ten hours per day at each facility during data collection activities, which provided opportunities to observe the setting, interact with participants, build rapport, and understand the contextual realities of rural and semi-rural CHCs. Where possible, data collection also included engagement with night-duty staff to ensure that the experiences of health professionals working different shifts were considered.
- Triangulation was achieved using multiple data sources field notes, focus group discussions and in-depth interviews. and integrating them with the qualitative findings from FGDs and IDIs were integrated with the quantitative findings to strengthen the consistency of the evidence (Polit & Beck 2021:432).

3.4.2.3 Dependability and confirmability

- Dependability and confirmability were ensured through a rigorous, transparent, and reflective research process, consistent with established standards for qualitative trustworthiness (Nyathi 2022:50). To achieve this, the study maintained a detailed audit trail, documented analytic decisions, and engaged in sustained reflexive journaling to bracket assumptions and minimise researcher bias. These actions ensured that the findings were both traceable and grounded in the data, thereby demonstrating methodological coherence and enhancing the neutrality and consistency of the study's outcomes.
- Audit trail: A comprehensive audit trail was maintained throughout the study, consisting of detailed records of research activities, raw data, coding decisions, analytic memos and methodological reflections. This transparent documentation supports dependability by allowing an independent reviewer to trace the research process step-by-step, demonstrating how interpretations were developed and ensuring the study remains auditable (Stahl & King 2020:24).

- Peer debriefing: Peer debriefing involved periodic review of preliminary codes and themes with the supervisor and statistician, providing an external credibility check and testing the defensibility of analytic decisions while ensuring final interpretations remained grounded in the data; such external review is identified as a key strategy for enhancing trustworthiness in qualitative inquiry (Tracy 2010:837-851).
- Reflexivity: The researcher maintained an ongoing reflexive journal, recording dated reflections, assumptions, emotional reactions, and methodological decisions throughout the study. This process served as a self-monitoring mechanism to bracket prior professional experience and acknowledge constraints encountered during data collection, consistent with reflexive practice described by Olmos, Hernández, Cruz and Martínez (2023:242).

3.4.2.4 Authenticity

Authenticity was ensured by accurately representing the lived experiences and perspectives of all participants throughout the research process (Polit & Beck 2021:361-362). The researcher employed several strategies to preserve the genuineness of participants' voices and ensure fairness in interpretation. These included prolonged engagement within the study sites, iterative validation of key themes with participants during interviews, and triangulation of data sources, namely questionnaires, focus group discussions, and in-depth interviews.

3.5 SUMMARY

The chapter focused on sequential explanatory mixed-methods design, which provided the framework for the study. The explorative, descriptive, and analytic elements were also explained in relation to the experiences of health professionals in the six selected CHC from the three provinces at which the study was conducted. The adoption of the mixed-methods approach was to ensure the reliability, validity, quality and maximisation of the accumulated data. The latter orientation also provided a constructive framework for explaining and understanding the evidential base of the study as detailed in the following chapters. The ethical considerations were also detailed to demonstrate the study's compliance with the professional, legal, and professional obligations in research-based studies in which human participants constitute the most essential and indispensable foundation of the much-needed evidence. The next chapter details the quantitative findings of this study.

CHAPTER 4

THE ANALYSIS AND PRESENTATION OF QUANTITATIVE DATA

4.1 INTRODUCTION

This chapter presents and discusses the quantitative results obtained from the self-administrative 5 Likert scale questionnaire. The questionnaire consisting of 69 variables, was designed to assess the experiences and perceptions of health professionals and union representatives working in rural CHCs across provinces. Tables and graphs were used in presenting the results. The presentation of results is structured into three main sections. Section A basically addresses the demographic profiles of the respondents. Meanwhile, Section B of the chapter focuses entirely on responses to specific questions and statements regarding the inherent dynamics of the selected rural CHCs; Section C is about participants suggested strategies for enhancing collaborative secure partnerships within the CHCs.

4.2 DATA MANAGEMENT AND ANALYSIS

This section outlines the processes implemented to ensure rigorous management, cleaning, and analysis of the quantitative data. Following the granting of ethical clearance and completion of the participant ethical briefing, the researcher distributed the finalised self-administered questionnaires to the consented health professionals. The data-collection process was monitored by the researcher through the use of a questionnaire control record to track questionnaires distributed and returned, allocation of unique study identification codes, checking returned questionnaires for completeness, and secure storage of completed questionnaires. The data-collection process was monitored by the researcher through direct distribution and returned, returned questionnaires for completeness, and secure storage of completed questionnaires. These steps were undertaken to uphold the security, accuracy, and integrity of all responses (Gray & Grove 2024:348; Polit & Beck 2022:316).

4.3 RESEARCH RESULTS

4.3.1 Sample characteristics

In this section, the chapter essentially presents the characteristics of the participants by firstly articulating their participation rates, followed by the actual demographic or bibliographic characteristics, as well as issues specific to the secure environment and its respective variables. Table 4.1 presents the response rate of the administered questionnaires that were distributed to respondents. The table distinguishes between questionnaires administered, returned, and included in the final analysis. The overall response rate was determined by calculating the proportion of usable questionnaires against the total number distributed, in line with quantitative survey reporting principles (Humble 2020:16). Table 4.1 presents the response rate for the questionnaires distributed to participants.

Table 4.1 Returned questionnaires (N=42; response rate = 61%)

Province (n=42; 61% response rate)	Distributed	Returned (%)
North-West Province	10	24
Mpumalanga Province	18	43
Gauteng Province	14	33
Total	**42**	**100**

Table 4.1 attests to a 61% response rate, with a total achieved sample of N=42 participants. The achieved sample composition was primarily Mpumalanga (n=18; 42.9%), followed by Gauteng (n=14; 33.3%), and North-West (n=10; 23.8%). These proportions describe the of returned questionnaires. The reporting of response patterns and usable questionnaires supports methodological transparency in the interpretation of the quantitative findings (Humble 2020:16; Measures Management System 2022:12). These proportions describe the distribution of returned questionnaires, across the three provinces and provide transparency regarding the quantitative sample composition. The reporting of response patterns and usable questionnaires supports methodological transparency in the interpretation of the quantitative findings (Humble 2020:16; Measures Management System 2022:12).

4.3.1.1 Age distribution

Figure 4.1 is a depiction of the age distribution of the forty-two respondents in the study. The findings confirm a minimum age of 25 years and a maximum age of 63 years, with 44 years as the mean. The different age cohorts are reflective of the multi-generational mix of health professionals working at the sampled six research sites.

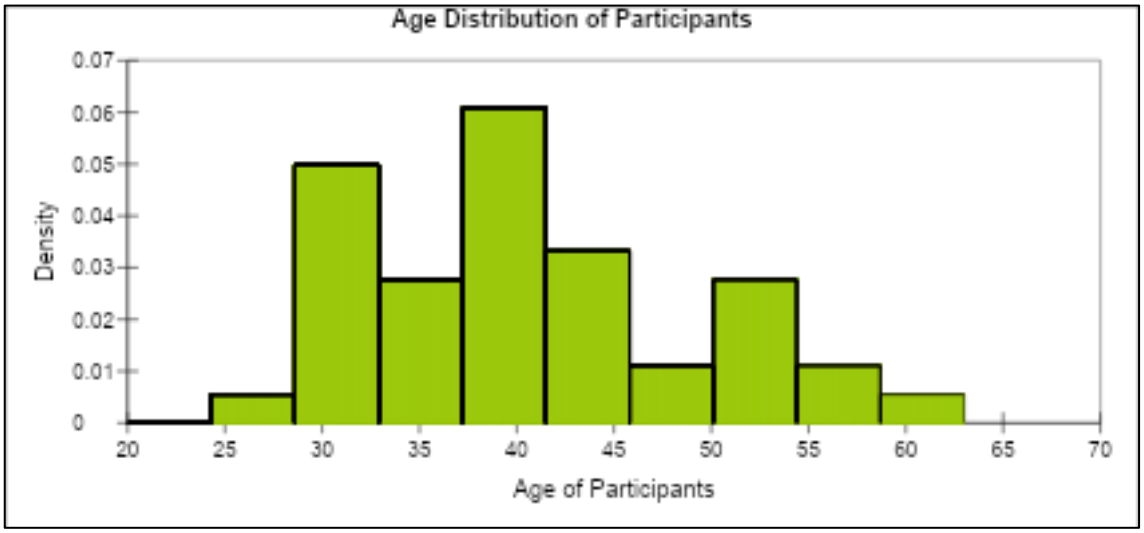


Figure 4.1 Age distribution of participants (N=42)

In terms of Figure 4.1, most participants (n=24, 60%) working in the CHCs are between the ages of 35 years and 40 years, with 95% (n=40) of the total sample being younger than 60 years old. This younger generational mix present in the sample is an indication that a positive institutional memory may be safely retained at these six CHCs.

However, staff retention may be a challenge as the older employees are in the minority, which could compromise the smooth transfer of accumulated experience and knowledge to the younger professionals. While Becker, Richards and Stollings (2020:460) caution that employees value generational mix as it increases team performance, they also note that the ability to communicate and transfer knowledge is not easy due to tensions in diverse teams.

4.3.1.2 Gender distribution

Figure 4.2 is illustrative of the respondents' gender distribution.

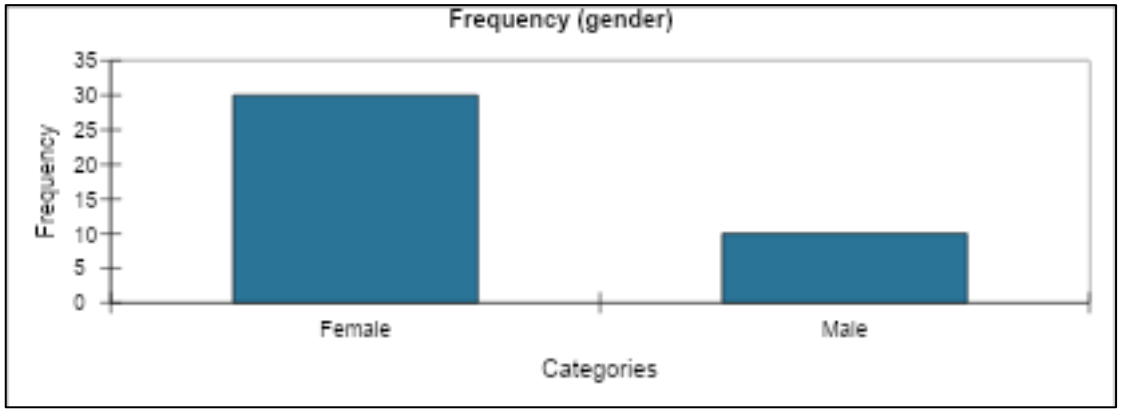


Figure 4.2 Gender distribution (N=42)

As shown in Figure 4.2, females constituted 77% of the sample, while males accounted for 23%. The predominance of female respondents is not unexpected, given the significant representation of nurses within the study population. Similar gender patterns have been reported in healthcare workforces internationally, particularly in nursing and primary healthcare settings (Santos & Amâncio 2019:161).

The statistical details are viewed as significantly acceptable, reflecting the historical trend of a female-dominated nursing profession, especially in rural areas. Ngomane (2019:10) suggests that workplace harmony and safety could be associated with gender due to socio-cultural practices where women are defined as best carers. The influential role of gender is further highlighted by Rabbie, Rossouw and Machobane (2021:11), who note that male nurses may be prevented from performing certain duties to avoid violation of patients' rights, thus are often allocated to administrative or low-touch clinical procedures (Nichols, Trimble & Stebbings 2020:11).

4.3.1.3 Home language

Figure 4.3 reflects the home language reported by respondents. Although 42 questionnaires were included in the quantitative analysis, one respondent did not indicate a home language. Therefore, the analysis for this variable was based on 41

valid responses. The missing response was treated as item non-response and was excluded from the calculation of percentages for this specific variable only.

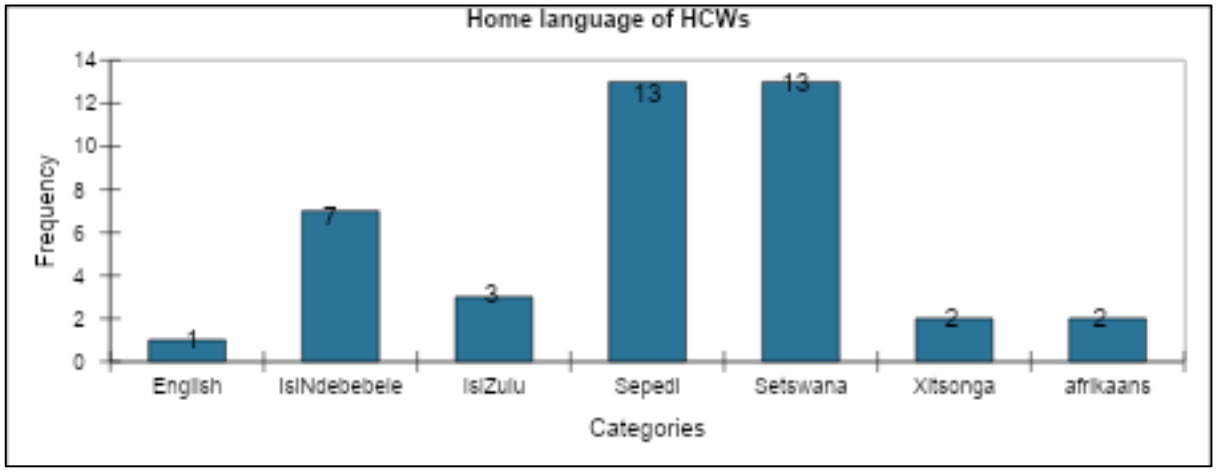


Figure 4.3 Home languages of the respondents (n=41)

All the diverse languages displayed in Figure 4.3 are official languages in South Africa, reflecting the national demographics represented in the three provinces. Sepedi and Setswana were the majority languages, each at 33% (n=13, 31.7%). Afrikaans and Xitsonga (n=2, 4.8%) each, and English (n=1, 2.2%) were the least spoken languages.

Freiermuth and Huang (2021:46) assert that to understand the culture, one must understand the use of language in context, thus determining what comprises the cultural components. Language is fundamental to relationship-building and communication. Nosratabadi, Mosavi, Shamshirband and Kazimieras Zavadskas (2020:14) alert that culturally intelligent individuals adapt to others' behaviour and can interpret that behaviour, leading to quality problem-solving and decision-making. Cultural intelligence is a required leadership skill that should be employed in enhancing positive workplace partnerships and collaborations.

4.3.1.4 Highest qualification

Beyond the cultural context established by the linguistic profile, professional capacity, may be driven by educational attainment. This is a key characteristic impacting the quality-of-service delivery and collaboration within the CHCs (Sang, González-Vallejo, Zhao & Long 2021:4; Su, Zhou, Si, Sylvia, Chen, Su, Rozelle & Wei 2021:5061). The

following section therefore details the highest qualifications held by the sampled health professionals.

Table 4.2 Highest qualification of health professionals (N=42)

Educational level	Frequency	Percentage (%)
No matric	1	2.3
Certificate	5	11.9
Diploma	24	57.1
Bachelor/Btech	8	19.0
Post-graduate Diploma	4	9.5
Honors/Master's/PhD	0	0.0%
Total	**42**	**100.0**

Table 4.2 shows that none of the respondents (n=0, 0%) possesses any qualification beyond the postgraduate Diploma. The majority of respondents (n=24, 57.1%) hold a Diploma qualification, followed by a Bachelor or BTech degree (n=8, 19%).

The fact that 71% of respondents possess a basic qualification (Diploma or lower) suggests a foundational, rather than advanced, skill base. This may imply a continuous need for support in complex areas like teamwork, innovation, and problem-solving, suggesting a greater reliance on supervisors (Nichols et al 2020:12). However, given that each CHC typically operates with only one Manager and faces considerable workload challenges, health professionals are often left to operate independently. This shortage of clinical oversight can exacerbate the possibility of staff making inappropriate decisions, which directly threatens collaborative partnerships by increasing the burden of litigation, conflicts, and complaints. As Corey, Corey, Coray and Callanan (2020:8) emphasise, health professionals require consistent clinical supervision for independently and appropriately engaging with colleagues, clarifying diagnoses, and treating clients. Therefore, improving educational qualifications and continuous professional development (CPD) is vital for enhancing safe, effective collaborative partnerships in the work environment.

4.3.1.5 Field of specialisation

Table 4.3 is an indication of the respondents' areas or fields of specialisation, all of which are indispensable CHC services. Regrettably, many participants do not hold the required

specialist aligned to the services provided in CHCs. The insufficiently skilled health professionals with deficiencies could risk prevalence of secure collaborative relations in the workplace. Health professionals, management and shop stewards are leaders who are to provide social support and collaboration to enhance interprofessional and inter organisational collaborative partnership in a secure CHCs, thus safety conscious behaviour (Ahluwalia, Spicer & Storey 2019:271).

Table 4.3 Participants' area field of specialisation (n=23)

Community Health Centre	Phar-macy	NIMART	Manage-ment	Infection control	Advanced midwifery	PHC	Others: Plus 101/HIV/ Forensic	Total
North-West, Gauteng, Mpumalanga	4.3% (n=1)	56.5% (n=13)	0%	0%	4.3% (n=1)	17.3% (n=4)	17.3% (n=4)	**23**

In terms of Table 4.3, only 23 respondents provided Information on their field of specialization. Therefore, the findings for this variable should be interpreted with caution as 19 respondents did not answer this item. Among the 23 valid responses nurse-initiated management of antiretroviral therapy (NIMART) specialty was the most frequently reported specialisation (n=13; 56.5%), followed by PHC and 'Other' respectively at (n=4; 17.3%) each.

The high proportion of NIMART among the valid responses reflects the primary health-care orientation of the participating CHCs. However, because of the high item non-response for this variable, the findings cannot be generalised to all 42 respondents. The limited reporting of other specialisations may suggest possible gaps in the availability of diverse specialised skills within rural and semi-rural CHCs, but this interpretation must be treated cautiously. Such skill gaps may affect the capacity of health professionals to support comprehensive CHC services and safe collaborative practice (Jeschke 2020:471).

This lack of specialised capacity is a common challenge in rural areas, where health professionals bear a maximum burden due to staff shortages, workload, poor leadership, and poor career progression (George 2020:59). De Brún and Mcauliffe (2023:167) further

indicate that collective leadership and the prevalence of safe, cordial, and efficient service delivery is highly interdependent. Cyr, Hains-Smith and Dubois (2019:14) support these findings as they alert that insufficient capacity in healthcare specialisation can delay meaningful professional relationships.

4.3.1.6 Further education registration status (educational advancement)

Figure 4.4 is an illustration of the respondents' registration for further educational advancement.

Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Ke, Kelley and Kistnasamy 2019:22) affirmed that the criticality of continuous educational advancement to achieve collaborated secure working environments serves as scaffolding that supports the development of social, emotional, professional, and cultural competence for health professionals. Moreover, the Nursing Act (No. 33 of 2005), Pharmacy Act (No. 54 of 1974), and the Health Profession Council of South Africa (HPCSA) jointly obligate compulsory CPD of all health professionals. Although Forsetlund, O'Brien and Forsen (2021:1) state that not all CPD educational lectures translate into new impactful knowledge, CPD initiatives allow health professionals to remain highly competitive and knowledgeable, generating positive change and enabling strong leadership (King, Taylor & Johnson 2021:13).

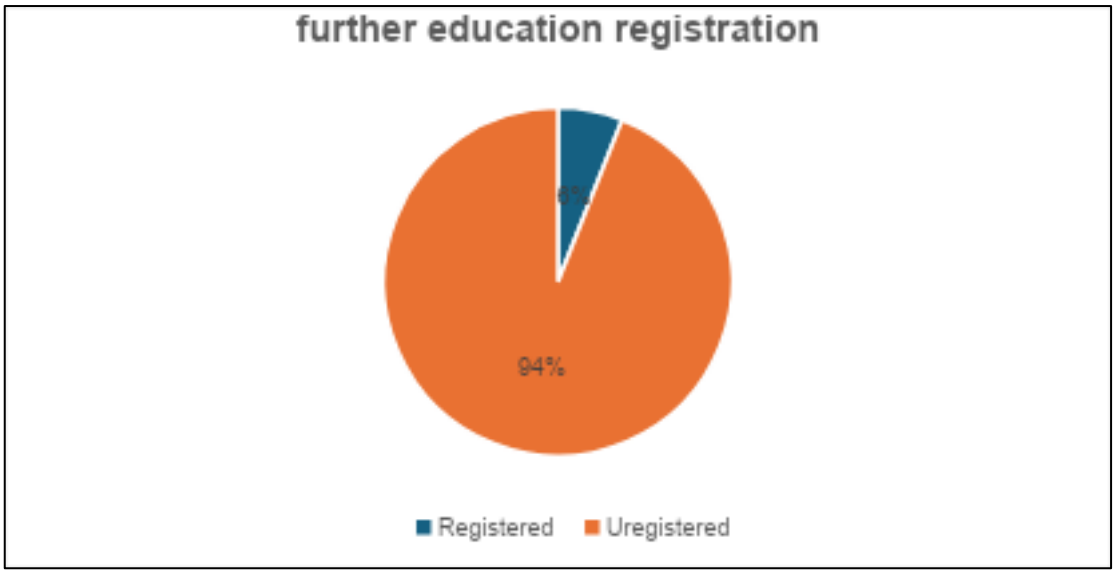


Figure 4.4 Participants' further education registration status (N=42)

Figure 4.4 shows that most HCPs (n=39, 94%) were not registered with any institution for further educational advancement. Contrastingly, only a minority (n=3, 6%) were registered with some institutions to advance their educational aspirations, which is a demonstration of individually initiated CPD. By implication, there is a dearth of structured CPD systems that can strengthen the capacity of health professionals in low-resource and rural settings. Merry, Castiglione, Rouleau, Létourneau, Larue, Deschênes, Gonsalves and Ahmed (2023:498) show that limited coordination, weak leadership support and fragmented CPD frameworks restrict opportunities for skills updating, professional growth and quality improvement. These systemic gaps undermine workforce competence and constrain the ability of health professionals to sustain safe, collaborative and effective practice in rural and underserved health facilities. Merry et al (2023:498) further highlight that without coherent CPD structures, healthcare systems struggle to maintain workforce readiness and service quality, particularly in contexts characterised by poverty, high workload and resource scarcity.

4.3.1.7 Union Membership/affiliation and status

Table 4.4 is a representation of the respondents' union membership or affiliation and status.

Table 4.4 Union membership and status (N=42)

Name of Union	Number	Percentage (%)
PSA	15	46.8
NEHAWU	8	25.0
DENOSA	7	21.8
HOSPERSA	2	6.25
No Union membership	10	23.8
Total	**42**	**100.0**

It is worth noting that n=32 (76%) of participants are legitimate union members, although n=10 (24%) are non-union members. To the largest extent, the apparent diversified union membership of the respondents is an affirmation of the relevancy of the participants who have the freedom or right of association to belong to one of the legally approved labour organisations in South Africa, as enshrined in the Labour Relations Act (No. 66 of 1995) and the Constitution of the Republic of South Africa (No. 108 of 1996) (South Africa 1996).

4.3.1.8 Professional body membership and status

Table 4.5 reflects the respondents' membership and status in a regulatory professional body.

Table 4.5 Professional body membership and status (N=42)

Professional body	Frequency	Percentage (%)
HPCSA	7	21.8
SANC	24	75.0
None	1	3.1
Not stated	10	23.8
Total	**42**	**100.0**

Only 32 responses confirmed affiliation with their regulatory bodies, while n=11 (26%) either reported no affiliation or did not state it. Overall, the findings confirm that the nurses who belong to the SANC as their regulatory body are the highest number of participants employed in rural CHCs. Health professionals, as rural CHC employees, are regulated by their respective Professional Regulatory bodies (SANC, HPCSA, and the South African Pharmacy Council), which support compulsory compliance for CPD, collaboration, partnership, and safety behaviour and culture (Health Professions Council of South Africa [HPCSA] 2025:15; SANC 2024:8).

4.3.1.9 Previous employment

Table 4.6 is a depiction of the respondents' previous employment. Such a focus enables determination of their experience and capacity regarding their roles in the establishment of viable therapeutic environments.

Table 4.6 Previous employment (N=42)

Facility type	Frequency	Percentage (%)
Tertiary hospital	5	16.6
Regional hospital	9	30.0
District hospital	9	30.0
Clinic	7	23.3
No completion	12	29.0
Total	**42**	**100.0**

The findings in Table 4.6 confirm that the highest number of respondents (n=9; 21.4%) previously worked at a regional hospital and an equal number (n=9, 21.4%) at a district hospital, followed by n=7 (16.7%) who previously worked at a clinic. The least number of respondents (n=5; 11.9%) had previously worked at a tertiary hospital. The findings confirm that the respondents' experience is highly relevant for continuity in enhancing collaborative partnership, as clinics are part of the PHC system, a most basic component (Christensen, Medew & Craft 2019:34).

4.3.1.10 Designation at preferred workstation

Table 4.7 is indicative of the respondents' various designations at their preferred workstations. Given that n=22 (52%) of participants failed to indicate a preference, the following data reflects only the preferences of the 20 respondents who completed this variable.

Table 4.7 Preferred workstations of participants (n=20)

Workstations/units	Frequency	Percentage (%)
Mother and child units (EPI)	2	10.0
Primary healthcare (PHC)	3	15.0
Maternity/reproductive	2	10.0
Chronic illness	10	50.0
Management	1	5.0
Pharmacy	1	5.0
Forensic nursing	1	5.0
Total	**20**	**100.0**

Table 4.7 presents the preferred workstations of the respondents. Of the 42 respondents, only 20 provided information regarding their preferred workstation, while 22 did not respond to this item. Therefore, the findings should be treated with caution as they represent only those respondents who provided a valid response. Among the 20 valid responses. chronic illness was the most preferred workstation (the (n=10; 50%), followed by primary healthcare (n=3; 15%). in the PHC units. Mother and child units (EPI) and maternity/reproductive units were each preferred by two respondents (n=2; 10.0%). Management, pharmacy, and forensic nursing were each preferred by one respondent (n=1; 5.0%).

The preference for chronic illness and PHC units may reflect the dominant service profile of rural and semi-rural CHCs, where management of chronic conditions, health promotion, disease prevention, and continuity of care constitute a significant proportion of daily activities. The lower preference for maternity, pharmacy, forensic nursing, and management units may indicate limited exposure, confidence, interest, or opportunities for practice in these specialised areas.

In rural CHCs, allocating personnel according to preferred workstations remains challenging because staff shortages, service demands and daily operational needs often require staff rotation across units (Christensen et al 2019:15). Although rotation and delegation may support service continuity and multi-skilling, they may also create dissatisfaction when health professionals are allocated to workstations that do not align with their preferences, competencies or areas of confidence. Delegated workstation arrangements may affect productivity and efficiency when staff are placed in areas that differ from their preferred or most competent work settings (Skakane-Masango, Mtshali & Ngcobo 2022:47). Such arrangements may also influence communication, coordination and collaboration within teams, particularly where workstation allocation is not clearly communicated or collaboratively managed (Ugoani 2020:82).

The findings suggest that balancing organisational needs with staff competencies and preferences remains a challenge in rural CHCs. Failure to achieve this balance may contribute to workplace dissatisfaction and could potentially affect interprofessional collaboration and the quality of healthcare services provided.

4.3.1.11 Number of previous employment workstations

Table 4.8 illustrates number of previous workstations in which respondents were employed. the number of previous employments workstations.

Table 4.8 Number of previous workstations where respondents were employed (n=21)

Number of stations	Frequency	Percentage (%)
1	6	28.6
2	3	14.2
3	12	57.2
Total	**21**	**100.0**

Extrapolated from Table 4.8 presents the number of previous workstations in which respondents had been employed. This item yielded 21 valid responses; therefore, percentages were calculated using the valid-response denominator. The remaining respondents did not complete this item and were excluded from the denominator; findings should therefore be interpreted with caution and not generalised to the full sample. The (n=12; 57.2%) respondents reported having previously worked at three (three) workstations, while six (28,6%) had worked in one workstation and three (14.2.%) in two workstations. The findings suggest that among respondents who answered this item, movement across workstations was common. This pattern may reflect the operational practice of rotating healthcare workers across service points in response to community health centre needs. Although such movement may promote multi-skilling, it may also indicate underlying staffing constraints, workload pressures and the need to distribute limited human resources across multiple workstations (Christensen et al 2019:34; Skakane-Masango, Mokoena & Ndlovu 2019:13).

4.3.1.12 Variation of shifts

Table 4.9 reflects the variation of shifts experienced by the participants. 57% (n=24) of participants did not complete this variable in the questionnaires.

Table 4.9 Variation of shifts (n=18)

Shift	Frequency	Percentage (%)
Night shift only	3	16.6
Day shift only	8	44.4
Day and night shift interchangeably	7	39.0
Total	**18**	**100.0**

As shown in Table 4.9, the (n=8; 44.4%) respondents worked on the day shift only, while (n=7; 39%) alternated between day and night shifts. A smaller proportion (n=3; 16.6%) reported working exclusively on the night shift. The practice of rotating between day and night shifts, reported by 39% of respondents, appears to be a common arrangement that may enhance interprofessional partnership by fostering interaction across different cadres. This arrangement further underscores the importance of collaboration and continuity in sustaining the 24-hour services delivered within rural CHCs.

4.3.1.13 Staff working hours, including overtime hours

Table 4.10 is an indication of the staff working hours, including overtime. A determination of these hours is also a possible factor in determining the extent of staff shortages.

Table 4.10 Number of overtime hours worked by staff per week (N=42)

Number of overtime hours per month	Frequency	Percentage
0 hours	25	59.5
1 hour to 12 hours	2	0.5.7
More than12 hours	5	12.1
More than 20 hours	7	17.0
More than 34 hours	2	0.5
Total	**42**	**100.0**

Table 4.10 presents the number of overtime hours worked by staff per month (n=25, 59.5%) of respondents reported that they did nt work overtime. However, seven (17.0%) respondents reported working more than 20 hours per month. This suggests that, although overtime was not reported by the majority, a proportion of healthcare personnel experienced extended working hours.

The findings may indicate uneven workload distribution and possible staffing constraints within the CHCs. Recent evidence shows that staff shortages in 24-hour PHC services contribute to increased workload and exhaustion among nurses (Mutshatshi & Munyai 2022:3). Similarly, Bae (2024:6) found that mandatory overtime was associated with increased intent to leave, while workload was significantly associated with burnout. In this context, extended working hours may compromise the physical, emotional and psychological well-being of healthcare personnel and may weaken secure collaborative partnerships within CHCs (Dlamini, Nkosi & Mokoka 2021:2; International Council of Nurses 2021:3).

The fact that health professionals could work a maximum of 34 hours of overtime per week, also confirms that staff shortage and a risk to physical safety of personnel are a common occurrence. Collectively, both the shortage of staff and increased workloads present risks and threats to the physical, emotional, and psychological well-being of the healthcare personnel, thus threatening collaborative secure partnership (Dlamini, Nkosi & Mokoka 2021:2).

4.3.1.14 Safety legislative framework

Table 4.11 presents the safety-related legislative, policy and standards frameworks identified by respondents. In this study, awareness was understood as respondents' self-reported familiarity with, or ability to identify, a safety-related framework. The item did not assess detailed knowledge of the content, provisions or application of the frameworks. The findings are therefore interpreted as self-reported awareness or recognition, rather than as tested legislative knowledge. The item was completed by 29 respondents, while 13 respondents did not provide a response. Percentages were therefore calculated using the valid-response denominator (n=29). The non-responses were treated as item non-response and were not interpreted as evidence of lack of awareness.

Table 4.11 Legislative framework related to safety (n=29)

Legislation	Frequency	Percentage (%)
Occupational Health and Safety Act	9	31.0
National Health Act/NHA	5	17.2
Infection Prevention and Control Policy	5	17.2
National Core Standards/NCS	3	10.3
SA Constitution	2	6.8
Compensation for Occupational Injuries and Diseases Act/COIDA	2	6.8
Labour Relations Act/LRA	1	3.4
Quality Assurance/QA	1	3.4
Sustainable Development Goals/SDGs	1	3.4
Total	**29**	**100.0**

Table 4.11 shows that the Occupational Health and Safety Act was the most frequently recognised instrument, acknowledged by nine (31.0%) respondents. This was followed by the National Health Act and the Infection Prevention and Control (IPC) policy, each cited by five (17.2%) respondents. The National Core Standards were identified by three respondents (10.3%), while the Constitution of the Republic of South Africa and the Compensation for Occupational Injuries and Diseases Act were each identified by two respondents (6.8%). The Labour Relations Act, Quality Assurance and Sustainable Development Goals were each cited by one respondent (3.4%).

In this study, awareness was understood as respondents' self-reported ability to identify a relevant safety-related framework. The item did not assess detailed knowledge of the content, provisions or application of the frameworks. The findings are therefore interpreted as self-reported awareness or recognition, rather than as evidence of legislative knowledge.

These findings suggest limited and uneven self-reported recognition of safety-related legislative, policy and standards frameworks. However, they should not be interpreted as evidence of respondents' legal competence or detailed understanding of the frameworks. This generalised lack of comprehensive legislative knowledge is a significant finding. Previous research in South Africa consistently indicates that low worker knowledge of occupational legislation impairs adherence to safety protocols and compromises effective implementation, despite the existence of robust legal frameworks South Africa consistently indicates that low worker knowledge of occupational legislation impairs adherence to safety protocols and compromises effective implementation, despite the existence of robust legal frameworks (Dlamini, Zogli & Lawa 2022:69). Specifically, the minimal awareness of COID Act and the Labour Relations Act is particularly critical, as these instruments govern injury compensation, grievance procedures, and fair working conditions. A healthcare workforce that is unaware of its legal rights and obligations under these fundamental acts is less likely to report hazards, utilise available protection mechanisms, or advocate for a safer working environment. Consequently, this deficit in knowledge acts as a structural vulnerability that impedes the realisation of safe, collaborative healthcare partnerships, reinforcing the need for targeted institutional training and policy communication (Saaida & Saaida 2023:72).

4.3.2 Section B: Dynamics of the secure collaborative relationship within the comprehensive health centres

In this section, the dynamics of the therapeutic environment are presented in the context of management and leadership; conceptualisation of safety; communication; infrastructural dynamics; organised labour experiences; as well as the positive and negative experiences of the health workers within their respective CHCs.

4.3.2.1 Leadership and management experiences

The manager's role is fundamentally profound insofar as ensuring policy implementation and overseeing employee performance. It is the duty of managers to ensure the prevalence of constructive interpersonal relationships among healthcare employees. The study by Adeyemi (2022:105) affirms that there is a direct relationship between workplace conflicts and employee productivity, noting that workplace conflict often causes relational and emotional instability. Table 4.12 is a depiction of the respondents' leadership and management experiences in this study.

Table 4.12 Leadership and management experiences

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. The weakened communication skills of leaders (Management) have led to a weakened relationship between health professionals.	(14) 33%	(11) 25%	(0) 0%	(15) 40%	(2) 2%	58% agree that weak skills of leaders led to weak relations between professionals. 58%) agree that weak skills of leaders led to weak relations between professionals.
2. Managers overlook privacy and rights most of the time at this CHC.	(15) 35%	(10) 24%	(10) 24%	(5) 12%	(2) 5%	59% agree that management overlooks privacy and rights of health professionals most of the time.
3. Supervisors, health professionals, come into my consultation room without knocking and unannounced.	(8) 19%	(10) 24%	(6) 14%	(18) 43%	(0)	43% agree that managers and colleagues have no respect of closed-door violating one's privacy and of patients.
4. The management employs creative approaches to maximise resources to focus on building partnerships.	(5) 12%	(16) 38%	(12) 29%	(6) 14%	(3) 7%	21% disagree with the effort to maximise resources that built partnerships exist.
5. Management plays an active role in identifying conflicts that is due to poor or unhealthy communication techniques applied between health professionals within the workplace.	(6) 14%	(18) 43%	(8) 19%	(6) 14%	(4) 10%	19%) uncertain and 24% disagree about positive conflict handling between HCP.
6. My supervision is friendly and approachable.	(14) 33%	(5) 12%	(10) 24%	(9) 21%	(4) 10%	24% uncertain and 31% disagree that supervisor is approachable.
7. Management uses positive communication techniques that	(10) 24%	(16) 38%	(9) 21%	(4) 10%	(3) 7%	21% uncertain and 17% disagree that positive

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
encourage dignity and human relations when they engage with workers.						communication techniques forging dignity and human relations are used.
8. The health workers feel safe from any conflict caused by other employees due to the management support.	(5) 12%	(15) 36%	(10) 24%	(8) 19%	(4) 9%	24% uncertain and 28% disagree to be feeling safe during conflict resolution due to management support.
9. My supervisor can be trusted.	(12) 29%	(14) 33%	(8) 19%	(5)12%	(3) 7%	9%) uncertain and 19% disagree that they can trust their supervisor.
10. Trusted supervision is positively linked to a safe work environment.	(13) 31%	(12) 29%	(9) 21%	(5) 12%	(3) 7%	60% agree that there is a relationship between trusted supervisors and safe working environment.
11. Management style that promotes little control over the staff and violates others' rights by shouting etc.	(11) 26%	(17) 40%	(7) 17%	(4) 10%	(3) 7%	66% agree that the management style promotes little control over staff and violates rights of staff.
12. Accounting to supervisors who have inconsistent treatment on staff, discriminate on gender, class and race interfere with healthy relationship.	(10) 24%	(19) 45%	(8) 19%	(3) 7%	(2) 5%	69% agrees that discrimination on gender, race class exist, and inconsistent treatment interfere with health relationships.

The findings reflected in Table 4.12 reveal a critical structural and relational deficit within the CHC management. While some areas of functional management exist, notably, 62% of respondents report using positive management communication techniques and 62% trust their immediate supervisor, the data points to pervasive systemic dysfunctions.

The most critical negative finding is the overwhelming consensus that leadership style actively violates employees' rights and negatively impacts the workplace environment. Specifically, 66% of respondents agree that the management style promotes poor control and violates rights by shouting, and a majority of 69% confirm the existence of discrimination based on gender, class, and race, coupled with inconsistent staff treatment. This indicates a systemic failure of leadership integrity and procedural fairness, pointing towards an autocratic and abusive management culture.

Furthermore, these managerial behaviours directly corrode the secure collaborative relationship: 58% of respondents link weak leadership communication skills to weakened relationships among health professionals. This high frequency of negative agreement, coupled with the finding that 59% perceive managers to overlook privacy and rights, suggests a significant trust deficit that hampers collaboration. Although 57% report management is active in identifying conflicts the high prevalence of discriminatory practices and rights violations suggest that the management's actions are often reactive or ineffective in fostering a truly safe and respectful environment. This systemic failure in upholding basic human dignity and professional respect, as evidenced by the high percentage agreements on statements 2, 3 and 4, is likely to result in a conflict-ridden setting, poor employee performance, and low productivity (Agyemang, Osei & Frimpong 2022:11).

4.3.2.2 Conceptualisation of safety within the therapeutic environment

Understanding safety within the CHC therapeutic environment is fundamentally a reflection of the extent to which an employee or professional nurse and manager are aware of their professional and labour rights (Bosire, Mendenhall, Norris & Goudge 2021:23). Table 4.13 reflects the respondents' understanding of safety within the CHC therapeutic environment.

Table 4.13 Conceptualisation of safety

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Good communication skills and healthy interpersonal relationships in any workplace.	(0)	(2) 5%	(0)	(19) 45%	(21) 50%	95% disagree - no good communication and interpersonal.
2. Safety is necessary to be measured, maintained and always achieved.	(22) 52%	(19) 45%	(1) 3%	(0)	(0)	97% agree that safety indeed necessary.
3. Safety in the workplace includes PPE and the conduct of employees.	(25) 60%	(15) 36%	(2) 4%	(0)	(0)	96% agree that safety includes Positive Practice E and conduct.
4. A safe workplace with positive interactions among employees.	(22) 52%	(17) 40%	(3) 8%	(0)	(0)	92% agree that positive interactions.
5. Established positive relationship and beneficial non- threatening partnership.	(22) 52%	(17) 40%	(2) 5%	(0)	(1) 3%	92% agree that established Positive relations are beneficial
6. Knowledgeable about the Occupational Health and Safety Act.	(26) 62%	(14) 33%	(2) 5%	(0)	(0)	95% agree to be Knowledgeable about the Occupational Health and Safety but demographic confirm otherwise.
7. CHC complies with prescripts OHS.	(24) 57%	(17) 40%	(1) 3%	(0)	(0)	97% agree that CHC are to Comply with the Occupational Health and Safety prescripts.
8. Each healthcare professional commits to application of positive communication techniques.	(19) 45%	(20) 48%	(2) 5%	(1) 2%	(0)	Commits to + communication tech- but evidence not applied.
9. Continuous training and skilling sustain safety compliance and culture.	(28) 68%	(10) 24%	(2) 4%	(2) 4%	(0)	CPD sustains safety.

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
10. Developed safety policies and procedures with communication lines for staff.	(12) 28%	(28) 68%	(2) 4%	(0)	(0)	Developed safety policies.
11. Safety starts with communication techniques.	(12) 28%	(25) 60%	(5) 12%	(0)	(0)	Safety starts with communication.
12. Active Union reps add value to sustain a safe workplace.	(3) 4%	(10) 25%	(12) 29%	(14) 33%	(3) 8%	29% are uncertain, and 41% disagree that unions add value to safety.
13. Safe workplace includes safety committees and union representatives.	(14) 33%	(21) 50%	(7) 16%	(0)	(0)	88% agree that safe workplace includes safety committees and union representatives.
14. Safety committee goes beyond compiling meetings, including personal interaction.	(16) 40%	(22) 52%	(2) 4%	(0)	(2) 4%	92% agree that Safety goes beyond meetings includes personal interaction.
15. Safe environment supports psychological, physical and spiritual need.	(16) 40%	(22) 52%	(2) 4%	(0)	(2) 4%	92% agree that safety supports physical, spiritual in line with Maslow’s hierarchy of needs.

The data in Table 4.13 reflects a profound dissonance between the respondents' conceptual and aspirational view of safety and the reported reality of their workplace. A significant majority (97%) agree that safety is a measurable and necessary outcome, and 92% understand that a safe environment must be holistic, supporting psychological, physical, and spiritual needs, an alignment with Maslow's hierarchy of needs. The findings concerning understanding of safety concur with

Chiao, Wu, Tzeng, Teng, Liao, Yu, Huang, Pan, Chen and Su (2021:6), who cite that physiological, safety, love, and belonging needs are collectively called "deficiency needs." When a workplace satisfies these hierarchical needs, employee satisfaction and safety are theorised to increase, leading to higher productivity (Bakker, Verhaegh, Kox, Van der Beek, Boot, Roelofs & Francke 2019:12). However, the lived experience sharply contradicts this aspirational safety culture. A staggering 95% of respondents explicitly disagree that good communication skills and healthy interpersonal relationships exist in their workplace. This high level of disagreement demonstrates a critical failure to implement the social and relational dimensions of safety that respondents clearly value.

A second key contradiction lies in legislative awareness. While 95% of respondents' self-report being knowledgeable about the Occupational Health and Safety Act, the earlier demographic data revealed that only 31.0% of respondents cited the Occupational Health and Safety Act when asked to list relevant safety legislation. This gap is a significant finding, pointing to an over-estimation bias in self-assessment of legislative competence. Such self-reporting bias is a well-documented phenomenon in social science research and must be critically assessed when evaluating the *actual* safety compliance capacity of the staff. The minimal support for organised labour's role in safety is also notable, 41% of respondents disagree that active union representatives add value. This challenges the traditional view of unions as key advocates for safety and suggests a need to re-evaluate the efficacy or perceived relevance of labour bodies in the CHC safety architecture.

4.3.2.3 Communication within the comprehensive health centres

Communication is a vital component of organisational development and performance. The study by Mukelabai, Chirwa and Mulenga (2021:19) discovered that effective communication has a positive effect on the performance of staff in the organisation, thus noting a positive relationship between the channel of communication and effective

communication. Effective communication involves interpersonal interactions among personnel intended for adequate mutual understanding, thus establishing a secure workplace. Table 4.14 indicates the respondents' experiences regarding communication within the CHCs.

Table 4.14 Communication within the community health centres

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Health professionals, unions and management use communication platforms that saves time and convey important messages.	(10) 24%	(8) 19%	(4) 9%	(10) 24%	(10) 24%	43% agree that the three role players use communication platforms.
2. Health professionals communicate poorly with one another and appear to worry about their personal interests than service outcomes.	(12) 29%	(12) 29%	(4) 10%	(8) 19%	(6) 13%	58% agree that health professionals communicate poorly and are selfish.
3. Your safety needs as a health worker are taken into consideration to enable you to be effective in the CHC.	(10) 24%	(8) 19%	(6) 14%	(14) 33%	(4) 10%	43% agree and 43% disagree that needs of HC are considered.
4. The well constituted safety committees conduct walk-about to identify conflicts amongst workers and report to management.	(10) 24%	(6) 14%	(4) 9%	(12) 29%	(10) 24%	53% disagree and 38% agree about safety committees that identify conflict and report to management.
5. Safety committees monitor management's response to correcting hazards communication and interpersonal relations.	(6) 14%	(16) 38%	(4) 10%	(8) 19%	(8) 19%	Safety committees monitor responses on correcting hazards, communication and interpersonal relations.
6. You can communicate with and/or serve on joint labour-management safety and health committees freely without fear of intimidation.	(8) 19%	(12) 28%	(2) 5%	(10) 24%	(10) 24%	48% disagree that they can communicate and serve joint committees freely without fear.
7. The absence of mechanisms to collect and exchange information threatens quality partnership in the CHC.	(8) 19%	(17) 40%	(2) 5%	(10) 24%	(5) 12%	59% agree that quality partnership is threatened due to absence of mechanism to collect and exchange information.
8. Lack of trust between employees, the professionals and non-professionals.	(6) 14%	(13) 31%	(2) 5%	(14) 33%	(7) 17%	45% agree there is lack of trust between employees and healthcare workers.

Based on Table 4.14, communication is confirmed as a critical barrier to the establishment of secure collaborative relationships. The findings reveal pervasive deficits in both interpersonal communication and structural communication systems.

The most concerning finding is the high proportion of respondents (58%) who agree that health professionals communicate poorly with one another and prioritise personal interests over service outcomes. This perception of egocentricity and professional isolation is compounded by the explicit finding that 45% of respondents agree there is a lack of trust between professional and non-professional health workers, demonstrating horizontal fragmentation within the CHC team structure. This inability to apply effective communication techniques, such as clarifying, reflecting, and listening) during interpersonal relations is a significant concern (Verma, Bhatt, Boothe & Cunningham 2019:88).

Furthermore, the integrity of the communication environment is undermined by fear and systemic failure. A significant 48% of respondents disagree that they can communicate freely and serve on joint labour-management committees without fear of intimidation. This highlights a palpable climate of fear and retaliation, which is directly linked to the structural deficit where 59% agree that the absence of mechanisms to collect and exchange information threatens partnership quality. Therefore, the findings confirm that the absence of trust and poor communication techniques, despite the theoretical competencies acquired during training (Ratna 2019:1), have a detrimental impact on collaboration and secure relations between all health professionals.

4.3.2.4 Organised labour experiences

Table 4.15 reflects participants' experiences with organised labour.

Table 4.15 Experience with organised labour

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. You are free to be organised, participate and attend union activities advocating for union activities and positive safe workplace and relevant committees.	(16) 38%	(12) 28%	(5) 13%	(9) 21%		21% disagree that they do not freely participate in union activities.
2. The unavailability of an active functional union has frustrated healthcare workers, thus impacting on their rights and safety in this CHC.	(15) 36%	(13) 31%	(3) 7%	(8) 19%	(3) 7%	67% agree that an absent active functional union as frustrated health professionals impacting on their safety and rights.
3. Poor interpersonal relations and poor communication skills are often noticed by HPs.	(8) 19%	(20) 48%	(8) 19%	(6) 14%	(0)	67% agree that poor communication and interpersonal relations are present in CHC between staff/management and union.
4. Organised labour advocates for positive communication skills and healthy interpersonal relationships among workers and management on their safety roles and rights.	(9) 22%	(21) 50%	(6) 14%	(6) 14%	(0)	14% are uncertain and 14% disagree that union advocates for staff.
5. Organised labour play an active role in identifying conflict that is due to poor or unhealthy communication techniques applied between health professionals and management within the workplace.	(11) 26%	(16) 38%	(8) 19%	(5) 12%	(2) 5%	19% uncertain and 17% disagree that organised labour plays a conflict resolution role between staff and management.
6. Labour take responsible action to help organise health professionals around positive interpersonal relationships and	(14) 33%	(15) 36%	(6) 14%	(7) 17%	(0)	14% uncertain and 17% disagrees that labour plays its role to enhance

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
positive/healthy communication skills communication without fear or favour.						positive relations without fear and favour.
7. Organised labour within the CHC advocate for positive interpersonal amongst staff without fear or favour CHC.	(15) 36%	(12) 28%	(15) 36%	(0) 0%	(0)	36% uncertain that Labour advocates for positive relations amongst staff.
8. Union communicates with and/or serve on joint labour, management safety and health committees.	(12) 29%	(17) 40%	(5) 12%	(8) 19%	(0)	12% are uncertain and 19% disagrees that the Union communicates and serves on safety committees.
9. Union representatives are objective; help organise and attend all safety committees with all role players within the CHC.	(7) 17%	(22) 52%	(7) 17%	(6) 14%	(0)	17% uncertain and 14% disagree that Union reps are objective, organised and attend committees within the CHC.
10. The health workers feel safe from any conflict caused by other employees due to the management support.	(10) 24%	(20) 48%	(4) 9%	(5) 12%	(3) 7%	9% uncertain and 19% disagree that management support is available for safe from conflict resolution between employees feel safe.
11. Union working with community and politicians can contribute to safe health facility always because they are leaders who provide harmonious relationships between healthcare workers and users of health facility.	(9) 21%	(18) 43%	(8) 19%	(4) 10%	(3) 7%	19% uncertain and 64% agree that working relations between union, community and politicians can contribute to safe

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
						CHC-forging harmonious relationship.
12. The Union participates positively in relationships (partnership) to advocate effective communication techniques between health professionals within the workplace.	(13) 31%	(14) 33%	(5) 12%	(7) 17%	(3) 7%	12% are uncertain and 24% disagree that Union participates positively to advocate effective communication between healthcare professional in the CHC.
13. The organised labour plays an active role in identifying conflict due to poor or unhealthy communication techniques between health professionals within the workplace.	(8) 19%	(18) 43%	(7) 17%	(9) 21%	(0)	17% uncertain and 21% disagree that Labour plays active role in identifying conflict due to poor communication techniques within the CHC.

The findings from Table 4.15 highlight a significant contradiction regarding the role and efficacy of organised labour. On the one hand, fundamental rights appear to be upheld: 66% of respondents agree that they are free to participate in union activities. This indicates that the environment, in principle, respects freedom of association.

However, this freedom is undermined by the perceived inactivity of the labour structures. A strong majority of 67% express frustration over the unavailability of an active functional union, believing this negatively impacts their rights and safety. This substantial finding suggests a critical disconnect where unions may exist but are not perceived as being functionally present or effective in addressing immediate workplace safety and rights concerns. This phenomenon is often rooted in the institutionalisation of labour relations, where union focus shifts to formal administrative and high-level negotiation duties rather than translating participation into effective shop-floor action (O'Toole & Tuck 2021:160; Wibberley & Wadsworth 2020:365). This lack of visible, active intervention fosters member disillusionment, causing workers to perceive the structure as present but functionally inert.

Despite the perception of non-functionality, respondents maintain a high aspiration for union involvement in partnership. 72% agree that the union advocates for positive communication, and 69% believe the union takes responsible action without fear or favour. Most critically, 64% agree that collaboration between unions, the community, and politicians can contribute to a safer health facility, suggesting that workers see organised labour as a necessary element in the external political and community dynamics of safety.

The findings align with Yue, Men and Ferguson (2019:9-10), who confirmed that partnership among all role players (staff, union, and management) results in increased transparency, improved respect, and overall quality improvement within the organisation.

4.3.2.5 Infrastructural dynamics in the secure community health centres

Poor infrastructure is a confirmation of the safety risks to patients and workers at many health facilities, which exacerbates the challenges present in respect of PHC service provision (Kabir, Karim & Billah 2022:10).

Adequate infrastructure provides essential support for ensuring that the core business of healthcare delivery is not unduly disrupted. The degree of infrastructural availability, or the absence thereof, is a crucial determinant of the degree of safety at any healthcare facility, and appropriate resources and infrastructure are required for quality improvement (Endalamaw, Takele, Abebe, Worku & Taye 2023:9-10). Table 4.16 indicates the infrastructure-related responses concerning the issues raised by the researcher at the consulted six CHCs in this study.

Table 4.16 Infrastructure-related context of secure working environments

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. The CHC makes efforts to improve the physical infrastructure.	(8) 19%	(20) 48%	(7) 17%	(4) 9%	(3) 7%	67% of participants agree that CHC try to improve physical infrastructure.
2. Resting and meditation space.	(4) 9%	(2) 5%	(6) 14%	(18) 43%	(12) 29%	69% disagree and 15% are uncertain that resting and meditation space is available for HCP.
3. View and access to nature is available from consulting rooms and wherever possible.	(3) 7%	(14) 33%	(4) 10%	(16) 38%	(5) 12%	12% and 38% disagree that they have a view and access to nature from their consulting rooms.
4. The CHC has acceptable noise levels commits to noise reduction.	(9) 21%	(19) 45%	(4) 10%	(2) 5%	(8)19%	66% agree that HCPs commit to noise reduction and CHC have acceptable noise level- There is a need for improvement as 24% disagreed.
5. Artwork on the wall with relevant photographs for the CHC.	(4) 10%	(5) 12%	(5) 12%	(22) 52%	(6) 14%	66% disagree that artwork is available on the walls of CHCs.
6. The HCPs enjoy consultation rooms with same resources.	(2) 5%	(10) 24%	(5) 11%	(21) 50%	(4)10%	11% are uncertain and 60% disagree that to be satisfied with the condition of the consultation rooms and resources not equally distributed.
7. Access to natural light.	(11) 26%	(17) 41%	(5) 12%	(9) 21%	(0)	Access - 21% disagree to access to natural light.
8. There is appropriate lighting to ensure safety in the CHC.	(13) 31%	(15) 36%	(3) 7%	(11) 26%	(0)	67% agree to light that promotes a safe secure workplace but 26% disagree.

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
9. Mild physical exercises and walking is allowed and encouraged.	(3) 6%	(5) 12%	(4) 10%	(23) 55%	(7) 17%	72% disagree that mild exercises and walking is encouraged in the CHC.
10. Sound of music pre-recorded, and programme is softly played to enhance calmness and positivity.	(20) 48%	(9) 21%	(5) 12%	(6) 14%	(2) 5%	69% agree that music calming staff is played to enhance calmness and positivity.
11. Services points are linked and in proximity allowing partnership and flow of services.	(7) 17%	(18) 43%	(10) 24%	(3) 6%	(4) 10%	16% disagree that services within CHC are linked, in proximity allowing flow of services and partnership. 60% agree.
12. Other Social activities allowing a sense of stimulation that helps nurture a worker's sense of positive wellbeing.	(2) 5%	(11) 26%	(5) 12%	(19) 45%	(5) 12%	57% disagree and 12% are uncertain CHC does not have/provide social activities that nurture positive well-being.
13. Decentralised supplies and stationery ensured not to delay service delivery.	(2) 5%	(16) 38%	(6) 14%	(14) 33%	(4) 10%	14% uncertain, yet 43% disagree that stationery and decentralised stores ensure undelayedly service delivery.
14. Resources to perform daily activities are adequate.	(5) 12%	(8) 19%	(3) 7%	(22) 52%	(4)10%	17% confirm that t resources to perform activities are not adequate.
15. There are organised staff focus groups where staff needs are evaluated.	(4) 10%	(16) 38%	(5) 12%	(14) 33%	(3) 7%	15% are uncertain and 49% agree that focus groups are organised to evaluate staff needs.

The infrastructure data demonstrates a management focus on the physical building structure, but a failure to prioritise ergonomic and psychological infrastructure essential for a secure working environment. On a positive note, 67% of participants agree that the CHC makes efforts to improve physical infrastructure, and 67% agree that access to natural light is available. Furthermore, 66% agree that the CHC commits to noise reduction and has acceptable noise levels. This indicates that basic compliance with some environmental standards is being attempted.

However, a critical failure exists regarding the infrastructure that supports the psychological and professional well-being of the staff. A significant 72% of respondents disagree that resting and meditation space is available. This deficit is crucial, as the absence of recovery spaces directly impacts staff burnout and resilience, which contradicts the earlier finding that 92% agree safety should support psychological and spiritual needs. Research consistently demonstrates that dedicated spaces for cognitive and emotional recovery (such as rest or meditation rooms) are a necessary structural intervention to mitigate the effects of chronic workplace stress and maintain employee well-being in high-demand healthcare settings (Bennett, Gabriel & Calderwood 2020:1164). Failing to provide these spaces constitutes an organisational system that does not support the necessary psychological boundary-setting required for emotional recovery and, therefore, accelerates job-related exhaustion (Montgomery, Panagopoulou & Andreou 2020:3).

Compounding this, 60% of respondents disagree that they enjoy consultation rooms with the same resources. This lack of equitable resource distribution suggests internal structural unfairness, confirming an issue of distributive injustice. Distributive justice refers to the perceived fairness of resource allocation (such as equipment, room quality, or administrative support) within an organisation (Colquitt 2021:5-6).

This pattern highlights the psychological and organisational risks posed by uneven resource access and weak workplace support, particularly in under-resourced health service environments where staff wellbeing and collaboration are already strained. When health professionals perceive that essential resources and organisational support are inequitably distributed, such perceptions contribute to emotional exhaustion, declining job commitment, and increased turnover intention. Recent systematic review evidence confirms that inadequate organisational support is significantly associated with higher

turnover intention and lower job satisfaction among nurses (Galanis, Moisoglou, Papathanasiou, Malliarou, Katsiroumpa, Vraka, Siskou, Konstantakopoulou, & Kaitelidou 2024:291). In rural and semi-rural community health centres, where scarcity is already pronounced, these inequities amplify stress, weaken professional engagement, and destabilise interprofessional and labour-management relationships.

This lack of equitable, fit-for-purpose resource allocation further reflects a poor alignment between workers and their practice environments, thereby reducing the level of safe, efficient, and supportive interaction between health professionals and their workplace systems.Thus lack of equitable distribution confirms a lack of fit-for-purpose and a reduced level of safe and efficient interaction between people and their surroundings (Endalamaw et al 2023:9-10) and contributes to the discrimination and inconsistent treatment reported in Table 4.12.

4.3.2.6 Positive experiences of healthcare workers/professionals

The positive experiences of health professionals are consistently linked to two critical workplace factors: enabled social support and the provision of a sense of control. Social support is crucial, as the nature and quality of interprofessional relationships directly influence nurses' stress levels and coping mechanisms (Cucolo, De Campos Oliveira, Rossit, Mininel, Perroca & Silva 2024:838). Consequently, health professionals are less susceptible to stress and are more adaptive when functioning in closely linked or cohesive groups, rather than in loosely cohesive environments. Furthermore, a sense of control offers a degree of professional autonomy and self-esteem, contributing significantly to the health professionals' sense of belonging (Butcher et al 2019:9). To mitigate psychological distress, managers must commit to proactive strategies, including the early identification of stress, mitigating risk factors that increase stress levels, providing formal psychological support, and actively cultivating coworker support mechanisms.

4.3.2.6.1 Enabled social support

Table 4.17 reflects the participants' responses regarding the extent to which social support is enabled within their respective therapeutic environments.

Table 4.17 Social support for health professionals

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Relaxing room, studying available.	(5) 12%	(13) 31%	(3) 5%	(17) 40%	(4) 12%	62% Not relaxing and studying room.
2. Places and opportunity where staff can engage socially or eat together is provided.	(4) 10%	(21) 50%	(2) 5%	(9) 21%	(6) 14%	35% Have no social merging opportunities.
3. CHC where there are unpleasant personal relations among professional health workers creates non-therapeutic working environment.	(18) 43%	(12) 29%	(5) 12%	(5) 12%	(2) 5%	72% agree that unpleasant and unprofessional relations create an insecure working environment.
4. The foundation of a therapeutic environment is about positive communication and intra-personal relations.	(20) 48%	(10) 24%	(7) 17%	(5) 11%	0	48% agree strongly that positive communication and intrapersonal relations are part of a secure therapeutic environment.
5. Staff accommodation facilities or contacts are provided for health workers.	(4) 10%	(22) 52%	(5) 12%	(8) 19%	(3) 7%	26% disagree that accommodation is provided to HCPs.
6. Organised focus groups and community council where specific needs of the community being served are evaluated and recommended.	(11) 26%	(19) 45%	(3) 7%	(7) 17%	(2) 5%	22% disagree that there is evaluation and communication forum with the communities they serve.
7. Health professionals do not undermine each other; medical doctors treat other health professionals (nurses) with respect and organise how their actions affect the rest of the practise.	(6) 14%	(23) 55%	(5) 12%	(5) 12%	(3) 7%	69% agree that health professionals undermine one another.

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
8. Health personnel try to communicate messages effectively and encourage both social and task-related relationship by being social themselves.	(6) 15%	(21) 50%	(9) 20%	(6) 15%	(0)	15% disagree that effort to communicate effectively-encourage social and task related relationships.
9. CHC environment is culture sensitive on all workers to promote partnership and lessen conflicts.	(8) 19%	(20) 48%	(9) 21%	(3) 7%	(2) 5%	12% disagree that the environment is culture sensitive and promotes partnership lessens conflicts.
10. CHC Communication culture is inclusive of people who have different background and of diverse cultures.	(12) 29%	(18) 42%	(6) 15%	(6) 15%	(0)	15% disagree that communication culture is inclusive.
11. CHC consider spaces that facilitate social behaviour and development of social groups.	(5) 12%	(21) 50%	(6) 14%	(7) 17%	(3) 7%	24% Disagree that spaces facilitating social behaviour and development of social groups exist.

Based on Table 4.17, the findings suggest that the community healthcare environment is characterised by inadequate social support and challenges in communication. The data highlights a critical lack of dedicated structural resources; only 43% of participants (12% strongly agree + 31% agree) affirm the availability of essential amenities such as relaxing rooms or study areas. This structural deficiency is compounded by relational issues, as a significant majority (72%) concur that unpleasant and unprofessional relations actively contribute to an insecure working environment.

While a majority (71%) state that health personnel attempt to communicate effectively, the presence of toxic relations and limited physical spaces for informal interaction (60% agree social interaction spaces are provided, but 24% disagree that spaces facilitating social groups exist, suggests a disjointed work culture. The environment's lack of positive social interaction, coupled with insufficient structural support, indicates a siloed workplace that hinders partnership, potentially exacerbates conflicts, and ultimately undermines a therapeutic environment for health professionals. This aligns with the literature that suggests culturally sensitive organisations are more likely to promote partnerships and lessen conflict (Avruch 2022:13). Most participants confirmed the foundational belief that a therapeutic environment relies on positive communication, mutual trust, and acceptable inter- and intrapersonal relations, including avenues such as focus groups for staff to express views, needs, and interests (Iversen, Riley, Råbu & Lorem 2025:424).

This overall lack of support undermines comprehensive health services. Biswas, Rahman, Isam, Zaman, Hasan, Ahmed and Siddique (2022:e908) recommend that an integrated approach to supporting worker health must provide comprehensive support based on objectives such as the protection and promotion of health at the workplace, and improved access to occupational health services. The views of participants suggest that enhanced social support would add substantial value to safe collaborative partnerships within the CHCs, which concurs with the study by Masterson, Casey, Hayes, O'Connor and Higgins (2022:910) emphasising the need for co-design and co-production in health and social care sectors.

4.3.2.6.2 Provision of a sense of control

Control is defined as the ability to exercise authority, oversight, or power to establish a degree of order or an organised pattern (Butcher et al 2019:10; Frechette Bitzas, Aubry,

Kilpatrick & Lavoie-Tremblay 2020:12). Within the context of this study, a sense of control relates to the community health workers' satisfaction, self-esteem, and confidence derived from their empowerment to make decisions and exercise control over their immediate environment regarding cleanliness, lighting, furniture, tools of the trade, and technology. The sense of control for health professionals is realised through choices afforded concerning lighting and dimming controls, control over radio station and television programming in appropriate areas, the choice of personal ornaments and artwork in the consulting room, and the location of essential amenities like water cans.

4.3.2.6.3 Expression of autonomy and control

The final component of the infrastructural dynamics explores the staff's sense of self-control over their professional practice, working environment, and the resources essential to their work. This sense of control is highly correlated with job satisfaction and reduced burnout (Ngomane 2019:10). Table 4.18 provides the detailed findings on the various aspects of autonomy and control within the CHCs.

Table 4.18 Provision of a sense of control

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Independent consulting rooms and working desks for health professionals are available to promote better out.	(12) 28%	(12) 28%	0	(10) 24%	(8) 20%	56% agree to Consulting room is available but 44% disagree that independent consulting rooms and working desks.
2. Staff are given as much privacy and control over their space that is consistent with the need for supervision.	(9) 21%	(20) 48%	(6) 14%	(4) 10%	(3) 7%	17% disagree to privacy and control of own working space.
3. Staff have control over their immediate environment on cleanliness.	(12) 29%	(18) 43%	(5) 12%	(7) 16%	0	16% disagree that staff have control over the cleanliness of their workplace.
4. Ways of finding signage for the built environment provide clear visual cues orient all workers and clients guiding them to their destination and on return in this CHC.	(8) 19%	(22) 52%	(5) 12%	(7) 17%	(0)	22% disagree on proper signage guiding clients and workers.
5. Building landscape, colour paint, artwork pattern does give you cues of compassion, caring and sanity.	(13) 31%	(17) 41%	(5) 12%	(5) 12%	(2) 5%	17% disagree that the landscape promotes compassion, caring and sanity.
6. Provision of mini libraries and computer terminals where staff can research the new body of knowledge, interventions, treatment and best practises that can support your competences.	(6) 14%	(19) 45%	(4) 10%	(11) 26%	(2) 5%	31% disagree on supportive services promoting competency - no library, computers for reference to ensure competent excellent services.
7. Workers have a choice of lighting where each worker can access dimming controls that suites her/him.	(4) 10%	(10) 24%	(2) 5%	(21) 50%	(5) 11%	Yes but 61% have no lighting control in their consulting rooms.

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
8. You have a choice of personal ornaments and artwork displayed around your workspace.	(3) 7%	(5) 12%	(14) 33%	(16) 38%	(4) 10%	Yes but 48% disagree that personal ornaments are encouraged around the workspace
9. The volume, station programming control of radio and television are in the appropriate location.	(3) 7%	(23) 55%	(5) 12%	(7) 16%	(4) 10%	The radio and TV 50% disagree that it is appropriate
10. Water cans are provided for staff on strategic points and cafeteria with a mobile service.	(4) 10%	(20) 48%	(6) 14%	(10) 24%	(2) 5%	29% disagree that water as an essential service is provided at strategic points
11. Storage area or lock cupboards for staff members are available in this CHC.	(18) 43%	(12) 29%	(2) 4%	(7) 17%	(3) 7%	24% disagree on availability of storage cupboards in CHC
12. Insufficient transfer of information when workers hand over at the CHC poses a threat to relations.	(19) 45%	(11) 26%	(4) 10%	(6) 14%	(2) 5%	71% agree that insufficient transfer of information poses a threat to relations – communication
13. The forum where all staff is represented to openly discuss non-compliance actions on therapeutic environment is established.	(8) 19%	(21) 50%	(7) 16%	(4) 10%	(2) 5%	15% disagree that can openly discuss non-compliance actions to establish a therapeutic environment.
14. Reporting of unsafe events on time increases trust among staff thus positive relations.	(13) 31%	(17) 41%	(4) 10%	(6) 14%	(2) 4%	72% agree that reporting unsafe events on time increases trust and leads to positive relations.
15. Shortage of the tools of labour and all other resources that support your job performance often cause strained partnerships between management health professionals and unions at this CHC.	(16) 38%	(20) 48%	(2) 4%	(4) 10%	(0)	86% agree that shortage of tools of labour impact on relationships between health professionals, management and organised labour.
16. Shortage of personnel contributes to conflict among healthcare workers in the workplace.	(20) 48%	(9) 21%	(7) 17%	(6) 14%	(0)	69% agree that shortage of personnel contributes to conflict among workers.

The quantitative findings regarding resource scarcity and environmental control are strongly corroborated by regional and international healthcare literature, highlighting systemic deficiencies that directly impact collaborative health services in Table 4.18. The overwhelming consensus from CHC staff, that the shortage of labour tools (86% agreement) and personnel (69% agreement) cause strained partnerships and conflict is a direct reflection of documented challenges in the South African public health sector, where resource constraints and human resource shortages are consistently linked to high staff turnover, burnout, absenteeism, and compromised quality of care (Maphumulo & Bhengu 2019:2; Mutshatshi & Munyai 2022:177).

Furthermore, the reported deficiencies in basic environmental control, such as 61% of staff lacking lighting control and 48% lacking choice over personal ornaments, reflect an environment that limits the nurse's control over nursing practice (CONP). Research consistently demonstrates that higher professional autonomy and CONP are critical components of a healthy work environment, contributing directly to increased job satisfaction, better patient safety outcomes, and a reduction in negative workforce consequences (Labrague, Sabei, Al Rawajfah, AbuAlRub & Burney 2022:276). Therefore, the data suggests that these seemingly minor environmental limitations are symptomatic of a deeper managerial failure to grant staff professional self-determination, which is necessary for effective interprofessional collaboration and a positive safety culture.

In addition to the ergonomically and spatially friendly settings and flexible availability of amenities, the sense of self-control is further expressed by means of the following work-specific examples:

- Independent consulting rooms and working desks, supported by 12 (28%) who strongly agree and another 12 (28%) who agreed.
- Privacy and control over their workspace, supported by 9 (21%) who strongly agreed and 20 (48%) who agreed.
- Provision of mini libraries and computer terminals where staff can research the new body of knowledge, as supported by 6 (14%) who strongly agreed and 19 (45%) who agreed.
- Reporting unsafe events on time to instil a positive safety culture, which is supported by 30 (72%) of the respondents who strongly agreed and 14 (56%) who agreed.

The ensuing section focuses on the researcher's proposed solutions for safe collaborative partnerships within the CHCs. These proposed solutions are inextricably connected with the quantitative findings themselves, which have been elaborated throughout this chapter.

4.3.3 Section C: Proposed solutions for secure collaborative partnership between union and health professionals

In this section, the proposed solutions emanating from the findings relate to strengthening the roles of management, organised labour, communication, competencies, safety training, as well as empathy.

4.3.3.1 Strengthening management roles

Management roles are influential for implementing the organisational policies and the productivity of employees within those organisations are directly related, the overall productivity increases including job satisfaction and employee loyalty (Dhir, Dutta & Ghosh 2020:1698). Table 4.19 is a representation of the proposed strengthening of managers' roles in CHCs.

Table 4.19 Proposed strengthening of managers' roles in community health centres

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Management must establish an informal platform that promotes amicable positive interpersonal relationship to discuss and listen to the feelings of all health professionals regarding certain actions of medical, allied and nursing staff.	(23) 55%	(9) 21%	(6) 14%	(4) 10%	(0)	76% agree that is management's role to promote amicable positive relationships to merge relations between various HCPs- medical, nursing and allied.
2. Effective engagement of leadership, union and staff in open discussions about workplace safety and collaborative approaches for solutions yield a positive working environment.	(18) 43%	(12) 29%	(4) 10%	(8)18%	(0)	72% agree that effective engagement, collaboration between unions, staff for open discussions about safety solutions yields a safe positive working environment.
3. Positive/quality of the relationship you have with your supervisor ensures your safety.	(10) 24%	(20) 48%	(7) 16%	(5) 12%	(0)	16% are uncertain and 72% agree positive relationship with supervisor assures a safe secure CHC.
4. Information exchange by management is critical for sustaining partnership in the workplace.	(8) 19%	(22) 52%	(7) 17%	(5) 12%	(0)	71% agree that Information sharing is critical to sustain partnership in CHC.
5. Partnership/teamwork between management, organised labour and employee's important foundation to establish and sustain partnership towards a therapeutic safe CHC.	(9) 21%	(22) 52%	(11) 27%	(0)	(0)	63% teamwork of union, management and employees is a core foundation to establish and sustain safe CHC and partnerships.
6. A safe therapeutic environment/climate includes management's understanding, support and their effective application of communication techniques.	(21) 50%	(11) 26%	(6) 14%	(4) 10%	(0)	76% agree that management understanding, support and effective application of communication techniques add value to safe therapeutic CHC.
7. Management is key to establish, monitor, providing resources and provide support towards a therapeutic milieu between health professionals in the CHC.	(16) 38%	(22) 52%	(4) 10%	(0)	(0)	90% agree that it is the role of management to provide resources for a safe therapeutic environment between HCP.

The findings in this variable confirm that the strengthening of management roles is proposed by means various measures. Bansal, Singh and Garg (2023:16) clarify that the participative management system is preferable for its increase of employee motivation, thus, generating ideas that reduce resistance to change and new processes and methods. As such, effective leadership and supervisory behaviour results in employees who care about their work. The leadership within the CHCs is to be actively involved to create better collaboration, trust and participation between employees.

The findings show that participants view empathy as a critical competency for achieving collegial respect, effective teamwork, and psychologically safe interprofessional relationships in CHCs. Almost all respondents (98%) supported structured training in empathy, active listening, constructive feedback, unconditional positive regard, and collaborative problem-solving. This aligns with contemporary evidence that empathy is a *trainable professional skill* which improves interpersonal effectiveness, patient outcomes and team climate (Adamson 2020:94; Hojat 2022:11).

Participants also emphasised the importance of humane workplace practices, such as respectful interaction, acknowledgment rituals and compassionate engagement during emotionally significant moments. Relational-centred practice is known to enhance morale and reduce interpersonal conflict, particularly in high-pressure health environments (Beddoe & Duke 2021:4).

Communication emerged as a central component of empathy, with participants strongly supporting deeper focus on listening, verbal clarity and respectful non-verbal engagement. This reflects current literature showing that active listening is the foundation of rapport, conflict resolution and trust in interprofessional teams (Emanuel 2021:219).

However, a critical warning signal surfaced: one-third of participants (33%) rejected the assumption that honesty leads to empathic relationships, citing mistrust and guarded behaviour. This points to a deficit in psychological safety, a climate where individuals feel safe to speak without fear of punishment or embarrassment (Edmondson & Lei 2021:9). Without psychological safety, vulnerability-based trust, which empathy relies on safety cannot develop (Newman, Donohue & Eva 2020a:491).

This relational breakdown was worsened by perceptions of resource inequity, with 64% disagreeing that consultation rooms were equally resourced. Such perceptions reflect failures in distributive justice, where staff believe resources are unfairly allocated (Greenberg 2020:343). When fairness is in doubt, empathy training alone becomes insufficient, because structural inequity erodes relational goodwill at its root. Thus, empathy development in CHCs must be paired with organisational commitments to fair resourcing, transparent decision-making and psychological safety. Only then can relational skills training have sustained impact. These measures can be clearly emphasised that:

- Establishment of informal platforms by managers to promote non-conflictual and positive interpersonal relationships, supported by 23 (55%) strongly agreeing and 9 (21%) who agreed.
- Collaboration between management, organised labour and employees, supported by 18 (43%) strongly agreed and 12 (29%) agreed.
- Development of quality relationships with supervisors, as shown by 10 (24%) who strongly agreed and 20 (48%) who agreed.
- Managers' provision and monitoring of the required resources, a perspective supported by 16 (38%) who strongly agreed and 22 (52%) who agreed.

The Labour Relations Act (No. 66 of 1995), Sections 80(2) and 84 prescribes that management best practices such as establishment of work forums require workplaces with more than hundred employees. Since CHCs generally have less than hundred employees in number, they do not qualify to set up such workplace forums. In such instances, the employees are then rendered voiceless and vulnerable to unilateral management decisions, therefore, it is necessary for employees to be involved in on-going information sharing and communication platforms using relevant communication skills and techniques.

4.3.3.2 Strengthening the role of organised labour

The role of labour unions appears to be diminished in many organisational settings due to a variety of factors (Cirilo, Silva & Almeida 2023:118). Emanating from the labour-related issues outlined previously in Section 5.3.4, Table 4.20 highlights the proposed strengthening of the role of organised labour.

Table 4.20 Proposed strengthening of the role of organised labour

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Organised Labour (Unions) as part of employees are responsible for a therapeutic environment between staff and management within the CHC according to legislative prescripts.	(15) 36%	(14) 33%	(8) 19%	(5) 12%	(0)	69% agree that Labour is responsible for safe environment as prescribes in the Acts.
2. The morale of the workers, management and union is high when they advocate for one another, thus an injury to one an injury to all attitudes.	(7) 17%	(23) 55%	(6) 14%	(6) 14%	(0)	72% agree that advocacy for each other keeps the moral of staff, management and union high.
3. Shared or focused united consensual leadership by union, management and health professionals' results in achievement of positive outcomes.	(0)	(0)	(0)	(1) 4%	(0)	O% Disagreed that shared united consensual leadership by union management and health professionals in getting outcome.
4. The union working with the community and politicians can contribute to a safe health facility because they are leaders who provide harmonious relationships between healthcare workers and users of health facilities.	(9) 21%	(21) 50%	(4) 10%	(6) 14%	(2) 5%	71% agreed union partnership with community can contribute to harmonious relationship.

In terms of Table 4.20, the overall proposal for strengthening the labour union is premised on a collaborative partnership of interests between union leaders, healthcare workers, the community, and political leaders. This view is shared by 9 (21%) who strongly agree, and 21 (50%) who agreed. Based on researcher's experience, the politicisation of the healthcare labour union sector is not beneficial to the health professional; union members raised concerns that systems get externally directed and controlled in the interests of the political leaders rather than the members themselves.

4.3.3.3 Strengthening of communication

Effective communication has a beneficial value in secure relationships contexts and affords opportunities for establishing and improving interpersonal and professional relationships, formulating individualised client-centred interventions, as well as optimising health outcomes (Eby & Robertson 2020:77). Emanating from the communication-related issues outlined previously in Section 5.3.3, Table 4.21 highlights the proposed strengthening of the role of communication.

Table 4.21 Propose strengthening of the role of communication

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. Effective communication is when individuals understand that both the reach (face to face) interaction and learn (emails and memos) communication channels are necessary channels and utilise them accordingly.	(14) 33%	(22) 52%	(0)	(6) 15%	(0)	85% agree that effective communication includes face to face platforms technology and reports.
2. Established work plans that clearly define each health professional's role are significant to ensure clear communication minimise conflict and build strong relations.	(14) 33%	(18) 43%	(10) 24%	(0)	(0)	76% agree that clear work plans clarified health professionals roles minimise conflict.
3. Developing the necessary communication skills for expressing problems to managers and co-workers must be a standard basic practice in the workplace.	(10) 24%	(26) 62%	(6) 14%	(0)	(0)	86% agree developed communication skills must be a basic practice in the CHC to express problems to managers and co-workers.
4. Communication, respect and teamwork with consensual and clearly defined roles and responsibilities of each professional on work activities enhance a therapeutic environment.	(9) 21%	(24) 58%	(9) 21%	(0)	(0)	Communication, respect and teamwork well define work roles and responsibilities merge safe secure workplace (CHC).
5. Support for efficient communication techniques (reflection, paraphrasing, probing, summarising between management and the health	(10) 23%	(25) 60%	(7) 17%	(0)	(0)	83% agree that efficient communication techniques between 3 role players are key to promoting positive safe partnership.

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
professionals is key to promote positive partnership in the CHC.						
6. Consensual shared, jointly defined and compiled goals, rules agreements to establish, maintain and sustain positive relations (partnership) with well-coordinated expertise teams in a CHC are a foundation of communication and partnership.	(8) 19%	(26) 62%	(8) 19%	(0)	(0)	81% agree that consensual, shared jointly defined goals, rules establish and sustain positive relations and are the foundation of communication and partnership.
7. A positive safety culture is characterised by communications founded on mutual trust, shared perceptions which yield confidence in workers.	(10) 24%	(22) 52%	(6) 14%	(4) 10%	(0)	76% agree that positive safe secure culture is characterised by communication, mutual trust which yields confident HCP-workers.
8. Communication to the organised teams and the problems that affect health professionals and seeking solutions as a collective will enhance trust and cohesion.	(26) 62%	(8) 18%	(4) 10%	(4) 10%	(0)	80% agree that collective communication and solutions seeking will enhance trust and cohesion amongst HCP.
9. The CHC require to cement the culture of positive communication and interactions adopting a five-step approach in daily practice motto - H.E.A.R.T.	(16) 38%	(19) 45%	(7) 17%	(0)	(0)	83% agree that cement into a positive communication culture and interactions must be a daily practice.
10. Interdepartmental, interpersonal, intra organisational and orientation to communication and interpersonal skills is a foundation for trust between health professionals.	(7) 17%	(23) 55%	(6) 14%	(6) 14%	(0)	72% agree that trust is founded on Interdepartmental, interpersonal, intra organisational and orientation to communication and interpersonal skills.

The findings in Table 4.21 show that the participants propose the strengthening of communication within the CHC by means of the following examples:

- Effective utilisation of both face-to-face and technological means of communication, as derived from the statements of 85% of the participants.
- Clear work plans that articulate communication lines between healthcare workers and management, which is also supported by 76% of the participants.
- Enhancement of teamwork, supported by 47% of responses strongly agreeing, and 43% agreeing.
- Promotion of mutual trust and respect, supported by 76% of the responses.
- Enhancing effective interdepartmental, interpersonal, and intra-organisational communication patterns among all relevant stakeholders.

The above-mentioned responses are in concurrence with the perspectives by Yang (2026:246) and Balcerzyk and Oslzlo (2024:35), who assert that effective communication at the interdepartmental, interpersonal, and intra-organisational levels serves the purpose of enhancing relevant partnerships and critical thinking between individuals and organisations. The International Council of Nurses (ICN) (2019:3) acknowledges that nurses, as part of the fraternity of health professionals, should embrace the partnership within their workplaces as an effective mechanism to achieving the desired health outcomes.

4.3.3.4 Proposed strengthening of safety competencies for healthcare professionals

Safety constitutes an integral part of employees' sense of protection from any physical, emotional, and psychological harm, threat, or risk (Søvold, Naslund, Kousoulis, Saxena, Qoronfleh, Grobler & Münter 2021:3). Based on the centrality of safety in this study, as well as the issues raised in Section 4.3.2, Table 4.22 outlines the proposed strengthening of safety training for HCPs.

Table 4.22 Strengthening safety competencies for health professionals

Statement	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	Summary
1. It is important to train all workers (not only health professionals- nurses, pharmacists, medical doctors, etc.) on establishing, maintaining and sustaining safety partnerships within CHC on a regular basis.	(15) 36%	(19) 45%	(8) 19%	(0)	(0)	81% agree training all workers to establish, maintain and sustain safe partnerships is important.
2. The curriculum of all HCPs that extensively includes a module with clinical practice of therapeutic interview with focus on communication and interpersonal skills towards achieving a safe workplace.	(10) 24%	(25) 60%	(7) 16%	(0)	(0)	84% agree to include a module with clinical practice of communication techniques and interpersonal relations to promote safety.
3. The induction programme to include the specific techniques and best practices on establishing a therapeutic milieu within this CHC.	(15) 35%	(27) 65%	(0)	(0)	(0)	100% agree to an induction programme that emphasise techniques and best practices on establishing a safe CHC
4. Workers to be encouraged to acquire in service/points on therapeutic milieu themes in their annual CPD programmes.	(25) 60%	(17) 40%	(0)	(0)	(0)	100% to be encouraged to acquire CPD points on safe/therapeutic environment themes
5. The compulsory CPD points programmes must include training and practice of communication techniques for all health professionals in the CHC.	(28) 67%	(14) 33%	(0)	(0)	(0)	67% strongly agree that CPD points must include communication techniques for all health professionals in the CHC
6. In-service training programmes must be scheduled for professional, administrative and general workers (all staff) regularly to improve interpersonal relations.	(26) 62%	(16) 38%	(0)	(0)	(0)	62% strongly agree and in-service programmes must be scheduled regularly to improve relations.

Based on the findings in Table 4.22, the following are an indication of the participants' proposals for the strengthening of safety competencies the health professionals:

- Training all workers to establish, maintain, and sustain safe partnerships (81%).
- Inclusion of safety in the nursing curriculum (84%).
- Annual CPD programmes should include in-service points that entail themes on therapeutic environments (100%).
- Regular in-service training programmes for professional, administrative, and general workers to improve interpersonal communication skills and competency development.

4.3.3.5 Strengthening of empathy considerations

Nursing is fundamentally a caring profession (Bosire et al 2021:2). As such, empathy constitutes a virtuous quality for all health professionals and medical practitioners to possess since their fundamental duties require that they understand and recognise the pain felt by the very patients they are treating.

The elements of empathy in this study are demonstrated, amongst others, by 56% (n=9) of the respondents agreeing that empathy with another person conveys warmth, validation, and caring. 63% (n=10) of the respondents disagreed that empathy requires conversational reference to one's own similar experiences for the purpose of reinforcing shared values as a foundational pillar of a good relationship. 50% (n=8) of the respondents disagree and uphold that empathy could be practiced or applied by keeping an open mind and being unbiased and respectful through communication. 56% (n=9) of the respondents agree that empathy involves listening to and keeping focus on the person feeling the pain or the loss.

Given the above assertions, the respondents proposed the following measures to strengthen the empathy aspect of the health professionals:

- Training on empathy, active listening skills, and proper use of feedback, unconditional acceptance and problem-solving methods to sustain positive relations with patients (98%).

- Emphasis on therapeutic communication techniques to enhance positive relations to genuinely understand individual needs, interests, and backgrounds with compassion (52%).
- Enhancing cordial and harmonious interaction (i.e., collaborative relationships) between managers and colleagues (81%, n=9).
- Treating others kindly to make them feel valued and cared for, without any name-calling and blaming (56%, n=9).

The respondents further intimated the enhancement of empathy as follows:

- Expressing or demonstrating diversity by respecting the rights of others (75%, n=12) amidst differences (25%, n=4), and learning about other people's culture or religion, which further makes them feel safe at work.
- Developing quality relationships by supporting each other's physical and mental health.
- Promoting meaningful workplace activities such as honouring birthdays and moments of grief to cement partnerships and lessen conflict (63%, n=10).
- Being assertive thoughtfully and considering feelings appropriately and respectfully (75%, n=12).
- Fostering listening skills is the first step to building strong rapport with others and maintaining positive body language to reinforce confidence by not interrupting others (69%, n=11).
- Reinforcing best application of verbal communication for positive impact and mood rejuvenation (63%, n=11), as well as non-verbal communication by, amongst others, maintaining eye contact and avoiding fidgeting and arm crossing (62%, n=6).
- Developing reciprocity by developing strong connections with others (63%, n=9) and offering help in overtime work and admin support without any expectations of payment since it is an act of kindness, such as giving a gift or words of encouragement.
- Solving conflict positively by avoiding aggressive language and name-calling and instead ask questions and present views fairly (63%, n=10).

Interestingly, 33% (n=7) of the respondents disagreed that honesty and transparency foster empathy, because people can disguise their true intentions, which in return increases the risk of compromised relationships. Additionally, 63% (n=9) supported the

above statement. The variance is critical for understanding the challenging process of building positive relationships in CHCs. While 63% (n=11) of the respondents could correctly identify the positive empathetic responses that enhance positive relations, 17% (n=2) did not answer the question. On the other hand, 20% (n=3) of the respondents provided unsupportive statements or unhelpful responses, confirming that some of the health professionals did not know or understand positive communication techniques, which constitutes the fundamental elements of positive communication.

While the dynamics of the secure and therapeutic environment of health professionals entail some of their positive experiences, the negative experiences were also expressed. For instance, the overall average of 64% (n=21) responses strongly disagree or disagree about the provision of consultation rooms with the same resources. They contend that there are discriminatory practices. Additionally, 51% (n=13) of the responses strongly disagreed and only 49% (n=12) agreed that there were adequate resources to perform daily activities and adequate staff focus groups for evaluating specific needs and appropriate recommendations. Also, 44% (n=11) of the respondents disagreed that decentralised supply of stationery was ensured for the CHCs' service delivery mandate.

4.4 SUMMARY

This chapter essentially presented and outlined the quantitative findings of the study, which constitute the participants' responses to the first or initial part of the research instrument as shown in Annexure E1. In that regard, the quantitative findings were presented in three critical sections, namely: the participants' demographic characteristics, the dynamics of the therapeutic environment, as well as the participants' proposed solutions for collaborative partnerships within the community care centres. The next chapter presents the qualitative findings of the study as a complement to the findings presented in the current chapter

CHAPTER 5

ANALYSIS, PRESENTATION AND DESCRIPTION OF QUALITATIVE DATA

5.1 INTRODUCTION

Chapter 5 presents and discusses qualitative findings of the research in terms of the narrative statements that emerged from the in-depth interviews and focus group discussions with the participants. The findings are presented according to themes and the subthemes; a literature review was conducted to support or refute the results.

5.2 DATA MANAGEMENT AND ANALYSIS

The data was collected through the audio recording during the three focus group discussions and 10 in-depth interviews from the in six provinces over eleven months. These recordings were converted from audio to transcripts. The audio recorded sessions with the informed consent of participants, and the field notes were analysed to ensure accurate captured rich discussions to make sense of the findings (Parameswaran, Ozawa-Kirk & Latendresse 2020:640). The interview guides were written in English and English language was used during the interview although sometimes expressions in se-Tswana were noted as part of expressions by some participants.

The transcripts were coded to ensure confidentiality in line with the ethical principles (Jones 2019:416). Data was further analysed then subdivided into concepts and grouped into themes, and subthemes according to Ullah, Khan and Nawi (2023:8138). The researcher's analysis started with the focus group discussions from 16 participants and in-depth interviews findings from the 10 participants.

The secure storing of data was observed using the password protected files and participant anonymity was observed for ethical considerations by randomly allocating numbers. The technique of organising raw data was transcription and following coding frameworks which were further analysed thematically, this manual coding method was selected as the suitable qualitative analysis (Williams & Moser 2019:48).

5.3 QUALITATIVE DATA FINDINGS

The findings present the demographic characteristics of health professionals who participated in the three focus group discussions and 10 in-depth interviews within the six CHCs in the Gauteng, Mpumalanga and Northwest provinces. Not every sampled CHC hosted both data-collection methods: focus group discussions were held at three CHCs, one per province, while in-depth interviews were held at four CHCs across the same three provinces. The qualitative data findings are further presented according to themes and subthemes that emerged.

5.3.1 Health professionals' demographic findings

Table 5.1 displays the demographic data according to age, gender age and years of experience in rural and semirural CHCs in the respective provinces.

5.3.1.1 Focus group discussions demographic findings (N=16)

Table 5.1 summarises the demographic details of the participants in the focus group discussion.

Table 5.1 Demographic profile of focus group participants by province and profession (N=16)

Province/CHC code	Profession	Assigned code	Gender	Age (years)	Experience (years)	Union membership
Mpumalanga (CHC B)	Nurse 1	**MP-FGB1**	Female	29	5	Member
	Nurse 2	**MP-FGB2**	Female	33	3	Member
	Nurse 3	**MP-FGB3**	Female	41	1	Member
	Nurse 4	**MP-FGB4**	Female	48	5	Non-member
	Pharmacist assistant	**MP-FGB5**	Female	35	2	Member
	Nutritionist	**MP-FGB6**	Male	50	4	Non-member
North-West (CHC A)	Nurse 1	**NW-FGA1**	Female	30	6	Member
	Nurse 2	**NW-FGA2**	Female	37	4	Member
	Nurse 3	**NW-FGA3**	Male	45	3	Member

Province/CHC code	Profession	Assigned code	Gender	Age (years)	Experience (years)	Union membership
	Social Worker	**NW-FGA4**	Female	38	5	Member
	Pharmacist assistant	**NW-FGA5**	Female	48	4	Member
Gauteng (CHC B)	Nurse 1	**GP-FGB1**	Female	28	2	Member
	Nurse 2	**GP-FGB2**	Female	36	4	Member
	Nurse 3	**GP-FGB3**	Male	44	6	Member
	Nurse 4	**GP-FGB4**	Female	52	11	Member
	Social Worker	**GP-FGB5**	Female	40	8	Member

The focus group participants were drawn from three anonymised CHCs, CHC A (Mpumalanga), CHC B (Northwest), and CHC C (Gauteng) and represented diverse professional categories, predominantly nurses. Most participants were female, reflecting the gender distribution common in CHC staffing. Ages ranged from 28 to 52 years, with professional experience spanning 1 to 11 years. Majority of the participants were union members currently employed in rural or semi-rural CHCs.

5.3.1.2 Demographic profile of in-depth interviews (N=10)

Table 5.2 summarises the demographic details of the participants.

Table 5.2 Demographic profile of in-depth interview participants by province and profession (N=10)

Province/CHC code	Profession	Assigned code	Gender	Age (years)	Experience (years)	Union membership
Gauteng (CHC A)	Nurse 1	GP-IDIA1	Female	33	7	Member
	Nurse 2	GP-IDIA2	Female	40	4	Member
	Facility Manager	GP-IDIA3	Male	45	3	Member
Gauteng (CHC B)	Radiographer	GP-IDIB1	Female	38	1	Member
	Facility Manager	GP-IDIB2	Female	50	5	Member
	Nurse	GP-IDIB3	Female	35	2	Member

Province/CHC code	Profession	Assigned code	Gender	Age (years)	Experience (years)	Union membership
Mpumalanga (CHC A)	Facility Manager	MP-IDIA1	Female	42	9	Member
	Nurse	MP-IDIA2	Female	36	4	Member
	Medical Doctor	MP-IDIA3	Male	47	1	Member
North-West (CHC B)	Social Worker	NW-IDIB1	Female	41	3	Member

Table 5.2 summarises the total of 10 participants took part in the in-depth interviews conducted across three anonymised CHCs located in Gauteng, Mpumalanga, and Northwest provinces. The sample comprised various professionals, including nurses, facility managers, a radiographer, a medical doctor, pharmacist assistant, nutritionist and a social worker, reflecting an interprofessional mix typical of CHCs. Most participants were female, aged between 33 and 50 years, with 1-9 years of experience. All participants were union members, consistent with the study's inclusion criteria.

5.3.1.3 Allocation of prefixes on participants during data collection process

The participants were allocated coded with prefixes for ethical considerations during the FGDs and IDIs. For Mpumalanga Province and first CHC MPA, second CHC is MPB; Gauteng Province first CHC is GP A and second CHC is GP B and North-West first CHC is NW A and second is NW B.

5.3.1.3.1 Focus group discussions prefix and coding (N=16)

Table 5.3 presents the coding framework for focus group participants. Each code represents the province (and corresponding CHC), data collection method, and participant number The prefixes used were as follows: for the Mpumalanga province, MP-FGB1–6 referred to Focus Group participants 1 to 6 from CHC B; for the Northwest province, NW-FGA1–5 referred to Focus Group participants 1 to 5 from CHC A; and for the Gauteng Province, GP-FGB1–5 referred to Focus Group participants 1 to 5 from CHC B. This approach allowed for clarity in data referencing, accuracy in attributing responses, and consistency during thematic analysis.

This coding approach ensured confidentiality while preserving the contextual relevance of quotations used in data presentation.

Table 5.3 Coding framework for focus group participants (N=16)

Province/CHC code	Participant categories	Assigned codes	Total participants
Mpumalanga (CHC B)	Four nurses One pharmacist assistant One nutritionist	MP-FGB1–MP-FGB6	6
Northwest (CHC A)	Three nurses One social worker One pharmacist assistant	NW-FGA1–NW-FGA5	5
Gauteng (CHC B)	Four nurses One social worker	GP-FGB1–GP-FGB5	5
Grand Total			**16**

The structured coding system facilitated the organisation of qualitative data, ensuring that quotations used in the results chapter could be accurately linked to each participant's professional category and province, while preserving anonymity. This systematic coding also strengthened the dependability and traceability of the data analysis process.

5.3.1.3.2 In-depth interview coding for anonymity

In-depth interview (IDI) participants were similarly coded to uphold confidentiality and maintain consistency with the qualitative data management process. Each code combined the province, CHC, and participant sequence, ensuring both ethical protection and analytical precision. The prefixes used were MP-IDIA1–3 for participants from Mpumalanga (CHC A), NW-IDIB1 for a participant from North-West (CHC B), GP-IDIA1–3 for participants from Gauteng (CHC A), and GP-IDIB1–3 for participants from Gauteng (CHC B).

This coding structure reflected the diversity of professions and roles within rural and semi-rural CHCs and allowed for nuanced analysis across varying provincial contexts. It also supported the process of thematic triangulation and the integration of qualitative and quantitative findings in subsequent chapters.

Table 5.4 Coding framework for in-depth interview participants (N=10)

Province/CHC code	Data collection method	Participant categories	Assigned codes	Total participants
Mpumalanga (CHC A)	In-Depth Interviews (IDI)	One facility manager One nurse One medical doctor	MP-IDIA1–MP-IDIA3	3
Northwest (CHC B)	In-Depth Interviews (IDI)	One social worker	NW-IDIB1	1
Gauteng (CHC A)	In-Depth Interviews (IDI)	One radiographer One facility manager One nurse	GP-IDIA –GP-IDIA3	3
Gauteng (CHC B)	In-Depth Interviews (IDI)	Two nurses One facility manager	GP-IDIB1–GP-IDIB3	3
Grand Total				**10**

The coding framework enhanced the transparency and credibility of the qualitative analysis process by linking participant insights to specific contexts while protecting individual identities. This structure also facilitated cross-case comparison and data integration during the meta-inference phase, enabling the synthesis of patterns across provinces and professional groups.

5.4 THEMATIC PRESENTATION OF QUALITATIVE INTERVIEWS

The results are from statements extracted from the transcripts and analysed in accordance with six themes and sub themes identified from the raw data. The coding systems presented in Tables 5.3 and 5.4 formed the foundation for organising and analysing qualitative data across provinces. The coded identifiers were systematically applied throughout the transcription, thematic analysis, and presentation of quotations to preserve anonymity while maintaining contextual depth. This consistent coding allowed for accurate cross-case comparison and ensured that each participant’s voice was traceable to their professional category and provincial context without compromising confidentiality.

The following section presents the qualitative findings that emerged from the focus group discussions and in-depth interviews, reflecting the lived experiences and perspectives of health professionals and trade union representatives working within rural and semi-rural CHCs. The verbatim statements by participants were analysed, translated and interpreted in the context of the literature perspectives to establish framework for the findings of the study. The researcher read the transcripts and transcribed verbatim of the focus group discussions and in-depth interviews.

The collected individual interviews and focus group discussions narratives were analysed thematically (Polit & Beck 2022:243). Six themes were identified from the raw data through content analysis. The six themes, and subthemes which emerged were interpreted in line with the research questions and the literature review. The six themes that emerged included: inadequate resources; poor management and leadership; inefficient and ineffective communication system; dysfunctional organised labour unions; ailing interprofessional and interunion relations; and measures to enhance collaboration and secure partnerships.

The focus group discussions were conducted with 16 health professionals from Gauteng, Northwest and Mpumalanga provinces; these included the assistant pharmacists, nutritionist social worker, nurses in majority. The other allied professionals' categories could not participate due to their overwhelming work rotation schedule; and the allocation schedule for various CHCs within the district. A total of twenty-six participants participated in both the individual interviews and focus group discussions. The 16 participants in the focus group discussions and 10 participants in the in-depth interviews; no participant took part in both methods. Other allied-professional categories could not participate owing to not employed for CHC and the demanding work-rotation and CHC allocation schedules within the district. It is also worth noting that three health professionals who are also union representatives, their union role was not separately to preserve anonymity and protect validity of the study. Table 5.5 presents the themes and subthemes.

Table 5.5 Thematic presentation of in-depth interviews and focus group discussions narratives from the study

THEME	SUBTHEME
Theme 1: Inadequate resources	1.1. Human resource constraints 1.2 Skill and experience gap among professionals 1.3 Inadequate material and clinical support resources 1.4 Unsafe and dysfunctional infrastructure 1.5 Limited working, resting and wellness spaces
Theme 2: Ineffective management and leadership	2.1 Poor leadership skills to enhance safe relations between health professionals 2.2 Ineffective people management strategies to enhance collaboration and secure workplace 2.3 Absent structured in-service training and CPD programme for health professionals 2.4 Discrimination and disrespectful practices 2.5 Non-collaborative enhancing systems and practices
Theme 3: Ineffective and inefficient communication	3.1 Non-cohesive and integrated communication between health professionals within the CHC 3.2 Limited technology driven communication 3.3 Poor interprofessional and interdepartmental communication
Theme 4: Dysfunctional organised labour	4.1 Absent organised labour representatives and structures 4.2 Unclear and poor commitment of health professionals to organised labour 4.3 Non-compliance with and misaligned labour legislative prescripts in rural CHCs
Theme 5: Ailing interprofessional and interunion relations	5.1 Minimal interprofessional interdisciplinary collaboration 5.2 Misuse of power among health professionals and unions
Theme 6: Measures to enhance collaboration and secure partnership	6.1 Avail the required resources to advance secure collaboration 6.2 Establish sustainable interprofessional and interunion collaboration partnership 6.3 Harmonising relations between health professionals, labour and management 6.4 Strengthening management and leadership roles and responsibilities 6.5 Strengthening of training and lifelong learning practice standards 6.6 Establish effective communication between health professionals, organised labour and management 6.7 Strengthening communication systems through interpersonal and technology-enabled platform

Table 5.5 depicts thematic presentation of qualitative narratives in the study.

The shared verbatim quotes by participants from all six rural and semi-rural CHCs were coded as described in Section 5.3.1.3 to comply with confidentiality requirements. The themes and subthemes are discussed in turn below, following the numbering used in Table 5.5.

5.4.1 Theme 1: Inadequate resources

The participants from all six sites reported inadequate resources were experienced as one of the barriers to a safe environment as well as positive collaborative partnership between health professionals. In this study, inadequate resources were not limited to material shortages, but included human resource constraints, gaps in skills and experience, insufficient clinical support resources, unsafe infrastructure, and limited working, resting and wellness spaces. The subthemes that emerged in this theme included inadequate resources were not limited to material shortages, but included human resource constraints, gaps in skills and experience, insufficient clinical support resources, unsafe infrastructure, and limited working, resting and wellness spaces. These resource-related challenges affected how health professionals performed their duties, communicated with one another, supported patients, and maintained collaborative working relationships

5.4.1.1 Subtheme 1.1: Human resource constraints

Participants across all six CHCs expressed deep frustration with persistent staffing shortages of health professionals, describing them as a daily operational reality that undermines the functioning of their facilities. Their narratives reveal not only a lack of personnel but also the emotional labour and moral distress associated with operating in a chronically understaffed environment. This was evident in sentiments such as:

> “The CHC has one operational manager in the district, eish!!” (MP-IDIA2)

> “The professional nurses are overloaded and cover the allied work … we guide patients on nutrition, how to exercise their body – we try hard.” (GP-FGB4)

> “Shortage of staff and increased policies and ever in meetings – as one manager, I am not coping.” (GP-FGB5)

> “I feel guilty to take leave as problems get easily escalated… mostly when I am off sick or on leave.” (GP-IDIB2)

> “Only one newly qualified medical doctor comes every week or sometimes once every two weeks; we have to work outside our scope.” (MP-FGB1)

> “We struggle to retain professionals; they come as fast as they leave due to accommodation, water and electricity issues.” (NW-FGA2)

Across the three provinces, participants described severe shortages of doctors, allied health professionals and experienced nurses, with many facilities relying on sessional, rotating or ad hoc staffing arrangements. The irregular presence of medical doctors, sometimes only weekly or fortnightly; this created backlog, rushed consultations, and task-shifting to nurses who were already overburdened. Staff expressed feelings of guilt, pressure, and emotional exhaustion when unable to take leave, knowing their absence could destabilise service delivery.

The scarcity of allied professionals further exacerbated the workload. Pharmacy assistants, intern psychologists and social-work interns often filled gaps beyond their competencies, while pharmacists, radiographers and dieticians rotated infrequently or were entirely absent. As a result, nurses routinely undertook nutritional counselling, psychosocial support, rehabilitation guidance and administrative duties outside their training and role expectations. Monthly rotation of acting managerial roles further disrupted leadership continuity and team cohesion.

Although psychological distress was not coded as a separate theme, the verbatim excerpts suggest that human resource constraints had psychological and relational consequences. Participants repeated inferences to “trying hard,” “not coping,” and “feeling guilty,” indicating that staff shortages affected morale, role confidence, trust and collaborative relationships within the CHCs. These accounts therefore extend the interpretation of inadequate resources beyond staffing numbers to include the emotional and relational burden carried by health professionals in under-resourced rural settings. These conditions forced staff to perform outside their scope, weakened their confidence

as partners in care, and undermined opportunities for meaningful interprofessional collaboration.

The instability caused by high turnover, often linked to poor accommodation, unreliable water and electricity, and inadequate infrastructure, thus further contributed to a fragile and fragmented workforce. This instability erodes morale, fuels uncertainty, and deepens the sense of working in isolation rather than as part of a coordinated team (Mosseri 2025:288).

These findings echo global evidence that chronic human resource shortages remain one of the most fundamental barriers to high-quality, collaborative healthcare delivery in rural areas. Zihindu (2019:3) confirms that insufficient staffing destabilises care continuity, while the WHO (2020b:7) emphasises that rural health systems continue to struggle with achieving the right skill mix and equitable distribution of staff. Nationally, the NDoH (2020:16) acknowledges persistent challenges in attracting and retaining skilled rural health professionals. More recent literature highlights that shortages not only reduce service capacity but also weaken interprofessional trust, teamwork and psychological security (Hudson 2022:52). This study reinforces those concerns, showing that resource-constrained CHCs lack the human infrastructure necessary for safe, collaborative and mutually secure partnerships.

5.4.1.2 Subtheme 1.2: Skill and experience gap among professionals

There is an indication that unskilled and semi-skilled health professionals are common practice. The participants reported that unskilled and semi-skilled health professionals were commonly employed in CHCs, often occupying roles that required higher levels of competence. The following verbatim statements reflect their experiences of how the lack of skill and professional experience affects collaboration and service delivery:

> “Shortage of skilled health practitioners has impact on partnership and collegiality.” (GP-FGB1)

> “No new recruitment of staff to replace resignations and retirements; we fight often, we are exhausted.” (GP-FGB3)

> “Only one newly qualified medical doctor who comes every week or sometimes once every two weeks; we have to work outside our scope.” (MP-FGB2)

> “No designated qualified pharmacist … if there are problems she has to phone the district hospital pharmacist.” (MP-FGB4)

> “Delay in patients getting services of dental care, physiotherapy, and dietetics because they rotate between clinics monthly.” (NW-IDIB1)

Participants explained that newly qualified doctors and nurses with limited primary-health-care experience were frequently allocated to CHCs and sometimes appointed to management positions requiring broader qualifications such as midwifery, community, or psychiatric nursing The perceptions shared appears to state that the skill and experience gap among health professionals is an important resource-related challenge within the rural and semi-rural CHCs. The concern was not only the numerical shortage of staff, but also the limited availability of appropriately qualified and experienced professionals to meet the complex service demands of comprehensive primary healthcare. The verbatim excerpts presented above indicate that participants experienced shortages of skilled health practitioners, delayed replacement of staff following resignations and retirements, limited access to medical officers, absence of designated qualified pharmacists, and rotation of allied health professionals between facilities.

Participants perceived this mismatch between experience and responsibility as compromising leadership quality and clinical decision-making because junior health professionals were reported to rely on personal discretion rather than established management, clinical governance or evidence-based decision-making principles. Some participants described situations where junior or less experienced health professionals were expected to tact in management roles during periods of managerial absence. Participants perceived that limited exposure to management and leadership processes could result in uncertainty in decision-making and reliance on personal discretion rather than established clinical governance, supervisory or evidence-informed decision-making principles. This explains why such arrangements were regarded by participants as inappropriate for maintaining safe, coordinated and collaborative practice within the CHCs.

While numerical shortages remain severe, the imbalance between qualified and semi-qualified staff is equally concerning. Inexperienced and inadequately prepared practitioners often occupy critical clinical and managerial roles, undermining confidence, communication, and teamwork among colleagues. This skill-mix imbalance compromises the safety and quality of patient care and contributes to weakened interprofessional collaboration.

These findings indicate that skill mix was experienced as a critical dimension of resource adequacy. A shortage of personnel alone does not fully explain the challenge; rather, the findings suggest that the availability, distribution and preparedness of skilled professionals influenced how services were delivered and how teams collaborated. Where experienced professionals such as pharmacists, doctors, radiographers, dietitians, physiotherapists and other allied health professionals were unavailable or rotated infrequently between facilities, participants reported delays in patient care, increased referrals and greater pressure on the remaining staff. Such conditions may weaken collegiality, reduce confidence among team members and place strain on interprofessional collaboration.

The findings therefore suggest that staffing challenges in the participating CHCs were both numerical and skill based. Where experienced professionals such as doctors, pharmacists, radiographers, dietitians, physiotherapists and other allied health professionals were unavailable or rotated infrequently, participants perceived this as placing additional pressure on the remaining staff and weakening continuity of care The absence of designated qualified pharmacists, as reflected in the participants' accounts, further suggests that medicine-related support in rural CHCs may become dependent on referral, telephone consultation or informal problem-solving. This concern is consistent with Magadzire, Budden, Ward, Jeffery and Sanders (2014:520), who found that frontline health workers in South Africa often functioned as brokers in addressing barriers to access to essential medicines.

These findings align with Twigg, Kutzer, Jacob and Seaman (2019:3404), who emphasise that the workforce skill mix, is an important determinant of quality and continuity of care to create the balance between qualified and less-qualified staff since it directly influences the quality of health outcomes. Adjusting this mix remains a persistent challenge in rural

health settings where registered and unregistered professionals must often perform beyond their formal competencies. Similarly, the WHO (2020a:7) highlights that achieving an appropriate skill mix is essential for sustaining effective and equitable healthcare delivery in resource-limited areas.

Inadequately trained staff and skill mix are confirmed as the most challenging and neglected issue in rural health facilities; safety and partnership between health professionals and management is therefore compromised. This is affirmed by the NDoH (2020:16) which alerts that over the past ten years South Africa has struggled with staff shortage and failed to attract and retain the appropriate skilled workforce that would respond to the burden of diseases, matches supply and demand and aligned distribution of the workforce in rural areas.

Thus, the skill and experience gap in this study reflects more than staff shortage. It points to a broader challenge of workforce distribution, preparedness and support, with implications for service continuity, decision-making and interprofessional collaboration in rural and semi-rural CHCs.

5.4.1.3 Subtheme 1.3: Inadequate material and clinical support resources

Participants across the three provinces' CHCs reported persistent shortages of basic clinical and operational resources essential for safe interprofessional collaboration and effective infection prevention and control (IPC) (NDoH 2020:5). This included soap, gloves, running water, hand-drying materials, personal protective equipment (PPE), and functional work tools. The lack of these resources was described as a daily reality that heightened infection risks, strained interpersonal relations, and destabilised teamwork. The following verbatim excerpts illustrate their experiences:

> "No resources to ensure minimal cross infection – paper hand towel, soap, and continuous running water reserves." (MP-FGB2)

> "Insufficient to absent materials, such as Kleenex for drying hands after handwashing." (GP-IDIB2)

> “In most cases, shortage of resources and shortage of gloves promote unhealthy and unsafe working environment.” (NW-FGA4)

> “No handwashing basins; we don’t have running water, and all the taps are closed – this causes a hindrance in proper health-care procedures.” (MP-IDIA1)

> Availability of resources can enhance a therapeutic and safe working place – in most cases, shortage of resources such as gloves promotes an unsafe environment.” (NW-IDIB1)

> “Availability of resources remains a critical component in delivering quality healthcare to recipients.” (MP-IDIA3)

> “Resources are very limited in our facility, thus frustrating staff in performing their duties. Partnership with private stakeholders can assist in providing resources and relieve the burden on health staff.” (GP-IDIB3)

> “Lack of files or paper files in the facility has been an ongoing problem.” (MP-FGB4)

Participants explained that these shortages extended beyond infection-control materials to include basic equipment, administrative supplies, and infrastructure required for routine functioning. The absence of running water, particularly in Mpumalanga and the Northwest, made it impossible to comply with IPC protocols. In Gauteng, respondents pointed out that inadequate office tools and faulty printers often led to interpersonal conflict and disrupted teamwork.

The narratives confirm that resource scarcity in CHCs is both a clinical and a relational risk Inadequate supplies such as gloves, soap, and PPE directly compromise infection-prevention standards, while a lack of functional tools and administrative materials fuels frustration, mistrust, and conflict among staff (Pittman & Meeker 2025:6). Resource inadequacy thus weakens psychological safety and undermines collaboration between health professionals (Magadzire, Budden, Ward, Jeffery and Sanders 2014:520). The findings are consistent with the WHO’s Interprofessional Framework (2020), which affirms that adequate resourcing as a prerequisite for effective teamwork and safe patient care (Vaseghi, Yarmaohammadian & Raeisi 2022:496). The Interprofessional Framework emphasises that strengthening health systems, functional teamwork competencies and

coordinated roles among professions are foundational for safe, effective care (Witti, Zottmann, Wershofen, Thistlethwatte, Fischer & Fischer 2023:1-5).

The DoH (2016a:12) similarly highlights that poorly equipped facilities compromise performance and teamwork. The NIOSH (2019a:3) notes that inconsistent physical environments negatively affect interpersonal relations and the psychological climate of workplaces. Within South Africa, the unavailability of soap, running water, and sterile or unsterile gloves in rural CHCs contradicts national IPC standards. The study by Azak, Sertcelik, Ersoz, Celebi, Eser, Batirel, Cag, Ture, Ozturk Engin, Yetkin and Kaygusuz (2023:11) clarifies that increasing human resources and reducing workload can prevent risks of infection. Literature affirms that inadequate resources heighten infection risk, emotional strain, and workplace conflict (Kim 2024:317).

5.4.1.4 Subtheme 1.4: Unsafe and dysfunctional infrastructure

Participants across the three provinces, Mpumalanga, North-West and Gauteng described unsafe and poorly maintained health facilities that posed daily risks to both staff and patients. They referred to leaking roofs, broken windows, lack of access control, and poor ventilation as hazards that compromised safety, morale, and collaboration. Participants' verbatim accounts illustrate these experiences:

> "The physical structure of the facility poses a risk for personnel on duty." (MP-FGB2)

> "There are no controlled access gates; everyone can access any place. Windows have no burglar bars, and escorts have no control." (NW-IDIB1)

> "Physical structure in the facility poses risk for personnel on duty. There are no access gates; everyone can enter and access any place in the facility." (GP-FGB2)

> "Emergency unit and the escort room have no access control; burglars enter through broken windowpanes." (GP-IDIA1)

> "The structure of the facility is not up to standard because of lack of space; some activities, for example curative and chronic care, are joined together. There is not enough air ventilation." (MP-FGB3)

“Physical structures that are not maintained pose a health and safety risk. For a long time, we have been working in an environment where doors are not closing, broken lights not replaced, the area is dark, very cold in winter and hot in summer.” (GP-IDIB3)

“Poor ventilation within the department, inappropriate roofing that allows dust accumulation and excessive airflow, very cold or hot areas increase respiratory illnesses among staff.” (NW-FGA2)

“Please prioritise ventilation within the X-ray department and work out a plan to fix the roofing.” (MP-IDIA2)

“It is tiring to continue to report when there is no action taken; this affects working relationships and safety in the workplace.” (GP-FGB3)

“Poor ventilation compels use of big wall-mounted fans that blow directly into our faces; the department is too small, and dust accumulates overnight.” (MP-IDIA3)

“Structure of the facility is not up to standard because of lack of space; some units are joined, such as curative and chronic care. Space is too small and not enough air ventilation.” (MP-FGB4)

Facility has ageing infrastructure and separated services, thus affecting integration of care.” (NW-FGA4)

“We only have two consulting rooms and an emergency room; sometimes the emergency room is used for labour, which delays other services and causes long queues.” (GP-IDIA2)

“Not enough consulting rooms. Chronic mixed with acute, IMCI mixed with EPI.” (MP-FGB5)

“There must be a resting place for staff during lunchtime.” (GP-FGB5)

These accounts demonstrate that deteriorating and poorly maintained infrastructure exposes health professionals to environmental and security risks while diminishing morale and teamwork. Participants described repeated maintenance reports that were

ignored, leaving them feeling unsafe and undervalued. Cracked walls, damaged roofs, and lack of controlled entry not only threaten physical safety but also disrupt infection-prevention and control standards.

The findings confirm that unsafe and dysfunctional infrastructure violates the physiological and safety needs. From a policy perspective, these structural deficiencies contradict the WHO's (2019 b:7) framework, which recognises adequate infrastructure as fundamental to UHC. Likewise, South Africa's National Health Insurance Act (No. 20 of 2023) underscores that safe and well-resourced facilities are prerequisites for equitable, quality healthcare delivery.

These accounts confirm that unsafe and dysfunctional infrastructure in rural CHCs threatens both the physical and psychological safety of health professionals. Cracked walls, leaking roofs, broken doors, and inadequate ventilation expose staff to environmental hazards, erode morale, and impede collaboration. The lack of controlled entry points and damaged security features also compromise personal security, with reports of intrusions and theft.

Such conditions contravene the basic physiological and safety needs articulated in Maslow's Hierarchy of Needs (Gawlik 2021:1469) and undermine the functional caring environment central to Watson's Theory of Human Caring (Wei, Roberts, Strickle, & Corbett 2021:1532). Participants' frustrations over repeated, unaddressed maintenance reports reflect a breach of organisational responsiveness and caring leadership, further eroding trust among teams.

Both frameworks underscore that safety and security are prerequisites for trust, collaboration, and effective functioning of HCPs. Furthermore, these results resonate with Mafhongo (2022:70), who found that CHCs in rural areas struggle with aged and overcrowded facilities, forcing staff to close services during adverse weather conditions or when safety risks escalate.

Likewise, Cordeiro (2022:904) and the DoH (2016a:12) emphasise that unsafe, poorly maintained environments erode teamwork and morale, compromising the effectiveness of interprofessional practice.

5.4.1.5 Subtheme 1.5: Limited working, resting and wellness spaces

In this study, the researcher noted the participants' concerns that the workspace is too small. Patients have no shelter and queue in open areas, which makes it difficult for the facility to operate when it is raining or there is a storm. To that effect, the participants corroborated thus:

> Structure of the facility is not up to standard because of lack of space; some units are joined, e.g., curative and chronic together. Space is too small, not enough air ventilation." (MP-FGB2)

> "Facility has ageing infrastructure and separated services, thus affecting integration of services." (NW-IDIA1)

> "Physical structure that is not maintained poses a health and safety risk. For a long time, we have been working in an environment where doors are not closing, broken lights not replaced, and the area is dark, very hot and cold working areas, reception, and waiting area for patients." (GP-FGB4)

> "The workplace must ensure that staff or employees have the required resources to perform the job. Lack of resources puts strain on working relationships and affects safety at work." (MP-IDIA3)

The findings confirm that the rural CHCs have infrastructure challenges; thus, health professionals struggle to provide services in a safe workplace. This is confirmed in the study of Mafhongo (2022:70) on challenges in rural community health centre (CHS) facilities in rural areas. Health professionals are left with no option but to close the facility and focus on critically ill clients only to prevent complications related to overcrowding and infection control (Al Haider, Alshahablah, Almajeba, Alyami, Alshehri, Al Tarouti, Alramadan, Al Bagshi, Alnahwi & Alajmi 2024:8269; Mafhongo 2022:70). The participants' opinions about limited working space are expressed below:

> "We only have two consulting rooms and emergency rooms; we sometimes use the emergency room for labour, which delays emergencies and increases long waiting times." (MP-IDIA1)

> “Not enough consulting rooms. Structure of the facility is not up to standard because of lack of space; some activities, e.g., curative and chronic, are joined together. There is not enough air ventilation.” (NW-FGA2)

> “The X-ray department is too small. Not enough rooms for services—chronic mixed with acute, IMCI mixed with EPI.” (GP-IDIA3)

> “No resting place for staff at lunchtime.” (GP-FGB5)

> “Inadequate space. We only have two consulting rooms and an emergency room. We sometimes use one consulting room in the case where we have a patient in the labour ward and emergency room; hence the delay in queues and longer waiting times.” (MP-IDIA3)

The findings confirmed that rural CHCs have limited consulting rooms, whereby some rooms are converted into a labour room in cases of emergency delivery. In this regard, the queues become very long because health professionals are left with only one consulting room. The PPE strategy is now compromised. A PPE is aimed at improving safe competent practice among health professionals, mediating unrealistic workloads, and addressing poorly equipped facilities and unsafe working conditions that affect the work life and performance of health professionals (Cordeiro 2022:904). The PPE supports safe collaborative partnerships as it establishes settings that ensure the health, safety, and wellbeing of health professionals. Poor-quality workplaces weaken the ability of employers to meet CHC quality-of-care outcomes (DoH 2016a:12).

Participants across the three provinces expressed serious concern about inadequate workspace and the absence of staff rest areas in their CHCs. Many described overcrowded consulting rooms, poor ventilation, and not sufficient shelter for patients waiting to be served. These spatial limitations were seen as daily barriers to safe, efficient, and dignified service delivery.

The participants’ narratives highlight severe space constraints that compromise service quality, infection control, and interprofessional collaboration. Across rural CHCs participants described working in small, congested rooms with poor air circulation, forcing them to merge chronic and acute care services. In several facilities, emergency rooms were converted into temporary maternity rooms, creating backlogs and prolonged waiting

times for patients. The absence of rest spaces for staff was viewed as further evidence of managerial neglect and disregard for employee wellbeing.

These findings are consistent with Mafhongo (2022:70), who observed that many rural CHCs operate in aged buildings with insufficient consulting and waiting areas, forcing closures during storms or overflows. Similarly, Al Haider et al (2024:8269) emphasise that overcrowded health facilities threaten infection-control standards and contribute to burnout among health professionals.

A PPE strategy is now compromised which is aimed at improving incompetent practices between health professionals to mediate on unrealistic workloads, poorly equipped facilities, and unsafe working conditions affect the work life and performance of health professionals (Cordeiro 2022:904). The PPE supports safe collaborative partnerships as it establishes settings that ensure health, safety and wellbeing of health professionals; poor quality workplaces weaken the ability of employers to meet the CHC quality health outcomes (DoH 2016a:12).

5.4.2 Theme 2: Ineffective management and leadership

The role of ineffective management being unavailable and not responding to emails and queries was a major concern for most participants. In this theme, the following categories emerged: poor leadership skills, ineffective people management strategies, absent structured in-service training and CPD, discrimination and disrespectful practices and non-collaborative enhancing systems and practices.

5.4.2.1 Subtheme 2.1: Poor leadership skills to enhance safe relations between health professionals

Across all three provincial sites, participants emphasised that ineffective leadership within CHCs stems primarily from the allocation of only one facility or operational manager per facility. This individual is expected to oversee all health professionals and administrative personnel while also attending frequent district and regional meetings outside the CHC. As a result, managerial support and supervision are limited, particularly during emergencies or night shifts. The participants' reflections illustrate this concern:

> “Senior managers are hardly available for support and empowerment.” (MP-FGB2)

> “Our clinic has one Operational Manager; we are delegated monthly to assist the OM or to be in charge if he is on leave or unavailable.” (GP-FGB3)

> “Absent managers — one Operational Manager on site, very limited, as all registered nurses rotate to stand in for him or her, which interferes with their core business.” (NW-IDIB1)

> “Only one manager per facility, who is often in meetings at the district office. If she is on leave or sick, there is no accountable leader to keep health professionals supported and confident.” (GP-IDIA2)

The narratives reveal a persistent leadership vacuum that leaves staff unsupported and facilities poorly coordinated. Participants described leadership as reactive rather than developmental, with limited mentoring, communication, or visibility of management. In some CHCs, professional nurses are rotated to act as temporary managers despite lacking formal leadership preparation, a practice that disrupts workflow and diminishes team cohesion.

The participants’ experiences confirm that ineffective leadership undermines both professional morale and patient safety. The absence of consistent supervision and constructive feedback was associated with anxiety, role confusion, and weakened trust among colleagues. The lack of visible leadership during critical situations further reduced confidence and accountability within interprofessional teams.

These findings align with Kurniawan, Tria and Hutami (2019:2529), who argue that effective health professional leadership requires cultivating mutual respect, loyalty, and professional affection to sustain supportive relationships among health workers. In the rural CHC context, leadership that is largely administrative rather than relational erodes collaboration, communication, and the psychological safety essential for cohesive teamwork and shared accountability.

5.4.2.2 Subtheme 2.2: Ineffective people management strategies to enhance collaboration and secure workplace

Participants across all provinces consistently described weak and ineffective leadership within rural CHCs. Many attributed this to the presence of only one operational manager per facility, responsible for both clinical and administrative oversight, and frequently unavailable due to district or regional meetings.

> "Subjective decisions by managers during conflict between staff are common because only one manager is placed at the facility." (NW-IDIB1)

> "Communication from management remains minimal. They are perceived as problem seekers rather than solvers." (MP-FGB2)

> "Management has poor communication and does not handle personnel well or with respect." (GP-IDIA2)

> "Conflict occurs from time to time between nurses and other health professionals, but unions and managers fail to mediate, especially between doctors and allied staff—it seems nurses feel inadequate as managers." (NW-FGA3)

> "Managers are failing to control personnel or manage the CHC due to poor communication and lack of qualifications to manage people effectively." (MP-IDIA3)

> "No formulated standard operating procedures within each professional's scope of practice—we perform duties outside our scope, which leads to conflict. When management intervenes, the blame game starts." (GP-FGB1)

The data reveal a pattern of reactive rather than proactive management, where interpersonal conflicts escalate due to the absence of clear operational procedures and consistent managerial guidance. Participants described management as inaccessible and ineffective, perceiving them as contributors to, rather than mediators of, workplace conflict. The absence of standard operating procedures (SOPs) and inconsistent enforcement of professional boundaries intensifies mistrust and tension among health professionals. As a result, leadership presence and guidance at the facilities are limited,

particularly during crises or night shifts. This absence of visible and competent leadership leaves health professionals unsupported, demotivated, and uncertain about accountability.

Participants explained that nurses are often delegated to act in managerial roles without adequate preparation, while operational managers are overextended between administrative responsibilities and external obligations. This leadership vacuum causes confusion, inconsistent supervision, and undermines teamwork and collaboration.

These findings align with Jerng, Huang, Liang, Chen, Lin, Huang, Hsieh and Sun (2017:44), who emphasised that interpersonal conflict is common in health professional teams when leadership capacity is weak. Similarly, Miao, Humphrey and Qian (2020:674) and Specchia, Cozzolino, Carini, Di Pilia, Ricciardi and Damiani 2021:14) found that poor people-management practices, limited emotional intelligence, and weak conflict-resolution skills hinder teamwork and collaboration. In the South African rural context, Mokoka, Oosthuizen and Ehlers (2021:1) confirm that managerial absenteeism and inadequate leadership training drive job dissatisfaction and staff turnover.

Rural CHCs require structured leadership systems that include clear SOPs, mentorship for emerging managers, and capacity-building programmes in communication, emotional intelligence, and conflict management. Strengthening leadership structures and people-management competencies would build trust, enhance collaboration, and contribute to a psychologically safe workplace.

The findings reflect what Kurniawan et al (2019:2529) describe as the erosion of supportive professional relationships in healthcare settings where leaders fail to foster respect, loyalty, and mutual trust. In such contexts, health professionals experience increased emotional exhaustion and reduced collaboration, as managerial absenteeism limits communication, mentorship, and conflict resolution.

Similarly, Mokoka et al (2021:3) observed that ineffective leadership and limited managerial presence are key predictors of job dissatisfaction and turnover among nurses in South African rural facilities.

5.4.2.3 Subtheme 2.3: Absent structured in-service training and CPD programme for health professionals

Participants expressed concern about the absence of formalised in-service training and ongoing professional development opportunities in their facilities. They described limited induction processes, inaccessible policy documents, and inadequate updates on legislative and professional frameworks. Their verbatim reflections included:

> "No induction and progressive update to staff about the legislative framework." (NW-FGA2)

> "No formulated standard operating procedure within each health professional's scope of practice – we perform our duties outside our scope, protocols, and standard operating procedures." (GP-IDIA3)

> "We have no induction; workload, staff shortages, and one manager – no workshops, the manager cannot manage alone." (MP-IDIA4)

> "Acts, policies, standard operating procedures, and protocols are in the manager's file, not accessible to individual staff or departments." (GP-FGB4)

> "There is a lack of information on safety measures and procedures; we are not aware of the Occupational Health and Safety Act." (MP-FGB2)

> "Policies? (translated from Tswana – 'policy files are kept in the manager's office')." (NW-IDIB1)

These accounts highlight the absence of a structured capacity-building system grounded in workplace learning, best practices, and legislative compliance. Health professionals described a culture of isolation from key information sources and professional support, which limits competence and confidence in their roles. Staff members rely on informal peer guidance rather than structured mentoring or training, leading to inconsistent standards and frequent errors in clinical or administrative practice.

The frustration expressed by participants is consistent with Jerng et al (2017:20), who emphasise that continuous education enhances health professionals' confidence,

interpersonal relations, and competence. The absence of such programmes not only erodes professional growth but also weakens collaborative practice and morale within teams.

In South Africa, the Nursing Act (No. 33 of 2005) mandates CPD as a cornerstone of safe and ethical practice, while the HPCSA enforces similar requirements for doctors and allied health professionals. Despite these regulatory expectations, participants confirmed that policy documents, standard operating procedures, and protocols are frequently inaccessible, locked away in managerial offices rather than displayed at points of service. Staff members often encounter these documents only during disciplinary processes or audits, rather than as tools for continuous improvement and empowerment.

The findings therefore underscore a systemic gap between policy intent and implementation in rural CHCs. Without structured in-service training and accessible CPD frameworks, health professionals remain under-supported, under-informed, and vulnerable to professional burnout and error, ultimately compromising interprofessional collaboration and patient safety.

The absence of CPD structures also contradicts Maslow's Hierarchy of Needs (1943), which positions competence and esteem as precursors to self-actualisation. When health professionals are denied opportunities to learn and improve, their sense of mastery and professional identity weakens, reducing their motivation to collaborate or innovate. Likewise, Watson's (2008) Theory of Human Caring stresses that a nurturing work environment grounded in education and empowerment is essential for sustaining caring relationships among staff and patients alike.

Ultimately, the participants' accounts illustrate a broader systemic failure to institutionalise lifelong learning within rural health services. Without structured induction, accessible policies, and continuous development, CHCs cannot sustain safe, collaborative, and quality healthcare practice, a finding echoed in national policy frameworks advocating professional growth and supportive workplace cultures.

5.4.2.4 Subtheme 2.4: Discrimination and disrespectful practices

Participants revealed pervasive experiences of discrimination and disrespect that undermine collaboration and teamwork in rural CHCs. They described how professional hierarchies, unequal access to facilities, and interpersonal prejudice create divisions that erode mutual respect, trust, and social cohesion. These discriminatory practices, often embedded in daily routines, were reported as toxic to teamwork and the interprofessional culture necessary for quality care.

> "The current eating and resting arrangements promote segregation based on professional class differences; it reflects a lack of respect, trust, and love. No social cohesion is encouraged daily." (NW-FGA4)

> "Medical officers enjoy better working hours, offices, and accommodation than all other health professionals; nurses are the most neglected." (MP-IDIA3)

> "The facility has separate resting rooms for different departments, which limits integration and promotes groupings." (GP-FGB4)

> "Some staff or sections are prioritised over others, for example, in access to telephone lines or quicker responses to resource requests." (MP-IDIA2)

> "Some staff members are discriminated against because of their level or type of qualification—Diploma versus B Tech nurses, doctors versus nurses." (NW-FGA5)

> "We are not united as staff; some sisters won't help when I am stranded, and our patients suffer. There is no teamwork." (MP-IDIA1)

> "Lack of recognition of each other's expertise in a multidisciplinary environment poses a risk to patient safety." (GP-FGB5)

> "There is a need for health professionals to respect each other's roles and expertise and take that into consideration at all times." (NW-IDIB1)

> "Some are not respecting others due to wealth and poverty, even religion—they use it to criticise each other." (MP-FGB4)

> “The multiple WhatsApp chat groups for different health professionals working at one CHC are not reliable platforms for all staff; they weaken teamwork and promote segregation.” (MP-FGB6)

These narratives demonstrate that discrimination in the workplace undermines professional dignity and psychological safety. Such behaviours diminish confidence, lower morale, and hinder cooperation among health professionals.

The findings conquer with Stephensons and De Longis (2020:18) who outlined that the group conflict occurs where members of one group project negative or incompatible attitudes and behaviours towards another group. The findings confirm that other categories of health professionals are commonly being undermined in the workplace such as with use of consultation space, tools of trade, resting space denied based on the level of their qualifications, the type of university the qualification was acquired. Similarly, Manojlovich, Adler-Milstein, Harrod, Sales, Hofer and Saint (2020:22) and Reeves, Pelone, Harrison, Goldman and Zwarenstein (2021:4) argue that respect, role recognition, and equitable access to resources are essential to sustaining interprofessional collaboration and patient safety.

This study found that discriminatory behaviour manifests structurally, through unequal allocation of resources, exclusionary communication systems, and professional hierarchies that prioritise medical doctors over nurses and allied professionals. These divisions weaken teamwork, reinforce power imbalances, and create a toxic work environment that discourages open communication and shared decision-making.

To address this, rural CHCs require deliberate structural reforms and cultural transformation. Establishing shared facilities, implementing joint professional development, and enforcing anti-discrimination and inclusion policies would promote equality, mutual respect, and cohesive interprofessional partnerships. Managers should lead by example in cultivating inclusive environments that value every professional’s expertise, thereby fostering safer, more collaborative, and compassionate workplaces.

5.4.2.5 Subtheme 2.5: Non-collaborative enhancing systems and practices

Participants across all three provinces described non-collaborative systems and organisational practices that undermine teamwork, communication, and professional cohesion. The existing model of personnel allocation was viewed as a major structural barrier to interprofessional collaboration. Nursing staff are grouped into separate shift teams, while allied and medical professionals operate under district-level supervision and rotate across facilities. This arrangement, according to participants, limits opportunities for collective problem-solving and weakens relationships within the same CHC. Their perceptions were captured as follows:

> "The nurses are two separate groups, psychologists and medical doctors are also separate, yet all are in one CHC. Everyone works without complementing or recognising each other's strengths and weaknesses." (GP-FGB4)

> "There are group A and B teams of nurses due to the off-duty model; we never meet unless one group is short-staffed." (MP-IDI2)

> "Interpersonal relationships are not promoted due to the off-duty model. There are two main shifts in each rota, so we are seen as separate teams, yet working in one facility." (NW-FGA5)

> "The multiple WhatsApp chat groups for different health professionals at our CHC are not effective for communication; information is fragmented and sometimes distorted." (MP-FGB6)

The findings reveal that shift structures and fragmented communication systems foster division among professionals. Rotational allocation of allied and medical staff from the district office further entrenches silos, as facility managers lack authority over their schedules. This separation limits shared planning, mentorship, and collective reflection, weakening the culture of interprofessional collaboration within CHCs.

These results support Murphy (2019:603), who argues that organisational systems that separate professional groups discourage the practice of interprofessional collaborative competencies, leaving engagement to occur only in times of crisis. Similarly, Joudyian, Doshmangir, Mahdavi, Tabrizi and Gordeev (2021:2) emphasise that professional silos

are toxic to workplace cohesion and that management plays a critical role in promoting intergroup communication and trust.

While one participant acknowledged positive interpersonal relationships within their immediate units, they stressed that such cohesion did not extend to other cadres:

> “Every staff member works with each other in harmony. Though the relationship with other allied workers is a little low, as we only interact mostly in patient care, the relationship is mutual for the benefit of the patient. This needs to be strengthened.” (GP-FGB6)

Participants further expressed concern about the lack of interdepartmental platforms and the absence of social or informal engagements that could enhance group cohesion and mutual respect:

> “Facilities have no interdepartmental platforms or integrated work forums that promote group cohesion, shared values, and trust – relations are limited.” (NW-IDIB1)

> “The nursing professionals work together as a team, but there is little to no communication between nurses, allied, and medical health professionals.” (MP-FGB4)

> “Reporting absenteeism or urgent work-related matters by doctors or pharmacists is delayed as it goes through the facility manager or district manager, who are not stationed at the CHC.” (GP-IDIA2)

> “No interdepartmental or multiprofessional meetings to ensure clarity of roles and build trust.” (MP-IDIA3)

> “The current eating and resting facilities promote segregation based on professional hierarchy and class – there is no daily social cohesion.” (NW-FGA4)

> “No social informal activities promote cohesion of all health workers. Nurses or admin staff sometimes organise events separately, excluding others.” (GP-FGB6)

The evidence confirms that fragmented management systems and weak communication channels foster a culture of separation and mistrust among CHC staff. This undermines interprofessional learning, teamwork, and patient safety. As Schmidt, Niemeijer, Leget, Trappenburg and Tonkens (2020:956) note, individuals derive dignity and professional identity through meaningful engagement and expression within their teams; the absence of such interaction diminishes respect and accountability.

The findings further align with Desmet and Fokkinga (2020:4), who highlight that fulfilment of relational needs such as belonging, trust, and communication depends on the satisfaction of basic physiological and safety needs. Participants in this study confirmed that the absence of social cohesion, resource scarcity, and poor engagement practices reduced their motivation and self-esteem, leading to feelings of isolation and burnout. This is supported by Moses, Dreyer and Robertson (2024:1), who associate non-collaborative work environments with increased stress, absenteeism, and professional disengagement.

Although some semi-rural CHCs in Gauteng demonstrated better attendance of structured workshops and communication initiatives, these practices remain inconsistent across provinces. The overall picture reflects a disjointed organisational culture that lacks collective accountability, reinforcing professional silos and obstructing the development of sustainable interprofessional partnerships.

Positive to poor interdepartmental communication and interpersonal relationships emerged as a major challenge across all CHCs. These findings demonstrate that weak communication structures negatively affect professional growth, collaboration, and teamwork, which in turn compromises the satisfaction of psychological and social needs outlined in Maslow’s Hierarchy of Needs and Watson’s Theory of Human Caring.

Competent leadership is central to building positive professional relationships, while emotional intelligence is a core attribute of transformational leadership (Baba, Makhdoomi & Siddiqi 2021:1072). Leaders who demonstrate self-awareness, empathy, diplomacy and emotional regulation are better able to manage interpersonal conflict, prevent discrimination and sustain psychologically safe work environments (Baba et al 2021:1093). High emotional intelligence enables leaders to support staff fairly, respond constructively to workplace tensions and foster trust and cohesion within multidisciplinary

teams, thereby strengthening organisational climate and collaborative practice (Baba et al 2021:1088-1094).

Baba et al (2021:1070-1096) demonstrate that leaders with high emotional intelligence are more likely to exhibit self-awareness, empathy, social awareness and interpersonal skills that enable them to manage conflict constructively, inspire followers and promote workplace cohesion. Baba et al 2021 (1070-1096) further suggest that these emotional competencies enable leaders to support team members without bias, and to handle difficult interpersonal situations with respect and skill, which contributes to healthier organisational climates.

Participants lamented the absence of structured interdepartmental forums that promote cohesion, shared values, and mutual respect. They also expressed dissatisfaction with the limited communication between medical, nursing, and allied health professionals. The following excerpts capture these sentiments:

> “Facilities have no interdepartmental platforms or integrated work forums that promote group cohesion, shared values, and trust—relations are limited.” (NW-IDIB1)

> “Nursing professionals work together as a team, but there is little to no communication between nurses, allied, and medical health professionals.” (MP-FGB4)

The researcher’s findings confirm that poor interdepartmental communication threatens collaboration and teamwork. Schmidt et al (2020:956) observed that when employees integrate themselves meaningfully into their work environment, they gain self-esteem and perform their duties with dignity and respect. The lack of engagement and accountability leads to absenteeism and disengagement, reflecting poor professional respect.

Participants further described their concerns about strained relationships and limited interaction between departments, which they viewed as unsafe for fostering collaborative partnerships:

> “Reporting absenteeism or urgent work-related matters by other health professionals (e.g., doctors, pharmacists) is delayed as it goes through the facility or district manager, who are not stationed at the CHC.” (GP-IDIA2)

> “No interdepartmental or multiprofessional meetings to ensure clarity of roles and build trust.” (MP-IDIA3)

> “The current eating and resting arrangements promote segregation based on professional hierarchy and class differences—no social cohesion is encouraged daily.” (NW-FGA4)

The limited presence of health professionals and lack of coordinated communication structures diminish psychological safety and belonging are key components of Maslow’s safety and love and belonging levels. This reality aligns with O’Donovan, De Brún, McAuliffe and McCarthy (2021:9), who highlight that siloed work environments and poor communication perpetuate toxic workplace cultures and hinder collaboration.

A weakened sense of belonging further reduces staff commitment, participation in meetings, and adherence to safety and teamwork values. The following excerpts illustrate participants’ perspectives:

> “Sharing of ideas and teamwork in the workplace are important; communication is key to a safe workplace.” (GP-FGB6)

> “No social informal activities promote cohesion of all health workers. Nurses or admin staff sometimes organise events separately, excluding others.” (MP-FGB5)

The findings indicate that health professionals in rural CHCs experience low self-esteem, poor work performance, and a lack of confidence due to dysfunctional communication and fragmented teamwork. Malomane (2020:239) affirms that these issues reflect compromised work relations and emotional insecurity among staff.

According to Desmet and Fokkinga (2020:4), meeting physiological and safety needs is fundamental before individuals can fulfil higher needs such as belonging, partnership, and self-actualisation. Moses et al (2024:1) further link poor communication, excessive workload, and lack of recognition to burnout and non-collaborative practices. In contrast,

participants from semi-rural Gauteng CHCs noted that structured workshops and assertive leadership helped improve engagement and communication between departments.

5.4.3 Theme 3: Ineffective and inefficient communication

In this theme the researcher noted that most participants were unhappy about the process adopted by the management based on communication. The subthemes that emerged include non-cohesive and integrated communication, between health professionals in the CHC, limited technology driven communication and poor interprofessional and interdepartmental communication

5.4.3.1 Subtheme 3.1: Non-cohesive and integrated communication between health professionals within the CHC

Effective communication is the foundation of interprofessional collaboration, yet participants consistently reported fragmented and exclusionary communication practices within rural and semi-rural CHCs. The responses highlighted that communication occurs in isolated professional silos, often limited to certain cadres or hierarchical levels, rather than functioning as an integrated, facility-wide system. This fragmentation has weakened teamwork, mutual trust, and information flow between management, nurses, allied professionals, and doctors. The verbatim opinions of participants are noted here:

> “Communication is key to a positive, therapeutic, and safe workplace.” (GP-FGB4)

> “Poor communication between workers and management. Information is always shared late.” (NW-IDIB1)

> “Lack of clear communication lines yields favouritism.” (MP-FGB5)

> “If communication is not good, professionals may even start disrespecting each other.” (NW-FGA5)

> “There is a need for positive communication among health professionals, with regular meetings to improve service delivery.” (GP-IDIA2)

Participants across provinces expressed dissatisfaction with informal communication systems used by management, particularly the overreliance on WhatsApp chat groups that exclude some staff and fail to create formal records of decisions. This practice was viewed as unprofessional and marginalising practice, supported by this statement:

> "Nursing professionals work together as a team, but there is little to no communication between nurses, allied, and medical health professionals." (MP-FGB6)

> "Facilities have no inter-departmental platforms or integrated forums that promote group cohesion, shared values, and trust." (NW-IDIB2)

> "The multiple WhatsApp chat groups for different professional groups in one CHC are not reliable or effective communication platforms; they weaken teamwork and promote segregation." (GP-FGB5)

> "The WhatsApp communication group is mainly for nurses; other professionals are unaware of critical work processes and challenges." (MP-IDIA3)

The data revealed that communication in rural CHCs is non-empathetic, fragmented, and unstructured, with management frequently perceived as inaccessible or dismissive. The absence of formal communication systems or structured staff meetings erodes morale and breeds mistrust among professionals.

These findings align with Mata et al (2021:1-2), who argue that effective communication training in healthcare reduces malpractice and enhances interprofessional coordination, and with Afriyie (2020:438), who emphasises that strong communication and trust are essential for psychological safety and professional cohesion. Yet, in the CHCs studied, communication remains largely unregulated, with minimal institutional oversight.

Several participants reported that poor communication from management often escalates conflict, delays decision-making, and fosters perceptions of favouritism and exclusion:

> "Management has poor communication and does not handle personnel well." (GP-IDIB2)

> "Social cohesion and collaboration are being challenged by the absence of a common communication platform that includes all health professionals." (NW-FGA4)

> "Managers use social media such as WhatsApp for communication, but these groups are limited to specific cadres, for example, doctors only or managers and nurses only." (MP-IDIA3)

The findings support West, Lyubovnikova, Eckert and Denis (2022:14), who observed that poor therapeutic communication among healthcare workers leads to misinterpretation of intent and perceived insubordination. Despite therapeutic communication being a core competency in nursing practice and education as defined by the South African Nursing Council (SANC) competency framework (SANC 2015:2), participants' accounts reveal a limited application of these communication skills in everyday practice. Likewise, research shows that even trained professionals sometimes fail to internalise effective communication behaviours, thereby fostering fear, mistrust, and barriers to collaboration (Kang, Ma, Chen, Yang, Wang, Li, Yao, Bai, Cai, Xiang Yang 2020:13).

In summary, the lack of a unified communication strategy within CHCs undermines professional respect, shared decision-making, and the spirit of collaboration. This fragmentation also weakens accountability and continuity of care. To strengthen interprofessional collaboration, CHCs must institutionalise structured, inclusive, and technology-supported communication platforms. Regular multidisciplinary meetings, shared reporting systems, and communication skills training should be prioritised to foster transparency, empathy, and teamwork among all cadres of health professionals.

5.4.3.2 Subtheme 3.2: Limited technology driven communication

Participants highlighted that the absence of modern, reliable communication technologies within rural CHCs severely limits the efficiency, safety, and integration of interprofessional collaboration. Despite living in a technology-driven era, most rural CHCs continue to rely on outdated or inconsistent communication systems. This has resulted in delayed information flow, fragmented coordination, and avoidable conflict among health professionals. Technology is driving the world today, thus limited exploration of

communication driven by technology is an oversight that cannot be accepted. The verbatim statements are as follows:

> “Not having access to internet services and telephones hinders the smooth flow of communication.” (NW-IDIB1)

> “There are no panic buttons or intercoms in the facility.” (GP-FGB2)

> “No access to internet and mobile telephones to ensure communication between health professionals. Only one mobile phone for the whole facility, used by one person at a time.” (MP-IDIA2)

> “WhatsApp chat groups are mainly for nurses only; other professionals are excluded from daily updates and decisions.” (NW-FGA3)

> “The multiple WhatsApp chat groups for different professional groups are unreliable and weaken teamwork.” (GP-IDIA3)

These experiences reveal that communication remains dependent on fragmented and low-tech systems that exclude many professionals. Participants emphasised that this not only limits operational efficiency but also breeds frustration, as critical updates are delayed or never received. In several CHCs, a single shared phone or lack of Wi-Fi meant that staff could not contact other departments or management promptly, a situation that compromises patient safety and collaborative responsiveness.

> “WhatsApp is limited to staff with smartphones and data; none of us receive telephone allowances or have Wi-Fi access. This causes conflict, as we use our own resources to communicate work matters.” (MP-IDIA3)

> “There are no landline or mobile phones for departments; access to the internet is limited to a few offices.” (NW-FGA4)

The findings indicate that communication technology, instead of enabling collaboration, has become a barrier due to inequitable access and lack of digital infrastructure. This creates power imbalances between cadres, as information becomes centralised within specific professional groups (often management or medical staff), while others remain

uninformed. Consequently, professionals misinterpret instructions, miss meetings, or are accused of insubordination when information was never properly shared.

These findings resonate with Stachová, Stacho, Blštáková, Hlatká and Kapustina (2020:21) and O'Donovan et al (2021:12), who argue that effective digital communication systems are essential to support teamwork and shared accountability in healthcare. Likewise, Deng, Duan and Wibowo (2023:404) note that technology-enabled communication enhances engagement, decision-making, and performance by fostering continuous connectivity among staff. Gopal, Suter-Crazzolara, Toldo and Eberhardt (2019:328) affirm that digital tools should be integrated into routine health operations to improve coordination and reduce human error, particularly in resource-limited settings.

Despite these international trends, the rural CHCs studied continue to depend on face-to-face interactions, handwritten reports, and ad hoc WhatsApp groups. This approach hinders the establishment of reliable communication pathways, impedes multidisciplinary teamwork, and perpetuates information silos. As Malakoane, Heunis, Chikobvu, Kigozi and Kruger (2020:3) emphasise, digital innovation in health service delivery can bridge rural inequities, streamline patient management, and improve staff responsiveness even where physical infrastructure is limited. Furthermore, to better have employees engaged, who can become effective decision-makers, with better job performance within the rural CHCs, health professionals are to consider innovative technology that will improve communication (Deng et al 2023:404).

In summary, this subtheme highlights that technological inequity within CHCs is both a symptom and driver of weak collaboration. Without consistent investment in digital infrastructure, such as Wi-Fi, secure communication networks, and shared information systems thus interprofessional collaboration will remain fragmented. Strengthening digital literacy, ensuring equitable access to technological tools, and institutionalising structured e-communication systems are crucial steps toward achieving safe, efficient, and integrated interprofessional practice in rural healthcare.

5.4.3.3 Subtheme 3.3: Poor interprofessional and interdepartmental communication

Communication among health professionals and across departments was described as a critical component of effective service delivery within the CHCs. However, participants reported limited confidence in applying communication skills in their daily interactions. They associated this with unclear communication structures, limited training opportunities, and strained interpersonal dynamics within departments. The following excerpts reflect participants' views and experiences of interdepartmental communication:

> "Communication is not good at all – we do not even respect each other." (NW-FG02)

> "There are no interdepartmental or multiprofessional meetings to ensure clarity of roles or build positive relations using technology or even ground lines." (GP-IDIA2)

> "Personnel are moved around to 'relieve' without clear reasons." (MP-IDIA3)

> "Nurses are disrespectful to each other, judging colleagues based on where they live, how they dress, even hairstyle – it's too toxic." (NW-FG03)

> "Managers use WhatsApp groups for communication, but each cadre has its own – doctors, nurses, allied – this creates favouritism." (GP-IDIA4)

> "It's tiring to keep reporting when nothing is done; it destroys relationships and workplace safety." (MP-FGB2)

These narratives show that fragmented communication has become normalised, producing feelings of exclusion, powerlessness, and fatigue among staff. Participants equated inconsistent feedback and selective attention from managers with disrespect and discrimination. Such organisational silence discourages initiative and reinforces defensive attitudes, ultimately weakening team cohesion.

The findings corroborate Yusoff, Ahmad, Ismail, Reffin, Chan, Kusnin, Bahari, Baharudin, Aris, Shen and Rahman (2023:84), who noted that communication failure in rural health settings heightens interpersonal tension and workplace hostility, eroding psychological

safety. Similarly, Cullati, Bochatay, Maître, Laroche, Muller-Juge, Blondon, Perron, Bajwa, Vu, Kim, Savoldelli, Hudelson, Chopard and Nendaz (2019:42) found that repetitive reporting without response fosters burnout and distrust, while Ankinwale and George (2020:72) linked positive communication climates to higher job satisfaction and collaborative behaviours.

Interpersonal and interdepartmental breakdowns also hinder mutual recognition of expertise. Participants described being reluctant to seek help or share responsibilities, fearing humiliation or indifference:

> "Each professional is an expert in his/her field and telling others what to do shows lack of respect." (MP-FGB5)

> "Lack of recognition of each other's expertise in a multidisciplinary environment poses a safety risk." (GP-IDIB3)

> "Many sisters won't help when I'm stranded; patients suffer if I'm not there – there is no teamwork." (NW-FGA4)

> "Health professionals must respect each other's jobs and expertise at all times." (MP-IDIA3)

> "Disrespect among colleagues is common; juniors are often ignored or spoken down to by seniors." (GP-FGB6)

> "Allied professionals are excluded from key meetings – it feels like our input is not valued." (NW-FGA5)

This pattern reflects what Carmeli, Dutton and Hardin (2021:1528) describe as the "erosion of relational capital", where trust and empathy deteriorate, and communication becomes transactional rather than collaborative. Participants' accounts confirm that communication fatigue, favouritism, and lack of structured dialogue reduce morale and compromise patient care.

At the same time, Cullati et al (2019:43) argued that workplace conflict, if addressed constructively, can become an opportunity for learning and improvement. Applied to

CHCs, this suggests that introducing structured reflection sessions, joint debriefings, and interprofessional communication workshops could turn conflict into a vehicle for professional growth. The findings concur with Yusoff et al's (2023:84) study that workplace violence between staff, patients and community is at high percentage in rural areas and promotes silos and retards group cohesion, teamwork and safe relations.

Ankinwale and George (2020:72) agree that job satisfaction leads to positive behavioural outcomes at work enable employees to satisfy each other and create a positive secure work environment. When interpersonal relations and communication among health professionals are lacking, the safety of CHCs becomes compromised. Evidence from a cross-sectional study shows that perceptions of patient safety culture and teamwork are significantly associated, indicating that effective teamwork and interprofessional communication underpin patient safety outcomes within healthcare organisations (Skoogh, Bååth & Hall-Lord 2022:5). This aligns with the present study's findings that a culture of caring, self-awareness, lifelong learning and team building in rural and semi-rural CHCs could strengthen professional relationships and yield a safer working environment.

The findings in this study illuminate that a culture of caring, self-awareness, life-long learning and building teams within the CHC could strengthen relationships and yield a safe working environment. Furthermore, participants alluded that to explore social safety, relevant stakeholders should re-engineer the workplace in line with the Maslow's hierarchy of needs and promote relationship centred care as supported by Tresolini, Fetzer, Dwamena, Frankel, Lepisto and Smith (2019:3).

The need for relationship-centred care, underpinned by Maslow's hierarchy of needs, the psychological safety, belonging, esteem and Watson's Theory of Human Caring, the transpersonal respect and empathy, was echoed throughout the data. Participants stressed that fostering caring communication, self-awareness, and mutual accountability could transform the toxic culture into one of cooperation and shared purpose.

In summary, the study reveals that poor interprofessional and interdepartmental communication in rural CHCs perpetuates hierarchy, mistrust, and unsafe practice. Restoring respectful, transparent, and inclusive communication structures, through regular interdepartmental meetings, open-door management policies, and CPD in

interpersonal skills is critical to strengthening collaboration and building safe, cohesive healthcare teams.

The participants posit that poor communication in the workplace is demeaning them and they are being treated differently and favouritism applied; this is equivalent to disrespect. The fatigue from reporting with no action confirms fatigue and burnout of health professionals: a cancer that destroys trust and dignity of health professionals, thus unsafe relations (Cullati et al 2019:42).

5.4.4 Theme 4*:* Dysfunctional organised labour

The responses from participants confirm that concerns cited in the three multiple subthemes confirming non-compliance to the prescripts of the organised labour. The dysfunctional organised labour refers to the union representatives who do not comply with the prescripts of the labour Act that is to promote a safe working environment.

5.4.4.1 Subtheme 4.1: Absence organised labour representatives and structures

The CHCs serve as workplaces providing health services that are expected to comply with the prescripts of the Labour Relations Act (No. 66 of 1995). Participants across the three provinces (Northwest, Gauteng and Mpumalanga) highlighted the absence or limited functionality of organised labour representatives in their facilities. This perceived absence has resulted in weak advocacy, poor representation, and limited engagement between unions and health professionals. The following excerpts illustrate these perceptions:

> “Lack of commitment from organised labour. Not effective role, they are passive to absent.” (NW-FGA1)

> “There is no functional or effective union representative for CHC staff.” (MP-IDIA2)

> “Participation of unions is very minimal; representatives are not even well known.” (GP-IDIA3)

> “Each professional has their chosen union, but I’ve never heard of any responsibilities of unions at our facility—yet everyone pays.” (NW-FGA2)

> “Unions should engage staff proactively, not just react when there’s an incident.” (MP-IDIA3)

> “I’ve lost confidence in the union. We shouldn’t pay.” (GP-FGB3)

> “Unions should be set up properly and focus on workplace and employee well-being.” (NW-IDIB1)

> “Most staff members are not members of any union.” (MP-FGB5)

> “Union representatives rarely visit or communicate; some staff don’t even know who their shop steward is.” (GP-FGB6)

These perspectives indicate that while some health professionals are union members, they perceive limited benefit from their membership due to non-functional or invisible structures. Participants described unions as “absent” or “passive,” noting that most workplace concerns are handled informally by employees themselves, without structured engagement or union intervention.

This situation contradicts Section 19(1) of the Labour Relations Act, which mandates consultation between the employer, organised labour, and employee representatives, including participation in safety and workplace committees. The lack of visible union activity in rural CHCs therefore reflects both structural and functional gaps in compliance.

The findings resonate with Gana (2022:5), who observed that some union leaders in the public sector have shifted focus from member advocacy to personal and political interests, thereby weakening representation. Similarly, Shierholz, McNicholas, Poydock & Sherer (2023:23) highlight that government labour reform efforts often fail to translate into practice in vulnerable and resource-limited sectors such as rural healthcare.

Participants further indicated that the absence of structured union activity extends to workplace safety and welfare issues. Many felt unprotected and silenced, particularly when raising grievances or reporting unsafe practices:

> “No union-led forums on safety. If you become vocal, you become a target, and your emotional and psychological safety is compromised.” (GP-IDIA1)

> “Union leaders are passive; they rarely engage unless there’s a crisis.” (NW-FGA1)

> “Each professional pays union fees, but there are no known representatives at our facility.” (MP-FGB2)

> “Unions should be proactive rather than reactive—organise awareness events, not only appear during elections.” (GP-IDIA2)

> “Unions only come when we have a problem; they take a long time to resolve issues.” (MP-IDIA3)

> “Unions are present but scared to be visible and are not actively engaged.” (NW-IDIB1)

> “Some shop stewards avoid meetings due to fear of management victimisation.” (GP-FGB5)

> “Union activities are not transparent; staff don’t know what progress has been made on grievances.” (MP-FGB6)

Despite these negative experiences, a few participants acknowledged that the idea of organised labour remains valuable for advocacy and worker protection, even though implementation in rural areas is weak. This mixed perception demonstrates both residual trust and deep frustration with the union system.

Hlatshwayo (2020:13) supports this dual view by showing that, although organised labour is intended to advance workplace justice and protect vulnerable health workers, its effectiveness is often constrained in marginalised and under-resourced settings. In rural and peripheral health services, union representatives are frequently stretched across wide geographical areas, face poor communication infrastructure, and receive limited organisational support, which significantly undermines their capacity to represent and mobilise workers effectively. Furthermore, to better have employees engaged, who can become effective decision-makers, with better job performance within the rural CHCs,

health professionals are to consider innovative technology that will improve communication (Deng et al 2023:404).

The data suggest that the erosion of union visibility in CHCs weakens interprofessional collaboration and contributes to a lack of collective voice. Union inactivity not only undermines the rights of health professionals but also perpetuates workplace fragmentation and psychosocial unsafety. Strengthening labour representation through regular meetings, clear reporting structures, and integration with management and clinical forums could therefore restore mutual accountability and trust between health professionals, unions, and management.

According to Section 19(1) of the Labour Relations Act (No. 66 of 1995), the findings that outlined that consultation between the employer, union and the health professionals and established safety committee are absent. The findings confirm that health professionals as union members devise some means to solve their challenges without the involvement of the labour union representatives and management. Therefore, the union representative's role is not impactful and beneficial to health professionals. The opinions from the respondents concur with the statement by Gana (2022:5), who mentioned that union leaders are there to enrich themselves, they are not interested with their members' grievances although they have been elected by members.

The findings are encouraging as some health professionals confirm the value of union representatives is still present while others are concerned that they are not effective and impactful in their rural CHCs. The government's labour department shifted from cautious, incremental changes in the health sector to more radical structural reforms confirming the poor implementation of union roles (Shierholz et al 2023:34). Based on the above statements by the participants, they confirm that indeed, the labour union's role has changed over time and is even worse in more vulnerable communities as well as the rural health facilities.

5.4.4.2 Subtheme 4.2: Unclear and poor commitment of health professionals to organised labour

Limited or unclear commitment of health professionals to organised labour structures emerged as a major concern across all participating CHCs. Many participants indicated

that union membership was either inactive or perceived as irrelevant, with few visible activities or representation by shop stewards at facility level. The following excerpts illustrate these perceptions:

> “Most staff members are not members of unions.” (NW-FGA1)

> “Participation of unions is very minimal; representatives are not even well known.” (GP-IDIA2)

> “Not active or visible, although I am a paid-up member.” (MP-IDIA3)

> “Not represented at the CHC; no shop stewards.” (NW-FGA2)

> “Shop stewards offer no support whatsoever.” (GP-IDIA3)

> “I cannot say anything about the unions because there is no shop steward for my union in this facility.” (MP-IDIA4)

> “There is no close relationship with employees; they seem to support management more than members.” (NW-FGA3)

> “Union leaders are neither active nor available.” (GP-IDIB3)

> “There is no functional or effective union representative for CHC staff.” (MP-FGB5)

> “I have lost confidence in the union; we shouldn’t pay.” (NW-IDIB1)

> “Union visits are rare; they come only during elections, not when we face workplace problems.” (MP-FGB6)

> “Even when we report issues, follow-up is slow, and we end up solving matters among ourselves.” (GP-FGB4)

> “At times, the union is seen as protecting certain groups instead of representing everyone equally.” (NW-FGA4)

Participants collectively expressed a sense of disconnection and mistrust between health professionals and organised labour representatives. Union visibility and engagement

were reported as minimal, with several participants acknowledging that they were unaware of who represented them at the facility. Some indicated that even though they paid membership fees, they had never attended meetings nor received communication from their unions.

This limited engagement appears to have created a perception that unions support management more than their members. Similar trends have been noted globally, where health workers express declining confidence in organised labour due to perceived inaction and weak advocacy (ILO 2023: section 4.2).

The findings also revealed that some union representatives themselves experience intimidation and fear of reprisal from management when attempting to intervene in disputes, thereby limiting their effectiveness. The following statements illustrate these dynamics:

> “Shop stewards feel threatened and victimised when defending workers; their role becomes compromised. One I know is planning to resign.” (MP-IDIA5)

> “Union representatives are not available; they only focus on formal workplace issues and neglect social well-being.” (GP-IDIA3)

> “Unions are present but scared to be visible and are not actively engaged.” (NW-FGA2)

> “Unions only come when there’s a problem; they take long to resolve issues.” (MP-IDIA3)

> “Unions should keep communicating with employees.” (GP-FGB4)

> “Union leaders rarely attend meetings with staff; we feel abandoned.” (NW-FGA5)

> “Even when we raise issues, they refer us to the district office, saying they can’t interfere.” (MP-FGB6)

The study findings align with Rayner and Lewis (2020:501), who note that fear of victimisation discourages union representatives from advocating for employees,

especially in hierarchical or resource-constrained institutions. Similarly, Kuto, Kwonyike and Mulongo (2021:21) found that both management and labour unions often fail to fully implement workplace safety and collaboration policies in rural settings.

Participants in this study described the resulting absence of functional union structures as leaving employees vulnerable, particularly in the face of occupational risks, long working hours, and limited protection mechanisms. These findings reinforce Couper, Lediga, Takalani, Floss, Yeoh, Ferrara, Wheatley, Feasby, De Oliveira Santana, Wanjala. and Tukur (2023:10), who highlight that health professionals in rural areas often face security and safety threats without institutional or union support.

Overall, the data indicate that health professionals' commitment to organised labour is superficial, with many subscribing for formal compliance rather than genuine engagement. This lack of trust and visibility weakens labour–management relations and limits interprofessional collaboration within CHCs.

Unclear commitment of health professionals to organised labour was discovered and the following verbatim statements from participants confirm the limited to absent commitment of organised labour in enhancing partnership and collaboration between health professionals.

Thus, findings from participants confirm that there was no trust between health professionals, the unions; and management does not seem concerned. The concern about commitment of representatives of various organised labour parties is a concern raised by most participants and it is a globally developing trend (ILO 2023:1). Participants echoed that the commitment of the labour union is very minimal or does not exist, which is the reason other participants are not members of any union. Other participants mentioned the fact that they are aware of an office occupied by a shop steward they have never seen or been addressed by that person.

The findings uncovered numerous tensions between employer, employee and organised unions, most of them emanating from working conditions, threats to health professionals. Similarly, the findings of this study concur with the findings in the study conducted by Kuto et al (2021:21) that the management and labour unions do not actively commit and comply with the prescripts of establishing a safe environment.

The findings affirm that it is unfortunate that the union members are unable to represent their members because of intimidation (Rayner & Lewis 2020:501). The health professionals must take responsibility to protect themselves, thus stay vigilant because thieves can enter at any time and attack them, especially at night (Couper et al 2023:10). This is a gross violation of workers' rights in which no legal representative in South Africa is accessible to save health professionals although health professionals are paying monthly subscription fees as union members. Organised labour structures and roles are absent in the rural CHCs and there is no clear legal recourse.

5.4.4.3 Subtheme 4.3: Non-compliance and misaligned labour legislative prescripts in rural CHCs

Participants expressed concern about the lack of compliance with labour legislation and misalignment of workplace practices to existing labour prescripts in rural CHCs. Both management and organised labour were perceived as failing to uphold their responsibilities in maintaining fair, safe, and collaborative work environments. The following excerpts illustrate these concerns:

> "There are no union-led forums on safety. Every employee serves their own interest to stay employed. If you become vocal, you become a target, and your safety—especially emotional and psychological—is compromised." (GP-IDIA2)

> "Management targets unions, and they become uncertain about their future, eventually becoming dormant or absent." (NW-FGA1)

> "Shop stewards offer no support whatsoever." (MP-IDIA3)

> "No support from management or unions." (NW-FGA3)

> "Union representatives avoid confronting management; they fear being labelled as troublemakers." (GP-FGB4)

> "Even shop stewards say, 'We can't fight the district,' so staff stop reporting issues." (MP-FGB5)

> “When unions speak up, they’re sidelined from meetings and accused of politicising the workplace.” (NW-FGA5)

Participants indicated that the absence of structured union forums and inconsistent management practices compromise employee protection and workplace safety. Labour relations appeared reactive rather than preventive, with engagement between management, organised labour, and employees occurring only after incidents. This reactive posture, participants noted, contributes to mistrust and weakens the implementation of labour policies.

The findings align with Shierholz et al (2023:34), who assert that both management and organised labour in public health settings often intervene only after serious incidents, rather than instituting preventive measures to protect workers and strengthen collaboration. This reactive pattern further erodes confidence in institutional support systems and contributes to unsafe psychosocial environments.

Participants also highlighted the absence of healthy relations between management, unions, and health professionals, as reflected in the excerpts below:

> No close relations between employees, unions, and management.” (MP-FGB3)

> “Shop stewards are present but scared to be visible because of fear of victimisation by management. One shop steward resigned for that reason.” (NW-IDIB1)

The data suggest that labour–management relations in rural CHCs are fragmented and compliance with legislative frameworks is weak. This non-compliance undermines the principles of the Labour Relations Act (No. 66 of 1995), which mandates structured consultation, fair representation, and joint safety and wellness committees at workplace level.

Consistent with Heery, Williams and Abbott (2020:333), effective labour relations depend on management viewing unions and employees as strategic partners in service delivery. However, the findings from this study indicate that such partnerships remain underdeveloped in rural CHCs, where resource constraints, fear of reprisal, and unclear accountability structures inhibit effective collaboration.

5.4.5 Theme 5: Ailing interprofessional and interunion relations

Participants shared positive and negative experiences and outcomes between health professionals, management and union. The subthemes emanating from perceived experiences are poor interpersonal relationships and misuse of power. The sub themes that emerged supported by the participants' utterances are minimal interprofessional and interunion relations and abuse of power.

5.4.5.1 Subtheme 5.1: Minimal interprofessional and interdisciplinary collaboration

Limited or absent interprofessional and interdisciplinary collaboration was consistently reported across the participating CHCs. Participants described a workplace culture characterised by professional silos, weak teamwork, and strained interpersonal relations. The following statements illustrate these concerns:

> Lack of appreciation of each other's expertise in a multidisciplinary environment poses a risk to safety." (GP-IDIA5)
>
> "Relationships are fairly good but could be improved." (NW-FGA5)
>
> "Working in silos is common. Health professionals work alone and only pair up when handling a complex client." (MP-FGB6)
>
> "We are not united as staff—no teamwork. When I'm on leave, no one assists my patients." (GP-IDIA4)
>
> "Conflict exists—planned absenteeism, late communication, and poor coordination." (NW-FGA4)
>
> "Interpersonal relations are fairly good to poor." (MP-IDIA4)

Participants' narratives reveal that collaboration is often incidental rather than systematic, with weak coordination and limited joint problem-solving. Ehrlich, Spiegel, Adu and Yassi (2020:112) caution that promoting seamless interprofessional and interorganisational

collaboration is complex because of entrenched interactional, organisational, and socio-political barriers, which conditions evident in these rural CHCs.

The data also suggest that poor interpersonal relationships and toxic communication between staff and supervisors contribute to psychological strain and declining service quality. Hayre-Kwan, Quinn, Chu, Orr and Snoke (2021:592) argue that when fundamental human needs for safety and belonging, identified in Maslow's hierarchy of needs are met, healthcare workers exhibit stronger team cohesion and job satisfaction. Unprofessional behaviours such as criticism, gossip, and disrespect were frequently cited, as reflected below:

> "Lack of appreciation of each other's expertise in a multidisciplinary environment poses a risk to safety." (GP-IDIA5)
>
> "Relationships are fairly good but could be improved." (NW-FGA5)
>
> "Working in silos is common. Health professionals work alone and only pair up when handling a complex client." (MP-FGB6)
>
> "We are not united as staff—no teamwork. When I'm on leave, no one assists my patients." (GP-IDIA4)
>
> "Conflict exists—planned absenteeism, late communication, and poor coordination." (NW-FGA4)
>
> "Interpersonal relations are fairly good to poor." (MP-IDIA4)
>
> "At our CHC we are not united as staff. Many professional nurses refuse to help when I am not available; there is no teamwork." (MP-IDI05)
>
> "Health professionals criticise, bad-mouth, and gossip about each other." (GP-FGB2)
>
> "We even disrespect one another." (NW-IDI03)

Such practices undermine collegial trust and contradict professional codes of conduct. The findings highlight that despite professional pledges and oaths committing healthcare

workers to dignity, respect, and service, everyday workplace interactions often reflect fragmentation rather than collaboration.

Wang, Zou, Zheng, Chen, Teng and Lu (2022:2) emphasise that therapeutic communication fosters trust, group cohesion, and belonging key prerequisites for collaboration. Likewise, Sharp, Bourke and Rickard (2020:433) link emotional intelligence to secure communication and teamwork, underscoring the need for coaching to strengthen relational and emotional competencies among rural health professionals.

Health professionals in rural CHCs must therefore cultivate shared purpose, respect, and trust as foundations for secure interprofessional partnerships. When individuals cooperate toward common goals within a caring and communicative environment, they build collective self-esteem and team stability. Schultz and Schkade (2020:12) confirm that a therapeutic milieu interconnects all health professionals, promoting human dignity, empathy, and intellectual engagement conditions necessary for a safe and restorative workplace culture.

5.4.5.2 Subtheme 5.2: Misuse of power among health professionals and unions

The misuse of power among health professionals emerged as a significant concern influencing workplace relations and collaboration in rural CHCs. Participants described how hierarchies based on qualification, socio-economic status, culture, or religion fostered disrespect, tension, and division within teams. Illustrative excerpts include:

> “We are, to some extent, united, but some health professionals do not respect others because of wealth or poverty; even religion is used to criticise each other.” (GP-IDIA2)

> “Some professionals show disrespect due to differences in education level, wealth, culture or language.” (NW-FGA1)

> “Colleagues undermine others’ roles because of qualification level – nurses with diplomas versus B Tech, or doctors versus nurses.” (MP-FGB2)

These accounts highlight how power dynamics and social hierarchies erode mutual respect and collegiality. Participants associated these behaviours with a lack of Ubuntu, the African philosophy of humaneness, respect, and collective responsibility. The findings echo Nicolaides (2023:77), who notes that the erosion of Ubuntu within health organisations fosters instability, weakens team cohesion, and undermines compassionate service delivery. Ubuntu principles, when practised, reinforce shared humanity and counteract domination or exclusion based on professional or social standing.

Power misuse was further expressed through subtle forms of bullying, gossip, and marginalisation. Einarsen, Hoel, Zapf and Cooper (2020:3310) report that such behaviours contribute to psychological distress, absenteeism, and unsafe work environments, with as many as one in four health professionals experiencing workplace bullying. Participants' narratives in this study align with this trend, indicating that the absence of mutual respect and recognition negatively affects both morale and performance.

From a human-needs perspective, these behaviours represent violations of the lower and middle levels of Maslow's hierarchy of needs, particularly physiological, safety, and esteem needs. When individuals feel disrespected or threatened, their sense of belonging and motivation declines, reducing productivity and care quality. Shaw, Flott, Fontana, Durkin and Darzi (2020:1541) warn that inadequate protection of workers' dignity and safety equates to the denial of self-actualisation, which is essential for effective, compassionate healthcare.

In addition, Ehrlich et al (2020:3) emphasise that fostering self-care and mutual respect within teams is vital for healthy organisational culture. Cultural and emotional intelligence are central to this process. Binsaeed, Yousaf, Grigorescu, Condrea and Nassani (2023:2) argue that while many health professionals demonstrate strong cognitive intelligence (IQ), deficiencies in emotional (EQ) and cultural intelligence (CQ) hinder effective collaboration and sensitivity to diversity in the workplace.

Overall, the findings demonstrate that misuse of power, manifested through disrespect, professional hierarchy, or social bias creates toxic and unsafe work environments in rural CHCs. Promoting Ubuntu-based leadership, emotional intelligence development, and

equitable recognition of all professional roles can restore respect, strengthen teamwork, and enhance interprofessional collaboration.

5.4.6 Theme 6: Measures to enhance collaboration and secure partnership

Measures or interventions to promote collaboration and positive relations are suggested by participants based on their experiences. The four subthemes evolved are discussed below.

5.4.6.1 Subtheme 6.1: Avail the required resources to advance secure collaboration

Participants highlighted that sustainable collaboration within rural CHCs depends on the availability of adequate human, material, and infrastructural resources. The lack of security, poor physical infrastructure, and limited staffing were identified as core threats to safety, efficiency, and teamwork. The following excerpts illustrate participants' perspectives:

> "Install security to ensure doors have locks and burglar bars on windows. Set up a specialised unit for psychiatric patients to ensure safety of health professionals and clients." (GP-IDIA3)

> "Prioritise ventilation within the X-ray department and repair the roofing." (NW-FGA1)

> "Renovate and expand the structure to include a theatre unit and rebuild the autoclave area to reduce delays in patient transfer." (MP-FGB2)

> "Improve physical structures—fence the facility and provide security guards to reduce environmental stressors." (NW-IDIB1)

> "Ensure proper lighting in access areas to enhance night-time safety." (GP-IDIA1)

> "Increase security personnel for night shifts." (MP-FGB3)

> "Recruit additional staff to replace those who resign or retire." (NW-IDI03)

> “Introduce staff rotation to promote multi-skilling and competence.” (GP-FGB1)

> “Re-plan patient flow because the current layout is too wide and inefficient.” (MP-IDIA4)

These reflections underscore that a safe and functional workplace requires both physical and human resource investment. The participants’ emphasis on infrastructure, staffing, and workflow redesign demonstrates an awareness of how material conditions influence collaboration and psychosocial security.

The findings correspond with Lim, Bogossian and Ahem (2022:2), who emphasise that establishing a safe healthcare environment demands significant investment in human resources, infrastructure, and ongoing monitoring and evaluation systems. The creation of a safe and collaborative work culture, they argue, requires joint commitment between management and staff to prioritise occupational health, safety and interprofessional teamwork.

Across facilities, staff described inadequate physical security, doors without locks, absence of perimeter fencing, poor lighting, and insufficient security personnel as major safety hazards. These vulnerabilities were compounded by chronic shortages of clinical staff and infrastructural deficits such as poorly ventilated X-ray departments and the absence of theatres. The lack of these essential resources not only undermines service delivery but also heightens occupational stress and perceived personal risk among health professionals.

Participants also suggested ways to strengthen communication and skill exchange as complementary measures to improve safety and teamwork:

> “Daily interdisciplinary rounds in critical areas such as maternity and casualty provide a learning platform and continuity of care.” (NW-FGA2)

> “Conduct daily 15-minute updates and meditation sessions to promote social cohesion.” (MP-IDIA2)

> "Use memoranda and notice boards to communicate safety and therapeutic measures." (GP-FGB3)

The findings affirm that structured communication and joint problem-solving platforms can enhance collaboration and morale. Such practices align with the NIOSH (2019a:103) framework, which advocates interprofessional coordination and consistent information exchange to maintain psychological and physical safety in healthcare environments.

The researcher's findings further confirm that a safe workplace does not come cheap; it requires extensive investment on human resources, infrastructure, protective and work equipment, as well as effective monitoring and evaluation as recommended by Lim et al (2022:2). There is an essential need to have a strong collaborative effort, support, and commitment from top management and the workers to protect themselves and develop a plan that will be acceptable, preventative to maintain and avail resources in the CHC (Lim et al 2022:2).

In summary, the availability of resources, both material and human forms the foundation for secure, collaborative practice in rural CHCs. Investing in infrastructure, staff development, and structured communication systems promotes a sense of safety, belonging, and shared accountability. These are essential preconditions for the effective implementation of interprofessional and interunion partnerships envisioned in the IPUCP model.

5.4.6.2 Subtheme 6.2: Establish sustainable interprofessional and interunion collaborative partnerships

This subtheme focuses on the establishment of interpersonal and organisational partnerships that promote constructive relationships between health professionals, management, and organised labour within rural CHCs. Participants consistently emphasised that proactive engagement, transparent communication, and inclusive structures are essential to strengthen teamwork and ensure a secure, collaborative workplace.

> "Engage staff, be proactive rather than reactive on union-related matters such as Workers' Day celebrations or voting periods." (GP-IDIA2)

> “Develop a work plan that clearly defines each professional’s activities and responsibilities to minimise conflict and strengthen relationships.” (NW-FGA1)

> “Notice boards can improve communication while reinforcing safety and therapeutic awareness.” (MP-FGB2)

> “We hold weekly meetings to discuss challenges and in-service trainings; telephone and notice-board communication keep us informed of upcoming events.” (NW-IDIB3)

> “Monthly multidisciplinary team meetings should be considered to improve care quality and foster a positive working environment.” (GP-FGB2)

> “Multidisciplinary meetings with an external facilitator encouraged collaboration, increased audit activity, and improved care.” (MP-IDIA3)

Participants believed that structured collaboration between management and labour unions could enhance shared accountability, improve nursing care standards, and raise job satisfaction. Their recommendations reflect a desire for stronger interprofessional relationships that balance clinical, managerial, and labour interests.

These findings align with Pereno and Eriksson (2020:3), who assert that building collaborative partnerships between health professionals, organised labour, and management is central to effective interdisciplinary teamwork. The authors highlight the importance of shared networks, mutual trust, and technological tools that facilitate communication and innovation. Similarly, Fana and Goudge (2024:103) observe that within South Africa’s complex labour context, limited leadership capacity and inadequate understanding of labour legislation constrain cooperation in rural health settings. Targeted capacitation of all stakeholders, management, unions, and health professionals is therefore necessary to mitigate conflict and foster collaboration.

Participants further proposed mechanisms to strengthen interprofessional engagement and relationship-centred teamwork:

> “Create open, comfortable rest and tea rooms with round seating and sponsor weekly or bi-weekly high-tea sessions during off-peak clinic hours.” (GP-IDIB1)

> “Establish departmental core teams representing multiple health professions, chaired by the facility manager.” (NW-FGA2)

> “Form interdepartmental and multidisciplinary teams for both physical and online interaction through regular handover briefings.” (MP-FGB3)

> “Hold interprofessional meetings as platforms for shared learning and development.” (GP-FGB3)

> “Conduct interprofessional rounds led by senior professionals in key areas—casualty, maternity, mother-and-child—to discuss challenges and share best practices.” (NW-IDIB2)

These recommendations demonstrate health professionals’ awareness that structured platforms can nurture collaboration, mutual respect, and psychosocial safety. Schaufeli (2021:3) adds that employees who feel engaged and supported by leaders exhibit stronger trust, lower turnover, and improved innovation. The outcomes directly tied to sustained interprofessional partnership.

Although a minority of participants supported the continued use of WhatsApp groups for communication, others expressed concern about limited data access and potential misuse by management. This underscores the need for reliable, transparent, and professionally regulated communication systems.

Martin, Ummenhofer, Manser and Spirig (2021:7) reinforce that interprofessional collaboration enables professional groups to work cohesively toward shared goals, even within resource-constrained rural facilities. They define IPC as a “negotiated agreement among professionals who value one another’s expertise and contributions”. Continuous learning opportunities, interprofessional meetings, and joint ward rounds are therefore necessary to institutionalise collaboration and resolve workplace challenges promptly.

In summary, the findings confirm that sustainable collaboration requires intentional structures that integrate management, labour, and clinical teams. Establishing formal

interprofessional meetings, interunion partnerships, and multidisciplinary learning platforms will enhance trust, accountability, and job satisfaction. These strategies align with the core principles of the IPUCP model, emphasising relational leadership, mutual respect, and shared responsibility in advancing secure and collaborative rural health systems.

The findings conquer with the study of Pereno and Eriksson (2020:3) that affirms that establishing collaborative partnerships and promoting relationships between health professionals, organised labour and management through the interprofessional and interdisciplinary collaboration within health teams is vital. The authors further encourage that creating networks with good practices, promoting technology are a good fertile ground of collaboration and partnerships. Fana and Goudge's (2024:103) study is aligned with the findings that alerts that within the South African context the labour relations history is complex because health professionals, organised labour and management in rural areas have limited knowledge, skills and authority to manage escalating tensions. Therefore, capacitation of all role players about organised labour legislative prescripts and leadership is necessary.

Schaufeli (2021:3) alerts that the more the workers engage in their work and are having positive behaviour, the more they enjoy support and greater trust from their immediate team leaders and their respective teams in the workplace. Engaged health professionals are innovative, value each other as a team, and self-actualised perform better thus there is less turnover of staff. The challenges would be shared to have the best solutions and best practices. Even though the minority of participants were in favour of the utilisation of WhatsApp group for continuous communication, most participants found it destructive and cited disadvantages such as unavailable internet services and might be misused by the management to disrespect them.

5.4.6.3 Subtheme 6.3: Harmonising relations between health professionals, labour and management

Participants consistently emphasised that poor harmony between health professionals, organised labour, and management undermines collaboration and compromises the safety and therapeutic climate of rural CHCs. Unresolved grievances, dismissive

leadership behaviours, and weak or absent union engagement were perceived as major contributors to mistrust, conflict escalation, and professional fragmentation.

Several participants stressed the importance of functional and visible union representation at facility level to mediate tensions and protect staff interests:

> "Shop stewards are needed in CHCs to address issues that may arise between employees and management." (GP-IDIA4)

Participants further argued that union representatives should be democratically elected, trained, active, and impartial, in order to build unity and reduce fear-based interactions:

> "Proper democratic election of union representatives—trained, active, and objective—is essential to merge unity and collaboration between all health professionals and management without fear or favour." (NW-FGA3)

Organised labour was viewed as a critical partner in sustaining a therapeutic workplace, rather than as an external or adversarial structure:

> "Organised labour unions are needed as part of employees to be responsible for the therapeutic environment between staff and management." (MP-IDI03)

> "Unions can try more to engage staff, all health professionals." (GP-FGB4)

Management behaviour was equally highlighted as central to harmonising workplace relations. Participants described daily engagement, approachability, and active listening as key leadership practices that reduce conflict and promote trust:

> "Management can enhance a therapeutic and safer workplace by engaging with staff daily and listening to their queries." (NW-IDIB1)

Across narratives, participants associated collegiality, mutual respect, and shared responsibility with improved morale and collaboration. These findings align with the National Academies of Sciences, Engineering and Medicine (2019:3), which affirm that respectful interprofessional teamwork optimises resource use, strengthens working relationships, and prevents burnout.

These findings align with research showing that unmet professional needs can undermine wellbeing and teamwork in healthcare settings (Carroll, Collins & McKenzie 2025:1-9). Similarly, contemporary applications of caring theory demonstrate how relational engagement and recognition support collaborative practice and positive professional interactions (Curcio, Lommi, Zambrano Bermeo, Esteban-Burgos, Pucciarelli & Avilés González 2024:2179-2191).

In summary, harmonising relations between health professionals, organised labour, and management requires active union representation, relational leadership, and consistent dialogue. When unions are credible and present, management is responsive, and professionals treat one another with respect, a psychologically safe and collaborative environment can be achieved. These relational conditions form a core pillar of the IPUCP model, positioning harmony, trust, and shared accountability as prerequisites for secure and sustainable partnerships in rural CHCs.

Resolving issues raised by employees is very important. As such, ignoring complaints or becoming arrogant towards fellow employees is not helpful to avoid commotion and escalated conflict amongst HCPs. Healthy workplace environment results in positive service levels. The collegial, sharing attitude and treating each other with respect is a collaborative enriching behaviour as expressed by participants in these findings. The study by National Academies of Sciences, Engineering, and Medicine (2019:3) affirms that health professionals can work as teams to save resources, advance positive working relations and prevent burnout; thus, promote positive achievement of quality outcomes and a positive work environment for themselves. The findings confirm that engagement and recognition enhance self-esteem, belonging and progression toward higher-order professional needs among health workers (Carroll et al 2025:1-9). Contemporary caring-based practice further demonstrates how relational engagement strengthens professional connection and collaborative climates (Curcio et al 2024:2179-2191). Digitally supported communication systems, including telehealth platforms, also facilitate interprofessional connection and coordination in resource-constrained settings such as rural CHCs (Sauter, Nordmann, Schaller, Redlich & Fischer 2025:24).

5.4.6.4 Subtheme 6.4: Strengthening management and leadership roles and responsibilities

Participants across all three provinces reported that distant, inconsistent, and unresponsive leadership within rural CHCs perpetuates organisational dysfunction and undermines staff safety, communication, and collaboration. Leadership was commonly described as invisible, disengaged, and unaccountable, which allowed psychosocial risks and professional tensions to remain unaddressed.

The following quotes illustrate what participants identified as critical leadership behaviours to restore safety and foster collaborative cultures:

> "Proper handling of staff and to solve problems." (MP-FGB2)

> "Improve communication by holding regular staff meetings, make use of notice or bulletin boards for communication." (NW-FGA4)

> "Walk about approach to identify gaps in service delivery and possible health and safety risks in relation to shortages of staff as well as inspecting the physical environment." (GP-FGB3)

> "Management can enhance a therapeutic safer working place through engaging with staff on daily basis. Communicate with staff listening to their queries." (MP-IDIA2)

> "Establish health and safety teams in the facility and conduct regular meetings with them." (GP-IDIB1)

> "Meetings monthly between staff and management promote positive interpersonal relations to discuss and listen to the feelings of all health professionals." (NW-FGA1)

> "Be there for staff and follow *up on issues reported in the facility."* (MP-FGB5)

These insights reveal that leadership failures in rural CHCs are not merely procedural; they are deeply relational and structural. What staff experience is not only a breakdown

in systems, but a lack of presence, empathy, and responsiveness from facility management. The absence of ward walkabouts, safety meetings, and leadership follow-through weakens psychological safety and creates fear, silence, and mistrust.

This aligns with psychological safety theory, which holds that health professionals only raise concerns, learn from mistakes and collaborate effectively when leadership is inclusive, visible and responsive (O'Donovan 2023:3). In such environments, staff feel safe to speak up about risks, workload pressures and errors without fear of blame, enabling shared problem-solving and continuous improvement.

When health professionals do not experience psychological safety, they are less likely to voice concerns, collaborate or innovate. Psychological safety theory explains that the absence of inclusive and supportive leadership creates fear-based climates in which silence, defensiveness and disengagement become dominant, weakening both teamwork and service quality (O'Donovan 2023:6). Where this form of leadership is lacking, psychological risk increases, trust erodes and fragmentation is reinforced, undermining cooperation between professionals and destabilising workplace relationships (Dong, Wang, Huo & Zhu 2025:107). In rural and semi-rural CHCs, these conditions directly threaten safe interprofessional collaboration and the ability of teams to protect both patients and one another.

The application of Maslow's Hierarchy of Needs reinforces that without meeting foundational safety needs, health professionals remain anchored in survival mode, unable to ascend to higher-order functioning such as teamwork, professional identity, and collective efficacy (Dietl, Schmidt & Reyes 2023:299; Hayre-Kwan et al 2021:590). In rural CHCs, where safety is compromised, management must first address these primary needs to unlock collaborative potential.

Further, Watson's Theory of Human Caring is directly applicable to leadership practice in strained systems. Relational leadership behaviours such as empathy, listening, presence, and authentic engagement function as therapeutic practices that strengthen trust, cohesion and morale among healthcare teams (Smith 2021:568). When these are absent, staff experience emotional fatigue, disengagement, and institutional trauma. Recent health systems research confirms that proactive leadership practices such as walkabouts, structured team meetings, and routine feedback loops; are among the strongest

predictors of psychological safety and error reporting in healthcare settings (El-Ashry, Abdelrahman & Ali 2025:77). In particular, Weaver, Dy, Rosen, Pronovost and Hughes (2019:44) demonstrated that leadership visibility and regular safety huddles directly correlate with staff speaking up about errors and workplace risks.

In rural contexts, where geographic isolation and chronic resource constraints exacerbate stress, leadership presence becomes even more critical. Hartviksen, Eggen, Fjalestad, Løhre, Vassbø and Haugland (2024:5) found that in rural CHCs, leadership communication and emotional availability matter more than policy frameworks in shaping team culture.

Therefore, leadership in CHCs must be repositioned as a protective intervention central to risk management, staff well-being, and interprofessional collaboration. This demands institutionalising leadership visibility, responsive communication, and accountability mechanisms. This is not as discretionary practices, but as core operational functions that build trust, reduce fragmentation, and protect the therapeutic integrity of the health system.

In rural and semi-rural CHCs, weak leadership acts as a structural barrier to safe interprofessional and labour-management collaboration. Without visible, communicative, and accountable management, mistrust, risk, and fragmentation persist, undermining both staff wellbeing and primary healthcare performance.

5.4.6.5 Subtheme 6.5: Strengthening of training and lifelong learning practice standards

This subtheme emphasises the importance of lifelong learning and structured training as enablers of interprofessional and interunion collaboration. Participants proposed retraining, curriculum review, and CPD as critical strategies to transform workplace culture, strengthen competencies, and promote positive interpersonal relationships within rural CHCs.

> “The way training occurs, and even CPD, needs to be reviewed for all HCPs.” (NW-IDIB1)

> “Strengthen staff competencies—recruit more professionals with PHC experience rather than only placing community service officers.” (GP-FGB2)

Participants viewed ongoing education as essential for building collaborative attitudes, improving communication, and addressing entrenched behavioural and hierarchical barriers. They argued that retraining should focus not only on technical competence but also on social and emotional intelligence, conflict management, and leadership, skills that are often underemphasised in conventional curricula.

These findings align with Wagner, Rieger, Manser, Sturm, Hardt, Martus, Lessing, Hammer and WorkSafeMed (2019:2), who assert that improved workplace safety and collaboration stem from exposure to continuous training in occupational health, communication, small group facilitation, and root cause analysis. Similarly, Walmsley, Luhanga, Wainwright and Reid (2021:669) highlight that positive safety culture depends on mutual trust, shared perceptions of responsibility, and ongoing professional education.

Participants further proposed that training institutions should form stronger links with rural CHCs to facilitate work-integrated learning (WIL) and interprofessional education (IPE). However, despite several CHCs being accredited by the SANC and the HPCSA for clinical placements, participants noted that interprofessional integration remains limited. Current WIL models often promote siloed practice rather than collaboration across professions, contrary to the WHO’s (2010:1) framework for interprofessional education, which encourages learning with, from, and about each other’s roles.

> “Ensure consistent updates for all staff and make policies, protocols, and standard operating procedures accessible at service stations—not locked in the manager’s office.” (MP-FGB1)

> “Sharing knowledge empowers staff, promotes confidence, and encourages critical thinking rather than passive compliance.” (NW-IDIB1)

> “Rotate staff to ensure multi-skilling and competency.” (GP-FGB3)

> “Train staff on the role of teamwork in healthcare settings.” (NW-IDIB3)

> “Recruit and train professionals with PHC and leadership competencies for all CHC services.” (MP-IDIA2)

Participants underscored that training should not only focus on compliance or task performance but also on cultivating reflective, collaborative, and empathetic practice. Strengthened competencies through structured in-service training can reduce professional insecurity, enhance self-efficacy, and promote mutual respect among disciplines.

These findings correspond with Ho, Jarvis-Selinger, Borduas, Frank, Hall, Handfield-Jones and Reeves (2023:2), who describe the interdependent, independent, and trans-dependent relationships among health professionals as foundational to effective interprofessional collaboration. Similarly, Hakami, Almutairi, Al Otaibi, Al Otaibi and Al Battal (2020:1) affirm that recognising the mutual dependence of professional roles improves teamwork, communication, ethics, and job satisfaction.

Participants also challenged the traditional discipline-specific curricula that segregate health professionals during training. They recommended common foundational modules and joint clinical simulations to prepare graduates for collaborative work environments:

> “Review the curriculum so that common modules like Communication, Psychology, basic health procedures, suturing, admissions, and ward rounds are attended by all health professionals.” (GP-FGB2)

> “Continuous multidisciplinary team meetings should be simulated during training—not only taught theoretically.” (NW-FGA1)

> “Empower each professional to understand the complementary role they play in patient care.” (MP-IDIA3)

> “Inclusive in-service training should break the silos between health professionals.” (GP-FGB1)

The respondents shared opinions that suggest a review on retraining and empowerment and review of curriculum to change the current practice and adopt interprofessional education models that encourages mixed socialisation of all health professionals whilst

they learn from and about each professionals' roles and responsibilities. Consider a revised curriculum that will promote interprofessional and interunion partnership in workplaces, discouraging working in silos. The strengthening of training is supported by most participants who mentioned that training is helpful in ensuring multi-skilling and competency among themselves.

These perspectives resonate with the IPEC Core Competencies framework, which identifies interprofessional communication, roles and responsibilities, teams and teamwork, and values and ethics as essential domains for collaborative practice. Furthermore, drawing on Watson's Theory of Human Caring and Maslow's Hierarchy of Needs, continuous learning fosters professional confidence, belonging, and self-actualisation conditions necessary for compassionate, person-centred care in rural CHCs.

The study of Wagner et al (2019:2) affirms the participants' opinions, best practice standard and literature, which indicates that one of the solutions to improve safety is exposing health professionals to training courses, especially on occupational health and safety procedures, small group facilitation, shared perceptions and root cause analysis.

Walmsley et al (2021:669) concur with the inputs of participants that embracing interprofessional practices such as teams, positive leadership, communication to facilitate policy implementation, clinic administration and collaboration with professional associations. Health facilities that practice a positive safety culture characterised by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures (Wagner et al 2019:2)

Qualitatively, responses echoed this emphasis on the importance of shared learning, clinical simulations, and in-service training that foster mutual understanding among health professionals. This strong alignment supports the WHO (2010) call for early and deliberate exposure to interprofessional education (IPE) as a strategy to break down professional silos and promote collaborative practice (Gilbert, Yann & Hoffman 2010:196-197). The WHO framework highlights that students from two or more professions should learn *about*, *from*, and *with* each other to develop collaborative competencies and be ready for interprofessional practice upon graduation.

Qualitatively, responses echoed this emphasis on the importance of shared learning, clinical simulations, and in-service training that foster mutual understanding among health professionals. This strong alignment supports the WHO (2010:1) call for early and deliberate exposure to interprofessional education (IPE) as a strategy to break down professional silos and promote collaborative practice. The WHO framework highlights that students from two or more professions should learn *about*, *from*, and *with* each other to develop collaborative competencies and be ready for interprofessional practice upon graduation. These academic health institutions interrelate with health professionals when students are placed for work integrated learning (WIL) throughout their training, however they are not in line with the interprofessional education prescripts by the WHO (2010:1-5). Currently only one of the six CHCs is accredited by the SANC and the HPCSA to expose health professional students for work integrated learning (WIL). The clinical skills such as observing infection control, communication, problem solving, people management and comprehensive assessment of patients are inclusive for nurses, medical officers and allied professionals, yet the teaching and practice is done in silos.

This document is the most relevant WHO policy reference to substantiate statements on *collective responsibility, safe systems, and supportive work environments* as international priorities.

This framework reflects international patient safety and health workforce priorities that emphasise collective responsibility, safe systems and supportive work environments as the foundation of high-quality care (WHO 2021d: strategic objectives 1-6).

In conclusion, the strengthening of lifelong learning and training standards is central to achieving sustainable interprofessional and interunion collaboration. Reorienting curricula toward shared learning, continuous capacity-building, and reflective practice will promote professional respect, improve service quality, and nurture a culture of mutual care and collaboration envisioned in the IPUCP model.

5.4.6.6 Subtheme 6.6: Establish effective communication between health professionals, organised labour and management

This subtheme focuses on the importance of establishing effective communication channels and multiple communication platforms that strengthen partnership and

collaboration between health professionals, organised labour, and management. Participants highlighted that effective communication is the cornerstone of teamwork, trust, and psychological safety in rural CHCs.

> "Communication among health professionals can be enhanced by encouraging respect and professionalism." (NW-IDIB3)

The findings reveal that fragmented and inconsistent communication practices undermine collaboration and strain interprofessional and interunion relations. Participants emphasised that respectful and structured communication strategies can strengthen workplace relationships, improve coordination, and ensure a shared understanding of common goals.

These findings are consistent with Amoah et al (2019:1), who caution that clinicians require standardised communication tools and structured therapeutic techniques to maintain efficient communication and secure interpersonal relationships. Similarly, Kwame and Petrucka (2021:2) highlight that effective communication between health professionals, organised labour, and management mitigates unprofessional conduct, prevents boundary violations, and enhances decision-making, social support, and workplace safety.

Participants proposed several practical solutions to strengthen communication and promote a culture of respect, collaboration, and support within CHCs:

> "Improve by establishing more social cohesion activities, daily 15-minute staff meetings for updates, meditation, or a moment of silence." (GP-FGB2)

> "Encourage team-building games." (NW-IDIB2)

> "Use appropriate language when communicating in patients' presence." (MP-IDIA1)

> "Avoid ignoring problems between health professionals and ensure immediate problem-solving between professionals." (GP-IDIA2)

> "Provide support groups for personnel who are burdened by work-related problems." (NW-IDIB1)

> "Encourage addressing professionals' problems in private." (MP-FGB2)

The participants viewed communication not merely as a tool for information exchange but as a relational process that builds trust and collegiality. Effective communication practices can help reduce burnout, foster empathy, and promote teamwork in the workplace. The researcher affirms that structured communication platforms, coupled with mutual respect and emotional intelligence, are vital for achieving positive interpersonal relationships and a sense of belonging among health professionals.

These findings align with Drossman and Ruddy (2020:6), who assert that communication training reduces malpractice and enhances patient outcomes. Wagner et al (2019:2) further note that all health professionals act as leaders in their clinical spaces and that adopting transformational communication styles can inspire organisational change. Similarly, Spiegel et al (2023:14) reference the Joint Commission International (JCI) (2021:3) report, which warns that communication failures remain a leading cause of preventable patient deaths globally, a finding that underscores the urgency of improving communication practices even in low-resource settings.

The study findings confirm that rural CHCs face dysfunctional collaborative relationships between health professionals, unions, and management due to poor problem-solving strategies, weak communication systems, and limited cohesion. Participants' recommendations point toward the need for a structured communication framework that includes social cohesion activities, daily briefings, and safe spaces for professional dialogue.

In alignment with Maslow's Hierarchy of Needs, effective communication fosters belongingness, esteem, and self-actualisation among professionals, while Watson's Theory of Human Caring reinforces the relational aspect of communication as a form of therapeutic engagement. Within the IPEC Core Competencies, it reflects the domains of interprofessional communication, mutual respect, and teamwork essential for achieving the secure, collaborative partnerships envisioned in the IPUCP model.

5.4.6.7 Subtheme 6.7: Strengthening communication systems through interpersonal and technology-enabled platform

Participants identified ineffective communication as one of the most significant barriers to collaboration between health professionals, organised labour, and management in rural CHCs. Fragmented, inconsistent, and hierarchical communication practices were perceived to fuel misunderstandings, professional disrespect, delayed problem-solving, and emotional exhaustion.

Respectful interpersonal communication was viewed as the foundation of teamwork and psychological safety:

> "Communication among health professionals can be enhanced by encouraging respect and professionalism." (NW-IDIB3)

Participants stressed that unresolved interpersonal issues should be addressed promptly and privately to prevent escalation:

> "Avoid ignoring problems between health professionals and ensure immediate problem-solving between professionals." (GP-IDIA2)

> "Encourage addressing professionals' problems in private." (MP-FGB2)

Several participants proposed structured interpersonal communication platforms to promote cohesion, reflection, and shared understanding:

> "Improve by establishing more social cohesion activities, daily 15-minute staff meetings for updates, meditation, or a moment of silence." (GP-FGB2)

> "Encourage team-building games." (NW-IDIB2)

> "Provide support groups for personnel who are burdened by work-related problems." (NW-IDIB1)

In addition to face-to-face engagement, participants strongly advocated for reliable, technology-supported communication systems, noting that the absence of basic communication infrastructure undermines emergency response and coordination:

> "Develop a chat group and on-site information-sharing meetings where all health professionals participate, as well as an internal intranet and notice board." (MP-FGB2)

> "Set up ground telephones or a mobile phone per department." (GP-IDIA1)

> "Install internet and intranet emails, as well as WhatsApp communication platforms." (NW-IDIB3)

Participants also emphasised the need for visible and accessible communication tools to enhance safety and trust:

> "Use memoranda, notice boards, intercoms, panic buttons, and whistles across departments. When you are informed, you gain trust and security." (MP-FGB3)

While a minority supported WhatsApp groups for rapid communication, others raised concerns about data access, confidentiality, and misuse by management, highlighting the need for professionally regulated and inclusive communication systems.

These findings are consistent with Amoah et al (2019:1), who caution that clinicians require structured communication tools to maintain therapeutic relationships and prevent conflict. Kwame and Petrucka (2021:2) similarly assert that effective communication between professionals, unions, and management enhances decision-making, social support, and workplace safety. International evidence further confirms that communication failures remain a leading cause of preventable harm in healthcare, reinforcing the urgency of strengthening communication systems even in low-resource settings (Joint Commission International [JCI] 2021:3; Spiegel et al 2023:14).

In alignment with Maslow's Hierarchy of Needs, effective communication supports belongingness, esteem, and self-actualisation, while Watson's Theory of Human Caring positions communication as a therapeutic and relational act. Within the IPEC Core Competencies, communication reflects mutual respect, role clarity, and teamwork.

Strengthening communication through integrated interpersonal and technology-enabled platforms therefore represents a core enabler of the secure, collaborative partnerships envisioned in the IPUCP model.

CHC is a complex workplace composed of diverse health professionals who function independently, co-dependently, and interdependently, sharing equal responsibility for maintaining a safe and efficient working environment. Communication between various departments and professional groups occurs continuously to coordinate care, exchange information, and support daily operations. Participants emphasised that effective communication structures are essential to strengthen collaboration and build mutual trust across professional and organisational boundaries.

> “Improve by establishing more social cohesion activities, daily 15-minute staff meetings for updates, meditation, or a moment of silence.” (NW-IDIB2)

> “Organise team-building trips for personnel to strengthen relationships outside the workplace. Celebrate each other’s birthdays and attend each other’s funerals.” (GP-FGB1)

The findings confirm that participants value diverse, inclusive communication platforms that promote social cohesion, teamwork, and multidisciplinary engagement. Participants called for structured interdepartmental, interprofessional, and interorganisational communication forums to foster belonging, understanding, and trust among health professionals. This aligns with Lecouturier (2022:3), who observed that the absence of interpersonal communication and teamwork weakens collaboration and negatively affects the quality of healthcare delivery.

The findings further indicate that communication between management and frontline workers is often limited or inconsistent. Participants expressed concern that management’s weak communication practices were exacerbated by the absence of functional labour union structures, leaving health professionals without effective support systems or avenues for grievance resolution.

Given the global shift toward digital health systems, participants highlighted the role of technology as a powerful enabler of communication and collaboration. They proposed

the adoption of blended communication methods, integrating digital and interpersonal tools to ensure inclusivity, efficiency, and transparency across the CHCs:

> “Develop a chat group and on-site information-sharing meetings where all health professionals participate, as well as an internal intranet and notice board.” (MP-FGB2)

> “Set up ground telephones or a mobile phone per department.” (GP-IDIA1)

> “Install internet and intranet emails, as well as WhatsApp communication platforms.” (NW-IDIB3)

> “Use memoranda, notice boards, intercoms, panic buttons, and whistles across departments. When you are informed, you gain trust and security.” (MP-FGB3)

These findings are consistent with Stockton, Fowler, Debono and Travaglia (2021:8), who urge policy makers, health managers, and educators to prioritise sustainable communication systems as part of interprofessional and interunion collaboration initiatives. Effective communication strategies should incorporate human resources, infrastructure, and digital tools to build trust, safety, and dignity among professionals.

The findings also support the Interprofessional Collaboration Union Partnership (IPCUP) Model, which reflects the principles of the 17th United Nations Sustainable Development Goal (SDG 17), Partnerships for the Goals, emphasising inclusive and technology-driven collaboration between multiple stakeholders (Kwame & Petrucka 2021:2)

These findings align with Kwame and Petrucka (2021:2), who affirm that multiple, technology-enhanced communication tools strengthen collaboration between professionals and stakeholders, improve health outcomes, and advance system-wide responsiveness. Strengthened communication systems thus represent a fundamental pillar of effective interprofessional collaboration and a vital enabler of secure, resilient, and equitable rural healthcare.

Participants unanimously agreed that each department or service station within the CHC should have a dedicated communication line, such as a mobile phone or landline to support urgent communication and emergency coordination. They further recommended

the installation of reliable internet connectivity to facilitate email, intranet, and social media communication.

5.5 DISCUSSION OF FINDINGS

The qualitative findings revealed the challenges and solutions to collaborative partnerships and mutually secure relations between health professionals and union representatives in rural and semi-rural CHCs. The shortage of human resources, limited resources and dysfunctional infrastructure, poor communication, dysfunctional organised labour and poor leadership and management support are disadvantageous collaboration between all role players.

5.5.1 Heath professionals and trade union as key role players

The experiences of health professionals and trade union collaborative partnership for mutually secure workplace in rural CHCs include the findings that uncovered the challenges that impact collaboration partnerships and recommendation are discussed here. The conclusions confirm the limitations between health professionals (health professionals) and organised labour representatives in rural CHCs in the Mpumalanga, Northwest and Gauteng province do deter collaborative partnership and rural CHCs that are not mutually secure. Health professionals are duly trained and experienced individuals in the provision of healthcare programs, services, and activities at the designated health facilities in accordance with their training, experience, or considerations deemed to be relevant by their employer (Mabusela & Ramukumba 2021:1). They include the medical doctors, nurses, physiotherapists, dietitians, radiographers, dentists etc. at the service level and management level within the CHCs.

The organised labour are the union representatives that are employed as health professionals who are nominated by employees within the CHC to represent them and defend their working conditions according to the Labour Relations Act (No. 66 of 1995) (South Africa 1995:22). The findings are responding to the research aims of exploring lived experiences on collaboration between health professionals and unions for prospects of mutually secure rural CHCs and explore possible measures to be employed in strengthening the collaboration between health professionals and trade unions for a prospect of secure CHCs.

- **Inadequate resources**

The findings uncovered the experiences of health professionals and unions and limitations that are a threat to collaboration between health professionals and union representatives. Idowu's (2023b:223) study is aligned to these findings, that inadequate resources, which include shortage of diverse health professionals, lack of resources that prevent and control infections, insufficient items for secure and collaborative work, unsafe infrastructure and limited working space contribute to a compromised insecure workplace which significantly hinders effective interprofessional collaboration in rural CHCs. The experiences of the participants are in line with Idowu's (2023b:223) study that the lack of funds, inadequate welfare and poor state of health facilities have demotivated health professional due to unsafe state of health facilities in rural areas. There is a relationship between safety and encompasses the availability of resources, skilled competent health professionals, positive practices and compliance with legislation in a healthy working place and the skilled workforce makes it easier to adapt to changes (Idowu 2023b:223). The shortage of health professionals and limited skill mix, and incompetent health professionals are confirmed to be a barrier in this study. The ICN (2019:8) indicated that it is imperative for CHCs to embrace legitimate recruitment procedures and enhance trust and confidence in health professionals, to achieve impactful nurses. The South African workforce training and capacity building is implemented through implementation of the Skills Development Act (No. 97 of 1988) which provides funds to employees to attend various training as part of the investment to employees, the labour force (Idowu 2023a:24), however, this study seems to suggest that the rural health professionals and union representatives are not benefiting accordingly.

The personal protection equipment (PPE) relates to availability of all critical resources in health facilities which are affirmed in the Occupational Health and Safety Act (No. 85 of 1993 to ensure a safety environment in the rural CHCs includes all resources shared by participants in this study. The resources for a safe hand wash, safe infrastructure and competent health professionals are all part of essential tools of the trade for health providers that advance collaborative relations and secure partnership.in rural CHCs. The findings confirm that absence of such resources will contaminate the environment and create conflict, barriers between health professionals, organised labour and management, thus limiting a collaborative and a mutually secure workplace. The

noncompliant physical structures are not compliant with the occupational health and safety legislation prescripts (Occupational Health Act (No. 67 of 1994); this is a direct violation of human dignity and failure to meet the Watson's and Maslow's first and second stage of needs.

The current CHCs physical structures are not compliant with the occupational health and safety legislation prescripts (Occupational Health Act (No. 85 of 1993)); this is a direct violation of human dignity and failure to meet the Watson's and Maslow's progressive needs which states that the basic needs must be met first before the higher needs are met (Aliyu 2019:83). There is a relationship between resources, safety and collaboration, thus if health professionals do not feel safe, they will not be able to develop teamwork, collaborate thus serving one another as role players within the CHCs, the health professionals, union representatives and management. The findings connote with the two hierarchical needs Maslow's and Watson's that people continuously strive for personal achievement in stages until the stage of self-actualisation with positive outcomes, trust, teamwork, safety and productivity.

Rutala and Weber's (2019:9) study supports that the identified threats in this study are the responsibility of all employees to ensure that sources of infection such as dust, dirt, spilled body fluids clean toilets and other contaminated material are removed and are properly disposed to secure a scrupulously clean environment that prevent spread of microbes that might lead to nosocomial infections and outbreaks. A non-infectious environment creates positive results whereby employees have felt mutually secure due to rich interpersonal relationships with therapeutic compassionate communication techniques and solid teamwork (Rutala & Weber 2019:9).

The findings in this study confirmed that the cracked walls, insufficient consulting rooms, not well-ventilated consulting rooms and secure doors and windows are noncompliant physical structures which are not compliant with the occupational health and safety legislation (Occupational Health Act (No. 67 of 1994)). This is a direct violation of human dignity thus failure to meet the Watson's and Maslow's first and second stage of needs threatened collaboration and secure relations within the rural and semi-rural CHCs (Aliyu 2019:83).

The *Five Moments for Hand Hygiene*, as outlined by the WHO (2021e:2-5) remain the global standard for understanding, training, monitoring and reporting hand hygiene, specifying key times during patient care when hand cleansing is critical. The findings confirm that the national call in South Africa in 2020 expressed in the practical manual for implementation of the (NDoH 2020:10) is not complied with in the rural CHCs. Health workers all as a collective must take an intentionally independent minute by minute decision to implement infection control and prevention practices in their behaviour as a core competency. The management has a responsibility to provide the resources, and organised labour must perform its monitoring duties as stated in the law.

- **Ineffective management and leadership**

The findings in this study confirm that ineffective management and leadership in the rural CHCs such as poor leadership and management skills, discriminatory practices, absent structures induction, in-service and CPD programme and non-collaborative enhancing systems and practices impact on collaboration and mutually secure relationships. The participants' views agree with those expressed by Tria and Hutami (2019:19), who confirm that the support given by the employer increases employees' job engagement cognitively, emotionally and physically this meeting one of Maslow's hierarchy of needs level two and three.

Support relates to the social and esteem level of Maslow and Watson by management, union and employees themselves, where the role players build relations and are competent and play their roles and responsibilities with grace (Aliyu 2019:83). The findings affirm that health professionals in CHCs due to their curriculum and graduate attributes are capacitated with leadership and management skills to advance positive interactive, intra-active and independent relations.

The process of this level of support signifies the value of emotional intelligence (EI) by all role players who collectively assist to promote the awareness, control, and expression of one's emotions and the ability to handle interpersonal relationships judiciously and empathetically by all role players in the rural CHC (Sharp et al 2020:433). The findings in this study affirm the impact of positive behaviour, emotional intelligence by each health professional is directly related to positive partnerships, collaboration and mutually secure CHCs.

These findings can be further argued considering the study by Laser and Bolton (2022:390) who acknowledged that the bottom-up practices suggested by participants in rural CHCs versus formal organisation practices are beneficial in workplaces with resource constraints, dignity challenges and disrespectful practices. The consideration of involving all role players and upgrading competency of staff members confirms that it will promote respect, self-awareness and dignity, thus promoting a positive workplace. Laser and Bolton 2022 warn that this approach comes with limitations as not all employees and workplaces would easily embrace this opportunity, be ready to manage this change.

It is imperative to avoid any dyadic conflict which might occur due to social episodes marked by overt behavioural oppositions (Stephensons & DeLongis 2020:18). According to Albert and Pappas (2024:32), relationships are a challenge and have a tendency of interfering with the ability of professionals to work with one another as partners, collaboration is essential in creating synergy to provide efficiency safe and high-quality positive work environment and health outcomes (Wei, Corbett, Ray & Wei 2020:324). The experiences and barriers are clearly a factor in rural CHCs and delay IPC and inter union collaboration for mutually secure relations.

- **Ineffective and inefficient communication**

The findings alert that ineffective and inefficient communication between all three role players within the rural CHCs to sustain or break collaboration and mutual safe relation between health professionals, union and management is at a low level. Furthermore, the findings affirm that social cohesion is necessary in dense networks which facilitate social interactions and coordinate collaboration thus promoting the Maslow's and Watson love belonging and communication needs. This promotes self-determination of health professionals within the organisation whose action will promote greater access to information within their networks (Bouwer, Pasquini & Baudoin 2021:2). Caution is cited by Spiegel et al (2023:33) that "studies have shown that seventy-one percent of malpractice techniques are the results of communication problems. Therefore, it is advantageous to strengthen therapeutic communication in the curriculum of HCPs that is to be applied in the workplace (Spiegel et al 2023:33).

The findings highlight that the rural CHCs require an integrated communication system that is technology driven and accessible to all to enhance interprofessional collaboration. This conquers with the study by Sauter et al (2025:3) who asserts that the need for a structured communication framework where all role players are committed to and invest in digital tools to bridge the uncovered communication gaps that threaten interprofessional collaboration. Academic health institutions engage with health professionals through the placement of students for work-integrated learning (WIL) across the duration of their training; however, these engagements are often not aligned with the interprofessional education (IPE) prescripts advocated by Gilbert et al (2010:197). Communication is a barrier to be considered from the shared experiences of health professionals in rural CHCs in the three provinces, yet positive communication promotes positive relations and partnership as confirmed in this study.

Gundle, Munroe-Gray and Academic Collaborative on Equality and Inclusivity in Surgery (ACEIS) (2023:803) discredit the rota staffing model as it does not foster group cohesion and collaboration between health professionals working in the same CHC. Nurses who make up over 80% of the health professionals in rural CHCs, allied health professionals and medical doctors who rotate in different CHCs fail to forge positive relations, share best practices because they never meet, as they report on duty in permanent separate. The model is not advancing the interprofessional collaboration practice competencies that are critical to advance positive interpersonal relations, group cohesion and positive work relations (IPEC 2023:1). The health professionals share their experiences only when there is a problem and once a week.

The findings confirm that it extends from staffing coordinators, supervisors and health professionals to ensure that the working schedule is balanced with necessary staff as well as sharing messages and facilitating communication across the facility. Findings argued by participants from all six sites that WhatsApp communication is not driven by technology, they have no efficient internet, only one mobile phone with no compensation. Overall, the silo groups with multiple WhatsApp groups for communication which is not promoting interpersonal collaboration in the rural CHCs s. The findings concur with Deng et al (2023:404) who assert that technology driven communication promotes collaboration. The growing interprofessional communication could be beneficial in assisting the individuals to respect one another and to cope with stress daily (Schot et al 2020b:338).

Furthermore, O'Daniel and Rosenstein (2021:283) support these findings that health professionals could utilise communication skills to convey the message to one another, and appropriate communication guarantees the better psychological position and satisfaction of recipients and peers in the workplace.

On the other hand, Nordin, Sturge, Ayoub, Jones, McKee, Dahlberg, Meijering and Elf (2021:2) affirm that although communication technology provides quick access to information and improves health services it implies loss of valued personal contact. A balancing factor should be a choice with greater utilisation of communication driven technology noting the findings in this study that supports maximum utilisation of technology to strengthen partnership and collaboration between health professionals, organised labour and management in rural CHCs.

- **Dysfunctional organised labour**

The findings of this study highlight that dysfunctional organised labour in rural CHCs is of significant concern. These findings align with Hlatshwayo's (2020:13) analysis of community health workers in South Africa, which shows that although trade unions are formally mandated to advance worker protection and workplace justice, their capacity to represent and support frontline health workers is often constrained in practice. In poorly resourced and geographically dispersed rural CHCs, union representatives face long travel distances, limited communication infrastructure and inadequate organisational support, all of which undermine effective representation.

The Labour Relations Act 66 of 1995 provides for the election of trade union representatives (shop stewards) based on workplace-level union membership thresholds and grants organisational rights intended to support collective bargaining and representation. However, this threshold-based model is poorly aligned with the organisational realities of rural primary healthcare, where small staff complements, multi-union fragmentation and wide geographic dispersion often prevent individual unions from qualifying for facility-based representation (Hlatshwayo 2020:13; Labour Relations Act 66 of 1995). Consequently, union representation is typically organised at district level, with a single shop steward responsible for members across multiple clinics operating under different managerial, interpersonal and service delivery conditions. This arrangement

constrains timely and context-specific grievance handling, weakens labour–management engagement and erodes workers' access to procedural justice, dignity and protection as envisaged in the Labour Relations Act and the Occupational Health and Safety Act 85 of 1993 (Hlatshwayo 2020:13; Venter 2019:31). These findings indicate a structural misalignment between national labour representation frameworks and the lived realities of rural healthcare workplaces, underscoring the need for context-sensitive adaptations to ensure equitable and effective union representation in dispersed primary healthcare systems.

This becomes challenging to cope with and therefore members experience the nominated union member as absent, invisible and neglecting her role. The outcome from the study appreciates the solutions sponsored that the labour relations policy be reviewed to suit rural CHCs dynamics.

The government's labour department shifted from cautious, incremental changes in the health sector to more radical structural reforms that include the rural facilities shape the implementation of union roles effectively (Shierholz et al 2023:34). Responses from participants suggest that shop stewards are not visible in rural facilities.

The findings shared by participants lament the need for good working relationships between managers, health workers and labour union members, which are in alignment with the findings by Gordon (2020:169). The study affirms that it is vital to resolve the issues between healthcare managers, unions and management through continuous vulnerability assessment of the health facility and creating an environment that motivates employees that allows employees to express themselves without fear of being victimised. The findings seem to support initiating integrated health systems such as the labour, interprofessional and management partnership strategy to resolve challenges and establish harmony within the CHCs (Angwenyi, Aantjes, Bunders-Aelen, Criel & Lazarus 2020:10).

Noting the suggested partnership is only possible in some areas where union representatives are available and supported by employees and management (Roczniewska et al 2024:1104). The implication is that the CHC staff is represented by shop- stewards who may be unfamiliar with the clinical dynamics of the members.

Labour representatives are all still duty-bound by their mandatory responsibilities and roles to fully implement their professional pledges and comply with the prescripts of the Occupational Health and Safety Act (No. 85 of 1993). The Occupational Health and Safety Act stipulate the establishment of a safe and harmonious partnership and interpersonal working relations between nurse managers, nurses, and organised labour (nurse shop stewards). This collaborative alliance is collectively tasked with creating a safe and positive workplace culture that inculcates employee well-being and reduction of health risks, as well as enforcement of accountability, collaboration and partnership (Liu, Liu, Liu, Baggs, Wang, Zheng, Wu, Li & You 2021b:7).

Taken together, these findings raise a substantive policy concern regarding the suitability of current labour relations legislation for rural primary healthcare contexts. While the Labour Relations Act 66 of 1995 and the Occupational Health and Safety Act 85 of 1993 provide important protections and organisational rights, their workplace-based and threshold-driven models of representation are premised on relatively large, stable and co-located workforces. The empirical evidence from this study shows that such assumptions do not hold in rural CHCs characterised by small staff complements, multi-union fragmentation and geographic dispersion. As a result, statutory mechanisms intended to secure representation, procedural justice and workplace safety become weakened in practice. These findings therefore point to the need for a review and contextual adaptation of labour relations frameworks to ensure that the rights and protections envisaged in national legislation can be realised equitably in rural and peripheral healthcare settings.

- **Ailing interprofessional interunion relations**

The findings in this study confirmed that the health professionals, union and management in rural and semi-rural CHCs experienced ailing IPUCP which threatens the secure relations and achievement of Watson's and Maslow's hierarchy of needs. Therefore, the importance of effective cross-cultural management in healthcare is increasingly acknowledged as it permits the appropriate promotion of competitive secure and positive interpersonal partnerships (Binsaeed, Alsubaie, Alharbi, and Alqahtani (2023:2) as cited by participants. Schultz and Schkade (2020:13) affirm that a therapeutic environment provides employees with a healthy easy choice to mitigate potential occupational and safety risks, and it is a personal commitment in daily work life.

The perceived poor interpersonal relationships between health professionals, management and union representatives intoxicate the working environment. The findings are supported by the study of Huei, Mansor and Tan (2020:17) who shared that good working relationships cause individuals to feel that other members within the organisation give attention to them, support them and contribute to them. This is in line with the Caritus theory, people reply by giving best to co-workers, supervisors and organisation, not disrespect, bad mouth and sabotage one another. Furthermore, Cardiff, Sanders, Webster and Manley (2020:11-12), alert that good working relationships between workers, supervisors, and colleagues' results in achievement of Maslow's levels which includes the psychological, safety and belonging (availability to one another), self-esteem and self-actualisation needs. The process of creating psychological safety for teams of health professionals enables professionals to develop authentic interprofessional relationships and positive health actions (Cardiff et al 2020:11-12).

The emphasis on work organisation, leadership responsiveness, and worker participation mirrors participants' calls for walk-abouts, safety committees, and psychosocial support systems. In this regard, NIOSH's Total Worker Health® approach provides a coherent theoretical lens through which the study's integrated quantitative and qualitative results can be interpreted.

The NIOSH (2019b: para 5) Total Worker Health framework cautions that sustainable workplace safety requires collective attention to both the physical work environment and the psychosocial conditions of work

The NIOSH Total Worker Health framework conceptualises workplace safety as an integrated system that simultaneously addresses physical hazards, psychosocial work conditions, organisational culture, and access to health resources (NIOSH 2019b: para 3-6). This approach integrates occupational safety and health protection with policies, programs, and practices that address injury prevention and worker well-being holistically, including work organization, workplace culture, and access to supportive health resources for employees and the community. Rather than viewing occupational safety and worker wellbeing as separate domains, the model requires employers and employees to act collaboratively in creating environments that promote both injury prevention and psychological health. This perspective directly aligns with the present study's findings, which demonstrate that interprofessional conflict, union disengagement,

and emotional exhaustion in rural CHCs are driven not only by material shortages but by unsafe organisational cultures and weak relational governance.

During the global plan of action for workers' health, emphasis was placed on health safety and psychological wellbeing in the work environment, including work organisation and culture and countries have endorsed the compulsory improvement of health for all workers (NIOSH 2019a:7). In South Africa the arguments are relevant as findings concur with Salmon and Walji (2019:305) that different knowledge, shared skills and insights, listening and learning with an open posture, and having a common ground assist to build a strong foundation for continuing collaboration (Salmon & Walji 2019:305-307).

Embracing the proposed global guidelines as asserted by Dehury (2022:5) that the government together with health professionals and unions are to develop health laws, health frameworks and regulations that promotes interprofessional collaboration, safe workplaces and protects health professionals. Additionally, the World Health Organization reminds health professionals that the Declaration of Alma-Ata articulated a holistic understanding of the interdependence between health, social development, economic wellbeing and the recognition of health as a fundamental human right (WHO 2019c:7). This foundational philosophy underpins modern primary healthcare approaches and is reflected in South Africa's health system reforms, including the National Health Insurance framework. In conclusion, achieving sustained collaboration and secure working relationships in rural CHCs requires a balanced and coordinated approach that includes competent health professionals, engaged trade unions, responsive leadership, robust health legislation, and ongoing professional education. Only through intentional alignment of these elements can interprofessional collaboration be strengthened, workplace safety be enhanced, and the core tenets of primary healthcare be realised in rural settings (WHO 2019b:15 WHO 2019c:8).

- **Measures to enhance collaboration and secure partnership**

Findings confirm that whilst challenges infest rural CHCs the measures to enhance interprofessional interunion collaboration to achieve mutually secure partnership is an open possibility. Xiu's (2021:64) study confirmed that the labour-management partnership model has been unsuccessful due to unfulfilled promises, unbalanced adoption and failed outcomes from both parties. Furthermore, Xiu (2021:65) warns that organisations and

unions as a collective must make an exerted effort to reconfigure the form and content necessary to manage workplaces better because of the weaknesses of unions, their declining power and non-substantive provisions and health professionals' experiences uncovered in this study. Therefore, there is an opportunity to embrace measures sponsored by participants and for the researchers to develop guidelines that enhance IPUCP in rural CHCs.

In South Africa the full compliance of employees, unions and management in workplaces including rural CHCs in line with the Occupational Health and Safety Act (85 of 1993) is compulsory although according to the research findings compliance is not monitored (Tresolini et al 2019:4). It remains a debate priority for countries to strengthen and close the gaps as emphasised in the SDGs 8 for decent work and economy and SDG 17 for the significance of partnership which are included in the Occupational Health and Safety Act (No. 85 of 1993). Most participants maintained the need for improved communication using multiple platforms, use of technology, and embracing safety therapeutic measures that would alleviate conflict and promote meditation and social cohesion.

Tresolini et al (2019:4) state that workplace challenges are best solved by the people who are conversant with their own daily activities because they best know how and what are the applicable long-term problem-solving strategies. The participants sponsored solutions to the challenges on safe collaborative partnership from the qualitative questionnaire and the interviews are viewed as relevant and critical. The participants' findings on measures to enhance IPCUP are aligned with Pomey, Clavel, Nomandin, Del Grande, Philip Ggadiri, Fernandex-McAuley, Boivin, Flora, Janvier, Karazivan and Pelletier (2021:1247) that improve strategic interventions on working conditions and secure workplaces such as recruitment of skilled and diverse health professionals, plan for allocation of resources, improvement of infrastructure and fostering of partnership between health professionals, union and management. Kreedi, Brown, Marsh and Rogers (2021:94), partnership is a form of collaboration that can overcome conflict, transfer cross sectional learning and turn differences into synergies between parties that inspire prosperous relationships with communal responsibility in clinical decision making.

The provision of secure health professionals is a basic legal and professional requirement, especially for health professionals who must contend with challenges such

as limited resources and rural community dynamics to provide comprehensive health services for patients (Pomey et al 2021:1247).

The study by Cullati et al (2019:43) cites problematic power dynamics, poor communication patterns, lack of understanding of one's own and others' roles and responsibilities, and conflicts might develop due to different personalities of individuals working together and might vary based on their duties. It is a threat to team (interprofessional) relations and security in the CHC (Cullati et al 2019:43). Interprofessional conflict, power imbalances, and role ambiguity are recognised internationally as major threats to workplace safety and team performance. The Organisation for Economic Co-operation and Development (OECD (2021:7-9) confirms that unsafe organisational cultures characterised by weak communication, unclear responsibilities, and unequal power relations undermine worker wellbeing and the quality of care. In healthcare settings, these dynamics lead to increased conflict, disengagement, and psychological harm, ultimately reducing professional collaboration and service effectiveness.

The OECD further emphasises that a safe workplace is not only a physical condition but a governance and relational system, requiring transparent communication, shared accountability, and leadership responsibility to protect staff from harm (OECD 2021:10; OECD 2023:4). These findings directly support the present study's evidence that dysfunctional labour relations, poor management communication, and professional hierarchies erode safety and interprofessional trust within rural Community Health Centres.

5.6 SUMMARY

In this chapter, the results of the qualitative research designs, the focus group discussions and in-depth interviews were presented. The findings revealed deep- seated systemic, structural and relational challenges that compromise the development of mutually secure and collaborative partnerships among health professionals, union and management in rural CHCs. The inadequate resources, ineffective leadership, poor communication, violation of the regulatory legislative frameworks and dysfunctional union representatives thus hinder compliance to Maslow and Watson hierarchy of needs including legislative prescripts.

The findings further affirm the need for systemic reform that aligns organisational policies, human resource practices and communication infrastructure in rural contexts. Chapter 6 integrates the quantitative and qualitative findings to generate meta-inferences that inform the development of the IPUCP model in Chapter 7.

CHAPTER 6

INTEGRATION OF QUANTITATIVE AND QUALITATIVE DATA

6.1 INTRODUCTION

Chapter 6 presents the integration of the quantitative and qualitative findings generated during the study. Rather than reporting the two datasets independently, the chapter brings them together to provide a comprehensive understanding of the factors influencing the establishment of safe interprofessional and union collaborative partnerships within rural CHCs. Integrating the findings enabled areas of convergence, complementarity and divergence to be identified, thereby strengthening the interpretation of the results and providing a richer understanding of the phenomenon under investigation.

6.2 THE INTEGRATION PROCESS

Data integration was undertaken after the completion of both empirical phases of the study. The quantitative phase comprised 42 completed questionnaires, while the qualitative phase consisted of three focus group discussions (FGDs) and ten in-depth interviews (IDIs). According to Creswell and Inoue (2024:426-433), integration enables the synthesis of statistical findings and qualitative insights to generate a more comprehensive understanding of the phenomenon under investigation. In this study, the quantitative and qualitative datasets were integrated to identify areas of convergence, divergence and expansion, thereby strengthening the interpretation of the findings. Consistent with the explanatory sequential mixed methods design, the integration process enabled participant experiences to explain, contextualise and extend the quantitative results (Creswell & Inoue 2024:426-433).

The integration strategy was designed to harness the complementary strengths of quantitative and qualitative evidence, thereby providing a richer understanding of the psychosocial, organisational and relational dimensions of the study (Wipulanusat, Panuwatwanich, Stewart & Sunkpho 2020:490). The process focused on integration during interpretation through the use of joint displays and the generation of meta inferences, which synthesised numerical findings with participants' experiences into

coherent theoretical explanations (Clark 2023:145; Guetterman & Creswell 2020:156; Poth 2021:84). This approach is consistent with Lehmann and Gilson's (2019:417) recommendation for inclusive, contextually grounded and methodologically diverse health systems research. The integration process was implemented in three sequential phases, as illustrated in Figure 6.1.

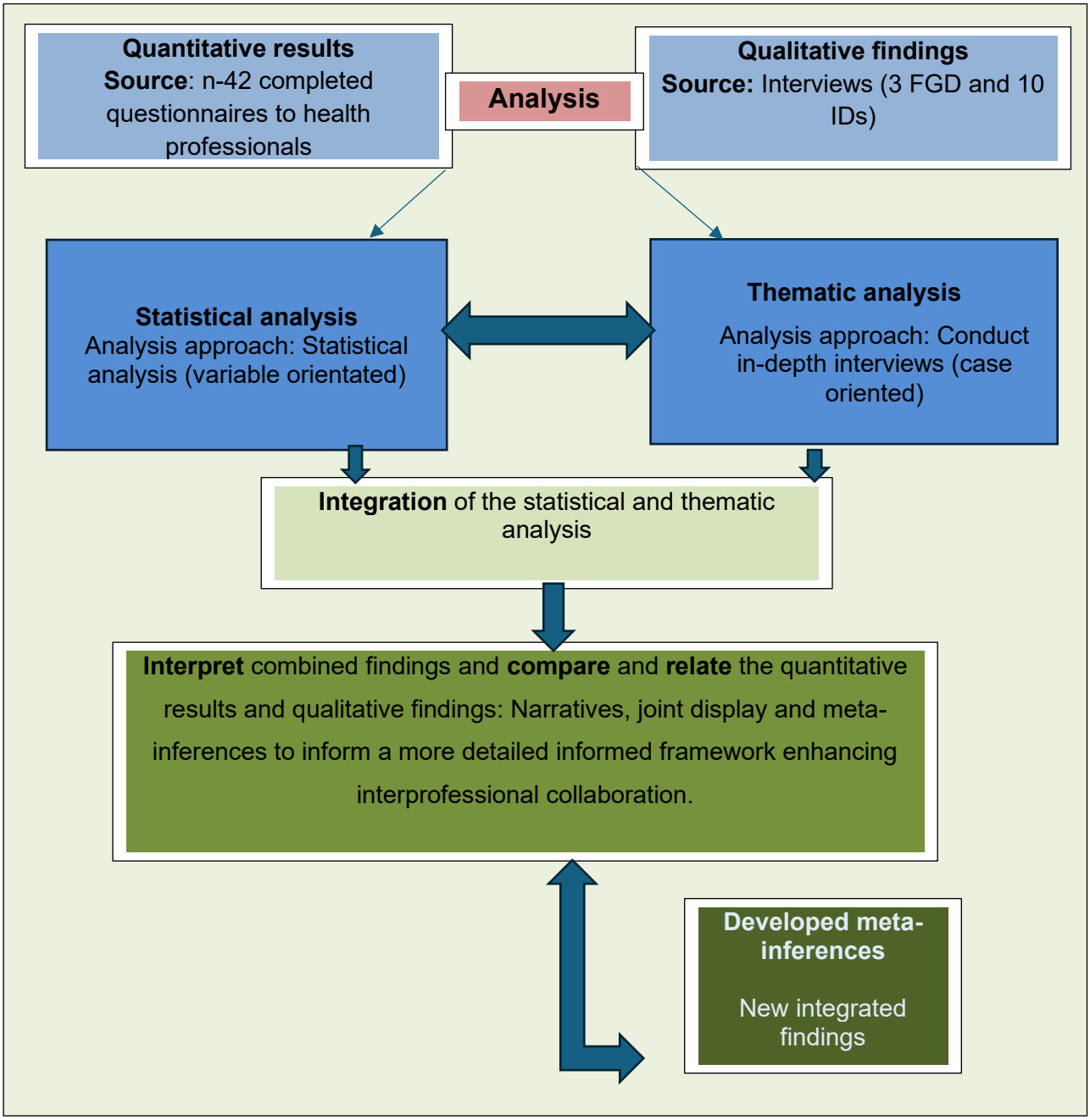


Figure 6.1 Process of qualitative and quantitative analysis and integration

Figure 6.1 illustrates the process of quantitative and qualitative data analysis and integration followed in this study. It demonstrates how findings from both strands were systematically brought together to achieve complementarity, identify areas of

convergence and divergence, and generate meta inferences that informed the overall interpretation of the integrated results.

6.2.1 Data integration approaches

The management of data in this study followed the sequential explanatory mixed methods design, whereby quantitative and qualitative data were managed separately before being integrated during interpretation. Quantitative data were organised to facilitate statistical analysis, while qualitative data were systematically prepared, coded and analysed to capture participants' experiences. Together, these processes ensured the integrity, organisation and accessibility of both data strands, thereby supporting rigorous integration and the generation of credible meta inferences.

6.2.1.1 Variable-orientated analysis

The variable-orientated analysis focused on the management and preparation of the quantitative dataset obtained during Phase 1 of the study. Following data collection, the completed questionnaires were checked for completeness, coded and entered into the statistical database for analysis. Each variable was managed systematically to ensure accuracy, consistency and data quality prior to statistical analysis. This approach enabled the identification of patterns, relationships and trends across the measured variables, providing an empirical foundation for subsequent comparison and integration with the qualitative findings. The management of the quantitative data followed established mixed methods procedures that support rigorous statistical analysis and meaningful integration with qualitative evidence (Creswell & Piano Clark 2023b:324).

6.2.1.2 Case-orientated analysis

Case-orientated analysis was applied to the qualitative phase of the study to examine the contextual experiences, interactions and meanings derived from the three focus group discussions and ten in-depth interviews conducted with health professionals in rural CHCs. Consistent with qualitative inquiry, this approach facilitated an in-depth understanding of participants' experiences and provided contextual explanations that expanded and enriched the quantitative findings (Creswell & Poth 2018:153-155). The qualitative analysis captured the complexity of collaborative practice and workplace

dynamics within the study setting, while its integration with the variable-orientated quantitative analysis strengthened the validity, comprehensiveness and practical relevance of the findings by combining the complementary strengths of both approaches (Fetters, Curry & Creswell 2019:214-215; Polit & Beck 2021:308-309). This integrated analytical approach generated a richer and more nuanced understanding of interprofessional collaboration and union dynamics in rural CHCs, thereby supporting the development of meaningful meta-inferences and contextually relevant conclusions (Guetterman & Creswell 2020:155-162).

6.2.2 Data integration analysis strategies

The data integration strategy employed in this study was guided by the objective of achieving complementarity between the quantitative and qualitative findings within the sequential explanatory mixed methods design. Integration occurred through three interrelated strategies, namely integration during interpretation, the use of joint displays, and the generation of meta-inferences, thereby enabling the strengths of both data strands to be combined into a coherent understanding of the research problem. This approach provided a more nuanced interpretation of collaboration in rural CHCs by addressing both the measurable patterns ('what') and the contextual experiences ('why') underlying the findings. Consistent with the principles of inclusive, contextually grounded and methodologically diverse research, the integration strategy also supported health systems responsiveness, knowledge translation and practice informed inquiry (Lehmann & Gilson 2019:417; Mertens 2020:143).

An integrative strategy further guided the explicit linking of the quantitative and qualitative datasets by demonstrating how the findings complemented, confirmed or expanded one another to produce contextually grounded interpretations (Åkerblad, Seppänen-Järvelä & Haapokoski 2021b:2). The integrated patterns that emerged during the analytical process strengthened understanding of collaboration by connecting statistical trends with participants' lived experiences, thereby extending beyond simple triangulation to the development of meaningful meta-inferences. As Zhou, Zhou and Machtmes (2024:2) observe, integration requires the deliberate connection of quantitative and qualitative findings into a unified interpretation. In the present study, this process generated contextually relevant conclusions that respond to the unique realities of rural South

African CHCs while strengthening the validity and practical applicability of the study findings.

6.2.2.1 Integration during interpretation

Integration during interpretation was achieved through a narrative weaving approach, whereby qualitative themes were integrated with the quantitative findings to identify areas of convergence, divergence and expansion. This strategy enabled the direct comparison of statistical patterns with participants' experiences, thereby strengthening explanatory depth and contextual understanding. As a recognised mixed methods integration technique, narrative weaving facilitates the merging of quantitative and qualitative evidence to identify corroborating and contradictory findings, enhancing the credibility and validity of the overall study conclusions (Fetters & Molina-Azorin 2020:288; Logan, Coker, Walker, Leukefeld & Buescher 2023:4320).

Within the present study, quantitative patterns relating to collaboration between health professionals and union representatives were interpreted alongside qualitative accounts that revealed experiences of exclusion, compromised participation and the persistence of professional hierarchies and silos in rural CHCs. This integrative process enabled the qualitative findings to clarify, explain and extend the statistical results, generating a richer understanding of collaborative practice within the study context (Guetterman, Fetters & Creswell 2021a:104). Consistent with Doyle et al (2020:353), the narrative weaving approach anchored numerical trends in the lived experiences of participants, thereby producing contextually grounded interpretations that informed the study's meta-inferences (Fetters & Molina-Azorin 2020:288).

6.2.2.2 Joint displays analysis and meta-references

Joint display analysis was used to facilitate the systematic integration of the quantitative and qualitative findings by aligning statistical results with the corresponding qualitative themes. The joint display tables illustrated areas of convergence, divergence and expansion across the two datasets, thereby enhancing the transparency and coherence of the integration process. Side-by-side tables were employed to visualise and analyse relationships between the quantitative and qualitative findings, enabling patterns to be identified and interpreted more effectively. As Cooper, Mitchell and Douglas (2024:5)

observe, joint displays provide a powerful means of illustrating the interplay between numerical trends and narrative evidence.

The integrated findings presented through the joint displays informed the development of meta-inferences by combining complementary evidence from both data strands into unified interpretations. Haynes-Brown and Fetters (2021:1) describe joint displays as an iterative process that visually represents quantitative and qualitative findings to communicate integrated results effectively, while Clark (2023:757) and Guetterman (2022:1-12) emphasise that graphs, tables and figures provide an effective visual platform for data integration. In the present study, the joint displays therefore served not only as an analytical tool for integrating findings, but also as the foundation for generating contextually grounded meta-inferences that informed the overall interpretation of collaboration within rural CHCs.

6.2.2.3 Meta-inferences

The final stage of the data integration process involved the development of meta-inferences; whereby overarching conclusions were derived from the integrated quantitative and qualitative findings. Meta-inferences enabled the generation of deeper insights that could not have emerged from either dataset independently by synthesising statistical patterns with participants' experiences into coherent explanations of the research phenomenon (Fetters & Molina-Azorin 2020:288; Guetterman et al 2021a:102). This integrative process is particularly valuable in health systems research because it bridges empirical measurement with contextual understanding, thereby informing policy, practice and organisational improvement (Hong, Pluye, Bujold & Wassef 2022:220). Consequently, the validity and practical utility of the study were strengthened through interpretations grounded in both quantitative evidence and qualitative experiences (Cooper, Creswell, Plano Clark & Ivankova 2024:11).

The integrated analysis generated six overarching meta-inferences that provide the analytical foundation for the presentation and discussion of findings in Sections 6.3 and 6.4. These meta-inferences indicate that: (i) resource insufficiency and unsafe infrastructure collectively undermine physiological safety and interprofessional collaboration; (ii) ineffective leadership constitutes a systemic barrier to trust, teamwork and psychological safety; (iii) weak and fragmented union structures limit employee

representation and the effective resolution of workplace safety concerns; (iv) ineffective communication impedes interprofessional relationships, collaborative decision-making and timely service delivery; (v) fragmented interprofessional relationships weaken coordinated service delivery and workplace cohesion; and (vi) structured organisational enablers, including governance reform, interprofessional education and technology-enabled communication, have the potential to strengthen sustainable collaborative partnerships within rural CHCs. These overarching meta-inferences provide the framework through which the integrated findings are interpreted and discussed in the sections that follow.

6.3 DATA INTERGRATION ANALYSIS AND DISCUSSIONS

This section presents the integrated analysis and discussion of the quantitative and qualitative findings in relation to the research questions, with particular emphasis on collaboration between health professionals and organised labour in establishing safe collaborative partnerships within rural CHCs across the three participating provinces. The quantitative findings comprised demographic information and responses relating to the key study variables, namely human and physical resources, the role of management, the role of organised labour, communication, collaborative processes, and strategies for strengthening safe collaborative partnerships. These findings were integrated with the qualitative evidence generated from the focus group discussions and in-depth interviews, from which six themes and related subthemes emerged. The integration of both data strands enabled a comprehensive interpretation of participants' perceptions, knowledge, experiences and understanding of collaborative partnership within the rural primary healthcare context.

The integrated findings are presented through joint displays in Tables 6.1 to 6.4 and Figures 6.2 and 6.3, which illustrate areas of convergence, divergence and expansion between the quantitative and qualitative results. Throughout this section, integration language is used deliberately to demonstrate the relationships between the two datasets, whereby findings that support one another are described as *converging*, those that differ as *diverging*, and qualitative findings that provide additional explanation as *extending* the quantitative results, consistent with mixed methods integration conventions (Zhou et al 2024:3). The joint displays and integrated discussion generated the meta-inferences that are interpreted in relation to the existing literature, thereby providing a deeper

understanding of health professionals' experiences of collaboration with organised labour in rural CHCs (Creswell & Poth 2018:214).

6.3.1 Inadequate resources impacting on secure collaborative partnership

The integrated findings indicate that inadequate human, material and infrastructural resources constitute a significant barrier to establishing secure collaborative partnerships within rural CHCs. Across both the quantitative and qualitative data, participants identified shortages of essential supplies, health personnel and appropriate infrastructure, including inadequate consulting rooms and unsafe facilities, as factors that compromise workplace safety, service delivery and effective collaboration among health professionals and organised labour. Table 6.1 presents the integrated quantitative and qualitative findings relating to resource availability and their influence on collaborative partnership within the participating CHCs.

Table 6.1 Representation of integrated analysis of resources

Theme	Quantitative results	Qualitative insights
Shortage of health professionals	n=17 (40.5%) work overtime, which confirms a high staff shortage n=20 strongly agree and 9 agree (69%) agree that shortage of personnel contribute to conflict among workers.	"The CHC has one operational manager in the district, eish!!" (MP-IDIA2) "The professional nurses are overloaded and cover the allied work as none is allocated here; we guide patients on nutrition, how to exercise their body – we try hard." (GP-FGB4) "Oh no, shortage of staff and increased policies and ever in meetings – as one manager, I am not coping." (GP-FGB5) "Only one newly qualified medical doctor comes every week or sometimes once every two weeks; we have to work outside our scope." (MP-FGB1)
Unskilled and semi-skilled health professionals	The findings uncovered that staff are mostly unskilled or semi-skilled (n=13; 56.5%) attended NIMART, followed by only (n=4; 17.3%) for	"Shortage of skilled health practitioners has impact on partnership and collegiality." (GP-FGB1) "No new recruitment of staff to replace resignations and retirements; we fight often, we are exhausted." (GP-FGB3)

Theme	Quantitative results	Qualitative insights
	PHC and 'Other' respectively.	"Only one newly qualified medical doctor who comes every week or sometimes once every two weeks; we have to work outside our scope." (MP-FGB2) "No designated qualified pharmacist… if there are problems she has to phone the district hospital pharmacist." (MP-FGB4)
Insufficient resources to control Infection compromise safety of health professionals	n=36 (86%) agrees that shortage of tools to health professionals' impact on relationships between health professionals, management and organised labour. n=11, 41% confirms that resources to perform activities are not adequate.	No resources to ensure minimal cross infection – paper hand towel, soap, and continuous running water reserves." (MP-FGB2) "Insufficient to absent materials, such as Kleenex for drying hands after handwashing." (GP-IDIB2) "In most cases, shortage of resources and shortage of gloves promote unhealthy and unsafe working environment." (NW-FGA4) "No handwashing basins; we don't have running water, and all the taps are closed – this causes a hindrance in proper health-care procedures." (MP-IDIA1)
Limited and dysfunctional infrastructure, with no noise control, sufficient light	n=8 (23%) is uncertain and n=11; 41% disagree that to be satisfied with the condition of the consultation rooms and resources not equally distributed.	"The physical structure of the facility poses a risk for personnel on duty." (MP-FG02) "There are no controlled access gates; everyone can access any place. Windows have no burglar bars, and escorts have no control." (NW-IDI01) "Physical structure in the facility poses risk for personnel on duty. There are no access gates: everyone can enter and access any place in the facility." (GP-FG02)

Table 6.1 demonstrates convergence between Table 6.1 converges the quantitative findings where the statistical analysis confirms the inadequacies in both human and material resources within the rural and semi-rural CHCs. The qualitative findings from participants across all three provinces reported that health professionals work outside their scope, thus shortages confirming quantitate pattern of overtime and role overload.

Adamopoulos (2022:7) affirms the WHO (2010) findings that during the COVID-19 pandemic the absence of essential resources such as water, rest facilities, and protective equipment led to increased stress and reduced job satisfaction among health

inspectors.This finding contradicts a simplistic reading of resource shortages as purely logistical problems: it demonstrates that resource inadequacy has direct psychological and relational consequences, undermining Maslow's physiological and safety tiers and Watson's caring environment simultaneously.

The findings of a study by Endalamaw et al (2023:9-10) on successes and challenges towards improving quality of PHC services is in unison with a concern on resource inadequacy, therefore, the degree of infrastructural availability, or the absence thereof, is a crucial determinant of the degree of safety at any healthcare facility, and the appropriate resources and infrastructure are required for quality improvement. It is worth stating that the infrastructure-related issues in this case relate to the physical buildings and resources of the CHCs.

The inadequate ‘tools of the trade’ escalate conflict and unsafe interpersonal relationships between health professionals; a challenge in rural health facilities in the context of the study by Cranage and Foster (2022:270). Further clarify that limited resources breed conflict and disrupt collaboration between all role players. Factors include staff shortages, lack of resources, poor skill mix and lack of supportive management.

The integrated findings confirm a degree of correlation between physical resources, medical resources, tools of the trade, and safe collaborative partnerships. The limited number of health professionals who are semi-skilled or unskilled, are a threat to safe collaboration and partnership between health professionals due to incompetence (Craveiro, Dussault, Russo & Ferrinho 2024:49). In this regard, health professionals in rural remote areas experience uncomfortable ill resources, unguided unskilled peers and managers, and area continuously impact their psychological and physical safety (Jahner Danyluk, Johnson & McGregor 2020:489). However, adversarial labour-management relations and blame cultures undermine this therapeutic environment, delaying corrective action and weakening collective problem-solving in rural health services (Bapuji, Ertug & Shaw 2020:62; Mannion & Davies 2020:3).

6.3.2 Role of management for health professionals

This category, the searcher elaborates on the role of management on HCPs. Table 6.2 shows the comparison of the role of management concerning health professionals' perceptions of dysfunctional leadership and management of health professionals.

Table 6.2 Role of management concerning health professionals

Category	Quantitative results	Qualitative results
Ineffective and inefficient management and leadership	n=30 (70%) of participants agree that weakened relationships, overlooked rights of professionals such coming in consultation rooms without knocking. 60% participants strongly agree that management make effort to fully support the staff.	"Senior managers are hardly available for support and empowerment." (MP-FGB2) "Our clinic has one Operational Manager; we are delegated monthly to assist the OM or to be in charge if he is on leave or unavailable." (GP-FGB3) "Only one manager per facility, who is often in meetings at the district office. If she is on leave or sick, there is no accountable leader to keep health professionals supported and confident." (GP-IDIA2) "Communication from management remains minimal. They are perceived as problem seekers rather than solvers." (MP-FGB2) "Management has poor communication and does not handle personnel well or with respect." (GP-IDIA2) "Conflict occurs from time to time between nurses and other health professionals, but unions and managers fail to mediate, especially between doctors and allied staff—it seems nurses feel

Category	Quantitative results	Qualitative results
		inadequate as managers.” (NW-FGA3)
	n=32 (78%) agrees that discriminatory practices between health professionals threatens collaborative partnership that promotes safety within CHCs.	“The current eating and resting arrangements promote segregation based on professional class differences—it reflects a lack of respect, trust, and love. No social cohesion is encouraged daily.” (NW-FGA4) “Medical officers enjoy better working hours, offices, and accommodation than all other health professionals; nurses are the most neglected.” (MP-IDIA3) “The facility has separate resting rooms for different departments, which limits integration and promotes groupings.” (GP-FGB4) “Some staff or sections are prioritised over others, for example, in access to telephone lines or quicker responses to resource requests.” (MP-IDIA2) “Some staff members are discriminated against because of their level or type of qualification—Diploma versus B Tech nurses, doctors versus nurses.” (NW-FGA5)

Based on Table 6.2, the quantitative and qualitative findings converge in demonstrating that ineffective leadership and limited managerial support significantly undermine secure collaborative partnerships within rural CHCs. The statistical findings confirmed weak managerial support, ineffective problem-solving, limited control over professional practice and perceptions of discrimination and factionalism, while participants described poor communication, inconsistent leadership, inadequate induction and the absence of structured in-service training. Together, these findings indicate that ineffective management weakens trust, communication and collaboration among health professionals, organised labour and facility leadership. Similar challenges have been

reported internationally, where strong local leadership, interdisciplinary collaboration and effective communication have been identified as essential for sustaining rural health services and workforce performance (Morgan, Kosteniuk, O'Connell, Seitz, Elliot, Bayly, Froehlich Chow & Cameron 2022:2-12; Morgan et al 2022:4-12).

The integrated findings further reveal that weak leadership extends beyond administrative shortcomings to undermine interprofessional collaboration and labour-management relationships. Participants consistently reported limited support from both facility managers and organised labour, resulting in poor coordination, weak shared decision-making and fragmented workplace relationships (Liu, Liu, Liu, Baggs, Wang, Zheng, Wu, Li & You 2021a:9). Contemporary evidence similarly demonstrates that participatory leadership, conflict resolution, effective communication and clearly defined roles are fundamental competencies for building psychologically safe and collaborative health teams (Vaseghi et al 2022:500). Conversely, the absence of these competencies contributes to recurring communication failures, weakened teamwork and ineffective collaboration between managers, health professionals and union representatives. Leadership development, supported by interprofessional education, therefore provides an important mechanism for strengthening collaborative practice within under-resourced rural health systems (Patel 2025:147-149).

Participants further emphasised that managerial effectiveness depends on fair delegation, competency-based supervision and continuous professional development. Managers were frequently perceived as delegating responsibilities according to personal preference rather than competence, thereby reducing staff morale, increasing role ambiguity and reinforcing workplace factionalism (Kosova 2020:242). These findings are consistent with evidence that supportive supervision, transparent delegation and structured leadership development strengthen communication, teamwork and accountability, particularly within resource-constrained primary healthcare settings (Alhassan, Sencherey, Bobuafor, Osei Berchie, Abraham, Asamoah, Kpessa Whyte, Oppong Kyeremeh & Ntiamoah Sarpong 2025:1094; Bornman, Cilliers, Booysen, Botha & Van Zyl 2023:52-60; Singh 2024:2-4). Similarly, participants identified structured induction, in-service education and continuing professional development as critical management responsibilities for building competence and sustaining collaborative practice. This finding accords with evidence that continuous professional development enhances communication, leadership capacity and interprofessional collaboration,

particularly within rural and under-resourced health services (Al-Omary, Abu-Moghli, Khalaf, Nabolsi & Ali 2024:3-5; Notarnicola, Stievano, De Vito, Mastrillo, Artioli, Lancia, Tampoia, Tartaglini & Gazzaruso 2025:56-70;).

Overall, the integrated findings demonstrate that effective leadership is a prerequisite for establishing psychologically safe, collaborative and accountable workplaces within rural CHCs. Competent managers who communicate effectively, delegate responsibilities according to merit, invest in staff development and engage constructively with organised labour are more likely to strengthen trust, teamwork and service continuity. Conversely, ineffective leadership, favouritism, fragmented training systems and weak managerial support contribute to interpersonal conflict, diminished staff morale and weakened collaborative partnerships. These findings are supported by evidence that leadership behaviours directly influence teamwork, conflict management and organisational performance, while competence-based delegation, inclusive leadership and psychologically safe work environments enhance collaboration and team resilience (Bowers, Fairbrother, Eagar & Jeon 2023:77-78; Nguyen & Mohamed 2022:232; Paganin, De Angelis, Pische, Violante, Guglielmi & Pietrantoni 2023:5; Rico, Sánchez-Manzanares & Gil 2021:221).

6.3.3 Perceptions of collaboration and partnership experiences between health professionals

This section presents the integrated quantitative and qualitative findings on health professionals' experiences of collaboration and partnership within rural CHCs, with particular attention to areas of convergence, divergence and expansion between the two datasets. Figure 6.2 illustrates the integrated findings, demonstrating that participants who reported conflict, mistrust and poor collaborative relationships also described experiences of compromised dignity, perceived violations of their rights and weakened workplace cohesion, highlighting the close relationship between interpersonal experiences and the establishment of safe collaborative partnerships.

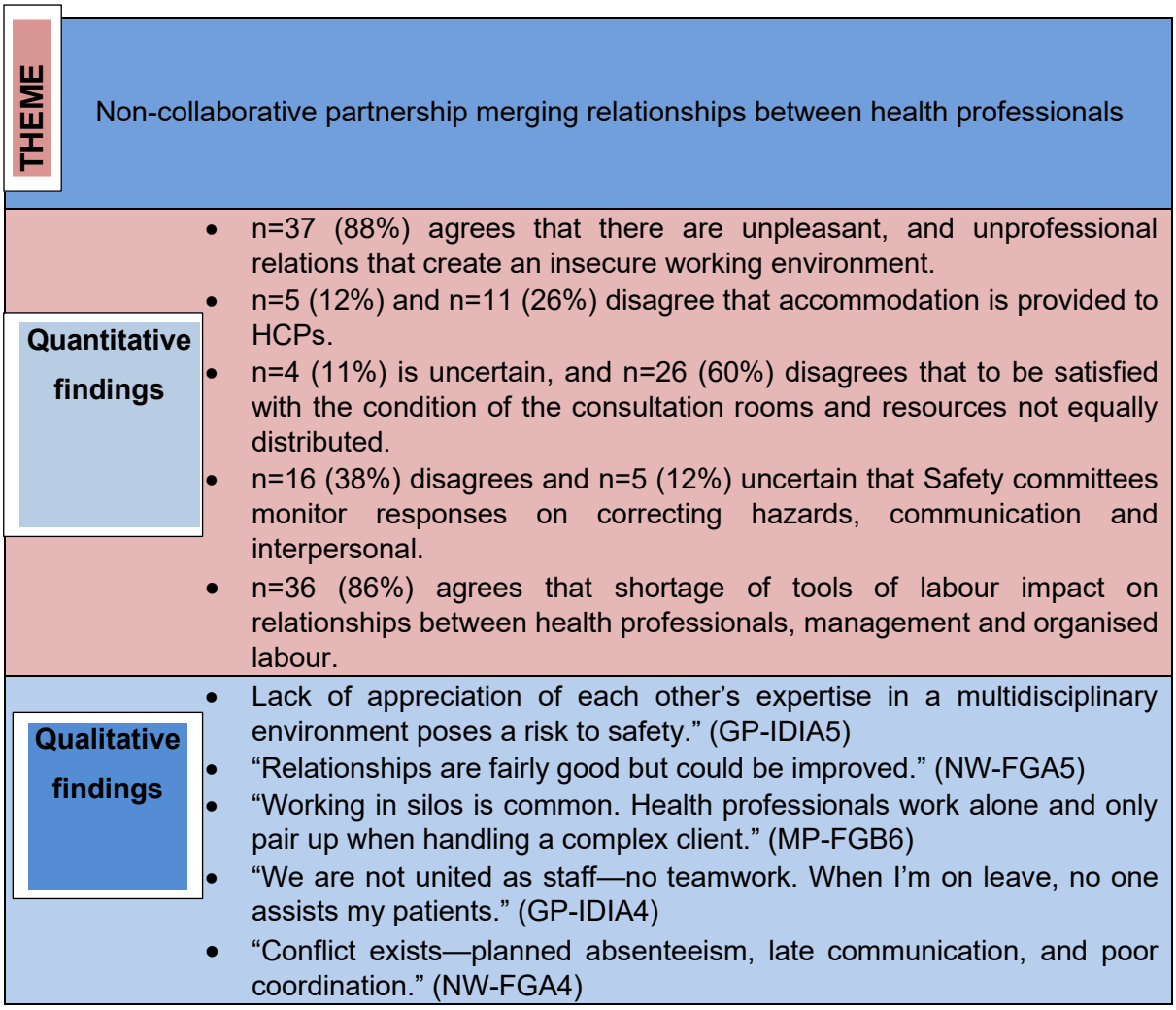


Figure 6.2 Collaborative experiences among health professionals

The integrated findings presented in Figure 6.2 demonstrate clear convergence between the quantitative and qualitative data regarding health professionals' experiences of collaboration within rural CHCs. While the quantitative findings revealed mixed perceptions of interprofessional collaboration, with many respondents' expressing uncertainty or dissatisfaction with workplace relationships, the qualitative narratives expanded these findings by illustrating how entrenched professional hierarchies, exclusion and fragmented workplace cultures undermine collaboration. Participants described experiences of neglect, disrespect, discrimination, gossip and inadequate access to essential resources, all of which contributed to perceptions of unsafe and unsupportive working environments. These findings are consistent with Petersen (2019:75), who similarly reports that poor professional relationships and inadequate workplace resources compromise collaborative practice within South African rural health facilities.

The integrated analysis further suggests that structural and historical factors, rather than individual attitudes alone, shape collaborative relationships among health professionals. Participants perceived professional silos, unequal access to opportunities and hierarchical organisational structures as important sources of mistrust and discrimination. These findings converge with Erasmus, Peadon and Lynch (2022:178), who argue that siloed service structures intensify tensions between professional groups in rural CHCs, while extending their work by identifying educational siloing as an additional structural contributor to fragmented collaboration. The emerging meta-inference therefore indicates that strengthening collaborative partnerships requires institutional interventions that promote shared professional education, clearer role definition and integrated models of practice, rather than focusing solely on individual behaviour. This interpretation is further supported by Olson (2022:25), who demonstrates that strategies aimed at breaking professional silos foster partnership, reduce power struggles and strengthen collaborative practice within rural healthcare settings.

6.3.4 Role of organised labour in the care of health professionals

Table 6.3 presents the integrated quantitative and qualitative findings relating to the role of organised labour in supporting health professionals within rural CHCs. The convergent findings demonstrate how participants perceived organised labour's contribution to workplace safety, employee representation, communication and collaborative partnership, while also highlighting areas where union support was considered inadequate or ineffective.

Table 6.3 Role of organised labour in the care of health professionals

Theme	Quantitative results	Qualitative insights
Dysfunctional union, health professionals and management relations	n=9 (21%) disagree that they do not freely participate in union activities. n=28 (72%) agree that they are free to be organised, participate and attend union activities and be advocated for but the union is unavailable and inactive dysfunctional union management relations.	No union-led forums on safety. If you become vocal, you become a target, and your emotional and psychological safety is compromised.” (GP-IDIA1) “Union leaders are passive; they rarely engage unless there’s a crisis.” (NW-FGA1) “Each professional pays union fees, but there are no known

Theme	Quantitative results	Qualitative insights
		representatives at our facility." (MP-FGB2) "Unions should be proactive rather than reactive—organise awareness events, not only appear during elections." (GP-IDIA2) "Some shop stewards avoid meetings due to fear of management victimisation." GP-GB5) "Union activities are not transparent; staff don't know what progress has been made on grievances." (MP-FGB6)
Absent organised labour and structures	n=17 (41%) disagrees that n=12 (29%) is uncertain, that unions add value to sustain safety. n=9 (21%) disagrees and n=5 (12%) uncertain that they do not freely participate in union activities. n=28, 66% agree that an absent active functional union as frustrated health professionals impacting on their safety and rights. n=8 (19%) is uncertain, and n-28(67%) agree that poor communication and interpersonal relations are present in CHC between staff/management and union.	Lack of commitment from organised labour. Not effective role, they are passive to absent." (NW-FGA1) "There is no functional or effective union representative for CHC staff." (MP-IDIA2) "Participation of unions is very minimal; representatives are not even well known." (GP-IDIA3) "Each professional has their chosen union, but I've never heard of any responsibilities of unions at our facility—yet everyone pays." (NW-FGA2) "Unions should engage staff proactively, not just react when there's an incident." (MP-IDIA3) "I've lost confidence in the union. We shouldn't pay." (GP-FGB3) "Unions should be set up properly and focus on workplace and employee well-being." (NW-IDIB1) "Most staff members are not members of any union." (MP-FGB5)

Theme	Quantitative results	Qualitative insights
Poor commitment of organised labour	n=16 (33%) uncertain and n=14 (32%) disagrees while n=10 (35%) agree that Union reps are objective, organised and attend committees within the CHC. n=6 (14%) uncertain and n=30 (72%) disagrees that union advocates for staff. n=6 (14%) uncertain and n=7 (17%) disagrees that labour plays its role to enhance positive relations without fear and favour. n=8 (19%) is uncertain, and n-28(67%) agree that poor communication and interpersonal relations are present in CHC between staff/management and union.	"Unions only come when we have a problem; they take a long time to resolve issues." (MP-IDIA3) "Unions are present but scared to be visible and are not actively engaged." (NW-IDIB1) "Union representatives rarely visit or communicate; some staff don't even know who their shop steward is". (GP-FGB6)."

Reflecting on Table 6.3, the integrated quantitative and qualitative findings converge in portraying organised labour as largely inactive, disengaged and insufficiently visible within rural CHCs. Although the quantitative findings showed that health professionals were generally free to participate in union activities, they also indicated that unions were perceived as inactive. The qualitative narratives expanded these findings, with participants describing union representatives as passive, largely unknown within facilities and seldom available to address workplace concerns. The resulting meta-inference suggests that union presence alone is insufficient to safeguard employees; meaningful workforce protection requires visible leadership, protected time for union engagement and formalised labour-management structures. These findings are consistent with Farrenkopf and Lee (2019:472), who report that dysfunctional labour structures undermine workplace relationships and safety.

The integrated analysis further demonstrates a divergence between formal union membership and effective employee representation. While organised labour is expected to protect employees and facilitate collaborative engagement, participants reported

limited advocacy, poor communication and minimal involvement in resolving workplace challenges. These findings align with Mngomezulu and Nhlabathi (2022:6), who critique the declining influence of organised labour within the public health sector, and with Bester and Mash (2022:6), who advocate for the revitalisation of union roles. This disparity between membership and meaningful representation highlights an important gap that the IPUCP Model seeks to address through strengthened labour-management collaboration and enhanced union capacity.

The findings also suggest that weak relationships between organised labour, management and health professionals compromise broader health-system functioning. Participants associated ineffective union participation with poor communication, limited trust, fear of intimidation, inconsistent leadership and weak monitoring of legislative compliance. Bhaumik, Jagadesh, Gupta and Kumar (2020:8) similarly argue that ineffective labour relationships weaken health systems, while Cook, MacKenzie and Forde (2020:24) emphasise that effective union partnerships should strengthen employee communication, human resource management practices and workforce outcomes. Collectively, these findings indicate that revitalising organised labour requires not only stronger representation but also collaborative engagement with management to promote accountability, communication and secure interprofessional partnerships within rural CHCs.

6.3.5 Dysfunctional communication structure

Communication emerged as a critical barrier to collaborative partnership, with the integrated quantitative and qualitative findings converging to show that ineffective communication between management, organised labour and health professionals weakens professional relationships within rural CHCs. While the quantitative findings indicated widespread agreement that poor communication negatively affects collaboration, the qualitative narratives expanded these findings by describing communication as fragmented, hierarchical and inconsistently implemented, with limited opportunities for feedback and cross-departmental engagement. Table 6.4 presents the integrated findings, demonstrating that dysfunctional communication structures undermine interprofessional collaboration, trust and service delivery, consistent with the findings of Kapepoa, Van Belle and Weimann (2025:10) and Olaoye and Onyenankeya (2023:10).

Table 6.4 Integrated analysis of communication challenges

Theme	Quantitative	Qualitative
Use effective communication platforms across departments and Health professionals	n=34 (80%) agrees that health professionals (health professionals) use time saving platforms. n=39 (92%) agree that absence of information-sharing mechanisms threatens partnerships. n=24 (56%) agrees health professionals communicate poorly. n=27 (64%) of respondents reported unclear communication channels within their CHCs.	"Engage staff, be proactive rather than reactive on union-related matters such as Workers' Day celebrations or voting periods." (GP-IDIA2) "Develop a work plan that clearly defines each professional's activities and responsibilities to minimise conflict and strengthen relationships." (NW-FGA1) "Notice boards can improve communication while reinforcing safety and therapeutic awareness." (MP-FGB2) "We hold weekly meetings to discuss challenges and in-service trainings; telephone and notice-board communication keep us informed of upcoming events." (NW-IDIB3) "Monthly multidisciplinary team meetings should be considered to improve care quality and foster a positive working environment." (GP-FGB2)
Limited access to technology driven communication.	n=20 (47%) agreed that digital tools are not available or utilised effectively in the CHC.	"Not having access to internet services and telephones hinders the smooth flow of communication." (NW-IDIB1) "There are no panic buttons or intercoms in the facility." (GP-FGB2) "No access to internet and mobile telephones to ensure communication between health professionals. Only one mobile phone for the whole facility, used by one person at a time." (MP-IDIA2)

Theme	Quantitative	Qualitative
Limited communication among health professionals and labour	n=13 (33%) reported active communication platforms with management and unions.	“Communication is not good at all – we do not even respect each other.” (NW-FG02) “There are no interdepartmental or multiprofessional meetings to ensure clarity of roles or build positive relations using technology or even ground lines.” (GP-IDIA2) “Personnel are moved around to ‘relieve’ without clear reasons.” (MP-IDIA3) “Nurses are disrespectful to each other, judging colleagues based on where they live, how they dress, even hairstyle – it’s too toxic.” (NW-FG03) “WhatsApp chat groups are mainly for nurses only; other professionals are excluded from daily updates and decisions.” (NW-FGA3) “The multiple WhatsApp chat groups for different professional groups are unreliable and weaken teamwork.” (GP-IDIA3) “It’s tiring to keep reporting when nothing is done; it destroys relationships and workplace safety.” (MP-FGB2)

The integrated findings illustrated in Table 6.4 converge in demonstrating significant weaknesses in communication systems across rural CHCs. Both the quantitative and qualitative data confirmed the absence of integrated, well-supported communication platforms, with participants identifying technology-enabled communication as a potential solution that remains constrained by limited rural ICT infrastructure. The resulting meta-inference suggests that communication dysfunction operates at multiple levels, including interactions among health professionals, communication between management and staff, and technological limitations. These findings indicate that strengthening collaboration will require a coordinated communication strategy incorporating organisational redesign,

leadership development and phased investment in information and communication technology.

The integrated analysis further shows that communication challenges are driven less by the availability of clinical resources than by weak implementation, ineffective leadership and fragmented organisational processes. Participants frequently reported feeling marginalised within hierarchical structures that limited information sharing, feedback and collaborative decision-making. These findings are consistent with evidence that rigid hierarchies, departmental silos and inadequate cross-departmental communication undermine interprofessional teamwork and coordinated service delivery in resource-constrained health systems (Kapepoa, Van Belle & Weimann 2025:10; Olaoye & Onyenankeya 2023:10).

6.3.6 Enablers collaborative partnership between health professionals and unions

The integrated quantitative and qualitative findings converge in identifying the key enablers required to establish and sustain safe collaborative partnerships within rural CHCs. Participants consistently emphasised the importance of adequate resources, effective communication, interprofessional training, continuous professional socialisation, supportive leadership and compliance with the legislative framework by health professionals, organised labour and management. Figure 6.3 presents these integrated findings by illustrating the qualitative themes alongside the corresponding quantitative response frequencies, thereby highlighting the principal strategies for strengthening collaborative partnership.

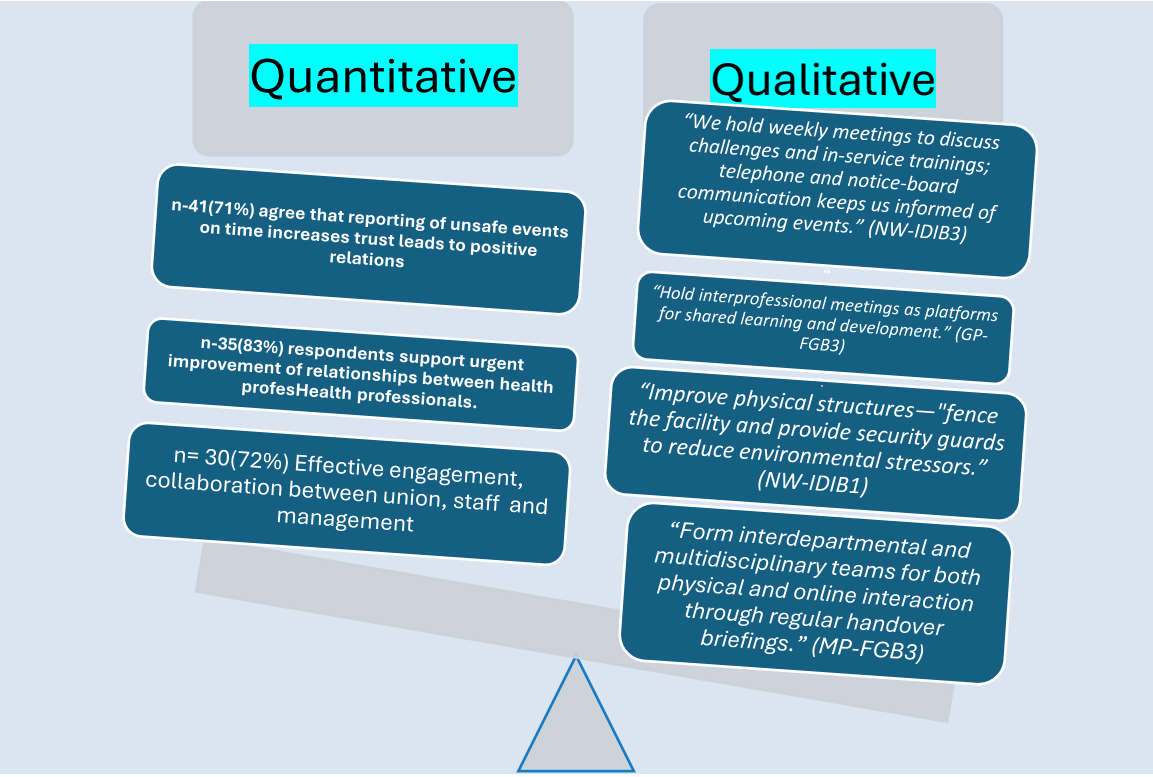


Figure 6.3 Possible solutions for a secure collaborative partnership

The integrated findings presented in Figure 6.3 demonstrate strong convergence between the quantitative and qualitative data regarding the measures required to establish secure collaborative partnerships in rural CHCs. The qualitative findings identify the proposed solutions as thematic categories, while the accompanying percentages represent the proportion of the 42 survey respondents who agreed or strongly agreed with the corresponding quantitative items. Considered together, these findings provide compelling evidence that sustainable improvement requires a structured model for collaborative partnership rather than isolated or ad hoc training interventions. This interpretation is consistent with Coulter (2025:67), who argues that innovative practices can strengthen rural health services, and Stanley and Stanley (2019:1323), who emphasise the importance of clinical leadership, teamwork and technology in improving collaboration, workplace safety and quality of care.

The integrated analysis further indicates that effective collaborative partnerships depend on coordinated organisational and system-level interventions. Participants consistently identified technology-enabled communication, strengthened leadership, improved resource allocation, partnerships with teaching institutions, curriculum reform and supportive policy implementation as essential enablers of collaboration. These findings

align with Horwood, Haskins, Luthuli and Rollins (2024:31), Lahr, Luijkx, Veenstra and Struijs (2021:5) and Mhlungu, Boererna and Ramukumba (2024:4585), all of whom highlight the importance of leadership support, technological innovation, workforce development and organisational investment in strengthening collaboration within rural healthcare settings.

The findings also demonstrate that legislative frameworks alone are insufficient unless supported by effective implementation, accountable leadership and institutional commitment. Participants highlighted weak labour-management structures, fragmented communication, limited intersectoral accountability and inadequate preparation of health professionals for collaborative practice. These findings are supported by Botha et al (2023:276), Madonsela and Mhlanga (2022:45), Naamati Schneider, Shani, Ziv, Goldstein and Poles (2025:5), Nyoni and Duma (2020:112) and WHO (2023:32), together with Dlungwane and Mabuza (2022:150), who collectively advocate for strengthened governance, curriculum reform, communication, shared decision making and psychological safety as essential conditions for sustaining collaborative partnerships in rural CHCs.

6.4 SYNTHESIS OF INTEGRATED FINDINGS INFORMING THE IPUCP MODEL

This section synthesises the integrated findings by consolidating the six theme-level meta-inferences into a coherent explanation of the factors influencing collaborative partnership within rural CHCs. The synthesis proceeds by mapping the interrelationships among the themes through a thematic network, generating an overarching meta-inference, and identifying the principal enablers that inform the development of the Interprofessional Union Collaborative Partnership (IPUCP) Model presented in Chapter 7. This integrative approach demonstrates how the combined quantitative and qualitative evidence provides a stronger explanatory basis for model development than either data strand alone.

To enhance interpretive clarity, Figure 6.4 and Table 6.5 present the thematic network and its alignment with the theoretical foundations underpinning the study. The thematic network illustrates the interconnections among the six organising themes, namely dysfunctional infrastructure and staffing; limited trust, transparency and safety reporting; the absence of inclusive interprofessional education and capacity building; weak

leadership engagement and communication; fragmented interprofessional relationships; and dysfunctional union structures. Together, these integrated patterns provide the structural, relational and human dimensions that underpin the IPUCP Model, thereby establishing the conceptual foundation for the model and implementation guidelines developed in Chapter 7.

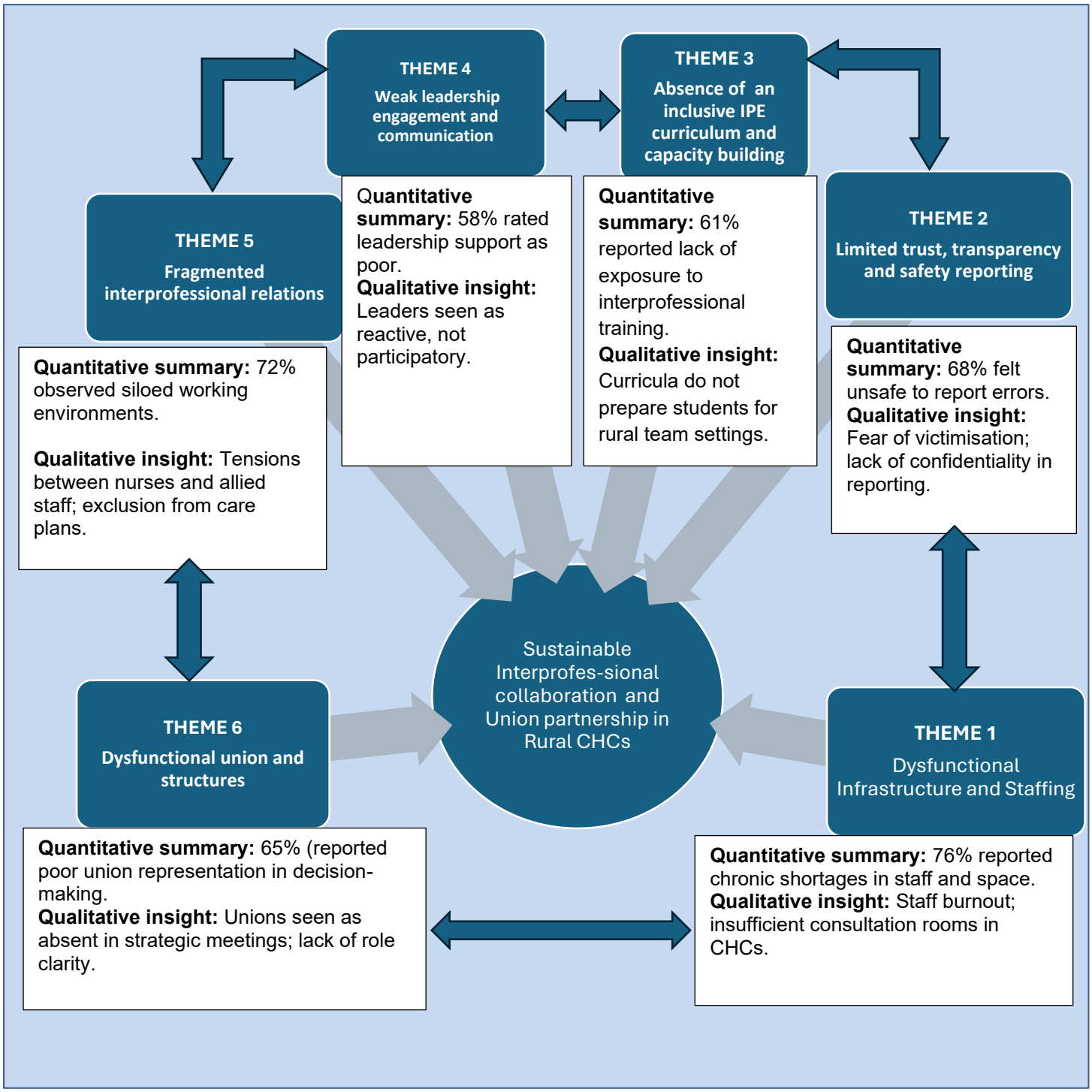


Figure 6.4 Self-generated thematic network diagram structure illustrating integrated

Figure 6.4 visually integrates the quantitative and qualitative findings by illustrating how the six organising themes collectively influence the attainment of sustainable interprofessional collaboration and union partnership in rural CHCs. The arrows linking each theme to the central outcome demonstrate that dysfunctional infrastructure and staffing, limited trust and safety reporting, the absence of interprofessional education and capacity building, weak leadership and communication, fragmented professional relationships, and dysfunctional union structures are interrelated barriers rather than isolated challenges. This integrated representation supports the analytical objective of showing how evidence from both data strands converges to inform a system-wide model for improving collaborative practice within rural health services.

The thematic network also serves as the analytical bridge between the integrated findings and the development of the IPUCP Model presented in Chapter 7. In mixed methods research, visual integration facilitates the interpretation of how quantitative and qualitative findings converge, expand and generate overarching meta-inferences (Fetters & Molina-Azorin 2020:288; Guetterman 2022:1-12; Haynes-Brown & Fetters 2021:1). Consistent with Braun et al (2022:424), thematic mapping further illustrates the interconnected structural, relational, leadership and educational dynamics that shape professional practice within resource-constrained rural health systems. The six meta-inferences are subsequently consolidated in Table 6.5, where they are interpreted in relation to the theoretical models underpinning the study and translated into the conceptual foundations of the IPUCP Model.

Table 6.5 Consolidated meta-inferences informing the IPUCP model

THEME	CONSOLIDATED META-INFERENCES	MODEL AND LEGISLATIVE ANCHOR
Inadequate resources	Resource inadequacy operates relationally as well as materially; shortages erode trust and ignite conflict, compromising physical and psychological safety.	Maslow Theory and OHS Act No. 85 of 1993
Leadership and management (6.3.2)	Leadership failure is structural, not only individual; single-manager design, merit-blind delegation and absent CPD undermine continuity and psychological safety.	IPEC framework and Watson Theory
Interprofessional relationships	Relational fragmentation, not resource scarcity alone, is the principal threat to workplace security and collaboration.	Watson; IPEC values AND ethics
Organised labour	Inactive, invisible and distrusted unions contradict the assumption of functional union partners; partnership must be built, not assumed.	LMP (critical); LRA No. 66 of 1995
Communication	Communication breakdown is structural: an absent integrated architecture and exclusionary informal channels entrench fragmentation.	IPEC interprofessional communication
Enablers	Secure partnership requires the convergence of structural provision and relational-educational investment; no single enabler suffices.	Maslow, Watson, IPEC, LMP combined

Table 6.5 presents the study's overarching meta-inference by integrating the empirical findings with the theoretical frameworks and legislative context underpinning the research. The synthesis demonstrates that workplace insecurity in rural CHCs is co-

produced by structural deficiencies, ineffective communication systems and fragmented relationships, resulting in compromised collaboration among health professionals, organised labour and management. These integrated findings indicate that sustainable improvement requires a model that combines human needs, caring relationships, collaborative competencies and shared governance, thereby providing the conceptual rationale for the Interprofessional Union Collaborative Partnership (IPUCP) Model developed in Chapter 7. The six interconnected meta-inferences illustrated in the thematic network are discussed in the sections that follow.

6.4.1 Theme 1: Dysfunctional infrastructure and staffing

The integrated quantitative and qualitative findings identify dysfunctional infrastructure and inadequate staffing as fundamental barriers to secure collaborative partnerships within rural CHCs. Both data strands converged in demonstrating that shortages of essential resources, inadequate infrastructure and an inappropriate staff mix compromise not only service delivery but also the ability of health professionals, managers and organised labour to work collaboratively. Participants described how persistent resource constraints increased workload, burnout and professional frustration, thereby weakening trust, teamwork and safe workplace relationships. The resulting meta-inference is that sustainable collaboration cannot be achieved where the basic structural conditions required for safe practice are absent.

This integrated finding is supported by Maphumulo and Bhengu (2019:5), who identify unsafe infrastructure and chronic under-resourcing as persistent threats to healthcare quality and staff wellbeing in rural CHCs. Similarly, Endalamaw et al (2023:9-10) emphasise that adequate infrastructure and resource availability are essential determinants of quality improvement within PHC services. Consistent with these findings, the present study demonstrates that dysfunctional infrastructure and staffing extend beyond operational challenges to undermine interpersonal trust, collaborative practice and organisational stability. Addressing these structural deficiencies therefore represents a foundational requirement for the IPUCP Model, as improvements in collaborative partnership are unlikely to be sustained without a safe, adequately resourced and appropriately staffed working environment.

6.4.2 Theme 2: Limited trust, transparency and safety reporting

The integrated quantitative and qualitative findings identify limited trust, transparency and safety reporting as critical relational barriers to collaborative partnership within rural CHCs. The quantitative findings showed that many health professionals felt unsafe to report errors and workplace concerns, while the qualitative narratives expanded this pattern by revealing that fear of victimisation, limited confidentiality, inadequate feedback and perceived management inaction discouraged open reporting. The resulting meta-inference is that safety reporting extends beyond procedural compliance and is fundamentally shaped by trust, transparency and psychological safety, all of which influence collaborative practice and workplace relationships.

This interpretation is supported by Van Rooyen, Rispel, Schneider and Brijnath (2021:132), who argue that trust and transparency strengthen workplace relationships and reduce fears associated with reporting adverse events. Similarly, Newman, Donohue and Eva (2020b:500) demonstrate that psychological safety promotes interpersonal trust, voice behaviour and collective learning, while Mannion and Davies (2020:3) caution that blame cultures discourage reporting and delay organisational learning. Consistent with this evidence, the present study found that limited trust and transparency weakened health professionals' willingness to report safety concerns, participate in collaborative problem-solving and engage constructively with management and organised labour. Strengthening psychological safety and fostering a culture of open communication therefore emerge as essential components of the IPUCP Model.

6.4.3 Theme 3: Absence of an inclusive IPE curriculum and capacity building

The quantitative findings showed strong support for the integration of interprofessional education in communication and safety should be integrated into all health curricula, induction and continuous professional development (CPD). Qualitatively, responses echoed this emphasising the importance of shared learning, clinical simulations, and in-service training that foster mutual understanding among health professionals. This integrated theme confirms that interprofessional collaboration cannot be assumed to develop automatically because health professionals work in the same facility. It must be deliberately taught, practised and reinforced through curriculum reform, simulation, shared learning, CPD and workplace-based capacity building.

This is consistent with the WHO framework for interprofessional education and collaborative practice, which emphasises that health professionals should learn with, from and about one another to strengthen collaborative practice readiness (Mohammed, Anand & Ummer 2021:8). It also aligns with the IPEC competency domains of roles and responsibilities, interprofessional communication, teams and teamwork, and values and ethics (IPEC 2023:1). Therefore, the absence of inclusive IPE and structured capacity building was interpreted as both an educational gap and a workplace collaboration risk. Msweli (2020:6) also emphasises inclusive, interdisciplinary training enhances respect among cadres and prepares graduated for the collaborative work environment.

6.4.4 Theme 4: Weak leadership engagement and communication

The integrated findings demonstrate that weak leadership engagement and ineffective communication constitute major barriers to secure collaborative partnerships within rural CHCs. The quantitative findings confirmed that participants viewed management as responsible for fostering positive interprofessional relationships and creating environments that encourage the timely reporting of unsafe events. The qualitative findings extended these results by identifying hierarchical organisational cultures, fear of reprisal, limited communication channels and inadequate infrastructure as underlying causes of communication breakdown. The resulting meta-inference is that leadership within rural CHCs extends beyond administrative oversight to include the relational responsibilities of promoting trust, transparency, shared decision making, open communication and collaborative problem-solving.

The literature strongly supports this interpretation by demonstrating that competent, visible and supportive leadership is fundamental to effective interprofessional collaboration. Wright, Crisp and Keeley (2020:122) contend that effective leadership strengthens psychological safety, accountability and team performance, while Letlape and Nkosi (2023:91) found that regular interprofessional engagement facilitated by leadership enhances resilience, communication and conflict resolution. Consistent with these findings, the present study demonstrates that engaged leadership creates the conditions necessary for collaborative practice, whereas weak leadership reinforces professional fragmentation, mistrust and communication failures. These findings position

leadership engagement and transparent communication as central organisational enablers within the IPUCP Model.

6.4.5 Theme 5: Fragmented interprofessional relations

The integrated quantitative and qualitative findings identify fragmented interprofessional relationships as a significant barrier to collaborative partnership within rural CHCs. The quantitative findings confirmed that unpleasant and unprofessional relationships undermine interpersonal trust and the establishment of a secure working environment, while the qualitative findings extended this evidence by revealing that historical professional silos, hierarchical practices and educational separation continue to reinforce mistrust among health professionals. Participants further identified unequal access to resources, cultural and qualification-based discrimination, and limited recognition of professional roles as factors that weakened teamwork and collaborative engagement. The resulting meta-inference is that sustainable collaboration depends not only on adequate resources but also on addressing the relational fragmentation that compromises trust, mutual respect and shared responsibility.

This interpretation is consistent with Erasmus et al (2022:178), who argue that siloed professional structures and hierarchical perceptions within rural CHCs intensify tensions between health professionals and hinder collaborative practice. Similarly, Van Wyk and Madiba (2021:9) demonstrate that structural inequalities and hierarchical workplace relationships undermine trust, continuity and effective teamwork. The present study extends these findings by showing that fragmented interprofessional relationships are rooted in both organisational structures and professional socialisation, reinforcing the need for deliberate interventions that promote role clarity, mutual respect, shared learning and inclusive collaboration. These relational elements therefore constitute an essential component of the IPUCP Model.

6.4.6 Theme 6: Dysfunctional union and structures

The integrated quantitative and qualitative findings identify dysfunctional union structures as a major barrier to sustainable collaborative partnership within rural CHCs. The quantitative findings revealed that although health professionals were generally free to participate in union activities, organised labour was perceived as largely inactive and

ineffective in representing employees' interests. The qualitative findings expanded this pattern by describing union representatives as passive, poorly visible and minimally engaged in workplace affairs, while poor communication between unions and management further weakened professional relationships. The resulting meta-inference is that union membership alone does not guarantee meaningful workplace representation, as effective collaboration depends on active union participation, constructive labour-management engagement and sustained organisational support.

This interpretation is consistent with the literature describing the declining influence of organised labour and the limited functionality of labour structures within the public health sector (Mngomezulu & Nhlabathi 2022:6). Likewise, Bester and Mash (2022:6) advocate for the revitalisation of union roles to strengthen workforce representation and collaborative governance. In the present study, dysfunctional union structures undermined employee voice, procedural justice, labour-management communication and collective problem-solving, thereby weakening secure collaborative partnerships. Collectively, the six integrated themes demonstrate that sustainable interprofessional collaboration and union partnership require coordinated interventions that address infrastructure, staffing, psychological safety, education, leadership, communication, interprofessional relationships and organised labour. This interpretation is consistent with thematic mapping approaches that explain the interconnected dynamics of professional practice, organisational governance and educational reform within resource-constrained health systems (Åkerblad, Seppänen-Järvelä & Haapokoski 2021a:310; Braun et al 2022:424; Zhou et al 2024:7) and provides the analytical foundation for the IPUCP Model and implementation guidelines presented in Chapter 7.

6.5 ENABLERS EMERGING FROM INTEGRATED FINDINGS

The section presents the key enablers that emerged from the integrated quantitative and qualitative findings and that collectively inform the development of the IPUCP Model. The meta-inferences demonstrate that sustainable collaborative partnerships in rural CHCs are strengthened by coordinated improvements in resource provision, leadership, communication, union functionality and visibility, conflict management, and interprofessional collaboration. These integrated enablers reflect areas where the quantitative and qualitative findings converged, expanded and, where applicable, diverged, thereby providing a coherent evidence base for the proposed model. The

findings are consistent with both international and South African literature, which recognises collaborative, team-based approaches as fundamental to strengthening healthcare systems and improving workplace safety within rural settings (Spiegel et al 2023:2; Van Diggele et al 2020:5).

6.5.1 Labour-management partnership

The integrated findings identify labour-management partnership (LMP) as a critical enabler for strengthening collaborative practice within rural CHCs, while simultaneously revealing significant weaknesses in its current implementation. Participants consistently highlighted declining union visibility, limited engagement and ineffective labour-management interaction despite widespread union membership. These findings converge with Liu et al (2021:65-66), who demonstrate that well-implemented LMP agreements have strengthened workplace collaboration in both the public and private sectors in the United Kingdom. The present study extends this evidence by suggesting that the principles underpinning LMP remain relevant within rural South African CHCs but require contextual adaptation to address resource constraints, organisational realities and local governance challenges.

The integrated meta-inference is that labour-management partnership remains a necessary, but insufficient, foundation for collaborative practice when implemented as a distant or fragmented organisational process. Rather, effective partnership must be operationalised at facility level through visible union representation, regular labour-management meetings, functional safety committees, transparent reporting systems and inclusive communication among management, health professionals and organised labour. This interpretation is supported by Naamati-Schneider, Shani, Ziv, Goldstein and Poles (2025:5), who identify communication, negotiation and teamwork as essential competencies for strengthening collaborative labour-management relationships in complex healthcare environments. Similarly, Botha et al (2023:276) and Dlungwane and Mabuza (2022:150) advocate for governance reforms that promote shared decision making, psychological safety and meaningful participation in workplace wellness and organisational governance.

The findings further indicate that sustainable labour-management partnership should not be confined to workplace interventions alone but should also be embedded within the

education and professional development of future health professionals. This meta-inference extends the literature by identifying interprofessional and labour-management competencies as foundational capabilities that should be developed through pre-service education, induction programmes and continuing professional development. A dual-track approach that strengthens existing labour-management structures while simultaneously embedding collaborative practice, communication and labour relations within health sciences curricula offers a context-sensitive strategy for improving governance, workplace relationships and sustainable partnership in rural CHCs.

6.5.2 Interprofessional collaboration partnership

The integrated findings identify interprofessional collaboration as a principal enabler of secure workplace relationships and sustainable service delivery within rural CHCs. The overarching meta-inference is that interprofessional collaboration and labour-management partnership should function as complementary rather than parallel processes. While interprofessional collaboration facilitates coordinated clinical practice and shared decision making among health professionals, labour-management partnership provides the governance, representation and organisational support necessary to sustain these collaborative efforts. When these two forms of partnership operate independently, clinical teams become inadequately supported and organised labour remains disconnected from the realities of frontline healthcare delivery. The findings therefore provide a strong rationale for an integrated interprofessional-union partnership approach within the IPUCP Model.

This interpretation is consistent with the WHO Interprofessional Education and Collaborative Practice (IPECP) framework, which advocates that health professionals should learn with, from and about one another to strengthen collaborative practice and improve health outcomes (Ruebling, Eggenberger, Frost, Gazenfried, Greer, Khalili, Ochs, Ronnebaum & Stein 2023:7; Utley et al 2020:4). Likewise, Van Diggele et al (2020:5) emphasise that effective interprofessional collaboration depends on appropriate planning, leadership development, communication and structured training. Hosono (2020:50-51) further argues that labour-management and employee partnerships strengthen organisational safety by promoting teamwork, consultation and shared responsibility, while Spiegel et al (2023:2) demonstrate that collaborative principles enhance safety and partnership across departments and multidisciplinary teams.

Collectively, these findings affirm that collaborative practice should extend beyond professional boundaries to include managers, organised labour and support personnel within a unified governance framework.

The present study further demonstrates that sustainable collaborative partnerships are strengthened when workplace problem-solving is led by those directly engaged in service delivery. Participants consistently supported stronger collaboration among health professionals, management and organised labour to improve communication, resource utilisation, workplace safety and quality of care. Conversely, unmet needs relating to resources, trust, respect, safety, professional recognition and organisational support were perceived to undermine both collaboration and service delivery, particularly where legislative responsibilities were poorly implemented. Consistent with Thomas and Stanley (2024:97), the findings suggest that rural CHCs should function as communities of practice that nurture innovation, shared learning and collaborative leadership. Accordingly, the IPUCP Model positions interprofessional collaboration and labour-management partnership as mutually reinforcing mechanisms for strengthening governance, workplace relationships and sustainable healthcare delivery in rural CHCs.

6.5.3 Interprofessional union and collaborative partnership

The integrated findings suggest the need for an Interprofessional Union and Collaborative Partnership (IPUCP) that brings together the principles of interprofessional collaboration and labour-management partnership. Rather than replacing existing labour-management structures, the IPUCP model integrates collaborative practice, role clarification, communication, shared accountability and workplace safety to strengthen partnerships among health professionals, management and organised labour within rural CHCs.

The rationale for the IPUCP model emerged directly from the integrated findings. Across both quantitative and qualitative strands, participants consistently identified resource shortages, weak leadership, fragmented communication, poor interprofessional relationships and dysfunctional union structures as interconnected barriers to collaboration. These findings indicate that sustainable collaboration cannot be achieved through isolated interventions but requires a coordinated partnership model capable of addressing structural, relational, professional and labour-related challenges simultaneously.

The findings further demonstrate that labour-management partnership provides an important governance foundation for collaborative practice but requires contextual adaptation for rural CHCs. Consultation between employees, organised labour and management remains a central principle of effective partnership, supporting joint problem-solving, participatory decision-making and workplace accountability (Hosono 2020:50; Spiegel et al 2023:2). The IPUCP model therefore extends conventional labour-management partnership by embedding interprofessional collaboration within these governance processes.

The integrated findings emphasise that shared expertise is essential for strengthening workplace trust, safety and collaborative practice. Health professionals, managers and organised labour each contribute distinct knowledge, responsibilities and perspectives that collectively enhance risk identification, decision-making and accountability. This interpretation is consistent with evidence that effective collaboration depends on mutual respect, shared responsibility and collective problem-solving across professional groups (Spiegel et al 2023:2; Van Diggele et al 2020:5).

Effective communication also emerged as a critical enabling condition for sustainable partnership. Participants identified fragmented communication, delayed feedback, multiple informal communication platforms and limited use of technology as major barriers to collaboration. The IPUCP model therefore advocates structured communication mechanisms that promote transparency, timely information sharing and inclusive participation among health professionals, management and organised labour, thereby strengthening psychological safety, trust and voice behaviour (Newman, Donohue & Eva 2020b:500).

The findings further highlight the importance of collaborative resource management and active stakeholder engagement. Persistent shortages of personnel, equipment, consulting space and infection prevention resources contributed to workplace conflict and strained professional relationships. The IPUCP model therefore promotes joint prioritisation, transparent resource allocation and shared monitoring processes to improve organisational responsiveness and strengthen collaborative decision-making within rural CHCs (Dlungwane & Mabuza 2022:150).

Another important finding is the need for flexible and context-responsive partnership mechanisms that recognise the realities of rural health services. Formal labour-management structures often operate at organisational levels removed from daily workplace challenges, limiting their responsiveness. The IPUCP model addresses this limitation by promoting facility-level collaboration where staffing shortages, unsafe infrastructure, communication failures and professional conflict can be resolved closer to the point of care (Sturm, Edwards, Fryer & Roth 2023:360).

The integrated findings further demonstrate that collaborative partnership contributes to staff morale, professional belonging and workforce retention. Participants consistently associated supportive leadership, respectful relationships and meaningful representation with improved motivation, dignity and professional commitment. These findings are consistent with Maslow's hierarchy of needs, particularly the importance of safety, belonging, esteem and self-actualisation, and Watson's Theory of Human Caring, which emphasises dignity, relational care and human connection within healthcare environments (Omodan 2022:370; Watson & Woodward 2020:2).

Finally, the integrated findings indicate that sustainable collaboration depends on shared governance and collective responsibility. Weak leadership engagement, fragmented interprofessional relationships and limited union visibility reduced accountability across rural CHCs. The IPUCP model responds by positioning health professionals, management and organised labour as equal partners in creating safe, respectful and collaborative workplaces, thereby strengthening organisational resilience and long-term partnership sustainability (Noordegraaf 2020:219).

6.6 SUMMARY

This chapter presented the integrated analysis of the quantitative and qualitative findings and interpreted the results through a mixed methods lens, supported by the relevant literature. The integrated findings demonstrated areas of convergence, divergence and expansion across the two data strands, providing a comprehensive understanding of the factors influencing collaboration between health professionals, organised labour and management within rural CHCs. Six overarching themes emerged from the integrated analysis, highlighting the influence of resource inadequacies, dysfunctional infrastructure, weak leadership, fragmented communication, limited trust, interprofessional

fragmentation and ineffective union participation on the establishment of safe collaborative partnerships. These findings collectively confirmed that sustainable collaboration depends on the interaction of structural, relational, educational and governance factors rather than on isolated organisational interventions.

The integrated analysis further generated a series of meta-inferences that informed the development of the Interprofessional Union Collaborative Partnership (IPUCP) Model. The findings support the need for strengthened labour-management partnerships, improved interprofessional collaboration, enhanced leadership engagement, effective communication systems, adequate resource provision, curriculum reform, technology-enabled communication and context-responsive governance within rural CHCs. Collectively, these findings provide the empirical and theoretical justification for the IPUCP Model and its implementation guidelines. Accordingly, Chapter 7 presents the development of the proposed model and accompanying implementation guidelines designed to strengthen safe, collaborative partnerships between health professionals, organised labour and management in rural CHCs.

CHAPTER 7

MODEL DEVELOPMENT AND VALIDATION

7.1 INTRODUCTION

This chapter describes the conceptual development, validation, and refinement of the Interprofessional Union and Collaborative Partnership (IPUCP) Model together with its implementation guidelines. The model is intended to promote sustainable collaboration between health professionals and labour unions, thereby supporting secure, effective, and enduring partnerships within rural and semi-rural CHCs.

The empirical findings identified several interconnected challenges that weaken workforce stability, limit meaningful union representation, and compromise workplace safety within rural CHCs. These findings highlighted the need for a theoretically informed and evidence-based framework capable of strengthening interprofessional relationships, enhancing union participation, and promoting safer working environments. In response, the IPUCP Model serves both as a conceptual framework and a practical guide that supports trust, shared governance, and psychosocial safety as essential elements of collaborative practice.

7.2 THEORETICAL AND CONCEPTUAL FOUNDATION OF THE INTERPROFESSIONAL UNION AND COLLABORATIVE PARTNERSHIP MODEL

The Interprofessional Union and Collaboration Partnership (IPCUP) model and its implementation guidelines are informed by four complementary theoretical frameworks, namely Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the Interprofessional Education Collaborative (IPEC) Core Competencies, and the Labour Management Partnership (LMP) Model. These frameworks collectively provide the ethical, conceptual, operational, and relational foundation required to strengthen collaboration between health professionals and labour unions within rural and semi-rural CHCs. Their selection reflects the contribution that each makes towards understanding the factors that influence trust, motivation, professional relationships, and collaborative

practice in complex healthcare environments. When considered together, they offer a comprehensive perspective that integrates individual wellbeing with organisational systems, thereby supporting sustainable partnerships, safe working environments, and patient centred care. Table 7.1 presents a comparative overview of the four frameworks by outlining their origins, key concepts, structural characteristics, intended goals, applicability within rural contexts, and their contribution to the development of the IPUCP Model.

Table 7.1 Comparative overview of theoretical frameworks and their relevance to the interprofessional union and collaborative partnership model

Framework/theory	Originator and domain	Core construct and structure	Primary mechanisms/competencies	Relevance in rural CHCs	Risks/limitations (contextual)	Contribution to IPCUP Model	Example of operationalisation in IPCUP
Maslow's Hierarchy of Needs	Maslow (1943); Psychology	Human motivation is arranged from physiological, safety, love/belonging, esteem, and self-actualisation	Sequenced fulfilment of needs to enable higher-order performance and collaboration	Prioritises safe staffing, equipment, and rest; builds belonging and esteem to stabilise teams	Chronic shortages can trap teams at lower tiers; burnout undermines higher-order collaboration	**Motivational pillar:** anchors psychological safety, recognition, and growth pathway	Safety audits; roster fairness; recognition schemes; protected rest; growth plans linked to CPD
Watson's Theory of Human Caring	Watson (1979) Caring Science	Ethical, relational caring (carative/caritas processes) fostering trust, dignity, empathy	Compassionate communication, reflective practice, authentic presence	Mitigates moral distress, discrimination, and conflict; improves psychosocial climate	Can be perceived as "soft" if not linked to governance; needs leadership modelling	**Relational pillar**: cultures of respect, empathy, and psychological safety	EI training; restorative circles; debriefs; civility standards; caring-based supervision
Interprofessional Education Collaboration (IPEC) Core Competencies	WHO (2010b); IPEC (2016); Health Professions Education	Four domains: values/ethics; roles/responsibilities; interprofessional communication; teams/teamwork	Shared language, role clarity, structured communication, teamwork routines	Enables team-based care under constraints; reduces duplication and errors	Turnover and uneven training threaten continuity; requires ongoing coaching	**Structural pillar**: competencies, tools, and routines that institutionalise teamwork	Role maps; SBAR/ISBAR; interprofessional huddles; joint case reviews; IPC orientation and QI teams
Labour-Management Partnership (LMP)	Kaiser Permanente and Unions (1997); Industrial Relations/Health Systems	Shared governance, joint problem-solving, participatory decision-making	Co-led committees, interest-based bargaining, joint metrics and accountability	Addresses labour tensions, retention, and safety through co-ownership	Weak/fragmented unions impede uptake; requires time and trust to mature	**Governance pillar**: unions embedded in decisions, SOPs, and accountability loops	LMP committees with TORs; SOPs for representation and release time; grievance ladders; joint safety rounds

Table 7.1 illustrates how the four theoretical frameworks are integrated to inform the development of the IPUCP Model. Maslow's Hierarchy of Needs provides the motivational foundation, Watson's Theory of Human Caring contributes the ethical and relational perspective, the IPEC Core Competencies define the capabilities required for effective collaborative practice, and the Labour Management Partnership (LMP) Model offers the organisational and labour relations dimension. Although each framework is presented individually to highlight its unique contribution, their collective integration underpins the development of the IPUCP Model and its implementation guidelines in this chapter. The operationalisation of the integrated model is further guided by the practice theory framework of Dickoff, James and Wiedenbach (1968) practice theory framework introduced in Section 7.3.

7.2.1 Maslow’s Hierarchy of Needs

Maslow’s (1943) Model conceptualises human motivation as a hierarchy, progressing from basic physiological needs to self-actualisation. In the rural CHC context, Maslow’s framework underscores that collaborative performance cannot be sustained if foundational safety, security, and resource needs remain unmet. This model emphasises:

- Physiological and safety needs: Adequate staffing, functional equipment, and safe infrastructure.
- Belongingness and esteem: Professional respect, inclusion in decision-making, and recognition of contributions.
- Self-actualisation: Opportunities for professional growth, interprofessional learning, and leadership development.

By incorporating Maslow's Hierarchy of Needs into the IPUCP Model, collaboration is conceptualised as a human centred process that reflects the everyday experiences of health professionals working in rural and semi-rural CHCs. Rather than viewing collaboration as an abstract organisational objective, the model recognises that effective partnerships are shaped by the extent to which individual needs are acknowledged and supported. Maslow's hierarchy is applied in this study through its original theoretical foundations and is extended to explain how motivation, interpersonal relationships, and broader socioeconomic conditions influence collaborative practice. Contemporary scholarship further demonstrates the continued relevance of Maslow's framework within

resource constrained healthcare environments, particularly in understanding workforce behaviour across culturally diverse and team-based health systems (Karadencheva 2025:49; Taş 2024:141).

In this study, Maslow's Hierarchy of Needs is used as an interpretive framework rather than as a rigid sequence of progressively fulfilled needs. The model recognises that health professionals may experience multiple needs simultaneously, such as a strong sense of belonging within a clinical team while continuing to face inadequate infrastructure or limited organisational support. This perspective moves beyond a strictly linear interpretation of the hierarchy and better reflects the realities of rural healthcare practice. Accordingly, the researcher developed the IPUCP Model and its implementation guidelines within an integrated theoretical framework in which Maslow's hierarchy provides the motivational and psychosocial foundation. From this perspective, unmet physiological, safety, social, and psychological needs can weaken trust, reduce team cohesion, diminish professional confidence, and discourage meaningful collaboration. The framework therefore identifies the enabling conditions that should be strengthened before the ethical, organisational, and behavioural dimensions of the model can be effectively implemented.

7.2.2 Watson’s Theory of Human Caring

Watson’s Theory of Human Caring provides the ethical and relational foundation of the IPUCP Model and is applied in this study through its original philosophical principles and science of caring. Watson (1979:17) conceptualises caring as the moral and ethical basis of professional practice, emphasising holistic care that values the dignity and humanity of every individual. Within the IPUCP Model, this perspective positions collaboration as a shared moral commitment among health professionals, labour unions, and management. Watson's ten carative factors are adapted to strengthen relational practices that promote trust, empathy, mutual respect, and a shared sense of purpose, all of which are essential for effective collaboration within resource constrained rural and semi-rural CHCs. The transpersonal caring relationship, as a central construct of the theory, further emphasises authentic human connection that extends beyond task focused interactions and recognises all professional groups as equal moral partners in collaborative practice (Watson 1979:31).

The application of Watson's theory in this study establishes an ethical context that supports caring relationships within rural CHCs while reinforcing professional accountability and interprofessional collaboration. The discussion extends these foundational principles by demonstrating their continued relevance in promoting ethical practice, relational responsibility, and collaborative engagement in contemporary healthcare settings. At the same time, scholarly critique acknowledges that an exclusive emphasis on caring may overlook structural power relationships and organisational challenges if applied without sufficient consideration of broader workplace realities (Alharbi & Baker 2020:13). For this reason, Watson's theory is intentionally integrated with the other theoretical frameworks used in this study to ensure that relational care complements, rather than replaces, organisational accountability, labour rights, and effective governance.

Within the integrated theoretical framework, Watson's Theory of Human Caring clarifies the respectful, caring, and relationally accountable conduct expected of health professionals, managers, and labour representatives (Wei & Watson 2019:21). These ethical principles are strengthened through the complementary contribution of the IPEC framework, which translates caring values into the practical competencies required for collaborative practice, effective communication, and relationship building. Together, these frameworks provide a balanced foundation for the IPUCP Model by combining ethical caring with behavioural competence and organisational accountability, thereby supporting sustainable labour management partnerships and safer collaborative practice within rural and semi-rural CHCs.

7.2.3 Interprofessional education collaboration core competencies

The IPEC framework contributes operational clarity to the IPUCP model. It identifies four domains critical to collaborative healthcare delivery:

- Values and ethics for interprofessional practice
- Roles and responsibilities
- Interprofessional communication
- Teams and teamwork

By embedding the IPEC Core Competencies within the IPUCP implementation guidelines, the model ensures that interprofessional collaboration extends beyond informal or ad hoc cooperation and becomes embedded in routine organisational practice. The competencies provide the structural framework through which Maslow's motivational principles and Watson's ethical foundations are translated into consistent collaborative behaviour. In this way, the model promotes shared standards, structured communication, clearly defined responsibilities, and coordinated decision making that strengthen partnerships within rural and semi-rural CHCs.

The four IPEC competency domains, namely communication, role clarification, teamwork, and professional values, establish the expected standards of practice for health professionals, managers, and labour union representatives within the workplace. These competencies encourage stakeholders to communicate effectively, understand and respect their respective roles, work collectively towards shared goals, and remain professionally accountable in advancing the objectives of the IPUCP Model. Their implementation is further supported by the Labour Management Partnership (LMP) Model, which provides the governance structure through which these competencies are embedded, sustained, and institutionalised within organisational practice.

7.2.4 Labour-management partnership model

The Labour Management Partnership (LMP) Model provides the governance foundation of the IPUCP Model by recognising that sustainable collaboration in healthcare depends on effective and constructive relationships between labour and management. Within the IPUCP Model, the LMP approach shifts workplace engagement from adversarial industrial relations towards joint problem solving, shared governance, and mutual accountability. The model draws on established labour management partnership principles within healthcare systems, including the Kaiser Permanente union partnership, to demonstrate how collaborative governance can strengthen organisational performance, workforce wellbeing, and service delivery (Crowley, Hilden, Silberger & Health and Public Policy Committee of the American College of Physicians 2025:835). However, evidence also indicates that labour management partnerships may be weakened where union structures are fragmented or where management commitment to meaningful shared governance is limited, allowing existing power imbalances to persist despite collaborative intentions (Iaione & Bertozzi 2025:2). Consequently, this study

recognises that the successful implementation of the LMP component requires deliberate capacity building for both management and labour representatives, supported by clearly defined guidelines, policies, memoranda of agreement, governance instruments, and realistic implementation timelines to facilitate ongoing monitoring, quality assurance, and accountability within rural and semi-rural CHCs.

Within the integrated theoretical framework, the LMP Model complements the motivational, ethical, and competency-based dimensions of the IPUCP Model by providing the organisational structures through which collaborative practice can be sustained. Maslow's Hierarchy of Needs identifies the motivational conditions that influence workforce engagement, Watson's Theory of Human Caring establishes the ethical and relational principles that guide professional interactions, and the IPEC Core Competencies define the behaviours required for effective interprofessional collaboration. The LMP Model integrates these complementary elements within a shared governance framework that supports their implementation and long-term sustainability. Together, the four frameworks demonstrate how workforce needs, ethical practice, collaborative competencies, and organisational governance interact to strengthen interprofessional partnerships within rural and semi-rural CHCs.

7.2.5 Interconnection in IPUCP model design

Building on the analytic comparison in Table 7.1, Figure 7.1 visually synthesises how the four frameworks converge within the IPUCP model. Maslow and Watson provide the humanistic base, IPEC contributes collaboration competencies, and LMP supplies the shared-governance architecture; the central form depicts IPUP as the point of integration in rural CHCs**.**

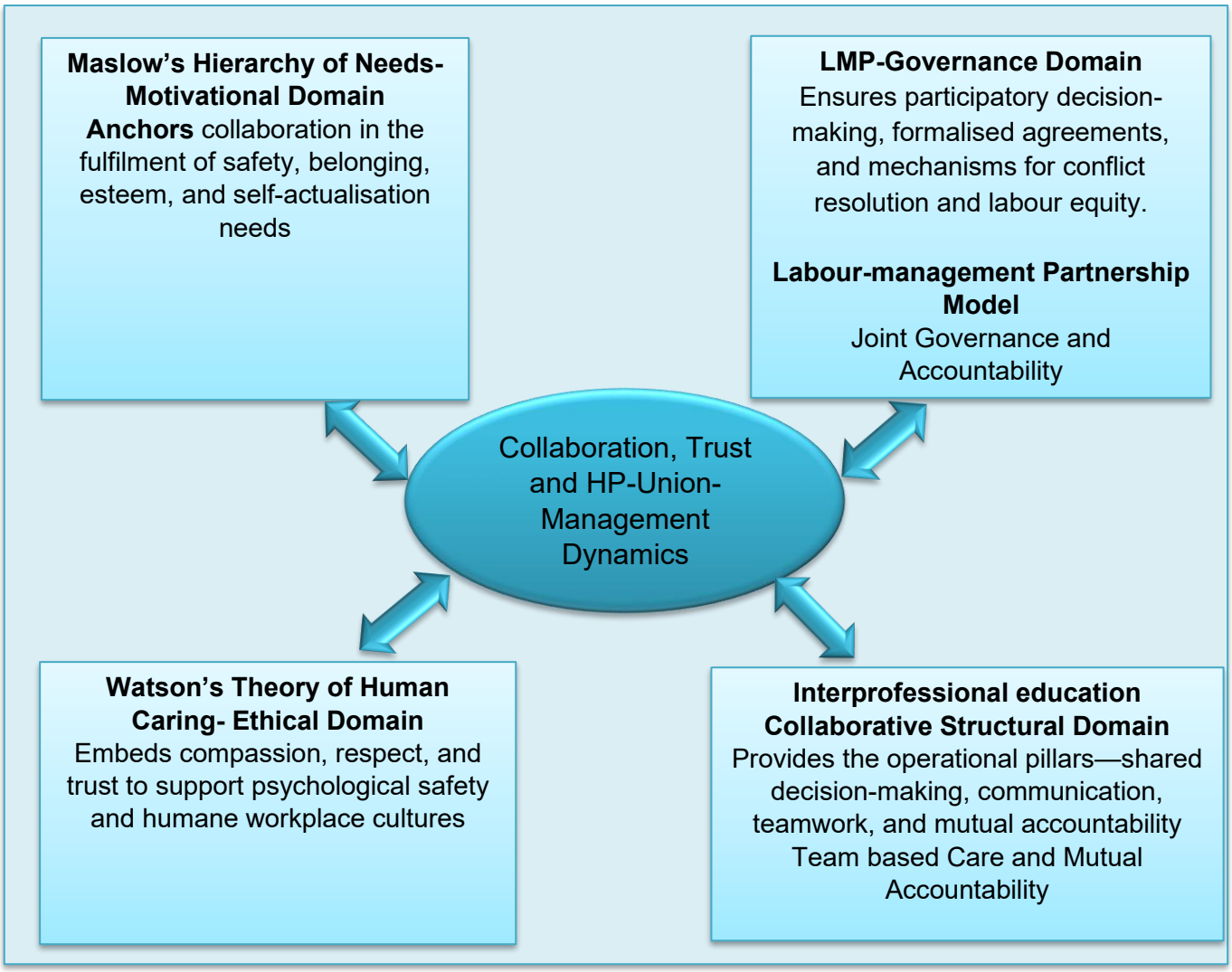


Figure 7.1 Interconnection of theoretical frameworks in the interprofessional union and collaborative partnership model design

As illustrated in Figure 7.1, the IPUCP Model functions as an integrated system rather than a simple combination of individual theoretical frameworks. This integration provides the conceptual foundation for the operational framework presented in Figure 7.2 by linking the theoretical underpinnings to their practical application. The four frameworks are intentionally sequenced to move from understanding workforce motivation, through ethical and relational practice, to organisational governance and ultimately to collaborative action. Maslow's Hierarchy of Needs identifies the motivational and psychological conditions that support sustainable collaboration, while Watson's Theory of Human Caring establishes the ethical principles and authentic interpersonal relationships required for meaningful interprofessional engagement. The Labour Management Partnership (LMP) Model extends this foundation by positioning labour, management, and governance as joint custodians of workplace conditions and institutional wellbeing.

The IPEC Core Competencies complete this integrated framework by translating motivational, ethical, and organisational principles into observable collaborative behaviours. Through competencies related to communication, role clarification, teamwork, and professional values, the model provides a structured pathway for strengthening workplace relationships and promoting institutional wellbeing. The deliberate sequencing and mutual reinforcement of these four frameworks distinguish the IPUCP Model from approaches that focus on only one aspect of collaboration, offering instead a comprehensive framework that integrates human motivation, ethical practice, professional competence, and shared governance to support sustainable collaboration within rural and semi-rural CHCs.

7.3 OPERATIONALISATION OF THE INTERPROFESSIONAL UNION AND COLLABORATIVE PARTNERSHIP MODEL

The operationalisation of the IPUCP model translates its theoretical foundations into practical, context-responsive strategies for rural and semi-rural CHCs. This section outlines how the model's components are implemented, monitored, and adapted to address the specific challenges of these environments.

Operationalisation was guided by Dickoff, James and Wiedenbach's (1968) practice theory framework, which identifies the agent, recipient, context, procedure, dynamics, and outcome of a practice. By applying this lens, the IPUCP model ensures that collaboration between health professionals, unions, and management is not merely conceptual but is embedded in day-to-day operations.

7.3.1 Framing and mapped elements (practice-theory lens)

Operationalising the IPUCP model requires translating its theoretical base into precise roles, settings, processes, and sustaining conditions. Guided by Dickoff, James and Wiedenbach's practice-theory (1968). Table 7.2 clarifies who acts, for whom, where, what is done, and what energises and sustains collaboration in rural CHCs.

Table 7.2 synthesises these five elements and their IPUCP expressions; the validated schematic representation, (Figure 7.2), locates them within a layered pathway from foundational needs and caring relations to institutionalised teamwork and shared

governance. The logic is sequential, yet mutually reinforcing agents convene and protect collaborative structures; recipients, staff, unions, patients, communities shape priorities and confer legitimacy; context determines prudent, low-tech, phased choices; procedures embed competencies, SOPs and feedback loops; and dynamics, trust, caring leadership, shared accountability sustain momentum under constraint. Sections 7.3.1.1-7.3.1.5 elaborate each element that underpins Table 7.2. This table provides the organising logic for the subsections that follows.

Table 7.2 Operationalisation of Interprofessional Union and Collaborative Partnership model components by practice theory elements

Practice theory element	IPUUP component	Operationalisation in rural CHCs
Agent (Who performs the activity)	CHC leadership, union representatives, interprofessional teams.	Lead implementation of collaborative structures; ensure policy alignment; facilitate union–management forums.
Recipient (Who benefits)	Health professionals, unions, patients, and communities.	Benefit from improved workplace safety, collaborative governance, and strengthened service delivery.
Context (Setting in which activity occurs)	Rural and semi-rural CHCs.	Resource-constrained environments with limited infrastructure, staff shortages, and diverse cultural contexts.
Procedure (Planned activities/processes)	IPUCP guidelines and implementation strategies.	Apply structured governance frameworks, role clarification, dispute resolution mechanisms, and team-building processes.
Dynamics (Energy sources/motivating factors)	Theoretical underpinnings (Maslow's hierarchy, Watson's caring theory, IPEC, LMP).	Drive motivation through meeting basic and professional needs, fostering psychological safety, and promoting mutual respect.
Terminus (Expected outcome)	Sustainable interprofessional collaboration and secure partnerships in rural CHCs.	Achieving improved workforce stability, union functionality, policy integration, and patient care quality.

As shown in Table 7.2, operationalising the IPUCP model through the Practice Theory lens offers a clear and actionable roadmap for implementation in rural CHCs. It delineates the actors responsible for driving change, identifies the intended beneficiaries, clarifies the contextual realities, and specifies the procedures, motivating forces, and intended outcomes. This mapping strengthens the model's practical relevance by ensuring that its theoretical underpinnings are systematically embedded into the day-to-day practices of

rural healthcare teams and union structures, thereby enhancing its potential for sustainability and scalability.

7.3.1.1 Agents

Operational definition: Agents are the role-players who initiate, drive and sustain collaboration within CHCs. Key actors include:

- Healthcare leaders and managers who create enabling conditions for interprofessional work and fair labour practices.
- Union representatives who advocate for staff rights and co-lead constructive decision-making.
- Interprofessional education (IPE) coordinators/champions who organise shared learning and role-clarity processes.

The agents populate the organisational layers and serve as conduits between policy (LMP) and practice (IPEC), embodying Watson's caring leadership and enabling progression of Maslow's tiers.

7.3.1.2 Recipients

Operational definition**:** Direct and indirect beneficiaries of IPUCP implementation, the primary recipients are the:

- Health professionals across cadres: benefit from safer work, clearer roles, and professional respect.
- Union representatives, patients and communities: benefit from coordinated care, fewer conflicts, and more reliable delivery of service.

Fit with schematic. Recipients sit within the pyramid's "belonging/esteem" and "self-actualisation" ambitions, quality care and dignified work realised through team-based practice (IPEC) and shared governance (LMP).

7.3.1.3 Context

Operational definition: The environmental conditions shaping implementation in rural and semi-rural CHCs, typically marked by:

- Chronic resource shortages (staffing, equipment, infrastructure).
- High turnover and burnout.
- Fragmented professional-union communication.
- Cultural and linguistic diversity affecting team cohesion.

Strategies must be realistic, resource-aware and culturally sensitive, prioritising low-tech options, phased roll-out, and community legitimacy structures depicted at the pyramid base.

7.3.1.4 Procedures

Operational definition: The planned, repeatable activities that move collaboration from policy to daily practice. Core procedure cycle.

- Establish governance: interprofessional-union committees, memorandum of understanding (MoU), and joint decision protocols (LMP).
- Build competencies: Training in communication, role clarity, and emotional intelligence (IPEC and Watson).
- Run feedback loops: Digital/paper surveys, suggestion boxes, joint reviews (IPEC and Maslow).
- Monitor and refine: Use indicators to adjust resourcing, training and governance this is part of continuous quality improvement (Maslow and LMP).

Procedures are the “rungs” that carry teams up the pyramid, operationalising structural safety (Maslow/Watson) and institutionalising teamwork (IPEC) within shared governance (LMP).

7.3.1.5 Dynamics

Operational definition: The motivational forces and relational conditions that keep collaboration viable over time.

Key dynamics to consider include:

- Trust-building through transparent, respectful communication.
- Shared accountability across unions, management and clinical teams.
- Mutual respect under caring leadership and equitable participation.

Dynamics cut horizontally across all layers of the pyramid, converting policies and procedures into lived experience, linking Maslow's safety and esteem needs and Watson's caring ethos to IPEC competencies and LMP co-ownership.

7.3.1.6 Terminus

Operational definition: The practical end-state envisaged by IPCUP in rural CHCs. Expected outcomes are:

- Workforce stability (retention, reduced absenteeism and grievances).
- Psychological and structural safety (perceived safety, civility, protected union time).
- Interprofessional cohesion (clear roles, reliable communication, effective QI teams).
- Constructive labour–management relations (routine joint problem-solving).
- Improved patient and community experience (continuity, responsiveness, trust).

The outcomes are at the apex of the pyramid, with secure, collaborative care which emerges when foundational needs (Maslow/Watson) are met, competencies (IPEC) are embedded, and governance (LMP) is shared and accountable.

Together, these six elements provide a coherent bridge from the conceptual schema to practice. The next section evaluates the IPCUP model's clarity, feasibility and contextual fit through expert validation, and documents refinements made in response to that process.

7.3.2 Integration with rural health policy

The operationalisation process aligns with the National Health Insurance Act (No. 20 of 2023) provisions for integrated service delivery, as well as the Occupational Health and Safety Act (No. 85 of 1993) and the Labour Relations Act (No. 66 of 1995). This ensures that the IPUCP model is not an isolated academic construct but a policy-compatible, implementation-ready framework.

The operationalisation of the IPUCP model was guided by Dickoff, James and Wiedenbach's (1968) Practice Theory, which provides a systematic approach to linking abstract theoretical constructs with practical, context-specific actions. This approach ensures that the model's conceptual foundations, drawn from Maslow's hierarchy of needs, Watson's Theory of Human Caring, the IPECP framework, and the Labour-management Partnership (LMP) theory are not only theoretically robust but also directly translatable into rural CHC practice.

7.4 VALIDATION OF THE INTERPROFESSIONAL UNION AND COLLABORATIVE PARTNERSHIP MODEL

7.4.1 Overview of validation approach

The validation of the IPUCP model and its accompanying implementation guidelines was a critical final step in ensuring conceptual rigour, contextual alignment, and practical applicability in rural and semi-rural CHCs in South Africa.

A blended deductive-inductive methodology was employed, guided by contemporary model validation frameworks (Grobler, Roodt, & Veldsman 2022:3; Tinch & Gray 2021:10), which emphasise the integration of empirical, theoretical, and ethical knowledge to strengthen model relevance. The process aimed at confirming:

- The structural coherence of the IPUCP model.
- The feasibility of its governance, interprofessional collaboration, and union partnership mechanisms.
- Its responsiveness to workplace safety concerns in under-resourced rural settings.

This validation approach draws on Lehmann and Gilson (2019:423) emphasis on combining scientific and conceptual evaluation to enhance both policy relevance and replicability in similar low-resource contexts.

7.4.2 Methodological process for validation

The validation of the IPUCP model and guidelines was conducted over a six-week period (June to July 2025) and was designed to combine quantitative rating with qualitative feedback ensuring both statistical rigour and contextual depth. The process was situated within the contextuality of rural and semi-rural CHCs where workforce shortages, safety, union dynamics and interprofessional and management challenges are present.

Expert reviews were purposely selected to represent a cross-section of stakeholders, including nursing service managers, union representatives, frontline health professionals, legislature policy experts and academic researchers. This diverse composition was intended to capture both professionals' practice and management and policy experts; thereby strengthening the model's feasibility and relevance.

The methodological approach was guided by Chinn and Kramer's (2014) criteria for theory evaluation which was also underpinned by the principles of credibility, inclusivity and transparency (Fawcett & Garity 2020:242; Walker & Avant 2021:157). Validation unfolded in two stages:

- Quantitative assessment: Experts completed a structured five Likert-scale questionnaire to rate the model across eight thematic domains developed for this study and informed by Chinn and Kramer (2014) criteria (Chinn & Kramer 2014:8).
- Qualitative feedback: Open-ended written responses and focus group discussions allowed experts to expand on strengths, limitations, and contextual applicability.

These approaches provided a balanced mechanism for systematically evaluating the model while integrating professional judgement and contextual realities.

7.4.3 Participants and criteria

Expert reviewers were purposively selected on the basis of their recognised expertise in one or more of the following areas: rural health service management, organised labour and union governance, interprofessional education, occupational health, or health policy. To be eligible for participation, reviewers were required to have at least five years of professional experience within their respective field together with current involvement in community health centre level practice, policy development, or related professional activities.

Inclusion criteria required participants to have:

- At least five years' experience in their professional domain.
- Direct exposure to labour–management relations in CHCs.
- Knowledge of interprofessional education and collaboration frameworks.

The expert panel comprised a balanced representation of nursing managers, labour union officials, public health specialists, and academics with experience in rural healthcare practice, thereby providing a multidisciplinary perspective for validating the IPUCP Model. Although the inclusion of eleven expert reviewers is recognised as a methodological limitation that may have constrained the breadth of contextual representation, the panel provided sufficient expertise to support the validation process. This limitation is acknowledged and discussed further in Section 8.4.

7.4.4 Findings: Quantitative and qualitative feedback

The expert validation of the IPUCP model and guidelines generated both quantitative and qualitative evidence, providing a comprehensive assessment of their clarity, coherence, and contextual relevance. To ensure methodological rigour, the findings are presented in two complementary components. The quantitative results offer a structured measure of expert agreement across predefined evaluation domains, while the qualitative feedback captures nuanced insights into strengths, limitations, and practical applicability. Together, these strands provide a balanced picture of the model's credibility and feasibility for implementation in rural CHCs.

7.4.4.1 Quantitative feedback

The eleven expert reviewers evaluated the IPUCP Model using criteria adapted from Chinn and Kramer (2014). These criteria were operationalised into eleven rating domains, which included the following:

- Simplicity: Structural clarity and logical flow
- Clarity of concepts: Definitions and applicability of core constructs
- Generalisability: Relevance across rural CHCs in different provinces
- Accessibility: ease of interpretation by unions, managers, and health professionals
- Scope of application: Potential influence on policy and operational practice
- Extent of use: Utility in training, implementation, and evaluation contexts
- Importance: Alignment with identified gaps in rural health collaboration and safety
- Logical development: Evidence-based progression from theory to strategy

Mean scores across domains ranged from 4.2 to 4.8 out of 5, indicating strong endorsement of the model's clarity, structure, and contextual fit.

The quantitative component of the validation process assessed expert agreement with the IPUCP model and guidelines across eleven thematic domains, using a five-point Likert scale (1=strongly disagree, 5=strongly agree). Table 7.3 presents the aggregated scores, reflecting the extent to which experts endorsed the model's conceptual clarity, structural coherence, contextual relevance, and feasibility for implementation in rural CHCs. These ratings provided a quantitative benchmark for identifying strengths and potential areas for refinement.

Table 7.3 Expert validation ratings of IPUCP model and guidelines

Thematic domain	Mean score	Key interpretation
Clarity and purpose	4.6	Strong agreement on model relevance, structure and clearly articulated purpose
Feasibility and applicability	4.4	Broad feasibility: rural constraints acknowledged, thus Viable with rural adaptation strategies.
Governance and policy	4.3	Sound alignment; implementation protocols require refinement, thus SOP detail improvement needed
Labour-management partnership	4.2	Trust gaps persist; structure sound, thus endorsed; trust-building remains essential
Safety and wellness	4.6	High endorsement of psychological and occupational safety

Thematic domain	Mean score	Key interpretation
Union functionality	4.2	Visibility and role clarity need strengthening
Leadership and capacity	4.3	Emotional intelligence and leadership training welcome
Communication and technology	4.5	Digital collaboration encouraged; rural tech gaps flagged
Learning and monitoring	4.4	Endorsed with need for infrastructure
Community integration	4.3	Local legitimacy key
Implementation strategy	4.5	Phased rollout perceives as pragmatic and realistic, phased approach praised

The consistently high ratings across most domains demonstrate a strong consensus among experts regarding the model's relevance and applicability. Lower-scoring areas, while still above the neutral threshold, highlighted the need for minor refinement, particularly in enhancing rural feasibility and union visibility which were addressed in the revised guidelines presented in Section 7.5.

7.4.4.2 Qualitative feedback

Qualitative feedback was obtained through open ended questions completed after each rating domain. The responses were analysed using inductive content analysis to identify recurring patterns, areas of agreement, and recommendations for improvement. The findings confirmed the theoretical coherence, practical relevance, and overall applicability of the IPUCP Model, while also identifying aspects that required contextual refinement to strengthen its implementation within rural and semi-rural CHCs. The thematic analysis of the open-ended responses identified several convergent strengths, including the following:

- Relevance and timeliness of addressing fragmented labour–management relations in rural CHCs.
- Integration of theoretical frameworks (Maslow, Watson, IPEC, LMP) as a distinctive strength.
- Clear operational pathways from policy principles to actionable strategies.
- Strong alignment with both workforce well-being and patient care improvement.

Experts also raised contextual cautions and refinements:

- The need for role clarification workshops to avoid duplication or conflict between unions and managers.
- Enhancing rural feasibility by adapting strategies for CHCs with severe staff shortages.
- Incorporating continuous feedback loops for ongoing monitoring and improvement.

To deepen the interpretation of the expert validation findings, a convergence-divergence analysis was conducted. This process mapped the alignment between quantitative Likert-scale ratings and qualitative narrative feedback, identifying areas of consensus (convergence) and points of divergence that required further exploration. The matrix presented in Table 7.4 distils these patterns, highlighting thematic strengths, contextual challenges, and opportunities for refinement of the IPCUP model and guidelines.

Table 7.4 Convergence-divergence matrix: Alignment and differences between expert ratings and comments

Domain	Convergent findings	Divergent findings	Implications/Actions
1. Governance and policy integration	Experts agreed that formalised governance structures and written policies are essential to embed IPC and LMP principles in rural CHCs.	Some expressed concern over bureaucratic delays and inconsistent enforcement of policies in rural provinces.	Streamline policy approval processes and integrate governance frameworks into existing CHC operational plans.
2. Labour-management partnership structures	Strong endorsement of joint committees and shared decision-making as mechanisms to reduce adversarial relations.	A few questioned whether management would fully commit to co-ownership of decisions.	Introduce accountability measures and regular joint performance reviews to build trust.
3. Safety and wellness	Consensus that physical and psychological safety are prerequisites for effective collaboration.	Divergence on whether psychological support services are feasible in severely resource-constrained CHCs.	Pilot low-cost mental health support options (e.g., peer debriefing circles) before scaling up.

Domain	Convergent findings	Divergent findings	Implications/Actions
4. Union participation and functionality	Agreement that union visibility and structured release time are crucial for advocacy.	Some noted that union inactivity or politicisation could limit effectiveness.	Develop performance indicators for union representatives and create transparent role definitions.
5. Transformational and caring leadership	Broad agreement on the need for leadership training in emotional intelligence and conflict resolution.	Concern from some about sustainability if leadership turnover remains high.	Embed leadership development into ongoing professional development programmes.
6. Communication and technology	Experts endorsed digital platforms for cross-disciplinary updates and real-time communication.	Divergence on whether all rural CHCs have sufficient ICT infrastructure.	Pair technological roll-out with basic ICT capacity-building and phased infrastructure upgrades.
7. Interprofessional Collaborative Practice	Strong support for institutionalising IPC as a standard operating procedure with role clarity.	Concern from some about resistance from entrenched hierarchical structures.	Integrate IPC principles into induction and orientation for all staff.
8. Motivation and team dynamics	Agreement on the value of recognition systems and psychological safety for team cohesion.	Divergent views on whether recognition systems should be monetary or non-monetary.	Adopt hybrid recognition models balancing cost and staff preferences.
9. Learning and continuous improvement	Experts supported ongoing interdisciplinary training aligned with rural needs.	Some felt workload pressures may limit staff attendance at training.	Schedule flexible, modular training sessions and provide protected learning time.
10. Monitoring and evaluation	Consensus that measurable indicators are essential for tracking progress.	Divergence on which indicators should be prioritised, staff well-being vs. service outcomes.	Develop a balanced scorecard including both workforce and service delivery metrics.
11. Implementation feasibility	General agreement that phased roll-out starting with pilot sites increases adoption likelihood.	Concern over potential pilot fatigue if implementation is too slow.	Ensure pilots have clear timelines and visible impact to maintain momentum.

The convergence-divergence analysis confirmed that the IPUCP model was conceptually sound and broadly endorsed by the expert panel. Divergences were constructive, cantering on the need to enhance rural adaptability, strengthen union engagement

mechanisms, and integrate culturally responsive strategies. These insights directly informed of the targeted adjustments detailed in Section 7.4.4 and the finalised guidelines presented in Section 7.5.

7.4.5 Adjustments made to the model

Based on the validation findings, several refinements were incorporated into the final IPUCP model and guidelines:

- Strengthened governance integration: MOUs now include explicit conflict-resolution timelines and shared monitoring responsibilities.
- Rural feasibility measures: Phased implementation plans adapted for CHCs with limited human and technological resources.
- Union visibility enhancement: Added provisions for scheduled staff–union engagement sessions and community-facing advocacy campaigns.
- Leadership capacity building: Expanded training modules on emotional intelligence, cultural competence, and caring leadership.
- Feedback and evaluation mechanisms: Embedded participatory monitoring tools (digital and manual) to track safety, collaboration, and morale indicators.

These adjustments ensure that the IPUCP model is contextually adaptable, operationally grounded, and academically defensible for implementation in South Africa's rural health system.

7.4.6 Visual representation of the developed IPUCP model

Integrating these refinements, the final validated IPUCP schematic is presented in Figure 7.2. The diagram consolidates the motivational (Maslow), relational (Watson), structural (IPEC), and governance (LMP) pillars and aligns them with the practice-theory elements (agent, recipient, context, procedures, dynamics, terminus) validated by expert review. It is a layered pyramid anchored by Maslow and Watson at the base, flanked by IPEC (competencies) and LMP (governance) pillars, with community governance at the foundation and the apex representing secure, collaborative care; cross-walked to the practice-theory elements.

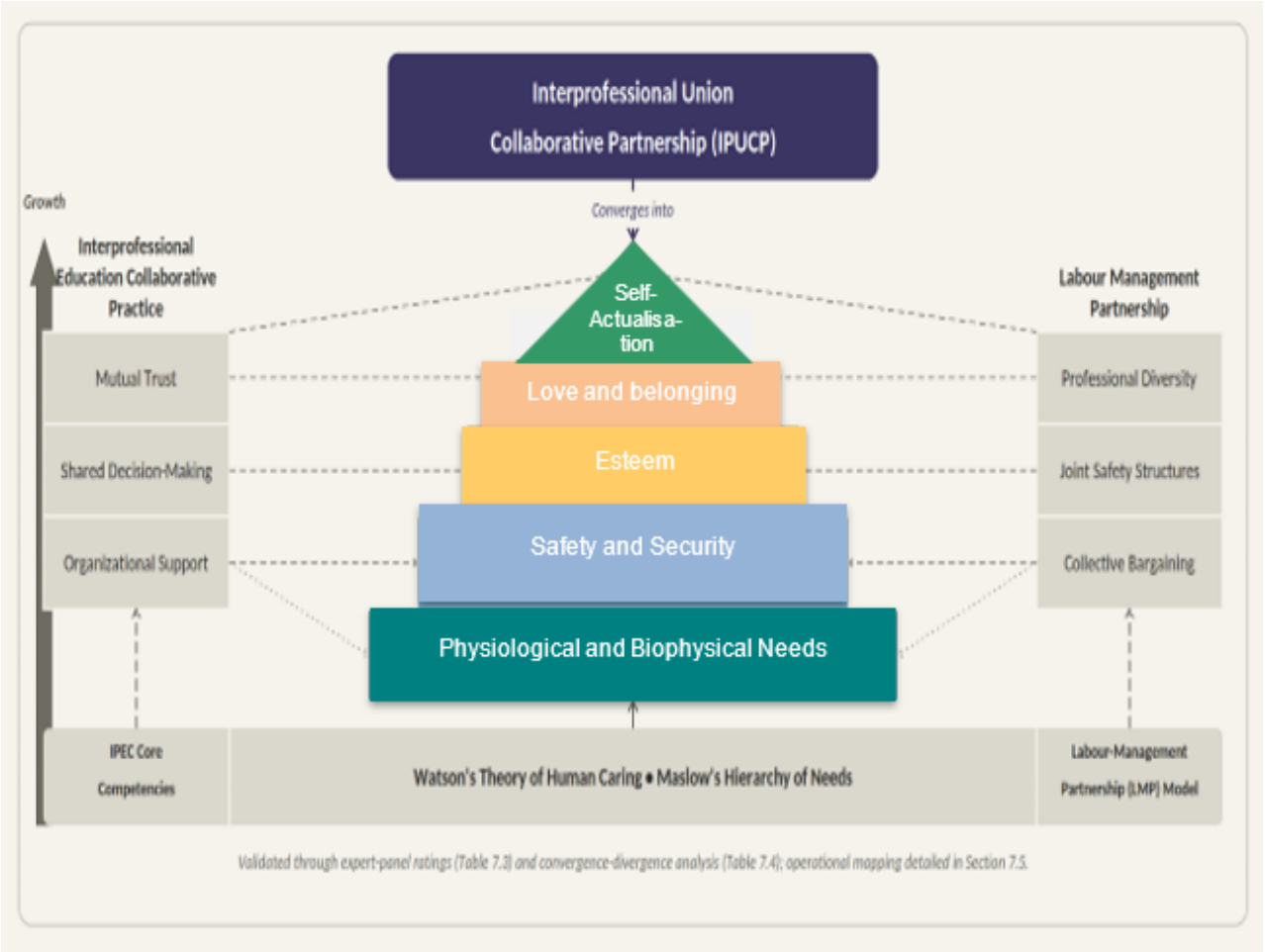


Figure 7.2 Final validated IPUCP schematic for rural comprehensive health centres

Figure 7.2 presents a schematic representation of the Interprofessional Union and Collaborative Partnership (IPUCP) Model. It integrates the expert validation findings, the quantitative ratings presented in Table 7.3, the convergence and divergence findings summarised in Table 7.4, and the operational guidelines discussed in Section 7.5. The figure therefore provides a visual synthesis of the empirical findings, theoretical foundations, and practical application of the model within rural and semi-rural CHCs. Each component of the schematic represents a specific element of the implementation framework. The schematic is organised into the following interconnected layers:

- **The central pyramid:** The pyramid illustrates the developmental structure of the model. Its foundation represents physiological and biophysical needs, informed by Maslow's Hierarchy of Needs and Watson's Theory of Human Caring. This level reflects the essential conditions for safe, caring, and dignified work, including adequate staffing, functional infrastructure, clinical resources, appropriate rest

facilities, and workforce wellbeing. Organisational Support (IPEC) and Collective Bargaining (LMP) reinforce this foundation and continue across the higher levels, emphasising that organisational and labour support remain integral throughout implementation.

- **The safety and security tier:** This level represents emotional safety, ethical leadership, equitable organisational policies, and protection from unsafe or disrespectful workplace practices. These priorities emerged strongly from both the empirical findings and expert validation. The tier is operationalised through Organisational Support (IPEC) and Collective Bargaining (LMP), which together create the structural and negotiated conditions required for a psychologically safe workplace.
- **The esteem tier:** This tier reflects professional recognition, respect, shared decision making, and meaningful participation in workplace governance. It acknowledges the importance of recognising the contributions of both health professionals and organised labour. Shared Decision Making (IPEC) and Joint Safety Structures (LMP) provide the mechanisms through which collective participation and accountability are strengthened.
- **The love and belonging tier:** This level represents mutual trust, interprofessional respect, teamwork, and a shared sense of belonging within the CHC. It aligns with the IPEC domains of values, ethics, and teamwork while responding directly to the study findings relating to fractured relationships and limited collaboration. Mutual Trust (IPEC) and Professional Diversity (LMP) reinforce an inclusive workplace culture that values diverse professional contributions.
- **The self-actualisation apex:** The apex represents the highest level of the model, where interprofessional collaboration and labour management partnership are fully integrated into secure, ethical, and sustainable workplace relationships. This stage reflects the intended outcome of the IPUCP Model.
- **The lateral anchors:** The lateral anchors demonstrate that the IPEC Core Competencies and Labour Management Partnership (LMP) principles operate across the entire model rather than as separate components. The left anchor represents interprofessional collaboration through organisational support, shared decision making, and mutual trust, while the right anchor represents labour management partnership through professional diversity, joint safety structures, and collective bargaining. Together, these anchors indicate that competency development and

shared governance remain continuous enabling mechanisms across every level of the model.

Figure 7.2 also conveys two important analytical propositions. Firstly, sustainable interprofessional and labour union collaboration depends on strong foundational workplace conditions, including adequate resources, physical and psychological safety, and effective organisational support. Secondly, the model supports phased implementation, enabling rural and semi-rural CHCs to strengthen fundamental organisational conditions before progressing towards more advanced forms of shared governance and collaborative partnership. Accordingly, the figure functions as both a diagnostic framework for assessing organisational readiness and a practical roadmap for implementing the IPUCP Model.

7.5 UPDATED IPCUP GUIDELINES AND IMPLEMENTATION STRATEGIES

The final IPUCP implementation guidelines were refined following the expert panel validation process to strengthen their clarity, relevance, and applicability within rural and semi-rural CHCs. These guidelines operationalise the theoretical foundations of the model by translating Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the IPEC Core Competencies, and Labour Management Partnership (LMP) principles into practical actions that support collaborative practice. Rather than functioning as a separate component, the guidelines provide the implementation pathway through which the IPUCP Model can be applied in everyday practice. Organised into eleven implementation domains (A to K) presented in Table 7.5, they reflect the integrated quantitative, qualitative, and validation findings and respond directly to the principal challenges identified during the study. Collectively, the domains address governance, labour management partnership, workplace safety and staff wellbeing, union participation, leadership, communication, interprofessional collaboration, workforce motivation, organisational learning, monitoring, and long-term sustainability.

For implementation purposes, the guidelines are structured across three complementary levels that facilitate a systematic and coordinated approach. The first level focuses on strategic governance through policy alignment, formal governance structures, and shared accountability, with Domains A, B, and D addressing these organisational requirements. The second level centres on implementation within the CHC by strengthening workplace

safety, leadership, communication, staff support, motivation, and interprofessional collaboration through Domains C, E, F, G, and H. The third level promotes continuous improvement by focusing on organisational learning, performance monitoring, evaluation, and sustainability through Domains I, J, and K. Together, these interconnected levels ensure that the IPUCP Model extends beyond a conceptual framework to become a practical mechanism for strengthening workplace relationships, collaborative decision making, and safe, high-quality service delivery within rural and semi-rural CHCs.

7.5.1 Governance and policy integration

Effective interprofessional collaboration and meaningful labour engagement require governance arrangements that are formally embedded at both CHC and district levels. To support this objective, health facilities should establish integrated collaboration frameworks, inclusive human resource and labour policies, and standard operating procedures that clearly define the respective roles and responsibilities of health professionals, managers, and organised labour representatives. Interprofessional union committees, supported by clearly articulated terms of reference, reporting mechanisms, and Memoranda of Understanding (MOUs), should facilitate coordinated decision making while also creating structured opportunities for early dialogue and resolution of workplace concerns before they develop into formal disputes.

7.5.2 Formalisation of labour-management partnership structures

The findings of this study indicate that the presence of labour unions alone is insufficient to achieve meaningful collaboration. Labour management partnership structures should therefore promote continuous engagement through shared governance rather than focusing solely on dispute resolution. Regular meetings of joint committees should provide opportunities to identify workplace concerns, align staff issues with management responses, monitor agreed actions using appropriate performance indicators, and strengthen transparency, accountability, and trust among management, health professionals, and organised labour.

7.5.3 Safety and wellness-centred work environments

A safe and supportive work environment is fundamental to effective collaboration within rural and semi-rural CHCs. The study demonstrated that unsafe conditions, limited organisational support, and experiences of disrespect undermine teamwork and professional engagement. Facilities should therefore implement comprehensive staff wellbeing initiatives, including counselling services, structured debriefing, wellness referral pathways, and confidential reporting systems, while addressing infrastructure deficiencies in high-risk clinical areas such as maternity, casualty, and night duty services. Regular staff surveys, suggestion systems, and feedback mechanisms should also be used to monitor safety concerns and guide continuous workplace improvement.

7.5.4 Revitalisation of union participation and functionality

The contribution of organised labour depends on its visibility, accessibility, and accountability to its members while maintaining a constructive partnership with management. Strengthening union participation requires ongoing education on labour rights, representative responsibilities, and collaborative problem solving, supported by joint dispute resolution structures that encourage the early management of workplace concerns. Clear release time arrangements for union representatives, transparent communication of representative structures, and regular engagement initiatives should further enhance understanding of union roles and encourage active participation where representation has become limited or ineffective.

7.5.5 Transformational and caring leadership capacity

Developing effective leadership is essential for fostering collaborative workplace relationships and sustaining organisational trust. Managers and supervisors should receive ongoing development in transformational leadership, emotional intelligence, conflict management, communication, labour relations, and interprofessional collaboration, with the principles of Watson's Theory of Human Caring incorporated into leadership programmes. Leadership development should extend beyond administrative responsibilities to cultivate fairness, empathy, respectful engagement, and inclusive decision making, while recognising leaders who consistently demonstrate collaborative and caring practices that strengthen workforce relationships.

7.5.6 Cross-disciplinary communication and technological integration

The findings identified ineffective communication as a major contributor to mistrust, uncertainty regarding professional roles, and fragmented teamwork. Strengthening communication therefore requires regular interprofessional meetings, multidisciplinary case discussions, safety briefings, and clearly defined communication pathways that connect professional, departmental, and labour structures. Secure digital platforms should support timely information sharing, meeting coordination, reporting of workplace concerns, and monitoring of agreed actions, while staff should receive appropriate training in professional communication, confidentiality, and the responsible use of digital communication technologies.

7.5.7 Institutionalisation of interprofessional collaborative practice

Interprofessional collaborative practice should be embedded within the routine functioning of rural and semi rural CHCs rather than implemented as an isolated initiative. This requires clear articulation of professional roles, scopes of practice, referral processes, and shared responsibilities to strengthen coordinated service delivery. Structured orientation programmes tailored to rural healthcare settings should prepare newly appointed staff for collaborative practice, particularly those with limited primary healthcare experience, while multidisciplinary quality improvement initiatives should promote collective problem solving, strengthen teamwork, and improve patient care, safety, resource utilisation, and service coordination.

7.5.8 Motivation and team dynamics

The findings demonstrated that inadequate recognition, limited organisational support, and weakened workplace relationships negatively influence staff morale and collaborative practice. CHCs should therefore strengthen team functioning through peer support initiatives, formal recognition of staff contributions, reflective team discussions, and inclusive decision-making processes that encourage active participation. Guided by Maslow's Hierarchy of Needs, these interventions should promote staff wellbeing, professional dignity, and a stronger sense of belonging, recognising motivation as an

essential component of sustainable interprofessional collaboration rather than an optional workplace initiative.

7.5.9 Learning and continuous improvement

Continuous learning should respond to the changing demands of rural healthcare by supporting the ongoing development of both professional and collaborative competencies. Training programmes should integrate ethics, effective communication, labour law, conflict management, leadership, and interprofessional collaboration, with health professionals, managers, and organised labour representatives participating in shared learning activities. This integrated approach promotes mutual understanding, strengthens collaborative relationships, and reduces divisions between clinical practice, organisational management, and labour representation.

7.5.10 Monitoring and evaluation

Ongoing monitoring and evaluation are essential to determine the effectiveness and sustainability of the IPUCP Model. Performance should be assessed using measurable indicators, including staff absenteeism, workplace grievances, unresolved conflicts, staff satisfaction, participation in meetings, reported safety concerns, referral delays, and evidence of interprofessional case reviews. Quarterly implementation reviews involving representatives from management, health professionals, and organised labour should be used to evaluate progress, identify areas requiring improvement, and guide corrective action. Monitoring should support organisational learning and continuous quality improvement by encouraging reflection and adaptation rather than focusing on punitive oversight.

7.5.11 Implementation considerations

Successful implementation of the IPUCP Model requires a phased approach supported by deliberate sustainability planning. Initial implementation should be undertaken in selected rural and semi-rural CHCs to evaluate feasibility, assess contextual suitability, and refine implementation tools before wider adoption. Long term sustainability depends on strong leadership commitment, ongoing district support, adequate resource allocation, protected time for collaborative activities, and the active participation of managers, organised labour representatives, and health professionals throughout implementation

and review processes. To promote continuity and institutional ownership, the model should be integrated into existing CHC management, quality improvement, human resource, and labour relations systems rather than introduced as a stand-alone initiative.

Table 7.5 consolidates the IPUCP implementation guidelines into eleven integrated domains that collectively provide both a conceptual framework and an operational roadmap for implementation. The guidelines translate the theoretical foundations of the model into practical strategies that strengthen governance, leadership, communication, workplace safety, union participation, interprofessional collaboration, monitoring, and long-term sustainability. Their integrated design ensures that implementation remains contextually relevant, measurable, and responsive to the evolving needs of rural and semi-rural CHCs.

For practical application, the implementation guidelines are organised across three complementary levels. The first level focuses on strategic governance through policy alignment, formal governance structures, and shared accountability. The second level addresses implementation within the CHC by strengthening communication, leadership, workplace safety, staff support, and interprofessional teamwork. The third level promotes monitoring, evaluation, and continuous improvement to sustain implementation over time. These interconnected levels position the IPUCP Model as a practical framework for improving workplace relationships, collaborative decision making, and safe service delivery. To facilitate implementation, Table 7.5 summarises the eleven domains, their purpose, and the corresponding implementation strategies, providing a practical reference for policy makers, district managers, CHC managers, organised labour representatives, and frontline health professionals responsible for embedding the model into routine practice.

Table 7.5 Interprofessional union collaborative practice guidelines and implementation domains with corresponding strategies

Domain	Purpose	Key strategies
A. Governance and policy integration – IPC and LMP	Institutionalise interprofessional collaboration and labour union engagement through structured governance and formal policy alignment.	• Develop a collaboration framework, inclusive HR–labour policies, and SOPs. • Establish interprofessional-union committees at CHC level. • Embed collaborative principles in both formal governance and informal relational spaces. • Draft MOUs defining shared goals and responsibilities across unions and clinical units.
B. Formalisation of labour-management partnership structures LMP	Shift from adversarial industrial relations to collaborative governance.	• Establish joint union–management committees with clear terms of reference (TORs). • Create feedback loops linking staff concerns to strategic decisions. • Monitor effectiveness using agreed performance indicators.
C. Safety and wellness-centred work environments	Promote psychological and physical safety as prerequisites for collaboration.	• Introduce psychological support services, including counselling and debriefing. • Upgrade infrastructure in maternity, casualty, and night-shift units. Use digital surveys, dashboards, and suggestion boxes to capture staff concerns.
D. Revitalisation of union participation and functionality	Re-establish unions as trusted, visible and accessible advocates.	• Launch union visibility and labour rights awareness initiatives • Create joint dispute-resolution committees. • Formalise release-time agreements for union representatives. • Clarify representative hierarchies and reporting pathways.

Domain	Purpose	Key strategies
E. Transformational and caring leadership and capacity building	Build emotionally intelligent, ethically grounded and collaborative leaders.	• Provide leadership training in conflict resolution communication and emotional intelligence. • Integrate human caring theory and IPC values into leadership workshops. • Recognise inclusive leadership behaviour.
F. Cross-disciplinary communication and technological integration	Enable inclusive, timely decision-making and relationship-building.	• Establish secure digital communication platforms. • Schedule safety briefings and case reviews. • Train staff in collaborative communication tools and digital etiquette.
G. Institutionalisation of interprofessional collaborative practice (IPCP)	Anchor team-based care as standard practice in rural and semi-rural CHCs.	• Define team roles and responsibilities. • Launch rural focused on boarding programmes. • Implement ongoing IPC quality improvement projects.
H. Motivation and team dynamics	Foster psychological safety, inclusion, professional esteem and team belonging.	• Use Maslow's framework to assess and address staff wellbeing. • Build peer support and recognition systems. • Promote team reflection and shared decision-making.
I. Learning and continuous improvement	Align learning processes with evolving rural care, labour and collaboration needs.	• Update curricula with ethics, communication, IPECP and labour law. • Host interdisciplinary workshops for staff, managers and organised labour representatives. • Create participatory learning and feedback systems.
J. Monitoring and evaluation	Track implementation fidelity, collaborative functioning and workplace impact.	• Use shared indicators. Such as absenteeism, grievances, safety concerns and IPC activities • Conduct Quarterly implementation reviews.

Domain	Purpose	Key strategies
		• Adjust strategies iteratively based on feedback and evidence.
K. Implementation and sustainable considerations	Ensure feasibility, engagement, and sustainability.	• Pilot in selected CHCs. • Engage unions, managers, and staff in reviews. • Secure long-term resources. • Embed IPUCP processes into routine operational planning and evaluations

By consolidating the IPUCP guidelines into these domains, Table 7.5 consolidates the IPUCP guidelines into implementation domains for rural and semi-rural CHCs. The table links the model's theoretical foundations to actionable strategies for governance, leadership, communication, safety, union participation, collaborative practice, monitoring and sustainability. This supports implementation that is contextually relevant, measurable, and adaptable to the evolving needs of rural and sei rural CHCs.

7.6 SUMMARY

This chapter presented the development, operationalisation, and validation of the IPUCP model, designed to strengthen collaborative relationships between health professionals, labour unions, and management in rural and semi-rural CHCs.

The chapter began by integrating the theoretical and conceptual foundations (Maslow's Hierarchy of Needs, Watson's Theory of Human Caring, the IPECP framework, and Labour-management Partnership principles) into a unified model that responds to the systemic challenges of workforce instability, union invisibility, and unsafe work environments. Through the operationalisation process, these frameworks were translated into actionable strategies that address governance, communication, safety, leadership, and continuous learning within the rural CHC context.

The four theoretical frameworks were not incorporated solely to support the conceptual development of the IPUCP Model but were critically examined through their original foundational sources. Each framework was evaluated for its contribution to the model

while recognising its contextual strengths and limitations within resource constrained and culturally diverse rural healthcare settings. To demonstrate their integration, concluding bridge paragraphs in Sections 7.2.1 to 7.2.4 explicitly explain the distinct contribution of each framework and illustrate how, collectively, they form the theoretical foundation of the integrated IPUCP Model.

The validation phase engaged a purposively selected panel of experts with diverse expertise in healthcare leadership, organised labour, interprofessional education, and rural service delivery. The use of a mixed-method validation design ensured both quantitative rigour and qualitative depth. Findings confirmed the model's conceptual clarity, structural coherence, contextual relevance, and practical feasibility, while also identifying refinements to enhance rural adaptability, union visibility, and leadership capacity.

Building on the validation results, updated IPUCP guidelines and implementation strategies were developed across eleven thematic domains (Section 7.5), offering a comprehensive roadmap for embedding interprofessional-union collaboration into policy, governance, and day-to-day operations of rural CHCs. These guidelines also incorporate mechanisms for monitoring, evaluation, and iterative improvement, ensuring sustainability and responsiveness to evolving service delivery demands.

In essence, the IPUCP model and guidelines represent a novel, evidence-based contribution to strengthening rural health systems in South Africa. They not only address the gaps identified in earlier chapters but also provide a replicable framework for fostering psychologically safe, equitable, and collaborative workplaces that align with both patient-centred care and labour rights imperatives.

Chapter 8 is a summary of the findings from the entire study, presenting the meta-inferences, conclusions, recommendations, and implications for policy, practice, education, and further research. It will also discuss how the IPUCP model integrates into the broader discourse on interprofessional collaboration and labour relations in low-resource health settings, positioning it as a potential blueprint for systemic reform.

CHAPTER 8

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

This chapter synthesises the study by presenting its main findings, conclusions, and implications. It highlights the contribution of the research to understanding interprofessional and union collaboration in rural CHCs in South Africa. The chapter also acknowledges limitations, sets out recommendations for policy, practice, education, and further research, and presents final reflections on the scholarly and practical value of the study.

8.2 OVERVIEW OF THE RESEARCH DESIGN AND METHODS

The study adopted a sequential explanatory mixed-methods design, deemed appropriate for addressing the complex dynamics of interprofessional and union collaboration in rural CHCs. Data was collected from health professionals and union representatives across six CHCs in Mpumalanga, Northwest and Gauteng Provinces. The design unfolded in three phases: quantitative, qualitative, and integration, culminating in the development and validation of the model and its operational guidelines. Each phase was conducted independently and later systematically integrated to ensure convergence, divergence, and expansion of findings. This approach allowed the strengths of one method to offset the limitations of the other, producing a comprehensive understanding of the phenomenon (Flanagan & Beck 2024:112).

The methodological significance lay in its ability to generate empirical evidence for the development of an evidence-based IPUCP model and guidelines aimed at strengthening collaboration in rural and semi-rural CHCs.

8.2.1 Quantitative phase

A structured questionnaire was distributed to 69 health professionals, of which 42 were returned (61% response rate). The tool employed a five-point Likert scale to assess

leadership, communication, safety, union visibility, and collaboration. Simple random sampling gave all potential participants an equal chance of inclusion. Validity and reliability were enhanced through pretesting, expert review, and item analysis. Descriptive statistics (frequencies and percentages) established patterns, while internal consistency testing ensured reliability.

8.2.2 Qualitative phase

Complementing the survey, qualitative data was generated through three focus groups and ten interviews. Eligibility requires at least six months' service in rural/semi-rural CHCs. Convenience sampling was used due to operational constraints such as shift rosters and staff shortages. Although this limits generalisability, credibility was enhanced by including diverse cadres across provinces and triangulating with survey findings (Emerson 2021:96-100; Lines, Sullivan, Smith & Patel 2022:574-576).

Analysis followed Braun and Clarke's (2021) six-step thematic framework: familiarisation, coding, theme searching, review, definition, and reporting (Sandiya & Bhuvaneswani 2025:296). Manual coding was employed, fostering deeper engagement with the data and nuanced theme development. Together, the two phases provided breadth and depth: quantitative data revealed measurable trends, while qualitative findings offered contextual richness and explanatory power.

8.2.3 Integration of data

The final phase involved meta-inference, integrating quantitative and qualitative results to guide model and guideline development. Integration entailed:

- Convergence: Findings reinforced across data sets.
- Divergence: Findings differed across data sets.
- Expansion: Qualitative insights extended statistical trends.

Integration strategies included narrative weaving, joint displays, and iterative interpretation (Bavaresco, D'Oca, Ghisi & Lamberts 2020:15; Creswell & Plano Clark 2023b:235). This strengthened explanatory power and provided a robust foundation for theory building.

The integrated findings informed the IPUCP model, theoretically grounded in Maslow's hierarchy of needs, Watson's theory of human caring, Interprofessional Education Collaborative (IPEC) competencies, and labour-management partnership (LMP) theory. These frameworks served as interpretive anchors, ensuring the model addressed the multi-layered needs of health professionals and unions. Following the three phases of data collection and integration, the model was subjected to expert validation using Likert-scale ratings and qualitative feedback. This was not a separate phase of the study, but a process to strengthen credibility and ensure practical applicability. This confirmed its relevance, feasibility, and clarity, while also generating refinement to strengthen contextual applicability.

8.3 SUMMARY AND INTERPRETATION OF FINDINGS ALIGNED TO OBJECTIVES

This section synthesises the findings in relation to the seven research objectives. By aligning quantitative and qualitative evidence with the theoretical foundations, the analysis demonstrates how the study achieved its aims and generated the IPUCP model. Each subsection revisits an objective, integrates results, and highlights its contribution to the development of the validated model.

8.3.1 Research objective 1: To explore the lived experiences of collaboration between health professionals and unions in rural comprehensive health centres

The findings revealed fragile but significant potential for collaboration between health professionals and union representatives. Narratives highlighted fragmented communication, weak union presence, and limited managerial support, yet also expressed a strong aspiration for trust-based partnerships that could safeguard both workforce and patients.

These experiences converge with Mabunda, Khoza-Shangase and Ramukumba (2022:10) on trust and psychological safety as foundations for collaboration, and with Wasti and Afsar (2023:112) on the coexistence of strain and aspiration in lived professional experience.

These experiences converge with Mabunda, Khoza-Shangase and Ramukumba (2022:10), who emphasise trust and psychological safety as foundations for collaboration. Wasti and Afsar (2023:112), further affirms these findings, that lived professional experiences often hold both strain and aspiration. The study extends this work, however, by showing that in rural CHCs the two are causally linked rather than merely co-present: the conditions that fragment collaboration are the same conditions that generate the aspiration for it. Aspiration should therefore not be mistaken for latent readiness while the material conditions that suppress it remain unaddressed. Research objective 1 was therefore realised by illustrating both the challenges and the possibilities inherent in rural CHC collaboration.

8.3.2 Research objective 2: To identify barriers that limit positive collaboration

Barriers to collaboration were systemic rather than incidental. More than 70% of participants reported inadequate communication structures, insufficient resources, and weak conflict-resolution mechanisms. Qualitative accounts confirmed that exclusion of unions from decision-making reinforced mistrust and adversarial relations. These findings align with Schot et al (2020b:340), who caution that poorly structured systems erode trust, and Carroll et al (2025:5), who notes that unmet workplace needs weaken collective agency. Research objective 2 was thus addressed by identifying how structural and organisational weaknesses undermine collaboration in rural CHCs.

8.3.3 Research objective 3: To explain the role of trade unions in fostering secure professional relationships in rural community health centres

This objective was achieved by clarifying both the potential and the shortcomings of union engagement. While unions are mandated to advocate for fair labour conditions, safety, and equitable staffing, participants frequently described them as absent or reactive. Quantitative findings showed that more than 65% of respondents perceived union visibility as weak.

These findings converge with Fasanmade's (2021:4) on union presence in low-resource health systems. The study extends it by distinguishing union presence from union effectiveness. In these CHCs staff paid dues to unions that were nonetheless functionally absent. Participants also highlighted instances where active union involvement improved

procedural fairness and staff protection, reinforcing findings by Mwangi, Karuiki and Mburu (2023:8) that unions remain vital actors in workforce stability. Thus, research objective 3 was achieved in showing that unions hold significant potential as partners in secure professional relationships, but their contribution is constrained by structural and organisational barriers.

8.3.4 Research objective 4: To describe the elements that promote positive collaborative relationships

The fourth objective was attained through both quantitative and qualitative data, which identified safety, transparent communication, respectful relationships, and role clarity as key enablers of collaboration. Survey results showed that 92% of participants endorsed safety as central to collaborative practice. These findings are consistent with Neubauer, Wagner, Lörwald and Huwendiek (2024:3), who argue that collaboration flourishes when grounded in clearly defined roles and trust-based leadership. Research objective 4 was therefore achieved by identifying a coherent set of structural and relational elements that collectively foster positive interprofessional and union collaboration in rural CHCs.

8.3.5 Research objective 5: To explore perceptions of health professionals and unions regarding collaborative relationships in rural comprehensive health centres

This objective revealed mixed perceptions. While most health professionals recognised collaboration as essential to safe and patient-centred care, they also described unions as inconsistent and often invisible. Read together, these positions locate the study's divergence from purely culturalist account. Alswayat, MacVaugh and Akbar (2021:2243) tie perceptions of collaboration to Visser (2024:651) similarly highlights that skepticism arises when collaboration does not translate into tangible improvements.

This study qualifies both by showing that, in rural CHCs, perception tracked structural reality more closely than culture alone, professionals' scepticism was a rational response to unmet resource and safety needs, not a cultural disposition to be corrected through attitude change.

Thus, objective five was achieved by demonstrating that while collaboration is widely valued, weak union engagement and resource gaps undermine professionals' confidence in sustaining effective partnerships.

8.3.6 Research objective 6: To explore possible measures for strengthening collaboration between health professionals and unions

The sixth objective was addressed by identifying context-sensitive measures to enhance collaboration. Participants recommended increased resource provision, embedding interprofessional education into staff development, establishing regular joint forums, and using technology to overcome communication barriers across dispersed rural sites. These measures align with global guidance from Vazquez-Brust, Piao, De Melo, Yaryd and Carvalho (2020:4), which stresses that sustainable collaboration requires structural support, training, and governance mechanisms. Research objective 6 (RO6) was thus achieved by presenting evidence-based measures that can strengthen collaboration and security within rural CHCs.

8.3.7 Research objective 7: To develop an evidence-based, validated model with guidelines

The seventh objective was optimally achieved through the development and validation of the IPUCP model and its operational guidelines. The model integrates empirical findings with theoretical frameworks, including Maslow's hierarchy of needs Watson's theory of human caring, IPEC collaborative competencies, and the Labour-management Partnership framework. Expert validation confirmed the model's clarity, feasibility, and contextual relevance, with mean ratings above 4.2 across domains. The IPUCP model provides a structured pathway to strengthen interprofessional and union partnerships in rural CHCs, addressing safety, inclusivity, and resilience.

The research model is consistent with literature indicting that, health system models are likely to be implemented successfully when they are grounded in shared governance, contextual responsiveness, and meaningful stakeholder participation (Best, Greenhalgh, Lewis, Saul, Carroll and Bitz 2022:12-14). Similarly, Reeves et al (2021:6-8) emphasise that interprofessional collaboration frameworks are effective only when organisational structures support trust, role clarity, and joint decision-making. From a governance

perspective, Ansell, Sørensen and Torfing (2023:574–576) argue that participatory and interactive governance strengthens accountability and sustainability in complex public health settings. In addition, models are more likely to succeed when they are responsive to local culture, context and stakeholder ownership (Crooks, Tully, Allan, Gillham, Durrheim and Wiggers 2022:183).

Research objective 7 was therefore achieved. The study developed and validated an evidence-based, contextually responsive IPUCP model with operational guidelines that can be piloted and applied to strengthen collaborative practice, workplace stability and secure partnerships in rural and semi-rural CHCs.

In conclusion, IPUCP model and the guidelines offer a more effective, flexible, and human centres approach to securing partnerships in rural areas aligning with Maslow and Watson hierarchy of needs. Unlike LMP, which often creates silos and power dynamics, IPUCP directly addresses workplace challenges within each CHC, ensuring the well-being of health professionals and strengthening the rural health system.

8.4 CONCLUSIONS

Read across the seven objectives, the findings resolve into a single argument: workplace insecurity in rural CHCs is co-produced by the interaction of structural, relational and governance failures, rather than by one isolated deficit. This study confirms existing scholarship on the centrality of collaboration to workforce retention, continuity of care and health system resilience (Britnell 2019:353; Elnaiem, Mohamed-Ahmed, Zumla, Mecaskey, Charron, Abakar, Raji, Bahalim, Manikam, Risk & Okereke 2023:703). However, it also extends this scholarship by showing that, in low-resource rural CHCs, collaboration cannot be treated as an independent variable that can be improved through goodwill alone. Rather, collaboration emerges when resources, trust, communication, leadership, role clarity and union visibility are strengthened simultaneously.

The study also qualifies the Labour-management Partnership literature. Labour-management Partnership assumes functional union structures and organised engagement; however, this study found that union presence does not automatically translate into union effectiveness. This reinforces the need for formalised union structures, role clarity and protected spaces for engagement in rural CHCs (Sinha, Chiu

& Srinivas 2021:667). The IPUCP model is therefore not merely an additive combination of four theoretical perspectives. It argues that human needs, caring relations, collaborative competencies and shared governance are interdependent conditions for secure interprofessional and union collaboration.

This study examined the dynamics of interprofessional collaboration and union engagement within rural CHCs in South Africa through a sequential explanatory mixed-methods design. By integrating survey trends, qualitative narratives, and expert validation, the study demonstrated that current systems in rural and semi-rural CHCs are not adequately positioned to ensure safe, cohesive, and sustainable service delivery. Six overarching conclusions are drawn:

- Collaboration is fragile
  Persistent professional silos, weak leadership, and limited union visibility fragment teamwork, erode trust, and destabilise the workforce. These conditions compromise continuity of care and confirm the centrality of collaboration to workforce retention and patient outcomes (Britnell 2019:353; Elnaiem et al 2023:703).

- Union roles remain marginalised
  Despite legislative provision, unions lack structural legitimacy and protected space for meaningful engagement in rural CHCs. Their exclusion often fosters adversarial relations. Validation findings confirmed the need for formalised union structures and role clarity to address tensions (Sinha, Chiu & Srinivas 2021:667).

- Ethical and inclusive leadership is indispensable
  The study highlighted the absence of fairness, empathy, and transparency in management. The relevance of Watson's Theory of Human Caring and emotional intelligence frameworks was affirmed; underscoring leadership grounded in compassion as vital for trust and cohesion (Juste 2024:14)

- Collaborative readiness must be built deliberately
  Effective collaboration requires intentional investment in communication skills, role clarity, and conflict management. Professional development and interprofessional education (IPE) are central to cultivating collaborative capacity (Gautama, Kharismawati, Astuti, Maulidyati & Hidayatulloh 2023:79).

- Safety perceptions determine collaborative success
  Fair labour practices, non-discrimination, and supportive supervision strongly influence health professionals' morale and willingness to collaborate. Where safety is assured, collective problem-solving becomes possible (Oppert, Dollard, Murugavel, Reiter-Palmon, Reardon, Cropley & O'Keeffe 2022:2).

- The IPUCP model provides a validated pathway for strengthening rural CHCs
  The IPUCP model emerged as a theoretically grounded and contextually feasible framework for strengthening collaboration in rural CHCs. Expert validation confirmed its clarity, safety emphasis, and communication value. By integrating Maslow, Watson, IPEC, and Labour-management Partnership theory, the model offers both conceptual legitimacy and practical applicability. Community and traditional leadership were identified as critical anchors for sustainability.

The IPUCP model supports enhanced communication, local problem-solving, resource responsiveness, stakeholder engagement, flexibility, staff morale and sustainable partnerships. It recognises that many rural CHC challenges require timely, context-sensitive responses rather than delayed escalation to external structures. By creating a platform for structured dialogue, shared accountability and negotiated solutions, the model can assist health professionals, management and organised labour to respond collectively to staff shortages, resource allocation concerns, professional disparities and strained workplace relations. In this way, the model promotes a human-centred approach aligned with the study's theoretical foundations and with the practical realities of rural and semi-rural CHCs.

Taken together, the study advances understanding of the systemic, relational, and organisational factors that shape interprofessional and union collaboration in resource-constrained settings. The development and validation of the IPUCP model constitute a substantive contribution, offering a structured, evidence-based, and context-sensitive framework to inform policy, guide professional practice, and enhance health system resilience in South Africa and comparable contexts.

8.4.1 Contribution of the research

This study was located within the pragmatist paradigm (Chapter 1 − see Section 1.7.2.1 to 1.7.2.5) and applied in Chapter 3. The paradigm contributed to the research by allowing the researcher to examine the interpositions and union collaboration in in rural ad semirural CHCs as both measurable and interpreted reality. This was important because workplace insecurity in these settings was not only reflected in quantifiable concerns such as staff shortages, resource gaps and weak communication systems, but also in the meanings that health professionals attached to those conditions through their lived experiences. The integration of these findings contributed to the development of the IPUCP model within clinical, organisational and social settings that remain under-represented in the workforce safety evidence base.

Ontologically, pragmatism enabled the study to recognise that the realities of rural CHCs are both structural and relational. The quantitative findings showed the extent of workplace challenges, while the qualitative findings explained how those challenges were experienced by health professionals and organised labour representatives. This made visible the co-production of workplace insecurity through staff shortages, resource gaps, relational strain, communication challenges and limited district-level support.

Epistemologically, the paradigm supported the generation of practical and actionable knowledge. The sequential explanatory design allowed the survey findings to identify patterns across the six CHCs, while the interviews and focus groups provided deeper explanations of the mechanisms behind those patterns. The integrated meta-inferences therefore became the practical knowledge base from which the IPUCP model was developed.

Axiologically, the pragmatist position aligned with the study's concern for workforce dignity, fair labour relations, safe working environments and collaborative practice. The study was not limited to describing problems; it sought to generate a model that could contribute to improving interprofessional and union collaboration in rural and semi-rural CHCs.

Methodologically, pragmatism justified the use of both quantitative and qualitative methods in a small, dispersed and resource-constrained rural context. The integration of

the two data strands strengthened the study by showing how structural conditions, relational experiences and governance gaps jointly shaped workplace insecurity and collaboration. This integrated approach enabled the study to explain both rural service-delivery dynamics and labour-related dynamics within the participating CHCs.The study managed to explain the rural dynamics and labour related dynamics integrating the two data strands followed from the pragmatist position.

The pragmatist paradigm was therefore not only a philosophical position, but also an active contributor to the study's outcome. It enabled the development of the IPUCP model as a contextually grounded and practice-oriented contribution to knowledge. A purely quantitative approach could have measured structural deficits, while a purely qualitative approach could have described relational strain. The pragmatist approach made it possible to integrate both forms of evidence and develop a model that responds to the realities of resource-constrained rural and semi-rural CHCs. The IPUCP model therefore contributes to knowledge by linking interprofessional collaboration, organised labour participation, human-centred leadership and shared governance as interconnected conditions for secure and sustainable workplace partnerships.

The model responds to the realities of rural and semi-rural CHCs by linking interprofessional collaboration, organised labour participation, human-centred leadership and shared governance as interconnected conditions for secure and sustainable workplace partnerships.

8.5 RECOMMENDATIONS

The findings of this study underscore the necessity of embedding collaborative governance mechanisms into the operational culture of rural CHCs. Literature affirms that sustainable healthcare delivery in rural and semi-rural contexts requires strong social and professional networks that foster trust, accountability, and joint decision-making (Almeida, Frino & Milosavljevic 2020:605). Building on the integrated evidence, three domains of recommendations are advanced: policy and practice, education and capacity building, and future research.

8.5.1 Recommendations for policy and practice

- Institutionalise the IPCUP model through DoH policies that mandate formalised collaborative structures at facility and district levels.
- Formalise joint labour-management committees with shared decision-making authority to address staffing, safety, and workplace conflict.
- Allocate protected and budgeted time for union representation, thereby preventing dual-role conflict and strengthening legitimacy of union functions.
- Implement accessible grievance mechanisms for staff and management in line with labour legislation, supported by independent monitoring.
- Mandate reporting on interprofessional collaboration indicators as part of facility performance metrics within the DHS.

8.5.2 Recommendations for education and capacity building

- Integrate interprofessional collaboration, ethical governance, and labour engagement into undergraduate and postgraduate health curricula.
- Establish CPD programmes on collaborative leadership, communication, and emotional intelligence.
- Adopt simulation-based interprofessional learning to strengthen teamwork, conflict resolution, and ethical decision-making in clinical settings.

8.5.3 Recommendations for research

- Pilot the IPUCP model across multiple provinces, monitoring long-term effects on staff retention, workplace safety, and patient outcomes.
- Examine the mediating role of leadership styles and organisational culture in shaping interprofessional collaboration.
- Explore the role of community actors, including traditional leaders and clinic committees, in sustaining workplace harmony and embedding collaborative practices.

8.6 CONTRIBUTIONS OF THE STUDY

This study makes contributions at several levels of scholarship and practice:

- Empirical contribution: It extends South African scholarship by examining interprofessional-union relationships in rural CHCs through a validated mixed-methods design, addressing an underexplored area in health systems research.
- Theoretical contribution: The study advances theory by integrating Maslow's hierarchy of needs, Watson's theory of human caring, IPEC collaborative competencies, and labour-management partnership (LMP) theory into the IPUCP model, a contextually grounded framework for collaborative practice in resource-limited rural health systems.
- Methodological contribution: The combination of manual thematic coding, supported by Excel for organising qualitative codes and themes, The SPSS version 26 based quantitative analysis demonstrates methodological rigour and replicability, providing a model for investigating sensitive labour–management dynamics in complex health environments. Practical contribution: The IPUCP model and its operational guidelines may provide a structured tool to pilot ready tool that can be applied to strengthen workforce stability, interprofessional trust, and union engagement. The framework is adaptable across health systems in Africa and other low-resource contexts.

8.7 LIMITATIONS AND STRENGTHS OF THE STUDY

While the study demonstrates methodological strength, certain limitations are acknowledged to guide interpretation, transferability, and replication.

8.7.1 Strengths of the study

- Multi-site rural realism: Data were drawn from six rural/semi-rural CHCs across three provinces, providing a credible cross-section of DHS realities.
- Objective attainment: All research objectives were addressed, culminating in a validated, implementation-ready IPUCP model and guidelines.

- Mixed-methods depth: Integration of qualitative narratives with quantitative endorsement enhanced validity, triangulated sensitive labour–management issues, and generated context-specific insights.

8.7.2 Limitations of the study

Design and sampling:

- The quantitative arm relied on non-probability sampling, limiting generalisability beyond the selected sites.
- Representation gaps emerged, with nurse predominance in rural CHCs overshadowing perspectives from other cadres and union groupings, although it is a reality in CHCs staffing skill mix.
- Conducting interviews and focus groups within CHC settings may have introduced social desirability and appeasement bias.

Data-collection context:

- Site and modality shifts led to replacement of some focus groups with individual interviews, which reduced interactional richness.
- Conducting interviews and focus groups within CHC settings may have introduced social desirability and appeasement bias.

Operational and logistical constraints:

- Geographical spread and safety concerns restricted repeat visits and limited the breadth of sampling.
- Financial and logistical constraints curtailed expansion beyond six CHCs.
- Shift rosters and workload pressures limited participation, potentially skewing data towards those most available.

External validity and timing:

- The study focused on rural and semi-rural CHCs in Gauteng, Northwest, and Mpumalanga; findings may require adaptation for other provinces.
- Core data were collected pre-COVID-19, with later systemic disruptions possibly altering dynamics, though many findings remain salient.

- The IPCUP model was validated but not piloted due to financial and time ring constraints.

8.7.3 Implications for interpretation and replication

- Analytical rather than statistical generalisation: Findings should be transferred to contexts with similar rural CHC conditions rather than assumed to hold universally.
- Bias mitigation: Triangulation across methods, convergence–divergence analysis, and expert validation enhanced credibility while acknowledging context-specific bias.
- Replication guidance: Future research should:
  - Employ probability or stratified sampling.
  - Expand inclusion of cadres and union groupings across provinces.
  - Pilot the IPUCP model in multi-site studies with 12 to24-month follow-up.
  - Incorporate standardised indicators of collaborative safety and labour functioning such as, safety-climate scores, turnover rates, and time-to-resolution of grievances.

The findings should be interpreted as analytically generalisable to comparable rural CHC contexts. Triangulation and expert validation mitigated bias and enhanced credibility. Future research should employ broader sampling, include more cadres and unions, and pilot the IPUCP model in multiple provinces with longitudinal follow-up.

8.8 CONCLUDING REMARKS

This study addressed a critical gap in understanding interprofessional collaboration and union partnerships within rural CHCs in South Africa. By integrating the voices of health professionals and union representatives, it highlighted that trust, psychological safety, shared leadership, and inclusive governance are essential to sustaining functional and secure CHCs.

The validated IPUCP model is the study's central contribution, offering a theoretically grounded and contextually relevant framework for guiding workforce stability and collaborative practice in resource-constrained settings. Beyond South Africa, the model and guidelines hold transferability potential for health systems across Africa and other low-resource contexts.

In conclusion, the study affirms that effective rural health systems require not only material and human resources, but also relational infrastructure built on dignity, inclusion, and shared purpose. The IPUCP model provides an evidence-based pathway towards this vision, offering policymakers, managers, and unions a pragmatic tool for reform.

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LIST OF ACTS

Allied Health Professionals Act (No. 63 of 1982) see South Africa. 1982.

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National Health Insurance Act (No. 20 of 2023 see South Africa. 2023.

Nursing Act (No. 33 of 2005) see South Africa. 2006.

Nursing Act (No. 50 of 1978) see South Africa. 1978.

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Pharmacy Act (No. 53 of 1974) see South Africa. 1974.

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ANNEXURES

ANNEXURE A: Ethical clearance certificate from the Research Ethics Committee, College of Human Sciences, University of South Africa (Unisa)

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

27 March 2017

HSHDC/687/2017
Mrs TH Kgongwana
Student: 3717-240-9

Supervisor: Prof ON Makhubela-Nkondo
Qualification: Doctorate Harvard University
Joint Supervisor: -

Dear Mrs TH Kgongwana

Decision: Ethics Approval

Name: Mrs TH Kgongwana

Proposal: Nursing, nurse and Trade Union partnership in comprehensive health clinics: promoting safety (safe patient, nurse and environment).

Qualification: DPCHS04

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 27 March 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

ANNEXURE B: Permission letter to the National Health Research Database (NHRD)

Confirmation of compliance with National Health Research Database (NHRD), online application process

To Whom It May Concern

This is to confirm that I, Ms. Thokozile Harriet Kgongwana (Ramoroko), a doctoral candidate in the Department of Health Studies at the University of South Africa (UNISA), duly complied with the requirements of the National Health Research Database (NHRD), online application process in April 2017.

Upon successful completion of this process, I was granted ethical clearance guidance and national-level permission by the National Health Research Database (NHRD). This authorisation enabled me to obtain subsequent district-level permission letters from three provinces, namely:

- Gauteng Province Rural and Semi-Rural Comprehensive Health Centres
- North- West Province – Rural and Semi-Rural Comprehensive Health Centres
- Mpumalanga Province – Rural and Semi-Rural Comprehensive Health Centres

These permissions were formally granted in May and August 2017 respectively before I commenced with conducting the doctoral study. The initial Title:

Health Professionals and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace in Comprehensive Health Centres in South Africa.

Reviewed to: Health professionals and trade union collaborative partnerships: prospects for a mutually secure workplace within Comprehensive Health Centres.

Ms. Thokozile Harriet Kgongwana (Ramoroko)



PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

ANNEXURE B1: Permission letter to Tshwane District Research Gauteng Province

Date: May 2017

To: Provincial Health Research Committee and the Tshwane District Research Office

Cc: Supervisor: Prof O. N. Makhubela-Nkondo, University of South Africa (UNISA)

Subject: Request for Permission to Conduct Research at two rural or semi-rural CHCs within Tshwane District

Dear Chairperson of the Research Ethics Committee

I, Thokozile Harriet Kgongwana, am a PhD candidate in the Department of Health Studies at the University of South Africa (UNISA). Under the supervision of Prof ON Makhubela-Nkondo (Professor of Nursing, UNISA), I am conducting doctoral research titled:

Health Professionals and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace in Comprehensive Health Centres in South Africa.

I hereby request formal permission to conduct this research at Mamelodi Stanza Bopape CHC and EKangala Tshwane CHCs in the Gauteng Province.

Study overview

- **Aim:** To explore the experiences and challenges of health professionals, trade union representatives, and management regarding collaboration and workplace safety in CHCs, and to develop model-based guidelines for sustainable collaboration.
- **Objectives:** Identify lived experiences; explore barriers; explain the role of unions; describe enabling elements; propose measures for strengthening collaboration; and develop an evidence-based model.
- **Significance:** The study will address gaps in union-professional collaboration in rural/semi-rural CHCs, provide insights for labour relations policy, inform interprofessional curricula, and contribute to safer workplaces that reduce litigation and attrition.
- **Design:** Sequential mixed-methods study (quantitative surveys, qualitative focus group discussions, and semi-structured interviews).
- **Sites:** Six CHCs across Gauteng, Mpumalanga, and North-West Provinces.

Ethics and compliance

- The research protocol has been reviewed and approved by the Research Ethics Review Committee of the College of Human Sciences, University of South Africa (UNISA), the HSDC/687/2017

- The study complies **with the National Health Act (2003), Labour Relations Act (1995), and Occupational Health and Safety Act (1993)**.
- Participation will be voluntary, with signed informed consent obtained. All data will be treated confidentially and anonymised in reporting.

Logistics and support

The study will require access to selected CHCs in your jurisdiction. With your approval, I will liaise with facility managers to schedule data collection at times that do not disrupt service delivery.

Benefits and risks

- **Benefits:** Contributes to evidence-based strategies for improving health professional, union and management staff collaboration, workplace safety, and health outcomes.
- **Risks:** Minimal; limited to participants' time for surveys and interviews.

I would be grateful for your written permission to proceed with the study. I am available to provide any further documentation (protocol, ethics certificate, supervisor support letter) as required.

Thank you for considering this request.

Sincerely



Thokozile Harriet Kgongwana
PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

ANNEXURE B2: Permission letter to Northwest Province

Date: April 2017

To: Provincial Health Research Committee and the Northwest Research Office

Cc: Supervisor: Prof O. N. Makhubela-Nkondo, University of South Africa (UNISA)

Subject: Request for Permission to Conduct Research at two rural or semi-rural CHCs within Tshwane District

Dear Chairperson of the Research Ethics Committee

I, Thokozile Harriet Kgongwana, am a PhD candidate in the Department of Health Studies at the University of South Africa (UNISA). Under the supervision of Prof ON Makhubela-Nkondo (Professor of Nursing, UNISA), I am conducting doctoral research titled:

Health Professionals and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace in Comprehensive Health Centres in South Africa

I hereby request formal permission to conduct this research at Bojanala or Madibeng CHCs in North-West Province.

Study overview

- **Aim:** To explore the experiences and challenges of health professionals, trade union representatives, and management regarding collaboration and workplace safety in CHCs, and to develop model-based guidelines for sustainable collaboration.
- **Objectives:** Identify lived experiences; explore barriers; explain the role of unions; describe enabling elements; propose measures for strengthening collaboration; and develop an evidence-based model.
- **Significance:** The study will address gaps in union-professional collaboration in rural/semi-rural CHCs, provide insights for labour relations policy, inform interprofessional curricula, and contribute to safer workplaces that reduce litigation and attrition.
- **Design:** Sequential mixed-methods study (quantitative surveys, qualitative focus group discussions, and semi-structured interviews).
- **Sites:** Six CHCs across Gauteng, Mpumalanga, and North- West provinces.

Ethics and compliance

- The research protocol has been reviewed and approved by the Research Ethics Review Committee of the College of Human Sciences, University of South Africa (UNISA), the HSDC/687/2017.

- The study complies with the **National Health Act (2003)**, **Labour Relations Act (1995)**, and **Occupational Health and Safety Act (1993)**.
- Participation will be voluntary, with signed informed consent obtained. All data will be treated confidentially and anonymised in reporting.

Logistics and support

The study will require access to selected CHCs in your jurisdiction. With your approval, I will liaise with facility managers to schedule data collection at times that do not disrupt service delivery.

Benefits and risks

- **Benefits:** Contributes to evidence-based strategies for improving health professional, union and management staff collaboration, workplace safety, and health outcomes.
- **Risks:** Minimal; limited to participants' time for surveys and interviews.

I would be grateful for your written permission to proceed with the study. I am available to provide any further documentation (protocol, ethics certificate, supervisor support letter) as required.
Thank you for considering this request.
Sincerely,



Thokozile Harriet Kgongwana
PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

ANNEXURE B3: Permission letter to Mpumalanga Province Health Research Committee

Date: May 2017

To: Provincial Health Research Committee and the Mpumalanga Province Research Office

Cc: Supervisor: Prof O. N. Makhubela-Nkondo, University of South Africa (UNISA)

Subject: Request for Permission to Conduct Research at two rural or semi-rural CHCs within Tshwane District

Dear Chairperson of the Research Ethics Committee

I, Thokozile Harriet Kgongwana, am a PhD candidate in the Department of Health Studies at the University of South Africa (UNISA). Under the supervision of Prof ON Makhubela-Nkondo (Professor of Nursing, UNISA), I am conducting doctoral research titled:

Health Professionals and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace in Comprehensive Health Centres in South Africa

I hereby request formal permission to conduct this research at Ithembalethu and Pankop CHC in the Mpumalanga province.

Study overview

- **Aim:** To explore the experiences and challenges of health professionals, trade union representatives, and management regarding collaboration and workplace safety in CHCs, and to develop model-based guidelines for sustainable collaboration.
- **Objectives:** Identify lived experiences; explore barriers; explain the role of unions; describe enabling elements; propose measures for strengthening collaboration; and develop an evidence-based model.
- **Significance:** The study will address gaps in union-professional collaboration in rural/semi-rural CHCs, provide insights for labour relations policy, inform interprofessional curricula, and contribute to safer workplaces that reduce litigation and attrition.
- **Design:** Sequential mixed-methods study (quantitative surveys, qualitative focus group discussions, and semi-structured interviews).
- **Sites:** Six CHCs across Gauteng, Mpumalanga, and North-West provinces.

Ethics and compliance

- The research protocol has been reviewed and approved by the Research Ethics Review Committee of the College of Human Sciences, University of South Africa (UNISA), the HSDC/687/2017.
- The study complies with the **National Health Act (2003)**, **Labour Relations Act (1995)**, and **Occupational Health and Safety Act (1993)**.
- Participation will be voluntary, with signed informed consent obtained. All data will be treated confidentially and anonymised in reporting.

Logistics and support

The study will require access to selected CHCs in your jurisdiction. With your approval, I will liaise with facility managers to schedule data collection at times that do not disrupt service delivery.

Benefits and risks

- **Benefits:** Contributes to evidence-based strategies for improving health professional, union and management staff collaboration, workplace safety, and health outcomes.
- **Risks:** Minimal; limited to participants' time for surveys and interviews.

I would be grateful for your written permission to proceed with the study. I am available to provide any further documentation (protocol, ethics certificate, supervisor support letter) as required.
Thank you for considering this request.
Sincerely,



Thokozile Harriet Kgongwana
PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

ANNEXURE B4: Initial research permission request letter

Date: 31 March 2017

To: National Department of Health Research Committee (NHREC)

Cc: Supervisor: Prof O. N. Makhubela-Nkondo, University of South Africa (UNISA)

Subject: Request for Permission to Conduct Research at Mpumalanga, North-West and Gauteng Province in two CHCs

Dear Research Chairperson of the Research Committee

I, Thokozile Harriet Kgongwana, am a PhD candidate in the Department of Health Studies at the University of South Africa (UNISA). Under the supervision of Prof ON Makhubela-Nkondo (Professor of Nursing, UNISA), I am conducting doctoral research titled:

Health Professionals and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace in Comprehensive Health Centres in South Africa

I hereby request formal permission to conduct this research at [insert facility names/districts in the province].

Study overview

- **Aim:** To explore the experiences and challenges of health professionals, trade union representatives, and management regarding collaboration and workplace safety in CHCs, and to develop model-based guidelines for sustainable collaboration.
- **Objectives:** Identify lived experiences; explore barriers; explain the role of unions; describe enabling elements; propose measures for strengthening collaboration; and develop an evidence-based model.
- **Significance:** The study will address gaps in union-professional collaboration in rural/semi-rural CHCs, provide insights for labour relations policy, inform interprofessional curricula, and contribute to safer workplaces that reduce litigation and attrition.
- **Design:** Sequential mixed-methods study (quantitative surveys, qualitative focus group discussions, and semi-structured interviews).
- **Sites:** Six CHCs across Gauteng, Mpumalanga, and Northwest provinces.

Ethics and compliance

- The research protocol has been reviewed and approved by the University of South Africa Research Ethics Committee (REC) [insert approval number].
- The study complies with the National Health Act (2003), Labour Relations Act (1995), and Occupational Health and Safety Act (1993).

- Participation will be voluntary, with signed informed consent obtained. All data will be treated confidentially and anonymised in reporting.

Logistics and support

The study will require access to selected CHCs in your jurisdiction. With your approval, I will liaise with facility managers to schedule data collection at times that do not disrupt service delivery.

Benefits and risks

- **Benefits:** Contributes to evidence-based strategies for improving staff collaboration, workplace safety, and health outcomes.
- **Risks:** Minimal; limited to participants' time for surveys and interviews.

I would be grateful for your written permission to proceed with the study. I am available to provide any further documentation (protocol, ethics certificate, supervisor support letter) as required.

Thank you for considering this request.

Sincerely,



Thokozile Harriet Kgongwana
PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

ANNEXURE C: Permission letter from the Department of Health North West Province



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Sekame & First Street
New Office Park
Mafikeng, 2745
Private Bag X2068
MMABATHO, 2735

Enq: Nthabiseng Mapogo
Tel: 018 391 4504
Fax: 018 386 6202
NMapogo@nwpg.gov.za
www.nwhealth.gov.za

2030 NDP

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : **Mrs. T.H. Kgongwana**
University of South Africa

Physical Address
(Work/ Institution)

Subject : **Research Approval Letter – Nursing, nurses and trade union Partnership in comprehensive health clinics: promoting safety (safe patient, nurse and environment).**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards.

Dr. FRM Reichel
Director: PPRM&E

LEPAPHA LA BOITEKANELO
DEPARTMENT OF HEALTH
Agriculture Post Private bag X2068
Mmabatho,2735
30 MAY 2017
NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

29/05/2017
Date

Researcher

Date

1

Healthy Living for All

ANNEXURE D: Permission letter from Department of Health Gauteng Province

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Lufuno Razwiedani
Tel: +27 12 451 9096
E-mail: lufuno.razwiedani@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

PROJECT NUMBER:69 /2017
NHRD REFERENCE NUMBER: GP_ 2017RP3_492

TOPIC: Nurses, nursing and trade unionism partnership in comprehensive health clinics: promoting safety (safe patient, nurse and environment)

Name of the Researcher: Thokozile Harriet Kgongwana

Name of the Supervisors: Prof. O Makhubela-Nkondo

Name of the Department: Health Studies
University of South Africa

Name of facilities: Tshwane District Health Facilities

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

Date: 11/09/2017

Dr. Lufuno Razwiedani
Chairperson: Tshwane Research Committee

Date: 12/9/2017

Ms. M Lerutla
Acting Chief Director: Tshwane District Health

ANNEXURE E: Permission letter from Department of Health Mpumalanga Province

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

MPUMALANGA
THE PLACE OF THE RISING SUN

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Letter of Support Signed by Chief Director (CD)/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	THOKOZILE HARRIET KGOMOWANA		
2. Title of Study: NURSES, HEALTH CARE WORKERS, UNION AND MANAGEMENT PARTNERSHIP: PROMOTING SAFETY			
3. Aim and population target: TO EXPLORE EXPERIENCES OF NURSES HEALTH CARE WORKERS UNION AND MANAGEMENT ON SAFETY IN A CHC AND DEVELOP A PARTNERSHIP SAFETY MODEL THAT PROMOTES SAFETY			
4. Period to undertake the study	From:	to:	
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study ALL WILLING WORKERS in the CHC; Security officer Cleaner Gardener, Pharmacist	(Yes) X How many: ALL WILLING WORKERS Nurses: Doctors: Other, please specify: ADMIN STAFF, ALLIED CLEANERS, CLINIC COMMITTEE;		NO
5.2: Patient Records/Files	Yes		(NO) X
5.3: Interviewing Patient at Facilities	Yes		(NO) X
5.4: Interviewing Patients at Home	Yes		(NO) X
5.5: Resource Flow (Are there benefits to Patients/community)	(Yes) V Trust on HCWs Please list: Improve public environment hygiene		NO
5.6: Resource Flow (Are there benefits to Facility/District)	(Yes) ↑ health outcomes, ↑ Job satisfaction Please list: Positive working relationships safe work place.		NO
6. Availability of Required Clearance			
6.1: Ethical Clearance	Yes X Clearance Number: HSHDC/687/2017	Pending	NO
6.2: Clinical Trial	Yes Clearance Number: N/A	Pending	NO X
6.3: Vaccine Trial	Yes Clearance Number: N/A	Pending	NO X
6.4: Budget	Yes R350.000.00 but only got Source of fund: HWSETA: R60 000.00		NO

Declaration by Applicant:
I Mr/Ms/Dr/Prof/Adv. THOKOZILE H KGOMOWANA agree to submit/present the result of this study back to the CEO/Institution/District.

Comment by CEO/CD/DM/PM: Director PHC. **Supported / Not Supported**

Please provide feedback on findings.

29.03.2017
Signature of CEO/CD/DM/PM **Stamp/Date:**
Name: LIBBIE NKOSI

Please email completed form to: JerryS@mpuhealth.gov.za or ThembaM@mpuhealth.gov.za

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE F: Participant information sheet

Title: Health professionals and trade union collaborative partnerships: prospects for a mutually secure workplace in comprehensive health centers

Date: 23 April 2017

Researcher: Ms **Thokozile H Kgongwana** (PhD candidate, UNISA)
Supervisor: Prof **ON Makhubela-Nkondo** (Professor of Nursing, College of Human Sciences, UNISA).

Dear Prospective Participant

My name is Thokozile Harriet Kgongwana, a student researcher at UNISA, and I am doing research with Prof O N Makhubela Nkondo, a Professor in Health Science towards a PHD degree at the University of South Africa. We are inviting you to participate in a study entitled: Health professionals and trade union collaborative partnerships: prospects for a mutually secure workplace in comprehensive health centers (CHCs).

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to explore the experiences and challenges of health professionals, labour union representatives and management regarding collaborative interprofessional relationships and secure safe workplaces in the context of community health centres and organised labour in South Africa and to develop evidence-based model and guidelines to promote positive and sustainable collaboration between managers, health professionals and shop stewards towards a safe working environment in the community health centre The ultimate goal is to develop model-based guidelines to promote positive, sustainable collaboration between managers, health professionals and shop stewards toward safe working environments in CHCs.

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WHY AM I INVITED TO PARTICIPATE?

You are invited because you are either a health professional, a labour union representative (shop steward), or a manager working in one of six Comprehensive Health Centres (CHCs) located in Gauteng, Mpumalanga, or North-West Provinces. These categories of participants were selected because they are directly involved in the day-to-day delivery of health services, workplace relations, and union–management interactions, which are central to the aims of this study.

Your contact details were obtained in accordance with the Protection of Personal Information Act, 4 of 2013 (POPIA), through one of the following:

- Official permission granted by the relevant District and Provincial Health Research Committees.
- Referral by facility managers who circulated invitations internally within the CHCs where you work. Your personal information will be used solely for the purposes of this research (scheduling participation and communication) and will not be shared outside the study team.

The study aims to involve approximately 60–120 participants across six CHCs, of which about 20–35 may be invited for in-depth interviews and or focus group discussions. This sample size allows for representation of multiple professions and unions, while reducing the risk of individual identification.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

If you agree to take part, you may be invited to participate in two or more of the following research activities:

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1 Questionnaire

- You will complete a structured survey with 5 Lickert scale questions and open-ended questions.
- Topics include workplace safety, collaboration with colleagues and unions, leadership, communication, and barriers to secure labour-professional relationships.
- Time required: about 20–30 minutes.

2 Focus Group Discussion (FGD)

- You may join a group of 4–8 colleagues from your CHC to discuss shared experiences.

- Questions will focus on your experiences, challenges, and recommendations in greater detail between health professionals and union representatives towards secure CHCs. These will be with focus on views of collaboration, barriers, enablers, and ideas for strengthening safe and mutually secure workplaces.
- Time required: about 60–90 minutes.

3 Individual Interview:

- You may be asked to participate in a one-on-one semi-structured interview.
- This will explore your personal experiences, challenges, and recommendations in greater detail between health professionals and union representatives towards secure CHCs.
- With your consent, the interview will be audio-recorded for accuracy.
- Time required: about 45–60 minutes.



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Your role as a participant is to share your perspectives and experiences honestly. There are no right or wrong answers. The study is interested in your lived experiences, professional insights, and recommendations that may contribute to developing an evidence-based model for collaboration in CHCs.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Statement that participation is voluntary and that there is no penalty or loss of benefit for non-participation.

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Yes, participation in this study is entirely **voluntary**. You are under no obligation to consent and there is no penalty or loss of benefit if you choose not to participate. If you do decide to take part, you will receive this information sheet to keep and will be asked to sign a written consent form. You are encouraged to participate in the study until completion of data collection.

Please note the following exceptions:

- If you complete and return an anonymous questionnaire, it will not be possible to withdraw your data afterwards because it cannot be linked back to you.
- If you participate in the survey, you are also obliged to participate in the interview or focus group, once data has been anonymised and analysed, it may no longer be possible to withdraw your individual contribution.



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Your decision to consider not participating in the study will not affect your employment, your relationship with your facility, your union, or the University of South Africa in any way.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

While there are no direct financial or material benefits to you as an individual, participation in this study may provide important benefits at multiple levels:

- **For individual participants:** You will have the opportunity to share your experiences of collaboration, union involvement, and workplace safety in a confidential and respectful setting. This may foster personal reflection and contribute to a deeper understanding of your professional role in advancing secure and collaborative workplaces.
- **For unions and organised labor representatives:** The findings will highlight challenges and opportunities for strengthening representation in Comprehensive Health Centres (CHCs). This evidence may assist unions in refining strategies to protect workers' rights, improve engagement with management, and secure safer and more supportive workplace environments.
- **For managers and health professionals:** The study aims to identify barriers and enablers to effective collaboration. These insights may lead to more inclusive teamwork, improved conflict resolution practices, and stronger leadership approaches in CHCs.
- **For regulatory and professional bodies:** The study will generate evidence that may inform reviews of professional scopes of practice, workplace safety standards, and interprofessional collaboration guidelines, thereby supporting better policy alignment.
- **For higher education institutions training health professionals:** The results will provide insights that can be integrated into interprofessional education (IPE) curricula, preparing future health professionals to collaborate more effectively with unions, managers, and community stakeholders.

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- **For community leaders and policymakers:** The recommendations may guide interventions at the community and district health levels, offering practical tools to reduce workplace conflict, enhance service delivery, and improve patient outcomes.
- **For the scientific and academic community:** The research will fill a gap in the literature on interprofessional collaboration and labour–management partnerships in rural and semi-rural health contexts, creating a platform for further scholarship and policy-relevant research.
- **For society and the health system as a whole:** By developing evidence-based model guidelines for collaboration and workplace safety, the study may contribute to reducing litigation costs, strengthening workforce stability, and ensuring that Comprehensive Health Centers deliver safer and more reliable healthcare to communities.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

Your participation in this study is not expected to involve any major risks. However, some potential inconveniences or discomforts may include:

- **Time commitment:** Completing a questionnaire may take approximately 30–45 minutes, while focus groups or interviews may last 60–90 minutes.
- **Emotional discomfort:** Discussions may involve sensitive issues such as workplace conflict, union–management relations, or personal experiences of stress and safety in the workplace. If you feel uncomfortable during these discussions, you are encouraged to indicate this, and the researcher will pause or redirect the conversation. Emotional support and referral to appropriate workplace or community support services will also be made available if needed.
- **Confidentiality concerns in group settings:** While the researcher will encourage all focus group participants to keep shared information confidential, it cannot be guaranteed that every participant will do so.

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The likelihood of these risks occurring is low, and the severity is considered minimal. To safeguard you:

- All interviews and discussions will be conducted respectfully, and you will be supported if you experience emotional strain.
- Participation will never expose you to financial, physical, or medical risks.
- This research is conducted under the University of South Africa's ethics protocols, which require responsible management of any potential harm.

This research is covered under the University of South Africa's ethics protocols, which provide responsible management of any potential harm. No separate indemnity or insurance scheme applies, as no physical or medical interventions are involved.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Yes. Every effort will be made to ensure your confidentiality and protect your identity:

- Confidentiality: Your name will not appear in any transcripts, reports, or publications. Instead, a code or pseudonym will be used. Only the researcher and the immediate research team will have access to the link between your identity and the data.
- Anonymity in publications: When findings are presented in research reports, journal articles, or conference presentations, no individual participant will be identifiable. Anonymous excerpts may be used to illustrate key points, but these will not be linked to your name or workplace.
- Access to data: Data may be seen by a professional transcriber and an external coder, both of whom will sign confidentiality agreements. In addition, the University's Research Ethics Review Committee may review anonymised data to ensure the study is being conducted properly.
- Storage of data: Hard copies of notes will be kept in a locked cabinet, and electronic data will be stored on a password-protected computer for five years before being securely destroyed (shredded or permanently deleted).



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- Focus group limitation: In focus groups, while the researcher will remind all participants to respect confidentiality, it cannot be absolutely guaranteed that others will not share information outside the group. Therefore, you are advised not to disclose highly personal or sensitive information in a group setting.

Your anonymised data may also be used for further scientific purposes such as journal publications or conference presentations, but privacy will always be protected.

WILL THE INFORMATION THAT I CONVEY TO THE RSEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Yes. Every effort will be made to ensure that the information you provide is treated with strict confidentiality.

- Confidentiality and anonymity: Your name will not appear in any questionnaire, transcript, report, or publication. Instead, your responses will be coded or assigned a pseudonym so that you cannot be personally identified.
- Research team and supervisors: Only the researcher (myself), my supervisors (Prof ON Makhubela Nkondo and Prof M Mathibe-Neke), and identified members of the research team such as a professional transcriber or external coder will have access to the raw data. All individuals with access are bound by confidentiality agreements or professional ethical codes.
- Ethics oversight: Members of the University of South Africa's Research Ethics Review Committee may review the data for quality assurance purposes, but your identity will remain protected.
- Publications: Findings from this study may be presented in research reports, journal articles, and conference presentations. However, no individual participant will ever be identifiable in any publication. Anonymous data may be used for these purposes.
- Data storage and disposal: Hard copies will be stored securely in a locked cabinet, and electronic data will be stored on a password-protected computer. All data will be retained for five years and then permanently destroyed (hard copies shredded, electronic files deleted).



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Focus groups

If you participate in a focus group, please note that while the researcher will encourage all participants to treat shared information as confidential, this cannot be fully guaranteed. For that reason, you are advised not to disclose highly personal or sensitive information during the group discussion. Every effort will be made to protect your privacy, and only coded/anonymous data will be reported.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

All information you provide will be kept secure and handled according to UNISA's ethical requirements:

- Storage of hard copies: Any paper-based questionnaires, consent forms, or notes will be stored in a locked cupboard in the researcher's office at the University of South Africa.
- Storage of electronic files: Electronic data (such as transcripts, recordings, or coded datasets) will be stored on a password-protected computer accessible only to the researcher and supervisors.
- Duration of storage: All data will be retained for five years for academic and verification purposes.
- Destruction of data: After this period, hard copies will be shredded, and electronic files will be permanently deleted from the computer using secure deletion software.

Future use of this data (for related research or publication) will require further Research Ethics Review and approval, ensuring ongoing protection of your rights.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no financial payment or other material rewards for taking part in this study. Participation is voluntary, and you will not incur any costs.

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HAS THE STUDY RECEIVED ETHICS APPROVAL?

Yes. This study has received written approval from the Research Ethics Review Committee of the College of Human Sciences, University of South Africa (UNISA), the HSDC/ 687/2017. A copy of the approval letter can be made available to you on request.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, you may contact:

Researcher:

Ms Thokozile H Kgongwana

Doctoral Candidate, Department of Health Studies University of South Africa (UNISA).
Email: 3172409mylife@unisa.ac.za Mobile: 0832733306

The findings will be accessible for a period of two years after completion of the study. If you require any further information or wish to discuss any aspect of the study, please contact me directly at the above details.

Supervisors:

Prof M Mathibe-Neke
Professor, UNISA – Department of Health Studies
Email: mathibejm@unisa.ac.za
Telephone: 0124296443

Prof ON Makhubela Nkondo now retired Professor of Nursing, UNISA – Department of Health Studies

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Research Ethics Enquiries:

If you have concerns about the way in which the research has been conducted, you may contact:

Chairperson: URERC@unisa.ac.za Research Ethics Review Committee (College of Human Sciences) University of South Africa (UNISA)

Research Integrity email: visagrg@unisa.ac.za
Ethics Hotline: 0800 075 278

Thank you for taking the time to read this information sheet and for considering participation in this study.

Signed: 

Ms Thokozile H. Kgongwana (Researcher)

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ANNEXURE F1: Consent to participate in the study

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the Focus group discussions and or the in-depth interview. I have received a signed copy of the informed consent agreement.

Participant Name and Surname ..... (please print)

Participant Signature …….. Date……

Researcher's Name and Surname ..... (please print)

Researcher's signature…….. Date……

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ANNEXURE F2: Qualitative interview guide

DEMOGRAPHIC DATA: REFER TO QUANTITATIVE CONSENT FORMS

Interview no.	
CHC District	

INTERVIEW QUESTIONS

The researcher will ask one central question to each participant. This type of question will be followed by probing statements that are open-ended questions and the use of communications skills. These questions will be asked according to how the participants respond to the central question.

CENTRAL QUESTION

Tell me about the experiences you have with trade union collaborative partnerships to establish mutually secure workplace in the comprehensive health centers

PROBING QUESTIONS

When probing the participants based on the central question, probing questions to the participants was sensitive and friendly. The researcher applied consistent form of questioning in both the focus group and individual interviews and recorded conversations making effort to construct the following questions:

- How can you describe your experiences in collaborating with other health professionals, shop stewards or union representatives and safety in this CHC?
- What is the relationship between management and unions in the CHC?
- What solutions do you suggest enhancing collaborative secure partnerships?

ANNEXURE F3: Consent to participate in the study

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the Focus group discussions and or the in-depth interview. I have received a signed copy of the informed consent agreement.

Participant Name and Surname ..... (please print)

Participant Signature …….. Date……

Researcher's Name and Surname ..... (please print)

Researcher's signature…….. Date……

ANNEXURE G: Assessment of data collection instrument

The structured questionnaire for Phase 1 was developed from a synthesis of empirical literature, national policy directives, and global guidelines, and aligned with the study objectives to measure health professionals' perceptions regarding safety and collaboration in comprehensive health centres. The instrument consisted of seven sections:

- Section A: Biographical information
- Section B: Experiences regarding safety
- Section C: Understanding of roles and responsibilities
- Section D: Perceived impact of limited partnership
- Section E: Perceived barriers to safety
- Section F: Cues to action for promoting sustainable safety

Sections B–F contained closed-ended items scored on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Methodological literature supports linking instrument content directly to study objectives to ensure content validity and conceptual clarity (Polit & Beck 2021:162-165).

A. Development of the qualitative instrument

The Phase 2 in-depth interview (IDI) guide and focus group discussion (FGD) guide were developed from literature and refined based on early quantitative insights, consistent with explanatory mixed-methods logic. Both tools were structured around one grand tour question supported by targeted probes to explore lived experiences, workplace relations, barriers, enablers, and solutions. This ensured coherence between phases and alignment with qualitative best practice in thematic exploration (Creswell & Plano Clark 2023a:190-193).

C. Supervisor and expert review

To ensure clarity, relevance, and content validity, both instruments were evaluated by three reviewers:

Reviewer	**Reviewer**
Supervisor	Supervisor
Senior Professional Nurse	Senior Professional Nurse
Facility Manager	Facility Manager

Reviewers assessed:

- alignment with research objectives
- clarity and neutrality of wording
- logical sequencing
- ethical sensitivity
- appropriateness for rural CHC-based professionals

Revisions were made where needed to strengthen clarity, remove ambiguity, and ensure professional acceptability.

A. Pilot test and outcomes

The quantitative instrument was pilot tested (n=9) at a semi-rural CHC in Gauteng not included in the main study. Participants included professional nurses, a union representative, a facility manager, and support staff. Pilot testing is recommended to refine tools before large-scale deployment (Creswell & Plano Clark 2023b:190-193).

The pilot yielded three key findings:

1. Language and comprehension limitations among non-professional staff
2. Construct misalignment, as collaboration content was not relevant to support roles
3. Item redundancy reported by management/union roles

As a result, the following actions were implemented:

- The quantitative instrument was restricted to health professionals only (clinical and allied groups)
- The qualitative phase retained union and management roles to capture broader context
- Ambiguous items were reworded for clarity and neutrality

E. Alignment with research objectives

Both instruments were mapped to the six research objectives to ensure each question served a clear analytical purpose, enabling the instruments to collectively address:

1. lived experiences and perceptions
2. barriers to collaboration
3. union roles
4. enabling elements
5. improvement measures
6. model development for secure CHCs

Confirmation of compliance: Researcher and supervisor:

Ms Thokozile Harriet Kgongwana



Doctoral Candidate – Department of Health Studies
University of South Africa (UNISA) PhD Candidate, UNISA
Email: 3172409mylife@unisa.ac.za
Mobile: 0832733306
Supervisor: Prof ON Makhubela-Nkondo
Email: makhubelaon@unisa.ac.za

Quantitative Data Collection Tool

Consent Form

Declaration by the participant

I, the undersigned confirm that:

1. I have been asked to participate in the above-mentioned research survey carried out by the University of South Africa (UNISA) through Ms Kgongwana.

2. It has been explained to me that:

2.1 The purpose of the research survey is to explore the experiences of nurses, healthcare personnel, clinic committees, organised labour and managers on safety in a comprehensive health centre (CHC) in line with the legislated prescripts and to develop a partnership safety practice model that promotes a safety (safe health personnel, patient and environment).

2.2 In order to collect this information I have been told that I will be asked a number of questions regarding:

- Health workers experiences on safety in line with the National Core standards.
- The role of healthcare workers clinic committees, organised labour and management on safety on comprehensive health centres.
- The impact of conflict relations in CHC among nurses, clinic committees, healthcare personnel and trade unions on establishing and maintaining safety.
- Identification of a possible collaborative partnership model beneficial to establish and sustain safety in the comprehensive health centres.

2.3 I have been told that this information will be collected from all willing healthcare workers, clinic committee members, managers and shop-stewards employed at the comprehensive healthcare centre.

2.4 I am aware that additional invitation will also be directed to any fifteen participants (representing employees from all units/departments within the CHC: healthcare worker, nurses, clinic committee, manager and organised labour, general workers) who completed this quantitative questionnaire, to participate in a focus group interview.

2.5 I have been told that it will not take longer than 45-60 minutes to complete the questionnaire and will not take more than six hours to participate in the focus group.

3. It was also explained to me that by participating in this survey I will help with improvements in safety in this comprehensive health centre.

4. It was also explained to me that the information will be kept confidential but that it the findings will be anonymously made available to the District Management team, comprehensive health centres, university management and organised labour.

5. I understand that I will have no direct access to the results of the survey but I can contact the researcher who will inform me of the findings.

6. It was also clearly explained to me that I can refuse to participate in this research survey. If I refuse, it will not be held against me in any way.

7. The information in this consent form was explained to me by Mrs TH Kgongwana in English and I confirm that I have asked for clarification in the language I understand and understood the explanations. I was also given the opportunity to ask questions on things I did not understand clearly.

8. No pressure was applied for me to take part in this research survey.

I hereby agree voluntarily to take part in this research survey.

Signed/confirmed at …… on …….

…….. in ……

Signature of respondents) ……. Signature of Witness …….

QUANTITATIVE DATA COLLECTION TOOL: QUESTIONNAIRE

Answer each question by indicating the chosen option/s with a tick (√) in the appropriate block OR fill in the information asked in the provided space. In some questions more than one answer may be given.

Tick (√) only in the space provided for answer. The right blocks are for office use only. The questionnaire consists of the seven (7) sections, and you are required to complete ALL the sections.

SECTION A: Biographical data
SECTION B: Experiences regarding the safety (employee, patient and environment)
SECTION C: The understanding of the different roles and responsibilities played by different role players in the healthcare facility
SECTION D: Perceived impact they have in case of limited partnership
SECTION E: Perceived barriers to acquire safety
SECTION F: Cues to action on promoting sustainable safety in comprehensive health centre.

Note that this questionnaire will focus mostly on your perception regarding safety and measures to establish safety in your in a comprehensive health centre.

It will NOT take you longer than 45-60 minutes to complete the questionnaire.

RESEARCH QUESTIONNAIRE

PHASE 1

QUESTIONNAIRE NUMBER:

Participation ID:

DESCRIPTIVE INFORMATION
Profile of the facility

Region
Province Code

Facility Code

Service Level CHC: 24 hours
Service Level CHC: 12 hours
Name of the Facility:
Languages spoken by the community:

INTERVIEW RESULTS
Total Number of staff
Category of staff interviewed
Facility Manager
Registered Nurse
Medical Doctor
Psychologist/Dental/Speech therapist
Pharmacists
Social Worker
Dentist
Other……

Support in completing the data provided/ not provided
State the support: language concept clarification instructions/interpretation

Participant
Work Title
Professional Title
Specialisation
Start date and Time finish
Date and Time

Person In charge:
Title:
Other Managers:

Head of Team:

Data Input: Complete/Incomplete

SECTION A: BIOGRAPHIC/DEMOGRAPHIC INFORMATION (PROFILE)

In this section, your biographic and educational information is required. Circle only the appropriate answer from the questions/statements below (One response only)

1.1.	Year of Birth: e.g. 1970	
1.2.	Gender: Male 1; Female 2	
1.3.	Ethnic Group: Black1; Indian 2; Coloured 3; White 4	
1.4.	Citizenship: SA1; Non-SA2 (Other: State Country of Origin)	
1.5.	Home Language: Afrikaans 1; English 2; Other3 (Specify)	
1.6.	Highest Qualifications: No Matric1; Matric2; Certificate3; Diploma 4; Bachelors or B Tech Degree 5; Post Graduate Diploma 6; Masters7; PhD8 (State the Name)	
1.7.	Indicate your speciality area (For health professionals only): None 1; Name 2 e.g., HIV/PLUS 101; NIMART; Management; Infection Control; Advanced Midwifery; Clinical Health Assessment Treatment) PHC); Other: (Specify) _____	
1.8.	Are you currently registered for any further education program/course to up-skill or advance your career?	
1.9.	Are you currently registered for any further education program/course to improve your work performance within this CHC Yes 1; NO 2 If yes state the names of the programs acquired in the past 3 years (any program, English, computer, HIV, Finance etc)	
1.10.	Indicate Workstation -Management 1; Operational 2; Union 3 (state station. e.g. Chronic Illness; Maternity; Dental; Reception; Security; Cleaning; Counselling	
1.11.	State your preferred workstation within the CHC	
1.12.	The number of works station you worked at since you were at this CHC: more than two 1; two 2; one 3 and state the names	
1.13.	Months you spent in this facility (months not years)	
1.14.	Months you spent on your current qualification (in months not years)	
1.15.	Months you spent in this area/Town (in months not years)	
1.16.	State number of health facilities/workplaces you worked before and the name(s)	

1.17.	State number of Union(s) you are affiliated with NEHAWU1; HOSPERSA2; PSA 3; DENOSA 4; Other (Please specify the name)	
1.18.	Indicate the status of your membership:1* Up to date and Current; 2* Current but not up to date 2/3 *Do not know 3/4*Lapsed/Expired.	
1.19.	Indicate your role as a Union member: ordinary member1/Shopsteward1/Chairperson/Secretary/Finance 4/Any other 5 (Please specify):	
1.20.	The professional body you are affiliated with: None 1; SANC 2; HPCSA 3; Any other 4 (Please specify)	
1.21.	Were you ever found guilty of any offence or professional misconduct by any Authority (e.g. Hospital or Clinic Manager, Department of Health, SANC): No1; Yes 2 (If yes, state who found you guilty and the reason):	
1.22.	Are you placed to work during Night only 1; Day only 2; Day and Night 3	
1.23.	What are the number of hours you spent on day shift per day	
1.24.	What are the number of hours you spent on night shift per night	
1.25.	Do you ever work overtime Yes 1/No 2? If yes how many hours per week	
1.26.	Do you spend any hours doing managerial work: No 1/Yes 2 (If Yes, state how many hours of work and state the managerial activities):	

4/HPCSA Act 5/Compensation on Injuries Act. (COID Act) 6/National Heath Core Standards 7/Infection Control policy8/Labour Relations Act and Regulations 9/International Labour Organization Act 10/Quality Assurance Policies 11/Sustainable development Goals 12. State any other: _____

SECTION B: OVERALL DYNAMICS OF THE THERAPEUTIC MILIEU/ENVIRONMENT WITHIN RESPECTIVE COMPREHENSIVE HEALTH CENTRES

1. Understanding of Safety within the CHC

State number of your choice from: * Strongly Agree; *2 Agree *3 Not know/uncertain *4 Disagree *5 strongly Disagree.

1.1 Definition of Safety
Good communication skills and healthy interpersonal relationships in any workplace are some of the critical components of my safety.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.2 Safety is a necessary outcome to be measured, maintained and always achieved in partnership with employees, organised labour and management in clinics

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.3 Safety in the workplace is one of the key constituents of Positive Practice Environment (PPE)

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.4 A safe workplace with positive interactions between health professionals yields job satisfaction and loyal long serving health workers who provide quality service and acquire their health outcomes.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.5. The health professionals' response and their communication with concerns for one another; where they actively listen, pose open ended questions, trust, respect, genuine and empathetic during interpersonal relations at work contributes to a safe workplace and partnership.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.6. Established positive relationship and beneficial non- threatening partnership between organised labour and management are part of a safe workplace.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.7. I am knowledgeable about the prescripts of the Occupational Health and Safety Act and Regulations as a worker

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.8. The CHC that complies with the prescripts of the Occupational Health and Safety Act and Regulations for all workers is a safe workplace

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.9. Committing to my role to observe safe practices as a worker at this CHC promotes safety

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.10. Training on any safety related procedures and standards sustains safety compliance

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.11. Developed safety policies and procedures with communication lines for staff enhances workers partnership (relations) at this CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.12. Receiving continuous training on communication skills and techniques*(active listening, paraphrasing, reflection, open ended questioning etc) to strengthen safety as a health professional is a must for all workers.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.13. There are active safety representatives/Champions for the CHC with no Union reps

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.14. There are constituted safety committees at the CHC with union representatives

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

1.15. The Safety Committee is functional holding scheduled meetings, minutes and all workers represented

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2. Experiences Relating to Therapeutic Environment

2.1. Which, if applied in the design of a healthcare environment, can measurably improve patient outcomes:

2.2. A healthcare environment that improves partnership/relations reduces or eliminates environmental stressors

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2,3. The CHC has acceptable noise levels and is committed to noise reductions

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.4. Health professionals enjoy similar resourced consultation rooms, e.g., medical doctors do not enjoy better office compared with nurse clinicians. Pharmacist,

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.5. You have access to natural daylight from your workstation

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.6. There is appropriate lighting in all areas in our work area

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.7. Access to use of Technology and internet

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.8. Services points link and proximity to one another and to other staff

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.9. Decentralised observation, supplies and charting

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.10. Providing 'off-stage' areas for respite observation, supplies, and chatting

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.11. Provide positive distractions

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.12. View of nature from consulting rooms and wherever possible there is access to nature, healing gardens

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.13. Resting/meditation space e.g., garden, Chapel, prayer, meditation room are available

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.14. Artwork on the walls with relevant photographs for this health facility are hung (e.g., hero of the month)

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.15. There is music recorded and programmed softly to enhance calmness and brainpower and positivity

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.16. Mild physical exercise is encouraged where spaces and gardens that allow walking, sitting, meditation are allowed when appropriate

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

2.17. Other social activities allowing a sense of stimulation that help nurture a worker's sense of positive well being

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3. social support

3.1. Visitors zone/relaxing room public phones, internet connectivity, reading studying desk out of the busy working area

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3.2. Provide places and opportunity where staff can engage socially eat together of a Family kitchen on inpatient units where family members can prepare food for patients and families to eat together

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3.3. Staff accommodation facilities or contacts are provided at this health facility

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3.4. There are organised staff focus groups and community councils where specific needs of the community being served are evaluated and recommended.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3.5. The CHC environment is culture sensitive on all workers to promote partnership and lessen conflicts

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

3.6. The CHC consider socio-petal spaces that facilitate social behaviour and development of social groups (non-fixed seating, round tables etc)

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4. Give a sense of control

4.1. Independent consulting rooms and working desks for health professionals are available to promote better outcomes

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.2. Staff are given as much privacy and control over their space that is consistent with the need for supervision.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.3. Staff have control over their immediate environment on cleanliness, lighting, furniture, tools of trade and technology.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.4. Wayfinding signage for the built environment provides clear visual cues to orient all workers and clients guiding them to their destination and on return in this CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.4. Landscaping buildings, color paint, artwork pattern does give you cues of compassion, caring sanity

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.5. Provision of mini libraries and computer terminals where staff can research the new body of knowledge, interventions, treatment and best practices that can support your competencies.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.6. Workers have a choice of lighting where each worker can access dimming controls that suites her/him

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.7. You have a choice of personal ornaments and artwork to your workspace/consulting room

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.8. The volume, station programming control of radio and television are in the appropriate area (resting rooms, toilets, passages, tea rooms)

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.9. Water cans on strategic points and cafeteria with a mobile service

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.10. Storage area for equipments available and well controlled and staff

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.11. Insufficient transfer of information when workers hand over at the CHC poses a threat to relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.12. The forum where all staff is represented to openly discuss safety errors and learn promotes safety

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.13. Reporting of unsafe events on time increases trust among staff thus positive relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.14. Shortage of the tools of trade and all other resources the support your job performance often causes strained partnerships between management health professionals and unions at this CHC, e.g.', cleaning material, medication, gloves, mask'

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.15. Shortage of personnel contribute to conflict among healthcare workers (e.g., few doctors and nurses) in the workplace

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.16. The creation of the standard operating procedures, schedule and accountability for issues related to organisational processes are critical to establish and sustain positive communication at work.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.17. The creation of a robust reporting and feedback system are critical to establish and sustain a safe working environment.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.18. A positive safety culture is characterised by communications founded on mutual trust, shared perceptions which yield confidence in workers.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

4.19. Effective engagement of leadership, union and staff in open discussions about workplace safety and collaborative approaches for solutions yield positive working environment.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

5. Communication

5.1. Health professionals, union and management understand and apply communication techniques to promote partnership and safety during working hours.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

5.2. The communication documents are posted in the bulletin boards, boardrooms at this CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

5.3. Management use positive communication techniques that encourages dignity and human relations e.g., clarification, open ended questions, paraphrasing etch, when they engage with workers.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

5.4. The health professionals, unions and management use communication platforms (face to face meetings for sensitive message, memos for routine matters, protocols to enhance work processes) that saves time and convey important messages.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

5.5. You are awarded the right to ask for what you need and want to be effective in the CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6. Leadership and Management

6.1. The foundation of a therapeutic environment is about positive communication, mutual trust and acceptable inter and intra-personal relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.2. Employee work processes are linked to management's commitment to a communication strategy which affirms commitment to safety and yield less conflict between professionals.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.3. The weakened communication skills of leaders (Management) has led to a weakened relationship (partnership) between health professionals.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.4. My supervisor is friendly and approachable.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.5. My supervisor can be trusted.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.6. Trust in supervisor is positively linked to a safe work environment.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.7. Lack of trust between employees, the professionals and non- professionals (admin staff, general workers, security etc., is a common challenge at our workplace.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.8. Management style that promotes little control over the staff and violates others' rights by shouting, ignoring etc., when they communicate/interac is poison to a therapeutic environment,

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

6.9. Accounting to supervisors who have inconsistent treatment on staff, discriminate on gender, class and race interfere with healthy relationships

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7. Union/organised Labour

7.1. You are free to organise, participate and attend union activities advocating for union activities and positive safe workplace and relevant committees

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.2. Poor interpersonal relations and poor communication skills are often noticed by and/or brought to the attention of union stewards.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.3. Organised labour advocate for positive communication skills and healthy interpersonal workers, management on their safety roles and rights.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.4. The organised labour plays an active role in identifying conflict due to poor or unhealthy communication techniques between health professionals within the workplace.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.5. Labour takes responsible action to help organise health professionals around positive interpersonal relationships and positive/healthy communication skills (i.e., wearing tacks, avoiding social relations, discrimination, denial to express oneself) without fear or favour.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.6. The Union communicates with and serves on joint labor-management safety and health committees

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.7. The Union reps are objective; help organise and attend all safety committees with all role players within the CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.8. The health workers feel safe from any conflict caused by other employees due to the management support

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.9. The Union working with community and politicians can contribute to a safe health facility always because they are leaders who provides harmonious relationships between healthcare workers and users of health facility.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.10. The Union participates positively in relationships (partnership) to advocate for effective communication in a CHC, thus protecting workers' rights and management.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.11. You are free to organise, participate and attend union activities advocating for union activities and positive safe workplace and relevant committees.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.12. Poor interpersonal relations and poor communication skills are often noticed by and/or brought to the attention of union stewards.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.13. Organised labour advocate for positive communication skills and healthy interpersonal workers, management on their safety roles and rights.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.14. The organised labour plays an active role in identifying conflict due to poor or unhealthy communication techniques between health professionals within the workplace.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.15. Labour takes responsible action to help organise health professionals around positive interpersonal relationships and positive/healthy communication skills (i.e., wearing tacks, avoiding social relations, discrimination, denial to express oneself) without fear or favour.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.16. The Union communicate with and/or serve on joint labor-management safety and health committees

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.17. The Union reps are objective; help organise and attend all safety committees with all role players within the CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.18. The health workers feel safe from any conflict caused by other employees due to the management support

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

7.19. The Union working with community and politicians can contribute to a safe health facility always because they are leaders who provides harmonious relationships between healthcare workers and users of health facility.

8. Communication

8.1. Positive communication skills and techniques *(active listening, paraphrasing, reflection, open ended questioning etc) are applied when I communicate with others in this workplace

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

8.2. Communication guidelines between workers are available to establish a safe working environment

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

8.3. There is commitment by management to ensure efficient communication and healthy interpersonal skills amongst all workers within the CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

8.4. Clearly documented standard operating procedures in the clinic are available to all employees not only to select few excluding allied, medical doctors, support staff, etc

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

8.5. The signage in the CHC is up legible on all areas in simple clear language that is understood by all employees and may enhance communication

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

8.6. The organogram is available and displayed on boards for every employee with contact numbers in case of emergencies

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9. Work relationship assessment: Trust

9.1. You feel comfortable/safe in receiving criticism from others to enhance or improve safety in this CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.2. You feel safe in giving criticism to others regarding their unprofessional behaviour.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.3. It is difficult working with professionals who do not listen to your concerns; I feel ignored, not trusted and disrespected when this occurs in this CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.4. You believe when you share perceptions openly amaong colleagues you can inspire a safe work practice and posiitive behaviour

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.4. Medical doctors/Nurse practitioners or any other allied health professionals seek input from each other with ease without fear of being ridiculed, harassed.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.5. Senior nurses or Managers seek input from medical doctors with ease and without fear.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.6. You are allowed to complete your work without unnecessary oversight by the supervisor.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.7. I feel comfortable discussing my job successes and failures with my colleagues

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

9.8. I do not feel comfortable communicating my job successes and failures with my manager

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

10. Diversity

10.1. The CHC communication culture is inclusive of people who have different backgrounds and of diverse cultures

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

10.2. I am encouraged to think differently about important issues and thus share my opini ons without being judged.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

10.3. I feel safe if I have a positive sense of belonging from everyone, I interact with in the CHC (nurses, managers, union and any other health professional).

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

11. Mindfulness

11.1. Your openness to new ideas is supported by your colleagues

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

11.2. You can talk freely without fear about what is and isn't working in the workplace

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

11.3. You can adjust your routine schedules in response to current or pressing need/situation with ease

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

11.4. Your day-to-day clinic activities are running on a structured program when interrupted there is communication to avoid conflict relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12 Interrelatedness

12.1. I am comfortable in being delegated to task outside my standard duties as well as larger goals at random

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.2.Each health professional is aware of her individual role and understand how they affect other functions and workers in the clinic.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.3. Some nurses/Doctor/pharmacist/do not respond professionally when we are in a challenging situation relating to work.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.4. I rarely rely on my colleagues because when you share or ask them, they are not willing to listen or to assist. I am afraid to expose my weaknesses to them

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.5. Some health professionals walk into my unit whilst you are progressing patients without greeting and communicating what they want; just grab what they want and leave.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.6. I always follow the instructions laid out in the workplace without questioning the compromise of my rights and being disrespected.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.7. I deny myself and take short-cuts to get my work done not following safe procedures e.g. not protective clothing, gloves, a musk, because of fear of my supervisor/medical doctors/managers

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.8.I often break safety rules to get the job done because there is no time

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12.9 I avoid violating and disrespecting the rights of others at work to avoid compromising interpersonal relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

12. Respect

13.1. Health professionals are considerate, honest and tactful to one another as they interact during work related activities most of the time at this CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.2. Professionals value one another's opinions without judgement, prejudice and doubt and spontaneously.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.3. Healthcare workers like any citizens of South Africa deserve their rights to be treated with respect and to express their opinion in the CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.4. Respect of one's privacy and rights as a health professional (medical doctor/nurse/psychologist, etc) is overlooked by other health professionals at this CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.5 Managers overlook privacy and rights of health professionals most of the time at this CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.6. Supervisors/, doctors/dentist/social workers come into my consultation room without knocking and unannounced.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.7. Some professionals are more professional than others whilst some express their temper and anger in a violent and threatening way with no consequences.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13.8. The Registered nurses, medical doctors, psychologist communicate poorly with one another and, it seems they worry about their personal interests than service outcome.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

13. Varied interaction

14.1. Health professionals understand and respect professional boundaries thus do not randomly establish and service casual, intimate social relationships at this working place

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

14.2. The managers encourage professionals to continuously develop their knowledge and skill on communication and interpersonal relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15 Miscellaneous

15.1. All workers, management and union representatives communicate with respect and dignity with one other towards safe communication and interpersonal practices in the CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.2. The absence of mechanisms to collect and exchange information threaten quality partnership in the CHC

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.3. When I ask the member of the multi-professional team to assist with a plan to have our workload better managed; they say it is the role of the facility manager/seniors.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.4. Health professionals don't want to take responsibility when there are abnormal events/incidents and increased workload

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.5. Facility Manager does not exercise her authority to mend conflict relations amongst health professionals without head office input; it is hard to establish a relationship and have continuity.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.6. Managers do not objectively support staff when a senior health professional lodges a complaint about them, thus un-therapeutic relations.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.7. Union leaders do not objectively support staff when a senior health professional lodges a complaint about them, thus un-therapeutic relations

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.8. The Manager, R/Ns. Medical doctors, psychologist and Unions conflict with one another; it seems they don't bother to communicate professionally and care about interpersonal relations.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.9 Absence of trust between employees makes individual to be vulnerable to others.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.10. Absence of trust between employees makes individual to be vulnerable to others.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.11 .Interpersonal trust with constructive feedback is vital in sustaining and improving safety related behaviour.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.12. The Union participates positively in relationships (partnership) to advocate for effective communication in a CHC, thus protecting workers' rights and management.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.13 The important events, updates, negative incidents etc. are posted in the union newsletters or shared in meetings to allow information sharing and learning for all employees.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.14. If you consult your union representative on any issue challenging your partnership and communication with others, they are knowledgeable and assist you efficiently.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.15. Safety representatives educate employees on how to resolve conflict relations problems at the CHC.

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.16. The management programs blame workers when they get have conflicts disagreements disputes and discourage reporting of such

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

15.17. Communication and interpersonal relationship are part of the planned or scheduled continuous professional development are in place to educate management, local union leaders, and staff

Strongly Agree	Agree	Uncertain/Not Know	Disagree	Strongly Disagree

ANNEXURE H: Qualitative questions (focus group and individual interviews)

PHASE 2: INTERVIEW GUIDE:

DEMOGRAPHIC DATA: REFER TO QUANTITATIVE CONSENT FORMS

Interview no.	
CHC District	

INTERVIEW QUESTIONS

The researcher will ask one central question to each participant. This type of question will be followed by probing statements that are open ended questions and the use of communications skills. These questions will be asked according to how the participants respond to the central question.

CENTRAL QUESTION

Tell me about the experiences you have with trade union collaborative partnerships to establish mutually secure workplace in the comprehensive health centres.

PROBING QUESTIONS

When probing the participants based on the central question, probing questions to the participants was sensitive and friendly. The researcher applied consistent form of questioning in both the focus group and individual interviews and recorded conversations making effort to construct the following questions:

- How can you describe what is your experiences in collaborating with other health professionals, shops stewards or union representatives and safety in this CHC?
- What is the relationship between management and unions in the CHC?
- What solutions do you suggest enhancing collaborative secure partnerships?

ANNEXURE I: Letter from statistician

STATISTICAL ANALYSES

The Chairperson,
Sefako Makgatho University Research Ethics Committee (SMUREC),
Box 163
SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

Dear Sir/Madam

STATISTICAL ANALYSES

I have studied the research protocol of

Thokozile Kgongwana

titled: Health Professional and Trade Union Collaborative Partnerships: Prospects for a Mutually Secure Workplace within Comprehensive Health Care Centers

and I agree to assist with the statistical analyses.

Yours sincerely,

KD Tshabalala

Signature: Statistician

DONALD TSHABALALA

Name in block letters

10 December 2025

Date

* Please delete which is not applicable. If you do not agree to assist with the statistical analyses, please provide reasons on a separate sheet.

ANNEXURE J: Letters from language editor

TO WHOM IT MAY CONCERN

I, the undersigned, hereby confirm the language editing of the **Doctoral thesis** manuscript of **Mrs Thokozile Harriet Kgongwana (Student Number: 37172409)**, submitted to me in respect of her fulfilment of the requirements for the Doctor of Literature and Philosophy (DLitt et Phil) in Health Sciences degree registered with the University of South Africa (UNISA), and entitled:

Collaborative relationship among health workers, managers and trade unions: Prospects for mutually safe workplace in a comprehensive health centre

All possible means have been expended to ensure the final draft of **Mrs T.H. Kgongwana's** thesis manuscript reflects both acceptable language control standards expected of postgraduate research studies at her level.

In compliance with expected ethical requirements in research, I have further undertaken to keep all aspects of **Mrs T.H. Kgongwana's** study confidential, and as her own initiative.

Sincerely,

T.J. Mkhonto.

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I, the undersigned, hereby confirm my language editing, and research methodology compatibility/ compliance check for Chapter 2 and Chapter 6 in the Doctoral thesis manuscript of **Ms Thokozile Harriet Ramoroko (Student Number: 37172409)**, submitted to me in respect of her fulfilment of the requirements for the degree of **Doctor of Literature and Philosophy (DLitt et Phil) in Health Sciences** registered with the University of South Africa (UNISA), and entitled:

Collaborative relationship among health workers, managers and trade unions: Prospects for mutually safe workplace in a comprehensive health centre

I attest that all possible means have been expended to ensure the final draft of **Ms T.H. Ramoroko's** manuscript reflects both acceptable research methodology practices and language control standards expected of postgraduate research studies at her level.

In compliance with ethical requirements in research, I have further undertaken to keep all aspects of **Ms T.H. Ramoroko's** study confidential, and as her own individual initiative.

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ANNEXURE K: Letters from technical editor

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STUDENT NUMBER: **37172409**

TITLE: **HEALTH PROFESSIONALS AND TRADE UNION COLLABORATIVE PARTNERSHIPS: PROSPECTS FOR A MUTUALLY SECURE WORKPLACE WITHIN COMPREHENSIVE HEALTH CENTRES**

This is to certify that the above thesis has been technically edited according to Tutorial Letter MNUALLL/301/0/2025 of the Department of Health Studies, Unisa.



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20 August 2026

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TO WHOM IT MAY CONCERN

STUDENT: **THOKOZILE HARRIET RAMOROKO**
STUDENT NUMBER: **37172409**

TITLE: **HEALTH PROFESSIONALS AND TRADE UNION COLLABORATIVE PARTNERSHIPS: PROSPECTS FOR A MUTUALLY SECURE WORKPLACE WITHIN COMPREHENSIVE HEALTH CENTRES**

This is to certify that the above thesis has been technically edited according to Tutorial Letter MNUALLL/301/0/2026 of the Department of Health Studies, Unisa.



Mrs EC Coetzer

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