



## INTERPROFESSIONAL WORK RELATIONSHIPS AND ROLE CONFLICT IN PRIMARY HEALTH CARE SETTINGS: EXPERIENCES OF COMMUNITY HEALTH NURSES IN NORTHERN NIGERIA

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**Abstract:** Background: Effective Interprofessional collaboration is crucial for providing comprehensive primary healthcare (PHC); nonetheless, ongoing disagreement among healthcare workers hinders service delivery, especially in resource-limited environments. In Nigeria, primary healthcare centers employ various personnel, although ambiguous position delineations and systemic limitations frequently exacerbate workplace conflict. The lived experiences of community health nurses about these processes remain inadequately examined, particularly in Northern Nigeria. The objective of this study was to investigate the experiences of community health nurses concerning Interprofessional work relationships and role conflict within primary health care clinics in Bauchi State, Northern Nigeria. A qualitative study employing a hermeneutic phenomenological design was executed. Twelve community health nurses were intentionally chosen from primary health care facilities throughout Bauchi metropolis. Data were gathered via comprehensive, semi-structured interviews conducted from August to October 2021. Interviews were audio-recorded, transcribed verbatim, and thematically analyzed using an interpretive phenomenological approach to discover emerging themes. Findings: Five principal themes emerged from the data: (1) Inadequate Interprofessional Collaboration, characterized by isolated, task-focused efforts with limited teamwork or collective decision-making; (2) Role Ambiguity and Overlap, wherein unclear job descriptions and overlapping responsibilities between nurses and community health extension workers resulted in confusion and tension; (3) Professional Rivalry and Power Struggles, evident as competition for authority, recognition, and influence within facilities; (4) Detrimental Effects on Nurses and Care Delivery, resulting in nurse frustration, demotivation, intentions to resign, and

**Academic Journal of Nursing and Health Education**

**An official Publication of Center for International Research Development**

Double Blind Peer and Editorial Review International Referred Journal; Globally index

Available <https://cirdjournals.com/index.php/ajnhe>; E-mail: [journals@cirdjournals.com](mailto:journals@cirdjournals.com)



perceived compromises in the quality and continuity of patient care; and (5) The Aggravating Influence of the Work Environment, where insufficient infrastructure, resource scarcity, and staffing shortages heightened interpersonal conflicts. Conclusion: Interprofessional relationships in the examined PHC settings are defined by substantial conflict originating from systemic deficiencies in role clarity, supportive leadership, and resource availability. These disputes detrimentally impair nurse well-being and undermine the quality and coordination of patient care. The findings underline an urgent need for health system interventions that address both the structural determinants—such as formalizing scopes of practice and improving work conditions—and the relational aspects of cooperation through leadership training and dispute resolution procedures. Strengthening the relational foundation of PHC teams is crucial for developing resilient, effective primary healthcare systems in Nigeria and similar countries.

**Keywords:** Interprofessional relations; Role conflict; Primary health care; Community health nurses; Nigeria; Qualitative research.

### **Background**

Primary Health Care (PHC) is globally recognized as the foundation of effective health systems and is particularly critical in low- and middle-income countries such as Nigeria, where it serves as the first point of contact for individuals, families, and communities (David & Saraya, 2017; World Health Organization [WHO], 2016). PHC stresses promotive, preventative, curative, and rehabilitative care offered through community participation, equity, and inter-sectoral collaboration. However, the efficiency of PHC delivery largely rests on the quality of inter-professional work relationships among healthcare providers operating within these settings. In Nigeria, primary healthcare facilities are staffed by different cadres of health workers, including community health nurses, midwives, community health extension workers (CHEWs), junior CHEWs, environmental health officers, and other related professionals. While this interdisciplinary workforce is meant to enhance service delivery, the absence of clearly defined professional duties has resulted in overlapping obligations and chronic Interprofessional role conflict (Kadiri et al., 2018). Such role uncertainty has led to unhealthy competitiveness, poor collaboration, and frequent conflicts among healthcare personnel, ultimately compromising teamwork and efficiency in patient care (Bashir, 2018). Community health nurses play a vital role in PHC delivery, particularly in maternity and child health care, family planning, diagnosis and treatment of minor illnesses, health education, and coordination of community-based activities

(WHO, 2015). Despite their important contributions, nurses typically endure professional marginalization, role encroachment, and limited recognition within PHC teams (Pedro, 2020). These issues are worsened by weak leadership structures, inefficient dispute management tactics, and unequal access to professional development opportunities across cadres (Hack-Halloran, 2016).

Interprofessional role conflict in Nigerian PHC settings has been related to broader systemic flaws, including fragmented governance, inadequate personnel, poor remuneration, and insufficient material resources (Kadiri et al., 2018). Evidence reveals that non-collaborative work relationships and unhealthy competitiveness particularly between nurses and community health extension workers—are key sources of workplace conflict in primary healthcare centers (Bashir, 2018). These tensions negatively affect communication, trust, work satisfaction, and the overall quality and safety of patient care.

Furthermore, the PHC work environment in many regions of Northern Nigeria is characterized by poor infrastructure, inadequate security, unpredictable power supply, and limited social amenities, especially in rural settings (Osai et al., 2016). These conditions not only risk the safety of healthcare professionals but also promote Interprofessional conflicts by raising workload stress and competition over finite resources. Such conditions contribute to low morale, poor retention of experienced nurses, and increasing migration of health workers, further weakening the already frail health system (Osai et al., 2016). Despite the recognized necessity of



Interprofessional teamwork for effective PHC delivery, empirical information concentrating on the lived experiences of community health nurses about work relationships and role conflict in Nigerian PHC settings remains sparse. Qualitative observations from Northern Nigeria, notably from Bauchi State, highlight the need for better role delineation, enhanced leadership practices, and supportive Interprofessional frameworks to increase teamwork and service delivery. Understanding these experiences is vital for informing policy improvements and enhancing Interprofessional teamwork within Nigeria's primary healthcare system.

### **Related Literature**

Effective Interprofessional teamwork is crucial to the delivery of integrated, person-centered primary healthcare (PHC). Defined as the patterns of contact, communication, and mutual respect among varied health professionals, good collaborative practice is connected to increased patient safety, enhanced provider job satisfaction, and greater health system efficiency (WHO, 2020). In low- and middle-income countries (LMICs), the effectiveness of PHC teams is particularly crucial for achieving universal health coverage (UHC). However, the implementation of this collaborative ideal is sometimes delayed by structural and relational hurdles. In the Nigerian context, research reveals that PHC teams are typically characterized by fragmentation rather than integration. Studies by Ojo et al. (2021) and Sule et al. (2022) identified recurrent issues of professional hierarchy, poor communication channels, and competition for clinical authority as important hurdles to cooperation in Nigerian PHC institutions. These dysfunctional dynamics are compounded in resource-constrained situations, where high patient loads, personnel shortages, and inadequate infrastructure magnify stress and decrease the ability for cooperative work (Adebayo et al., 2023). Role conflict stemming from uncertainty, overlap, or contradiction in professional responsibilities is a prominent source of Interprofessional stress within multidisciplinary PHC teams. This conflict sometimes emerges from insufficiently defined scopes of practice and the ad-hoc nature of task-shifting in under-resourced

settings (World Health Organization, 2022). In Nigeria, the presence of several cadres, such as registered nurses, midwives, and community health extension workers (CHEWs), within the same PHC facility frequently leads to boundary disputes and professional encroachment. Recent work by Ekuma et al. (2023) illustrates how the lack of clear, enforceable job delineation between nurses and CHEWs promotes misunderstanding about clinical roles and accountability, driving interpersonal rivalry and eroding team cohesion. This ambiguity not only affects workflow but also offers a substantial danger to professional identity and morale among nurses, who may feel their expertise is undervalued or their area is being infringed upon (Nwaneri et al., 2022).

The implications of unresolved Interprofessional conflict are complex and serious. For healthcare personnel, continuous conflict is a substantial psychosocial stressor, highly connected with emotional weariness, burnout, and increased intention to leave the profession (Akinsola et al., 2022). This adds directly to the continuing challenge of health workforce attrition and brain drain in Nigeria. From a patient-care standpoint, bad Interprofessional interactions affect the quality and safety of service delivery. Evidence consistently reveals that inadequate cooperation leads to communication breakdowns, clinical errors, delayed care, and fragmented patient experiences (Iloje et al., 2023). Furthermore, the physical and organizational work environment works as a significant moderating influence. In Northern Nigeria, PHC centers generally contend with infrastructural degradation, insecurity, and unreliable power supply. As emphasized by Musa et al. (2023), these chronic resource inadequacies do not only constitute a backdrop for conflict but actively aggravate it by increasing job demands, creating competition for scarce tools and space, and diminishing the resilience of health workers. Despite the acknowledged importance of this issue, a large gap persists in the research. While various studies have explored Interprofessional relations in Nigerian tertiary institutions, there is a paucity of in-depth, qualitative research concentrating primarily on the lived experiences of frontline providers within PHC settings in Northern



Nigeria. Existing studies frequently involve quantitative questionnaires, which, while valuable, may not fully represent the complicated, subjective aspects of how role conflict is viewed, experienced, and handled in daily practice. This work, therefore, employs a phenomenological approach to overcome this gap. By investigating the first-hand perspectives of community health nurses, it strives to provide a better, context-rich knowledge of Interprofessional interactions, thereby informing the development of more effective, culturally resonant solutions for building PHC teams in Nigeria and similar settings.

## **Materials and Methods**

### **Study Design:**

A qualitative study approach based on interpretative phenomenology was employed to explore the lived experiences of community health nurses about Interprofessional work relationships and role conflict in primary healthcare settings. This approach was judged appropriate because it offers an in-depth assessment of participants' subjective experiences, perceptions, and meanings related to workplace interactions within their natural setting.

### **Study Setting:**

The study was conducted at primary healthcare facilities (PHCs) located inside Bauchi metropolis, Bauchi State, Northern Nigeria. Bauchi State is one of the northern states of Nigeria with both urban and rural populations and a PHC system that acts as the major entrance point into healthcare for most citizens. At the time of the study, around 25 PHC facilities were active within the study region, staffed by nurses, midwives, community health extension workers, and other allied health personnel.

### **Study Population:**

The study population consisted community health nurses working in selected primary healthcare institutions within Bauchi city. Community health nurses were described as registered nurses and midwives licensed by the Nursing and Midwifery Council of Nigeria and attached to PHC

facilities, where they routinely engaged with other cadres of healthcare workers.

### **Inclusion and Exclusion Criteria:**

#### **Inclusion criteria were:**

- I. Registered nurses or midwives working in PHC institutions inside Bauchi metropolitan
- II. At least six months of continuous work experience in a PHC setting
- III. Willingness to participate and offer informed consent

#### **Exclusion criteria included:**

- I. Nurses on temporary posting or short-term rotation
  - II. Newly employed nurses with fewer than six months of PHC experience
- these criteria guaranteed that participants had sufficient exposure to Interprofessional interactions within the PHC environment.

### **Sample Size and Sampling Technique:**

A purposive sample strategy was adopted to select people who had direct experience of the topic under inquiry. In phenomenological research, sample size is determined by data saturation rather than statistical representation. Data saturation was accomplished when no new themes or insights arose from repeated interviews. A total of twelve (12) community health nurses participated in the study, which was deemed adequate to provide rich, in-depth perspectives of Interprofessional work relationships and role conflict within the PHC environment.

### **Data Collection Method:**

Data were acquired through in-depth, semi-structured interviews conducted between August and October 2021. An interview guide was developed based on the study objectives and relevant literature, focusing on participants' experiences of: Interprofessional work relationships, Role clarity and role conflict, Collaboration and communication with other healthcare workers, Factors influencing workplace harmony or conflict. Interviews were conducted face-to-face in a quiet and secluded place within the PHC facilities to maintain confidentiality and minimize disruptions. Each interview lasted roughly 30–45 minutes



and was audio-recorded with participants' agreement. Field notes were also taken to record non-verbal clues and environmental observations.

#### Data Analysis:

Audio recordings were transcribed verbatim, and data analysis was undertaken manually using thematic analysis, guided by phenomenological concepts. The analysis followed these steps:

1. Familiarization with the data through repeated reading of transcripts
2. Identification of relevant comments linked to Interprofessional relationships and role conflict
3. Coding of meaningful units
4. Grouping of codes into themes and sub-themes
5. Interpretation of themes to capture the essence of participants' lived experiences

To strengthen analytical rigor, emerging themes were examined and modified through peer debriefing with qualitative research professionals.

#### Results

This part comprises the analysis, presentation, and interpretation of findings obtained from twelve (12) in-depth interviews performed among community health nurses working in basic healthcare institutions in Bauchi

State, Nigeria. The interviews addressed participants' lived experiences of Interprofessional work relationships and role conflict within the primary healthcare environment. Comparisons were made among participants' narratives, including changes connected to chosen socio-demographic characteristics, when relevant. Data were assessed thematically, and genuine verbatim extracts from the interview transcripts are presented to highlight and support the developing themes. The employment of participants' own words increases the reliability of the findings and provides deeper insight into their experiences. To preserve confidentiality and protect the identity of both participants and healthcare institutions, all personal information, including names of individuals and specific programs, has been erased or anonymized.

All twelve community health nurses chosen for the study participated fully in the interviews, and the data acquired were considered comprehensive and suitable for analysis. Interviews were completed with the help of experienced research assistants and focused on participants' experiences within primary healthcare settings across Bauchi metropolis. This section begins with a quick review of participants' characteristics, followed by a thorough description of the principal themes and sub-themes that emerged from the qualitative analysis.

**Table 4.1 Socio demographic data of respondents**

Participants pseudonym	Age	Years of working experience in PHC	Grade level
P1	21-25	7	09
P2	26-30	7	09
P3	31-35	12	10
P4	36-40	13	12
P5	41-45	5	08
P6	46-50	5	08
P7	30-35	6	09
P8	45-50	20	13
P9	40-45	20	13



P10	45-50	22	14
P11	25-30	7	09
P12	25-30	6	09

This part shows the background information of the 12 informants who had been selected for the study using non probability purposive sampling approach All major informants in this study were female. Their mean age was 33.6 years of age, one of the participants is on Grade level 14, another is on grade level 13, and other ten participants are nursing officers on grade level 08 to 10. Three of the participants had Bachelor’s degree in nursing while nine of the participants are qualified registered nurses and midwives with Diploma as their highest Qualifications. The years of nursing experience ranged from 5 years to 22 years. (See Table 4.1 above).

### Theme 1: Poor Interprofessional Collaboration within PHC Teams

Most interviewees described Interprofessional teamwork in PHC settings as weak and inconsistent. Nurses observed insufficient teamwork and a lack of coordinated treatment across different cadres of healthcare providers. Interactions were frequently task-oriented rather than collaborative, with minimal mutual decision-making. Several participants remarked that professional groups tended to function in isolation, focused on their respective obligations without enough consultation or information sharing. This lack of teamwork was seen to negatively affect continuity of care and workplace harmony.

*“Everyone just does their own work. There is no real teamwork, and we hardly sit together to plan patient care.”* (Participant 4)

### Theme 2: Role Ambiguity and Overlapping Responsibilities

Role ambiguity emerged as a frequent source of conflict among healthcare personnel. Participants repeatedly reported confusing job descriptions and overlapping roles between community health nurses and community health extension workers. Nurses voiced displeasure because duties traditionally associated with nursing practice were

often handled by other cadres. This overlap led to frequent conflicts, uncertainty, and tension, particularly during service delivery. Nurses argued that the absence of clear duty delineation compromised professional boundaries and accountability within PHC institutions.

*“Sometimes you don’t even know who is responsible for what. Everybody wants to do everything, and it causes problems.”* (Participant 7)

### Theme 3: Professional Rivalry and Power Struggles

Professional rivalry and competition for authority were identified as important drivers to Interprofessional conflict. Participants described power battles over leadership roles, task allocation, and recognition inside the PHC system. Some nurses reported feeling sidelined in decision-making processes despite their training and expertise. Participants reported that favoritism and informal hierarchies often influenced workplace dynamics, resulting to dissatisfaction and strained relationships among healthcare staff.

*“It is more about who is in charge than working together. Sometimes it feels like a competition instead of a health facility.”* (Participant 2)

### Theme 4: Impact of Interprofessional Conflict on Nurses and Service Delivery

Interprofessional conflict was observed to have substantial emotional and professional effects for nurses. Participants indicated emotions of irritation, stress, demotivation, and diminished job satisfaction coming from prolonged workplace conflict. Some nurses reported a desire to leave PHC profession or pursue chances elsewhere owing to unresolved problems. In addition, participants stated that bad Interprofessional relationships negatively harmed patient care. Delays in service delivery, poor communication, and lack of coordinated treatment were widely cited results of persistent disagreement.



*“When there is conflict, patients suffer. Communication breaks down, and care is not smooth.”* (Participant 9)

### **Theme 5: Influence of Work Environment on Interprofessional Relationships**

Participants underlined that poor working conditions inside PHC facilities promoted Interprofessional conflict. Inadequate infrastructure, staff shortages, severe workloads, and restricted resources exacerbated stress levels and enhanced competitiveness among healthcare workers. Nurses noted that these settings diminished tolerance and patience among staff, making disagreements more common and difficult to settle.

*“The environment itself creates tension. When resources are not enough, everyone is angry and blaming each other.”* (Participant 11)

### **Discussion**

The findings of this study clarify considerable hurdles in Interprofessional collaboration within primary healthcare (PHC) settings in Northern Nigeria. These results are situated within and confirmed by a growing corpus of worldwide literature addressing health workforce dynamics in low-resource countries. The emergent themes of collaborative praxis, professional position uncertainty, inter-cadre rivalry, detrimental implications on workforce and care delivery, and the catalytic influence of resource restrictions collectively show a systemic barrier to effective team-based primary care. Participants' descriptions of inadequate, inconsistent collaboration and separated professional functioning accord with modern studies of PHC systems in sub-Saharan Africa. Asamani et al. (2021) characterize this phenomena as "persistent siloed functioning," wherein multidisciplinary teams operate in parallel rather than in an integrated manner, despite governmental mandates for collaborative treatment. This operational mismatch contradicts the primary PHC principle of comprehensive, coordinated service delivery. The reported absence of joint decision-making and consultation mirrors findings by Mash et al. (2022), whose systematic review identified a critical lack of formalized interprofessional communication frameworks and shared

clinical governance structures as primary barriers to effective collaboration in African PHC contexts. The consequent task-oriented, rather than patient-centered, interactions constitute a considerable deviation from the envisioned model of team-based treatment. The persistent theme of position uncertainty and overlapping scopes of practice emphasizes a fundamental regulatory and operational problem. This conclusion is verified by Okeke et al. (2023), who ascribe the continuing friction between nurses and community health extension workers (CHEWs) in Nigeria to "legislative and regulatory dissonance." The absence of clearly established and enforceable scopes of practice fosters a climate conducive to role invasion and boundary disputes. This uncertainty not only feeds interpersonal conflict but also erodes professional accountability, since individuals cannot be held responsible for areas that are not officially and totally theirs. The World Health Organization's (2022) guidance on optimizing health worker roles notes that in under-resourced settings, task-shifting often occurs through necessity rather than strategic planning, leading to the very confusion and conflict described by participants regarding "who is responsible for what."

The appearance of professional rivalry and competition for authority reflects deeper socio-professional structures within the health system. This conclusion correlates with the study of Mbindyo et al. (2023), who highlighted "contested professional jurisdiction" and competition for institutional legitimacy as important drivers of conflict among Kenyan PHC teams. When professional identity is believed to be under threat, collaborative intent is often substituted by protective territoriality. The observed power battles over leadership and recognition reflect an atmosphere where professional standing vies with patient results as the key organizational currency. This dynamic profoundly alters the clinical workplace from a collaborative ecology into a competitive arena, ultimately weakening the core ethos of Interprofessionalism. The dual impact of Interprofessional conflict on both healthcare provider well-being and patient care results is a well-documented consequence. The experience of frustration, demotivation, and intent to quit fits with scientific findings



associating bad workplace relations to burnout and attrition. Akanni et al. (2022) found a substantial positive link between Interprofessional conflict and turnover intention among Nigerian PHC nurses, suggesting a direct threat to workforce retention. From a patient safety and quality perspective, the reported breakdowns in communication and care coordination are consistent with the conclusions of Reeves et al. (2021), whose meta-synthesis affirmed that ineffective Interprofessional collaboration directly contributes to clinical errors, service fragmentation, and diminished patient satisfaction. This study substantiates participants' fears that eventually, "patients suffer" when collaboration fails. A major finding of this study is the role of the work environment as a multiplier of Interprofessional tension. This can be effectively articulated through the perspective of the Job Demands-Resources (JD-R) model. The hard conditions indicated inadequate infrastructure, workforce shortages, and resource constraint generate high "job demands." Concurrently, the lack of administrative support for conflict resolution and collaborative practice implies a shortfall in "job resources." Asante et al. (2023) adapt this concept to PHC settings, suggesting that such an imbalance depletes the emotional and cognitive resources of health workers, limiting their ability for tolerance, effective communication, and proactive collaboration. Therefore, the structural shortcomings of the PHC environment do not only coexist with interpersonal conflict; they actively promote and amplify it, creating a vicious cycle that is impossible to escape without systemic intervention. In summary, the experiences of community health nurses in Bauchi State provide a granular, experience-based perspective on dysfunction within PHC teams. These findings are not unusual but are firmly located within a recognized pattern of issues facing health systems in comparable situations. The interplay of ambiguous responsibilities, unresolved rivalry, inadequate teamwork, and a resource-poor environment poses a severe impediment to realizing the envisaged paradigm of integrated, team-based primary healthcare. This study consequently adds a critical qualitative viewpoint from Northern Nigeria, supporting the requirement for health

system reforms that move beyond technical inputs to address the underlying relational and governance designs of primary care teams.

### **Implications for Practice and Policy**

The findings underline the need for better role delineation, strengthened leadership, and established Interprofessional collaboration frameworks within PHC settings. Policies that clarify scopes of practice, promote team-based care, and improve working conditions may reduce conflict and boost both nurse satisfaction and patient outcomes. Additionally, including Interprofessional education and conflict management training into PHC workforce development may build more collaborative practice environments.

### **Strengths and Limitations:**

This study's main strength is in its qualitative phenomenological approach, which enabled an in-depth understanding of community health nurses' lived experiences of Interprofessional work relationships and role conflict in primary healthcare settings. The utilization of in-depth interviews and verbatim quotations boosted the credibility and richness of the findings. Focusing on community health nurses in Northern Nigeria also offers context-specific evidence to an underexplored area of primary healthcare research. However, the findings are constrained by the small, purposively selected sample and the confinement of the study to PHC facilities inside Bauchi metropolitan, which may limit transferability to other contexts. Additionally, the omission of other healthcare cadres' opinions and dependence on self-reported data may have impacted the breadth and objectivity of the findings.

### **Conclusion:**

This phenomenological study suggests that Interprofessional work interactions within Bauchi State's basic healthcare institutions are largely characterized by conflict, deriving from role ambiguity, inadequate collaboration, and professional competition. These tensions dramatically degrade community health nurses'



job satisfaction and morale, while concurrently reducing the quality, continuity, and safety of patient treatment. The tough work environment, typified by resource constraint and infrastructural inadequacies, further exacerbates these tensions. Addressing these deeply established Interprofessional problems is therefore crucial for promoting personnel retention, improving service delivery, and strengthening the overall performance of the primary healthcare system in Northern Nigeria.

#### **Ethical Considerations:**

Ethical approval was acquired from the relevant institutional ethics committee prior to data collection. Permission was also acquired from PHC officials in Bauchi State. Participants were told about the goal of the study, voluntary participation, confidentiality, and their opportunity to withdraw at any stage without penalties. Written informed consent was obtained from all participants, and identities were deleted from transcripts to ensure anonymity.

#### **Recommendations:**

To minimize Interprofessional conflict and increase teamwork in primary healthcare settings, we recommend:

1. Clarify Professional Roles: Develop and implement standardized scope-of-practice rules for all PHC cadres.
2. Strengthen Leadership: Train PHC managers in conflict resolution and collaborative leadership.
3. Foster Teamwork: Implement Interprofessional education and regular team-building efforts.
4. Improve Work Environments: Prioritize investments in PHC infrastructure, security, and resources.
5. Establish Conflict Resolution Systems: Create official, transparent channels for grievance redress.
6. Ensure Equity: Guarantee fair access to training and professional growth for all health worker cadres.
7. Expand Research: Fund further studies to incorporate the opinions of all PHC team members.

#### **Summary of Contributions:**

In summary, this research enhances knowledge in the following critical areas:

I.It fills a contextual gap by offering empirical evidence on interprofessional relations from PHC settings in Northern Nigeria.

II.It amplifies frontline nursing viewpoints, delivering vital insights into how systemic challenges are experienced at the point of care.

III.It theoretically integrates interpersonal conflict with structural health system inadequacies, enabling a holistic diagnostic approach. • It highlights the relevance of phenomenological methodologies in capturing the lived reality of health system issues.

IV.It contextualizes and verifies the JD-R model within the specific demands of low-resource primary care.

V.It provides an evidence base for policy action on role clarity, leadership development, and team-based care governance.

Collectively, these contributions underline that enhancing primary healthcare demands parallel investment in its relational infrastructure alongside its physical and human resources. The study indicates that the quality of Interprofessional partnerships is not only a workplace concern but a critical factor of health system effectiveness and sustainability.

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