



Hierarchical Labour Conflicts in Healthcare Settings: Perceptions of Subordinates and Superiors at the Muhala-Expansão Health Centre, Nampula

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ABSTRACT

Hierarchical labour conflicts are a ubiquitous phenomenon in healthcare organisations, with direct impacts on organizational climate, functional interdependence, and care quality. This study assessed the effects of hierarchical labour conflicts as perceived by subordinates and superiors at the Muhala-Expansão Health Centre (CSME), Nampula, Mozambique, using a mixed-methods descriptive design. The population comprised 247 employees, with a calculated sample of 151 (95% confidence; 5% margin of error); 236 respondents ultimately participated. Four validated instruments were administered: a Demographic and Conflict Perception Questionnaire (QDC), an Organizational Health Perception Scale (EPSaO), a Task Interdependence Scale (EIT), and an Outcome Interdependence Scale (EIR). Data were analysed descriptively (SPSS v.25) and through thematic content analysis. Results showed that 68% of conflicts occur between staff and management, with felt conflict predominating (52%). Organizational health scored a mean of 3.75 (EPSaO), indicating partial integration, while a critical imbalance was observed between high task interdependence (EIT = 4.87) and low outcome interdependence (EIR = 2.04). The Nursing sector concentrated the highest tension indices. The findings indicate that differentiated perception across hierarchical levels amplifies conflict and compromises organizational cohesion, and that effective management requires a holistic approach centred on communication, equity, and empathetic leadership training.

General Terms

Human Resource Management, Organizational Behaviour, Healthcare Management.

Keywords

Hierarchical labour conflicts; human resource management; organizational health; task interdependence; Mozambique.

1. INTRODUCTION

Healthcare organizations constitute sociotechnical systems of considerable complexity, distinguished by an intensive division of labour, multiple hierarchical strata, and functional interdependence amongst heterogeneous professional categories. Within this milieu, labour conflicts do not represent aberrant occurrences but, rather, a structural dynamic inherent to organizational life [1], [2]. The coexistence of “real teams” characterised by strong cohesion and genuinely interdependent objectives, as exemplified by surgical units, alongside “pseudo-teams”, in which professionals share the care of the same

patient without common or mutually binding goals, fosters interprofessional and hierarchical divergence [3].

The consolidated literature distinguishes conflict from its pathological representation: whereas conflicts of moderate intensity are associated with optimal performance, excessive or suppressed conflicts correlate with diminished productivity, absenteeism, staff turnover, and deterioration in the quality of care [4]. In lower-middle-income countries such as Mozambique, such deterioration acquires critical dimensions: it is estimated that five million deaths annually, on a global scale, are attributable to inadequate care — a figure that surpasses mortality attributable to the mere absence of access to health services [5].

The perception of conflict varies systematically between subordinates and superiors, thereby compromising the effectiveness of managerial interventions [6], [7]. Research conducted within health services demonstrates that the centralisation of authority, the absence of effective communication channels, and managerial unpreparedness rank amongst the principal antecedents of hierarchical conflict [8], [9]. Despite the evident significance of this topic, the scientific literature remains conspicuously deficient in empirical studies situated in sub-Saharan African contexts, where the organizational and cultural specificities of health facilities engender conflict dynamics that diverge markedly from those documented in Euro-American scholarship.

Confronted with this lacuna, the present study formulated the following research question: how does the perception of subordinates and superiors regarding hierarchical labour conflicts at the Muhala-Expansão Health Centre (CSME), in the district of Nampula, influence working relations and the organizational environment?

The overarching aim was to assess the effects of hierarchical labour conflicts as perceived by both categories of staff. The specific objectives encompassed: (a) identifying the principal typologies and causes of labour conflicts at the CSME; (b) analysing the influence of such conflicts upon organizational climate and health; and (c) investigating their impact upon task interdependence and sectoral performance.

2. THEORETICAL FRAMEWORK

2.1 The Nature and Typology of Labour Conflicts

The concept of conflict derives from the Latin *conflictus* — a clash between those who struggle — and denotes a situation of incompatibility, disagreement, or dissonance between



individuals, groups, or organisations [10]. The theoretical evolution of the twentieth century displaced the understanding of conflict from a phenomenon to be suppressed, as propounded by the classical and scientific management schools, towards a dynamic to be strategically governed, with recognition accorded to its constructive potential when appropriately channelled [12].

Contemporary scholarship classifies conflicts into two cardinal categories: (a) task conflicts, pertaining to divergences regarding the content and objectives of work; and (b) socio-affective conflicts, arising from interpersonal and emotional incompatibilities [11], [13]. This distinction carries considerable managerial significance, as task conflicts of moderate intensity may stimulate innovation and critical deliberation, whilst socio-affective conflicts tend to exert a deleterious influence upon performance and employee well-being [14], [15]. Broader treatments of organizational conflict management further underscore that unresolved task conflict frequently transmutes into relational tension over time, particularly where feedback channels are weak [16].

Concerning aetiology, the literature identifies four principal antecedents in healthcare contexts: communication deficiencies, power asymmetries, dehumanisation in professional interactions, and ambiguity in work-flow processes [3], [17]. Dehumanisation, in particular, manifests through the stereotyping and stigmatisation of professional categories — physicians, nurses, pharmacists — thereby undermining the interprofessional collaboration that is indispensable to patient safety [18].

2.2 Models of Conflict Management

The classical processual model of organizational conflict delineates conflict dynamics across five sequential stages: (1) potential opposition, anchored in structural antecedents; (2) cognition and personalisation, wherein the parties perceive and internalise the conflict; (3) behavioural intention; (4) manifest behaviour; and (5) evaluation of outcomes [19]. This model demonstrates that conflict is not a static condition but a dynamic process whose consequences — enhancement or diminution of performance and satisfaction — are contingent upon the interventional strategies employed.

Amongst the available strategies, two fundamental responses are distinguished: avoidance — a temporary suppression that tends to intensify conflict — and constructive confrontation, which may take the form of dispute, negotiated compromise, or collaborative solution-building [17], [20]. The role of the human resource manager is pivotal in this regard: the capacity to identify conflict indicators at an early stage, facilitate communication, and mediate between the parties involved determines, to a considerable degree, the organizational outcome [21], [22].

2.3 Organizational Health and Interdependence in Healthcare Teams

The construct of organizational health reflects the degree of integration between the organisation's internal systems, its adaptive capacity relative to the external environment, and the quality of interpersonal relations amongst its members [23].

Organizational health has further been shown to moderate the relationship between conflict intensity and performance, buffering or amplifying the downstream consequences of unresolved conflict according to the integrative capacity of the institution [24].

The Organizational Health Perception Scale (EPSaO), developed and validated by [23], operationalises this construct across measurable dimensions, enabling the diagnosis of areas of organizational vulnerability. Functional interdependence in healthcare teams operates along two distinct yet interrelated dimensions: task interdependence — the extent to which members depend upon one another to execute their functions — and outcome interdependence — the extent to which individual outcomes are contingent upon collective results [25]. The literature indicates that imbalances between these dimensions — high task interdependence coupled with low outcome interdependence — constitute fertile ground for conflict, inasmuch as professionals are functionally dependent yet do not perceive themselves as co-responsible for organizational outcomes [26].

3. METHODOLOGY

3.1 Study Design

The present study adopted a mixed-methods approach (qualitative-quantitative) with a descriptive design and field research procedure [27], [28]. The rationale for the mixed-methods approach resides in the nature of the phenomenon under investigation: hierarchical conflicts encompass both measurable dimensions — frequency, typology, and intensity — and subjective meanings attributed by participants to their lived experiences, the comprehension of which necessitates qualitative content analysis techniques.

3.2 Research Context and Participants

The study was conducted at the Muhala-Expansão Health Centre (CSME), a Type II public health facility situated in the district of Nampula, northern Mozambique, established in 2008 and serving approximately 9,699 inhabitants across twenty-five communities. The CSME employs 247 professionals distributed across clinical sectors (Nursing, Emergency Ward, Maternity, Pharmacy) and administrative departments (Secretariat), operating under a hierarchical structure comprising general management, clinical directorate, nursing management, and administration.

The sample size was calculated using a formula for finite populations [29], with a 95% confidence level and a 5% margin of error, yielding $n = 151$. Inclusion criteria were defined as follows: current employment at the CSME during 2023/2024; direct experience of hierarchical conflicts; membership of distinct hierarchical levels; and voluntary informed consent. Exclusion criteria encompassed employees without involvement in the conflicts under investigation or unavailable during the data collection period. Of the 247 eligible employees, 236 agreed to participate (response rate = 95.5%), of whom 6.8% occupied supervisory or managerial positions and 93.2% were subordinates.

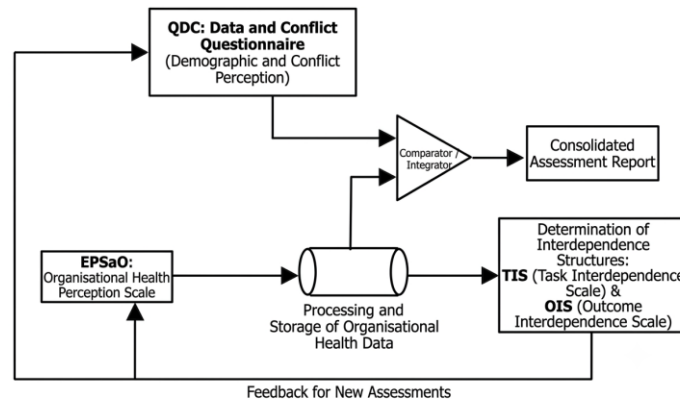


Fig 1: Data collection instruments used in the study
Source: compiled by the authors, adapted from [23].

As summarised in Table 1, the instruments were made available in digital format (Google Forms) and in paper-based format, with an estimated completion time of 20 minutes. The EPSaO, EIT, and EIR scales employ standardised evaluation parameters as described by [23]. The QDC assessed conflict typologies through a three-point ordinal scale (1 = No; 2 = Not always; 3 = Very frequently), supplemented by open-ended questions subsequently subjected to content analysis.

3.3 Data Analysis

Data were entered and cleaned in Microsoft Excel 2016 and analysed in SPSS v.25 for descriptive statistics (frequencies, means, standard deviations). Open-ended responses from the QDC were submitted to thematic content analysis. The research received institutional approval from UnISCED and was conducted in accordance with Mozambican legislation [30] and the principles of the Declaration of Helsinki, ensuring anonymity, voluntariness, and non-punitiveness.

4. RESULTS AND DISCUSSION

4.1 Sociodemographic Profile of Participants

Of the 236 respondents, 6.8% (n = 16) occupied managerial or supervisory positions and 93.2% (n = 220) were subordinates.

The preponderance of subordinates in the sample reflects the pyramidal hierarchical structure typical of Mozambican public health facilities and lends particular salience to the perspective of those occupying lower hierarchical strata in the analysis of conflicts. The sectors represented comprised Nursing, Maternity, Emergency Ward, Pharmacy, and Secretariat, thereby encompassing the principal clinical and administrative axes of the CSME.

4.2 Typology and Sectoral Distribution of Conflicts

Figure 1 presents subordinates' perceptions of the frequency of labour conflicts by sector. Sectoral analysis demonstrates that employer non-compliance — encompassing the delayed payment or withholding of overtime remuneration — constitutes the sole conflict category present in every sector at maximum frequency (VF), thereby configuring a transversal source of institutional dissatisfaction. The Nursing sector recorded the highest tension indices, with very frequent occurrence across six of the ten categories investigated, followed by Maternity and the Emergency Ward. The Secretariat returned the lowest index, consistent with its predominantly administrative function and comparatively limited functional interdependence with the clinical sectors.

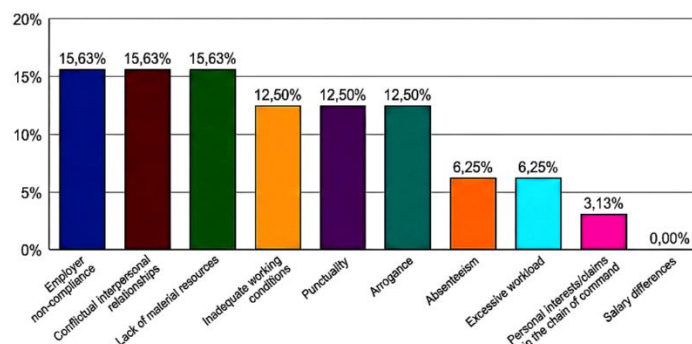


Chart 1: Subordinates' perceptions of the frequency of labour conflicts by sector
Source: primary research data (2024).

These findings corroborate [3], who identify the emergency-driven nature of clinical work and high functional interdependence as amplifying factors of conflict in highly complex health units. The literature specific to Mozambican nursing points to functional overload and structural

precariousness as critical antecedents of conflict within this professional category [5], thereby conferring ecological validity upon the results obtained.

4.3 Synthesis of Quantitative Scores

The mean EPSaO score of 3.75 indicates that the organizational health of the CSME resides in a state of partial integration: the organisation demonstrates adaptive capacity, yet exhibits

significant fragilities in interpersonal and inter-sectoral integration. This finding is consonant with [31], for whom organizational cultures characterised by low integration tend to exhibit heightened perception and greater intensity of hierarchical conflicts.

Table 2. Synthesis of scores obtained on the validated scales (CSME, 2024)

Dimension	Instrument	Mean / %	Interpretation
Organizational health	EPSaO	3.75	Partial integration
Task interdependence	EIT	4.87	High interdependence
Outcome interdependence	EIR	2.04	Low interdependence
Conflicts with management	QDC	68%	Critical level
Conflicts among colleagues	QDC	22%	Moderate level
Felt (emotional) conflict	QDC	52%	Majority of respondents

Source: primary research data (2024); EPSaO, EIT and EIR adapted from [23].

The imbalance between the EIT score (4.87) and the EIR score (2.04) represents the analytically most consequential finding of the study, corresponding to a ratio of approximately 2.4:1 between the two dimensions. Whilst professionals perceive a high degree of mutual dependence in the execution of their duties, dependence in terms of outcomes is perceived as low. This discrepancy generates a motivational asymmetry:

employees regard themselves as functionally bound to one another, yet do not perceive themselves as co-responsible for organizational outcomes, thereby producing tension without collective engagement in its resolution. A configuration of this nature is identified as a precondition for persistent process conflicts in hospital teams [26].

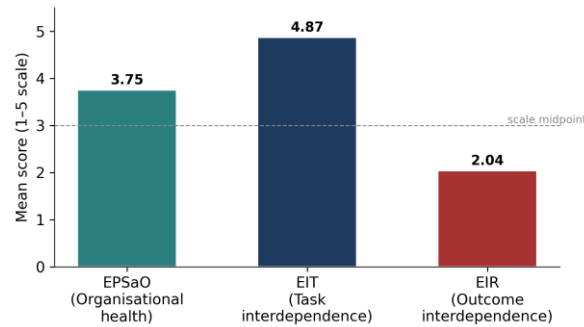


Chart 2. Mean scores on the three validated organizational instruments

Source: primary research data (2024), plotted from Table 2.

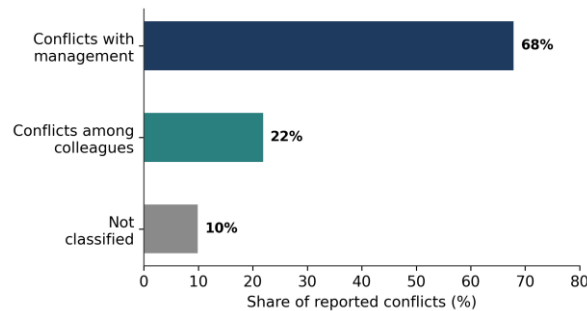


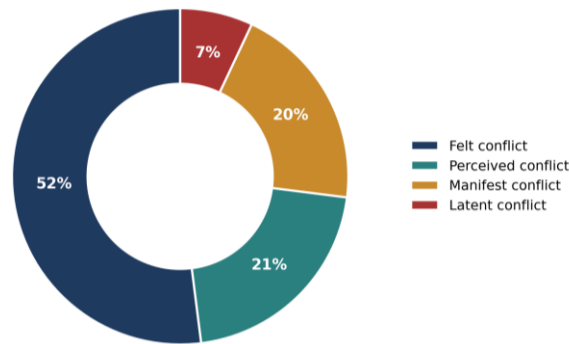
Chart 3. Locus of reported conflicts: management versus peer level

Source: primary research data (2024), plotted from Table 2.

4.4 Conflict Manifestations and Differentiated Perceptions

The distribution of conflict manifestations, presented in Figure 4, revealed that 52% of participants experience felt conflict — actively undergoing negative emotional states such as frustration, discontent, and anxiety — whilst 20% exhibit

manifest conflict, characterised by visible confrontational behaviour; 21% report perceived conflict; and a mere 7% indicate latent conflict. This distribution is of considerable clinical concern: the predominance of felt conflict, in accordance with [32], is associated with emotional reactions that erode individual performance and team cohesion prior to any explicit behavioural manifestation.



Pie Chart 4. Distribution of conflict manifestation types among respondents

Source: primary research data (2024).

Perceptions diverge significantly between hierarchical levels, as illustrated in Figure 5. Amongst subordinates, 74.6% recognise conflict as an inherent feature of organizational life and actively seek to resolve it; however, a mere 12.2% demonstrate an empathic orientation — that is, taking into account the needs of the opposing party. Amongst superiors, 51.7% acknowledge the dual potential of conflict —

simultaneously disruptive and innovative — and 29.8% regard it as inevitable; yet only 12.6% perceive it as an opportunity for systemic improvement. This perceptual asymmetry is consistent with [6], who demonstrate that the incompatibility of cognitive frames across hierarchical levels amplifies conflict escalation.

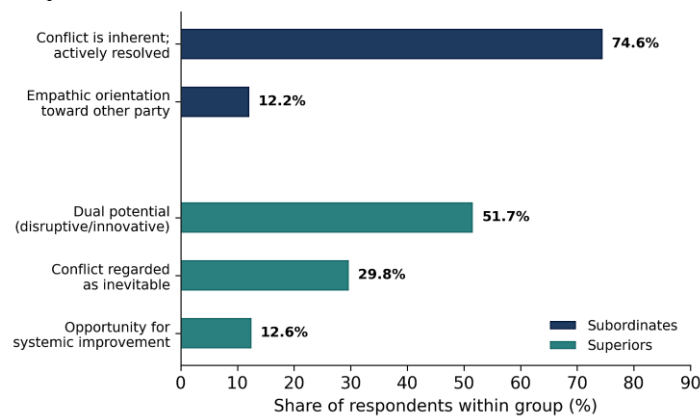


Chart 5. Differentiated perceptions of conflict by hierarchical level

Source: primary research data (2024).

The high incidence of 68% of conflicts between employees and management significantly exceeds the 22% of peer-level conflicts — a pattern that diverges from studies conducted in high-income healthcare organisations, in which intra-peer conflicts tend to be more prevalent [33]. This result points to specificities of the Mozambican context, most notably the centralisation of authority, the weakness of formal participatory channels, and the generalised perception of distributive injustice, corroborating [9] and [8], who identify managerial unpreparedness and ineffective communication as the principal mediators of vertical conflictuality in African public health services.

4.5 Comparative and Scenario Analysis Across Sectors and Hierarchical Levels

To extend the depth of the evaluation beyond isolated indicators, the principal metrics obtained — sectoral tension, instrument scores, conflict locus, manifestation type, and hierarchical perception — are here read jointly, as an integrated model (Figure 6), rather than as separate results. Three converging lines of evidence support this reading. First, at the sectoral level, Nursing simultaneously records the highest frequency of very-frequent conflict episodes (§4.2) and

operates under the steepest task-interdependence conditions implied by the EIT/EIR imbalance (§4.3), suggesting that structural workload, rather than isolated interpersonal friction, underlies its elevated tension. Second, at the hierarchical level, the near six-fold gap between subordinates who view conflict as something to resolve (74.6%) and those who report an empathic orientation toward the other party (12.2%) indicates that engagement with conflict does not, on its own, translate into perspective-taking — a distinction with direct implications for the design of mediation training, which should target empathic skill specifically rather than assume it follows from willingness to engage. Third, the predominance of felt over manifest conflict (52% versus 20%) implies that a substantial share of organizational tension remains invisible to routine managerial observation, meaning that incident-based monitoring alone would systematically under-detect the problem documented here.

These convergences support two contrasting scenarios for the CSME. Under a status-quo scenario, in which the EIT/EIR imbalance and the concentration of unresolved felt conflict in Nursing are left unaddressed, the pattern reported by [26] predicts a self-reinforcing cycle in which functional dependence without shared accountability sustains, rather than

resolves, tension. Under a targeted-intervention scenario, in which outcome interdependence is deliberately raised — for instance through collective performance indicators and participatory decision channels — the same theoretical mechanism predicts a narrowing of the EIT/EIR gap and, consistent with the moderating role of organizational health documented by [24], a reduction in the downstream escalation of felt conflict into manifest and absenteeism-related outcomes. Distinguishing these scenarios analytically, rather than only descriptively reporting the underlying percentages, is what motivates the intervention priorities proposed in the concluding

section.

This comparative reading should nonetheless be interpreted as an analytical deepening of a single institutional dataset rather than as evidence drawn from multiple independent settings. The CSME findings are internally triangulated across four instruments and two hierarchical vantage points, which strengthens confidence in the patterns reported here for this facility; external validity across other Mozambican health units, discussed further as a limitation below, would require replication with comparable instruments at additional sites.

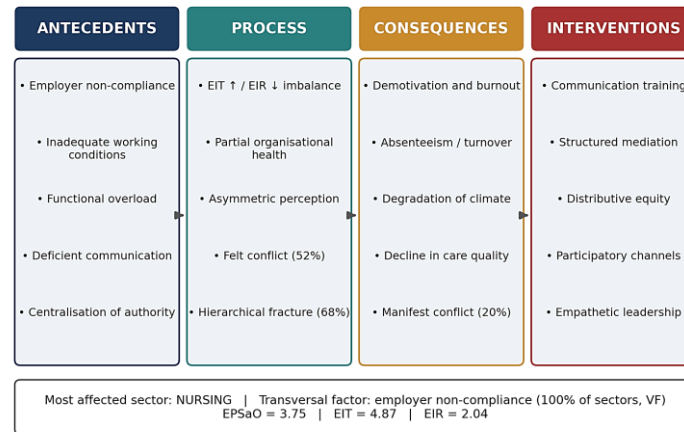


Fig 6. Integrated findings model of hierarchical conflicts at the CSME
Source: compiled by the authors on the basis of primary research data (2024).

5. CONCLUDING REMARKS

The findings of this study furnish a substantive response to the research question posed: the asymmetric perception of hierarchical conflicts between subordinates and superiors at the CSME compromises the quality of working relations and contributes to an organizational environment characterised by emotional tension, attenuated interpersonal integration, and deteriorating organizational health. The study fully attained its three specific objectives: it identified employer non-compliance, inadequate working conditions, and interpersonal conflicts as the dominant typologies; it demonstrated that partial organizational health (EPSaO = 3.75) is associated with the elevated frequency of hierarchical conflicts; and it revealed that the imbalance between task and outcome interdependence (EIT = 4.87 vs. EIR = 2.04) constitutes a critical driver of process conflicts in the Nursing sector.

The original scholarly contribution of this study resides in the empirical demonstration, within a sub-Saharan public health context, that the structural imbalance between task interdependence and outcome interdependence amplifies conflictual perception in vertically asymmetric hierarchies. This finding adds a structural dimension to the understanding of conflicts in health services in lower-middle-income countries, where extant scholarship tends to emphasise individual and communicational factors to the detriment of systemic organizational conditions.

On the basis of the empirical evidence, the following recommendations are advanced: (a) the implementation of training programmes in non-violent communication and conflict mediation for all hierarchical levels, with explicit attention to empathic skill-building rather than conflict engagement alone; (b) the establishment of formal mechanisms

for subordinate participation in decision-making processes, with particular emphasis upon the equitable distribution of resources and overtime remuneration; (c) the institution of periodic multi-directional feedback forums, designed to surface felt conflict before it escalates into manifest or absenteeism-related outcomes; and (d) the reformulation of sectoral performance indicators to incorporate interdependent collective targets, thereby correcting the EIT/EIR imbalance identified, with priority implementation in the Nursing sector.

Several limitations of the present study must be acknowledged when interpreting its findings. The restriction to a single health centre constrains the generalisability of the results to other Mozambican health facilities, and the comparative analysis presented in §4.5, while internally rigorous, remains bounded by this single-site dataset. The absence of longitudinal data precludes causal inference. The preponderance of subordinates in the sample (93.2%) may have introduced a perspectival bias. Future research should incorporate multi-centre samples, longitudinal designs, and clinical performance measures as dependent variables, with a view to establishing causal relationships between hierarchical conflicts and care quality. Replication in health contexts across other sub-Saharan African countries would enable an assessment of the cultural specificity of the findings herein reported.

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