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The effect of quality, health, safety and environment (qhse) practices on the sustainable performance of Ivorian Hospitals: The case of the Islamic Hospital Of Daloa

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ABSTRACT

Background: The sustainable performance of healthcare institutions increasingly depends on systematized Quality, Health, Safety and Environment (QHSE) management practices. Since the 2019 hospital reform law, Côte d'Ivoire has made accreditation and quality improvement strategic axes of health system modernization. However, empirical evidence regarding the effect of QHSE practices at the level of Ivorian hospitals, particularly in private or faith-based institutions, remains limited. The Islamic Hospital of Daloa, commissioned in 2019, provides a relevant case for examining the relationship between QHSE practices and sustainable organizational performance. Objective: This study aims to analyze the current state of QHSE management practices at the Islamic Hospital of Daloa, assess their effects on service quality, patient safety, worker health, and environmental performance, and identify institutional obstacles to sustainable performance improvement. Methods: A cross-sectional mixed-methods design was adopted. Quantitative data were derived from a questionnaire administered to 121 patients and from analysis of internal quality and safety records. Qualitative data were obtained through semi-structured interviews with hospital management and key personnel. The assessment of QHSE practices was based on core elements of ISO 9001, ISO 14001, and ISO 45001 frameworks, adapted to the Ivorian hospital context, supplemented by provisions of the Labour Code relating to occupational health services, working hours, and accident reporting. Results: The Islamic Hospital of Daloa demonstrates a proximity-oriented mission, with a patient catchment area limited to surrounding neighbourhoods, characteristic of a primary care mission. Regarding QHSE practices, the hospital has established basic mechanisms for infection control, biomedical waste management, and patient reception, but the degree of systematization remains limited. Key constraining factors include: insufficient provision of occupational health services in healthcare institutions; underreporting of workplace accidents and occupational diseases; and incomplete integration of healthcare institution data into the national health information system. At the sustainable performance level, the hospital faces structural challenges in financial sustainability, environmental footprint management, and staff retention. Conclusion: The QHSE practices of the Islamic Hospital of Daloa are at a stage of basic institutionalization, without having achieved an integrated management system. Improving sustainable performance requires coordination among leadership commitment, systematic risk management, staff participation, and data-driven continuous improvement. Embedding an integrated QHSE framework into the hospital's daily operations, rather than treating it as an add-on requirement for external accreditation, is the key pathway to long-term sustainability..

Keywords: QHSE, sustainable performance, hospital management, Côte d'Ivoire, patient safety, occupational health, quality of care

RESUME

Contexte : La performance durable des établissements de santé dépend de plus en plus de pratiques systématisées de gestion de la Qualité, de l'Hygiène, de la Sécurité et de l'Environnement (QHSE). Depuis la loi de 2019 portant réforme hospitalière, la Côte d'Ivoire a fait de l'accréditation et de l'amélioration de la qualité des axes stratégiques de la modernisation de son système de santé. Cependant, les preuves empiriques concernant l'effet des pratiques QHSE au niveau des hôpitaux ivoiriens, en particulier dans les établissements à statut confessionnel ou privé, restent limitées. L'Hôpital Islamique de Daloa, mis en service en 2019, offre un cas pertinent pour examiner la relation entre les pratiques QHSE et la performance organisationnelle durable. Objectif : Cette étude vise à analyser l'état de mise en œuvre des pratiques QHSE à l'Hôpital Islamique de Daloa, à évaluer leurs effets sur la qualité des services, la sécurité des patients, la santé des travailleurs et la performance environnementale, et à identifier les obstacles institutionnels à l'amélioration de la performance durable. Méthodes : Un devis transversal à méthodes mixtes a été adopté. Les données quantitatives proviennent d'un questionnaire administré à 121 patients et de l'analyse des registres internes de qualité et de sécurité. Les données qualitatives ont été obtenues par des entretiens semi-structurés avec la direction de l'hôpital et le personnel clé. L'évaluation des pratiques QHSE s'est appuyée sur les éléments centraux des référentiels ISO 9001, ISO 14001 et ISO 45001, adaptés au contexte hospitalier ivoirien, complétés par les dispositions du Code du travail relatives aux services de santé au travail, à la durée du travail et à la déclaration des accidents. Résultats : L'Hôpital Islamique de Daloa présente une orientation de proximité, avec un bassin de recrutement circonscrit aux quartiers environnants, caractéristique d'une mission de soins de premier recours. Concernant les pratiques QHSE, l'hôpital a établi des dispositifs de base en matière de contrôle des infections, de gestion des déchets biomédicaux et d'accueil des patients, mais le degré de systématisation demeure limité. Les principaux facteurs contraignants incluent : la dotation insuffisante des services de santé au travail dans les établissements de soins ; la sous-déclaration des accidents du travail et des maladies professionnelles ; et l'intégration incomplète des données des établissements de santé dans le système d'information sanitaire national. Conclusion : Les pratiques QHSE de l'Hôpital Islamique de Daloa se situent à un stade d'institutionnalisation de base, sans avoir atteint un système de management intégré. L'amélioration de la performance durable nécessite une coordination entre l'engagement de la direction, la gestion systématique des risques, la participation du personnel et l'amélioration continue fondée sur les données.

Mots-clés : QHSE, performance durable, gestion hospitalière, Côte d'Ivoire, sécurité des patients, santé au travail, qualité des soins

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1. INTRODUCTION

Performance assessment in healthcare institutions is undergoing a paradigm shift: from a narrow focus on clinical outcomes and financial indicators toward a sustainable performance framework encompassing quality, safety, environment, and social responsibility. This shift is driven globally by multiple forces—the rise of patient rights awareness, the persistence of healthcare-associated infections and occupational exposure risks, concerns about the environmental impact of medical waste, and increasingly stringent accreditation and regulatory requirements.

In Côte d'Ivoire, this shift has a specific institutional context. Article 17 of the 2019 Hospital Reform Law (Law No. 2019-678) explicitly requires hospital institutions to "participate in accreditation and certification procedures," marking a formal national commitment to systematized quality management. The Ministry of Health set targets of 20% of institutions certified by 2023 and 40% by 2025. In 2024, the Ministry launched a project to certify five molecular biology laboratories to ISO 15189 standards, building on quality improvement processes in which these laboratories had participated since 2022. By 2023, the proportion of certified laboratories reached 25%, exceeding the 20% target.

However, the accreditation process faces significant structural constraints. The Ministry's own assessment notes that "certain EPH lack sufficient infrastructure and modern medical equipment, limiting their capacity to provide quality services and advance laboratory certification. The high cost of quality improvement processes is also a major obstacle to institutional participation." These constraints may be even more pronounced in resource-limited private or faith-based healthcare institutions.

The Islamic Hospital of Daloa provides a distinctive case for examining these issues. The hospital was commissioned in 2019, initiated by health personnel from the Islamic Medical Relief Organization (SEMI) and supported by Al Barakat, an Islamic microfinance institution in Daloa. Its explicit mission is to provide "appropriate-priced medical services" to "primarily vulnerable populations," while alleviating the geographic accessibility barriers for residents of the city's southeastern and southwestern neighbourhoods—areas located more than 5 kilometres from the Regional Hospital Centre (CHR). This community-oriented positioning places it in a special position within Côte d'Ivoire's health system, between the public system and the purely private sector.

This study aims to analyze the current state of QHSE practices at the Islamic Hospital of Daloa and their effects on sustainable performance. The QHSE framework—integrating quality (ISO 9001), health and safety (ISO 45001), and environmental (ISO 14001) dimensions—provides a systematic perspective for assessing healthcare institutions' comprehensive performance beyond clinical outcomes. Against a backdrop in which hospital management research in Côte d'Ivoire remains predominantly focused on clinical and financial indicators, this analysis helps fill a knowledge gap regarding the relationship between QHSE practices and organizational sustainability.

2. LITERATURE REVIEW

2.1 Quality and Safety Governance in Côte d'Ivoire's Health System

The quality governance framework of Côte d'Ivoire's health system has undergone significant institutionalization over the past decade. The performance-based financing (FBP) model was introduced in 2016 with World Bank support, aiming to "revitalize the health system." FBP operations rely on periodic quality assessments conducted by Regional Health Directorates (DRS) and

Departmental Health Directorates (DDS) with support from Contracting and Verification Agencies (ACV), as well as cross-verification executed by independent external verification agencies (AVEI).

However, this quality assessment system faces reliability challenges. An analysis of 220 quality assessments in 100 referral hospitals between 2022 and 2024 found that "68.6% of assessments showed significant discrepancies." Factors associated with discrepancies included "non-compliance with verification standards" and "lack of proper file management systems." Cross-verification revealed "major differences from initial survey results, indicating poor consistency in perceived quality assessments." The study's public health message explicitly states: "Capacity building and better documentation management are necessary for reliable quality assessment."

The implications of this finding for QHSE practices are profound. If the quality assessments serving as the basis for performance-based financing themselves contain systematic bias, the improvement incentives signaled by assessment results may not effectively drive actual quality improvement. For private institutions such as the Islamic Hospital of Daloa, which may not fully participate in the FBP system, the drivers of quality improvement may depend more on internal commitment than on external financial incentives.

2.2 Occupational Health and Safety in Healthcare Institutions

Côte d'Ivoire's Labour Code (2015) provides the foundational legal framework for occupational health and safety. Article 43.1 requires that "all employers must ensure occupational health services, regardless of the number of employees," and that this service "organizes three key visits—pre-employment, periodic, and return-to-work—to monitor fitness and enable early detection of occupational diseases." The occupational physician "performs prevention work rather than treatment work," with national-level coordination provided by the Occupational Health and Safety Directorate.

However, the implementation of this institutional framework in healthcare institutions faces significant constraints. The analysis notes that "treatment still takes priority over prevention, and the number of occupational physicians remains insufficient"—as of 2018 data, there were only about 14 labour inspection physicians and a few regional branches nationwide. Employers bear "sole and personal responsibility" for protecting workers' lives and health (Articles 41.1 to 41.8), and the reporting deadline for accidents and occupational diseases is 48 hours, but "underreporting" is identified as one of four major challenges.

The working environment of healthcare institutions has specific risk characteristics. A study of safety culture in three Ivorian health institutions (PSP, CNTS, and ICA) revealed systemic problems. The study found that "none of the three institutions had sufficient staff to cope with the workload" (PSP 32%, CNTS 45%, ICA 25.4%), "nor were they characterized by freedom of expression" (PSP 33%, CNTS 47%, ICA 53.3%), and "the quality of service was poorly organized, not allowing for improvement in the quality

of care" (PSP 46.7%, CNTS 53.3%, ICA 48.3%). The teamwork dimension scored higher (average 79.5%), but significant gaps remained in management support and staff participation.

2.3 Medical Waste Management and Environmental Performance

The environmental management of medical waste is a core concern of the environmental dimension of the QHSE framework. Research in Côte d'Ivoire indicates significant deficiencies in biomedical waste management quality. A survey conducted at a military hospital in Abidjan found that "45.2% of personnel were unaware of proper waste management," "25% did not clean and disinfect equipment," and "75.6% admitted that open-air burning was the treatment method." The study concluded that "in Africa, biomedical waste management suffers from poor organization. To achieve sound management, training and awareness-raising of health personnel, as well as treatment equipment, are needed."

These findings have direct relevance for assessing QHSE at the Islamic Hospital of Daloa. As a community hospital, its medical waste management practices affect not only environmental performance but also directly impact the health risks of staff and the surrounding community.

2.4 Integrated Management Systems: Theory and Practice

The ISO 9001, ISO 14001, and ISO 45001 standards share a "Harmonized Structure," enabling organizations to integrate quality, environmental, and occupational health and safety management into a unified framework. SGS analysis notes that "the success of an integrated management system (IMS) depends more on leadership behaviour and organizational maturity than on document structure."

The benefits of integration include "more efficient processes," "more effective risk and compliance management," "elimination of redundant requirements," "consistent organizational terminology," and "a culture supporting continuous improvement." However, implementation challenges are equally significant: "One of the most important challenges is that organizations often fail to integrate their documentation and management processes. For example, quality teams focus on defects, environmental teams focus on environmental impacts, and health and safety teams focus on injuries."

This theoretical framework provides a benchmark for analyzing the QHSE practices of the Islamic Hospital of Daloa: Does the hospital treat quality, safety, and environmental management as dispersed compliance tasks, or does it integrate them into a unified continuous improvement system?

3. RESEARCH QUESTIONS

This study addresses the following core questions:

1. What specific practices has the Islamic Hospital of Daloa implemented in Quality, Health, Safety and Environment (QHSE) management, and what is the degree of systematization and institutionalization of these practices?
2. What observable effects do QHSE practices have on the hospital's sustainable performance—including service quality, patient safety, worker health, and environmental performance?
3. What are the main institutional obstacles constraining the effectiveness of QHSE practices and the improvement of sustainable performance?
4. Given the hospital's organizational and resource constraints, what measures can promote the integration and continuous improvement of QHSE practices?

4. METHODOLOGY

4.1 Research Design

This study adopts a cross-sectional mixed-methods design, combining quantitative patient surveys with qualitative management interviews to obtain multidimensional evidence on QHSE practices and their effects. The use of mixed methods is based on the following consideration: certain dimensions of QHSE practices (such as infection control protocols and waste treatment procedures) can be assessed through document review and observation, while their organizational effects (such as staff safety perceptions and patient satisfaction) require understanding through stakeholder perspectives.

4.2 Study Setting

The Islamic Hospital of Daloa is located in the central-western Ivorian city of Daloa, at the intersection of several road axes. The city is Côte d'Ivoire's third-largest urban agglomeration, after Abidjan and Bouaké. The hospital was commissioned in 2019, covers an area of 3,485 square metres, and was built at a cost of 180 million CFA francs. Facilities include medical, surgical, paediatric, gynaecological, ENT, and ophthalmology services, as well as a dental clinic, a maternity ward, and a mosque. The hospital operates 24 hours a day.

4.3 Data Collection

Quantitative data: A patient questionnaire (n=121) was administered in December 2021, covering patients' neighbourhood of origin, sociodemographic characteristics, service utilization patterns, and satisfaction perceptions. Internal hospital quality and

safety records (including infection control logs, waste treatment records, and incident reports) were used to assess the degree of institutionalization of QHSE practices.

Qualitative data: Semi-structured interviews (n=5) were conducted with hospital management and key department heads, covering themes of QHSE policy formulation and implementation, resource allocation, staff training, and obstacles to improvement.

4.4 QHSE Practice Assessment Framework

The assessment framework integrates core elements of three ISO management standards, adapted to the specific legal requirements of Ivorian healthcare institutions:

Quality dimension (referencing ISO 9001): Existence of a written quality policy; patient reception and complaint handling procedures; standardization and compliance monitoring of clinical protocols; staff competency management and training records.

Health and safety dimension (referencing ISO 45001 and Labour Code Articles 41–43): Accessibility of occupational health services; accident and occupational disease reporting and investigation mechanisms; provision and use of personal protective equipment; adequacy of workload and staffing.

Environmental dimension (referencing ISO 14001): Medical waste segregation, collection, storage, and treatment protocols; separation of infectious and general waste; wastewater management; environmental compliance assessment.

4.5 Limitations of the Method

This study has several methodological limitations. First, the limited sample size. Although the patient survey sample (n=121) provided valuable descriptive data, it was insufficient for statistical inference or multivariate analysis. Second, the time window. Data collection was concentrated in December 2021, and hospital operations may have changed since then. Third, the generalizability limitations of a single-case design. As a faith-based community hospital, the Islamic Hospital of Daloa's QHSE practices may not represent the situation of Ivorian public hospitals or large private institutions. Fourth, the absence of longitudinal QHSE performance data. This study cannot establish a causal time-series relationship between QHSE practices and performance improvement. Fifth, the absence of on-site observation. Self-reports and document reviews may not fully reflect behavioural deviations in actual practice.

5. RESULTS

5.1 Service Positioning and Patient Characteristics

The Islamic Hospital of Daloa demonstrates a distinct community service orientation. Survey data indicate that patients' origins are "quite limited to the surrounding neighbourhoods," indicating that the hospital has achieved its founders' goal of "providing medical services to the nearby population," which is "far from the Regional Hospital Centre (CHR) traditionally sought."

Table 1: Sociodemographic Characteristics of Patients at the Islamic Hospital of Daloa (n=121)

Characteristic	Category	Percentage
Sex	Male	55.4%
	Female	44.6%
Age	15 years and above	82.6%
Monthly income	Below 100,000 FCFA	29.8%
	100,000–200,000 FCFA	39.7%
	Above 200,000 FCFA	30.6%
Nationality	Ivorian	85.1%
	Foreign	14.9%

Source: Guele & Kouassi (2022).

The economic characteristics of the patient population are noteworthy: approximately 70% of patients have monthly incomes below 200,000 FCFA, consistent with the hospital's mission positioning of "providing appropriate-priced medical services to vulnerable populations." The higher proportion of male patients (55.4%) contrasts with findings from certain other faith-based hospitals for example, 1999 data from Saint Camille Catholic Hospital in Bouaké showed 63.2% female patients suggesting that the Islamic Hospital of Daloa's patient composition may be influenced by its geographic location and service types.

5.2 Current State of QHSE Practice Institutionalization

Table 2: Dimensional Assessment of QHSE Practices at the Islamic Hospital of Daloa

Dimension	Assessment Element	Institutionalization Level	Main Observation
Quality	Written quality policy	Limited	No standalone quality policy document; quality-related protocols embedded in departmental operating manuals

	Patient complaint handling	Basic	Informal feedback channels exist; no systematic complaint tracking and closed-loop mechanism
	Clinical protocol compliance monitoring	Limited	Relies on individual professional judgment; no periodic review records
	Staff competency management	Basic	Induction training exists; continuing education opportunities constrained by resources
Health and Safety	Occupational health services	Absent	No in-house occupational health service provision; relies on external system
	Incident reporting mechanism	Weak	Low reporting rates; no systematic root cause analysis
	Personal protective equipment	Basic	Basic equipment provided; supply stability questionable
	Staffing adequacy	Insufficient	Staff express concerns about workload
Environment	Waste segregation protocols	Basic	Segregation awareness exists; operational consistency limited
	Waste treatment methods	Needs improvement	Treatment facilities and external contractual arrangements unclear
	Environmental compliance assessment	Absent	No periodic environmental audit records

In the quality dimension, the hospital has established basic infection control procedures including hand hygiene facilities, instrument disinfection processes, and isolation measures but these practices have not yet been incorporated into a unified, patient-outcome-oriented quality management system. Patient reception processes reflect the hospital's emphasis on community service, but systematic satisfaction monitoring and improvement cycles are lacking.

In the health and safety dimension, the most significant gap is the absence of occupational health services. Under Article 43.1 of the Labour Code, all employers must ensure occupational health services, but the implementation of this service in healthcare

institutions faces systemic challenges. The workload issues faced by hospital staff are consistent with findings from other Ivorian health institutions limited freedom of expression, insufficient staffing, and poorly organized service quality.

In the environmental dimension, medical waste management is at a stage of basic institutionalization. Segregation awareness exists, but systematic training, facility provision, and transparency of external treatment contracts are insufficient. This is consistent with the general challenges in biomedical waste management in Ivorian healthcare institutions: 45.2% of personnel were unaware of proper waste management, and 25% did not clean and disinfect equipment.

5.3 Constraints on Sustainable Performance

Table 3: Institutional Factors Constraining QHSE Effectiveness and Sustainable Performance

Constraining Factor	Manifestation	Institutional Root
Insufficient occupational health service provision	Scarcity of occupational physicians and occupational health professionals in healthcare institutions	Only about 14 labour inspection physicians nationwide; prevention-priority mechanism not established
Underreporting of accidents and occupational diseases	Weak enforcement of the 48-hour reporting obligation	Identified as one of four major institutional challenges
Information system fragmentation	Private institution data not fully integrated into DHIS2	Only 400 private institutions report data, while 3,178 were registered in 2021
Quality assessment reliability	68.6% of assessments showed significant discrepancies	Insufficient compliance with verification standards and lack of file management
Accreditation cost barrier	High cost of quality improvement processes	Limits participation of resource-constrained institutions

The incompleteness of the information system constitutes a structural constraint on QHSE monitoring at the Islamic Hospital of Daloa. National data for 2024 show that "only 400 private health institutions reported data in the national DHIS2 database, while the 2021 mapping recorded 3,178 private institutions." This "systematic underrepresentation of private sector data" means that private healthcare institutions—including faith-based hospitals such as the Islamic Hospital of Daloa—may remain outside the visibility of national quality monitoring and improvement systems.

5.4 Organizational Climate from the Staff Perspective

Although this study did not conduct a systematic staff survey, indirect evidence and management interviews revealed several concerns in the organizational climate. Working conditions faced by hospital staff are similar to patterns prevalent in Ivorian healthcare institutions: insufficient staffing to cope with workload, limited freedom of expression, and room for improvement in service quality organization. These factors have a direct impact on the effectiveness of QHSE practices: staff who feel overburdened and lack voice are less likely to proactively report safety hazards, comply with infection control protocols, or participate in quality improvement initiatives.

6. DISCUSSION OF RESULTS

6.1 The Stage of QHSE Practice Institutionalization

The QHSE practices of the Islamic Hospital of Daloa can be positioned at a stage of "basic institutionalization"—that is, operational norms have been established for infection control and basic safety practices, but a systematic, continuous-improvement-oriented management system has not yet been formed. This judgment is based on three observations: quality practices are embedded in departmental operations rather than a unified policy framework; occupational health services are absent at the institutional level; and environmental management is concentrated on waste treatment without a broader environmental performance perspective.

This stage characteristic is consistent with the hospital's development trajectory. As a young institution that only began operating in 2019, its primary tasks must necessarily have been establishing basic clinical service capacity and achieving financial sustainability. The systematization of QHSE typically requires organizational maturity and resource accumulation as prerequisites. The accreditation process at the national level with laboratory certification rates reaching 25% in 2023 from a starting phase in 2022 indicates that even better-resourced institutions require years to establish systematized practices meeting international standards.

6.2 Multidimensional Constraints on Sustainable Performance

The hospital's sustainable performance is constrained from multiple directions, and the roots of these constraints extend beyond the control of any single institution.

Institutional level: The insufficient provision of occupational health services in healthcare institutions is a systemic problem. When there are only about 14 labour inspection physicians nationwide, the capacity of individual hospitals to establish effective occupational health services is structurally limited. Similarly, the underreporting of accidents is identified as an institutional

challenge rather than an institutional failure, meaning that even if hospital management has the will to improve the reporting culture, it requires coordination with national-level inspection and assurance systems.

Information level: The underrepresentation of private healthcare institutions in DHIS2 means that the QHSE performance of the Islamic Hospital of Daloa cannot be incorporated into national monitoring and comparison frameworks. This informational isolation limits the formulation of evidence-based improvement strategies—the hospital does not know its relative position among peers, nor can it benefit from national-level quality improvement support.

Economic level: The characteristic that approximately 70% of the patient population has monthly incomes below 200,000 FCFA reflects both the hospital's mission achievement in serving vulnerable populations and implies structural limitations on its revenue base. Against a backdrop of high quality improvement costs and significant investment requirements for certification processes, economic constraints may force the hospital to make difficult trade-offs between service expansion and systemic improvement.

6.3 Feasibility of an Integrated Management System

The harmonized structure of ISO 9001, 14001, and 45001 provides a theoretical pathway for the hospital's transition from basic institutionalization to systematized QHSE management. The core advantage of this pathway is that shared framework elements (leadership, risk-based thinking, performance evaluation, improvement) can reduce the redundancy of multi-standard implementation, while unified policies, objectives, and review mechanisms can promote cross-departmental coordination.

However, SGS analysis offers a critical caution: "The success of an integrated management system depends more on leadership behaviour and organizational maturity than on document structure." For the Islamic Hospital of Daloa, this means that the systematization of QHSE cannot be understood merely as introducing a new set of documents and procedures; rather, it requires leadership to establish QHSE as an organizational priority, allocate corresponding resources, and cultivate a culture of staff participation and continuous learning.

The role of hospital management is decisive here. If QHSE is positioned as a compliance burden in response to external accreditation requirements, integration efforts may produce formalized documentation without substantive behavioural change. If QHSE is embedded in the hospital's mission realization providing safe, dignified medical services to vulnerable populations then systematization can become part of the natural evolution of a quality culture.

6.4 Recommendations for Policy and Practice

Based on the above analysis, this study proposes the following recommendations:

For hospital management: Formulate a written QHSE policy that articulates organizational commitment and specific objectives for quality, safety, and environmental management. Establish a cross-departmental QHSE committee that includes clinical, nursing, logistics, and administrative staff in decision-making processes. Prioritize addressing the basic provision of occupational health services, even through external contractual arrangements.

For health authorities: Accelerate the integration of private healthcare institutions into the DHIS2 reporting system so that institutions such as the Islamic Hospital of Daloa can benefit from national quality monitoring and improvement support. In advancing accreditation, consider the special needs of resource-constrained institutions and provide phased, affordable technical assistance.

For development partners: Incorporate QHSE capacity building into support programmes for private and faith-based healthcare institutions, recognizing both the unique value of these institutions in serving vulnerable populations and the special constraints they face.

7. CONCLUSION

The QHSE practices of the Islamic Hospital of Daloa reflect the general situation of community-oriented healthcare institutions in Côte d'Ivoire regarding systematized management: basic operational norms have been established in core clinical service areas, but the integration, institutionalization, and continuous improvement of quality, safety, and environmental management remain at an early stage.

The hospital's sustainable performance is constrained by factors at multiple levels: leadership commitment and resource allocation at the institutional level, insufficient occupational health service systems and fragmented information infrastructure at the institutional environment level, and revenue base limitations at the economic level. The complexity of these constraints means that internal management improvements alone are insufficient to achieve significant enhancements in sustainable performance; coordinated action among institutions, regulators, and development partners is required.

The value of the QHSE framework for the Islamic Hospital of Daloa lies not in its certification label but in the systemic thinking tools it provides: viewing quality as a product of organizational culture rather than the result of inspections, viewing safety as an outcome of staff participation rather than compliance with regulations, and viewing environmental responsibility as an extension

of community mission rather than an externally imposed obligation. When these dimensions are integrated into the hospital's daily operations and decision-making logic, sustainable performance can be transformed from a concept into practice.

8. LIMITS OF THE STUDY

This study has the following limitations.

Methodological limitations: The single-case design limits the ability to draw causal inferences about the relationship between QHSE practices and performance. As a faith-based community hospital, the Islamic Hospital of Daloa's experience may not be generalizable to public hospitals or large private institutions. The size of the patient survey sample (n=121) limits the depth of statistical analysis.

Data limitations: Longitudinal data to track the evolution of QHSE practices and performance changes are lacking. The QHSE practice assessment relies primarily on document review and indirect evidence, lacking systematic on-site observation of actual operations. Staff perspective data collection is incomplete, limiting the depth of research into organizational climate and QHSE culture.

Temporal limitations: Primary data were collected in 2021, and hospital operations and the external environment may have changed since then. Côte d'Ivoire's health system quality governance framework is itself in rapid evolution, and the study's conclusions must be understood within a dynamic context.

Conceptual limitations: The operational definition of "sustainable performance" in this study focuses on quality, safety, and environmental dimensions, without fully encompassing financial sustainability, social impact, and governance dimensions of assessment.

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10. AUTHOR CONTRIBUTIONS

Yameogo Ernestine is the sole author of this manuscript and was responsible for all aspects of the research, including conceptualization, data collection, analysis, interpretation, and manuscript preparation.

11. COMPETING INTEREST

The author declares no competing interests.

12. FUNDING INFORMATION

No funding was received for this research.

13. DATA AVAILABILITY

The quantitative data analyzed in this study are derived from published academic research (Guele & Kouassi, 2022). Policy documents and institutional reports are publicly available materials. Qualitative interview data are subject to institutional confidentiality requirements and may be made available at the author's discretion upon reasonable request.

14. DISCLAIMER

The views expressed in this article are those of the author alone and do not reflect the official position of any affiliated institution or the Government of Côte d'Ivoire.

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