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Motivation as an effective source of organizational performance improvement, the case of health facilities in kindu, maniema province, democratic republic of the congo: a cross-sectional observational study with descriptive and analytical aims.

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Abstract

Background: The performance of a health facility depends on staff competencies, work organization, available resources, leadership, and professional motivation. Care for older people particularly requires continuous, coordinated, and person-centred services.

Objective: To analyze motivation as a potential lever for improving the performance of health facilities in Kindu and to propose the RACINE de TUKALUP model as an action framework for strengthening the quality of integrated care for older people.

Methods: A descriptive secondary analysis of available results from a cross-sectional study involving 423 healthcare providers in the Kindu and Alunguli health zones was conducted. Motivation and performance theories were used to interpret the organizational findings.

Results: A total of 39.0% of healthcare providers fell below the high-quality threshold for integrated care established by the source study. Staff shortages and excessive workloads were reported by 25.1%, inadequate training in geriatrics and palliative care by 22.7%, shortages of medicines and equipment by 18.9%, and difficulties with referral and care coordination by 17.3%. Only 16.1% reported having a formal monitoring system, while 48.5% indicated that patient feedback was never collected.

Conclusion: An equitable motivation policy combining recognition, participation, training, supportive supervision, adequate working conditions, and the availability of necessary resources may support staff engagement and organizational performance. The RACINE de TUKALUP model proposes a systemic approach whose effectiveness will need to be evaluated prospectively.

Keywords: motivation; organizational performance; quality of care; older people; health workforce; Kindu; RACINE de TUKALUP.

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Introduction

Management encompasses both the organization of day-to-day activities and the administration of institutions and public services. In their work on health planning and organization, Lufuluabo et al. (2019) describe management as a cross-cutting activity that is essential to any collective action aimed at achieving a specific objective. In the health sector, management involves organizing human, material, and financial resources to transform available inputs into services that meet the population's needs. Atshwel (2019), in turn, emphasizes the role of management style in service performance: managers must provide direction, coordinate efforts, and prioritize collective objectives.

In an environment where healthcare needs are changing and resources remain limited, health facilities must continually improve their practices. This requirement depends not only

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on technology or the availability of equipment but also on staff knowledge, competencies, cooperation, and commitment. Senker (2022) emphasizes that human resources are a key asset in enabling an organization to achieve its objectives. Consequently, staff management, the quality of professional relationships, and working conditions are important dimensions of organizational performance.

Motivation is one of the mechanisms that may support this commitment. Hellriegel and Slocum (2006) discuss the relationship between motivation and performance, while Robbins and Judge (2006, 2011) describe motivation as a process involving the intensity, direction, and persistence of effort toward achieving an objective. In a health facility, motivated staff may be more willing to comply with clinical protocols, communicate effectively with patients, collaborate with colleagues, and participate in quality improvement initiatives. However, motivation cannot replace adequate staffing, medicines, equipment, or effective organization. It must be supported by a working environment that enables healthcare professionals to perform their duties effectively.

This issue is particularly important in the care of older people. Integrated care for older people requires multidimensional assessment, prevention of complications, management of chronic diseases, pain relief, palliative care when indicated, involvement of family members, and coordination between services. The World Health Organization recommends person-centred care pathways that respond to changes in individuals' intrinsic capacity (WHO, 2017, 2019, 2025). Research on integrated care indicates that coordination, continuity, and service adaptation are essential, although organizational and professional barriers may hinder their implementation (Threapleton et al., 2017; Briggs et al., 2018).

In Kindu, the available findings from a study involving 423 healthcare providers highlight difficulties related to excessive workloads, training, the availability of essential supplies, coordination, and quality monitoring. These findings make it relevant to examine the conditions that enable healthcare professionals to remain engaged in providing care over time. Nevertheless, because motivation was not directly measured in the results presented here, it is considered a potential explanatory factor to be investigated rather than an established cause of care

Research Objectives

General Objective

To analyze the contribution of healthcare providers' motivation and organizational management theories to improvements in professional performance and the quality of integrated care for older people in health facilities in Kindu, with a view to proposing strategies suited to the local context.

Specific Objectives

1. To describe the sociodemographic, sociocultural, and professional characteristics of healthcare providers involved in the integrated care of older people in health facilities in Kindu.
2. To assess the quality of services provided to older people using indicators of prevention, health promotion, comprehensive needs assessment, follow-up, coordination, continuity of care, and pain management.
3. To analyze the relationships between healthcare providers' motivation, organizational management practices—including professional recognition, equity, leadership, participation in decision-making, goal setting, and teamwork—and their performance in delivering integrated care to older people.
4. To propose strategies for motivating healthcare providers and improving professional performance based on the needs identified in health facilities, using the RACINE de TUKALUP model as a conceptual and operational framework.

Research Hypotheses

General Hypothesis

Healthcare providers' motivation and the application of appropriate organizational management practices are positively associated with their professional performance and with better-quality integrated care for older people in health facilities in Kindu.

Specific Hypotheses

Hypothesis 1: The sociodemographic, sociocultural, and professional characteristics of healthcare providers are associated with their level of performance and the quality of integrated care provided to older people.

Hypothesis 2: The quality of services provided to older people remains open to improvement, particularly because of shortcomings in formal monitoring, care coordination, specialized training, and the availability of resources required for integrated care.

Hypothesis 3: Higher levels of motivation, supported by professional recognition, organizational equity, participatory leadership, continuing professional development, and good working conditions, are associated with better healthcare provider performance and higher-quality care for older people.

Hypothesis 4: Implementing an integrated strategy inspired by the RACINE de TUKALUP model—which combines governance, financial protection, care coordination, service integration, competency development, and family and social support—could help strengthen healthcare providers' motivation and sustainably improve the quality of care for older people.

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Methods

Study Setting and Design

This study was conducted from May to August 2024 in public and private health facilities located in the Kindu and Alunguli Health Zones, in Kindu City, Maniema Province, Democratic Republic of the Congo. The study covered 14 health facilities selected from the health facilities included in the sampling frame. The study employed an observational, descriptive and analytical cross-sectional design. It aimed to describe integrated care practices for older people and examine their associations with healthcare providers' sociodemographic and professional characteristics, as well as institutional and organizational factors. The cross-sectional design allowed these dimensions to be assessed during a defined period without experimental intervention. However, it does not establish causal relationships. The study reporting was guided by the STROBE recommendations for observational studies (von Elm et al., 2007).

Study Population, Sampling, And Participants

Sample Size

:For our study, the sample size was determined using the following Fisher's formula:$n=\frac{Z^2.P.Q}{d^2}$: Where: N = Sample size; Z = Confidence coefficient at the 95% confidence level (α = 0.05), corresponding to 1.96; p = Expected proportion in the target population; d = Acceptable margin of error (precision), set at 0.05 (5%).

Study Population, Sampling and Sample Size Determination

The target population consisted of healthcare professionals working in public and private health facilities in Kindu. Since the total number of healthcare professionals working in the city was not known, the sample size was determined using Fisher's formula for estimating a proportion in a population of unknown size ; The final sample size was consequently set at 423 healthcare professionals. This increase was intended to provide an adequate margin for potential losses during data collection and to preserve the required sample size for statistical analysis. The 14 health facilities were selected by simple random drawing. The name of each facility in the sampling frame was written on a separate slip of paper, placed in an urn, mixed, and drawn at random until 14 facilities had been selected. Eligible participants were healthcare professionals actively working in the selected facilities, involved in the delivery, organization or continuity of healthcare services, and who provided free and informed consent. Only questionnaires meeting the predefined completeness and data-quality criteria were retained for analysis.

Variables and Data Collection

The dependent variable was integrated care for older people. Its assessment was based on the dimensions covered by the data collection instrument : comprehensive assessment of needs; consideration of chronic diseases and comorbidities; management of pain and other symptoms; attention to functional autonomy and psychosocial needs; prevention; health education; patient referral; and continuity and coordination of care. The explanatory variables included the sociodemographic and professional characteristics of healthcare providers, particularly age, sex, professional category, educational level, and length of service, as well as their experience in caring for older people, participation in continuing professional development, and institutional and organizational factors. These factors included the availability of staff, medicines, and equipment; the existence of care procedures; workload; and referral and counter-referral mechanisms.

Data were collected using a structured questionnaire administered to the healthcare professionals concerned. A pre-survey conducted in a neighbouring health zone was used to assess the comprehensibility and feasibility of the instrument, after which adjustments were made to some questions. During the main survey, the research objectives were explained to participants, and responses were collected using a standardized procedure. Questionnaires were checked for completeness and consistency. The information collected covered respondents' characteristics, their professional knowledge and practices, and the material and organizational conditions under which care was provided.

Data Processing and Analysis

The analysis comprised descriptive and analytical components. The descriptive component aimed to present participants' characteristics and describe care practices and the operating conditions of the health facilities. The analytical component sought to examine associations between healthcare providers' characteristics, organizational factors, and indicators of integrated care.

For categorical variables, Pearson's chi-square test was planned when its assumptions were satisfied. Fisher's exact test could be used when expected cell counts were insufficient. Depending on the nature and distribution of the variables, multivariable analyses could be considered to examine adjusted associations. The statistical significance

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threshold was set at 5%, with interpretation taking into account measures of association and, where available, their 95% confidence intervals. The findings were to be interpreted in light of the cross-sectional nature of the study and the limitations associated with information reported by participants.

Ethical Considerations

The protocol received approval from the Ethics Committee of the School of Public Health at the University of Kinshasa under reference ESP/CE/37/2024. Access to the health facilities was facilitated by a research authorization letter issued by the University of the Martyrs of the Congo. Participants were informed about the objectives and procedures of the study. Participation was voluntary, and consent was sought before data collection. The confidentiality of responses and the protection of respondents' identities were maintained throughout data collection, processing, and presentation. Participants retained the right to refuse to answer any question or to decline participation in the study without adverse consequences.

Methodological Perspective

The data collected were intended to characterize care practices and the factors associated with integrated care for older people in the health facilities studied. They also provide an empirical basis for informing the proposed RACINE de TUKALUP model, particularly with regard to strengthening professional competencies, formalizing care procedures, improving interprofessional coordination, and monitoring the quality of care. The relevance of the model should be assessed in light of the study findings, while its effectiveness will require a subsequent, appropriately designed evaluation.

RESULTS

I. UNIVARIATE ANALYSES

Table 1. Sociodemographic Profile of Healthcare Providers

Variable	Category	Frequency (N = 423)	%
Age (years)	20–30 years	63	14.9
	31–40 years	176	41.6
	41–50 years	143	33.8
	51–60 years	39	9.2
	61 years and older	2	0.5
Sex	Female	163	38.5
	Male	260	61.5
Marital status	Other/prefer not to say	7	1.7
	Single	168	39.7
	Divorced	20	4.7
	Married	221	52.2
	Widowed	7	1.7
Educational level	Other	17	4.0
	State diploma or equivalent	66	15.6
	Doctorate	15	3.5
	Undergraduate degree/Bachelor's degree	237	56.0
	Master's degree	88	20.8
Initial field of training	Other	26	6.1
	Physiotherapy/rehabilitation	20	4.7
	Medicine	90	21.3
	Nutrition	18	4.3
	Pharmacy	42	9.9
	Psychology	16	3.8
	Public health	21	5.0
	Nursing sciences	190	44.9
Geriatrics training	No	291	68.8
	Yes	132	31.2

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Type of geriatrics training	Workshop/seminar	26	6.1
	Continuing professional development	24	5.7
	Formal qualification programme	26	6.1
	Online training	24	5.7
	Workplace training	32	7.6
	Not applicable	291	68.8
Palliative care training	No	309	73.0
	Yes	114	27.0
Health promotion and prevention training	No	259	61.2
	Yes	164	38.8
Most recent relevant training	Within the past 12 months	63	14.9
	13–24 months ago	73	17.3
	No training attended	135	31.9
	Do not know	85	20.1
	More than 24 months ago	67	15.8
Profession	Other healthcare professional	13	3.1
	Nurse	237	56.0
	Physiotherapist	28	6.6
	Physician	83	19.6
	Nutritionist	17	4.0
	Pharmacist	36	8.5
	Psychologist	9	2.1
Position	Other	16	3.8
	Healthcare provider	303	71.6
	Unit/department manager	42	9.9
	Health facility manager	32	7.6
	Supervisor/coordinator	30	7.1
Type of health facility	Other	15	3.5
	Health centre	190	44.9
	Clinic/polyclinic	69	16.3
	Hospital	149	35.2

Commentary: Table 1 presents the sociodemographic, professional, and training characteristics of the 423 healthcare providers surveyed. For each variable, the analysis focuses on the category with the highest frequency and the category with the lowest frequency to highlight the main trends observed in the study population.

Table 2. Professional Profile and Work Experience

Variable	Category	Frequency	%
Ownership/status of health facility	Other	16	3.8
	Private faith-based	85	20.1
	Private for-profit	105	24.8
	Public	217	51.3
Department of assignment	Surgery	21	5.0
	Outpatient department	48	11.3
	Management/administration	24	5.7
	Maternity	22	5.2
	Internal medicine	75	17.7
	Nutrition	16	3.8
	Paediatrics	25	5.9
	Pharmacy	30	7.1
	Psychology	19	4.5
	Rehabilitation	15	3.5

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	Nursing services	81	19.1
	Emergency department	47	11.1
Years of professional experience	0–5 years	137	32.4
	6–10 years	146	34.5
	11–15 years	90	21.3
	16–20 years	35	8.3
	21 years and above	15	3.5
Years working at the facility	0–5 years	127	30.0
	6–10 years	187	44.2
	11–15 years	85	20.1
	16 years and above	24	5.7
Experience in caring for older people	1–4 years	200	47.3
	10 years or more	44	10.4
	5–9 years	81	19.1
	Less than one year	65	15.4
	No direct experience	33	7.8
Older patients seen during the past three months	Do not know	12	2.8
	No	72	17.0
	Yes	339	80.1
Number of older patients seen per month	0 patients aged 60 years and above	85	20.1
	1–5 cases per month	87	20.6
	6–10 cases per month	114	27.0
	11–15 cases per month	70	16.5
	16 cases or more per month	67	15.8
Sufficient time per patient	Never	25	5.9
	Sometimes	196	46.3
	Rarely	105	24.8
	Often	77	18.2
	Always	20	4.7

Commentary: Table 2 shows that most healthcare providers work in public facilities (51.3%), while nursing services (19.1%) and internal medicine (17.7%) are the most represented departments. Most respondents have 6–10 years of professional experience (34.5%), and 80.1% reported having cared for older people during the preceding three months. However, 46.3% stated that they only sometimes had sufficient time for each patient.

Table 3. Quality of Integrated Care

Variable	Category	Frequency	Percentage
I10. Follow-up monitoring	Do not know	39	9.2
	No	143	33.8
	Yes, informal follow-up	173	40.9
	Yes, formalized system	68	16.1
I11. Patient feedback	Never	205	48.5
	Do not know	35	8.3
	Occasionally	141	33.3
	Regularly	42	9.9
I12. Priority for improving quality	Coordination among healthcare professionals	93	22.0
	Availability of medicines	86	20.3
	Pain assessment	44	10.4
	Human resources	58	13.7
	Follow-up and continuity of care	57	13.5
	Time devoted to patients	85	20.1

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Commentary: Table 8 shows that patient follow-up is mainly informal (40.9%) and that patient feedback is never collected in 48.5% of cases. Coordination among healthcare professionals (22.0%), medicine availability (20.3%), and the time devoted to patients (20.1%) are the main priorities for improvement.

Table 4. Constraints That May Affect the Professional Engagement of Healthcare Facility Staff

Identified constraints	Percentage (%)
Staff shortages and excessive workloads	25.1
Inadequate training in geriatrics and palliative care	22.7
Shortages of medicines and medical equipment	18.9
Referral and care coordination difficulties	17.3
Insufficient time for health education and salary-related motivation	16.1

Note. Percentages represent the proportion of respondents who reported each constraint.

Table 5. Lack of Professional Training in Selected Areas of Healthcare

Training areas	No training received (%)
Geriatrics	68.8
Palliative care	73.0
Health promotion and disease prevention	61.2

Note. Percentages represent the proportion of participants who had not received training in the respective areas. The results presented in Table 1 show that staff shortages and excessive workloads were the most frequently reported constraints (25.1%), followed by inadequate training in geriatrics and palliative care (22.7%). Shortages of medicines and medical equipment (18.9%), referral and care coordination difficulties (17.3%), and insufficient time for health education and salary-related motivation (16.1%) were also identified as important barriers to professional engagement. Furthermore, Table 2 reveals substantial gaps in continuing professional development. Specifically, 73.0% of participants had not received training in palliative care, 68.8% had not received training in geriatrics, and 61.2% had not received training in health promotion and disease prevention. These findings suggest that organizational constraints and inadequate professional training may limit the effective utilization of healthcare workers' skills, reduce their sense of professional efficacy, and undermine teamwork and collaboration among staff members.

Therefore, the findings highlight the need to implement a motivation policy that addresses actual working conditions. Such a policy should include adequate staffing levels, the availability of essential medicines and equipment, continuing professional development, constructive supervision, shared organizational objectives, and an equitable system of professional recognition and rewards.

Table 6 : Summary of Findings

Indicator from the source study	Result	Organizational implication
Insufficient quality of integrated care	39.0%	Strengthen care practices and quality monitoring.
Staff shortages/excessive workload	25.1%	Review task allocation and staffing levels.
Inadequate training in geriatrics and palliative care	22.7%	Organize targeted continuing professional development.
Shortages of medicines and equipment	18.9%	Ensure the availability of essential supplies.
Referral and coordination difficulties	17.3%	Formalize care pathways and responsibilities.
Formalized follow-up system	16.1%	Develop monitoring tools and feedback mechanisms.
Patient feedback never collected	48.5%	Establish mechanisms for service-user participation.

Table 7. Organizational Constraints and Factors That May Influence Professional Engagement

Organizational constraints identified in healthcare facilities	Frequency (%)	Potential implications for healthcare providers' work	Proposed improvement measures

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Staff shortages and excessive workload	25.1	Heavy workloads may lead to professional fatigue and make it more difficult for healthcare providers to carry out their daily responsibilities.	Adjust staffing levels to service needs, distribute responsibilities more equitably, and improve work schedules.
Inadequate training in geriatrics and palliative care	22.7	Limited specialized training may undermine healthcare providers' confidence in caring for patients with specific needs.	Promote continuing professional development and organize practical skills-enhancement sessions.
Shortages of medicines and medical equipment	18.9	The lack of essential resources makes daily work more challenging and may prevent healthcare providers from adequately meeting patients' needs.	Improve the supply of medicines and ensure the availability of essential equipment.
Difficulties with patient referral and care coordination	17.3	Inadequate coordination may hinder collaboration among healthcare professionals and compromise continuity of care.	Improve communication between departments and strengthen patient referral mechanisms.
Limited time for health education and salary-related motivation	16.1	These difficulties may restrict health education activities and affect how healthcare providers perceive the recognition and value of their work.	Allocate more time to health education and explore ways to improve staff recognition and remuneration mechanisms.

Source: Study data.

Interpretation

The findings indicate that the challenges faced by healthcare providers extend beyond the delivery of care itself. They also involve the day-to-day organization of work and the conditions under which professionals carry out their responsibilities. Staff shortages and excessive workloads, reported by 25.1% of participants, particularly illustrate this situation.

In healthcare facilities, maintaining sustained professional engagement can be difficult when staff members are required to work with insufficient personnel or limited resources. Similarly, access to training, the quality of relationships among colleagues, and recognition of professional efforts may all influence the way healthcare providers approach their work. These findings therefore highlight the importance of improving working conditions as part of any strategy aimed at strengthening staff motivation and healthcare service performance

Table 8 . Professional Training Among Healthcare Providers and Identified Needs for Skills Development

Training area	Participants who had not received training (%)	Main concerns	Priority actions	Expected improvements
Palliative care	73.0	A large proportion of staff members had not received specific training in this area.	Organize theoretical and practical training in palliative care.	Improve healthcare providers' skills in caring for patients requiring palliative care.
Geriatrics	68.8	The specific needs of older people require appropriate knowledge and professional skills.	Strengthen training in geriatrics and integrated care for older people.	Promote more appropriate care and strengthen healthcare providers' professional confidence.
Health promotion and disease prevention	61.2	Inadequate training may limit staff participation in health education and	Develop skills in health communication and disease prevention.	Improve the quality of preventive activities and healthcare professionals'

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				disease prevention activities.
				involvement in patient care.

Source: Study data.

Interpretation

The current state of professional training deserves particular attention. Indeed, 73.0% of participants had not received training in palliative care, while 68.8% had not received training in geriatrics. Furthermore, 61.2% had not received training in health promotion and disease prevention. These findings highlight a substantial need for capacity-building within the healthcare facilities included in the study. Healthcare providers need appropriate knowledge and practical skills to respond effectively to patients' needs, particularly those of older people. Continuing professional development could therefore help strengthen their confidence in carrying out their duties, enhance their professional competencies, and encourage their involvement in achieving institutional objectives. Beyond improving knowledge and skills, investing in professional training also reflects an institution's recognition of the importance of its workforce. Such investment in professional development may contribute to greater staff engagement and motivation.

Table 9. Quality of Integrated Care and Healthcare Provider Characteristics Associated with Observed Outcomes

Variables examined	Analysis results	χ^2	p-value	Implications for healthcare organization
High-quality care	61.0% of healthcare providers	—	—	An encouraging finding indicating that the majority of providers met the quality criteria established for the study.
Insufficient-quality care	39.0% of healthcare providers	—	—	This proportion highlights the need for continued efforts to improve professional practices.
Age	Statistically significant association	21.972	<0.001	Differences across age groups should be considered when organizing services and providing staff support.
Sex	Statistically significant association	16.004	<0.001	An association was observed between sex and quality of care.
Educational level	Statistically significant association	39.752	<0.001	Educational background is an important consideration when planning professional skills development.
Professional category	Statistically significant association	14.597	0.024	Professional needs and responsibilities may differ across occupational categories.
Training in gerontology	Statistically significant association	9.437	0.002	Training in gerontology was associated with the quality of care.
Professional experience	No statistically significant association	1.585	0.663	When considered independently, professional experience was not significantly associated with quality of care in this analysis.

Source: Study data.

Interpretation

The analysis of integrated care quality showed that 61.0% of healthcare providers delivered care that met the quality criteria established for the study, whereas 39.0% were classified as providing insufficient-quality care. This finding is important for two reasons: it recognizes the positive results achieved by a substantial proportion of the workforce while also drawing attention to areas where further improvement is needed. The bivariate analyses also revealed

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statistically significant associations between care quality and several healthcare provider characteristics, including age, sex, educational level, professional category, and training in gerontology. The finding concerning gerontology training is particularly noteworthy, as it highlights the importance of specialized knowledge in providing care for older people. In contrast, no statistically significant association was observed between professional experience and quality of care ($p = 0.663$). This finding suggests that length of service alone does not necessarily guarantee the quality of care provided. Updating professional knowledge, continuing education, and appropriate professional support therefore remain important considerations in improving healthcare services. Overall, these findings encourage healthcare facilities to take greater account of staff profiles, training needs, and working conditions when developing strategies to improve the quality of care.

Table 10. Strategic Approaches to Strengthening Staff Motivation and Improving the Organizational Performance of Healthcare Facilities

Priority areas	Main findings from the study	Actions recommended to healthcare facility managers	Expected improvements	Proposed monitoring indicators
Working conditions	25.1% of participants reported staff shortages and excessive workloads.	Review task allocation, adjust staffing levels to service needs, and improve work schedules.	Create a more balanced working environment that supports professional engagement.	Workload per healthcare provider, staff-to-patient ratio, and absenteeism rate.
Training and professional development	73.0% had not received training in palliative care, and 68.8% had not received training in geriatrics.	Establish a regular continuing professional development program tailored to service needs.	Strengthen professional competencies and enable healthcare providers to perform their duties with greater confidence.	Proportion of staff trained, number of training sessions conducted, and competency assessments.
Availability of resources	18.9% reported shortages of medicines and medical equipment.	Improve stock management, procurement, and equipment maintenance.	Facilitate healthcare providers' work and improve the conditions under which patients receive care.	Availability of essential medicines and proportion of functional equipment.
Collaboration and care coordination	17.3% reported difficulties with patient referral and care coordination.	Organize regular meetings, improve communication, and clarify referral procedures.	Promote teamwork and ensure better continuity of care.	Number of meetings held and proportion of properly documented referrals.
Staff recognition and appreciation	The findings identified salary-related motivation as a reported concern, although professional satisfaction was not directly measured.	Develop transparent recognition mechanisms and acknowledge staff efforts and initiatives.	Foster a sense of professional recognition and strengthen staff engagement.	Staff satisfaction levels, perceived recognition, and intention to remain in the facility.
Health education and disease prevention	61.2% of participants had not received training in this area.	Strengthen training and allocate dedicated time for health education activities.	Encourage more active staff participation in educational and preventive activities.	Number of health education sessions conducted and proportion of healthcare providers trained.

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Source: Study data for the findings; proposed interventions and monitoring indicators developed based on the study results.

Interpretation

The findings of this study indicate that improving the performance of healthcare facilities depends not only on the individual competencies of healthcare providers. It also requires appropriate work organization, adequate resources, opportunities for professional development, and effective collaboration among healthcare professionals. The recommendations presented in this table reflect this broader perspective. They aim to address the difficulties encountered in the field while recognizing the essential role of healthcare personnel in achieving institutional objectives. A fairer distribution of responsibilities, regular access to training, the availability of medical equipment, and recognition of professional efforts could help create more supportive working conditions and encourage greater staff engagement. Professional motivation therefore emerges as an important dimension to consider in human resource management strategies. By paying greater attention to healthcare providers' needs and working environments, facility managers may encourage stronger staff involvement and support sustained improvements in the quality of care.

DISCUSSION

The results of this study, conducted among 423 healthcare providers in health facilities in the city of Kindu, highlight important challenges in human resource management, organizational performance, and quality improvement in services for older people. The proportion of 39.0% of healthcare providers classified as providing insufficient-quality care, compared with 61.0% classified as providing high-quality care according to the criteria adopted, reveals considerable variation in professional practices and calls for a structured institutional response. From a healthcare management perspective, this situation cannot be attributed exclusively to individual competencies. It also calls for an examination of work organization, resource availability, coordination mechanisms, supervisory capacity, and quality management systems.

These results must nevertheless be interpreted in accordance with the study design. Since healthcare providers' motivation was not directly measured, the data do not establish that demotivation explains the observed shortcomings in care quality. Rather, motivation represents a theoretically relevant dimension for analyzing the conditions under which human resources contribute to the performance of healthcare organizations. This distinction is essential to avoid confusing empirical findings, managerial interpretations, and explanatory hypotheses. It also makes it possible to formulate operational recommendations consistent with the available data while identifying variables that should be measured in future research.

Healthcare Provider Profiles and Differences in Organizational Performance

The bivariate analyses revealed statistically significant associations between the quality of integrated care and several healthcare provider characteristics. Age was significantly associated with care quality ($\chi^2 = 21.972$; $p < 0.001$), as were sex ($\chi^2 = 16.004$; $p < 0.001$), educational level ($\chi^2 = 39.752$; $p < 0.001$), and professional category ($\chi^2 = 14.597$; $p = 0.024$). These findings indicate that the distribution of care quality varied according to certain sociodemographic and professional characteristics within the study sample. However, they do not demonstrate that these characteristics are, by themselves, causal determinants of performance.

From an organizational perspective, these associations warrant an examination of how competencies, responsibilities, and professional development opportunities are distributed across staff categories. The observed differences may be related to exposure to clinical activities, access to specialized training, task allocation, or the responsibilities assigned to individual staff members. These explanations nevertheless remain hypotheses until the relationships have been examined using an adjusted statistical model.

Briggs et al. (2018) show that integrated care approaches for older people rely on several interdependent components, including coordination, service integration, and the adaptation of interventions to beneficiaries' needs. Similarly, Threapleton et al. (2017) highlight the importance of factors that facilitate or hinder the implementation of integrated care for older populations. These studies suggest that performance should not be assessed solely through individual professional characteristics but also through an organization's ability to mobilize staff competencies within a coherent care process.

For health facilities in Kindu, this interpretation implies the need for differentiated human resource management based on the identification of competency gaps, clarification of roles, and alignment between assigned responsibilities and

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professional qualifications. At the operational level, facility managers could organize regular experience-sharing sessions, establish professional mentoring systems, and conduct periodic assessments of care practices. At the strategic level, health authorities should incorporate the specific needs of older people into workforce planning, continuing professional development policies, and quality improvement mechanisms.

Professional Qualifications, Continuing Training, and Operational Capacity

Educational level and professional category were statistically significantly associated with the quality of integrated care. In addition, training in gerontology was associated with observed care quality ($\chi^2 = 9.437$; $p = 0.002$). These findings highlight the importance of examining whether available competencies match the technical requirements of caring for older people. However, they do not allow care quality differences to be attributed directly to training, since trained providers may also differ from others in their roles, experience, responsibilities, or working conditions.

The World Health Organization's approach to integrated care for older people, particularly its 2017 guidelines and 2019 implementation framework, emphasizes the importance of strengthening professional capacity and organizing services around beneficiaries' individual needs (WHO, 2017, 2019a, 2019b). The second edition of the ICOPE handbook, published in 2025, extends this approach by providing person-centred assessment tools and care pathways adapted to primary care services (WHO, 2025).

These recommendations have direct implications for the operational management of health facilities. Integrated care requires work procedures that enable staff to identify the physical, psychological, and social needs of older people, prevent complications, organize chronic disease follow-up, adapt communication, and ensure continuity of interventions. It also requires palliative care competencies when clinically indicated. Continuing professional development should therefore be considered an organizational investment rather than an occasional activity disconnected from service priorities.

In Kindu, this approach could be implemented through an annual competency development plan based on an assessment of facilities' needs. The plan would specify training objectives, the professional categories concerned, supervisors' responsibilities, required resources, and methods for evaluating learning outcomes. Operational indicators could include the proportion of providers trained, mastery of clinical protocols, completion of comprehensive assessments, quality of clinical documentation, and follow-up of older people after consultations.

The value of this approach lies in linking individual competencies with the institution's capacity to put them into practice. Training cannot achieve its full potential when medicines, equipment, monitoring tools, or coordination mechanisms are inadequate. Strategic planning must therefore combine competency development with improvements in the material and organizational conditions required to apply those competencies.

Professional Experience and Organizational Learning

Unlike the associations observed for several other characteristics, length of professional experience was not statistically significantly associated with the quality of integrated care ($\chi^2 = 1.585$; $p = 0.663$). This finding means that the data did not identify a statistically significant difference in care quality across the professional experience categories examined. It does not demonstrate that professional experience has no value in healthcare practice.

From an organizational behaviour perspective, experience represents a potential resource whose contribution depends on the conditions under which knowledge is updated, shared, and translated into professional practice. Robbins and Judge (2011), as well as Hellriegel and Slocum (2006), provide a theoretical framework for understanding the role of individual behaviour, competencies, and the organizational environment in team functioning. However, these established references should be complemented by contemporary research on service integration and quality improvement to determine the specific implications for current healthcare settings.

In health facilities in Kindu, professional experience should be valued through structured knowledge-sharing, mentoring, and collective review of clinical practices. Experienced professionals could contribute to team supervision, while continuing education could update knowledge relating to ageing, prevention, palliative care, and care pathway coordination.

From a managerial perspective, this approach favours competency management based on demonstrated abilities and service needs rather than years of employment alone. At the operational level, it requires supportive supervision,

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experience-sharing procedures, and competency monitoring tools. At the strategic level, it involves incorporating organizational learning into human resource development plans.

Professional Motivation, Equity, and Recognition in Healthcare Organizations

Work motivation is a theoretical mechanism that may contribute to healthcare providers' engagement, involvement in care activities, and participation in quality improvement processes. Adams (1965) emphasizes the importance of perceived equity in social exchanges, particularly when individuals assess their contributions in relation to the benefits they receive. McGregor (1960), in turn, highlights the influence of managerial assumptions on employee participation, accountability, and autonomy.

Applied to healthcare management, these perspectives encourage an examination of the transparency of task allocation, access to training, recognition practices, and staff participation in decisions concerning service operations. They support the hypothesis that a professional environment perceived as fair and conducive to initiative may strengthen team engagement. However, this hypothesis cannot be considered established by the present study because motivation and organizational equity were not directly measured.

Contemporary literature on integrated care also indicates that quality improvement requires coordination among professionals, clearly defined responsibilities, and service organization centred on beneficiaries' needs (Briggs et al., 2018; Threapleton et al., 2017). These requirements call for a working environment in which healthcare providers have clear instructions, appropriate resources, and opportunities to report difficulties encountered in performing their duties.

In health facilities in Kindu, a recognition policy could combine financial measures compatible with available resources and non-financial measures, such as acknowledging relevant initiatives, ensuring equitable access to training, providing feedback on professional practices, and involving staff in decision-making. Recognition criteria should be transparent, documented, and adapted to the roles performed. They could include compliance with protocols, quality of clinical records, communication with older people, continuity of care, and contributions to quality improvement activities.

However, implementing such measures should not turn performance indicators into exclusively punitive instruments. Management based solely on sanctions may discourage staff from reporting difficulties and conceal structural constraints. A developmental approach, by contrast, makes it possible to combine professional accountability, analysis of performance gaps, team support, and corrective action addressing organizational problems.

Work Organization, Resource Availability, and Service Performance

The proportion of 39.0% of healthcare providers classified as delivering insufficient-quality care indicates substantial room for improvement in care practices. This situation should be interpreted within the broader context of healthcare organizations, where outcomes depend on the interaction between human resources, essential supplies, procedures, supervision, and service coordination.

The joint report by WHO, the Organisation for Economic Co-operation and Development (OECD), and the World Bank on healthcare service quality emphasizes that improving health outcomes requires systems capable of delivering safe, effective, person-centred care in a coherent manner (WHO, OECD, & World Bank, 2018). From this perspective, quality cannot be reduced to the individual competencies of healthcare providers; it also depends on an institution's capacity to organize work processes and ensure the resources required to implement them.

The studies by Briggs et al. (2018) and Threapleton et al. (2017) reinforce this interpretation by showing that integrated care for older people depends on several interrelated components. Fragmented services, coordination difficulties, and inadequate continuity mechanisms can limit the response to older people's complex needs, even when healthcare professionals possess appropriate competencies.

In Kindu, operational improvement requires institutional priorities to be translated into practical procedures. Health facility managers could organize periodic clinical practice review meetings, monitor the availability of medicines and equipment, assess the quality of clinical documentation, and review referral and counter-referral difficulties. These activities should be supported by a dashboard for monitoring essential indicators of care quality, resource availability, and continuity of services.

At the strategic level, health authorities should incorporate care for older people into workforce planning, budgeting, procurement, and supervision systems. This approach would

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link quality objectives to the resources required to achieve them. It would also help prevent responsibility for improving care from falling exclusively on frontline providers when some constraints arise from institutional decisions and financing limitations.

Integrated Care, Palliative Care, and the Protection of Older People

Integrated care for older people requires a response that goes beyond clinical consultations and takes health, functional, psychological, and social needs into account. WHO (2017, 2019a, 2019b) recommends a person-centred approach based on assessing intrinsic capacity, identifying individual needs, and organizing appropriate care pathways. The 2025 ICOPE handbook provides updated guidance for individualized assessment and care in primary healthcare settings (WHO, 2025).

Palliative care is also an important component of this approach. WHO's guide on integrating palliative care and symptom relief into primary healthcare emphasizes the importance of symptom control, communication, family support, and continuity of care within service organization (WHO, 2018). Furthermore, WHO's global report on assessing palliative care development provides indicators that health systems can use to examine their capacity in this area (WHO, 2021a).

In the Congolese context, the findings of Mangbala Ekibe et al. (2023), based on an assessment of holistic care provided to older people in the Kintambo and Kabinda nursing homes in Kinshasa, offer a contextually relevant reference for discussing multidimensional care for older people. Their study provides a useful national point of comparison, although differences in context, population, and care settings must be considered before making direct comparisons with the findings from Kindu.

Saka et al. (2019), in their review of national policies on healthcare for older people in sub-Saharan Africa, also emphasize the importance of political and institutional frameworks in responding to this population's health needs. The challenge therefore extends beyond individual practices: it concerns health systems' capacity to translate ageing-related policy commitments into policies, resources, and services that are genuinely accessible.

At the operational level, health facilities in Kindu could strengthen comprehensive assessments of older people, complication prevention, pain relief, communication with families, and coordination with social services where available. At the strategic level, health authorities should support the development of appropriate protocols, professional training, and monitoring indicators specific to integrated and palliative care.

Health Governance, Strategic Management, And Accountability

Care quality also depends on organizations' ability to define objectives, allocate responsibilities, mobilize resources, and monitor outcomes. From this perspective, health governance is not limited to the existence of formal rules. It also includes the decision-making, coordination, supervision, oversight, and accountability mechanisms that enable policy directions to be translated into concrete action.

The report by WHO, OECD, and the World Bank (2018) highlights the importance of a systemic approach to healthcare service quality. WHO (2019b), through the ICOPE implementation framework, also emphasizes the need to organize systems and services to support integrated care for older people. These recommendations call for strategic planning to be aligned with the operational processes of healthcare facilities.

In Kindu, this alignment could be organized around three complementary levels. The strategic level would address priority setting, resource allocation, adoption of standards, and coordination among stakeholders. The organizational level would focus on the distribution of responsibilities, team management, supervision, and service organization. The operational level would concern implementation of protocols, completion of assessments, documentation of care, referral of beneficiaries, and monitoring of outcomes.

This structure would make it possible to link institutional objectives to verifiable indicators. These could include the proportion of providers trained, the availability of essential supplies, completion of comprehensive assessments, continuity of follow-up, and the quality of clinical documentation. The indicators should be reviewed periodically to identify gaps, determine their organizational causes, and establish corrective measures.

Nevertheless, process indicators must be distinguished from outcome indicators. Holding meetings, conducting training sessions, or having protocols in place demonstrates organizational activity but does not automatically prove that care quality has improved. Evaluation should therefore also examine changes in professional practices and, where data

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permit, outcomes for older people.

Strategic Contribution of the RACINE de TUKALUP Model (2026)

The study findings, considered alongside contemporary recommendations on healthcare service quality and integrated care for older people, highlight the need for a response that brings together healthcare professionals, facilities, and institutional stakeholders. The RACINE de TUKALUP model (2026) can be proposed as a conceptual framework for structuring such a response in the context of Kindu. It seeks to organize responsibilities and interventions around six complementary dimensions: governance, financial protection, coordination and continuity, care integration, competency development, and the family and social environment.

The pillar relating to responsibility, regulation, and governance concerns the definition of standards, public-sector commitment, and institutional accountability. The pillar dedicated to accessibility and financial protection concerns mechanisms that may reduce economic barriers to healthcare, including mutual health insurance schemes where these are accessible and functional. The coordination and continuity pillar seeks to strengthen links between health facilities, residential care structures, and other relevant stakeholders. The care integration pillar focuses on comprehensive assessment, prevention, treatment, and support centred on older people. The pillar concerning competency levels, training, and research promotes professional development and the generation of context-specific evidence. Finally, the pillar dedicated to a supportive environment and family and social support emphasizes the role of older people, families, and communities.

This structure is consistent with the principles of integrated care described by Briggs et al. (2018) and Threapleton et al. (2017), as well as WHO guidance on ICOPE implementation (WHO, 2019b, 2025). It makes it possible to view quality as the product of interactions among individual competencies, work processes, institutional resources, and coordination between stakeholders. It also provides a framework for connecting facilities' operational management with the health system's strategic priorities.

However, the RACINE de TUKALUP model remains a conceptual proposal whose effects cannot be considered demonstrated by the findings of this survey. Its operationalization will require an action plan specifying objectives, activities, responsibilities, resources, timelines, and monitoring indicators. A pilot phase should assess its feasibility, acceptability among stakeholders, implementation constraints, and observable changes in practice. A longitudinal or comparative evaluation could subsequently determine the extent to which its implementation contributes to improved integrated care quality.

Generalizability of the Findings

The generalizability of the findings of this study should be considered in relation to its geographical coverage, study population, and methodological design. Conducted among 423 healthcare providers working in health facilities in Kindu, Maniema Province, Democratic Republic of the Congo, this study provides context-specific evidence on healthcare workforce characteristics, professional competencies, organizational constraints, and the quality of integrated care for older people.

The findings may be relevant to other health facilities in the Democratic Republic of the Congo, particularly those operating in urban settings with similar organizational structures, human resource constraints, and healthcare delivery conditions. The observed proportion of healthcare providers delivering insufficient-quality care (39.0%), together with the significant associations between care quality and age, sex, educational level, professional category, and gerontology training, highlights organizational and professional issues that may also arise in comparable healthcare settings. Furthermore, reported constraints, including staff shortages and excessive workloads (25.1%), inadequate training in geriatrics and palliative care (22.7%), shortages of medicines and equipment (18.9%), and referral and coordination difficulties (17.3%), may provide useful reference points for health managers and policymakers facing similar challenges.

The substantial gaps in professional training also deserve attention beyond the study setting. The proportions of participants who had not received training in palliative care (73.0%), geriatrics (68.8%), and health promotion and disease prevention (61.2%) suggest potential weaknesses in continuing professional development that may be relevant to other healthcare institutions with comparable training systems and resource limitations.

Nevertheless, these findings should not be generalized automatically to all health facilities in the Democratic Republic of the Congo or to other countries. Differences in geographical location, institutional capacity, staffing levels,

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financing mechanisms, professional training opportunities, and access to essential medicines and equipment may influence healthcare providers' working conditions and the quality of services delivered. In addition, the cross-sectional design and the bivariate nature of the statistical analyses limit the interpretation of relationships between the variables and do not establish causal effects. Accordingly, the findings are most transferable to healthcare facilities sharing organizational and operational characteristics with those included in the study. Further multicentre studies involving different provinces, rural and urban healthcare settings, and diverse categories of healthcare providers are recommended to assess the consistency of these findings and strengthen their external validity.

Study Limitations

This study has certain limitations. Since it was conducted in 14 health facilities in the Kindu and Alunguli health zones, the generalizability of the findings to other settings should be approached with caution.

Conclusion

Motivation represents an important, although not standalone, lever for improving organizational performance. The available results from health facilities in Kindu highlight shortcomings in the quality of integrated care, as well as constraints related to staffing, training, supplies, coordination, and follow-up. These challenges may limit healthcare workers' ability to deliver the expected standard of care, even when they are willing to perform their duties effectively. A sustainable response must therefore combine recognition, equity, participation, training, supportive supervision, and improvements in material working conditions.

Adequate motivation, supported by appropriate competencies and sufficient resources, may promote conscientious work, better cooperation, and more respectful and continuous care for older people. The RACINE de TUKALUP model proposes bringing together public authorities, financial protection mechanisms, coordination structures, health facilities, universities, and families around a common objective: improving the quality, dignity, and continuity of care. Its relevance and effectiveness will need to be assessed through a pilot implementation and a study that directly measures staff motivation and care outcomes.

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Authors' Contributions

Tunda Kasongo Lukali Prosper: Contributed to the literature review, development of the theoretical framework, structuring of the article, and drafting of the general presentation.
Senker Ndimba Bob: Contributed to the methodological design, organization of field data collection, data processing and analysis, and scientific interpretation of the findings.
Kafinga Luzolo Emery, Ndjonka Dieudonné, Masandi Milondo Alphonse, and Hamuli Mastaki Benjamin: Provided scientific supervision and methodological guidance, critically reviewed the manuscript, and contributed to improving the final version.

Ethical Considerations

The research protocol was approved by the Ethics Committee of the School of Public Health at the University of Kinshasa under reference number ESP/CE/37/2024. Access to the health facilities was facilitated by a research authorization letter issued by the University of the Martyrs of Congo. Participation in the study was voluntary, following the provision of information to participants and the obtaining of their informed consent. The confidentiality of responses and the protection of participants' identities were ensured throughout data collection, processing, and presentation.

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Conflicts of Interest

The authors declare that they have no conflicts of interest related to the conduct of this study, the analysis of the data, or the publication of the findings.

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Recommendations

In light of the findings, health facility managers and health authorities are encouraged to strengthen continuing professional development in geriatrics, palliative care, and health promotion; improve staffing levels and working conditions; ensure the availability of essential medicines and equipment; and strengthen care coordination. It is also recommended that a regular system for monitoring the quality of services be established, and that professional recognition and staff participation in decision-making be promoted. Further studies should directly measure motivation in order to assess its contribution to organizational performance.

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Data Availability

The data used in this study are available from the corresponding author upon reasonable request. Access to these data is subject to compliance with confidentiality principles and ethical requirements for the protection of participants. Individual-level data will not be made publicly available in order to preserve the anonymity of the healthcare providers who participated in the study.

List of Abbreviations

- BMJ: *British Medical Journal*.
- ICOPE: *Integrated Care for Older People*.
- ISTM: *Institut supérieur des techniques médicales*.
- OECD: *Organisation for Economic Co-operation and Development*.
- PhD: *Doctor of Philosophy*.
- STROBE: *Strengthening the Reporting of Observational Studies in Epidemiology*.
- WHO: *World Health Organization*.

Statistical Symbols and Parameters

- N: Sample size.
- Z: Confidence coefficient associated with the selected confidence level.
- p: Expected proportion in the target population in the sample size calculation formula; also denotes the probability value associated with a statistical test.
- d: Margin of error or desired precision in the sample size calculation.
- α: Statistical significance level.
- χ^2: Pearson's chi-square test statistic.
- %: Percentage.

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