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Level of Integration of Health Services of the Catholic Church of the Archdiocese of Lubumbashi in Health Zones

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Abstract

Introduction: The private health sector plays an important role in the health system in the Democratic Republic of Congo; however, its proliferation does not guarantee the quality of the service. The Ministry of Public Health is concerned with reinvesting its role in cleaning up the medical and health sector. It also has an interest in supervising and integrating the lucrative and non-profit private sector into the country's health system to avoid the "Public Sector - Private Sector" compartmentalization. Patients who are treated in health structures belong to the state and the State has the right to review what happens in these different health structures to avoid anarchy, hence the importance of integration. The objective of our study is to take stock of the level of integration of the health services of the Catholic Church within the health zones of the Archdiocese of Lubumbashi in the city of Likasi and that of Lubumbashi, determine the framework for analyzing the level of integration of health facilities into the local health system. **Methods:** This is a multiple case study in the Archdiocese of Lubumbashi concerning Catholic health facilities in the city of Likasi and Lubumbashi from December 2021 to October 2023. The multiple case study allowed us to assess the level integration in health zones, by studying 40 Catholic health services, the Ministry of Health (health zones, Provincial Health Division: DPS, Provincial Health Inspectorate: IPS and Diocesan Office of Medical Works: BDOM). 31 people were interviewed at the Ministry of Health and BDOM. **Results:** The level of normative integration in general is average; it is

0.60% or 60%. As for the level of functional integration, it is generally high, 0.80% or 80%. The level of integration of clinical teams is generally high, 0.77% or 77%. That of integration of care is generally very high, 0.99% or 99%. As for the level of systemic integration, it is generally average, 0.41% or 41%. **Conclusion:** Catholic Health Training is integrated into the local health system, firstly the integration of care, followed by functional integration, integration of clinical teams, normative integration and finally systemic integration.

Subject Areas

Health Policy

Keywords

Integration, Health Zone, Archdiocese, Lubumbashi, Likasi, Health Service

1. Introduction

Health, which has always been an important value in Western societies, has for several decades appeared to be a fundamental social priority for all governments on a global scale. The latter also continue to devote a significant part of their resources to it [1].

The World Health Report 2008 structures primary health care reforms that reflect the convergence between conditions for effectively meeting the health challenges of today's world, the values of equity, solidarity and social justice that drive the primary health care movement and the growing expectations of the population in societies [2]. The same report cites Primary Health Care reforms needed to reorient health systems towards health for all: universal coverage reforms, service delivery reforms, public policy reforms, leadership reforms.

Forty years later, the principles defended at Alma Ata remain relevant, as highlighted at the Astana conference in October 2018. All member states of the World Health Organization (WHO) remain convinced that strengthening primary health care is the most comprehensive, effective and cost-effective approach to improving the physical and mental health of populations, as well as their social well-being, and that primary health care is the cornerstone of a system sustainable health with a view to universal health coverage [3]. The Astana Declaration, adopted unanimously by WHO Member States, makes commitments in four key areas: 1) Making courageous policy choices for health in all sectors; 2) Establishing sustainable primary health care; 3) Empowering individuals and communities; 4) Supporting the involvement of all stakeholders in national policies, strategies and health plans [4]. Furthermore, the health district is the operational level for the implementation of primary health care [5].

The first challenge in low-income countries in Africa and Asia remains the simple coverage of basic health needs. The high rates of infant and maternal mortality

show that nothing is resolved [6]. In the Democratic Republic of Congo (DRC), poor health coverage limits the country's capacity to deploy the Primary Health Care strategy and pushes around 60,000,000 Congolese to travel more than 5 km to have access to the nearest health center which meets the standards in infrastructure and medical-sanitary equipment [7]. The private non-profit sector seems to provide a real alternative. In certain African countries such as the DRC, private non-profit providers, particularly faith-based, are crucial players in the health of the poorest. Overall, they are better owners than the central state [8]. Current budgetary constraints and increased demand are forcing States to regulate the organization of services in order to improve the relevance and efficiency of the socio-health system and response to the needs of populations [8].

The integration of networked services thus leads to a rationalization of the offer of services distributed in a territory and to significant coordination of the activities of organizations and players in a sector [8].

It is increasingly recognized that the integration of private sector health services, particularly those of the Catholic Church, can contribute to an extension of coverage in the health district. Its objective is to limit duplication and improve the quality of services. This concept involves the implementation of management mechanisms and clinical approaches that aim to improve the efficiency of health systems and make providers of the services provided accountable [9].

Health system integration involves basic health services and the referral hospital being organized and coordinated in such a way that they constitute a single entity with a common goal [10]. In other words, a district's health services should be structured and managed as a coherent district health system [11]. Integration is the way in which societies around the world hope to master the tensions and contradictions that are at the origin of the dysfunctions of their health systems, such as fragmentation of care, inadequate use of skills, and inequitable access to certain services [12].

2. Methodology

2.1. Study Environment

The Archdiocese of Lubumbashi is limited to the North-East by the Diocese of Kilwa-Kasenga, to the North-West by the Diocese of Kamina, to the South-East by the Diocese of Sakania-Kipushi and Zambia and to the South-West by the Diocese of Kolwezi. After the administrative division of the DRC, the Archdiocese straddles two provinces, Haut-Katanga and Lualaba.

2.2. Study Method and Period

This is a multiple case study. Case studies can be used to: define the models and strategies used by programs, describe the use of resources, evaluate effectiveness, guide quality improvement approaches, identify the strengths and weaknesses of programs, identify issues that require in-depth investigation and study period [12]. Case studies can describe in detail how services are integrated by providing

faithful photographs at the national, provincial and peripheral levels, also allowing territorial departments to discuss their respective practices in order, possibly, to identify transferable lessons [13].

The survey started from December 2021 until October 2023.

2.3. Conduct of the Study and Data Collection

Our study used the quantitative study whose sample was exhaustive including all 32 health structures of the Catholic Church of the Archdiocese of Lubumbashi located in the city of Lubumbashi and the 8 located in the health zones from the city of Likasi.

For data collection, we referred to the following techniques: questionnaires which focused on integration indicators, checklists, non-participatory observation and documentary research. The latter analyzed the supervision registers, activity registers and activity reports.

The data collected was first coded by health service and by health zone. They were subsequently encoded, processed and analyzed using Epi info and Excel software.

For reasons of summons, we interviewed key people from Catholic Health Formations, Ministry of Public Health (Health District: ZS, Provincial Health Division (DPS), Health Inspectorate (IPS) of Haut-Katanga) and BDOM (Diocesan Office of Medical Works)/Lubumbashi.

2.4. Study Population Criteria for Selecting Samples and Sampling

The Catholic Church health structures constituted our study population and our sampling is exhaustive and its size is 40 health structures under the supervision of the provincial health division of the Haut Katanga province.

3. Results

3.1. Functional Integration

This Table 1 shows us that the qualification of staff, the availability of basic medicines and the service schedule are criteria which are respected in Catholic structures which correspond to a score of 1 each; participation of staff in continuing training is assessed at 0.97, the condition of participation in meetings convened by the Central Office is followed at 0.925; therapeutic regimens, algorithms, flowcharts and their use are respected at 0.85, the presence of equipment in Catholic structures is estimated at a score of 0.75; the criteria of existence of an organization chart, a job description and a building sketch are respectively evaluated at 0.58; 0.45 and 0.21. The level of overall functional integration according to the providers is high at 10.21% or 78.5%.

The results of this Table 2 show us that FOSACA (health facility belonging to the Catholic Church) have organization charts, service providers trained in flowcharts and participate in meetings convened by the ECZ. The level of overall functional integration according to the BDOM is 3, this level is very high and is

Table 1. Level of implementation of functional integration according to service providers.

Functional integration attributes	Frequency n = 40	Score/1
Existence of an organization chart	23.5	0.588
Presence of a service schedule	40	1
Existence of a job description	18	0.45
Presence of a plan or sketch of the building	8.5	0.213
Presence of materials	31.5	0.788
Participation of staff in continuing training	39	0.975
Use of flowcharts or benchmarks, therapeutic schemes	34	0.85
Existence of flowcharts, therapeutic schemes and benchmarks	34	0.85
Service providers trained in Flowchart/protocol	30	0.75
Participation in meetings convened by ECZ	37	0.925
Staff qualification	40	1
Presence of registers	32.81	0.82
Availability of medicines	40	1
Total obtained	408.31	10.21
Maximum	520	13

Table 2. Implementation level of functional integration according to BDOM.

Attributes of functional integration	Frequency n = 3	Score/1
Existence of the organization chart in all FOSACA (health facility belonging to the Catholic Church)	3	1
Training of FOSACA providers in Flowchart or support protocols/references	3	1
Participation of service providers in meetings convened by the BCZS	3	1
Total	9	3
Maximum	9	3

above 2.4.

The analysis of this Table 3 shows that the participation of service providers in the meetings convened by the ECZ is evaluated at 0.89. The level of overall functional integration according to the ministry is high (1.96) or 65.4%.

After analyzing this summary Table 4, it results that the level of functional integration is high at 15.17% or 79.84%.

Table 3. Level of implementation of functional integration according to the Ministry of Health.

Functional integration attributes	Frequency n = 28	Score/1
Existence of the organization chart in all FOSACA	16	0.571
Training of FOSACA providers in Flowchart or support protocols/references	14	0.5
Participation of service providers in meetings convened by the BCZS	25	0.893
Total	55	1.964
Maximum	84	3

Table 4. Summary of functional integration.

Groups Level of integration	Groups Level of integration
Integration at service provider level	10.21
Integration at BDOM level	3
Integration at the Ministry level	1.96
Total	**15.17**

3.2. Integration of Clinical Teams

It appears from this Table 5 that all Catholic Health Trainings use multidisciplinarity of personnel; they organize team meetings and participation in staff meetings is estimated respectively at 0.525 and the participation of CODESA (Health Development Committee) in meetings organized by FOSACA (health facility belonging to the Catholic Church) has a score of 0.238. The overall level of integration of clinical teams according to providers is average (2.28) or 57.2%.

Table 5. Level of implementation of clinical team integration according to providers.

Attributs de l'intégration de l'équipe clinique	Frequency n = 40	Score/1
Presence of Multidisciplinarity (nurse, manager, laboratory technician, doctor and community relay	40	1
Team meeting organizations are organized	21	0.525
Participation in meetings (meeting)	21	0.525
CODESA (Health Development Committee) participation in meetings organized by FOSACA (health facility belonging to the Catholic Church)	9.5	0.238
Total	91.5	2.288
Maximum	160	4

3.3. Integration of Care

This Table 6 shows us that curative and promotional activities are integrated, they are estimated respectively at 1. The overall level of integration of care according to the providers is very high (2.975) or 99%.

Table 6. Level of implementation of care integration according to providers.

Attributes of Care Integration	Frequency n = 40	Score/1
Existence of Preventive activities	39	0.975
Existence of Curative activities	40	1
Existence of promotional activities	40	1
Total	119	2.975
Maximum	120	3

The results of this Table 7 show us that the types of care are integrated into all FOSACA. The level of overall integration of care according to the BDOM is very high (3).

Table 7. Level of implementation of care integration according to the BDOM.

Attributes of Care Integration	Frequency n = 3	Score/1
Integration of preventive activities	3	1
Integration of Curative activities	3	1
Integration of Promotional Activities	3	1
Total	9	3
Maximum	9	3

It appears from these Table 8 results that these types of care are integrated. The level of overall integration of care according to the ministry is very high (3).

Table 8. Level of implementation of care integration according to the Ministry of health.

Attributes of Care Integration	Frequency n = 28	Score/1
Integration of preventive activities	28	1
Integration of Curative activities	28	1
Integration of Promotional Activities	28	1
Total	84	3
Maximum	84	3

3.4. Systemic Integration

It follows from Table 9 that the transmission of activity reports to the BCZ and the reference and counter-reference system are respected by the FOSACA at 0.925, the supervision of Catholic health facilities by the ECZ is evaluated at 0.85, the compliance with the PMA or PCA is estimated respectively at 0.6. As for the reference and counter-reference ticket, it exists at 0.62. Existence of reference and counter-reference registers is respectively at 0.425 and 0.07. The presence of a notice of establishment is assessed at 0.475, the possession of a report of inspection of the premises is estimated at 0.32, the possession of a report of second expertise is evaluated at 0.27 and the existence of an opening authorization is assessed at 0.15. The level of overall systemic integration according to the providers is assessed at 6.25% or 52.08% which corresponds to average integration.

Table 9. Level of implementation of systemic integration according to providers.

Attributes of systemic integration	Frequency n = 40	Score/1
Presence of an implantation notice	19	0.475
Possession of a site inspection report document	13	0.325
Possession of a document, a report of the second opinion	11	0.275
Existence of an opening authorization	6	0.15
Compliance with the PMA or PCA	24	0.6
Existence of a surgical operating room	24	0.6
Organization of a reference and counter-reference system	37	0.925
Existence of a reference register	17	0.425
Existence of a counter-reference register	3	0.075
Existence d'un modèle de billet de référence ou contre référence	25	0.625
Transmission des rapports d'activités au BCZ	37	0.925
Supervision par le BCZ	34	0.85
Total	250	6.25
Maximum	480	12

This Table 10 shows us that the opening processes are not followed in the FOSACA, supervision is assessed at 1. The level of systemic integration according to the BDOM is low 1 (20%).

It appears from Table 11 that the presence of the Notice of establishment, report of site inspection, report of second expertise and the opening authorization from the Ministry are evaluated respectively at 0.57; 0.21; 0.04 and 0.04. The achievement of supervision by the ECZ in FOSACA is estimated at 1. The level of

systemic integration is low 1.86 (37.2%).

Table 10. Level of implementation of systemic integration according to BDOM.

Attributes of systemic integration	Frequency n = 3	Score/1
Possession of the Implementation Notice by FOSACA issued by the Health Zone	0	0
Possession of a report of site inspection by FOSACA	0	0
Possession of a second opinion report by FOSACA	0	0
Possession of opening authorization from the National Ministry of Health	0	0
Supervision of FOSACA by the BCZ	3	1
Total	3	1
Maximum	15	5

Table 11. Level of implementation of systemic integration according to the Ministry of Health.

Attributes of systemic integration	Frequency n = 28	Score/1
Possession of the Implementation Notice by FOSACA issued by the Health Zone	16	0.57
Possession of a report of site inspection by FOSACA	6	0.21
Possession of a second opinion report by FOSACA	1	0.04
Possession of opening authorization from the National Ministry of Health	1	0.04
Supervision of FOSACA by ECZ	28	1
Total	52	1.86
Maximum	140	5

From this Table 12, it appears that the level of systemic integration of the synthesis is average, which is 9.11% or 41.4%.

Table 12. Summaries of systemic integration.

Groups Level of integration	Groups Level of integration
Integration at service provider level	6.25
Integration at BDOM level	1
Integration at the Ministry level	1.86
Total	9.11

This Table 13 shows us that the general level of integration is high, which is 50.76 or 65%.

Table 13. General integration level.

Dimensions	Expected	Observed	Standardization to 1
Normative integration	19	11.4	0.60
Functional integration	19	15.17	0.80
Integration of clinical teams	8	6.18	0.77
Integration of care	9	8.9	0.99
Systemic integration…	22	9.11	0.41
Total	**77**	**50.76**	**0.65**

4. Discussion

4.1. Functional Integration (Tables 1-4)

Here are some results which brought functional integration to a high level of 10.21% or 78.5%. Participation of Catholic Church Health training (FOSACA) in training organized by the ECZ: 0.97% or 97%.

Qualification of staff in FOSACA: 1% or 100%.

Use of flowcharts by FOSACA: 0.85% or 85%.

The presence of medical equipment in FOSACA: 0.78% or 78%.

The presence of the organization chart: 0.58% or 58%.

The presence of job description: 0.45% or 45%.

The presence of the work schedule: 1% or 100%.

Participation in meetings organized by the ECZ: 0.92% or 92.5%.

The presence of registers: 0.82% or 82%.

4.1.1. Participation of FOSACA in Training Organized by ECZ

From the perspective of clinical governance, the training of practicing professionals is a central issue in improving clinical processes. The complexity and rapid changes of clinical and technological innovations in the health field are quickly making the initial training of professionals and other stakeholders in the health network obsolete. Continuing training is essential for maintaining qualifications, developing the expertise of professionals and providing quality interventions. [14]. We found that Catholic health facilities participate in capacity building in different themes at 0.97%. Our results are similar to the study on the private health sector carried out in Burkina-Faso (2012) which showed that continuing training seems quite frequent and does not only concern state agents, it also concerns a large majority (66%) of healthcare professionals working in private healthcare establishments [15]. These results contrast with the study carried out in Cameroon by Gruénais [16] who found that often, staff from religious health facilities hardly benefit from the refresher training offered to civil service staff, and therefore are sometimes less informed than them about certain therapeutic advances (Gruénais,

2002), another study carried out in Goma by Kamundu *et al.* (2021) found that almost half (55.1%) of private FOSAs have never strengthened capacities or retrained their staff during the exercise [17].

4.1.2. Qualification of Personnel in Catholic Health Facilities (FOSACA)

Our study revealed that the qualification of staff in Catholic health services is at 1 or 100%, our results are the same as those of Cibangu *et al.* which showed that 100% of healthcare personnel in private structures had a required level, but our results are close to those found by Marius *et al.* who stipulated that in the private sector, the category of qualified personnel agents had a qualification adequate of 80.8%. The results of our study differ from those found in Benin by AYIKOUE who showed that the personnel used in private health structures do not comply with established standards. In 33% of cases, permanent staff do not correspond to the profile required to open and serve in these structures [18].

4.1.3. Use of Flowcharts by FOSACA

Better involvement of private medical care structures is necessary, particularly in the use of algorithms, data collection, participation in training [19]. Our survey proved that the use of flow charts is 0.85% or 85% in Catholic structures, our results are similar to Barry's study in Guinea which mentions without specifying the percentage that in health centers, the provision of services is governed by the flow charts [20].

4.1.4. The Presence of the Organization Chart

The organization chart is a document that shows the positions planned in an organization, the relationships between the different positions [21]. Our study showed that the organization chart is present in FOSACA at 0.58% or 58%, these results are opposed to those found by Cibangu *et al.* which stipulate that in private structures, the presence of the organization chart was 10/13 (76.9%) [22].

4.1.5. Présence De Job Description

The purpose of describing tasks is to reduce variability and control the work [22]. The results of our research show that the presence of job descriptions in FOSACA is 0.45% or 45%; these results differ from those produced by Cibangu *et al.* who demonstrated that in private structures, the job description is 13/13 (100%) [23].

4.1.6. Presence of Work Schedule

The time spent on work depends on the schedule [22]. Our work showed that the presence of the working schedule in FOSACA is 1% or 100%, these results are almost the same as those found by Cibangu *et al.* showing that in private structures, the working schedule was 12/13 (92.3%) [23].

4.1.7. Presence of Registers

Registers are part of the data collection tools in Health Training. Our data shows that the average presence of registers in FOSACA is 0.82% or 82%. These data are similar to the study carried out by Cibangu *et al.* which found that the presence of

registers in FOSAs, made up mainly of private ones (93%), was on average at 94.9% [23]. Our results are also similar to those found by the Kinshasa health school which states that 99% of private religious health care facilities had the tools (registers) to regularly collect health data [24].

4.1.8. Participation in Meetings Organized by the Health Zone Management Teams

It is one of the conditions for private health services to be integrated into the health system. Meetings constitute a way of formally communicating during which we communicate on the objective of the organization to obtain the internalization of the objective by the group, the understanding of the role of each in achieving this objective and the performances achieved by the organization [22]. Our study proved that in Catholic health structures 0.92% or 92.5% participate in meetings convened by the ECZ. But these results are different from those observed in the study conducted in Kinshasa by Katshi, which revealed that board meetings are irregular and partners do not even participate, however, the author did not give the percentage of participation on the board of directors [24]. The annual and monthly reports of the ECZ and BDOM have shown that Catholic health facilities participate in CAs, monitoring and reviews.

4.2. Integration of the Clinical Team (Table 5)

Here are some results which brought the integration of the clinical team to the average level of (2.28) or 57.2%:

- The organization of team meetings: 0.525% or 52.5%.
- CODESA (Health Development Committee) participation in meetings organized by FOSACA: 0.238% or 23.8%.

4.2.1. Team Meeting Organizations

In relation to this attribute, our work showed that 0.525% or 52.5% of Catholic Health Trainings organize team meetings, these results are similar to those found by the Kinshasa health school which showed that 51% of Private denominational FOSA organize management meetings with documentation at least once every 6 months [25].

4.2.2. CODESA (Health Development Committee) Participation in Meetings Organized by FOSACA

Community participation is an important focus of the primary health care strategy. It allows it to be an actor and therefore an essential partner in the production of care from which it benefits [8]. Our survey revealed that in Catholic structures, community relays participate in meetings at 0.238% or 23.8%. These results are similar to the survey conducted by Marius et al, which showed that community relays participated in pricing community activities at 34.6% [26], our results are similar to the observation expressed in the Health System Strengthening Strategy document which states that one of the central ideas of community participation is that the population should have a say in what is offered to them, however we are

far from it [8]. Our results differ from those carried out by the Kinshasa health school which showed that 51% of private religious health centers organize documented meetings with community participation at least once every 6 months.

4.3. Integration of Care (Tables 6-8)

Here are the results which brought the integration of care to a very high level of 2.975% or 99%: L'existence des activités préventive: 0.975 soit 97.5%.

- The existence of curative activities: 1% or 100%.
- The existence of promotional activities: 1% or 100%.

FOSACA Provide Curative, Preventive and Promotional Care

Our results show that it is in Catholic health facilities that the three types of health care are respected. Our results are similar to the study carried out by Denise Deroeck in Tanzania which showed that private health facilities in the non-profit survey provide a complete set of health services, but without giving the percentage [27].

4.4. Systemic Integration (Tables 9-13)

Here are some results which brought systemic integration to an average level of 6.25% or 52%: L'avis d'implantation: 0.475% soit 47.5%.

- The report of the expertise: 0.325% or 32.5%.
- The second opinion report document in Catholic structures: 0.275% or 27.5%.
- Opening authorization: 0.15% or 15%.
- The presence of a reference and counter-reference system: 0.925% or 92.5%.
- Transmission of activity reports: 0.925% or 92.5%.
- Supervision by the ECZ: 0.85% or 85%.

4.4.1. Opening Procedures

Our research has demonstrated that possession of the notice of establishment in FOSACA is at 0.475% or 47.5%, that of the expert report document is at 0.325% or 32.5%, possession of the document of second-expertise report in Catholic structures is 0.275% or 27.5% and that of the opening authorization from the National Ministry of Health is 15%. In Benin, Boni Gratien *et al.* found that nearly 75% of structures operating illegally [25]. In Burkina Faso in the town of Bobo Dioulasso, a study showed that nearly 20% of active establishments operate without authorization (8% of for-profit establishments and 32% of non-profit establishments). In Senegal, on the other hand, a study carried out on 2537 Private Health Structures (SPS) by the Ministry of Health discovered almost all (90%) having responded to the survey, declared having an authorization to open. A study carried out in India (2003) showed in a survey by the Directorate of Health Services of the State of Delhi that 80% of private clinics, or 1603 establishments, were not registered and did not respond to the notebooks of charges of the Delhi Nursing Home Act, two procedures which are nevertheless obligatory [25]. A study carried out in Benin by AYIKOUE showed that 46% of the managers of the private structures visited

claimed to have authorization to open, but 1/10th of them could not immediately produce the administrative document justifying it [8]. In Goma, Kamundu *et al.* discovered that 58.8% of private structures had not respected the opening procedure [17]. Our results differ greatly from those carried out in Mbujimayi in the DRC by Cibangu *et al.* which showed that the opening authorization was 10/13 (76.9%).

4.4.2. The Presence of a Reference and Counter-Reference System

Compared to the reference and against reference, our work showed that the Catholic structures in the city of Likasi and Lubumbashi are at 0.925% or 92.5%, these results differ widely from those found by Kamundu *et al.* who said that 763,600 patients were registered in these health facilities, of which only 149 (0.01%) were transferred to a higher level health structure; a deviation is also observed in the referred cases, where only 4% (6/149) of counter-references were sent back to the original structures, the reference and the counter-reference are almost non-existent as a system of communication of the lower level to higher level, between non-state health facilities and HGRs [17]. The referral and counter-referral system is not strictly respected by both patients and providers [26].

4.4.3. Transmission of Reports to BCZ

Information is also one of the pillars of the health system, the data from our study shows that 0.925% or 92.5% of Catholic Health Facilities transmit activity reports to the central health zone offices. However, the PNDS speaks of the weak integration of private structures in the management of health information [8]. Our data deviate from the study by Marius *et al.* who mentioned that the rate of reports submitted to the hierarchy was 25.8% [8].

4.4.4. Supervision of FOSACA by the Central Offices of Health Districts (BCZs)

The concept of supervision is widely used in the field of public health as the process of monitoring, analyzing problems, identifying the causes of problems, investigating to improve solutions, explaining guidelines and suggestions and guidance for improving operations in terms of service systems management [27]. Our study showed that 0.85% or 85% of FOSACA are supervised by the ECZ, the frequency of which is either monthly, quarterly, annual. Our results are similar to those of the report produced by the Kinshasa health school which reported 84% of private confessional FOSA having had supportive supervision [1]. These results differ from the study carried out in Benin by Gratien *et al.*, which showed that 23.07% received a visit from the control services at least 6 months before the survey, the same study shows that 17.48% did not receive one between 6 to 12 months before the survey, and also 24.82% received a visit from a control structure more than a year ago before the survey, the rest *i.e.* 101 private health facilities or 35.33% have not been subject to any inspection since opening [25]. A study carried out in Goma by Kamundu *et al.* its results showed that only 13 (12.6%) non-state health

structures were supervised by the supervisory health zones and no non-state health structure was supervised during this period by the provincial health division nor the provincial health inspection, private FOSAs are less supervised by the supervisory hierarchy [17]. Private health facilities integrated into the health system benefit from supervision by the BCZ [8].

5. Conclusions

The private sector, although present in the health system, especially following the socio-economic recession, has not been properly involved; each intervened independently of each other. The Ministry of Health is committed to reforming health systems with the aim of better coordinating the medical and health activities of the public and especially private sectors. All policies taken concerning the different categories of interventions aim to integrate the private sector into health systems for better distribution of activities among the population.

Our study shows that Catholic Health Training is integrated into the local health system. However, it remains that studies must be undertaken to determine the level of private contribution in health systems, the reason for the level of integration of one or another dimension and the efforts undertaken by the State to enable private structures to integrate into the health system.

Monitoring the attributes of the functional dimension gives rise to a summary of a high level of integration which is 15.17% or 80%; these attributes are: the existence of an organization chart, the presence of a work schedule, the existence of a job description, the presence of a plan or sketch of the building, the presence of materials, the participation of staff continuing training, the existence of flowcharts or benchmarks, algorithm, therapeutic diagnosis and treatment regimen, use of flowcharts or benchmarks, algorithm, therapeutic diagnosis and treatment regimen; providers trained in flowcharts, participation in meetings convened by the ECZ, the qualification of staff called upon to work within the establishment, presence of registers, availability of medicines. Monitoring the attributes of the integration of clinical teams gives rise to a summary of a high level of integration of 6.18% or 77%. Its attributes are: the presence of multidisciplinarity (nurse, manager, laboratory worker, doctor and community relay), the organization of team meetings in the FOSA, participation in meetings, participation of CODESA (Health Development Committee) members in meetings organized by FOSACA. The implementation of the attributes of care integration has brought health structures to a summary of a very high level of integration which is estimated at 8.9% or 99%. Respect for the attributes of the dimension of systemic integration has enabled the health services of the Catholic Church to obtain a summary of an average level of integration which is estimated at 9.11% or 41%. Generally speaking, the health services of the Catholic Church are integrated into the health system, and the level of general integration is high, which is 50.76.

Integration is of great importance both socially and practically, because it makes it possible to improve the provision of health services.

Conflicts of Interest

The authors declare no conflicts of interest.

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