WWJMRD 2025; 11(12): 1-8
www.wwjmrd.com
International Journal
Peer Reviewed Journal
Refereed Journal
Indexed Journal
Impact Factor SJIF 2017: 5.182 2018: 5.51, (ISI) 2020-2021: 1.361
E-ISSN: 2454-6615

Docteur Abraham A.A. DOBA, Ph.D in History, the University of Ngaoundere (Cameroon), Departement of History, Economy and Society Laboratory.

Correspondence:
Docteur Abraham A.A. DOBA, Ph.D in History, the University of Ngaoundere (Cameroon), Departement of History, Economy and Society Laboratory.

The Medical Work of The Catholic Church in Benue (North-Cameroon) From 1956 To 2020

Docteur Abraham A.A. DOBA Orim, Samuel Orim, Orim, Matthew Ashike

Abstract
Faced with recurring and persistent diseases, including infectious, venereal, Childhood, and maternal diseases, the populations of Cameroon in general and those of the Northern region in particular remain dependent on health assistance. In this sense, the objective of this study is to reveal the contribution of the Catholic Church in managing the health problems of local populations in Benue from 1956 to 2020. To carry out this work, which was part of a dual approach (qualitative and quantitative), we conducted interviews and surveys with resource people and the population, in addition to documentation. Also, observations made of the way and means of caring for patients enriched our data. The development of the Catholic Church's medical work has led to the establishment of health facilities for effective care. We were able to observe an increasing percentage of curative use within Catholic health facilities, increasing from 23.3% to 61% between 2015 and 2019, while the percentage of attraction decreased from 68% to 65% over the same period. These statistics reveal, on the one hand, the effectiveness of the health activity carried out among the population and the limitations encountered by Catholic health facilities in their operation, justified on the other hand by the decreasing percentage of attraction

Keywords: Diseases, health problems, Benue, Catholic Church, medical work.

Introduction
The presence of the Catholic Church in North Cameroon and more precisely in Benue, is the work of the missionaries of “Oblat de Marie Immaculée” (OMI) who arrived on November 6, 1946. Having left France in August of that same year, their mission was to proclaim the Gospel in Northern Cameroon and Mayo-Kebi (Chad), a territory where they encountered populations who adhered to traditional religions, Islam, and Protestantism. Thus, in order to be well received by the latter and to better settle, they undertook several strategies. Providing health care to the populations was then one of the most noted and effective strategies to open the way to the Gospel and ensure the presence of the Catholic Church. In this sense, all the health actions undertaken by the first missionaries and which have continued until now, direct this theme on: **"The medical work of the Catholic Church in Benue from 1956 to 2020."** The choice of these dates is of major interest in that they reveal the evolution of the work accomplished by the Catholic Church in the management of the health problems of the populations initiated in 1956. We are witnessing the construction of a first dispensary by Priest Balliere to offer health care to the populations of Ndoudja. This achievement perceived as the beginnings of the health work accomplished in Benue will see a convincing development until 2020 by the construction of other health structures ensuring in this sense, the care of the populations. The contribution of the Catholic Church in terms of providing health care to the populations in Benue remains poorly known or better still unnoticed. In this sense, the present study questions the work accomplished by the Catholic Church in terms of management of the health problems of the populations in Benue from 1956 to 2020. Starting from the context medical intervention of the Catholic Church in Benue, this work will address the Functioning of its health work and its contribution to the physiological well-being of the populations while also noting some shortcomings of this work.

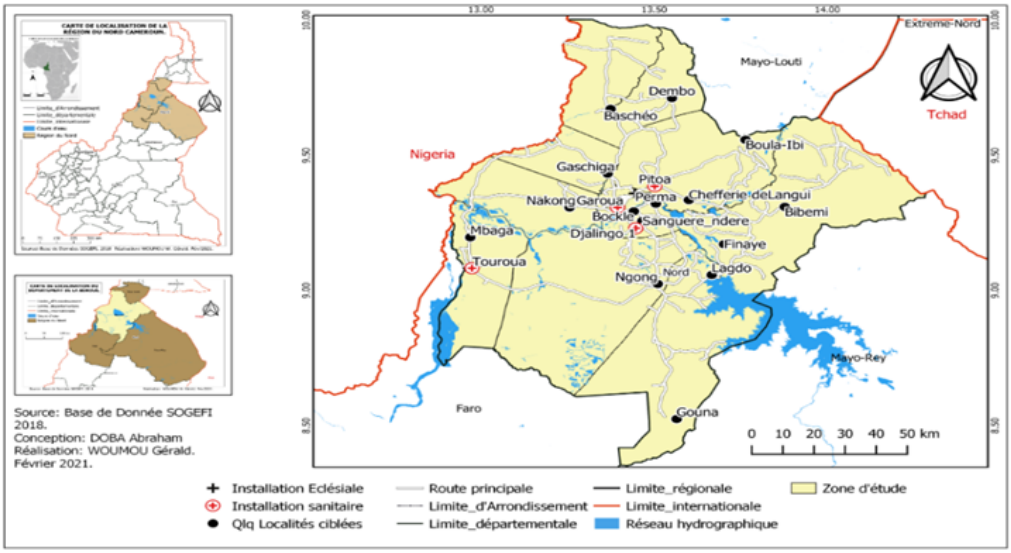
1. Methodology

1.1Presentation of the study area

Benue is one of the departments of the North region with Garoua as its capital. It has nine (09) districts and twelve (12) counsels. The districts covered in this study are those of Garoua I, II and III, Lagdo, Tcheboa, and Touroua.

The climate is of the Sudano-Sahelian type, characterized by a long dry season from October to April, and a short rainy season extending from May to September. The poor distribution of rainfall in time and space is noted from one year to another, even from one month to another. This then leads not only to disruptions in the agricultural calendar which impacts the yield causing famine crises, but also the constant change of climate and temperatures determining the spread of pathologies on the local population. The Division is watered mainly by the Benue, the rivers and the mayo. These waterways often constitute channels for the spread of waterborne diseases such as cholera, bilharzia, typhoid etc., from which the populations suffer.

Map: Location of the study area.



Conception: A.A. Doba **Realization**: WOUMOU Gerald

Benue has a population of approximately 851,955 inhabitants, and an average density of 62.6 inhabitants/km^2. Men are represented at 49.7% and women at a figure of 50.3 %. Several ethnic groups have settled there. These are the Fali, Bata, Tchamba, Foulbe, Mbororo, Haoussa, Kanouri, Daoyo, and the Choa Arabs. The people from the Far North include the Toupouri, the Mousgoum, the Moundang, the Massa, the Mafa, the Kapsiki, the Matal, etc. The ethnic groups from Adamaoua are the Dii, the Mboum, and the Gbaya. To these ethnic groups, we can add those from the southern part of Cameroon, including the Bamileke, the Bamoun, the Beti, etc. While the Sara, the Laka, the Gambayes, the Lele arrived from Chad. There are also populations from Mali, Senegal, and Niger. Fulfulde is the main lingua franca in this department. Spontaneous and uncontrolled migrations caused by several factors (the deterioration of climatic conditions, difficult living conditions, insecurity problems, etc.), as well as internal migrations marked by seasonal transhumant pastoralists, justify the ethnic mosaic of the Division of Benue.

These population movements would also be one of the causes of the persistence and spread of diseases in Benue. In the religious field, religious denominations are between Islam, Protestantism and African religions with which Catholicism has come up against. The economic activities are those of agriculture (cotton, sorghum, corn, rice, peanuts, soybeans, beans, sesame, onions, potatoes, etc.), livestock (cattle, sheep, goats, poultry), fishing (fresh, dried and smoked fish), trade, transport, processing /industry (textiles/CICAM, cottonseed oil/SODECOTON, beverages/SABC, Manu Cycle, tourism), crafts and natural resources.

These sectors of activity are then centers of meetings, exchanges and relationships between human groups; which often facilitate the spread of diseases such as pneumonia, tuberculosis, cancer, etc., among local populations.

1.2. Type of study and survey

This study is both qualitative and quantitative. This choice is justified by the need to obtain the maximum amount of information that can allow us to better understand the subject of study. For this purpose, we identified several categories of actors including the apostolic clergy (Priests) of the diocese of Garoua, staff of the Diocesan Health Coordination in Garoua, health facilities, the Regional Delegation of Public Health of the North and the Garoua Health District, health workers from NGOs, patients and their relatives, local populations and vaccination and disease control campaign workers. To this end, the field surveys carried out between September and November were based on interview guides previously designed according to the type of information sought as well as according to the categories of informants mentioned above. Observations made during vaccinations and patient care helped enrich our data. To this end, the collection of iconographic data was also added.

The research and consultation of various written sources such as general and specialized works, theses and dissertations were possible in the following documentation centers: the Libraries of the University of Ngaoundere, in particular the Central Library, “Ngaoundéré Anthropos” and the library of the Faculty of Arts, Letters and Human Sciences, the African Center for Sharing and Knowledge and

the French Cultural Alliance (in Garoua). In addition to the written documents cited above, activity reports of Catholic health training were used at the Diocesan Coordination of Health of Garoua, at the "Notre Dame des Apôtres" Hospital in Djamboutou, at the "Notre Dame du Perpetual Secours" Catholic Health Center in Pitoa, at the Joséphine Rodolphi Rehabilitation Center in Djalingo, without forgetting the Regional Delegation of Public Health of the North, more precisely at the Garoua 1st Health District. The collection of data on the internet which made it possible to constitute the electronic sources of this work should not be ignored.

1.3. Sampling method

The collection of quantitative and qualitative information was made from questionnaires from sixty-one (61) peoples in the cities of Garoua (1, 2, 3), Pitoa, Ngong, Lagdo and Touroua. These questionnaires focused on the history of the establishment of the Catholic Church in Benue and on all the health actions it has carried out. Based on the criteria of age, level of education and social status, and place of residence, we made a selection of people to participate in the study. The interviews, conducted mostly in French and also in Fulfulde (a local language spoken mainly in Benue), were conducted privately and semi-privately.

1.4. Method of processing the collected data

Regarding the data analysis, we preceded by a confrontation and a critique in order to find the hard core, because there was some ambiguous information. Following this analysis of the information, we used two approaches namely the synchronic and diachronic. The synchronic approach consisted of grouping the facts and elements into centers of interest. As for the diachronic approach, it made it possible to reconstruct the facts studied according to their evolution.

2. Results of the study

The analysis of the collected data made it possible to present the results below that we will introduce in interrogative forms

2.1. What are the motives of the medical work of the Catholic Church in Benue?

The intervention of the Catholic Church in providing health care to the populations of Benue is justified by three essential reasons. These are the Christian ideology on health, the worrying health situation of the populations and the inadequacy of state health action in this department. The primary motive for the Catholic Church's medical intervention in Benue is based on the dogmas of Christianity. In the Gospels, the writings recount the story of Jesus-Christ caring for sick people and taking action to heal them. He recommends all his followers to do the same.

The primary objective of the Catholic Church in Benue remains the evangelization of the local populations. For this, the exercise of charity translated by the desire to respond to health problems through the essential care provided to the populations, was then a proselytizing means. Cardinal Lavigerie then affirmed:

"We will treat them with charity, and we will give them everything we can to relieve them. If they have wounds to think about, the brothers or fathers designated for this office of charity will care for them as best they can.". Victims of malaria, dysentery, phagedenic ulcers, snake bites and many other health problems, the populations implemented local therapeutic methods. These had some limitations to which the missionaries were able to improve. Thus, the practice of charity through health care provided to the sick was part of the logic of the quest for trust from the populations, which was a slow and tiring but essential action. The second motive for the health action undertaken by the Catholic Church in Benue is that based on the worrying health situation of the populations. Located in the intertropical zone where climatic conditions are increasingly favorable to the outbreak of epidemics, they are confronted with the problems of drought and famine which facilitate the proliferation of diseases thus making the epidemiological profile worrying. Firstly, there are diseases of the faecal peril (bilharzia, filariasis, cholera, dysentery amoebiasis, typhoid); tropical diseases due to vectors (malaria, recurrent snake bites, filariae); venereal diseases (HIV/AIDS, hepatitis, syphilis, gonorrhoea); those related to pneumonia (lung cancer, tuberculosis, bronchitis); those related to cardiovascular diseases (stroke, rheumatism); those related to oral and mental health. Indeed, the various diseases that attack the populations push the public authorities and health authorities to be concerned about the health situation of the latter The third motive for the medical intervention of the Catholic Church in Benue is that based on the inadequacy of state health action and justified by the deficit of human, infrastructural and socioeconomic resources. In the 1960s, a deficit of human resources in health was marked. This glaring lacks then made it possible to assign on average 1 doctor for 75,000 inhabitants in 1963. For the populations of Benue, the staff assigned to the regional hospital of Garoua was composed of a head doctor, a surgeon, a radiologist, a maternal and child protection doctor and a midwife. These were to support a population of 275,000 inhabitants. In addition, the inadequacy of state health action in Benue can also be seen in terms of infrastructure.

A study conducted by Pontabry and Weber on state health structures in 1960 reveals that Benue had a state hospital in Garoua, state health centers in Pitoa, Adoumri, Hama Koussou, Gouna and communal health centers in Touroua, and Boula Ibib.

These health structures had a population of approximately 87,000 inhabitants to cover. However, the population covered by all these structures was approximately 46,000 inhabitants, or 52% of this health coverage between 1936 and 1970 Total health coverage will then be possible through the multiplication of health infrastructures: an expectation to which the Catholic Church finally responded by building health facilities. The socioeconomic situation in the aftermath of the economic crisis that occurred during the 1990s led to precarious living conditions within the population regarding education, employment, housing, nutrition, access to drinking water. These are all problems that impact health and thus cause a crisis in its system marked by a lack of adequate infrastructure as well as an exodus of qualified human resources to large cities. Poverty, uncontrolled urbanization, inequalities in the distribution of wealth from the exploitation of natural resources, and youth unemployment are all challenges facing the administration. This situation also justifies its limitations in the effective management of the population's health problems.

In view of these three fundamental motives, the medical intervention of the Catholic Church in Benue had as its main concerns the care of the sick at home, health activities in the villages and the construction of dispensaries The health work undertaken by the missionaries in Benue has evolved and led to the establishment of health facilities in order to make the provision of care to the population more effective. Indeed,

the call of the missionary sisters contributed to apostolic works and in particular to the provision of health care.

In 1958, the nuns of the "Sœurs du Sacré Cœur de Jésus" arrived in Garoua where they began by offering their health services at the Garoua hospital as well as in the surrounding communities and villages. Their contribution consists of health animation sessions, Maternal and Child Protection, a fight against malnutrition which was very common in Ngong, the training of health officials for childbirth (two midwives per village), for village pharmacies, and other health-related actions such as providing drinking water by digging wells and boreholes. In the villages where the mission is established, they set up health centers with nivaquine, the aim of which was to prevent malaria, which was a major threat to the population, and aspirin, which was used as an anti-inflammatory.

They continued to train families in the health field through the various existing groups, Christian homes, the Living Ecclesial Community, and meetings for women and young girls. They then received rules of sanitation for the surroundings of the houses, of purification of drinking water through boiling and bleaching. Also, latrines were recommended to them because it was not healthy to make a fecal deposit in the open air; all this in order to avoid certain waterborne diseases such as cholera, schistosomiasis or bilharzia. Although these habits have not completely disappeared in 2020, it remains that this hygiene education given by the nuns participated in raising awareness among the populations in the rules of environmental sanitation. Also, the nuns set up a Caritas emergency fund to assist the sick in financial difficulties.

The creation of hospitals next to the Churches has always been a model and a major concern of the Christian missions. In Benue, the Catholic Church built four (04) health stations. These are "Notre Dame des Apôtres" Hospital in Garoua, the "Vincent de Paul" Catholic Health Center in Touroua, the "Notre Dame du Perpétuel Secours" Catholic Health Center in Pito and the "Josephine Rodolphi" Rehabilitation Center in Djalingo between 1988 and 2001. Since then, the installation of health facilities has been fundamental for the continuity of the health work undertaken by the missionaries in Benue. Also, it is important to question the functioning of this health action undertaken.

2.2. How does the medical work of the Catholic Church in Benue operate?

The functioning of the medical work of the Catholic Church in Benue involves its organization and the constitution of its resources (financial and human) for the provision of health care to local populations. The organization of the medical work of the Catholic Church in Benue allows us to discuss here the role played by the Church and the public authorities in the management and administration of medical actions implemented in this part of the country. In order to better coordinate all the diocese's interventions in the social field, a Diocesan Committee for the Development of Social Activities was set up in 2003.

It is important to note that before the establishment of the latter, all health actions were under the supervision of Priests at the local level. In their parish activity reports, the health component was also mentioned and then sent to the bishopric. The Diocesan Health Coordination plans, organizes and supervises health activities at the level of the diocese of Garoua. After defining the objectives to be achieved in the provision of health care to the population, the Diocesan Health Coordination ensures their implementation through quarterly visits that it carries out within its health facilities. The Catholic Health Care Facilities are those who provide health care to the population both in fixed strategy (within the Health Care Facilities) and advanced strategy (within the community/outside the Health Care Facilities). The activities they offer in advanced strategy are mainly preventive and concern prenatal consultations, postnatal consultations, and awareness raising and health education.

The care offered in fixed strategy mainly concerns curative care by managing various health problems (illnesses, surgery, childbirth, etc.) daily and weekly. Also, the Catholic Health Care Facilities are run by nuns who, for the most part, work there as nurses. For the Hospital "Notre Dame des Apôtres" in particular, the management has been held by a lay person since 2005. However, the presence of a nun as a nurse has always been noted until 2020. Beyond the dependence on ecclesiastical organization, the Catholic Health Care Facilities established in Benue also operate in strict compliance with the state system. They are under the authority of the Ministry of Public Health through the Regional Delegation of Public Health of the North and the Health Districts to which they belong and to which they continually provide activity reports and receive quarterly visits from Health District or Regional Delegation of Public Health of the North agents for quality supervision. The latter consists of an evaluation of the provision of health care to the population by verifying the technical, material and human improvement of medical care, and compliance with the protocols of said care.

The organization of the Catholic Health Care Facilities makes it possible to identify the systems included in their administration and management, including the ecclesiastical and state systems. Also, their operation requires various resources.

As for financial resources, the health work of the Catholic Church is based mainly on donations, project grants (by NGOs) as well as the self-financing of health facilities through their own economic product.

Donations coming mainly from Europe, the United States and Canada were permanent in the phase of the establishment of the Catholic Church in Benue. Indeed, Catholic Priests of French, Italian and Canadian origin used to send requests for assistance for the health development of local populations to the bishopric of their country, to their close acquaintances (most of whom came from wealthy families), and to certain NGOs in their country of origin. These donations consisted of finances for the construction of health structures installed in Benue, medicines and sometimes medical equipment (prostheses, orthopedic wheelchairs).

Project grants are essentially the area of action of the Diocesan Health Coordination engaged since 2006 and are summarized in the design of three-year projects. In this sense, a project set up between 2007 and 2011 made it possible to subsidize health actions carried out at the central prison of Garoua for seventy-eight (78) prisoners suffering from tuberculosis and HIV. Between 2006 and 2019, four (04) projects were launched and are oriented towards the construction of health facilities, their equipment with materials necessary for the operation of services (laboratory, maternity, pharmacy, surgery, odontostomatology, ultrasound, pediatrics) for effective management of health problems and assistance to disadvantaged people within the

populations

Catholic Health Care Facilities are also financed by their economic products. Indeed, the sale of medical procedures (curative care, deliveries), the sale of medicines and rehabilitation equipment allows them to self-finance, by covering the various costs of the structure as well as that of the staff. Financial, material and technical assistance is largely internal, but also external from the State, NGOs (UNICEF, WHO) and programs against malaria, tuberculosis and malnutrition which have the inputs for the provision of health services to the population. The health structures of Catholic Church also receives support from the "Performance Based Findings" (PBF) project.

This is a project to support investment in the health sector agreed between the Ministry of Public Health and the World Bank and implemented it since 2012. Health structures are then subsidized on the basis of their performance, relative to the quality and quantity of health services provided to the population.

In addition to these financial resources, there are human resources. The medical work of the Catholic Church in Benue required a workforce made up of healthcare personnel and a group of people sensitive to the health situation of the local populations. It all began with the missionaries (Priests and nuns) OMI who arrived in 1946. Among the populations, they were health workers, responding to wound dressings, stomach aches with nivaquine and malaria with chloroquine thanks to the health kits they had available. Over time, the construction of the Health Facilities pushed the Catholic Church to hire local and specialized personnel who could take over the health work started by the missionaries because the health needs were significant and the workforce insufficient

In 2020, this staff consists of administrators, accountants, doctors, state-certified nurses, medical-health technicians, midwives, nursing assistants, maintenance and security staff, physiotherapists, and orthopedic technicians. Having followed conventional professional training, they continually participate in training and refresher sessions planned by the Diocesan Health Coordination and the Regional Delegation of Public Health of the North for the provision of health care to local populations. The implementation of various resources (financial and human) by the Catholic Church thus allows for effective management of the health problems of the populations by its health structures in Benue. Also, questions are raised about the medical contribution of the Catholic Church in Benue.

2.3 What is the medical contribution of the Catholic Church in Benue?

The medical contribution of the Catholic Church to the populations settled in Benue is expressed through the provision of preventive and curative health care. Before the construction of health facilities, preventive care was mainly translated into health animation within the communities. It consists of health education sessions on hygiene. The nuns in charge of it proposed to address the themes of household hygiene, food to consume, the environment, the body, toilets and the sanitation of drinking water.

The construction of health structures paid great attention to maternal and child protection due to the importance given to them by the Millennium Development Objectives (MDO); this through prenatal and postnatal consultations. In addition to these consultations, prevention campaigns against certain target diseases (meningitis, cholera) are also carried out.

Prenatal consultation is a preventive medical act allowing detecting and treating possible complications during pregnancy. The prenatal consultation follow-up, which is held in four (04) periods, makes it possible to preserve not only the health of the mother and the fetus. But also, to prevent risks and complications during childbirth. Thus, prenatal consultation sessions are done in two parts: promotional and preventive care of the pregnant woman. During the prenatal consultation sessions, several themes are addressed in order to educate women mainly on their households. Preventive care of the pregnant woman systematically focuses on maternal and neonatal tetanus, anemia, maternal-fetal transmission of HIV, and malaria. Tetanus toxoid vaccination is then offered by maternal and child health programs, in order to improve the chances of survival of women and newborns. These Tetanus toxoid vaccinations are accompanied by the distribution of Vitamin A to address the problem of anemia. The Tetanus toxoid vaccination rates administered by the Catholic Health Care Facilities reveal statistics of 3,386 in 2012, 3,207 in 2013, 2,474 in 2014, 3,568 in 2015, and 3,158 in 2016, 2,591 in 2017, 2,268 in 2018 and 3,048 in 2019.

The preschool consultation for its part, largely integrates promotional and preventive activities to ensure harmonious growth and development for children aged zero (0) to five (05) years. Its objective is to prevent and detect any growth risk, to detect deficiency diseases, to refer cases of severe malnutrition to a nutritional recovery center, to prevent through vaccination the eight target diseases of the Expanded Program on Immunization namely tuberculosis, poliomyelitis, diphtheria, tetanus, whooping cough, measles, yellow fever and hepatitis B. During the preschool consultation, many tips are given to mothers for the well-being of their children. This is the case for the promotion of breastfeeding, the use of drinking water, the use of impregnated mosquito nets, the use of health services, as well as the vaccination of children. The percentage of vaccination coverage is increasing, therefore 39.12%, 68.49%, 95.79% in 2017, 2018 and 2019.

These activities have very often been combined with National/Local Vaccination Days as well as Child and Maternal Health and Nutrition Action Weeks. They consist of providing polio vaccines to all children aged zero (0) to five (5) years, administering Vitamin A to all children aged six (06) months to five (05) years, and deworming all children aged one (01) to five (05) years with Albendazole. They are carried out two to three times a year according to the activity schedule defined by the Ministry of Public Health, whose vaccination coverage percentage is 85.5%. In addition to prenatal consultation and preschool consultation, certain epidemics such as meningitis and cholera also required preventive measures implemented during the campaigns. Meningitis, also called inflammation of the meninges, is a serious infectious disease that can be bacterial, parasitic, or viral. Without treatment, 70% of cases die, but with adequate antibiotic therapy, mortality rates are usually around 10%.

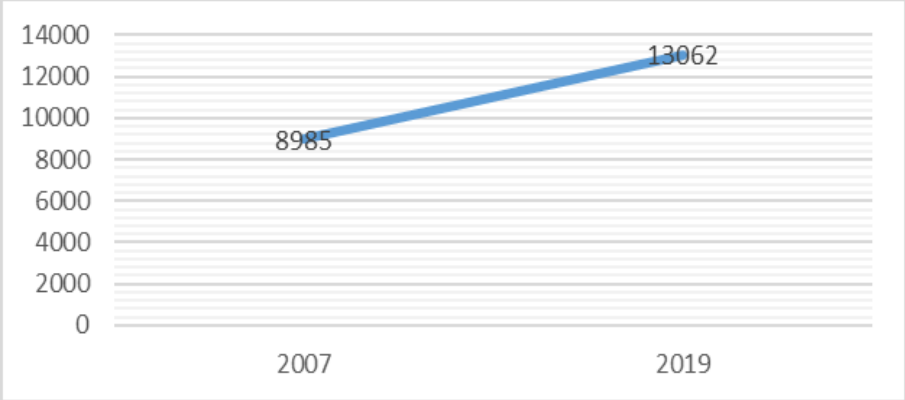
The WHO proposes a meningococcal conjugate vaccine for this purpose, which induces stronger and longer-lasting immunity, preventing nasopharyngeal carriage of the bacteria, and therefore its transmission. In this sense, the health structures of Catholic Church participated in this preventive action strategy by administering meningococcal

vaccines between 2003 and 2010. The statistics of the vaccination coverage rate against this epidemic reveal rates of 20.33% in 2007, 14.31% in 2008, 11.11% in 2009 and 4.47% in 2010. The decreasing vaccination coverage rate justifies the reduction in the scale of this epidemic among the local populations of Benue

As for cholera, the scale of this epidemic in 2019 with a case fatality rate of 5% in the Health District of Benue (Garoua I, Garoua II, Bibemi, Gashiga, Golombe, Ngong, and Pitoa), pushes the government with the help of partners to undertake preventive measures. Its in this sense that, the Hospital "Notre Dame des Apôtres" being located in the Health Area of the Health District of Garoua I, participated in a cholera awareness and response campaign held from August 1 to 5, 2019.

The campaign aimed to prevent the disease, fight the epidemic and reduce deaths, by administering a dose of oral cholera vaccine to everyone over one year old. Cholera awareness reached 12,798 inhabitants including 10,705 households in 11 neighborhoods. Its then important to specify that the Hospital "Notre Dame des Apôtres" did not take charge of cholera cases. Any reported case was directly referred to the Health District of Garoua 1. Indeed, the management of epidemic diseases is the responsibility of the Health District in which cases are recorded. In addition to preventive health care, curative health care was also offered. Curative medicine is understood as all health care provided for medical conditions where a cure is considered achievable, or even possibly redirected to this end. Before the construction of the Catholic Health Care Facilities in Benue, the curative care provided by the missionaries focused on medication and dressings. Indeed, being equipped with medical kits, they provide the population with basic care. These kits contained medicines such as chloroquine, aspirin, paracetamol, nivaquine, etc., dispensed to suffering people to alleviate their ailments (fever and stomachache)

Graph 1: Evolutionary curve of malaria cases in Catholic Health Care Facilities between 2007 and 2019.



Source: Results of field surveys at the Diocesan Health Coordination Design**:** AA Doba.

The graph presented above reveals an increasing curve in the number of malaria patients received by Catholic Health Care Facilities between 2007 and 2019. The death rate is recorded mainly among children under five years of age because their immune system is still fragile. The complications and the increase in malaria cases led the Ministry of Public Health, through the National Malaria Control Program, to define several means and strategies to combat malaria. These include the implementation of the Rapid Diagnostic Test for patient consultations, the distribution of Long-Lasting Impregnated Mosquito Nets in which the Hospital "Nôtre Dame des Apôtres" participated with the statistics of 1,459 bales in 2016 and 1,272 bales in 2019, and the institution of Seasonal Malaria Chemoprevention campaigns through the intermittent administration (August, September and October) of a complete treatment of a combination of two antimalarial drugs, Sulfadoxine-Pyrimetamine and Amodiaquine (SP/AQ)

The overall objective of the postnatal consultation is to reduce malaria-related morbidity and mortality by 75% in children aged 3 to 59 months in the northern regions. Since 2016, Catholic Health Care Facilities have been taking part in this campaign, during which more than three thousand children per postnatal tour are eligible for the distribution of SP/AQ. This is what also helps reduce the number of cases among children under five, going from 66.53% to 42.13% between 2017 and 2019

Another significant cause of morbidity and mortality is AIDS. In Ngong, the nuns of the "Soeurs du Sacré Coeur de Jesus" congregation in collaboration with the hospital have worked in the care of people with HIV/AIDS. This action required raising awareness among the entire population before carrying out tests and giving antiretroviral (ARVs) as treatment to people with HIV/AIDS in 2010. In 2020, the Catholic Health Care Facilities also contribute to the management of HIV/AIDS by carrying out tests, distributing ARVs and providing psychosocial support to people affected according to the table below:

Table 1: Statistics on HIV/AIDS management by the Catholic Health Care Facilities between 2016 and 2019.

Years	Positive tests	ARV treatment (HNDA)	Deaths
2016	620	114	00
2017	292	100	00
2018	262	243	01
2019	264	328	00

Source: Results of field surveys by the Catholic Health Care Facilities **Design:** AA Doba.

The management of tuberculosis in the Catholic Health Care Facilities was effective with the implementation of implementation of the Primary Health Care Reorientation Policy and the health sector reform in Cameroon. Its treatment is based on the combination of four antibiotics including isoniazid, rifampicin, pyrazinamide and ethambutol every day for at least three to six months. One of the preventive measures against this disease is BCG (Bacilli Calmette Guérin) vaccination, particularly for young children and infants with severe forms of tuberculosis. The contribution of Catholic Health Care Facilities to management over the last four years has had a remarkable incidence, falling from 236 to 93 cured 38 between 2016 and 2019. In addition to tuberculosis, malnutrition is also a major cause of morbidity and mortality among populations in Benue.

The North Cameroon region records a rate of 5.8% of overall acute malnutrition, for a prevalence of 1.2%. The crude death rate is 0.74% per 10,000 per day among children under five. This situation is then due not only to insufficient access to drinking water in households (53.1%), but also to food insecurity (15.3%), of which 10.3% of households are affected. Between 2012 and 2015, a high rate of malnutrition cases was recorded within the Catholic Health Care Facilities ranging from 233 to 336 42. However, although these cases are high, the reality is that the prevalence of the death rate due to malnutrition in children under five years old increased from 3.5%, 2% to 1.6% between 2015, 2017, and 2019 43 This allows us to observe effective management and an improvement in malnutrition cases.

It is then recommended to have a diet based on flour products (80% corn and 20% soy) rich in minerals and vitamins, but also plumpy nuts, and nutritional milks for infants, particularly F75 and F100, allowing nutritional recovery of malnourished people thanks to their protein and nutrient content.

In addition to the curative care offered by the Catholic Health Care Facilities, we add health services offered by the "Josephine Rodolphi" Rehabilitation Center. The health action of the Missionaries of the Immaculate in Djalingo is based on a particular observation made on the difficult health situation of children living with a disability. In this sense, several objectives have been defined by the "Josephine Rodolphi" Rehabilitation Center for the care of People Living with a Disability. These are: to promote the prevention of all forms of motor disability, to work for rehabilitation and functional re-education, to manufacture prostheses and popularize equipment useful for the autonomy of people with a disability, to promote education, training and integration into school or socio-professional life of people with a disability.

The "Josephine Rodolphi" Rehabilitation Center offers several services including reception of patients, treatment (consultation, rehabilitation, re-education or physiotherapy), the manufacture/repair of prostheses and orthopedic devices and the regular monitoring of the disabled.

The "Josephine Rodolphi" Rehabilitation Center covers paralyzing disabilities (hemiplegia, paraplegia, quadriplegia, and Cerebral Palsy), impairments of impaired motor function (valgus knee, valgus knee, flat foot, club foot), cerebrovascular accidents (CVA), distortions, sprains, contractures, arthritis, sciatica, lower back pain, pneumotism, injection after-effects. In 2019, the statistics for the care of people living with a disability amounted to 161 people, 43 children, and 78 adults 170.

3. Discussion

Faced with various health problems, the populations of Benue have benefited from the medical contribution of the Catholic Church. In this sense, we want to discuss the scope, challenges and limitations of this health work undertaken. Three essential reasons justify the scope of the medical work of the Catholic Church in Benue. These are the qualities of communication, reception and care offered to the population.

Health communication can be understood as a way of informing the populations on health issues. Before the construction of the Health Facilities, during neighborhood animations, the method of the Research and Support Group for Peasant Animation was one of the most used communication methods. In 2020, this involves health communications aimed at informing or raising awareness among populations during the various campaigns as well as the use of posters.

Health communication in Benue also places particular emphasis on young people as a communication target. This then led to the establishment of the Education for Life and Love program in the Archdiocese of Garoua in 2003.

Its main objective is to educate young people aged ten (10) to thirty (30) about sexuality. This is to prevent early or unwanted pregnancies, abortions, prostitution and much more, the risks of contracting Sexually Transmitted Diseases (STDs), which constitute one of the serious health problems among young people. The quality of reception mainly includes the motivation of the staff and their availability. The populations generally justify their preference for Catholic Health Care Facilities because of the attention they receive. They report that these structures are characterized by their proper functioning and the good treatment of patients by health personnel. Regarding the quality of health care offered by Catholic Health Care Facilities, the populations take into account the quantity of resources available to them, whether in medicines or other resources.

Although medicines and care are considered a little more expensive. That in the Public Health Facilities it remains that the Catholic Health Care Facilities offer better quality and more effective medicines than those sold on the street. Also, several issues (religious, socio-economic and medical) are to be noted in the health work undertaken by the Catholic Church in Benue. On the religious level, it has been noted that the Catholic Health Care Facilities are places of propaganda of the Catholic Christian faith (through the images and statutes of Mary and Jesus), and the promotion of the virtues of Christianity. Also, a session of prayer and meditation of the Holy Scriptures is held collectively at the beginning of the day with the staff, as well as with those who are there (Patients and their relatives). It is thus appropriate to say that the so-called charitable work of the Catholic Church in any country whatsoever would be reduced to the consolidation of its evangelizing mission on the idle populations.

This is also justified by the financial spring. If initially, the mission's health action served as a maneuver for the colonial power in the exploitation of local populations, it is important to specify in the second instance that this health action presents in the aftermath of independence a strategy and a means of generating financial resources to increase and extend the local missionary work in Benue. Because regardless of the reality, the mission has a social doctrine for which it must do everything possible to achieve it. On the

medical level, the health action undertaken by the Catholic Church in Benue gave precedence to modern medicine over African or "traditional" medicine. For a long time, the latter was essential to protect local populations against diseases.
Considered as cultural and historical riches of the local populations of Benue, the therapeutic techniques of the local pharmacopoeia are increasingly less used. We then note that the place of the pharmacopoeia is at risk. However, modern and traditional medicine should complement each other. Also, the medical work of the Catholic Church in Benue is not without limits. As for the limits to the medical work undertaken by the Catholic Church in Benue, we can note various shortcomings related to finances, human and material resources. The provision of health care by the Catholic Church to the populations of Benue.
This funding based on project subsidies from donors is becoming scarce [52]. Everything that came from outside is becoming scarce, and is even disappearing completely. One of the main causes of the scarcity of funding is the rise of a new generation of young people who believe that Christianity is there to put people to sleep. The problems related to human resources primarily concern the insufficiency of healthcare staff, particularly at the Catholic Health Care facilities of Pitoa and Touroua. This means that staffs are forced to work 24 hours after two days off. Increasing the number of staff will then facilitate and make the work easier. In addition to the limitations in human resources, those of material resources must also be noted.
Material resources allow us to discuss the infrastructural and technical aspect. This includes, among other things, an increase in infrastructure and services (medical imaging for health centers). Also, we can mention a certain number of equipment that is often insufficient in the Catholic Health Care facilities of Benue. These are: hospital beds (as well as sheets), examination tables, medical cabinets, wheelchairs, general surgery kits, malnutrition program supplies. Despite the particular interest shown by the populations of Benue in the Catholic denominational health offer, the mission and even more so its Health Facilities encounter enormous difficulties in implementing their vision of pastoral health care. This allows us to record a decreasing percentage of attraction going from 68% to 65% between 2015 and 2019.

Conclusion

This study aimed to reveal the contribution of the Catholic Church in addressing the health problems of local populations in Benue between 1956 and 2020. The implementation of a dual approach (qualitative and quantitative), data from surveys of resource persons and the population, written, documentary and archival data made it possible to obtain convincing results. The medical work undertaken by the Catholic Church in Benue is fundamental in the process of establishing the said Church in this part of the country and is gradually increasing. The Christian ideology on the healing of men, the worrying epidemiological profile of the local populations and the inadequacy of state health action constituted the motives for its medical intervention. All the preventive and curative care offered holds a prominent place among the populations.
This shows that this denominational health sector was then opportunely established as an essential alternative to compensate for the inadequacies of the public sector healthcare provision. Beyond the fact that it served the colonial administration, the said work proved to be an issue on the religious, socio-economic and even medical levels. Despite the limits due to financial, human and material resources, the medical work undertaken by the Catholic Church in Benue has the challenge of improving the management of the health problems of the populations and making healthcare more accessible to them. It therefore wishes to establish Health Facilities in each parish in order to achieve the objectives related to pastoral health care defined by the said Church.

References

1. A.A. Doba, D. A., 2020, « L'œuvre médicale de l'Église catholique dans la Bénoué de 1956 à 2020 », Mémoire de Master en Histoire, Université de Ngaoundéré.
2. Bouron, J. M., « Le paradigme médical en milieu catholique : offre sanitaire missionnaire et demande de santé en Haute-Volta (actuel Burkina Faso) », *Histoire et missions chrétiennes,* Vol 1, n° 21, pp.103-136.
3. Deussom Noubissié, G., 2005, « Catholicisme, forces politiques au Nord-Cameroun : instruments de transformation sociale de l'origine au XXe siècle », Thèse de Doctorat en Histoire, Université de Ngaoundéré.
4. Elikia M'bokolo, 1978, *Des missionnaires aux explorateurs, les européens en Afrique*, vol 7, Paris Coll. « ABC ».
5. Fadibo, P., 2006, « Les épidémies dans l'Extrême-Nord du Cameroun : XIXe-XXe siècle », Thèse de Doctorat en Histoire, Université de Ngaoundéré.
6. Fongang, L-S., 2010, « L'évolution des politiques sanitaires au Cameroun (1920-2000) » in le paludisme médical en Afrique, Colloque International de Yaoundé, PUCAC-Karthala.
7. Gruénais, M. E., 2004, « Les qualités de l'offre de soins confessionnelle en Afrique subsaharienne », Presses de Sciences Politiques, n° 29, pp.29-46.
8. Itina, F., 2017, « La prévention des maladies endémiques et épidémiques à Lagdo : cas de la méningite bactérienne, de la fièvre typhoïde et du choléra de 1979 à 2016 », Mémoire de Master en Histoire, Université de Maroua.
9. Médard, J. F., 2001, « Décentralisation du système de santé publique et ressources humaines au Cameroun », Bulletin de l'APAD, pp.1-25.
10. Plumey, Y., 1990, Mission Tchad-Cameroun. L'annonce de l'évangile au Nord Cameroun et au Mayo-Kébbi, 1946-1986, Trinita, Editions Oblates.
11. Pontabry et Weber, 1970, « Contribution à l'étude des problèmes de la santé au Nord Cameroun », Grenoble, Université de Grenoble II, IREP.
12. Siaka Keita, 2008, « Évaluation de la qualité des consultations prénatales dans le centre de santé de référence de Kita », Thèse de Doctorat en Médecine, Université de Bamako.
13. Todou Avaika, R., 2018, « L'identité ethnique et le vivre ensemble à Garoua entre 1924 et 2017 », Mémoire de Master en Histoire, Université de Ngaoundéré.
14. MSP-OMS, 2019, Rapport de suivi des 100 indicateurs clés de santé au Cameroun en 2019, Yaoundé.
15. Annuaire statistique du Cameroun, édition 2016, Institut National de la Statistique. https://www.google.com/url?q=http://slmp-550-104, consulté le 18 mars 2020.