The Dictatorship of Biomedicine in Equatorial Guinea

Carolina Nvé Díaz San Francisco

Abstract

This paper offers a critique to the present-day biomedical health care system in Equatorial Guinea. It argues that biomedical care represents a failure to meet its people's needs. A preliminary research study and the collection of published work and data drawn from observations during 2017 and 2018 concluded that the current Equatoguinean dictatorship has negatively influenced the development and success of biomedicine as a model of equitable and accessible medicine, and quality health care for all. Despite the investments of global health organizations and the government's commitments, the rates of maternal, child, and infant mortality remain high while the prevalence of endemic and epidemic diseases, such as malaria and HIV/AIDS, continues to rise. In addition, biomedical infrastructures lack committed and caring medical personnel, efficient technological environments, accessible and affordable health care programs, and awareness campaigns that reach out to the population. This paper highlights the reasons why biomedical care in Equatorial Guinea fails to meet its people's needs. Biomedicine was rooted and developed within a social, political, and economic terrain dominated by colonialism and two consecutive dictatorships. All of the institutional mechanisms that sustain the country are controlled by the head of state. Under the reigns of the head of state, international agencies and non-independent medical institutions lead the practice and development of biomedical care. There is real lack of incentive for Equatoguineans to participate in educational and practical enterprises that may lead to a better understanding of the roles that biomedicine can play in daily life. Health care programs and awareness campaigns fail to reach the population due to a lack of full commitment to involve communities. Biomedical care in Equatorial Guinea constitutes a failure on the part of international agencies and non-independent

medical institutions to meet people's needs, due, first and foremost, to the marginalization of the civil society and other healing systems, as well as to unlawful tendencies to fulfill obligations, limited investment, control over non-independent institutional spheres, disparity in care, and medical and educational maldistribution. This paper intends to foment further investigation into the social, economic, and political contexts of the diseases, endemic illnesses, and epidemics that are currently impacting bodies in Equatorial Guinea. This paper encourages further inquiry into the ways in which learning about perceptions, healthcare-seeking trajectories, and health care systems can support solving health and healthcare problems. The goal is to open debate over possible ways in which medical anthropologists can support rising mechanisms for quality health care, inclusivity, community, and freedom of expression.

Introduction

This paper offers a critique to the present-day practice of biomedicine in Equatorial Guinea. Biomedical care in the country fails to meet its people's needs. The rates of maternal, child, and infant mortality remain high while endemic and epidemic diseases such as malaria and HIV/AIDS continue to rise. Biomedical care, or the orthodox, biological knowledge and practice that has Western roots and foundations in universalism, reductionism, and modeling, arrived in Equatorial Guinea in the late 1800s through Spanish colonization. Biomedicine, a science dependent on capital, research, and technological investment, is globally present, variable, and also regionally and transnationally malleable according to economic and political localities, governmental institutions, laws, and regulations.[1] In Equatorial Guinea, the practice of biomedicine is not a tool to improve people's lives, but rather a stagnant medium at the service of a dictatorship. The socio-economic and political conditions that mold biomedical health care systems and modern clinical enterprises in Equatorial Guinea have endorsed futile functionalities to one of the longest dictatorship regimes that remain in Africa today.[2]

The year 2018 culminated and coincided with the 50th anniversary of Equatorial Guinea's independence from Spain in 1968. The year also commemorates 39 years of the second dictatorship that ruled the country, led by Teodoro Obiang Nguema, the

self-proclaimed head of state since 1979.[3] This collection of published work and data drawn from interviews and observations from one year of fieldwork between 2017 and 2018 suggests that the current Equatoguinean dictatorship has negatively influenced the development and success of biomedicine as a model of equitable and accessible medicine and quality health care for all.[4]

Perspectives of critical medical anthropology support equitable care access to health care worldwide and argue that socio-cultural and economic constructions of systems of care are potential contributors to social suffering. Critical medical anthropology and scrutiny base this argument on the idea of structural and institutional violence, or, in other words, sustainable webs of bio-social, political and economic contexts, and scientific knowledge and practice can be maneuvered to suit power and political ownership over bodies.[5] The governance in Equatorial Guinea is an example of structural and institutional violence. The head of state has overtaken the entire system of governance, and that includes the executive, legislative, and judiciary powers. This means that the head of state has control over infrastructure, contracts, sponsorships, biomedical and pharmaceutical businesses, health care projects implemented in the country, and the research and intellectual property related to biomedical spheres. The position of the head of state represents a source of social oppression.

This paper explains the relationships that coexist between the role of the head of state, biomedicine, and social oppression in Equatorial Guinea. The aim is to highlight the socio-historical relations between biomedical networks and political systems that are not fully democratic to support the argument that biomedical care and the dictatorial regime in Equatorial Guinea function altogether to diminish health, opportunity, and freedom. The goal is to introduce Equatorial Guinea's biomedical health care systems and socio-political spheres, and inspire open debate over possible ways in which medical anthropologists can support rising mechanisms for change and innovation.

The Perfect Breeding: Colonial Legacies

Biomedicine found in colonialism a medium to maneuver its way into African countries.[6] In Equatorial Guinea, biomedicine was born out of Spanish colonial interests that sought protection from

new biological challenges. The persistence to control every impact that tropical environments had upon Western bodies turned out to be relatively successful. Conveniently, the favorable outcome of biomedicine in the tropics opened the door to colonial hegemonies, or dominances over a group or population of people. Biomedicine grew hand in hand with the progressive colonial invasion of Bioko Island, Annobón, Corisco, and Rio Muni in Equatorial Guinea, and most especially of the urban areas. From the late 1800s, the Spanish governance in Equatorial Guinea implemented medical expeditions, established health care protocols, and urban hospitals and clinics as part of a health care model managed by colonial officials, white medical doctors, and religious missionaries, and ultimately directed to white and black bodies. Biomedicine in Equatorial Guinea is rooted within a context of domination not only over bodies, but also over systems of beliefs, performances, language, lands and territories.[7]

After the independents' movements and international pressure, Equatorial Guinea gained independence from Spain in 1968. In that same year, civil servant Francisco Macías Nguema won the first and only democratic election that has ever been held in the country at the national level. By Macías' standards, biomedicine represented all of the dangers of the Western world: domination and repression. Macías undertook as his personal project to eliminate the presence of the Spanish population. With a few supporters by his side, who would later become involved in a series of tragic accusations of treason and death, the new president expelled Spanish communities, renamed towns and cities to indigenous names, and left biomedical care institutions to perish. Francisco Macías Nguema initiated a morbid decline of the economic, social, and moral sustainability of the country. His rule lasted 11 years.[8]

In 1979, Francisco Macías Nguema's nephew, Teodoro Obiang Nguema became president by violent means. He ordered the assassination of his uncle Macías. By that time, many residents in Equatorial Guinea had died, migrated, or tragically survived in the midst of poverty and fear. During an initial phase that seemed to be openly democratic, and economically and socially invested, the new government handed the organization of modern biomedical health care to international medical and religious agencies, external actors that would assume their leading role in the medical

sciences fervently.[9] The institutional restoration of biomedical health care under the oversight of the governmental chair and his close allies meant that an exclusive group of individuals from the same ethnic (the Fang) and family group had legitimate rights to rule over the country. By the mid-1990s, oil was discovered in Equatorial Guinea. The beginning of oil exploitation, mercantilism, and international contracts was massive enough to reinforce the inheritance of power gathering by a single family in the entire country. Although the availability of natural resources and economic revenues have significantly declined in recent years, the head of state continues to control the oil exploitation, turning any sort of profit not available to the rest of the population.[10] The participation, investment, and initiatives related to the biomedical re-launch left other social spheres in the country forcibly at the margins. The general marginalization to participate in national interests linked to the re-enforcement of modern medicine also affected other medical systems, such as practices of traditional medicine, home-based midwives, healing religious pastors, and Chinese medicine. These other forms of curing and healing did not receive the same national and international boost or attention that biomedical care had. The new and emerging biomedical care programs did not consider, as part of the health care agenda, diverse perceptions on the body, illness and healing, as well as alternative health care seeking behaviors and therapeutic trajectories. Biomedicine officially became the hegemonic health care system in place.[11]

Present-day biomedicine in Equatorial Guinea can be visually and spatially perceptible at the infrastructural level. Biomedicine is represented by the Ministry of Health and Welfare, the Ministry of Labor and Social Security (INSESO), regional and public hospitals, and private hospitals and clinics such as La Paz and the INSESO hospital, which are exclusive health care centers for those who have social security and medical coverage. Other biomedical installations include privately owned clinics and pharmacies, one medical school, and national and international non-governmental organizations (NGOs). These institutional infrastructures are mainly located in the cities of Malabo and Bata. In the rural areas, small medical posts have been installed through diverse Spanish NGOs, although they are currently not being utilized due to the lack of investment required to maintain them.

At the operational and administrative levels, existing national laws, inherited from the Spanish Constitution in 1968 and a succession of protocols outlined throughout the history of the country, regulate biomedical education and practice. However, present-day biomedicine in Equatorial Guinea is mainly regulated and supported by the government. All medical sectors, except private businesses that struggle to survive, are publicly or state owned. Non-state-owned, or private, companies and other international agencies utilize their own resources to sustain their own biomedical infrastructure and practice. However, their involvement in biomedical care is mostly related to the dependency of a business-like relationship with the head of state. In this manner, the biomedical health care systems in Equatorial Guinea can be presented as a health care market owned by the government and compensating international medical corporations.[12]

An array of performances has been implemented as a result of business-like and transnational convergences on biomedical care. First, the established biomedical health care systems have been able to produce public reports about the most challenging diseases that affect people in Equatorial Guinea. This effort has been effected through exhaustive research sustained by international agencies and governmental cooperation. Since the last decades, external aid, and more recently, the National Institute of Statistics have published numerous health reports, statistics, and demographic censuses dedicated to target needs and action.[13] Although these nationally and internationally produced statistics have delivered unfinished and low-quality reports,[14] they confirm that a few more challenges remain toward creating a sustainable medical health care system for all. The existence of multiple health care programs and campaigns implemented in Equatorial Guinea have not eradicated prevalent diseases such as HIV/AIDS and malaria, nor have they provided significant and beneficial advancement in the understanding of cancer and mental health care, or care toward women, pregnant women, infants, children, and the elderly.

The Numbers Tell It: Prevalence and Rising Rates

National initiatives aided by international agencies to fight against the epidemic of HIV/AIDS aim to provide free distribution of

condoms to the sexually active population, free testing, counseling, anti-retroviral treatment, and continuous development of information and awareness conferences and campaigns. Some of these initiatives include a straightforward set of laws and regulations,[15] health care reports,[16] and programs such as the National Primary Health Care to provide 100% financing to individuals with HIV/AIDS, the National Committee/National Program for the Prevention and Fight against HIV/AIDS, the National Reproductive Health Program, the Program for the Prevention of the Transmission of HIV/AIDS from Mother to Child, and the implementation of the 2009-2010 Emergency Plan.[17] Nationally produced and internationally divulged statistics report, however, that from the 1990s to 2015, the epidemic of HIV/AIDS continued to rise as the main cause of morbidity and mortality in Equatorial Guinea. The data currently available shows extremely high infection and prevalence rates: from 3.5% in 1997 to 7.2% in 2001. In 2005, about 11,000 individuals were registered as infected. The HIV/AIDS epidemic accounted for 85% of all the medical consultations registered in 2005.[18] The results of the HIV tests in the country carried out between 2012 and 2016 in a private clinic confirm the increase of the infection. In 2012, 311 people were examined and 31 (9.96%) tested positive. In 2013, 393 individuals were evaluated and 33 (8.4%) tested positive. In 2014, 400 individuals were evaluated and 42 (10.5%) were positive. In 2016, there was a slight decrease: tests were carried out on 280 individuals and 18 (6.4%) were positive.[19] In the entire country, about 35,000 individuals were counted as infected in 2016, and 53,000 adults and minors in 2017.[20] In addition, tuberculosis (TB) co-infections and cases of co-infection with HIV have increased. The annual percentage rate of detection of cases of HIV/TB was 37.2% in 2016.[21]

Equatorial Guinea participated in the United Nations Millennium Summit held in New York in September 2000. Equatorial Guinea committed to The Millennium Development Goals, which include improving maternal health, reducing infant mortality, and combating malaria and other prevalent illnesses.[22] The country created the Primary Health Care system in 2014 to also provide 100% financing to pregnant women and to infants and children, and agreed to adopt measures to reduce maternal and infant mortality rates and ensure that public hospitals and other health centers provide affordable and accessible maternal and

child health care services.[23] However, mortality rates in Equatorial Guinea represent one of the highest ratios of maternal mortality in Africa.[24] The rates of maternal mortality descended slowly during 2015 through 2018 and have remained high. In 2015, the maternal mortality rates were recorded as 352 deaths per 100,000 live births.[25] In 2018, the maternal mortality rates were recorded as 324 deaths per 100,000 live births, and the prevalence of risk factors especially affect pregnant women between 15 and 19 years of age, a sector that represents 29% of the population in 2018.[26]

The government has committed to protect infants and children. The Expanded Program of Vaccination (PAV) was established in Equatorial Guinea in 1983. This program represented an approach required and stipulated by WHO (World Health Organization) in cooperation with The United Nations Children's Fund (UNICEF) in the launch and maintenance of the vaccination campaign for all children from birth to five years old, pregnant women, and others of childbearing age through the ACD Strategy (Achieving Each District). However, the mortality rates of infants and children under five years of age during 2015 and 2016 remained high.[27] The data pointed out that the mortality rates of children under five years of age were registered as 94 deaths per 1,000 live births in 2015, and 91 for every 1,000 live births in 2017.[28] In addition, free access is often a fallacy, thus causing low vaccine coverage. In 1990, the country had the highest rates with respect to vaccine access, while in 2016, only 24% of the younger population received the full and recommended doses.[29]

The National Plan to Combat Malaria (PNLP) is also another example of the failure that biomedical care represents in Equatorial Guinea. The PNLP is a government project coordinated by the Ministry of Health and Welfare and funded by the Ministry of Mines, Industry, and Energy, as well as by companies established in the country, such as Marathon, Noble Energy, Atlantic Methanol and EGLNG.[30] Despite these huge investments, malaria remains prevalent. Free access to diagnosis and treatment in the field of outpatient care is only available on the island of Bioko, where the prevalence is low (8%), while prevalence in the continental area remains high (46%).[31]Another example of biomedical failure is the Cervical Cancer Screening and Treatment Project of Equatorial Guinea (EG-CCST) carried out by international medical organizations. These agencies performed breast, cervical,

and prostate cancer tests in 2014. There is no reported continuity of cancer care or monitoring or surveillance plans other than limited cervical screenings implemented and administered by international organizations. Cancer care is not generally available at the primary or secondary public or private health care levels, and deaths still occur since there is no chemotherapy or existing treatment programs in the country. Only individuals with means can travel abroad to receive treatment. Lastly, mental health care also represents a challenge for biomedicine. There is no legal legislation or protocols regarding mental health care and treatment in Equatorial Guinea. Although private institutions and NGOs assume key roles to protect those vulnerable to mental health illness, the lack of government action to implement care for the population blocks the development of independent initiatives.[32]

Paradoxes and Voices of Dissent

The preliminary review presented above offers insight into how the impact of diseases, endemic illnesses and epidemics on people in Equatorial Guinea, as well as a detailed process of the implementation and evaluation of global health programs and statistical standards, deserve more attention and further research. This preliminary review on the health care programs established in the country and the persistent prevalence and rise of diseases and mortality rates, however, bring forth additional insights. This is where paradoxes come into place: On one hand, the reports shown above demonstrate that standardized biomedical methods designed specifically to target diseases do fail despite considerable amounts of investment and resources. On the other hand, the voice of power in the country, or the head of state, claims that the government is implacably improving the health care system, and that for that reason, Equatorial Guinea is a progressive country and an example to other African countries.[33]

Voices of dissent, or expressions from individuals encountered during fieldwork,[34] question these programs as well as the government's active involvement and real commitment to fulfill all expectations that come from international and national demands and needs. Sectors of the population, and more especially the elders, express that the medical system was better during the colonies, "when we read newspapers, and wore ties."[35] There

exists a general discontent in the country with respect to health care institutions and programs. Narratives often refer to "everything needs to be done in this country," "nothing is being done in this country for us," and "women are abandoned."[36] The rural areas are the most impoverished, including the island of Annobón, and there exists yet an ordeal of "things that need to be done"[37] in the health care and social welfare fields and beyond. There is a nationwide deception that the impressive reputation that Equatorial Guinea seems to enjoy internationally, along with its economic status as the third largest producer of oil in Africa, do not peacefully correlate with the fact that more than half of the population still does not have access to clean water or electricity.[38]

The problem with the national and international health care programs, according to voices of dissent, is that biomedical health care programs do not reach all of the population. Most of the programs remain distant from the rest of the population in their everyday lives. The initiatives included in the reports are part of artificial programs and are façades of a corrupt government that only takes care of its own. Voices of dissent, or sectors of the population in Equatorial Guinea do not trust the head of the state, members of his family, and allies, suggest that all of the data presented in the reports are "lies."[39] Little is known about the origins of statistical data or how the reports are produced. National institutions, private companies, and international NGOs collect their own data separately. This is the case of regional and private hospitals and private companies. Because institutions collect their own data for their own means and with limited publicity, there is little public knowledge about the distribution and implementation of health care programs, their results and evaluations, and their collective coordination.

In reality, biomedical health care programs do not reach out to the population because most initiatives are non-existent, in process, or remain so centralized that they have a limited impact on the targeted population. Voices of dissent claim that health care programs supported by the government do not realize their full potential in part due to inefficient organization. Some families do not know about these programs. Biomedical health care programs have failed in their full implementation because they are not entirely socially focused. Initiatives on biomedical care do not include as a priority the commitment to learn about tackling

vulnerabilities, health care-seeking behaviors and perceptions, and other existing medical and healing systems. In this manner, deception and clear disappointment incite the belief that the government-financed health care programs represent mere patches that do not eradicate real problems from the roots. In the case of the rising epidemic of HIV/AIDS, there is no sexual education implemented in the national education system. The programs that target HIV/AIDS awareness do not focus on individuals of all ages and across the country. The topic of sex and sexually transmitted diseases is taboo among families and within public spaces like schools, leaving young people unaware of the disease and how it is contracted. The symptomatic effects of the HIV infection are believed to be a derivative action of witchcraft, or "something that someone gives to someone else."[40] Contradictions between the perceptions of the population and those of the biomedical programs are so widespread that raising awareness regarding other manifestations of infection, such as vertical transmission from mother to child and social stigma surrounding the disease remain great challenges to tackle.

Voices of dissent[41] question the advantages of biomedical health care programs. Even if these programs exist and are being implemented at regional hospitals and clinics, families, especially mothers and their children, have immediate problems with the accessibility to general care, prenatal, birth and postnatal care. The entire biomedical infrastructure does not support the community need for accessible health care. In addition, most biomedical infrastructures lack appropriate and efficient technological environments and are often not medically equipped to solve dilemmas of co-infections or surgical complications. What is more, health care programs need more professional health care providers and specialized personnel prepared to endorse those programs for care and trust, cooperation, and collaboration nationwide.

The Monopoly of Biomedicine: Unlawful, Neglectful, and Divisive

One of the fundamental reasons the investment in biomedical care has no influence on quality and accessible health care or social well-being is the violation of laws and commitments. Behind the international democratic façade, the head of state does not

respect constitutional policies, suggestions, or proposals to protect the right to quality health care for all people.[42] In addition, the national and public income derived from the exploitation of national resources, including oil, minerals, and wood, are directed and organized by the government, and decisions on investment in social needs have been nefarious. Under a culture with no inclination for social welfare, expenditure on security and personal profit surpasses all resources dedicated to the provision of biomedical health care.

The institutional framework in which the biomedical system functions in Equatorial Guinea does not have the independence to present incentives and coordinate action to support change and amendments. Civil servants, the executive, the judiciary, the legislature, security and police departments, and systems of health and education operate under the scrutiny of the head of state. Government officials and ministers are appointed not by merit, but by personal choice and affiliation to the only leading national political party. Most civil servants have rarely been educated to assume their high governance positions. Those who demonstrate opposition or disdain or express desire to improve policies and protocols are silenced, dismissed, or even marginalized to prevent them from seeking and obtaining future employment.[43]

The dynamics that disrespect the rule of law—and the rightful sharing of public funds and social investments as well as intellectual input—create disparity. This is reflected first in the distribution and geographical layout of biomedical care and delivery of social security. The Ministry of Health and Welfare dedicates a designation of investment to cover 100% of primary health care services, a program created in 2014 and implemented in regional and public hospitals in the main cities of Malabo and Bata.[44] The program finances checkups and treatments for pregnant women and for infants and children, and those living with HIV/AIDS, malaria, and tuberculosis (TB). However, the coverage fees are often misleading, because individuals still receive charges at public hospitals. Services that have user fees are often not provided many hospitals. The Ministry of Labor and Social Security (INSESO) covers medically only those who have been contributing fees, and it offers services at the two INSESO hospitals located in Malabo and Bata. Those in informal employment, or not employed through legal contracts, represent more than half

of the population, and they do not have social security. The most vulnerable, including migrants, persons with disabilities, individuals in detention facilities, and orphans are also on the margins of medical care.

Disparity is also reflected in the distribution of medical care through so-called private hospitals dedicated to those who are or have been employed in the formal sector through legal contracts, and to those who can afford to pay user fees and medical costs. Private hospitals are in better condition than public ones—with specialized personnel, superior venues and technological resources—because they receive better investment. Challenges also escalate when there is a need for referrals between public and private hospitals. Referrals to perform additional services such as X-rays, or assistance from specialist doctors, are only found at private hospitals. These high-profile centers contain their own medical supplies, distributed by centralized systems. These sites have protocols, and they maintain a full regime of vaccines and anti-retroviral medication, forcing individuals to travel to the main cities—if they have the means to afford the journey as well as the treatment.

Marginalization, Repression, and Violence toward the Civil Society

Not all sectors of the community, that is, civil society, unions, political parties, associations and national independent groups and NGOs, participate in public-national decisions. Although the constitution and the law allow and encourage free association and freedom of political participation, the civil society is non-existent in the public and global spheres.[45] This section of the population is not integrated at the social, economic, and political levels. Members of civil society believe that the power of biomedicine fails because it excludes an integral part of the population in decision-making and community outreach.

Doctors, medical personnel, administrators, and civil employees express, in their words, that they "have their hands tied."[46] Their work has been already stipulated, and they are unable to offer suggestions or apply changes. Some Equatoguinean doctors, on their return from studying abroad, arrive with enough motivation to improve the biomedical system. This was the case

of one doctor who requested medical certification from other practicing doctors at a regional hospital. This doctor was fired. Another doctor suggested HIV/AIDS screenings at birth among infants instead of waiting six months. Most medical personnel who complain decide to direct their doubts and suggestions to the Ministry of Health and Welfare; however, their voices go unheard. During situations in which patients and their families cannot pay user fees, sometimes doctors pay for them. These doctors claim there is need for better coordination and cooperation between medical and social services supposedly mediated by the Ministry of Gender and Social Services. Attention to the population with respect to social and individual needs can positively impact health care outcomes; however, this integration is not a priority in the biomedical care agenda. Children and women arrive when it is too late at hospitals. Members of civil society believe in the need to train and integrate diversity in personnel to fully understand needs and the health care trajectories of the population, and ultimately to involve other medical systems, in view of the multiple existing diagnoses and systems of beliefs with regards to origins of illnesses and healing methods.

Individuals and communities that are part of NGO personnel and health care organizations also find their inclusion in biomedical decision-making rather limited. The international organization UNICEF has managed to integrate groups of the community to fight HIV/AIDS through multiple programs and awareness campaigns to stimulate and educate the youth. However, efforts are also limited. A local theater company successfully launched an awareness-raising campaign in 2016 in collaboration with an NGO. The group carried out art performances as scheduled prior to having their activities suspended by the government. Actors were harassed and threatened by security forces because they thought their program was politically engaged.

Local and national NGOs have difficulties in obtaining recognition and registering officially as independent organizations. One NGO, for example, struggles to implement alternative community healing into their programs. Their goal is the implementation of mental health care legislation and protocols of care. The NGO asserts that care in biomedical spaces over-medicalizes, injures both the body and mind during hospitalization, and limits the inclusion of family and community as effective healing methods.

Hospitals have a shortage of professionals that "understand the culture,"[47] and they lack the means to coordinate efforts with the entire web of biomedical institutions in order to protect abandoned and homeless individuals. This NGO, in particular, fights to obtain the government's attention to have their organization legally registered and receive support; however, their interaction in biomedical spheres, controlled by the head of state, is minimal. While this NGO remains marginalized, one psychiatric hospital has been erected with government resources, yet challenges remain for this site and local NGOs. For example, follow-ups continue to be inconclusive because care is not being distributed evenly across the country.

Civil society has no free access to public media. Television and radio are privately owned by the head of state. A group of religious leaders that wanted to promote awareness on the prevention of HIV/AIDS in young people through a religiously oriented show were banned despite their contract because their initiative was thought to be critical and political. An educator claims the government "does not allow them to do their job"[48] as navigators and mediators of social perceptions and practices related to illness and health care. The use of national capital and resources by independent initiatives in ways that can benefit all, biomedical care included, is not pluralistic. The freedom of expression to reveal afflictions, needs, and challenges is non-existent in Equatorial Guinea. On the contrary, attempts made by the civil society to exert their rights have met suppression, repression, incarceration, and torture. There are few national NGOs legally operating in the country. One NGO that defends human rights was suspended by the Ministry of the Interior in 2016, accused of making comments likely to revolutionize the youth.[49] Political parties from the opposition do not participate freely in national elections, and most have been shut down. Journalists and practicing lawyers cannot freely and ethically practice their professions. The reality of censorship in Equatorial Guinea does not guarantee the protection of human rights. In a country where arbitrary detention, violence, and torture of political prisoners correspond to normality, and where social and political movements generate repression and fear, social well-being, health, opportunity, and freedom cannot emerge.

From Critical to Applied Medical Anthropology

This paper highlights the reasons why biomedical care is a failure in the eyes of the people of Equatorial Guinea. Biomedicine was rooted and developed within a social, political, and economic terrain dominated by colonialism and two consecutive dictatorships. Present-day biomedicine in Equatorial Guinea fails all people due to the democratic façade that the head of state constantly attempts to reflect from national to international platforms since 1979, and through multiple agreements, programs, and commitments. In reality, and under the reign of the head of state, only international agencies and non-independent medical institutions lead the practice and development of biomedical care. There is a real lack of incentive given to Equatoguineans and residents to participate in educational and practical enterprises that may lead to a better understanding of the roles that biomedicine can play in daily life. Healthcare programs and awareness campaigns do not reach the population due to a lack of a full commitment to involve communities; unlawful tendencies; a disinterest in fulfilling agreements; limited investment in and control over non-independent institutional spheres; disparities in care, medical, and educational distribution; and, foremost, the marginalization of other care systems and of civil society.

This paper intends to foment further investigation on the social, economic, and political contexts of the diseases, endemic illnesses, and epidemics that are currently impacting individuals in Equatorial Guinea. The focus of future research can rely on the kind of power that generates social suffering,[50] and it can rely on how social inclusion, equitable distribution of resources, and the understanding of perceptions, health care-seeking trajectories, and health care systems can altogether support solving health care problems. What would be the best ways to understand social needs, well-being, and welfare? In what way can community involvement support an effective biomedical health care system, the implementation of sexual education, and good governance? What are the best ways to change and create policies and practices that promote healing to all people?

Notes

[1] Margaret M. Lock and Vinh-Kim Nguyen, *An Anthropology of Biomedicine*, 2nd ed., (Hoboken, New Jersey: Wiley Blackwell, 2018), 1-2.

[2] Benita Sampedro Vizcaya, "La Economía Política de la Sanidad Colonial en Guinea Ecuatorial," *ENDOXA: Series Filosóficas,* no. 37 (2016): 295.

[3] Max Liniger-Goumaz, "Guinea Ecuatorial. Diecisiete Años De La Segunda Dictadura Nguemista (1979-1996)," *Estudios de Asia y* África XXX1, no. 3 (1996): 646.

[4] Ilcheong Yi, Elizabeth Koechlein, and Armando de Negri Filho, "Introduction: The Universalization of Health Care in Emerging Economies," in *Towards Universal Health Care in Emerging Economies: Opportunities and Challenges*, ed. Ilcheong Yi (London: Palgrave Macmillan, 2017), 1-26.

[5] Merrill Singer, Nicola Bulled, Bayla Ostrach, and Emily Mendenhall, "Syndemics and the Biosocial Conception of Health," *The Lancet* 389, no. 10072 (2017): 941.

[6] Claire L. Wendland, *A Heart for the Work: Journeys through an African Medical School*, (London: University of Chicago Press, 2010), 39-45.

[7] Benita Sampedro Vizcaya, "Health, Raciality, and Modernity in Colonial Equatorial Guinea," in *Post/Colonialism and the Pursuit of Freedom in the Black Atlantic*, ed. Jerome C Branche (Routledge, 2018): 61-84.

[8] Olegario Negrín Fajardo, "Las Máximas Educativas de la Dictadura de Francisco Macías Nguema," in *Misceláneas Guineo Ecuatorianas I: del Estado Colonial al Estado Dictatorial*, ed. Max Liniger-Goumaz, (La Chaux, Switzerland: Editorial Tiempos Próximos, 2002), 87-100.

[9] Daniel Cobos Muñoz, "Descentralización de los Sistemas de Salud: Revisión Sistemática de la Literatura y Estudio de Caso en Guinea Ecuatorial" (PhD diss., Universidad Complutense de Madrid, 2015), 35-36.

[10] Alicia Campos Serrano, "Guinea Ecuatorial: ¿"Maldición de los Recursos" o "Extraversión" Histórica del Poder?" *Boletín Elcano, no. 121 (2010): 8.*

[11] Jones Alvar Sánchez, "Marcos Formales, Recorridos Informales: Las Lógicas del Consumo Terapéutico en Guinea Ecuatorial. Plan de estudios: el Mundo Hispánico: Patrimonio Intercultural" (PhD diss., Universidad de Castilla-La Mancha, 2016), 32-66.

[12] Carlota Mofuman Engama Obono, "Estudio de los Indicadores Sanitarios de Guinea Ecuatorial" (N.P. diss., Universidad de La Laguna, 2015), 1-13.

[13] "Publicaciones recientes," Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html. "Anuario Estadístico de Guinea Ecuatorial, 2017," Publicaciones, Instituto Nacional de Estadística de Guinea Ecuatorial, last modified June 10, 2018, http://www.inege.gq/index.php/publicaciones/.

[14] See existing incongruences in data about mortality rates among women and infants in reports 2005 through 2015. "Publicaciones recientes," Guinea

Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.

[15] For instance, Law No. 3/2005 and Decree No. 107 / 2006 on the prevention and fight against HIV/AIDS. "Legislación de Guinea Ecuatorial," Decretos y Leyes de Guinea Ecuatorial, WordPress, last modified June 20, 2018, https://leydeguinea.wordpress.com/2014/08/21/decretos-y-leyes-de-guinea-ecuatorial/.

[16] Women's Association in the Fight against HIV/AIDS and NGO AMUSIDA launched the national test for the HIV campaign in December 2014 with the slogan "I choose to know if I have HIV." The National Program to Fight HIV/AIDS is a new framework, or strategic plan for the 2014-2018 period, and implies universal access and equity, respect for human rights, logistics services based on the needs of people, decentralization of services, organization, participation and shared responsibility, and good governance. "República de Guinea Ecuatorial. Programa Nacional de Lucha Contra el Sida," GNQ Report 2014, UNAIDS, last modified May 15, 2018, http://www.unaids.org/sites/default/files/country/documents/GNQ_narrative_report_2014.pdf.

[17] "Publicaciones recientes," Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.

[18] "Country Fact Sheets. Equatorial Guinea, 2017," UNAIDS, last modified June 20, 2018, http://www.unaids.org/en/regionscountries/countries/equatorialguinea.

[19] Personal communication. Interviewee remains anonymous, Bata, July and November, 2018.

[20] "Informe Temático sobre el Objetivo de Desarrollo del Milenio Nº 6: 'Combatir el VIH/SIDA, el paludismo y otras enfermedades,' 19 de diciembre de 2014," Publicaciones recientes, Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.

[21] "Estrategia de Cooperación, Resumen," Guinea Ecuatorial, World Health Organization, last modified June 10, 2018, http://apps.who.int/iris/bitstream/handle/10665/137167/ccsbrief_gnq_es.pdf;jsessionid=E68C492A8609D514397022CD19C06F3F?sequence=1.

[22] "Millennium Summit (6-8 September 2000)," Conferences, Meetings and Events, United Nations, last modified May 15, 2018, http://www.un.org/en/events/pastevents/millennium_summit.shtml.

[23] "Review on 05 May 2014," Equatorial Guinea, UPR Process, UPR Info, last modified May 15, 2018, https://www.upr-info.org/en/review/Equatorial-Guinea/Session-19---April-2014.

[24] "Maternal mortality ratio (modeled estimate, per 100,000 live births)," Data, The World Bank, last modified June 10, 2018, https://data.worldbank.org/indicator/sh.sta.mmrt.

[25] "Publicaciones recientes," Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.
[26] "World Population Dashboard, Equatorial Guinea," Data, United Nations Popular Fund, last accessed May 15, 2018, https://www.unfpa.org/data/world-population/GQ.
[27] "Country Cooperation Strategy at a Glance," Equatorial Guinea, World Health Organization, last modified June 10, 2018, https://apps.who.int/iris/bitstream/handle/10665/137168/ccsbrief_gnq_en.pdf;jsessionid=C67DC074DC79B31BEF4ACF1C7EE88CFB?sequence=1 "Estrategia de Cooperación, Resumen," Guinea Ecuatorial, World Health Organization, last modified June 10, 2018, http://apps.who.int/iris/bitstream/handle/10665/137167/ccsbrief_gnq_es.pdf;jsessionid=E68C492A8609D514397022CD19C06F3F?sequence=1.
[28] "Country Profiles," Equatorial Guinea, Data by Topic and Country, UNICEF Data: Monitoring the situation of children and women, UNICEF, last accessed June 20, 2018, https://data.unicef.org/country/gnq/.
[29] "UNICEF Annual Report," Equatorial Guinea, UNICEF, last modified June 20, 2018. https://www.unicef.org/about/annualreport/files/Equatoria__Guinea_2017_COAR.pdf.
[30] "El Gobierno de Guinea Ecuatorial en la lucha contra el Paludismo," Noticias, PDGE, last modified June 20, 2018, https://www.pdge-guineaecuatorial.com/el-gobierno-de-guinea-ecuatorial-en-la-lucha-contra-el-paludismo/.
"Marco de Asistencia para el Desarrollo Del Sistema de Naciones Unidas de Guinea Ecuatorial 2013-2017," Ecuatorial Guinea, UNDAF 2013-2017, last modified May 15, 2018, https://www.unfpa.org/sites/default/files/portal-document/Equatorial%20Guinea_UNDAF%202013-2017.pdf.pdf. "Informe Temático sobre el Objetivo de Desarrollo del Milenio Nº 6: 'Combatir el VIH/SIDA, el paludismo y otras enfermedades,' 19 de diciembre de 2014," Publicaciones recientes, Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.
[31] "Consejo Económico y Social," Documento del Programa para el País, Guinea Ecuatorial, Naciones Unidas, https://www.unicef.org/about/execboard/files/2018-PL19-Equatorial_Guinea_CPD-ODS-ES.pdf.
[32] Interview with author, interviewee remain anonymous, Malabo, April, 2018.
[33] "Publicaciones recientes," Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.
[34] Fieldwork involved trajectories across healing spaces in the country and requesting interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[35] Interviews with elders. Interviewees remain anonymous, Bata, November, 2018.
[36] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.

[37] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[38] Hannah C. Appel, "Walls and White Elephants: Oil Extraction, Responsibility, and Infrastructural Violence in Equatorial Guinea," *Ethnography* 13, no. 4 (2012): 440-441.
[39] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[40] Interviews with author. Interviewees remain anonymous, Bata and Malabo, July and November, 2018.
[41] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[42] "Database of Recommendations," UPR Info's Database, UPR, last modified May 15, 2018, https://www.upr-info.org/database/index.php?limit=0&f_SUR=54&f_SMR=All&order=&orderDir=ASC&orderP=true&f_Issue=All&searchReco=&resultMax=300&response=&action_type=&session=&SuRRgrp=&SuROrg=&SMRRgrp=&SMROrg=&pledges=RecoOnly.
[43] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[44] "Publicaciones recientes," Guinea Ecuatorial, PNUD, last modified October 10, 2018, http://www.gq.undp.org/content/equatorial_guinea/es/home/library/mdg.html.
[45] The Constitution of Equatorial Guinea, in its article 13, letter k) stipulates that every Equatorial Guinean citizen has the right to free association, assembly and manifestation, and the right of association according to law 12/1992. "Cuestionario sobre Medidas de Libertad de Reunion," Documents, Issues, United Nations Human Rights, last modified June 20, 2018, https://www.ohchr.org/Documents/Issues/FAssociation/Responses2012/NGOs_and_other_stakeholders/Guinea_Ecuatorial-cooperacion_y_desarollo.pdf.
[46] Interviews with author. Interviewees remain anonymous, Bata and Malabo, April, 2017, and July and November, 2018.
[47] Interview with author. Interviewee remain anonymous, Malabo, July, 2018.
[48] Interview with author. Interviewee remain anonymous, Malabo, July, 2018.
[49] "Comunicado ante la suspensión de CEID por el Ministerio del Interior de Guinea Ecuatorial. CEIDGE," Sociedad, Asodegue, last modified July, 2018, http://www.asodeguesegundaetapa.org/comunicado-ante-la-suspension-de-ceid-por-el-ministerio-del-interior-de-guinea-ecuatorial-ceidge/.
[50] Donald Joralemon, *Exploring Medical Anthropology*, (New York: Routledge, 2010), 41-47.