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The ethics of the public Health System in Equatorial Guinea



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I. INTRODUCTION

Before I tackle the issue of choice here, allow me to brief on the cultural and social context of my country: Equatorial Guinea.

EQUATORIAL GUINEA

Equatorial Guinea lies in sub-Saharian Africa, west of Central Africa in the Gulf of Guinea, Atlantic Ocean. The country borders with the Federal Republic of Nigeria and Sao Tomé and Príncipe. It has a total surface area of 28.051 km², which encloses the following geographic regions:

- The *Continental Region,* that lies between Camerún and Gabón, has a surface area of 26.000 km². Within this region we find the Isles of Corisco (15 km²), Elobey Grande (2.27 km²) and Elobey Chico (0,19 km²), the latter two uninhabitable.

- The *Island Region*, that is composing of several islands: Bioko, Annobón, and nearby islets.

The Island of Bioko is volcanic in origin, which accounts for the extraordinary fertility of the lands here, and it is the largest of the islands in surface area: 2.017 km². It boasts the capital of the nation, Malabo and is 270 nautical miles off the Continental Region.

The Isle of Annobón, with a surface area of 17 km², lies south of the Republic of Sao Tomé and Príncipe. Being located at a distance of 600 miles from Malabo, easy access to hospitals in the region in the event of emergencies. is most difficult to gain. In addition, the rough orography of the island yields poor opportunities for agriculture and places the inhabitants in risk of malnutrition and famines.

Equatorial Guinea is *multi-ethnic and multi-cultural*. Within a population of 504.000 inhabitants and an estimated population of 1.318.008 in the next ten years, there are five major ethnic groups: the Fang, from inner Continental Region; the Bisio and the Ndowé, in the coastal strip; the Bubis, native inhabitants of the Island of Bioko; and the Annoboneese, native inhabitants of the Isle of Annobón.

Each of these ethnic groups has its own culture and tradition, to include a language, tribal dances and rites among other differences. In addition, there is a common trait to all the ethnic groups: the hispanic heritage, which serves as a link from which a sort of "national culture" stems.

Percentually speaking, the representation of the different ethnic groups in Equatorial Guinea provides the following picture: the Fang, totalling 82.9 % of the population, are the largest subgroup against the 17.1 % made up by the remaining four ethnic groups in the country. *This uneven distribution is most often a source of conflict in what regards cultural expression, discrimination and exclusion of minority ethnic groups.*

• The sources of income in Equatorial Guinea are:

Currently, the economy of Equatorial Guinea is almost exclusively grounded on the hydrocarbon extractive sector (oil, gas and methanol), which accounts for 94% of the GNP. It is the third oil-producing country in sub-Saharian Africa and first in the EMCCA (Economic and Monetarian Community of Central Africa).

- Agriculture: subsistence agriculture. The soil of the Island of Bioko is most fertile and has enough capacity to sustain the agricultural development requiered for food self-sufficiency. However, this natural asset is under-exploited. In addition, the forest-land is home to abundant fauna to secure a source of protein availability.

- Coffee and cocoa production has dropped. 2.900 tons/year of cocoa are currently being produced against the 50.000 tons produced back in 1968. This important decrease is owed to a lack of incentives for farmers but also because of the big drop in prices forced by the market policies of the North and the influence of the oil-producing sector on the economy.

- Fishing: Catches are currently estimated to be of 2.000 tons/year, despite the potential 30.000 tons that could be yielded without a negative impact on fisheries or rersources. Again, it is because the fisheries are in tthe hands of foreing companies of the Northt that resources do not reach the population. It follows that locals have to rely on subsistence fishing.

- Wood resources. The pace of deforestation within the national territory is but outrageous. There is no compliance whatsoever with minimum conservation standards as to natural resources is concerned. In year 1991 wood production represented 75% of the country´s gross export goods, ranking second after hydrocarbons.

- Oil, our first source of income, attracts labor-force from every corner of the country. More than a million barrels are extracted daily in the island region (one barrel per person and day). The spectacular benefits yielded by the hydrocarbon sector only serves to blind the falling of what used to be the country´s pride export: wood, coffee and cocoa. Hence, our economy has moved from the "okume"cycle to the "black gold" cycle (1).

Our country still depends heavily on food imports to supplement our deficient domestic production, due to the abandonment of farming practices but also because of lack of political vision in what regards re-investing oil turn-over into the revitalization of agriculture and fishing sectors as potential national sources of income.

• A few data on the Human Development Index in Equatorial Guinea

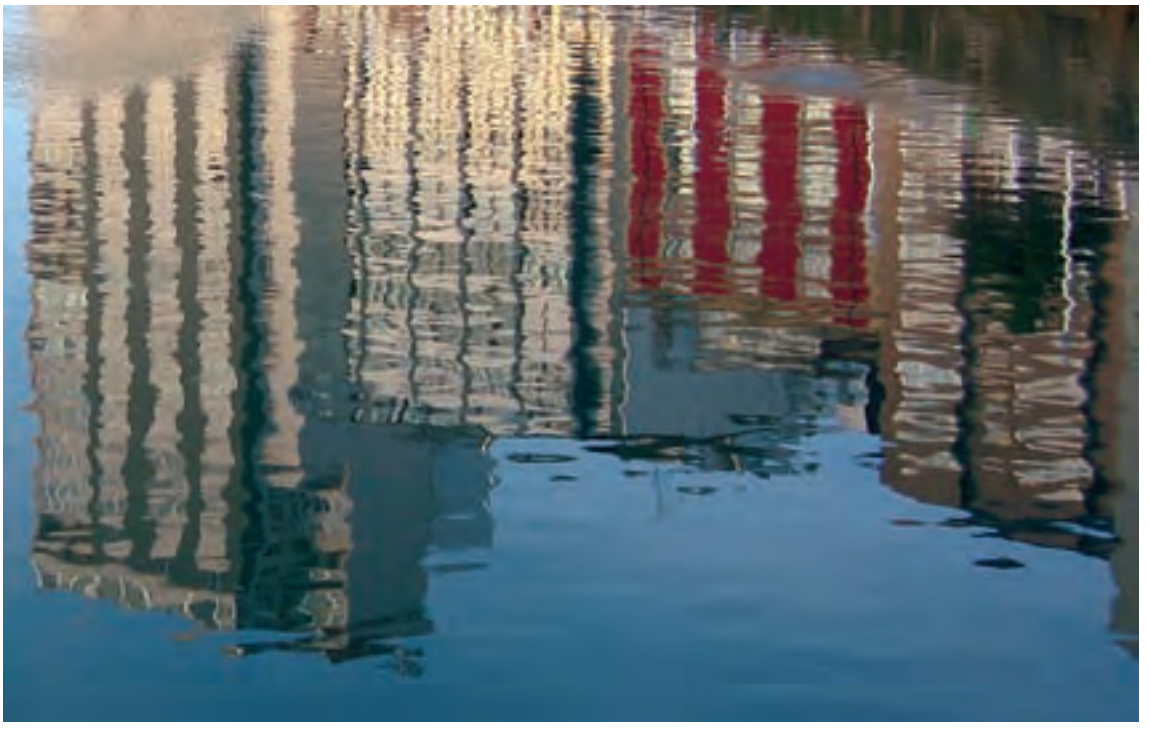
- Total GNP per capita has grown from 700 dollar in 1992 to current 16.742 (in dollar million) , with an annual growth rate of 34.2% (2). Inflation went up from 3,1% to 8,8%, in the mean time (3). A direct consequence of it was a reduction in purchasing power for the population, most particularly for the poorer segments of society. This rate of economic growth is on account of the oil industry, namely in the hands of US companies, and has placed Equatorial Guinea within the group of medium income countries.

This rapid growth in our economy has not traslated into a reduction of poverty. About 70% of the population are living below the threshold of poverty, that is to say, on an income that equals to 1 dollar per individual and day. On the other hand, 5% of the population hold control over 80% of the country´s riches while the remaining 25% are living in extreme poverty conditions.

- Equatorial Guinea is in the group of countries with food deficit. This assert comes confirmed by the surveys conducted by UNICEF, OCEAC, 1992/1993, according to which only 10% of the population actually succeeed in covering their daily needs of calorie and protein intake. Hence, it is a fact that the country is dangerously exposed to food shortages and the subsequent risk of food-related diseases associated to malnutrition, most often inflicting children and pregnant mothers.

- The rate of literacy is 83.2% (illiteracy in women is of 73% and in men 44.9%.)

- Population without access to drinking water: 56%. Equatorial Guinea is a country with a high pluviosity, which accouts for



Reflection on the water

sweet water availability all the year round. However, the infrastructure required to contain, store and channel water resources and to secure water quality and safety is almost non-existent. Over 60% of hospitals and health care centers do not have running water.

- Population enjoying adequate sanitation systems: 53%

II. THE ETHICS OF THE NATIONAL HEALTH SYSTEM IN EQUATORIAL GUINEA

Under the classic standards of moral thinking it is said that Ethics will deal with human happiness, a condition that is to be made accessible to man and that is for man to enjoy and exercise. Aristotle said the aim of Ethics is not that of learning what it is being good, but rather to be good.

Following the argument above and knowing that *health deontology* from the ethics standpoint is but a theory of professional duties, let us see how this realizes in the national health system of Equatorial Guinea.

1. Health state of the population in Equatorial Guinea

The population of Equatorial Guinea are living under most precarious conditions in what regards health standards, which accounts for the human development data presented elsewhere above.

- The child mortality rate is 97/1000 infants born alive. The maternal mortality rate is 352/100.000 infants born alive (4).
- Corrected life expectancy for disability is 44,1 years. This means that mortality and, consequently, morbidity is high for children and young adults. Life expectancy at birth is 43.5 years.
-12.000 children die before reaching the age of five.
- One year-olds fully vaccinated against TB total 48% and vaccination against measles totals 24%.
- The population with access to essential drugs and medicines totals 49%.
- Infectious diseases account for over 85% of medical consultation:

• *Malaria* is the major endemic disease and accounts for 61% of medical visits and for 37,5% of mortality.

• *Acute respiratory infections (ARI) rank* as second cause in mortality-related casuistics.

• *Diarrhoea* and related problems account for 15,9% of deaths.

• *HIV-infection* prevalence rate is estimated to be 7,2% in the age group

ranging between 15-49 (5). The speed at which the disease will progress might be dramatically high in the next few years given the sexual precocity, prostitution... in a context of alarmingly low levels of health education.

- The number of *TB cases* recorded in the last five years has increased in two fold, going from 305 cases in 1995 to 591 cases in year 2000 (127 per 100.000 inhabitants). The propagation of HIV across the country is a an aggravating factor to account for that.
- *Oncocerciasis* (river blindness) has a prevalence rate of 75% on the Island of Bioko and a rate of 20% in the continental region.
- *Trypanosomiasis* bouts are most often observed in the continental region.
- *Measles* epidemics come and go. The last one was in 2001. Vaccine coverage for diseases under the PVA Programme varies: 19% for measles; 34% for BCG; 32% for DTP3 and 40% for poliomyielitis (6).

- Non transmittable diseases are namely associated to *malnutrition*, a problem affecting 18% of infants and children. About 40% of children under the age of five suffer from severe malnutrition.

Likewise, *alcohol* abuse is becoming an alarmingly serious health and social problem; the same could be said about the increasing use of *hallucinogenic plants* often associated to certain spiritualist ceremonies ans rites. *Diabetes and cardiovascular diseases* pose serious problems to public health and account for a great number of early deaths; these cases are not documented.

2. What response does the Government of Equatorial Guinea provide in view of this health scenario?

Art. 60 of Decree II in the Fundamental Act of Equatorial Guinea reads: *"It is for the State to protect the health of its citizens and, consequently, it is for the State to provide for and organize a system of Public Health to suit the nation´s needs"*. How does this realize on a day to day basis?

2.1 Financing

National Health policies (7) include State funding (budget increase for the health sector), public insurance system (INSESO) and user co-payment (fund return) in order to warrant availability of resources within the health system.

I shall try to describe briefly how the three provisions above actually work out:

Funding by the State

The National Conference on Economy of 1997 recommended the allocation of important resources to social and sub-social sectors mounting 40% of total public expenditure, 10% of which to be allocated to the health sector -as recommended by the WHO. In addition, we count with non-government contributions from external parties engaged in cooperation affairs, such as NGOs, International Cooperation Funds, United Nations and other alike. This extra funding does reach the population, indeed.

If we are to take fund allocation as successful all in all, the same cannot be said about real financial outlay.

What has become of this?

- Between years 2000 and 2002 there has been no financial outlay for investment. This means that no developments in the health system have been implemented in that period.
- The real public expenditure per inhabitant through the MINSABS (Ministry for Health and Social Welfare) went from 2$ to 3$, a figure far below recommendations by the World Bank, and that is equivalent to 1.3% of GNP.

Financing through the social security system

The INSESO (Social Security Institute) is the only one public institution to manage and administer Social Security in Equatorial Guinea. It provides health coverage for about 38.000 individuals (3.7% of total population). Needless to say, the system is very much deficient.

Direct financing by the users (co-payment)

Funds returned by users through co-payment are not used to cover needs of the health services at local level. 80% of these funds are deposited in a bank account of the

MINSABS. Only 20% of this return is actually re-invested into the health system.

2.2 Human resources

- 70,4% (1.059) out of all professional categories are health workers.
- 10,3% (155) are physicians, that is, 0.25 doctors per thousand inhabitants.
- 0,7% (11) are pharmacists.
- 14,1% (212) are nursing staff
- 2,2% are biologists or lab technicians.
- 0,9 % (13) are midwives.

Overall, the qualification of health professionals is rather poor, with a predominance of health workers. The training and qualification of the latter proves insufficient for them to fulfil the tasks they are forced to assume, at least not from the medical deontology standpoint: in-practice consultation, treatment prescription, and management and distribution of pharmacological stocks in particular. Hence, it follows that the care provided by these health workers results poor in quality and that current epidemiology patterns fail to improve. This accounts for the strong prevalence of the major pathologies observed in the country. Hence the high mortality rates and the risk of permanent damage and disability. Maternal mortality is certainly high. But the likelihood of reducing the number of deaths without first increasing the number of midwives made available is rather a difficult objective.

87,4% of health professionals can be found in urban areas where 38,8% of the country population live, whereas only 12,6% work in rural areas to provide health care to 61,2% of the population total.

It is common to find a health worker who cannot either speak or read Spanish nor be able to solve basic mathematical problems. But he/she can prescribe drugs and medicines, can perform scrapes, drain abscesses...! And when things go wrong and the patient dies, neither the health worker assumes nor the family demand responsibilities for the patient's death. It is simply taken as bad luck, that his/her time had come, or that a bad spell had done away with his/her life.

A health worker may not know for sure what actions to take in a given case, but he/she must be aware of the fact that he/she is not there to kill or cause damage to any one. Unfortunately, in Equatorial Guinea health workers are not aware of anything, neither the good they must do nor of the bad they have caused or done.

The respect to human life must be taken as a duty that ought to realize in the following practices: any health worker must be aware about the fact that he/she is to avoid conduct that is ilegal, such as that of performing practices which he/she is not skilled nor trained to do.

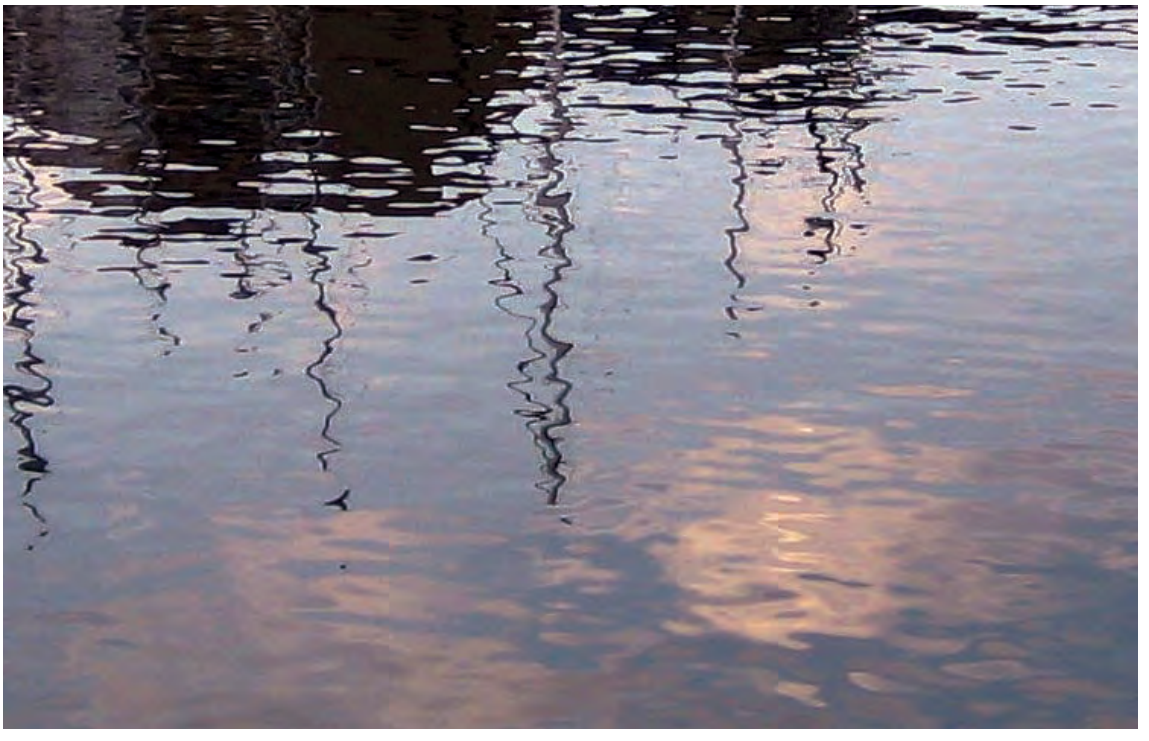
One of the pilars of Bioethics is the principle of *autonomy*. But the Guinean patient is not given the chance, neither are his relations, to decide upon what he/she will allow to have done. That we have come to know as "Informed Consent" or the right of patients to be informed about everything related to diagnosis and treatment of their condition. And, provided the patient is competent, the right to accept or refuse the therapeutic approach envisaged to treat his/her condition. Nobody offers information before or after, nor explanation whatsover when exits occurs.

2.3 Infrastucture and furnishings

The country has hospitals, health centers, a rehabilitation center for the leper, several health posts, a clinic hospital and one out-patients. Some of these health facilities are in need of refurbishing works and they all lack of adecuate furnishings; beds, matresses, medical instrumentation, and material of all sorts. The lack of basic good supplies (electricity, running water, waste management systems, etc,) for the better maintenance of hospital infrastructure and facilities, yet reduces the state of safety of facilities, material and equipment. The largest hospital is in Malabo, with 226 beds and the smaller one is that in Riaba, with 10 hospital beds.

Most health centers remain closed because they lack of qualified professionals and essential equipment.

There is not one electrocardiograph in the whole of the national health territory to allow for a simple ECG reading, not to mention the possibility of performing a complete blood count or of recording sugar levels in blood...



Reflection on the water

The clinic hospital governned by the INSESO counts with sufficient equipment and means to perform reliable, essential diagnostic procedures. But they are under-used because there are no qualified professionals to operate them.

The family must provide bed linnen for the patient to use while in hospital and become responsible over associated cleaning chores. They even have to bring in water for the patient to shower every day. Every family is in charge of feeding their respective in-patient since there are no kitchen facilities nor drinking water. Being a health worker assimilates to being a saler. At hospitals and care centers, when a patient arrives or even while in-hospital, in order to get due attention and care, one needs to bribe health workers, nurses and doctors. Often, to bring in a doctor requires a quest around the city to find him/her in a first instance, and then "putting something" in his hand to urge him into action. The picture one gets of the relationship heath provider-patient is that of "in-debt", as if the patient were in debt with anyone that is supposed to care after him/her.

We also find large number of clinics - surgeries, to be precise- that do not meet minimum hygene standards, where Spanish is not spoken nor understood, but where sure enough there are pills and tablets that are sold. These are medicines that are labelled in Chinese, without prospects to indicate what they are for and what are the likely effects on the body.

Native doctors and nurses earn additional wages at "shabby" surgeries of their own, where not only counselling and diagnostics is offered but also medicines and drugs, and where clinical tests are performed just for the sake of economic gain alone. More often than not, neither the medicines nor the tests will actually suit the needs of the ill individual.

Medical ethics has adopted as universal principle that of *beneficency*, which means "you do as you can in the best interest of the patient". In Equatorial Guinea - as described earlier above- the only principle that rules among heath professionals is "get the greatest benefit for yourself".

One needs to recognise and acknowledge the work of many foreign and native persons, and that of humanitarian task-forces in the promotion of quality heath care for the peoples of Equatorial Guinea, among which we can note the FERS (Spanish Federation of Religion-oriented social and health workers).

2.4 Pharmaceutical policy

An overview of the national pharmaceutical policy shows that there is a n approved list of essential medicines and a National Committee for the Selection of Pharmaceutical Products (CNSPS), whose major function is that of checking the list on regular basis.

There is no local production of medicines. Pharmaceutical products are still being imported from Europe or nearby countries to Equatorial Guinea. Since there is no organised structure for the provision, reception, storage and distribution of medicines, the Ministry for Health simply secures event-related supplies, which results in a permanent shortage of pharmaceutical stocks

There is no effective regulation mechanism for price control - neither for the public nor for the private sectors- and, hence, medicines are made inaccessible to the general population. Most medicines are of dubious quality, above all those produced in African countries. Causes to account for that: deficient regulation (no registers, no verification of authorised product for sale requirement); no quality control system; insufficient number of inspectors; clandestine import; deficient transport and storing requirements.

Apart from anti-malarial, anti- intestinal parasite medicines, a few antibiotics, pain killers and a number of vitamines, it is impossible indeed to find any other type of medication (for instance, one cannot buy insuline at a chemist´s; on occasion, one may get oral anti-diabetic drugs, and in the event of angina pectoris one will have to place an order by phone and have the medicine sent from abroad as soon as possible). In between life and death, the population of Equatorial Guinea lead a most precarious existence.

When patients arrive at our hospitals, they are given a prescription for them to find, buy and hand over before they are cared after. And they will suffer in the meantime, for nothing will be done until they present with the medicines requested. Hospitals do not have emergency drugs or medicines, not even to treat a wound.

3. After this overall and realistic view of the ethics of the health system in Equatorial Guinea we note that:

- There is evidence of *structural injustice* that is strengthened now by the exploitation of oil resources.. The economic reality we are experiencing - there is money indeed- does not contribute to the improvement of the living conditions of the population: the distribution of benefits is not equitative and the current economic growth is not participated.
- The fruits of economic growth do not reach every citizen or the population as a whole. Global well being, universal and constitutional rights and power are but for a handful of country fellows. The reasons are plain and clear: non-defined territorial, ethnical and genre policies. The 20% of the population total hold control over all the riches and resources in the country, and it is they who are granted access to the best health care by flying a private jet abroad in the event of a medical emergency.
- The situation the country is experiencing leads to a general exodus of the disfavoured from the rural areas towards urban areas in pursuit of better job opportunities, better heath care, better education... moved by a strong desire to leave behind a life of misery and subsistence. This exodus towards the cities results in greater crowding together. People are forced to share understandard dwellings lacking essential goods, such as electricity, running water, letrines... All of the above contributes to yet worsen the state of health of the population.
- New infrastructure is imported -hotels, luxury homes, sports facilities, swimming-pools...- High domestic investment for foreigners to enjoy, the same foreigners who are exploiting the country's natural resources, and also for a fortunate minority of citizens. There is no room for thinking about the needs of our population, nor investment for health infrastructure and furnishings.
- There is consented ignorance and lack of information that leads to a most passive interest in what regards education and training of quality that dignifies the living of a human being.
- The small population of Equatorial Guinea is a good indicator that things could improve by large easily, but provided there is a political will to bring about the

changes and provided the countries in the North, that are benefiting from the exploitation of our natural resources, are supportive of the idea and demand that those changes take place. But for the time being they are not contributing as to the improvement of domestic standards of living. They simply support the governments that are favourable to their own economic interests.

- Unfortunately, the economic growth of Equatorial Guinea does not reflect on indicators for social expenditure, education and national health.

III. CHALLENGES, OPPORTUNITIES AND OBSTACLES FOR EQUATORIAL GUINEA

Challenges

- Against this economic scenario rises the hope for a living with dignity that is directed towards : a moral rearmament that promotes responsibility over public goods; an emerging desire to give priority to common good and honesty to overtly condemn and fight abuse. To protect and secure the health of the population by improving the quality of care and health provision policies in accordance with international recommendations, and the implementation of a generalised basic education that reaches every individual in the country.

- Against the poor life expectancy resulting from transmittable diseases that can be avoided, it is urgent that measures are implemented to control the major causes of morbidity and mortality among thet young, AIDS included.

Opportunities

- The positive economic growth the country enjoys.

- Support by third parties as to the development of health infrastructure and care provision.

Obstacles

- Poor expenditure and embezzlement of the budget share allocated to the health sector.

- Politization of the health system.

The country is not being -nor has been- objective-wise geared towards the construction of a future and identity of its own. All of this might reverse for the better should a clear vision exisisted, a vision of a future that is shared and co-participated by the population. Such a vision will serve indeed to bring together the different interests and efforts.

IV. WHAT IS THE RESPONSE OFFERED BY THE CASTROVERDE LABORATORY IN VIEW OF THE STATE OF HEALTH CARE IN EQUATORIAL GUINEA?

The Castroverde Laboratory takes on responsibility over the challenges ahead in the area of health care in Equatorial Guinea: *Health* is scarce in Equatorial Guinea.

The high morbidity rate the country exhibits is caused by diseases that can be treated and avoided. The poor access individuals have to western-style health care resources. Our hospitals, health centers, care facilities... though basic in what regards material and human resources, stand in such abandonment and decay that they cannot secure sufficient care nor warrant any possibility of cure, not even the life of the patients.

The Castroverde Laboratory has as major aim that of: *contributing to the improvement of quality in primary health care that is accessible to everyone in the population, increasing efforts as to serving the most disfavoured, offering reliable diagnosis and testing procedures regardless of the monetary means of the patients.*

The Castroverde Laboratory is located in the Elá –Nguema Quarter (formerly San Fernando)–, three kilometres away from the city of Malabo. The quarter developed at the end of the 50s to house the native population. Most of the quarter remains unpaved, and locals suffer from frequent disruptions in electricity and water supply. The population within has grown larger in the last few years, with the consequent flourishing of a shanty town on the outskirts of the area and a significant crowding together. The Castroverde Laboratory developed as an idea in 1992 and opened its doors to the public in March 1993.

This action was launched to respond to the demands of the population and after the following needs were mapped:

- The national territory counted with four lab facilities alone. The only tests that could be performed were for malaria, hemoglobine measurements and parasite detection in faecal samples. For other basic procedures, such as biochemical analysis, etc, the only option was to have the tests performed elsewhere abroad and, of course, this was a choice for the wealthier only.

- The poor reliability of the tests performed at domestic level because of insufficient skills and training on the part of care providers; scarce technical means to perform the tests and deficient professionalism.

- Discontinuity in health related activities in the country resulting from:

- the lack of supplies and, on occasion, discontinuity of reactive stocks.
- the assistential nature of the system and the non- participation on the part of the beneficiaries. Since self-funding is not sought, all projects are brought to an end when funds get exhausted.
- the training of personnel at local level is not promoted.

The specific objectives of the Castroverde Laboratory are:

- To increase reliability of routine diagnostic tests that are performed at other labs in the city.

- To broaden the variety of lab tests offered as a means to improve diagnosis.

- To offer specific training in lab testing modalities for Guinean health-providers and to offer essential health education for the beneficiary population..

- To make all sorts of tests accessible to the population regardless of their economic power.

- To develop and make available a good system for the collection and registration of data.

- To secure self-funding.

The services offered by the Castroverde Laboraotry are:

- Clinical testing..

- Attention to children suffering from malnutrition.

- Follow-up on patients with diabetes, hypertension and varicose ulcerations.

- A Medical Library to aid in the continuous training and up-dating of the health personnel engaged with the Center and extending this opportunity to other health workers in the area.

- Large scale education and training of lab technicians already working in health centers. This is achieved with the support of the FERS (Spanish Federation of Religion-oriented Social and Health workers), On-site assessment and supervision of the labs. Permanent education and training of the personnel engaged with Castroverde Laboratory with the aim of increasing their level of responsibility and autonomy so that the project can eventually rest in the hands of the local staff.

- In what regards health education, our Laboratory contributes the following activities:

- Courses on Health Education at the Adult Education Center "Virgen María de África".
- Publication of a Guide on Health Education.
- Work-shop on the Didactics of Health Education at the Poveda Center for Teacher Training.

- Provide access to sweet water collection to over 60 families living in the vicinity of the Laboratory - with an average of 8 members within the same household- and under the condition that they have participated in the health education courses related to good use and treatment of water.

The beneficiaries of this project are:

- The population of Malabo, namely, and the smaller settlements in the Island of Bioko. Other users from different areas in the country can also benefit from the project's activities.

- The staff engaged with the Laboratory who receive up-dated training every year.

- Those living elsewhere who come for training in lab techniques, and also those who are users of the labs involved in the training.

The project has been highly appraised both by the population and the clinicians. Likewise, it boasts recognition on the part of international agencies and institutions. The Laboratory takes priority in good service and attention and in making everyone to feel unique and important. No preferential treatment is given to anyone on the basis of hierarchy: a most rigorous order of visits is followed, so that every one awaits his/her turn.

V. ACTION LINES TO IMPROVE THE ETHICS OF THE HEALTH SYSTEM IN EQUATORIAL GUINEA

Encourage a greater effort in securing the quality of care provided:

- Turn the services more humanitarian and better adapted to suit the needs of the population.
- That services secure health provision and count with the means required to allow everyone access to treatment and care that secure a sound diagnosis and recovery.
- Promote training for the staff and health workers on a regular basis, thus favouring information and education on health-related issues that will be useful not only at expert level but also to the general population.
- Pay greater attention to prevention vs. treatment of disease.
- Demand from the large pharmaceutical corporations that object to the marketing and sale of generic medicines on the argument that they are holders of a given patent rights, that they facilitate their medicines at no expense whatsoever for the most disfavoured countries. Only then might thousands of lives be spared from a difficult living and early death.
- The government should launch a coordination policy on human and material resources, so that optimization of their use can be achieved for the benefit of all and a good quality of health care is assured.
- Work together towards the full development of Equatorial Guinea, beyond the economic growth resulting from the exploitation of oil resources, and invest in education, health provision and housing schemes..
- That our health practice is geared from the principle of *non-maleficence*, which demands equal respect and treatment at biological level. That is, not to inflict damage, consciously or unconsciously. And also from the principle of *justice*, that is, to treat everyone with the same consideration and respect at a social level. In short: an equitative sharing of the resources that are available.
- It is mandatory that a value-based education is implemented. An education that takes into account not only the moral values of the community but also the social, human and universal values so that the life we were once gifted with will continue, and that the moral duties we have inherited (from the standpoint of the Bantú culture) will serve to ground all of our future deeds.

I should like to make mine the words of Camerooneese theologist and anthropologist Jean Marc Elá: *"We need to re-discover Africa, a continent that encloses a vast reservoir of good sense and resources: this is the capital we need cling onto and value if we want the seed of hope to germinate in the hearts of "the doomed" and see the rising of new horizons in Africa... Beyond well-worn stereotypes, Africa re-lives."*

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ABSTRACT

In view of the deterioration of the Guinean System of Health at every level it is most difficult to speak of health ethics in our country,. Overall, this is a concept that has not integrated into our system, neither at theoretical nor at praxis levels. The situation demands urgent action and work towards the improvement of health care in our country. A

more humanitarian sort of care to better suit the needs of the population. It is mandatory that health centers serve to safeguard health and be sufficiently equipped to treat all segments of the population; that everyone can have access to therapies and treatment to secure relief and recovery. We have to work towards a population-based development of Equatorial Guinea, beyond the current economic growth yielded by the oil turn-over, and re-direct our efforts towards the development of individuals by investing in education, health and worthy housing...

