

OPERA IN PRACTICE: DEFENDING REPRODUCTIVE RIGHTS OF ANGOLAN WOMEN

This brief case study examines the use of OPERA, CESR's monitoring framework, to prepare a submission to the Committee on the Elimination of All Forms of Discrimination against Women on Angola in 2013. It is part of a series of case studies produced by CESR to share insights and learning from the use of OPERA in a variety of contexts and settings.

ECONOMIC AND SOCIAL RIGHTS MONITORING



After a decade of oil-fueled economic growth, health services in Angola continued to be undermined by inequitable resource distribution, with maternal and infant mortality rates among the poorest in the world. Working in collaboration with Chr. Michelsen Institute (CMI) of Norway, and Open Society Institute for Southern Africa (OSISA) in Angola, CESR used OPERA to frame a submission to the Committee on the Elimination of all forms of Discrimination Against Women (CEDAW) on this issue, when it reviewed Angola's sixth Periodic Report in early 2013.

In line with the guidelines from the Committee, the submission was short (15 pages in total) and focused on highlighting priority concerns in its sub-headings and suggesting specific recommendations in its final section. The submission was prepared on the basis of desk-based research and then shared with groups in the country for their feedback and comments. Using OPERA allowed us to show how the economic boom that Angola experienced after three decades of civil war came to an end (the country's economy increased nearly tenfold between 2003 and 2011) failed to benefit the majority of the population, especially women.

Assessing outcomes

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) addresses many aspects of women's rights. However, the submission focused specifically on maternal and reproductive health. We prioritized this issue as it was one of the starkest illustrations of how the humanitarian calamity of the

civil war had been exacerbated by growing economic inequalities in the decade since.

What were we trying to measure? To assess the extent to which women in Angola were able to enjoy their rights to maternal and reproductive health we focused on three main human rights norms:

- **Minimum core obligations:** To what extent do women in Angola enjoy basic levels of the rights to maternal and reproductive health?
- **Non-discrimination:** Are there disparities among different groups of women in how much they are able to realize these rights? These include differences related to age, residence or income level, which could suggest discrimination.
- **Progressive realization:** How has rights realization changed in recent years? Progressive realization requires that levels of rights realization improve over time in line with available resources. Measuring progressive realization considers the rate of change, the direction of change, and differences in rates of change among various groups, taking resources into consideration.

How did we measure? In order to evaluate maternal and reproductive health outcomes we selected indicators that could provide a proxy measurement reflecting realization of the right to maternal and reproductive health. Along with the country's maternal mortality rate, we looked at infant mortality (death in the first year of life) and



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neonatal mortality rates (death in the first month after birth). These two indicators indirectly measure maternal health, since an infant's health is strongly dependent on its mother's survival. Fertility rates, rates of contraception use, and rates of unplanned pregnancies were used to examine reproductive health.

We referred to the latest "Trends in Maternal Mortality" report produced by WHO, UNICEF, UNFPA and the World Bank for data on maternal mortality; estimates developed by the UN Inter-Agency Group for Child Mortality Estimation for infant mortality data; and health surveys conducted in 2006 and 2011 by Cosep Consultoria, Consaúde, and ICF International for reproductive health data.

In order to assess outcomes regarding minimum core obligations, we compared data on Angola to other relevant countries. Where available, we analyzed data disaggregated according to levels of education received, amount of wealth, and location of residence (focusing on urban/rural) to uncover patterns of discrimination and disparities between groups. Finally, to assess progressive realization we examined changes in the data over time.

What did we find? The data on maternal and reproductive health showed that overall levels of realization were deficient, that they were marked by disparities, and that it was unclear whether there had been improvement over time.

The mortality rate in Angola was 450 per 100,000 live births in 2010; this was lower than the Sub-Saharan average, but at more than 300 that is still considered "high" according to UNFPA classification. Perhaps more troubling, "a third of female mortality in Angola is linked with maternity".

There were also marked inequalities. For example, fertility data from 2006 and 2011 showed that poor, uneducated women, living in rural areas had the highest fertility rates. The fertility rate for girls aged 15-19 was especially troubling; it was the fourth highest globally.

Assessing policy efforts

By ratifying CEDAW, Angola committed to creating policies that ensure women and girls receive the care they need to survive pregnancy and childbirth. Evaluating whether Angola had taken adequate steps to meet this obligation required examining the legal, policy and programmatic measures the government had put in place in regarding maternal and reproductive health. It also required examining how these measures had translated into necessary goods and services on the ground.

What were we trying to measure? To fully assess Angola's compliance with its human rights obligations, we evaluated the policy efforts taken by the government against three norms:

- **Obligation to take steps:** Has the government taken steps to enact legislative, administrative and programmatic measures to ensure women can realize their right to maternal and

reproductive health? These steps must be deliberate, concrete and targeted.

- **AAAAQ criteria:** Have the steps taken led to maternal and reproductive health services that meet standards of availability, accessibility, acceptability, and being of adequate quality?
- **Participation, transparency, accountability, and the right to a remedy:** Have the steps taken been implemented with active participation of the women affected? Are remedies available if and when laws, policies or programs violate women's rights?

How did we measure? We evaluated the steps Angola had taken with regards to the right to maternal and reproductive health by comparing constitutional provisions, legislation, and government policies, with the standards contained in the international treaties it had ratified.

We identified indicators that could show what maternal and reproductive health services were available, the quality of those services, where they were available, and who was using them. To that end, we gathered data on the number and location of health care facilities, the staff and services available at health care facilities, and women's use of maternal and reproductive healthcare services. This data came from surveys, reports from the Ministry of Health, and analysis from USAID and the World Bank. The information was then compared against international guidelines, regional standards, and government targets.

To analyze how transparent, participatory and accountable policymaking was, we reviewed position papers by UNDP, reports by human rights organizations, public surveys, qualitative academic data, and an open letter signed by dozens of human rights organizations to the government of Angola.

What did we find? While Angola had ratified international health obligations and passed national legislation to support maternal health, some of the legislative and policy measures taken did not fully support women's right to maternal and reproductive health. Further, these policies had not translated into improvements on the ground, especially among marginalized communities, and the processes that guided these policies were not sufficiently accountable.

Angola had ratified six international and regional human rights treaties which include protections for women's reproductive rights. Domestically, Article 77(2) of the Constitution states the government has the obligation to "develop and ensure the functionality of a health service throughout Angola", which should be interpreted to include reproductive health services. However, a number of legislative provisions were detrimental to women's reproductive health; most significantly, at the time of the submission, abortions were illegal on any grounds (although reports suggested this prohibition was often not enforced when a mother's life was at risk or if a pregnancy was the result of rape). Further, Angola did not have a national strategy regarding the promotion of family

planning and distribution of contraceptives was carried out “on an ad hoc basis”.

These steps had not translated into sufficient or equitable maternal and reproductive health services. For example, although the number of Angolan women giving birth with the assistance of a skilled health professional was comparable to regional averages, wide disparities appeared when the data was disaggregated. Less than a quarter of women in rural areas gave birth with the assistance of skilled health personnel, compared to nearly three quarters in urban areas. Similarly, under a third of women in the poorest quintile gave birth in the presence of skilled health personnel, in contrast to 93% of women in the top quintile. Admission fees significantly impacted the accessibility of health centers. Despite the ban on collecting admission fees, one fifth of facilities did so on average, while 70% did so in the province of Luanda. Additionally, patients were forced to purchase necessary drugs and supplies from providers, contributing to more than half of Angolan households’ direct health costs and discriminating against the poorest.

Further, the ability of facilities to provide maternal and reproductive healthcare services did not meet international quality standards. Although Angola had nearly tripled the number of health facilities between 2003 and 2009, reports from UNICEF and USAID found caesarian sections, transfusion services, and family planning services were not sufficiently available, especially in rural areas. These facilities were not supplied with adequate drugs, equipment, or qualified healthcare professionals and, perhaps most troubling, a number of facilities did not have access to the electrical grid, generators, or a regular water supply. A lack of quality assurance mechanisms meant that the performance of healthcare workers remained unexamined, and patients had no recourse to evaluate the quality of care received.

Assessing resources

As CEDAW emphasized in its General Recommendation No.24, states must act to the maximum extent of their available resources to ensure that women’s rights to maternal and reproductive health are realized. Thus, it was crucial that the submission also examine how resources were generated, allocated, and the mechanisms that drove those processes.

What were we trying to measure? To determine whether Angola had moved to progressively realize the maternal and reproductive rights of women in the country according to its ‘maximum available resources’, we measured:

- Planned and actual resource allocation for relevant social programs: How much of the budget does Angola allocate to social spending, and specifically to maternal and reproductive health?
- The methods by which Angola generated its resources: What have been the government’s main sources of revenue?

Revenue sources should be adequate to meet government obligations regarding maternal and reproductive health and burdens should be fairly and equitably distributed throughout the society.

- Levels of transparency, participation by civil society, and accountability: Are budgetary processes open to public scrutiny and input? The public should participate in the design, implementation and evaluation of fiscal and monetary policies and the economic policy process should be transparent.

How did we measure? In order to understand resource allocation patterns we analyzed spending ratios. For example, we compared per capita spending (i.e. the amount spent per person) and household spending (how much each person spent on out-of-pocket healthcare costs) to regional averages. We also used the government’s Abuja Declaration commitment as a benchmark for judging its budget allocation to health over time.

What did we find? Although the budget Angola dedicated to health was comparable with other countries in the region, the government had not met its commitments, there were wide disparities in allocations within the country, and the process was marked by corruption.

Per capita health spending was higher than the regional average and out-of-pocket spending by households was less than in neighboring countries. However, the amount of the government’s budget dedicated to health had declined since 1999 and remained below the 15% commitment in the Abuja Declaration. Additionally, there were wide disparities in the allocation of funds between provinces.

Less than 75% of funds directed to the health sector were actually spent, in large part due to corruption, transparency, and a lack of accountability. Angola was described as having an “opaque budget formulation process” and a “disconnect between planning and budgeting.” It’s Open Budget Index score was 26 out of 100, considerably lower than the average of 42 among the 94 countries surveyed.

Assessment

This step drew together and synthesized all the findings from the previous steps in order to provide a complete picture of Angola’s compliance with its obligations to fulfill the right to maternal and reproductive health. It also drew on our analysis of the contextual issues that impact Angolan women’s ability to claim their rights to maternal and reproductive health and the Angolan government’s capacity to meet its obligations.

What were we trying to measure? We analyzed other factors influencing the government’s actions to get a more complete picture of the environment in which the right to maternal and reproductive health is addressed in Angola.

To conduct that assessment, we considered:

- Contextual factors that limit the enjoyment of the right: What other factors may be inhibiting women from enjoying their rights? This analysis considers social, economic, political and cultural factors that may be limiting their ability to realize the right to maternal and reproductive health.
- Constraints placed on the state by outside actors: How do the acts or omissions of third parties or structural dysfunctions impact on the state's ability to fulfill the right to maternal and reproductive health?

How did we measure? We looked at general demographic indicators such as literacy rates, as well as levels of overall development in Angola. Data for these indicators came from ministries in the Angolan government and intergovernmental organizations. We examined Angola's socio-economic and political climate through news articles and other relevant reports from organizations such as UNDP, Human Rights Watch and USAID.

What did we find? Angola faced many challenges from social, cultural and political dynamics that inhibit realization of maternal and reproductive health rights and make it difficult for the government to meet its legal obligations.

Angola is categorized as a 'developing state' with 'low human development.' Nearly 40% of its population under-18 lived in poverty in 2008. Education levels in Angola, especially among women were very low. Almost half of women in Angola were illiterate, compared to the national average of 34%.

Angola has had the same president, José Eduardo dos Santos, since 1979 and the judicial and legislative branches wield little-to-no power over the office of the president. The concentration of power in an individual goes some way to explaining the corruption in the country and places a constraint on Angola's ability to realize rights. Given that Angola is not a country bereft of resources, the almost total absence of civil society participation in policy development and resource management was particularly lamentable. We concluded that overcoming Angola's governance issues would be crucial to challenge the economic and political dynamics of self-enrichment and exclusion in the country, to ensure that economic growth makes a meaningful difference to the lives of Angolan women.

Outcomes, conclusions and lessons learned

The submission offered another example where our analysis was limited by the lack of (reliable) data published by the government. Nevertheless, the fact that the government was not collecting and utilizing information on the rights to maternal and reproductive health itself indicated they were not taking adequate steps to fulfill these rights. OPERA's focus on the need for high quality data in

ensuring evidence-based, accountable policymaking allowed us to draw out this issue and make a number of recommendations centered on the creation of national health data, especially concerning maternal mortality and morbidity.

Using OPERA to frame the submission also allowed us to present a more complete picture of how the Angolan government's policies impacted the realization of the right to maternal and reproductive health. In spite of the data challenges, the submission was able to pinpoint certain key areas where government policies were contributing to shortfalls in realization. For instance, we were able to highlight the discrepancies between realization of maternal and reproductive rights between rural and urban areas, and then to connect that to a lack of funding in health budgets for particular regional areas. This analysis helped us create robust and targeted recommendations that focused on addressing that gap.

In its Concluding Observations, the Committee touched on many issues raised in our submission and called on Angola to, among other things, "Strengthen the maternal and infant mortality reduction programme, and eliminate the causes of such mortality, which include limited access to obstetrical care and the low number of births attended by skilled personnel." They also recommended that Angola promote education on sexual and reproductive health rights, and promote the education of and use of contraceptives and family planning. The following year, a number of countries picked up the issue of health rights when Angola appeared before the Human Rights Council's Universal Periodic Review.

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