

SUBMISSION TO THE COMMITTEE ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

On the occasion of the review of Angola's Sixth Periodic Report at the Committee's 54th Session, 11 February – 1 March 2013

Submitted by

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This submission outlines the key concerns and recommendations of the organizations listed above on the occasion of Angola's review before the Committee at its 54th session in February 2013. The submission supplements information presented in Angola's 6th Periodic Report of September 2011, highlighting key areas of concern regarding the State's compliance with its obligations under the International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). It focuses, in particular on maternal and reproductive health in Angola, in line with Articles 12, 14 and 16 of the Convention. It finds that despite the country's high rates of oil-fuelled economic growth, efforts to address maternal and reproductive health remain inadequate. While national data is grossly deficient, there are some visible shortcomings and inequalities in terms of maternal and reproductive health outcomes, as well as in service provision and resource allocation. While the paucity of disaggregated data prevents us from detailing discriminatory trends in the provision of maternal and reproductive health care services, in broadly terms rural and less-wealthy areas are being left behind. This inequity is fuelled by a concomitant lack of accountability and marked concentration of political and economic power, which largely excludes citizens and civil society groups from policy-making and resource management.

The extraordinary post-war economic boom has not improved life for many Angolan women

For nearly 30 years Angola was ravaged by one of Africa's longest civil wars (1974–2002). The conflict caused a serious humanitarian disaster for the country. It is estimated to have displaced more than four million people, while also severely destroying

public infrastructure and damaging the economy. The long conflict also left Angola with some of the poorest development indicators in the region.

While conflict in Angola affected everybody, women were particularly hard hit and the gendered impacts of the conflict continue to be felt; with almost a quarter of all households in the country female-headed,

women in Angola sustain a heavy burden of labor, largely in the informal economy.¹

The end of the war presented Angola with the opportunity to achieve sustainable economic growth. Angola is an important oil producer; in 2011 it was the second largest crude oil producer in Africa after Nigeria. The country's oil output, which accounted for 45.9% of GDP in 2011, has more than tripled in the wake of the conflict.² Angola exports most of its oil to China and the United States.

As a result of increased oil production, Angola has experienced spectacular rates of economic growth. World Bank data shows that in 2003, Angola's GDP was just USD 12.5 billion; in 2011 it was USD 104.3 billion, an almost ten-fold increase.

Nevertheless, the country's wealth has not trickled down to the majority of the population and Angola continues to be categorized as a "low human development" country on the Human Development Index. With a GDP per capita of \$5,812 USD, it is the richest among this category.³ According to the 2008-9 Integrated Population Welfare Survey (IBEP), approximately two fifths of its 18-million population lives under the poverty line and the incidence of poverty is three times higher in rural areas than in urban areas.⁴ Angola has a Gini coefficient score (which measures income inequality) of 58.6, among the highest in the world.

Structural inequalities are particularly pronounced between men and women and between the urban and rural population. For example, while 34% of the population is illiterate, this proportion is higher in rural areas (more than 70%) and among women (almost 50%). Only 40% percent of women from rural areas know how to read and write (in contrast to 84% in the urban areas).⁵

Angola's maternal and infant mortality rates are among the poorest in the world

In its 2004 Concluding Observations on Angola, the Committee expressed its concern

about women's low life expectancy, high maternal mortality and morbidity rates, high fertility rates and low rates of contraceptive use.⁶ According to the latest estimates from WHO, UNICEF, UNFPA and the World Bank, Angola's maternal mortality ratio was 450 deaths per 100,000 live births in 2010.⁷

Although slightly lower than the average for Sub-Saharan Africa, this is still considered a 'high' maternal mortality ratio.⁸ It equates to a 1 in 39 lifetime risk of maternal death for women in Angola.⁹ A third of female mortality in Angola is linked with maternity.¹⁰

Observing the trends in these estimates suggest that Angola has made advances in reducing its maternal mortality ratio in the past decade; from an estimate of 890 in 2000, it declined to 610 in 2008, and then to 450 in 2010. However, the accuracy of these figures is highly questionable. Accounting for the range of uncertainty (confidence interval), the 2010 ratio may in fact be anywhere from 210 to 1,000.¹¹ UNFPA notes that Angola is one of 27 countries where "no good quality national data" is available on maternal mortality.¹²

As a result, it is impossible to say whether and to what extent levels of maternal mortality have declined in Angola and whether the country will achieve Millennium Development Goal Five to reduce maternal mortality by three quarters by 2015.

As an infant's health is strongly dependent on its mother's survival, rates of infant mortality (death in the first year of life) and neonatal mortality (death in the first month after birth) may be used as indirect indicators of maternal health. Here too, Angola has extremely high mortality rates. Most recent World Bank data from 2011 estimates Angola's neonatal mortality rate to be 43 deaths per 1,000 live births, making it the seventh highest in the world. Its infant mortality rate is the eighth highest at 96— notably higher than the regional average for Sub-Saharan Africa at 69.¹³ Though infant mortality reduced from 117 in 2001, change

in neonatal mortality has been negligible, falling only slightly from 48 in 2001.

Risk of maternal death is aggravated by low contraceptive use and a high number of unplanned pregnancies

Women and girls in Angola are at greater risk of maternal death due to a high fertility rate, especially among the poorest. The Malaria Indicator Survey (MIS) shows that the country’s total fertility rate increased from 5.8 births per woman in 2006 to 6.3 in 2011 and, again, there are wide demographic disparities:¹⁴

Characteristic	2006	2011
<i>Residence</i>		
Urban	4.4	4.6
Rural	7.7	7.7
<i>Education</i>		
No education	7.8	8.0
Primary	5.9	6.6
Secondary or higher	2.5	3.3
<i>Wealth Quintile</i>		
Lowest	8.0	8.0
Second	7.4	7.3
Middle	6.7	7.6
Fourth	4.9	6.7
Highest	2.8	4.5
<i>Total</i>	5.8	6.3

According to World Bank data, Angola’s adolescent fertility rate was the fourth highest in the world in 2010, at 157 births per 1,000 girls aged 15-19. This is particularly troubling, given this group is most at risk of dying from pregnancy-related complications.

Angolan women face particular challenges in being able to plan their pregnancies; a serious risk-factor for maternal health. In general, the use of contraceptives in Angola is low. Data from the 2008-9 IBEP indicates that only 17.7% of married women between 12 and 49 years use a contraceptive method.¹⁵ According to World Bank data, the regional average for Sub-Saharan Africa is 22%.¹⁶ In rural areas this percentage is even lower at 6.6%.¹⁷ It is therefore not surprising that a

significant number of births in Angola are unplanned: 22% in urban areas and 13.8% in rural areas according to the 2008-9 IBEP. Among adolescent girls (aged 15-19) the rate of unplanned pregnancies is particularly troubling at almost 40%.¹⁸

Measures to give effect to Angola’s commitments on women’s health are not sufficiently concrete and targeted

Angola has signed and ratified a number of international conventions that protect women and girls’ right to life, health, and non-discrimination. These include:

- Convention on the Elimination of All Forms of Discrimination against Women (1986)
- African Charter on Human and Peoples’ Rights (1990)
- Convention on the Rights of the Child (1990)
- International Covenant on Civil and Political Rights (1992)
- International Covenant on Economic, Social and Cultural Rights (1992)
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) (2007)

By ratifying these conventions Angola has committed to ensuring women and girls receive the care they need to survive pregnancy and childbirth. Most maternal deaths can be avoided by providing essential services along the continuum of care—from pre-pregnancy (family planning, treatment of sexual transmitted infections, including HIV), to pregnancy (antenatal care, management of unintended pregnancies, including safe abortion services), birth (delivery assistance and emergency obstetric care), and infancy (postnatal and neonatal care).

These commitments are incorporated into the domestic legal order through Article 13 (1) of the Constitution of Angola, which states that “international law, received pursuant to this Constitution, forms an integral part of the Angolan legal system”. As noted in the State

Report, Article 77(2) further outlines the government’s obligations in relation to health. In particular, it states that:

To guarantee the right to medical and health care the Government must:

- a) Develop and ensure the functionality of a health service throughout Angola;*
- b) Regulate the production, distribution, trade in and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis;*
- c) Incentivize the development of medical and surgical education and medical and health research.*

Angola’s national health system was established at independence in 1975. From 1975 to 1992, the system was based on the principles of universal and free primary health care. This changed in 1992 with the adoption of Law 21-B/92, which allowed for user fees and the provision of health services by the private sector.¹⁹ Nevertheless, Law 21-B/92 maintained a role for the state in promoting and guaranteeing citizens’ access to health care within the limits of available human, technical, and financial resources.

The health sector has been influenced by the government’s push towards decentralization and both provincial and district governments are experiencing a major transition as the health system devolves responsibility for primary care from the provincial to district level.²⁰ In 2003, Law 54/03 approved the general regulation of health clinics and established that health services would be delivered at three levels: primary, secondary and tertiary (the two latter levels are defined as specialized care). This corresponds to the three government levels: district, provincial and national. The Ministry of Health has developed a district health strategy (Revitalização dos Serviços Municipais de Saúde) to guide its decentralization process.²¹

Primary level health institutions include health posts, health clinics, district hospitals

and referral health centers. The second level includes general hospitals and the third level includes central hospitals.²² User fees were abolished in primary facilities in 2008. Relevant maternal and reproductive health services provided at each level are outlined in the table below.²³

Classification	Type of care
<i>Health Post I</i>	Primary care (including family planning and pre-natal care)
<i>Health Post II</i>	Primary care and laboratory
<i>Health Center</i>	Primary care, laboratory, and labor and delivery
<i>Referral Health Centers and District Hospitals</i>	First referral level (including in-patient care)
<i>General Hospitals</i>	Second referral level (including surgery, gynecology and obstetrics)

In 2007 Law 2/07 established the districts as the basic unit responsible for health service management. The district administrator is supported by a health management department, with members appointed by the administrator. The administrator is appointed by the Provincial Governor, who in turn is appointed by the President.

The State Report is silent on initiatives undertaken to meet the health needs of women in the country. Reproductive health, and most specifically maternal health, has been stressed as a priority by the Government of Angola in the following:

- Strategic Plan for the Accelerated Reduction of Maternal and Child Mortality (2004-2008);
- District Health Strategy;²⁴
- Investment Plan for the Accelerated Reduction of Maternal and Child Mortality (2007-2013);²⁵
- National Health Policy (Presidential Decree 262/10); and
- Campaign to Accelerate the Reduction of Maternal and Infant Mortality (CARMMA), launched in August 2010.²⁶

However, while these policies provide a general direction in which the health sector should be heading, detailed arrangements for how these overarching initiatives will be funded, implemented and monitored are generally lacking. As a result, resources are not being used optimally and better health status has not been achieved.²⁷ For example, the National Health Policy establishes committees at the national, provincial and district levels to audit maternal deaths and monitor key maternal health indicators without specifying what these are.

The African Development Bank also reports that Angola lacks a national strategy to promote family planning, which means that “the distribution of contraceptives is done on an *ad-hoc* basis, if and when requested by NGOs or provincial health departments”.²⁸

Further, despite concerns about mortality resulting from unsafe abortions, such terminations remains illegal under the Penal Code, although as noted in the state’s response to the Committee’s list of issues, the code is reportedly not enforced in situations where an abortion is carried out to save the mother’s life, or where pregnancy is the result of rape. In August 2011, a draft bill reforming the Penal Code was introduced that would codify the circumstances and conditions under which abortion would be permitted; however, it is yet to be adopted.

Few women and girls have timely and affordable access to quality maternal and reproductive health care services

A comprehensive evaluation of the extent to which the policies and programs noted above have been implemented in practice; the resources allocated to them; the results they have achieved; together with the challenges faced during their implementation, would be beyond the scope of this submission. Nevertheless, a review of available data, including a survey conducted by CMI in 2010,²⁹ highlights concerns over the degree to which reproductive health programs at the

central level penetrate down to the provincial and district levels.

As noted in its state report, Angola’s major challenges in terms of maternal and reproductive health are to “improve universal coverage at the municipal level of routine provision of the full essential package of maternal and child care and services, and to ensure the provision of emergency obstetric care and basic and complete neonatal care to women”. Service coverage—throughout the continuum of care—is indeed far from universal and urban-rural disparities in the level of coverage of maternal and reproductive health care services are stark.

According to the 2008-9 IBEP, for example, while 60.9% of urban women make the recommended four antenatal visits, only 31.7% of rural women do so; 47.3% of rural women do not receive any antenatal care.³⁰ The same data indicates that girls under 14 years, women over 30, and women without any primary education are also less likely to have any antenatal care.

The latest available World Bank data, from 2007, indicates that 47% of women in Angola delivered with the assistance of skilled health personnel.³¹ While this figure reflects the regional average for Sub-Saharan Africa, data from the 2008-9 IBEP again illustrates pronounced disparities within the country: 73.1% of women in urban areas were assisted by skilled health personnel, compared with only 23.5% of women in rural areas.³² Data from CMI’s survey shows further disparities by wealth quintile: 93% of women in the richest wealth quintile were assisted by skilled health personnel, compared to only 32% in the poorest quintile.³³

There are several reasons for low coverage of services in Angola, including physical access to health facilities, availability of equipment and medications, and lack of qualified health service providers.³⁴ The following paragraphs lay out some of the principal concerns with the delivery of maternal and reproductive health services that suggest areas where

policy efforts have not translated into health facilities, goods and services that meet the international standards of availability, accessibility, acceptability and quality.³⁵

The lack of professionals, drugs and supplies limits the availability of essential services, especially in rural areas.

In its 2004 Concluding Observations, the Committee noted its concern about poor health infrastructure, which results in women's lack of access to health services and their low health status.³⁶ Since the end of the war, the government has prioritized investment in large-scale infrastructure projects in the country, including the construction of health facilities. The total number of facilities nearly tripled between 2003 and 2009.³⁷ However, the country faces a shortage of professionals, drugs, and supplies, which means that improved physical infrastructure alone does not give a complete picture of the maternal and reproductive health care services offered across the country.

For example, the availability of units providing emergency obstetric services remains inadequate. Guidelines jointly issued in 1997 by WHO, UNICEF, and UNFPA, recommended that for every 500,000 people there should be four facilities offering basic and one facility offering comprehensive essential obstetric care. With a population of 18 million, this would translate to 182 units of which 36 should provide comprehensive care. According to the Ministry of Health, the country has 46 units that provide emergency obstetric and neonatal care; 37 offer complete and nine provide basic emergency obstetric and neonatal care, far short of the 144 needed to meet international guidelines.³⁸

As a result, in practice few facilities are able to provide sufficient services to assist women who experience complications during childbirth. Caesarian section is needed by between 5% and 15% of all pregnant women. This service should be available at all

hospitals. Yet only one out of six of the hospitals surveyed by CMI in 2010 had the equipment to perform the procedure satisfactorily.³⁹ The Ministry of Health also recognises that three out of four women who visit a health facility with an obstetric emergency do not receive adequate attention.

Functioning transfusion services are also not readily available, despite the fact that hemorrhage is a principal cause of maternal mortality in the country. At the national level some 319 of 400 health facilities reported not having carried out any transfusions in the preceding three months.⁴⁰

Other essential reproductive health services are not being offered. Most notably, one study reported that only 10% of Health Posts II and 43% of health centers were offering family planning services.⁴¹ The Ministry of Health also recognizes that information on contraceptives is not always available at health facilities, and that only around 13% provide family planning services.⁴²

One of the greatest constraints to improving the availability of maternal and reproductive health care services is human resource deficiencies. Overall, the number of public sector health workers per 1,000 inhabitants is close to the WHO-recommended ratio of 2.28 health workers per 1,000.⁴³ However, their poor distribution within the country is a serious issue.⁴⁴ Further, only a very small proportion is considered to be properly trained and skilled. The decades of war severely weakened the country's capacity to produce a health workforce that is able to respond appropriately to women's health needs. As part of the peace negotiation process in 2002, the government absorbed approximately 9,000 people into the health workforce, many of whom are basic-level *técnicos* and are still in need of training.⁴⁵ On average, only 24% of health centers and 1% of health posts have a physician on staff.⁴⁶

Frequent shortages and stock-outs of essential medications also limit the availability of maternal and reproductive

health care services. For example, oxytocin, which treats two of the leading causes of maternal death—excessive bleeding after childbirth and high blood pressure during pregnancy—is not regularly available at health facilities, despite being on the national list of essential drugs.⁴⁷ The government's project to introduce misoprostol in health facilities, which was launched in June 2012, should be commended, however.

Similarly, most pregnant women do not have access to malaria prophylaxis during pregnancy, even though malaria is a major cause of maternal deaths. The MIS 2011 indicates that 31.7% of urban women and 11.9% of rural women receive two doses of SP/Fansidar recommended by the Ministry of Health.⁴⁸ The use of treated mosquito nets among pregnant women is also poor (16.2% in rural areas compared to 20.2%).⁴⁹

Long distances to health facilities, as well as formal and informal costs create barriers to accessing care.

In the absence of an effective health information system in the country, information regarding service utilization again is limited. However, data collected by the World Bank, CMI and other sources makes it clear that the physical accessibility and affordability of services remain major impediments for Angolan women.

To begin with, health units providing emergency obstetric and neonatal care are poorly distributed across the country; many outer provinces fall far short of providing the number necessary for their population size, while others far exceed the quantity required. Luanda Province, for example, only manages to provide 8% of the target, while Zaire Province exceeds the number required.⁵⁰

The IBEP 2008-9 indicates that three quarters of Angolans in rural areas and a third in urban areas must walk over 2 kms or more to reach a health facility.⁵¹ Nevertheless, without transport, even closer facilities can be difficult to access. In CMI's 2010 study,

more urban women (30%) cited "long distance" as a reason for not giving birth in a health facility than rural women (19%).⁵²

The country's referral system is also deficient, with less than 50% of general hospitals and 33% of maternity hospitals having a working ambulance.⁵³ Without an ambulance, women experiencing birth-related complications must provide their own transportation in order to reach appropriate care.

Angola eliminated user fees at primary-level public facilities in 2008, though patients must still pay fees in order to access services at secondary- and tertiary-level public facilities.⁵⁴ Despite the national regulations, on average 18% of health units charged admission fees. This was more common in provinces such as Luanda (71%), Benguela (44%) and Zaire (41%).⁵⁵

Further, the lack of medications and supplies at public facilities generates "de facto" fees; patients must buy drugs and supplies from private providers, generating an economic barrier to accessing health care. Expenditure on medications and medical supplies represents approximately 51% of Angolan households' direct health costs.⁵⁶

Corruption in the health sector has likewise been cited as an economic barrier to accessing care. Angolans have identified the health sector as the third-largest culprit in relation to corruption.⁵⁷ A World Bank social assessment recorded complaints that health workers require patients to make informal payments in order to access care.⁵⁸

Poor treatment by under-qualified staff in poorly maintained facilities deter women from seeking care.

As noted in the Committee's General Recommendations No.24, health care services should be delivered in a way that ensures a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. Here, too, there seem to be

concerns about the acceptability of maternal and reproductive health care in Angola.

In CMI's 2010 study, 18% of rural women and 15% of urban women cited "home more comfortable" as a reason for not giving birth in a health facility and a small number specifically cited "not received well" (2% and 3% respectively).⁵⁹ Poor treatment in health facilities was also a complaint raised in a World Bank social assessment, resulting in some women preferring to deliver at home.⁶⁰

It also appears that the government has not devoted adequate attention to the cultural adaptation of healthcare services to accommodate, for example, the fact that many Angolans speak languages other than Portuguese, such as the Bantu languages.

Data collected on service provision in Angola suggests these services are frequently substandard and that, as a result, women's lives and wellbeing are put at risk. This poor quality stems from a lack of trained personnel (discussed above); inadequate maintenance of buildings and equipment; the lack of a quality-assurance system that monitors the

performance; and the absence of accountability mechanisms allowing users to evaluate services.

Widespread deficiencies in the provision of maternal and reproductive health care services are evidenced by the fact that many basic and complete emergency obstetric and neonatal services are not performed by qualified professionals. Data from the Ministry of Health indicates that 94% of deliveries in health facilities are assisted by a basic-level nurse. Data from 2006 indicated that basic-level nurses performed the following procedures at health facilities, despite not being qualified to do so under Angolan law: manual removal of placenta (at 78% of facilities), removal of retained products (at 26% of facilities), and neonatal resuscitation (at 86% of facilities).⁶¹

The high percentage of maternal deaths due to direct complications in some facilities—in some cases up to five times the national average of 2%, as shown in the table below — is particularly troubling in this regard.⁶²

Case mortality rate (by direct complications) at health units with complete emergency obstetric and neonatal care			
Health unit	Province	# of women with direct complications	# of maternal deaths due to direct causes
Caxito Maternity Hospital	Bengo	114	22 (19%)
Lobito Municipal Maternity	Benguela	147	25 (17%)
Povincial Maternity	Benguela	406	12 (3%)
C. Catumbela Maternity	Benguela	195	10 (5%)
H.P.C Maternity	Cabinda	542	24 (4%)
Provincial Hospital	Huambo	490	18 (4%)
Lubango Provincial maternity	Huila	995	25 (3%)
Capelango Hospital	Huila	208	10 (5%)
Amboim Maternity Hospital	Kwanza Sul	109	12 (11%)
Sumbe Maternity	Kwanza Sul	3573	9 (0.25%)
Lucrecia Paim	Luanda	7904	103 (1%)
Augusto Ngangula Hospital	Luanda	2635	76 (3%)
K Kiayi Hospital	Luanda	715	11 (2%)
Central Dudo Hospital	Lunda Norte	37	37 (100%)
Malanje Maternity	Malanje	167	25 (15%)
C.M Infantil	Namibe	128	20 (16%)
Negage Municipal Hospital	Uíge	164	17 (10%)
Provincial Hospital and Maternity	Uíge	195	16 (8%)

The Ministry of Health meanwhile recognises that maintenance of many facilities is deeply inadequate. A significant number of hospitals and clinics lack connections to the electricity grid, functioning generators, and regular water supply, all of which are likely to compromise the quality of service provided.⁶³

Another issue inhibiting the quality of maternal and reproductive health care services in Angola is that most facilities reportedly do not have individual patient records. This has been identified as a serious obstacle to improving maternal health outcomes, given that a complete and accurate patient history is often not accessible to the attending clinician during delivery.⁶⁴

Lack of transparency and accountability in how funds are allocated and spent impedes effective investment in maternal and reproductive health care services

As the Committee emphasizes in its General Recommendation No.24, states must act to *the maximum extent of their available resources* to ensure that women realize their rights to health care. In its 2008 Concluding Observations on Angola, the Committee on Economic, Social and Cultural Rights noted its concern that, in spite of the country's significant economic growth and huge natural wealth, the resources allocated to social services and public infrastructure were far from adequate. The Committee recommended that Angola "take all appropriate measures, including by allocating product of oil and diamond revenues, to accelerate the rehabilitation and reconstruction of public infrastructure and social services in both urban and rural areas".

The Angolan Government has made a major effort to build up public infrastructure—including health facilities—that was seriously damaged by the civil war and, at the aggregate level, Angola appears to be investing in the social sector. In the 2012 budget, the social sector was allocated over

30% of total public expenditure and spending on education and health increased by 10%.⁶⁵ Nevertheless, an opaque budget formulation process and concerns about the actual execution of funds, raise questions about the degree to which Angola is in fact supporting programs to improve maternal and reproductive health care services to the maximum extent of available resources.

Angola compares relatively favorably on select health financing indicators. In 2010, per capita health spending was estimated to be USD 123, compared to a regional average of USD 85.⁶⁶ Household out-of-pocket spending on health is lower in Angola than in its neighbors; it was estimated to account for 18% of health expenditure in 2010, compared to the regional average of 32%.⁶⁷ It is also less dependent on external sources of funding; 3% of health expenditure in 2010 came from external sources, compared to a regional average of 10%.⁶⁸

Nevertheless, the share of government spending allocated to health remains low compared to government spending overall. Although health spending climbed steadily from 2% of the budget in 1999 to 10% in 2009, it then dropped to 7% in 2010.⁶⁹ This is still well below the Abuja Declaration commitment to allocate 15% of government spending to health.

Moreover, general increases in health spending do not provide a full picture of who is benefiting from allocated resources. Angola lacks a comprehensive health infrastructure development plan accompanied by a clear budget. In its consolidated budget, the Ministry of Finance categorizes allocations as being either 'institutional', 'functional' or 'economic', which makes it difficult to discern amounts invested in each area.⁷⁰

In 2010, a Health Systems Assessment conducted by USAID noted that allocation patterns appeared to be increasingly prioritizing primary care, in both absolute and relative terms, when compared to

secondary and tertiary care. However, the same report raised concerns about wide variations between provinces in terms of allocations for both infrastructure investment and recurrent expenses.⁷¹

Further, there is no information publically available on the amount of money allocated specifically to maternal and reproductive health. However, it is notable that, according to the same USAID assessment, the Reproductive Health Program “lacks the basic resources to run effectively” since it lost donor support a few years ago, which seriously undermines Angola’s ability to improve its maternal health indicators.⁷²

Part of the challenge in evaluating Angola’s financing of maternal and reproductive health care is the closed nature of the budgetary process in the country. In 2010, Angola’s Open Budget Index (OBI) score was 26 out of 100, which is significantly below the average (42) for the 94 countries surveyed. Angola’s score indicates that the government provides the public with “minimal information” on the central government’s budget and financial activities. Angola’s OBI score did increase substantially, from 4 out of 100 in 2008. This is largely because the government started publishing an Executive Budget Proposal, though “it is far from being comprehensive”.⁷³

Significantly, spending is not having the expected impact on health outcomes.⁷⁴ There are issues in relation to how effectively allocated resources flow from the central government to health service providers. With most of the budget still allocated through the central government (86% in 2010, for example⁷⁵), this is a major issue.

Available data from 2000-2005 indicate that, on average, less than three quarters of resources allocated to health were actually spent.⁷⁶ In line with its decentralized structure, the Ministry of Finance allocates budgets to the Health Ministry; national and provincial hospitals; and provincial and some district governments, who in turn allocate funds to primary care facilities. Primary

health facilities are dependent entities without budgetary authority, whose operational resources are delivered in-kind. Provincial and district governments retain some autonomy over how they allocate funds. Meanwhile, the Ministry of Administration pays all civil servants, including health workers, directly.

A disconnect between planning and budgeting, together with weak financial management, and excessively bureaucratic and time-consuming procurement procedures limits the capacity of health service providers to use resources effectively. This, in turn, exacerbates problems related to the poor maintenance of health facilities and equipment (including ambulances) and the lack of drugs and medical supplies.

More troublingly, weak financial management fuels corruption. In its 2008 Concluding Observations, the Committee on Economic, Social and Cultural Rights noted with concern that “the State party has not yet adopted strong and efficient measures to combat corruption and impunity, despite the fact that the State party is a country with a high level of corruption”.⁷⁷ Organizations such as OSISA, Christian Aid and Human Rights Watch have documented the “immense” corruption and mismanagement in Angola.⁷⁸ Angola was ranked 168 out of 182 countries in Transparency International’s Corruption Perceptions Index, with a score of 22 out of 100.⁷⁹ It has remained among the most corrupt countries in the index since it was first introduced in 2000.⁸⁰

The World Bank has similarly expressed concerns about the lack of transparency and accountability in public spending in Angola, in particular that accountability is directed “upward to the president, not toward public institutions, civil society or media”.⁸¹ Recently, there have been some initiatives to increase accountability for public spending, such as the implementation of an Integrated Financial Management System. However, this new system has weaknesses, including a poor

financial statistical system, which prevents Angolans from evaluating how the government uses public funds.⁸²

Lack of accountability and transparency also weakens the country's ability to effectively mobilize resources for social services, including maternal and reproductive health. For example:

- Human Rights Watch reports that from 1997 to 2002, approximately USD 4.2 billion disappeared from government coffers, roughly equal to all foreign and domestic social and humanitarian spending in Angola in the same period.⁸³
- A study by Tax Justice Network found that the amount of revenue lost by Angola to tax evasion is equivalent to 86% of the amount of money spent on healthcare by the central government.⁸⁴
- UNDP estimates that from 1990 to 2009 illicit financial flows amounted to 10.9% of Angola's GDP, more than twice the average for least developed countries (4.8%).⁸⁵

Participation has been stifled by the concentration of political power among a ruling economic elite

In its 2004 concluding observations on Angola the Committee urged the state to make the promotion of gender equality an explicit component of all its national development strategies, policies and programmes, in particular those aimed at poverty alleviation and sustainable development. It called, in particular, for the participation of rural women, women heads of household, refugee women and internally displaced women in decision-making and in the formulation and implementation of policies and programmes.

However, there is a marked paucity of participation in Angola, including a lack of:

- institutional mechanisms for ensuring people's participation;

- capacity-building activities that address empowerment and power relations;
- ongoing engagement (in setting the agenda for discussion, policy choices, implementation, monitoring, and evaluation); and
- accessible accountability and conflict-resolution mechanisms.⁸⁶

The roots of this problem lie in the country's history of protracted conflict and colonization. After independence, the war provided a justification for the suppression of civil society, and this practice remained in place after the end of the fighting. UNDP reports that cooptation, particularly through the country's Public Utility legislation, is commonplace, along with outright repression and prohibition.⁸⁷ Several international civil society organizations have also expressed their concern about threats and attacks on human rights defenders in Angola—including activists, journalists, lawyers, religious leaders, academics and artists—and the lack of investigation into such incidents.⁸⁸

In line with efforts to decentralize Angola's government, which were initiated in 1999, municipalities are responsible for the management and planning of health services. However, there is no formal mechanism in place to ensure that appointed public servants, who are responsible for implementing the decentralization process, guarantee a participatory process.⁸⁹ Of late, consultative forums⁹⁰ have been organized in many districts in an effort to improve planning, but they are still far from representing meaningful citizen involvement in policy design and implementation.⁹¹

However, decentralization undertaken with the aim of boosting democratic systems and improving institutional efficiency, has not succeeded in dissolving the concentration of authority in the country, which also manifests in the process of selecting public officials, such as provincial health directors, and in control over resources.

Angola has a “presidential system to an extreme degree”.⁹² President dos Santos has been in office since 1979, and in January 2010 Parliament ratified a new constitution eliminating presidential elections and allowing him (so long as he remains MPLA leader) to stay in power until 2022.⁹³ Moreover, the executive branch of government does not depend on Parliament and cannot be voted out, the Supreme Court exercises little influence over the government, and Parliament has a very narrow mandate.⁹⁴ According to Human Rights Watch, the President and ruling MPLA party have secured a near stranglehold on political power in the country, which is also a path to economic enrichment.⁹⁵

Given that Angola is not a country bereft of resources, the almost total absence of civil society participation in policy development and resource management is particularly lamentable. Overcoming Angola’s governance issues is crucial to challenging the economic and political dynamics of self-enrichment and exclusion in the country, so as to ensure that economic growth makes a meaningful difference to the lives of Angolan women.⁹⁶

In effect, the signatories to this submission are concerned that Angola has not taken adequate measures to fulfill women’s right to reproductive health. In particular, we are concerned about the country’s slow progress in reducing maternal and neonatal mortality; high and highly uneven fertility rate, especially among teenage girls; and low contraceptive use. Progress on these indicators does not suggest improvements commensurate to the ten-fold increase in the country’s wealth in the past decade.

We are also concerned that Angolan women, particularly poor women and women living in rural areas, continue to face acute physical, economic and socio-cultural barriers to accessing essential services along the continuum of care—from pre-pregnancy (family planning, treatment of sexual transmitted infections, including HIV), to

pregnancy (antenatal care, management of unintended pregnancies, including safe abortion services), birth (delivery assistance and emergency obstetric care), and infancy (postnatal and neonatal care). While welcoming the government’s efforts to rebuild health infrastructure and decentralize health services to the local level, we are concerned that the resources allocated to such efforts are insufficient and ineffective due to a pronounced lack of participation, transparency and accountability. Angola’s vast oil wealth gives it a great opportunity to make a difference to maternal and reproductive health. However, we are concerned that it has not dedicated the maximum extent of available resources to reducing disparities in coverage of essential services across the country.

For the Committee to meaningfully assess the efforts undertaken by Angola to fulfill women’s reproductive health rights, it is necessary that the state go beyond simply naming policies and programs to provide specific details about the resources allocated to them, their implementation in practice, and the outcomes they have achieved.

We therefore propose that the Committee consider addressing the following questions to the Angolan government delegation during its 54th Session

- How does the government plan to improve the availability of quality national data on maternal and reproductive health outcomes?
- What specific steps have been taken to reduce deaths due to pregnancy and birth-related complications? In particular what is being done to:
 - Ensure that healthcare facilities are adequately equipped?
 - Address shortages and stock-outs of essential medicines and supplies?
 - Increase the numbers of qualified personnel?

- Reach rural communities and households with cost-effective interventions?
- Raise awareness about the importance of seeking care during pregnancy and childbirth?
- Provide women with effective remedies for violations of their rights?
- How are these initiatives monitored and evaluated? Can the government point to any specific results achieved in progress towards the goal of reducing the maternal mortality rate?
- What is the status of the bill that codifies the circumstances in which abortion is permitted? What other steps are being taken to ensure that safe, legal abortions can be obtained in public hospitals in accordance with the existing penal code?
- How is the state budgeting specifically for maternal and reproductive health and the prevention of maternal mortality? What oversight mechanisms ensure the timely disbursement and effective use of funds?
- What channels are there for women to participate in developing, implementing and monitoring reproductive health policies?

We further submit the following recommendations that the Committee may wish to consider incorporating into its concluding observations for Angola.

Within the framework of the Committee's General Recommendation No.24 (1999), the State party should take all necessary measures to reduce the country's high maternal mortality rate. In particular, the State party is urged to:

- (a) Prioritize, as a matter of urgency, the regular collection, analysis and publication of disaggregated data on maternal mortality and morbidity across the country.
- (b) Build an effective health information system that regularly collects disaggregated data on the provision and utilization of maternal and reproductive health care

services to support evidence-based planning and budgeting.

(c) Develop and implement a reproductive health strategy and plan of action that includes concrete, time-bound targets for improving the coverage and quality health services along the continuum of care—particularly for poor women, rural women, and adolescents.

(d) Scale up efforts to address human resource gaps in relation to maternal and reproductive health care services, particularly in rural areas.

(e) Improve management systems to address the chronic shortage and stock-outs of medicines and supplies essential for maternal and reproductive health in public health facilities.

(f) Adopt reforms to the penal code and take necessary measures to provide safe and legal abortions and quality post-abortion care.

(g) Ensure that the strategy and plan of action are sufficiently funded and effectively managed by: increasing resources allocated to maternal and reproductive health and clearly identifying them in the overall health budget; improving budget execution rates; and guaranteeing that the devolution of funds is used to promote equity by allocating more funds to poorer provinces.

Endnotes

¹ See Ducados, H. (2004) 'Angolan women in the aftermath of conflict', *Accord 15*.

² AfDB, OECD, UNDP, UNECA (2012) *African Economic Outlook 2012: Angola*, 2.

³ UNDP (2011) *Human Development Report 2011- Sustainability and Equity: A Better Future for All*, Statistical Tables.

⁴ Instituto Nacional de Estatística (2011) *Inquérito Integrado sobre o Bem-Estar da População 2008-2009*.

⁵ Ministério do Planeamento (2010) *Relatório sobre os objetivos de desenvolvimento do Milénio*.

⁶ CEDAW (2004) *Concluding Observations on Angola*, para. 162.

⁷ WHO, UNICEF, UNFPA & World Bank (2012) *Trends in Maternal Mortality: 1990 to 2010*.

⁸ High MMR is defined as ≥ 300 maternal deaths per 100,000 live births. Angola is one of 40 countries that UNFPA identifies in this category.

⁹ Id. at 32.

¹⁰ Ministério Do Planeamento, above n 5.

¹¹ WHO et al, above n 7, at 32.

¹² Id, at 50.

¹³ Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. UNICEF, WHO, World Bank, UN DESA, UNPD (2011) *Level and Trends in Child Mortality*.

¹⁴ Cosep Consultoria, Consaúde, and ICF International (2011) *Angola Malaria Indicator Survey 2011* and Consultoria de Serviços e Pesquisas–COSEP Lda., Consultoria de Gestão e Administração em Saúde–Consaúde Lda. [Angola], and Macro International Inc. (2007) *Angola Malaria Indicator Survey 2006-07*.

¹⁵ Ministerio Do Planeamento, above n 5.

¹⁶ Data source: Household surveys, including Demographic and Health Surveys by Macro International and Multiple Indicator Cluster Surveys by UNICEF.

¹⁷ Instituto Nacional De Estadística, above n 4.

¹⁸ Ministério Do Planeamento, above n 5, at 47.

¹⁹ Frøystad M., Mæstad O., & Villamil N. (2011) 'Health services in Angola: Availability, quality and utilisation', *CMI Report*, 3.

²⁰ Id. at 4.

²¹ Id. at 7.

²² Id. at 4.

²³ Connor, C., Averbug, D. et al (2010) *Angola Health System Assessment 2010*, USAID Health Systems 20/20 Project, 71.

²⁴ Id. at XXIV.

²⁵ World Bank, (2010) 'Project appraisal document on proposed credit in the amount of SDR 46.7 million to the Republic of Angola for a municipal health service strengthening project (MHSS)', 29.

²⁶ UNICEF (August 2010) 'UNICEF welcomes Angolan Government campaign to reduce maternal and infant mortality', News Note.

²⁷ World Bank, above n 25 at 29.

²⁸ African Development Bank (2008) *Angola: Country Gender Profile*, 21.

²⁹ The survey collected data in the Cazenga, Klimba Kiayi and Ingombota municipalities in the Luanda province, and in the Uíge, Quitexe and Puri municipalities in the Uíge province in collaboration between CMI and the Centro de Estudos e Investigação Científica (CEIC) in 2010. 40 health facilities (6

hospitals, 19 health centers and 15 health posts) and 953 households, where at least one child was born in the last five years were surveyed. CMI (2012) 'Angola health survey: Opportunities to reduce maternal and newborn mortality', *Angola Brief*, Volume 2, No.3.

³⁰ Ministério Do Planeamento, above n 5, at 49.

³¹ Data source: UNICEF, State of the World's Children, ChildInfo, and Demographic and Health Surveys by Macro International.

³² Ministério Do Planeamento, above n 5, at 48.

³³ CMI, above n 29, at 3.

³⁴ Connor et al, above n 23 at 73.

³⁵ OHCHR, *Technical Guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality* (2 July 2012) U.N. Doc A/HRC/21/22, para. 20.

³⁶ CEDAW, above n 6 at paras. 162, 165.

³⁷ Ministério da Saúde & UNICEF (2010) *Relatório final conjunto*.

³⁸ Ministério da Saúde, above n 37 at 132.

³⁹ CMI, above n 29 at 3.

⁴⁰ Ministério da Saúde, above n 37.

⁴¹ Connor et al, above n 23 at 72.

⁴² Ministério da Saúde, above n 37, at 38.

⁴³ Ibid.

⁴⁴ Connor et al, above n 23, at 38.

⁴⁵ Id. at 37.

⁴⁶ Ministério da Saúde, above n 37, at 35.

⁴⁷ Wilson, R., Kade, K., Weaver, A., De Lorenzi, A., Yeager, B., Patel, S., Ahmed, K., Armbruster, D. & Bergeson-Lockwood, J. (2012) *Medicines for Maternal Health: Key data and findings*. PATH, SIAPS/MSH, UNFPA, USAID.

⁴⁸ Cosep Consultoria et al, above n 14, at 26.

⁴⁹ Instituto Nacional De Estadística, above n 4.

⁵⁰ Ministério da Saúde, above n 37 at 132.

⁵¹ Instituto Nacional De Estadística, above n 4. at v.

⁵² CMI, above n 29 at 2.

⁵³ Ministério da Saúde, above n 37.

⁵⁴ Connor et al, above n 23. Secondary level care refers to specialised and consultative services, while tertiary level care refers to highly technical services, often only available at a major medical centre.

⁵⁵ Ministério da Saúde, above n 37.

⁵⁶ Ibid.

⁵⁷ *Angolan Civil Society Report concerning the Right to Education, to Housing, to Employment, to Health and to Food*, Submitted to the Committee on Economic, Social and Cultural Rights, 2008.

⁵⁸ World Bank, above n 25 at 23.

⁵⁹ CMI, above n 29 at 2.

⁶⁰ World Bank, above n 25 at 23.

⁶¹ Ministério da Saúde, above n 37.

⁶² Id, at 138.

⁶³ Ibid.

⁶⁴ Connor et al, above n 23, at 62.

⁶⁵ AfDB, OECD, UNDP, UNECA, above n 2.

⁶⁶ Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but does not include provision of water and sanitation. World Health Organization National Health Account database.

⁶⁷ Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure. World Health Organization National Health Account database.

⁶⁸ External resources for health are funds or services in kind that are provided by entities not part of the country in question. The resources may come from international organizations, other countries through bilateral arrangements, or foreign non-governmental organizations. These resources are part of total health expenditure. World Health Organization National Health Account database.

⁶⁹ WHO (2010) 'Health System Financing Country Profile: Angola', available online at http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_COUNTRY_PROFILE.

⁷⁰ Connor et al, above n 23, at 30.

⁷¹ Id. at 27-29.

⁷² Id. at 72.

⁷³ Open Budget Partnership (2011) *Open Budget Index: Angola 2010*. See: <http://internationalbudget.org/wp-content/uploads/2011/04/OB12010-Angola.pdf>

⁷⁴ World Bank, above n 25 at 28.

⁷⁵ Governo da República de Angola, (2010) 'Orçamento Geral do Estado. Proposta orçamental. Exercício Económico de 2010'.

⁷⁶ Connor et al, above n 23, at 34.

⁷⁷ CESCR (2008) *Concluding Observations on Angola*, at para.10.

⁷⁸ See, e.g. Human Rights Watch (2010) *Transparency and Accountability in Angola: an update*, 1.

⁷⁹ Transparency International, Corruption Perceptions Index online data tool. See:

<http://www.transparency.org/cpi2012/results>

⁸⁰ Human Rights Watch, above n 78, at 2.

⁸¹ World Bank, above n 25.

⁸² Human Rights Watch, above n 78.

⁸³ Id. at 1.

⁸⁴ Tax Justice Network (2011) *The Cost of Tax Abuse: A briefing on the cost of tax evasion worldwide*.

⁸⁵ Illicit financial flows involve the cross-border transfer of the proceeds of corruption, trade in contraband goods, criminal activities and tax evasion. UNDP (2011) *Illicit Financial Flows from the Least Developed Countries: 1990-2008*.

⁸⁶ Potts, H. (2008) 'Participation and the right to the highest attainable standard of health'. Essex, Human Rights Centre, University of Essex.

⁸⁷ E.g., the human rights organization Mpalabanda, which gathered evidence of human rights violations by members of the government, was summarily shut down in 2006. Similarly, in July 2007 the director of the Government's Technical Unit for the Coordination of Humanitarian Aid (UTCAH) declared in radio and TV interviews that some CSOs, including SOS Habitat and Open Society Angola, were not fully legalized and threatened them with prosecution or expulsion. For more information, see: UNDP Angola (2008), 'Position Paper II, Civil Society and Government Accountability'.

⁸⁸ ACAT-France et al (2011) 'Joint Open Letter to the authorities', 16 August 2011 (letter signed by 12 international organizations with regard to the human rights situation in Angola), available at: <http://www.fidh.org/Joint-Open-Letter-to-the>

⁸⁹ Connor et al, above n 23.

⁹⁰ These are known as Conselhos de Auscultação e Concertação Social (Social Dialogue and Consultation Councils).

⁹¹ Connor et al, above n 23.

⁹² Isaksen, J., I. Amundsen et al (2007) 'Budget, State and People. Budget Process, Civil Society and Transparency in Angola'. *CMI Report*.

⁹³ Human Rights Watch, above n 78.

⁹⁴ Isaksen, J., I. Amundsen, (et al), above n 92.

⁹⁵ Human Rights Watch, above n 78, at 3, 5.

⁹⁶ Comerford, M. (2007) 'Peace agreements in Angola and implications for governance'. *Conflict Trends*.