GOOD PRACTICES FOR ENSURING ACCOUNTABILITY FOR WOMEN'S REPRODUCTIVE HEALTH
SUBMISSION TO THE INDEPENDENT EXPERT REVIEW GROUP CALL FOR EVIDENCE
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This submission responds to the Expert Review Group's request for information on good practices or obstacles in accountability arrangements as they relate to the implementation of the Commission on Information and Accountability (Commission) recommendations. The submission focusses specifically on recommendation 7, which calls for transparent, inclusive national accountability mechanisms. It focuses on good practices from human rights-based accountability mechanisms to promote and protect women's and adolescents' reproductive health, and in particular to secure women's access to safe abortion. Part I demonstrates how human rights accountability mechanisms can constitute a crucial component of implementing the Global Strategy for Women's and Children's Health (Global Strategy) and Commission recommendations. Part II examines types of human rights accountability apparatuses that, where implemented effectively, have allowed for positive steps to be taken towards securing the right to health for women.

I. THE ROLE OF ACCOUNTABILITY IN IMPLEMENTING THE GLOBAL STRATEGY

As the Global Strategy acknowledges, international human rights treaties firmly establish women's and children's health as a fundamental human right. Human rights are not only moral or political commitments, but also legal obligations. Accountability is the process whereby States, as duty-bearers, demonstrate, explain and justify how they have discharged their human rights obligations to rights-holders and provide remedies and redress where they have failed.[1]

Effective accountability arrangements – operating locally, nationally and internationally – must be both prospective and retrospective. Prospective aspects of accountability fit in with the core components of the accountability framework identified by the Commission to monitor, review and act.[2] Accountability mechanisms help identify which laws, policies and plans work, so that they can be continued, and which are not successful, so they can be reevaluated.[3] Accountability requires the establishment of accessible mechanisms through which the government can explain and justify its policies and programs to rights-holders and receive their feedback. Concurrently, such mechanisms must empower citizens, particularly members of marginalized groups, to claim

their rights and participate in formulating and monitoring policies that impact their lives.[4] Thus, an effective accountability system increases the transparency of State decision-making, enhances public access to information, and demands active participation from diverse stakeholders.[5] Monitoring mechanisms complement accountability mechanisms by ensuring the collection and analysis of appropriate data to measure the State's compliance with its human rights obligations.[6]

It is essential that accountability mechanisms as envisaged in the Commission's recommendation 7 include those that act retrospectively. Retrospective aspects of accountability remedy and redress the State's failures to fulfill its human rights obligations. Human rights law guarantees the right to an effective remedy,[7] which includes reform of policies or programs, introduction of legislation, or human rights trainings for government officials or others who implement relevant programs. Remedies also include traditional forms of redress such as compensation for victims of human rights violations.

Establishing and supporting effective accountability mechanisms, and implementing their recommendations, is crucial to ensuring the commitments that States have made under the Global Strategy and as States parties to international human rights treaties are upheld. By providing a forum to assess States' compliance with their human rights obligations, accountability mechanisms can translate human rights into concrete realities for individuals.[8]

II. Good practices in Using Human Rights Accountability Mechanisms to Promote Women's Health

Accessible, transparent, independent and effective accountability mechanisms are fundamental to improving policies and programs to ensure women's and children's health.[9] We have divided them into three general groups: judicial, quasi-judicial and non-judicial mechanisms.

a. Judicial

Judicial mechanisms have enabled rights-holders to bring claims before a third-party arbiter at the national, regional or international level to determine whether rights violations have occurred.[10] Through judicial review, courts have determined whether a State failed to meet its constitutional and international human rights obligations related to women's and children's health, compel state action to correct systemic policy failures or order remedies for victims.[11]

i. National Courts

In India, advocates in domestic courts have successfully drawn on constitutional and human rights law to argue that the State is not fulfilling its legal obligations to prevent maternal

mortality and morbidity.[12] In the 2010 decision of *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others*, the Delhi High Court recognized a constitutionally-protected right to maternal healthcare and ordered compensation for rights violations experienced by two impoverished women, one of whom died during childbirth. The High Court recognized the State's failure to implement various programs to reduce maternal and infant mortality.[13] It ordered the State to financially compensate the women's families[14] and specifically directed the State to remedy deficiencies in and improve monitoring of public health programs.[15]

Similarly, in the case of *Sandesh Bansal v. Union of India and Others* local advocates represented by the Human Rights Law Network, brought a case against Madhya Pradesh to push for structural change to address the State's high rates of maternal mortality.[16] In particular, the case sought to hold the State of Madhya Pradesh accountable for the unacceptable conditions in its health facilities, which contribute to the state's high maternal mortality ratio, and achieve implementation of existing maternal health policies and programmes. The final decision in this case, issued in February 2012,[17] held the government responsible for failing to implement its own policies on maternal health and, more specifically, for failing to ensure timely access to maternal health care. It provided specific orders calling for basic infrastructure improvements, ensuring the availability of an emergency vehicle, the provision of vaccinations to pregnant women and the establishment of a monitoring system to track patient records. Interim orders issued by the High Court of Madhya Pradesh while the case was still pending led to the approval of a license for a long-awaited hospital blood bank and construction of a water tank to help bring a primary health center into compliance with the applicable standards.[18]

ii. REGIONAL HUMAN RIGHTS COURTS

Regional human rights courts, such as the African Court on Human and Peoples' Rights, the Inter-American Court of Human Rights and the European Court of Human Rights, have played an important role in ensuring accountability for pregnancy-related rights violations in cases where national oversight has failed or been insufficient. These mechanisms play an important role in issue legally-binding rulings and advisory opinions on the interpretation of treaties relevant to women's and children's health.[19] For example, in the 2009 case of *Xákmok Kásek Indigenous Community v. Paraguay*, about the right of an indigenous community to ancestral land, the Inter-American Court of Human Rights condemned the absence of special measures to protect pregnant women for as contributing to the pregnancy-related deaths of indigenous women,[20] rebuking Paraguay's failure to implement policies to train skilled birth attendants, provide pregnancy-related care, and document cases of maternal mortality.[21] It ordered the State to establish immediate measures to provide healthcare for pregnant women[22] and directed it to conduct a study with the participation of community members and experts, to identify means for

adapting maternal care to community needs.[23] In crafting this remedy, the Court mandated broad stakeholder participation in developing policies to combat maternal death.

b. QUASI-JUDICIAL

Quasi-judicial bodies, including NHRIs, health tribunals and U.N. Treaty Monitoring Bodies (TMBs), are also important mechanisms for holding states accountable to their obligation to ensure women's and children's right to health.[24]

i. NATIONAL HUMAN RIGHTS INSTITUTIONS (NHRIS)

NHRIs are independent governmental bodies that advance and defend human rights.[25] Therefore, they have an important role in ensuring national oversight for maternal health. NHRIs can use their powers to conduct inquiries into women's health issues and make recommendations to the government aimed at improving progress towards health outcomes, human rights obligations and other global commitments.[26]

In 2011, the Kenya National Commission on Human Rights (KNCHR) initiated a public inquiry into sexual and reproductive health rights in Kenya. The KNCHR recently released a report documenting the findings of this inquiry, and included concrete recommendations for removing barriers to the realization of women's right to sexual and reproductive health, including improving access to contraceptive information and services, maternal healthcare, and safe and legal abortion, and protecting the sexual and reproductive health rights of vulnerable or marginalized groups.[27]

Through this inquiry, the KNCHR played a positive role in promoting accountability, using its formal, non-partisan powers to call for change in line with constitutional protections and international legal standards

ii. OMBUDSPERSON OR PATIENT'S RIGHTS TRIBUNALS

Likewise, Ombudsperson offices, Patient's Rights Tribunals and Healthcare Commissions, as autonomous quasi-judicial accountability bodies, have played a crucial role in furthering accountability. Specifically, the creation of an independent Ombudsperson on women's and children's health, or dedicated unit within an Ombudsperson's office, can provide oversight of the maternal and pediatric health systems and a mechanism to facilitate dialogue among different actors involved in such healthcare, and can also promote access to judicial mechanisms where necessary.[28] The Peruvian Ombudsman (Defensoría del Pueblo) has a dedicated Women's Rights Unit, which includes a focus on maternal health,[29] and the Ombudsman's office has investigated

violations of the right to safe motherhood[30] and the right to access contraceptive services free from coercion.[31]

Patient's Rights Tribunals or Healthcare Commissions handle complaints about the healthcare system, services or employees.[32] These quasi-judicial mechanisms may also issue binding resolutions that compel changes within the health sector, conduct investigations into particular facets of the health system and formulate recommendations for implementation by policymakers.[33] In the United Kingdom, following a national review of maternity services conducted by the Healthcare Commission, which revealed troubling variations in the quality of care throughout the country, in 2008, the Healthcare Commission collaborated with stakeholders, such as women and clinicians, to establish performance benchmarks for providing maternity services.[34]

iii. U.N. TREATY MONITORING BODIES

U.N. TMBs have developed a vast jurisprudence in relation to national efforts to provide quality health care to women and children.[35] This jurisprudence supports the Global Strategy's call for the use of existing global accountability mechanisms "to support accountability efforts at the national and global level."[36] In this way the TMBs have served as essential forums for accountability where national oversight has failed to ensure accountability to women seeking access to safe abortion or for equitable distribution of resources.

The Global Strategy urges states to ensure that women "have access to a universal package of guaranteed benefits, including … safe abortion services (when abortion is not prohibited by law)."[37] The cases of *L.C. v. Peru*, which the Center for Reproductive Rights and its partner organization Promsex filed before the Committee on the Elimination of Discrimination against Women (CEDAW Committee), and *K.L. v. Peru*, which the Center for Reproductive Rights and its partner organizations DEMUS and CLADEM filed before the Human Rights Committee, demonstrate the importance of TMBs in holding States accountable for access to safe abortion services, where national efforts have been unsuccessful.

L.C., a 13-year-old girl, became pregnant as a result of rape and, scared and ashamed, she attempted suicide by jumping off the roof of a building near her home. Her suicide attempt resulted in a devastating spinal injury, and doctors concluded that an emergency surgery was necessary. However, when hospital staff learned that L.C. was pregnant, they postponed the surgery. L.C. and her mother requested a legal therapeutic abortion, but hospital officials denied their request. L.C. was only able to access the surgery weeks later, after she had miscarried, at which point the procedure was virtually useless. L.C. is now quadriplegic.[38] In 2011, the CEDAW Committee agreed, finding that the Peruvian government violated L.C.'s rights to health and to freedom from discrimination by denying her a safe, legal abortion, and called on

the government to compensate L.C. and provide measures of rehabilitation. The Committee also urged Peru to establish an effective mechanism for ensuring access to abortion where necessary to preserve a woman's physical or mental health and to consider decriminalizing abortion where pregnancy is a result of rape or sexual abuse.[39]

When K.L., a 17-year-old girl, learned that the fetus she was carrying had anencephaly—a condition that is fatal in all cases—her physician advised her to terminate the pregnancy and K.L. sought an abortion. Hospital officials, however, prevented K.L. from accessing a legal abortion, forcing her to carry an unviable fetus to term, with significant consequences to K.L.'s mental health. In 2005, the Human Rights Committee found that the Peruvian government had violated K.L.'s rights to be free from cruel, inhuman and degrading treatment, to privacy, and to special protection as a minor by denying her a safe, legal abortion, and called on the Peruvian government to take steps to prevent similar violations from occurring.[40]

The Global Strategy also calls for states to "strengthen health systems to deliver integrated, high-quality services….especially at the community level and to the underserved."[41] The case of *Alyne da Silva Pimentel v. Brazil*, which the Center for Reproductive Rights and its partner organization Advocaci filed before the CEDAW Committee on behalf of a woman who suffered a preventable maternal death, provides another example of how TMBs have been used to ensure accountability, in this case where national efforts to ensure equitable distribution of resources have been insufficient.[42] Alyne, an Afro-Brazilian woman living in one of the poorest districts of Rio de Janeiro, died from preventable causes when she sought maternal care for signs of a high-risk pregnancy from her local health center. Recognizing that racial and gender inequalities underlie Brazil's high maternal death rates and that Alyne's death in particular stemmed from multiple forms of discrimination in terms of both the health care that she had access to and the quality of care that she received as an Afro-Brazilian woman, the CEDAW Committee established that the Brazilian government had violated Alyne's rights to health and to freedom from discrimination.[43] In particular, the Committee drew attention to the fact that while policies and measures for the provision of quality medical care did exist in Brazil, the failure to manage human resources and allocate funding to policy implementation contributed to the violation of Alyne's rights. The CEDAW Committee's jurisprudence in this way shines a light on an obstacle to implementation of the Global Strategy, and supports efforts for accountability that national mechanisms have been unable to address.

c. NON-JUDICIAL

i. MATERNAL DEATH REVIEWS

Maternal death reviews, which are community and/or facility based, systematically examine the incidence and prevalence of maternal mortality and morbidity, thereby enabling health professionals to review the treatment provided and identify ineffective medical practices.[44] Community-based maternal death reviews have established the cause of death and illuminate any personal, familial and/or community factors contributing to the death. Generally, in such reviews trained field-workers interview family members and others who can help to identify factors leading to the death.[45] This community level discussion can facilitate the introduction of measures to prevent maternal deaths and disability.[46] Facility-based reviews are "qualitative, in-depth investigations of the causes of, and circumstances surrounding, maternal deaths which occur in healthcare facilities."[47] In 1986, Sri Lanka made qualitative investigations into the causes of maternal deaths obligatory, and these audits have been an effective tool for identifying key gaps in the provision of services that contribute to preventable maternal deaths, which in turn has informed development of maternal health policies in the country.[48]

Where information gathered from maternal death reviews informs efforts to develop better policies, it can improve the quality of maternal health services and shape resource distribution. Reviews also serve as a baseline to measure progress in reducing maternal deaths and disability. However, in order to increase accountability, an independent body with authority to oversee State action and to verify the implementation of recommendations, must review the data to ensure the provision of objective, non-biased analysis and recommendations to policymakers.[49]

ii. POLITICAL AND LEGISLATIVE PROCESSES

Political and legislative processes are essential non-judicial mechanisms to hold governments accountable to implement laws and policies that promote women's and children's health. The effectiveness of political processes varies among countries, depending upon the political structure, the strength of political parties and the level of popular participation in free and fair electoral processes.[50] Civil society's ability to hold political actors accountable may be greater in countries with well-developed and transparent political and legislative systems.

One legislative process to enhance accountability is the creation of Parliamentary Committees, which can evaluate and investigate proposed policy or legislation, and determine budgetary allocations.[51] They also engage civil society by relying on relevant reports or testimony from outside parties to inform their analysis. In 2001, an Inquiry Commission established by the Brazilian National Congress published a report on the incidence of maternal mortality. The report resulted from hearings and public debates with civil society individuals and organizations

and contained recommendations for government agencies on improving women's access to quality maternal healthcare services and strengthening accountability systems.[52]

Political and legislative processes are most effective when States utilize them jointly. Specifically, legislative measures must accompany a State's political commitment to reducing preventable maternal death and disability.[53] For example, in 2002, Mali enacted a law on reproductive health, which recognizes that one aim of reproductive healthcare is to reduce maternal mortality and morbidity.[54] Furthermore, it ensures the women's rights to healthcare during pregnancy and childbirth.[55]

III. CONCLUSION

Implementation of the Global Strategy and the Commission's recommendations must be supported through a broad conceptualization of accountability. The absence and ineffectiveness of such mechanisms presents one of the biggest challenges in realizing their human rights. As set out above, different types of local, national and international mechanisms play an important role in upholding human rights obligations regarding women's and children's health: these obligations require States to take action through reviewing laws and policies, assigning budgets, eliminating discrimination and ensuring cross-sector programming, and thus accountability mechanisms must reflect all these obligations. Regional and international accountability mechanisms fill a crucial gap where national mechanisms do not provide the necessary oversight. We recommend that the first iERG report capture this broad conceptualization of accountability, and, in particular, recognize the essential role played by international, regional, and national human rights mechanisms in furthering accountability as envisaged in the Global Strategy.

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[1] *See* HELEN POTTS, UNIVERSITY OF ESSEX HUMAN RIGHTS CENTRE, ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH 13 (2008) [hereinafter POTTS, ACCOUNTABILITY].

[2] COMM'N ON INFORMATION AND ACCOUNTABILITY FOR WOMEN'S AND CHILDREN'S HEALTH, KEEPING PROMISES, MEASURING RESULTS 3 (2011) [hereinafter KEEPING PROMISES].

[3] *See id*. at 13-14.

[4] *Id*. at 13. For more on participation and human rights, *see* HELEN POTTS, UNIVERSITY OF ESSEX HUMAN RIGHTS CENTRE, PARTICIPATION AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH (2008), *available at* http://www.essex.ac.uk/human_rights_centre/research/rth/docs/Participation.pdf.

[5] POTTS, ACCOUNTABILITY, *supra* note1, at 13; Alicia Ely Yamin, *Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health*, 10 HEALTH & HUM. RTS. 1, 2 (2008), *available at* http://www.hhrjournal.org/index.php/hhr/issue/view/2.

[6] POTTS, ACCOUNTABILITY, *supra* note 1, at 14.

[7] *See, e.g.,* Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in marriage and family relations*, (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies Vol. II, at 337, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (2008); Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, (22nd Sess., 2000), para. 59, U.N. Doc. E/C.12/2000/4 (2000); Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation on States Parties to the Covenant*, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add/13 (2004).

[8] *See* POTTS, ACCOUNTABILITY *supra* note 1, at 13.

[9] *Id.* at 17.
[10] *Id*.
[11] *Id*. at 18; *see also* INTERNATIONAL COMMISSION OF JURISTS, COURTS AND THE LEGAL ENFORCEMENT OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMPARATIVE EXPERIENCES OF JUSTICIABILITY 6 (2008).
[12] The Center for Reproductive Rights has partnered with the Human Rights Law Network (HRLN), an Indian NGO, to develop a litigation strategy around maternal mortality and morbidity in India. For more information *see* CENTER FOR REPRODUCTIVE RIGHTS, MATERNAL MORTALITY IN INDIA: USING INTERNATIONAL AND CONSTITUTIONAL LAW TO PROMOTE ACCOUNTABILITY AND CHANGE 9 (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_br_maternal_mortality_in_india_2009.pdf [hereinafter MATERNAL MORTALITY IN INDIA]; *see also* Human Rights Law Network, *PILS & Cases*, http://www.hrln.org/hrln/index.php?option=com_content&view=category&layout=blog&id=109&Itemid=197 (last visited May 24, 2012).
[13] For a description of the relevant government programs, *see* Laxmi Mandal *v.* Deen Dayal Harinagar Hospital & Ors W.P. (C) No. 8853/2008 (Delhi H.C., 2010) paras. 3-9, 12-18.
[14] *Id.* paras. 51-61.
[15] *Id.* paras. 62, 64-70.
[16] *Sandesh Bansal v. Union of India & Others* W.P. (C) No. 9061/2008 (M.P. H.C., 2008).
[17] *Madhya Pradesh court declares violations of women's fundamental rights in Sandesh Bansal decision,* CENTER FOR REPRODUCTIVE RIGHTS (Feb. 29, 2012), http://reproductiverights.org/en/press-room/madhya-pradesh-court-declares-violation-of-women%E2%80%99s-fundamental-rights-in-sandesh-bansal-d.
[18] For more information on the implementation of these and other maternal mortality cases being litigated in India, see MATERNAL MORTALITY IN INDIA, *supra* note 12.
[19] *See* Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, *adopted* Jun. 9, 1998, art. 4, A.U. Doc. CAB/LEG/665 (*entered into force* Jan. 1, 2004); Convention for the Protection of Human Rights and Fundamental Freedoms, *adopted* Nov. 4, 1950, art. 47, 213 U.N.T.S. 222, Eur. T.S. No. 5 (*entered into force* Sept. 3, 1953); American Convention on Human Rights, *adopted* Nov. 22, 1969, art. 64, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978).
[20] Xákmok Kásek Indigenous Community of the Enxet-Lengua People and Its Members v. Paraguay, Judgment, Inter-Am. Ct. H.R. No. 12,420 para. 232-234 (Aug. 24, 2010).
[21] *Id*. para. 233.
[22] *Id*. para. 301.
[23] *Id*. para. 303-06.
[24] POTTS, ACCOUNTABILITY *supra* note 1, at 17.
[25] *Id*. at 18.
[26] *Id*.
[27] KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, REALISING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR A REALITY?: A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA (2012), *available at* http://www.knchr.org/Portals/0/Reports/Final%20Report_%20Sexual_Reprodutcive_health.pdf.
[28] PHYSICIANS FOR HUMAN RIGHTS, DEADLY DELAYS: MATERNAL MORTALITY IN PERU, A RIGHTS-BASED APPROACH TO SAFE MOTHERHOOD 131 (2007), *available at* http://physiciansforhumanrights.org/library/documents/reports/maternal-mortality-in-peru.pdf.
[29] Defensoría del Pueblo de Perú [Peruvian Ombudsman], *Grupos de especial protección: Mujeres* [Groups of Special Protection: Women], http://www.defensoria.gob.pe/grupos-eatencion.php?des=23 (last visited May 24, 2012).
[30] DEFENSORÍA DEL PUEBLO DE PERÚ [PERUVIAN OMBUDSMAN], DERECHO A UNA MATERNIDAD SEGURA: SUPERVISIÓN NACIONAL DE LOS SERVICIOS DE GINECOLOGÍA Y OBSTETRICIA DEL MINSA [RIGHT TO SAFE MOTHERHOOD: NATIONAL SUPERVISION OF THE GYNECOLOGICAL AND OBESTRICAL SERVICES OF THE NATIONAL MINISTRY OF HEALTH] (2008), *available at* http://www.defensoria.gob.pe/modules/Downloads/informes/defensoriales/Informe-Defensorial-N-138.pdf.
[31] Defensoría del Pueblo de Perú [Peruvian Ombudsman], Resolución Defensorial N° [Ombudsman Resolution No.] 031-2002/DP (Oct. 23, 2002).

[32] POTTS, ACCOUNTABILITY *supra* note 1, at 19.
[33] *Id.*
[34] *Id.* at 20.
[35] *See* Center for Reproductive Rights, *Bringing Rights to Bear: Preventing Maternal Mortality and Ensuring Safe Pregnancy* (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_Maternal%20Mortality_10.08.pdf.
[36] UNITED NATIONS SEC'Y-GENERAL BAN KI MOON, GLOBAL STRATEGY FOR WOMEN'S AND CHILDREN'S HEALTH 15 (2010) [hereinafter GLOBAL STRATEGY].
[37] *Id.*, at 7.
[38] L.C. v. Peru, CEDAW Committee, Commc'n No. 22/2009, para. 8.17, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
[39] *Id.*, para. 12.
[40] K.L. v. Peru, Human Rights Committee, Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005).
[41] GLOBAL STRATEGY, *supra* note 36, at 7.
[42] Alyne da Silva Pimentel v. Brazil, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (Aug. 10, 2011).
[43] *Id.*, paras. 7.4-7.7.
[44] POTTS, ACCOUNTABILITY *supra* note 1, at 20.
[45] WHO, BEYOND THE NUMBERS: REVIEWING MATERNAL DEATHS AND COMPLICATIONS TO MAKE PREGNANCY SAFER 14 (2004).
[46] *Id.* at 45.
[47] *Id.* at 57-59.
[48] *See, e.g.*, Dr. Hiranthi Wijemanne, What are Maternal Death Audits: A Sri Lankan Case Study (2010). Unpublished conference paper, see http://righttomaternalhealth.org/roundtable-presentations.
[49] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, *Addendum: Mission to India*, para. 75, U.N. Doc. A/HRC/14/20/Add.2 (Apr. 15, 2010) (by Paul Hunt).
[50] POTTS, ACCOUNTABILITY, *supra* note 1, at 22.
[51] *Id.* at 21.
[52] The 2001 report on the incidence of maternal mortality by the Brazilian National Congress, *available in Portuguese at* http://www.portalmedico.org.br/biblioteca_virtual/cpi/CPIMortalidade_Matern.htm.
[53] See CENTER FOR REPRODUCTIVE RIGHTS, GAINING GROUND: A TOOL FOR ADVANCING REPRODUCTIVE LAW REFORM, *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_GG_pregnancy.pdf.
[54] *Loi No 02-044 du 24 Juin 2002 Relative a la Santé de la Reproduction* [Law No. 02-044 of June 24, 2002, on Reproductive Health] (Mali).
[55] *Id.* art. 4.