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Human rights accountability for maternal death and failure to provide safe, legal abortion: the significance of two ground-breaking CEDAW decisions

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Abstract: *In 2011, the Committee on the Elimination of Discrimination against Women (CEDAW) issued two landmark decisions. In *Alyne da Silva Pimentel v. Brazil*, the first maternal death case decided by an international human rights body, it confirms that States have a human rights obligation to guarantee that all women, irrespective of their income or racial background, have access to timely, non-discriminatory, and appropriate maternal health services. In *L.C. v. Peru*, concerning a 13-year-old rape victim who was denied a therapeutic abortion and had an operation on her spine delayed that left her seriously disabled as a result, it established that the State should guarantee access to abortion when a woman's physical or mental health is in danger, decriminalise abortion when pregnancy results from rape or sexual abuse, review its restrictive interpretation of therapeutic abortion and establish a mechanism to ensure that reproductive rights are understood and observed in all health care facilities. Both cases affirm that accessible and good quality health services are vital to women's human rights and expand States' obligations in relation to these. They also affirm that States must ensure national accountability for sexual and reproductive health rights, and provide remedies and redress in the event of violations. And they reaffirm the importance of international human rights bodies as sources of accountability for sexual and reproductive rights violations, especially where national accountability is absent or ineffective.*

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Keywords: human rights, maternal mortality, safe abortion, accountability, remedies and redress, access to justice, UN treaty monitoring bodies, Convention on the Elimination of All Forms of Discrimination against Women, Peru, Brazil

In 2011, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) issued two groundbreaking decisions: *Alyne da Silva Pimentel v. Brazil* and *L.C. v. Peru*.^{1,2} The cases involve two critical issues for women's sexual and reproductive rights: access to appropriate and quality maternal health services, and access to safe, legal abortion. They build on recent developments in the interpretation of international standards on sexual and reproductive health rights.

This article focuses on these two important decisions. It begins by providing a summary of the facts and relevance of the cases. It then proceeds by analysing the decisions, including the recommendations made by the CEDAW Committee to Peru and Brazil. These recommendations are based on the Committee's analysis of the international human rights obligations of States under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).³ Whether or not Brazil and Peru will implement the recommendations is

an open question at this writing. These cases have global significance because they provide authoritative interpretations of CEDAW, which is binding on its 187 States Parties. This article explores the global implications of these decisions, highlighting some of the international human rights procedures which may be used to hold States to account for their obligations if national accountability is absent or ineffective.

The facts of the two cases

Alyne da Silva Pimentel v. Brazil concerned a 28-year-old Brazilian woman of African descent. She had a five-year-old daughter and was six months' pregnant with her second child when she died in late 2002, following inadequate treatment at a local health centre and the failure of the centre to provide timely referral to emergency obstetric care. The health centre was private but partly state-financed, and was in one of Rio de Janeiro's poorest districts. Alyne was near the end of her second trimester of pregnancy when she went there, complaining of high-risk pregnancy symptoms, including severe abdominal pain, nausea and vomiting. Staff at the health centre misdiagnosed these symptoms and sent her home, delaying emergency medical care. She went back to the health centre two days later and was finally admitted. Doctors could no longer detect a fetal heartbeat, and therefore induced delivery. After the stillbirth, Alyne's nausea, vomiting and abdominal pain persisted and worsened, and she became disoriented. 14 hours after delivery she underwent surgery to remove portions of the placenta. After the operation, her condition continued to worsen; she began severe haemorrhaging and vomiting blood. Her blood pressure was also low, and she refused food. However, staff at the health centre assured her family that she was well. The following day, her condition further worsened, but the health centre failed to perform any additional tests to determine what was wrong. Although she required referral to a hospital, she had to wait to be transferred for hours, as only one municipal public hospital had an available bed and refused to send its only ambulance to collect her. After she had been waiting in critical condition for eight hours, the municipal hospital finally agreed to authorise the use of their ambulance to transport her. Upon arrival at the hospital, she was placed in a corridor because there was no longer a bed available. She did not receive immediate medical attention. The hospital staff did not know that she

had just delivered since her medical records had not been transferred with her; instead, the treating doctor was provided with a brief verbal account of her symptoms. Alyne died in hospital the following evening. Her death could have been prevented.¹

The case of *L.C. v. Peru* concerned a young girl from a very poor area of Peru. Over the course of four years, L.C. had been repeatedly raped by different men in her neighbourhood. When in 2006, at the age of 13, she discovered that she was pregnant, she became seriously distressed and threw herself from the roof of a building, but her suicide attempt failed and she was taken to hospital. The following day, L.C. was assessed to be at risk of permanent paralysis. The head of the neurosurgical department recommended immediate realignment of her spine, but the available surgeon refused to perform the surgery due to her pregnancy. The medical board of the hospital refused to perform an abortion, even though Peruvian law permits abortion in cases where a woman's health or life are at risk. It was only after she miscarried, three months after being admitted to hospital, that doctors were willing to perform the necessary surgery. The enormous delay dramatically diminished the success of the intervention, and, as a result, L.C. is now quadriplegic.²

Alyne's death and L.C.'s tragedy involved circumstances which are all too common for pregnant women in many countries: a lack of access to appropriate emergency obstetric care; unjustifiable delays in referral and treatment; denial of access to safe and legal abortion; discrimination and inequalities faced by marginalised women, including women living in poverty, ethnic and racial minority women, indigenous and afro-descendant women, and adolescents; and a lack of appropriate remedies and redress at the national level. These problems lead to poor health outcomes and deaths.

The families of both Alyne and L.C. pursued but failed to obtain appropriate remedies or redress at the domestic level. After Alyne's death, her family sought civil redress, but the case languished in court for over four and a half years. No preliminary hearing was ever held, and it took the court three years and ten months to appoint a medical expert, although court rules require that this be done within ten days. In the case of L.C., there was no protocol in place that would have allowed her to demand that medical personnel and the authorities guarantee her access to a legal abortion within the limited period of time that exists under such circumstances. For these reasons, two women's

rights organisations, Advocaci (in Brazil), and Promsex (in Peru), with the families of Alyne and L.C. respectively, supported by the Center for Reproductive Rights, took their cases to the CEDAW Committee, using what is called the optional communications procedure under the Convention. This procedure allows individuals and groups of women or girls who believe that they have been victims of violations of the rights protected under the Convention to bring cases against States which have ratified the optional protocol.⁴

The CEDAW Committee's decisions and recommendations

In their decisions on these cases, the CEDAW Committee made concrete recommendations to Brazil and Peru that highlight some of the important actions required of States to ensure the highest attainable standard of sexual and reproductive health and rights for women and girls.

In total, there are nine core UN human rights treaties, as well as a range of regional human rights treaties in Africa, the Americas and Europe. Some of the treaties include explicit protections for sexual and reproductive health rights, while other treaties include more general provisions which have been applied in the context of these rights. Various international monitoring bodies and regional human rights mechanisms have developed an increasingly rich jurisprudence on sexual and reproductive health rights. The key elements of these decisions build on existing jurisprudence under CEDAW and other international human rights treaties. However, the two decisions mark the first times that a UN treaty monitoring body has established that States have violated the right of access to health care services as an aspect of non-discrimination on the basis of sex, by failing to provide adequate and quality reproductive health services in conditions of equality.

Ensuring women's right to safe pregnancy and childbirth

In the Alyne decision, the Committee examined whether the government had put in place adequate measures to ensure equitable access to good quality maternity services. The Committee concluded that Brazil had failed to do so since it had not ensured timely emergency obstetric care or referral for Alyne. The Committee also established that Alyne had not only been discriminated against because she was a woman, but also

because she was poor and of African descent, thereby exposing the multiple forms of discrimination that women may experience when accessing maternity services. In the decision, the CEDAW Committee stated that:

"The lack of appropriate maternal health services in the State party clearly fails to meet the specific, distinctive health needs and interests of women... [and] has a differential impact on the right to life of women." (Para. 7.7)

The Committee had previously established that denying women health services which only they need constitutes sex-based discrimination.⁵ The case of Alyne is the first decision in which the Committee has specifically required that a State provide adequate and quality maternal health care services as part of its non-discrimination obligations. The Committee recommended that Brazil ensure women's right to safe motherhood and affordable access for all women to emergency obstetric care and reaffirmed that state policies should be action-oriented as well as adequately funded.

This decision must be seen in the context of increasingly widespread recognition amongst international and regional human rights bodies that maternal mortality is a human rights issue, as well as an increasingly prominent issue on the public health and development agenda.⁶ CEDAW and the International Covenant on Economic, Social and Cultural Rights⁷ contain explicit references to the obligation to protect the rights of women during pregnancy and childbirth. The content of these obligations has been specified by the UN treaty monitoring bodies^{5,8,9} as well as by the Human Rights Council,^{10–12} the Special Rapporteur on the right to [the highest attainable standard of] health,^{13,14} and the Office of the High Commissioner for Human Rights.¹⁵ They have highlighted that States' obligations to ensure safe pregnancy and childbirth include ensuring accessible, adequate and quality maternal health care services; eliminating all barriers in laws, policies and practices that are detrimental to women's health; ensuring the underlying determinants of health; and allowing women to make autonomous decisions regarding their sexuality and reproduction.

Maternal mortality has also been a focus of decisions by certain domestic courts. Most recently, the High Court of Madhya Pradesh held that the "inability of women to survive pregnancy and childbirth violates her fundamental rights as guaranteed under Article 21 of the Constitution of India".

It emphasised that “it is the primary duty of the government to ensure that every woman survives pregnancy and childbirth, for that, the State of Madhya Pradesh is under obligation to secure their life”.^{16,17}

Access to safe and legal abortion on the grounds of rape and health

Human rights treaties, UN treaty monitoring bodies, regional and national courts have increasingly recognised – and have been producing a growing body of jurisprudence that establishes – that the respect, protection and fulfillment of sexual and reproductive health rights require States to:

- ensure that abortion is legal in cases where the health and life of the woman are at risk and/or where pregnancy results from rape and incest, and that in these cases States must ensure that women can access safe abortion services;
- amend laws that criminalise medical procedures needed only by women and/or that punish women who undergo those procedures;
- provide rapid access to post-abortion care regardless of the legal permissibility of abortion.⁹

In L.C., the CEDAW Committee reinforced the above standards, calling on Peru to:

“Review its laws with a view to establish a mechanism for effective access to therapeutic abortion under conditions that protect women’s physical and mental health, prevent further occurrences in the future of violations similar to the ones in the present case; and to review its legislation with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse.” (Para. 9(b)(i))

As in its Alyne decision, the Committee found L.C.’s rights were violated because the State had failed to take all appropriate measures to eliminate discrimination and to ensure men and women access to health care services on a basis of equality. L.C. did not have access to any effective, accessible procedure that would have allowed her to establish her entitlement to the medical services (spinal surgery and therapeutic abortion) that her physical and mental health condition required. The Committee found this even more serious because she was a minor, a victim of sexual abuse and in poor mental health, as evidenced by her suicide attempt.

L.C. is the second decision by a UN human rights treaty monitoring body in recent years that

has focused on the denial of access to legal therapeutic abortion. The case of *K.L. v. Peru* (2005),¹⁸ decided by the Human Rights Committee, which monitors the International Covenant on Civil and Political Rights, concerned a 17-year-old who was diagnosed with an anencephalic fetus at 14 weeks of pregnancy. Even though her pregnancy endangered her physical and mental health, and Peru’s law permits therapeutic abortion, she was denied a legal abortion and was forced to carry the pregnancy to term and breastfeed the baby until its death four days later. The Human Rights Committee found that Peru had violated the right to be free from cruel, inhuman and degrading treatment and the right to privacy and special protection as a minor under the International Covenant in this case. However, Peru has yet to implement the recommendations which the Human Rights Committee made to them in this decision.¹⁹

The L.C. decision reinforces the findings in K.L. by emphasising that where abortion is legal, States have a duty to ensure access to it. The L.C. case additionally establishes that access to legally permitted abortion is a matter of non-discrimination against women. It also provides a refined analysis of selected requirements to guarantee accessibility of legal therapeutic abortion. The Committee considered that:

“...since the State party has legalized therapeutic abortion, it must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee necessary legal security, both for those who have recourse to abortion and for the health care professionals that must perform it... It is essential for this legal framework to include a mechanism for rapid decision making, with a view to limiting to the extent possible, risk to the health of the pregnant woman, that her opinion is to be taken into account and that there is a right to appeal.” (Para. 8.17)

There are legal restrictions in many countries on access to abortion. These are often justified on the basis that they will result in fewer abortions. However, evidence shows that legal restrictions on abortion do not result in fewer abortions, and that making abortion unlawful does not decrease the need for, nor prevent, recourse to abortion. Rather, the principal effect of legal restrictions is to force women either to pay a lot of money for a safe abortion, seek unsafe abortion because safe abortion is not affordable,

which contributes to pregnancy-related mortality and morbidity,^{20,21} or travel for an abortion to other countries, which is costly and makes the abortion later than necessary. This set of options, none of which is acceptable, are indicative above all of social inequity.²²

Accountability of the State for the private sector

According to international human rights standards, States have an obligation to protect human rights not only against violations by their representatives, but also against harmful acts by private persons or entities.²³ Due diligence provides an entry point to ensuring the prevention, investigation and punishment of those responsible for any harm caused by private persons and for the provision of effective remedies. States must also ensure that the privatisation of health services does not threaten the availability, accessibility, acceptability and quality of care in them, on the basis of equality and non-discrimination.²⁴

Evidence suggests that privatisation and outsourcing of sexual and reproductive health services often results in an authority vacuum, without any State body sufficiently in charge of ensuring that the highest attainable standard of health is secured for all.²⁵ In the *Alyne* case, the CEDAW Committee held that Brazil must exert due diligence to ensure that private health care facilities comply with relevant national and international standards for reproductive health care and ensure affordable access for all women to adequate emergency obstetric care. The Committee confirmed that the State is responsible for the actions of private institutions when it outsources its medical services, and always has a duty to regulate and monitor private health care institutions. The Committee's finding was based on the obligation of States parties under CEDAW to take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise (CEDAW, Article 2.e).

Accountability of health care providers

The CEDAW Committee observed in both cases that negligence by health care providers was involved and, in the case of L.C., also stereotyping. In the *Alyne* case, the Committee pointed out that there had been professional negligence and that *Alyne* did not receive the medical care that she required. In the case of L.C., doctors failed to recognise the risk of permanent disability and provide appropriate services that could have

protected L.C.'s health, a right enshrined in the Peruvian Constitution. The Committee found that postponing the provision of abortion and surgery was "influenced by the stereotype that the protection of the fetus should prevail over the health of the mother". The Committee explained that the State failed to fulfill its obligation to eliminate all practices which are based on stereotyped roles of women, since the timely access to necessary medical treatment was made conditional on carrying to term an unwanted pregnancy. The "stereotype" concerned was explained as placing L.C.'s reproductive function above her fundamental human rights (Para. 8.15 and 9).

The CEDAW Committee's recommendations in both decisions highlighted States parties' obligation to provide adequate professional training for health workers, including for care involving women's sexual and reproductive health rights. This helps to ensure quality medical treatment during pregnancy and delivery, as well as timely emergency obstetric care. In L.C., the Committee called on Peru to take measures to ensure that reproductive rights are understood and observed in all health care facilities:

"Such measures should include education and training programmes to encourage health providers to change their attitudes and behavior in relation to adolescent women seeking reproductive health services and respond to specific health needs related to sexual violence. They should also include guidelines or protocols to ensure health services are available and accessible in public facilities." (Para. 9(b)(2))

Monitoring and review

In *Alyne*, the CEDAW Committee recommended that Brazil implement its National Pact to Reduce Maternal and Neonatal Death, including through establishing more maternal mortality committees to monitor the number and causes of maternal deaths.

Maternal death audits and reviews are conducted in many countries worldwide.²⁶ The data generated provide an important basis for determining policy and funding priorities for addressing these causes and reducing maternal deaths. Such data are increasingly used in the field of human rights. Human rights-based approaches to policy and programming emphasise the importance of indicators, including reliable qualitative and quantitative data, to enhance their effectiveness and sustainability. Reliable data are also increasingly

used to review progress or in human rights accountability processes.

A strong capacity in countries to collect such data, including on the health of women, is essential to determine where investments should be focused and whether progress is being made.²⁷

Access to justice, remedies and redress

The inaccessibility of justice and effective remedies impedes the realisation of sexual and reproductive health and rights. Often when a pregnant woman is denied access to urgent life-saving and health-preserving medical services, there are also multiple obstacles to accessing justice and remedies afterwards. Alyne's family was obstructed by the failure of the domestic authorities to establish professional responsibility and by severe delays in judicial proceedings. L.C. was faced with the absence of an appropriate administrative mechanism that would have allowed her to terminate her pregnancy for therapeutic reasons and have surgery, as well as access to an effective judicial mechanism to provide redress for the violation of her rights.

Victims of human rights violations have a right to effective remedy and reparation. Remedies take a variety of forms, including: restitution (re-establishing the situation before the violation took place); rehabilitation (e.g. medical or psychological care or social or legal services); compensation (payment for financially assessable damages); satisfaction (e.g. acknowledgement of a breach or an apology); and guarantees of non-repetition (e.g. legislation, organisational improvements).²⁸ Some of these measures primarily address the individual victims of violations, others are more directed at the general population, to proactively protect their rights. Depending on the situation, full reparation for a violation may require a combination of these measures.²⁹

In both decisions, the CEDAW Committee recommended remedies that not only addressed the violations suffered by Alyne and L.C., but also called for systemic changes in the health care and justice sectors, and in the law itself, to prevent similar abuses occurring in the future. In Alyne, the Committee recommended that Brazil provide appropriate reparation, including financial compensation, to the daughter of Alyne, commensurate with the gravity of the violations against her. The Committee also recommended that Brazil ensure access to effective remedies in cases where women's reproductive health rights have been vio-

lated, and provide training for judiciary and law enforcement personnel.¹

In L.C., the Committee recommended that Peru:

“provide reparation that includes adequate compensation for material and moral damages and measures of rehabilitation, commensurate with the gravity of the violation of her rights and the condition of her health, in order to ensure that she enjoys the best possible quality of life... [and] review its laws with a view to establishing a mechanism for effective access to therapeutic abortion under conditions that protect women's physical and mental health and prevent further occurrences in the future of violations similar to the ones in the present case.” (Para 12.a,b)

Further, the Committee also recommended that Peru “review its legislation with a view to decriminalising abortion when the pregnancy results from rape or sexual abuse.” The Committee also made recommendations to Peru to take steps to increase awareness about reproductive rights in all health care facilities, including through training of health care providers, and implementation of guidelines and protocols to ensure health services are available and accessible in public facilities.² These recommendations require Peru to take proactive measures to ensure that similar violations can be avoided in the future and women and girls in similar situations to L.C. can have better access to services.

The global relevance of these cases

CEDAW requested that the States of Brazil and Peru submit, within six months, a written response detailing any action taken in the light of decisions and recommendations. These responses are due in the first quarter of 2012. Under CEDAW, States are required to submit periodic reports on their implementation of the treaty every four years. The State party reporting process under CEDAW will provide formal opportunities for follow-up by CEDAW.

Whilst the CEDAW Committee's legal and policy recommendations were made to Brazil and Peru, they can and should influence law and policy-making and implementation in other States, since the circumstances of these cases exemplify some of the key obstacles to sexual and reproductive health care worldwide. While the decisions are not in themselves legally binding on all States parties to CEDAW, they are authoritative interpretations of this treaty, which does impose legally binding obligations on its 187 States parties.

The decisions can also provide guidance to other treaty monitoring bodies, regional human rights bodies and domestic courts on the application of human rights in relation to maternal health and abortion. Furthermore, the standards established in the decisions will be taken into account in the policies and programmes of United Nations agencies and international organisations working on sexual and reproductive health.

These cases highlight that international human rights mechanisms can be used to hold States to account for sexual and reproductive health rights, including where domestic accountability is absent, inaccessible or ineffective, as it was for L.C. and the family of Alyne. As well as CEDAW, other UN human rights treaty bodies, the UN Human Rights Council and regional human rights mechanisms are among the key bodies which may play a role. Most of these bodies operate periodic reporting procedures involving the scrutiny of States' human rights performance. Some of these bodies, like CEDAW, also have complaints procedures which can be used by individuals and/or groups.

A new independent Expert Review Group was established in September 2011, with responsibility for reporting to the UN Secretary-General on progress towards implementing the Global Strategy on Women's and Children's Health. It has also been tasked with following up on the recommendations of the Commission on Information and Accountability, which identified accountability as a missing element for the improvement of women's and children's health worldwide.³⁰ The Review Group has a human rights purview and this provides a new, potentially important opportunity for improving maternal health in a broader women's rights and sexual and reproductive health framework.

Conclusion

Women's right to access sexual and reproductive health care, including good quality maternity care and safe, legal abortion are protected under international human rights law. In addition UN treaty monitoring bodies, regional and national legislative and human rights bodies are increasingly recognising that safe abortion services should be legal and accessible at a minimum on the grounds of protecting the life and health of the woman and in cases of rape and sexual abuse.

The Secretary General's Global Strategy on Women's and Children's Health, and the Commission on Information and Accountability for Women's and Children's Health which was established in its wake, have highlighted that accountability is an essential, but often neglected, strategy for improving women's and children's health, including for reducing maternal mortality and morbidity.³⁰

The decisions highlight the key role that human rights can play in seeking to hold States accountable for sexual and reproductive health, in order to protect the health and lives of women like Alyne and adolescent girls like L.C. Brazil and Peru need to take urgent steps to implement the recommendations of the Committee. Implementation of these decisions will not only have significance from the domestic perspective and the perspectives of the families affected, but would also impact global normative developments in this regard.

Note

The views in this article are those of the authors alone, and do not necessarily represent the positions of their organisations.

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Résumé

En 2011, le Comité pour l'élimination de la discrimination à l'égard des femmes a publié deux décisions historiques. Dans l'affaire *Alyne da Silva Pimentel c. Brésil*, premier cas de mortalité maternelle examiné par un organe international des droits de l'homme, il a établi que les États ont l'obligation de garantir que toutes les femmes, quels que soient leur niveau de revenu ou leur appartenance ethnique, bénéficient de soins de santé maternelle adaptés dans les meilleurs délais, et sans subir de discrimination. Dans l'affaire *L.C. c. Pérou*, concernant une adolescente âgée de 13 ans victime d'un viol à qui on a refusé un avortement thérapeutique et dont l'opération à la colonne vertébrale a été retardée, ce qui l'a rendue gravement handicapée, il a établi que l'État doit garantir l'accès à l'avortement quand la santé physique ou mentale de la femme est en danger, dépénaliser l'avortement quand la grossesse résulte d'un viol ou d'abus sexuels, réviser son interprétation restrictive de l'avortement thérapeutique et établir un mécanisme pour que les droits génésiques soient compris et respectés dans tous les centres de santé. Les deux affaires montrent que des services de santé accessibles et de qualité sont essentiels pour les droits fondamentaux des femmes et élargissent les obligations des États à cet égard. Elles rappellent aussi que les États doivent rendre compte des droits génésiques au niveau national, et prévoir des réparations et des recours en cas de violation. Et elles réitérent l'importance des organes internationaux des droits de l'homme comme sources de responsabilisation pour les violations des droits génésiques, particulièrement lorsque les mécanismes nationaux de responsabilisation sont absents ou inefficaces.

Resumen

En el año 2011, el Comité para la Eliminación de la Discriminación contra la Mujer (CEDAW) emitió dos decisiones históricas. En *Alyne da Silva Pimentel contra Brasil*, el primer caso de muerte materna decidido por un organismo internacional de derechos humanos, se confirma que los Estados tienen la obligación de derechos humanos de garantizar que todas las mujeres, sin distinción de sus ingresos u origen racial, tengan acceso a servicios oportunos, no discriminatorios y adecuados de salud materna. En el caso de *L.C. contra Perú*, concerniente a una niña de 13 años víctima de violación, a quien se le negó un aborto terapéutico y quien sufrió grave discapacidad a consecuencia de una demorada operación en la médula espinal, se estableció que el Estado debe garantizar acceso a los servicios de aborto cuando la salud física o mental de la mujer corra peligro, despenalizar el aborto cuando el embarazo sea producto de violación o abuso sexual, revisar su interpretación restrictiva del aborto terapéutico y establecer un mecanismo para asegurar que los derechos reproductivos sean entendidos y respetados en todas las unidades de salud. Ambos casos afirman que los servicios de salud accesibles y de buena calidad son vitales para los derechos humanos de las mujeres y amplían las obligaciones de los Estados al respecto. Asimismo, afirman que los Estados deben garantizar la responsabilidad nacional de la salud y los derechos sexuales y reproductivos, y ofrecer recursos y reparación en caso de violaciones. Además, reafirman la importancia de los organismos internacionales de derechos humanos como fuentes de responsabilidad de impedir las violaciones de los derechos sexuales y reproductivos, especialmente ante la ausencia o ineficacia de la responsabilidad nacional.