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Accountability Beyond Blame: Rethinking Maternal Death Surveillance and Response

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Abstract

Maternal death reviews or audits are among several interventions used to reduce maternal mortality. The maternal death surveillance and response (MDSR) system is one such mechanism, combining case identification with analysis of underlying causes to inform corrective action. Although introduced to generate information for accountability in maternal health, the meaning and implications of accountability in this context remain underexamined. A dominant framing of MDSR as an internal quality assurance tool—coupled with a narrow, punitive conception of accountability—appears to limit its potential to help address preventable maternal deaths. This paper draws on the stated objectives and structural design of MDSR to argue that reconceptualizing it as a mechanism of human rights accountability not only aligns with its normative aims but also provides a more robust framework for tackling maternal mortality. It responds to the challenge of achieving accountability without reducing it to blame, examining how MDSR can foster accountability consistent with international human rights standards and what this would entail in practice.

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Introduction

Maternal mortality emerged as a global concern in the 1980s, propelled by small but significant data fragments from a few developing countries.[1] As attention to the issue grew—spurred broadly by research exposing the neglect of maternal health in global policy, increasing awareness of its preventability, and the convergence of the safe motherhood, reproductive rights, and human rights movements—the need to better understand its scale, causes, and distribution has grown in importance.[2] This depth of insight is essential not only for raising awareness and sustaining attention but also to support ongoing efforts to address it through learning.

These efforts gained momentum when it became clear that progress toward achieving the Millennium Development Goals on maternal and child health was falling behind. The United Nations Secretary-General's Global Strategy for Women's and Children's Health, issued in 2010, marked a pivotal moment in this regard. Recognizing and concerned by the slow progress in meeting maternal and child health goals, the strategy called on the World Health Organization (WHO) to chair "a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health."[3] This led to the establishment of the Commission on Information and Accountability for Women's and Children's Health.[4] The commission found that many countries with apparently high maternal death burdens lacked reliable systems to capture such deaths and that this absence of reliable data on key indicators, including maternal mortality, not only hampered efforts to monitor progress but also contributed to the persistent lack of meaningful improvement. Characterizing this as a "scandal of invisibility," the commission emphasized the importance of information for accountability.[5] Among other things, it recommended that states without functioning systems establish mechanisms to register vital events, including maternal deaths.[6]

This political momentum, combined with WHO's existing technical work on tracking maternal deaths and investigating their causes, contributed to the development of the maternal death surveillance and response (MDSR) system.[7] Primarily intended for countries without reliable systems to track maternal mortality, MDSR is a continuous process that identifies and reviews all maternal deaths to inform ongoing improvement.[8] Since the 2013 release of the MDSR Technical Guidance (hereafter WHO MDSR Guidance), many countries—particularly in Africa—have adopted the system under various names and with contextual adaptations. WHO continues to support its implementation through technical assistance, updated guidance, and progress reviews.[9]

Given its origin, MDSR—and maternal death audits more broadly—has been framed as an accountability mechanism for fulfilling maternal health commitments. As will be shown below, MDSR's operational instruments identify accountability as one of the system's objectives. The United Nations Special Rapporteur on the right to health expressed early concern that without a reliable civil registration system, many maternal deaths go uncounted and unreported.[10] He urged states to implement effective registration and a system of maternal death review.[11] More specifically, the Office of the United Nations High Commissioner for Human Rights lists maternal death reviews among human rights accountability tools.[12] Instructively, in an introduction to a foundational volume on human rights accountability for maternal mortality, Paul Hunt described maternal death audits as an example of novel human rights accountability approaches that complement efforts to strengthen existing mechanisms, stating:

> *The second approach is by identifying existing processes that were not conceived as accountability arrangements but—suitably refined—they might be able to serve this purpose, such as maternal death audits or reviews. Processes of this sort are often designed, and primarily used, by health professionals who have to be willing to listen to, and learn from, the human rights experts.*[13]

Nonetheless, positioning MDSR as a tool of accountability is not without challenges. References

to accountability in this context are often inconsistent, even conflicting.[14] On the one hand, MDSR is presented as an instrument of accountability for maternal health—that is, a mechanism to reduce maternal mortality by generating information to guide corrective action.[15] On the other, health workers frequently perceive the same framing as assigning personal blame, where detailed case reviews may expose them to censure or liability.[16] As Vincent De Brouwere and colleagues noted early in the system's development, "because the focus is on creating changes by improving accountability … MDSRs might threaten confidentiality, essential for facility-based [maternal death reviews]."[17]

Three interrelated factors further entrench this interpretive tension. First, accountability is understood in divergent ways, including within the health sector. As Hunt observes, it is frequently reduced to either simple monitoring or punitive enforcement.[18] Second, although MDSR is intended as a confidential, non-punitive process under a strict "no name, no blame" principle, the absence of legal protections amplifies concerns about blame and liability.[19] Third, and closely related, the literature often frames MDSR as an internal performance monitoring tool, reinforcing its association with individual staff appraisal rather than systemic learning.[20] These concerns are supported by studies indicating that the system is often used to shift responsibility onto health workers, particularly those in lower-level facilities—a dynamic one study described as "sharp downward, blunt upward."[21] Such a narrow framing not only hollows out the concept but also shapes actors' behavior because "the way accountability … is discussed and disseminated by those intervening will have an influence on prospects for implementation."[22]

Against this background, I examine the potential of a human rights approach to reframe MDSR to enhance its potential as an accountability mechanism. In a way, this paper responds to the call by the former Special Rapporteur on the right to health to explore how maternal death review systems can be strengthened through a human rights-based approach. It does so by analyzing the objectives and structure of MDSR, clarifying the essence of accountability in general as well as human rights discourse, and assessing the relevance of this framework to efforts aimed at reducing preventable maternal deaths.

However, this short paper is principally conceptual and does not aim to provide empirical evidence or a detailed outline of the human rights accountability framing of MDSR that it advances. Rather, it aims to clarify the conceptual foundations of such a framing and to draw out its implications for how MDSR might more effectively serve accountability for maternal health.

The next section introduces the notion of accountability as it informs the analysis of MDSR. The following section offers an overview of the system as set out in WHO guidance. I then explore how a human rights-based understanding of accountability could offer a more relevant and potentially effective framework for interpreting MDSR. I outline its key elements, discuss potential challenges, and conclude with final reflections.

Accountability: Essence and controversies

Accountability is an elusive concept and "crops up everywhere, performing all manner of analytical and rhetorical tasks and carrying most of the burdens of democratic governance."[23] Broadly construed, it "embraces (or at least overlaps with) lots of other terms—surveillance, monitoring, oversight, control, checks, restraint, public exposure, punishment."[24] Its breadth has been a source both of its attractiveness but also of its limitation.[25] In his frequently cited work, Andreas Schedler describes accountability as follows: "A is accountable to B when A is obliged to inform B about A's (past or future) actions and decisions, to justify them, and to suffer punishment in the case of eventual misconduct."[26] Similarly, Messner notes that "to give an account means to provide reasons for one's behavior, to explain and justify what one did or did not do."[27] A similar understanding is shared in the health sector.[28]

While three components of accountability—namely, information, justification, and enforcement—appear to be the minimal elements

of consensus about the notion, the status of the last element raises more questions.[29] According to Schedler, while the first two elements correspond to the etymological ambiance of the notion between bookkeeping (information provision) and storytelling (discursive or exploratory aspect), the element of enforcement (sanctions) seems to be a rational addition to make it bite.[30] Writing from a historical perspective, Richard Mulgan underscores that the original and widely accepted understanding of accountability refers to the process of being called to account by an authority for one's actions. While it aims at rectification, he notes that the role of sanctions remains contested.[31]

The tension among the three core components and the uncertainties regarding the appropriate balance in any given setting continue to challenge efforts to design effective accountability mechanisms. A notable dilemma in health governance is finding the balance "between accountability for control, with its focus on uncovering malfeasance and allocating blame, and accountability for improvement, which emphasizes discretion, embracing error as a source of learning, and positive incentive."[32] A further challenge is the tendency to reduce accountability to its third element—enforcement or sanctions.[33] This is evident in legal discourses, including civil and political human rights, where accountability is often equated with sanctioning violators, and in health systems, where lower-level health workers are frequently penalized for failures and become scapegoats for broader systemic problems.[34]

Despite these conceptual ambiguities, there is a broad consensus that the core purpose of accountability is to restrain power and help ensure its reasonable exercise.[35] This implies, among other things, that the design of an accountability mechanism must give careful consideration to the nature of the power it seeks to regulate. It also suggests that accountability should not be "reduced to a technical exercise; its essence remains ... dialogue and debate."[36] Accountability needs to focus on highlighting "the *procedural* deficits that characterize many aspects of decision-making and the exercise of power."[37] This is particularly relevant given that "unsettling entrenched power dynamics is crucial to changing the patterns of health and ill health."[38]

The other implication is that, insofar as the objective of constraining power is achieved, the three elements of accountability—information, justification, and enforcement—need not operate simultaneously.[39] In some contexts, "accounting agents" primarily demand enforcement, as in elections; in others, enforcement may have little place, as in the South African Truth and Reconciliation Commission, where accountability for apartheid-era abuses rested on truth-telling and acknowledgment rather than punishment. More broadly, the role of enforcement varies across accountability settings—from a central feature in criminal proceedings to being largely absent in media and civil society, where constraint is discursive rather than coercive.[40] Accordingly, while all three elements remain essential, "how they are assembled is contingent on the type of activity, the level of uncertainty, [and] the ability to define agreed-upon measures of performance."[41]

This shift toward a more nuanced understanding of accountability is driven largely by the increasing diffusion of accountable power. In the context of preventable maternal deaths, the progressive nature of state obligations and the involvement of multiple nonstate actors influencing health outcomes mean that traditional approaches centered solely on identifying violations and violators provide an inadequate basis for accountability.[42] Reflecting this broader and more differentiated understanding, three main types of accountability strategies are commonly identified in the field of sexual and reproductive health and rights: performance, social (or community), and legal.[43] Performance accountability refers to "internal systems that governments hold service providers and health systems to account," with MDSR listed as a prime example.[44] Social or community accountability strategies broadly aim to "bolster the capacity of communities to demand improved services and provider responsiveness through community awareness and voice."[45] Legal accountability, by contrast, involves some form of litigation or hearing in response to alleged rights

violations. As discussed below, a human rights-based approach to MDSR can strengthen its role as a social accountability mechanism, bringing it closer to exposing—if not restraining—power, while reducing its use for individual legal accountability.

Maternal death surveillance and response: Structure and objectives

The MDSR system is a continuous and structured process to identify, report, and review all maternal deaths, assess preventability, guide responses, and monitor effectiveness.[46] Its stated objective is to "count every maternal death, permitting an assessment of the true magnitude of maternal mortality," and "eliminate preventable maternal mortality by obtaining and using information on each maternal death to guide public health actions and monitor their impact."[47]

While the primary objective of MDSR is to generate evidence to prevent the recurrence of preventable maternal deaths, the WHO MDSR Guidance also identifies advocacy and accountability as complementary objectives. On advocacy, it notes that "the evidence and stories behind the maternal deaths are the ingredients for powerful and effective advocacy."[48] Regarding accountability, it emphasizes that "government accountability … requires the periodic and transparent dissemination and discussion of key results … among stakeholders, including the civil society at large," and that accurately assessing the magnitude of maternal mortality through MDSR helps "provide accountability for results" and "compels decision-makers to give the problem the attention and responses it deserves."[49] The guidance further suggests that "by investigating a woman's death, MDSR inherently places value on her life—an important form of accountability for families and communities."[50]

To operationalize these objectives, the WHO MDSR Guidance requires the identification and reporting of all suspected maternal deaths, whether they occur in facilities, in transit, or at home. It calls for making maternal deaths notifiable events, assigning coordinating health officers, establishing review committees, and engaging with communities and other stakeholders.[51] Review committees are expected to be multidisciplinary, bringing together clinical, public health, administrative, and community perspectives to ensure that medical and systemic factors are jointly analyzed. These committees should use medical records, accounts from care providers, and information from verbal autopsies with relatives or community members to establish the circumstances, causes, and contributing factors of each death and assess its preventability. Each review, along with aggregated trend data, is intended to inform further analysis regarding the causes, trends, and geographic patterns of maternal deaths.

To foster candid reporting and participation, the guidance and subsequent instruments emphasize confidentiality and the use of review findings exclusively for learning and improvement, separate from punitive processes.[52] This often requires establishing an enabling legal framework—a step that, by and large, has yet to be undertaken in many countries.[53] Owing to weak legal and institutional support, among other factors, MDSR implementation faces persistent challenges, including the underreporting of deaths, incomplete data, superficial reviews focused mainly on medical causes, limited community and civil society engagement, and the weak dissemination and translation of findings into action.[54] As one study observed, this creates a vicious cycle: weak implementation yields limited results, reinforcing demotivation and systemic dysfunction.[55] Key barriers include a limited understanding of MDSR's objectives and principles, together with a pervasive fear of blame, exacerbated by the absence of adequate legal protections.[56] This environment sustains a prevailing "blame culture" in which the intervention is used to appraise staff or assign individual fault and, more critically, fosters defensive practices that undermine its intended purpose.[57]

These challenges not only undermine implementation but also reveal a deeper limitation in how accountability is currently conceived within MDSR. A narrow operational focus—centered on generating evidence for action at the individual and facility levels while overlooking broader systemic

and structural factors—appears to be a major cause. This limits the system's transformative potential and may perpetuate the vicious cycle described above.

This limitation is reflected in the WHO MDSR Guidance, which adopts a predominantly medical lens in attributing causes and contributing factors to maternal deaths. It prioritizes data collection on indicators such as skilled birth attendance and access to emergency obstetric care.[58] While acknowledging that "the problems leading to maternal death are frequently not all medical," reviewers are nonetheless directed to focus "only on those events that may have directly contributed to the maternal deaths."[59] Consequently, social and structural factors are often treated as secondary.

While the "three delays" model—a framework for understanding how delays in seeking, reaching, and receiving care contribute to maternal deaths—is recommended as an analytic tool, its application tends to emphasize clinical issues such as delayed recognition of complications or substandard care.[60] Although the WHO MDSR Guidance recognizes the need to consider household decision-making within the broader sociocultural context, it frames this instrumentally, as a means to "frame behavior-change strategies."[61] Reinforcing this medicalized approach, and to promote comparability, the guidance encourages assigning a specific cause of death in line with the ICD-Maternal Mortality classification, which broadly centers on identifying the single disease or event that led to the death.[62] The review's overarching aim, accordingly, is described as identifying "modifiable factors and behaviors and linkages with proven interventions and strategies to improve maternal survival."[63]

This emphasis on medical and procedural dimensions is further reflected in the assessment of avoidability, which plays a central role in shaping responses. A maternal death is considered avoidable "if it might have been avoided by a change in patient behavior, provider or institutional practices, or health-care system policies."[64] Although the guidance recommends including in the assessment "social and economic barriers related to the status of women, women's literacy level, and gender-based beliefs and practices that may be a root cause of poor service utilization," the response "should be specific and linked with avoidable factors," arguably reinforcing a focus on medical causes.[65] In addition, quality of care—assessed against "accepted local standards and best medical evidence," and within the limits of available resources—is central to this inquiry, though the guidance offers little direction on how resource constraints should be interpreted or applied.[66] By prioritizing responses to measures achievable at the facility level, the guidance further narrows the scope of analysis and action.[67]

This narrowing of focus also manifests in how responsibility is distributed. Strikingly, the state is largely absent as an actor, both in the analysis of causes and as an addressee of recommended responses. The focus remains on the family, local actors, and the health system. For instance, recommendations are to be addressed to the community, care sites, and providers.[68] This deflects attention from the structural determinants of preventable deaths, concentrating instead on implementers with limited capacity to effect meaningful change. This structural flaw arguably contributes to MDSR functioning as a performance review rather than a mechanism for systemic accountability. Evidence from a decade of global MDSR implementation also indicates a continued emphasis on quality of care, with little to no engagement with civil society, the media, or human rights organizations.[69]

This dynamic may also reflect a broader misalignment between MDSR's two core components—surveillance and review. The surveillance component focuses on generating data on the magnitude and trends of maternal mortality and primarily draws state interest, given its relevance to international performance metrics and reputational concerns. Particularly in authoritarian settings, this dynamic may invite political interference in reporting, discouraging candid participation by health workers and producing cascading effects throughout the system.[70] By contrast, the review component is intended to support learning and action across all levels of the health system—from individual providers and facilities to national

policy makers. However, a narrow conception of accountability, reinforced by pressure to produce evaluative metrics, often leads administrators to use the data to assess staff performance rather than to drive systemic improvement. This, in turn, constrains the space for honest reflection and review. In other words, the evaluative and learning functions of surveillance and review, when combined with a reductive notion of accountability, risk rendering MDSR ineffective.

Framing maternal death surveillance and response through a human rights lens

Human rights accountability

Human rights law obliges states to reduce preventable maternal deaths as part of multiple rights, including the rights to life, dignity, reproductive autonomy, health, and equality.[71] Several international instruments also explicitly affirm special protections to ensure safe motherhood.[72] These rights entail both negative and positive obligations. The right to health—most relevant in the context of this paper—requires states to take appropriate measures to progressively eliminate preventable maternal mortality. This includes ensuring access to essential health services, such as skilled birth attendance, emergency obstetric care, and accurate health information, as well as implementing effective public health strategies.[73] Equally important, advancing gender equality by tackling discrimination embedded in laws and practices, harmful gender norms, sociocultural barriers, marginalization, and illiteracy is widely recognized as essential to addressing the root causes of maternal mortality.[74]

Accountability is an integral principle of human rights, as rights entail duties that are realized through systems of accountability. Accountability in human rights is a mechanism to provide rights holders "with an opportunity to understand how those with responsibilities have discharged their duties."[75] While there is no universally accepted understanding of human rights accountability, the essence is to ensure that duty bearers and others provide information regarding what duty bearers do, and fail to do, to comply with their obligations; duty bearers should also have to explain their decisions.

The Office of the United Nations High Commissioner for Human Rights, in its technical guidance on a human rights-based approach to reduce preventable maternal morbidity and mortality, presents accountability as a multidimensional duty extending beyond punishment.[76] Accordingly, accountability is a continuous process applied across all stages of the policy cycle—from conducting situational analysis and planning to budgeting and implementation. It involves monitoring through indicators and benchmarks that assess structural conditions, policy and budgetary efforts, and health outcomes. It also includes diverse forms of review and oversight to evaluate processes and results against human rights obligations, as well as remedies.

Another relevant source in which a human rights understanding of accountability is elaborated describes accountability as "the relationship of government policy makers and other *duty bearers* to the *rights holders* affected by their decisions and actions."[77] Accountability comprises three key elements: responsibility, which requires clearly defined duties and standards; answerability, which obliges public officials to justify their actions and devise effective oversight; and enforceability, which demands mechanisms to monitor compliance and apply sanctions when necessary.[78]

Beyond framing accountability as a continuous process of information, justification, and enforcement, which is crucial to "expose the hidden priorities and structures behind violations," human rights accountability grounds assessment in established legal obligations.[79] Most importantly, and relevant to eliminating preventable maternal deaths, a human rights framing—and the accountability systems it promotes—seeks to drive transformative change by empowering individuals and communities to reshape the power relations that underlie patterns of health and ill health. Furthermore, a human rights approach demands attention beyond biological factors to the social, political, historical, and economic contexts in which health is pro-

duced, experienced, and understood.[80] This, in turn, "forces us to see the suffering that is not the result of 'natural' biological causes but rather stems from human choices about policies, priorities, and cultural norms."[81]

Making the case for a human rights-based maternal death surveillance and response

Applying a human rights-based approach to maternal mortality is complex. It would broadly involve identifying and applying the key values, principles, and elements of the relevant right (health) and a mechanism in question (MDSR for accountability) into the six essential building blocks of the health system, which are critical for addressing maternal mortality.[82] While such an exercise is beyond the scope of this work and deserves further research, here I outline key aspects of human rights accountability and their implications for MDSR.

A central implication is the need to treat maternal deaths as potential violations of a state's human rights obligations. Promoting this understanding, including in technical guidance and among implementers and the public, has the potential to reshape how citizens perceive their relationship with the state, paving the way for stronger civic engagement and mobilization. This is crucial given that maternal deaths often persist not because effective interventions are unknown but because entrenched gender biases have naturalized such deaths as inevitable.

As part of a continuous process within the policy cycle, human rights accountability invites MDSR to examine how decision-making in policy and budgeting contributes to each death under review. Grounding the assessment in legal obligations further broadens the frame of analysis, extending it from immediate health needs and quality of care to structural barriers such as laws, social norms, and sociocultural conditions. These dimensions require an expanded scope of the MDSR review process, with questions formulated to interrogate relevant decision-making processes.[83]

By linking rights to duty bearers, a human rights accountability framework would also require the maternal death review process to identify the relevant duty bearers and clarify their respective obligations in progressively reducing preventable maternal deaths. Linking MDSR review to decisions by local, regional, or national authorities can expose deeper patterns of neglect or underinvestment. By focusing on the state rather than individual actors, a human rights-based approach also redirects attention from isolated errors or delays to broader structural drivers. Emphasizing duty may likewise counter the tendency to disregard MDSR recommendations. Moreover, the authoritative guidance developed by human rights monitoring bodies—including on standards for health services and goods, the notions of minimum core obligations, the progressive realization of rights, and the use of maximum available resources in assessing state obligations—can help structure the assessment of preventability and guide appropriate responses.[84]

A human rights-based accountability framework can further support MDSR implementation in at least three ways. First, human rights law requires states to establish mechanisms for remedying violations. Recognizing this can ease the pressure on MDSR to serve punitive ends by providing alternative avenues for redress. The fact that MDSR is not designed and should not be used for legal proceedings does not, however, mean that legal or judicial mechanisms have no role to play in addressing preventable maternal deaths. Indeed, evidence shows that litigation, when embedded in broader social and political mobilization, has advanced maternal health.[85] Properly conducted MDSR reports can even inform such litigation by identifying areas of persistent failure.

Second, framing MDSR as a tool for fulfilling states' human rights obligations to advance maternal health underscores the duty of implementing states to ensure that the process is carried out in accordance with human rights norms and that it achieves effectiveness.[86] This requires, among other things, establishing adequate legal frameworks and safeguarding the professional freedom of health workers, both of which are central to effective implementation. Such empowerment would help enable health workers to safeguard the integrity of the process. Furthermore, this framing implies that

other relevant actors beyond the health sector, including civil society, the media, and human rights monitoring bodies, should be engaged. This way, MDSR can serve as a tool for social accountability, expanding the possibility of exposing deeper causes of preventable maternal deaths.[87] This calls for revising dissemination structures to ensure that relevant actors beyond the health sector are identified and engaged to fulfill their roles.

Third, by extending the inquiry to the deeper structures of power, a human rights-based accountability approach can foster more meaningful change that goes beyond improving care delivery. This shift could, in turn, encourage broader engagement and help break the vicious cycle that risks reducing MDSR to a procedural formality rather than a vehicle for transformation.

Challenges in applying a human rights-based approach

Recasting MDSR through a human rights-based lens presents several conceptual and practical difficulties. More broadly, operationalizing a human rights-based approach is challenging, and even its validity is questioned when "retroactively fitting human rights into health programs … that were not explicitly designed around rights," such as MDSR.[88] Similarly, while human rights accountability is about restraining and shifting power that underpins ill health, identifying where power lies and how it operates, including in the context of maternal mortality, is a daunting task because it often involves uncovering hidden and systemic forms of influence embedded in institutions, norms, and everyday practices.[89] Within this context, three major challenges can be identified.

The first relates to the tension between the transformative ambition of human rights accountability and the institutional inertia that resists it. While the normative appeal of such a transformation is strong, human rights accountability aims to disrupt entrenched systems and practices. Integrating human rights into MDSR involves identifying systemic injustices and interrogating established decision-making processes, which is often uncomfortable for those in power. One significant challenge, therefore, is resistance from power holders who resist applying the language of rights. The problem is particularly acute in settings with weak rule of law, common in many African countries where maternal mortality remains high. As Alicia Yamin and Rebecca Cantor have noted, human rights-based approaches aim to subvert existing power distribution and are often met with suspicion or pushback from those who benefit from the status quo.[90] Rosemary McGee also documents that resistance from anti-accountability forces is to be anticipated.[91] Strong resistance in the 1980s to incorporating social determinants—particularly race—into the UK Confidential Enquiry into Maternal Deaths provides a relevant example.[92]

One way to counter this challenge is to act strategically—using diverse approaches and enlisting reformers both within the state and in the community.[93] In the context of MDSR, this could involve engaging committed health workers, parliamentarians, civil society, the media, and human rights organizations to build broad-based support. It might also begin with expanding the composition of, at least, national MDSR steering committees. In the UK's Confidential Enquiry into Maternal Deaths, for instance, broadening the committee to include public health experts and drawing on human rights discourse helped overcome similar resistance, widening both participation and the understanding of accountability.[94]

The second challenge may be described as a data-quality paradox: How can a system that produces poor or even manipulated maternal mortality data be used as a tool to drive deeper, systemic change? While this remains a serious challenge—given that accountability, particularly for obligations to progressively reduce maternal mortality, depends on reliable data—it can be overcome. Misunderstandings about the objectives of MDSR contribute to this problem; clarifying its purpose and refocusing the inquiry may help. Because a rights-based approach aims to create a "dynamic of entitlement and obligation," it has the potential to encourage health workers not only to claim their rights but also to act as "local audits" in generating accurate and disaggregated data, there-

by supporting the integrity of the MDSR process and improving data reliability.[95] External actors, including human rights monitoring bodies, can likewise play a role by examining the processes that produce maternal mortality—an emerging metric for assessing states' human rights obligations.[96] In this way, the misalignment between the surveillance and review components of MDSR, evident in its current implementation, can be eased.

The third, more practical challenge concerns the feasibility of implementation. Applying a human rights approach generally involves expanding the remit of MDSR. However, in many settings, the system already faces implementation hurdles, including resource constraints, limited coverage, and a lack of institutional support.[97] Adding layers of legal, policy, and sociopolitical analysis to an already fragile system—often implemented and managed by overstretched health workers—risks further overburdening them. A more feasible approach may involve conducting deeper human rights-based analyses in selected cases, while maintaining the surveillance component to capture and confirm all maternal death. This is reflected in emerging models in Kenya and Ethiopia, where complementary confidential inquiries are being introduced on the premise that they allow for more in-depth investigation.[98] Another human rights approach, as recommended by the Special Rapporteur on the right to health, is to establish national, regional, or global independent, transparent, non-statist bodies charged with responsibility for identifying, analyzing, and publicizing the structural injustices exposed by MDSR.[99]

In sum, the transition to a human rights-based MDSR is both necessary and complex. It calls for political will, institutional adaptation, and strategic engagement with actors at all levels to ensure that the transformative potential of human rights is not lost in implementation.

Conclusion

In discussing accountability within MDSR, two mutually reinforcing paradoxes merit attention. While accountability in both general literature and human rights discourse comprises elements of information, justification, and enforcement, it is often reduced to notions of blame and punishment. Similarly, although MDSR is intended as a confidential and non-punitive process, inadequate legal safeguards—and its framing as an internal performance tool—tend to reinforce its association with sanctions. These dynamics undermine both the system's intended function and trust among health workers and stakeholders. Combined with the narrow scope of data collection and use outlined in the WHO MDSR Guidance, the system risks ineffectiveness, perpetuating weak implementation and defensive practices that may further compromise care. This reinforces earlier critiques that questioned the feasibility of implementing MDSR in low-resource settings.[100]

Rethinking MDSR as a tool for fulfilling states' human rights obligations to eliminate preventable maternal deaths can help address implementation challenges and enhance effectiveness by reshaping what is investigated, how data are used, and for what purpose. It also requires the state to carry out these processes in accordance with principles such as due process, which often calls for an appropriate legal framework. While improving data quality and review, information alone cannot shift attitudes or drive action. The goal should be to expose "layers of systemic and structural norms that marginalize, disempower and dispossess."[101] A human rights framing of maternal deaths—and the accountability it demands—aligns more closely with this transformative vision. Crucially, MDSR must generate relevant data that actors beyond the health system can use to demand explanation and change, mainly targeting the state as the duty bearer.

However, applying a human rights approach requires significant changes and a fundamental refocusing of MDSR, which are likely to encounter various obstacles. It would thus require mobilizing support from activists, civil society, health professionals, parliamentarians, and human rights bodies to enable MDSR to play a more transformative role. As the Special Rapporteur noted, this may also call

for a distinct yet complementary human rights accountability mechanism to address the structural injustices it routinely confronts.

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