POLICY BRIEF

Maternal Mortality in Kilifi County

Counting the Deaths, Auditing the Response, and Reading the Ratio Correctly

SEPTEMBER 2026

INDICATORS

- **No. of maternal deaths reported**
- **Maternal deaths audited within 7 days**
- **Facility maternal mortality ratio per 100,000 live births**

**All from routine KHIS data.*

AT A GLANCE

Counting the deaths directly tells a clearer story than any ratio. Kilifi recorded 353 maternal deaths as at FY 2025/26[1], with no sustained decline: the annual count moved between 30 and 44, peaking in 2021/22.

The burden is heavily concentrated. Malindi and Kilifi North together account for about 73 percent of all recorded maternal deaths. Malindi alone tripled from 8 deaths in 2019 to about 30 in 2021 and has stayed elevated.

The maternal mortality ratio per 100,000 is often quoted as the headline measure, but it can swing sharply from year to year and should be read with caution. It becomes unstable when survey figures are mixed with facility data, or when small facility birth counts distort the maths. This brief therefore leads with the number of maternal deaths and the share that are audited, which are more reliable, rather than a volatile ratio.

Audit coverage is the fixable weak link: in between 2015 and April 2026, fewer than 8 in 10 deaths were audited within 7 days, dropping to about 44 percent in 2021, the very year deaths peaked.

PURPOSE AND SOURCES

This brief examines maternal mortality in the County through three named routine indicators. It sets out what the data can reliably support, addresses a measurement problem in how the maternal mortality ratio is commonly reported, and aligns the response with the County's new health law. It draws on:

1. MOH 711 / KHIS routine data for Kilifi County: number of maternal deaths reported, maternal deaths audited within 7 days, and facility maternal mortality ratio per 100,000, 2015 to early 2026 (the three named source files).
2. Kilifi County Factsheet, and national maternal mortality reference estimates (2019 Census, UN, and peer-reviewed facility-data studies).
3. The Kilifi County Reproductive, Maternal, Newborn Child and Adolescent Health Act, 2025.

[1] *There is a caveat that this report reflects up to May 2026. The June 2026 data will be refreshed in the document after 15th of July, 2026 - which will be the exact end-of-Financial-Year.*

Indicator One: Number of Maternal Deaths Reported

KHIS recorded 353 maternal deaths across the County between FY 2017/18 and FY 2025/26. The annual number of deaths has shown no sustained decline, ranging from 30 to 44 deaths per year between FY 2017/18 and FY 2024/25. However, it peaked in FY 2025/26 when maternal deaths rose sharply to 55, representing the highest annual total recorded during the period.

Financial Year	No. of deaths
FY 2017/18	**33**
FY 2018/19	**39**
FY 2019/20	**44**
FY 2020/21	**36**
FY 2021/22	**44**
FY 2022/23	**36**
FY 2023/24	**30**
FY 2024/25	**36**
FY 2025/26	**55**

Table 1. Reported maternal deaths, Kilifi County. Source: KHIS.

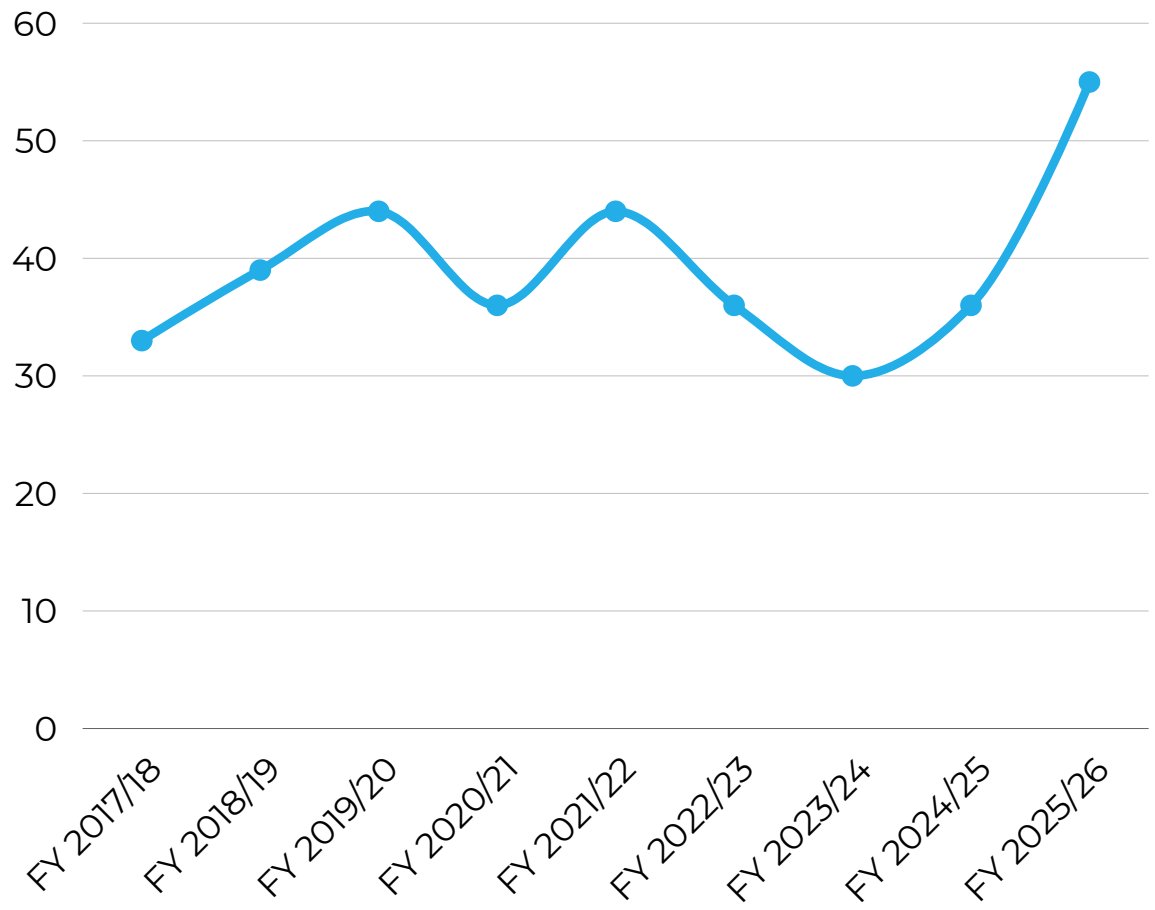

Figure 1. Reported maternal deaths per year, 2017 to 2025

1.1. Where the deaths are concentrated

The geographic pattern is the single most actionable finding in this brief. Two sub-counties carry most of the burden.

Sub-county	Deaths 2017/18 - 2025/26	Share of county	Pattern
Malindi	121	about 38%	Highest burden; roughly tripled 2019 to 2021, stays elevated
Kilifi North	126	about 34%	Consistently high, second-largest burden
Kaloleni	68	about 18%	Elevated, peaked 2021
Kilifi South	13	about 3%	Low and stable
Magarini	13	about 3%	Low recorded, likely under-reporting
Rabai	7	about 2%	Low recorded, likely under-reporting
Ganze	5	about 1%	Low recorded, likely under-reporting
County total	**353**	**100%**	

Table 2. Reported maternal deaths by sub-county, 2017 to 2025. Source: KHIS.

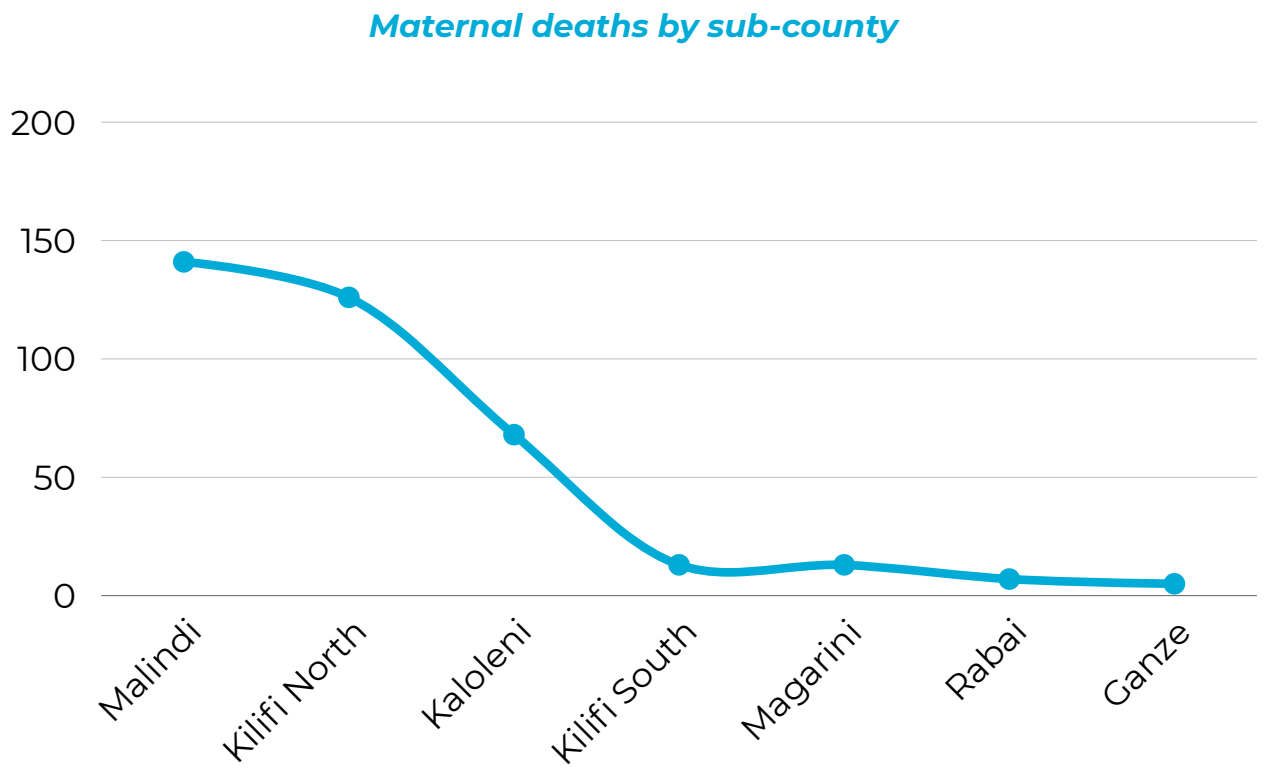

Figure 2. Maternal deaths by sub-county, 2017 to 2025

Malindi and Kilifi North together account for roughly 73 percent of recorded maternal deaths, at about 42 and 31 percent respectively. These are the County's main delivery and referral hubs, so part of this reflects women in need of specialised care being referred in. But Malindi's sharp rise around 2019 to 2021, sustained since, is a genuine warning.

1.2. Causes of Maternal Death

According to the MPDSR (Maternal and Perinatal Death Surveillance and Response) report for 2024/25, obstetric haemorrhage is the leading cause of maternal deaths in Kilifi County, accounting for 47 percent of cases, followed by hypertensive disorders and eclampsia at 16 percent. The remaining 37 percent comprises pregnancy-related sepsis and other direct and indirect causes, which could not be separately quantified in the figures available for this brief from the full MPDSR report. These findings mirror national trends, where obstetric haemorrhage, hypertensive disorders in pregnancy, and pregnancy-related sepsis remain the top three drivers of maternal mortality. Weekly MPDSR meetings are held to review these cases and identify systemic gaps, though this practice needs to be cascaded to every facility, backed by a clear follow-up work plan to track implementation of the agreed interventions.

Overall, a number of these maternal deaths are avoidable, pointing to gaps across the pathway from the onset of complications to definitive care. The contributing factors from the MPDSR report map onto the three delays in maternal survival. The first delay, in deciding to seek care, is reflected in delayed decision-making by clients. The second delay, in reaching an appropriate facility, is reflected in delayed referral of high-risk cases and a lack of transport for referral. The third delay, in receiving adequate care once at a facility, is the most prominent and includes inadequate monitoring of mothers in labour, recurrent blood and blood product shortages, and delays in initiating emergency obstetric interventions once complications arise, such as limited theatre availability. Addressing these gaps will require strengthening referral pathways, reinforcing use of the labour care guide, ensuring a consistent blood supply at facility level, and building capacity for prompt, decisive emergency response. Implemented consistently across all facilities, these measures could substantially reduce preventable maternal deaths in the County.

A caution on the low-count sub-counties: very low recorded deaths in Ganze and Magarini do not necessarily mean fewer mothers are dying there; they may be referring cases or it may also mean deaths occur at home. This is consistent with the County's separate adolescent maternal-death records, which showed a cluster in Ganze. Low facility counts in remote sub-counties should be read as a possible reporting gap, not a clean bill of health. There is a need for future data capture for the deaths out of referrals to other subcounties.

Indicator Two: Maternal Deaths Audited Within 7 Days

Auditing every maternal death quickly is how a system learns why mothers die and prevents death through timely implementation of the action points. The RMNCAH Act makes this a duty. The supplied data compares the number of deaths audited within 7 days against the number of deaths reported, giving an approximate audit coverage.

Financial Year	Deaths reported	Audited within 7 days	Approx. coverage
FY 2017/18	33	31	about 94%
FY 2018/19	39	42	about 108%
FY 2019/20	44	42	about 95%
FY 2020/21	36	23	about 64%
FY 2021/22	44	42	about 66%
FY 2022/23	36	33	about 92%
FY 2023/24	30	28	about 93%
FY 2024/25	36	39	about 108%
FY 2025/26	55	55	100%

Table 3. Audit coverage proxy: maternal deaths audited within 7 days against deaths reported. Coverage above 100 percent (2025) reflects timing or counting differences between the two routine streams and should be verified. More than 100% audits denotes data quality issues in uploading deaths Sources: KHIS and MOH 711.

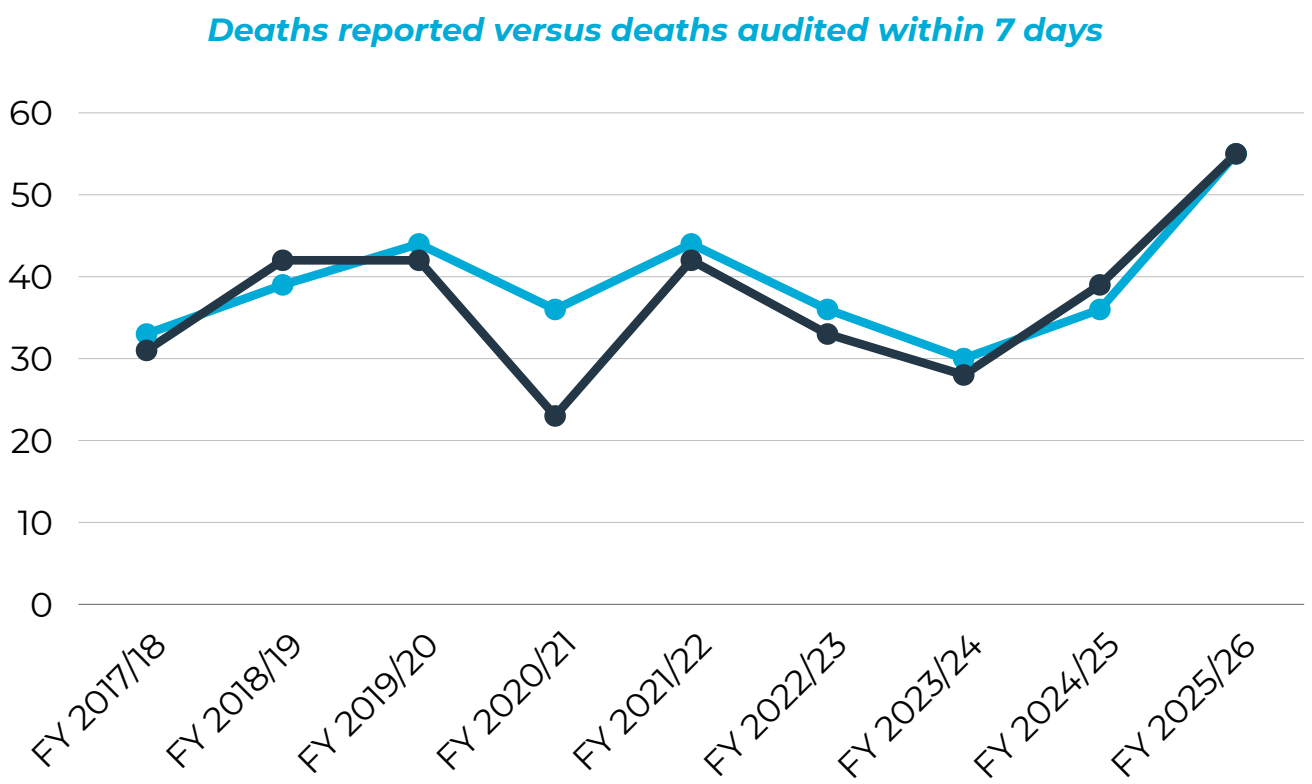

Figure 3. Deaths reported versus deaths audited within 7 days, by year

The pattern is concerning. Maternal deaths remained high, ranging from 30 to 44 annually through FY 2024/25, before rising sharply to 55 in FY 2025/26. Meanwhile, the number of deaths audited was inconsistent, with notable gaps between deaths recorded and those audited. The largest gap occurred in FY 2020/21, when 36 maternal deaths were recorded but only 23 were audited within a week, highlighting a critical gap in timely review and accountability.

Indicator Three: The Facility Maternal Mortality Ratio

Where it is useful is at the high-volume hospitals, whose birth numbers are large enough to make the ratio meaningful. There the picture is consistent with the death counts: the burden sits at the referral hubs, and Malindi runs higher than Kilifi County and Referral Hospital.

Hospital (annual ratio)	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25	FY 2025/26
Kilifi County and Referral Hospital	258	179	226	172	243	284	258	233	338
Malindi Sub-County Hospital	406	301	312	556	624	356	227	301	467

Table 4. Facility maternal mortality ratio per 100,000 at the two main referral hospitals. Source: KHIS. Hospital-level values are shown because their birth volumes make the ratio interpretable; county-wide and dispensary-level ratios in the source file are distorted by very small denominators and are not reported here.

It is important to interpret facility level mortality figures with caution, as higher counts at referral facilities partly reflect their role in absorbing severe and complicated cases from lower level hospitals (or even referral from other counties) rather than indicating poorer quality of care. Kilifi County Referral Hospital, as the county's primary referral facility, recorded mortality ratios ranging from 172 in FY 2020/21 to a high of 338 in FY 2025/26, with intermediate fluctuations between FY 2021/22 and FY 2024/25. Malindi Sub-County Hospital, similarly serving as a referral point for the lower-northern sub-counties in Kilifi, recorded consistently higher ratios between 2020 and 2022 before declining to 227 in 2023, 301 in 2024, and rising again to 467 in 2025. Elevated mortality counts at Kilifi County Hospital and Malindi SubCounty Hospital should not be read in isolation as markers of facility performance, but rather understood within the broader referral chain, where they may signal both the appropriate functioning of the referral system and the need for strengthened emergency obstetric and newborn care (EmONC) capacity at the receiving end.

Even at hospital level these ratios should be read as broad signals, not precise rates. Their value is corroborative: they point to the same Malindi and Kilifi North concentration the death counts show.

NATIONAL CONTEXT

Whichever measure is used, Kilifi's maternal mortality is (seems to be remaining) high. The honest comparison uses population-level estimates against the national figure and the global target.

Reference point	Value	Type
Kenya maternal mortality ratio	about 355	Population (2019 Census)
Kenya, UN modelled estimate (2020)	about 530	Population (UN)
Kenya institutional MMR (facility), 2021	about 99	Facility
SDG 3.1 target by 2030	70	Policy target
Maternal deaths in referral hospitals (Kenya)	about 60 to 70%	Literature

Table 5. National benchmarks. KDHS 2022 did not include a maternal mortality module; national MMR figures come from the 2019 Census and UN modelling and vary by source. Facility and population MMR are different measures and are not directly comparable.

Two national facts frame Kilifi's response. Kilifi's population maternal mortality (about 532) sits close to or slightly above the national level and is far from the SDG target of 70. And nationally, 60 to 70 percent of maternal deaths occur in referral hospitals, which is exactly where Kilifi's own deaths concentrate. This makes strengthening the Malindi and Kilifi North maternity and referral units the highest-yield action available.

The deeper diagnostic, which the earlier note framed well, is the paradox of high antenatal coverage alongside persistent deaths. Kilifi exceeds the national average on four-or-more antenatal visits (77 against 66 percent, KDHS 2022), yet mothers still die. The constraint is not getting women into care; it is the quality of care during ANC, labour, delivery and the first hours afterward, where postpartum haemorrhage and eclampsia must be managed. Note that the specific PPH and eclampsia case totals in the earlier note could not be verified from the three named files and should be confirmed from KHIS before external use.

THE RMNCAH ACT, 2025: THE MANDATE TO RESPOND

The Act postdates this data and so did not shape it. Its value is the duties it creates, which map onto these three indicators:

1. Maternal death audit is now a duty. Section 6(h) requires medical audit of deaths with emphasis on maternal and neonatal deaths, and section 9(d) requires the Advisory Committee to commission periodic inquiry into maternal and perinatal deaths and publish an annual report. This is the legal basis to fix the audit-coverage gap shown in Section 4.
2. Emergency obstetric care and referral. Sections 6, 11 and 19(2) require emergency obstetric and ambulance services, prohibit denial of care, and impose a referral duty, central to the Malindi and Kilifi North concentration.
3. Free maternity care and no detention. Sections 19(2) and 20 guarantee free antenatal, delivery and postpartum care and prohibit detaining mothers for inability to pay, removing financial delay at the point of emergency.
4. Skilled staffing and commodities. Section 6 obliges the County to ensure skilled human resources and essential supplies, the uterotonics, magnesium sulphate and blood needed to manage the leading clinical causes of death.

RECOMMENDATIONS FOR MANAGEMENT

Immediate (next 1 to 3 months)

1. Adopt the maternal death count and audit coverage, not the facility ratio per 100,000, as the County's headline maternal mortality indicators, and retire the unsupported 80 percent reduction claim.
2. Restore audit coverage toward 100 percent within 7 days under section 6(h), starting with Malindi and Kilifi North, and review every 2021 death that was never audited.

Short term (this financial year)

1. Commission a focused clinical and referral review of Malindi Sub-County Hospital, given its tripling of deaths since 2019, pairing the death count with delivery and referral volumes to separate case-mix from quality.
2. Investigate the low recorded deaths in Ganze and Magarini as a possible reporting gap, cross-checking against community and adolescent death records rather than assuming low risk.
3. Stand up the County RMNCAH Advisory Committee (sections 8 and 9) and give it ownership of a monthly maternal death and audit dashboard, so a reversal like 2020 to 2021 is caught early.

Ongoing (build into routine systems)

1. Equip every delivery unit with uterotonics, magnesium sulphate and blood transfusion capacity, and run regular obstetric emergency drills, prioritising the high-burden hubs.
2. Close the antenatal-to-delivery quality gap with a documented delivery plan for every woman with an identified risk, and strengthened monitoring in the first 24 to 48 hours after birth.
3. Clean the routine MMR data so dispensary denominator artifacts no longer distort county reporting, and triangulate facility data against population estimates and the Kenya Vital Statistics Report.

Acknowledgement

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