

Kenya's Maternal Death Crisis: We Have the Data, We Lack the Discipline

She walks into the hospital quietly, accompanied by her sister. This is her third pregnancy so there is no anxiety of the unknown this time, only the fatigue of carrying life for nine months. She is ready to meet her baby and return home, where her husband and two children wait. For a brief moment after the birth of her baby boy, everything is as it should be. Then something changes: the energy in the room shifts, movements become urgent and a moment of joy gives way to irreversible loss.

This is not an isolated story; it is a pattern. Across Kenya, maternal and newborn deaths often follow familiar pathways: delayed referrals, gaps in emergency response, shortages of blood products and limited theatre access. These are not unpredictable events. They are known, recurring and, in many cases, preventable.

Kenya's Maternal and Perinatal Death Surveillance and Response (MPDSR) system was established to confront exactly these reality. The MPDSR seeks to ensure that every maternal and newborn death triggers a structured review to identify contributing factors and generate actions to prevent recurrence. While clinical teams across our counties continue to conduct these reviews with diligence and technical candor, the execution remains incomplete.

When the same findings i.e delayed referrals, blood shortages, and overstretched theatres continue to emerge repeatedly across facilities and over time, the issue is no longer purely clinical but systemic. These deaths underscore the importance of strong, well-coordinated governance in how health services are organized and resourced.

Under the Fourth Schedule of the Constitution, County Governments are responsible for delivering health services. This places the determinants of survival, staffing, infrastructure, referral systems, and emergency readiness squarely within the devolved governance. However, when MPDSR processes remain primarily anchored at the facility level, findings captured in reports do not consistently translate into system-wide action. A clinical team may document a lack of blood, but addressing this requires stronger supply systems beyond the reach of a single facility. Strengthening the link between these findings and government planning and resource allocation is therefore essential.

Kenya does not have a knowledge problem; it has an execution problem. We know why mothers and newborns are dying, and we document it every day, but documentation is not action. A woman does not die because a report was incomplete. She dies because a system gap was identified and left unresolved.

Ending these deaths will not come from new guidelines or more data, but from discipline. We must ensure that every preventable death triggers a clear, time-bound response that is owned within the health system, funded through budgeting processes and tracked through to

closure. This requires a more structured approach that embeds routine leadership reviews and aligns MPDSR priorities with resource allocation.

Devolution also presents an opportunity for peer learning. A structured inter-county platform for exchange would allow counties to replicate what works, from referral coordination to expanding surgical capacity, rather than repeating the same challenges. Maternal mortality is not a competition between counties; it is a shared national challenge.

The effectiveness of our system can ultimately be measured by a simple question: did the review of the last death reduce the risk of the next one? If the answer is unclear, then the system is not yet working as intended. That mother did not walk into the hospital expecting to become a statistic; she came expecting to return home to her family. Kenya has the expertise and the policy framework to ensure she does. The question is no longer whether these deaths can be prevented, but whether our systems are designed to do so.

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<https://www.the-star.co.ke/opinion/star-blogs/2026-05-19-mwiti-kenya-has-data-on-maternal-deaths-but-little-action>