

Circumstances Related to Pregnancy-Associated Deaths Among Oklahoma Mothers

What is a Maternal Mortality Review Committee (MMRC)?

A Maternal Mortality Review Committee collects and reviews information on maternal deaths to understand the circumstances around the death, determine whether it was related to pregnancy, and to create recommendations to prevent deaths in the future. MMRC efforts are designed to improve public health efforts to reduce and prevent maternal death in Oklahoma, as well as improve the identification of high-risk groups and develop targeted, effective interventions for these groups.¹ Oklahoma's MMRC became a statutory committee in 2019 as part of House Bill 2334, the "Maternal Mortality Review Act," giving the MMRC authority to review pregnancy-associated deaths, and obtain relevant medical records.²

The Oklahoma MMRC reviewed 70 maternal deaths occurring between 2022 and 2023, 37.1% of which were pregnancy-related. Of these pregnancy-related deaths, 61.5% were determined to be preventable. These cases were evaluated to determine the circumstances around the maternal death, specifically obesity, discrimination, substance use disorder, mental health conditions* other than substance disorders, suicide, and homicide.

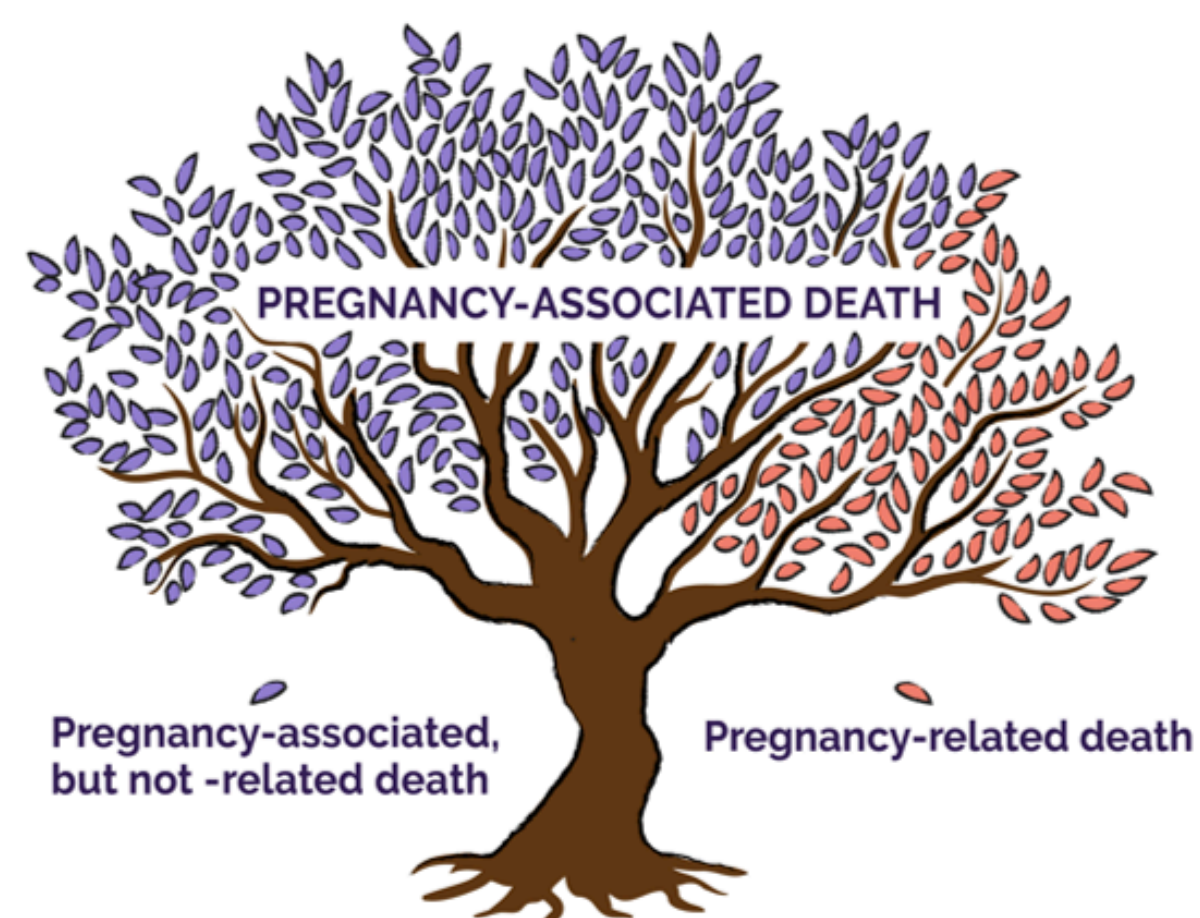
*Identifying discrimination and these conditions can be difficult due to limited documentation, so their impact is likely underestimated in the data.

MMRC Definitions

Pregnancy-associated death: A death during or within one year of pregnancy, regardless of cause. These deaths make up maternal mortality, and within this category are pregnancy-related deaths and pregnancy-associated but not related deaths.

Pregnancy-associated, but not related death: A death during or within one year of pregnancy, from a cause that is not related to pregnancy.

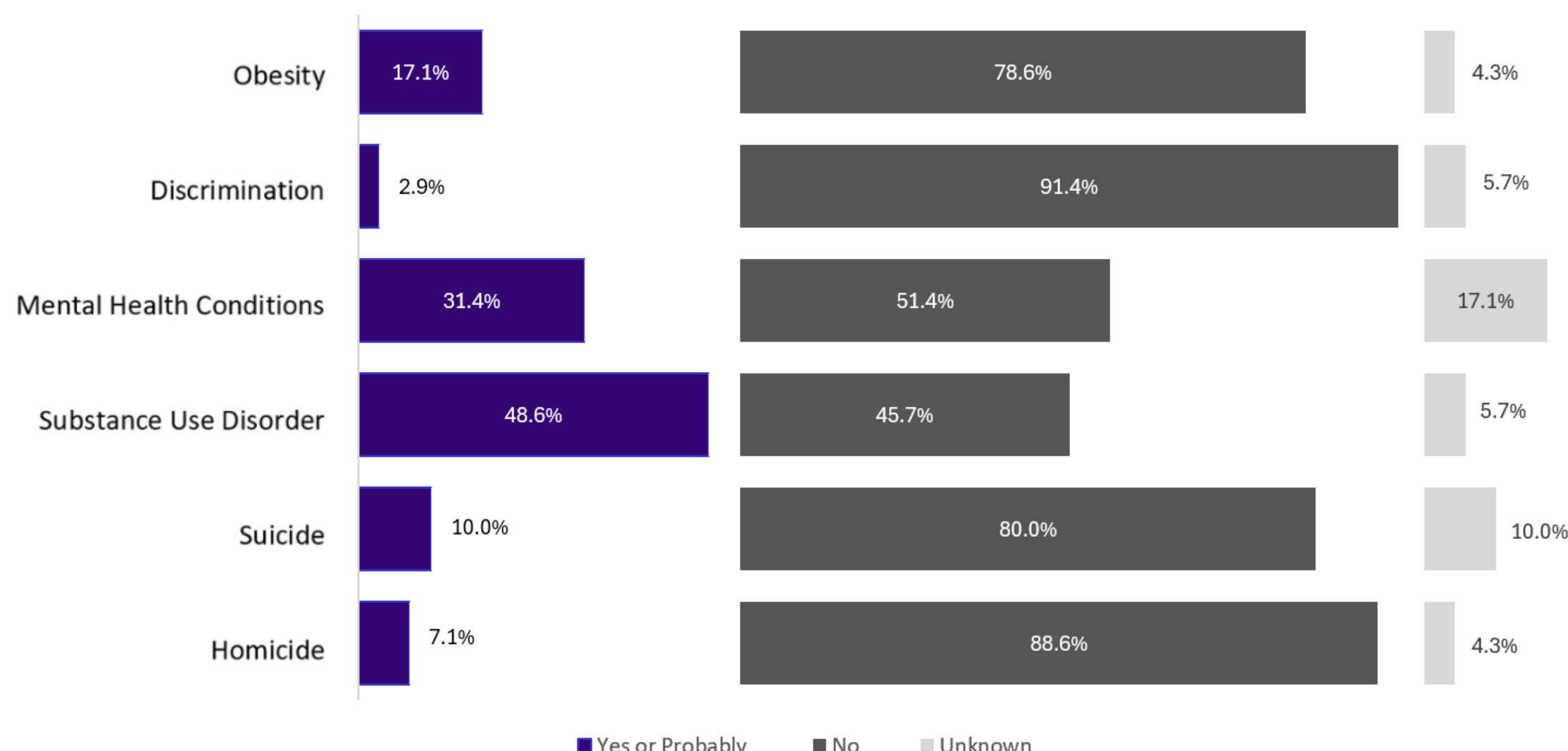
Pregnancy-related death: A death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.



Circumstances contributing⁺ to pregnancy-associated deaths in Oklahoma 2022-2023

Source: Oklahoma Maternal Mortality Review Committee, 2022-2023

+Circumstances were considered contributing to the death if the MMRC determined "Yes" or "Probably" for "Did [circumstance] contribute to the death?" or "Was death a [circumstance]?" for suicide and homicide.

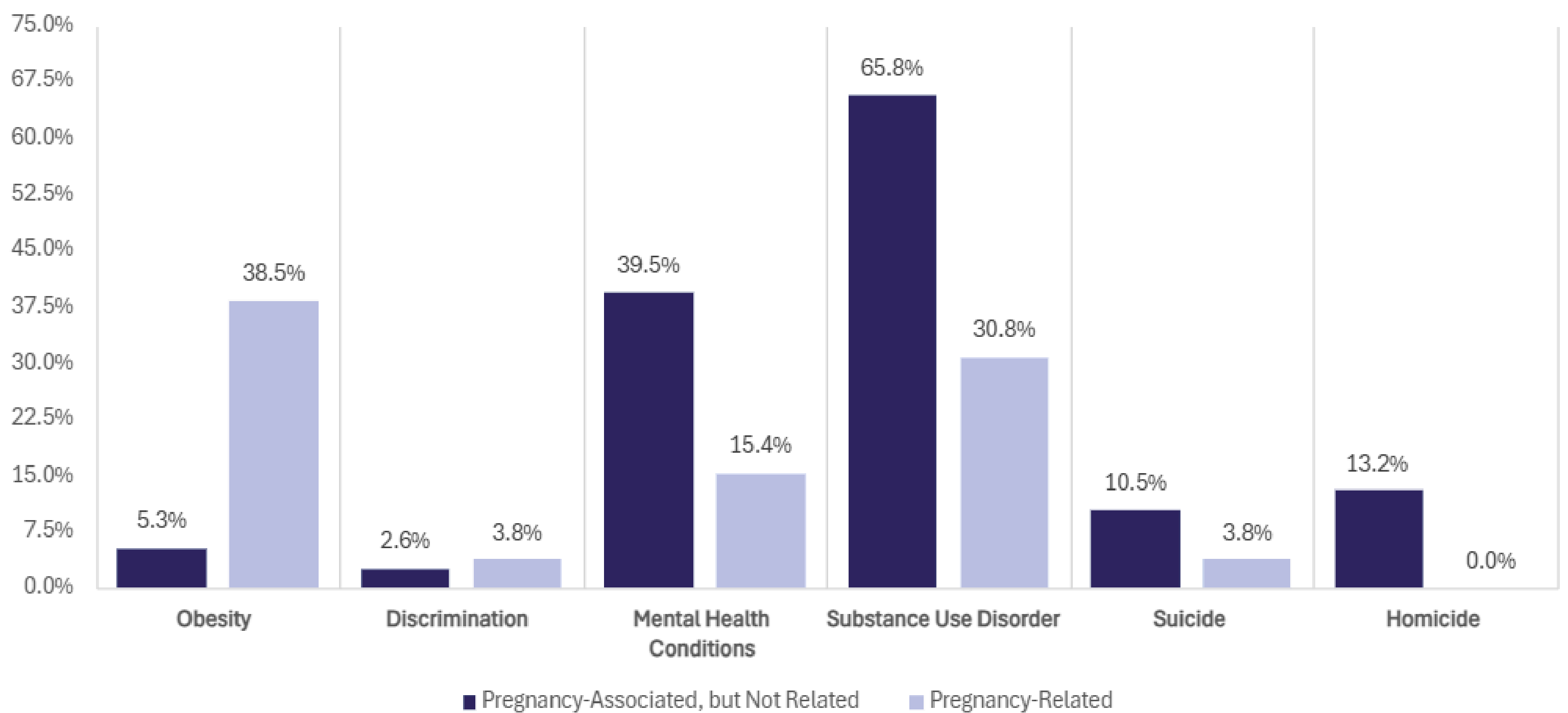


Overall, for **pregnancy-associated** deaths, substance use disorder and mental health conditions were the largest contributing factors, contributing to 48.6% and 31.3% of deaths, respectively.

Circumstances contributing⁺ to pregnancy-associated deaths by pregnancy-relatedness, Oklahoma 2022-2023

Source: Oklahoma Maternal Mortality Review Committee, 2022-2023

+Circumstances were considered contributing to the death if the MMRC determined “Yes” or “Probably” for “Did [circumstance] contribute to the death?” or “Was death a [circumstance]?” for suicide and homicide.



The circumstances around deaths differed by pregnancy-relatedness. For **pregnancy-related** deaths, obesity and substance use disorder were large contributors to deaths. For **pregnancy-associated but not related** deaths, substance use disorder and mental health conditions were the largest contributors to deaths, and obesity was a much smaller percentage.

Relevant MMRC Recommendations for Mental Health and Substance Use

- The MMRC should establish an advisory group to address perinatal mental health and substance use.
- Providers should screen every pregnant patient for mental health conditions and substance use disorders, document screenings, and refer patients to appropriate resources
- Substance use disorder providers and methadone treatment centers should assure access to family planning resources and information.
- For pregnant patients with mental health conditions, providers should encourage and refer to a perinatal psychiatrist.
- Support funding for providers to become certified through Postpartum Support International.
- Professional licensing boards, educational institutions, and professional organizations should develop educational resources for identifying and referring pregnant and postpartum patients with mental health conditions.

Committee recommendations were simplified for use in this factsheet. For the full MMRC Recommendations list (included in meeting minutes), click [here](#).

Information about the implementation of MMRC recommendations can be found in the annual MMRC report, available at the [MCH Data Portal](#) under Perinatal and Reproductive Health.

REFERENCES

1. CDC. (2022). Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees. Centers for Disease Control. Accessed at <https://www.cdc.gov/maternal-mortality/php/data-research/> on May 1st, 2026.
2. Oklegislaturegov “HB2334 (2019): Maternal Mortality Review Act” Oklegislature gov, May 28, 2019 Accessed May 22, 2026 <http://www.oklegislature.gov/BillInfo.aspx?Bill=HB2334>

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