

MATERNAL MORTALITY REVIEW PROGRAM



Who Are We?

The Connecticut Maternal Mortality Review Program (MMRP) is a statewide program run by the Connecticut Department of Public Health (DPH). Since June 2018, **we've been working to better understand why some moms die during pregnancy or soon after giving birth. Our goal is to find ways to help prevent these deaths and keep mothers safe.**

We receive support from the Centers for Disease Control and Prevention (CDC) and are part of a national program called ERASE MM. This program includes 46 states and 6 U.S. territories. Thanks to this support, we are able to study each case carefully, see if the death could have been prevented, and find ways to improve care for others in the future.



What Have We Learned?

Pregnancy-related deaths can happen, but many can be prevented. Some of the reasons include:

- Not being able to get the care they need
- Delays in finding out what's wrong
- Signs of a problem were missed

80% OF PREGNANCY-RELATED DEATHS WERE PREVENTABLE. The top causes of deaths related to pregnancy were mental health problems, heart problems, and infections.¹

Ways to Help Prevent Pregnancy-Related Deaths

COMMUNITY MEMBERS



Support MMRP and our work

DOCTOR'S OFFICE / CLINIC



Make sure care plans and emergency plans are clear and followed

MOMS & FAMILIES



Learn and share signs of problems

DOCTORS & NURSES



Help patients handle long-term health problems and talk about warning signs

HEALTH CARE SYSTEM



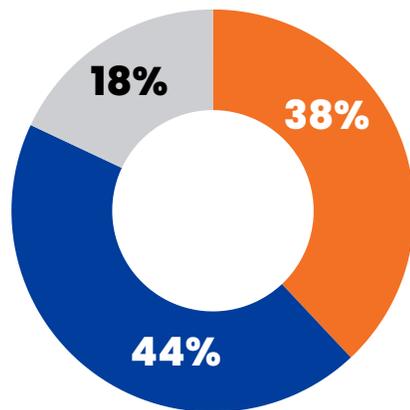
Give better care before and after pregnancy, and train more health workers

MMRP Committee Members

Experts who review the facts about women who did pass away

- A doctor for pregnant women (*OB/GYN*)
- A licensed social worker
- A doctor who helps with mental health
- A person who has experienced pregnancy-related challenges
- A nurse-midwife
- A doula (*a trained helper who supports moms during pregnancy and birth*)
- A labor and delivery nurse
- An epidemiologist (*someone who studies health patterns*)
- A medical examiner
- A doctor who works with babies and children
- A community health worker
- A psychologist
- A heart doctor (*cardiologist*)

Pregnancy-Associated Deaths



When a woman dies during pregnancy or within a year after the pregnancy ends, no matter the reason. (*CT-MMRIA, 2015-2021*)

- Related to being pregnant
- Not related to being pregnant
- Unknown

- In the U.S., **Black and American Indian/Alaska Native women were about 3X more likely to die from a problem related to being pregnant** than White women.
- In Connecticut, **non-Hispanic Black women are the most likely to die from problems related to being pregnant.**
- In Connecticut, **almost half (49%) of deaths related to being pregnant happen between 43 days to 1 year after pregnancy**, 23% happen during pregnancy, and 28% happen less than 42 days after pregnancy.

Resources

For more information on The Connecticut Maternal Mortality Review Program, [CLICK HERE](#)

For more information on Maternal Mortality Prevention (CDC), [CLICK HERE](#)

For more information on Hear Her (CDC), [CLICK HERE](#)

For more information on Prenatal and Preconception Care, [CLICK HERE](#)

¹ CDC's 38 state brief: Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 US States, 2020 available at: <https://www.cdc.gov/maternal-mortality/php/data-research/2020-mmrc.html>.