The Years They Skipped

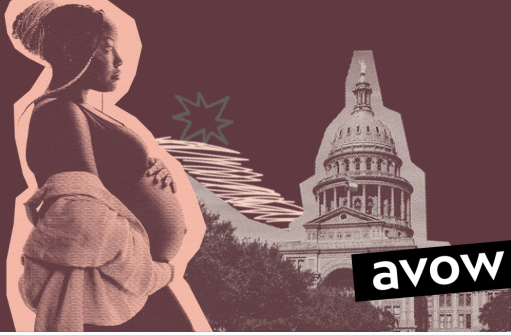
An Abortion-Forward Briefing on Texas' 2026 Maternal Mortality and Morbidity Report



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Overview

Contextualizing the Report



What the Report is:

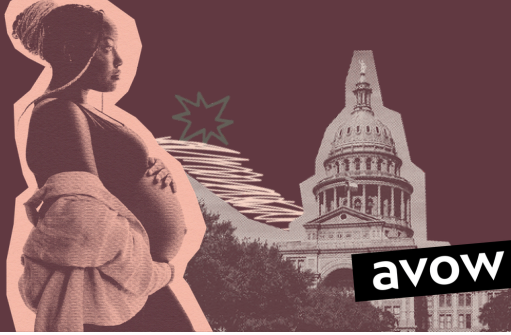
Every two years, Texas law requires that the Maternal Mortality and Morbidity Review Committee (MMMRC) and the Department of State Health Services (DSHS) publicly report on maternal deaths and morbidity in our state. In plain terms, these reports track two things: who dies from pregnancy-related causes, and who survives but is seriously harmed—conditions like severe hemorrhage, sepsis, or organ damage that leave lasting health consequences.

To produce this report, the MMMRC reviews a representative sample of maternal deaths in Texas, determines the underlying causes of those deaths, and then issues recommendations on what our state can do to improve maternal health outcomes.

This year's report looks at two case cohorts: 2021 (one year before Texas banned all abortions) and 2024 (two years into Texas' total abortion ban). The MMMRC reviewed 158 sampled deaths from 2021 and 127 from 2024, and issued 11 recommendations.

Overview

Contextualizing the Report

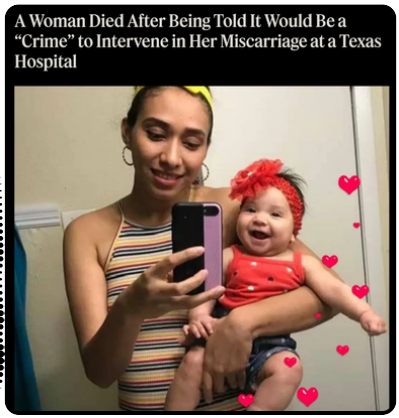


What the Report is not:

Across 56 pages, the report documents deaths, contributing factors, and recommendations—yet never names the economic and political conditions under which its subjects became pregnant, sought care, or died.

The MMMRC did not conduct case review for 2022 and 2023—the first two years after Texas' total abortion ban went into effect. The Committee says this was a methodological choice with no political motivation, but the decision was made as Texas faced national scrutiny over post-ban deaths, including those of Nevaeh Crain, Josseli Barnica, Porsha Ngumezi, and Tierra Walker.

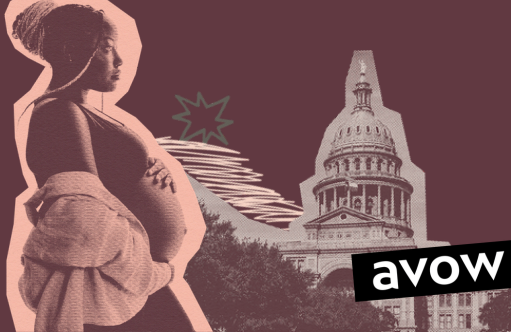




Pictured Here: Nevaeh Crain (Left) and Josseli Barnica (Right)

Overview

Contextualizing the Report



What the Report is not (Continued):

The Committee's hands are partly tied. Texas law prohibits the MMMRC from collecting or reviewing records involving "voluntary or therapeutic termination of pregnancy." However, that restriction doesn't require the report's findings and recommendations to pretend Texas' abortion bans don't exist. This report could have named the policy environment without counting those specific cases—and it chooses not to.

This omission also distorts how the report reads, and what it can tell us about maternal death and morbidity in our state. With only 2021 and 2024 reviewed, every change shows up as a startling leap—a sudden rise in mental health deaths and in intimate partner violence. Two unexamined years sit between those data points, and a steady climb across them would look exactly the same. The impact is that advocates and legislators alike cannot tell a spike from a slope, and that ambiguity will shape every bill and budget line that follows.

Analysis

An Abortion-Forward Look at the MMMRC's 2026 Report



#1. The leading causes of maternal death shifted toward obstetric emergencies. (Pg. 12 + 13)

In 2021, infection was the leading cause of pregnancy-related death (55%)—but 91% of those infections were COVID-19. By 2024, the leading causes were mental health conditions (20%), hemorrhage (15%), hypertensive disorders (14%), embolism (12%), and infection (10%)

Hemorrhage, hypertension, embolism, and sepsis are obstetric emergencies—the conditions where timely care most determines whether someone lives. The report's own top barriers in 2024 were delays in receiving treatment (45%), lack of access to care before, during, and after pregnancy (34%), repeated urgent or emergency visits (27%), and care inconsistent with best practices (23%).

The state can wave off 2021 as a pandemic anomaly, but the 2024 shift is harder to explain away. This is what happens when clinicians delay care out of legal fear, and when pregnant Texans have no entry point to receive maternal healthcare until it is an emergency.

Analysis

An Abortion-Forward Look at the MMMRC's 2026 Report



#2. The number of potentially preventable maternal deaths did not fall. (Pg. 14 + 15)

The pregnancy-related mortality ratio fell from 30.0 per 100,000 live births in 2021 to 20.7 in 2024, but the number of potentially preventable deaths held steady. Of the pregnancy-related deaths reviewed by the MMMRC, 46 of 60 in 2021 and 45 of 59 in 2024 were potentially preventable—roughly three in four both years. A lower rate of maternal deaths did not translate into fewer preventable deaths.

#3. Violence against pregnant Texans rose. (Pg. 13)

Violent pregnancy-related deaths (homicide and suicide) jumped from 5% in 2021 to 19% in 2024. In every pregnancy-related homicide across both years, the perpetrator was the decedent's partner. Among 2024's violent deaths, 27% had a documented history of intimate partner violence and 64% had evidence of IPV screening.

Research suggests this violence is common in states where abortion care is hardest to reach. According to the National Bureau of Economic Research, intimate partner violence rose 7–10% in counties where people had to travel farther for abortion care—an estimated 9,000 additional incidents in states that restrict abortion.

Analysis

An Abortion-Forward Look at the MMMRC's 2026 Report



#4. Hospital emergency rooms should be a safety net, but emergency medical care is failing, too. (Pg. 28)

83% of 2024 pregnancy-related decedents had an emergency department or EMS record in the two years before death. Pregnant people are cycling through emergency care and dying anyway. The MMMRC treats the ER as a site of missed opportunity; in reality, care is being denied.

> ***In Arlington, Kelsie Norris-De La Cruz was sent home from an emergency room with an untreated ectopic pregnancy. When she returned later, the pregnancy had ruptured. She lost a fallopian tube and most of an ovary, compromising her future fertility.***
>
> ***"The doctors knew I needed an abortion, but these bans are making it nearly impossible to get basic emergency healthcare," she said.***
>
> ***Center for Reproductive Rights, August 2026***

Abortion is part of the spectrum of maternal health care. When it is banned, one more intervention disappears from the emergency toolkit—and the medications and procedures most associated with it become objects of fear. Kelsie's case was not a missed opportunity; it was an outright refusal of care because Texas has made treating emergencies feel more dangerous than abandoning patients during one.



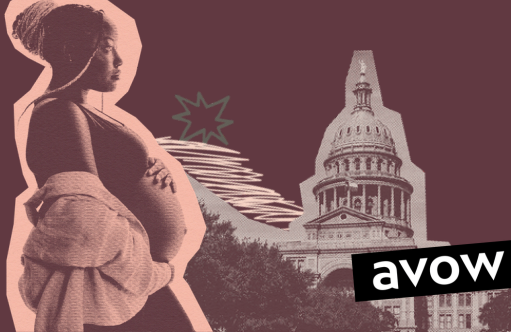
#5. Mental health deaths cluster after care ends, and abortion bans are part of what drives them. (Pg. 15 + 16)

All of the 2021 mental-health pregnancy-related deaths and 75% of the 2024 deaths occurred between 43 days and one year postpartum, after the typical coverage and care window closes. Between 92% and 100% were preventable. For many Texans, maternal mental health support ends just as the hardest stretch of the postpartum period begins.

The stressors driving maternal mental health extend beyond the clinic. Can a family afford a pregnancy at all, or reach care with what they have, in a state with the highest uninsured rate in the nation and local maternity wards shuttering? Under Texas' abortion bans, patients must now travel out of state, paying out of pocket and arranging time away from work, which falls hardest on families with the least to spare. According to a 2026 AJMC study, the share of Texas mothers reporting fair or poor mental health nearly doubled after the total abortion ban—from 4.6% to 9.3%. Mental health is not the result of one program or policy, but the result of our entire lived experience. Texas makes life harder for our families, and the consequences for mental health are clear.

End Notes

Why Reproductive Justice-Centered Governance:



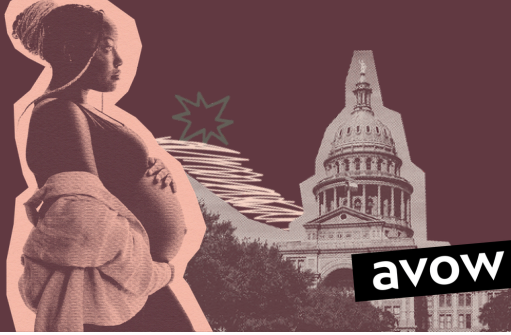
Conclusion:

Earlier this year, Harris County was declared the deadliest place in the country for Black people to give birth. In February, our organization convened community members in Houston to talk about that reality. A central theme was how the naming of this crisis and the interventions that follow keep pointing to solutions too small for the problem.

The MMMRC's analysis does the same. Its fourth recommendation, on engaging Black communities (Pg. 23), asks for respectful communication, culturally respectful education tools, and including patient voices in quality improvement. In fact, nearly all 11 recommendations the Committee makes are aimed at the clinic or the classroom. A patient-centered doctor still operates inside a structurally racist system, and good intentions cannot overcome structural inequality.

End Notes

Why Reproductive Justice-Centered Governance:



Conclusion (Continued):

Medicaid was the most common source of payment for pregnancy-related deaths in both 2021 and 2024 (57% and 53%), and 22% of decedents in each year either paid out of pocket or had no payor listed (Pg. 13 & 14). These are Texans priced out of life in our state.

When the report cites chronic conditions or weight-related health as contributing factors (Pg. 20), it treats them as individual risks rather than environmental outcomes. It does not name the food apartheid, the lack of safe green space, the chronic stress of structural racism, or the absence of primary care that shape those conditions. It measures bodies without measuring the conditions that make them sick and, often, kill them.

Reproductive justice, as articulated by its Black foremothers, insists on four things: the right to have a child, the right not to have a child, the right to parent in safe and healthy environments, and the right to bodily autonomy. Governance on these terms is the only solution to the high rates of maternal death and morbidity in our state and the country.