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Maternal health and beyond: lost opportunities in suicide prevention for women

Suicide is a leading cause of death among women aged 15–49 years, with an estimated 240 000 maternal deaths and 132 000 deaths of women aged 15–49 years occurring globally in 2023.[1] Substantial strides have been made in reducing maternal mortality due to obstetric complications, which are undoubtedly crucial concerns, but these are not the only threats to maternal wellbeing. When a mother dies by suicide—whether during pregnancy, postpartum, or in the years after childbirth—her death affects her children's survival, development, and wellbeing. As a mother's role as a caregiver does not end at 42 days postpartum or 1 year after the end of pregnancy,[2] we argue that, without addressing maternal suicide, efforts to reduce child mortality and enhance children's developmental outcomes will remain incomplete.

We use the term woman and mother to refer to cisgender women who can become pregnant or give birth, but emphasise the need to understand the experiences of all people with the capacity to become pregnant and give birth, regardless of their gender identification, and enumerate their psychosocial experiences of pregnancy and parenthood within our health strategies, including in mental health and suicide prevention.

WHO and UNICEF's Survive and Thrive agenda for children is severely threatened when they are deprived of one of the most crucial protective factors in their lives: their mother. Maternal loss often destabilises the caregiving environment and can result in emotional trauma; reduced access to health care; poor nutrition; disrupted education; economic insecurity; increased risk of depression, anxiety, and substance misuse; and an intergenerational increased risk of suicide later in life.[3] Therefore, safeguarding maternal mental health—and preventing suicide—is not only a matter of women's rights, but also essential to ensuring a just and healthy future for all children. When maternal suicide is recognised as a maternal health issue, this recognition also helps families to understand the medical and social factors involved, reduces stigma, and enables better access to bereavement support, mental health care, and legal or social assistance.

From a public health perspective, high rates of suicide among women of a reproductive-age (15–49 years) women signal a crucial failure in maternal mental health services, gender-responsive policies, community safety nets, and structures of support around women, including those experiencing motherhood. Maternal death by suicide is deeply influenced by mental health and a range of intersecting social determinants (eg, intimate partner violence, stigma, poverty, and insufficient social support), which contribute to suicidal ideation and behaviour,[4,5] showing that maternal suicide is a societal issue.

Deaths by suicide are preventable, and maternal health systems have a unique opportunity to intervene during a period when women are in frequent contact with health services for both themselves and their children. A framework shift is needed that redefines maternal health to include services that carefully address and prioritise maternal mental health and suicidal thoughts and behaviours among mothers to bring visibility to the gendered risks mothers face, and holds multiple systems (not only health systems , but also social welfare, legal, and community support systems) accountable for ensuring that mothers receive comprehensive support beyond their physical health.[5] Addressing maternal suicide effectively will also require a life course and rights-based approach for women that considers the complex ecosystem in which women's health is embedded for women to thrive and realise their rights. Models of care should recognise women as whole individuals, beyond giving birth or being the primary caregiver, and challenge the systems that place disproportionate responsibility for childrearing and caregiving on women. Therefore, as maternal health strategies evolve to meet new challenges, suicide prevention needs to become a core priority.

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