

Building the Economic Evidence Base for Birth-Related Trauma

Barriers, Gaps and Future Directions

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*“Birth-related trauma is becoming clinically visible
—
but remains economically invisible.”*

Under-prioritised
in policy

Under-funded
in research

Under-served
in practice

→ Why? And what can we do about it?

What We Know About Birth-Related Trauma

Prevalence estimates vary widely (9–50%) — the range itself reflects inconsistent measurement approaches across studies.

9–50%

of women describe at least one aspect of
birth as traumatic (subjective experience)

(O'Donovan et al., 2014; Stramrood et al., 2011; Thomson & Downey 2016)

~4% / 18.5%

CB-PTSD in community samples /
high-risk groups (Dikmen-Yildiz et al., 2017)

4.7% / 13%

CB-PTSD / CB-PTSS in mothers
(Heyne et al., 2022; N=54,711)

1.2%

of fathers develop CB-PTSD —
birth trauma is a family-level event
(Heyne et al., 2022)

The Costs Are Not Small — But a Standalone Estimate Is Still Missing

£6.6bn

Perinatal depression & anxiety
(UK, 2013 birth cohort)

Bauer et al. 2016

\$14bn

Perinatal depression & anxiety
(US, 2017 birth cohort)

Luca et al. 2020

?

Birth-related trauma
(any country, any year)

No standalone estimate exists

Note: Health economists working in perinatal mental health are few. Existing simulation modelling studies bundle depression, anxiety, and sometimes PTSD within sensitivity analyses (Bauer et al., 2016; 2022a; 2022b) — but do not disaggregate birth-related trauma as a standalone condition. Generating a dedicated estimate would be one of the most powerful policy arguments this field could make.

Mapping the Economic Evidence: A Scoping Review

6,062 • studies identified across 7 databases (searched to July 2025)

4,845 • screened at title/abstract level (after deduplication)

69 • screened at full-text level

9 • met inclusion criteria

The 9 studies covered:

5 RCTs • 1 cohort • 1 cross-sectional • 1 simulation modelling study • 1 systematic review

Published 2013–2022 | 5 Europe • 2 Australia • 1 South Africa • 1 multi-country

What the Evidence Shows — and What It Misses

✓ What Was Found

- Lower HRQoL among women with traumatic birth
- Reduced quality of life persists up to 12 months postpartum
- Increased healthcare utilisation: longer hospital stays, more GP visits, greater use of psychological support
- Simulation modelling (South Africa): total lifetime cost USD 2.8 billion — quality-of-life losses (USD 1.8bn) the primary cost driver (Bauer et al., 2022)

✗ What Is Missing

- Despite growing clinical recognition, no standalone economic evaluation exists

Five Reasons Economic Evidence Lags Behind

01

Low awareness of the phenomenon

A woman-centred definition was established (Leinweber et al., 2022) — but awareness among clinicians, policymakers and researchers remains insufficient, and this has not yet translated into economic research agendas.

02

Short follow-up horizons

All existing studies end within 12 months. PTSD symptoms may emerge or persist years after birth — short follow-up studies are likely to substantially underestimate the long-term economic burden.

03

Economic outcomes are secondary

HRQoL and costs are tagged on as add-ons; no study was designed primarily around economic questions.

04

Multi-person complexity

Birth trauma affects mother, child, partner, and family. Standard single-patient economic frameworks don't accommodate this.

05

No standalone economic evaluations

No cost-effectiveness or cost-utility analysis exists for birth-related trauma specifically — the minimum needed to inform investment decisions.

Making Birth-Related Trauma Economically Visible

Methodological

- Use standardised definitions & outcome measures
- Extend follow-up ≥ 2 years (ideally lifetime)
- Adopt societal perspective incl. productivity & family costs
- Develop core economic outcome sets for birth trauma research;
 - A preference-based health-related quality of life measure (e.g. EQ-5D)
 - Healthcare utilisation costs
 - At least one family-level outcome

Research

- Design studies with economic evaluation in mind from the outset (Tecirli et al., 2025)
- Measure both costs and health outcomes using preference-based instruments (e.g. HRQoL/QALYs)
- Capture family and intergenerational impacts using linked longitudinal data (Ayers et al., 2024; Bauer et al., 2025)
- Prospectively collect data to enable future policy impact evaluation (baseline service use, screening coverage, and policy-linked outcomes e.g.)

Policy

- Recognise CB-PTSD as a distinct clinical and policy priority - and integrate validated screening instruments (e.g. City Birth Trauma Scale) into existing maternal follow-up pathways; EPDS alone is insufficient
- Build a coherent service framework - from screening to referral to treatment, with clear institutional responsibility at each step
- Address the help-seeking gap - individuals experiencing mental health difficulties often cannot recognise their own need for support; passive service models fail them. Active outreach and low-threshold access are essential
- Embed birth trauma in national perinatal mental health guidelines (Ayers et al., 2024; Donegan et al., 2025)

Thank You!

Three Things to Take Away

1

The clinical case is made. The economic case is not — and without it, policy will not move.

2

Economic evidence in this field is so scarce it barely exists. This is not a gap waiting to be filled — it is a gap that must be deliberately built.

3

If we cannot quantify the burden, we cannot make the case. And if we cannot make the case, women will continue to bear costs that remain invisible to health systems—and therefore remain unfunded.

A Note on Türkiye — and Where We Go from Here

Türkiye: Perinatal Mental Health in Primary Care

PPD prevalence 15–28% — robust academic evidence across multiple national studies

How screening works in practice

Postnatal: EPDS included in the Postnatal Care Management Guideline (MoH PHGD, 2018); cut-off score of 12; integrated into family physician performance assessment

Antenatal: Depression flagged as a risk factor— but no validated screening instrument specified

Gaps in current practice

Following a positive postnatal screen, no standardised referral or follow-up pathway exists — access to treatment remains largely dependent on individual initiative

Birth-related trauma (CB-PTSD) absent from all clinical guidelines

Perinatal mental health not named as a priority in any upper-tier policy document — no coverage target, no dedicated budget line, no strategic monitoring framework

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