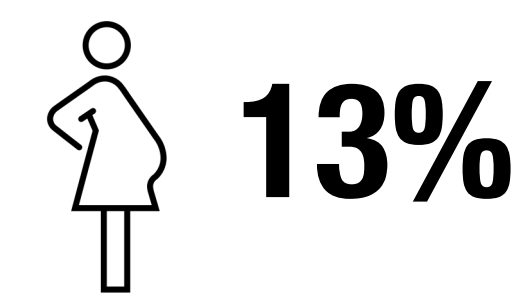


Improving experience of gestational diabetes in pregnancy and reducing further diabetes risk

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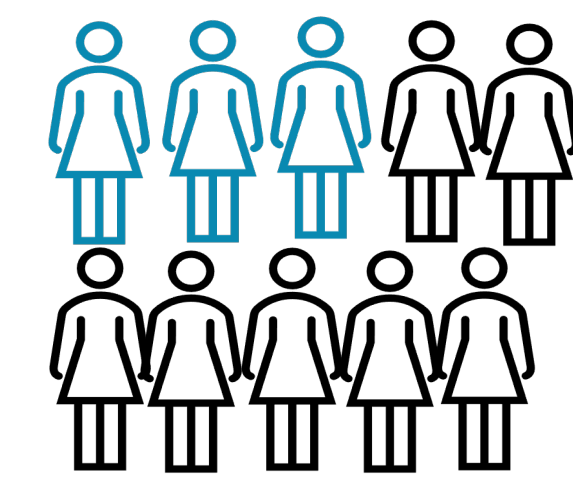


1. Why is this research needed?



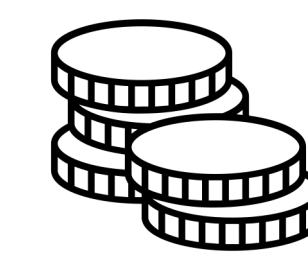
13%

of pregnancies are complicated by gestational diabetes (GDM) increasing risk for mother and child. Lifestyle change is the cornerstone of care.¹



33%

of women with gestational diabetes get type 2 diabetes (T2D) in later life. The rate is highest for women from minority ethnicities.¹



£1.5m
per hour

is spent treating people with diabetes by the UK NHS. Again, lifestyle change and self-management are central to care.²

2. What questions do we need to answer?

- What factors support engagement with the GDM lifestyle change guidance in pregnancy?
- What factors support lasting behaviour change to reduce long term risk of T2D?
- What cultural and social factors influence the GDM experience?
- How can we intervene to improve outcomes?

3. Our approach



Building community relations to encourage engagement.



Semi-structured interviews with diverse sample of women.

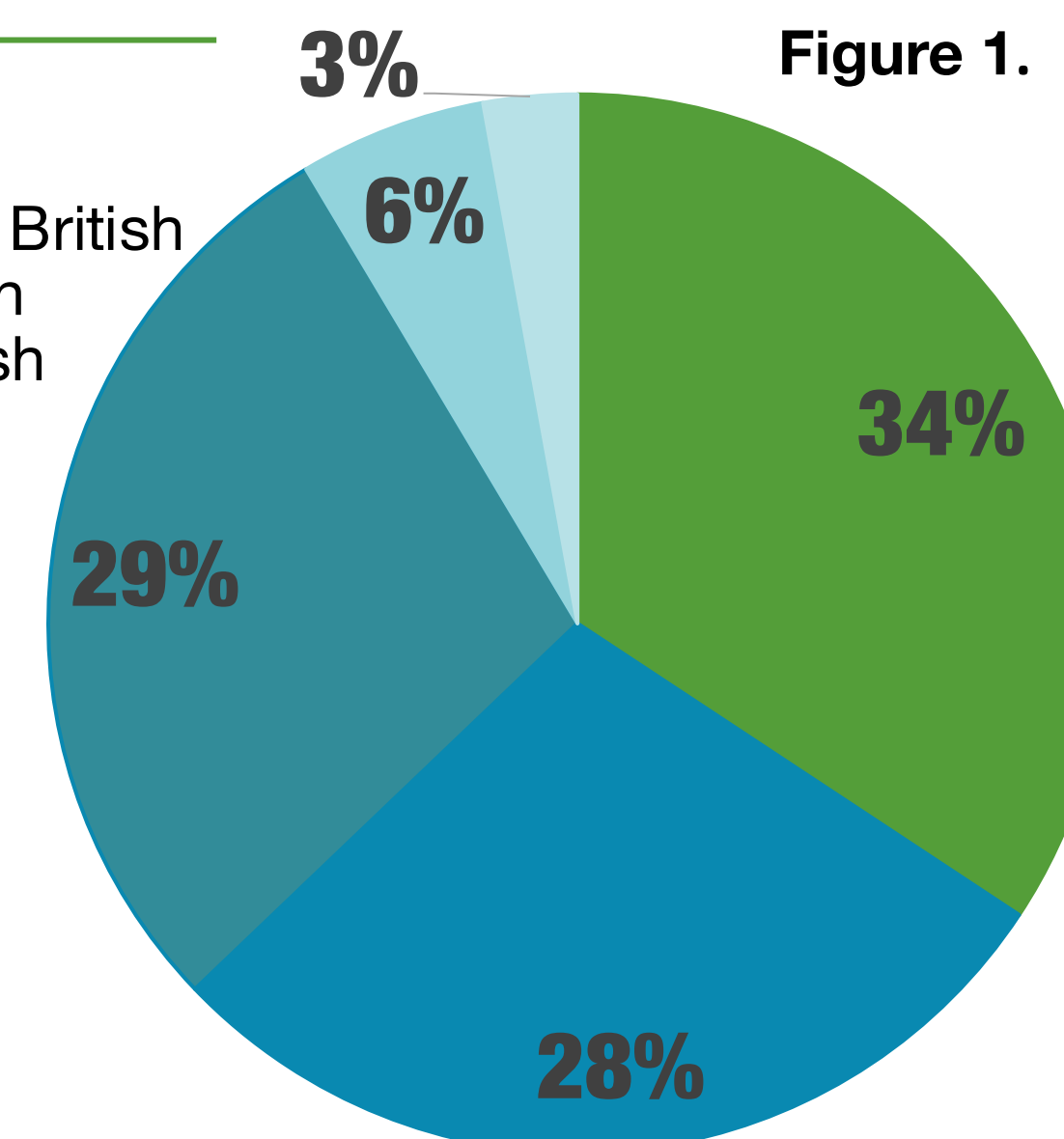


Thematic content and patient journey mapping analysis.

3. Participants

- White British/Other
- Black African/ Black British
- S. Asian/Asian British
- SE Asian/Asian British
- Mixed race

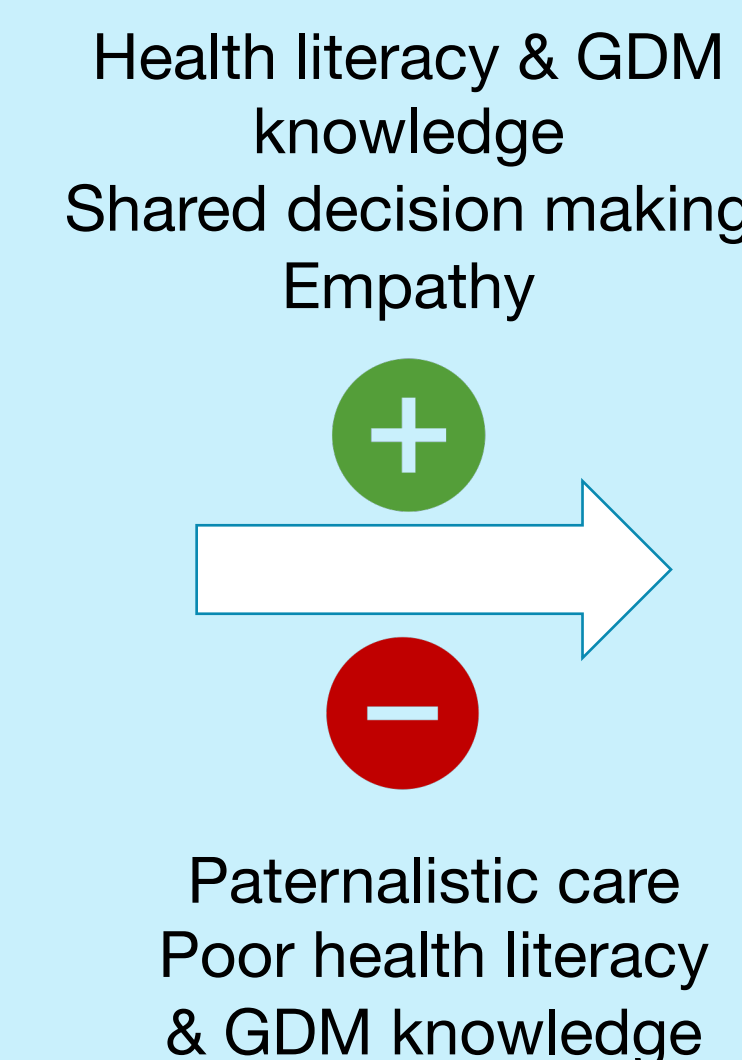
n = 35
66% minority ethnicities



5. Results

- GDM impacts on mental wellbeing and enjoyment of pregnancy.
- Healthcare support can feel generic, women want lifestyle advice to be tailored to their personal habits and culture.
- Women turn to internet information and online support groups to help them navigate GDM.
- They wanted to understand their personal risk and be treated accordingly in pregnancy and postpartum.
- They felt 'left at sea' after pregnancy, getting mixed messages from healthcare and feeling ill-informed about reducing further risk.

Figure 2.



Challenges of GDM

Loss of control

- Blood glucose management was unpredictable.
- It became hard to foresee how the pregnancy would proceed
- women felt a loss of control over birth and treatment plans.

Burden of guilt

- Women felt guilty they should have done more to prevent GDM.
- They worried their baby would be harmed as a result of their choices.
- Guilt was made worse for some with the progression to medication.

One size fits all

- Lifestyle advice could be generic and so not valued.. This reduced trust, added stress and led to seeking of alternative information.
- Women wanted to be treated according to their risk.

PREGNANCY

Adapting to GDM

Seeking support

- Information seeking online supplemented lifestyle advice.
- Women appreciated online support groups for their immediacy and two-way interaction.
- Family and friends could be included in education to support engagement and reduce stigma.

Retaining power

- GDM technology supported behaviour change and helped women feel in control.
- Self-advocacy and/or supportive healthcare teams increased feeling of self-empowerment.
- Some women disengaged to retain their sense of control

POSTPARTUM

Looking to the future

Left at sea

- Mixed messages from healthcare teams about future risk.
- Trust in and desire for GP to engage more in postpartum support.
- Lack of detailed knowledge of recommended changes to reduce long-term risk

Moving forward

- Caring duties limit opportunity and motivation for engagement.
- 9-12 months good time to engage.
- Social pressures for some make further engagement challenging but motivation to test annually is high.
- Idea of personal risk calculator welcomed

5. Recommendations

Timepoint 1: Early pregnancy

1. Information about GDM and lifestyle changes welcomed by women at risk, early in pregnancy.

Timepoint 2: During pregnancy

1. GDM technology is likely to benefit engagement and could be improved with two-way communication & peer interaction.
2. Signpost to online information verified and/or developed by/with the NHS.
3. Reflect personal risk in birth planning and risk communication.

Timepoint 3: Early postpartum

1. Increase awareness and understanding of HbA1C testing annually.
2. Improve consistent messaging about long-term T2D risk.
3. Provide stratified risk advice.

Timepoint 4: Later postpartum

1. Provide annual reminders for HbA1c.
2. Give women clear guidance about reducing long-term risk at first annual HbA1C screen.
3. Sign-post to online information and support this with short face-to-face or online sessions.

6. Conclusions

More patient-centered care and tailored lifestyle advice is needed. Technology is acceptable amongst a diverse group of women and can help improve engagement. Postpartum engagement may be improved with streamlined messaging, improved engagement from primary care and clear guidance about HbA1C testing and the need for and nature of beneficial lifestyle changes.

