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## Introduction

Number of pregnancies with a pair of gestational diabetes (GDM) in the United Kingdom is currently about 1/2 pregnancies in women with pre-existing gestational diabetes. This proportion is still rising because the age of onset for GDM increases in pregnancies in women with gestational diabetes are related to associated degree of cumulative risk of adverse maternal, vertical and fetal outcomes. The danger of miscarriage and vertical death is 4-5 times higher in women with GDM compared to those without gestational diabetes. Further risks include: infant morbidity; and fetal anomalies. Several of the processes that drive these adverse risks occur within the trimester of gestation before a girl presents to prenatal services. Therefore, it is vital to minimise these potential hazards before conception with effective pre-pregnancy care.

Pre-pregnancy care (C) measures for women with GDM include: reducing weight; rising glycaemic control; achieving high self-liaison; and stopping probly agent. These measures will considerably reduce the danger of adverse outcomes. However, the bulk of women with GDM presently do not receive C, and give to services already pregnant, usually late within the trimester or within the trimester, with preventable risk factors for adverse outcomes. Hence, increasing the uptake of C in women with GDM. These factors are a unit event at the individual, (women understanding of physiological state risks) health care provider (lack of awareness of the necessity for generative care) and system (lack of visibility of levels of generative care). Review of intervention studies aimed to start up C in women with gestational diabetes have tested variety of various methods, including: education for attention professionals; patient registries; electronic prompts and reminders; and mass-media promotion. Whereas these studies show some improvement in C among women with gestational diabetes (GDM), the impact on women with GDM

are professional); psychological feature participation (constructing a positive narrative for physiological state and sport activities); collective action (increasing the visibility of the generative wants of girls, desegregation health care systems and utilising adjunctive techniques); and reflexive watching (using multi-modal approaches to support systemisation) [7-9].

As most services are unit situated in specialist polygenic disease centres wherever ladies with T1DM are unit managed by health professionals, national attention is given to the need for a responsible team for both type 1 and 2 diabetes, compared to ladies with T2DM, national attention is given to unit management in medical care. Generative care is not a routine component