

Therapeutic Adherence and Preconception Care in Women with Diabetes: A Call for Integrated Strategies in Obstetric Practice

Marilyn Hernández Gómez and Juan Antonio Suárez González*

Specialist in Obstetrics and Gynecology, Full Professor, Hospital Materno Mariana Grajales, Santa Clara, Cuba

***Corresponding Author:** Juan Antonio Suárez González, Specialist in Obstetrics and Gynecology, Full Professor, Hospital Materno Mariana Grajales, Santa Clara, Cuba

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Diabetes mellitus during pregnancy represents one of the most significant challenges in contemporary obstetric practice. The convergence of two critical periods-the metabolic demands of pregnancy and the chronic complexity of diabetes-creates a clinical scenario where adherence to therapeutic recommendations and adequate preconception preparation are not merely desirable but essential for optimal maternal and perinatal outcomes.

In this issue of **Ecronion Gynecology**, we present the findings of two original investigations conducted at a tertiary-level hospital in Cuba, which, although not yet published in indexed journals, represent significant contributions to our understanding of diabetes care in pregnancy within the local context. These studies, developed as part of the specialty training in Obstetrics and Gynecology, examine two interrelated dimensions of this clinical problem and provide a comprehensive view of the challenges faced by women and healthcare providers.

The adherence gap: A global challenge

The first article reveals a sobering reality: only 24.4% of pregnant women with diabetes adhere to medical recommendations. This finding, while alarming, is consistent with international literature reporting adherence rates between 30 - 60% across different populations [1]. What makes this particularly concerning is the pattern of non-adherence. Women demonstrated commendable commitment to avoiding alcohol and tobacco (92.7%), recognizing the immediate fetal risks. However, adherence to lifestyle modifications-regular physical activity (26.8%) and balanced diet (39.0%)-was strikingly low.

This disparity reflects a fundamental challenge in diabetes care: patients often prioritize interventions with perceived immediate benefits while struggling with long-term behavioral changes that require sustained effort and motivation. Physical activity and dietary modification demand not only knowledge but also practical support, environmental facilitation, and psychological readiness. The fact that 68.3% of women reported no difficulties following treatment suggests that the barrier may not be technical but motivational and contextual. This is where our clinical approach must evolve-from merely prescribing recommendations to actively supporting behavioral change through shared decision-making, motivational interviewing, and practical problem-solving.

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The significant association between previous gestational diabetes mellitus (GDM) and complications in the current pregnancy (OR = 4.6; $p = 0.014$) is a critical finding that should reshape our approach to women with a history of GDM. These women are not just at risk of recurrence; they represent a population requiring intensive preconception evaluation, metabolic optimization, and close surveillance. The risk extends beyond pregnancy, as women with GDM have a seven-fold increased risk of developing type 2 diabetes within ten years postpartum [2]. Pregnancy is, therefore, a “teachable moment” and a window of opportunity for long-term cardiovascular risk reduction.

The pregestogram: A missed opportunity

The second article focuses on women with pregestational diabetes, who represent a particularly vulnerable group. The findings are equally concerning: only 19.2% completed the pregestogram adequately, with specialist evaluations showing the lowest compliance—stomatology (15.4%), nephrology (34.6%), and ophthalmology (38.5%). More than half (53.8%) of pregnancies were unplanned, a figure that has remained stubbornly unchanged over decades despite advances in diabetes care [3].

The pregestogram, or preconception risk assessment, is arguably the most powerful tool we have for preventing diabetes-related complications. When a woman with diabetes enters pregnancy with optimal glycemic control ($\text{HbA1c} < 7\%$), the risk of congenital malformations approaches that of the general population. Each percentage point increase in HbA1c above 7% doubles the risk of congenital anomalies [4]. Yet, we continue to see women presenting with unplanned pregnancies and suboptimal control, often at gestational ages where irreversible embryopathy has already occurred.

The low compliance with specialist evaluations is particularly concerning. Diabetic retinopathy and nephropathy can progress rapidly during pregnancy, and preconception identification of these conditions allows for risk stratification, treatment optimization, and informed counseling. Stomatology, often overlooked, is essential because periodontal disease has been associated with poor glycemic control and adverse pregnancy outcomes [5]. These are not esoteric recommendations; they are evidence-based components of comprehensive care that we are failing to deliver consistently.

The psychosocial dimension: An underrecognized barrier

Both studies highlight the high prevalence of stress and anxiety (56.1% and 57.7%, respectively), with a significant association between stress and lower adherence to lifestyle recommendations (OR = 0.17; $p = 0.040$). This finding is consistent with a growing body of evidence that psychological factors profoundly influence diabetes outcomes [6].

Pregnancy in women with diabetes is inherently stressful. The constant demands of blood glucose monitoring, insulin adjustments, dietary restrictions, and the pervasive fear of harming the baby create an overwhelming burden. When we add socioeconomic challenges, limited social support, and the logistical complexities of navigating healthcare systems, it is not surprising that adherence suffers.

Yet, our clinical models have been slow to integrate mental health support into routine diabetes and pregnancy care. We prescribe insulin, educate about diet, and monitor blood glucose, but we often fail to ask, “How are you coping with all of this?” The integration of psychological support—whether through screening, referral, or integrated care models—should become a non-negotiable component of diabetes care in pregnancy.

The planning gap: A failure of systems and communication

The finding that 53.8% of pregnancies were unplanned in women with pregestational diabetes reflects a systemic failure. This is not simply about individual responsibility; it represents missed opportunities across the healthcare continuum. Women with diabetes often receive fragmented care, with endocrinologists focusing on metabolic control and obstetricians only seeing patients once they are pregnant. The absence of a structured transition from diabetes care to preconception counseling creates a critical gap.

Effective preconception care requires:

1. Systematic contraceptive counseling for all women with diabetes of reproductive age.
2. Clear communication between endocrinology, primary care, and obstetrics about the importance of planned pregnancy.
3. Patient education about the risks of unplanned pregnancy and the benefits of preconception optimization.
4. Access to effective contraception until metabolic targets are achieved.

These are not complex interventions, but they require coordination, documentation, and accountability. A simple checklist integrated into routine diabetes visits-asking about pregnancy intentions, contraception use, and preconception readiness-could dramatically improve outcomes.

The way forward: A call for integrated, patient-centered care

The evidence presented in these studies compels us to move beyond the traditional biomedical model toward integrated, patient-centered care. I propose the following strategic priorities:

- **Implementation of structured preconception programs:** Every woman with diabetes of reproductive age should have a preconception risk assessment. This includes an up-to-date pregestogram, which should become a standard quality metric. Clinical systems should incorporate prompts and checklists to ensure that HbA1c measurement, retinal examination, renal function assessment, and folic acid prescription are addressed systematically.
- **Integration of psychosocial support:** Mental health screening should be routine in diabetes and pregnancy care. Trauma-informed, culturally sensitive psychological support should be accessible. Brief interventions-such as stress management techniques, cognitive-behavioral approaches, and peer support groups-can be integrated without requiring extensive resources.
- **Strengthened interdisciplinary collaboration:** The management of diabetes in pregnancy requires seamless coordination between endocrinology, obstetrics, nutrition, psychology, and specialist services (ophthalmology, nephrology). The “virtual clinic” model, where a multidisciplinary team reviews cases and coordinates care, has been shown to improve outcomes [7].
- **Patient empowerment through education and self-management support:** Education alone is insufficient; we need to equip women with practical skills for self-management. This includes problem-solving around dietary barriers, strategies for incorporating exercise into daily routines, and techniques for managing stress. Peer support programs and community-based interventions can extend the reach of clinical services.
- **Addressing the planning gap:** We must systematically address pregnancy planning in all diabetes care encounters. This requires training clinicians in reproductive health counseling, ensuring access to contraceptive options, and creating clear pathways for women who desire pregnancy.
- **Health systems strengthening:** Electronic health records should incorporate diabetes and pregnancy care alerts. Clinical guidelines should include pregestogram completion as a quality indicator. Performance feedback to clinicians can drive improvement.

Conclusion

The findings from these Cuban studies are a mirror reflecting challenges faced by obstetric services worldwide. We have the knowledge and tools to prevent many of the complications associated with diabetes in pregnancy. The barrier is not scientific but organizational, educational, and cultural.

We must recognize therapeutic adherence and preconception care not as individual responsibilities but as healthcare system responsibilities. When women fail to adhere, we must ask not “What is wrong with the patient?” but “What can we do differently to support her?”

The pregnancy of a woman with diabetes is a high-stakes situation where the consequences of suboptimal care can be devastating. Yet, it is also an opportunity-a chance to engage a woman in her health, to prevent complications for her and her baby, and to set the stage for long-term cardiovascular health. The investment in preconception and pregnancy care for women with diabetes pays dividends in healthy babies, reduced healthcare costs, and healthier women.

As obstetricians, we have a privileged role in this critical period. Let us embrace this opportunity with systematic, compassionate, and evidence-based care. Let us move beyond documentation of the problem to implementation of solutions. The time for action is now.

Conflict of Interest

The authors declare no conflicts of interest.

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