

FACT SHEET:

Gestational diabetes

What is it?

Gestational diabetes mellitus (GDM) is having too much glucose (sugar) in your blood when you're pregnant. **Some** of the risk factors for developing gestational diabetes include those who:

- have had GDM in a previous pregnancy
- are older, especially 40 years or over
- have a family history of type 2 diabetes or a mother or sister who has had GDM
- are First Nations women
- are above the healthy weight range

Gestational diabetes may also occur with no known risk factors.

Effects of untreated gestational diabetes

If gestational diabetes is not treated, high blood glucose levels can cause problems such as:

- high birth weight
- difficult birth or stillbirth
- needing a caesarean section
- too much fluid around baby
- baby being born too early
- after birth baby having:
 - low blood glucose levels
 - breathing problems
 - jaundice (yellow eyes and skin)



If your blood glucose levels stay too high for too long, it may harm your baby.

How is gestational diabetes diagnosed?

- With an oral glucose tolerance test (OGTT).

It is recommended to have an HbA1c test to rule out undiagnosed Type 2 Diabetes.

If the early HbA1c test is normal, you'll have an OGTT preferably at 10 -14 weeks of pregnancy.

This test checks how your body processes sugar. First, a blood sample is taken to measure your fasting blood glucose level. Then you'll drink a sugary drink, and your blood will be tested again one hour and two hours later. You'll need to sit and wait during this time.

If your glucose levels are higher than normal at any of these points (fasting, one hour, or two hours), you'll be diagnosed with gestational diabetes.

If you have not been diagnosed with diabetes, you will be offered an OGTT at 24-28 weeks of your pregnancy.

Why 28 weeks?

All women are usually tested at around 28 weeks as the placenta produces more hormones that make it harder for your body to use insulin. If your pancreas can't keep up and make enough extra insulin, glucose builds up in your blood. This extra glucose passes through the placenta into your baby's bloodstream.

What are the effects on your baby?

- If your blood glucose level is high, the baby will also have raised blood glucose levels.
- The more glucose that goes to baby, the more insulin baby makes.
- Too much of baby's own insulin and glucose makes your baby grow too big.

To manage gestational diabetes

- Eat healthy food (see Factsheet 'Eating for Gestational Diabetes').
- Regular physical activity eg walking to help lower blood glucose levels.
- Keep in touch with your healthcare team.

When to test your blood glucose levels

- Test before you eat or drink anything first thing in the morning.
- Your healthcare team will tell you what other times to test and what levels are okay.
- Record your results in your blood glucose record book or app.
- Your clinic may have a blood glucose monitor for you or you may need to buy one.
- Speak to your healthcare team about signing up to the NDSS to access subsidised blood glucose monitoring strips or free insulin pen-needles (if you require insulin).



Your questions answered

It's not unusual to get back from an appointment and suddenly realise you have a 100 questions you wished you'd asked. We tackle some of the most common ones below.

I don't want to take any drugs that will cross the placenta. Can I refuse to take metformin? I've heard insulin is safer.

Metformin does cross the placenta but studies have found that it is generally safe to use in pregnancy and use is widespread. Some women are not comfortable using Metformin and may have insulin prescribed instead. Some people find Metformin easier to take as it is a tablet form and unlike insulin has no risk of hypoglycaemia (low blood glucose levels).

I'm finding it really hard to reach my target blood glucose levels and I'm scared I'm hurting my baby. What's the worst that can happen?

Most women with gestational diabetes go on to give birth to happy, healthy babies. If your blood glucose levels are out of range make sure you contact your diabetes team for advice as instructed by the team. Do not panic or blame yourself. Often people follow their GDM plan perfectly and their BGL still goes out of range.

By contacting your team they can work with you to get the BGLs back into target range. By doing this you are helping to minimise the risks associated with GDM. Poorly controlled gestational diabetes can lead to complications but there is time to do something about it!

Remember, your treating team are there to help you achieve a healthy baby. They will review what you are doing in terms of diet and exercise and there is the possibility that you may need medication which can be either a tablet (Metformin) or insulin. Your treating doctor will determine the appropriate medication.

Everyone is different and treatments will vary. If you keep in regular contact with your treating team and manage your GDM well the risks are greatly minimised.

Will I get GDM next time I get pregnant?

Once you have had gestational diabetes there is an increased chance of you getting it again but this is certainly not always the case. In most instances you will have an oral glucose tolerance test earlier in any subsequent pregnancies.

How long will it take for my GDM to go away?

Once your baby is born the GDM usually resolves itself. It is recommended that you have a repeat OGTT test six to eight weeks after the birth of your baby to confirm that the diabetes has gone.

If I avoid carbs during my pregnancy will my GDM disappear?

Unfortunately no. GDM will not disappear and it is not recommended that you try to avoid carbohydrates as they are your and your baby's main source of fuel. When you are diagnosed with GDM you should see a dietitian or a diabetes educator who will explain the role of carbohydrates and how to spread them out throughout the day to best help your diabetes management.

Managing skills

- If you eat and drink healthy food and do physical activity but your blood glucose levels are still too high, it means your body can't make enough extra insulin for pregnancy.
- You may need to inject insulin or use tablets if your doctor thinks this is suitable. Don't worry, it will not hurt the baby.
- Your diabetes educator, Aboriginal Health Practitioner, nurse or healthcare worker will teach you to give yourself insulin injections if required
- Keep all equipment (monitor, lancets, and medication) out of reach of children. Remember to put lancets and needles in a sharps container.

Visit the clinic every 1 to 2 weeks

So we can see how your treatment is working, bring your:

- blood glucose record book
- food and drink records

If you are on insulin injections, it may need to be adjusted every 3 or 4 days. If you're unable to attend, consider phone or telehealth options.

Acknowledgement of Country

Diabetes Australia acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners and Custodians of this Country. We pay the utmost respect to them, their cultures and to their Elders, past and present. We extend that respect to the Aboriginal and Torres Strait Islander people here today. Diabetes Australia is committed to improving health outcomes for all Aboriginal and Torres Strait Islander people affected by diabetes and those at risk.

About the artwork: A Pathway to Health

By starting this journey together, we can move towards healthier communities for future generations and take control of our family's health. By yarning and understanding diabetes together, we are strong and can get through this together. This painting was created for Diabetes Australia by artist Keisha Leon (Thomason), an Aboriginal Graphic Designer and Artist. Keisha is a proud Waanyi-Kalkadoon (Mount Isa, Queensland) and Chinese woman.

This information is intended as a guide only. It should not replace individual medical advice and if you have any concerns about your health or further questions, you should contact your health professional.



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