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Review Article

Prevalence, risk factors and quality of life in gestational diabetes mellitus: a scoping review

Priyanka Pandey, Hari Prakash Gunisetty*, Tejaswini B. Darukaradhya

Division of Public Health, Department of Allied Health Sciences, Faculty of Life and Allied Health Sciences, M.S. Ramaiah University of Applied Sciences, Bengaluru, Karnataka, India

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***Correspondence:**
Dr. Hari Prakash Gunisetty,
E-mail: hariprakashg.ah.ls@msruas.ac.in

ABSTRACT

Gestational diabetes mellitus (GDM) is one of the most common complications of pregnancy and is associated with adverse maternal and neonatal outcomes. Its burden is increasing globally, particularly in low- and middle-income countries. Beyond physical health impacts, GDM may also affect the quality of life (QoL) of pregnant women; however, evidence on this aspect remains limited. This scoping review aimed to map existing evidence on the prevalence of GDM, associated risk factors and quality of life among women diagnosed with GDM. The review followed Joanna Briggs Institute methodology and PRISMA-ScR guidelines. Electronic databases including PubMed and Google Scholar were searched for studies published in English between 2010 and 2025. Observational studies, systematic reviews and narrative reviews reporting on prevalence, risk factors or quality of life related to GDM were included. Eleven studies met the inclusion criteria. Reported prevalence ranged from 9.7%-37.6%, with higher prevalence observed in Asian populations and hospital-based studies. Common risk factors included advanced maternal age, obesity, family history of diabetes, previous GDM and hypertension. None of the included primary studies assessed quality of life using validated instruments. The review concludes that GDM is a growing public health concern, but evidence regarding quality of life among affected women remains scarce, highlighting the need for future research incorporating standardized QoL assessments.

Keywords: Gestational diabetes mellitus, Prevalence, Risk factors, Quality of life, Pregnancy

INTRODUCTION

Gestational diabetes mellitus (GDM) is defined as glucose intolerance with onset or first recognition during pregnancy. It is a major public health concern because of its significant short-term and long-term consequences for both mother and child. Type 2 diabetes mellitus, preeclampsia, and obstetric difficulties are more common in women with GDM, while macrosomia, birth trauma, neonatal hypoglycaemia and subsequent metabolic abnormalities are more common in infants.[1] The prevalence of GDM varies widely across countries and regions, influenced by differences in diagnostic criteria, population characteristics, healthcare access and lifestyle factors. Rapid urbanization, sedentary lifestyles, unhealthy dietary patterns and increasing maternal age have contributed to a rising burden of GDM, particularly in Asian countries. A growing body of research has explored the epidemiology of GDM and identified multiple clinical and demographic predictors, including maternal age, body mass index, family history of diabetes and previous obstetric history. Several systematic reviews and large observational studies have confirmed the central role of obesity and metabolic health in the development of the condition. However, most investigations have focused primarily on biomedical outcomes, with comparatively limited attention paid to the lived experiences of women diagnosed with GDM.[2] Beyond

clinical outcomes, GDM can also affect the psychological well-being and daily functioning of pregnant women. Dietary restrictions, frequent blood glucose monitoring, fear of complications and repeated hospital visits may contribute to stress, anxiety, fatigue and reduced quality of life. Despite this, evidence on quality of life among women with GDM remains sparse and methodologically heterogeneous, with few studies employing validated patient-reported outcome measures.[3] A scoping review is appropriate to carefully map the available literature, identify major findings and highlight research gaps given the increasing incidence of GDM and the fragmented nature of existing information. The prevalence, risk factors, and quality of life of women with gestational diabetes mellitus are the three main aspects of this review. Such synthesis is particularly relevant for informing future primary studies and designing comprehensive maternal health interventions. This scoping review aimed to map existing evidence on gestational diabetes mellitus with respect to its prevalence, associated risk factors and quality of life among affected women.

METHODS

Scoping review design and guiding framework

This scoping review was conducted in adherence to the Preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) guidelines.[4] Scoping reviews are designed to map the breadth and scope of available evidence within a topic area, characterise study types and methodologies and identify research gaps rather than assess causality or conduct meta-analysis.[5,6] This approach was selected because the research question encompasses heterogeneous study designs, diverse geographic settings, and multiple outcome measures- all factors suitable for scoping methodology.[7] The review was not prospectively registered but followed the systematic stages outlined in the PRISMA-ScR checklist: defining the research question and eligibility criteria, identifying relevant studies, study selection, extracting and charting data and collating and summarising results.[4]

Population, concept and context framework

Population

The population of interest for this scoping review comprised pregnant women diagnosed with gestational diabetes mellitus, irrespective of age, parity or stage of pregnancy.

Concept

The review focused on three key concepts related to gestational diabetes mellitus: the prevalence of the condition, the demographic, obstetric and metabolic risk factors associated with its development and the quality of life or related psychosocial outcomes among affected women.

Context

The context of the review included studies conducted across all geographical regions and healthcare settings, including community-based populations, primary healthcare facilities and hospital or tertiary-level antenatal care services, without restriction by country income level or health system type.

Search strategy

A comprehensive search strategy was conducted in PubMed using the following search strategy.

Initial search

An initial exploratory search was conducted in PubMed and Google Scholar to identify relevant keywords and index terms. The following preliminary keywords will be used:

Keywords

“Gestational Diabetes Mellitus”, “GDM”, “prevalence”, “risk factors”, “quality of life”, “QoL”, “India”, “urban”, “Bengaluru”. Titles, abstracts and index terms from the initial search will be analysed to refine the final search terms.

Comprehensive search

A comprehensive search was conducted and the core string used in PubMed was: ("Gestational Diabetes"(Mesh) OR "Gestational Diabetes Mellitus" OR "GDM") AND ("prevalence" OR "epidemiology" OR "burden") AND ("risk factors" OR "determinants" OR "associated factors") Out of the 1337 results, duplicates were found to be 83 and it was resolved. Title screening was done based on inclusion and exclusion criteria. All imported records were initially screened based on their titles. Each study was independently classified as “include”, “exclude” or “maybe” to facilitate systematic decision-making. The screening process was guided by the Population–concept–context (PCC) framework to ensure consistency with the review objectives. Reasons for exclusion, such as irrelevant outcomes or non-relevant topics, were documented and tagged using the labelling function in Rayyan to maintain transparency and reproducibility of the selection process.

Eligibility criteria

Inclusion criteria

Studies were eligible for inclusion if they addressed gestational diabetes mellitus in a relevant way. Observational study designs, including cross-sectional,

case-control and cohort studies, as well as systematic reviews, and narrative reviews were considered. Eligible studies were required to report on the prevalence and/or risk factors of GDM or to examine quality-of-life outcomes among affected women. Only articles published in peer-reviewed journals with full-text availability in the English language were included. Geographical location was not a limiting factor and all articles were taken into account.

Exclusion criteria

Studies that did not address gestational diabetes mellitus as the primary condition of interest or that only addressed pre-gestational diabetes were excluded. Articles that, despite reasonable efforts, could not be obtained in their entirety were also eliminated. In addition, publications that were only accessible as abstracts, conference proceedings, posters, editorials, commentary or opinion pieces were not taken into account. After full-text evaluation, studies that did not fit the review's objectives or central ideas were removed from the final list. Non-English language was also excluded. After full text screening, 11 articles were included.

Study selection process

All identified articles were screened using a standardised screening form. Title and abstract screening were performed first to identify potentially eligible articles, followed by retrieval and assessment of full-text articles against the detailed eligibility criteria.[4] Discrepancies in eligibility decisions were resolved through discussion and consensus between reviewers, with a third reviewer consulted if necessary to achieve agreement.[5]

Data extraction

A standardised data extraction form was developed and piloted on five included articles to ensure consistency, completeness and alignment with the review objectives. Data extracted from each study included bibliographic details (author, year of publication, country, and journal); study characteristics (study design, setting, sample size, and inclusion and exclusion criteria); and population characteristics (maternal age, parity, body mass index, and relevant clinical or obstetric history). Information on diagnostic criteria used to identify gestational diabetes mellitus was also extracted, including the type of oral glucose tolerance test and the guidelines followed (e.g., WHO, ADA, IADPSG). In addition, data related to reported prevalence of gestational diabetes mellitus, identified risk factors (demographic, obstetric, metabolic, and clinical), and measures of association from multivariate analyses (adjusted odds ratios, confidence intervals, and p values) were recorded where available. For studies addressing quality of life or related psychosocial outcomes, details of data collection methods and instruments, including any validated scales, were extracted. All data were entered into a standardised extraction table and organised by country, study design, and outcome domain to facilitate comparison and synthesis across studies.

Data synthesis approach

Given the heterogeneity in study designs, populations, diagnostic criteria and outcome measures a narrative synthesis approach was adopted. Findings were organised thematically according to the core concepts of the review: prevalence of gestational diabetes mellitus across regions and study settings, demographic and obstetric risk factors, metabolic and clinical risk factors, contextual determinants such as urban residence and healthcare setting and evidence related to quality of life and psychosocial outcomes among women diagnosed with GDM. This thematic organisation enabled identification of patterns, similarities and gaps in the existing literature and supported a comprehensive mapping of current evidence.[8]

The systematic search and screening process yielded 11 studies that met the inclusion criteria for this scoping review (Figure 1-PRISMA flow diagram). A total of 1,389 records were identified through database searching. After removal of 83 duplicates, 1,306 records were screened by title and abstract, of which 1,288 were excluded. Eighteen full-text articles were assessed for eligibility and 7 were excluded for not meeting the review objectives or lacking relevant outcome measures. Finally, 11 studies were included for data extraction and synthesis.

The included studies were published between 2020 and 2025 and represented evidence from South Asia, Southeast Asia, East Asia, Europe and multinational datasets. Study designs comprised cross-sectional studies, case–control studies, retrospective cohort studies, systematic reviews and narrative reviews. The characteristics of the included studies are summarised in Table 1. Most primary studies were conducted in hospital or antenatal clinic settings, including tertiary care hospitals. Sample sizes ranged from 134 to 1,200 participants in individual primary studies, while pooled samples in secondary studies exceeded 50,000 participants and one meta-analysis included more than 1.8 million pregnancies.

The diagnostic criteria used to identify gestational diabetes mellitus varied across the included studies. Most primary studies relied on the oral glucose tolerance test, applying either World Health Organization or American Diabetes Association/American College of Obstetricians and Gynecologists criteria. In retrospective cohort studies, diagnosis was based on clinical records extracted from electronic medical record systems. For systematic reviews, diagnostic definitions were adopted as reported in the original studies included within those reviews.

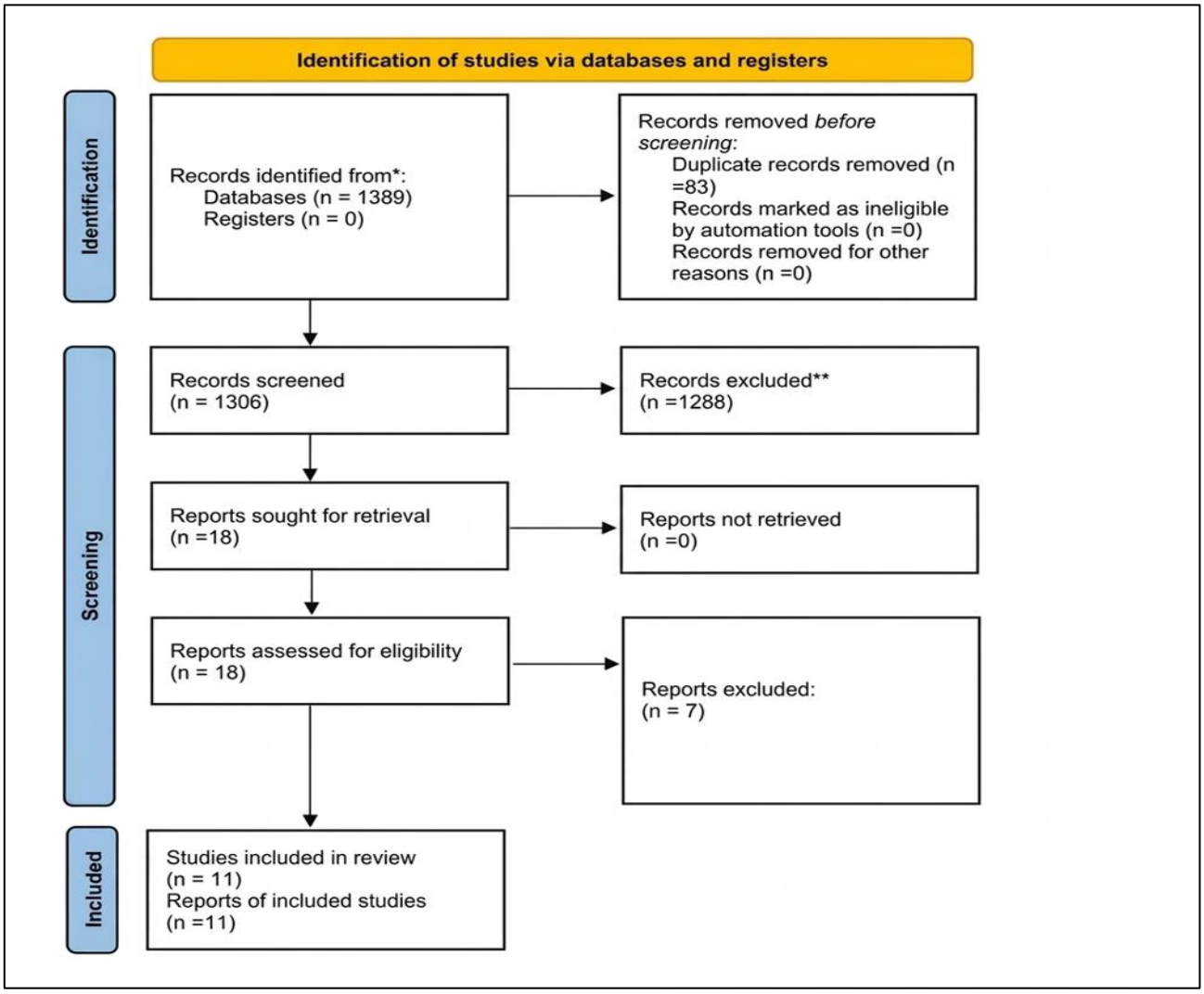

Figure 1: PRISMA 2020 flow diagram illustrating the study selection process.

Prevalence of gestational diabetes mellitus

Substantial heterogeneity in GDM prevalence was observed across geographical regions and study settings, with reported prevalence ranging from 9.7%-37.6%. The reported prevalence of gestational diabetes mellitus across the included studies are summarised in Table 2. In the National demographic and health survey of Bangladesh, GDM prevalence was reported as 35% (95/272) among pregnant women using WHO diagnostic criteria. Urban residence was significantly associated with higher odds of GDM (adjusted OR=2.74, 95% CI:1.43-5.27).[10] In Turkey, reported a hospital-based prevalence of GDM of approximately 13.9%.[9] In Indonesia (Jambi province), a case-control study reported a prevalence of 37.6% among women screened between 24 and 28 weeks of gestation using OGTT.[12] In Pakistan, a hospital-based cross-sectional study reported a GDM prevalence of 9.73%.[11] Overall, higher prevalence was consistently reported in Asian populations and in urban or hospital-based settings, indicating a substantial and growing burden of GDM in these contexts.

Risk factors associated with GDM

Across the included studies, multiple demographic, obstetric and metabolic risk factors were consistently identified. The risk factors associated with gestational diabetes mellitus identified across studies are summarised in Table 3.

Demographic and obstetric factors

Advanced maternal age was a strong and recurrent predictor of GDM. In Bangladesh, women aged ≥25 years had significantly higher odds of GDM (adjusted OR=2.03, 95% CI:1.13-3.65).

Urban residence was another significant determinant (adjusted OR=2.74).[10] Previous history of GDM and multiparity were repeatedly associated with increased risk in studies from Indonesia and Pakistan, indicating that women with prior metabolic dysregulation during pregnancy remain vulnerable in subsequent pregnancies.[12]

Table 1: Characteristics of included studies (n=11).

No.	First author (year)	Country	Sample size	Study design	Diagnostic criteria
1	Canday et al, 2024[9]	Turkey (hospital-based)	474	Cross-sectional	OGTT (ADA/ACOG criteria)
2	Mazumder et al, 2022[10]	Bangladesh (national survey)	272	Cross-sectional (DHS data)	WHO criteria
3	Wagan et al, 2021[11]	Pakistan (clinic study)	185	Cross-sectional	OGTT
4	Dewi et al,[12]	Indonesia (community-based, Jambi province)	324	Case–control	OGTT
5	Wu et al, 2024[13]	Netherlands and USA	24,053	Retrospective cohort	Clinical diagnosis (EMR-based)
6	Zhang et al, 2025[2]	Multiple countries	>1.8 million	Meta-analysis	As per included studies
7	Gajera et al, 2023[14]	Global	NA	Narrative review	NA
8	Juan et al, 2020[15]	China	NA	Narrative review	NA
9	Kyrkou et al, 2024[16]	Multiple countries	39,735	Systematic review	As per included studies
10	Wicklow et al, 2023[1]	Global	NA	Narrative review	NA
11	Liang et al, 2024[3]	China	NA	Systematic review protocol	Planned extraction

Table 2: Prevalence of GDM.

Study	Country	Study setting	Sample size	Reported GDM prevalence
Mazumder et al, 2022[10]	Bangladesh	National survey (DHS)	272	35.0%
Canday et al, 2024[9]	Turkey	Multiple regions	474	Approx. 13.9%
Dewi et al, 2024[12]	Indonesia (Jambi)	Community-based	324	37.6%
Wu et al, 2024[13]	Netherlands and USA	University hospital (retrospective cohort)	24,053	Not primary outcome

Table 3: Risk factors associated with GDM.

Category	Risk factors identified
Demographic	Advanced maternal age, urban residence
Obstetric	Previous history of GDM, higher parity, history of macrosomic baby
Metabolic	Overweight/obesity (BMI>30 kg/m²), excessive gestational weight gain
Clinical	Hypertension, family history of diabetes mellitus
Socioeconomic /contextual	Urban lifestyle, hospital-based antenatal population

Metabolic and clinical factors

Obesity and elevated body mass index emerged as the most consistent metabolic risk factors. In Indonesia, BMI >30 kg/m² was significantly associated with GDM (OR=1.47), along with hypertension (OR=2.12) and family history of diabetes (OR=1.61).[12] In Pakistan, higher BMI, previous GDM and family history of diabetes were significant predictors.[11] Global meta-analytic evidence confirmed that advanced maternal age, pre-pregnancy overweight/obesity, family history of diabetes, previous GDM and prior macrosomia were among the strongest risk factors.[2]

Quality of life and related outcomes among women with GDM

Only one study among the included literature addressed quality of life in the context of gestational diabetes mellitus, and this was a systematic review protocol rather than a completed empirical investigation.[3] Proposed a systematic review to examine quality of life among

women with GDM using planned extraction of patient-reported outcome measures; however, no results were available at the time of publication. None of the other included primary studies assessed quality of life using standardized instruments such as the WHOQOL-BREF or SF-36. This indicates a substantial gap in the existing evidence base, with current research predominantly focused on prevalence and clinical risk factors rather than the psychosocial and functional impact of GDM on affected women.

DISCUSSION

This scoping review brings together evidence on gestational diabetes mellitus (GDM) to understand how widely it occurs, which women are most at risk, and how far existing research has engaged with women lived experiences. The findings suggest that GDM is a growing public health concern, particularly in South and Southeast Asia, with prevalence varying substantially across countries and study settings. The wide range of reported prevalence, from under 10% in some hospital-based studies to over one-third of pregnant women in population-level analyses, reflects not only true epidemiological differences but also variation in screening practices, diagnostic criteria and study design.

The very high prevalence reported in the national survey from Bangladesh stands out and suggests that earlier clinic-based estimates may have underestimated the true burden of GDM in the community.[10] This finding is especially important in the context of expanding use of newer WHO diagnostic criteria, which tend to identify milder forms of glucose intolerance that may previously have gone undetected. Similarly, the high prevalence reported in Indonesia points to the rapid epidemiological transition occurring in many low-and middle-income countries, where changes in diet, physical activity and maternal age are reshaping the risk profile of pregnant women.[12] In contrast, lower prevalence estimates from hospital-based studies in Pakistan and Turkey may reflect differences in population characteristics or selective screening, highlighting the need for caution when comparing prevalence figures across studies.[9-11]

Across settings, several risk factors appeared consistently, reinforcing well-established pathways in the development of GDM. Increasing maternal age was one of the most commonly reported predictors, with population-based evidence showing significantly higher risk among women aged 25 years and above.[10] This finding mirrors global evidence and is particularly relevant in contexts where delayed childbearing is becoming more common due to educational, economic and social changes.[15] The role of obesity and elevated body mass index was equally prominent, with studies from Indonesia and Pakistan demonstrating strong associations between GDM and obesity, hypertension and family history of diabetes.[11,12] These findings underline the central role of underlying metabolic vulnerability and insulin resistance during pregnancy. A previous history of GDM and a family history of diabetes emerged repeatedly as important predictors, pointing to the recurrent and intergenerational nature of metabolic risk. Evidence from long-term follow-up studies suggests that women with GDM are not only at increased risk in subsequent pregnancies but also face a substantially higher likelihood of developing type 2 diabetes later in life.[1] This reinforces the need to view GDM not as a transient pregnancy complication but as an early marker of long-term metabolic risk. Urban residence was also identified as an important contextual factor, reflecting the influence of lifestyle changes associated with urban living, such as reduced physical activity and dietary shifts.[10]

While the epidemiological and clinical dimensions of GDM are well represented in the literature, this review highlights a striking lack of attention to quality of life and psychosocial outcomes. None of the included primary studies assessed quality of life using validated instruments, and only one identified study was a protocol proposing to synthesise such evidence, with no results yet available.[3] This gap is notable given that narrative and clinical reviews describe the significant emotional and practical burden faced by women with GDM, including anxiety related to dietary restrictions, frequent glucose monitoring, fear of adverse pregnancy outcomes and concerns about future health for themselves and their children.[1] The absence of patient-reported outcomes limits understanding of how GDM affects women beyond clinical indicators and risks reinforcing a narrowly biomedical approach to care. Taken together, the findings of this scoping review suggest that although GDM is widely recognised as an important obstetric and public health issue, research has largely prioritised prevalence estimation and risk factor identification over women's experiences and wellbeing. Future studies should aim to integrate validated quality-of-life measures and adopt longitudinal designs to capture how women adapt to and live with a diagnosis of GDM over the course of pregnancy and beyond. Such evidence is essential for informing care models that are not only clinically effective but also responsive to the needs and experiences of women.

Strengths and limitations

This review employed a systematic and transparent methodology in line with JBI and PRISMA-ScR guidance and included diverse study designs across multiple regions. By including different range of studies such as cross sectional, case control, systematic reviews, the review was able to capture the broad overview of existing evidence on GDM. However, several limitations should be acknowledged. The review was restricted to English-language publications and did not include grey literature, potentially omitting relevant studies. Considerable heterogeneity across diagnostic criteria limited direct comparison of prevalence estimates. Lack of primary studies assessing quality of life limited the ability of this

review to draw conclusions about the psychosocial impact of GDM, underscoring an important gap in the existing evidence base. Additionally, most primary studies were hospital-based, which may reduce generalisability to community populations.

Implications for research and practice

Routine screening and early identification of high-risk women should be strengthened, particularly in urban and tertiary-care settings. Antenatal programmes should integrate lifestyle counselling to address modifiable risk factors. From a research standpoint, there is a clear need to move beyond prevalence estimation and risk factor identification.

Future studies should prioritise the inclusion of validated quality-of-life instruments to better understand the psychosocial and functional impact of GDM on women. Longitudinal designs would be particularly valuable in capturing how quality of life changes across pregnancy and the postpartum period. Incorporating patient-reported outcomes into GDM research could support the development of more holistic, woman-centred models of care and inform policy decisions aimed at improving maternal health outcomes.

CONCLUSION

This scoping review synthesised evidence from eleven studies to provide an overview of the prevalence, risk factors, and quality of life related to gestational diabetes mellitus. The findings indicate that GDM is highly prevalent in many Asian and hospital-based populations, with advanced maternal age, obesity, family history of diabetes, and previous GDM emerging as consistent risk factors across settings.

Despite the growing epidemiological burden of GDM, the review identified a substantial lack of empirical research addressing quality of life among affected women. This gap limits understanding of the broader impact of GDM and highlights the need for future research that integrates clinical and psychosocial perspectives. Addressing this gap is essential for developing comprehensive, woman-centred approaches to the prevention and management of gestational diabetes mellitus.

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