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Women, Migration, and Diabetes

What Is the Connection?

Migration is a growing phenomenon that reflects social, economic, and health inequalities across different regions of the world. It is estimated that in 2024 there are approximately 281 million migrants, representing 3.6% of the global population. Of these, 135 million are women (3.5% of the global female population) and 146 million are men (3.7% of the global male population) (1). Europe has become the main destination for migrants, with 87 million (30.9%), followed by Asia (30.5%), North America (20.9%), and Africa (9%). The leading receiving countries include the United States, Germany, Saudi Arabia, Russia, the United Kingdom, the United Arab Emirates, France, Canada, Australia, and Spain. On the other hand, India, Mexico, Russia, China, Syria, Bangladesh, Pakistan, Ukraine, the Philippines, and Afghanistan are the largest countries of origin. In Latin America and the Caribbean, migration has doubled in the past 15 years, rising from 7 to 15 million people, with the Mexico–United States migration corridor standing out as the largest in the world, involving nearly 11 million people (1). By 2025, according to the National Statistics Institute, most migrants to Spain come from Colombia, Venezuela, and Morocco.

These data are not just numbers—behind each figure are people: stories, bodies, and experiences. There are women who migrate in search of better opportunities for themselves and their families, and who must face health systems that are unfamiliar, often inaccessible, or that ignore their cultural and gender-specific needs. Understanding the context of migration from a human and gender-sensitive perspective is crucial to addressing the health inequities experienced by migrant women, particularly when they live with chronic conditions such as diabetes.

The prevalence of diabetes is higher among migrant women, with significant variations depending on ethnicity and the length of residence in the host country (2). The risk of developing type 2 diabetes (T2DM) is significantly greater among women from regions such as South Asia, sub-Saharan Africa, and Latin America and the Caribbean—especially those with a history of gestational diabetes mellitus (GDM) (3). This increased risk persists regardless of the length of residence in the host country. Pregnancy outcomes in women with diabetes who migrate also show higher rates of complications, including preterm birth, preeclampsia, and cesarean delivery vs the non-migrant population (4). The American Diabetes Association (ADA) highlights that among the agricultural and seasonal migrant workforce, a significant segment faces numerous barriers to adequate diabetes management, including cost, cultural differences, language, literacy, transportation, and geographic distance. These barriers can lead to serious complications due to interruptions in care and limited access to resources such as medications and culturally tailored education (5). Although this data has yet to be disaggregated by gender, the burden is likely different for women and men.

MIGRANT WOMEN WITH DIABETES AND HEALTH PROFESSIONALS

People migrate within or outside their country of origin for work, family, academic, or difficult circumstances such as conflict or disaster. For many migrant women, this process involves additional challenges: language barriers, limited access to services, stigma, restrictive gender norms, and lack of culturally adapted information. Addressing the social determinants of health—such as socioeconomic status, housing, and food security, which influence diabetes management—is essential in clinical practice. The quality of the relationship between health professionals and migrant women is crucial. If care is perceived as deficient, the likelihood of adopting self-care practices—especially for conditions like diabetes—decreases (6). As professionals, we have a responsibility not to exclude anyone based on origin, language, skin color, or beliefs. It is also important to avoid prejudice and stereotypes about migrants, recognizing that each individual is different. Adapting health care environments to meet the needs of women is key to providing empathetic, respectful, and gender- and culturally-sensitive care. Similarly, timely referrals to social workers, associations, and community resources are vital to help mitigate these barriers (5).

CHALLENGES, PROPOSALS, AND STRATEGIES

Migrant women living with diabetes face multiple barriers that go beyond glycemic control. These challenges result from a combination of social, economic, occupational, structural, and reproductive health factors that interact and affect their ability to access continuous, culturally sensitive, empathetic, and needs-centered care. Recognizing these dimensions is essential for designing comprehensive, gender-sensitive interventions that guarantee more equitable and effective care. ***Figure 1*** illustrates the main challenges related to sex- and gender-specific aspects in women who have migrated and live with diabetes.

To improve diabetes care for migrant women who face linguistic, social, economic, and cultural barriers, several strategies can be implemented:

1. **Linguistically appropriate care and communication:** Health systems should develop and provide educational programs and materials in languages understood by patients. Free language assistance is also recommended. The ADA emphasizes avoiding the use of untrained interpreters, including family members, to prevent confusion in communication (5, 7).

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UNDERSTANDING MIGRATION FROM A HUMAN AND GENDER-SENSITIVE PERSPECTIVE IS CRUCIAL TO ADDRESSING THE HEALTH INEQUITIES FACED BY MIGRANT WOMEN, PARTICULARLY WHEN LIVING WITH CHRONIC CONDITIONS SUCH AS DIABETES

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH—SUCH AS SOCIOECONOMIC STATUS, HOUSING, AND FOOD SECURITY—THAT INFLUENCE DIABETES MANAGEMENT IS ESSENTIAL IN CLINICAL PRACTICE

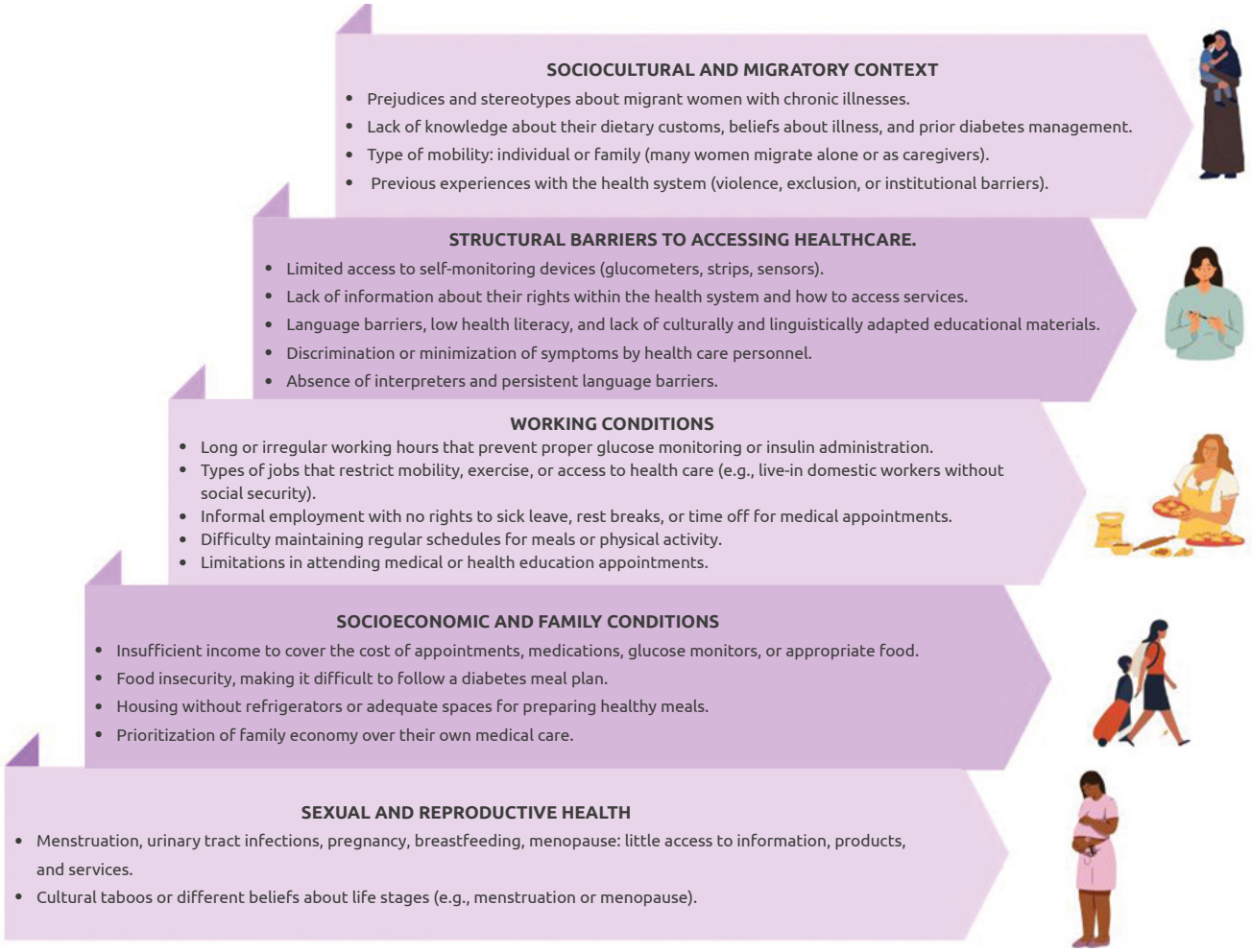

FIGURE 1. Prepared by the authors.

» **2. Culturally adapted diabetes education programs:** The ADA recommends that diabetes self-management education be culturally appropriate and tailored to individual preferences, needs, and values (5, 7). For example, individualized lists of carbohydrate counts for various dietary patterns (Latin American, sub-Saharan African, Asian, Eastern European) could improve adherence to diabetes treatment. »

3. **Peer support:** Peer-led interventions can help bridge gaps in care by providing culturally adapted education and support. This approach has been shown to improve diabetes outcomes in various migrant communities (8). Such groups can empower individuals, provide reassurance, and create supportive resources in different languages to help them manage both their health and migration-related challenges.

4. **Telemedicine and mHealth technologies:** These can provide continuous care and education tailored to cultural and linguistic needs, allowing follow-up without the need for travel (5). For professionals, these tools can facilitate the use of visual aids—such as images of traditional family meals—to improve understanding of glucose charts and carbohydrate counting.

5. **Health professional–patient relationship:** It is essential for this relationship to be empathetic toward the woman's migratory situation. Building trust and a sense of safety is fundamental for treatment adherence and for truly supporting diabetes management in migrant women. D

CONCLUSIONS

Migrant women with diabetes require specific interventions that address cultural, linguistic, and socioeconomic barriers to improve their health outcomes and diabetes management. Migration status impacts access to diabetes care through a combination of barriers and challenges. Overcoming these requires targeted interventions that improve access to health care and provide culturally and linguistically appropriate services. It is important to continue producing research that recognizes differences between women and men to advance health equity, as well as to observe the intersection of gender and migration, since this directly affects care approaches. Identifying the migrant populations present in each health unit is essential to adapt diabetes education programs accordingly.

As professionals, we must also examine our own biases toward difference or the unfamiliar. Migrant women already carry stigmas and judgments simply for having moved: "the woman who left her family, the woman who abandoned her maternal role, the woman frowned upon for migrating alone," etc. Our role is to listen without judgment, fostering a positive, supportive relationship with them.

REFERENCES:

1. International Organization for Migration. World Migration Report 2024. Stylus Publishing, LLC; 2024. 492 p.
2. Shah SM, Ali R, Loney T, Aziz F, ElBarazi I, Al Dhaheri S, et al. Prevalence of Diabetes among Migrant Women and Duration of Residence in the United Arab Emirates: A Cross Sectional Study. PLoS One. 2017 Jan 18;12(1):e0169949.
3. Ho JSS, Read SH, Giannakeas V, Sarma S, Berger H, Feig DS, et al. The association between immigration status and the development of type 2 diabetes in women with a prior diagnosis of gestational diabetes: A population-based study. Diabet Med. 2023 Aug;40(8):e15128.
4. Vangen S, Stoltenberg C, Holan S, Moe N, Magnus P, Harris JR, et al. Outcome of pregnancy among immigrant women with diabetes. Diabetes Care. 2003 Feb;26(2):327–32.
5. American Diabetes Association Professional Practice Committee. 1. Improving Care and Promoting Health in Populations: Standards of Care in Diabetes-2025. Diabetes Care. 2025 Jan 1;48(Supplement_1):S14–26.
6. Hyman I, Shakya Y, Jembere N, Gucciardi E, Vissandjée B. Provider- and patient-related determinants of diabetes self-management among recent immigrants: Implications for systemic change. Can Fam Physician. 2017 Feb;63(2):e137–44.
7. American Diabetes Association Professional Practice Committee. 3. Prevention or Delay of Diabetes and Associated Comorbidities: Standards of Care in Diabetes-2025. Diabetes Care. 2025 Jan 1;48(Supplement_1):S50–8.
8. Torres HA, Schmidt VA. Maximizing diabetes education efforts in vulnerable populations - newer delivery concepts. Curr Opin Endocrinol Diabetes Obes. 2022 Feb 1;29(1):23–8.