***Table 1*: SWOT analysis for Black African/Black Caribbean women**

Strength	Weakness	Opportunity	Threat
A-Receptivity to support • receptivity to care and encouragement from healthcare providers (25) • receptivity to information and instruction from healthcare providers (25) • receptivity to care from family (25) • compliance to self-management activities when social support is adequate (**22**) ***B-Spirituality as coping*** • spirituality/religion used as coping strategy (*7*, 16) ***C-Motivation*** • desire to prevent complications due to family history of disease and awareness of its complications (15)** • belief that diet and exercise can prevent complications (15)**	***A- Knowledge deficiency*** • lack of meal preparation knowledge (9) • lack of knowledge about diabetes complications (15)** • minimal knowledge about diabetes prior to the diagnosis (4)* • confusion about role of nutrition and diet modification in diabetes management (15)** ***B- Beliefs*** • perception that diabetes is only hereditary therefore unpreventable (4)* ***C- Skills deficiency*** • difficulty understanding food labels hinders shopping or meal planning (9) • dependence on others for self-management activities (e.g. insulin injections, cooking, blood sugar testing) after diagnosis (24) ***D – Financial limitations*** • unable to afford computers which limits access to health information (**14**) • expensive equipment, food, medications and healthcare services (9, **13**, *20*) ***E - Actual barriers*** • lack of support from family made daily life difficult (24) • time constraints in grocery shopping and meal planning (9) • diabetes-related physical complications limits exercise (15)** ***F – Family and culture*** • difficulty with self-management due to stress from multicaregiver role (7, 21) • negative perceptions of ability to manage	***A-Family and friends*** • family support influences self-management positively(15)** • female family and friends are main providers of diabetes-related support (16) husbands are great supports for diet and weight loss and their inclusion in education classes is beneficial (15)** ***B-Cultural relevance*** • culturally relevant diabetes education is effective in overcoming challenges of following recommended diet (9) • culturally specific education tools are preferred (15)** ***C-Knowledge acquisition*** • Acquisition of diabetes information through religious affiliation (19) ***D-Experience with healthcare*** • Participants recommend more frequent follow-up or contacts in diabetes programs (15)** • participants suggest exercise in future diabetes programs (15)**	***A-Family and friends*** • lack of exercise partner (15)** • patients' diet needs secondary to family preferences, therefore adherence is challenging and inconvenient when having to prepare a separate meal (15)** • social network has limited understanding about diabetes(5) ***B-Experience with healthcare*** • physicians not spending enough time on diabetes self-management education(15)** • unrealistic weight loss goals set by providers (15)** • lack of provider empathy concerning fears (15)** • regular visits to a health care provider is challenging because of a lack of continuity of care, poor quality of care, difficulty securing appointments, and logistical obstacles to being seen by physician (*20*) ***C-Physical environment*** • Living environment unsuitable for walking and thus limits exercise (15)** ***D-Accessibility*** • limited access to transportation and grocery stores (9)

	diet and control diabetes related to multicaregiver role (**17**)		

*denotes Black Caribbean population; **denotes undefined Black population

***Table 2*: SWOT analysis for Hispanic/Latin American women**

Strength	Weakness	Opportunity	Threat
A-Receptivity to support • identification of male authorities e.g. physicians as support (6) ***B- Spirituality as coping*** • spirituality and religion used as coping strategy (1) ***C- Diabetes knowledge*** • high diabetes patient knowledge is related to family support and confidence in managing diabetes (3)	***A-Knowledge deficiency*** • lack of knowledge about disease, management and coping strategies (3, 23) • uncertainty about effects of blood sugars and medications on long-term health outcomes (23) • confusion regarding disease and its management (e.g. diabetes type, diet, complications, blood glucose testing, exercise) (3) ***B-Beliefs*** • traditional remedies may replace western medical recommendations (2, 3) • denial of the seriousness of diabetes (11) • denial of serious symptoms after diagnosis, except for when experiencing blurry vision and fatigue (**10**) • denial of disease impedes self-care (2) • distrust healthcare providers so do not seek care (3) • external locus of control prevalent within Latino culture (fatalism) (1) ***C-Skills deficiency*** • need to learn to cope with stresses of family and culture (23) • little control over meal preparation makes self-care difficult (2) • difficulty adapting to strict lifestyle changes (1) • Avoiding some foods is easier than selecting options that comply with recommended diet(1) • difficulty making appropriate food choice at social events (1) • overeating and giving in to cravings (3) • lack of self-confidence inhibits self-care	***A-Cultural relevance*** • participants suggest easy access to clear, consistent information, visual aids such as bilingual reading materials and videotapes, incorporation of traditional foods, salsa dancing for exercise programs, and information about home remedies for future diabetes programs (23) ***B-Experience with healthcare*** • participants appreciative of healthcare professionals who explained management in a respectful and meaningful way (1) • participants suggest diabetes "hotline" and incentives to keep steady blood sugar (23)	***A-Family and friends*** • insufficient support from family (3,6) primarily due to lack of understanding (2) • family members need more information to help with self-management (23) and are not involved in diabetes education (2) ***B-Cultural relevance*** • cultural foods and traditions not acknowledged by healthcare providers (23) • lack of provision of culturally sensitive content by providers and educators (1) ***C-Experience with healthcare*** • language barriers experienced with health care providers (1,11) • feelings of discrimination by healthcare providers who did not provide language assistance (11) • long wait times for health care due to lack of interpreters (11) • healthcare provider's approach to clients influences compliance (e.g. scare tactics worsened fears) (1) • ongoing healthcare from country of origin due to strong rapport with providers (11) ***D-Physical environment*** • poor weather conditions restricts

	(i.e.. question personal ability to care for self, question awareness of what one can and cannot do, fear sharing diagnosis with others, fear walking, feel strange)(3) ***D-Actual barriers*** • transportation limitations inhibit self-care (2) • medical complications limits exercise (2) • lack of motivation to change lifestyle (3) ***E-Mental Health*** • Anger due to living with diabetes and its challenges seems uncontrollable and out of proportion (1) • Sadness due to diagnosis of the disease leads to perceived loss of control (1) • Fear of complications from diabetes and of family history (3) ***F-Financial limitations*** • Expensive equipment, food, medications and healthcare services (3, 6, 11) • Economic limitations inhibit self-care (2) • lack of financial resources limit exercise (2) ***G-Family and Culture*** • family responsibilities is higher priority than exercise (2) • dietary restrictions conflict with cultural food preferences (1) • attachment to traditional foods and high calorie/high fat foods (2) • priority is cooking foods that family prefers over their own diet (2)		exercise (2)

***Table 3*: SWOT analysis for South Asian women**

Strength	Weakness	Opportunity	Threat
• None found in literature	***A- Knowledge deficiency*** • lack of knowledge of diabetes management and complications (**12**) • low knowledge of blood sugar monitoring and management (**12**) • illiteracy linked to low knowledge of self-management (**12**) ***B- Beliefs*** • belief in traditional food practices (**12**) ***C- Skills deficiency*** • difficulty coordinating meal and work schedules (8) ***D- Actual barrier*** • Cultural/religious limitations in self-management activities (e.g. dietary changes) are more pronounced in minority populations in new country of residence (8)	• None found in literature	***A-Cultural relevance*** • cultural barriers (e.g. preference for gender-specific programs) to knowledge acquisition (21) ***B-Experience with healthcare*** • language barriers experienced with health care providers (8) ***C-Physical environment*** • cold climate deters leaving house for physical activity (8) ***D-Cultural minority*** • stress from immigrant experience and being part of minority culture/religion and not aware of the new cultural norms(8) • limited availability of preferred foods that are part of minority culture (8)

Qualitative

Quantitative

mixed