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Exploring Factors Impacting the Self-Management of Type 2 Diabetes in Older Black African and Afro-Caribbean People (BAACP): A Qualitative Evidence Synthesis

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Abstract

Purpose: The purpose of this qualitative evidence synthesis (QES) was to synthesize qualitative evidence on perceived barriers and facilitators influencing self-management of type 2 diabetes mellitus (T2DM) among older Black African and Afro-Caribbean adults.

Methods: A QES of qualitative and mixed-methods studies with extractable qualitative findings was conducted using the PICO (Population, Phenomena of Interest, Context) framework and PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidance. Searches were undertaken in MEDLINE, PubMed, CINAHL, PsycINFO, African Journals Online, and Worldviews on Evidence-Based Nursing for studies published between January 2010 and June 2025. Studies were screened against predefined eligibility criteria. Methodological quality was assessed using the Critical Appraisal Skills Program checklist, and findings were synthesized thematically.

Results: From 5092 records, 12 studies met the inclusion criteria. Five overarching themes were identified. Key facilitators included spirituality, culturally responsive health care, and strong family or community support networks. Major barriers included limited health literacy, mistrust of health care systems, cultural conflicts with biomedical advice, and structural barriers such as financial constraints, limited access to health care services, and racial discrimination.

Conclusion: Self-management of T2DM in older Black African and Afro-Caribbean adults is shaped by interconnected cultural, relational, and structural influences. Diabetes services should prioritize culturally tailored education, trust-building clinical relationships, family and community-engaged interventions, and addressing social determinants and racial inequalities to improve self-management outcomes in this population.

Keywords: self-management, type 2 diabetes mellitus (T2DM), older adults, Black African and Afro-Caribbean

Introduction

Type 2 diabetes mellitus (T2DM) is a chronic metabolic condition and is one of the most prevalent diseases, with approximately 589 million people worldwide living with the condition,[1,2] and it contributes to greater global morbidity and mortality due to it serving as a precursor to other health conditions.[3-5] Its characteristics include insulin resistance and persistent hyperglycemia, which, if left unregulated, can lead to damage to vital organs; the development of conditions such as coronary heart disease, foot ulcers, diabetic retinopathy, and nephropathy[4,6,7]; affect quality of living; and cause diabetes distress and depression.[8] Self-management in T2DM includes maintaining a prescribed medication plan, engaging in physical activity, making appropriate dietary changes, regularly monitoring blood glucose levels, and scheduling regular health checks with health care practitioners.[9,10] Economic strains are particularly evident in the health care system, with the global cost of diabetes estimated at approximately USD$1 trillion.[4,11] The vast majority of these expenditures arise from older adults (50-79 years old) with diabetes-related

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health issues.[12] With advancements in technology, health care access, and medical treatment, the number of older adults in the population has increased.[13] Approximately 130 million older adults were living with T2DM globally in 2023, and these numbers are expected to increase.[14] Undeniably, there have been tremendous improvements in the diagnosis and treatment plans for T2DM. However, ethnic and age-related disparities persist, especially among older adults of South Asian, Black African, or Afro-Caribbean descent, which causes conditions like T2DM to have an even more lasting and negative impact on their health outcomes.[7,15] These populations are highly vulnerable and at higher risk of complications due to genetic predisposition, socioeconomic disadvantage, poor self-management, limited access to culturally appropriate care, and inaccessibility to diabetes health care.[16-18]

Unfortunately, T2DM prevalence is higher among Black African and Afro-Caribbean people (BAACP) than among other Global Majority populations and White populations, with studies reporting higher morbidity and mortality and poorer health outcomes.[5,19-21] This disparity is especially pronounced among older adults from these backgrounds.[17] Older adults face barriers to self-management due to age-related changes in physical, cognitive, and social domains.[10,22] Aging, ethnicity, and a chronic disease like T2DM can combine to compound the challenges faced in maintaining effective self-care routines, especially in the Black African and Afro-Caribbean community, resulting in poorer self-management and disparities in diabetes outcomes.[23] Despite the recognized importance of diabetes self-management, there is limited synthesis examining how cultural, structural, environmental, and interpersonal factors influence self-management specifically among older Black African and Afro-Caribbean adults. Understanding these influences is essential for designing culturally responsive interventions for diabetes self-management education and support. Therefore, this qualitative evidence synthesis (QES) aimed to synthesize qualitative evidence on perceived barriers and facilitators to self-management of T2DM in this population.

Methods

This QES followed Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 reporting guidance and used the PICO (population, phenomena of interest, context) framework to structure the research question and eligibility criteria. Qualitative and mixed-methods studies with extractable qualitative findings were included to capture experiences and contextual influences on diabetes self-management. A systematic search of the literature was conducted by searching gray literature sources via ProQuest Dissertations and Theses, organizational and government websites such as Diabetes UK and the Centers for Disease Control and Prevention, as well as databases such as Ovid Medline, PubMed, CINAHL, PsycINFO, and African Journals Online, and the Sigma Journal (Worldviews on Evidence-Based Nursing) for qualitative and mixed-methods studies published between January 2010 and June 2025 in the English language. Typically, a 10-year limit is used for inclusion ranges in a QES to ensure relevance; however, for this review, the limit was extended to 15 years as there were very few studies focused on the key population of older Black African and Afro-Caribbean people ages 65 and above. Additionally, older adults are defined as 65 and older.[24] However, due to paucity in research studies, the eligibility criteria were expanded to include studies with a mean sample of 55 years and older and where these voices were in the majority. This approach facilitated flexibility in the study inclusion and allowed for a focus on older BAACP with T2DM.

Search Strategy

The search strategy was developed to identify literature highlighting the barriers and facilitators to self-management of T2DM in older BAACP, as experienced by affected individuals, their family members, and health care professionals. Search terms were combined using Boolean operators (“AND”, “OR”) and truncation along with MeSH terms and keywords to yield the maximum number of results. Words included (“Type 2 Diabetes” OR “T2DM”) AND (“self-management” OR “self-care”) AND (“Black African” OR “Afro-Caribbean” OR “African Caribbean” OR “African descent”) AND (“barriers” OR “facilitators” OR “challenges” OR “enablers”) AND (“older adults” OR “elderly” OR “aged”). For reproducibility purposes for this review, Table 1 shows a comprehensive example of the search string applied to all databases. Filters such as the English language and the time frame 2010 to 2025 were used. Gray literature was searched utilizing key search terms, including “type 2 diabetes” AND “self-management” OR “self-care” AND “Black African” OR “Afro-Caribbean.” The search took place in June 2025.

Table 1. Search Terms Used in Key Databases.

Database	Search Terms and Keywords	No. Articles	Date Accessed
Medline via PubMed	(((((Type 2 diabetes or type 2 diabetes mellitus or t2dm or type two diabetes or type two diabetes mellitus) AND (Facilitat* or enable* or motivat* or influenc* or influencing factors or determinants)) AND (Barrier* or Challenge* or limit* or hurdle* or difficult* or obstacle* or restraint* or hind* or drawback*)) AND ("older adult*" or senior* or elderly or "senior citizen*" or "older people" or "older person*" or aged)) AND ("Black African" OR "Afro-Caribbean" OR "African Caribbean" OR "African descent" OR Black or Caribbean or "Black Caribbean" or "Black West Indian*")) AND ("Self-manag*"or "self-car*"or "self-regulat*" or "self-control*" or "self-support*" or control* or management) AND ((medline[Filter]) AND (humans[Filter]) AND (english[Filter]) AND (aged[Filter]) AND (2010:2025[pdat])) AND ((medline[Filter]) AND (humans[Filter]) AND (english[Filter]) AND (aged[Filter])) AND ((medline[Filter]) AND (humans[Filter]) AND (english[Filter]) AND (aged[Filter]))	114	June 5, 2025
Embase	Type 2 diabetes or type 2 diabetes mellitus or t2dm or type two diabetes or type two diabetes mellitus) AND (Facilitat* or enable* or motivat* or influenc* or influencing factors or determinants)) AND (Barrier* or Challenge* or limit* or hurdle* or difficult* or obstacle* or restraint* or hind* ordrawback*)) AND ("older adult*" or senior* or elderly or "senior citizen*" or "older people" or "older person*" or aged)) AND ("Black African" OR "Afro-Caribbean" OR "African Caribbean" OR "African descent" OR Black or Caribbean or "Black Caribbean" or "Black West Indian*")) AND ("Self-manag*" or "self-car*"or "self-regulat*" or "self-control*" or "self-support*" or control* or management {Including Related Terms}	4438	June 5, 2025
APA PsycINFO	Type 2 diabetes or type 2 diabetes mellitus or t2dm or type two diabetes or type two diabetes mellitus) AND (Facilitat* or enable* or motivat* or influenc* or influencing factors or determinants)) AND (Barrier* or Challenge* or limit* or hurdle* or difficult* or obstacle* or restraint* or hind* or drawback*)) AND ("older adult*" or senior* or elderly or "senior citizen*" or "older people" or "older person*" or aged)) AND ("Black African" OR "Afro-Caribbean" OR "African Caribbean" OR "African descent" OR Black or Caribbean or "Black Caribbean" or "Black West Indian*")) AND ("Self-manag*"or "self-car*"or "self-regulat*" or "self-control*" or "self-support*" or control* or management	32	June 5, 2025
CINAHL	Type 2 diabetes or type 2 diabetes mellitus or t2dm or type two diabetes or type two diabetes mellitus) AND (Facilitat* or enable* or motivat* or influenc* or influencing factors or determinants)) AND (Barrier* or Challenge* or limit* or hurdle* or difficult* or obstacle* or restraint* or hind* or drawback*)) AND ("older adult*" or senior* or elderly or "senior citizen*" or "older people" or "older person*" or aged)) AND ("Black African" OR "Afro-Caribbean" OR "African Caribbean" OR "African descent" OR Black or Caribbean or "Black Caribbean" or "Black West Indian*")) AND ("Self-manag*"or "self-car*"or "self-regulat*" or "self-control*" or "self-support*" or control* or management	24	June 8, 2025
Sigma Worldviews on Evidence-Based Nursing	Type 2 diabetes AND "facilitator" OR "enabler" OR "barrier" OR "obstacle" OR "challenge" OR "difficulty" OR "difficulties" AND"Older adult" or Elderly	122	June 8, 2025
African Journals Online	Type 2 diabetes or T2D AND facilitator OR enabler OR barrier OR obstacle OR challenge OR difficulty OR difficulties AND Older adult or Elderly	362	June 8, 2025

Table 2. Eligibility Criteria.

Inclusion Criteria	Exclusion Criteria
Studies where participants are older Black African or Afro-Caribbean people	Studies including other ethnic groups
International studies on older Black African or Afro-Caribbean people	Studies that focused solely on other chronic conditions
Published between January 2010 and June 2025	Studies focused on preventing T2DM in healthy individuals
Studies published in the English language or were translated into English language	Studies in other languages that have not been translated into English
Primary studies that are qualitative or mixed-method research with adequate information on qualitative research methods and data included	Papers with secondary evidence (any type of review) or quantitative research
Studies that have findings related to the barriers or facilitators to self-management intervention	Studies where participants had mental health illness or learning disability
Studies exploring self-management intervention for T2DM	Studies looking at type 1 diabetes mellitus
Studies involving participants 55 years and over who have been diagnosed with T2DM	
Gray literature, peer-reviewed and non-peer-reviewed published articles	

Abbreviation: T2DM, type 2 diabetes mellitus.

This QES forms a part of a doctoral research program; a study protocol was developed but not registered in PROSPERO due to the qualitative focus and institutional timeline constraints. However, the review followed PRISMA 2020 reporting guidelines for methodological transparency and rigor.

Research Question

Research Question 1: What are the barriers and the facilitators to self-management of T2DM in older BAACP?

Methods

Inclusion Criteria

Articles were either included or excluded from the study based on the predetermined eligibility criteria (Table 2). The search was conducted using the PICO method for qualitative studies to determine eligibility criteria for inclusion in this qualitative evidence synthesis. For population (P), studies were included if they reported participant data, had a mean sample age $\geq$55, and reported findings that reflected the experiences of older Black African and Afro-Caribbean adults with T2DM. Phenomena of interest (I) included factors affecting self-management of T2DM. The context (Co) was international studies.

Exclusion Criteria

Studies focused on other older adults from different ethnicities and individuals who had cognitive dysfunction were excluded.

Study Selection Process

In this QES, studies were selected in accordance with the PRISMA framework. The Zotero data management software tool was used to remove duplicate records retrieved from electronic databases. Initial screening was conducted using post-de-duplication titles, abstracts, and full texts, and additional steps were taken to ensure rigor was maintained. A second and third reviewer, EE and RA, tested the references and independently screened the full texts; any issues of variance were resolved among the reviewers. Selection bias was minimized by continuously revising the inclusion and exclusion criteria (Table 2) during the screening process, engaging in dialogue with

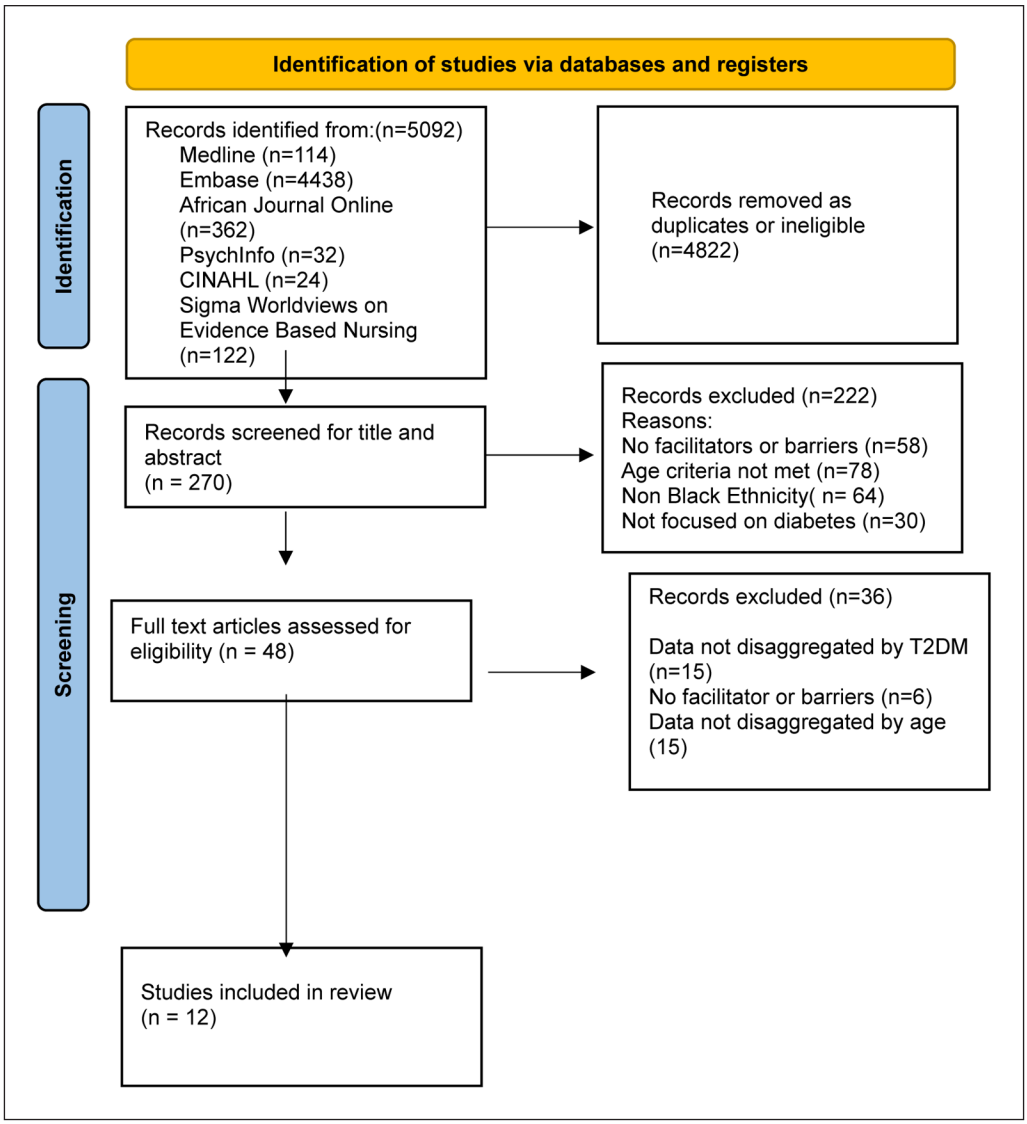


Figure 1. PRISMA[25] (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram for identification of studies.

reviewers to address any uncertainties that arose, and maintaining an audit trail throughout each step. Similarly, gray literature sources were screened using the same process, with both the title and full text, to determine whether they aligned with the required population and methodology for inclusion.

PRISMA Tool for Identification of Studies

The QES was conducted in accordance with the PRISMA framework. Hence, the following tools were utilized: the PRISMA 2020 checklist[25] and the PRISMA 2020 flow diagram for systematic reviews,[25] with a focus on qualitative evidence. This facilitated transparency, consistency, rigor, and completeness for this study. The PRISMA flow diagram was used to present the number of records identified, screened, excluded, and included at each stage of the selection process. The total number of identified articles was 5092. After removing duplicate and ineligible records, 270 articles remained. These articles were then screened by title and abstract. After which, 48 full-text articles were assessed for eligibility. Ultimately, 12 studies were included in the QES (Figure 1).

During the screening process, each article was evaluated against the preestablished inclusion and exclusion criteria to ensure the research question was addressed. Barriers and facilitators were not always explicitly stated in the

study's aim; other terms could have been used, such as "factors," "enablers," "motivators," "obstacles," and "hindrances"; therefore, this was considered during the identification process. Facilitators were defined as those that aided in managing T2DM, while barriers were believed to have prevented its management. The focus population of this research study included only Black African or Afro-Caribbean adults ages 55 years or older. Thus, only studies with a mean age of 55+ addressing self-management of T2DM, those with a qualitative component, and those with sufficient data for synthesis were included.

Conversely, many studies were excluded for these reasons: They focused on a younger population (mean age <55 years) and were not from Black African or Afro-Caribbean backgrounds. The focus was more on the experiences of living with T2DM and navigating health care access, with little emphasis on self-management of the disease, which was unrelated to the research topic and was instead focused on other chronic diseases. Some mixed-method studies were purely quantitative, lacked sufficient qualitative data, and were not in English.

When searching for gray literature, only a small number of documents addressed T2DM in ethnic minority populations; none met the full inclusion criteria. The identified sources did not focus on older adults (ages 55 and above) or provide data specific to Black African or Afro-Caribbean individuals. Most referred to broader ethnic groups without disaggregation by age or ethnicity. As a result, no gray literature was included in the final synthesis.

Data Extraction Process

Data extracted from the included studies were presented in a tabular format to facilitate analysis. Microsoft Excel was the primary tool for managing and organizing data in tabular format. The extraction process considered the following key details: author, year, location, purpose of the study, study population, design and method, data collection, major findings, and limitations (Table 3).

Critical Appraisal for the Included Studies

The Critical Appraisal Skills Program (CASP) tool[26] comprises 10 criteria and was used to assess the quality of the studies included in the review. This toolkit helps researchers critically appraise research articles and determine whether they are suitable for inclusion in the study. A structured scoring framework was adapted from Njau et al,[27] where each CASP domain was categorized as "yes," "partially," or "no," facilitating the systematic comparison of included studies. If the criterion was met entirely, it was categorized as yes (2 points); criterion partially met was categorized as partially (1 point); and if the criterion was not applicable/unmet/not mentioned, it was categorized as no (0 points). Finally, the study quality was classified accordingly by total score: 20 = high quality, 16 to 19 = moderate quality, and ≤15 = low quality. A total of 7 high-quality articles and 5 moderate-quality articles were identified. All articles were of excellent quality despite variation in scoring; therefore, all were included in the review (Table 4).

Rationale for Qualitative Evidence Synthesis

A QES was undertaken to systematically identify, appraise, and integrate findings from qualitative and mixed-methods studies exploring the factors affecting self-management of T2DM among older BAACP. QES is recognized as a systematic review that brings together the findings of numerous qualitative studies to provide a richer, deeper understanding of participants' experiences, beliefs, perceptions, and contextual influences than could be achieved with individual studies alone. Qualitative data provide a better understanding of the experiences, cultural beliefs, and social contexts[28] that influence the decision to self-manage their condition. Hence, qualitative studies and qualitative components of mixed-methods studies were included. This was done to bring participant-driven narratives to the forefront. The converse is true for quantitative studies. Lim[29] highlights that quantitative studies often test a hypothesis, utilize closed-ended questions, and are more objective in nature.

Ethical Considerations

This research took the form of a QES, synthesizing data from previously published studies. The published studies have already received ethical approval from the respective review boards. No additional ethical approval was required. Nonetheless, ethical principles were applied throughout this study, including proper citation,

Table 3. Data Extraction Table for Included Studies.

Source	Location	Purpose	Study Population	Design and Method	Data Collection	Major Findings	Limitations
1. Casarez et al[30]	USA (rural community in Texas)	To explore spiritual practices in self-management of T2DM among African Americans	20 African American participants (40+) Mean age 64 y	Exploratory qualitative design	Semistructured interviews, analyzed with thematic coding	Spirituality for some African Americans is crucial for management for T2DM. Spirituality used in interventions may facilitate better self-management and health promotion; health providers need to understand the relevance of spirituality in the lives of their patients.	Geographically limited, small sample size (not generalizable), religious orientation not broadly representative
2. Chard et al[15]	USA (mid-Atlantic city)	To explore how Black older adults define and carry out diabetes self-care in the context of intersecting social, structural, and health-related pressures	41 older Black adults with T2DM (50+) Mean age 61.6 (SD 5.6)	Qualitative study using narrative approach	In-depth, semistructured illness narrative interviews conducted in participants' homes where possible, audio-recorded and transcribed; thematic analysis	Key influences on self-care included multimorbidity management, financial well-being, family support, and formal health care.	Sample may not reflect higher-SES Black adults or those with postsecondary education. Drawn from one urban area; findings may not generalize nationally. The use of narrative methods means findings are contextually rich but not generalizable in a statistical sense.
3. Chlebowy et al[31]	USA (Southeastern urban city)	To identify facilitators and barriers to T2DM self-management in African Americans	38 African American adults with T2DM Mean age 66 (SD 11.3)	Mixed method Quantitative used 10-item survey; obtained demographic and medical history	Focus groups (60-90 min), audio-recorded, analyzed using Atlas.ti 6	External support (family, peers, health care providers) facilitated; internal factors (fear with glucose monitoring, lack of self-control) hindered management.	Limited to 1 urban area and convenience sampling

(continued)

Table 3. (continued)

Source	Location	Purpose	Study Population	Design and Method	Data Collection	Major Findings	Limitations
4. Kindarara et al[32]	Greater Sacramento region, California, USA	To describe Sub-Saharan African immigrants' health-illness transition experiences associated with T2DM self-management	10 participants (5 men, 5 women), age range 44-76 (mean age 60.3) Recruited using purposive and snowball sampling from 4 Sub-Saharan African immigrant churches	Qualitative descriptive design guided by Meleis's middle range theory of transitions	Semistructured interviews and demographic and transition questionnaires Interviews were audio-recorded, transcribed verbatim, and analyzed using qualitative content analysis.	4 main domains emerged: (1) knowledge of T2DM self-management behaviors, (2) current T2DM self-management behaviors, (3) inhibitors of self-management (eg, cultural beliefs, SES, diet), and (4) facilitators (eg, routine, social support, spirituality, HCP relationships).	Small sample from 1 geographic region; exclusion of non-English speakers may have limited insights; findings may not be generalizable to broader Sub-Saharan African immigrant populations.
5. Magny-Normilus et al[33]	USA (Northeast region)	To describe experiences of older adult Haitian immigrants managing T2DM	20 older adult Haitian immigrants (≥65 years), purposive sampling	Descriptive qualitative design, semistructured interviews	Face-to-face interviews (40-90 min), NVivo used for analysis	Financial hardship and social isolation were key barriers; community support facilitated management.	Limited generalizability; specific to Haitian immigrant churches in one region
6. Mogre et al[40]	Ghana (Tamale Metropolis)	To explore patients' and HCPs' perspectives on barriers to diabetic self-care behaviors	23 patients with T2DM and 14 HCPs (doctors, nurses, nutritionists and dieticians) Mean age of patients 60.9 (SD 12.6)	Qualitative study using semistructured interviews	In-depth interviews, data analyzed using constant comparative method and theory of planned behavior framework	Barriers included misconceptions about diabetes, use of herbal medicines, inadequate family support, social stigma, poor income, and health care access issues.	Regional sample, findings may not generalize across Ghana or other low-middle income countries

(continued)

Table 3. (continued)

Source	Location	Purpose	Study Population	Design and Method	Data Collection	Major Findings	Limitations
7. Moore et al[36]	London, United Kingdom	To explore the perspective of Black African and Caribbean individuals living with T2DM and identify how cultural salience of self-management advice can be improved	41 participants: 23 Black African, 18 Black Caribbean; recruited via community venues, faith institutions, and primary care Mean age 62.4 (SD 11.7)	Qualitative design using grounded theory.	8 focus groups stratified by gender and ethnicity; sessions lasted 2 h, were audio-recorded and transcribed; analysis conducted with NVivo using open, selective, and theoretical coding	Major themes were (1) misalignment between cultural norms and medical advice; (2) reconciling perspectives—negotiating advice within cultural frameworks; (3) importance of trust and relationship with HPCs. Community support and culturally relevant information facilitated self-management.	Limited generalizability due to sample being drawn from London boroughs with dense minority ethnic populations. Findings may not reflect those in less diverse or more affluent settings.
8. Reshid et al[38]	Ethiopia	To examine factors contributing to delayed insulin initiation among T2DM patients	27 participants total: 15 patients with T2DM, 12 HCPs (7 physicians, 3 nurses, 2 pharmacists) 6 participants ages 51 and older	Qualitative descriptive study design using thematic analysis	In-depth semistructured interviews, conducted in Amharic, transcribed and thematically analyzed; interviews lasted 30-60 min	Patient-level factors: fear of injections, cost of insulin, religious practices, insulin misconceptions Physician-level: lack of motivation/communication, insufficient training Institutional-level: lack of guidelines, A1C testing, educational materials, and overloaded systems	Findings may not generalize to primary/private health care settings. Biomedical background of researchers may have introduced bias. Limited to tertiary public setting.
9. Sapkota et al[37]	UK (West Midlands)	To explore beliefs and experiences influencing self-management among African and Caribbean adults	19 African-Caribbean individuals age over 50, diagnosed with T2DM	Qualitative study	3 focus groups, facilitated by insiders and outsiders, reflexive thematic analysis	Highlighted community and religious influences, mistrust in health care, and systemic barriers	Limited geographic scope; small sample size

(continued)

Table 3. (continued)

Source	Location	Purpose	Study Population	Design and Method	Data Collection	Major Findings	Limitations
10. Sherman & Fawole[34]	Houston, Texas, USA	To explore treatment preferences for managing T2DM among African American men	19 African American men ages 35-69; 68.4% were age 55+; recruited via barbershops and churches	Qualitative phenomenological approach	Face-to-face semistructured interviews audio-recorded and transcribed; thematic analysis applied	Preferences varied: Most favored oral medication for convenience; some preferred lifestyle changes; many used a combination. Social support and education played critical roles.	Small, nonrandom sample from 1 geographic area; findings not generalizable; more research needed on the impact of social support
11. Tewahido & Berhane[39]	Ethiopia (Addis Ababa)	To explore self-care practices and challenges among patients with diabetes in Addis Ababa	13 patients with T2DM, age 35-65 y, diagnosed for at least 5 y	Qualitative study using purposive sampling based on demographic and behavioral variation	Semistructured in-depth interviews conducted in Amharic, audio-recorded, transcribed, translated, and thematically analyzed	Poor overall self-care practices; medication adherence better than diet, exercise, and foot care; low knowledge levels; patients categorized as "negligent," "confused," and "endeavor to be compliant"	Limited to interviews only from public hospitals; possible social desirability bias
12. Wallace et al[35]	Baltimore, Maryland, USA	To examine the self-management strategies and experiences of older African American men with T2DM and explore how these intersect with expressions of masculinity	15 African American men, ages 53-73 Mean age 62.3 y (SD 6.1)	Qualitative study using an intersectional framework; thematic analysis of illness narratives	Modified McGill Illness Narrative Interview; in-home interviews lasting 40-120 min	Participants employed active diabetes management strategies: seeking education, healthy eating, medication adherence, and maintaining supportive relationships. Participants challenged cultural stereotypes about Black masculinity and health disengagement by embracing proactive self-care and familial responsibilities.	Small, geographically limited sample; findings may not be generalizable beyond the Mid-Atlantic region or to younger age cohorts. Exploratory focus limits broader applicability.

Abbreviations: HCPs, health care providers; SES, socioeconomic status; T2DM, type 2 diabetes mellitus.

Table 4. CASP Appraisal of Included Studies 26.

Study	Clear Aims	Qualitative Methodology Appropriate	Research Design Appropriate	Recruitment Strategy Appropriate	Data Collection in Detail	Researcher-Participant Relationship Considered	Ethical Issues Considered	Rigorous Data Analysis	Clear Findings	Research Value
1. Casarez et al[30]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	Moderate-19
2. Chard et al[15]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20
3. Chlebowy et al[31]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	Moderate-19
4. Kindarara et al[32]	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	Moderate-18
5. Magny-Normilus et al[33]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20
6. Mogre et al[40]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	Moderate-19
7. Moore et al[36]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	High-20
8. Reshid et al[38]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20
9. Sapkota et al[37]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20
10. Sherman & Fawole[34]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20
11. Tewahido & Berhane[39]	Yes-2	Yes-2	Yes-2	Partially-1	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Moderate-19
12. Wallace et al[35]	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	Yes-2	High-20

Table 5. Themes, Barriers, and Facilitators Across the 12 Studies.

Theme	Barriers and Facilitators
Personal beliefs and health literacy	Barriers: limited understanding of diabetes (Moore et al[36]; Kindarara et al[32]; Reshid et al[38]; Mogre et al[40]; Tewahido & Berhane[39]) Facilitators: culturally appropriate and simplified education increases awareness and compliance (Magny-Normilus et al[33]; Wallace et al[35]; Mogre et al[40]; Reshid et al[38];Tewahido & Berhane[39])
Structural, economic, and access-related challenges	Barriers: cost of medication and health care/food insecurity (Tewahido & Berhane[39]; Reshid et al[38]; Mogre et al[40]; Kindarara et al[32]; Chard et al[15]; Magny-Normilus et al[33]) Facilitators: free health care, accessible education. and accessible health care services (Tewahido & Berhane[39]; Reshid et al[38]; Mogre et al[40]; Kindarara et al[32]; Chard et al[15]; Magny-Normilus et al[33])
Family, peer, and community support	Barriers: stigma, lack of family support, family conflict (Kindarara et al[32]; Magny-Normilus et al[33]; Chard et al[15]; Moore et al[36]; Sherman & Fawole[34]; Wallace et al[35]; Chlebowy et al[31]; Magny-Normilus et al[33]) Facilitators: advice, support and encouragement from family, peer groups, community members, and faith leaders (Kindarara et al[32]; Magny-Normilus et al[33]; Chard et al[15]; Moore et al[36]; Sherman & Fawole[34]; Wallace et al[35]; Chlebowy et al[31])
Cultural and religious influences	Barriers: cultural conflict with biomedical advice, overreliance on spirituality and faith (Casarez et al[30]; Mogre et al[40]; Kindarara et al[32]; Moore et al[36]; Magny-Normilus et al[33]; Chard et al[15]; Sapkota et al[37]) Facilitators: spiritual practices integrated into care, partnership with God, doctrines teach healthy eating and lifestyle (Casarez et al[30]; Mogre et al[40]; Kindarara et al[32]; Moore et al[36]; Magny-Normilus et al[33]; Chard et al[15])
Wariness and misalignment with health care systems	Barriers: mistrust in health care providers, poor communication (Moore et al[36]; Sapkota et al[37]; Chard et al[15]; Reshid et al[38]; Mogre et al[40]; Sherman & Fawole[34]; Wallace et al[35]; Chlebowy et al[31]) Facilitators: relational care and culturally competent providers (Moore et al[36]; Sapkota et al[37]; Chard et al[15]; Reshid et al[38]; Mogre et al[40]; Sherman & Fawole[34]; Wallace et al[35]; Chlebowy et al[31])

transparency in the research and writing process, and ensuring that participants' voices and personal experiences were well represented in the review, as they were in the original study.

Results

Study Characteristics

Twelve studies were included; they were conducted in the United States (n = 7),[15,30-35] the United Kingdom (n = 2),[36,37] Ethiopia (n = 2),[38,39] and Ghana (n = 1).[40] Eleven studies used qualitative designs, and 1 used a mixed-methods design. Sample sizes ranged from 13 to 41 participants. Most studies used interviews or focus groups and purposive recruitment. Participants were described as African American, Black African, Ethiopian, Ghanaian, or Afro-Caribbean. Mean participant ages ranged from approximately 60 to 66 years. The publication years ranged from 2010 to 2025. Ten studies were focused on participants with T2DM,[15,30-37,39] and 2 studies involved health care practitioners and patients.[38,40] Thematic synthesis identified 5 interconnected domains influencing diabetes self-management: (1) cultural and religious influences, (2) trust and alignment with health care systems, (3) family and community support, (4) structural and economic constraints, and (5) personal beliefs and health literacy (Table 5).

Culture and Religious Influences

Culture and religion have significant influence on self-management, especially among African individuals[41] and those of African descent, such as Afro-Caribbean individuals. Cultural norms greatly influence dietary practices,

body image, and perceptions of illness. Traditional foods were central to identity and social belonging, creating tension when biomedical advice conflicted with cultural expectations. Culture can influence whether individuals apply certain self-management principles, especially key cultural factors such as fatalism, collectivism, and cultural norms. There may be a clash between biomedical advice and cultural practices.[42] One participant expressed, "They told me don't eat rice. . . . If you have diabetes, you don't eat fufu every day. But it is your diet. Fufu is your diet. Rice is your diet. . . . There is no African man who will not eat rice, will not eat fufu"[32] Often, members of this community are advised against eating cultural foods such as yam and rice and given alternatives, leading to a natural stance of defiance.[32,36,37,40] In some settings, a larger body size was often associated with prosperity and good health, reducing the urgency for lifestyle modifications.[36,40]

Fatalistic beliefs and perceptions of diabetes as being inevitable further diminished motivation for lifestyle changes.[37] Religion is a valuable tool for self-management, especially for religious and spiritual African and Afro-Caribbean people.[43] Religious belief functioned both as a facilitator and a barrier. One example of religious belief as a facilitator was one participant stating "When you read the Word [the Bible], it makes you help yourself too, like follow your diet. And God wants to see you get better. . . . He wants you to be healed . . . so you won't be diabetic no more."[30] Faith provided emotional stability, coping, and motivation for discipline, with religious teachings encouraging self-care.[30,32-36,43] Churches and mosques emerged as culturally acceptable venues for discussing health and encouraging peer support.[36] Nonetheless, spiritual perceptions of illness often promoted reliance on natural remedies or divine healing, contributing to medication hesitancy or delayed biomedical engagement.[36,37,40,43]

Wariness and Misalignment With Health Care Systems

Mistrust and perceived misalignment with health care systems were recurring themes. Participants expressed experiencing fragmented care,[15,38] concerns about experimentation/"feeling like guinea pigs,"[15] and surveillance.[37] One participant expressed, "I will never take part in [organized training event] . . . I do not know where the people [who give training] are coming from."[37] Generic body mass index charts were deemed inappropriate for the population being served, and dietary recommendations were categorized as prescriptive, which led to the belief that care was not culturally tailored.[36] Medication side effects, fears regarding insulin, and inconsistent explanations from providers reduced maintenance of the prescribed medication plan.[40] Conversely, when health care professionals provided clear explanations, emotional support, and culturally responsive communication, participants experienced greater empowerment and motivation to self-manage.

Family, Social Support, and Community Networks

Family, social support, and community networks played a crucial role in shaping self-management behaviors. Family members contribute to overall well-being and the management of T2DM,[44] especially for older adults. They experienced improved health outcomes, particularly in blood glucose targets, compared with those without family support.[45] Family members, particularly spouses, children, and parents, played a crucial role in managing the condition by providing support, encouraging maintenance of the prescribed medication plan, administering medication as needed, assisting with dietary adjustments, and facilitating attendance at appointments.[15,31-33,35,40] One participant expressed, "My wife . . . she gives me my shots in my stomach and helps me to take my medicine."[31] Social support refers to friends, colleagues, community leaders, church members, or others. This support has been found to influence how the individual perceives their condition and copes with it and alleviates the financial, emotional, physical, and spiritual burdens associated with it.[46]

Peer groups and church communities provided emotional support, accountability, and shared personal experiences.[30,33] Community champions and peer support initiatives were viewed favorably.[31,32] However, social environments could also undermine management. One participant expressed, "In my community or people from my country, we get together a lot. It's hard because you get together with people you know around food. . . . Nobody is educating others. Saying hey, watch what you're eating . . . so it makes it very hard when you're gathering around the food to be able to manage your diabetes"[32] High-calorie foods at social gatherings, secrecy related to having T2DM,[32] and the stigma surrounding insulin administration[38] contributed to suboptimal self-management. Additionally, participants reported elevated glucose levels due to family conflict and social misunderstanding.[15,32]

Structural, Economic, and Access-Related Challenges

Structural inequities and inequalities have a major impact on self-management capacity. Participants' financial insecurity limited access to medication,[33,40] healthy foods,[15,32,37,40] and health care services.[32,40] Some participants reported skipping medication or borrowing supplies due to cost.[15,33,38] Long waiting times, overburdened systems,[38,40] and limited culturally competent services compounded these challenges. One participant stated, "Sometime I don't get my medicine because I don't have the money at the time."[15] Migration-related adjustments, racial discrimination, and linguistic barriers, with some participants feeling alienated due to their ethnicity and "foreign accent and broken English,"[33,37] further exacerbated marginalization.

Personal Beliefs and Health Literacy

Based on participants' expressions, providing only knowledge about T2DM to effect change in health behavior is insufficient; health literacy and illness representation strongly influence self-management behaviors. Theories such as the health belief model and the theory of planned behavior have been successfully employed in effecting health behavior change interventions.[47] One's health behavior can be predicted by assessing their illness representation. Illness representation refers to the individual's personal beliefs about a condition, how they come to understand the condition, regarding how it is caused and manifested, and how to manage it ultimately.[48] Participants relied on bodily cues rather than glucose monitoring, misunderstood concepts such as body mass index and their diabetes diagnosis,[32] and lacked confidence in using their glucometers.[40] One participant expressed this about using the glucometer: "The difficulty is just the pricking part of it."[40] Some participants held beliefs about possible dependence on medication[40] and the inevitability of developing T2DM due to family traits or external forces.[37] In the case of older adults, their preferred method for information was printed materials and face-to-face education,[31,32] in comparison to digital health resources, due to not being able to use these technologies.[37] Additionally, participants and health care providers have agreed that advanced age hinders physical activity due to the pain experienced.[40] Hence, comorbidities and chronic pain reduced physical activity capacity.[15,40] One participant expressed, "I get pain from even exercising, but I do it as much as I can."[15] Therefore, the International Diabetes Federation has proposed that comprehensive assessments of pain be conducted to enable the development of appropriate plans for physical activity for older adults with T2DM who are also managing chronic pain.[49]

Discussion

This QES explored the barriers and facilitators that influence the self-management of T2DM in older BAACP. Five interconnected themes were identified: cultural and religious influences; structural, economic, and access-related challenges; wariness and misalignment with health care systems; family and community support; and personal beliefs and health literacy. Despite participants acknowledging the importance of recommended self-management behaviors, their capacity and motivation to participate in self-management were influenced by cultural systems, religious beliefs, health care relationships, social networks, and structural inequities. These findings highlight the multidimensional nature of diabetes self-management and reinforce that it is not solely an individual responsibility but is embedded within broader sociocultural and health system contexts. To enhance self-management abilities, the approach needs to be culturally tailored, client-centered, include familial and social support where possible, and address existing racial discrimination and health inequalities rather than focusing solely on individual behavior change.

Cultural and Religious Influences

This QES identified culture and religion as key influences impacting the self-management of T2DM in older BAACP. Cultural beliefs and traditions, as well as religious values, shaped participants' willingness to follow medical recommendations, their dietary choices, the use of traditional remedies, and their health-seeking behaviors. The study showed that traditional foods, cultural norms, and practices are embedded in an individual's cultural identity and family traditions and form part of participants' sense of belonging. Therefore, modifications to diet, the use of contemporary medicine, perceptions of T2DM, and even losing weight where necessary may at times encroach on these belief systems, hence creating tension between medical advice and the preservation of one's cultural identity. Standardized diabetes education that lacks cultural appropriateness fails to elicit change and lacks

engagement. However, when interventions were culturally tailored, including traditional foods rather than eliminating them, and practitioners employed culturally appropriate education and interventions, health outcomes improved, and this was actually a priority need voiced by individuals in the Black African and Afro-Caribbean populations.[50]

When adapting programs such as Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND), socioeconomic deprivation needs to be considered in certain contexts. Lamptey et al[51] conducted a randomized controlled trial in which they adapted DESMOND to the Ghanaian context. There was a reduction in A1C in the intervention group; however, there was no significant improvement in glycemic levels, suggesting that culturally sensitive education alone may not be sufficient. Socioeconomic deprivation and financial constraints limit an individual's ability to self-manage T2DM and must be considered when creating culturally sensitive education, which will be further discussed. Additionally, faith was instrumental in instilling hope, emotional resilience, and coping when living with T2DM. However, there were situations where belief in divine healing and natural remedies hindered health care engagement. Therefore, one's religious beliefs can be either advantageous or disadvantageous to self-management of T2DM. Duke's[52] qualitative study emphasized the importance of faith and spirituality for people living with T2DM. This was further supported by an integrative review by Molla et al,[53] which highlighted how spirituality facilitates T2DM self-management through access to emotional support, faith communities, and a means to cope with the impact of T2DM.

As health care professionals, we can see the interconnectedness of faith, caring for one's body, and trusting in God's divine help in managing T2D. We also need to recognize the importance of having access to a community of people of a shared religious background who encourage and provide support, whether financially, spiritually, or emotionally. It is important to prioritize culturally and religiously sensitive health care to improve self-management in older BAACP and reduce inequalities in access to health care. Health care providers need to shift from a strict focus on dietary restrictions and generic lifestyle advice to meaningful dialogue that includes cultural beliefs, traditional dietary practices, the client's cultural identity, and spirituality. This care can be further enhanced by collaborating with cultural/community leaders, faith leaders, and faith-based organizations to gain a deeper understanding of cultural and religious influences. Through this collaboration and understanding, there is further reach and support of older BAACP with T2DM through the development of culturally and religiously tailored interventions, information sharing, reinforcement of self-management, strengthening trust, and increasing message uptake within this population.

Structural, Economic, and Access-Related Challenges

The literature emphasized that structural and socioeconomic factors impact an individual's ability to self-manage T2DM. Inaccessibility to healthy foods and medication, inability to access health care due to costs and distance, systemic racism, and discrimination because of being Black African or Black Caribbean in a host country—these issues reduce participants' motivation and ability to develop health-seeking behaviors and self-manage T2DM. These findings are consistent with the World Health Organization's report[54] on the social determinants of health. This report states that government bodies need to eradicate structural discrimination and economic inequality to establish health equity. To address this issue, the National Health Service England's Core20Plus5: reducing health care inequalities among older people[55] was developed and proposes to reduce health care inequalities and address the discrimination faced by individuals from the global majority communities, vulnerable migrants, and individuals at risk of experiencing systemic racism. Deprivation and an individual's inability to access healthy food and medical supplies constrained one's ability to apply self-management advice, as seen in the Ghanaian adaptation of the DESMOND program.[51] This study highlighted that culturally tailored education was acceptable. Still, improvements in glycemic control remained limited due to financial constraints and socioeconomic deprivation being experienced by participants, which prevented the sustainability of lifestyle and dietary changes. Practitioners and policymakers should acknowledge the systemic racism and social determinants of health that are experienced by older BAACP living with T2DM, which influence self-management behaviors. There need to be efforts to address the policies that shape the broader social and economic determinants of diabetes, such as advocating for reducing structural inequalities and providing more equitable and safe health services, tackling existing racial discrimination, improving the affordability of healthy foods and medications, training the workforce to be culturally competent, improving pathways to care, and expanding access to health care services.

Wariness and Misalignment With Health Care Systems

Participants' mistrust of health care professionals and perceived misalignment of health care services along with culture, religion, and health inequalities influenced T2DM self-management. Participants expressed preexisting displeasure with the health care sector and prescribed medication and even questioned the agenda of the health and pharmaceutical sector. Consequently, health care providers have a great responsibility to help fix the fragmented care that exists and the kinds of interactions that occur from the provider to the patient level. Participants appreciated patient, emotionally intelligent, and respectful health care professionals who tried to understand their backgrounds and provide culturally relevant health advice. This increased the participants' willingness to self-manage their T2DM. However, the converse was true when participants interacted with culturally insensitive, unempathetic, and judgmental practitioners; self-management, trust in the health care service, and willingness to engage in diabetes education or health services were discouraged.

Study findings are consistent with Goff et al,[50] who emphasized the importance of culturally competent diabetes education and educators for Black African and Afro-Caribbean communities, and align with the NICE guidance,[56] which champions the application of person-centered care and shared decision-making. This is especially important in ethnically diverse populations that experience discrimination and health inequalities. Person-centered care addresses health needs, unique social situations, and decision-making and provides the necessary support for self-management techniques. It is important to improve and strengthen trust, empathy, and cultural competence not merely as an individual practitioner's aim but as an organizational-level endeavor to provide culturally responsive and equitable care for older BAACP with T2DM. Additionally, health care providers must maintain continuity of care and ensure adequate consultation time. Diabetes educators must avoid being dismissive and instead help address clients' misconceptions. This will improve engagement with diabetes services and lead to better health outcomes for these individuals.

Family, Social Support, and Community Networks

Family, social, and community support were both facilitators and barriers to diabetes self-management. The family played an important role in providing emotional and practical support, including encouragement, medication management, dietary adjustments, and attendance at appointments. Similarly, community and faith organizations provided support through health advice, sharing personal experiences, and social connectedness. However, family and community networks may have cultural traditions, dietary practices, and expectations that are at odds with medical advice, leading to conflict and reducing self-management among older BAACP. Singh et al's[57] systematic review concurred with the importance of culturally tailored interventions that incorporate community leaders and peer support to improve engagement among Black community members living with long-term conditions such as T2DM. Similarly, the Heal-D program[50] has demonstrated the importance of including not only Black African and Afro-Caribbean individuals living with T2DM but also health care practitioners, commissioners, and community leaders in the development of interventions as it facilitates diabetes education that is relatable and reflects dietary practices and the lived experiences of Black African and Afro-Caribbean communities. However, there was no inclusion of family members in the intervention or program delivery. Chard et al[15] highlighted the importance of family support in the management of T2DM. Health care providers should consider how family members who support these individuals can be included in interventions geared toward older BAACP living with T2DM. This will result in improved participation and sustainability of self-management interventions. These findings emphasize the inclusion of family members and community organizations, particularly in the provision of care, support, and diabetes education. Rather than clinic-centered delivery, faith organizations and community-centered education can be culturally appropriate alternatives for promoting health, given the preexisting social support. There is also a need for creating peer-support programs in the community to prevent isolation that is often accompanied by having a long-term condition.

Personal Beliefs and Health Literacy

The influence of personal beliefs and health literacy regarding T2DM and its effects on health cannot be overemphasized. Participants who understood what T2DM was, its complications when poorly controlled, and the importance of self-management in meeting blood glucose targets had greater confidence in self-management and in maintaining lifestyle changes and medication management. However, for participants who lacked confidence in monitoring their

glucose levels, held misconceptions about T2DM, and were unable to access information from digital resources, this impeded their self-management and delayed their engagement with recommended medical advice.

Study findings align with Bandura's[58] self-efficacy theory, which emphasizes that individuals must not only have knowledge but also be confident in their abilities to change health behaviors. Participants in this study highlighted that although knowledge is important, self-management is shaped by cultural and familial factors, structural constraints, and trust in health care professionals, further emphasizing the complex interactions between individuals and the contexts in which they are situated. Diabetes education must strengthen self-efficacy whilst also improving individuals' health literacy to sustain self-management of the condition. Diabetes care and education specialists and health practitioners, therefore, must include simplified, culturally and age-appropriate material; facilitate training in using glucometers; and consider that comorbidities are common in older populations and support the holistic management of these individuals. There is also a need for collaboration in the decision-making process, and health literacy levels must be considered in this process. Therefore, adaptations such as accurate pain assessment, effective pain management, and appropriate exercises tailored to older adults' capacity will be needed to support their participation in self-care.

Limitations

Steps were taken to ensure the study was rigorous, transparent, and comprehensive. Several limitations are to be considered when interpreting the results of this synthesis. The studies included were limited to English-language publications, resulting in English-language bias and the exclusion of studies on the topic from non-English-speaking regions. Most of the studies in the review were based on BAACP experiences in the United States of America, which limits their representativeness and generalizability to other Black African and Afro-Caribbean populations in other countries as health care systems, health-seeking behavior, health policies, culture, and societal norms vary across the world. Few studies focused on older BAACP, hence the inclusion of studies with a mean sample age of 55 or older. This decision was justified due to the paucity of research; the findings might not be a true reflection of the experiences of the oldest BAACP living with T2DM.

Additionally, the voices of Afro-Caribbean persons were underrepresented in this study, whereas more studies included those of Black African participants. Additionally, the available research evidence varied in methodological quality, sample size, and reporting practices, which might affect the depth of thematic interpretation. Notwithstanding this, QES provides a comprehensive synthesis of qualitative evidence and offers invaluable insights into the interconnected cultural, social, structural, and health care factors that influence diabetes self-management among older BAACP living with T2DM.

Conclusion

This QES demonstrates that a complex interaction among cultural meaning systems, social support structures, health care relationships, and structural inequalities influences diabetes self-management among older BAACP. Interventions aimed at improving outcomes in this population should extend beyond education to include culturally responsive care, family inclusion, community partnerships, and strategies that address access, social and racial inequalities, and trust amongst these individuals.

Implications for Future Research

This synthesis highlights several priorities for future research. There is a need for high-quality qualitative studies on older BAACP with T2DM, especially those ages 65 and older, whose experiences remain underrepresented. Future research needs to distinguish between Black African and Afro-Caribbean populations where appropriate as these groups exhibit diverse cultural beliefs, migration histories, and health care experiences. Future research also needs to evaluate the effectiveness of culturally and spiritually tailored self-management interventions and the inclusion of family- and community-based approaches for improving long-term health outcomes for T2DM. Additionally, longitudinal qualitative studies would aid in understanding how self-management evolves over time and in response to aging, multimorbidity, and changes in social situations. Finally, there is also a need for implementation research to explore how culturally responsive and compassionate diabetes care can be incorporated into routine clinical practice. This will aid in translating existing evidence into sustainable improvements in health service delivery and reduce the long-standing racial and social inequalities in diabetes outcomes.

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Data Availability Statement

The systematic review consists of published studies that are publicly available and have been cited in the reference list. The full search strategy, results, and Critical Appraisal Skills Program appraisal of included studies are available in the supplementary material for perusal.

Supplemental Material

Supplemental material is available online.

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