Table 1. Main findings of the four qualitative studies reviewed.

Author (year)	Purpose	Participant demographics and study setting	Key findings (grouped into themes)	Quality assessment
Carolan et al (2012)	To understand the factors that facilitate or inhibit women's understanding and adherence to GDM dietary self-management principles	15 pregnant women with GDM, who spoke English and with no known serious abnormalities US	**Barriers** *Time pressure:* Participants felt they had limited time to understand their diagnosis and had to urgently adopt new dietary changes. *Physical constraints:* Participants did not feel they were able to exercise regularly. The most common reasons why they did not meet exercise requirements were pelvic pain and back ache. *Social constraints:* Participants found it difficult to self-manage their GDM. It disrupted their family life due to having to make separate meals, as well as affecting their ability to eat how they would like at certain festivities or social functions. **Lack of knowledge** *Limited comprehension:* Participants did not understand what GDM was and did not understand self-management requirements. *Insulin is an easier option:* Participants felt it was easier to just take insulin versus changing their diet and exercising. **Responsibility/support** *Psychological support:* Participants identified psychological support as being very important and encouraging in helping them master the daily tasks of GDM self-management. *Realisation:* Participants came to the realisation that they were responsible for their own health and they had to do the work for self-management of GDM. *The baby:* Participants had a powerful interest in maximising fetal health and had motivation to avoid foods they were not supposed to eat and adhere to the self-management regimen.	Level of evidence: C JBI score: 9/10
Oza-Frank et al (2018)	To examine healthcare experiences of a diverse sample of low-income women with a history of GDM	12 women (African–American, Hispanic or Appalachian), age 18–45 years, with a diagnosis of GDM within the past 10 years Ohio	**Lack of knowledge:** Healthcare providers affected the quality and quantity of care received, the women's knowledge, management of GDM and follow-up of GDM. Hispanic women felt they were given little information on GDM by their providers, and what information they did receive was found to be lost with other information provided. They also felt they would have breastfed for longer if they had been notified of the connection between breastfeeding and type 2 diabetes after pregnancy; they did not understand the risk to their children from GDM. Lastly, they felt the high risk of developing type 2 diabetes after the postpartum period was not communicated. **Barriers:** Hispanic women found it very overwhelming to change their diet and craved foods they were told to avoid. Cost and transportation were also barriers to seeking healthcare and managing their GDM. Hispanic women without health insurance tended not to schedule follow-up office visits and felt they needed Emergency Medicaid extended after pregnancy. The cost of healthier foods was also a barrier. They felt the need to care for their family and home first before follow-up office visits.	Level of evidence: C JBI score: 8/10
Ingol et al (2020)	To examine perceived barriers to adoption of lifestyle changes for type 2 diabetes prevention among diverse, low-income women with a history of GDM	64 women aged 18–45 years with a diagnosis of GDM within the past 10 years who spoke English or Spanish. An interpreter was used for Spanish-speaking participants Appalachian communities throughout the state of Ohio	**Lack of knowledge:** Knowledge of healthy eating, physical activity and other behaviours for the prevention of type 2 diabetes had similarities and variations among different racial/ethnic groups. Hispanic women expressed a need for more information and resources on nutrition. A common misconception within this group was that they could eat any vegetable without a negative impact on their blood glucose; they were surprised when told to limit their intake of vegetables such as corn or potatoes due to their high carbohydrate content. Hispanic women also believed healthcare providers underestimated the level of exercise they engaged in every day; they were not accounting for the amount of walking the women did at work and around the home in tasks such as cooking. **Barriers:** Hispanic women felt it was hard to eat healthily due to having to cook and being unable to afford the food. They were unable to afford a gym membership to work out and would also have to pay for childcare whilst at the gym, which they could not afford. Participants reported personal and environmental barriers to accessing community resources. Some were not aware of the resources within their community and others felt they were not welcomed when trying to go. Within the Hispanic population, resources were available at church; however, the meetings always involved potluck meals with unhealthy food options. **Responsibility/support:** Support was identified as an important motivator for engaging in lifestyle approaches known to improve GDM and reduce the risk of type 2 diabetes. Social support from family and friends helped empower the women. Hispanic women reported successful breastfeeding experiences because of the encouragement from family and friends.	Level of evidence: C JBI score: 8/10
Tang et al (2014)	To explore the perspective of Hispanic, African–American and White women affected by GDM	23 women diagnosed with GDM, stratified into three racial/ethnic groups: African–American, Hispanic and non-Hispanic white. The participants spoke English or Spanish. Women's hospital in Chicago	**Lack of knowledge:** Participants believed type 2 diabetes was a more severe condition which could lead to blindness or amputation and reduce both their lifespan and quality of life. Women were familiar with type 2 diabetes but had little understanding of GDM prior to diagnosis. As time progressed within the women's pregnancy, they began to minimise the diagnosis of GDM due to perceiving it as common, mild, easy to control and/or temporary. **Responsibility/support** *Perceived benefits of engaging in healthy behaviours:* There were several motivations to improving health behaviours, including avoiding type 2 diabetes, staying healthy to care for their children and serving as a role model to their children. Participants were motivated to change in order to avoid type 2 diabetes; however, they were less motivated about preventing GDM in future pregnancies. **Barriers** *Perceived barriers to engaging in healthy behaviours after delivery:* Although their children were a motivator for behaviour change, they were also a barrier to implementing it. The participants found it to be more important to take care of their newborn or other children than to spend that time on exercise or meal planning.	Level of evidence: C JBI score: 8/10

GDM=gestational diabetes; JBI= Joanna Briggs Institute Critical Appraisal Tool for Qualitative Research.