

Community Reintegration Experiences of Stroke Survivors and their Family Caregivers in Africa: A Qualitative Systematic Review

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Abstract

Objective: To identify, appraise, and synthesize qualitative evidence on community reintegration experiences of stroke survivors and family caregivers in Africa, highlighting key challenges, opportunities, barriers, facilitators, and specific needs.

Introduction: Stroke is a major cause of long-term disability globally, with a growing burden in Africa. Survivors often experience persistent impairments that limit participation in daily life, while family caregivers assume substantial caregiving responsibilities. In many African contexts, community reintegration occurs within under-resourced health systems characterized by limited rehabilitation services, high out-of-pocket expenses, and reliance on informal care. These conditions reflect broader health inequities, including urban-rural disparities, weak financial protection, and gendered caregiving roles. However, qualitative evidence on how these factors shape reintegration experiences remains unsynthesized.

Inclusion Criteria: This review included qualitative studies involving adult stroke survivors aged 18 years or older and their family caregivers in African settings, focusing on lived experiences of community reintegration.

Methods: A comprehensive search of CINAHL, MEDLINE, Embase, Google Scholar, African Index Medicus, and ProQuest Dissertations and Theses Global was conducted from inception to 30 January 2025. No language or publication date restrictions were applied. Two reviewers independently screened, appraised, and synthesized using JBI SUMARI. Methodological quality was assessed using the 10-item JBI critical appraisal checklist. Data were extracted using a standardized JBI extraction tool and synthesized through meta-aggregation. Confidence in the findings was assessed using the ConQual approach.

Results: Twenty-four studies involving 379 participants were included, with overall high methodological quality. Two synthesized findings captured the community reintegration experiences of stroke survivors and caregivers. Reintegration was shaped by structural inequities, including limited access to rehabilitation services, financial barriers, and fragmented care systems. Survivors experienced disrupted livelihoods, reduced social participation, and loss of identity, while caregivers faced substantial emotional, physical, financial burdens, and gendered caregiving expectations. Persistent gaps in health literacy, emotional support, and continuity of care further constrained recovery. Informal support networks, cultural practices, and adaptive coping strategies facilitated reintegration. Survivors expressed a critical need for emotional support, health literacy, and caregiver involvement, while caregivers demanded training, financial assistance, and home-based care.

Conclusion: Community reintegration after stroke in Africa is a multidimensional process shaped by structural inequalities in health systems and caregiving arrangements. Stroke survivors and caregivers navigate a terrain marked by adversity yet imbued with resilience, agency, and hope. Addressing these inequities requires strengthening rehabilitation services, improving financial protection, and supporting caregivers through inclusive, community-based rehabilitation to promote equitable recovery outcomes.

Keywords: Africa; Caregivers; Community Reintegration; Qualitative Systematic Review; Stroke Survivors

Abbreviations

CINAHL: Cumulative Index to Nursing and Allied Health Literature; JBI: Joanna Briggs Institute; MOOSE: Model of Occupational Self-Efficacy; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses; SUMARI: System for the Unified Management of Assessment and Review of Information

Introduction

A stroke refers to the sudden onset of neurological deficit caused by vascular lesions, with symptoms lasting more than 24 hours [1] and leading to brain tissue damage or death, disability, or mortality [2,3]. Stroke survivors experience widespread long-term, life-altering impairments affecting physical, sensory, cognitive, communicative, and emotional functions [2,4]. These long-lasting disabilities significantly impact their daily lives and those of their family caregivers [4,5].

Although stroke caregiving can foster a deepened sense of purpose, emotional closeness between the care recipient and caregiver, and personal growth, [6-8] many caregivers report increased care burdens negatively impacting their emotional, physical, psychological, and financial well-being [6-8]. Following urgent care and rehabilitation for stroke, survivors undergo a process of community reintegration, a crucial phase for sustained recovery and improved quality of life [9].

Community reintegration is a multidimensional construct that describes the process by which stroke survivors and their caregivers resume meaningful roles and activities within their communities [10,11]. Community reintegration experiences refer to the lived subjective realities of stroke survivors and their caregivers as they navigate returning to home and community after hospitalization [12-15]. These experiences encompass challenges, opportunities, barriers, facilitators, and expressed needs of stroke survivors and caregivers during transition to home and community life [16-19].

Stroke survivors and caregivers in many low-resource African settings often face numerous community reintegration difficulties, such as limited rehabilitation services, a shortage of trained health professionals, and inadequate healthcare infrastructure [13-15,20-22]. Such constraints, common in environments lacking sufficient financial, human, and infrastructural resources to support effective health and caregiving, directly hinder the process of community reintegration by restricting access to essential care, prolonging functional impairments, and increasing caregiver burdens [23].

There is a lack of comprehensive understanding of the full spectrum of community reintegration experiences of stroke survivors and caregivers in Africa that limits the development of targeted interventions. Therefore, exploring community reintegration experiences in terms of system challenges and opportunities, as well as individual-level barriers and facilitators, is essential. While barriers and facilitators may also occur at the system level, this review focuses on the individual level to capture the immediate, lived dynamics of reintegration for survivors and caregivers. Identifying specific community reintegration needs in this context can help to inform contextually relevant support strategies and improve outcomes.

A preliminary search in PROSPERO, PubMed, the Cochrane Database of Systematic Reviews, and the Joanna Briggs Institute (JBI) Evidence Synthesis was conducted, and no current or in-progress qualitative systematic reviews on the topic were identified. Hence, this qualitative systematic review aimed to summarize the insights from qualitative evidence regarding the community reintegration experiences of stroke survivors and their caregivers as survivors return home and to the community in Africa.

Review questions

The overarching question was: What are the community reintegration experiences of stroke survivors and their family caregivers in Africa? This review sought to answer three sub-questions: (1) What are the challenges and opportunities of community reintegration for stroke survivors and caregivers? (2) What are the barriers and facilitators of community reintegration for stroke survivors and caregivers? (3) What are the community reintegration needs of stroke survivors and caregivers?

Inclusion and exclusion criteria

Participants

The review focused on studies that included adult (18 years or older) stroke survivors and their caregivers.

Phenomena of interest

The phenomenon of interest was community reintegration experiences, described as the lived, subjective realities of stroke survivors and their caregivers as they navigate returning to home and community after hospitalization [13-15].

Context

The review focused on studies conducted in Africa. Multi-country studies were eligible only if the characteristics and findings of participants from African countries were reported separately. This ensured that the synthesis reflected experiences specific to the African context, without conflating them with data from other regions. Exploring community reintegration experiences of stroke survivors and caregivers within this context offers valuable insights to inform the design of tailored interventions.

Types of studies

This review considered qualitative studies, including phenomenology, grounded theory, ethnography, action research, and other methods generating narrative data [24-26]. Grey literature, theses and dissertations, and non-peer-reviewed publications were included to minimize publication bias and capture a broader range of data and perspectives. No restriction on publication date or language was applied.

Materials and Methods

This systematic review was conducted in accordance with the JBI methodology for systematic reviews of qualitative evidence [27], and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [28]. The protocol was registered in PROSPERO (CRD42025644447), and no amendments were made.

Search strategy

A three-step comprehensive search strategy was devised in consultation with a librarian. First, a limited initial search was conducted in CINAHL, MEDLINE, Embase, Google Scholar, and African Index Medicus to identify articles on the topic, followed by analysis of the words in the titles and abstracts and the index terms used to describe the articles. A second search, using all identified keywords and index terms, was then conducted across all included databases using these search terms: (Community) OR (Community integration) OR (Community reintegration) OR (Community integration Experience) OR (Community reintegration experience) AND (Stroke) OR (Cerebrovascular accident) OR (Stroke care) OR (Stroke rehabilitation) OR (Life after stroke) OR (Post-stroke) OR (Stroke survivor) OR (After stroke) AND (Family) OR (Caregiver) OR (Carer) OR (Family caregiver) AND (Sub-Saharan Africa) OR (Africa). See supplementary file 1 for the full search strategy. Finally, the reference lists of the included studies were screened for additional relevant studies. A study published in French was included [29]. The search for unpublished grey literature included ProQuest Dissertations and Theses Global. All databases were searched from their inception to 30 January 2025.

Study selection

Following the search, all identified studies were exported to EndNote 20.0.0.14672 (Clarivate Analytics, PA, USA), where duplicate records were identified and removed. The remaining studies were then organized and uploaded to the JBI System for the Unified Management of Assessment and Review of Information (SUMARI) [30] for screening and data extraction. Two reviewers conducted a pilot test by independently screening the titles, abstracts, and full texts of 2 papers before a consensus meeting to discuss each study and clarify any eligibility-related doubts or uncertainties. Following the pilot test, the 2 reviewers independently screened studies based on

titles and abstracts. To ensure inclusivity, the French-language study was translated into English using the DeepL translator and reviewed by a bilingual colleague. Eligible studies advanced to full-text review, where they were screened against the inclusion criteria. Full-text studies that did not meet the inclusion criteria were excluded, and reasons for their exclusion are provided in supplementary file 2. Any disagreements between the reviewers at each stage of the selection process were resolved through discussion.

Assessment of methodological quality

Eligible published and unpublished studies were critically appraised for methodological quality by 2 independent reviewers using the standard JBI critical appraisal checklist for qualitative research [27]. The JBI critical appraisal checklist comprises 10 items, each with 4 response options: 'yes' - indicating clear, appropriate, and rigorously described research elements, enhancing credibility and relevance; 'no' - indicating vague, inappropriate, or poorly explained research elements, reducing trustworthiness and applicability; 'unclear' - indicating an element of the research is not explicitly stated or insufficiently described or ambiguously reported, making its quality or relevance difficult to assess; and 'not applicable' - indicating that a particular criterion does not apply or is irrelevant to the specific research element. Studies were categorized into low quality, having less than 6 'yes' responses, medium quality, 6 to 7 'yes' responses, and high quality, 8 or more 'yes' responses out of a possible 10 [31,32]. Any disagreements between the reviewers were resolved through discussion. Data were extracted from medium and high-quality studies [31,32]. Critical appraisal results are reported in narrative and tabular formats.

Data extraction

Data were extracted from included studies by the 2 independent reviewers using a standardized data extraction tool from JBI SUMARI [27,33]. Before data extraction, the 2 reviewers independently conducted a pilot test of the data extraction checklist on a random sample of 2 studies [34,35] to reduce errors and ensure clarity, comprehensiveness, data consistency, and accuracy. As shown in supplementary file 3, the extracted data included: i) study details (author(s), publication title, source, year, geographical location of study, study methods, sample size), ii) phenomena of interest relevant to the review questions, iii) setting/context/culture, iv) participant characteristics, and v) description of the main results. Findings and their verbatim illustrations were extracted and assigned credibility levels. In meta-aggregation, a finding is a verbatim extract of the author's analytic interpretation of their data [27]. Although the authors of the primary studies presented results at various levels, such as themes, subthemes, or standalone findings, the reviewers agreed that organizing the data by themes during extraction would best capture and represent the core phenomenon of interest in this review. To ensure consistency, findings were extracted at the same thematic level across all studies. The authors' verbatim words from the included studies were extracted precisely as written, without editing. Meta-aggregation also requires reviewers to extract only a single illustrative excerpt to support a specific finding from the authors. Verbatim illustrations include direct participant quotes. Findings and their verbatim illustrations were extracted verbatim and assigned a level of credibility. Supplementary file 4 shows a list of studies, findings, and illustrative quotes.

Reviewer reflexivity was maintained by the acknowledgement of their positionality as external reviewers and by preserving the integrity of participants' voices and local meanings, thereby supporting a nuanced synthesis. Both reviewers engaged in regular calibration to resolve discrepancies and ensure consistency, while a transparent audit trail documented all decisions and procedural adjustments. Any disagreements were resolved through discussion between the reviewers.

Data synthesis

Qualitative findings were pooled using JBI SUMARI with a meta-aggregation approach, which synthesizes findings into aggregated statements by assembling them and categorizing them according to similarity in meaning [27]. To guide the synthesis, findings were classified into 5 categories: challenges, opportunities, barriers, facilitators, and expressed needs. Challenges are systemic or contextual factors that constrain reintegration, whereas opportunities are broader enablers, such as community-based programs or supportive policies. Barriers denote immediate personal obstacles, such as mobility limitations, financial hardship, and stigma, whereas facilitators denote personal or relational supports, for instance, family caregiving, adaptive coping, and peer support. For clarity, this review distinguishes between system-level influences (challenges and opportunities) [36,37], and individual-level experiences (barriers and facilitators) [38-40], while recognizing that these may intersect. These categories were then synthesized to produce a comprehensive

set of findings that can serve as a basis for evidence-based practice. Data were rated using 3 scales. Unequivocal findings include clear illustrations that are not open to challenge. Credible findings have illustrations that lack a clear association and are open to challenge. Not-supported findings do not meet unequivocal or credible standards and are unsupported by data [41,42]. The data synthesis included unequivocal and credible findings. A narrative report is presented, supported by tables that illustrate the study characteristics, synthesized findings, supporting categories, and quality assessment results.

Assessing confidence in the findings

The final synthesized findings were graded according to the ConQual approach for establishing confidence in the output of a qualitative research synthesis and presented in a summary of findings [43]. Based on the dependability and credibility of individual findings, confidence rankings ranged from high to very low. Dependability was ranked as follows: findings were unchanged with 4-5 ‘yes’ responses, downgraded by 1 level (-1) with 2-3 ‘yes’ responses and downgraded by 2 levels (-2) with 0-1 ‘yes’ responses. For credibility ranking, the synthesized findings that contained only unequivocal findings remained unchanged [43]. Findings with a mix of unequivocal and credible findings were downgraded by 1 level (-1). Findings composed entirely of credible content were downgraded with 2 levels (-2). Findings with a mix of credible and unsupported content were downgraded by 3 levels (-3). Findings that were not supported were downgraded by 4 levels (-4). The title, participants, phenomena of interest, and the review’s context are also included [43]. Each synthesized finding from the review is presented along with the type of research that informs it, the dependability and credibility scores, and the overall ConQual score [27,41,42,44].

Results

Study inclusion

A total of 3251 studies were retrieved. After removing 1206 duplicates, the title and abstract of 2045 studies were screened. From these, 47 studies advanced to full-text review, and 24 studies met the inclusion criteria [8,34,35,45-65]. The study selection process is shown in figure 1 [28]. Studies were excluded because of an ineligible phenomenon of interest (18, 78%) [66-83], ineligible context (3, 13%) [84-86], ineligible population (1, 4%) [87], or duplication 1 (4%) [52]. Supplementary file 2 shows a list of ineligible studies excluded at full-text review.

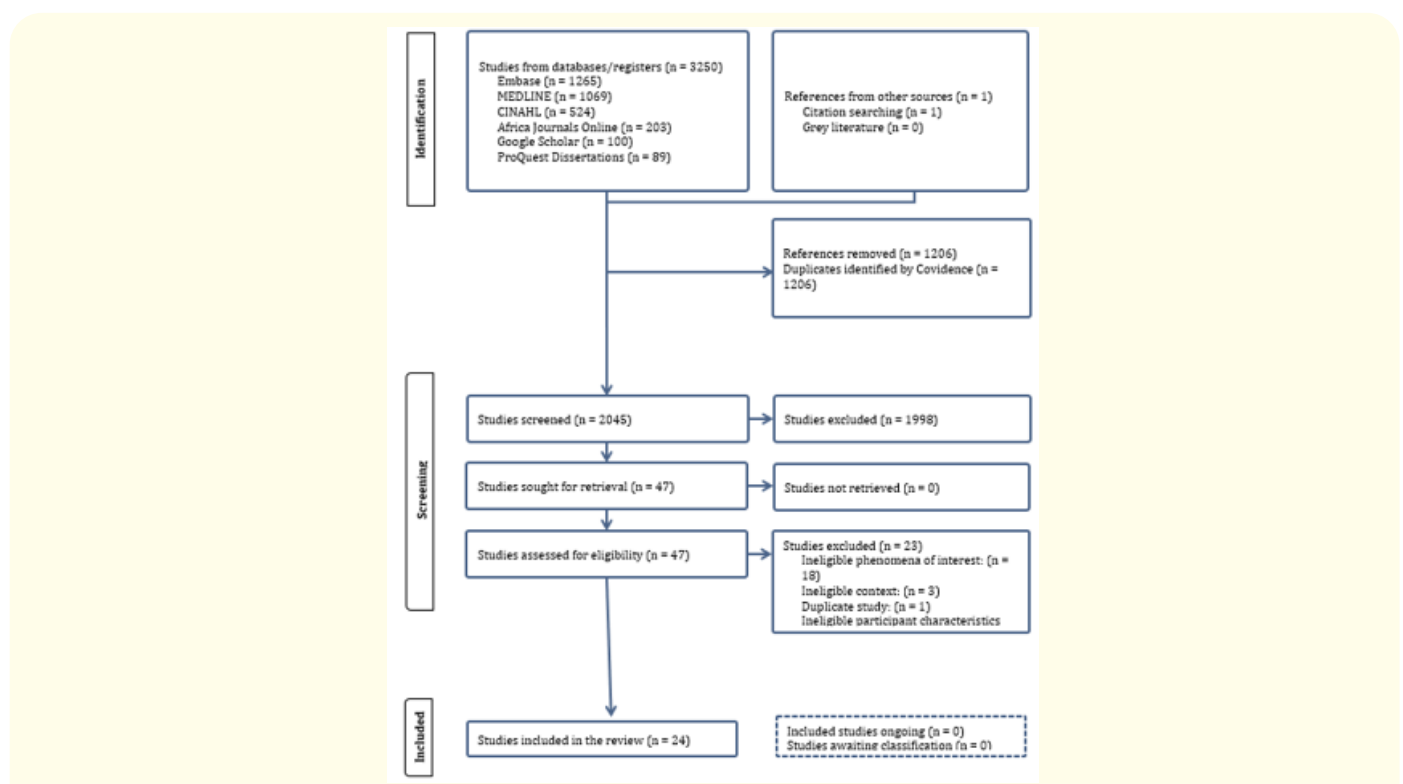


Figure 1: The PRISMA flow chart shows search results, study selection and inclusion process.

Methodological quality

The quality assessment score revealed high quality. See table 1 for detailed critical appraisal results of eligible studies. Of the 24 included studies, (11, 46%) scored 8 out of 10 on the JBI checklist [34,45,47,51-58]; (6, 25%) scored 9 [46,50,59,61,62,64]; (5, 21%) scored 10 [8,35,49,60,63], and (2, 8%) scored 7 [48,65]. Notably, (10, 42%) studies omitted explicit cultural or theoretical positioning, and (8, 33%) failed to articulate the reciprocal influence between researchers and participants.

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
De Witt., <i>et al.</i> 2024 [34]	Y	Y	Y	Y	Y	U	U	Y	Y	Y
Gawulayo., <i>et al.</i> 2021 [46]	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Gertrude., <i>et al.</i> 2019 [48]	U	Y	Y	Y	Y	N	U	Y	Y	Y
Govender., <i>et al.</i> 2019 [47]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Kamwesiga., <i>et al.</i> 2017 [50]	Y	Y	Y	Y	Y	Y	U	Y	Y	Y
Kamwesiga., <i>et al.</i> 2023 [49]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Khondowe., <i>et al.</i> 2007 [51]	Y	Y	Y	Y	Y	U	N	Y	Y	Y
Khuabi., <i>et al.</i> 2020 [52]	Y	Y	Y	Y	Y	Y	N	Y	U	Y
Lindner 2022 [35]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Makganye 2015 [8]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Maleka., <i>et al.</i> 2012 [53]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Masuku., <i>et al.</i> 2018 [54]	Y	Y	Y	Y	Y	U	N	Y	Y	Y
Mohotlhoane and Nematikanga 2023 [55]	Y	Y	Y	Y	Y	U	N	Y	Y	Y
Ogunlana., <i>et al.</i> 2023 [56]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Opoku., <i>et al.</i> 2020 [57]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Persson., <i>et al.</i> 2024 [58]	Y	Y	Y	Y	Y	U	U	Y	Y	Y
Sanuade., <i>et al.</i> 2021 [59]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Scheffler and Mash 2020 [60]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shewangizaw., <i>et al.</i> 2023 [45]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Smythe., <i>et al.</i> 2022 [61]	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
Soeker and Olaoye 2017 [62]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Soeker., <i>et al.</i> 2024 [63]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tchokote 2020 [64]	Y	Y	Y	Y	Y	Y	Y	Y	U	Y
Timm., <i>et al.</i> 2023 [65]	U	Y	Y	Y	Y	N	U	Y	Y	Y
Total %	92	100	100	100	100	42	33	100	92	100

Table 1: JBI critical appraisal results of eligible studies.

Q: question; Y: Yes; N: No; U: Unclear.

Q1 = Is there congruity between the stated philosophical perspective and the research methodology?

Q2 = Is there congruity between the research methodology and the research question or objectives?

Q3 = Is there congruity between the research methodology and the methods used to collect data?

Q4 = Is there congruity between the research methodology and the representation and analysis of data?

Q5 = Is there congruity between the research methodology and the interpretation of results?

Q6 = Is there a statement locating the researcher culturally or theoretically?

Q7 = Is the influence of the researcher on the research, and vice-versa, addressed?

Q8 = Are participants, and their voices, adequately represented?

Q9 = Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body?

Q10 = Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Characteristics of included studies

Supplementary file 3 shows the characteristics of the included studies. The studies consisted of (21, 88%) journal articles, 1 book chapter (4%) [52], and (2, 8%) theses [8,35], with a total of 379 participants. All studies took place in Sub-Saharan Africa between 2007 [51] and 2024 [34,58,63]. Half of the studies were conducted in South Africa [8,34,35,46,47,52-55,60,61,63,64]. Ghana [57-59] and Uganda [48,50,65] each contributed 3 studies (13%). Nigeria contributed 2 studies (8%) [56,62], while Ethiopia [45], Kenya [49], Cameroon [64], and Zambia [51] each contributed 1 study (4%). Fifty percent of the studies focused only on stroke survivors [34,35,47,49,53,55-58,61,63,65], one quarter examined both stroke survivors and caregivers [8,45,50,59,60,62], and the remainder focused solely on caregivers [46,48,51,52,54,64]. Half of the studies were conducted in urban or semi-urban contexts, such as cities or metropolitan regions [54,57,58]. About one-third of the studies (7, 29%) took place in semi-urban and rural settings [53], while 5 studies (21%) were set in mixed environments, including hospitals and clinical settings. The data collection methods were interviews (22, 92%) [8,34,35,45-59,61,63-65], and focus groups (2, 8%) [60,62].

Review findings

Table 2 summarizes the meta-aggregative results. This review identified 2 major synthesized findings on the lived experiences of community reintegration among stroke survivors and caregivers in Africa. These findings emerged from 24 qualitative studies, were supported by 104 individual findings and participant quotes, and produced 10 categories that reflect the complex interplay of system-level influences (challenges and opportunities) [36,37], and individual-level experiences (barriers and facilitators) [38-40], and expressed needs [88,89], shaping the transition from hospital to home and community life after stroke.

Synthesized findings	Supporting categories	Individual findings
Synthesized finding 1: Stroke survivors in Africa faced structural challenges and personal barriers to reintegration, yet they are supported by cultural values and emerging opportunities, highlighting the need for holistic, context-specific reintegration approaches.	Challenges	4
	Opportunities	1
	Barriers	40
	Facilitators	16
	Needs	3
Synthesized finding 2: Caregivers experienced complex challenges and needs, but they relied on informal supports and personal resilience to navigate community reintegration.	Challenges	2
	Opportunities	0
	Barriers	19
	Facilitators	13
	Needs	6

Table 2: Meta-aggregation synthesis of findings.

Synthesized finding 1

Stroke survivors in Africa face structural challenges and personal barriers to reintegration; however, they are supported by cultural values and emerging opportunities, highlighting the need for holistic, context-sensitive approaches

This synthesized finding draws on 64 unequivocal findings from 20 studies, organized into 5 categories: challenges, opportunities, barriers, facilitators, and needs. Stroke survivors in Africa navigate multifaceted experiences shaped by personal circumstances, social dynamics, and healthcare systems.

Category 1: Challenges of community reintegration for stroke survivors

Four studies identified challenges of community reintegration for stroke survivors, based on 4 unequivocal individual findings [47,55,58,62]. These challenges include limited rehabilitation services, environmental constraints, and disruptions to employment.

Limited access to rehabilitation and healthcare services hindered recovery and preparedness for returning to occupational roles. Many reported difficulties resuming their pre-stroke occupational roles. A 69 years old female survivor explained, “*Right now, I don’t go [to the clinic and hospital] as frequent[ly] as before. I can’t go; it is far and there is no one to take me*” (p.5) [47]. Limited transportation and a lack of tangible support disrupted the continuity of care, further constraining the survivor’s ability to rebuild the functional capacity necessary for occupational reintegration [47].

Employment-related challenges also reflected broader structural barriers. Another survivor described, “*If one is working in a private establishment, to stop work will be a difficult thing, they will dismiss one because what they are after is productivity level*” (p.602) [62]. This quote illustrates the employment insecurity and discrimination survivors face in private-sector settings, where productivity expectations often lead to job loss after a stroke [58]. Collectively, this reflection underscores a key challenge to reintegration: the loss of occupational roles due to rigid workplace expectations and limited accommodation for disability, highlighting the socioeconomic vulnerability of survivors in contexts with inadequate employment protections and inclusive labour policies [62].

Category 2: Opportunities of community reintegration for stroke survivors

One study identified an unequivocal finding that highlights the potential for community reintegration among stroke survivors [62]. The analysis revealed the presence of rehabilitation and social support systems that, when tailored to local rural contexts, create meaningful opportunities for successful reintegration [62]. Rehabilitation intervention programs, such as the Model of Occupational Self-Efficacy (MOOSE), were particularly influential in facilitating the recovery of occupational identity and purpose, thereby enabling survivors to gradually regain functional independence. MOOSE is a client-centred framework designed to support stroke survivors in regaining confidence, functional ability, and participation in work and community life [63]. The framework progresses through 4 stages: developing belief in functional ability, gaining control over life circumstances, building competence through occupational engagement, and achieving independent capability [63].

In line with this finding, a stroke survivor remarked: *The rehabilitation people helped me, their contribution is vital because they are the ones that really make one resume back to work, because like me, they engaged me and also direct me in doing different exercises so they quicken my recovery and this helped me to resume at work* (p. 603) [62].

This quote highlights the importance of targeted rehabilitation in facilitating functional recovery and work resumption, demonstrating how structured support can create tangible opportunities for reintegration for stroke survivors [62].

Another stroke survivor added to the premise: *I had to tell you what I like, so that you can make me feel included. I was very nervous when I came there, (laughs), uhm, we did also or wait you did ask me what I do for a living like my work and so on. You (occupational therapist) helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better. I don’t feel like that anymore* (p. 347) [63].

This quote illustrates how personalized, supportive rehabilitation approaches can foster a sense of inclusion, restore confidence, and promote gradual functional improvement, thereby enhancing opportunities for community reintegration [63].

Category 3: Barriers to community reintegration for stroke survivors

Fifteen studies identified barriers to community reintegration for stroke survivors, drawing 40 unequivocal individual findings [8,34,35,45,47,49,53,55-59,61,62,65]. Survivors reported that physical, psychological, financial, and social isolation hindered their

reintegration. Reduced mobility, loss of autonomy and identity, dependence on caregivers, and economic constraints were recurring issues.

Physical impairments were particularly prominent. One survivor described: *When I had my stroke, I could not do anything. I could not walk or talk. Even now, the only thing that has improved is my speech. I am still wheelchair-bound. My waist and legs are the most affected areas. The stroke has affected my balance and mobility. I can walk a bit but I don't have balance, hence I use a wheelchair. My speech was slurred at first, but because I am attending speech therapy it is a bit better. I have pain all over my body, but mostly in my hand* (p. 70) [8].

Another participant added, *"Sometimes I fear going out on my own because I think I will be stuck, and I am not able to get back home"* (p. 96) [55].

Together, these accounts reflect a commonly shared experience of physical barriers among stroke survivors. Impairments such as reduced mobility, pain, and balance issues act as significant physical and psychological barriers that limit autonomy and restrict community participation.

Beyond the physical limitations, many survivors expressed a sense of grief over lost roles and opportunities. These emotional barriers were compounded by health system challenges, including limited access to care, out-of-pocket costs, and stigma. Cultural beliefs and low health literacy further shaped survivors' care-seeking behaviours. One participant explained: *"Before the stroke, [as my work] I was part of a team that used to go to the community and help people in need ... But now I [can] only do paperwork and give out medication"* (p.3) [47]. This quote illustrates a profound shift in occupational role and sense of purpose following stroke. Physical and functional limitations reduced the survivor's ability to engage in meaningful, community-based work, confining the survivor to less interactive tasks. This perceived loss of active contribution underscores the emotional and identity-related impact of stroke, revealing how diminished capacity can hinder reintegration into pre-stroke roles and valued social functions.

Category 4: Facilitators to community reintegration for stroke survivors

Eleven studies identified facilitators to community reintegration for stroke survivors based on 16 unequivocal individual findings [8,34,35,45,47,49,50,56,57,63,65]. These facilitators include strong social connections and a sense of belonging, spiritual and cultural beliefs, adaptive coping mechanisms, and meaningful participation in daily routines. Survivors who engaged in community or family life expressed a renewed sense of identity and connection.

To illustrate the role of social support, one survivor shared: *I used to share good moments with friends before I had a stroke. Now I am limited in many ways and people do not have much time to come here and talk. I use my phone to reach them and we communicate and after that I feel very good, I get more energy to do more exercises and feel inside myself that my life is coming back. I think communication is powerful. I am only limited by airtime on the phone; otherwise, I would go on and on* (p. 5) [50].

This account demonstrates that maintaining social connections, including phone communication, serves as a powerful facilitator of community reintegration. Accessible communication technologies help reduce isolation and promote overall well-being and engagement in recovery activities.

Coping strategies, resilience, and psychological adjustment also emerged as key enablers of reintegration after a stroke. In support of this category, a participant reflected: *I am just praying to God that he will take me out of it . . . with the encouragement from my fellow Christians . . . with the help of the bible, I really got this courage to keep trusting in Jehovah than ever* (p. 1791) [57].

This quote highlights the central role of spirituality and religious faith in fostering emotional resilience and psychological adjustment after stroke. Many survivors draw strength from prayer, encouragement from fellow believers, and inspiration from religious texts to help

sustain their hope and perseverance. Faith-based support can be a powerful facilitator of community reintegration by promoting inner strength and a positive outlook in the face of post-stroke challenges [57].

Category 5: Community reintegration needs of stroke survivors

Two studies identified community reintegration needs of stroke survivors through 3 unequivocal individual findings [60,61]. These needs include emotional support, improved communication with healthcare providers, and guidance for navigating healthcare services. Survivors emphasized the importance of caregiver support, resilience-building, and tailored information to enhance self-management.

The need for emotional support was particularly evident. One of the stroke survivors shared, *"I'm used to do my own work. I am used to looking after myself. I cannot handle this. It is very difficult."* (p. 6) [60].

This reflection shows the emotional struggle of stroke survivors adjusting to a loss of independence and highlights the central role of emotional support during reintegration. The ongoing stress and vulnerability experienced during adaptation to post-stroke life underscore the importance of sustained emotional and psychological assistance.

Survivors also stressed the need for supportive and responsive care from healthcare providers and caregiver support. One participant recounted: *I couldn't walk to the toilet. I lay there and wet myself. I lay there for a long time - wet. I asked for someone to come help me, and then they walked out of the ward...they are not competent to do that type of work* (p. 7) [61].

This account highlights the survivor's need for respectful, dignified care and emphasizes the importance of a supportive relationship between healthcare providers and users. The lack of assistance and compassion reflects a failure in care satisfaction and reinforces the need for effective communication and empathic caregiving to build resilience and enable meaningful engagement in the reintegration process.

The need for clear information and communication also emerged as a key theme.

Another survivor explained: *I think you need to prepare your kids to understand better and not panic when something happens... I'm not that old, but still, these things are happening, and they also need to know about it. We need to educate them about these kinds of things* (p. 8) [61].

This quote underscores the importance of providing survivors and their families with accessible information to enhance understanding and preparedness. Education and communication can strengthen caregiver support, bolster survivors' resilience, and improve their ability to participate in community and family life during reintegration and beyond.

Synthesized finding 2

Caregivers experienced complex challenges and needs, but they relied on informal supports and personal resilience to navigate community reintegration

This synthesized finding draws on 38 individual findings, 35 equivocal and three credible ones, from 10 studies, organized into 5 categories: challenges, opportunities, barriers, facilitators, and needs [8,45,46,48,50,52,54,60,64]. Caregiver experiences often mirrored those of stroke survivors but also revealed unique burdens and adaptive processes.

Category 1: Challenges of community reintegration for caregivers

Two studies identified challenges of community reintegration for caregivers through 2 unequivocal findings [54,60]. These challenges are the feminization of caregiving, where women disproportionately assume caregiving responsibilities without adequate support, and

the organization of rehabilitation services, including how rehabilitation care is delivered, the consistency of providers, and integration across settings.

One caregiver explained: *My father-in-law came to live with us because my husband is the firstborn, and being the daughter-in-law, I have to take care of him. Remember, in our culture, you marry the whole family. I was working full-time, but I have had to take part-time employment so that I can spend some time to care for him. Yoh [exclamation], it's not easy* (p. 5) [54].

This quote illustrates how caregiving responsibilities are often assigned to women, reflecting a cultural norm that positions women as primary caregivers regardless of their personal or professional commitments. These expectations, combined with limited formal support, substantial caregiving burden on women and complicate community reintegration for both caregivers and stroke survivors.

Challenges also emerged regarding the organization and delivery of rehabilitation services.

One caregiver shared: *Now, just give us our own little team. I've had them before at home. If we can only get them. ... This week, it is this team. Next week you see new faces. If you think you just get used to one and you can share secrets ... then you look into a new face!* (p. 7) [60].

Another caregiver added. *"Hello! I'm so and so. And all those things. No! We know they [CHWs] are here in [ward]. They know our backgrounds. Teach them about our needs"* (p. 7) [60].

These accounts highlight caregivers' frustration with inconsistent and fragmented rehabilitation services. Caregivers express desire for dedicated, familiar care team, noting that frequent changes in providers undermine trust, continuity, and personalized care. Caregivers also emphasized the value of community-rooted support, suggesting that local community health workers could be more effective with adequate training. Collectively, these reflections reveal how systemic service issues increase caregiver burden and make the reintegration process more stressful and less effective.

Category 2: Opportunities for community reintegration for caregivers

No eligible study provided sufficient data on caregivers' opportunities for community reintegration, indicating an absence of evidence in this category. This gap highlights the limited attention given to enabling factors that support caregivers during the reintegration process.

Category 3: Barriers to community reintegration for caregivers

Seven studies identified barriers to community reintegration among caregivers across 19 individual findings: 18 unequivocal and 1 credible [8,45,46,48,52,54,64]. These studies reported a wide range of barriers, including emotional distress, financial strains, and changes in social roles. Caregivers frequently experienced burnout, role overload, and limited professional support. Many described profound disruptions in their personal and family lives, exacerbated by poor communication and systemic limitations within healthcare resources.

Emotional burden and burnout emerged as the most pervasive barriers for caregivers. Caregivers commonly reported frustration, emotional exhaustion, grief, feelings of unpreparedness, and a mismatch between their expectations and the reality of caregiving. One caregiver explained: *"For me, staying with someone who has had a stroke is emotionally draining because I have to deal with his irritability, being reprimanded for no particular reason and the expectation that I must always be with him"* (p.103) [8].

Financial strain was another recurring barrier, often linked to loss of income, high treatment costs, and employment insecurity.

A caregiver described financial strain as: *Things are really tough. My husband used to earn R800 per week when he was still employed. He also used to do piecework fixing machines for the community, earning +- R1 000 per week. Since the stroke he now receives the disability grant and does not receive the full amount because I earn more than R4 000. Things are a bit tough. I might lose my job because I always take*

time off to attend to him and to go to all the offices that want to have sessions with us. I am not sure how are we going to survive if I lose my job (p.79) [8].

These accounts illustrate how caregiving responsibilities generate emotional exhaustion and economic vulnerability, both of which constrain caregivers' ability to reintegrate socially and economically while simultaneously supporting survivors' recovery.

Category 4: Facilitators to community reintegration for caregivers

Eight studies identified facilitators to community reintegration for caregivers through 13 individual findings, 11 unequivocal and 2 credible [8,45,48,50,52,54,60,64]. These facilitators incorporated coping strategies, social support, emotional resilience, and structured routines. Many caregivers also reported finding renewed purpose and identity through caregiving.

Post-stroke coping strategies were widely echoed across the literature [8,48,64], emphasizing acceptance, emotional adjustment, hope, and resilience in the face of caregiving challenges [8,48,64].

One caregiver reflected: *I cannot say we are coping because we have long passed the stage of coping. To be honest, now we are fine, and I think the worst is over. The days when we were stressed are over now. I know my mom's speech and her movement are not yet completely sharp, but we are hopeful that she will get better. What motivates me is that she still attends treatment and she is positive that her health will be back to normal. I am also happy that she appreciates everything that is being done for her and she is not stressed by anything* (p. 105) [8].

This account illustrates how emotional acceptance, optimism, and mutual appreciation between caregivers and survivors foster resilience and ease the demands of caregiving. The shift from initial stress to hope and adaptation demonstrates how sustained treatment, survivors' positive attitude, and family support can facilitate caregivers' reintegration into community life.

Social support also emerged as a key facilitator. Caregivers frequently cited the importance of social networks, neighbours, and family members who shared caregiving responsibilities and provided practical assistance.

One caregiver explained: *Our neighbours and family have also given us support, like one neighbour gave us her daughter to take care of our home, and she looks after the children. She is the one who keeps the home tidy and clean, she cooks. While also this patient's friends keep on giving us some money. and buy food and put it at home to sustain the children* (p. 1554) [48].

This quote highlights how collective support, through shared caregiving, household assistance, and financial support, can buffer the pressures of caregiving and strengthen caregivers' capacity to remain engaged in community and family life.

Category 5: Community reintegration needs for caregivers

Two studies identified community reintegration needs among caregivers through 6 unequivocal individual findings [51,60]. These needs include information and education about stroke [51,60], practical help with caregiving [51], home-based care services [51] and financial support [51].

Caregivers frequently emphasized the need for clear, accessible information and education about stroke. One daughter explained: *"I don't think I have enough information about stroke... very little. The doctors have tried to give me whatever they think is adequate but some information is still lacking"* (p.15) [51].

Similarly, a wife reported: *At discharge not enough information was given to me about what I was going to do with the stroke patient at home. I need information to help in rehabilitation of the patient on how to deal with his moods at home* (p.15) [51].

These accounts highlight caregivers' strong need for practical, tailored education on managing stroke-related challenges at home, including rehabilitation tasks and emotional support. Without adequate information, caregivers' confidence and capacity to provide effective care are significantly undermined.

Caregivers also described feeling isolated, overwhelmed, and unsupported in their roles. Many stressed the need for practical assistance to balance caregiving with other responsibilities and to allow for essential breaks. One caregiver noted: *"I need a person to help me so that I am not alone helping the sick person"* (p.16) [51]. Another added: *"I need someone to help in caring. Sometimes I need to do some other things but cannot because if I do then no one will remain with the patient"* (p.16) [51]. These reflections underscore the importance of respite, shared caregiving, and accessible home-based support services to reduce caregiver burden and promote reintegration.

Financial pressures remained a significant barrier for caregivers, who struggled to balance household income, healthcare expenses, and time demands. These barriers underscored the need for financial assistance, covering expenses, or subsidized care. One caregiver explained: *"It is difficult to cope with financial needs, especially that I have children to take to school and the health costs to take care of"* (p.15) [51]. Another caregiver added: *"I spend too much money for him, about five million kwacha a month ... I have a job and need much time"* (p.15) [51]. These accounts highlight the need for financial assistance or subsidized care to alleviate economic strains and support caregivers' ability to sustain their caregiving role while maintaining household stability.

Discussion

This qualitative systematic review aimed to synthesize qualitative evidence on the lived experiences of community reintegration among stroke survivors and their caregivers in Africa, with the goal of identifying system- and individual-level factors that influence this process. Meta-aggregation revealed two synthesized findings, each classified into 5 categories: community reintegration challenges, opportunities, barriers, facilitators, and needs. The review reveals a layered, culturally embedded narrative of post-stroke community reintegration, showing how stroke survivors and caregivers in low-resource settings navigate multifaceted sociocultural, economic, and systemic constraints and possibilities. This discussion situates the findings within the broader literature, considers their implications, and examines the methodological strengths and limitations of the review.

The findings align with global evidence showing that stroke survivors face substantial challenges in community reintegration, including physical impairments, emotional distress, and socioeconomic hardships [90-92]. The review reinforces the synthesized findings in the African context and extends the literature by highlighting how cultural norms, health system gaps, and geographic and economic barriers uniquely shape the community reintegration experiences of stroke survivors and caregivers in Sub-Saharan Africa. For instance, the burden of caregiving disproportionately falls on the shoulders of women due to cultural expectations [54], extending gendered critiques of caregiving roles in stroke literature [93]. Women are often positioned as default caregivers, irrespective of their own socioeconomic status, employment, or personal aspirations. This not only reinforces traditional gender hierarchies but also places women at heightened risk of economic insecurity, emotional burnout, and social isolation. In stroke care, the expectation that daughters, wives, or daughters-in-law will assume full caregiving responsibilities mirrors global evidence that women bear a disproportionate share of unpaid care work [94]. However, in resource-constrained contexts, the absence of formal support structures exacerbates these inequalities, magnifying the invisible labour that women provide and constraining their ability to pursue educational, employment, or self-care opportunities. Thus, the finding broadens gendered critiques by linking caregiving burdens to systemic neglect and cultural norms that, together, deepen women's marginalization.

The review challenges dominant assumptions in global stroke discourse, which often emphasize biomedical and formalized rehabilitation pathways. In contrast, the African experiences captured here emphasized the centrality of informal, community-embedded resources and coping mechanisms [95]. The global discourse often underappreciates culturally specific enablers, such as faith-based

support or extended family caregiving, which are essential for reintegration in low-resource settings [50,63]. Furthermore, while global frameworks often assume the availability of a coordinated rehabilitation care team, participants in the included studies reported receiving fragmented and inconsistent rehabilitation care [60], underscoring the need for more locally adapted, culturally sensitive, and community-driven models of care [95]. Therefore, the findings both affirm and advance the existing knowledge base by demonstrating how broader system-level factors, challenges and opportunities, and individual-level factors, barriers and facilitators, and expressed needs interact to shape reintegration experiences. The results also highlight how survivors and caregivers draw on coping strategies, spiritual resources, and social networks to rebuild meaning and function amid adversity [96]. This insight challenges one-size-fits-all models of post-stroke care, underscoring the need for more culturally responsive and contextually grounded rehabilitation approaches.

This review reveals that stroke survivors and caregivers in Africa face a complex interplay of system-level challenges and opportunities and individual-level barriers and facilitators, and specific needs that shape their reintegration into community life. These intersecting factors carry significant implications for health policy, community programming, and rehabilitation practice.

The healthcare system needs to prioritize integrating community-based rehabilitation and long-term care into existing stroke care pathways [23,97], as many survivors lack continuous access to services due to infrastructure and workforce shortages, particularly in rural settings [47,60,98,99]. Health policies that support mobile rehabilitation services, tele-rehabilitation, and training of community health workers with stroke-specific competencies are essential and must be culturally tailored to local contexts. Rehabilitation programs need to be reoriented towards functional reintegration goals, including returning to work, engaging in social activities, and regaining autonomy.

Programs such as MOOSE exemplify how rehabilitation can move beyond biomedical recovery to address the functional reintegration needs of survivors. MOOSE is a structured, client-centred program designed to rebuild occupational identity, self-efficacy, and independence after stroke [63]. Delivered over eight weeks with biweekly sessions, it combines psychological and vocational components to promote work-like behaviours, such as punctuality, productivity, and adaptive coping, in real-life contexts. Importantly, MOOSE targets barriers such as stigma, a lack of workplace support, and negative self-perceptions, which are often overlooked in conversational programs. Evidence shows that MOOSE enables survivors to re-establish a sense of capability and successful return to competitive employment, even in rural or resource-limited environments [63]. This demonstrates the value of integrating occupation-based interventions into post-stroke care, aligning with calls to reorient rehabilitation towards functional reintegration goals such as returning to work, engaging socially, and regaining autonomy. By embedding such models into multidisciplinary teams and ensuring continuity of care post-discharge, survivors are better supported to reduce care dependency, rebuild meaningful roles, and improve long-term quality of life. MOOSE therefore underscores the importance of culturally adaptable, holistic rehabilitation approaches in Africa.

Caregivers need further highlight the urgency of rehabilitation policy reform. Caregivers require emotional, informational, and practical support [8,51], and rehabilitation policy should formally include structured caregiver training, home-based therapy services, and respite care to mitigate burnout and enhance caregiving capacity [100]. Moreover, addressing the gendered burden of caregiving through financial subsidies and more flexible workplace policies is equally critical. Policymakers should invest in community awareness and health literacy initiatives to dismantle stigma, improve stroke knowledge, and promote early help-seeking behaviour. Public education can empower families in navigating services more effectively and reinforce community reintegration supports. Hence, this review advocates for an integrative model of stroke rehabilitation that extends beyond clinical recovery to encompass the social, emotional, and economic dimensions of reintegration, particularly in low-resource settings in Africa. Addressing these priorities can improve health outcomes, reduce long-term disability, and elevate the quality of life of both stroke survivors and their caregivers.

Strengths of the Study

This review demonstrates the methodological strengths of the JBI meta-aggregative approach, which is particularly well-suited to synthesizing culturally embedded, methodologically diverse qualitative data across African contexts [27,41,42]. The systematic search

strategy, adherence to PRISMA guidelines, and critical appraisal using the JBI checklist enhanced the transparency and rigour of this review [101].

Limitations of the Study

First, despite employing a comprehensive search strategy, some relevant studies may still have been missed [102]. Second, while the meta-aggregative approach preserves study integrity, it may obscure nuanced, context-specific interpretations, particularly at the macro level, such as the influences of political economy, governance, and global health policy on stroke care and reintegration. Third, there was an uneven distribution across the ten analytical categories. Barriers were extensively explored in stroke survivors, whereas opportunities and needs were notably underrepresented, especially in caregiver-focused studies. For example, no eligible study provided sufficient data on caregivers' opportunities, highlighting a clear evidence gap. Future research should therefore address these unexplored domains of community reintegration, incorporating perspectives from both survivors and caregivers to achieve a more balanced understanding. Fourth, geographical representation was limited, with most studies conducted in southern and eastern Africa and little or no representation from the northern, western, and central regions. This geographic skew limits the generalizability of the findings across diverse linguistic, cultural, and health systems contexts on the continent. Expanding research to underrepresented regions would strengthen the evidence base. Finally, the included studies varied in epistemological approaches, participant demographics, methodological rigour, and analytical approaches. For instance, many studies lacked theoretical frameworks (42%) or reflexivity (33%), which complicated synthesis and reduced transparency.

Conclusion

Community reintegration following stroke in Africa is a complex and multidimensional process shaped by structural inequalities, cultural frameworks, and relational dynamics. Stroke survivors and caregivers navigate a terrain marked by adversity yet sustained by resilience, agency, and hope.

Effective support for stroke survivors and caregivers must extend beyond hospital settings by integrating community-based rehabilitation, structured caregiver training, and coordinated health and social services. Such an approach is essential for enabling sustainable and equitable community reintegration across diverse African contexts. Future research should examine still unexplored dimensions of post-stroke community reintegration and systematically investigate survivors' and caregivers' needs and opportunities across different settings. Expanding geographic representation, particularly from underrepresented regions, will strengthen the evidence base and inform more contextually relevant, continent-wide rehabilitation strategies.

Acknowledgements

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Conflict of Interest

The authors declared no conflict of interest.

Protocol Registration

The protocol for this review is published in PROSPERO and can be accessed at <https://www.crd.york.ac.uk/PROSPERO/view/CRD42025644447>.

Data Availability

All data generated and analytic codes are available in the Supplementary File attached to this document.

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Author Contributions

AAM conceptualized the study, designed the methodology, curated the data, conducted formal analysis, investigated and wrote the original manuscript. ALM curated the data. AF supervised the review. All authors reviewed and approved the manuscript.

Supplementary Files

Supplementary File 1: Full search strategy

CINAHL search conducted on 30 January 2025		
Search	Query	Records retrieved
S17	S5 AND S9 AND S16	524
S16	S10 OR S11 OR S12 OR S13 OR S14 OR S15	580,615
S15	(TI (family or families or wife* or husband* or spouse* or sibling* or “adult child*” or brother* or sister*)) OR (AB (family or families or wife* or husband* or spouse* or sibling* or “adult child*” or brother* or sister*))	316,248
S14	(MH “Family”) OR (MH “Adult Children”) OR (MH “Nuclear Family+”)	181,847
S13	TX (“post stroke*” or “stroke survivor*” or “community integration” or “community reintegration” or “life after stroke”)	14,326
S12	TX (“care provider*” or (provid* N1 care))	101,795
S11	TX (caregiver* or carer* or caregiving)	110,056
S10	(MH “Caregivers”)	44,872
S9	S6 OR S7 OR S8	166,895
S8	(MH “Stroke Patients”)	8,902
S7	TX stroke*	166,724
S6	(MH “Stroke+”)	81,057
S5	S3 NOT S4	209,070
S4	TX (“guinea pig*” or “African-American”)	38,659
S3	S1 OR S2	247,729
S2	(MH “Africa+”)	101,916
S1	TX (Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or “South Africa*” or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or “Ivory Coast” or “Cote d’Ivoire” or Niger* or “Burkina Faso” or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or “South Sudan*” or Togo or “Sierra Leone” or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or “Guinea-Bissau” or “Equatorial Guinea” or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or “Cape Verde” or “Cabo Verde” or “São Tomé” or Seychell*)	247,615

Table A

Ovid MEDLINE(R) ALL search conducted on 29 January 2025

https://proxy.queensu.ca/login?url=https://ovidsp. EWS=NandPAGE=mainandSHAREDSEARCHID=1BUxkcgrhWR4MwuxmP5oEP8Q9dTGF4LEGAeTgaFjYkg3gDgFXqJ3GLXdoM6ahuhBs

1 (Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or "South Africa*" or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or "Ivory Coast" or "Cote d'Ivoire" or Niger* or "Burkina Faso" or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or "South Sudan*" or Togo or "Sierra Leone" or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or "Guinea-Bissau" or "Equatorial Guinea" or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or "Cape Verde" or "Cabo Verde" or "São Tomé" or Seychell*).mp. 866754

2 (Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or "South Africa*" or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or "Ivory Coast" or "Cote d'Ivoire" or Niger* or "Burkina Faso" or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or "South Sudan*" or Togo or "Sierra Leone" or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or "Guinea-Bissau" or "Equatorial Guinea" or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or "Cape Verde" or "Cabo Verde" or "São Tomé" or Seychell*).in. 617598

3 exp africa/ 349083

4 or/1-3 1201947

5 "guinea pig*".mp. or "African-American*".ab,ti,kw. 220380

6 4 not 5 981567

7 exp Stroke Rehabilitation/ or exp Stroke/ 192579

8 stroke*.mp. 419492

9 7 or 8 443073

10 Caregivers/ 56102

11 (caregiver* or carer* or caregiving).mp. 141127

12 ("care provider*" or (provid* adj1 care)).mp. 106912

13 Survivors/ or Community Integration/ or ("post stroke*" or "stroke survivor*" or "community integration" or "community reintegration" or "life after stroke").mp. 55396

14 family/ or adult children/ or nuclear family/ or only child/ or exp parents/ or siblings/ or spouses/ 262864

15 (family or families or wife* or husband* or spouse* or sibling* or "adult child*" or brother* or sister*).ab,ti. 1332705

16 or/10-151689580

17 6 and 9 and 16 1069

Embase Classic+Embase search conducted on 29 January 2025

https://proxy.queensu.ca/login?url=https://ovidsp.ovid.
andNEWS=NandPAGE=mainandSHAREDSEARCHID=7TR0oPNkk4BKMAvaG9kVHpkI3qSr9112Ahd8IIetSi3JwDKQ5TfSeWSPcWSbn07Mj

1 (Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or "South Africa*" or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or "Ivory Coast" or "Cote d'Ivoire" or Niger* or "Burkina Faso" or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or "South Sudan*" or Togo or "Sierra Leone" or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or "Guinea-Bissau" or "Equatorial Guinea" or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or "Cape Verde" or "Cabo Verde" or "São Tomé" or Seychell*).mp. 1101835

2 (Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or "South Africa*" or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or "Ivory Coast" or "Cote d'Ivoire" or Niger* or "Burkina Faso" or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or "South Sudan*" or Togo or "Sierra Leone" or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or "Guinea-Bissau" or "Equatorial Guinea" or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or "Cape Verde" or "Cabo Verde" or "São Tomé" or Seychell*).in. 902127

3 exp africa/ 472504

4 1 or 2 or 3 1599181

5 "guinea pig*".mp. or "African-American*".ab,ti,kw. 303292

6 4 not 5 1295889

7 exp Stroke Rehabilitation/ or exp Stroke/ or exp cerebrovascular accident/ or post-stroke depression/ or stroke patient/ 500614

8 stroke*.mp. 595167

9 7 or 8 713312

10 6 and 9 14858

11 Caregivers/ 131016

12 (caregiver* or carer* or caregiving).mp. 206835

13 stroke survivor/ or community integration/ or ("post stroke*" or "stroke survivor*" or "community integration" or "community reintegration" or "life after stroke").mp. 43208

14 family/ or adult children/ or nuclear family/ or only child/ or exp parents/ or siblings/ or spouses/ 511833

15 (family or families or wife* or husband* or spouse* or sibling* or "adult child*" or brother* or sister*).ab,ti. 1722663

16 ("care provider*" or (provid* adj1 care)).mp. 140189

- 17 or/11-162284738
- 18 10 and 17 1918
- 19 limit 18 to (conference abstract or conference paper or “preprint (unpublished, non-peer reviewed)”) 653
- 20 18 not 19 1265

ProQuest Dissertations search conducted on 30 January 2025

Search	Query	Records re-trieved
S1	noft(stroke)	17320
S2	noft((caregiver* or carer* or caregiving) OR (“post stroke*” or “stroke survivor*” or “community integration” or “community reintegration” or “life after stroke”) OR (family or families or wife* or husband* or spouse* or sibling* or “adult child*” or brother* or sister*))	372225
S3	noft((Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or “South Africa*” or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or “Ivory Coast” or “Cote d’Ivoire” or Niger* or “Burkina Faso” or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or “South Sudan*” or Togo or “Sierra Leone” or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or “Guinea-Bissau” or “Equatorial Guinea” or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or “Cape Verde” or “Cabo Verde” or “São Tomé” or Seychell*)) OR ulo((Africa* or Nigeria* or Ethiopia* or Egypt* or Congo* or Tanzania* or “South Africa*” or Kenya* or Uganda* or Sudan* or Algeria* or Morocco* or Angola* or Mozambique* or Ghana* or Madagascar* or Cameroon* or “Ivory Coast” or “Cote d’Ivoire” or Niger* or “Burkina Faso” or Mali or Malawi* or Zambia* or Senegal* or Chad or Somalia* or Zimbabwe* or Guinea or Rwanda* or Benin* or Burundi* or Tunisia* or “South Sudan*” or Togo or “Sierra Leone” or Libya* or Liberia* or Mauritania* or Eritrea* or Namibia* or Gambia* or Botswana* or Gabon* or Lesoth* or “Guinea-Bissau” or “Equatorial Guinea” or Mauritius or Eswatini or Djibouti or Comoros or Sahrawi or “Cape Verde” or “Cabo Verde” or “São Tomé” or Seychell*))	243907
S4	[S1] AND [S2] AND [S3]	89

Table B

Google Scholar and African Journals Online search conducted on 30 January 2025

Using Publish or Perish Version 8, searching Google Scholar (limit to top 100 results, no patents) and Africa Journals Online:

“stroke” AJOL caregiver*

“stroke” Africa caregiver*

Supplementary File 2: List of ineligible studies in full-text review

1. Anderson, Sharon *et al.* “Staying married after stroke: a constructivist grounded theory qualitative study.” *Topics in Stroke Rehabilitation* vol. 24,7 (2017): 479-487. doi:10.1080/10749357.2017.1342335. (Ineligible context)

2. Eriksson, Gunilla Margareta *et al.* "The everyday life situation of caregivers to family members who have had a stroke and received the rehabilitation intervention F@ce in Uganda." *Archives of Public Health = Archives Belges de Sante Publique* vol. 79,1 100. 15 Jun. 2021, doi:10.1186/s13690-021-00618-z. Available from: <https://link.springer.com/article/10.1186/s13690-021-00618-z>. Ineligible phenomena of interest
3. Glickman, Leslie B, and George Chimatiro. "Clients with stroke and non-stroke and their guardians' views on community reintegration status after in-patient rehabilitation." *Malawi Medical Journal : the journal of Medical Association of Malawi* vol. 30,3 (2018): 174-179. doi:10.4314/mmj.v30i3.8. Ineligible phenomena of interest
4. Hamzah, Ali, *et al.* "Participatory learning is needed to increase family independence in handling post-stroke patients at home." *Journal of Nonformal Education* 10.1 (2024): 49-61. Reason for exclusion: Ineligible context
5. Visagie, Surona. "Strain experienced by caregivers of stroke survivors in the Western Cape." *South African Journal of Physiotherapy* (2011). Reason for exclusion: Ineligible phenomena of interest
6. Igwesi-Chidobe, C., N. Aronu, and B. Ozumba. "'Caged in hell or unable to escape': the lived experiences of adult stroke survivors in rural Nigeria." *Physiotherapy* 123 (2024): e245-e246. Available from: <http://proxy.queensu.ca/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=177944471&site=ehost-live>. Reason for exclusion: Ineligible phenomena of interest
7. Jabbar, Rukhsar. "Post-Stroke Rehabilitation Explained." *Dateline Health Africa*. [Internet 2024 May 20] Cited (2024); Available from: <https://www.datelinehealthafrica.org/post-stroke-rehabilitation-explained>. Reason for exclusion: Ineligible phenomena of interest
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Supplementary File 3: Characteristics of included studies

F = Female; M = Male; n = Number of participants.

First author/ Year/ Country	Type of article	Phenomena of interest	Setting/Context/Culture	Methods for data collection	Methods for data analysis	Participant characteristics and sample size	Description of main results
De Witt, <i>et al.</i> 2024, South Africa	Journal article	Environmental barriers and facilitators to community reintegration after stroke	Low socioeconomic urban metropolitan area	In-depth interviews	Thematic analysis/ Descriptive phenomenological approach	Stroke survivors (n=11)	Two themes: <ul style="list-style-type: none"> Perceived and experienced environmental barriers to community reintegration Perceived and experienced environmental facilitators to community reintegration
Gawulayo, <i>et al.</i> 2021; South Africa	Journal article	The experiences and influence of stroke on family functioning	Peri-urban community	In-depth interviews	Thematic analysis/An explorative descriptive research design	Caregivers (n=8, 5F/3M)	Four themes: <ul style="list-style-type: none"> Reduced interactions with family members due to communication barriers The influence of stroke on family relationships Emotional engagement in caring for a family member with a stroke Financial implications of stroke on family functioning
Gertrude, <i>et al.</i> 2019; Uganda	Journal article	Informal caregivers' experience of looking after a stroke patient	peri-urban	In-depth interviews	Thematic analysis	Caregivers (n=25)	Four themes: <ul style="list-style-type: none"> Taking on new responsibilities Certain factors that protect caregivers Limited resources Caregivers shared their experiences with patient outcomes
Govender, <i>et al.</i> 2019; South Africa	Journal article	Community Reintegration of CVA Survivors in South Africa	Peri-urban community	In-depth interviews	Thematic analysis	Stroke survivors (n=8, 5M/3F)	Six themes: <ul style="list-style-type: none"> Loss of autonomy and roles Barriers to community reintegration Social isolation, participants' ability to find internal strength Enablers of community reintegration Recommendations for rehabilitation Stressing the need

Kamwe-siga., <i>et al.</i> 2017; Uganda	Journal article	The experiences of using mobile phones in everyday life among persons with stroke and their family members.	Urban	In-depth interviews	Thematic analysis / constant comparative grounded theory approach	Stroke survivors (n=11) and Caregivers (n=9)	Seven categories: <ul style="list-style-type: none"> • Enabler of communication and connections • Source of inspiration for agency • Structuring routine and ADL • Facilitator of social and economic well-being • Promoter of belonging and participation in social relationships • Facilitator of reintegration • Enabler of family members to feel secure.
Kamwe-siga., <i>et al.</i> 2023; Kenya	Journal article	The experiences of participation in everyday activities post-stroke	Urban	In-depth interviews	Thematic analysis / content analysis	Stroke survivors (n=9)	Three themes: <ul style="list-style-type: none"> • A sense of satisfaction at being involved in everyday life • Challenges in everyday activities and social participation • Dependence as enabling or hindering participation
Khondowe., <i>et al.</i> 2007; Zambia	Journal article	The needs of caregivers of stroke patients receiving outpatient physiotherapy	Urban	In-depth interviews	Thematic analysis	Caregivers (n=10)	Five themes regarding caregivers' needs: <ul style="list-style-type: none"> • Lack of stroke information • Skills training • Financial support • Home-based therapy • Physical assistance
Khuabi., <i>et al.</i> 2020; South Africa	Book chapter	Perceived well-being of family caregivers of stroke survivors	Predominantly Urban	In-depth interviews	Thematic analysis / phenomenological approach	Caregivers (n=8)	Five themes: <ul style="list-style-type: none"> • Role change • Time usage • Types of support and the relief it brings • Merged identity • The essence of caring

Lindner 2022; South Africa	Theses	Community reintegration experiences of stroke survivors	Urban	In-depth interviews	Thematic analysis / descriptive phenomenology	Stroke survivors (n=11)	Three themes: <ul style="list-style-type: none"> • The changes in occupational performance experienced • Barriers to community reintegration • Facilitators to community reintegration.
Makganye, 2015; South Africa	Theses	Psychosocial experiences of patients and their caregivers following a stroke	Rural	In-depth interviews	Thematic analysis/collective case study	Stroke survivors (n=5) and Caregivers (n=5)	Nine themes: <ul style="list-style-type: none"> • Stroke onset • Physical consequences • Spiritual, religious and cultural aspects of post-stroke • Financial consequences • Emotional consequences • Social consequences • Patient's greatest loss • Caregiver burden • Coping strategies
Maleka, et al. 2012; South Africa	Journal article	The Experience of Living with Stroke in Low Urban and Rural Areas	Low Urban and Rural	In-depth interviews	Thematic analysis	Stroke survivors (n=32)	Seven themes: <ul style="list-style-type: none"> • Loss of mobility • Social isolation • role reversal and loss of personal identity • Loss of role • Loss of meaningful ADL • Threat to livelihood • Loss of hope
Masuku, et al. 2018; South Africa	Journal article	Caregiving experiences of primary caregivers of persons with aphasia	Urban Semi-urban Semi-rural Rural	In-depth interviews	Thematic analysis	Caregivers (n=14)	Six themes: <ul style="list-style-type: none"> • Understanding aphasia • Engagement • Support • Emotions (burn-out and burden of care) • Challenges to care • Feminization of caregiving

Mohothoane and Neman-ga,2023; South Africa	Journal article	Barriers to Stroke Survivors' Participation in Meaningful Occupations within Rural and Semi-Rural Communities	Rural and Semi-rural communities	In-depth interviews	Thematic analysis	Stroke survivors (n=10)	Four themes: <ul style="list-style-type: none"> Physical barriers Psychological barriers Financial barriers Environmental barriers
Ogun-lana., <i>et al.</i> 2023; Nigeria	Journal article	Community reintegration experiences of Nigerian stroke survivors	Urban	In-depth interviews	Thematic analysis	Stroke survivors (n=12)	Three themes: <ul style="list-style-type: none"> Activity limitations Participation restriction Barriers/enablers for community reintegration
Opoku., <i>et al.</i> 2020; Ghana	Journal article	Community reintegration experiences of Nigerian stroke survivors	Urban	In-depth interviews	Thematic analysis / content	Stroke survivors (n=10)	Three major categories: <ul style="list-style-type: none"> Psychological disruption Disruption to social identity Coping strategies
Pers-son., <i>et al.</i> 2024; Ghana	Journal article	Perception of stroke survivors with disabilities	Urban	In-depth interviews	Thematic analysis	Stroke survivors (n=14)	Four themes: <ul style="list-style-type: none"> Mobility limitations Psychosocial burden Employment limitations Financial burden
Sanuade., <i>et al.</i> 2019; Ghana	Journal article	Understanding explanatory models for stroke survivors and caregivers in Ghana	Urban	In-depth interviews	Thematic analysis	Stroke survivors (n=22) and Caregivers (n=29)	Three sections: <ul style="list-style-type: none"> Illness onset and emotional responses after the stroke onset Pre-diagnosis awareness and causal theories of stroke Causal theories of stroke complications
Scheffler and Mash 2020; South Africa	Journal article	Experience and perceived needs of stroke survivors, their caregivers, and community Health Workers	Rural	8 FGDs	Thematic analysis / descriptive exploratory study	Stroke survivors (n=26), Caregivers (n=21)	Four themes: <ul style="list-style-type: none"> Figuring it out by yourself Need for emotional support Impact of contextual factors Implications of the organization of services

Shewan-gizaw, <i>et al.</i> 2023; Ethiopia	Journal article	The social and psychological consequences experienced by stroke survivors and their caregivers following a stroke	Urban	In-depth interviews	Thematic analysis	Stroke survivors (n=13) and Caregivers (n=13)	Six themes: <ul style="list-style-type: none"> • Explanatory model • Living a new body • Living on the breadline • Psychological toll • Elephant in the room • Finding the silver lining
Smythe <i>et al.</i> 2022; South Africa	Journal article	Perspectives and experiences of people with stroke (PWS) regarding their access to healthcare services in South Africa.	Urban and Rural	In-depth interviews	Thematic analysis	Stroke survivors (n=16)	Five themes comprise Levesque <i>et al</i> framework on health care access: <ul style="list-style-type: none"> • Ability to perceive • Ability to seek • Ability to reach • Ability to pay • Ability to engage
Soeker and Olaoye 2017; Nigeria	Journal article	Challenges and facilitators related to returning to work after experiencing a stroke	Urban	In-depth interviews and focus group discussions	Thematic analysis	Stroke survivors (n=9), Caregivers (n=8).	Three themes: <ul style="list-style-type: none"> • Rehabilitation and social support as enablers to resume stroke survivors' work roles after stroke • Returning to work is a struggle • Experience of loss by stroke survivor
Soeker, <i>et al.</i> 2024; South Africa	Journal article	The experiences and perceptions of stroke survivors regarding the usefulness of MOOSE to return to work	Urban Semi-Urban Semi-rural Rural	In-depth interviews	Thematic analysis	Stroke survivors (n=8)	Three themes: <ul style="list-style-type: none"> • Obstacles affecting the return to work • Re-establishing a strong belief in functional ability through participation • MOOSE enables transition to the worker role in a rural context
Tchokote 2020; Cameroon	Journal article	The lived experiences of family caregivers providing care to parents who have suffered strokes	Urban	In-depth interviews	Thematic analysis/interpretative phenomenological analysis (IPA)	Caregivers (n=8)	Four major themes emerged: <ul style="list-style-type: none"> • Family experience of a parent's illness • Experiencing the limits of medico-social resources and psychological support • Conscious strategies and defensive mechanisms in the face of suffering • Sense of motivation and involvement for the family

Timm., <i>et al.</i> 2023; Uganda	Journal article	The experiences of individuals living with stroke in a rural area of Uganda.	Rural	In - depth interviews, observation, and field notes	Thematic analysis	Stroke survivors (n=14)	Five themes: <ul style="list-style-type: none"> • Accepting and adapting to new ways of managing everyday life • Changing roles and hierarchical positions • Depending on caregiver support • Interrupted care due to economic constraints • Stroke leading to losses and losses leading to stroke
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Table C

Supplementary File 4: List of studies, findings, and illustrative quotes

Study: De Witt., <i>et al.</i> 2024	
Finding	Perceived and experienced environmental barriers to community reintegration (SS) (U)
Illustration	I got that walking [frame] ... at the club, the stroke club. I can't really use the thing because I don't [get it down the stairs] to the bottom on the ground level (SSP 7, page 40).
Finding	Perceived and experienced environmental facilitators to community reintegration for stroke survivors (SS) (U)
Illustration	The church people also supported me when I had the stroke and motivated me a lot (SSP 2, page 41). The stroke group helped a lot ... because [before] I just sat here and spoke to nobody but noV½ I can speak to them and so and I do [the] exercises that they give me and so (SSP 9, page 41).
Study: Govender 2019	
Finding	Social isolation ('I'm always alone') (SS) (U)
Illustration	I can't go to different places like before; my life is stuck in one place (Sbo, age 38, male, grade 12, employed, page 4). I hated being bottled up, I hated not going to work, I like to be with people, to be with my friends. I hated being at home the whole day (Xolani, age 41, male, grade 12, employed, page 4).
Finding	Enablers of community reintegration post-stroke (SS) (U)
Illustration	Seeing people [friends and neighbours] reaching out and coming to visit me at home has been not only good for me but for the family, because we needed everyone's support ... people came and showed us love (Buhle, age 63, female, grade 8, retired, page 4).
Finding	Loss of autonomy and roles experienced post-stroke: 'Life is different' (SSs) (U)
Illustration	Before the stroke, [as my work] I was part of a team that used to go to the community and help people in need ... But now I [can] only do paperwork and give out medication (Xolani, age 41, male, grade 12, employed, page 3). ... even if I do go to church, I sit in the benches and I can't sing and dance as before. It makes me not want to go to church because people start feeling sorry for me because I am not as active as before (Ziyanda, age 55, female, grade 7, employed, page 3).
Finding	I feel more like myself again (SS) (U)
Illustration	I am happy because I feel like I am going back to my old self, and that to me is a big deal because it means that the exercises that I do at home and the clinic are working (Xolani, age 41, male, grade 12, employed, page 4). It feels good to be able to wake up in the morning and go to work again; I never liked staying at home the whole day watching TV (Xolani, age 41, male, grade 12, employed, page 4).

Finding	Recommendations for rehabilitation services (SS) (U)
Illustration	Right now, I don't go [to the clinic and hospital] as frequent[ly] as before. I can't go; it is far and there is no one to take me (Thandi, age 69, female, tertiary level education, retired, page 5). I want to continue doing exercises here at home; because I can't go to the clinic, it is better if they would come and see me here at home (Buhle, age 63, female, grade 8, retired, page 5).
Finding	Barriers to community reintegration post-stroke (SS) (U)
Illustration	No one [in the hospital] prepared me to go home. When I was at home it was even harder for me because I was very weak at that time and none knew how to take care of me (Phindile, age 76, female, grade 10, retired, page 4). When I was in hospital I did not get any rehabilitation, but they promised me that the physiotherapist would come; but no physio came to me and I was later discharged (Phindile, age 76, female, grade 10, retired, page 4).
Study: Gawulayo., <i>et al.</i> 2021	
Finding	Financial implications of stroke on family functioning (CG) (U)
Illustration	He had a job before the stroke. After his stroke, we lost income, and I had to start a business to support the family. However, I cannot run it well because I must make time to care for him. It gets tiresome to balance these demanding tasks (P5, female, 59 years old, page 6).
Finding	Emotional engagement in caring for a family member with a stroke (CG) (U)
Illustration	It gets really difficult at times and I tend to feel very emotionally drained.... (P5, female, 59 years old, page 6). It gets very painful sometimes. I thought that as a parent I would be resting now and that he would be the one taking care of me, not the other way around (P2, female, 52 years old, page 6).
Finding	Reduced interactions with family members because of communication barriers due to stroke (CG) (U)
Illustration	My mother used to be a talkative person. However, after the stroke she tends to withdraw herself from interacting with people. (P1, female, 42 years old, page 4).
Finding	The influence of stroke on family relationships (CG) (U)
Illustration	[...M]y husband isolates himself and does not want to engage in activities that we used to do as a family (P5, female, 59 years old, page 5). His interaction with our children was reduced after the stroke. He became hard on them and they did not understand him. He got along with them more than I did before he had a stroke (P5, female, 59 years old, page 5).
Study: Gertrude., <i>et al.</i> 2019	
Finding	Experiences of taking on new responsibilities post-stroke for caregivers (CG) (U)
Illustration	I am affected financially for there are many people, around 10 of them in the home and I have to care for everybody. You look for their food, clothing, school fees, so you have to make an adequate budget for all that, while you have to get medication for the patient (41-year-old female sibling, page 1553).
Finding	Limited resources in care of stroke patients for caregivers (CG) (U)
Illustration	I wanted support like to feed the patient with fruit, for they used to be scarce. Like I have told you, I stopped working otherwise I would have bought fruit, milk for she used to like drinking more than eating, oil for messaging the affected side of the body, which was so expensive at 16,000/- (approximately £4) (a 22 -year -old grand daughter, page 1554).
Finding	Factors that protected caregivers from breaking down (CG) (U)
Illustration	Our neighbours and family have also given us support like one neighbour gave us her daughter to take care of our home and she looks after the children. She is the one who keeps the home tidy and clean, she cooks. While also this patient's friends keep on giving us some money. and buy food and put it at home to sustain the children (a 41-year-old male sibling, page 1554).
Finding	Experiences with patient outcomes post-stroke for caregivers (CG) (U)

Illustration	Yes, the hardest moment was when I was calling mum and she couldn't open her mouth, she was gone... that was the hardest moment [...] and the situation has really not been easy. It has affected me so much as an individual. Not me alone but also my siblings. I lost my job because I needed to take care of mum [...]. now I am struggling to survive, everything is hard now, yet they have never been hard. All that has happened after mum died (a 22- year- old daughter, page 1555).
Study: Kamwesiga., <i>et al.</i> 2017	
Finding	Structuring routines and ADL post-stroke (CG) (U)
Illustration	I became dependent on the phone and most of my daily activities were done with it. I used to go to the bank to pay utility bills but now i use mobile phone to receive send money, pay water, electricity and TV bills. I try to learn more about how to care for my patient using the Internet, for example, finding what exercises he can use on YouTube and when I am not busy, I use my mobile phone for Facebook and I read a lot of books on the Internet (Family of participant 11, page 7).
Finding	Source of inspiration for agency post-stroke (SS) (U)
Illustration	Well words from a close friend can mean a lot, more than anything. If somebody sends a message you just say, okay it's Mary, but if you hear her voice saying how are you, you feel great happiness. I spend the whole day at home talking to nobody, so when someone calls me, I get encouraged (Participant 7, male, age 53, page 6).
Finding	Belonging and participation in social relationships post-stroke (SS) (U)
Illustration	My mobile phone helps me feel close to the others that I used to interact with before I got the stroke because it's important for me to keep my friends and it is through talking to them that I know I am improving (Participant 6, male, age 54, page 8).
Finding	Facilitator of reintegration to community post-stroke (SS) (U)
Illustration	... if a therapist says, hello and how are you? Can you please do this or that exercise, I will be very happy. I even get encouraged because of talking with the therapist. Someone whom you should initially call but instead he/she calls you, it shows how important you are and the hope of recovery he/she has in you (Participant 7, male, age 53, page 8).
Finding	Post-stroke communication and connections with other people (SS) (U)
Illustration	I used to share good moments with friends before I had a stroke. Now I am limited in many ways and people do not have much time to come here and talk. I use my phone to reach them and we communicate and after that I feel very good, I get more energy to do more exercises and feel inside myself that my life is coming back. I think communication is powerful. I am only limited by airtime on the phone otherwise I would go on and on (Participant 6, male, age 54, page 5).
Finding	Facilitator of social and economic wellbeing of an individual or family (SS) (U)
Illustration	... I have a shop that deals with motor spare parts and my son now helps to run it but most of the decisions are made by me through communicating with him. All the time I am in constant contact with him and I know how much money he is making each day. If I did not have that shop my wife would have left and I would suffer (Participant 9, male, age 43. page 7).
Finding	Enabler of family members to feel secure (CG) (U)
Illustration	sometimes I do night duties, I used to call at any time in the night to check whether the person with stroke was fine at home. The phone calls took away my worries of not being physically at home (Family member for Participant 8, female, age 25, page 8).
Study: Kamwesiga., <i>et al.</i> 2023	
Finding	Challenges in doing everyday activities and social participation (SS) (U)
Illustration	I prepare my own food . . . It is sometimes a challenge, but I, but I do . . . Mmm taking food from the plate was a problem. Even right now sometimes. The right hand does not work properly (participant 8, page 4). Because I can't meet friends. And some friends when you are sick they cannot move near you (participant 3, page 5).
Finding	Dependence as enabling or hindering participation (SS) (U)

Illustration	When I do the washing, I'm done with my washing, ready to put my clothes on the hanging line. I must call someone to come and help me with the hanging (participant 2, page 5). Yes driving . . . Mmm cause now I have to, depend on a driver, the taxi. Uh I don't like that . . . I lost my free dom (participant 9, page 5).
Finding	A sense of satisfaction at being involved in everyday life post-stroke (SS) (U)
Illustration	And I started doing things myself. Then slowly I increased my independence (participant 4, page 4). So I find I'm able to help, to reach out to more people, encourage them and think, I find a lot of . . . fulfilment in that Being active and reaching out. Being able to be there for someone else even with my limitations (participant 9, page 4).
Study: Khondowe <i>et al</i> , 2007	
Finding	Need for training in caring for a patient at home (CG) (U)
Illustration	At discharge not enough information was given to me about what I was going to do with the stroke patient at home (wife, page 15). I need information to help in rehabilitation of the patient on how to deal with his moods at home (wife, page 15).
Finding	Need for home-based therapy (CG) (U)
Illustration	If a physiotherapist could come to our homes, it would be better (daughter, page 16). We need community health workers to do visits in our homes than us coming here, because it is very costly (son, page 16).
Finding	Need for assistance in caring for the patient at home (CG) (U)
Illustration	I need a person to help me so that I am not alone helping the sick person (brother, page 16). I need someone to help in caring. Sometimes I need to do some other things but can't because if I do then no one will remain with the patient (wife, page 16).
Finding	Need for information for caregivers (CG) (U)
Illustration	I don't think I have enough information about stroke... very little. The doctors have tried to give me whatever they think is adequate but some information is still lacking (daughter). I don't know how stroke begins (son, page 15). At the village the traditional healer was attending to the patient as we thought he was bewitched (daughter, page 15). I don't know where this stroke is coming from as my child has no hypertension or diabetes (mother, page 15).
Finding	Need for financial assistance for caregivers (CG) (U)
Illustration	It's difficult to cope with financial needs especially that I have children to take to school and the health cost to take care of (husband, page 15). It's financially a problem to bring the patient to the hospital (sister, page 15). I spend too much money for him, about five million kwacha a month ... I have a job and need much time (son, page 15).
Study: Khuabi <i>et al</i> , 2020	
Finding	The essence of caring (CG) (U)
Illustration	Yes, because it is not only my responsibility, its everyone's responsibility, because we no longer have parents, it is only us brothers and sisters. One brother and three sisters and that's our other brother. So, it is our duty to care for him... that is what our parents would have wanted (Participant 6, 35-year-old female, lines 184-187, page 196). Where I started learning was when my mom cared for my grandmother and my aunt who was also in the house with us. We had a big family like a close family, and everyone in one house always came to my grandmother. And so, this is how we grew up. (Participant 8, 71-yearold female, lines 75-78, page 196).
Finding	Role change (CG) (C)
Illustration	But it's almost like looking after a child. He's my child every day, this husband of mine (Participant 8, 71-year-old female, lines 77-78, page 191).
Finding	Merged identity (CG) (U)
Illustration	And the moods she went through makes you depressed. If she is angry, then you start to feel edgy. And then I feel like I am on the edge to explode (Participant 4, 48-year-old female, lines 254-256, page 196).

Finding	Time usage (CG) (C)
Illustration	Just to be somewhere alone where I can't be disturbed without anyone calling me or asking something from me or where I can just sit alone and watch TV, you just want to be alone (Participant 6, 35- year-old female, lines 79-81, page 193).
Finding	Types of support and the relief it brings (CG) (U)
Illustration	No last time I hurt my back, he is very fast and shaky, so I hurt my back by bending down. He didn't have a wheelchair yet, so I had to pick him up and make him walk till here and then I hurt my back. We finally got a wheelchair and I am very happy (Participant 3, 64-year-old female, lines 151-153, page 194).
Study: Lindner 2022	
Finding	Facilitators to community reintegration as perceived and experienced by stroke survivors (SS) (U)
Illustration	I learned a lot [at the in-patient rehabilitation centre] ...[I] exercised a lot in the morning from about 10 o'clock, every day... It helped a lot; I have to say I quickly made changes after the stroke Ma'am won't believe me, when I got there, I could not walk ... And when I left there, I walked (SSP 10, page 86). ... They [the church] really carried me through Oh, they, they often came to me. They still come to visit me like this and bring me things, like bread and [other] things they bring me (SSP 7, 89).
Finding	Changes in occupational performance experienced by stroke survivors (SSs) (U)
Illustration	Look I could not go back, I could not go back to my work because of my stroke that I had, because many things in my body are different, my body is different now (SSP 2, page 57). I want to wash myself ... Yes look, she washes me, my wife, all these things she washes for me. Uh, its bitter for me. This is a terrible disease, ma'am (SSP 1, page 61).
Finding	Perceived and experienced barriers to community reintegration (SS) (U)
Illustration	People's attitudes are a little difficult for me. The children shout at me 'rock star', now They shout at me 'rock star' ... 'Abby the rock star'... Because I walk like this now ... I rock It does bother me now and then ... (SSP 6, page 80). Stairs remain my problem. If there are no railing and stuff, then it can be very [challenging] (SSP 3, page 81).
Study: Makganye 2015	
Finding	Financial Consequences of stroke (CG) (U)
Illustration	Things are really tough. My husband used to earn R800 per week when he was still employed. He also used to do piece jobs fixing machines for the community, getting +- R1 000 per week. Since the stroke he now receives the disability grant and does not receive the full amount because I earn more than R4 000. Things are a bit tough. I might lose my job because I always take time off to attend to him and to go to all the offices that want to have sessions with us. I am not sure how are we going to survive if I lose my job (one of the caregivers, page 79).
Finding	Social consequences of stroke (CG) (U)
Illustration	I am very close to my mother. We were close before stroke but I think now I am a bit over protective of her. I do everything for her and I do not want to see her sad. Luckily, the mother of my child understands that I cannot leave my mother, so every weekend she visits us with my son. My mother is very close to them and cannot wait for the weekend to come so that she can see my son. My mother is caring and loves being around people (caregiver, page 93).
Finding	Post-stroke Caregiving burden (CG) (U)
Illustration	For me, staying with someone who has had a stroke is emotionally draining because I have to deal with his irritability, being reprimanded for no particular reason and the expectation that I must always be with him (another caregiver, page 103).
Finding	Emotional consequences of stroke (CG) (U)
Illustration	My grandfather is a bit irritable with me and forgetful at times. He wants me to do things his way. He is also a bit anxious about falling. He wants me to always be at home in case he falls. This is also a bit frustrating for me because I was never prepared for all these things that he expects from me (Caregiver, page 85).

Finding	Post-stroke coping strategies for caregivers (CG) (U)
Illustration	I cannot say we are coping because we have long passed the stage of coping. To be honest, now we are fine and I think the worst is over. The days when we were stressed are over now. I know my mom’s speech and her movement are not yet completely sharp but we are hopeful that she will get better. What motivates me is that she still attends treatment and she is positive that her health will be back to normal. I am also happy that she appreciates everything that is being done for her and she is not stressed by anything (Caregiver, page 105).
Finding	Physical consequences of stroke (SS) (U)
Illustration	When I had my stroke, I could not do anything. I could not walk or talk. Even now, the only thing that has improved is my speech. I am still wheelchair-bound. My waist and legs are the most affected areas. The stroke has affected my balance and mobility. I can walk a bit but I don’t have balance, hence I use a wheelchair. My speech was slurred at first but because I am attending speech therapy it is a bit better. I have pain all over my body but mostly in my hand (page 70)
Finding	Spiritual, religious and cultural aspects of post-stroke (SS) (U)
Illustration	I attend International Pentecostal Church (IPCC) and I have told myself that this is the will of God and have hope that things will get better because there are some improvements from where I started (patient 2, page 76).
Finding	Patient’s greatest loss due to stroke (SS) (U)
Illustration	Being unable to walk and drive is my greatest loss. I know I can walk with help but I wish I could walk the way I used to. My movements are also limited because I cannot drive (patient, page 99).
Study: Maleka., <i>et al.</i> 2012	
Finding	Threat to livelihood (sustainable/productive livelihood) (SS) (U)
Illustration	I have to go back to work because I need to pay rent for this (pointed at the room) room or else I would have to go back home in the Eastern Cape (urban participants, page 29).
Finding	Social isolation (SS) (U)
Illustration	“I am really on my own; my children leave me here at home all the time” “I cannot get up, my whole left side is not working, I find it difficult to do anything for myself, I really feel trapped in this body. I cannot go anywhere, visit family, neighbours, friends; I am forever locked in this room until my daughter comes back from work. I really feel all alone. I can’t remember when last did I get out of this place” (participants from both setting, page 28).
Finding	Loss of community mobility or restriction in community mobility (SS) (U)
Illustration	Yes, I do. I am always at home, I do not go anywhere. Where could I go? I am unable to walk. When I go out with other people they say I slow them down so it is better to stay at home. I am also afraid that I will fall when I walk with my walker. The roads are also not in a good condition, they are very rocky and uneven, not tarred. So I stay home all the time (a rural participant, page 27). I can’t and I don’t want to be seen like this (pointing at her body) in public (urban participant, page 27)
Finding	Loss of meaningful activities of daily living (SS) (U)
Illustration	I cannot cook for my husband, clean my house, wash dishes, clothes, iron our clothes and sweep my yard. I cannot attend local funerals, church, weddings, parties and burial society or social club, it makes me feel sad (most women in urban and rural, page 28). I am unable to go to the graveyard to assist with digging of the grave. I normally stay at the home of the people who are burying instead of going to the graveyard (a rural participant, page 28).
Finding	Loss of hope (SSs) (U)
Illustration	I wish I could die than to be a burden to my children (page 29). I don’t think there is a cure for a stroke; does it mean I am going to live like this until I die?(page 29). I know God is there, he will heal me, and I believe in Him (page 29).

Finding	Loss of role within the family and community (SS) (U)
Illustration	...I am no longer a breadwinner in my house and that affect the decision I can or cannot make within the family. My wife now is the head of the family (a man from the urban, page 28).
Study: Masuku., <i>et al.</i> 2018	
Finding	Engagement (CG) (U)
Illustration	Okay now honestly, I find that there is not that much communication because I cannot understand him when he is talking. I can barely make out what he is trying to say. I can ask him a question and he will struggle to answer me (Participant 2, 23 years old, daughter, page 4). Yes, it's tough. Sometimes I feel like I am losing patience with her. She keeps saying 'leyami' ['that's mine' - a contextually meaningless word in isiZulu] and I really don't understand. I just get impatient. Sometimes I even say to her that she must not say anything, because I don't understand what she really wants. I have lost my patience with her because eyi ['hey' - exclamation] it's been what, 8 months and her speech is not back like normal, like before the stroke (Participant 1, 21 years old, daughter, page 4)
Finding	Challenges to care (CG) (U)
Illustration	I don't think that you bring stroke upon yourself, so I don't think that it is necessary for us to be paying for everything. I mean in one visit to the hospital, you pay at the doctor's, at the physios, at OT and at Speech. How much is that all together. Now I have had to stop OT and speech and we can only afford physio for now (Participant 1, 21 years old, daughter, page 5)
Finding	Support (CG) (U)
Illustration	Ja [Yes], support was there. Ja [Yes], especially at the time when she had just had her stroke attack. When she had just had her stroke, there was so much support, but now I feel like people are tired or something, I really don't know. All I know is that we currently don't have as much support as we had in the beginning.' (Participant 1, 21 years old, daughter, page 5).
Finding	Emotions (Burnout and burden of care) (CG) (U)
Illustration	I felt pain. So much pain. You see because it was such a change. Let me tell you something that you probably don't know about me. I am person of arthritis and all the other things that affect a person at the old age and it therefore becomes very difficult to have to carry this person, think for this person and wash this person whether I like it or not.' (Participant 14, 65 years old, wife) 'I felt pain. I felt deep pain, because of this thing of him not talking. Because of this talking thing (Participant 13, 53 years old, wife, page 5).
Finding	Understanding of aphasia (CG) (U)
Illustration	I know that he can't talk. What I know is how sometimes his mind is going down. He now thinks like a child and cannot talk. He uses his hands. He is behaving like a child. Ja, his mind is just upside down and I am told it's because of a stroke. I cannot understand how it's because of a stroke.' (Participant 8, 37 years old, wife, page 4). Well, there are certain causes depicted of them, it's that it may have been caused by alcohol intake, cigarette intake and he used to be actively doing such things and he is also old, and I mean we don't really know why he is not talking. I mean, it's a right-hand stroke, it's probably the most dangerous, but we don't know. So it could have been due to multiple factors, I don't know.' (Participant 6, 35 years old, daughter; highest level of education is a diploma, page 4).
Finding	Feminisation of caregiving (CG) (U)
Illustration	My father-in-law came to live with us because my husband is the first born, and being the daughter-in-law, I have to take care of him. Remember in our culture you marry the whole family. I was working full time, but I have had to take part-time employment so that I can spend some time to care for him. Yoh [exclamation], it's not easy (Participant 4, 28 years old, daughter-in-law, page 5).
Study: Mohotihoane and NemaKanga 2023	
Finding	Psychological barriers (SS) (U)

Illustration	Sometimes I fear going out on my own because I think I will be stuck, and I am not able to get back home (P03, page 96). My husband has to wake up in the morning and do everything. I had asked him to stop washing me because it was too much for him, and he had focus on other things such as cleaning and maintaining the yard and other things (P02, page 96)
Finding	Physiological barriers (SS) (U)
Illustration	I become easily tired. I just do a bit, and I rest when I feel tired (P03, page 95). I have severe pain in my shoulder and hand. I am not able to bend it. I am unable to do most of the things because of the pain in this arm (P05, page 95).
Finding	Environmental factors (SS) (U)
Illustration	I wear a nappy because the toilet is outside, and I cannot walk (P07, page 96). We have to walk to the main road to catch a taxi, did you see how far it is (P02, page 96).
Finding	financial barriers (SS) (U)
Illustration	We have to hire a car for R50 to take us to church. We are both not working (P01, page 96-97). We live on pension grants. We take care of our grandchild. We have to hire a car for R400 to take me to the hospital for check-ups. Money does not last (P02, page 97).
Study: Ogunlana., <i>et al.</i> 2023	
Finding	Enablers/barriers to community reintegration for stroke survivors (SS) (U)
Illustration	I play with my younger sister’s children. My church members come to visit too, and they encourage me (P2, female, 52 years old, page 5). I can’t talk the way I used to talk. My tongue was twisted initially. I couldn’t talk well initially but I am getting better. I can talk better now but I can’t shout (P6, female, 64 years old, page 5)
Finding	Restriction of participation experienced by stroke survivors (SS) (U)
Illustration	I was hardworking before the stroke. I can’t do anything now. I can’t go to the market anymore ... This stroke stopped me from working. I don’t have much energy now ... because I don’t have strength (P3, female, 69 years old, page 3). My sister died; I couldn’t go because of this stroke (P4, male, 62 years old, page 4).
Finding	Activity limitation as pointers to the quality-of life experience of stroke survivors (SS) (U)
Illustration	I watch movies, I gist. I stay on the balcony to see what is going on outside (P9, female, 38 years old, page 4). I can drive a small car but not a big one like a truck (P1, male, 51 years old, page 4).
Study: Opoku., <i>et al.</i> 2020	
Finding	Disruption to social identity (SS) (U)
Illustration	I can meet someone and they would ask what has happened to me and I will say stroke and they will say you young boy and you have had a stroke. (Sulley, page 1790) Some think you are a witch or that you are paying for a particular sin . . . They think we have gone to do something bad or gone for something from a fetish priest . . . I feel lonely, all my friends have left me. (Serwaa, page 1790) Sometimes I wonder if my daughter has a boyfriend . . . since the stroke affected us, I have observed that some people are scared. Some of the boys might even say this family has stroke cases and that if you marry from it the person might get a stroke. (Serwaa, page 1790)
Finding	Psychological disruption (SS) (U)
Illustration	I never knew I was hypertensive so the whole stroke thing is a disappointment . . . I have let myself down by not going for regular checkups (Bonsu, page 1790). I really feel like ending it all . . . just to kill myself . . . because I sometimes felt if I had even died it would have been better (Delali, page 1790).
Finding	Coping strategies (SS) (U)
Illustration	I’m just praying to God that he will take me out of it . . . with the encouragement from my fellow Christians . . . with the help of the bible I really got this courage to keep trusting in Jehovah than ever (Delali, page 1791).
Study: Persson., <i>et al.</i> 2024	
Finding	Employment limitations (SS) (U)

Illustration	I cannot sustain it (the work hours). Because they go in the morning at 7.30, I'm at work, and we will be the last people to close at 5 or 6, and if the boss don't leave, I can't leave (Man 40-60 years, page 4). I wasn't happy; I wasn't happy at all because I wanted to go to work. But they are not waiting for me (Man 40-60 years, page 4).
Finding	Mobility limitations (SS) (U)
Illustration	... Maybe they [the city] should have more for the disabled. People are disabled, ... but Accra is not disability friendly, you know (Man ,40-60 years, page 3). I want to go to church, unfortunately they haven't installed the elevator yet. And eeh they have done the walkway, but it is steep (Woman ,40-60 years, page 3).
Finding	Psychosocial burden (SS) (U)
Illustration	Now I am handicapped, I have to lie down and get care. I'm handicapped. I cannot do anything (Man, 60-80 years, page 4). So, when you see the people around you, it seems like they are tired, they are fed up with you, it really, really brings you down, and it is not easy (Woman 40-60, page 4).
Finding	Financial burden (SS) (U)
Illustration	It is very, very difficult. This condition has really drained us. The money which has to go in, into paying the physiotherapist, paying medication, paying to go to health units. It is not easy. Not easy at all (Woman 40-60 years, page 5).
Study: Sanuade., <i>et al.</i> 2021	
Finding	Causal theories of stroke complications (SS) (U)
Illustration	Stroke survivors' knowledge on stroke complications fell under three themes: (1) physical disability, (2) cognitive disability, and (3) stigmatization (page 712). ...as you are sitting down and you can't move your leg, those are some of the things and the changes it brings to your life...because of this now I cannot walk properly. I cannot move out. Even when I am staying out I don't feel okay. When I am among people I cannot stay with the people. It is a lot of things. (Female, 43 years, page 713). The end result of such a case is that you will die. Because you would also think a lot; and with this kind of situation, you don't have to think a lot. Because when you have stroke, it comes with BP, so you don't have to think too much.... (Male, 20 years, page 714).
Study: Scheffler and Mash 2020	
Finding	Impact of contextual factors (CG) (U)
Illustration	Every day, they tried their best to get her to the living room so that she could sit with them. So, every day, they stood together and carried her (Caregiver as translated by CHW, page 7).
Finding	Need for emotional support (SS) (U)
Illustration	I'm used to do my own work. I am used to looking after myself. I cannot handle this. It is very difficult." (Stroke survivor, FG-1, page 6).
Finding	Figuring it out by yourself (CG) (U)
Illustration	I did not know. There was no one to ask. I had to figure it out by myself (caregiver, page 5).
Finding	Implications of organisation of services (CG) (U)
Illustration	It helps a lot. He could not eat by himself. The "Physio" gave him exercises and taught him to become left-handed. It's still a struggle. His speech is improving. He could not eat. And the leg too. The exercises help a lot (Caregiver, FG-3, page 8). Now, just give us our own little team. I've had them before at home. If we can only get them. ... This week it is this team. Next week you see new faces. If you think you just get used to one and you can share secrets ... then you look into a new face! "Hello! I'm so and so. And all those things. No! We know they [CHWs] are here in [ward]. They know our backgrounds. Teach them about our needs (Caregiver, FG-4, page 7).
Study: Shewangizaw., <i>et al.</i> 2023	
Finding	Living on the bread line (CG) (U)

Illustration	... he would at least bring something to eat, as he always did, we both were daily labourers our life was from hand to mouth, he used to wash cars and I worked in people's houses washing clothes or ...; but now he is not working could not even sit up on his own and I have to be here all the time because he does not want anyone else to take care of him, there are days where my children went to sleep in the empty stomach (caregiver_5, page 318).
Finding	Finding the silver lining (SS) (U)
Illustration	I used to be a soldier ... I am the man of the house, I wanted everything to be done my way, only my way ... I have never listened to my wife nor the children ...but after the stroke, it gave me time to be calm, I do not shout like I used to ... I realize I was the one disturbing my family ...now I listen to them, pray to God, have time for myself... I have never felt calmer ...it's just sad it took a stroke to realize this (stroke survivor_10, page 320).
Finding	New body (SS) (U)
Illustration	I am not lucky enough to hold my child, breastfeed her or even help to bathe her; my heart aches when I think of my incapacities...it's sad...I just could not command my hand to ...as I want to... (Stroke survivor_1, page 318).
Finding	Explanatory model (perceived cause) (CG) (U)
Illustration	The bad spirit got to her when she went to use the toilet, she should not have gone alone since she just gave birth, the bad spirit possessed her. It is 'ልክፍት' (caregiver_1, page 317).
Finding	Psychological toll (SS) (U)
Illustration	I thought about ending my life.... a lot it's just I didn't think I could I just did not want to live like this.... it was all darkness.... very hard to explain.... I thought of going to the streets and standing in front of a bus... (stroke survivor 9, page 319).
Finding	Elephant in the room (SS) (U)
Illustration	Sometimes I wanted to go to a friend's or relatives' weddings, but I do not want to ruin their memories, or pictures with my disability; I do not want to get in people's ways. I just do not go; maybe if it is death I might just go like after the third day to pay my respect and condolences (stroke survivor_3, page 319).
Study: Smythe <i>et al.</i> (2022)	
Finding	Ability to seek (knowledge of health care options, attitudes, and stigma) (SS) (U)
Illustration	No, I'm not even sure where you get a counsellor... I don't know because I didn't experience or I never had the need to go see a counsellor, so I never bothered with those kinds of things. (PWS_female_urban, page 6). At first I was very ashamed because I'm so young and I had a stroke and I was so shy to tell people (PWS_female_urban, page 6)
Finding	Ability to reach (transport, pathways to care, physical mobility related to stroke, social/family support) (SS) (U)
Illustration	I walked because I don't have a car... and then I... rested three times on the way there and on the way back (PWS_female_urban, page 6).
Finding	Ability to pay (out of pocket payments, transport costs, opportunity costs in seeking care) (SS) (U)
Illustration	They sent me a bill. I don't even have money. I don't know how I am going to pay it. It is stressful because they call almost every week (PWS female urban, page 7). There was a recommendation that he should also see a psychologist to help with stress, but this is not possible with his medical aid... I feel that the medical aids should definitely add more support in that area (PWS male urban, page 7).
Finding	Ability to engage (health provider-user relationship, caregiver support, satisfaction with care, information/communication, resilience) (SS) (U)
Illustration	I couldn't walk to the toilet. I lay there and wet myself. I lay there for a long time - wet. I asked for someone to come help me, and then they walked out of the ward...they are not competent to do that type of work (PWS_male_rural, page 7). I think you need to prepare your kids to understand better and not panic when something happens...I'm not that old but still, these things are happening, and they also need to know about it. We need to educate them about these kind of things (PWS female urban, page 8).

Finding	Ability to perceive: health literacy related to stroke, health beliefs, spiritual beliefs, and expectations (SS) (U)
Illustration	It is only God who knows why you have that stroke. If God wants me to have a stroke then who are we to question? (PWS_female_urban, page 6).
Study: Soeker and Olaoye 2017	
Finding	Rehabilitation and social support as enablers to resume stroke survivors' worker roles after stroke (SS) (U)
Illustration	The rehabilitation people they helped me, their contribution is vital because they are the ones that really make one resume back to work because like me, they engaged me and also direct me in doing different exercises so they quicken my recovery and this helped me to resume at work (P8: stroke survivor, page 603).
Finding	Returning to work is a struggle (SS) (U)
Illustration	. . . if one is working in a private establishment, to stop work will be a difficult thing, they will dismiss one because what they are after is productivity level (P3: stroke survivor, page 602).
Finding	Experience of loss by stroke survivor (SS) (U)
Illustration	It is difficult when you have been using two hands to do before, when you have been using two hands for before and you can no longer use those two hands, you are left with one normally functioning hand (P2: stroke survivor, page 600).
Study: Soeker, et al. 2024	
Finding	Re-establishing a strong belief in functional ability through occupation (MOOSE enhances one's work identity) (SSs) (U)
Illustration	I had to tell you what I like, so that you can make me feel included. I was very nervous when I came there, (laughs), uhm we did also or wait you did ask me what I do for a living like my work and so. You (occupational therapist) helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better. I don't feel like that anymore (P1; GW, page 347).
Finding	The MOOSE enables transition to the worker role in a rural context (Facilitators) (SS) (U)
Illustration	The OT did teach us how to bend and pick up heavy goed (translated; goods), and how to make the work space better. You (occupational therapist) helped, because I got so tired after the stroke, I did feel like I had no energy, so you gave me tips, like to exercise or go for a walk. That helped, and it got better. I don't feel like that anymore (P3; JF, page 347-348).
Finding	Obstacles that affect the return to work of stroke survivors in a rural community (barriers) (SS) (U)
Illustration	That was very bad, because I wanted to go back to work, and I wanted to get better, but no one wanted to help me. No one could tell me who I needed to speak to (P6; SL, page 346).
Study: Tchokote 2020	
Finding	Conscious strategies and defensive mechanisms in the face of suffering (CG) (U)
Illustration	Case Aid3 comments: "It's sad! It makes us really sad... we wonder, we question ourselves... why..., how? In short, it's hard! (page 103). There's nothing we can do about it! It's God, 's willwe accept it" (Aid3, page 103).
Finding	Sense of motivation and involvement for family (relational and closeness the quest for family) (CG) (U)
Illustration	Aid4 explains that "I felt very concerned when I saw my mother managing to look after my grandmother! I volunteered to help her! But I had to rethink my schedule! It wasn't easy, but it was really necessary (page 104).
Finding	Family experience of a parent's illness (painful experience of the diagnosis; emotional reaction to the suffering of caregivers and parents) (CG) (U)
Illustration	We noticed that suddenly he couldn't speak, he was paralyzed, he couldn't move! He lost his speech and his body movements, and we had to support to move him... he was really depressed and spent all his time crying... he was also constipated and held back his sphincters for more than two weeks, he also suffered from enuresis (silence). He was really depressed because he'him d become dependent so... (stammering) he didn't accept the dependency and he cried constantly! (Aid 2, page 101).

Finding	Experiencing the limits of medico-social , resource care and psychological support (difficulties linked to the medical and psychological care of caregivers and parents, stroke, the experience of care practice, the management of the disease with its impact on the personal and professional lives of family caregivers, and financial limits) (CG) (U)
Illustration	The situation is very difficult, have you to reconcile your daily life with his (father’s), with his condition, and the situation he finds himself in, but when you can’t see the evolution, it’s complicated, it could be a comfort if you could see the evolution, but there’s no positive impact of what I do! It’s disturbing that, despite all the efforts and resources put in place, we can’t see the expected results It’s not easy enough to get organized (Aid2, page 103).
Study: Timm., <i>et al.</i> 2023	
Finding	Changing roles and hierarchical positions (SSs) (U)
Illustration	Except when I do... when it don’t happen I go there and I supervise the workers. I have done like that... (ID: 6, page 6).
Finding	Depending on caregiver support (SS) (U)
Illustration	Um, until I got used [to it] and I saw those that prepared for me my food, by then my aunt was still [on] the other side... in Ngolwe. So then I reached a consensus and I said to myself that in this sickness of mine...will I be in one place. Then I sold my land there, part of it, and he started building for me a house there. My aunt [on] the other side had some problems too, and I brought here there...she could peel, and we cook on a charcoal stove (ID: 7, page 7).
Finding	Interrupted care due to economic constraints (SS) (U)
Illustration	Participant: [Laughs] we always drunk the medicine saying, uh, hopefully the diseases might not be in the body... And we drunk some... Interviewer: Uhh, which kind of disease were you frightened about? Participant: Stroke, diabetes, those what and the rest of the diseases (ID: 9, page 7).
Finding	Stroke leading to losses and losses leading to stroke (SS) (U)
Illustration	All my things have perished, they have died out. I don’t have even where I could start from now. All my things have perished (ID: 13, page 8).
Finding	Accepting and adapting to new ways of managing everyday life (SS) (U)
Illustration	I’ve seen the situation is permanent...There is a period I pity myself in life, it’s inevitable. Then I say to myself that even if I pity myself, it came... it’s not going back, I am not now expecting that I will go back to the way I was before. And then I got used to it so that I can work within it. When I get something to do here...I do it for myself so that I know that I earn something, a shilling (ID: 7, page 5).

Table D

C = Credible; CG = Caregiver; CHW = Community health worker; FG = Focus group; ID = In-depth interview; P = Participant; PWS = Person with stroke; SS = Stroke survivor; U = Unequivocal.

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