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Review Paper

Adult Stroke Survivors' Reintegration to Normal Living: A Scoping Review

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ABSTRACT

Background and Objectives: Stroke is a leading cause of long-term disability globally. Successful recovery depends on reintegration to normal living (RNL); a synthesis of the drivers of RNL across global contexts remains incomplete. This study aimed to systematically map and synthesise evidence on the determinants, interventions, and outcome measures associated with adult stroke survivors' RNL.

Methods: Guided by the Arksey and O'Malley framework and PRISMA-ScR guidelines, a systematic search of five databases (PubMed, CINAHL, Health Source, Web of Science, and Scopus) was conducted for studies published between January 1995 and December 2024. Inclusion criteria focused on peer-reviewed primary research involving adult stroke survivors (≥18 years) exploring RNL determinants or interventions.

Results: Fifty-five studies met the inclusion criteria (44 quantitative, 10 qualitative, and 1 mixed-method). Quantitative synthesis revealed that motor function and mobility were the most frequently identified significant predictors in 36% of quantitative studies. Psychosocial factors, including depression (14%) and social support (18%), were consistently linked to RNL outcomes. The RNL Index (RNLI) was the predominant measure, utilized by 57% of the included studies. Qualitative synthesis highlighted environmental barriers and the fear of falling as primary inhibitors of social participation. Effective interventions included occupational coaching, family-centred programs, and Telehealth-based self-management.

Conclusion: Return to normal living is governed by a complex interplay of physical and environmental factors. While mobility is a primary driver, emotional health and social support are equally critical. Clinical implications: Rehabilitation should shift from impairment-based models to environment-specific strategies. Providers must prioritize gait threshold attainment, address post-stroke depression, and facilitate caregiver involvement to ensure sustainable community reintegration.

Keywords: Stroke, Community reintegration, Reintegration to normal living (RNL), Rehabilitation, Stroke survivors, Determinants, Interventions

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What is "already known" in this topic:

Stroke is the second most common cause of death and disability worldwide; Reintegration to normal living (RNL) is one of the essential elements of stroke rehabilitation; High cost of neuro-rehabilitation services in the home environment hindered the reintegration of stroke survivors into the community.

What this article adds:

Motor function and mobility were the most frequently identified significant predictors of reintegration to normal living (RNL); Psychosocial factors, including depression and social support were consistently linked to RNL outcomes; The RNL Index was the predominant measure utilized by the included studies;. Environmental barriers and the fear of falling were the primary inhibitors of social participation; Effective interventions included occupational coaching, family-centred programs, and Telehealth-based self-management

Introduction

Cerebrovascular accident, or more commonly, stroke, is the second most common cause of death and disability worldwide. About 84% of the global stroke burden in 2021 was attributed to 23 modifiable risk factors. High systolic blood pressure remains the single most significant driver, contributing to over 56% of all stroke-related disability-adjusted life years (DALYs) [1]. With increasing sophistication in the medical care of stroke incidents, there is a gradual increase in the number of stroke survivors with stroke-related morbidities. These morbidities have necessitated increased utilization of physical rehabilitation facilities. Neurorehabilitation is often a long process that requires protracted periods of intervention, both in inpatient and outpatient facilities. Care is usually continued at home or community level to adapt the intervention to each survivor's natural environment. Neuro-rehabilitation services are costly when available in the home environment. This has hindered the reintegration of stroke survivors into the community [2].

Reintegration to normal living (RNL) is one of the essential elements of stroke rehabilitation [3]. It is defined as the 'reorganisation of physical, psychological, and social characteristics so that the individual can resume well-adjusted living after incapacitating illness or trauma' [4]. Reintegration into normal living is synonymous with functional status—the individual's typical performance [5]. The return of stroke survivors to family and community life involves engaging in normal roles and contributing to social groups. This successful transition depends on several complex factors [6–9]. The main determinants of reintegration include individual, physical, psychosocial, and environmental domains. Specifically, depressive symptoms and the perception of overall recovery significantly affect social reintegration [6, 10]. While Obembe et al. [8] also revealed that post-stroke depression was significantly associated with reintegration into normal living, they emphasised that motor recovery was equally crucial for community reintegration. Return to instrumental activities of daily living, such as driving a car, is significantly associated with reintegration into normal living among stroke survivors [11]. In a similar scoping review, Engel-Yeger et al. [7] recommended that participation outcomes be recovered as necessary for stroke survivors' functional recovery. Wesselhoff et al. [12] in a systematic review reported that stroke survivors' community mobility was significantly decreased compared to those without any neurological impairment. Community reintegration is a key indicator of participation and community mobility for stroke survivors; hence, more recent research has focused on it.

This review critically examined the evidence on RNL following a stroke. Despite these findings, existing literature often focuses on isolated variables rather than providing a holistic map of how physical and environmental factors intersect in the home environment. There remains a lack of clarity on which specific barriers most significantly impede the transition from clinical recovery to community participation. A scoping review methodology was selected to identify research areas on RNL for stroke survivors, using a range of research approaches, and to identify gaps in the current knowledge base to guide future research in the field.

Materials and Methods

This scoping review was based on the framework outlined by Arksey and O'Malley [13], which includes six iterative steps: (i) identifying the research question, (ii) searching for relevant studies, (iii) selecting the studies, (iv) charting the data, (v) collating, summarising, and reporting the results, and (vi) consulting with stakeholders to inform or validate findings. The sixth step, consultation with relevant stakeholders, remains optional and is considered a valued additional step, but has been excluded from this review. Recommendations made by Levac and colleagues [14] were also considered. The PRISMA extension for a scoping review (PRISMA-ScR) checklist was followed to report this study [15]. This protocol was registered on the Open Science Framework.

Step 1: Identifying the research question

Table 1 illustrates the study's population, concept, and context. This scoping review aimed to answer the following question: "To date, what evidence exists on adult stroke survivor's RNL?" The sub-questions for this review included the following:

1) To date, what evidence is there on the determinants of reintegration of adult stroke survivors into normal living? 2) What protocols, strategies, and interventions currently facilitate community reintegration for adult stroke survivors? 3) What are the gaps that exist in the reintegration of adult stroke survivors to normal living?

Step 2: Identifying relevant studies

Information Sources: With support from a subject librarian, the authors conducted a systematic search in the following electronic databases: PubMed, cumulated index to nursing and allied health literature (CINAHL), Health source: Nursing/Academic Edition, Web of Science, and Scopus for relevant published literature between January 1995 and December 2024. The initial search was conducted in 2021 and was subsequently updated in January 2025 to include all relevant literature published through December 31, 2024. The search was limited to peer-reviewed English-language articles. Grey literature, including dissertations, policy documents, and unpublished reports, was not included to ensure that the synthesized evidence has undergone rigorous peer review and methodological scrutiny. This study used a comprehensive search strategy that employed keywords, medical subject headings (MeSH), and subject-heading search terms related to key concepts, as well as the Boolean operators "AND" and "OR." A sample PubMed search is presented in Table 2. A secondary search of relevant articles from the reference lists of the included studies, using a snowball approach, was performed. Training exercises were conducted before the screening process to ensure reliability between reviewers. A single arbitrator/reviewer resolved all discrepancies between reviewers by revisiting the inclusion and exclusion criteria and instituting an additional pilot test. The EndNote reference manager was used to compile all relevant articles and identify duplicate records.

Step 3: Study selection

Eligibility criteria

This review included primary research across various designs, including randomized controlled trials (RCTs), observational studies (cohort and cross-sectional), and qualitative studies, to capture a comprehensive view of

Table 1. Eligibility criteria

Criteria	Inclusion	Exclusion
Sample	Studies involving stroke survivors ≥18 years old	Studies involving stroke survivors <18 years old
Concept	Studies reporting evidence on stroke survivors' reintegration into normal living	Studies that did not report on community reintegration into normal living
Context	Acute settings, hospital settings, rehabilitation centres, and community centres	Study settings that included only hospital-level care
Study Design	All study designs (interventional, observational, qualitative, and mixed methods)	Opinion pieces, commentaries , review studies
Language	English articles	All non-English articles
Sources	Full-text articles published to the date of the last search in 2021	Full-text articles that could not be accessed and grey literature

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Table 2. Summary of search strategy using PubMed (1995-2024)

Search Concept	Keywords and MeSH	No. of Results
Concept 1: Stroke	"Stroke" [MeSH], "cerebrovascular accident", "CVA", "hemiplegia", "brain attack", stroke survivors, stroke patients	441,050
Concept 2: Reintegration	"Patient discharge" [MeSH], "social participation" [MeSH], "community reintegration", "social integration"	3838
Concept 3: Outcomes	"Activities of daily living" [MeSH], "quality of life", "functional status", "recovery of function"	11
Combined search	(Concept 1 AND concept 2 AND concept 3) Limit: 1995/01/01 to 2024/12/31; English language; peer-reviewed	63998

reintegration. The study included articles that met the defined eligibility criteria as follows:

Selection process

A thorough title screening was conducted by Michael O Ogunlana and Ifeoma Blessing Nwosu in the electronic databases guided by the eligibility criteria. All relevant articles were imported into an EndNote library, and duplicates were removed. The EndNote library was shared among the review team for the next stage of the study selection process. A screening tool was developed using the eligibility criteria for the abstract and full-text screening phases. Two reviewers (Pragashnie Govender and Michael O Ogunlana) independently conducted abstract and full-text screening and grouped them into "include" or "exclude" categories. Discrepancies between Pragashnie Govender and Michael O Ogunlana during the abstract screening phase were addressed through discussion among the review team until consensus was reached. At the full-text phase, Ifeoma Blessing Nwosu and Olufemi O. Oyewole resolved any discrepancies between Pragashnie Govender and Michael O Ogunlana. Where an article could not be accessed freely online, assistance from the institution's library services was sought. The original authors were also accessed via email for requests for complete texts, if necessary. Cohen's kappa coefficient (κ) statistic was calculated to determine the inter-rater agreement between the reviewers at the end of the full-text screening phase. The PRISMA flow diagram [16] was adopted to report the screening results, as illustrated in Figure 1.

Step 4: Charting the data

A form was developed in Google Forms for data extraction and piloted to ensure accuracy. After thoroughly reading the full texts, Pragashnie Govender and Michael O Ogunlana extracted all relevant data from the included articles. The data extraction form included the following details: (i) title of the study, (ii) year of publication, (iii) study setting, (iv) aims, (v) country of the study, (vi) study design (vii), study participants (viii), study results, (ix) findings relevant to answer the question, (x) conclusion, and (xi) recommendations. Any discrepancies during data extraction were resolved through discussion among the two extractors (Pragashnie Govender and Michael O Ogunlana), with Olufemi O. Oyewole serving as a third-party arbitrator when consensus could not be reached. The form was continually updated to capture all relevant data to answer the review question.

Step 5: Collating, summarizing, and reporting the results

The review team ensured that the extracted data were exposed to thematic analysis [17]. Relevant themes and sub-themes relating to the study objectives were developed around the following: (i) determinants of reintegration, (ii) protocols, strategies, and interventions available for stroke survivors that assist in community reintegration, and (iii) identified gaps in the successful reintegration of stroke survivors to their relevant communities. This was presented as a narrative of the relevant themes and sub-themes. Where possible, tables and figures were also used to show the results.

Step 6: Methodological quality appraisal

Although not mandatory, the critical appraisal of evidence sources was included in this review to assess methodological quality using the Mixed Methods Appraisal Tool (MMAT) [18]. This instrument has a prescribed set of questions that examine the appropriateness of the different sections reported in each evidence source. A quality score was assigned to each reported study, with ≤50% interpreted as low quality, 51-75% as average quality, and 76-100% as high quality [19]. Two reviewers (Michael O Ogunlana and Olufemi O. Oyewole) independently conducted the quality appraisal to reduce bias. The quality appraisal scores were used to contextualize the strength and reliability of the evidence; however, low-quality studies were not excluded from the thematic analysis, consistent with the inclusive nature of scoping review methodology.

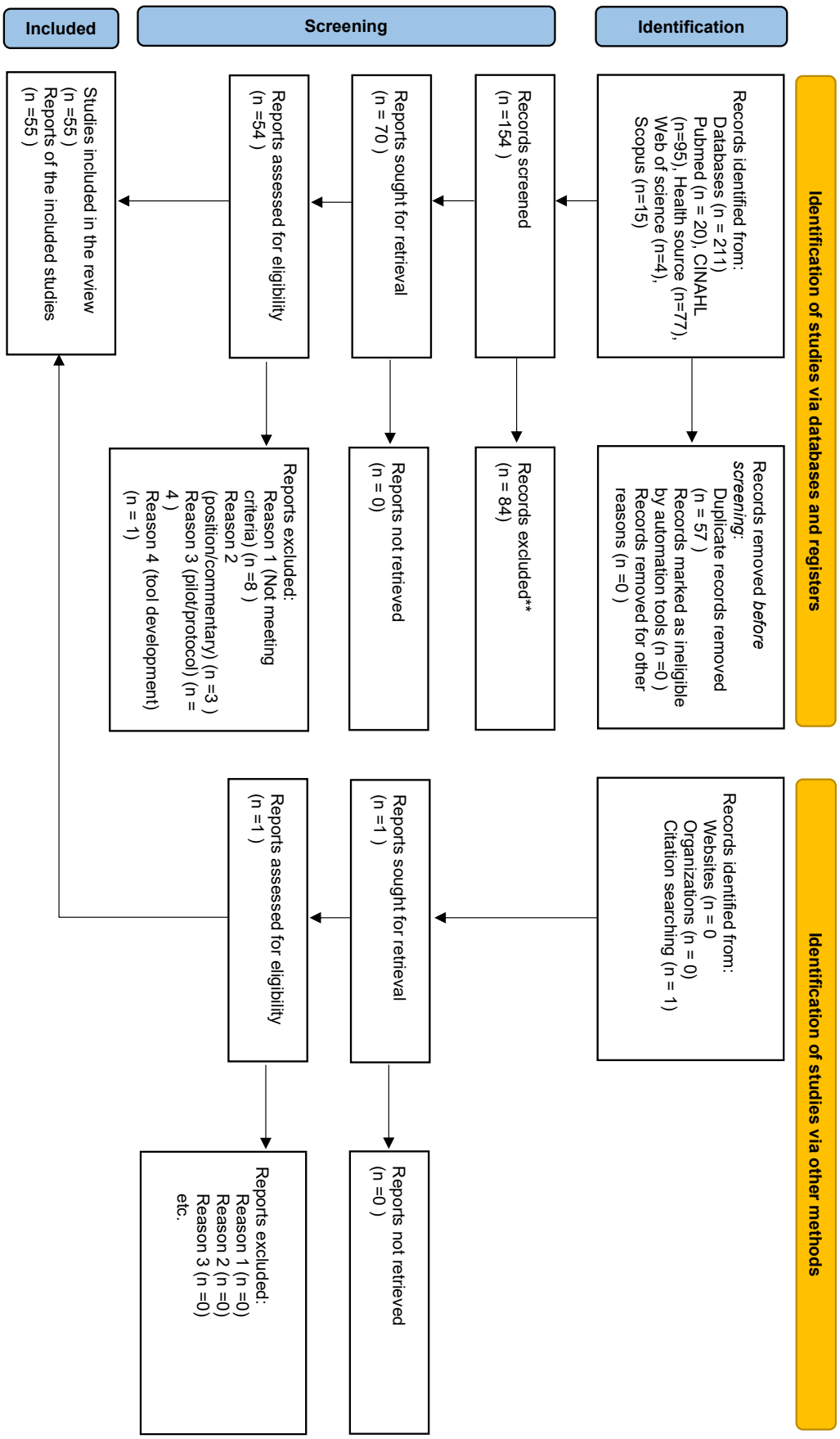

Figure 1. PRISMA flow diagram [16]

Results

One hundred and fifty-four (154) articles met the eligibility criteria following the deletion of 57 duplicates from the 211 articles identified at the title screening stage, as illustrated in the PRISMA flow diagram (Figure 1). Subsequently, 84 and 16 articles were excluded following abstract and full-text screening, respectively. Reasons for exclusion after full-text screening included: a tool development and validation study in the post-stroke population [20], a tool development and validation study in the post-stroke population [20]; a position paper on the return to driving and reintegration of stroke survivors [21]; Cott et al. [22] wrote a commentary on preparing stroke survivors for reintegration; Jhaveri et al. [23] reported a pilot study on the feasibility of Telerehabilitation for stroke survivors; and Merz et al. [24] reported a factor analysis of the RNL index. Miller et al. [25] published a position paper on the transition of stroke survivors to the home environment, and Plow et al. [26] also published a proposal on a weight management program for stroke survivors. Montgomery et al. [27] and Somerville et al. [28] published protocols on the community reintegration of stroke survivors. Ogourtsova et al. [29] reported clinicians' opinions on the use of virtual reality in the assessment of hemineglect. Sieber et al. [30] reported an autoethnography on the authors' personal experience as stroke survivors. Stark et al. [31] reported an unpowered study that examined the feasibility of community-based environmental modification intervention (COMPASS) among stroke survivors. A study [32] reported the inter-rater reliability of the RNL Index; two studies [33, 34] reported the psychometric properties of the subjective index of physical and social outcome (SIPSO); and a study [35] reported the perceptions of stroke survivors about therapeutic relationships and client-centered practice. Overall, 55 studies met the study eligibility criteria for data extraction, including one study identified following an updated search. There was substantial agreement between the reviewers' responses at the full-text screening stage (Kappa statistic=0.90, P<0.01).

Characteristics of the included studies

The characteristics of the 55 studies included are summarized in Appendices 1, 2 and 3. Ten studies utilized a qualitative methodology [9, 36–44]. A study used a mixed-methodology [45], while the remaining 44 studies used a quantitative methodology. All included studies were published in English between 1995 and 2024. Twenty-two studies [11, 37, 41, 42, 45–62] were conducted in institutionalized settings, like rehabilitation homes, hospitals, and outpatient care, while the remaining 33 studies were conducted in community settings. Of the 55 studies, 17 were conducted in Canada [11, 40, 43–46, 53, 59, 63–71], eight studies were conducted in the USA [39, 48, 49, 58, 62, 72–74], seven studies were

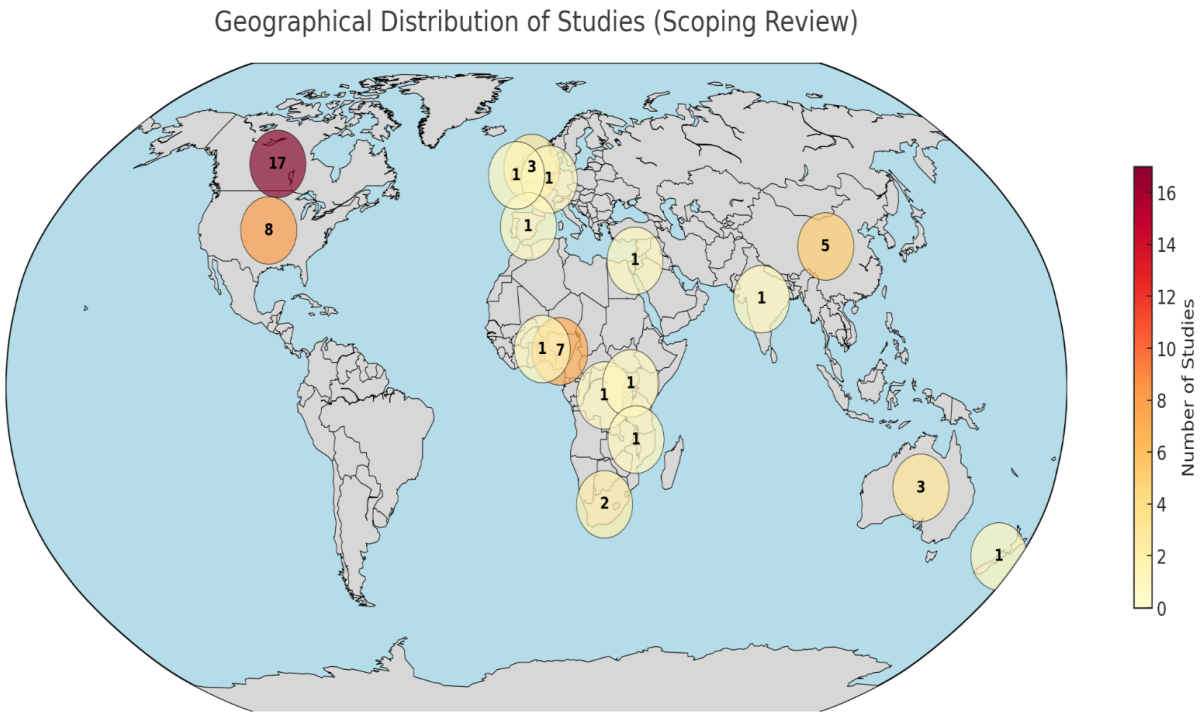

Figure 2. Geographical distribution of studies (n=55)

conducted in Nigeria [8, 54–56, 61, 75, 76], four studies were conducted in China [47, 60, 77, 78], three studies were conducted in Australia [38, 52, 79], two studies were conducted in each of South Africa [9, 51], and the United Kingdom [80, 81]. One study was conducted in each of these countries: Netherlands [82], Congo [83], India [84], Israel [50], New Zealand [42], Uganda [41], Spain [85], Benin [86], Ireland [57], Scotland [36], Hong Kong [87], and Malawi [37] (Figure 2).

Quality of evidence

The 55 studies underwent methodological quality assessment using the Mixed Methods Appraisal Tool (MMAT software, version 2018) [18]. Out of the 44 included studies that had a quantitative methodology, the methodological quality appraisal score ranged from 50 to 100%, with 15 studies [8, 46, 58, 61–63, 65, 66, 68, 69, 78, 81–83, 85] scored 100%, 26 studies [11, 47–49, 51–57, 60, 64, 67, 70, 72–77, 79, 80, 84, 86, 87] scored 75%, and three studies [50, 59, 71] scored 50%. Ten studies used a qualitative methodology, with quality appraisal scores ranging from 75% to 100%. Three of these studies [37, 38, 41] scored 100%, and 7 of these studies [9, 36, 39, 40, 42–44] scored 75%. The only mixed-method study [45] scored 100%. Methodological limitations were primarily found in quantitative, non-randomized studies, where pre-stroke functional status was often not accounted for as a confounding variable. In qualitative studies, the most common deficit was a lack of transparency regarding 'researcher reflexivity'—how the researchers' own perspectives may have influenced the data collection and analysis.

Study finding

Determinants of stroke survivors' reintegration into normal living

Different authors described the determinants of stroke survivors' reintegration into normal living in various ways across studies using quantitative methodologies. Some authors described this construct as a predictor of community reintegration; others referred to it as a measure of participation, handicap, satisfaction, and well-being. Mulder et al. [82] concluded that a comfortable gait speed of not less than 0.5 m/s positively predicted community reintegration for stroke survivors. This was supported by other two studies [56, 83]. Mwaka-Rutare et al. [83] reported that higher walking speed improves basic activities of daily living, thereby improving community reintegration, while Olawale et al. [56] focused on increasing cadence (steps per minute) as a positive determinant of community reintegration. Increasing gait speed is also associated with improved motor function, as reported by Obembe et al. [8] as a positive predictor of community reintegration. However, Olawale et al. [56] also reported functional mobility. Hoffman et al. [52] also reported that balance self-efficacy, mobility, and stroke duration positively predict community reintegration. They further identified decreased stride time and fall self-efficacy as negative predictors of community reintegration for stroke survivors.

Some researchers [60, 77, 86, 87] examined the roles of balance self-efficacy, participation self-efficacy, absence of fear-avoidant behaviors, and self-efficacy as positive predictors of community reintegration. Pang et al. [87] reported that balance self-efficacy accounted for 6.5% of the variance of community reintegration. Some studies [54, 56, 76] reported increasing post-stroke duration as a positive predictor of community reintegration; however, only one study [73] reported increasing post-stroke duration as a negative predictor of community reintegration. Demographic variables, such as age and gender were also found to significantly influence community reintegration. Increasing age was unanimously described as a negative predictor of community reintegration for stroke survivors [8, 52, 75]. Being female [79] was a positive predictor of home integration, but Soni et al. [84] concluded that gender was not a determinant of community reintegration among stroke survivors.

Stroke survivors' social status, like living in a higher-income neighbourhood [66], being employed post-stroke [75], having higher levels of well-being through higher incomes [67], and having social (family and spousal) support [54, 65, 72, 74], significantly predicted community reintegration positively. Beckley [72] reported that after controlling for many factors, like age, race, income, and functional limitation, social support was found to be most predictive of community reintegration among stroke survivors. The car driving status was also investigated; researchers [11, 48] reported that the ability to return to driving a car was a positive predictor of community reintegration. The ability to drive post-stroke, when combined with stroke severity, predicted 32% of the possibilities of attaining community reintegration [11], especially among male stroke survivors 48]. The presence of comorbidities, like high blood pressure and T2DM [75], depression/poor emotional health [8, 65, 74, 75, 79], disabilities [65], and dependence on assistive mobility devices [75] were negative predictors of community reintegration. The absence of subjective cognitive complaints was also positively associated with community reintegration [79].

The qualitative research reviewed explored the determinants of community reintegration among stroke survivors. Govender et al. [9] reported the fear of falls and stigma as barriers and family/friend support as enablers to community reintegration. Similarly, Maratos et al. [43] reported that ease of access to social support services, adequate transportation, and accommodation post-stroke enable community reintegration. The need to focus on the transition to a home environment during rehabilitation was reported as an enabler of community reintegration by Gustafsson and Bootle [38], and uneven environmental terrains, altitudes, and inaccessible structures were reported to hinder community reintegration [37]. Kamwesiga et al. [41] reported a focus on the use of mobile phones by stroke survivors as an enabler of social integration that may aid community reintegration. The role of timely education about oriental diets and traditional medicines for stroke survivors' rehabilitation is reported as an enabler of community reintegration [44]. Attainment of rehabilitation goals, like improvement in hand function, balance, driving, and memory are enablers of community reintegration [39]. The use of community-based recreational services is also reported to enhance community reintegration [40]. Accordingly, determinants of reintegration can be categorized into four primary domains: Physical and functional: gait speed and motor recovery were the most frequently cited predictors [8, 56, 82]. Specifically, a gait speed of ≥0.5 m/s served as a critical threshold for community mobility [82, 83]. Psychological: Self-efficacy and the absence of depression were consistently linked to higher participation [8, 65, 87]. Conversely, fear of falling emerged as a primary psychological barrier in qualitative reports [9, 39]. Social: family and spousal support were the strongest predictors of social reintegration across both high- and low-resource settings [54, 72]. Environmental factors, such as car-driving status [11] and neighbourhood income levels [66], significantly influenced the ease of community re-entry. Appendices 1, 2, 3, 4, 5 and 6 present the summary of these findings.

Protocols, strategies, and interventions to support community reintegration for stroke survivors

Thirteen articles reviewed described protocols, strategies, and interventions to support stroke survivors in achieving community reintegration. Kessler et al. [68] reported the usefulness of occupational performance coaching in enhancing stroke survivors' achievement of community reintegration. The family-centred community stroke program [71] improved the perception of leisure competence of stroke survivors and their spouses, and was reported to have enabled reintegration into the community. Different versions of the Improving Participation After Stroke Self-Management (IPASS) contributed to enhancing community reintegration. Harel-Katz et al. [50] used the culturally adapted version of IPASS, while Lee et al. [62] used the rehabilitation version of the IPASS in their article. Huijbregts et al. [53] reported the use of a Telehealth stroke self–management program called Telehealth Moving on After Stroke (T-MOST), which helps enhance community reintegration for stroke survivors.

Multimodal exercise rehabilitation program [85], primary healthcare-based physiotherapy intervention [55], getting on with the rest of your life mission possible [69] community re-engagement cue to action trigger tool - CRCATT [45], community-based recreation [40], and coaching-based Tele-occupational guidance [78] were all documented to have enhanced community reintegration among stroke survivors. Client-centred ‘tune-ups” [46] and Family Support Organizer Program [81] are strategies that did not significantly enhance community reintegration. Intervention efficacy appeared to be influenced by delivery mode and intensity. Programs utilizing Telehealth [53, 78] or intensive coaching [68] reported higher participant engagement and significant RNLI improvements compared to one-off 'tune-up' sessions [46], which lacked the sustained intensity required for long-term behavioural change.

Measures of community reintegration

Most articles (56.4%, 31 out of 55) that qualified for this review utilized the Return to Normal Living Index (RNLI) to measure the extent of community reintegration. Other articles measured community reintegration using a Community Ambulation Questionnaire [82], a Community Integration Questionnaire [79], a Community Integration Measure [77], a Direct Measure of Community Mobility [49], and working speed [85]. The Adapted Maleka Stroke Community Reintegration Measure [54] was used to estimate the extent of community reintegration. Tools used in other research include the return-to-work [57], SIPSOs [46], and post-stroke checklist [47, 70, 80]. While the RNLI was the most frequent measure (57%), it focuses heavily on subjective perception. In contrast, tools, like the SIPSO and Maleka measures showed lower adoption rates, likely due to a lack of extensive psychometric validation across diverse cultural contexts compared to the well-established RNLI.

Quantitative synthesis of results

Of the 44 quantitative studies included in this review, several key determinants of RNL were consistently re-

ported. Motor function and mobility indicators, such as gait speed, cadence, and balance, were among the most frequently assessed variables. These were investigated in approximately 16 studies (36%), and nearly all identified them as strong positive predictors of reintegration outcomes. For example, a gait speed of ≥0.5 m/s was linked to better reintegration in studies by Mulder et al. [82] and Mwaka-Rutare et al. [83], while cadence and motor recovery were emphasized in studies from Nigeria by Olawale et al. [56] and Obembe et al. [8]. Depression and emotional health were examined in at least 6 studies (14%). All of these studies reported negative associations between post-stroke depression and reintegration, suggesting that emotional well-being plays a critical role in post-stroke recovery and community participation [59, 74, 75, 79]. Balance between self-efficacy and confidence in performing daily activities was evaluated in 6 quantitative studies (14%), including those by Pang et al. [87], Liu et al. [77], and Honado et al. [86]. These studies found statistically significant positive relationships between self-efficacy scores and reintegration outcomes.

Social support was identified as a facilitating factor in at least 8 quantitative studies (18%), including those by Egan et al. [67], Okoye et al. [54], and Beckley [72]. These studies highlighted that stroke survivors with strong family or spousal support were significantly more likely to achieve higher reintegration scores. Post-stroke duration was assessed in 5 quantitative studies (11%), with mixed findings. While three studies [56, 75] found that longer duration post-stroke improved reintegration, at least one study [73] indicated a decline over time. Comorbidities, such as hypertension, diabetes, and stroke-related complications were reported as barriers to reintegration in approximately 5 studies (11%), with all of them showing negative associations [75, 79]. Demographic variables, particularly age, were commonly analyzed. Older age was found to negatively impact reintegration in at least 5 studies (11%), including those by Hoffman et al. [52] and Olawale et al. [56]. Gender was reported in several studies but showed no consistent pattern; for instance, Kimonides et al. [79] found gender-specific effects, while Soni et al. [84] found no significant association. Driving ability and return to work as indicators of functional independence were studied in 2–3 quantitative studies (4–7%), such as studies by Finestone et al. [11] and Griffen et al. [48], and were found to have positive correlations with reintegration scores. Interventional studies among the 44 quantitative papers numbered about 13(30%). Most of these interventions—including Telehealth, occupational coaching, and structured self-management—reported statistically significant improvements in reintegration scores post-intervention [53, 62, 68, 71]. However, two studies [46, 81] showed no significant effect, suggesting the need for context-specific or more personalised approaches. Regarding measurement tools, the RNLI was the most frequently used instrument, applied in about 25 of the 44 quantitative studies (57%). Other tools included the SIPSO and the community integration questionnaire, though these were used less consistently.

Qualitative synthesis of results

The qualitative studies included in this review provided deep insights into how stroke survivors experience reintegration into their communities [9, 36, 38, 40, 41, 43, 44, 53, 88]. Emotional, social, and environmental dimensions were consistently highlighted as shaping the reintegration process.

A key theme across several studies was the emotional complexity of reintegration [9, 36, 43]. Survivors often expressed fear, anxiety, and frustration about resuming social and occupational roles [9, 43]. For example, Govender et al. [9] emphasized that fear of falling and social stigma restricted survivors' community mobility, even in the presence of good physical recovery. Similarly, Maratos et al. [43] reported that high-functioning survivors withdrew from public spaces due to internalized emotional and psychological challenges.

Environmental and societal barriers were another frequent theme [9, 36, 41, 88]. Studies conducted in low-resource settings, such as Malawi [88] and Uganda [41], identified poor infrastructure, inaccessible public transport, and lack of rehabilitation continuity as key constraints. These structural limitations restricted survivors' ability to fully participate in community life [41, 88]. Brookfield et al. [36] also described how physical environments could either facilitate or obstruct reintegration, depending on their design and accessibility.

Social relationships emerged as a vital component of successful reintegration [38, 44, 53]. Survivors emphasized the importance of family, caregivers, and peers in supporting their transition from rehabilitation to home and community [38, 44]. In Yeung et al.'s study [44] involving Chinese-Canadian stroke survivors, family support was essential to rebuilding confidence and promoting functional participation. In contrast, the absence of such support was linked to emotional isolation and reduced community participation [44]. Some studies reported that survivors relied on personal agency and adaptive coping strategies to reclaim autonomy [40, 41]. These included spiritual practices, goal-setting, and use

of mobile phones to enhance communication and independence [41]. Hebblethwaite and Curley [40] highlighted how community recreation activities served as meaningful platforms for survivors to reestablish identity and social connection.

Finally, studies examining survivors' feedback on rehabilitation interventions showed that while structured programs were helpful, many participants preferred person-centered, flexible, and emotionally attuned approaches [36, 53]. Ryan et al. [71] and Huijbregts et al. [53] both reported a mismatch between professional goals and survivor expectations, reinforcing the need for holistic and individualised models of care [36, 53].

Discussion

The present scoping review aimed at mapping the evidence of stroke survivors' reintegration into community living. The available resources and evidence on factors that determine reintegration into normal living among stroke survivors were highlighted in the scoping review. Different authors described the determinants of stroke survivors' reintegration into normal living in various ways across studies using both quantitative and qualitative methodologies. RNL is a multifaceted process influenced by the intersection of physical, psychological, and social domains. In the physical domain, mobility functions—specifically gait speed, cadence, and motor recovery—showed strong associations with successful reintegration [8, 56, 82, 83]. Notably, a gait speed threshold of 0.5 m/s appears to be a critical indicator for community-level ambulation [82, 83]. While these findings suggest that maximizing motor recovery before discharge is vital, the cross-sectional nature of most included studies means these should be viewed as correlates rather than direct causes of reintegration.

Evidence from previous studies suggests that balance efficacy and the absence of fear- avoidant behavior are significant determinants of stroke survivors' community reintegration [56, 77, 86, 87]. Stroke survivors have expressed fear of falls as a barrier to their community reintegration [9]. Most stroke survivors are elderly, and fall risk is reported to be high among the elderly [88, 89]. Thus, this should be addressed before discharge home. All stroke survivors should be prepared for home discharge, focusing on balance efficacy, proper education on fall risk, self-efficacy, and fear-avoidant behavior to enhance better community reintegration. Beyond physical capacity, psychological readiness is paramount. Our review highlights that balance self-efficacy and the absence of fear-avoidant behaviours are significant predictors of participation [56, 77, 86, 87]. Qualitative insights further clarify this, revealing that even survivors with high physical function may withdraw from social spaces due to a fear of falling or the stigma associated with visible disability [9, 43]. This psychological burden is often exacerbated by environmental barriers. Qualitative evidence suggests that uneven terrains and inaccessible public structures do not just hinder physical movement; they actively discourage social participation [37, 38]. Transitioning from institutional care to the home environment requires a shift in focus from "impairment-based" recovery to "environment-specific" adaptation.

It is noteworthy that some included studies reported that an increase in post-stroke duration is a positive predictor of community reintegration among stroke survivors [54, 56, 76]. Stroke survivors have probably mastered their environment, thus limiting the risk of falls and fear-avoidant behaviour. They may improve their motor function over time and can now engage more in physical activities, such as driving a car, which they could not do before. The ability to return to driving a vehicle has been reported as a positive predictor of community reintegration [11, 48]. However, the gains of longer post-stroke duration are reduced by comorbidities associated with stroke incidents. As expected, comorbidities, such as high blood pressure, diabetes, and depression compromized community reintegration among stroke survivors [8, 74, 75, 79]. This suggests that comorbidities should be considered and treated promptly while stroke survivors undergo rehabilitation.

Better social support and improved social status were also discovered to influence good community reintegration among stroke survivors [54, 66, 67, 72, 74, 75]. These underscore the importance of all stakeholders, including spouses, family members, friends, and governments, providing adequate social support. Ease of access to social support for all stroke survivors should be enhanced and promoted by all stakeholders. Efforts should be directed toward rehabilitation to improve post-stroke employment and enhance financial independence, as this may allow survivors to live in higher-income neighbourhoods and achieve higher levels of well-being, all of which have been reported as positive factors for community reintegration [66, 67].

Demographics, such as age and gender were also identified as determinants of community reintegration among stroke survivors. Increased age was associated with poor community reintegration [8, 75]. Probably, older people are more prone to disabilities and more dependent on assistive mobility, which explains the observation. Dis-

abilities and dependence on assistive mobility devices have been noticed to hamper community reintegration [65, 75]. This implies that while preparing older people with stroke for home, all support needed to facilitate smoother community reintegration should be provided, and all factors that could limit it, such as depression, disabilities, and comorbidities, should be addressed before discharge. Though there are conflicting reports about gender influence on community reintegration among stroke survivors, all stroke survivors should be given equal attention while preparing for home.

The home and community environments matter, as they have been suggested to influence reintegration. The focus on transitioning to a home environment during rehabilitation was reported as an enabler of community reintegration [38]. Uneven environmental terrains, altitudes, and inaccessible structures should be addressed before discharge, as these have been reported to hinder community reintegration [37]. The present scoping review highlighted helpful strategies and interventions to support stroke survivors in achieving community reintegration. Strategies, such as occupational performance coaching and family-centred community stroke programs have been documented as enablers of community reintegration among stroke survivors [68, 71]. The success of interventions, such as occupational coaching [68] and telehealth-based self-management [53] likely stems from their ability to provide sustained, contextualised support in the survivor's natural environment. In contrast, 'tune-up' strategies [46]—which are often brief or isolated—may fail because they do not address the complex, evolving psychosocial barriers that survivors face months after discharge. This suggests that for rehabilitation to be effective, it must be longitudinal and adaptive rather than episodic. Adding these strategies will enhance community reintegration, improve quality of life, and provide social support.

The studies included in this scoping review are well distributed across continents and countries, and most are of higher quality. However, a few limitations are worth mentioning. First, the significant heterogeneity of outcome measures—ranging from the RNLI to self-developed questionnaires—hinders the ability to compare findings across different geographic regions. Second, excluding grey literature while maintaining peer-reviewed standards introduces a potential publication bias, particularly by omitting localized policy reports from low- and middle-income countries. Finally, because most included studies were cross-sectional, we cannot definitively establish a temporal causal relationship between the identified determinants and reintegration outcomes.

Conclusion

This scoping review highlights the multifaceted nature of reintegration into normal living among adult stroke survivors, revealing a complex interplay of physical, psychological, social, and environmental determinants. Key factors, such as gait speed, motor function, balance self-efficacy, social support, and post-stroke duration are critical facilitators of success, while comorbidities, depression, environmental inaccessibility, and advanced age remain significant barriers. Although community-based, person-centred interventions involving caregivers show promise, their long-term effectiveness remains unestablished. Furthermore, the heterogeneity of outcome measures and the inconsistent application of validated tools, such as the reintegration to normal living index (RNLI), hinder meaningful cross-study comparisons. To address these gaps, we recommend standardizing reintegration outcome measures to enable global data synthesis. Most critically, the primary research priority moving forward must be the conduct of high-quality RCTs to evaluate scalable, culturally sensitive, community-based interventions, particularly within low- and middle-income countries.

Future research should focus on these underrepresented populations to design interventions that holistically integrate physical, emotional, and social rehabilitation. Ultimately, effective community reintegration must become a central objective of stroke rehabilitation. Stakeholders—including clinicians, policymakers, and community organizations—must work collaboratively to implement evidence-informed strategies that support survivors' return to meaningful roles and improved quality of life.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of University of KwaZulu-Natal, Westville-KZN, South Africa (Code: 00008037).

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Authors' contributions

All authors drafted the initial protocol, critically reviewed it for intellectual content, subsequently revized it for publication, and read and approved the final version of the manuscript.

Conflict of interest

The authors declared no conflict of interest.

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Appendix 1. Characteristics of the Qualitative Studies (n=10)

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Finding(s)
Govender et al. 2019 [9]	South Africa	To explore CVA survivors' experiences of community reintegration in a peri-urban context	Explorative qualitative design; semi-structured interviews; thematic analysis	8 CVA survivors (5 males, 3 females), aged 38–79, purposively sampled	KwaDabeka, peri-urban community, KwaZulu-Natal	Six themes: 1) Loss of autonomy and roles, 2) barriers to reintegration, 3) social isolation, 4) internal strength, 5) enablers (support & rehab), 6) recommendations (home-based rehab, caregiver training).
Brookfield & Mead 2016 [36]	Scotland, UK	To explore the role of the physical environment in community reintegration post-stroke	Qualitative study (focus groups)	29 participants (17 members, 10 volunteers, 2 support workers)	Community stroke clubs, Scotland, UK	Stroke altered perceptions of the environment; accessible public/social spaces (cafés, parks, and theatres) facilitated reintegration; peer support is valuable.
Chimatiro 2012 [37]	Malawi	To explore barriers to reintegration experienced by stroke clients post-discharge from rehabilitation	Qualitative study (in-depth interviews)	23 participants (8 clients, 8 caregivers, 7 service providers)	MAP kachere rehabilitation Centre and community, Malawi	Barriers existed at individual (impairments, depression, anxiety, comorbidities) and environmental (poor terrain, inaccessible structures, poverty, stigma) levels.
Gustafsson & Bootle 2013 [38]	Australia	To understand transition experience for clients with stroke and their carers during discharge and the first month at home	Descriptive qualitative study; semi-structured interviews; inductive thematic analysis	5 clients with stroke and 5 carers, one month post-discharge	Metropolitan hospital rehabilitation unit; participants discharged home	Client themes: 1) Rehabilitation was good, 2) it is a struggle, 3) supports/assistance. carer themes: 1) purpose of rehabilitation , 2) life is different now, 3) looking to the future. the study highlighted gaps in preparation and challenges of disrupted routines.
Hay et al. 2022 [39]	USA	To examine the utility of IPA to identify goal priorities in community-dwelling stroke survivors	Cross-sectional structured interviews; quantitative IPA analysis	38 community-dwelling stroke survivors (mean age 63; 50% White, 37% Black; avg. 8 years post-stroke).	Houston & Galveston, Texas; recruited from support groups & outpatient rehab	IPA identified top priority goals: Hand function, driving, balance, memory, and arm strength. Men rated mood control more important; older survivors prioritized home accessibility and skin health. Supports need for individualized goal setting.
Hebblethwaite & Curley 2015 [40]	Canada	To explore the role of community-based recreation in stroke recovery among survivors engaged in TR	PAR using photovoice; photographs, individual interviews; constant comparative method	14 stroke survivors (6 women, 8 men); age 52–76 (mean: 66); average 3.8 years post-stroke	Community stroke rehabilitation team (grey-bruce region, Ontario, Canada)	Recreation supported recovery by fostering collective support, hope, and community engagement. Group leisure helped participants adapt, persevere, regain confidence, and re-integrate socially.
Kamwesiga et al. 2016 [41]	Uganda	To describe the experiences and meaning of using mobile phones in everyday life after stroke among survivors and their families	Qualitative; semi-structured interviews; constant comparative GT	11 cases with stroke (age: 25–75; 2 months to 3 years post-stroke; Barthel Index varied 35–100) plus 9 family caregivers	Kampala, Uganda and suburbs; home environments and rehabilitation centers	Seven categories were identified: Phones as enablers of communication, agency, structuring routines, social/economic well-being, belonging, reintegration, and caregiver security. Core category: Mobile phone as a "lifeline" and extension of the body.

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Finding(s)
Lemke et al. 2019 [42]	New Zealand	To explore motivators and barriers to ICT use in everyday life after stroke	Qualitative+ video observation; semi-structured interviews; thematic analysis	6 stroke survivors (4 men, 2 women), age: 60–82, 8 months to 12 years post-stroke, with upper-limb disability	Participants' homes and clinic settings (urban and rural NZ)	Motivators: Connection with others, safety, reintegration, leisure, rehabilitation, and tech adoption. Barriers: Sensory/motor impairments, limited vision/speech, and device-specific limitations. ICT supported social interaction and safety but smartphone use was challenging.
Maratos et al. 2016 [43]	Canada	To explore the lived experience of high-functioning stroke survivors using photovoice	Qualitative study using photovoice and interviews/ group discussions	High-functioning stroke survivors	Community	Highlighting invisible disabilities, identifying shifts and the importance of social support and meaningful activities for integration.
Yeung et al. 2015 [44]	Canada	To examine the experiences and needs of Chinese-Canadian stroke survivors and family caregivers during reintegration	Qualitative descriptive study using in-depth interviews	Stroke survivors and family caregivers	Community	Cultural values, language barriers, and family obligations shaped reintegration; the need for culturally sensitive support.

CVA: Cerebrovascular accident; IPA: Importance-performance analysis; TR: Therapeutic recreation; PAR: Participatory action research; GT: grounded theory.

Appendix 2. Characteristics of the mixed methods study (n=1)

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
McKellar et al. 2015 [45]	Canada	To evaluate the impact of the community re-engagement "cue to action" trigger tool post-stroke	Mixed-methods: quantitative measures + qualitative interviews	Community-dwelling stroke survivors	Community rehabilitation programes	The trigger tool enhanced reflection, goal-setting, and activity participation post-stroke.

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Appendix 3. Characteristics of the quantitative studies (n=44)

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
Obembe et al. 2013 [8]	Nigeria	To explore the association of community reintegration with motor function and post-stroke depression	Cross-sectional study; assessments of motor function, depression, and community reintegration	Ninety community-dwelling stroke survivors	Community/outpatient setting in Nigeria	Both motor function and depression were significantly associated with community reintegration; better motor function and lower depression were associated with higher reintegration.
Finestone et al. 2010 [11]	Canada	To investigate the relationship between driving versus not driving and community integration after stroke.	Prospective longitudinal study; data were collected three times (at baseline and ≥1 month, 3 months, and 1 year after stroke). Semi-structured interviews and RNLI	53 community-dwelling post-stroke patients referred for driving assessment; at 1 year, 43 remained in the study.	Six driving evaluation centres; a community setting in Ontario, Canada	Driving status at 1 year was significantly associated with community integration–drivers had higher RNLI scores than non-drivers. People who resumed driving had increases in RNLI. Driving+health status explained about 32% of the variance in RNLI scores.
Brouwer et al. 2018 [46]	Canada	To assess the effect of client-centred "Tune-Ups" on reintegration, mobility, and QoL after stroke	Randomized controlled trial	Community-dwelling stroke survivors	Outpatient/ Community rehabilitation	Client-centred tune-ups significantly improved reintegration and mobility vs. usual care.
Chau et al. 2021 [47]	Hong Kong	To identify factors associated with post-stroke depression	Cross-sectional study with structured assessments	Chinese stroke survivors	Hospital and community	Depression is associated with functional dependence, poor social support, and lower QoL.
Griffen et al. 2009 [48]	USA	To examine the relationship between driving status and community integration post-stroke	Observational quantitative	Stroke survivors (drivers vs. non-drivers)	Community	Driving is linked to higher community integration and social participation.
Hanke et al. 2019 [49]	USA	To measure community mobility using GPS in stroke survivors	Prospective observational with GPS tracking	Stroke survivors	Urban community	GPS provided objective mobility data; variability in community engagement was observed.
Harel-Katz et al. 2020 [50]	Israel	To test the feasibility/effectiveness of a culturally adapted participation-focused self-management program	Randomized pilot study	Stroke survivors in Day Rehabilitation Center	Day Rehabilitation Center	The program was feasible; improved participation, self-efficacy, QoL vs. controls.
Hassan et al. 2012 [51]	South Africa	To assess community integration and productivity outcomes in Western Cape CVA survivors	Cross-sectional survey	Community-dwelling stroke survivors	Western Cape Metro	Moderate community integration; poor employment/productivity outcomes; the need foe targeted rehabilitation and social support.
Hoffman et al. 2003 [52]	Australia	To investigate post-stroke outcomes: ADLs, community reintegration, and health status	Observational cohort	Stroke survivors post-discharge	Community	Independence in basic ADLs was achieved; limitations remained in instrumental ADLs, participation, and QoL.
Huijbregts et al. 2009 [53]	Canada	To explore the feasibility/efficacy of a telehealth stroke self-management program	Pilot study, mixed-methods	Community-dwelling stroke survivors	Telehealth program	Telehealth is feasible; it improved self-management, confidence, and participation.

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
Okoye et al. 2019 [54]	Nigeria	To examine the relationship between caregiver well-being and survivor QoL/ community reintegration	Cross-sectional survey	Stroke survivors + informal caregivers	Community	Better caregiver well-being is associated with improved survivor QoL and reintegration.
Olaleye et al. 2013 [55]	Nigeria	Development and evaluation of the primary healthcare-based physiotherapy intervention and its effects on selected indices of stroke recovery	Randomized controlled trial; participants were assigned to physiotherapy at a PHC or at their homes (domicile group). The intervention was performed twice weekly for 10 weeks; task-specific exercises. Outcomes: motor function, balance, walking speed, handicap (via RNLI), etc.	52 stroke survivors (24 males, 28 females) recently discharged from inpatient facilities in Ibadan. PHCG (n=25), DG (n=27).	Primary health care centre vs. home environment in Ibadan, Nigeria	Both groups showed improvement over 10 weeks in all measured indices (motor function, balance, walking speed, RNLI etc.), but no statistically significant difference was found between the two groups. Intervention at either PHC or home was effective.
Olawale et al. 2018 [56]	Nigeria	To identify predictors of community reintegration in adult stroke survivors	Cross-sectional analytical	Adult stroke survivors	Community rehabilitation	Functional independence, social support, and absence of depression predicted reintegration success.
Walsh et al. 2015 [57]	Ireland	To investigate community reintegration and long-term needs within 5 years post-stroke	National survey	Stroke survivors ≤5 years post-event	Community	Persistent unmet needs in mobility, social participation, and psychological support.
Wolf et al. 2012 [58]	USA	To compare activity participation between younger and older stroke survivors	Cross-sectional	Younger (<65) vs. older (≥65) stroke survivors	Community	Younger survivors are more engaged in work/ social activities; older survivors focus home-based activities.
Kapoor et al. 2017 [59]	Canada	To examine cognitive impairment, depressive symptoms, and social restrictions in physically recovered stroke patients	Observational	Physically recovered stroke survivors	Community	Many experienced cognitive deficits, depression, and social restrictions despite physical recovery.
Lo et al. 2022 [60]	Hong Kong	To investigate the association between participation self-efficacy and participation	Cross-sectional	Community-dwelling stroke survivors	Community	Higher self-efficacy is strongly associated with greater participation.
Olaleye et al. 2014 [61]	Nigeria	To compare physiotherapy outcomes at primary health centres vs. home	Quasi-experimental, pre-post	Stroke survivors	Primary health centres vs. home	Both settings improved function; home-based was linked to higher participation and convenience.
Lee et al. 2017 [62]	USA	To examine the feasibility/ outcomes of participation-focused self-management intervention	Quasi-experimental pilot, pre-post	Stroke survivors in Day Rehabilitation Center	Day Rehabilitation Center	Improved self-management, goal-setting, and community participation; feasible for larger trials.

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Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
Allen et al. 2016 [63]	Canada	To compare community stroke rehabilitation outcomes in rural vs. urban residents.	Retrospective cohort	Stroke survivors	Rural and urban rehabilitation centers	Rural residents had similar functional outcomes but faced more access barriers; they need tailored rural services.
Bluvol 2004 [64]	Canada	To examine the relationships between hope, family health promotion, and quality of life after stroke	Descriptive correlational; stroke survivors & spouses completed questionnaires (Herth Hope Index, Health Options Scale, RNL Index, demographic questionnaire).	40 families of stroke survivors with moderate to severe functional impairments, and their spouses	Community/outpatient/ families	Moderate positive relationships between hope, health work, and quality of life for both survivors and spouses. Family health work is positively associated with survivor quality of life. Spouses' employment status, number of supports, and functional independence at discharge predicted a significant portion of variance in QOL.
Clarke et al. 1999 [65]	Canada	To examine the social consequences of stroke (handicap) using the WHO ICIDH, and to identify factors influencing handicap in the first year post-stroke	Cross-sectional data from a clinical cohort of hemispheric stroke survivors at 3 months (n=145) and 1 year (n=135) post-stroke. Measures included the RNLI, Adams' Hemispheric Stroke Scale, Zung Depression Scale, and FIM	145 survivors at 3 months; 135 at 1 year; recruited from 450 consecutive hemispheric stroke admissions	Acute-care teaching hospital in Toronto, Canada, with follow-up in the hospital clinic	Physical disability and depressive symptoms were strongly associated with handicap at both 3 months and 1 year. Cognitive disability and prior stroke were associated with handicap at 1 year only. The presence of a spouse benefited male survivors at 1 year. Findings highlight the need to address disability, depression, and social supports to reduce handicap.
Egan et al. 2015 [66]	Canada	To examine the impact of neighbourhood income on participation among community-dwelling stroke survivors during the first two years post-stroke	Secondary analysis of a prospective cohort study in which participation was measured at 6, 9, 12, 18, and 24 months post-stroke with the RNLI	67 community-dwelling stroke survivors (first-ever stroke, discharged from acute or rehabilitation)	Acute care hospitals and rehabilitation centres; follow-up in the community	RNLI scores at each follow-up showed no improvement over time compared to gradual improvement in higher-income groups. Very low neighbourhood income independently predicted lower participation, even after controlling for impairment, mobility, health, and emotional well-being.
Egan et al. 2014 [67]	Canada	To examine reciprocal effects between participation and well-being in the first 2 years post-stroke	Prospective cohort study with data collected at 6, 9, 12, 18, and 24 months post-stroke using the RNLI, General Well-being Schedule, and General Self-rating of Health	67 adults discharged after first stroke, able to communicate in English or French, recruited from an acute hospital and a rehabilitation centre	Community	Participation significantly predicted later emotional well-being; marginal effect on physical well-being. Higher well-being also predicted increased participation. Effects were moderated by income and impairment. The study supports a two-pronged rehabilitation approach targeting both participation and affect

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
Kessler et al. 2017 [68]	Canada	To assess the feasibility and preliminary efficacy of occupational performance coaching for stroke survivors (OPC–Stroke) to improve participation	Pilot randomized controlled trial, with participants randomised to OPC–Stroke or usual care; outcome measures included RNLI, COPM, HADS, GSAB–DFI, MoCA	21 community-dwelling stroke survivors (mild stroke); randomized intervention vs. control	Community rehabilitation	Moderate effect on goal performance and satisfaction, significant effect on cognition; participation improved in both groups with different trajectories. OPC–Stroke appears promising but requires further testing.
Mayo et al. 2015 [69]	Canada	To evaluate the effectiveness of a structured, community-based "Mission Possible" program in enhancing participation and life engagement among community-dwelling stroke survivors	Randomized trial with immediate vs 4-month delayed entry. Outcomes were measured at baseline and 3, 6, 12, and 15 months. RNLI, Depression and Apathy Scale, gait speed, EQ-5D, and stroke-specific quality of life were measured.	186 community-dwelling stroke survivors within 5 years of onset, cognitively intact, and able to toilet independently	Eleven community sites in seven Canadian cities	Significant improvements were observed in hours of meaningful activity, community integration satisfaction, and stroke-specific quality of life. Over 45% of participants achieved ≥3 hours/week increase in meaningful activity, often requiring a full year of participation. Community-based programs targeting participation are feasible and effective, though improvements require time.
Parks et al. 2012 [70]	Canada	To examine fatigue levels in younger vs. older stroke survivors using the Fatigue Impact Scale	Observational, self-report	Stroke survivors	Community	Younger survivors reported higher fatigue than older adults.
Ryan et al. 2008 [71]	USA	To evaluate the family-centred leisure education approach to community reintegration	Intervention study, pre-post	Stroke survivors +family caregivers	Community	Improved participation, social engagement, and caregiver involvement.
Beckley 2007 [72]	Australia	To investigate the influence of social support on community participation	Cross-sectional survey	Community-dwelling stroke survivors	Community	Quality/quantity of social support positively predicted participation.
Béthoux et al. 1999 [73]	France	To examine changes in the quality of life of hemiplegic stroke patients over time	Longitudinal observational	Hemiplegic stroke patients	Hospital/ community follow-up	Modest QoL improvement; persistent physical/social participation limitations.
Ianni et al. 2023 [74]	Canada	To examine emotional health, social support, and executive function in participation	Cross-sectional	Community-dwelling stroke survivors	Community	Emotional health/social support is associated with participation; executive function is not significant.
Akosile et al. 2016 [75]	Nigeria	To assess community reintegration and related factors	Cross-sectional survey	Stroke survivors	Community	Functional independence, social support, and absence of depression are positively associated with reintegration.

Authors (y)	Country	Aim/Purpose	Study Design & Methods	Sample/ Population	Setting	Key Findings/Results
Obembe et al. 2010 [76]	Nigeria	To evaluate community reintegration in Osun State stroke survivors	Cross-sectional survey	Stroke survivors	Community	Limited reintegration; barriers included mobility restrictions and poor social support.
Liu et al. 2015 [77]	Hong Kong	To identify predictors of community reintegration	Observational	Community-dwelling stroke survivors	Community	Fear-avoidant behaviour is the strongest predictor; walking endurance is not predictive.
Zhang et al. 2022 [78]	China	To evaluate coaching-based teleoccupational guidance for home-based survivors/caregivers	Pilot RCT	Stroke survivors+ caregivers	Home-based telehealth	Improved participation, self-efficacy, and caregiver support.
Kimonides et al. 2018 [79]	Australia	To examine cognitive complaints/ depressive symptoms in social reintegration.	Cross-sectional, mediation analysis	Community-dwelling stroke survivors	Community	Depression mediated the relationship between cognitive complaints and social reintegration.
Crow 2018 [80]	UK	To identify unmet needs in patients discharged from the hyperacute stroke unit	Observational 2-week review	Recently discharged stroke survivors	Home/ community	Significant unmet needs in mobility, social participation, and support services.
Tilling et al. 2005 [81]	UK	To evaluate the family support organizer for patients/carers	RCT	Stroke patients + carers	Community/home-based support	Improved caregiver support and patient satisfaction, enhancing reintegration.
Mulder et al. 2019 [82]	Netherlands	To classify community walkers after a stroke	Prospective observational	Community-dwelling stroke survivors	Community	Classification distinguished high vs. low-functioning walkers; walking ability was linked to mobility and participation.
Mwaka-Rutare et al. 2020 [83]	Rwanda	To assess activity and participation post-stroke in a low-income setting	Cross-sectional survey	Stroke survivors	Community	Participation was limited; socioeconomic/ environmental barriers influenced reintegration.
Soni et al. 2019 [84]	India	To explore community reintegration post-stroke	Cross-sectional survey	Community-dwelling stroke survivors	Community	Reintegration is influenced by functional status, social support, and access to rehabilitation.
Grau-Pellicer et al. 2019 [85]	Spain	To determine if walking speed predicts mobility and QoL post-stroke	Observational	Community-dwelling stroke survivors	Community/ outpatient	Faster walking speed predicted better mobility and QoL.
Honado et al. 2023 [86]	Sub-Saharan Africa	To examine relationships between self-efficacy, activity limitations, locomotor ability, physical activity, and community reintegration	Cross-sectional	Stroke survivors	Community	Higher self-efficacy is associated with greater participation and activity engagement.
Pang et al. 2007 [87]	Canada	To identify determinants of satisfaction with community reintegration in older adults with chronic stroke	Observational	Older adults with chronic stroke	Community	Balance self-efficacy is a significant determinant of satisfaction with reintegration.

PHC: Primary health center; ICIDH: International classification of impairments, disabilities and handicaps.

Appendix 4. Summary of key determinants for reintegration into normal living in stroke survivors

Supporting Studies	Determinant	Direction of Influence	Notes
Mulder et al. [82], Mwaka-Rutare et al. [83]	Gait speed	Positive	A gait speed ≥0.5 m/s is associated with improved reintegration
Olawale et al. [56], Obembe et al. [8]	Cadence and motor function	Positive	Improved motor recovery supports independence
Pang et al. [87], Liu et al. [77], Honado et al. [86]	Balance self-efficacy	Positive	Enhancing confidence in mobility and participation
Govender et al. [9], Hoffman et al. [52]	Fear of falling/fear-avoidant behavior	Negative	Fear of falling and fear-avoidant behavior limit community mobility
Obembe et al. [8], Kapoor et al. [59], Ianni et al. [74]	Depression	Negative	Depression is linked to reduced social interaction and motivation
Olawale et al. [56], Akosile et al. [75], Béthoux et al. [73]	Post-stroke duration	Mixed	Early phase may hinder reintegration; adaptation may improve with time
Obembe et al. [8], Hoffman et al. [52], Olawale et al. [56]	Age	Negative	Older age is linked to disability and comorbidities
Kimonides et al. [79], Soni et al. [84]	Gender	Mixed	Some studies favor females in home domains, others report no difference
Beckley [72], Okoye et al. [54], Egan et al. [67]	Social support	Positive	Family/spousal support is a key facilitator
Egan et al. [66], Kessler et al. [68]	Socioeconomic status	Positive	Employment and income are linked to higher well-being
Olawale et al. [56], Kimonides et al. [79]	Comorbidities	Negative	Hypertension, diabetes, etc. hinder reintegration
Kimonides et al. [79]	Cognitive complaints	Negative	Subjective complaints reduce social participation
Finestone et al. [11], Griffen et al. [48]	Driving ability	Positive	Return to driving is associated with community reintegration

Appendix 5. Summary of interventions supporting reintegration and their reported outcomes

Supporting Studies	Reported Outcome	Type	Intervention/Strategy
Kessler et al. [68]	Improved participation and reintegration	Psychosocial	Occupational performance coaching
Harel-Katz et al. [50], Lee et al. [62]	Enhanced self-efficacy and reintegration	Self-management (culturally adapted)	IPASS
Huijbregts et al. [53]	Increased community reintegration	Telehealth	T-MOST
Ryan et al. [71]	Improved leisure competence and family support	Community-based	Family-centred community stroke program
Zhang et al. [78]	Increased participation and confidence	Tele-rehabilitation	Coaching-based teleoccupational guidance
Olaleye et al. [55]	Improved functional recovery and reintegration	Home/community-based	Primary health care-based physiotherapy
Hebblethwaite & Curley [40]	Enhanced social engagement	Community reintegration	Community-based recreation programs
Brouwer et al. [46]	No significant effect on reintegration	Individual rehabilitation	"Tune-Ups" (client-centred)
Tilling et al. [81]	No significant improvement in reintegration outcomes	Family-focused	Family support organizer program
Grau-Pellicer et al. [85]	Improved mobility and quality of life	Physical rehabilitation	Multimodal exercise rehabilitation

IPASS: Improving participation after stroke self-management; T-MOST: Telehealth moving on after stroke.

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Appendix 6. Comparing determinants of reintegration by study methodology and country

Supporting Studies	Country/Region	Study Methodology	Determinant
Mulder et al. [82], Mwaka-Rutare et al. [83], Olawale et al. [56]	Netherlands, Congo, Nigeria	Quantitative	Gait speed
Obembe et al. [8]	Nigeria	Quantitative	Motor function
Pang et al. [87], Honado et al. [86], Liu et al. [77]	Hong Kong, Benin, Israel	Quantitative	Balance self-efficacy
Govender et al. [9]	South Africa	Qualitative	Fear of falling
Obembe et al. [8], Kapoor et al. [59], Ianni et al. [74]	Nigeria, Canada, USA	Quantitative	Depression
Olawale et al. [56], Akosile et al. [75], Béthoux et al. [73]	Nigeria, Spain, USA	Quantitative	Post-stroke duration
Obembe et al. [8], Hoffman et al. [52], Olawale et al. [56]	Nigeria, Australia	Quantitative	Age
Kimonides et al. [79], Soni et al. [84]	UK, India	Quantitative	Gender
Beckley [72], Okoye et al. [54], Egan et al. [67]	Canada, Nigeria, USA	Mixed, Quantitative	Social support
Egan et al. [66], Kessler et al. [68]	Canada	Quantitative	Socioeconomic status
Olawale et al. [56]	Nigeria	Quantitative	Comorbidities
Kimonides et al. [79]	Australia	Quantitative	Cognitive complaints
Finestone et al. [11], Griffen et al. [48]	Canada, USA	Quantitative	Driving ability