Reviewer's report

Title: Process and outcomes of inpatient stroke rehabilitation in Africa: Quantitative and Qualitative Findings

Version: 3 Date: 2 January 2015

Reviewer: Mary Egan

Reviewer's report:

Major compulsory revisions

I believe the manuscript has benefited from the additional information regarding the regions from which the patients came.

I continue to be concerned about the qualitative section of the manuscript and the discussion for a number of reasons:

1. First, I do not believe that these data reflect the outcome of rehabilitation. If they did the assumption would be that with more rehabilitation these problems would not exist. This is clearly not the case as even where services are relatively available participation problems continue to be an issue for people post stroke. We are only really beginning to understand how to address participation issues - we do not have a definitive rehabilitation treatment to address them - so more therapy is not the answer and continued participation problems are not the outcome of less therapy. I believe that restating the objective of this data collection and analysis as “to gain an understanding of the longer term problems experienced by people who have been hospitalized for stroke” (or something like that) is a necessary revision to this manuscript.

2. There is some lack of clarity over the analysis. The authors start off by describing an inductive process of developing codes and themes, but then seem rather to be using the larger components of Goddard, Ripat and Mayo’s model as the themes around which they organized (and possibly identified) codes. I believe this should be clarified.

3. “Lack of autonomy” among the participants could be seen as an overarching issue. Participants spoke about wanting to do things (go to church, work in the field) that they could probably do if given some support (a drive, someone to work alongside them for short periods of time). Would there be ways of providing support for autonomy within these communities? Is there a role for rehabilitation that could encourage such community activation (rather than simply training family members to do exercises etc.) What could be done to improve the physical environment that might further encourage participation among stroke survivors?

4. Related to #3, when I referred to community-based rehabilitation in my previous review, I was thinking more of CBR as defined by ILO/WHO/UNESCO: http://whqlibdoc.who.int/publications/2004/9241592389_eng.pdf?ua=1 While
many suggest that ways should be found to import/adapt North American models of restorative stroke rehabilitation (see for example, Hachinski, Vladimir, et al. "Stroke: working toward a prioritized world agenda."International Journal of Stroke 5.4 (2010): 238-256), I think that rehabilitation leaders in Africa have the opportunity to develop services more responsive to the community re-integration needs of stroke survivors. Responsive innovations could work at both the family/individual level and the community level to improve participation and quality of life post hospital discharge.

Minor essential revisions:
1. There are still some problems with English, particularly in the quotes (e.g., "I am a catholic church...")

**Level of interest:** An article of importance in its field

**Quality of written English:** Needs some language corrections before being published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests