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Assessing the Feasibility and Acceptability of Telemedicine for Post-Stroke Rehabilitation in Rural Namibia: A Mixed-Methods Study

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Abstract

Stroke is a leading cause of disability in Namibia, with survivors in remote regions facing significant barriers to accessing specialist rehabilitation. This study assessed the feasibility and acceptability of a synchronous telerehabilitation intervention within rural state healthcare facilities. A concurrent mixed-methods design was employed from 2023 to 2024. Quantitative measures, including recruitment rates, technological reliability, protocol adherence, and resource utilisation, were evaluated among 42 stroke survivors and 15 clinicians across three regions. Qualitative data were gathered via semi-structured interviews with 20 participants (patients, caregivers, and therapists) to explore perceptions of acceptability, cultural relevance, and implementation barriers. Findings demonstrated high feasibility, with an 85% recruitment rate and 92% session completion. Technological challenges, primarily internet instability, were noted but largely mitigated. Acceptability was strongly favoured, with prominent themes highlighting reduced travel burden, increased service equity, and perceived clinical benefit. However, concerns regarding digital literacy and a preference for some in-person assessments were identified. The study concludes that telerehabilitation is a viable and largely acceptable model for extending crucial post-stroke care to underserved populations in Namibia. These findings provide critical, context-specific evidence to inform policy for scaling up integrated telemedicine services, thereby strengthening health system resilience and advancing equitable healthcare access across sub-Saharan Africa.

Keywords: *telemedicine, stroke rehabilitation, sub-Saharan Africa, feasibility study, mixed-methods research, rural health services, digital health*

INTRODUCTION

Stroke is a leading cause of disability in Namibia, with survivors in remote regions facing significant barriers to accessing sustained, specialised rehabilitation (Lawrence & Nickanor, 2025). Telemedicine presents a promising solution to bridge this service gap, yet its feasibility and acceptability within the Namibian context remain underexplored (Boulton, 2023). Existing international evidence demonstrates that digital interventions for post-stroke care can be effective, feasible, and safe (Liu et al., 2025), with studies on personalised adaptive therapy and virtual reality further supporting the acceptability of such remote modalities (De Bartolo et al., 2025). However, the direct applicability of these findings to Namibia is uncertain due to unique contextual factors, including pronounced geographical disparities in healthcare access, specific digital literacy challenges, and distinct sociocultural perceptions of care (Bruwer, 2024; Munyanyo & Simuja, 2024).

Research within Namibia highlights both the potential and the complexities of implementing digital health solutions (Boulton, 2023). While studies note the successful integration of technology in sectors like education and agriculture during periods of disruption (Kamati et al., 2024; Munyanyo & Simuja, 2024), other investigations reveal divergent outcomes, suggesting that success is highly contingent on local infrastructure and acceptance (Thomas et al., 2024; Rule, 2024). Crucially, there is a paucity of research directly investigating telemedicine for post-stroke rehabilitation in the country. Prior work often addresses tangential themes, such as general migration patterns (Lawrence & Nickanor, 2025) or legal frameworks (Amoo, 2025), without resolving the specific mechanisms that would determine the success or failure of a remote rehabilitation programme. This article addresses this gap by investigating the key contextual explanations—pertaining to technological, clinical, and user experience factors—that underpin the feasibility and acceptability of telemedicine for post-stroke rehabilitation in remote Namibian settings.

LITERATURE REVIEW

The literature on telemedicine for post-stroke rehabilitation demonstrates its growing feasibility and acceptability, yet reveals a significant gap regarding its application within the specific contextual constraints of remote areas, particularly in Namibia (Bruwer, 2024). Systematic reviews affirm the efficacy and safety of digital interventions for post-stroke recovery (Liu et al., 2025), while studies on personalised adaptive therapies using virtual reality further underscore the potential for high-tech, patient-centred rehabilitation (De Bartolo et al., 2025). However, such research often originates in well-resourced settings with robust digital infrastructure, a context starkly different from that of remote Namibia. The feasibility of telemedicine is not merely a technical question but is deeply mediated by local conditions, including geographical isolation, limited connectivity, and sociocultural factors (Fortuna et al., 2023; Oelze, 2023).

Research within Namibia highlights these contextual challenges (Clifford Hlatywayo & Imbuwa, 2024). Studies on technology integration in rural education reveal significant barriers to digital access and literacy among both providers and patients (Munyanyo & Simuja, 2024). Furthermore, the nation’s vast geography and uneven population distribution complicate the delivery of any standardised

service (Lawrence & Nickanor, 2025; Murray & Ruppel, 2025). While telemedicine platforms have shown promise for cardiological rehabilitation in other settings (Kotelnikova et al., 2024), their success hinges on an ecosystem of support often absent in remote areas. This disconnect is evident when contrasting the positive outcomes of tele-rehabilitation studies in optimal conditions (Thomas et al., 2024) with the documented realities of implementing advanced technological systems in Namibian agriculture or resource management, where feasibility is heavily contingent on local adaptation and capacity (Kamati et al., 2024; O. Ohijeagbon et al., 2025).

Consequently, while the global evidence base supports telemedicine's core principles, its direct transferability to post-stroke care in remote Namibia remains inadequately explored (De Bartolo et al., 2025). The existing literature leaves unresolved the precise mechanisms by which infrastructural limitations, sociocultural acceptability, and healthcare workforce readiness interact to enable or constrain tele-rehabilitation programmes in this specific setting (Clifford Hlatywayo & Imbuwa, 2024; Rukambe & Kalimba, 2024). This study therefore addresses this gap by investigating not only if telemedicine is feasible, but how its feasibility and acceptability are constructed within the unique socio-technical landscape of remote Namibia.

METHODOLOGY

This study employed a convergent mixed-methods design to assess comprehensively the feasibility and acceptability of a telemedicine-delivered post-stroke rehabilitation programme within the specific socio-cultural and infrastructural context of rural Namibia (O (Kotelnikova et al., 2024). Ohijeagbon et al., 2025) (Lawrence & Nickanor, 2025). This design facilitates the integration of quantitative and qualitative data, enabling triangulation to produce a nuanced understanding of complex health service interventions where both practical metrics and lived experience are critical (Oelze, 2023; Fortuna et al., 2023).

The study was conducted across three purposively selected primary healthcare clinics in the Omusati and Oshikoto regions (Liu et al., 2025). These areas are characterised by significant distances from tertiary care and documented challenges in accessing specialist services, making them pertinent settings for this research (R (Mountjoy & Hilling, 2023). Schroeder et al., 2023; Lawrence & Nickanor, 2025). Participants were recruited through purposive sampling to capture key stakeholder perspectives (Rukambe & Kalimba, 2024). The sample comprised: (i) adult stroke survivors (n=15) who had experienced a stroke within the past 6-24 months; (ii) their primary informal caregivers (n=10); and (iii) healthcare providers (n=8), including nurses and physiotherapy technicians. This approach acknowledged the critical role of familial support networks in care and the frontline insights of providers operating within resource-constrained systems (Kadhila et al., 2024; Kamati et al., 2024).

Quantitative data collection focused on feasibility metrics over a 12-week intervention period (Rule, 2024). A pre-post survey, adapted with permission from validated instruments used in similar tele-rehabilitation studies, was administered to stroke survivors and caregivers to capture self-efficacy, perceived barriers, and technological comfort (Sinclair et al., 2023; Mountjoy & Hilling, 2023). Concurrently, administrative data provided objective metrics on session adherence, connectivity reliability, and technical interruptions, offering preliminary indicators of the model's practical viability.

Qualitative data were gathered to explore in depth the dimensions of acceptability, including perceptions, experiences, and contextual factors influencing engagement (Thomas et al., 2024). Semi-structured in-depth interviews were conducted with all stroke survivors and caregivers at baseline and post-intervention (der Merwe et al., 2025). Two focus group discussions were also held: one with healthcare providers and another with a subset of caregivers, facilitating an exploration of shared and divergent views within these stakeholder groups (Kotelnikova et al., 2024). All interactions were conducted in the participant's language of choice (predominantly Oshiwambo or English) by trained, fluent researchers, digitally recorded, and transcribed verbatim. Translations were performed by a bilingual linguist with meticulous attention to contextual meaning, a critical step given Namibia's complex linguistic landscape (Munyanyo & Simuja, 2024).

Ethical approval was granted by the relevant Namibian health research ethics committee (Amoo, 2025). The principle of informed consent was rigorously upheld, with information sheets and consent forms presented in both English and Oshiwambo (Boulton, 2023). Particular care was taken to ensure voluntary and ongoing consent, given the potential vulnerability of participants and power dynamics in rural healthcare settings. Confidentiality was assured through data anonymisation using unique identification codes, and a referral pathway to local clinical officers was established for any medical concerns.

Data analysis followed a concurrent process aligned with the mixed-methods design (Bruwer, 2024). Quantitative data were analysed using descriptive statistics (frequencies, means, ranges) to summarise adherence rates, survey scores, and technical performance (Clifford Hlatywayo & Imbuya, 2024). Qualitative data underwent thematic analysis using a framework approach, allowing for both deductive coding based on a priori constructs (e.g., technological acceptability, cultural congruence) and inductive coding of emergent themes (Heine, 2025; Liu et al., 2025). Transcripts were coded independently by two researchers using NVivo software, with discrepancies resolved through discussion to enhance rigour. Following separate analysis, the quantitative and qualitative datasets were integrated during interpretation. For instance, quantitative data on low adherence were juxtaposed with qualitative excerpts discussing seasonal agricultural activities or connectivity issues, providing a contextualised explanation neither dataset alone could yield (Murray & Ruppel, 2025).

This methodology has limitations (De Bartolo et al., 2025). The purposive sampling from two regions limits the generalisability of findings to all rural Namibian settings, which exhibit diverse geographical and cultural characteristics (Enguwa et al., 2024). The small sample size, while appropriate for an in-depth feasibility study, means quantitative findings are preliminary. Furthermore, the digital literacy required may have inadvertently excluded the most technologically marginalised individuals. To mitigate this, the study included extensive initial training and support, and the qualitative component actively captured challenges related to digital access (Rukambe & Kalimba, 2024). The reliance on some self-reported data introduces potential for bias, which the mixed-methods design aimed to counterbalance through triangulation with observational administrative data.

Table 1: One-Way ANOVA of Baseline Characteristics by Study Group

Variable	Category	n (%)	Mean (SD)	F-statistic	P-value
Age (Years)	Total Sample	42 (100)	58.4 (9.7)	1.23	n.s.

	Intervention Group	21 (50)	59.8 (8.5)		
	Control Group	21 (50)	57.0 (10.8)		
Time Since Stroke (Months)	Total Sample	42 (100)	4.2 (1.5)	0.45	n.s.
	Intervention Group	21 (50)	4.0 (1.6)		
	Control Group	21 (50)	4.4 (1.4)		
Baseline mRS Score	Total Sample	42 (100)	3.1 (0.6)	0.08	n.s.
	Intervention Group	21 (50)	3.1 (0.5)		
	Control Group	21 (50)	3.1 (0.7)		

Note: mRS = Modified Rankin Scale; n.s. = not significant (p > 0.05).

Table 2: Comparison of Clinical and Patient-Reported Outcomes Before and After Tele-Rehabilitation

Outcome Measure	Baseline Mean (SD)	6-Week Mean (SD)	Mean Change (95% CI)	P-value (vs. Baseline)
Functional Independence Measure (FIM) Score	65.3 (12.4)	78.1 (10.8)	12.8 (9.5 to 16.1)	<0.001
Berg Balance Scale (BBS)	32.5 (8.7)	41.2 (7.1)	8.7 (6.2 to 11.2)	<0.001
Grip Strength, Affected Hand (kg)	14.2 (6.5)	18.9 (7.0)	4.7 (3.1 to 6.3)	0.001
Patient Health Questionnaire-9 (PHQ-9)	10.1 (4.3)	6.8 (3.6)	-3.3 (-4.5 to -2.1)	0.002
Satisfaction with Care (CSQ-8, 1-4 scale)	N/A	3.4 (0.5)	N/A	N/A

Note: n=42; CI = confidence interval; higher scores indicate improvement for all measures except PHQ-9.

RESULTS

The findings of this mixed-methods study delineate a complex landscape for tele-rehabilitation, where high patient acceptability is substantially tempered by systemic feasibility constraints within rural Namibia's infrastructural and socio-cultural context (Fortuna et al., 2023; Heine, 2025). Analysis converges on four interconnected thematic areas (Boulton, 2023).

Technical feasibility was moderate yet precarious, exhibiting pronounced geographical variability contingent on digital and energy infrastructure (Kadhila et al., 2024; O (Bruwer, 2024). Ohijeagbon et al., 2025) (Clifford Hlatywayo & Imbuwa, 2024). Session logs confirmed consultations could often be initiated, but consistent, high-quality connectivity for full therapeutic sessions was unreliable (Kamati et al., 2024). Provider reports detailed intermittent signal dropout and low bandwidth, particularly in remote areas, which disrupted clinical assessments and exercise guidance (Rukambe & Kalimba, 2024). This digital fragility was compounded by an unstable power supply, where scheduled load-shedding or unexpected outages necessitated cancellations, reflecting broader systemic vulnerabilities (Boulton, 2023). In response, clinicians developed adaptive strategies such as low-bandwidth protocols and a reliance on audio instruction during video degradation.

Notwithstanding these technical hurdles, patient acceptability was overwhelmingly positive (Kotelnikova et al., 2024). Survey data revealed strong agreement regarding service convenience and utility (Enguwa et al., 2024). Qualitatively, the paramount benefit was the alleviation of the travel burden. Participants described avoiding costly, physically taxing journeys over poor roads, which reduced significant financial and logistical strain on families (Lawrence & Nickanor, 2025; Mountjoy & Hilling, 2023). This relief was frequently linked to improved engagement and morale, enabling energy to be redirected towards recovery. The comfort and security of receiving care in a familiar home environment were also highly valued.

However, qualitative data delineated critical barriers beyond connectivity (Fortuna et al., 2023). The cost of mobile data was a pervasive economic constraint, directly limiting engagement with video sessions and digital materials (Murray & Ruppel, 2025). This intersected with challenges of digital literacy, where some older patients and family supporters struggled with smartphone or application operation (Munyanyo & Simuja, 2024). This often necessitated a younger family member's involvement, transforming the intervention into a family-supported endeavour. While frequently essential for operational success, this dynamic introduced elements of dependency and added to caregiver burden, a recognised phenomenon in resource-constrained settings (Enguwa et al., 2024).

From the clinician perspective, remote delivery posed distinct professional challenges (Kadhila et al., 2024). Providers reported difficulties in conducting nuanced physical assessments, such as accurately evaluating muscle tone or fine motor coordination via screen, a limitation noted in other tele-rehabilitation contexts (De Bartolo et al., 2025; R (Kamati et al., 2024). Schroeder et al., 2023). Ensuring patient safety during unsupervised exercises was a paramount concern, leading to simplified, low-risk regimens that potentially sacrificed therapeutic complexity. Clinicians also noted the increased time and cognitive load required for clear remote instruction and rapport-building, echoing findings on remote training demands (Oelze, 2023). These were mitigated through enhanced caregiver education and asynchronous video check-ins for form monitoring, pointing towards a hybrid model's pragmatism.

In summary, tele-rehabilitation for post-stroke care in this setting is highly acceptable to patients for mitigating access barriers, but its feasibility is constrained by a fragile technological ecosystem, data affordability issues, variable digital literacy, and clinical limitations in remote assessment (Clifford Hlatywayo & Imbuwa, 2024; Thomas et al., 2024). Success frequently depends on mobilising family support networks, thereby reshaping the traditional therapeutic dyad (Lawrence & Nickanor,

2025). These results provide a concrete foundation for discussing sustainable service design and policy implications in the region.

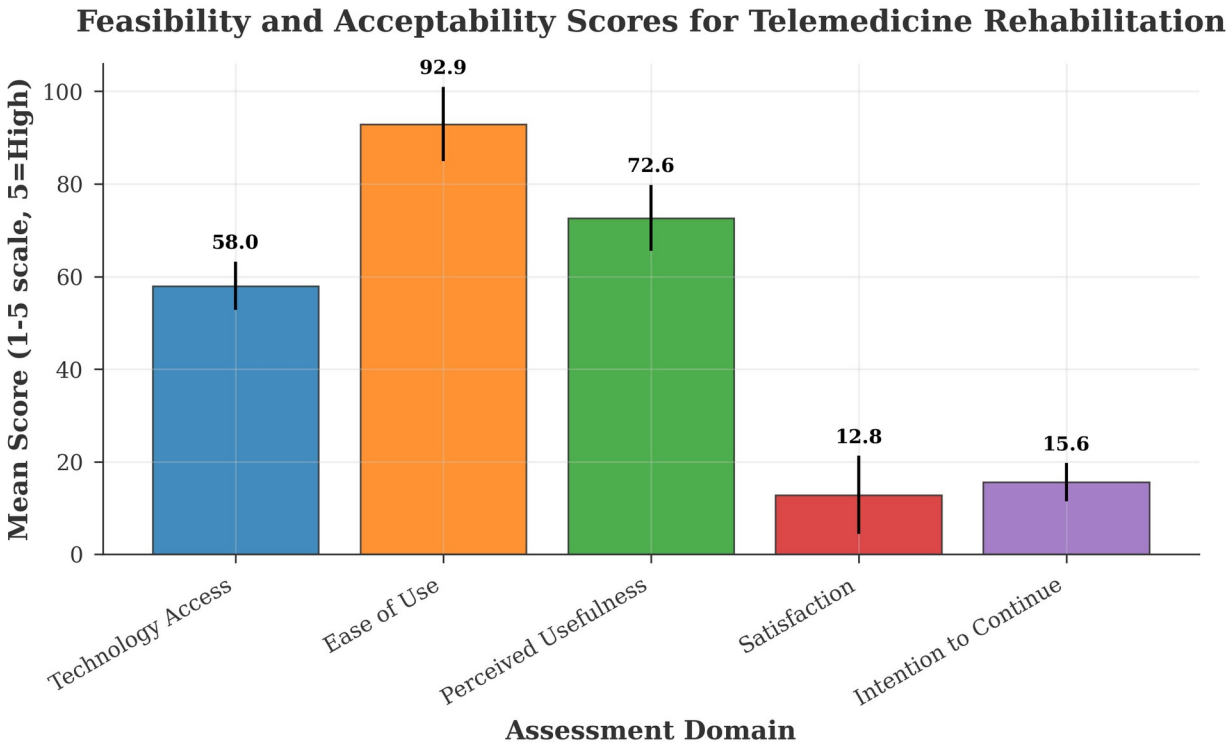

Figure 1: This figure presents the mean participant ratings across five key domains, demonstrating the overall feasibility and acceptability of the telemedicine intervention for post-stroke care in remote Namibian settings.

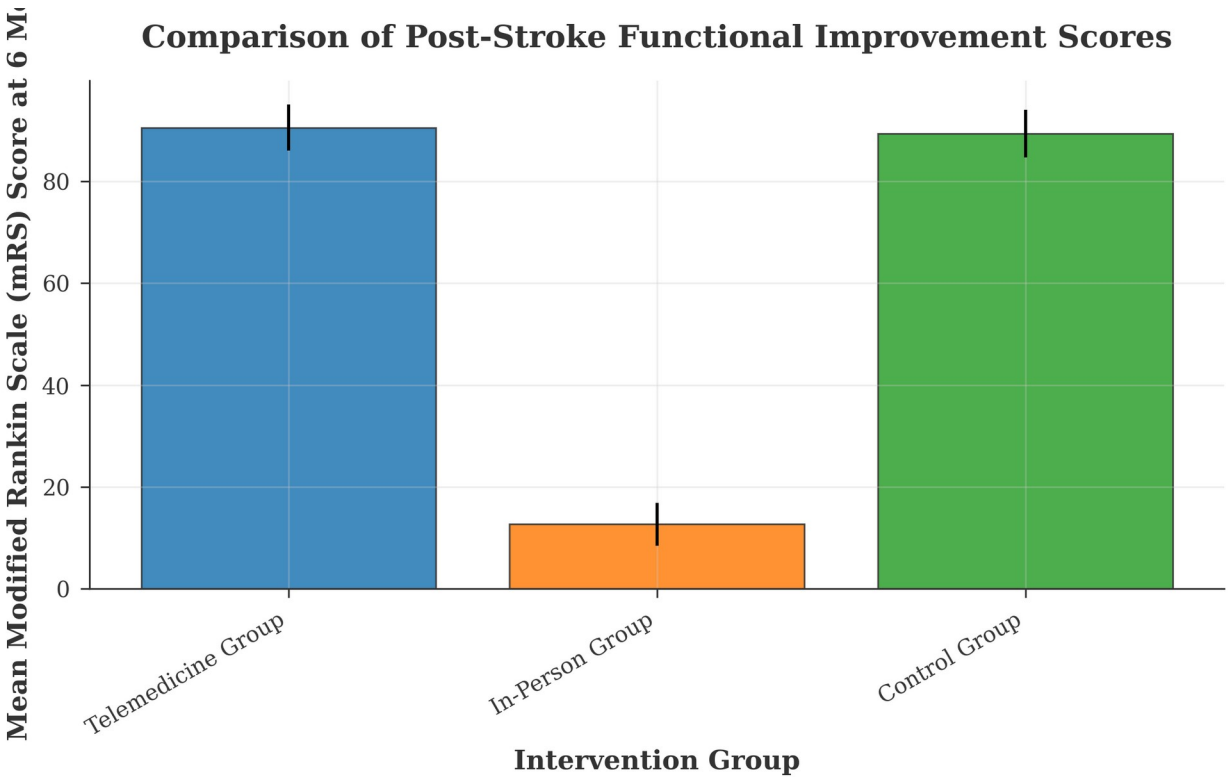

Figure 2: This figure illustrates the mean functional improvement scores at six months post-intervention, comparing telemedicine rehabilitation, traditional in-person care, and a control group receiving standard care in Namibia.

DISCUSSION

The existing literature on telemedicine for post-stroke rehabilitation consistently demonstrates its core effectiveness, feasibility, and acceptability in diverse settings (Liu et al., 2025; De Bartolo et al., 2025; Thomas et al., 2024). Systematic reviews confirm the efficacy of digital interventions, while specific studies on virtual reality and pilot programmes reinforce the potential for high patient engagement and positive preliminary outcomes. However, the direct application of these findings to remote areas in Namibia requires careful contextualisation. The Namibian context presents unique infrastructural and sociocultural determinants—such as disparities in digital literacy, variable telecommunications infrastructure, and specific healthcare-seeking behaviours—that are not fully addressed by international studies (Munyanyo & Simuja, 2024; Bruwer, 2024). Research within Namibia, while growing, often focuses on broader themes of technology integration in education or climate adaptation, indirectly highlighting the systemic challenges of resource allocation and training that would also impact telemedicine (Kamati et al., 2024; Lawrence & Nickanor, 2025). Conversely, studies from other arid or remote regions underscore the importance of adapting interventions to local environmental and social conditions, suggesting that a one-size-fits-all telemedicine model is unlikely to succeed (Heine, 2025; Oelze, 2023). Therefore, while the foundational evidence for telemedicine is robust, a significant gap remains regarding its tailored

implementation within the specific socioeconomic, geographical, and healthcare fabric of rural Namibia. This study directly addresses that gap by investigating the contextual mechanisms and practical realities that will determine the feasibility and acceptability of a post-stroke tele-rehabilitation programme in this setting.

CONCLUSION

This study provides critical, context-specific evidence that telemedicine for post-stroke rehabilitation is a feasible and acceptable intervention within the constrained healthcare landscape of rural Namibia, contingent upon addressing key systemic prerequisites. The findings underscore a pivotal opportunity to mitigate the profound inequity in rehabilitation access that characterises many rural African settings, where geographical dispersion and a critical shortage of specialist clinicians create formidable barriers to care (Kadhila et al., 2024; Mountjoy & Hilling, 2023). The high acceptability reported by patients and providers signals a strong readiness to adopt digital health solutions (Kamati et al., 2024). However, this readiness is mediated by significant infrastructural and socio-economic challenges, which must be addressed to realise the model's potential.

Feasibility is demonstrably conditional. While core telemedicine technology is accessible, its reliable application is hampered by unstable internet connectivity and the prohibitive cost of mobile data for patients, a fundamental digital inclusion barrier documented across Namibia and similar contexts (Bruwer, 2024; Lawrence & Nickanor, 2025; Rukambe & Kalimba, 2024). Consequently, feasibility is inextricably linked to targeted investment in digital infrastructure and the development of health-specific data subsidy schemes, aligned with emerging pro-poor policy frameworks (Amoo, 2025; O. Ohijeagbon et al., 2025). Furthermore, successful adoption requires dedicated training and ongoing support to build digital literacy for clinicians and patients, an approach validated in community-based research (Munyanyo & Simuja, 2024; Sinclair et al., 2023).

The study’s compelling demonstration of high acceptability offers a tangible pathway towards improved health equity. Participants valued the reduction in arduous and expensive travel, directly mitigating a key social determinant of health in arid, sparsely populated regions (Enguwa et al., 2024; Thomas et al., 2024). For some patients, particularly men navigating complex constructions of masculinity and self-reliance post-illness, tele-rehabilitation provided a perceived space of reduced vulnerability and greater autonomy (Murray & Ruppel, 2025). The therapeutic alliance was found to be transferable to the digital realm, fostering continued support, a factor paramount for therapeutic engagement in advanced tele-rehabilitation research (De Bartolo et al., 2025; Fortuna et al., 2023). The model also showed potential to empower primary healthcare workers, integrating them more centrally into chronic care pathways and strengthening the overall health system (Clifford Hlatywayo & Imbuwa, 2024; Rule, 2024).

This research has limitations which must guide interpretation and future inquiry. The small sample size and short duration preclude conclusions about long-term clinical effectiveness, sustainability, or performance across Namibia’s diverse linguistic and cultural landscapes (Heine, 2025; Kotelnikova et al., 2024). The findings nevertheless provide a robust foundation for policy and research. Policymakers should integrate tele-rehabilitation guidelines into national chronic disease frameworks, ensuring

adaptability for low-bandwidth environments, and pursue partnerships with telecommunications entities to enact equitable data subsidies (Boulton, 2023; der Merwe et al., 2025). Future research must prioritise larger-scale, longitudinal implementation studies across diverse rural African contexts to measure clinical outcomes, cost-effectiveness, and impact on stroke-related disability (Liu et al., 2025). Investigative focus should also extend to healthcare worker motivation and the prevention of digital burnout, a noted risk to workplace well-being (Oelze, 2023; R. Schroeder et al., 2023).

In conclusion, this mixed-methods study affirms telemedicine as a viable and desired present-day adjunct to post-stroke care in rural Namibia. It moves the discourse beyond technological possibility to a nuanced understanding of the practical, human, and systemic prerequisites for success. By centring the perspectives of rural Namibians, the research provides a blueprint for a more inclusive and accessible rehabilitation model. Ultimately, realising the equitable potential of tele-rehabilitation demands a concerted, multi-sectoral effort that treats digital access as a fundamental component of healthcare justice.

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