Title:
Qualitative research in physiotherapy: a systematic mapping review of 20 years literature from sub-Saharan Africa.

Abstract:

Study aim: To summarize the current state and quality of qualitative research conducted by physiotherapists in sub-Saharan Africa (SSA).

Methods: We systematically searched multiple databases from 2000 till December 2020 and included peer-reviewed qualitative studies conducted by physiotherapists in SSA countries. Two reviewers independently screened citations, extracted data, and assessed the quality of the included studies using the 45-items checklist by Lundgren et al. (2012). Conventional content analysis was employed to create physiotherapy subject areas from the included studies.

Results: We included 114 studies, a majority of 84 (74%) conducted in South Africa. Included studies were categorized into five subject areas: sports (n=2), disability (n=16), professional practice (n=24), education and training (n=36) and care provision (n=36). We rated 74 (65%), 29 (25%), and 11 (10%) of the included research as low reporting quality, moderate-and high reporting quality, respectively. There was a significant lack of reporting on researchers' team characteristics, reflexivity and member checking.

Conclusion: We conclude that the reporting of published qualitative studies in SSA show variable quality, albeit mostly low, focused mainly on care provision, education and training. Physiotherapy-researchers are encouraged to report reflexive practice and member checking when conducting qualitative research.

Keywords: Qualitative research, physiotherapists, systematic mapping review, sub-Saharan Africa

Introduction
Qualitative research methods have become increasingly popular in physiotherapy research, but there is an ongoing discussion among qualitative researchers about the quality of data produced, how they are reported, and how they can be improved (Jette, Delany, and Lundberg, 2019). The debates on quantitative research's relative merits versus qualitative research are unending, (Sackett et al., 2000) but it is generally recommended to use of both when needed (Morgan, 1998). For instance, qualitative research "harness the benefits of trials" by helping to understand how an intervention works in practice (O'Cathain et al., 2014).

The value of qualitative research is undoubtedly evident in the literature. Qualitative research gives entry to understanding patients'/families' perspectives and values concerning their care (Lobiondo-Wood, Haber, Berry and Yost, 2013), and also offers a rich method to explore anything from physiotherapy policy to physiotherapist-patient/relatives interactions. Qualitative research seeks to critique or explain the complexity hidden in most descriptive studies or studies that control and measure set variables (Jette et al., 2019). With the current shift in health care models towards the person-centered approach in physiotherapy practice (Morgan and Yoder, 2012), there is an increasing interest in incorporating patients'/families' experiences, values, and interpretations to care (Jones et al., 2006). Besides, qualitative studies provide information that enables physiotherapists to understand how clients perceived health services, achieve their treatment goals to improve functions. Therefore, good clinical practice and policies could depend on knowledge generated through small, in-depth qualitative studies (Braun & Clarke, 2019). For instance, Okoh et al.'s (2020) qualitative case study that developed five-key practice concepts of a transdisciplinary approach to
older adults’ care is an example of how small-scale qualitative can provide insight to clinical practice.

Qualitative approaches are essential in physiotherapy practice when researchers want to ask why patients/relatives and healthcare workers (e.g., physiotherapists) behave in a particular way. For instance, Ntamo et al. (2013) explored the factors affecting poor outpatient physiotherapy attendance by stroke patients discharged from a general hospital in South Africa. They reported that 86% of patients did not attend outpatient physiotherapy after discharge from the hospital. However, they interviewed the patients who reported that poor finances and living a long distance from the hospital were the reasons they were not attending the outpatient physiotherapy clinic. Qualitative research explores why something happens and may generate ideas to solve complex problems. Conducting qualitative research in the physiotherapy profession can be most informative and adds value to our professional practice, as it can help physiotherapists understand complex human beliefs, attitudes, and behavior regarding impairment, disability, and therapeutic interactions (Jette et al., 2019).

The rise of qualitative research in physiotherapy in SSA has been steady, with some authors publishing qualitative research related to patients/relatives experience on conditions or physiotherapy care (Halpin et al., 2019; Khondowe, Rhoda, Mpoful, 2007), professional clinical practice (Chetty, 2016; Nwankwo et al., 2019; Okoh et al., 2020), and education/training (Odole et al., 2014; Julie et al., 2016). However, qualitative research has been under intense scrutiny for its methodology and reporting. As a result, researchers and networks have developed reporting guidelines and checklists to guide qualitative methods enhancing rigor. Such guidelines/checklists include consolidated...
criteria for reporting qualitative research (COREQ) (Tong et al. 2007), standards for reporting qualitative research (SROR) (O'brien et al. 2014), Lundgren et al.'s (2012) 45 items.

Arguments have shifted from the value of qualitative methods to the quality of qualitative methods (Jette et al., 2019). "Quality" in qualitative research describes rigor and trustworthiness reflected through practical conceptual frameworks, methodological rigor in sampling, data collection and analysis, and improved quality of reporting of these qualitative studies (Kortstjens and Moser, 2018). Typically, rigor has been described in qualitative studies in terms of credibility (e.g., member checking, peer debriefing, and triangulation), transferability (e.g., thick description of participation and phenomena of interest), dependability (e.g., external audits), confirmability (e.g., audit trail and reflexivity) (Lincoln and Guba, 1985).

As with the rest of the world, Sub-Sarah Africa, the African countries fully or partially located south of Sahara accounting for 46 of Africa’s 54 countries (excluding Algeria, Djibouti, Egypt, Morocco, Somalia, Sudan, and Tunisia) (Ajadi 2018) have seen some increase in the number of qualitative research I physiotherapy. Given that all the authors of this paper are sub-Saharan Africa physiotherapist involved in qualitative research, we have a vested interest in ensuring that the quality of qualitative research published by sub-Saharan physiotherapy researchers adhere to international recognised standards. In addition, our interest is further driven by the need to contribute to the global understanding of the trends and quality of qualitative research in physiotherapy by providing the benchmark and perspective from sub-Saharan Africa. Therefore, the objective of the study was to summarize the current state and quality of qualitative research conducted
by physiotherapists in sub-Saharan Africa (SSA). We summarized the qualitative study design, sampling techniques, data collection, and data analysis methods employed, created themes, and assessed the quality of the qualitative studies.

**Methods**

We used a systematic mapping review method (Grant and Booth, 2009) and the Search-Appraisal-Synthesis-Analysis framework (SALSA) (Grant & Booth, 2009) to provide a structured framework for searching the literature and selecting studies to include or exclude pre-determined eligibility criteria and quality appraisal, and synthesizing and analyzing the findings from each included study.

**Search**

We searched the literature in consultation with an expert librarian in the following databases: PubMed, EMBASE, CINAHL, PEDRO (physiotherapy evidence database), Cochrane CENTRAL, PsychINFO and Web of Science from 2000 till Dec 2020. We used 2000 as the starting point of the search for two reasons. First, although physiotherapy researchers in SSA published qualitative studies before 2000, they were rare. For instance, only one qualitative study was published in the South African Journal of Physiotherapy in 1999 (across the four issues), and this number becomes worst or remains the same in years below 1999. Besides, case reports were mainly published years below 2000 as against qualitative studies. Alongside the timeline of this project, using 2000 as a starting point seems feasible. We acknowledged this in the limitation sections. Another reason to have 2000 as a starting point is that the importance of qualitative evidence as a vital component of the evidence-based practice/research was
brought to light in 2000 by Sackett and colleagues. Additionally, we hand-searched the references of included studies, relevant reviews, and review proceedings from pertinent conferences (e.g., World Confederation of Physical Therapists- African region conference proceedings, African Health Research Journal, African Journal of Physiotherapy and Rehabilitation Science, South African Journal of Physiotherapy, Nigerian Journal of Medical Rehabilitation). A combination of medical subject headings (MESH) and keywords - "Physiotherapis*" OR "Physical Therapis*" OR "Therapis*" AND Qualitative studies OR focus group OR interviews OR ethnography OR Grounded theory OR interpretive description OR Case study OR qualitative description AND "SSA" OR "Subsaharan Africa" OR "Africa South of the Sahara" OR "Africa, Central" OR "Africa, Eastern" OR "Africa, Southern" OR "Africa, Western" OR "Nigeria" OR "Ghana" OR "South Africa" OR "Uganda" OR "Kenya" OR "Tanzania" OR "Rwanda" OR "Zimbabwe" OR 'Ethiopia"- were adapted for each database.

**Study selection**

We included studies if:

a. conducted with any of the qualitative study designs, including, but not limited to, grounded theory, ethnography, qualitative description, interpretive description, phenomenology, qualitative case study, narratives.

b. the phenomenon of interest focused, but not limited, on explaining physiotherapy-related clinical problems or clinical decision-making process, exploring values, beliefs and practice cultures, evaluating/understanding care models or physiotherapy programs, describing care/intervention experiences/satisfaction. This phenomenon of interest can be researched via
the perspectives of clinicians, students or patients residing in SSA (population of interest).

c. the qualitative findings of the study emerged from either individuals/focus group interviews or/and observation/document analysis.

d. at least one author should (e.g., the principal or corresponding author) be affiliated with a physiotherapy department in the SSA countries. This inclusion is to ensure that we included research done by physiotherapists and not any other rehabilitation professionals. When all authors are not affiliated to the physiotherapy department but were affiliated to, e.g., the department of health and rehabilitation sciences or studies, disability studies, we googled or contacted them to ask if their primary profession is physiotherapy. SSA countries are African countries fully or partially located south of Sahara; the countries include all 46 of Africa's 54 countries, excluding Algeria, Djibouti, Egypt, Libya, Morroco, Somalia, Sudan, and Tunisia (Ajadi, 2018).

e. published in the English language.

We excluded all quantitative studies, mixed-method studies, clinical case notes/reports (with one participant) or opinion papers with no qualitative data. We excluded studies whose participants were not from SSA, even though (some) authors have SSA affiliations.

Duplicates of studies from database search were removed in RefWorks (RefWorks©, 2016 version). Two reviewers (ACO, EMA) independently screened all titles and abstracts simultaneously. Similarly, two reviewers (ACO, EMA) completed and the full-text assessment. The Kappa for both abstract/title and full-text screening was 0.96,
suggesting excellent agreement (Landis and Koch, 1977). Disagreements were resolved through discussion or consultation with a third reviewer. Furthermore, we contacted corresponding authors of included studies with the list of their included studies, requesting qualitative studies published that were not already included.

**Quality assessment of included studies**

We assessed the quality of the included studies using a 45-items tool previously described by Lundgren et al. (2012). We choose this tool because it provides additional items such as ethical issues, audit mechanism, relevance and transferability lacking in some other checklists used in assessing the quality of qualitative studies (e.g. Consolidated criteria for reporting qualitative research 32-item checklist). The Lundgren et al.’s (2012) 45 items composite grid checklist has five domains: research team and reflexivity (8-items), scope and purpose (2-items), study design (17-items), analysis and findings (14-items), and relevance and transferability (4-items). We rated all 45-items as 0 (no or not applicable) or 1 (yes); the highest possible score is 45. We rated the quality of the included studies as high (39-45 points), moderate (31-38) and low (≤30) (Lundgren et al. 2012). The inter-rater reliability for the 45 items was $\alpha=0.87$ between the reviewers. Discrepancies between the raters were resolved by discussion in research team meetings.

**Extracting the evidence**

We developed and piloted extraction form to extract the data from the included studies, including the authors' names, country the study was conducted, study setting, study design, sampling method and participants characteristics, sample size, data
collection method, data analysis and study findings. Two authors extracted the studies independently, with a third review author available to resolve any disagreement.

Data synthesis

Data was analyzed using conventional content analysis (Hsieh and Shannon, 2005). The included study aims/research questions guided the development of subject areas for qualitative studies in SSA. Often, qualitative research questions and aims contain the population and phenomena of interest regarding experiences, values and clinical processes (Kalu, 2019). Therefore, the study aim/research questions will provide more specific subject areas than the included study themes (findings). Two author reviewers (AOU and MEK) independently read the included study aims/research questions word by word and highlighted the exact words to drive codes. Each author made notes of his impression on the meaning of the codes. They independently merged their codes to derive categories. Each author reviewer presented the categories he developed in a research team meeting (consisting of 3 additional authors). The categories were discussed and merged to form the central subject area (themes). See Table 1, for example, of coding.

Researchers positioning (reflexivity)

All six authors have varying levels of experience conducting qualitative research. MEK considers himself to be primarily a qualitative researcher because most of his training focused on qualitative research, and he has published over ten qualitative studies using different approaches. AOU is a mixed methodologist who has constantly used qualitative research in his research. ACO, COO, MCI are both trained in both quantitative and qualitative research. ACO and MCI's current research approaches are
primarily qualitative, and they have published some articles in the qualitative paradigm. While **COO**, **EMA** primarily classifies themselves as quantitative researchers, they have recently started incorporating qualitative approaches in their research. All the six authors are physiotherapists trained in one of the SSA countries. While **ACO**, **EMA**, **MCI**, and **COO** at the time of writing this paper are currently residing in [name withheld for peer review; but a country in SSA], **MEK** and **AUO** are residing [name withheld for peer review, but outside the SSA], but continues to maintain research relationships with PTs in that region. We identified that we might have some "Subjective I's" (Peshkin, 1988, Kalu, 2019)- those values, beliefs, and assumptions based on our experience as physiotherapists and researchers in this region that might bias the discussion of our review findings. During training and practice in the SSA, some of the authors did not experience conducting or using qualitative research, but upon experiencing practice and research across different world regions, they believed that qualitative research and its use in practice are evolving in SSA. This assumption may influence how the authors interpret the findings. However, each author stated how these beliefs would influence the data collection, analysis, and discussion. This approach will help us not direct our conscious ideas to influence the data analysis and interpret our research findings.

**Results**

We retrieved 674 studies from the database searches. After removing duplicates, 611 citations underwent abstract and title screening, and we excluded 478. The remaining 133 studies underwent full-text screening, and we included 72 studies. Additional 20
studies from the hand-searching of the included studies and African journals and 22 studies were retrieved from 19 authors, resulting in 114 studies (Figure 1).

**Description of included studies**

We presented the 114 studies included in this review in Table 2. Included studies were conducted in 12 countries: South Africa (84 studies), Nigeria (14 studies), Kenya (3 studies), Tanzania, Zambia and Zimbabwe (two studies each), Botswana, Rwanda, Ghana, Malawi, Uganda and Madagascar (one study each). One study was conducted in both Kenya and Zambia. One hundred (87.7%) studies were published between 2011 and 2020 (see Figure 2 for publication trend).

**Designs, sampling and participants in included studies**

Forty-six (40.3%) of the included studies did not specify the study design. Where specified most were qualitative descriptive (n=17), phenomenology (n=16), exploratory (n=16). See Table 2. Sampling method was not reported in ten (9.5%) of the included studies. Where reported, most studies (n=75, 65.8%) used purposive sampling, with just one study using random sampling. Among the 75 studies that used purposive sampling, 47 (62.7%) did not specify the type of purposive sampling. Nonetheless, 15 used maximum variation (Chetty et al., 2016; Chiwaridzo et al., 2019a, b; Diameta et al., 2018; Dizon et al., 2016, 2017; Hanass, Hancock, Myezwa, Nixon, and Gibbs, 2015; Joseph, Wahman, Phillips, and Nilsson Wikmar, 2016; Kambole and Struthers, 2009; Maddocks et al., 2018; Maddocks et al., 2020; Misra, Chemane, Maddocks, and Chetty, 2019; Rowe, 2015; Urimubenshi and Rhoda, 2011; Visagie and Swartz, 2016), seven used criterion sampling (Akinrolie, Okoh, and Kalu, 2020; Igwesi-Chidobe, Sorinola, Kitchen and Godfrey, 2018a; Khondowe Rhoda, and Mpofu, 2007; Meyer, Louw, and Ernstze, 2019;
Mweshi and Mpofu, 2001; Schmutz, Meyer, and Archer, 2019; Seymour, Geiger, and Scheffler, 2019), two used random purposive (Ernstzen and Bitzer, 2012; Ernstzen, Bitzer, and Grimmer-Somers, 2010), while one each used study multi-stage (Stander, Grimmer, and Brink, 2019), cluster purposive (Lowu et al., 2018), theoretical sampling (Shead, Roos, Olivier, and Ihunwo, 2019) and criterion based and extreme/deviant case sampling (Kalu et al., 2020).

Mostly included studies involved only healthcare professionals (n=40), patients (n=26), healthcare students (n=19) and patient/relatives (n=6), whilst some involved students (n=10), relative (n=3), patients (n=3), patients and relatives (n=1) in addition to healthcare professionals. Two studies recruited patients, relatives, students and healthcare professionals (Chetty, Hanass, and Myezwa, 2016) and unconventional practitioners, including patent medicine sellers, herbalists and pastors (Igwesi-Chidobe, Sorinola, Kitchen and Godfrey, 2018b). Participants' age ranges from 15 years old (Mweshi and Mpofu, 2001; Wazakili et al., 2011) to 86 years (Khondowe, Rhoda and Mpofu, 2007).

**Methods of data collection in included studies**

Majority of the included studies (n=102, 89.5%) collected data through individual (n=59) or focus group discussions (n=30) or both (n=12). For other data collection methods and sample size, see Table 2.

More than half (n=63, 55.2%) of the studies did not state the length of either their interviews or focus group discussions. Where stated, interviews or focus group duration ranged from less than 45 minutes (n=12), between 45 to 60 minutes (n=22), to more than 60 minutes (n=15). Although most (95/114; 95.8%) reported using interview guides, only
14 provided the interview guide (Adandom et al., 2020; Okoh et al., 2020; Kalu et al.,
2020; Nwankwo et al., 2019; Chiwaridzo et al., 2019a, b; Diameta et al., 2018; Ernstzen
and Bitzer, 2012; Obi et al., 2019; Ernstzen, Bitzer, and Grimmer-Somers, 2010; Maleka,
2012; Stander, Grimmer, and Brink, 2019; Odole, Odunaiya, Ojo and Afolabi (2015);
Odole, Afolabi, Ushie and Odunaiya, 2020).

Data analysis used in included studies
The method of data analysis was not defined in seven of the included studies
(Dizon et al., 2016; Hanekom, Van Aswegen, Plani, and Patman, 2015; Ennion and Hess,
2020; Grimmer-Somers, Crous, Marais, and Amosum, 2007; Mweshi and Mpofu, 2001;
Struters and Phil, 2006; Taukobong, 2004). When analysis methods were defined,
themetic analysis (n=54) and content analysis (n=35) were the most common method
used.

Rigour and Ethics
About one third (36/114; 31.6%) of the studies did not discuss the process of ensuring
rigour in conducting the qualitative studies, and only 12 studies described all four process
(credibility, confirmability, dependability and transferability) of ensuring rigour (Voges and
Frantz, 2019; Kambole and Struthers 2009; Narain and Mathye, 2019; Stander et al.
2019; Kumurenzi et al., 2015; Joseph et al., 2016; Mathye and Eksteen, 2015; Abdullahi
and Isah, 2020; Cunningham et al., 2019; Adandom et al., 2020; Okoh et al., 2020; Kalu
et al. 2020). Forty-four studies described at least one process of ensuring rigour:
credibility (n=32), confirmability (n=8), dependability and transferability (n=2, each), while
22 studies described at least two processes of ensuring rigour during qualitative inquiry.
Almost all the studies provided information about ethical approval (110/114, 96.5%) and
information about obtaining informed consent from their study participants (109/114; 95.6%).

**Research Subject Areas**

The conventional content analysis yielded 64 codes that were later merged to form 18 categories and subsequently six themes: sports (n=2), disability (n=16), professional practice (n=24), education and training (n=36) and care provision (n=36). **Sport-related studies** investigated coaches’ criteria for selecting players and rugby players’ motivation for participating in rugby. **Disability-related studies** explored or described lived experiences, perceptions or issues affecting people with disabilities such as social stigma and discrimination, activity limitation and participation restriction. **Professional practice studies** explored the experiences of physiotherapists on the implementation (barriers and facilitators) of clinical guidelines, inter-professional practice with other healthcare professionals and clinical practice. **Care provision studies** explored clients’ experiences on the effectiveness of physiotherapy interventions, client satisfaction with physiotherapy care, issues on the burden of care and welfare of informal caregivers and issues affecting the rehabilitation services. **Education and training studies** explored the clinical/teaching experiences of physiotherapy students and/or clinical instructors during physiotherapy training, interprofessional practice and the development and evaluation of physiotherapy clinical or academic curriculum.

**Quality Assessment**

We presented the result of the quality assessment of the 114 studies in Table 3. We rated 74 studies as low-quality qualitative studies, 29 as moderate (Adandom et al., 2020; Cunningham et al., 2019; Gona et al., 2013; Louw et al., 2018; Tawiah, Borthwick
The common quality gaps included no statement on (a) the gender of the researcher(s) (n=102), (b) relevant experiences or training that the researcher(s) had (n=87), (c) any relationship established between participants and researchers before study start (n=92), (d) participant knowledge of the interviewer (n=98), (e) whether or not field notes were used (n=80), (f) evidence provided that data reached saturation (n=80), member checking (n=95), (f) whether or not the researcher(s) "dwelt with the data," interrogating if for alternative explanations of phenomena (n=93) and (g) good discussion of the research process such that others can follow decision trails (n=72).

Discussion
This mapping review aimed to summarize the current state and quality of qualitative research conducted by physiotherapists in SSA. We included 114 qualitative peer-reviewed studies published from 2000-2020. Findings showed that current qualitative research conducted by physiotherapists in SSA covered a wide range of research areas, with most of the research published by South-African based physiotherapy-researchers. The research areas focused on five themes: sports, care provision, disability, related studies, professional practice and education and training. Authors in the included studies explored these research areas from the perspectives of patients/relatives, healthcare professionals and students, including physiotherapists and physiotherapy students.

The dominance of South African researchers in the studies included in this review highlights the dearth of qualitative research in physiotherapy in SSA countries outside South Africa as previously reported in aging (Kalu et al., 2021) and end-of-life (Gysels et al., 2011) research in SSA. Could this dominance be because of South-African entry-level training schools having continuous qualitative program evaluation (Ramklass et al., 2013), offering more postgraduate degrees in PT or related fields, including rehabilitation sciences/studies or disability studies (Agho and John, 2017), or having more qualified faculties with qualitative methodology expertise than other schools in SSA countries? Historically, South-African researchers (including physiotherapists) have more collaborations with countries outside SSA, leading to high amounts of qualitative research (Boshoff, 2010; Onyancha, 2011). Another reason could be our inclusion criteria of at least one author of the qualitative evidence must be affiliated to the physiotherapy department but provided the qualitative study was conducted in SSA.
Overall, we observed a low reporting quality of qualitative studies conducted in the SSA. These low reporting qualities ranged from not reporting qualitative study type, sampling, and poor strategies reporting to ensure rigour. Qualitative researchers should specify the type of qualitative design (e.g., grounded theory, phenomenological study) and the type of purposive sampling employed (e.g., maximum variation, homogenous, criterion-based) to allow readers a logical process that will add credibility to the result findings.

To ensure transferability and credibility, attaining a "data detailed and thick description" depends mainly on developing trusting relationships with participants, which invariably encourages spending quality time with the participants. Because qualitative physiotherapy reports from SSA lack detailed and thick descriptions, it questions the applicability of their findings in a similar context. Questions regarding if qualitative physiotherapy researchers from SSA understand the importance of qualitative research reporting and its implications in research and clinical practice should be the subsequent qualitative priority research in this region. Among other factors, journals word count limit could hinder qualitative physiotherapy researchers from reporting elements to ensure rigour in qualitative research (Braun & Clarke, 2019). Member checking, peer debriefing, and/or data triangulation as strategies were less reported in the included studies. Member checking could trigger traps as the process may instill participants with feelings of disappointment, uncertainty wildly if the researcher misrepresented or misinterpreted their ideas (Kortsjens and Moser, 2018). Since qualitative research is evolving in physiotherapy, qualitative physiotherapy researchers may be cautious, as member checking can threaten their relationships with participants and possibly the stability of the
study. Reflectively understanding that qualitative findings give power and voice to the participants' narrative experience undermines the traps associated with member checking. In our research network (Emerging Researchers and Professionals in Ageing-African Network- www.erpaan.org), we have used a focus-group format of member checking (e.g., town meetings) to seek further feedback from our participants regarding our interpretation of their experiences.

Reporting of reflexivity in qualitative research was lacking in most included studies. This finding is not entirely surprising because while physiotherapy practice in the countries in Global North started embracing reflective practice in early 2000 (Cloder, 2000), a report of reflective practice was first noted in a Global South nation, for instance, in South Africa, ten years after (Ramklass, 2009). Reflection is essential in clinical and research practice and depicts a bidirectional relationship between researchers and participants in the research process and clinicians and clients in clinical practice. Reflection can be prospective (thinking of how one’s biases will influence research or how their actions will influence patients care) or retrospective (how researcher or clinicians thought, or experiences had influenced the research or patient care). Practicing reflection is a needed skill as it is among the eight unique physiotherapists' practice competence (World Physiotherapy, 2020).

Moreover, EBP integrates the best available research evidence that builds on the clinical expertise of the clinician while understanding the patients/relative values and experiences (Sacket et al., 2000). High-quality qualitative studies, often observed by transparent, high-quality reporting, can provide valuable information (e.g., patients' experience/values) that will guide the application of findings from systematic reviews and
meta-analyses in a practice setting. For example, to increase unrestricted mobility and participation for older adults with preclinical disabilities, clinicians are encouraged to recommend the use of walking aid (Skantz et al., 2019). However, an individual may be comfortable walking with an aid; another may not want to, probably due to the negative stigma associated with the use of walking aids in some societies (Nwankwo et al., 2019; Cabral, Barbosa, Rebello, and Vilanova, 2019). Therefore, clinicians ignoring the qualitative evidence that provides this subtle, implicit and essential information to enhance evidence-based treatment could contribute to poor treatment outcomes.

The person-centred approach to care is currently the recommended care model (Santana et al., 2018); this approach requires understanding the patient's experiences, needs and preferences. Therefore, with a person-centred approach to care as the focus, qualitative inquiries can no longer be relegated, as it is a suitable approach for eliciting the much-needed in-depth and rich data that would guide practical goal-setting based on patients' needs (Gibson and Martin, 2003). As evidence in good quality reporting, more high-quality qualitative studies are needed to provide evidence that will guide physiotherapists in SSA in clinical decision-making to use a person-centered approach to care.

While this might be the first study that has summarized the state and quality of published peer review qualitative studies conducted by physiotherapists in the SSA countries, it has some limitations. We may have missed some qualitative studies because we searched only peer-reviewed literature (no grey literature search) and studies published in English and have restricted inclusion and exclusion criteria. Since some of the national journals in SSA are not indexed in MEDLINE or related databases (Hofman
et al. 2009), we may have also missed some studies. Most of our included studies were from South Africa; therefore, this might not be a complete representation of qualitative evidence conducted by physiotherapy-researcher in SSA. The mapping review only provides a surface-level description and does not provide a critical and robust analysis (Grant and Booth, 2009). However, we intended to present a pioneer study on the current state and quality of qualitative study conducted by physiotherapists in the SSA. We hope that further study will explore how physiotherapists in the SSA countries identify and use high-quality qualitative evidence in clinical decisions complementary to clinical guidelines.

We conclude that the reporting of published qualitative studies in SSA show variable quality, albeit mostly low, covering various subject areas, including experiences in receiving and providing care, physiotherapy training and education but conducted mainly by physiotherapists in South Africa.

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