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PATIENT-CENTRED PERSPECTIVES ON STROKE CARE: CHALLENGES AND PRIORITIES

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Abstract

Worldwide, between 122 and 256 people per 100,000 population suffer from stroke annually, but in Kazakhstan, this number is much higher, from 258.4 to 433.7 cases per 100,000 between 2015 and 2020. The country also has the highest death rate from ischemic stroke in the world, reflecting problems such as late treatment, health inequalities, and limited rehabilitation opportunities. Human-centred care, which focuses on the needs of patients and their active role in recovery, can help bridge these gaps. However, little is known about how stroke survivors actually receive medical care in Kazakhstan. This study examines their opinions and perspectives to gain a deeper understanding of the barriers, outcomes, and opportunities for improvement.

The purpose of the study. To analyze the experiences and challenges faced by stroke patients during care and recovery.

Materials and Methods. A qualitative study was conducted in Almaty from May to August 2025, involving 31 stroke patients, who consented to face-to-face semi-structured interviews. Data were manually recorded, transcribed, and analyzed using a two-step coding process – open coding followed by thematic coding. Two authors independently coded transcripts, with additional review to ensure reliability and validity.

Results. Out of 31 stroke patients surveyed, most were over 60 and retired, with 23 experiencing a stroke for the first time. Common risk factors included chronic conditions and low physical activity. Recovery varied, with many needing ongoing rehabilitation and clearer home care guidance. Patients highlighted delays in medical evaluations, limited specialist access, and insufficient psychological support. While 24 had digital access, older respondents often distrusted telemedicine. Faster ambulance response, public awareness campaigns, and more personalized care were key recommendations. Patients emphasized regular check-ups, physical activity, and emotional resilience as essential for recovery and prevention of future strokes.

Conclusions. Accessible, patient-centred stroke care is essential, especially for older adults, with urgent needs to reduce delays in diagnosis, improve rehabilitation access, and strengthen psychological support. Future efforts should focus on integrating digital tools, public education, and personalized care to support long-term recovery.

***Keywords**: Stroke care, patient-centred care, technology in healthcare, integrated care, health equity.*

Introduction

Stroke is a significant public health problem worldwide, with epidemiology varying greatly by country. Incidence rates range from a median of 122 to 256 cases per 100,000 people for cerebrovascular disease (hereinafter – CVD), 95.6 to 246.1 per 100,000 for ischemic stroke (hereinafter – IS), 19 to 43 per 100,000 for hemorrhagic stroke (hereinafter – HS), and 4.8 to 13.5 per 100,000 for subarachnoid hemorrhage (hereinafter – SAH). While many countries in Europe and North America exhibit stable or decreasing trends, rising incidence has been reported in countries such as China, Singapore, France, and Australia. The highest stroke burden is concentrated in East Asia, particularly in countries like China, India, Indonesia, and Japan [1-3]. Stroke poses a significant health challenge in Kazakhstan, with increasing incidence rates from 258.4 to 433.7 cases per 100,000 population between 2015 and 2020-and the country recording the highest global age-standardized mortality rate from ischemic stroke, driven by healthcare disparities, delayed treatment, and limited resources. Efforts to improve outcomes focus on expanding advanced technologies, such as AI and telemedicine, enhancing healthcare professional training, and increasing public awareness, particularly in underserved regions [4-7].

Person-centred care (hereinafter – PCC) is increasingly valued in clinical practice for its holistic focus on the individual's life, preferences, and empowerment beyond just medical treatment, especially in stroke rehabilitation. However, despite its recognized benefits, PCC lacks a universally accepted definition, emphasizing the need for ongoing research-particularly qualitative studies-to understand patient experiences and improve care, while also underscoring the importance of training healthcare professionals to address patients' identities and promote active participation in decision-making [8; 9]. Additionally, L. Busetto emphasizes the critical need to prioritize patient-centred care during the post-treatment phases of acute stroke care, where communication and decision-making difficulties are most prominent, and calls for clear guidelines and accessible resources to strengthen patient-centredness in these key moments [10].

Person-centred care is especially important for stroke patients in Kazakhstan, where healthcare disparities and delayed treatment contribute to high mortality rates. By focusing on the individual's unique needs, preferences, and active involvement in their rehabilitation, PCC can help bridge gaps in care quality and accessibility, particularly in underserved regions. Integrating PCC into stroke care aligns with broader goals of achieving universal health coverage by promoting equitable, patient-focused services that improve outcomes and empower patients within the healthcare system.

The purpose of this study was to analyze the experiences and challenges faced by stroke patients during care and recovery, with a focus on factors that affect outcomes, access to rehabilitation, and the use of digital health tools.

Materials and Methods

This qualitative study was conducted from May to July 2025 in Almaty, Kazakhstan, to explore patients' experiences and perceptions related to stroke care. The study was approved by the Local Ethics Committee of Asfendiyarov Kazakh National Medical University (No. 4.140, May 3, 2023). At the study's outset, a letter was sent to the hospitals in Almaty with stroke centers. This letter was issued by the freelance neurosurgeon of Almaty, responsible for monitoring neurosurgical conditions and facilitating engagement with stroke patients.

Out of 60 eligible patients diagnosed with stroke, 31 provided informed consent to participate in face-to-face interviews. Nine patients declined participation, citing reasons such as a dislike of interviews or providing no reason at all. Data collection involved semi-structured interviews lasting approximately 20 to 30 minutes, conducted in person. Interviews were manually recorded on paper, later transcribed verbatim, and uploaded into Dedoose software for qualitative analysis.

The interview guide covered a broad range of topics derived from preliminary results, including stroke experience, recovery challenges, access to care, rehabilitation, awareness of stroke symptoms, pre-hospital and hospital care, telemedicine use, and suggestions for improving stroke services.

Data analysis followed a two-step coding process. Initially, open coding was applied through line-by-line reading of transcripts to identify and label discrete concepts and categories that emerged inductively from the data, without predefined codes. Each meaningful text segment was assigned one or more descriptive codes. The following open coding and thematic coding grouped related codes into broader themes, reflecting key patterns aligned with the study objectives, such as stroke care preparedness, resource challenges, training practices, and public awareness.

To ensure reliability, two authors independently coded the transcripts, resolving any discrepancies through discussion. Additional authors reviewed the coding and thematic interpretations to enhance methodological rigor and validity.

Results

Out of 31 respondents, the majority (23) experienced a stroke for the first time, highlighting the sudden and unpredictable nature of the condition for most patients. Recurrent strokes or mini-strokes (TIAs) were reported by 8 individuals, including one case with as many as 15 prior mini-strokes. Most participants were over 60 years old and retired (at least 22), which emphasizes age as a significant risk factor. Some patients described earlier strokes as more severe, such as loss of consciousness or speech, while others noted a worsening of symptoms over time, including paralysis or motor deficits. A few respondents (3) had experienced a second or even third stroke years apart from the first, underscoring the importance of long-term monitoring and prevention. There was also variation in patients' ability to recall the timing and symptoms of their stroke, which may reflect the cognitive impacts of the condition. Most strokes occurred in August 2025 (at least 23), suggesting possible seasonal effects or that data were collected within a defined research period. Despite differences in age and background, respondents shared similar challenges in recovery, particularly following recurrent strokes.

Most respondents with chronic conditions (19) were over the age of 60, confirming age as a key risk factor for stroke. The most common conditions included hypertension, diabetes, high cholesterol, and autoimmune disorders. Participants under 60 were more likely to report no known chronic illnesses (12), which may indicate undiagnosed or unmonitored health issues prior to the stroke. In terms of lifestyle, both older and younger respondents (17 in total) reported being physically active before their stroke. Younger participants often mentioned structured exercise, such as going to the gym or swimming, while older individuals referred to activities like walking, gardening, or household tasks. However, 14 respondents – mainly in the older age group – led a sedentary or low-activity lifestyle, which, combined with chronic conditions, likely increased their stroke risk.

Regarding preventive care and medical check-ups, 20 respondents, most of them over 60 years old, stated that they visited doctors at least once a year. This may reflect increased health awareness or the need that comes with age. Still, 11 participants, including several elderly individuals, did not undergo regular screenings, often relying on subjective well-being, which may have contributed to the late detection of pre-stroke conditions.

Awareness of Stroke Symptoms and Responses by Age Group

Younger respondents (under 60) were often unaware of stroke symptoms before their experience, learning about them only afterward. Older participants (70 and above) generally had more knowledge from sources like newspapers or personal experience, which helped them recognize symptoms sooner. Symptoms varied by age, with older individuals experiencing more severe signs such as paralysis, while younger ones reported milder symptoms like headaches and dizziness. Most people, regardless of age, sought medical help quickly once symptoms appeared. Some younger patients faced misunderstanding from others, who sometimes thought they were intoxicated, while older respondents often had family members who recognized the signs and acted promptly. This highlights the need to raise stroke awareness, especially among younger people.

Experience of pre-hospital care, hospitalization, and treatment of patients with stroke by age groups

Patients under 60 years old (n = 10) often decided to call an ambulance themselves or with the help of their family. They usually reached the hospital by ambulance, but sometimes they encountered misunderstanding from medical staff (e.g., a 43-year-old woman, whose stroke was not recognized immediately). The ambulance usually arrived quickly when patients or their relatives showed initiative and persistence in seeking hospitalization. Patients aged 60 to 80 (n = 15) relied more on relatives or close acquaintances to call for an ambulance and assist with transportation. They often faced challenges in transporting bedridden patients due to a lack of support. Patients usually had to wait for an ambulance for 10 to 30 minutes, but doctors responded promptly. Patients over 80 (n = 5) mostly depended on their family to call for help. Barriers included a lack of information about what to do before medical help arrives and fear of self-transport. Ambulance response was generally fast, but patients often appeared unprepared due to a lack of guidance before arrival.

Young and middle-aged patients (n = 10) received prompt professional care, including quick CT/MRI scans. Staff were attentive, providing clear explanations. Surgeries and rehabilitation (including massage and exercises) were common, although not everyone completed the rehabilitation program. Patients aged 60-80 (n = 15) had mixed experiences – they encountered friendly staff, but also experienced some delays and unclear information. Special treatments were less frequent but administered promptly. Rehab included exercises, massage, and diet, but not all received full care. Elderly patients (aged 80 and above, approximately n=5) faced longer wait times, mixed staff attitudes, and stress. The understanding of diagnosis was lower. Surgeries were rare, with a greater emphasis on explaining outcomes. Rehab was less available and less organized.

Rehabilitation Access and Methods

Most patients (about 20) underwent or are undergoing rehabilitation, mainly physical therapy, massage, psychological support, and sanatorium treatments. Some were referred to specialized centers, while others received care at home or in hospitals. Older patients (e.g., those aged 58 to 83 years) faced additional challenges, such as repeat surgeries and prolonged recovery times. Some complained about lengthy and time-consuming medical evaluations. About 8 patients, mostly younger or middle-aged, had not yet received discharge or rehab referrals.

Perception of Recovery and Treatment Results

Most patients rated their recovery as normal or good, but felt that ongoing treatment was needed (approximately 18 respondents). Some experienced incomplete recovery with issues like fatigue, balance problems, pain, and weakness, mostly in the ages of 40 to 70. Patients expressed a need for more personalized support, including speech therapy, psychological counseling, and physiotherapy, as well as improved communication with their doctors.

Patient Suggestions regarding hospitalization

Patients highlighted several areas for improvement in stroke rehabilitation. One key concern was the need to reduce bureaucratic delays in medical commissions, which were particularly burdensome for those with ongoing health issues (an individual aged 58). Others emphasized the importance of increasing access to physiotherapy and specialist sessions, as current rehabilitation services were often seen as insufficient for full recovery (individuals aged 60, 68, and 70). There was also a call to provide clearer instructions for home exercises to maintain the effectiveness of rehabilitation beyond the hospital setting (an individual aged 68). The need to offer more psychological support was noted, acknowledging the emotional challenges that many patients experienced during recovery (an individual aged 67). Some patients recommended extending the duration of inpatient rehabilitation, allowing more time to regain function under professional supervision (an individual aged 83). Additionally, improving the overall quality of medical care and attention, with a stronger focus on personalized and patient-centered approaches, was seen as essential (by an individual aged 53).

Attitudes Toward Telemedicine and Technology

Out of 30 respondents, over 20 (n=24), including those over 60 (e.g., individuals aged 58, 61, 68, and 83), reported having access to devices (phone, tablet, internet) that suggested a high potential for digital rehabilitation. However, the opinions varied, with 12 patients expressing positive or neutral attitudes. Some believed it saved time (e.g., an individual aged 75), is more convenient (40, 60, 73), or even received online psychological support (40). Skepticism and a preference for in-person care were common among older patients, especially those 70 years and older, who raised concerns about internet stability (43), the risk of misdiagnosis (82, 83), and the lack of personal contact (68, 83). Digital challenges were mentioned by patients aged 67 and 44, including difficulties using apps or understanding technology. Overall, while access is not a barrier, trust and usability remain key issues, particularly among patients aged 70 and above.

Patient Recommendations for Improving Stroke Care

Patients wanted quicker ambulance response and rapid diagnosis (ages 58, 60, 83). Other respondents suggested better public awareness and education: one younger respondent (59) emphasized the need for aggressive public campaigns about stroke symptoms, comparing it to flu awareness. The patients also requested that more specialists and staff be provided (43, 60, 83); the requests included more speech therapists, physiotherapists, and trained emergency staff.

Home care support and clear instructions from day one (80, 68) were especially relevant for older and immobile patients. Several patients (40, 67, 43) recommended psychological support and emotional encouragement for stroke survivors. Eventually, much emphasis should be placed on regular check-ups, controlling blood pressure, exercising, and maintaining a positive attitude (common across ages 58-75).

Table 1 summarizes patients' experiences, challenges, and suggestions related to pre-hospital care, hospitalization, rehabilitation, and recovery after stroke. It highlights issues such as delays, variability in care quality, and the need for more personalized support and improved communication throughout the care continuum.

Table 1. Summary of Key Findings, Challenges, and Recommendations on Stroke Care and Recovery

Category	Key Points	Challenges	Recommendations
Stroke Experience	Most (23/31) had first stroke; 8 had recurrent or mini-strokes; majority over 60 and retired	Cognitive recall variability, symptom severity and progression; seasonal timing of strokes	Long-term monitoring and prevention, especially for recurrent stroke patients
Chronic Conditions & Lifestyle	19/31 had chronic illnesses (hypertension, diabetes); physical activity varied by age	A sedentary lifestyle combined with chronic illnesses increased risk; some lacked regular check-ups	Promote regular screenings and active lifestyles, especially in older adults
Awareness of Symptoms	Older patients (70+) more aware; younger often unaware before stroke	Misunderstanding of symptoms in younger patients; delayed recognition in some cases	Increase stroke symptom education, targeting the younger population
Pre-hospital Care, Hospitalization, Rehabilitation & Recovery	Ambulance response generally timely; younger self-initiate calls; elderly rely on family; rehab common but variable; recovery often rated as good with ongoing needs; persistent symptoms like fatigue and balance issues	Transport difficulties for bedridden; inadequate pre-arrival guidance; staff delays; incomplete rehab; ongoing symptoms; need for personalized care	Improve pre-hospital guidance and family support, reduce hospital delays, expand access to rehabilitation, and provide personalized therapies and clearer home rehabilitation instructions.
Patient Suggestions	Bureaucratic delays in commissions, insufficient rehab options, and a lack of psychological support	Delays and insufficient rehab services; emotional challenges	Streamline medical processes; extend rehab duration; enhance psychological and patient-centred care
Telemedicine & Technology	High device access (24/30); mixed attitudes toward digital rehab	Skepticism, tech difficulties, preference for in-person care, especially in the 70+ age group	Improve tech usability and trust; offer hybrid digital/in-person rehab options
Overall Stroke Care Improvement	Need faster ambulance, better public awareness, more specialists	Lack of public education, insufficient staff, and unclear home care instructions	Public campaigns on stroke symptoms, more trained staff, and clear home care guidelines

Source: compiled by the authors

Discussion

We found that most experienced their first stroke unexpectedly, with older age, chronic conditions like hypertension and diabetes, and sedentary lifestyles – particularly among the elderly – being key risk factors. Despite some patients attending regular check-ups, many lacked early detection, revealing gaps in preventive care. These findings align with broader research emphasizing the critical role of managing modifiable risk factors and the urgent need for comprehensive prevention strategies and public health campaigns globally [11-15].

Our study found that younger patients were often unaware of stroke symptoms and sometimes faced stigma or misinterpretation, emphasizing the importance of targeted awareness campaigns. Similarly, in Saudi Arabia, stroke awareness was shaped by factors like marital status, income, and family history, suggesting the need to reach younger, less-informed populations [16]. In Korea, although knowledge of stroke signs and treatments improved, declining awareness of risk factors – especially among those without vascular conditions – highlights the importance of sustained education using modern platforms [17]. In Canada, despite multiple FAST campaigns, stroke sign awareness remained low among men, retirees, and those with lower socioeconomic status, underscoring the need for more inclusion and targeted public health strategies [18].

In our findings, the ambulance remains the primary mode of transport, with younger patients showing greater autonomy in decision-making and older individuals relying more on family support, a pattern that parallels themes in UK and Canadian research, which emphasize patient-family dynamics and transport logistics [19; 20]. Delays in ambulance arrival, poor symptom recognition by healthcare providers, and limited patient/family knowledge were notable barriers in our setting, aligning with global concerns seen in low- and middle-income countries where pre-hospital delays, weak public awareness, and infrastructure gaps persist [21]. In contrast, centralized models in the UK and improved ambulance-based interventions have shown promise in enhancing early care, while experiences from Korea and Saudi Arabia highlighted persistent gaps in symptom and risk factor awareness. Despite improvements from targeted campaigns, such as FAST in Canada [16-18; 22], or the establishment of integrated units in New Zealand [23], consistent issues remain globally, underscoring the need for standardized pre-hospital protocols, enhanced communication between services, and widespread public education to improve timely stroke response and outcomes.

Our results showed that younger patients generally received faster and more comprehensive hospital treatment and rehabilitation, while older patients faced delays, less structured care, and lower understanding of their diagnosis. Across all age groups, many experienced incomplete rehabilitation, persistent symptoms, and communication gaps in follow-up care. Stroke rehabilitation is further challenged by limited access to personalized information, inadequate facilities, a shortage of trained community workers, and poorly designed assistive devices [24; 25]. Patients often leave the hospital without proper guidance for home-based recovery, leading to poor adherence and uncertainty. Fear of judgment also causes many to tolerate pain and fatigue in silence, underscoring the need for individualized rehab plans [26; 27]. A lack of peer support reduces motivation, while high costs and income loss add financial strain. These findings underscore the pressing need for enhanced policy support, comprehensive insurance coverage, and accessible, personalized rehabilitation services to enhance long-term outcomes [28].

We have also found that although high digital device access presents strong potential for remote stroke rehabilitation, trust and usability concerns – especially among older patients – as well as mixed attitudes toward telemedicine, underscore the need for tailored, user-friendly solutions. Similarly, stroke patients expressed mixed feelings about digital health technologies, but valued features such as credible health information, personal health records, and online rehabilitation support, while emphasizing the importance of simple and accessible designs customized to their needs. To facilitate the successful implementation and scaling of telemedicine initiatives, the Telemedicine Community Readiness Model (hereinafter referred to as TCRM) provides a practical framework for communities to assess and enhance their readiness, enabling decision-makers to foster environments that promote widespread adoption and improve healthcare access and quality [29-31].

Although this study provides important insights into the experiences of patients in Almaty, it is essential to consider that access to medical care, rehabilitation resources, and awareness levels may vary significantly across different regions in Kazakhstan. Future comparative studies in urban and rural settings are needed to identify regional differences and ensure that stroke care recommendations are nationally representative.

Limitations and Future Directions. This study's findings are based on a relatively small, urban sample of 31 stroke patients from Almaty, which may limit generalizability to other regions or rural populations. The use of manual transcription and qualitative coding, while conducted rigorously, may introduce interpretative bias despite efforts to enhance reliability through multiple coders. Another limitation is the possible impact of post-stroke cognitive impairments, which may have affected patients' memories and the accuracy of their responses during the interview.

Future research should include larger and more diverse patient samples across different geographic and socioeconomic settings to improve representativeness. Longitudinal studies are recommended to better understand the trajectories of stroke recovery and the sustained impact of rehabilitation interventions over time. Investigating tailored digital health solutions that address usability and trust concerns, particularly among older adults, could enhance the uptake of remote rehabilitation. Further exploration of strategies to reduce bureaucratic barriers, expand access to specialists, and integrate psychological support within stroke care pathways is essential. Additionally, community-based interventions to increase stroke symptom awareness, promote patient-centred care, and support ongoing lifestyle management should be developed and evaluated. Future research should consider using digital transcription and encoding tools to reduce potential subjectivity.

Reflecting patients' perspectives, future recommendations emphasize the urgent need for faster ambulance response times and more rapid stroke diagnosis to improve outcomes. Expanding access to specialized care, including speech therapy, physiotherapy, and psychological support, is critical to addressing the full spectrum of recovery needs. Simplifying bureaucratic processes and providing clearer, more practical guidance for home-based rehabilitation will enhance adherence and effectiveness. Moreover, regular follow-up check-ups, comprehensive lifestyle management, and a stronger focus on personalized, patient-centred care are crucial for supporting long-term recovery and improving the quality of life for stroke survivors. Since this study was conducted exclusively in Almaty, the results obtained may not fully reflect the situation in other regions of Kazakhstan, especially in rural or low-income areas, where access to timely diagnosis, rehabilitation, and psychological support may vary significantly.

Conclusions

There is a growing need for more accessible, patient-centred stroke care, particularly for older adults. Reducing delays in diagnosis, improving access to rehabilitation, and enhancing psychological support are crucial for achieving better recovery outcomes. As digital tools become more widespread, tailored training and intuitive platforms can help older patients engage with tele-rehabilitation. Public education campaigns remain essential for boosting awareness of stroke symptoms and promoting a rapid response. Looking ahead, stroke care should move toward integrated, technology-enhanced models that address medical, emotional, and social needs throughout the recovery journey.

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ИНСУЛЬТКЕ КҮТІМ ЖАСАУ ТУРАЛЫ ПАЦИЕНТКЕ БАҒЫТТАЛҒАН КӨЗҚАРАСТАР: МӘСЕЛЕЛЕР МЕН БАСЫМДЫҚТАР

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Аңдатпа

Дүние жүзінде жыл сайын инсульттан 100 000 тұрғынға шаққанда 122-ден 256 адамға дейін зардап шегеді, бірақ Қазақстанда бұл сан әлдеқайда жоғары – 2015-2020 жылдар аралығында 100 000 адамға шаққанда 258,4-тен 433,7 жағдайға дейін. Сондай-ақ, елде ишемиялық инсульттан болатын өлім-жітім деңгейі әлемдегі ең жоғары, бұл уақтылы емделмеу, денсаулық сақтау саласындағы теңсіздік және оңалтудың шектеулі мүмкіндіктері сияқты мәселелерді көрсетеді. Пациенттердің қажеттіліктеріне және олардың қалпына келтірудегі белсенді рөліне бағытталған адамға бағытталған көмек бұл олқылықтарды жоюға көмектеседі. Дегенмен, инсульттан аман қалған адамдардың Қазақстанда медициналық көмекті қалай алатыны туралы аз мәлімет бар. Бұл зерттеу кедергілерді, нәтижелерді және жақсарту мүмкіндіктерін жақсырақ түсіну үшін олардың пікірлері мен перспективаларын қарастырады.

Мақсаты: инсультпен ауыратын науқастардың тәжірибесін, сондай-ақ күтім мен қалпына келтіру кезінде туындайтын қиындықтарды зерттеу.

Материалдар мен әдістер. Сапалық зерттеу 2025 жылдың мамыр-тамыз айларында Алматы қаласында инсульт алған және жеке жартылай құрылымдалған сұхбатқа қатысуға келісім берген 31 пациенттің қатысуымен жүргізілді. Деректер қолмен жазылып, транскрипцияланып, екі кезеңді кодтау – ашық және тақырыптық кодтау арқылы талданды. Екі автор транскрипцияларды тәуелсіз түрде кодтап, қосымша сарапшылар талдаудың шынайылығы мен сенімділігін тексерді.

Нәтижелер. Сауалнамаға қатысқан 31 пациенттің көпшілігі 60 жастан асқан және зейнеткерлікке шыққан, 23 жасында инсульт бірінші рет болған. Негізгі қауіп факторлары созылмалы аурулар және белсенділіктен қорғау болды. Қалпына келтіру әр түрлі жолмен жүрді, көп жағдайда ұзақ қалпына келтіру және үйде күтім жасау бойынша нақты ұсыныстар қажет болды. Пациенттер медициналық мекемелердегі кідірістерді, мамандарға қол жетімділіктің шектелуін және психологиялық қолдаудың жеткіліксіздігін атап өтті. 24 адам сандық құрылғыларға қол жеткізе алғанымен, егде жастағы адамдар көбінесе телемедицинаға сенбеді. Негізгі ұсыныстар көмек көрсету бойынша жұмысты жеделдетуге, жеке тұлғаларға хабардарлықты арттыру және жекелендірілген тәсіл бойынша іс-шаралар өткізуге бағытталған. Пациенттер қалпына келтіру және қайта кеңес беру үшін тұрақты тексерулерге, жаттығуларға және эмоционалды тұрақтылыққа назар аударды.

Қорытынды. Қол жетімді және пациентке бағытталған кеңес беру көмегі диагностиканың кешігуін азайту, дағдарысқа қол жеткізуді жақсарту және психологиялық қолдауды күшейту қажеттілігі бар жәрдемақы алатын адамдар үшін өте маңызды. Болашақта ұзақ мерзімді қалпына келтіруді қолдау үшін цифрлық технологияларды, білім беру стратегияларын және жеке денсаулық сақтауды қарастыруға назар аудару керек.

***Түйін сөздер**: Инсультті емдеу, пациентке бағытталған көмек, денсаулық сақтаудағы технологиялар, кешенді көмек, денсаулық сақтаудағы теңдік.*

ОРИЕНТИРОВАННЫЕ НА ПАЦИЕНТА ВЗГЛЯДЫ НА ПОМОЩЬ ПРИ ИНСУЛЬТЕ: ПРОБЛЕМЫ И ПРИОРИТЕТЫ

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Аннотация

Во всем мире ежегодно от инсульта страдают от 122 до 256 человек на 100 000 населения, но в Казахстане это число намного выше – с 258,4 до 433,7 случаев на 100 000 в период с 2015 по 2020 год. В стране также самый высокий в мире уровень смертности от ишемического инсульта, что отражает такие проблемы, как несвоевременное лечение, неравенство в сфере здравоохранения и ограниченные возможности реабилитации. Помощь, ориентированная на человека, которая фокусируется на потребностях пациентов и их активной роли в восстановлении, может помочь устранить эти пробелы. Тем не менее, мало что известно о том, как на самом деле люди, пережившие инсульт, получают медицинскую помощь в Казахстане. В этом исследовании рассматриваются их мнения и точки зрения, чтобы лучше понять барьеры, результаты и возможности для улучшения.

Цель: изучить опыт пациентов, перенесших инсульт, а также трудности, возникающие при уходе и восстановлении.

Материалы и методы. Качественное исследование было проведено в Алматы с мая по август 2025 года с участием 31 пациента, перенесшего инсульт, согласившегося на личное полуструктурированное интервью. Данные вручную записывались, транскрибировались и анализировались с помощью двухэтапного кодирования – открытого и тематического. Два автора независимо кодировали транскрипты, при этом дополнительные эксперты проверяли достоверность и надежность анализа.

Результаты. Из 31 опрошенного пациента, перенесшего инсульт, большинство были старше 60 лет и находились на пенсии, у 23 пациентов инсульт случился впервые. Основными факторами риска были хронические заболевания и низкая физическая активность. Восстановление проходило по-разному, многим потребовалась длительная реабилитация и более четкие рекомендации по домашнему уходу. Пациенты отмечали задержки в медицинских учреждениях, ограниченный доступ к специалистам и недостаточную психологическую поддержку. Хотя 24 человека имели доступ к цифровым устройствам, пожилые люди часто не доверяли телемедицине. Ключевые рекомендации были направлены на ускорение работы по оказанию помощи, проведение мероприятий по повышению осведомленности и более персонализированного подхода к отдельным лицам. Пациенты подчеркивали важность регулярных осмотров, физической нагрузки и эмоциональной устойчивости для восстановления и предотвращения инсультов в будущем.

Вывод. Доступная и ориентированная на пациента помощь при консультировании особенно важна, особенно для пожилых людей, с острой необходимостью сокращения задержки в диагностике, улучшения доступа к реабилитации и усиления психологической поддержки. В будущем следует сосредоточиться на рассмотрении цифровых технологий, просветительских стратегий и персонализированного здравоохранения для поддержки долгосрочного восстановления.

Ключевые слова: *лечение инсульта; пациенто-ориентированная помощь; технологии в здравоохранении; комплексная помощь; равенство в здравоохранении.*

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