

Not So F.A.S.T.: Uncovering the Decision-Making Processes Behind Seeking Emergency Medical Care for Stroke Among Survivors and Their Caregivers — An Exploratory Qualitative Descriptive Study in Northern British Columbia

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Abstract

Transport practices for seeking emergency stroke care remain largely under-researched and poorly understood, particularly for individuals living outside of major cities. This qualitative descriptive study aims to address this knowledge gap concerning the decision-making process of seeking emergency medical attention for stroke survivors and their caregivers. Twelve semi-structured qualitative interviews with stroke survivors (n = 12), some accompanied by their caregivers (n = 7), were undertaken. Findings provide key contextual insights related to the experiences of seeking

emergency stroke care in a northern region of Canada and resulted in key themes including the sense-making of symptoms, the influence and impact of others, and an unwillingness to seek care. This research addresses an important knowledge gap concerning the transport practices of those with stroke. It is anticipated that findings from this work will help inform the planning and delivery of stroke-related health services and public awareness campaigns.

Keywords: stroke, qualitative, health services, emergency

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Key Highlights

- Knowledge gaps and symptom appraisals (e.g., discounting non-classic symptoms) contributed to delayed EHS activation.
- Caregivers and bystanders played dual roles, as facilitators and, at times, unintentional barriers, to calling EHS.
- Local context (distance, perceived transport times, prior healthcare experiences) shaped decisions to self-transport versus call EHS.
- Public messaging should broaden beyond F.A.S.T. to include diverse symptoms and explicitly target caregivers and bystanders.

Stroke is a leading cause of death and disability in Canada (Heart and Stroke Foundation, 2022, 2024). Research has shown people who suffer a stroke and are transported to the hospital by ambulance have lower rates of death and better outcomes, including lower rates of disability (Heart and Stroke Foundation, 2024). Because of this, considerable

human and fiscal resources have been invested in stroke awareness initiatives like Face Arms Speech Time (F.A.S.T.) to increase public awareness of stroke symptoms and what to do in the event of a stroke (Heart and Stroke Foundation, 2022, 2024). The F.A.S.T. campaign, a widely disseminated, multi-channel public health initiative, emphasizes facial drooping, arm weakness, and speech changes as triggers to act fast and call 911 or emergency health services (EHS).

Despite substantial investment in public stroke awareness campaigns, delayed symptom recognition and underutilization of EHS remain significant barriers to timely, evidence-based stroke care (Brisette et al., 2023; Dawson et al., 2016; De Silva et al., 2007; Fladt et al., 2019; Flynn et al., 2014; Hickey et al., 2018; Heart and Stroke Foundation, 2024; Howard et al., 2008). These delays are concerning given early recognition of stroke symptoms and rapid activation of EHS are critical for reducing mortality, disability, and treatment delays (Curran et al., 2011; Fleet et al., 2018; Rosznagel et al., 2004; Schroeder et al., 2000; Seo et al., 2014).

While considerable attention has been devoted to improving hyperacute and acute stroke care, less is known about the factors influencing stroke awareness and EHS use outside of major cities, particularly in small urban, northern, rural, and remote communities. This knowledge gap is especially important given that more than 20% of Canadians live in rural or remote areas (Fleet et al., 2014). Understanding how stroke survivors and their caregivers recognize symptoms and make decisions about seeking emergency care in small urban, northern, rural, and remote communities may help identify barriers to timely care and inform strategies to improve stroke outcomes in these often-underserved populations. Accordingly, the objective of this study was to explore stroke awareness and decision-making related to EHS use among stroke survivors and their caregivers residing in northern British Columbia.

Aim and Methods

Study Design

The aim of this qualitative descriptive study was to explore how stroke survivors residing in northern region of British Columbia, Canada recognize symptoms and decide whether and how to seek emergency care, including activation of EHS. Qualitative description is well suited to research aimed at producing a rich, straightforward account of participants' experiences while staying close to the data and participants' own language. This study was approved by the University of Northern British Columbia (UNBC E2018.0226.019.00H) and Northern Health (RRC-2018-0056) Research Ethics Boards and all participants provided informed consent.

Participants and Setting

Adult stroke survivors were eligible to participate if they were residing in small urban, northern, rural, or remote communities within northern British Columbia, had experienced an ischemic or hemorrhagic stroke in the last five years, and were able to take part in an interview in English. In some cases, survivors were accompanied by their caregivers who were eligible to be present if they were involved in decision-making related to seeking care during the stroke event. Individuals were excluded if they were unable to provide informed consent. Participants were recruited using a multi-pronged approach that included postings in community, social, and health-related settings. Although some stroke events occurred several years before data collection, retrospective interviews allowed participants to reflect on the factors influencing their care-seeking decisions and the meaning they attributed to their experiences.

Data Collection

Interviews were conducted by Kandola, using a semi-structured interview guide co-developed with a patient partner with lived experience of stroke survivorship in northern British Columbia (The interview guide is provided in Box 1.). A total of 12 semi-structured, qualitative interviews were undertaken either in-person ($n = 5$) or by telephone

Box 1

Semi-Structured Interview Guide

1. Tell me about your experience of stroke.
 - a. When did it occur? Where did it occur?
 - b. What symptoms did you experience?
 - c. Had you or anyone you know experienced a stroke or stroke-like symptoms before?
2. What factors did you consider when thinking of getting to the hospital?
3. Tell me about your experience in the hospital setting. What happened during your initial time in the hospital?
 - a. How long was your hospital stay?
4. Is there anything else you would like to add? Or anything you think would be helpful for us to know?

($n = 7$) ranging from 23 to 52 minutes in duration, with stroke-survivors ($n = 12$), some of which were accompanied by their caregivers, including spouses and family members ($n = 7$; Table 1). Interviews were digitally recorded and transcribed verbatim. Recruitment and data collection continued until saturation was achieved, or the point at which no new codes developed, and themes and subthemes were fully fleshed out (Padgett, 2008).

Data Analysis

Consistent with qualitative description (Colorafi & Evans, 2016), data from semi-structured, open-ended interviews were analyzed thematically using an inductive and iterative approach. Transcripts were reviewed multiple times to support data familiarization and initial manual notetaking. Codes were then further developed and organized into a codebook using NVivo (QSR International, Pty Ltd., 2018). Coding was undertaken by Kandola, with portions of transcripts independently reviewed by Banner to enhance analytic rigor. Codes were then organized into themes and subthemes using a visual conceptual mapping process. Recoding occurred throughout the analysis to ensure themes were coherent and meaningful in relation to one another and the broader dataset (Braun & Clarke, 2006, 2014). Sub-themes, or "themes-within-a-theme," helped establish a hierarchy within themes (Braun & Clarke, 2006, 2014, 2022). Themes were further refined through regular discussions among the research team to refine interpretations and enhance analytic rigor.

Positionality

As a researcher living and working in northern British Columbia with interests in rural health services and stroke systems of care, Kandola engaged in reflexive discussions throughout data collection and analysis with other members of the research team to minimize assumptions and maintain attention to participant perspectives. The research

Table 1*Survivor-Participant Characteristics (n = 12)*

Participant ID	Sex	Age	Occupation status	Mode of hospital presentation	Stroke type	Date of stroke	Home site	Treatment site
P001*	M	74	Retired	EHS	Ischemic	2015	Terrace	Terrace
P003	M	23	Employed	EHS	Ischemic	2018	Prince George	Prince George
P004	F	41	Employed	EHS	Ischemic	2018	Prince George	Prince George
P005	F	44	Self-employed	EHS	Ischemic	2015	Fort St. John	Prince George, Vancouver
P006	F	54	Employed	non-EHS	Hemorrhagic	2018	Prince George	Prince George
P008	F	60	Retired	EHS	Hemorrhagic	2016	Prince George	Prince George
P010*	F	65	Retired	non-EHS	Ischemic	2019	Vanderhoof	Prince George
P011*	M	67	Retired	EHS	Ischemic	2019	Prince George	Prince George
P013	M	44	Employed	EHS	Hemorrhagic	2018	Prince George	Prince George, Vancouver
P017*	M	66	Employed	EHS	Ischemic	2017	Kitimat	Terrace
P018*	M	59	Employed	EHS	Ischemic	2018	Smithers	Terrace
P020*	M	63	Retired	non-EHS	Ischemic	2018	Dawson Creek	Dawson Creek

Note. *caregiver present for interview but caregiver demographics were not collected.

EHS-emergency health services, non-EHS-other means of transport, including private car, taxi.

Home site refers to the participant's community of residence at the time of stroke and treatment site refers to the hospital where acute stroke care was received.

team included researchers with expertise in stroke care, rural health services, and qualitative research methods. Several team members also had professional experience working in northern healthcare contexts, which informed sensitivity to regional healthcare access challenges.

Results

Twelve stroke survivors (5 women, 7 men; ages 23–74 years), some accompanied by their caregivers, contributed their perspectives. Most survivors experienced ischemic stroke ($n = 9$) and a minority hemorrhagic stroke ($n = 3$), and modes of presentation included EHS ($n = 9$) and non-EHS ($n = 3$) transport. Three overarching themes were identified that structured the decision-making trajectory: (1) Sense-making and deciphering symptoms; (2) The influence and impact of others; and (3) Unwillingness to seek care. During interviews, both survivors and their caregivers reflected upon their experience with stroke, including symptom onset, specific symptoms experienced, and other factors considered when thinking of whether to seek medical care, including their transport means for getting to the hospital.

When examining their decision-making during the period immediately following stroke, survivors described numerous factors that influenced their decision to seek care and call EHS. These included their level of stroke knowledge, the perceived seriousness and duration of symptoms experienced, and the impact of others around them, including having a caregiver or bystander present, and acting out of concern for others. Similar to survivors, caregivers described factors such as their level of stroke knowledge and F.A.S.T. awareness as being an important factor in the decision to seek emergency medical care. However, some caregivers also reflected on how they established contact with primary care providers to assist in the decision-making process and others relied on their knowledge of local health resources, including the availability of EHS to decide on the best way to seek care. In addition, many caregivers relied on their personal knowledge of the survivor and knowing how there was something different about them, even if they did not immediately recognize this difference as being a stroke. Each of these factors influenced the decision to call EHS or to self-transport to the emergency department (ED).

Sense-making and deciphering symptoms

Both survivors and caregivers, sought to make sense of emerging symptoms, attempting to decipher potential causes and determine whether to seek emergency care. Many survivors recalled monitoring their symptoms before seeking help. Throughout interviews, knowledge gaps specific to the recognition of stroke symptoms were commonly reported. Most survivors recalled feeling confused about their symptoms during the immediate period following stroke. Some confused symptoms with other conditions, such as a myocardial infarction or headache, while others recalled feeling uncertain about whether to wait to see if symptoms resolved, to seek immediate emergency medical attention, or call EHS. More than half of the survivors interviewed ($n = 7$) did not think the symptoms they experienced, including those of speech challenges, confusion, and disorientation, were indicative of stroke. As a result, many stated that they acted to seek emergency medical attention based on the type of symptoms experienced or the length of time they experienced these symptoms, as opposed to acting due to the symptoms being indicative of stroke and recognizing that as a medical emergency. For example, as one participant explained:

I just went upstairs and I felt totally fine, I went upstairs and looked in the bathroom, looked in the mirror and saw that my face wasn't droopy and I could lift my hands above my head. So I don't know and I was thinking that I, I thought well it can't be a stroke then because I feel fine and there's nothing here, I just can't talk... I know the warning like I know the warning signs but I just, I don't know what I was thinking that was kind of some of the other confusion that was going on with me not feeling, feeling well. [P005]

Similar uncertainties and knowledge gaps were identified from many of the caregivers ($n = 3$), and this was another key factor that influenced the decision to seek help following a stroke. Like some of the survivors, many of the caregivers also reported feeling confused about symptoms, often attributing these to other less serious conditions. Through the process of deciphering and making sense of symptoms, survivors attempted to determine how to respond and whether to seek emergency care. In some cases, caregivers similarly reported attempting to make sense of this, which in turn made them delay seeking urgent medical attention or prevented them from calling EHS for care, while others were hesitant to use community medical resources. For example, as one participant stated:

Yes, my husband drove me, and like I say we're a half an hour, we, we live out the west in [small remote area] so we're about a half an hour out of town... Yeah, I, I was just thinking it was a headache and not to call 911, yeah, we didn't, you know, we didn't even think about it, it was like let's just get in the car. [P006]

While some survivors considered their symptoms to be more benign, such as a simple headache, caregivers often confused the symptoms experienced by survivors for completely

different conditions entirely, contributing to further delays in seeking prompt medical attention. Other caregivers ($n=3$) reported relying on their experiential knowledge when attempting to decipher symptoms. Having known others who had had a stroke was a helpful motivator when deciding to seek emergency medical care for some caregivers. As one caregiver explained:

I knew immediately by the side face. And not being able to talk to me and just the look in her eyes I've seen several people that have had strokes... Or seizures and I knew the minute I looked at her that she was having a stroke. [P010 Caregiver]

Knowledge gaps became apparent in many forms throughout the analysis and were present even among those that reported having a good knowledge of stroke symptoms, including an awareness of high-profile public health campaigns like F.A.S.T. Three survivors recalled evaluating their symptoms concerning F.A.S.T. during the immediate period following the onset of symptoms, while others discounted their symptoms as they did not fit with these past experiences or their previous knowledge, including the specific criteria addressed in the F.A.S.T. campaign. This perceived disconnect between their symptoms and these campaigns created confusion and uncertainty when deciding on whether to seek EHS care. This process of deciphering symptoms deterred some from seeking timely help or calling for EHS. As one caregiver reflected:

In hospitals when they have posters up for F.A.S.T., I have taken my little pen out of my purse and I add on balance issues, nausea, eyes, those are also symptoms of stroke. I realize it's kind of defacing public property [laughing] but if it saves one person or twigs one person or one nurse walks by and knows it. [P020 Caregiver]

While there were gaps in knowledge and confusion around symptoms for some, others, both survivors ($n = 2$) and caregivers ($n = 3$) identified that their awareness of stroke symptoms and F.A.S.T. served as a motivation for calling EHS. Some made direct references to the media campaign and television advertisements put forth by the Heart and Stroke of Canada. For example, Participant Eight, who suffered a hemorrhagic stroke, recalled how her headache prompted her to think what she was experiencing was a stroke. She recalled the experience as follows: "But those commercials on TV because I said to my husband 'I think I'm having a stroke'... Yes, that, the worst headache of your life I remember that, and this was the worst headache of my life". [P008]

Similar experiences were reported by some of the caregivers as being important in how they made sense of stroke symptoms and considered whether to seek help. For example, some caregivers ($n = 3$) mentioned the F.A.S.T. television advertisements as being an important factor in their decision-making. In particular, the recollection of these advertisements seemed to assist caregivers in recognizing the symptoms of stroke. As one caregiver explained:

if it hadn't been for the ads on the TV about the heart and stroke signs I wouldn't have caught, I really wouldn't because he started slurring, he couldn't lift his hand and the ad jumped into my head and I said P I think you're having a stroke and just need to call 911 which I didn't do right away. I called my daughter who then called 911 so, you know, there are moments there where you aren't thinking very clearly but everything jumped into mind from one of those commercials, it's just amazing. [P001 Caregiver]

Still another caregiver said:

You know that commercial on TV...So I, yeah, I told him to lift his arm up and he could do one arm but he couldn't do the other arm and then he, he got kind of garbled and his face didn't really slant but he just didn't look right so I went oh my god he's really having a stroke and I had the cell phone in my hand because I was gonna shut it off... And so I got 911 and I got the ambulance here as quick as I could and I phoned my sons as quick as I could. [P017 Caregiver]

While multiple factors influenced the decision of survivors to seek emergency help, the perception of the seriousness of symptoms, including the duration of symptoms experienced, was identified as a common factor that impacted help-seeking behaviors. For survivors who waited to seek care ($n = 4$), and particularly among those who did not call for an EHS ($n = 2$), the perception of the seriousness of symptoms was a major factor in deciding to seek care. In these situations, survivors were seeking to make sense of the seriousness of their symptoms. Other survivors ($n = 4$) also reported a lack of perceived seriousness regarding the specific symptoms they experienced. They described how this resulted in a delay in seeking help. For example, one survivor commented about their perception of their headache, stating: *"And I said, well, I really would hate to go to the hospital for it's just a headache, right? And I said Well, let's have some breakfast and let's, let's go to, to the emergency". [P006]*

For other survivors, the more serious the symptoms were deemed to be, the more likely they were to think it was important to seek emergency medical care. Symptoms, including vision and loss of motor function, were cited as a cause for concern among survivors who did not immediately recognize the symptoms as stroke related. The loss of motor function was another symptom that some survivors cited as being concerning, even if they did not think it was directly related to stroke. Participant Four described how the initial tingling sensations in their limbs did not lead them to think they needed to see a doctor. Instead, it was the loss of their walking ability that was a facilitating factor in seeking emergency medical attention. They said: *"But once I couldn't walk it was like, okay, this is pretty serious like, alright, let's, let's go, call an ambulance". [P004]*

The Influence and Impact of Others

When survivors were asked about what influenced their decision to seek emergency care, some reflected on the presence of caregivers or bystanders as a motivation for seeking care. While in some cases, having others nearby served as a barrier to seeking emergency care. For example, survivors who were not alone at the initial onset of symptoms relied on their caregivers to make the call on whether to seek medical attention. For other participants, both survivors and caregivers, ($n = 2$), particularly those that lived at a distance from the hospital or outside of city limits, there was discussion about actively choosing not to use EHS, because they knew it would be faster to get to the ED using private transportation. For example, a caregiver recounted:

I knew that it would be faster to just take her than to wait, we would probably be fifteen to thirty minutes to get an ambulance, uh, I [didn't] know just what the procedure would be at the hospital, but I knew she needed to be there. [P010 Caregiver]

In other instances, ($n = 2$), caregivers and bystanders decided to call for EHS upon recognizing that the symptoms the survivor-participant was experiencing were of stroke. For example, the caregiver of Participant 17 stated: *"Um, well you're supposed to get help as fast as you can with a stroke, right? ... And so, I just called 911 that's what you're supposed to do right because I couldn't do anything for him". [P017 Caregiver]*

Unwillingness to Seek Care

For a minority of survivors ($n=2$), there was a distinct decision not to seek help. Reasons included not wanting to go to the hospital because of previous interactions with the healthcare system, as well as financial concerns. In these instances, caregivers played an important role in trying to convince survivors to seek medical care. For example, Participant Five recalled how her husband, whose father had previously experienced a stroke, wanted to take her to the hospital when observing speech-related symptoms. But she had decided to wait and see if the symptoms resolved themselves, explaining that she was feeling a sense of fatigue from having made a few visits recently to see family in the hospital. They said: *"I didn't feel a need, and I didn't want to go to the hospital. I'd been to the hospital probably three times... In the last six weeks but I didn't want to go to the hospital that night". [P005]*. For another survivor, being on a limited income prevented seeking timely care due to cost concerns. As a caregiver explained:

About a month later he had a tingling in his arm and I didn't want to leave him and but he refused to go see the doctor so I said well take an Aspirin at least for me... And then he had the tingle in his arm and he also seemed more tired than normal. And so we were gonna, we asked him to go to the doctor, he said no so we tried to talk him into going to get an eye exam. Because you can see a lot in an eye exam. And we told him that we would pay for it but he

wanted to wait until his pension came in, okay? So I just told him to take an Aspirin a day until we get this straightened out because my fear was he was going to have a stroke.
[P011 Caregiver]

In summary, knowledge gaps, perceived symptom seriousness, the impact of others on the decision-making process, and an unwillingness to seek care, were key factors in the decision to seek emergency care including calling for ambulance.

Discussion

During interviews, both survivors and caregivers described their decision-making process including ‘sense-making’ and more specifically the process of recognition, interpretation, and negotiation in their path of deciding on a course of action following stroke. Barriers to seeking timely emergency care included having a knowledge gap, experiencing symptoms that were not consistent with those covered in F.A.S.T., the perceived seriousness of symptoms experienced, having a caregiver or bystander present at the time of symptom onset, one’s geographical proximity to the hospital at the time of stroke, prior contact with a primary care provider, and the unwillingness of the survivor to seek care, including due to prior negative experiences with the healthcare system.

In the case of stroke, there appeared to be an interplay of factors explaining individual responses to using EHS. For example, in this study, there was evidence of knowledge gaps among more than half ($n = 7$) of survivors interviewed. This lack of symptom awareness was indicated by not knowing the signs of stroke, confusion of stroke symptoms with those of heart attack, and not understanding the recommended course of action in response to stroke symptoms (i.e., seeking immediate emergency medical attention and calling for EHS). For others, it was clear that while there was knowledge of stroke symptoms, this did not translate into the action of seeking emergency medical attention either by calling for EHS or going to the ED.

Existing evidence surrounding stroke awareness and knowledge is generally inconclusive, however, there appears to be a knowledge-to-action discordance captured within the literature in which previous knowledge or awareness of stroke is not associated with reduced presentation delay or greater use of EHS (Kitko & Hupcey, 2008; Naveed et al., 2023). For example, one qualitative study undertaken to explore the decision-making process concerning treatment-seeking behaviours for acute stroke found that late presentation was associated with a lack of knowledge of stroke symptoms (Kitko & Hupcey, 2008). Conversely, having experienced a previous stroke or having an awareness of stroke signs and symptoms was not found to be associated with an earlier presentation to the hospital (Kitko & Hupcey, 2008).

Related to the theme of knowledge, there was discussion in this study among both survivors and caregivers about awareness and knowledge of health campaigns, including

F.A.S.T. when recalling their experience of stroke. Some credited the F.A.S.T. advertising with helping them recognize the signs and symptoms of a stroke. Others felt that the F.A.S.T. campaign did not go far enough in spreading awareness of stroke symptoms. For example, among those who were aware of F.A.S.T., there was specific criticism of the advertisements not referring to headaches as a potential symptom of stroke. This has been previously documented as one of the limitations of the F.A.S.T. campaign as the symptom of sudden onset headache is not covered in the F.A.S.T. messaging (Naveed et al., 2023). This is despite nearly one-third of stroke survivors reporting headache as one of their primary symptoms at stroke onset (Naveed et al., 2023; Tentschert et al., 2005).

In this study, other factors were also identified as being important aspects of the decision-making process for seeking emergency medical care. Interestingly, the presence of a caregiver or bystander was found to be both a facilitator and a barrier to seeking prompt emergency medical attention and calling for an EHS in an acute stroke event. For some, caregivers were an important factor in encouraging a timely call for EHS. Conversely, in other instances, caregivers relied on the judgment of the individual experiencing stroke to seek care, and in some cases, this resulted in delays in seeking prompt medical attention. These findings are consistent with other research that has investigated the impact of caregiver and bystander effects on decision-making in stroke (Robinson et al., 2012; Moloczij et al., 2008; Wein et al., 2000). For example, Moloczij et al. (2008) found that at times the presence and influence of another person can contribute to delays in seeking help. Likewise, Wein et al. (2000) found that only 4.3% of cases were the call for EHS made by the survivor-participant. A far greater amount of the time the use of EHS was initiated by a family member or significant other 60.1% of the time, followed by a paid caregiver 18.4% of the time, and finally 12.9% of calls were made by a co-worker or bystander. This highlights the importance of expanding stroke symptom awareness to the greater public domain, instead of only focusing on those at the highest risk of a stroke event.

The findings also highlight the importance of considering how rural and northern contexts shape decisions about seeking emergency stroke care. Some participants described choosing private transportation over EHS because they perceived it to be faster than waiting for an ambulance, particularly when living outside city limits or at considerable distances from healthcare facilities. These perceptions reflect the unique realities of rural and northern regions, where long travel distances, dispersed populations, and concerns about ambulance availability may influence care-seeking behaviours. In such settings, decisions regarding transportation may not solely be based on stroke symptom recognition but also influenced by practical considerations related to geography, access, and anticipated response times. This finding suggests that public awareness campaigns emphasizing ambulance use for stroke should be accompanied by efforts

to understand and address local barriers to EHS use in rural and northern communities. These findings are consistent with emerging evidence, that has found that the effectiveness of stroke awareness initiatives and care-seeking behaviours may vary across sociodemographic and geographic groups (Rioux et al., 2022). This further emphasizes the need for context-specific approaches to stroke education and emergency response planning.

Limitations

This study is limited by a modest sample of mainly Caucasian participants from one northern Canadian region and potential recall bias given that many stroke events occurred several years prior. Despite these limitations, the study provides contextualized insights into decision-making in rural and northern geographies.

Implications and Conclusion

In conclusion, there was a multitude of factors that influenced the decision-making process that occurs when experiencing symptoms of acute stroke. Each of the survivors and caregivers interviewed for this work provided unique and critical insights related to the process of deciding whether

or not to seek emergency medical attention. While small, the experiential insights gathered add to the knowledge base by providing invaluable context and perspective to the personal journey of experiencing stroke for those in small urban, northern, rural, and remote communities. This research addresses an important knowledge gap concerning the transport practices of those with stroke. It is anticipated that the findings from this work will help inform the planning and delivery of stroke-related health services and public awareness campaigns. Future research in this area could further explore the experiences of help-seeking in more geographically and racially diverse populations to address inequities and barriers for stroke care.

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