Supporting Information

Supplementary material

This appendix was part of the submitted manuscript and has been peer reviewed.

It is posted as supplied by the authors.

Appendix to: Dos Santos (Gumbaynggirr, Kwiamble) A, Cheong E, Balabanski AH, et al. First stroke incidence, causes, treatments, and outcomes for Aboriginal Peoples in South Australia and the Northern Territory: a pilot prospective study. *Med J Aust* 2024; doi: 10.5694/mja2.52356.

Table 1. CONSIDER Statement

Guest Editors of the 2024 *Indigenous Health Special Issue* acknowledge the Indigenous expertise that informed the establishment of the CONSolIDated critERia for strengthening the reporting of health research involving Indigenous Peoples (CONSIDER) statement.

Authors should indicate how they have supported ethical publishing and reporting practices by providing the details of the research practices aligned with this publication in accordance with the CONSIDER statement. The reporting should not exceed two pages. This reporting will be published as online supplementary information. Detailed items can be accessed in the publication:
https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-019-0815-8

Governance
Our research design and rationale underpin the significance of Indigenous self-determination and leadership, a notion further supported by the extensive involvement of multiple Aboriginal organizations in this study. The implications for future study design and conduct suggest that a larger study will delve into and report on the relationships forged between researchers and the Indigenous community and organizations.
Prioritization
Our research illustrated the alignment of Indigenous health priorities and researchers, demonstrated by ideas formed by Aboriginal researchers and consultation with Aboriginal organizations and the co-development of research aims. This process emphasises the importance of such collaborative approaches as an essential component of Indigenous health research.
Relationships (Indigenous stakeholders/participants and Research Team
The methodologies detail the ethical processes undertaken, the involvement of Indigenous participants and stakeholders, and the expertise of the research team in Indigenous health research. Further, approval from all appropriate Aboriginal ethical bodies following extensive discussions with Aboriginal stakeholders, acknowledges the team's experience and knowledge of Aboriginal histories and culture.
Methodologies
Our research design and rationale ensured the selection of an appropriate methodology for addressing the research question. These elements are essential components of a prospective stroke incidence study, and research involving Aboriginal communities.
Participation
Our study data will be solely used for this research, with any further usage requiring separate ethics applications. Future study design and conduct, suggest that a properly funded project would be able to provide remuneration for the time and knowledge of Aboriginal organizations and stakeholders. If participant data collection extends beyond usual care, remuneration for participants will be provided accordingly.
Capacity
Our study, from inception, was led by Aboriginal researchers. The implications for future studies suggest that with proper funding, non-Indigenous researchers could undergo cultural safety training before participating in the study, and funding could be allocated to support positions for more Aboriginal team members.
Analysis and interpretation
The presentation of data emphasizes a strengths-based approach and integration of cultural beliefs and values. Analysis and interpretation involve all researchers within the team, including Aboriginal researchers, with a focus on avoiding the affirmation of stereotypes or bias. A larger study with adequate funding could expand the team to include more Aboriginal researchers, thereby enhancing the interpretation of the data.

Dissemination
Leveraging relationships with Indigenous stakeholders and community groups, the results of the pilot study will be widely distributed. Implications for future study design and conduct highlight the need for additional funding to facilitate the distribution of results to all relevant stakeholders and community groups.

Table 2. Missing data summary

Characteristic	Aboriginal people			Non-Indigenous people		
	Present	Absent	Missing	Present	Absent	Missing
Number of people	10			113		
General practitioner	9 (90%)	0	1 (10%)	103 (91%)	8 (7%)	2 (2%)
Employed	3 (30%)	7 (70%)	0	27 (24%)	86 (76%)	0
Pre stroke mRS (0-2)	9 (90%)	1 (10%)	0	74 (65.%)	39 (34.5%)	0
Initial presentation to non-primary stroke centre	5 (50%)	5 (50%)	0	30 (26.5%)	72 (64%)	11 (9.5%)
Completed NIHSS on admission	1 (10%)	9 (90%)	0	35 (30.9%)	78 (69.1%)	0
Obesity	4 (40%)	6 (60%)	0	22 (19.5%)	79 (69.9%)	12 (10.6%)
Hypertension Treated*	5 (50%) 3 (60%)	5 (50%) 2 (40%)	0 0	77 (68%) 59 (76.6%)	36 (32%) 18 (23.4%)	0 0
Diabetes Treated*	5 (50%) 2 (40%)	5 (50%) 3 (60%)	0 0	29 (25.6%) 22 (75.8%)	84 (74.4%) 6 (20.7%)	0 1 (3.5%)
Hypercholesterolemia Treated*	5 (50%) 3 (60%)	5 (50%) 2 (40%)	0 0	55 (48.6%) 45 (81.8%)	57 (50.4%) 7 (12.7%)	1 (1%) 3 (5.5%)
Ischaemic heart disease	1 (10%)	9 (90%)	0	23 (20.3%)	88 (77.8%)	2 (1.9%)
Rheumatic heart disease	1 (10%)	8 (80%)	1 (10%)	3 (2.6%)	110 (97.4%)	0
Peripheral vascular disease	0	10 (100%)	0	6 (5.3%)	106 (93.8%)	1 (0.9%)
Known atrial fibrillation Treated with anticoagulation	2 (20%) 0	8 (80%) 2 (100%)	0 0	20 (17.7%) 17 (85%)	84 (74.3%) 3 (15%)	9 (8%) 0
Ever smoker	5 (50%)	3 (30%)	2 (20%)	57 (50.4%)	36 (31.8%)	20 (17.8%)
Alcohol consumption	5 (50%)	2 (20%)	3 (30%)	53 (46.9%)	33 (29.2%)	27 (23.9%)
CT brain	9 (90%)	1 (10%)	0	112 (99.1%)	0	1 (0.9%)
MRI brain	5 (50%)	5 (50%)	0	78 (69%)	34 (30%)	1 (1%)
Vessel imaging (CT angiogram, carotid duplex, or MR Angiogram)	9 (90%)	1 (10%)	0	105 (93%)	8 (7%)	0
Stenosis present	0	8 (80%)	2 (20%)	20 (17.7%)	84 (74.3%)	9 (8%)
ECHO or TOE	9 (90%)	0	1 (10%)	63 (55.7%)	7 (6.2%)	43 (38.1%)
Holter monitor or telemetry	8 (80%)	1 (10%)	1 (10%)	63 (55.7%)	7 (6.2%)	43 (38.1%)
TpA eligible Administered	3 (30%) 3 (100%)	7 (70%) 0	0 0	24 (21.2%) 6 (25%)	89 (78.8%) 18 (75%)	0 0
Large vessel occlusion (ischaemic stroke only) ECR	2 (22.2) 0	0 2 (100%)	0 0	10 (10.9) 4 (40%)	82 6 (60%)	0 0
Antiplatelet or anticoagulant within 48 hours (Ischaemic strokes only)	8 (88.9%)	1 (11.1%)	0	89 (96.7%)	3 (3.3%)	0
Physiotherapy assessment within 48 hours	9 (90%)	1 (10%)	0	97 (85.8%)	15 (13.3%)	1 (0.9%)
Swallow screen documented	9 (90%)	1 (10%)	0	98 (86.7%)	13 (11.5%)	2 (1.8%)
Antithrombotic or anticoagulant on discharge (ischaemic strokes only)	8 (88.9%)	1 (11.1%)	0	92 (100%)	0	0
Antihypertensive on discharge	6 (60%)	4 (40%)	0	76 (67.3%)	30 (26.5%)	7 (6.2%)
Statin on discharge (ischaemic strokes only)	4 (44.4%)	5 (55.6%)	0	69 (75%)	16 (17.4%)	7 (7.6%)
Current smoker at 3 months	0	3 (30%)	7 (70%)	8 (14%)	80 (70.8%)	25 (15.2%)
Taking anticoagulant or antithrombotic at 3 months (ischaemic strokes only)	3 (33.3%)	0	6 (66.7%)	76 (82.6%)	14 (15.2%)	2 (2.2%)
Taking antihypertensive	3 (30%)	0	7 (70%)	69 (61%)	20 (17.7%)	24 (21.3%)
Taking statin (ischaemic strokes only)	2 (22.2%)	0	7 (77.8%)	52 (56.5%)	21 (22.8%)	19 (20.7%)
Employed	1 (10%)	5 (50%)	4 (40%)	11 (9.7%)	71 (62.8%)	31 (27.5%)

3-month mRS (0-2)	3 (30%)	1 (10%)	6 (60%)	45 (39.8%)	44 (38.9%)	24 (21.3%)

AF: atrial fibrillation, GP: General practitioner, mRS: Modified Rankin Scale, NIHSS: National Institute of Health Stroke Scale, CT: Computed Tomography, MRI: Magnetic Resonance Imaging, ECHO: Echocardiogram, TOE: Transoesophageal Echocardiogram, Treated*: Patients taking medications for conditions diagnosed in community before presentation.

*Vessel Imaging includes CT angiogram, carotid duplex, or MR Angiogram

† % of those eligible for treatment; ‡ among those with ischaemic stroke only