Supplementary 5

Levesque et al. framework domain	Concept	Key themes	Illustrative quotes
Demand Ability to perceive	Health promotion to increase assessment and treatment of sore throat and skin sores	Responses focused on *how* to do health promotion (for example through songs, posters, events, radio), *who* should do health promotion (with strong support for school-based health promotion) and *where* to do health promotion (particularly outreach and home visits). Many participants identified the need for health promotion to be accessible to Aboriginal and Torres Strait Islander people through the use of local languages and with cultural and contextual relevance.	"Most health inequity is due to ongoing colonisation including loss of languages and culture. Including Aboriginal languages especially on a health topic sends a very strong message" **ID 23, R2, I1"**
Demand Ability to seek	Activate or empower people to seek health services for skin sores and sore throat	eDelphi strategies presented in this domain generated little qualitative engagement. Instead, qualitative feedback strongly supported the need for children to be able to seek healthcare at school.	"Provide flexible access options to assessment and treatment. Perhaps option of streamlined skin check clinics, perhaps clinic for adults as well as their children collocated at school for pickup drop off time walk-in" – **ID 16, C3**
Demand Ability to engage	Engage communities at risk of ARF in preventing the disease	There was strong support for the importance of 'engagement' and the need for community leaders to be involved in improving primary prevention. Specific engagement strategies included sharing local burden of disease data with the community and addressing community attitudes to skin sores. A number of participants identified the importance of reducing both the stigma, and the normalisation, of skin sores.	"Engage community leaders to identify opportunities for prevention of ARF – e.g. a community forum on primary prevention" **ID 5, C2** Strategies to effectively manage and destigmatise are important. Needs to be done with the elders and Tos (traditional owners) or community spokespeople. **ID19, R2, I9**
	Support people at risk of ARF/RHD to be engaged in their own healthcare and self-management	Qualitative responses had a very strong focus on community-level engagement with multiple participants identifying the need for 'community governance' or a 'community reference group'. Two participants identified governance and representation within community-controlled health services as problematic. A small number of specific strategies for increasing individual engagement in care, including education for people to	"Obviously we already know what works with primary prevention of RHD so we just need to work on implementing it better and the people who can assist with guiding this are the communities themselves" **– ID 5, FT16**

		their own skin sore dressings, peer support groups or digital tools to support self-management.	
Supply Availability and accommodation	Actively work to identify people with skin sores	eDelphi statements in this concept included various strategies to actively deliver skin checks (through outreach, opportunistically to people attending clinic, through scheduled child health checks). There was a low level of support for these and few qualitative responses addressed any of these strategies directly. Some respondents highlighted the risks associated with active case finding of skin sores.	"Health service led efforts are never going to be as effective as community led initiatives to improve treatment uptake and may contribute to stigma associated with skin sores." **ID13, R2, I8**
Supply Appropriateness	Make health care delivery more acceptable	Acceptability (and thereby appropriateness) eDelphi statements were largely focused on ensuring culture was embedded in care delivery. This included strong support for the use of Aboriginal and Torres Strait Islander language in clinical care and increased recruitment, retention and role expansion for Aboriginal and Torres Strait Islander health staff. Responses supported cultural training to reduce racism of health care providers. There was equivocal support for incorporating elements of traditional medicines into management protocols for skin sores and sore throat.	"And how to manage culture shock and be aware of Own prejudice when treating patients – can be very hard for patients to keep turning up when they feel misrepresented and misunderstood". **ID19, R2, I14**
Supply Approachability	Make it easier for people access assessment and treatment of skin sores / sore throat	Qualitative responses highlighted the need for flexibility in delivering clinic-based services. Specifically, this included a need to reduce waiting times, offer walk-in appointment and ensure a welcoming experience. Some participants supported an increase in after-hours service provision.	"Again, many of these strategies are still focused on somebody having access to the clinic. If they work or want their children to attend school, they may not want to miss large amounts of time waiting at least an hour to be seen in the clinic. Staff are generally quite aware of these things in remote health centres, but the system isn't designed to cope with the number of presentations and waiting times are often unacceptable" – ID 13, C6
	Make assessment and treatment available in more places	eDelphi statements in this concept included some of the approaches derived from the (urban) New Zealand experience of providing services in pharmacies, dental clinics and social services. These were generally not considered applicable to the	"Move care outside of the clinic more – e.g. a skin / sore throat mobile team to review and treat people in their homes" – **ID 5, C4**

		remote Australian setting (“*In aboriginal communities ... there are no dentists, pharmacies”* – ID 21, C9) but qualitative responses reflected strong support for outreach service outside of the clinic, to schools or homes. The practicalities of outreach services were addressed by some participants, including scope for telehealth from outreach workers to clinics and the potential constrain of regulations about delivering treatment outside of clinical settings.	“Employ family-based support workers to perform household outreach for education, assessment, treatment, and prevention activities” – **ID 29, C7**
	Provide practical or physical support to assist people to access health services	Qualitative responses emphasised the importance of providing transport for people to attend the clinic and identified various strategies for this to be achieved (including taxi vouchers, regular bus routes and clinic transport). The costs of providing transport were identified as a barrier for clinics to improve services. A number of participants noted that outreach services or telehealth capacity could obviate some of these transport needs.	“Funding transport would not be as cost effective as Telehealth (emailing or texting photographs of sores and if relevant throats)” – ID 18, C4 “Must be tied with the outreach service being able to provide treatment rather than client then need to attend the health service(removes a barrier for timely treatment).” **ID16, R2, I4**
Supply Affordability	Reduce the costs for people seeking assessment and treatment of skin sores	eDelphi statements in this concept included cost reduction approaches used in New Zealand, including free medical visits and medications. Most participants identified these are not relevant to remote Aboriginal and Torres Strait Islander communities where clinic attendance and medication are generally free at point of care. The need to minimise costs in urban setting was noted.	“This may be an issue in metropolitan services but not one in community government funded clinics.” **ID19, R2, I5** “in the context I work in there isn’t any cost. In areas where there is a cost associated with accessing care then maybe this is a significant barrier (I wouldn’t really know) however if care was available in schools etc this would also get around the cost issue.” **ID13, R2, I5**
	Improve service delivery by reducing costs to clinics	eDelphi statements in this concept included suggestions about funding clinics for consumable products (particularly dressings for skin sores). There was little support for this approach. Instead, qualitative responses identified the need for the Section 100 medication to be available in urban settings and for bulk billing of consults. A small number of participants	“Aboriginal medical services in cities such as Darwin, need to be provided free medications such as Benzathine penicillin (like under S100) to give immediate treatment for skin sores as well patients needing 2ndary prophylaxis” – **ID 16, C12**

		suggested new Medicare item numbers be created for skin checks.	"? An item number for Aboriginal and Torres Strait Islander skin presentations to signal how important this consultation is" – **ID 23, C12**
Supply Acceptability	Improve clinical guidelines on the assessment and management of skin sores / sore throat	There was limited support for improving or expanding clinical guidelines in eDelphi statements. Qualitative feedback suggested that existing guidelines were sufficient and that other issues (time, staff training, accessibility of guidelines) were more significant barriers to the delivery of guideline-based care. A small number of specific recommendations about guideline content were made (*"Clarify the distinction between 'scabies' and impetigo"* – ID 12, C13)	"Guidelines existing are reasonable." **ID27, R2, I13** "My experience is often poor diagnosis including hospitals giving NSAIDS for painful knees and sending home. Maybe not guidelines improvement, maybe just following guidelines may help." **ID1, R2, I13**
	Train or educate health care staff	Although there was limited support for general staff training in eDelphi responses, qualitative feedback indicated that time sensitive training for new or locum staff prior to working in remote settings was important. A small number of participants provided feedback on existing training resources, specifically that there "*needs to be a punchier, short version of RHD online modules*" ID 16, C14	"I think the awareness in the remote NT of this issue is already very high and I don't think that further education is a high priority in this context but this may be an issue interstate??" **ID13, R2, I14** "Ensure any locum staff (doctors or nurses) have ARF/RHD/skin sore training PRIOR to starting at the clinic – mandatory prior to starting placement" **– ID 22, C14**
	Improve treatment of scabies, which can cause skin damage, which contributes to skin sores	Qualitative feedback on improving scabies treatment elicited some specific opinions related to scabies management (including details of lycear use) and broad support for action on the environmental health to mitigate scabies risk. This included support for washing, housing and bedding facilities. Many of these themes were re-emphasised in general qualitative feedback.	"Embed health hardware home visits as part of follow up of patients presenting with scabies, skin sores, ARD, RHD" – **ID 16, C7**
	Support quality of care delivery	Qualitative responses on improving quality of care delivery were mixed. Some participants identified the value of clinic audits or key performance indicators for quality improvement. Others felt these activities could be distracting or burdensome to clinics. A small number of participants identified specific process	"Bulk-bill, more Aboriginal health workers, subsidise the treatment, facilitate the access to the service, educate the community about what you are doing, audit and review really important.

		indicators which may help identify progress towards improve primary prevention.	Everyone thinks they are doing a good job until they are audited" **– ID 23, FT16** "I think this is a good idea but wonder if it will seem like a burden to clinics..." **ID15, R2, I15"**
General qualitative feedback		At the end of the eDelphi process participants were asked to 'Please suggest any other ideas you have to improve delivery of primary prevention in primary care'. Overwhelmingly two issues were raised: - the need for prevention of skin sores/sore throat rather than improving treatment - the need to increase the Aboriginal and Torres Strait Islander health workforce. Implicit in some of these comments, and in qualitative feedback on other concepts, was the idea that disease-specific approaches which have a narrow focus are likely to be counterproductive in the absence of system-wide strategies.	"Primary prevention ultimately can only be effective in reducing ARF alongside more effective primordial prevention measures" - **ID 20, FT16** "There needs to be engagement of other government departments ie: housing to improve health hardware, expedited repair of housing issues especially health hardware, more housing with RHD clients given priority, more availability of emergency housing for families in communities" - **ID 22, FT16** "Many of the ideas here were related to educating staff however in the NT at least most staff are very proactive about treatment, however access to services, waiting times and staff shortages are the biggest barriers. Improving access to treatment for these conditions in easy to access places (such as school nurse/health workers, or in places that do have a private pharmacy etc) would do much more than telling overworked primary health care staff what they already know and are trying their best to achieve"- **ID 13, FT16**