

Supplementary File 2. Reflexivity

General reflections on the autoethnographic process:

Some team members were at first hesitant to embark on this work. This was largely driven by the perception that the outcomes evaluation (a very traditional research output) was of more interest to academic audiences. It took some time to reassure the broader team that autoethnography could highlight important lessons learned during the research process. SR was a champion for the work and was able to assure other senior team members of its utility. After the interviews we received feedback that the interview and writing process was a “cathartic experience” and team members reflected how talking through their experiences gave them a much-needed sense of coherence and sense-making. This feeling continued through manuscript writing as team members not familiar with qualitative methods quickly began to offer valuable feedback that took a critical and reflexive lens to the process and the dynamics of the team.

Reflections from co-author and guidelines project lead (XW):

At the start, I (XW) had questions about how we would be able to describe and synthesise the process of creating the guidelines materials. I have qualitative and implementation science experience, but I am an implementation scientist with a focus on outcomes research. During team discussions SR and VH explained how collaborative autoethnography can be an extension of our conversations, and are a way to add depth to our research process. Collaborative autoethnography required buy in, support, and active participation from leadership and all levels on the team. I see my role on the team as both guiding the overall project and supporting team members to develop their skills, so I encouraged the team to reflect in this way. As project lead, my support was important to help the team feel confident and comfortable to share their experiences openly, however I was also conscious of the ways my perceived authority could impact the writing and discussion process. To address this, I was clear in communicating that I considered each team member to be an authority in their aspect of the project. Overall, I found autoethnography useful for 1) bringing teams together; 2) communicating the details of research and development; and 3) reflecting on the complexities of being a multi-national, multi-disciplinary research team.

Reflections from a co-author and data curator (VH):

The authorial team has been open, frank and candid with me (VH) as we curated the collaborative autoethnography. This rapport could be due to several factors including my gender, age, lived experience, also that 1) I am a PhD candidate, and in my role as student it may be perceived as easier to share and explain perspectives to me; and 2) I have been acting as coordinator providing direct project support and also a listening ear to team members, thus affording me trust. However, I also felt at times uncomfortable with my role. I'm not based in either setting and I worried both about replicating colonial structures and perpetuating harmful paradigms. Indeed, I have privilege and power ascribed to me by my role, race, language, where I live, my past work and educational experience, and current institutional affiliation that afforded me the ability to be in this role and undertake this work. These all influence, to varying degrees, the rapport between myself and others in ways both apparent and more subtle. During data collection and analysis, I remained aware of the lens I apply, the perspective I bring,

and the rapport I had with my colleagues. This included considering how my positionality shaped the questions I ask and my interpretation of responses. Part of this reflection was considering the foreign gaze, which I unpacked with SR, WD and through drawing on my past feminist and post-colonial literature studies to interrogate the act of writing, representation, and authorship. These were fruitful conversations but also highlighted some of the 'wicked problems' in global health research and the ways in which academic outputs are valued, disseminated, and used. Discussion, group feedback, and a collaborative editing process were key to acknowledging and navigating through these important factors that shaped both our shared experience and my experience curating this work.

Reflections from a co-author and data curator (SR):

I (SR) got involved with the project in February 2020 when we started writing the grant proposal. I had a reasonable understanding of the healthcare system in Sri Lanka where I had my medical training. Through our regular conversations with the team members in Philippines and Sri Lanka we had a sense of what was going on in those two countries as the pandemic spread. At the early stages, Sri Lanka was doing so well with pandemic containment that I asked our team members in Sri Lanka if it was even worth continuing our project there as they seemed to be doing so much better than many developed countries including Canada. I felt as if we were trying to tell another country how to manage the pandemic while we had suboptimal pandemic management in Canada, as I would be considered a Canadian in Sri Lanka. However, responses such as "you know how it is here and can you just highlight the section that I have to check" made me feel as if I was part of the Sri Lanka team. When I expressed my concern to the team in Sri Lanka, we were assured that additional training and training material will be useful as there was significant concerns about a second wave. The team in Sri Lanka identified their learning needs and additional needs assessment of all potential participants to identify what they wanted to learn and how they wanted in delivered was conducted.

Our needs assessment interviews were to happen in November, and by December of 2020 Sri Lanka was well into its second wave of the pandemic. I am a full-time emergency physician in Canada, and I was seeing increasing workloads, delay in frontline workers getting vaccines and staff fatigue. I think that being a frontline worker during the pandemic made me more acceptable to the clinicians in the team as someone 'in the same boat' as they called it. I am a clinician first and a researcher second and the pandemic was very real for me both professionally and personally. As such, I wanted the guidelines to be evidence informed but feasible and practical for clinical settings in each country. Working full time in the emergency department amidst rapidly changing protocols, trying to keep up with the literature and keeping the project going was taking its toll on me, as on other members of our team. It was the understanding that no one is safe until everyone is safe that kept me going. The team members had each other's phone numbers and we would call and have informal chats about the project, life and the pandemic. This project had to be modified and modulated as the pandemic progressed. I am not sure what the outcomes of this research would be as it would be impossible to tease out the effects of this intervention as many pandemic related outputs and outcomes are significantly impacted by the socioeconomic, political and policy dynamics of each country. The process to create role specific IPC guidelines for a LMIC and to modify it and

adapt to another LMIC was a collaborative effort that literally took a global village to get it done. Over the course of the year many of the team members had made further personal connections with each other and it was easy to talk to each other and gather the narratives. Our partners in other countries said they their hands were full managing the pandemic and were not able to commit to taking any additional work in creating the drafts. However, all authors were enthusiastic in reviewing the drafts to ensure that their experiences were captured and voices are present in the master narrative.

Reflections from a co-author and data curator (NP):

Following my (NP) public health postgraduate training in Sri Lanka, I was a visiting fellow in Canada experiencing the public health system Canada under supervision of SR. With the emergence of the pandemic, I got the opportunity to join the research team through my supervisor. My guilt of being away from the country at this critical moment was relieved a bit by joining this research activity. I was in constant touch with the team members from Sri Lanka while the pandemic management activities rolled out.

In advance of reporting cases from Sri Lanka, the public health officials prepared their clinical guidelines and acquired testing capacity. At such a state our role was to complement the national guidelines, and supplement training materials to both clinical and field health staff. The team members from Sri Lanka were enthusiastic to join this international collaborative activity and much support was obtained from the highest authority of the health ministry to the grass root level community and clinical health staff. Most of the interviews were conducted after 7 or 8p.m. at night, the only free time with their tiring schedule.

My Sri Lankan understandings in clinical and public health system was valuable in adapting the guidelines prepared for the Philippines to Sri Lankan context, it was necessary to consider closely the resemblance and disparities in health infrastructure, roles of different health workers and management strategies. The inputs from training programmes from Philippines influence a lot in shaping training modules for Sri Lanka.