S1. Author reflexivity statement

1. How does this study address local research and policy priorities?

Systematic inequities and biases in global surgery affect low- and middle-income country practitioners, researchers, and policymakers across many settings in the Global South.

2. How were local researchers involved in study design?

BA, IO, and RQ conceived the study when they partook in a two-year research fellowship together. After study conception, BA, IO, and RQ, contacted their respective mentors and colleagues to form this group. All authors conceptualised and designed the study together during early meetings. Local researchers were involved in several ways. BA, JK, and HL are LMIC practitioners currently based in LMICs. JK is indigenous in a settler-colonial HIC. AB, IO, and RXQ born in LMICs and currently based in HICs, with ongoing collaboration with practitioners, policy makers, and researchers in LMICs. JB is an HIC researcher with subject matter expertise in historical analysis and decolonisation studies. Despite our diverse backgrounds and cultural heritage, most of us are affiliated with HIC institutions. We acknowledge our privilege and recognise the irony of needing a certain amount of privilege to access forums to discuss and call out the inequities in global health and global surgery.

3. How has funding been used to support the local research team(s)?

This project was not funded.

4. How are research staff who conducted data collection acknowledged?

This is a group consensus-building study using a modified Delphi process. We had no research staff.

5. How have members of the research partnership been provided with access to study data?

All study data were made available to every single member of the research staff through a shared google drive.

6. How were data used to develop analytical skills within the partnership?

This group-based Delphi consensus-building study has a participatory design. All participants were simultaneously researchers. During meetings, all authors reviewed the study data and contributed to their analysis.

7. How have research partners collaborated in interpreting study data?

The team held various virtual meetings. Through discussions and deliberations, all authors bounced off each other's contribution and explored connections, interlinkages, and underlying reasons behind codes and subthemes for qualitative synthesis.

8. How were research partners supported to develop writing skills?

BA, IO, and RQ were supported by the senior authors to each write a section of the first draft and polish subsequent versions.

9. How will research products be shared to address local needs?

After publication, we hope to disseminate the manuscript to a wide base of global surgery practitioners in LMICs and HICs. By calling out the systematic inequities in global surgery, we hope this work will set the tone for what is acceptable and what is not and assist LMIC practitioners in asserting their sovereignty and reducing inequities in global surgery.

10. How is the leadership, contribution and ownership of this work by LMIC researchers recognised within the authorship?

LMIC researchers have been recognised as a co-first author (BA) and co-senior author (HL).

11. How have early career researchers across the partnership been included within the authorship team?

The co-first authors, BA, IO, and RQ, are all early career researchers.

12. How has gender balance been addressed within the authorship?

Attention was specifically paid to diversity in gender and profession during the formation of the group. 4/9 authors are female, including 2/3 co-first authors.

13. How has the project contributed to training of LMIC researchers?

The project has contributed to developing analytical and writing skills of the co-first author (BA).

14. How has the project contributed to improvements in local infrastructure?

Through calling for greater ownership and agency of LMIC government to contribute funding to surgical system strengthening, we hope local infrastructure could be improved in the long-term.

15. What safeguarding procedures were used to protect local study participants and researchers?

The meeting time zone was rotated so as not to place burden on LMIC researchers to attend zoom meetings outside of office hours and during unreasonable hours.

S2. Positionality statement and demographics of the authors

Judy Khanyola
Judy Khanyola is the Chair for the Center for Nursing and Midwifery at the University of Global Health Equity in Kigali, Rwanda. She is a black, African, cisgender female and a proud nurse. She has lived and worked in Africa all her life and in her career as a nurse and midwife, advancing the profession of nursing and midwifery in Africa. Judy's areas of expertise are critical care and renal nursing, HIV, palliative care and she now focusses on nursing and midwifery leadership and education. Judy is fluent in a number of African languages and English. Judy is committed to ensuring that nurses and midwives who play such a big part in delivering health in Africa are also included in the decision – making for health.

Rennie Qin
I was born in the city of Xi'an, the home of the terracotta warriors and the start of the silk road. Like the kiwifruit, I was uprooted from the mountainous Shaanxi province (home of the Chinese gooseberry) and transplanted onto the soils of Aotearoa New Zealand at the age of 13. My path followed that of millions of Chinese migrants following the invasion of China by the eight-nation alliance, the Opium war, and the colonisation by Japan. I experienced the socioeconomic and ethnic inequity first-hand at medical school coming from the low-income, multi-ethnic suburb of Papakura. I come into global surgery after a decade of experience in global health and climate change advocacy. Working to support Pacific Island Countries in developing National Surgical, Obstetric, and Anaesthesia Plans (NSOAPs) has exposed me to the ongoing coloniality of global surgery. Whilst my background has sensitised me to the inequities in global surgery, I am also aware of the privilege I hold through my profession and my location in the Global North.

Jonathan Koea
I am Māori – Aotearoa/New Zealand's Indigenous people. I work as a hepatobiliary surgeon and a Professor of Surgery at the University of Auckland. My whole career has been focussed on ensuring that Indigenous voices are heard in the practice of medicine in our country. While those who wish to purely suppress the Indigenous world view are less common, just as insidious are those that would speak for, and make decisions on behalf of Indigenous people. The latter are often well meaning – Noel Pearson's 'progressive upper middle stratum' - intent on solving the many problems they and their forebears created with the missionary zeal of those forebears. Aid, even kindly, is another form of colonialism. The challenge for global surgery is to cede control to the communities it seeks to help, to listen to those communities so they can build a future in their own image – not that of the West.

Desmond Jumbam
I grew up in Cameroon until I was 17. Then moved to the United States to complete my bachelor's degree in biological sciences and master's degree in global health. After graduating from University, I have mostly been employed by institutions based in the United States, including the current NGO for which I work. Most of my global surgery work focuses on Africa, although I work with teams from all around the world. I am a black, African, cisgender male and a global surgery researcher with particular interest in health policy and

health systems strengthening. I am interested in studying decolonizing global health although I would not necessarily consider myself a decolonial scholar.

Adeline A. Boatin
I was born in Ndola, Zambia to Ghanaian parents, both of which had the privilege of attending higher education. As a child and adolescent, I lived in Zambia, Ghana and the United Kingdom. I moved to the US as a young adult for an undergraduate degree at Harvard University and have completed all my higher education (MD, MPH, post-graduate OB/GYN training) at institutions in the United States as an international student. After completing training my primary appointment has been maintained at an academic institution in the USA that has afforded me permanent residency in the US and the opportunity to have the majority of my research in sub-Saharan Africa. I have since worked in Ghana and Uganda as a researcher. My clinical practice, however, is solely in the USA.

Isioma Okolo
I am a cisgendered, heterosexual, Black African, non-disabled woman born in Nigeria, now living in Scotland with dual citizenship(Nigerian/British). In some rooms I am an immigrant, and others an expat. I have been educated and worked in Nigeria, Togo and the UK. I speak Igbo, English and Portuguese. Despite growing up in a Catholic, low-income, upward mobilising family, I am now firmly middle class and university educated up to Masters degree level. I am currently only affiliated with high income institutions. The focus of my scholarship and advocacy in Scotland is eradicating health disparities that Women of African descent in the diaspora experience across the life course. In this capacity I serve as a clinician, researcher, and community organiser for KWISA- African women in Scotland. As an obstetrician and gynaecologist, I also represent the group who historically have perpetuated reproductive injustice thus garnering mistrust amongst racially minoritised women.
So in effect I am a cultural chameleon, expert code switcher, and ultimately a global citizen wielding my insider-outsider status and learning to simultaneously embrace the tension and opportunities to do good within my various communities in Scotland.

Henry Mark Lugobe
I was born in Uganda and had undergraduate and resident training in Uganda. I am an obstetrician and gynaecologist currently teaching and working at a university and teaching hospital in Uganda. I have collaborated with colleagues from the USA and UK during my research work. My interest is improving maternal health and reducing maternal mortality in my country.

Barnabas Alayande
I was born within a state minority in North Central multi-ethnic Nigeria, to low-income educated Nigerian parents, and raised by my mother. I have been very locally itinerant and have lived with my family in North-East, North-Central, South-West, South-East Nigeria. I was exposed to multinational culture early in life and in a sustained way through academic pursuits in national unity schools, and international schools. I have a background in global surgical care, theology, and business. I completed my higher education in Nigeria with a medical degree, postgraduate specialist surgical training in general surgery, a postgraduate diploma in theology, and a diploma in data processing; and attended United States-based institutions for business school and a global surgery research fellowship while still resident

in a sub-Saharan African context. I am aware that I bring all these perspectives to my work in surgical care. My surgical practice is in Nigeria and Rwanda, and I have had experience in local private surgical practice, not-for-profit organisations, and academic institutions. I speak English, Yoruba, and some French and Hausa. I am a cisgendered, heterosexual, black African male. My current affiliations are primarily with LMIC institutions and one HIC organisation in a combined fellowship capacity. The focus of my scholarship in sub-Saharan Africa is surgical education, equity in surgical care, innovation and improvisation, surgical safety and human factors all for surgical care in variable resource contexts and at the crossroads of surgery and public health.

Jesse Bump

I grew up on a cattle farm in the US state of Vermont in a family with more education than money. Personal responsibility, community accountability, and an emphasis on work were common there, as they are in many rural areas, but books revealed to me that the fairness implied by these values did not apply in wider world. I studied history to learn how the distribution of resources became unequal and to how major systems of inequality were created. I continued this inquiry by doing a PhD in the history of medicine. I focused on colonial history and the history of public health because I wanted to know how ideas moved around, and to learn how colonialism had become such a major determinant of inequality now. As I investigated, I learned that the colonial project was much more cruel than I had imagined and its influence far more pervasive than I had believed. I began working in global health because I felt that might be a way of rectifying past harms and supporting better health for Africans. That is not a primary objective in history departments so a few years after my PhD I went back to school for an MPH. I felt that it was unacceptable to have global health programs without any historical perspective and that inspired me to become an academic. At the beginning, I thought I could change global health and I focused my efforts on trying to help. But I soon shifted to a more critical view because I did not think the major actors and institutions were engaging the countries or peoples whom they were supposed to be helping. And I did not see why the global health agenda should be dominated by arbitrary interest groups. As an historian, I had studied the close connections between colonialism and development, and I knew perfectly well that colonial ideas and patterns persisted. I did not know that so many people in global health, and all of its major institutions, actually wanted to sustain the unfairness and the inequality. My teaching has been on these topics since the beginning, reflecting my conviction that students needed to be informed and empowered in this way. My scholarly articles have evolved in an arc of declining faith in the elite mainstream's willingness and ability to advance meaningful change. My projects are all explicitly historical, a strategy that makes it harder for people to avoid confronting colonial legacies and the unearned privileges that it sustains. I choose to base my activities at an elite institution because it has power an authority that can be redistributed.