DRAFT: HIFA discussion on healthcare professionals' experiences and perceptions of open access publishing

13 October to 14 November 2025

Selected contributions organised under heading and subheadings (up to 7 November)

More information about the discussion here: https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare-professionals%E2%80%99-experiences-and-perceptions-open

Contents

(each heading/subheading links to corresponding section in text)

Introduction

- Benefits of open access
- Objectives
- Definitions and scope
- Open access to pharma-funded research
- Acknowledgement

Week 1. What is the impact of open access (OA) on health care?

- What kinds of information do health professionals need to deliver quality health care?
    - Example: Information for prescribers and users of medicines
  - Use of abstracts by health professionals
- To what extent do health professionals need access to original research to deliver quality health care?
- What are the benefits and limitations of open access to original research for health professionals?
- Has open access to research ever saved a life?
- To what extent do health professionals have access to subscription journals?
- How can we describe the direct impacts of open access to original research
  - Specific examples: from HIFA members
    - South Africa
    - Afrihealth Optonet Association
    - Central Hospital, Yaounde
    - Hospital Escuela in Tegucigalpa, Honduras
    - SHDEPHA+, Tanzania
  - Specific examples from Chat GPT
    - Update a clinical guideline

Child with fever
Early Detection of Stroke Using MRI
Antibiotic Resistance and Treatment Protocols
Early Intervention for Preterm Birth
Emergency Treatment for Cardiac Arrest
Nutritional Interventions for Malnutrition in Children
Indirect impacts of open access to original research
Impact of OA on society
Impact of OA on the overall global evidence ecosystem
Impact of OA on evidence generation: health research
Impact of OA on evidence synthesis: systematic reviews and clinical guidelines
Impact of OA on evidence repackaging
Impact of OA on HIFA
Relevance and reliability of open access content
Quality of evidence
Examples of open access to research resources
PubMed Central
Morbidity and Mortality Weekly Report
Non-research OA resources (eg training materials, guidelines, health education materials)
Wikipedia
Afrihealth OptoNet
Week 2. What is your experience of OA as a healthcare professional/reader?
Positive impacts
Directory of Open Access Journals
Citations
Supporting policy and practice
Negative impacts
Epistemic impact
Access to subscription journals
Week 3. What is your experience of OA as a researcher/author?
Introduction
Positive impacts
General comments
Increasing the reach and impact of research
Conception and implementation of research
Promoting research collaboration

Positive experience with preprints
Negative impacts: APCs
APC waivers
Negative impacts
Predatory journals
Publisher-researcher relations
Lack of incentive for researchers
Negative perceptions of OA journals
Week 4. How would you design an OA system that retains the benefits but fixes the problems of the current OA system?
Introduction
What different approaches can we identify and what are their strengths and weaknesses?
Preprints
Plan U
APCs
Funders should stop paying APCs
Gates Open Access Policy
Potential consequences of stopping APCs
Funders should cap APCs
Other issues to consider with APCs
Preprints
Problems of preprints
Systems-thinking approach
What do publishers think?
Commercial agreements between academic institutions and publishers
APC-free journals
Other APC models
Governance
Week 5. Open discussion and next steps.
Other issues.
ICTs and AI
Open data
Language
Case study: GHSP
Notes

Introduction

Benefits of open access

Joanna Donnelly: The benefits of open access publishing are well established, as outlined in the UNESCO recommendations on open science (https://www.unesco.org/en/legal-affairs/recommendation-open-science).

Neil Pakenham-Walsh: The Open Access Network open-access.net - a platform that 'provides comprehensive information on the subject of Open Access (OA) and offers practical advice on its implementation'. https://open-access.network/en/information/open-access-primers/arguments...

Neil: It describes 12 benefits of open access:

1. Faster and Cost-Free Access to Scholarly Information
2. Fair Use of Taxpayers' Money, Research Funders' Guidelines
3. Open Access to Results of Publicly Funded Research
4. Greater Visibility and Citation Frequency of Publications
5. Promotion of International and Inter-Disciplinary Cooperation
6. Authors Retain the Right to Exploit their Works
7. Long-Term Availability of the Documents
8. Promotion of Research Efficiency
9. Improvement of the Information Supply and a Way Out of the Serials Crisis
10. Advantages in Networked, IT-Supported Work Environments
11. Establishing Priority
12. Good Findability via Search Engines and Indexing Services

Neil: For each of the above there is a short description. I think 1, 4, 10 and 12 would potentially have a direct impact on the availability and use of reliable healthcare information, and therefore potential impact on health care. Some of the others might have an indirect impact.

Objectives

Joanna: Healthcare professionals' perceptions and experiences of open access publishing have not been well documented. To address this knowledge gap, we are keen to explore the following factors:

• How important is open access publishing for healthcare professionals?

• What are the perceived benefits and barriers of open access publishing for healthcare professionals, as readers and users of scientific content?

• What is the impact of *not* publishing open access on healthcare professionals, especially for those who *do not* have access via an institutional subscription?

We seek input from all stakeholders in the global evidence ecosystem

We are especially interested to hear actual practical examples and observations. For example, can you describe a situation where (lack of) access to the full text of a paper has impacted a healthcare professional's ability to optimally manage a patient?

The suggested sequence of the discussion (by week) is:
1. What is the impact of open access (OA) on health care?
2. What is your experience of OA as a healthcare professional/reader?
3. What is your experience of OA as a researcher/author?
4. How would you design an OA system that retains the benefits but fixes the problems of the current OA system?
5. Open discussion and next steps.

Uzodinma Adirieje, Nigeria: I expect that this deep-dive discussion on open access publishing will explore its principles, benefits, and challenges in advancing equitable knowledge sharing. I expect that participants will gain a clear understanding of how open access enhances research visibility, collaboration, and global impact, especially for scholars like me who are in resource-constrained low- and middle-income countries. The discussion should also examine funding models, quality assurance, copyright, and predatory publishing concerns. By the end, we should be able to identify best practices for publishing in credible open-access journals, leveraging repositories, and aligning with policies that promote transparency, innovation, and inclusive access to scientific and academic information worldwide, especially in Africa and all developing countries globally, towards achieving the overall goals of the SDGs/Agenda 2030, and African Union's 2063 Agenda.

Definitions and scope

For the purpose of this discussion, when we refer to 'open access' we use the Budapest Open Access Initiative (BOAI) definition: 'Open access to scientific literature means free availability on the public internet, permitting any users to read, download, copy, distribute, print, search, or link to the full texts of these articles...' https://www.budapestopenaccessinitiative.org/read/

The term 'scientific literature' here refers to 'peer-reviewed articles and other formal publications' https://www.sciencedirect.com/topics/social-sciences/scientific-literature

We are particularly keen to look at open access to peer-reviewed academic research papers, which are mostly published in biomedical research journals. Such papers are typically either original primary research or secondary research such as systematic reviews. So a more specific wording of our question would be: What is the impact of open access to health research on health care?

The term 'open access' can be applied not only to research papers but to almost any type of publication: educational resources, formularies, books, clinical guidelines, editorials, commentaries, blogs, books...

Neil: By definition, open access content is more useful than closed-access content, because it can be accessed by anyone (with an internet connection) and it can be freely adapted, reused and reproduced.

Open access to pharma-funded research

Joanna: Although pharma companies fund approximately half of all biomedical research, access to a substantial amount of this biomedical research is restricted by journal paywalls. Open access publishing ensures that the highest quality peer-reviewed evidence is available to anyone who needs it, anywhere in the world. This has the potential to improve transparency, advance medical science and, we believe, improve patient care. Our position statement on open access ultimately advocates for all research to be made free to read and reuse from the date of publication.

Neil: If all pharma-funded research were open access, would this help drive improvements in patient care?

Chris Winchester: I am a co-Founder of Open Pharma, an initiative to advance the publication of pharmaceutical and biotech company results. Pharmaceutical companies now publish essentially all of their clinical trials but many of the results are stuck behind paywalls. To achieve 100% open access, they will have to persuade some of the world's most influential journals to change their policies, and offer them the same opportunity to publish open access as non-commercial funders such as the National Institutes of Health, the Gates Foundation and Wellcome Trust.

Acknowledgement

HIFA is grateful for sponsorship from Oxford PharmaGenesis, a HealthScience communications consultancy based near Oxford UK.

Week 1. What is the impact of open access (OA) on health care?

Neil: Our discussions over the years on HIFA have demonstrated that access to relevant, reliable healthcare information is essential for quality care. Such information is essential not only in hospital environments, but also in the home, community and primary care. And it is as essential for a family living in a remote rural area of a low-income country as it is for a tertiary care specialist.

What kinds of information do health professionals need to deliver quality health care?

Neil: What is most useful and most reliable for health workers is repackaged information (such as clinical guidelines, formularies, educational resources, textbooks) that are rigorously developed (which normally means they are based on cumulative evidence synthesis such as systematic reviews).

Neil: Access to the full text of original research papers is not the main priority for the vast majority of health professionals to guide their decision-making. Single research studies are seldom sufficient to inform decision-making (for reliable evidence we need the input of component 3 - those who synthesise evidence as in systematic reviews and guidelines). Further, the full text of research papers is not in a format that is useful to most users (for this we need the input of component 4 - those who repackage evidence). After all, a research paper describes the method and findings of the study, but is not designed to make recommendations. The same can be said of systematic reviews - 'Cochrane has always emphasised that systematic reviews do not make recommendations' https://pmc.ncbi.nlm.nih.gov/articles/PMC10845861/ It is the task of guideline developers to oversee the formulation of key questions, evidence retrieval and synthesis (eg systematic reviews), and appraisal of the quality of the evidence, and on the basis of these to make recommendations.

Example: Information for prescribers and users of medicines

Neil: Prescribers and users do not have access to the reliable information they need to use antibiotics responsibly, as noted by HIFA in our systematic review: How primary healthcare workers obtain information during consultations to aid safe prescribing in low-income and lower middle-income countries: a systematic review https://pubmed.ncbi.nlm.nih.gov/32337085/

Neil: A recent paper estimates that 30-36% of antibiotics consumed worldwide are used inappropriately, https://bmjpublichealth.bmj.com/content/3/1/e002411

Neil: And the latest district health study in India finds that 1 in 5 children with simple diarrhoea seen by a health worker are inappropriately given antibiotics. ('Simple' refers here to diarrhoea without blood. The presence of blood may indicate a bacterial infection that requires antibiotics) https://www.hifa.org/about-hifa/why-hifa-needed

Neil: Health workers need not only information on individual medicines, but, even more importantly, guidance on which antibiotic to prescribe in any given clinical context. In the UK there is a guide called the British National Formulary, paper copies of which are commonly used by health workers worldwide (many of them supplied by the Commonwealth Pharmaceutical Association). The BNF used to be freely available on the internet, but this is no longer the case. Furthermore the publisher is stopping print copies. It is hard to estimate how many lives would be saved if the BNF - and national adaptations of it - were freely available to all prescribers (and to all users) of medicines. We have asked this question before, but it is worth asking again: What if the British National Formulary was made available under an open access licence?

Use of abstracts by health professionals

Neil: A google search identified a BMJ correspondence (2009) from a physician in the Philippines asks: Can journal abstracts alone be used for clinical decision making?

Neil: He notes: 'We recently asked some physicians practicing mostly in developing countries whether Medline abstracts are adequate for clinical decisions: 28% (15/54) categorically stated they are. Forty three percent (23/54) said no, but that they had no access to full-text journals and another 28% also said no, but they had no time to read full-text articles. One respondent did not use Medline abstracts at all. This preliminary study confirms access issues in these countries, but also the potential value for abstracts if these could be made available easily through their existing infrastructure.'

Neil: The authors didn't acknowledge the wider limitations of using single research papers to inform decisions.

Neil: 'If journal abstracts are accepted as ‘current evidence’ suitable for evidence-based practice, then all who are involved in the publication process -- authors, journal reviewers and editors, need to ensure that the abstract is indeed an accurate summary of the full paper.'

To what extent do health professionals need access to original research to deliver quality health care?

Neil: The full text of original research is not the most important requirement for most health professionals and patients in most circumstances. A health professional (or patient) would not normally be advised to make a healthcare decision on the basis of a single research paper. Typically their information needs are met by derivative publications, developed rigorously on the basis of evidence synthesis/systematic reviews.

Neil: What evidence do health workers need to guide their decision-making? Arguably, they do not generally need access to original primary research as this is almost always inconclusive.

Neil: Who needs access to original research and why? What information sources do health professionals most often use to guide healthcare decisions? original research papers, drug formularies, systematic reviews, clinical guidelines, textbooks, websites, patient information leaflets? What information sources do patients most often use to guide healthcare decisions? original research papers, drug formularies, systematic reviews, clinical guidelines, textbooks, websites, patient information leaflets?

What are the benefits and limitations of open access to original research for health professionals?

Chris Zielinski: Open Access allows those wishing to read health literature to do so for free, without any paywalls, without paying heavy journal subscription costs. This is obviously very welcome, particularly in resource-poor environments.

Neil: We have discussed previously on HIFA how the term 'evidence-informed practice' continues to be misunderstood. We have heard for example that there are many healthcare providers who will base a clinical decision on the findings of a single study, misunderstanding that doing so is 'evidence-informed practice' (it isn't). Evidence-informed practice demands that healthcare providers make their decisions on the cumulative evidence, as provided by systematic reviews (which in turn inform recommendations and guidelines).

Neil: The impact of open access on translation of evidence into practice will therefore depend not only on everyone having access to the full text, but as much (if not more) on knowing when and how such full text is to used.

Has open access to research ever saved a life?

Neil: We are struggling to find any specific examples where, for example, access to an original research paper has helped save a life or even led to better quality of care.

To what extent do health professionals have access to subscription journals?

Neil: I am getting a sense from our discussion and one-to-one communications that access to full text of subscription journals is not a major problem for health professionals who work in a university setting, because universities typically subscribe to all the major journals. That said, I expect some universities are unable to afford to subscribe to these journals so paywalls remain a problem. Would anyone like to comment, whether from a high-income or LMIC?

Indi: Great question. As someone with the privilege of working in universities in high-income countries, I've virtually never been unable to access a subscription-only article. The universities and hospitals subscribe to large numbers of journals, usually through package deals with publishers which do indeed have the benefit of allowing smaller less-profitable journals to survive. On those occasions where an article or journal was not available, our libraries can generally get access to virtually any article (or book) by borrowing from a partner university through an inter-library loan. This may take a few extra days for an article but access is almost always available, so ultimately it hasn't been a real problem yet, at least for large American universities as far as I have seen.

Indi: The cost of these university [subscription] packages continues to increase and much has been written about how difficult it is for university library budgets to keep supporting these, which is especially ironic since it is often the same university researchers that are producing the content that goes into those journals, research that is often publicly funded itself. A vicious circle that has led to some high-profile disagreements between universities and publishers. It is not clear how these conflicts will play out, but one approach here has been for the university to set up agreements with certain publishers for the university to pay for their researchers' open-access fees instead of, or in addition to, paying for the subscription costs to the journals.

Neil: Some universities can benefit from Hinari, which provides free or low-cost access to many subscription journals for specific types of institutions in eligible countries. Further details are here: https://www.research4life.org/access/eligibility/

Neil: It would be great to hear from Hinari users. Some years ago HIFA members reported difficulties with access to Hinari, but hopefully these have now been resolved? See also: Research4Life: January 2025 Newsletter and Impact Report - https://www.hifa.org/dgroups-rss/research4life-january-2025-newsletter-a...

How can we describe the direct impacts of open access to original research

Neil: Open access has the potential for direct and indirect impact on the availability of reliable healthcare information and therefore, by extension, quality of health care.

Neil: Our question then becomes: To what extent does open access help to create a world where every person has access to the reliable information they need to protect their own health and the health of others?

Neil: There is a potential DIRECT impact of open access on health care (whether through a better-informed health worker or patient).

Neil: There is a wide assumption that open access to original research helps to meet the information needs of healthcare professionals and thereby improves patient care. Can anyone give an example of personal experience to corroborate this assumption? For example, can you describe a situation where open access to a research paper helped you to make a clinical decision?

Specific examples: from HIFA members

South Africa

Neil: There is an interesting anecdote in a paper by Virginia Barbour and colleagues: Barbour V, Chinnock P, Cohen B, Yamey G. The impact of open access upon public health. Bull World Health Organ. 2006 May;84(5):339. doi: 10.2471/blt.06.032409. Epub 2006 May 17. PMID: 16710533; PMCID: PMC2627358.
https://pmc.ncbi.nlm.nih.gov/articles/PMC2627358/pdf/16710533.pdf

Neil: 'Arthur Amman, President of Global Strategies for HIV Prevention (www.globalstrategies.org), tells the following story: "I recently met a physician from southern Africa, engaged in perinatal HIV prevention, whose primary access to information was abstracts posted on the Internet. Based on a single abstract, they had altered their perinatal HIV prevention program from an effective therapy to one with lesser efficacy. Had they read the full text article they would have undoubtedly realized that the study results were based on shortterm follow-up, a small pivotal group, incomplete data, and were unlikely to be applicable to their country situation. Their decision to alter treatment based solely on the abstract's conclusions may have resulted in increased perinatal HIV transmission."

Neil: At first sight, we may say this is a classic example of where access to the full text is critical. It would be interesting to have more information about the case, including a citation for the article in question. It seems that access to the full text would have made a difference. However, the story illustrates a more fundamental issue: it seems that the health professionals had a flawed approach to evidence-informed practice. The development of a perinatal HIV prevention program should never be dependent on the full text of a single research study, let alone an abstract. Such a program demands a rigorous approach based cumulative evidence from systematic review. A first step would have been to identify whether there is a current international guideline on this topic from a body such as WHO or UNAIDS. This guidance would neeed to be formally studied and adapted by a team of health professionals in South Africa, usually led by the Ministry of Health, and taking into account the cumulative evidence available in South Africa as well as economic and cultural considerations.

Afrihealth Optonet Association

Uzo: Open Access (OA) has emerged as a transformative force in global health care, redefining how knowledge is shared, accessed, and applied. By removing subscription barriers to scientific research and medical literature, OA ensures that clinicians, researchers, policymakers, and community organizations can access the latest evidence without financial constraints. This democratization of information has profound implications for improving patient care, accelerating health innovations, and enhancing public health interventions. Health care providers can make timely, evidence-based decisions, while policymakers can design programs grounded in the latest data, ultimately improving health outcomes and equity.

Uzo: For organizations like Afrihealth Optonet Association (AHOA), OA is particularly impactful. AHOA's mission of strengthening health systems and promoting community-driven health initiatives relies heavily on access to up-to-date research, global best practices, and innovative solutions. OA enables AHOA's researchers, practitioners, and partners to access a vast repository of knowledge, facilitating evidence-informed decision-making and program design. Moreover, OA allows AHOA to share its own research findings, case studies, and policy recommendations with a global audience, amplifying the organization's influence and fostering cross-border collaborations.

Uzo: In essence, Open Access strengthens AHOA's role as a knowledge-driven, community-centred health organization. By bridging the gap between global research and local practice, OA empowers AHOA to translate evidence into action, driving sustainable improvements in health care delivery and outcomes across Africa.

Uzodinma Adirieje: OA allows me to access the latest research, guidelines, and policy reports without financial or institutional barriers. This immediate access ensures that the provision of care is evidence-based, innovative, and aligned with global best practices, while remaining adaptable to local health realities.

Central Hospital, Yaounde

Marileine Kemme: As a Mental Health specialist I have often experienced both sides of the "access" divide in scientific information.

Marileine Kemme: In my daily practice, I regularly seek up-to-date evidence to guide patient management, especially concerning harm reduction strategies and the mental health impacts of substance use. There have been many occasions when I was unable to access crucial research articles because they were behind paywalls, limiting my ability to integrate new findings into local care protocols.

Marileine Kemme: Conversely, open access publications have been tremendously valuable. Freely available studies on community-based harm reduction and brief motivational interventions have directly inspired the design of our psychosocial support programs and professional training modules.

Marileine Kemme: I strongly believe that open access to scientific knowledge is a cornerstone for reducing global health inequities, empowering frontline practitioners, and improving care outcomes — particularly in low- and middle-income countries.

Hospital Escuela in Tegucigalpa, Honduras

Jackeline Alger: The experience of the Parasitology Service of the Hospital Escuela in Tegucigalpa illustrates how open access to scientific information can have a direct impact on people's health and lives. For more than two decades, the laboratory team has used the resources of the Virtual Health Library of Honduras (VHL HN) to access updated evidence, review diagnostic procedures and guide clinical staff in the identification of parasitic diseases.

Jackeline Alger: Thanks to this availability of reliable and freely accessible information, it has been possible to improve diagnostic accuracy, update training materials and strengthen evidence-based clinical decision making. In contexts where resources are limited, this open access translates into more timely diagnoses, more accurate treatments and, ultimately, saved lives.

Jackeline Alger: Therefore, we can affirm that open access to research saves lives—not only because of the great discoveries it disseminates, but because of the possibility that each health professional, from their local environment, has the necessary tools to offer quality care, supported by the best available evidence.

Jackeline Alger: The following official links, which document the work of the Virtual Health Library of Honduras (BVS HN) and its relationship with the Teaching Hospital:

Virtual Health Library of Honduras (VHL HN):
https://honduras.bvsalud.org/es/

Network of Virtual Health Libraries (VHL) – PAHO/WHO and BIREME: https://bvsalud.org/es/rede-bvs/

Reference on the creation of the BVS HN (Faculty of Medical Sciences Magazine, 2015): https://www.bvs.hn/RFCM/pdf/2015/pdf/RFCMVol12-2-2015.pdf

SHDEPHA+, Tanzania

Rabia: Reflecting on Question 2 — *my experience of open access as a healthcare professional and reader* — I find that OA has played a quiet but powerful role in bridging what I call the "last mile" between evidence and practice.

Rabia: In many community health contexts, particularly in low-resource settings, access to peer-reviewed knowledge through open platforms has enabled better-informed advocacy, design of training materials, and gender-responsive program adaptation.

Rabia: However, the experience also reveals a paradox: while access to full-text articles has improved, many health workers and local researchers still face challenges translating OA content into actionable guidance. Language barriers, limited internet access, and the lack of synthesized, context-specific summaries often dilute the potential impact of OA on day-to-day practice.

Rabia: Perhaps this is where the open-access movement can evolve — not just opening doors to research, but opening pathways for its practical use at the frontline of health service delivery.

Specific examples from Chat GPT

Neil: I asked ChatGPT: Do you have any examples where open access to research led to a direct improvement in patient care? Or saved a life?

Update a clinical guideline

Open Access and Tropical Disease Research (this example referred to 'open-access journals like PLoS Neglected Tropical Diseases... where clinicians in endemic regions can use this research to update treatment guidelines...' [not specific]

Neil: ChatGPT has perhaps a distorted view of how treatment guidelines are updated and adapted for national use. In my understanding, it is more usual (and more reliable) for a treatment guideline to be informed by WHO international recommendations and guidelines, adapted for national use on the basis of local research and knowledge. A clinician would not normally update a treatment guideline on the basis of an open-access research paper, although there is perhaps some truth in suggesting that open access to the scientific literature can facilitate the collective process. (Notwithstanding, Hinari allows most guideline developers in LMICs to access subscription content free or at low cost.)

For example, here is a description of how the guideline development process works for malaria. https://www.who.int/teams/global-malaria-programme/guideline-development...

Child with fever

Neil: On 21 October I asked ChatGPT for an example specifically where open access to a full research paper saved a life. It replied with a compelling answer: '...One day, the hospital admitted a young child with a high fever and other symptoms that were suggestive of an infection. Based on the algorithm described in the paper, the hospital's doctors quickly identified early-stage sepsis—before it had a chance to progress to septic shock. This allowed the doctors to intervene early with antibiotics and fluids, saving the child's life... 'This case demonstrates how open access to a full text of a research paper enabled a healthcare provider in a remote area to make use of cutting-edge, evidence-based knowledge that directly led to saving a life. The research paper wasn't just theoretical — its open access allowed it to be applied in real-world, life-or-death situations.' https://www.hifa.org/dgroups-rss/open-access-48-has-open-access-research...

Today I asked GPT for clarification of the above and further details. Can you give me the citation of the paper or a reference to the case study? It replied:

"I was unable to locate any credible evidence that the scenario — a specific open-access paper in The Lancet (or elsewhere) being downloaded by a rural hospital in a developing country and directly saving a patient's life via an early sepsis-detection algorithm — actually took place."

This appears to be another example of AI hallucination.

Early Detection of Stroke Using MRI

Context: A study published in Neurology (2015) explored a new method for detecting strokes using advanced MRI imaging techniques, allowing for earlier identification of ischemic strokes (where blood flow to the brain is blocked). The Role of Open Access: The paper was open access, so it was freely available to hospitals around the world, including many community hospitals with limited resources. The study detailed new MRI scanning protocols that could detect smaller, early-stage strokes that conventional imaging methods missed....

COMMENT (NPW): We need clarification on this. It seems odd to talk of a 'small, rural hospital' with 'advanced MRI techniques'. ChatGPT said the patient 'presented with symptoms of a stroke' but hthen said 'Without access to the specific imaging techniqu, the hospital would have missed the early signs of stroke'. The suggestion that the full text of the paper prompted 'early treatment with clot-busting drugs' is also odd. It is normal practice, based on established clinical guidelines (and not a specific paper), to treat suspected thromboembolic stroke with 'clot-busting drugs'.

Antibiotic Resistance and Treatment Protocols

Real-Life Impact: A middle-aged man arrived at the hospital with severe cellulitis and signs of sepsis caused by MRSA. The healthcare team, guided by the open access paper, implemented the new antibiotic treatment protocol for resistant infections. The patient's condition improved significantly after receiving the appropriate combination of antibiotics, and he survived a potentially fatal infection.

Why Open Access Was Crucial: In the absence of this open access research, the clinicians might not have known about the new protocol for handling resistant infections. Access to the paper allowed them to administer the correct treatment quickly, which saved the patient's life by preventing septic shock.

COMMENT (NPW): We need clarification. What is the 2016 paper that ChatGPT refers to? It is highly unusual for a research paper to outline a new protocol for treating drug-resistant infections. Normally such protocols are developed by international teams, typically convened by the World Health Organization, which make their deliberations based on systematic review. These recommendations would be issued as international guidelines, and it is the responsibility of country-based teams, typically convened by the ministry of health, to adapt these guidelines for national use, taking into account local research and national profiles on antibiotic resistance, antibiotic availability, and other contextual factors.

Early Intervention for Preterm Birth

Context: A study published in The Lancet (2017) reviewed clinical trials on interventions for preventing preterm birth and identified several effective treatments. The paper included evidence that administering magnesium sulfate to mothers at risk of preterm labor could significantly reduce the likelihood of severe complications in premature infants... Without the paper's specific guidance on magnesium sulfate use, the hospital staff might have missed the window to administer the life-saving drug. The open access research allowed them to intervene in a timely manner, saving both the mother and child.

COMMENTS (NPW):
1. I was unable to find the 2017 study in The Lancet. It's notable that the purpose of the synthesis was to assess interventions for preventing preterm birth, but the authors appear to have made a conclusion about a different endpoint.
2. I found a paper in PLOS Medicine - Antenatal magnesium sulphate and adverse neonatal outcomes: A systematic review and meta-analysis - dated 2019. Curiously this paper did not mention the supposed 2017 Lancet paper.
3. I also located a 2018 paper in The Lancet - Interventions to reduce premature births: a review of the evidence - but this is not open access. The paper comprised only a conference abstract which included the sentence 'Identified interventions with strong evidence of benefit were smoking cessation, progesterone supplementation, cervical cerclage, preterm surveillance clinics and screening, diagnosis and preparation, corticosteroids, magnesium sulphate, and tocolysis'. It would not make sense for the doctors mentioned above to have provided magnesium sulphate on the basis of such an abstract.
4. For any information to be reliable and applicable, the ideal pathway is not by reading an abstract (or open-access full text) of a single research paper. ChatGPT reports that the 2017 paper was a synthesis and this gives stronger grounds for clinical decision-making. Systematic reviews may or may not include recommendations. Furthermore, there may be several extant systematic reviews that have relevance. The most robust way forward is to convene a clinical guideline group which uses a rigorous approach to assess all the available evidence and make international guidelines that can be adapted at country level.
5. Magnesium sulphate is currently recommended for neuroprotection of preterm infants for women at risk of preterm birth at less than 30 weeks' gestation, based on high quality evidence of benefit
6. I located 'The Antenatal Magnesium Sulphate for Neuroprotection Guideline Development Panel: Antenatal magnesium sulphate prior to preterm birth for neuroprotection of the fetus, infant and child: National clinical practice guidelines'. This was published back in 2010. The WHO Essential Medicines List includes magnesium sulfate for pre-eclampsia and eclampsia but curiously the indications do not include neuroprotection in preterm birth.

Neil: I asked ChatGPT to give me the citation of the paper and it 'admitted': 'I could not locate a 2017 open-access paper in The Lancet exactly matching the description you provided (i.e., a 2017 Lancet review of magnesium sulphate for pre-term birth interventions that is open access).' Presumably this was a 'hallucination'. This puts into doubt the whole example.

Emergency Treatment for Cardiac Arrest

Context: A 2019 study published in the New England Journal of Medicine explored new approaches to the early defibrillation of patients who experience sudden cardiac arrest outside of a hospital setting. The research highlighted the importance of immediate use of Automated External Defibrillators (AEDs) and proper CPR techniques.

The Role of Open Access: The study was made available as open access, and a volunteer in a high school gym who had been trained in CPR and AED use was able to access this paper. The paper described updated guidelines for handling cardiac arrest more effectively.

Real-Life Impact: A 16-year-old student collapsed during a basketball game from sudden cardiac arrest. The gym teacher, who had read the open access paper, immediately applied the updated defibrillation guidelines and used the AED to restart the student's heart. The student regained consciousness and survived the cardiac event with minimal damage.

Why Open Access Was Crucial: The updated treatment protocol in the open access paper allowed the gym staff to use the most effective defibrillation technique. Without it, the student might not have survived. Open access research made this vital information available to those in real-time emergency situations.

Today I asked ChatGPT for more details: 'A few days ago I asked you to give me specific examples where access to original health research helped to save a life. I would like to ask you to give me more details on one of the examples you gave. Here is what you said... Specifically, can you give me the citation for the 2019 paper in the New England Journal of Medicine?'

It replied: 'Thank you for following up — and I want to clarify something important. The example I gave earlier about a 2019 New England Journal of Medicine (NEJM) paper on early defibrillation being accessed openly and directly leading to a gym teacher saving a student's life was illustrative, not a documented real case. It was meant to show how open access to medical research could plausibly save lives — not to cite a specific, verifiable event or article. To be clear: NEJM articles are rarely open access, especially those from 2019. There was a real 2019 NEJM paper on defibrillation practices... That paper analyzed outcomes of early CPR and defibrillation in cardiac arrest and influenced global resuscitation guidelines — but there's no verified case linking its open access availability to a specific life-saving event by a gym teacher.'

This appears to be yet another example of a 'hallucination' by Chat GPT.

Nutritional Interventions for Malnutrition in Children

Context: A 2014 study published in the Journal of Nutrition investigated the impact of specific nutritional interventions to treat severe malnutrition in children under five years old. The study showed that ready-to-use therapeutic foods (RUTF), like peanut-based pastes, dramatically improved recovery rates for severely malnourished children... Without the open access paper, the clinic might not have had the latest evidence on the most effective treatment for malnutrition. The ability to access this research allowed them to provide the most appropriate care in time, saving the child's life.

Indirect impacts of open access to original research

Neil: We are interested not only in the direct impact of open access to health research on the availability of reliable healthcare information and health care, but also the indirect impact. For example, how does open access to primary research enable evidence synthesis such as systematic reviews and clinical guidelines? And in what ways does open access to research facilitate the development of educational resources, formularies, books…?

Impact of OA on society

Rabia: Knowledge should never be a privilege but a shared resource for all. To me, open access is not only about removing paywalls, but about removing barriers between evidence and impact, between research and real-life change.

Impact of OA on the overall global evidence ecosystem

Ruwaida Salem : I believe the solution to translating evidence into practice requires a whole knowledge ecosystem approach in which different actors work together to do their part.

Neil: I think the indirect impacts of open access are hugely important in' removing barriers between evidence and impact, between research and real-life change'. Open access is already having a profound positive impact on the functional integrity of the global evidence ecosystem. This will increase further as AI plays an increasing role in the system (AI depends largely on freely available content). Moreover, the ethos of the open access movement is a positive driver for cooperation and collaboration in an increasingly divided world.

Neil: These indirect impacts could relate to one or more of the six components of the global evidence ecosystem: 1 researchers, 2 journal publishers, 3 systematic reviewers and guideline developers, 4 publishers of content for end-users, 5 library and information professionals, and 6 healthcare professionals. Open access to research potentially strengthens any or all six components, thereby supporting evidence-informed policy and practice and leading to improved health outcomes. For example, open access to research may facilitate the development of systematic reviews and guideline development, which requires access to full text.

Margaret: a. How can OA help research and knowledge from LMICs be peer reviewed, published, translated, and disseminated?

Neil: How does open access facilitate the peer review, publication, translation and dissemination of research? With most open access licences, translation and dissemination of research is unrestricted, thereby increasing availability and applicability. Does open access also facilitate peer review, and perhaps some aspects (which?) of the publishing process?

Margaret: c. How can OA help ensure that journal content from LMICs is indexed and discoverable via search engines? (WHO databases may contain LMIC content that is not indexed in other ways, but those databases may not be searched by usual search engines.)

Rabia: How can open access initiatives do more to support translation of evidence into practice, especially in low-resource settings?

Rabia: Could open access platforms collaborate more with those developing guidelines, job aids, and community health materials, so that synthesized evidence flows more efficiently to end users?

Neil: For me, what is more important is the impact of open access to health research on the integrity of the overall global evidence ecosystem, and on each of the six components of the system (generate, publish, synthesise, repackage, find, apply) https://www.hifa.org/about-hifa

Impact of OA on evidence generation: health research

Joseph: In 2011, at the BioMed Central (BMC) OA conference... I ended my presentation on Open Access Challenges... Restricted access to research is also an obstacle to the production of new knowledge.'

Impact of OA on evidence synthesis: systematic reviews and clinical guidelines

Neil: 1. What is the impact of open access to original primary research on the development of evidence syntheses or systematic reviews? Do paywalls continue to be a major problem for evidence synthesis teams, even though they may have access to institutional subscriptions?

Neil: 2. How common is it for evidence syntheses or systematic reviews to be behind a paywall? What difference could it make if all were available open access?

Unni Gopinathan: (1) On open access: Accessible research papers, particularly those published under open access, present both opportunities and challenges for evidence use in health systems. On the positive side, open access practices have democratized access to research and made it easier to conduct evidence syntheses (such as systematic reviews of effectiveness or qualitative evidence syntheses) by removing paywalls that previously might have limited inclusion of relevant studies. This can have allowed researchers in low-resource settings to participate more fully in global evidence generation. Yet, this accessibility has probably also a downside: it has also contributed to a proliferation of low-quality or poorly designed studies that must be screened, increasing the workload of reviewers and making tools like machine learning-assisted screening increasingly central.. We have in our work experienced the challenge of not being able to access relevant research papers, even with substantial institutional access. Such barriers are likely to create more pronounced inequities for researchers and practitioners in settings without institutional subscriptions.

Neil: To what extent do health professionals in different contexts require access to the full text of systematic reviews? What subset of health professionals require such access?

Neil: What is the relative value of clinical guidelines (rigorously produced and based on evidence synthesis) compared to systematic reviews for different types of health professional? (Is it fair to assume that most health professionals would use guidelines and other derivative products in preference to systematic reviews in order to inform healthcare decisions?)

Unni Gopinathan: I think for most clinical and managerial contexts, people will benefit more from synthesized and repackaged evidence—such as guidelines, policy briefs, or decision-support tools—than from direct access to primary studies, which are often inconclusive in isolation. However, for questions related to health system organization, governance, and financing, access to local research remains particularly valuable. Local studies often contain contextual insights not necessarily present in global syntheses and can inform decisions about service delivery models or participatory mechanisms. Perhaps such local evidence together with global syntheses can be useful for interpreting and applying evidence meaningfully within local contexts.

Neil: In terms of ecosystem integrity, and from a perspective that is strongly supportive of evidence synthesis and rigorous guideline development, I would put systematic reviewers and guideline developers as the key users of the full text of research papers, as implied by the Synthesis component of the global evidence ecosystem graphic on the HIFA website.

Neil: For example, in relation to the Synthesis component, we have heard from a systematic reviewer, Unni Gopinathan, that open access facilitates the systematic review process by removing paywalls. On the other hand, he notes that open access 'has also contributed to a proliferation of low-quality or poorly designed studies' that make things more challenging for systematic reviewers. (Meanwhile, we have to take into account the increasing role of AI in systematic reviews, and to note that the quality of AI itself is largely dependent on research being freely accessible - arguably the impact of OA on AI will prove to be much more important than the impact of personal access to specific papers) https://www.hifa.org/dgroups-rss/open-access-33-open-access-and-availabi...

Impact of OA on evidence repackaging

Rabia: Could open access platforms collaborate more with those developing guidelines, job aids, and community health materials, so that synthesized evidence flows more efficiently to end users?

Neil: Promoting better communication among all stakeholders in the system is extremely important. This is the central rationale for HIFA as described here: https://www.hifa.org/about-hifa

Neil: The term 'open access platform' is very wide, but it is a truism to say that any content platform needs to understand and address the needs of its users (researchers, indexers, reviewers, end-user content producers, library and information professionals, health professionals, policymakers, patients...) and therefore to communicate/collaborate more.

Impact of OA on HIFA

Neil: As coordinator of HIFA for almost 20 years, open access has had a hugely positive impact.

Neil: When HIFA first launched in 2006, many of not most research papers were behind a paywall. Gradually the situation has changed completely, with open access being the norm rather than the exception.

Neil: This is important for my work, as it enables me to send messages to HIFA forum highlighting papers that relate to the HIFA remit.

Neil: I need access to the full text of any research paper that I may highlight on HIFA. The ideal is that the paper is open access, so that I know that all HIFA members will be able ot read it.

Neil: When I identify a paper of interest and find it to be behind a paywall, I feel a sense of disappointment. I have often send messages to HIFA nevertheless, and I remember HIFA member Joseph Ana (Nigeria) has often commented 'What is the point of sending a message about a restricted-access paper?' He has a point, but at the same time there are reasons for doing so: many HIFA members do have access through their institutional subscription, including those LMIC institutions registered with HINARI. Also, by occasionally highlighting restricted-access papers this highlights the issue. It also raises a question about researchers' awareness of their right to also publish their preprint paper in an OA institutional repository. Most journals allow this (often with restrictions) but it seems that a lot of researchers do not take advantage of it.

Neil: HIFA does not have the funds to purchase subscriptions, but we have previously approached publishers to provide us with complementary personal access for my role in facilitating HIFA, and as a result I am grateful to The Lancet and The BMJ.

Neil: We look forward to hear how open access to research has helped you in *your* work, whether as a health professional, researcher or other role.

Relevance and reliability of open access content

Rabia: How do we ensure that quality and relevance move hand in hand, so that open access truly helps close the gap between evidence and impact?

Neil: If 'high-quality evidence' is open access, then I agree it is available to anyone who has an internet connection and, because open access allows reuse, it is also potentially available to those without an internet connection (for example as print copies). Open access also delivers 'low-quality evidence' (and lots of it).

Quality of evidence

Neil: What do we mean by 'high-quality evidence'? Back in 2004, the GRADE working group suggested the following definitions in grading the quality of the evidence:

'High = Further research is very unlikely to change our confidence in the estimate of effect.
Moderate = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low = Any estimate of effect is very uncertain.'
https://pmc.ncbi.nlm.nih.gov/articles/PMC428525/

Neil: Then in 2008 the same group proposed a different approach to the definition:

'In the GRADE approach to quality of evidence, randomised trials without important limitations constitute high quality evidence. Observational studies without special strengths or important limitations constitute low quality evidence. Limitations or special strengths can, however, modify the quality of the evidence.'
https://pmc.ncbi.nlm.nih.gov/articles/PMC2364804/#:~:text=In%20the%20GRA....

Neil: The 2008 approach is arguably in contradiction with the 2004 approach, because it is very unusual for a single randomised controlled trial ('high quality' 2008) to be so conclusive that 'further research is very unlikely to change our confidence in the estimate of effect' ('high quality' 2004).

Simon Lewin: In relation to your question on what do we mean by 'high quality evidence', I think for evidence users this should ideally be evidence syntheses that are relevant to their questions, well conducted, timely and that deliver findings in forms that can be understood, packaged (for instance, into frameworks to inform guidelines and other decisions) and acted on by a range of stakeholders. I would want to see the whole evidence pipeline being open access, but I think it particularly important for evidence synthesis products to be open access as these are critical components for informing decision making.

Examples of open access to research resources

PubMed Central

Neil: Thanks to Margaret Winker for her message just now about PubMed and PubMed Central. This is a reminder that PubMed Central is a very important benefit of open access publishing. 'PubMed Central (PMC) is a free digital repository that archives open access full-text scholarly articles that have been published in biomedical and life sciences journals... PubMed Central is distinct from PubMed. PubMed Central is a free digital archive of full articles, accessible to anyone from anywhere via a web browser (with varying provisions for reuse). Conversely, although PubMed is a searchable database of biomedical citations and abstracts, the full-text article resides elsewhere (in print or online, free or behind a subscriber paywall).' https://en.wikipedia.org/wiki/PubMed_Central

Neil: Can anyone say more about the use of PubMed Central as a tool for direct or indirect impact on health? I note from the NLM website that PubMed is used by about 3.5 million people every day, but cannot find figures specifically for PubMed Central. I would like to ask HIFA members: do you use PubMed Central in your work? What difference does it make? Can you give any examples?

Morbidity and Mortality Weekly Report

Neil: The Morbidity and Mortality Weekly Report (MMWR) is a series of epidemiological science periodicals published by the United States Centers for Disease Control and Prevention (CDC). It appears to be under threat.

Read in full: https://www.statnews.com/2025/10/21/cdc-mmwr-alternative-new-report-anno...

'The New England Journal of Medicine and the Center for Infectious Disease Research and Policy will begin publishing "public health alerts" in the coming month'. The alerts "will basically serve to be a way to convey the information that once was shared in the MMWR with all of us in a very timely way."

Neil: This action may well be necessary to meet information needs, which are currently on pause during the government shutdown (but which might be expected to resume). However, does it give the green light for policymakers to shut down MMWR? Also it is not clear whether the new service will be open access.

Indi Trehan: This move by NEJM Evidence taking up the mantle of the type of information traditionally published by MMWR is especially important given the unfortunate recent conversion of the ProMED service, published by the International Society for Infectious Diseases, to a paid model also.

Non-research OA resources (eg training materials, guidelines, health education materials)

Wikipedia

Tomas Rees: Another consideration is the impact of open access on public discourse. There is a recent paper (1) that found that OA articles are more likely to be cited in disputes ("edit wars") on Wikipedia. They conclude:

Tomas Rees: 'Our analysis shows that OA publications are significantly more likely to be involved in disputes, and that disputes concerning OA articles tend to emerge sooner after publication. This pattern can be explained by the increased accessibility of OA articles [Yang et al., 2024], which facilitates rapid dissemination and critical evaluation by a broader and more diverse editor base. These results extend existing literature on OA's role in enhancing visibility, readership, and scholarly engagement [Yang et al., 2024]. Furthermore, OA articles may disproportionately address emerging, interdisciplinary, or controversial topics, which naturally attract greater contestation and discussion. This is consistent with prior findings that disputes around contested content on Wikipedia often mirror broader societal controversies [Borra et al., 2015].' 1. Yang, P., Traag, V., Costas, R., & Colavizza, G. (2025). Contested Citations: The Role of Open Access Publications in Wikipedia's Scientific Disputes. https://arxiv.org/pdf/2510.14071

Neil: Wikpedia is itself a hugely important open access initiative and thrives on open access sources, including open access to peer-reviewed research.

Neil: Collectively, the open access movement is having a profound positive impact on the global evidence ecosystem.

Neil: The impact of open access to research on Wikipedia is a good example of an important indirect impact of open access to research. We have been discussing here on HIFA about examples where open access to research has led directly to better health care. But I suspect the indirect impacts are more important.

Afrihealth OptoNet

Uzo: OA supports capacity building within AHOA's network by providing training resources, guidelines, and health education materials to both professionals and communities. This enhances the organization's ability to deliver high-quality, locally relevant interventions, from disease prevention to health promotion campaigns. It also promotes transparency and accountability in health research, reinforcing trust with stakeholders, funders, and communities.

Week 2. What is your experience of OA as a healthcare professional/reader?

Neil: Can you describe a situation where (lack of) access to the full text of a paper has impacted on the care of a patient?

Positive impacts

Directory of Open Access Journals

Najeeb: OA is great. I have finished an online course on how to register a journal in the DOAJ (DOAJ.org).

Citations

Joseph: Researchers and clinicians, policymakers, and implementers should be able to access references (citations), but often these citations are not available because they are behind pay walls!

Supporting policy and practice

Uzo: My engagement with Open Access exemplifies how freely available knowledge can directly enhance healthcare practices, research, and health system improvements. My hands-on use of OA demonstrates a commitment to bridging global insights with local action, advancing healthcare quality, and fostering a more equitable and informed health community

Negative impacts

Epistemic impact

Chris Zielinski We should consider what new health literature is suddenly being made available as the cost barrier falls away. Is it mostly Western/Northern/rich-country literature describing actions and interventions requiring expensive equipment and medicines, trained staff and robust institutions, or is it information about locally relevant, appropriate treatments that are applicable in low-resource-settings? My question is deliberately framed in extremes, in order to illustrate the "epistemic injustice" noted in recent literature: the local is being swamped by the global, the traditional healers are being swept away without replacement by the chattering of well-paid allopathic professionals, the inexpensive local cures are being challenged by unaffordable, unattainable medicines that work just as well or badly.

Chris Z: Cons include:

- Opens the floodgates to outside resources, swamping local literature (>80% of it is in English, almost nothing in local languages)
- Makes it harder to find literature on locally appropriate solutions
- Forces an industrialised-country perspective on the developing world ("epistemic injustice")
- Usually refers to medical practices requiring expensive equipment, pharmaceuticals and care regimes..
- APCs: epistemological discrimination, when the subject matter is not of a type that attracts research sponsors (e.g., ethics, knowledge management, intellectual property, ...)
- APCs: social/ethical discrimination, when applicants for APC waivers have to justify their inability to pay
- Provides unremunerated training materials for AI chatbots;
- Encourages disputes and controversies;
- Can lead to a decline in peer review; Research that is not locally relevant can result in inappropriate local policies and consequently failures in practice

Access to subscription journals

Indi Trehan: As someone with the privilege of working in universities in high-income countries, I've virtually never been unable to access a subscription-only article. The universities and hospitals subscribe to large numbers of journals, usually through package deals with publishers which do indeed have the benefit of allowing smaller less-profitable journals to survive. On those occasions where an article or journal was not available, our libraries can generally get access to virtually any article (or book) by borrowing from a partner university through an inter-library loan. This may take a few extra days for an article but access is almost always available, so ultimately it hasn't been a real problem yet, at least for large American universities as far as I have seen.

Week 3. What is your experience of OA as a researcher/author?

Introduction

Joanna: - How often do healthcare professionals participate as authors on research articles?
- Do healthcare professionals consider OA publishing as a driving factor when selecting

journals?
- How would you rate healthcare professionals understanding of Creative Commons licences?

Joanna: We are especially interested to hear actual practical examples and observations. For example, can you describe a situation where a healthcare professional made a conscious decision to publish with or without OA, including the reasons behind the decision?

Neil: One obvious benefit is that your research is accessible to anyone with an internet connection. Can you say whether/how this has benefited your work? For example, has it resulted in your research being read by more people? Has this in turn led to more contacts and more opportunities? Do you think it has made a difference to the number of times that your research has been cited by others? If you have published research in subscription-based journals and open-access journals, what were the differences in your experience?

Julie Reza: I'm sure there are others like me who'd appreciate a simple listing of the "carrots" (incentives) and "sticks" (disincentives) for researchers to publish in open access journals - especially when the research topic is of importance to low- and middle-income countries.

Positive impacts

General comments

Uzodinma Adirieje: In essence, my hands-on experience with Open Access epitomizes its critical role in advancing research quality, visibility, and impact. OA has empowered me to conduct meaningful studies, share knowledge globally, and contribute to evidence-driven healthcare improvements, reinforcing my commitment to bridging science, policy, and practice for better health outcomes in Africa and beyond.

Increasing the reach and impact of research

Uzo: Beyond personal use, I actively contribute to the OA ecosystem by publishing my own research and programme reports in open-access platforms. This ensures that findings from African healthcare settings reach a global audience, support knowledge exchange and enable other professionals to replicate successful interventions. I therefore view OA not only as a professional tool but as a means to democratize healthcare knowledge, reduce inequities in information access, and promote evidence-driven solutions across our communities.

Uzo: As an author, one publishes his research in open-access journals and platforms, ensuring that our work reaches a broad and diverse audience. By making my studies and writings freely available, I have contributed to the democratization of knowledge, allowing practitioners, policymakers, and fellow researchers—particularly in resource-limited settings—to apply insights to real-world healthcare challenges. Several of my OA articles have informed policy development, guided programme implementation, and fostered innovations in community health interventions across Africa and global South.

Chris Z: Open Access papers are read, and therefore cited, far more often than papers in non-OA subscription journals

Najeeb: OA allows more citations (counting). So what? There is a huge gap between what is called "researchers" in the academia and "decision-makers". That gap makes researchers look into the Internet (for OA) journals to cite.

Conception and implementation of research

Uzo: Throughout my career, OA has provided me with extensive access to a wealth of scientific literature, global health reports, and peer-reviewed studies, enabling me to conduct timely and comprehensive research. This access is especially valuable in multi-country studies, systematic reviews, and health systems analyses, where up-to-date evidence is critical for producing robust and relevant findings.

Promoting research collaboration

Uzo: OA has also facilitated collaboration in my work, enabling me to work closely with international researchers, share data, and co-author publications that bridge local and global health perspectives. I actively engage in OA networks, advocating for wider adoption of open publishing practices to promote equity in knowledge access, strengthen research capacity, and accelerate the translation of evidence into practice.

Positive experience with preprints

David Cawthorpe: There is a pre-print service that is free with minimal cost peer-review.

https://www.qeios.com/

My last paper got an excellent review at the preprint level for free and some papers I have published with them have had seven reviews. They also had reasonable indexing, which will likely become more important with the current state of the US national library and PubMed!

Negative impacts: APCs

Chris Zielinski: a. Do APCs inhibit science? Well, take the case of individual researchers – researchers not affiliated to an academic institution willing to pay for their publishing, researchers that don't work on funded projects with publishing budgets. Such researchers are clearly inhibited from publishing. Researchers in resource-poor environments are similarly inhibited. Even though many publishers will waive APCs for such authors, there can be a reluctance to being obliged to turn out your pockets to show you cannot pay. There is no uniformity in the waiver system.

Chris Zielinski: b. Does the inability to pay the APC raise the acceptance barrier? Does your paper have to be considered to be better than run-of-the-mill if you are getting a waiver?

Chris Zielinski: c. Who publishes in the journals with the highest APCs? Is it the best authors or those from the wealthiest universities?

APC waivers

Joseph: Groups like HINARI and some OA journals that offer targeted free access, in the form of waivers, or reduced Author Pays Charges (APC) have helped, but if a researcher is from a LLMIC country he/she may face another unique challenge: if the country works to increase its GDP, the researchers/authors/institutions suddenly cannot access HINARI, e.g. Nigeria. It appears that it has become a 'crime' for a country to make economic progress, even if notionally, because the lag-time that takes place between the GDP going up and people, including researchers, seeing the money in their wallets is not taken into account, as the country is excluded from accessing OA (e.g. HINARI) before the lag-time is over.

Negative impacts

Predatory journals

Chris Zielinski: Predatory publishers require little staff, no investment apart from a rudimentary website, and a batch of form letters. Such publishers will publish anything because they don't care about the quality of what they publish. They have no incentive to care. Consequently, predatory publishers muddy the waters by producing poor, discredited science. Unfortunately, this is something which Open Access enables.

Chris Z: Just as an illustration of how predatory journals use Open Access in their business, I received yesterday "a cordial call for paper invitation" from the "Journal of Clinical and Medical Images, Case Reports with ISSN 2771-019X and Impact Factor 2.1." In the subject line it said "Now Accepting Submissions – No Article Processing Fee, Only DOI Fee".

Chris Z: This was new to me – a Digital Object Identifier (DOI) fee? As one of the elected founder members of the International DOI Foundation back in 1999, I knew perfectly well that there is no charge for a DOI if you publish in a journal (the cost to the publisher is a negligible $1 per DOI and to a pre-print repository $0.15 per DOI).

Chris Z: So I wrote to the journal editor to ask "How much is the DOI fee?" and got the following reply: "Since it is an invited submission, we charge 220 USD only towards the manuscript DOI expenses." 220 USD!!! And when I asked if it was possible to publish without the DOI, I was told no, since "DOI is a digital object identifier of your work and gives international visibility." At least the last part was correct. This was clearly an Article Processing Charge (APC) in disguise. DOIs are certainly valuable, but they are free to authors.

Chris Z: This kind of blatant, unscrupulous financial twisting is injurious to authors, to the good name of publishers, and to the resulting quality of science. We need to find some method to shut down such abusers of trust. Open Access has this unfortunate downside of facilitating predatory journals.

Publisher-researcher relations

Gauri Divan: In my understanding the process of OA predicates
1. The data is collected by the research team
2. The research team has to pay for the open access
3. Open access implies that the publication technically belongs to the publishers

Lack of incentive for researchers

Julie Reza: If research tenure at an academic institution is based on impact, inevitably researchers will want to publish in a so-called "high impact" journal, with OA a secondary consideration.

Negative perceptions of OA journals

Neil: On HIFA we have previously discussed how some senior academics have a bias against open access journals in terms of quality. This has pushed some researchers towards subscription journals. Is this still a problem or is it resolved?

Joseph: "University Appointment and Promotion panels (A&P) were discriminating against, and stigmatising OA publications, in their procedures: claiming that OA was inferior and apportioning higher scores/grades to papers carried in the traditional model publishing print journals against OA journals papers, even if the OA journals fulfilled all the accepted international (and local) parameters and indicators for quality publishing and papers. Across the LLMICs, as researchers and authors seek to publish in proper, high impact, visible journals to disseminate their work such stigmatisation is a big handicap.”

Julie Reza: Perceptions about "impact" and "research quality", publication costs, predatory journals, and confusion about types of OA (hybrid etc) may discourage OA publication.

Neil: The research fellows in this study (based in New York City) 'expressed hesitation to publish OA related to confusion surrounding legitimate OA and predatory publications and frustration with APCs [author processing charges]'. I look forward to hear the experience of HIFA members as researchers/authors. What are the main incentives and disincentives for you to publish your research open access? How could these be optimised? CITATION: Publishing habits and perceptions of open access publishing and public access amongst clinical and research fellows. Robin O’Hanlon et al. J Med Libr Assoc. 2020 Jan 1;108(1):47–58. doi: 10.5195/jmla.2020.751. https://pmc.ncbi.nlm.nih.gov/articles/PMC6919981/

Week 4. How would you design an OA system that retains the benefits but fixes the problems of the current OA system?

Introduction

Indi: How would YOU design an OA system that retains the benefits -- and fixes the problems! -- of the current OA system? We are eager to hear creative ideas. Build upon what's worked. Throw out what hasn't. Be flexible, be innovative. By pooling our collective experiences together, hopefully we can design a system that will lead to better access to health information for all!

What different approaches can we identify and what are their strengths and weaknesses?

Neil: I would urge us to look at the OA system not in isolation but as an integral part of the wider global evidence ecosystem. www.hifa.org/about-hifa The purpose of the global evidence ecosystem, and those who work within it, is to meet the information needs of health professionals, the general public, policymakers and others.

Neil: The global evidence ecosystem can be described as having six components:
1. Generate evidence
2. Publish evidence
3. Synthesise evidence
4. Repackage evidence
5. Avail evidence
6. Apply evidence.

Neil: An ideal OA system is not one that necessarily benefits researchers, nor even readers. It is one that strengthens the global evidence ecosystem as a whole.

Neil: An ideal OA system serves to build a world where every person has access to the reliable, relevant healthcare inforamtion they need to protect their own health and the health of others. The translation of evidence into policy and practice is paramount. OA is an enabler of knowledge translation. But it has limitations.

Preprints

Suranjana Banik: In genomics and related fields, preprints have already become a valuable tool for rapid data sharing and collaboration ... The move away from APC-funded journals also addresses a persistent inequity in academic publishing, allowing researchers from low- and middle-income countries to disseminate their work without prohibitive costs.

Suranjana Banik: From a healthcare standpoint, it is vital that preprints are interpreted responsibly. For clinicians, especially those in evidence-based fields, preprints can offer early insights but should never be the sole basis for clinical decision-making.

Neil: 'Pre-prints'. There are pros and cons with pre-prints.

Pros: The main pro is rapid dissemination of results without the delay of journal peer review. This may be important for fields that are rapidly developing, and is perhaps especially useful to promote efficient exchange among researchers. The usefulness for end-users of research is less clear.

Cons: Pre-prints are less reliable than journal papers that have undergone peer review. They are more likely to contain errors or methodological flaws. The authors' interpretation of the findings is more likely to be biased. Pre-prints that have sensational findings are likely to add to dangerous misinformation. For example, pre-prints contributed to misinformation about the effectiveness of hydroxychloroquine to treat COVID-19.

Neil: It is unclear whether and how frontline healthcare providers and patients use pre-prints to inform their health decisions. And, if they do, whether the benefits outweigh the risks. If I were a frontline healthcare provider, I would almost never use pre-prints. I would rely primarily on the work of others to synthesise and repackage evidence. I look forward to comments on this.

Plan U

Chris Zielinski: Velterop advocates for the adoption of the so-called Plan U (for “Universal OA”) – funders should mandate that research results must always be posted on an openly accessible preprint server before they are submitted to a journal. That way, the communication of science results would not be confused with the scientists' efforts to enhance their reputations through publication in "high-impact" journals."

APCs

Funders should stop paying APCs

Lacey Lagrone:- The needs of the patient/provider (i.e. access to information) and the publishers (i.e. financial gain) are not aligned, and this systematically and structurally inhibits the flow of evidence into practice. There are 'outcome positive partners' in the space, including, for example, pharmaceutical companies that make products which are generic, time-sensitive, affordable, and according to the highest level of evidence life-saving (e.g. TXA, alteplase). The current system is organized around enormous financial gain for publishers (some of which have a higher profit margin than any industry besides the entertainment industry), and 'every system is perfectly designed to get the results it gets'. - Given the current less than ideal options, and following the lead of a global Open Access champion (Gates' Ashley Farley), I favor publishing pre-prints and then in an APC-free journal, so as not to financially bolster a broken system.

Neil: 'So as not to financially bolster a broken system'. I would agree that the current system can be improved, but I wouldn't say the whole system is broken and that it needs to be swept aside. I would suggest to look at what are the biggest problems with OA publishing, and discuss how to address them. We are currently looking at the problem of inflated APCs, which I think is relatively straightforward to address - what other problems of the current system do we need to look at?

Gates Open Access Policy

'We are stopping support for APCs... this is a critical step in achieving more equitable open access business models moving forward' [Neil: but what will be the impact on the global evidence ecosystem? on the availability or reliable healthcare information? - below]

https://blogs.lse.ac.uk/impactofsocialsciences/2024/04/09/is-the-bill-and-melinda-gates-foundations-new-oa-policy-the-start-of-a-shift-towards-preprints/

'The Bill and Melinda Gates Foundation (the second largest charitable foundation in the world) recently announced a new open access (OA) policy. They will require articles resulting from work they fund to be posted as preprints and no longer cover fees for their publication in academic journals. This shift in focus from the peer-reviewed journal article to preprints aligns with a proposal called Plan U and marks a significant policy change for a major funder. It comes at a time of much discussion about the future of academic publishing, as journal peer review is coming under increased scrutiny and some are questioning whether it's necessary at all...

'The academic community has been arguing about OA for almost three decades. Few dispute that articles reporting research findings should ideally be freely accessible to anyone. How exactly to achieve this, in particular how OA should be paid for, has been hotly debated...

'In the model favoured by commercial journal publishers and, until recently, many funders and OA advocates, publication costs are covered by article processing charges (APCs) levied on the authors. But these merely shift the access barrier from readers to authors...

'A solution to the access problem has however been staring at us in the face for years: preprints, draft versions of articles that have yet to go through the expensive and time-consuming journal peer review process...'

Potential consequences of stopping APCs

Neil: Gates Foundation says that stopping payment of APCs would lead to 'achieving more equitable open access business models moving forward' But what will be the impact on the global evidence ecosystem? on the availability or reliable healthcare information?

Neil: Publishing of research (including editing and peer review) is one of the six critical components of the global evidence ecosystem [https://www.hifa.org/about-hifa]. If we mess with this component, we risk weakening the overall ecosystem and reducing the availability and use of reliable healthcare information. I agree that it is important to explore new models, including the potential of preprints and open peer review, and the increasing role of AI. However, in the meantime I would advocate for funders to take responsibility for *reasonable* APC costs as a budget line in the research proposal.

Neil: The Gates Foundation has a clear policy on APCs - they will stop paying them altogether. The question is whether this will increase or decrease the dissemination and application of research evidence, in the short- and long-term, and whether it will thereby improve or worsen health outcomes.

Neil: I am concerned about the decision by the Gates Foundation to stop funding APCs. They say that 'By discontinuing to support Open Access fees, we can work to address inequities in current publishing models and reinvest the funds elsewhere'. Instead they are mandating researchers to publish preprints. I am not convinced by their arguments and I believe that it would be a retrograde step for funders to stop paying APCs. APCs represent a tiny fraction of the total costs of research, and the journal publishing process is an indispensable part of knowledge translation. I suggest that such action by Gates and others will lead to fragmentation of research outputs, out-of-pocket costs to researchers, weakening of the overall global evidence ecosystem, reduced effectiveness of knowledge translation and adverse health outcomes.

Neil: We should not accidentally throw away something important just to get rid of something we don't like.

Funders should cap APCs

Neil: Since the 1990s, when open access was really taking off, I have always assumed that the funders of research would take responsibility for author processing charges. It is in the interests of research funders that the research is published and disseminated, in a format that is most trustworthy and useful for readers. This added value has traditionally been provided by the editorial and peer review processes of academic journals. APCs typically represent a very small percentage of the total costs of research.

Neil: How can we design a better system? I would suggest an evolution in the current system rather than a revolution, retaining the benefits and fixing the problems. It seems to me that the biggest problem is unaffordable APCs. I look forward to hear about other problems that need to be addressed.

Neil: I value highly the contribution of journals in the global evidence ecosystem. They represent component 2 - Publish evidence - one of the six pillars of the ecosystem. They serve to make a preliminary assessment of the quality and reliability of a research manuscript; to copy-edit and proofread the paper through its stages; to manage the peer-review process; and finally to format and deliver the final definitive paper in a way that best meets the needs of readers.

Neil: I would engage rather than exclude journal publishers. Not to do so is to throw away something important just to get rid of something we don't like (unaffordable APCs).

Neil: For me, a better system would be one that is similar to what we already have, but where funders accept the responsibility for paying APCs as (a very small) part of the research budget. We would look at different approaches to ensure that the cost of APCs reflects the actual cost of article processing. The simplest way to do this would be to assess these costs and cap the APC budget line accordingly. The cap would be decided (and made public) by the funder, and would take into account, for example, the cost of the overall research proposal.

Neil: There are lots of other ways in which the publication of health research can evolve, including adoption of artificial intelligence (which should further reduce APCs).

Neil: For me, it would be simple - and more flexible - for funders to cap APCs. In the above example, the budget line for APC might be $2,000 rather than $7,000 (depending on the funder's stated APC policy). Even for a million-dollar project this would represent only 0.2% of the total cost of the research. 0.2% to procure editorial expertise, peer review and open access of a final definitive publication.

Neil: Why have [Gates] come to this decision? I have spoken to some who are in favour of the policy, and a key argument is that some OA publishers have been profiteering from the APC system. I agree. In my view, the obvious way forward is not to exclude publishers entirely, but to call them out and negotiate. It would seem feasible for funders and publishers to agree *reasonable* APC costs, taking into account both the size of the research budget and the amount of work required by the publisher. If necessary, funders could cap the APC budget line in research proposals, or they could instead have a broader 'dissemination' budget line which would give authors choice on where and how to spend on the dissemination of their research.

Other issues to consider with APCs

Indi: My personal opinion is indeed that APCs should be covered by funders, but it is very challenging for us as researchers to plan an accurate line-item in grants for APC fees. We can't accurately predict years ahead of time how much APCs will be (as prices are always going up), whether we will even publish something open access, how many papers will come out of a study, etc. Another challenge is that grant funding has an end-date whereas publications often continue for months to years after the end of the funding so money may not be available.

Neil: For me, it seems relatively straightforward to estimate an APC. Yes, it is impossible to predict exactly what the costs will be at the end of the project (which may be years ahead) as this will depend on many factors. As we have discussed, funders can have clear policies on APCs.

Indi: I think another dimension would be to consider whether Gates and other funders would be willing to reconsider perhaps funding APCs for non-profit publishers such as PLOS or society journals, rather than for-profit publishers.

Preprints

Neil: What is a preprint? 'In academic publishing, a preprint is a version of a scholarly or scientific paper that precedes formal peer review and publication in a peer-reviewed scholarly or scientific journal.' Wikipedia

Quoting from Gates OA policy: ' [Preprints are] also journal agnostic which means the research can be evaluated in its own merit and not the journal in which it's published' [Neil: a key function of journals is to evaluate papers on their own merit]

Quoting from Gates OA policy: '[Preprints] allows for the research community to quickly respond and address any issues [Neil: if we have a precipitation of preprints, will this help the research community to 'respond quickly'?]

Quoting from Gates OA policy: 'Which will thus make it more trustworthy' [Neil: will we trust preprints more than journal articles?]

Problems of preprints

Neil: A potential downside to Plan U is that it may drive a substantial increase in poor-quality research. This could be mitigated by editorial screening processes (perhaps using AI to detect spam, plagiarism etc). Also, it will be essential for all papers to be clearly labelled in terms of whether or not they have been through peer review (and the process this peer review comprises). The preprint does not seek to replace peer review, but may lead to different models of subsequent review as compared with the current dominant journal model of a few peer reviewers to assess the paper. Whether or not Plan U would lead to better informed healthcare professionals is debatable. It can be argued that a healthcare professional should seldom if ever base a clinical decision on a single peer-reviewed research paper. This warning would apply even more so to a preprint that has not been peer reviewed. Another consideration is the impact on journal publishing and how the relation between preprints and journals would evolve. Any thoughts?

Neil: Suranjana Banik says "In genomics and related fields, preprints have already become a valuable tool for rapid data sharing and collaboration… From a healthcare standpoint, it is vital that preprints are interpreted responsibly...

Neil: I agree. I understand that pre-prints originated as a method for rapid exchange of results among relatively small groups of specialist researchers, and perhaps this role remains the most important? Over time, proponents of pre-prints appear to be embracing not only specialist researchers, but frontline healthcare providers, the general public, policymakers and even the media in a much wider target audience. This ramps up the risks of pre-prints.

Neil: One article I read on this topic (although from a PubMed journal I had not heard of before) concluded: 'While preprints offer many benefits, the misuse of AI technologies like ChatGPT only adds to the great risks associated with their use. Therefore, it is critical that all parties involved in medical research take a more cautious and responsible approach to the use of preprints. We suggest a complete reconsideration to the framework for publishing preprint articles. By doing so, we could ensure medical research is conducted and shared while benefiting society and minimizing the risks of "fake science" arising from the use of preprints in scientific publications.'

Systems-thinking approach

Neil: Rwaida Salem (United States) wrote: "I believe the solution to translating evidence into practice requires a whole knowledge ecosystem approach in which different actors work together to do their part."

Neil: Yes, indeed this is the rationale behind HIFA's existence: first, that the majority of the world's population does not have access to relevant, reliable healthcare information, and this is a major contributor to avoidable death and suffering; second, that meeting people's information needs depends on the integrity of the global evidence ecosystem. HIFA was established to address three intrinsic weaknesses in the ecosystem: poor communication among the stakeholders; poor understanding of information needs and how to meet them; and poor advocacy associated with lack of political and financial commitment to universal access to reliable healthcare infoaamtion. We have made some progress through our forums, projects and advocacy programme, but there is much more yet to be achieved. You can read more about our approach here: https://www.hifa.org/about-hifa

What do publishers think?

Neil: I would like to invite HIFA members to share any experience they have with sustaining open access journals.

Neil: Second, is there potential for global health journals (eg GHSP, The Lancet, The Lancet Global Health, BMJ Global Health, WHO Bulletin) to collaborate and build solidarity, particularly in this era of financial cuts to global health by the US and UK governments? We have representatives of all these journals on HIFA and we would welcome their inputs. This is also an area that WAME (World Association of Medical Editors) might be able to support. HIFA Steering Group member Chris Zielinski is currently President of WAME and may like to comment.

Commercial agreements between academic institutions and publishers

Indi Trehan: The cost of these university packages continues to increase and much has been written about how difficult it is for university library budgets to keep supporting these, which is especially ironic since it is often the same university researchers that are producing the content that goes into those journals, research that is often publicly funded itself. A vicious circle that has led to some high-profile disagreements between universities and publishers. It is not clear how these conflicts will play out, but one approach here has been for the university to set up agreements with certain publishers for the university to pay for their researchers' open-access fees instead of, or in addition to, paying for the subscription costs to the journals.

APC-free journals

Neil: 'APC-free journals'. Open-access journals that are able to deliver quality editorial and peer review without APCs are commendable. I invite HIFA members to describe examples of such journals. I understand that many of these are small enterprises, perhaps funded by their academic institution. I think all the major OA journals - those with the highest impact funders - rely on APCs?

Neil: I would question whether APC-free is better than APC-affordable, particularly for the larger journals. I would argue that research funders should pay APCs, and that these should reflect the actual cost of processing rather than the current exploitative stance that is currently used by some journals. This can be promoted by capping APCs (and perhaps other approaches?).

Other APC models

Uzo: Global OA Fund: Supported by governments, philanthropic foundations, and international health organizations, covering APCs for researchers without institutional backing.

Uzo: Sliding-Scale APCs: Authors with institutional or private funding may contribute proportionally.

Uzo: Institutional Memberships: Universities and organizations pay annual contributions that subsidize publications.

Governance

Uzo: Community Governance. Managed by an international consortium of researchers, practitioners, and policymakers to ensure accountability, transparency, and adaptability.

Week 5. Open discussion and next steps.

Other issues.

ICTs and AI

Margaret: b. How can journals in LMICs and other journals with few resources have access to tools to screen manuscripts for potential scientific misconduct and other issues, including plagiarism, image manipulation, papermills, and AI-generated content that authors have not identified as such? Such tools are available to many journals with large publishers, but these publishers don't work for, or with, many LMIC journals for a number of reasons, and journals in LMICs often cannot afford to pay for the tools.

Lacey Lagrone - Just like the development of the internet, the introduction of genAI holds huge promise, and huge risk, and its use will likely bend towards profit-generation for industries except where persons whose incentives are aligned with the patient choose to take an active role in defining how/where/when genAI is used in the evidence to practice continuum. In other words, it will be new tech, in an old way (the old way being inequity).

Open data

Simon Lewin: Ensuring that research evidence is available open access was an important point of discussion within the Evidence Synthesis Infrastructure Collaborative (ESIC) deliberations and part of the ESIC roadmap is looking at how to provide 'open reusable data' that can be incorporated into workflows for decision support products such as systematic reviews and evidence briefs for policymaking. Linked to this, ESIC also recommended that 'Knowledge Hubs' to established to 'offer streamlined access to multiple ESIC partner databases for evidence producers and intermediaries from diverse disciplines'. This is described in more detail in the ESIC Roadmap that is available
here: https://evidencesynthesis.atlassian.net/wiki/spaces/ESE/pages/243138561/...

Neil: CITATION: Open science must include effective results dissemination to study participants [uncorrected proof]
Ka Hin Tai et al. Published: October 15, 2025
https://doi.org/10.1371/journal.pmed.1004780

SUMMARY: Open science often centers around publications and data transparency. We highlight how and why disseminating results to study participants is essential for maximizing the values and benefits of open science...

Language

Najeeb: The assumption is that ALL can speak and write in English. This is a wrong assumption. Not all health science scientists in LMICs master English as native speakers. Look at the Chinese scientists, Gulf Countries or any other LMIC country when scientists speak English (or they think they speak English) the money is there to pay for OA as processing charges. I was really shocked to learn in one Arab country, (I am ready to say which country) the government forced the scientists to publish in English.

Neil: Understandability is also dependent on language. HIFA has argued that the abstracts (at the very least) of all health research papers should be available in the language of the country/ies where they are most likely to be applied. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30384-X/fulltext

Case study: GHSP

Ruwaida Salem: I can offer my perspective, as the Managing Editor of a diamond OA journal, Global Health: Science and Practice (GHSP), on what an OA journal might be able to contribute in this ecosystem. Briefly, GHSP is published by the Johns Hopkins Center for Communication Programs (CCP) and in its 12th year of publication. Up until February of this year, we were able to offer our publication free of charge to both readers and authors with funding from the U.S. Evolution of the current system

Agency for International Development (USAID). The loss of USAID support forced us to temporarily halt our operations, but CCP relaunched the journal in August and is committed to exploring ways to sustain GHSP without imposing fees on authors or readers. (See https://www.ghspjournal.org/content/13/1/e2400608)

Ruwaida Salem: From the outset, GHSP's goal was to facilitate the use of valuable knowledge and experience from public health program implementation by other practitioners to maximize program investments, avoid reinventing the wheel, and ensure positive health impact. We do this through a number of ways:

Ruwaida Salem: - First and foremost, GHSP eliminates barriers to sharing and accessing knowledge in scholarly publications—with no author fees or reader fees. Running a journal takes money though, and the business model for most OA journals is to charge article processing fees to authors. We believe this creates many inequities and problems, one of which is a tendency for OA journals to focus on the quantity of articles published (to bring in sufficient revenue) rather than the quality of articles. Support from donors, philanthropies, or others for community-owned diamond OA journals is critical for sustaining high-quality publications that focus on sharing thoughtful and useful knowledge that readers, in turn, are more likely to put into use.

Ruwaida Salem: - We are flexible in our article format to make the content more practical and accessible. We also use various formatting and synthesis techniques to further distill key points of articles, such as a Key Findings and Implications box at the beginning of articles and call-outs in the sidebar throughout the articles.

Ruwaida Salem: - We have adapted published articles into different formats to better reach different audiences, including practitioners at the community level. Admittedly, we haven't been able to do as much of this as we want to due to limited resources, and we welcome opportunities to invest even more in this.

Ruwaida Salem: - Last but not least, we work in partnership with our authors to ensure the key messages of articles are shared with practitioners in the countries of focus of the articles. For example, in our author reflexivity checklist (https://www.ghspjournal.org/content/instructions-authors#Reflexivity), we ask authors to have a plan in place to share their findings with country stakeholders.

Ruwaida Salem: I would love to hear other ideas on what more OA journals, like GHSP, can do to help translate evidence into practice!

Notes

Neil: From Evidence to Impact: Launch of the Research into Policy Toolkit
Date & time: 13 November 2025 | 13:00–14:30 UTC

Chris Zielinski: “Who Owns Our Knowledge? The Future of Equitable Open Access”, co-hosted by IGI Global Scientific Publishing, eContent Pro International Press, and the Open Access Publishing Association (OAPA), and sponsored by the Open Science Education Institute (OSEI).