

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

From 13 October to 14 November 2025 HIFA hosted an in-depth discussion on healthcare professionals' experiences and perceptions of open access publishing, sponsored by Oxford PharmaGenesis

Details here: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare-professionals%E2%80%99-experiences-and-perceptions-open>

There were 130 messages from 25 participants in 12 countries (Australia, Cameroon, Canada, Honduras, India, Jordan, Nigeria, Norway, Switzerland, Tanzania, UK, US).

This document includes all the messages in full. To review other outputs see: <https://www.hifa.org/projects/open-access>

Open Access (1) Please forward this message to your networks and contacts!

4 October, 2025

Dear HIFA colleagues,

Please forward this message to your networks and contacts as widely as possible. We aim to welcome 100 new members in the coming days.

HIFA announces a deep-dive discussion on healthcare professionals' experiences and perceptions of open access publishing, starting 13 October 2025

<https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

Join HIFA today (free) to take part in this global discussion! www.hifa.org/join

We shall explore open access issues in depth here on the HIFA forum. Here are some questions to help guide the conversation:

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

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

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

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

Week 5. Open discussion and next steps.

We shall focus mainly on peer-reviewed academic research papers, which are mostly published in biomedical research journals. The discussion will be global, including a focus on low- and middle-income countries, reflecting the global distribution of the HIFA membership (20,000 members in 180 countries).

We seek input from all stakeholders in the global evidence ecosystem (1 researchers, 2 journal publishers, 3 systematic reviewers, 4 publishers of content for end-users, 5 library and information professionals, and 6 healthcare professionals, among others).

The outputs will be published in manuscript form and presented at publisher and medical communications congresses, for example, the Annual Meeting of the International Society of Medical Publication Professionals (Washington DC, April 2026) and will help guide next steps to maximise the benefits of open access for better health.

Acknowledgement

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

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Open Access (2) Welcome to our deep-dive discussion on open access publishing, starts 13 October 2025

9 October, 2025

Dear HIFA colleagues,

Welcome to our deep-dive discussion on healthcare professionals' experiences and perceptions of open access publishing. The discussion officially starts on 13 October 2025, but we welcome your questions, comments and contributions from TODAY.

We propose the following guiding questions:

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.

In our first week (13-20 October) we shall address Q1, and so on for each week. However, please note that ANY question can be addressed at any time. Furthermore, we welcome ANY contributions relating to other aspects of open access. The questions are just a guide.

Let's take a look at Q1: WHAT IS THE IMPACT OF OPEN ACCESS ON HEALTH CARE?

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

There are also potential INDIRECT impacts on health care. 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. On the other hand, those responsible for systematic reviews are typically able to access content behind paywalls thanks to their institutional subscriptions.

We look forward especially to hearing your experience and views on open access, wherever you live and work (HIFA has 20,000 members in 180 countries), and in whatever capacity (health worker, researchers, patient, publisher...)

Meanwhile, please forward this message to your contacts and networks and invite people to join us www.hifa.org/join The more new members we welcome, the richer will be our discussion.

You can point them to our news page:

<https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

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

Best wishes, Neil

On behalf of the HIFA Open Access working group (comprising representatives of our sponsor Oxford PharmaGenesis and HIFA volunteers: <https://www.hifa.org/projects/open-access>)

HIFA profile: Neil Pakenham-Walsh...

Open access (3) Looking forward to your contributions

9 October, 2025

Dear HIFA colleagues,

I look forward to your engagement with the upcoming discussion on open access, officially starting 13 October.

We are grateful to Oxford PharmaGenesis for sponsoring this project. We are dependent on sponsored projects to provide the income we need to maintain and develop HIFA. Such projects account for more than two-thirds of our total income.

Here again are the guiding questions:

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

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

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

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

the current OA system?

Week 5. Open discussion and next steps.

The best way for you to support this project is by sending an email (or several!) to hifa@hifaforums.org - we look forward to your contributions. The more contributions we have, the richer will be our discussion.

You are welcome to comment on any of the above questions at any time.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open Access (4) Introduction: Indi Trehan, United States

9 October, 2025

[Re: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>]

Hi Neil and the HIFA community,

As a researcher in child nutrition, pediatrician, advocate, and someone who works closely with policymakers, I am greatly looking forward to this discussion so we can all work together to improve open access publishing for all involved.

cheers,

indi

HIFA profile: Indi Trehan is a physician-scientist and academic researcher based in Seattle, United States. He is a professor of paediatrics at Seattle Children's Hospital; adjunct professor of global health and epidemiology at University of Washington; investigator at UW Global Center for Integrated Health of Women, Adolescents, and Children; and investigator at Seattle Children's Research Institute Center for Clinical and Translational Research. He has published in many different journals, some open, some hybrid, some closed. He has run into the various issues with trying to get funding for open publishing access. He is also an editor at multiple journals and has mentored many junior researchers in both HICs and LMICs on how to navigate open access issues. He is a member of the HIFA Project on Open Access. <https://www.hifa.org/support/members/indi> indi AT alum.berkeley.edu

Open Access (5) Introduction: Indi Trehan, United States (2) Introducing the Open Access project working group

9 October, 2025

Many thanks Indi,

As mentioned in his HIFA profile, Indi is a volunteer on the HIFA Open Access project working group, along with Chris Winchester and Joanna Donnelly (both representing our sponsor Oxford PharmaGenesis), Lacey Lagrone (United States), Rabia Khaji (Tanzania), Virginia Barbour (Australia) and myself. You can see our profiles here: <https://www.hifa.org/projects/open-access>

While we were discussing which questions to ask, Indi proposed Question 4: How would you design an OA system that retains the benefits but fixes the problems of the current OA system? We're very much looking forward to hear your views on this.

Here again are the guiding questions for our discussion:

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

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

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

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

Week 5. Open discussion and next steps.

Feel free to comment on any aspect of open access at any time.

Invite your contacts and networks to join us: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Open Access (6) My Expectations from our deep-dive discussion on open access publishing, starts 13 October 2025

10 October, 2025

[*Note from HIFA moderator (NPW): Thank you Dr Adirieje. This is very helpful and it's a great idea to share expectations. I encourage other HIFA members to do the same today and over the weekend. Email: hifa@hifaforums.org]

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.

Uzodinma

Dr. Uzodinma Adirieje, DDP, CMC, CMTF, FIMC, FIMS, FNAE, FASI, FSEE, FAHOA, FICSA
<<https://druzoadiriejefoundation.blogspot.com/2024/07/cv-of-dr-uzodinma-a...>

Health Economist; Certified Evaluation and Projects/Programmes Management Consultant; Conferences and Workshops Organizing Expert; Researcher; Health/Development, Climate Change/Biodiversity and Human Rights Advocate; Facilitator/Trainer; Blogger; Writer/Columnist

CEO and Permanent Representative to the United Nations,

Afrihealth Optonet Association (AHOA) - CSOs Global Network and Think-tank for Health, Climate Actions and Development (Winner of the SDG 3 – Good Health and Wellbeing Champion Award).

<<https://afrihealthcsos.blogspot.com/2024/03/about-afrihealth-optonet-ass...>

National Coordinator,

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<<https://web.facebook.com/groups/430841322740151/>>Email: afrihealthoptonet2gmail.com, uzodinma.adirieje@afrihealthcsos.org

X (Twitter):

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@afrihealthcsosInstagram: @druzoadirieje;

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HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton@yahoo.com

Open access (7) Directory of Open Access Journals (DOAJ)

10 October, 2025

OA is great. I have finished an online course on how to register a journal in the DOAJ (DOAJ.org). It is a fantastic course I encourage all of us to enroll in that course. It's online and gives a full description via PPPs and videos to OA and many other topics to register a journal.

With kind regards

Najeeb Al-Shorbaji, PhD FIAHSI

HIFA profile: Najeeb Al-Shorbaji recently retired from the World Health Organization (WHO), where he has worked since 1988 in different capacities. He was most recently Director of the Knowledge, Ethics and Research Department at WHO headquarters, Geneva. Previously he was Coordinator for Knowledge Management and Sharing in EMRO (Eastern Mediterranean Regional Office), Egypt. He is a member of a number of national and international professional societies and associations specialised in information management and health informatics. He has authored over 100 research papers and articles presented in various conferences and published in professional journals. He is also a member of the HIFA steering group. Email: shorbajin AT gmail.com <https://www.hifa.org/support/members/najeeb>

Open Access (8) Introduction: Rabia A Khaji, Tanzania - Removing barriers between evidence and impact

10 October, 2025

Dear Neil and HIFA colleagues,

Warm greetings from Tanzania.

I'm honored to be part of this global conversation on open access publishing a topic that resonates deeply with my belief that 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.

I'm eager to explore with all of you how open access can extend beyond journals reaching the hands, minds, and hearts of those who use knowledge to serve others.

Warm regards,

Rabia Khaji

Member, HIFA Open Access Working Group

Ms. Rabia A. Khaji

Head of MEL and TB Portfolio

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"Together We Are Hope and Life"

HIFA profile: Rabia Abeid Khaji is the Head of Monitoring and Evaluation and TB Portfolio at SHDEPHA+ in Tanzania. Her professional work is fundamentally centered on overcoming barriers to health information access, particularly for healthcare professionals and vulnerable communities in low-resource settings. Her experience includes:

- Gender and Equity Focus: She recently led a comprehensive TB gender assessment for Tanzania and contributed to the national TB Gender Operational Plan, directly engaging with the challenges of equitable access to health information and publishing.
- Community-Led Monitoring: She developed frameworks for Community-Led Monitoring (CLM) of TB services, empowering communities to identify and report service gaps—a process that deeply resonates with understanding end-user needs in the evidence ecosystem.
- Research and Advocacy: She co-authored published operational research on TB and has extensive experience presenting findings at international conferences, such as the Union World Conference on Lung Health, International Aids Society etc. I understand the critical importance of disseminating research findings effectively to impact policy and practice.
- Stakeholder Engagement: She serves on the boards of the Tanzania STOP TB Partnership and the Tanzania TB Community Network (TTCN), and is a member of the SMART4TB Afro Community Advisory Board. These roles require constant collaboration with diverse stakeholders, from policymakers to community health workers. <https://www.hifa.org/support/members/rabiabeid> AT gmail.com

Open Access (9) Introduction: Joanna Donnelly, UK - Oxford PharmaGenesis

10 October, 2025

Dear Neil and HIFA colleagues,

On behalf of Open Pharma and Oxford PharmaGenesis, we are delighted to be part of this important conversation.

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.

We are looking forward to exploring healthcare professionals' perspectives and experiences of open access publishing!

Many thanks and best wishes,

Joanna

Joanna Donnelly PhD
Communications Consultant

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HIFA profile: Joanna Donnelly DPhil is a Communications Consultant at Oxford PharmaGenesis and leads the open access working group and AI discussion forum at Open Pharma, a multi-sponsor collaboration facilitated by Oxford PharmaGenesis seeking to drive transparency in the communication of pharma-sponsored research. She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/joanna> joanna.donnelly AT pharmagenesis.com

Open access (10) Q1. What is the impact of open access on health care?

12 October, 2025

Dear all,

Welcome to our discussion on Open Access, supported by Oxford PharmaGenesis. A special welcome to all (100+) who have joined us in the past several days. We look forward to learning from your experience and expertise. To contribute, please send an email to: hifa@hifaforums.org You can review past messages on our RSS feed here: <https://www.hifa.org/rss-feeds/17>

Here again is our landing page for further information: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

The HIFA Open Access working group proposes the following guiding questions:

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.

Feel free to comment on any aspect of open access.

This week (13-20 October) we are looking at Q1: What is the impact of open access on health care?

I note the previous message from Uzodinma Adirieje (Nigeria) message where he writes: "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" And Rabia Khaji (Tanzania): "To me, open access is not only about removing paywalls, but about removing barriers between evidence and impact, between research and real-life change." Also Joanna Donnelly (United Kingdom) who writes: "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."

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 on the care of a patient?

We look forward to your contributions: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh...

relations with the World Health Organization. Email: neil@hifa.org

Open access (11) Q1. What is the impact of open access on health care? (2)

12 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-8-introduction-rabia-khaji-...>

Dear Rabia and all,

Thank you for your message. I was struck by your words ‘Open access is not only about removing paywalls, but about removing barriers between evidence and impact, between research and real-life change’.

This aligns closely with Question 1. What is the impact of open access (OA) on health care?

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.

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.

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?

In our opening message for this question we noted DIRECT and INDIRECT impacts of open access on health care and I look forward to exploring both of these over the coming week.

We wrote:

“There is a potential DIRECT impact of open access on health care (whether through a better-informed health worker or patient). Who needs access to original research and why? ...”

“There are also potential INDIRECT impacts on health care. 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....”

We typically think of direct impacts, and it would be great to hear examples where open access to original research has made a difference to health care (or, conversely, where a paywall has frustrated healthcare decision-making).

However, it can be argued that the direct impact of open access to a specific research article is limited by the fact that single research articles should usually not be relied on to inform clinical (or policy) decisions. As described in the global evidence ecosystem, decisions should normally be based on the cumulative available evidence rather than single studies.

By contrast, 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.

What do you think?

HIFA profile: Neil Pakenham-Walsh...

Open access (12) Q4 How would you design an OA system that retains the benefits but fixes the problems of the current OA system?

12 October, 2025

Dear Neil and all,

Your list of questions is very thorough, and very broad. I recommend that the following specific topics be addressed as part of question 4, as some of the problems with the current OA system that are less often discussed but still very important to health, and particularly to research and knowledge in LMICs.

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

Thank you for this valuable project.

Best wishes,
Margaret Winker, MD
eLearning Program Director
Trustee
World Association of Medical Editors

wame.org
WAME eLearning Program

@WAME_editors

www.facebook.com/WAMEmembers

HIFA profile: Margaret Winker is Trustee and Past President of the World Association of Medical Editors (WAME) and Director of the WAME eLearning Program. She is based in the US.

Professional interests: WAME is a global association of editors of peer-reviewed medical journals who seek to foster cooperation and communication among editors, improve editorial standards, promote professionalism in medical editing through education, self-criticism, and self-regulation, and encourage research on the principles and practice of medical editing.
margaretwinker AT gmail.com

Open access (13) Definitions: 'open access' and 'scientific literature'

13 October, 2025

Dear HIFA colleagues,

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' 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... We are interested not only in the direct impact of open access to health research on health, 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...?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (14) Q4 How would you design an OA system? (2) Meeting the needs of those who do not speak English

13 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-12-q4-how-would-you-design-...>]

Dear all

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.

With kind regards

Najeeb Al-Shorbaji, PhD FIAHSI

HIFA profile: Najeeb Al-Shorbaji recently retired from the World Health Organization (WHO), where he has worked since 1988 in different capacities. He was most recently Director of the Knowledge, Ethics and Research Department at WHO headquarters, Geneva. Previously he was Coordinator for Knowledge Management and Sharing in EMRO (Eastern Mediterranean Regional Office), Egypt. He is a member of a number of national and international professional societies and associations specialised in information management and health informatics. He has authored over 100 research papers and articles presented in various conferences and published in professional journals. He is also a member of the HIFA steering group. Email: shorbajin AT gmail.com <https://www.hifa.org/support/members/najeeb>

Open access (15) PubMed and PubMed Central (5)

13 October, 2025

[*See note below]

Following up on the question regarding the future of PubMed, two days ago Hilda Bastian posted "Tracking Shutdown Impact and Changes at PubMed" <https://hildabastian.wordpress.com/2025/10/10/tracking-shutdown-impact-a...>

, which might be useful to those interested in this topic. Some excerpts below:

"These days, the process of keeping PubMed up-to-date is largely automated and/or done by journal publishers, and it doesn't look as though there has been a major disruption so far.* The longer the shutdown goes, though, the more likely being on a skeleton crew will have an impact...If there's a PubMed outage, remember that EuropePMC <<https://europepmc.org/>> will have all the records PubMed had released... In September, the NLM announced <https://www.nlm.nih.gov/pubs/techbull/so25/so25_medline_selection.html> that they are reviewing their new MEDLINE journal selection system. That process <https://www.nlm.nih.gov/medline/medline_journal_selection.html> is a couple of consultants advising on whether a journal meets the MEDLINE scientific and editorial standards. This is the same process that's been used for years for the second set of journals that feed articles into PubMed: Open access journals in PMC <<https://pmc.ncbi.nlm.nih.gov/pub/journalselect/>>.

(There are over 2,700 non-MEDLINE journals in PMC <[https://www.ncbi.nlm.nih.gov/nlmcatalog?term=\(journalspmc\)%20NOT%20currentlyindexed](https://www.ncbi.nlm.nih.gov/nlmcatalog?term=(journalspmc)%20NOT%20currentlyindexed)> at the moment.)...I think this change in system would make it much simpler to politicize journal inclusion in PubMed. The NLM Director can make their own decisions and reject the advice of the consultants, without having to bother with overhauling a committee's membership and the unpredictability of members."

Best wishes,
Margaret Winker, MD

eLearning Program Director

Trustee

World Association of Medical Editors wame.org

WAME eLearning Program <<https://wame.org/wame-elearning-program.php>>

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www.facebook.com/WAMEmembers

HIFA profile: Margaret Winker is Trustee and Past President of the World Association of Medical Editors (WAME) and Director of the WAME eLearning Program. She is based in the US.

Professional interests: WAME is a global association of editors of peer-reviewed medical journals who seek to foster cooperation and communication among editors, improve editorial standards, promote professionalism in medical editing through education, self-criticism, and self-regulation, and encourage research on the principles and practice of medical editing.
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[*Note from HIFA moderator (NPW): Thank you Margaret. I have included this message in our open access discussion as PMC (PubMed Central) is clearly a very important benefit of open access publishing.]

Open access (16) PubMed and PubMed Central (6)

13 October, 2025

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

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?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (17) Q1. What is the impact of open access on health care? (3) Afrihealth Optonet Association

13 October, 2025

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.

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.

In addition, 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.

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.

Dr. Uzodinma Adirieje

Programmes Director/CEO

Afrihealth Optonet Association (AHOA) - CSOs Global Network and Think-tank

Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. <afrepton@gmail.com>

Open access (18) My Expectations from our deep-dive discussion on open access publishing (2)

13 October, 2025

[*Note from HIFA moderator (NPW): This message was previously sent on 10 October but there was a formatting problem that made it hard to read. Hopefully this message will format correctly. I invite others to share their expectations for the discussion also. Are there any specific topics you would like to cover?]

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.

Dr. Uzodinma Adirieje

Programmes Director/CEO

Afrihealth Optonet Association (AHOA) - *CSOs Global Network and Think-tank*

Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. <afrepton@gmail.com>

WHO warns of widespread resistance to common antibiotics worldwide (2) Open access (19) Meeting the information needs of prescribers and users of medicines

13 October, 2025

Dear Joseph,

Thank you for alerting us to this WHO press release today.

The critical point, which is mentioned but not emphasised is that 'The misuse and overuse of antimicrobials in humans, animals and plants are the main drivers in the development of drug-resistant pathogens.' Instead most of the focus is on other secondary aspects, such as how to develop new antibiotics.

The misuse and overuse of antibiotics includes:

- inappropriate prescription of antibiotics when they are not indicated (for example with viral infections)
- inappropriate prescription of broad-spectrum antibiotics and 'blockbuster' antibiotics when cheaper, more targeted antibiotics are indicated
- failure of the patient to take the full course of antibiotics
- prescribing the 'wrong' antibiotic

All of the above are major causes of antibiotic resistance.

Dr Tedros says: "Antimicrobial resistance is outpacing advances in modern medicine, threatening the health of families worldwide," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "As countries strengthen their AMR surveillance systems, we must use antibiotics responsibly, and make sure everyone has access to the right medicines, quality-assured diagnostics, and vaccines. Our future also depends on strengthening systems to prevent, diagnose and treat infections and on innovating with next-generation antibiotics and rapid point-of-care molecular tests."

In fact, the problem is not just that "Antimicrobial resistance is outpacing advances in modern medicine". It is that poor clinical practice is driving resistance. Furthermore it can be said that "Pharmaceutical advertising is outpacing medical practice", driving the prescription of inappropriate blockbuster drugs that drive resistance in the population.

Meanwhile 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/>

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

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>

Finally, I would like to consider two aspects of the relation between open access, responsible prescribing and better health for individual patients and populations.

First, in a previous message Joanna Donnelly (UK) said: '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.' Can we substantiate this or develop it further? If all pharma-funded research were open access, would this help drive improvements in patient care?

Second, 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?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (20) Q4 How would you design an OA system that retains the benefits but fixes the problems of the current OA system? (3)

13 October, 2025

1. As an early supporter of the Budapest Open Access Initiative (BOAI) statement (February 14, 2002 – <https://www.budapestopenaccessinitiative.org/>), I have long campaigned for OA and watched with initial delight as the uptake of all forms of Open Access have rocketed (<https://stm-assoc.org/oa-dashboard/oa-dashboard-2/uptake-of-open-access/>).
2. 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.
3. University libraries can stop paying high subscription costs for journals that have adopted OA, while their parent institutions establish funding mechanisms to pay the article processing charges (APCs) incurred by authors from those universities. Overall, universities should find a net balance between lower library costs and paying for APCs. As a rule, Open Access papers are read, and therefore cited, far more often than papers in non-OA subscription journals. So both the readers and the writers are happy. What could be wrong with such a model? Well, there are a few points of concern.
4. The equilibrium suggested above, of lower subscription costs paying for APCs, has proved to be an illusion. According to Jan Veleterop, a leading OA actor, “The hope that this would result in not only an open research publishing infrastructure, but also a more efficient, less expensive, and less profit-extractive one, was, alas, not fulfilled... The hope that the amount of money siphoned off from the budgets for scholarly research – just to pay for publication – would decrease did not materialise.” 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."

5. Many of the best and most respected journals in the world are now published using the Open Access model. However, we have also watched the rise of predatory journals using OA purely as a means to make money. Predatory journals use a very simple economic and production model:

- a. Think up a resounding journal name (“International”, “Global” etc)
- b. Have as many papers as possible submitted
- c. Accept them all without excessive peer review
- d. Collect a hefty article processing charge for each paper
- e. Dump them on your website (=“publish”)

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.

6. Open Access relies on journals being paid an article processing charge (APC) to publish. The APC can be paid by the author, by an academic institution, government or by some other source willing to pay for the author. Journals may also offer waivers of APCs when authors meet certain conditions. There is no rule about the size of an APC – it can range from zero to thousands of dollars. APCs raise a number of questions:

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

7. Finally, among the possible downsides of Open Access, 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 Zielinski

Centre for Global Health, University of Winchester, UK and

President, World Association of Medical Editors (WAME)

Blogs; <http://ziggytheblue.wordpress.com> and <http://ziggytheblue.tumblr.com>

Publications: <http://www.researchgate.net> and <https://winchester.academia.edu/ChrisZielinski/>

HIFA profile: Chris Zielinski: As a Visiting Fellow and Lecturer at the Centre for Global Health, University of Winchester, Chris leads the Partnerships in Health Information (Phi) programme, which supports knowledge development and brokers healthcare information exchanges of all kinds. He is President of the World Association of Medical Editors. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. He also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. Chris has been a director of the UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). chris AT chriszielinski.com. His publications are at <https://www.researchgate.net/profile/Chris-Zielinski> and <https://winchester.academia.edu/ChrisZielinski/> and his blogs are <http://ziggytheblue.wordpress.com> and <https://www.tumblr.com/blog/ziggytheblue>

Open access (21) Open access and availability of high-quality evidence

14 October, 2025

Dear Joanna and all,

Thank you for your message a few days ago. [<https://www.hifa.org/dgroups-rss/open-access-9-introduction-joanna-donne...>]

You wrote: "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."

I would like to invite us all to develop this further. With regards to the first sentence:

1. 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).

2. 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/>

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...>

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).

We have several HIFA members with expertise in this area, including a few on the GRADE group, and we would welcome their inputs and perspectives on the impact of open access on the availability of high-quality evidence.

3. 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. 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).

This week we are looking at the impact of open access to research on health, with a particular focus on peer-reviewed research. Can anyone provide an example where open access to research (as opposed to repackaged information) has informed (or frustrated) clinical decision-making?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (22) Q4 How would you design an OA system? (4)

14 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-12-q4-how-would-you-design-...>

Margaret Winker asks: How can open access help research and knowledge from LMICs be peer reviewed, published, translated, and disseminated?

There are several points we might consider, raising wider questions about how the OA system could be designed to better meet the needs of researchers and publishers in LMICs.

1. How does open access (to peer-reviewed primary and secondary research) facilitate the conception and implementation of relevant, high-quality research?

For example, to what extent do researchers in LMICs benefit from open access to identify research priorities and questions? How does open access facilitate a systematic review (or an informla review) of the relevant literature in the ealry stages of research?

2. 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?

I look forward to read your thoughts. Please email: hifa@hifaforums.org

Previous messages are available on our RSS feed: <https://www.hifa.org/rss-feeds/17>

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (23) Q1. What is the impact of open access on health care? (4)

14 October, 2025

Dear HIFA colleagues, Thank you for all your contributions so far. This is already becoming a very interesting discussion.

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

It responded with five examples (four of which were not relevant to the question):

1. Open Access and the COVID-19 Pandemic (this example referred to open sharing of data rather than open-access publishing)
2. The Human Genome Project (again, open data)
3. Stroke Treatment Guidelines (this is an example of open access to guidelines, not open access to research)
4. 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...')
5. Open Data in Cancer Genomics (another open data project).

The only example that ChatGPT offered that is relevant to us is #4. However, 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...>

I would like to present a challenge for all of us. Can you identify a practical example where open access to research led to a direct improvement in patient care? Perhaps from your own experience? Or from a google search?

I'm sure there must be examples. But I suspect they are rarer than we may think.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (24) Definitions: 'open access' and 'scientific literature' (2)

14 October, 2025

Is open access truly open access? 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

Warm regards,
Gauri

Dr Gauri Divan

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HIFA profile: Gauri Divan is a paediatrician working in the non-governmental organisation Sangath (www.sangath.com). Her interests include child development, disability and mental health with a special focus on task sharing to non-specialists. gauridivan AT gmail.com

Open access (25) Removing barriers between evidence and impact

15 October, 2025

Dear HIFA colleagues,

Thank you, Neil and all open access group, for opening this rich conversation on open access and the availability of high-quality evidence.

Building on this discussion, I keep thinking about what happens after evidence becomes available — how it moves (or sometimes fails to move) from publication into the hands and decisions of those who can act on it. Open access may remove the financial barrier to reading research, but many healthcare professionals still face barriers of time, capacity, and context that prevent them from turning evidence into action.

This raises a few questions I would love to explore further:

- How can open access initiatives do more to support translation of evidence into practice, especially in low-resource settings?
- What can be done to make open access content more usable and understandable for frontline health workers who may not have research training?
- 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?
- And perhaps most importantly — 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?

I'd be very interested to hear colleagues' perspectives or examples of how open access has either facilitated or struggled to bridge this gap in their contexts.

Warm regards,

Rabia Khaji
Tanzania,
HIFA Open Access Working Group

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HIFA profile: Rabia Abeid Khaji is the Head of Monitoring and Evaluation and TB Portfolio at SHDEPHA+ in Tanzania. Her professional work is fundamentally centered on overcoming barriers to health information access, particularly for healthcare professionals and vulnerable communities in low-resource settings. Her experience includes: - Gender and Equity Focus: She recently led a comprehensive TB gender assessment for Tanzania and contributed to the national TB Gender Operational Plan, directly engaging with the challenges of equitable access to health information and publishing.[...] She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/rabia> rabiabeid AT gmail.com

Open access (26) Q1. What is the impact of open access on health care? (5) 12 benefits of open access

15 October, 2025

Dear HIFA colleagues,

We do not yet have any examples where open access to original research (or lack of it) has directly impacted on quality of health care, although I am sure such examples exist. If you can help, please email: hifa@hifaforums.org

We may also consider the extent to which open access increases the availability and use of reliable healthcare information, which is a proxy indicator for evidence-informed health care. To help explore this question I reviewed the benefits of open access as described by 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...>

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

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.

That said, 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.

What do you think? I invite your thoughts on any of the above points.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (27) 12 benefits of open access (2) OA and citation frequency

15 October, 2025

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. They do not for solutions to local problems, in addition to the barriers you mentioned to implement the evidence.

With kind regards

Najeeb Al-Shorbaji, PhD FIAHSI

HIFA profile: Najeeb Al-Shorbaji recently retired from the World Health Organization (WHO), where he has worked since 1988 in different capacities. He was most recently Director of the Knowledge, Ethics and Research Department at WHO headquarters, Geneva. Previously he was Coordinator for Knowledge Management and Sharing in EMRO (Eastern Mediterranean Regional Office), Egypt. He is a member of a number of national and international professional societies and associations specialised in information management and health informatics. He has authored over 100 research papers and articles presented in various conferences and published in professional journals. He is also a member of the HIFA steering group. Email: shorbajin AT gmail.com <https://www.hifa.org/support/members/najeeb>

Open access (28) Removing barriers between evidence and impact (2) From Evidence to Impact: Launch of the Research into Policy Toolkit

15 October, 2025

The announcement below is forwarded from The Global Health Network. <https://tghn.org/> - a HIFA supporting organisation with over 1 million members, mostly health researchers.

One of its aims is: To drive equity in who takes part and who benefits from health research by enabling the open movement of health research information, data and know-how between diseases areas, regions, organisations and communities.

I have written to them to invite their participation in our discussion.

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From Evidence to Impact: Launch of the Research into Policy Toolkit

Date & time: 13 November 2025 | 13:00–14:30 UTC

Turning research into real-world impact is a shared goal - but it is not always straightforward. While significant progress has been made in clinical research on HIV/AIDS, tuberculosis, and malaria, opportunities remain to strengthen how evidence informs policy and practice.

Challenges such as limited collaboration between researchers and policymakers, differences in working environments, and the need to tailor global evidence to local contexts can slow this process. But solutions are emerging.

The European & Developing Countries Clinical Trials Partnership (EDCTP) and The Global Health Network have developed a new open-access Research into Policy toolkit on the EDCTP Knowledge Hub.

Join this launch event to explore how this practical resource supports researchers, policymakers, and health leaders to work together so that evidence leads to real-world impact.

Register: https://zoom.us/webinar/register/7517598529234/WN_gXioQ-q7S8Ktq5LaFaajPw

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HIFA profile: Neil Pakenham-Walsh...

Open access (29) Webinar: "Who Owns Our Knowledge? The Future of Equitable Open Access"

15 October, 2025

Those interested in Open Access might be interested in a webinar titled "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).

The webinar is on Monday, October 20, 2025 at 9:00 AM Eastern Standard Time. It is free to attend and open to all, but registration is limited. To register, click <https://events.teams.microsoft.com/event/71ff1254-e8fc-42b2-afd0-d826749...@068bde83-3dda-41fc-9565-4b16e4ebb35b>

Chris

Chris Zielinski

Centre for Global Health, University of Winchester, UK and
President, World Association of Medical Editors (WAME)

Blogs; <http://ziggytheblue.wordpress.com> and <http://ziggytheblue.tumblr.com>

Publications: <http://www.researchgate.net> and <https://winchester.academia.edu/ChrisZielinski/>

HIFA profile: Chris Zielinski: As a Visiting Fellow and Lecturer at the Centre for Global Health, University of Winchester, Chris leads the Partnerships in Health Information (Phi) programme, which supports knowledge development and brokers healthcare information exchanges of all kinds. He is President of the World Association of Medical Editors. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. He also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. Chris has been a director of the UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). Chris AT chriszielinski.com. His publications are at <https://www.researchgate.net/profile/Chris-Zielinski> and <https://winchester.academia.edu/ChrisZielinski/> and his blogs are <http://ziggytheblue.wordpress.com> and <https://www.tumblr.com/blog/ziggytheblue>

Open access (30) Access to research in low- and middle-income countries

15 October, 2025

We welcome this re-visit by HIFA to discussion on Open Access and are particularly impressed by the many comments posted so far. In 2018, when HIFA deliberated on Open Access, one of the questions was 'What other steps (other than Open Access) are needed to increase the availability and use of health research information?'. The discussion drew attention to a particular hindrance to leveraging on the benefits of Open Access, namely, 'access to citations in publications, which are not available because they are behind pay walls. To understand why this hindrance persists, we need to understand the origins of Open Access, the progress made so far, and why fully achieving the initial aim has eluded many efforts.

To its credit, HIFA forum has hosted discussions on the advantages of Open Access and obstacles that beset the model which hinders achieving access to and use of information especially in LLMICs. I recall our discussing one significant hindrance: 'access to citations in publications'. Meanwhile to make Open Access even more open, 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!

Even before the internet there were efforts to both share knowledge for the good of all ('Common Knowledge') and reduce the quantity of low quality information (publisher-pays model was the physicist 'Leó Szilárd')

The 'social movement' idea and practice of providing free online access to journal articles Open Access (which initially refers to unrestricted online access to scholarly research, primarily intended for scholarly journal articles) can be traced back to at least the 1950's. From the 1990s, with availability of Internet access, it became possible to publish a scholarly article and also make it instantly accessible anywhere in the world, so long as there are computers and Internet connections. It impacted on the fixed cost of publishing which was rising and the cost of the online distribution which became much cheaper. At this time the traditional, print-based scholarly journals system was in serial crisis, the number of journals and articles produced had been increasing at a steady rate but the average cost per journal had been rising at a rate far above inflation for decades, and budgets at academic libraries have remained static. The result was decreased access – ironically, just when technology (internet) has made almost unlimited

access a very real possibility, for the first time. Libraries and librarians played significant part in the open-access movement, alerting faculty and administrators to the serials crisis and developing the Scholarly Publishing and Academic Resources Coalition (SPARC), in 1997.

The first online-only, free-access journals (eventually to be called "open-access journals") began appearing in the late 1980s and early 1990s, using pre-existing infrastructure such as e-mail without any intent to generate profit.

Coupled with the explosion of interest in the 1990's, and emergence of the internet. 'the term "Open Access" itself was first formulated in three public statements in the 2000s: the Budapest Open Access Initiative in February 2002, the Bethesda Statement on Open Access Publishing in June 2003, and the Berlin Declaration on Open Access to Knowledge in the Sciences and Humanities in October 2003.' These are seminal, must-read statements! The same momentum led to HINARI (Health InterNetwork Access to Research Initiative) was formed by World Health Organisation in 2001 with the purpose, 'To provide free or low-cost online access to academic journals in Biomedicine and Social science'. The online Open access Books in 1994 provided free online full-text editions books alongside priced, printed editions. In 2025, according to the Directory of Open Access Books, there are over 99,000 academic peer-reviewed books.

The Journal of Clinical Investigation became the first major non-profit biomedical journal to be freely available on the web in 1996. Other pioneers in open-access publishing in the biomedical domain included BMJ, Journal of Medical Internet Research, and Medscape, who were created or made their content freely accessible also in the late 1990s. By 2001, dozens of for-profit open access Journals were launched by what was then the Current Science Group (the founder of the Current Opinion series and now known as the Science Navigation Group). Thus, two groups had emerged: non- profit free and for-profit Open Access Journals. In 2001, the Public Library of Science (PLOS), an advocacy organization emerged after many scholars around the world signed "An Open Letter to Scientific Publishers", calling for "the establishment of an online public library that would provide the full contents of the published record of research and scholarly discourse in medicine and the life sciences in a freely accessible, fully searchable, interlinked form". Some of the signatories decided to stop publishing or peer review for the for-profit (commercial) Journals, while others continued to publish and review for non-open-access journals. 'PLOS launched its first open-access journal, PLOS Biology in 2003, with PLOS Medicine following in 2004, and PLOS One in 2006. Critics have argued that, equipped with a \$10 million (seed) grant, PLoS competes with smaller open-access journals, especially LLMICs, for the best submissions and risks destroying what it originally wanted to foster.'

In 2011, at the BioMed Central (BMC) OA conference at the Kwame Nkrumah University of Science and Technology, Kumasi Ghana (KNUST), I ended my presentation on Open Access Challenges, with a quotation that sadly still resonates today: '----- in many developing countries, research has limited social and economic impact because doing it is not widely available and accessible. Restricted access to research is also an obstacle to the production of new knowledge. Open access (OA) provides a solution by making scientific research visible and freely available online' (<https://www.eifl.net/eifl-in-action/open-access-ghana>); AND that "Africa cannot attain sustainable development without access to knowledge and information sharing. Knowledge sharing is also important to higher education to facilitate national development" (Professor Olugbemiro Jegede, Secretary General of the Association of African Universities). At the conference, and I don't think that the situation has changed much, the participants were unanimous about how importantly Africa needs OA, but also how 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. Money is also scarce for most of these researchers, authors and institutions because most of them are in the LLMICs where pay remains low, investment in research and education generally very low, and poverty for even educated scientists is worsening.

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. Some commentators have stated that 'even though it does not excuse the criminality, the emergence of multiple predatory journals is partly to fill the gap that the huge global appetite for research and knowledge has created, and partly due to the challenges to access and use of accurate information and evidence caused by traditional print journal model.

To conclude, we advocate that one additional measure needed to make Open Access even more open for researchers and clinicians, policymakers and implementers should be ability to (availability to) access citations (references) that is to eliminate paywalls particularly for LLMICs. Billions are spent in public for information creation, but most global research remains locked behind corporate paywalls, whereas publishers' profit, students and researchers are denied access. Many scientific journals, rated as high-impact journals, will publish outside of their paywall only if one pays a hefty fee, often unaffordable for LLMIC practitioners. Journal subscriptions cost millions of dollars a year for institutional access and hundreds to thousands of dollars for individual access. It is re-assuring that Open-Access initiatives, that are an alternative to paywalled journals, e.g. arXiv and PubMed Central, are rising. Removing paywalled access to research creates an ethical way to access currently restricted research and enhances equity in knowledge acquisition and its application everywhere.

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HIFA profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria, established by HRI Global (former HRIWA). He is a member of the World Health Organisation's Technical Advisory Group on

Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health, he led the introduction of the Homegrown Quality Tool, the 12-Pillar Clinical Governance Programme, in Nigeria (2004-2008). For sustainability, he established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria. His main interest is in whole health sector and system strengthening in Lower, Low and Middle Income Countries (LLMICs). He has written six books on the 12-Pillar Clinical Governance programme, suitable for LLMICs, including the TOOLS for Implementation. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Nigeria Medical Association's Award of Excellence on three consecutive occasions for the innovation. He served as Chairman, Quality & Performance, of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He is member, National Tertiary Health Institutions Standards Committee of the Federal Ministry of Health. He is the pioneer Secretary General/Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.
(<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>).
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Open access (31) Open access and availability of high-quality evidence (2) Open access, evidence synthesis and systematic reviews

16 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-21-open-access-and-availabi...>]

Dear colleagues

Thanks, Neil, for flagging these issues.

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/...>

These are really positive steps and it looks like some major research funders are getting behind these proposals (see <https://www.evidencesic.org/>). It would be great to discuss how HIFA members could get involved in and contribute to these developments.

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.

Best
Simon

HIFA profile: Simon Lewin is a health systems researcher at the Norwegian University of Science and Technology (NTNU) (<https://www.ntnu.edu/employees/simon.lewin>), the South African Medical Research Council (www.mrc.ac.za) and the Norwegian Institute of Public Health (<https://www.fhi.no/en/kn/ceir/>). He has a keen interest in how research evidence can be used to inform decisions for health systems in low- and middle-income countries (LMICs) and at the global level in multilateral organisations such as the WHO. As Co-Lead of Cochrane People, Health Systems and Public Health, he has played a key role in strengthening Cochrane's work in the field of health systems and in developing Cochrane methods for qualitative evidence synthesis. Cochrane is a HIFA supporting organisation and Simon is a member of three HIFA working groups: CHWs; mHealth-Innovate (informal use of mobile phones by health workers) and Support-Systems - How can decision-making processes for health systems strengthening and universal health coverage be made more inclusive, responsive and accountable? <https://www.hifa.org/support/members/simon> Email: simon.lewin AT ntnu.no

Open access (32) Open access and availability of high-quality evidence (3) Open access, evidence synthesis and systematic reviews (2)

16 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-31-open-access-and-availabi...>

Dear Simon and all,

Many thanks for your message. This raises a few other questions that I would love you all to consider and comment on (please send comments to: hifa@hifaforums.org):

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?
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?
3. 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?
4. 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?)

HIFA profile: Neil Pakenham-Walsh...

Open access (33) Open access and availability of high-quality evidence (4) Open access, evidence synthesis and systematic reviews (3)

16 October, 2025

Dear Neil, Simon and HIFA colleagues

Very interesting to follow this deep dive. A couple of reflections from me on the issues flagged by Neil, especially on the benefit and challenges of open access, as well as thoughts on how we should think about what health workers and managers of health systems might value:

(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.

(2) On what research might be valuable: 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.

Best wishes

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HIFA profile: Unni Gopinathan is a Senior Scientist at Norwegian Institute of Public Health, Norway. He is a principal, investigator with the HIFA Project on SUPPORT-SYSTEMS - How can decision-making processes for health systems strengthening and universal health coverage be made more inclusive, responsive and accountable? <https://www.hifa.org/support/members/unni> unni.gopinathan AT fhi.no

Open access (34) Removing barriers between evidence and impact (3) Global Health: Science and Practice

16 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-25-removing-barriers-betwee...>]

Thank you for raising these important questions, Rabia.

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.

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. 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>)

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:

- 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.
- 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.
- 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.
- 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.

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

Best regards, Ruwaida Salem

HIFA profile: Ruwaida Salem is a Senior Program Officer at Johns Hopkins Center for Communication Programs, in the United States. She is the managing editor of Global Health: Science and Practice. Email: ruwaida.salem AT jhu.edu

Open access (35) PLOS Medicine: Open science must include effective results dissemination to study participants

17 October, 2025

Here is a new paper from PLOS Medicine. Citation, summary, extracts and comment from me below.

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.

EXTRACTS

A recent PLOS Medicine study [3] reviewed 96 studies on global practices, expectations, barriers, and impacts of sharing research results with study participants. The results showed that most participants expect results regardless of outcome, seeing this as recognition of their contribution and a foundation for trust. Researchers described dissemination as a moral obligation, but practices remain inconsistent: although two-thirds of surveyed U.S. researchers thought results should always be shared, only 8% had concrete plans to do so. Common methods included mailed lay summaries or letters, while group presentations and workshops were more often reported in lower-income or community-based settings such as Uganda and Brazil...

To keep up with the evolving expectations, open science practices should also be systematically reviewed and explicitly encouraged by IRBs, including open access publications, responsible data sharing, and dissemination of findings to participants and the public.

COMMENT (NPW): It's curious that the paper does not specifically advocate that research should be published open access. In addition to 'lay summaries or letters... group presentations and workshops', there is a strong case that the research paper itself should be open access so that any interested participants can review the findings in detail. Another question is: 'When they agree to participate, do study participants expect the findings to be made available to everyone through open access publication?' I suspect that most study participants would prefer this, and some might be concerned to think the findings would be locked behind a paywall. What do you think?

HIFA profile: Neil Pakenham-Walsh...

Open access (36) Incentives and disincentives for researchers to publish in open access journals

17 October, 2025

Dear HIFA colleagues,

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.

I know, for example, that mandates by funders such as the Wellcome Trust support OA publication. Good global reach is probably another carrot.

On the other hand, perceptions about "impact" and "research quality", publication costs, predatory journals, and confusion about types of OA (hybrid etc) may discourage OA publication.

We need to know more about these carrots and sticks so that we can explore the role that funders, policymakers, research institutions and others can play in encouraging use of OA. For example, 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.

Best wishes

Julie

HIFA profile: Julie N Reza is a UK-based specialist in communications for biosciences, global health & international development (www.globalbiomedia.co.uk). She predominantly works with NGOs and not-for-profit organisations. Previously she was the senior science editor at TDR, based at the World Health Organization (WHO) in Geneva; prior to this she worked at the Wellcome Trust, UK, leading educational projects on international health topics including trypanosomiasis and trachoma. She has a PhD in immunology and a specialist degree in science communication. She also has several years research and postgraduate teaching experience. She is a member of the HIFA Steering Group and HIFA Social Media Working Group. <https://www.hifa.org/support/members/julie-n> naimareza AT hotmail.com

Open access (37) How to follow the discussion

17 October, 2025

Dear HIFA colleagues,

The topic of open access is generating a lot of messages - 37 in total including this one. This is great in terms of knowledge exchange, but some of you may be finding it challenging to keep up!

The easiest way to review/follow a HIFA discussion is to visit our RSS feed: <https://www.hifa.org/rss-feeds/17>

Here you will find all messages that have been approved on HIFA, with the most recent at the top. The list is updated every 4 hours.

Detailed guidance on how to use the HIFA forums (English, French, Portuguese, Spanish) is available here: <https://www.hifa.org/forums/how-use-hifa-forums>

To contribute a message to the forum, simply send an email to: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh...

Open access (38) Q4 How would you design an OA system? (5) Preprints and Plan U

18 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-20-q4-how-would-you-design-...>

Dear Chris (Zielinski) and all,

Thank you for introducing Plan U whereby funders would mandate that research results must always be posted on an openly accessible preprint server before they are submitted to a journal.

I just read an interesting blog on this topic: 'Is the Bill and Melinda Gates Foundation's new OA policy the start of a shift towards preprints?'

<https://blogs.lse.ac.uk/impactofsocialsciences/2024/04/09/is-the-bill-an...>

Extracts and a comment from me below.

EXTRACTS

'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...'

COMMENT (NPW): 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?

Best wishes, Neil

Open access (39) Q4 How would you design an OA system? (6) Preprints and Plan U (2)

19 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-38-q4-how-would-you-design-...>]

Dear Neil and all,

Thank you for sharing this insightful article and for your reflections on Plan U and the Gates Foundation's new open access policy.

As a clinical geneticist and academic, I find this shift towards mandatory preprints particularly interesting. In genomics and related fields, preprints have already become a valuable tool for rapid data sharing and collaboration — something especially relevant during public health emergencies and in rare disease research where time-sensitive knowledge exchange can directly impact patients.

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. However, as you point out, ensuring quality and transparency remains key. Clear labelling of peer-review status, AI-assisted screening for quality and integrity, and open or community peer review models could help safeguard scientific reliability.

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. Perhaps HIFA could play a vital role here in promoting awareness about how to critically appraise and appropriately use preprint data in healthcare contexts.

Ultimately, this transition could help journals evolve from gatekeepers of access to curators of validated, synthesized evidence — adding interpretive value to an open and dynamic research ecosystem.

Warm regards,

Dr. Suranjana Banik (MD, PDF)
Clinical Geneticist

Post-Doctoral Fellow, Department of Medical Genetics
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HIFA profile: Suranjana Banik is a Doctor at Christian Medical College Vellore, India.
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Open access (40) Removing barriers between evidence and impact (4) Open access, evidence synthesis and systematic reviews (4)

19 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-25-removing-barriers-between...>

Dear Rabia,

Thank you for your message a few days ago. You ask four important questions. I shall try to answer the first question and look forward to comments by others on the other three.

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

For the purpose of this discussion we are looking particularly at 'peer-reviewed academic research papers, which are mostly published in biomedical research journals'.

<https://www.hifa.org/dgroups-rss/open-access-1-please-forward-message-yo...>

So, one approach to your question is to ask 'how can open access to peer-reviewed academic research papers support translation of evidence into practice?'

The first aspect of this question leads us to ask: "How important is access to the full text of original research to inform practice?"

There is an interesting anecdote in a paper by Virginia Barbour and colleagues:

'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."

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 need 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.

Access to the full text of research will usually be a positive, but it is even more important for health professionals to take an evidence-informed approach to policy and practice, recognising the limitations of single studies.

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).

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 be used.

As Unni Gopinathan has mentioned, open access also has an important impact (both positive and negative) on the development of systematic reviews.

<https://www.hifa.org/dgroups-rss/open-access-33-open-access-and-availabi...>

I look forward to further discussion on the above and your other questions:

"2. What can be done to make open access content more usable and understandable for frontline health workers who may not have research training?

3. 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?

4. And perhaps most importantly — 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?"

HIFA profile: Neil Pakenham-Walsh

Open access (41) Removing barriers between evidence and impact (5)

19 October, 2025

I forgot to include the citation of the paper by Virginia Barbour et al.

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>

HIFA profile: Neil Pakenham-Walsh

Open access (42) Healthcare professionals' experiences of open access publishing

19 October, 2025

Dear all,

Welcome to week two of our discussion on Open Access, and in particular to those who have joined us over the past seven days! We look forward to learning from your experience and expertise. To contribute, please send an email to: hifa@hifaforums.org You can review past messages on our RSS feed here: <https://www.hifa.org/rss-feeds/17>

Here again is our landing page for further information: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

This week (20-27 October) we are looking at Q2: *What is your experience of OA as a healthcare professional/reader?*

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>). Despite this, 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 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?

Please do feel free to comment on any aspect of open access that you feel is relevant to this discussion.

As a reminder, the HIFA Open Access working group proposes the following guiding questions:

1. What is the impact of open access (OA) on health care? (last week)
2. What is your experience of OA as a healthcare professional/reader? (this week)
3. What is your experience of OA as a researcher/author? (next week)
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.

We look forward to your contributions: hifa@hifaforums.org

Many thanks, Joanna

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HIFA profile: Joanna Donnelly DPhil is a Communications Consultant at Oxford PharmaGenesis and leads the open access working group and AI discussion forum at Open Pharma, a multi-

sponsor collaboration facilitated by Oxford PharmaGenesis seeking to drive transparency in the communication of pharma-sponsored research. She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/joanna>

Open access (43) Experience of OA as a healthcare professional/reader

19 October, 2025

Dear Neil,

I have experienced firsthand how Open Access (OA) transforms healthcare practice and decision-making. In my daily work as a global health and development systems advocate, 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.

In practical terms, I frequently use OA resources to inform health care advocacy, design community health interventions, and implement health promotion programs. During the recent COVID-19, during outbreaks and emerging health challenges, I have relied on freely available research and case studies to develop responsive strategies that are both effective and culturally appropriate. OA also empowers me to mentor younger healthcare professionals and researchers by guiding them toward credible, accessible sources of knowledge, thereby strengthening capacity within Afrihealth Optonet Association (AHOA) and other networks.

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.

In summary, 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.

Dr. Uzodinma Adirieje

CEO and Permanent Representative to the United Nations,
Afrihealth Optonet Association (AHOA) - CSOs Global Network and Think-tank for Health,
Climate Actions and Development (Winner of the SDG 3 – Good Health and Wellbeing
Champion Award).

<https://afrihealthcsos.blogspot.com/2024/03/about-afrihealth-optonet-ass...>

National Coordinator,

Civil Society Partnership for Sustainable Development Goals in Nigeria (CSP-SDGs Nigeria)

Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative

health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (44) Removing barriers between evidence and impact (6) Global Health: Science and Practice (2)

20 October, 2025

Dear Ruwaida and all,

You 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."

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 information. 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>

I would emphasise the importance of sponsored HIFA projects. Our current discussion on open access is a typical example of a HIFA project, which helps make HIFA financially viable and also provides a focus for HIFA members to explore in depth. We invite all HIFA members to consider new projects for 2026. www.hifa.org/projects

Thank you also for describing the work of your journal: Global Health: Science and Practice (GHSP). HIFA has referred to and discussed papers in this journal frequently. Further to the cut in funding from USAID, we wish you every success in sustaining GHSP without imposing fees on authors or readers. I would like to invite HIFA members to share any experience they have with sustaining open access journals.

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

First and foremost, I hope you will be able to sustain GHSP as I believe it is recognised as one of the top, most important journals in global health. It is very important for global health that these top journals flourish.

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.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (45) Removing barriers between evidence and impact (7) Relying on abstracts for clinical decision-making

20 October, 2025

Dear HIFA colleagues,

In a message yesterday I noted the example of a South African physician who altered their perinatal HIV prevention program from an effective therapy to one with lesser efficacy, on the basis of an abstract, as they did not have access to the full text.

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>

I'm curious to know more about the use of abstracts to guide clinical (and policy) decision-making.

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?

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.'

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

'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.'

Yes. I have previously noted on HIFA my perception that the abstracts in some subscription journals are less informative than those in open-access journals. Sometimes the former appear to be more of a 'teaser' than an informative summary. For example, we sometimes read something like the following in an abstract "Our findings have important implications" without describing what those findings or implications are.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (46) The impact of open access on public discourse (1) Wikipedia

20 October, 2025

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:

'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>

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Open access (47) Experience of OA as a healthcare professional/reader (2) HIFA

21 October, 2025

Dear HIFA colleagues,

Thank you for all your messages about open access. This is building into a great discussion!

This week we are discussing Q2: What is your experience of OA as a healthcare professional/reader?

I would particularly like to encourage you to share your *practical experience* of open access and how this affects (or has affected) your work.

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

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.

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

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 to read it.

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.

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.

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.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (48) Has open access to research ever saved a life?

21 October, 2025

This week we are exploring question 2: What is your experience of OA as a healthcare professional/reader?

We look forward to hear about your experience. 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?

It would be especially powerful to have examples where access to the full text has saved a life. Can anyone give an example of this kind of direct impact?

I asked ChatGPT for an example specifically where open access to a full research paper saved a life. It replied:

"Here's a clear example of how access to a specific research paper made a direct impact:

Example: Open Access Paper on "The Efficacy of Early Sepsis Detection"

Sepsis is a life-threatening condition that occurs when the body's response to an infection goes awry, leading to tissue damage, organ failure, and potentially death. Sepsis can progress very quickly, and identifying it early is crucial for improving survival rates.

In 2018, a groundbreaking study was published in *The Lancet*, a prestigious medical journal, which examined a new algorithm for early sepsis detection using a combination of clinical data and machine learning. This paper was open access, meaning that it was freely available to hospitals, clinics, and healthcare providers worldwide, regardless of their resources.

The Role of Open Access:

This research paper outlined a method for detecting sepsis much earlier than traditional approaches. The new algorithm was shown to be more sensitive and accurate at identifying sepsis in its early stages, when it's most treatable. However, many hospitals—especially in low-resource settings—are not subscribed to expensive journals and often have limited access to cutting-edge research. The open access nature of the paper meant that it could be accessed globally by any healthcare facility, no matter their funding.

Real-Life Impact:

A rural hospital in a developing country (for example, a hospital in sub-Saharan Africa) that didn't have the budget for expensive journal subscriptions, was able to download the full text of the sepsis detection paper. The hospital's medical team applied the early sepsis detection algorithm outlined in the study to their clinical practice.

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.

Why Open Access Was Crucial:

Had the paper not been open access, the hospital would have been unable to read or apply the new algorithm in time to help the child. In fact, many healthcare professionals might never have heard about the algorithm if it wasn't freely available. The ability to access that specific research paper, in full, allowed them to adopt a new, life-saving approach to sepsis detection.

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."

I then asked "How many other specific examples can you give where access to the full text of a research paper saved a life?"

ChatGPT replied with five examples, which I'll send in my next message.

Can we - HIFA members - describe any other examples?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (49) Has open access to research ever saved a life? (2)

21 October, 2025

I asked ChatGPT: How many other specific examples can you give where access to the full text of a research paper saved a life? ChatGPT provided 5 examples (below). I have added a personal comment on example 1 and invite you to join me in critical appraisal of the five examples that ChatGPT provides.

Here is ChatGPT's response:

1. Example: Open Access to Research on "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.

Real-Life Impact:

A patient in a small, rural hospital presented with symptoms of a stroke — weakness on one side of the body and difficulty speaking. The healthcare team, who had access to the open access research, used the advanced MRI techniques from the paper to identify micro-strokes that would have otherwise gone unnoticed. Early treatment with clot-busting drugs (tPA) helped prevent major brain damage, and the patient survived with minimal neurological deficits.

Why Open Access Was Crucial:

Without access to the specific imaging technique outlined in the research paper, the hospital would have missed the early signs of stroke. The open access availability made it possible for the hospital to apply the latest, life-saving imaging technology in an underserved community.

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 then said 'Without access to the specific imaging technique, 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'.

I invite HIFA members to comment on the above, and to apply your critical appraisal to the other examples that ChatGPT provides:

2. Example: Open Access to Research on "Antibiotic Resistance and Treatment Protocols"

Context:

A 2016 study published in *The Lancet Infectious Diseases* investigated the growing issue of antibiotic resistance and outlined a new protocol for treating drug-resistant infections. The paper presented detailed, evidence-based guidelines on how to effectively treat infections caused by resistant bacteria like MRSA (Methicillin-resistant *Staphylococcus aureus*).

The Role of Open Access:

The paper was made open access, and a healthcare provider in a developing country gained access to the full text. The local hospital had seen an increase in patients with drug-resistant infections, and the clinicians were struggling to treat these infections with the limited antibiotics available to them.

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.

3. Example: Open Access to Research on "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.

The Role of Open Access:

The paper was open access, so it became available to hospitals in regions with high rates of preterm births, including low-resource areas. One hospital in a developing country used the information from the paper to improve its maternal care protocol.

Real-Life Impact:

A pregnant woman at 27 weeks of gestation came into labor unexpectedly. The doctors, having read the open access research, immediately administered magnesium sulfate, which greatly reduced the likelihood of the newborn developing severe neurological issues associated with preterm birth. The infant survived, and the mother recovered without complications.

Why Open Access Was Crucial:

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.

4. Example: Open Access to Research on "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.

5. Example: Open Access to Research on "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.

The Role of Open Access:

This paper was open access, which allowed NGOs and healthcare workers in rural areas of countries like Ethiopia and Somalia to access the latest evidence on how to combat malnutrition effectively.

Real-Life Impact:

A severely malnourished child was brought to a remote clinic. The clinic workers, who had access to the open access research, immediately administered the recommended RUTFs. Over the next few weeks, the child regained weight and strength, avoiding life-threatening complications like organ failure or death from malnutrition.

Why Open Access Was Crucial:

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.

==

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (50) The impact of open access on public discourse (2) Wikipedia (2)

21 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-46-impact-open-access-publi...>

Dear Tomas and all,

You note the impact of open access on public discourse on Wikipedia.

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

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

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.

I look forward to hear your views.

HIFA profile: Neil Pakenham-Walsh

Open access (51) Has open access to research ever saved a life? (3)

22 October, 2025

To date, we have not yet identified an example where open access to a research paper has helped save a life. If you can identify such an example, please let us know. We would also be interested to learn any examples where open access to research has facilitated clinical decision-making.

Yesterday I asked ChatGPT: How many other specific examples can you give where access to the full text of a research paper saved a life?

It gave five examples which you can review here: <https://www.hifa.org/dgroups-rss/open-access-49-has-open-access-research...> I invite your comments.

In the above message I commented on the first example and concluded:

'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 then said 'Without access to the specific imaging technique, 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'.

Here is the second example with a comment from me below.

2. Example: Open Access to Research on "Antibiotic Resistance and Treatment Protocols"

Context: A 2016 study published in *The Lancet Infectious Diseases* investigated the growing issue of antibiotic resistance and outlined a new protocol for treating drug-resistant infections. The paper presented detailed, evidence-based guidelines on how to effectively treat infections caused by resistant bacteria like MRSA (Methicillin-resistant *Staphylococcus aureus*).

The Role of Open Access: The paper was made open access, and a healthcare provider in a developing country gained access to the full text. The local hospital had seen an increase in patients with drug-resistant infections, and the clinicians were struggling to treat these infections with the limited antibiotics available to them.

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): 'Again, 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.'

I look forward to your comments on the above, and the other three examples that ChatGPT gives.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (52) Experience of OA as a healthcare professional/reader (3)

22 October, 2025

Dear HIFA colleagues,

Question 2 in our deep-dive about open access to research is: What is your experience of OA as a healthcare professional/reader?

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?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (53) Has open access to research ever saved a life? (4)

24 October, 2025

This week we are looking at perspectives from health professionals about the benefits of open access. We look forward to any personal, practical experience you have had with regards to open access (or restricted access). What difference has this made to your work and can you give a specific example?

A related question is 'How many specific examples can you give where access to the full text of a research paper saved a life?' I asked this question to ChatGPT and it gave 5 examples. I have previously commented on examples 1 and 2 here:

<https://www.hifa.org/dgroups-rss/open-access-49-has-open-access-research...>

and here

<https://www.hifa.org/dgroups-rss/open-access-51-has-open-access-research...>

Here is Example 3 with my comments below. I think it's an interesting example of a ChatGPT hallucination.

=

3. Example: Open Access to Research on "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.

The Role of Open Access: The paper was open access, so it became available to hospitals in regions with high rates of preterm births, including low-resource areas. One hospital in a developing country used the information from the paper to improve its maternal care protocol.

Real-Life Impact: A pregnant woman at 27 weeks of gestation came into labor unexpectedly. The doctors, having read the open access research, immediately administered magnesium sulfate, which greatly reduced the likelihood of the newborn developing severe neurological issues associated with preterm birth. The infant survived, and the mother recovered without complications.

Why Open Access Was Crucial: 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.

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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.

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.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (54) Has open access to research ever saved a life? (5)

24 October, 2025

Dear HIFA colleagues,

I would like to share the translation of a message on our Spanish-language forum, HIFA-Spanish, from Jackeline Alger (Honduras), currently the lead moderator of HIFA-Spanish. She has no doubt that open access ultimately saves lives.

I think it is worth noting that Latin America is a world pioneer in open access, thanks to SciELO and Virtual Health Library due to the efforts of Abel Packer and others since the 1990s. (Abel was a co-author with me and others of the 2004 Lancet paper 'Can we achieve health information for all by 2015?')

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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.

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.

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.

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>

HIFA profile: Jackeline Alger, MD, PhD, is a parasitologist associated to the Department of Clinical Laboratory of the University Hospital; Executive Director of the Antonio Vidal Institute for Infectious Diseases and Parasitology; Tegucigalpa, Honduras. HIFA Country Representative of the Year for the years 2015 and 2018. Email jackelinealger AT gmail.com

Why did I join HIFA? <https://www.youtube.com/watch?v=2NZ-U5Wv9FU>

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Open access (55) Morbidity and Mortality Weekly Report

24 October, 2025

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 MMWR has been published weekly since 1952 and has become part of the bedrock of public health; historically it's been where details of new outbreaks and emerging diseases are first reported. But many public health practitioners' trust in the publication has been shaken. In the earliest days of the Trump administration, new articles could not be published because of a communications pause, making it the first time in the journal's history that it missed publishing a new edition. Weekly editions have been paused again during the government shutdown, and earlier this month, much of the team behind the journal was laid off before being reinstated hours later.'

'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."

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.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (56) Morbidity and Mortality Weekly Report (2) ProMED

24 October, 2025

Hi Neil,

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 [*see note below]. Given the growing threat of infectious disease and other outbreaks (eg, toxicology) around the world due to climate change, conflict, decreasing vaccination coverage, and more, this type of information will become even more important as time goes on and clinicians need rapid access to the latest information on the infectious threats that may be occurring nearby.

cheers,

indi

HIFA profile: Indi Trehan is a physician-scientist and academic researcher based in Seattle, United States. He is a professor of paediatrics at Seattle Children's Hospital; adjunct professor of global health and epidemiology at University of Washington; investigator at UW Global Center for Integrated Health of Women, Adolescents, and Children; and investigator at Seattle Children's Research Institute Center for Clinical and Translational Research. He has published

in many different journals, some open, some hybrid, some closed. He has run into the various issues with trying to get funding for open publishing access. He is also an editor at multiple journals and has mentored many junior researchers in both HICs and LMICs on how to navigate open access issues. He is a member of the HIFA Project on Open Access. <https://www.hifa.org/support/members/indi> indi AT alum.berkeley.edu

[*Note from HIFA moderator (NPW): Thanks Indi. This announcement in 2023 explains the change from ProMED being a free service to a subscription service. <https://isid.org/futureofpromed/> Can anyone comment whether this is part of a trend?]

Open access (57) Experience of OA as a healthcare professional/reader (4) Strengthening translation and usability of evidence

24 October, 2025

Dear HIFA colleagues,

Warm greetings from Tanzania.

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.

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.

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.

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.

Warm regards,

Rabia Khaji

Tanzania | Member, HIFA Open Access Working Group

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Ms. Rabia A. Khaji

Head of MEL and TB Portfolio

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HIFA profile: Rabia Abeid Khaji is the Head of Monitoring and Evaluation and TB Portfolio at SHDEPHA+ in Tanzania. Her professional work is fundamentally centered on overcoming barriers to health information access, particularly for healthcare professionals and vulnerable communities in low-resource settings. Her experience includes: - Gender and Equity Focus: She

recently led a comprehensive TB gender assessment for Tanzania and contributed to the national TB Gender Operational Plan, directly engaging with the challenges of equitable access to health information and publishing.[...] She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/rabia> rabiabeid AT gmail.com

Open access (58) A clinician, investigator, innovator perspective

25 October, 2025

Hello HIFA Forum!

I am a trauma surgeon, dissemination and implementation scientist, and public benefit corporation co-founder. My research focus for the last decade has primarily been rooted in understanding what clinicians do when they experience clinical uncertainty, and what they want from the resources they go to. I've had the privilege of partnering widely in these efforts.

In reflecting on the Impact of OA on health care, and my experience of OA as a healthcare professional/reader and researcher/author -

After years of querying different populations and defining the problem in different scenarios, I've come to believe the following things:

- 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'.

- 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).

- 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.

Satire is often the most effective means of communication: <https://www.youtube.com/watch?v=8F9gzQz1Pms>

Its an honor to be part of the community and to learn from each of you! - Lacey

HIFA profile: Lacey N LaGrone is Associate Director of Trauma Medical Research, UCHHealth, United States. Professional interests: Evidence to practice gap / dissemination and implementation science. Global health. Injury. Lacey is a member of the HIFA working group on open access. <https://www.hifa.org/support/members/lacey> lacey.lagrone AT gmail.com

Open access (59) Experience of OA as a healthcare professional/reader (5) Hinari

25 October, 2025

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?

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/>

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?

Best wishes, Neil

See also: Research4Life: January 2025 Newsletter and Impact Report
- <https://www.hifa.org/dgroups-rss/research4life-january-2025-newsletter-a...>

HIFA profile: Neil Pakenham-Walsh

Open access (60) Experience of OA as a healthcare professional/reader (6)

25 October, 2025

Dear Neil,

Please accept my apologies for this delayed response — I was fully engaged in finalizing the Global Mental Health Symposium we recently organized in Yaounde. I am now delighted to take the time to contribute to this important discussion.

As a Mental Health specialist I have often experienced both sides of the “access” divide in scientific information.

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.

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.

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.

Thank you once again for the opportunity.

Warm regards,

Marileine

Dr. Marileine Kemme

MD – Addiction Practitioner, Mental Health & Drug Harm Reduction Expert,
Head of Centre La Vie – Care, Support and Prevention Centre in Addictology
Central Hospital of Yaounde, Cameroon
marileinekemme@gmail.com

HIFA profile: Marileine Kemme is a Doctor, graduated from the National Memorial University of Pirogov in Ukraine in 2012. She is fluent in five languages (Bankôn, French, English, Russian and Ukrainian) and currently practices at the Central Hospital of Yaounde specifically at the Support and Prevention center in Addictology as an Addictologist. She is passionate about issues of mental health in general, addictions and substance use disorders. Marileine.kemme AT medcamer.org

Open access (61) A clinician, investigator, innovator perspective (2) How would you design an OA system (7)

25 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-58-clinician-investigator-i...>]

Dear All,

Lacey makes important points in her post on this discussion on OA, in particular I am drawn to three points that she makes:

i) '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.';

ii)' In other words, it will be new tech, in an old way (the old way being inequity).'; and

iii) 'I favor publishing pre-prints and then in an APC-free journal, so as not to financially bolster a broken system'.

On points i) and ii), it is a pity that the focus on profit will continue to trump altruism and maybe ethics and public good. Profit is not a bad thing but in health care it should not hinder universal access to reliable information for all. On point iii), I have my concerns, because as we all noticed during the recent pandemic, publishing research results in pre-print version, before peer review is completed, caused confusion and led to many retractions later, but by which time the retracted false results have already been applied in practices somewhere, risking public harm. (---'papers were retracted amid concerns that a rush to publish coronavirus research had eroded safeguards at prestigious journals').

If

I may suggest, the way forward is APC-Free Journals for LLMICs and subsidised APC Journals for HICs, if possible.

Joseph Ana

Prof Joseph Ana

Lead Senior Fellow/ medical consultant.

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HIFA profile: Joseph Ana is the Lead Senior Fellow/Medical Consultant at the Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria, established by HRI Global (former HRIWA). He is a member of the World Health Organisation's Technical Advisory Group on Integrated Care in primary, emergency, operative, and critical care (TAG-IC2). As the Cross River State Commissioner for Health, he led the introduction of the Homegrown Quality Tool, the 12-Pillar Clinical Governance Programme, in Nigeria (2004-2008). For sustainability, he established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria. His main interest is in whole health sector and system strengthening in Lower, Low and Middle Income Countries (LLMICs). He has written six books on the 12-Pillar Clinical Governance programme, suitable for LLMICs, including the TOOLS for Implementation. He served as Chairman of the Nigerian Medical Association's Standing Committee on Clinical Governance (2012-2022), and he won the Nigeria Medical Association's Award of Excellence on three consecutive occasions for the innovation. He served as Chairman, Quality & Performance, of the Technical Working Group for the implementation of the Nigeria Health Act 2014. He is member, National Tertiary Health Institutions Standards Committee of the Federal Ministry of Health. He is the pioneer Secretary General/Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

(<http://www.hifa.org/support/members/joseph-0> <http://www.hifa.org/people/steering-group>).
jneana AT yahoo.co.uk

Open access (62) Experience of OA as a healthcare professional/reader (7) Q4 How would you design an OA system? (8)

25 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-59-experience-oa-healthcare...>]

Hi Neil,

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.

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.

cheers,
indi

HIFA profile: Indi Trehan is a physician-scientist and academic researcher based in Seattle, United States. He is a professor of paediatrics at Seattle Children's Hospital; adjunct professor of global health and epidemiology at University of Washington; investigator at UW Global Center for Integrated Health of Women, Adolescents, and Children; and investigator at Seattle Children's Research Institute Center for Clinical and Translational Research. He has published in many different journals, some open, some hybrid, some closed. He has run into the various issues with trying to get funding for open publishing access. He is also an editor at multiple journals and has mentored many junior researchers in both HICs and LMICs on how to navigate open access issues. He is a member of the HIFA Project on Open Access. <https://www.hifa.org/support/members/indi> indi AT alum.berkeley.edu

Open access (63) Free courses from The Global Health Network

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26 October, 2025

The message below is translated from our HIFA-Spanish forum, with thanks to Jackeline Alger (lead moderator, HIFA-Spanish)

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Dear Forum members,

We are in the second week of discussion on the topic of open access.

We share with you that The Global Health Network Latin America and the Caribbean Consortium (TGHN LAC) offers the following online courses for free: 1) What is open science? and 2) Open access

Online courses are available at the following link: <https://lac.tghn.org/elearning/>

WHAT IS OPEN SCIENCE?

The objective of this course

Present the Open Science movement and its various practices, expectations and controversies to the scientific community.

Upon completion of this lesson, you will be able to:

- Understand what open science is and why you should adopt it;

- Know the main dimensions of open science;
- Understand how to make your own research more open and how it can benefit your career.

OPEN ACCESS

Course summary

Aim

- Present a bit of the history of the open access movement and its implications in scientific communication.
- Learn a little more about the main concepts, historical frameworks, different forms of application and various open access initiatives, both on the international scene and in relation to Brazilian experiences.
- Present the practical modalities of peer review and introduce the concept of immediate publication or preprints as an alternative to accelerate the process of dissemination of scientific research.

We invite you to explore these free courses that offer certificate (assessment with grade >80%).

==

HIFA profile: Neil Pakenham-Walsh

Open access (64) Introduction: Chris Winchester, United Kingdom

26 October, 2025

Hello everyone!

My name is Chris Winchester and 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.

If you think 100% OA is a goal worth fighting for, tell us why! What tangible difference does it make to have open access to published clinical trials results? What problems does it cause you and those around you when such results are stuck behind a paywall? We'd love to hear your experiences.

Chris Winchester DPhil (he/him)

Chief Executive Officer

Let us know how we're doing <<https://forms.office.com/Pages/ResponsePage.aspx?id=o-yV6kVaqUK4yzaYHLKc...>>

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HIFA profile: Chris Winchester DPhil is CEO of Oxford PharmaGenesis, an award-winning, independent HealthScience communications consultancy with 500 employees in Europe, North America and Asia Pacific. The company helps its clients in pharmaceutical and biotech companies communicate the evidence behind new drugs and vaccines to healthcare professionals, payers and patients. Chris is a Co-founder of Open Pharma, a Director of Oxford Health Policy Forum CIC and an Associate Fellow of Green Templeton College, Oxford. He is a member of the HIFA working group on open access. <https://www.hifa.org/support/members/chris-3> chris.winchester AT pharmagenesis.com

Open access (65) Q4 How would you design an OA system? (9) Book: Who should control open access, the markets or the commons?

26 October, 2025

(With thanks to Carlos Marin, Colombia, who posted this on HIFA-Spanish)

Read a review of the book

online: <https://blogs.lse.ac.uk/impactofsocialsciences/2025/10/24/who-should-con...> [includes link to the full open-access book]

Extracts below:

'In Publishing Beyond the Market, Samuel A. Moore examines the ills of a marketised system of academic publishing that can justify charging over £9000 for a single paper and outlines how commons-based approaches could be an alternative. Readers will have much to gain from the book's theorisation and championing of scholar-led publishing, writes Thomas A. Graves.

'Why make publications open access? Who benefits from the current systems of open access academic publishing? How does the marketisation of open access affect scholarship? How can open access be reoriented according to the research needs and academic freedom of scholars, rather than large corporate publishers?...

'Chapter three captures the heart of Moore's argument, and his solution to the marketisation of scholarly publishing. In it, he explores how groups of scholars have worked to set up their own non-profit scholar-led academic journals, working predominantly on the voluntary labour of academics, with a researcher-oriented, rather than market-oriented publishing agenda. The chapter also looks into how these groups have operated diamond OA systems, whereby neither the author nor the reader pays for the published version to be publicly accessible...

'The conclusion takes this argument beyond open access. He suggests that the horizontal, localised, and "scaled-small" methods of governance used by scholar-led journals could usefully be extended to broader systems of academic governance...

'However, there are two key criticisms I would make of Moore's proposed solutions to the problems of marketised OA publishing. One of these is located in his diagnosis of the problem. If prestige journals are still valued highly by academics, then why would they switch to publishing in scholar-led journals? The second is that Moore's approach to bottom-up, community driven solutions to OA and Higher Education governance would not be sufficient to overcome the large-scale problems of marketisation in OA and Higher Education...'

HIFA profile: Neil Pakenham-Walsh

Open access (66) Removing barriers between evidence and impact (8)

26 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-25-removing-barriers-between...>

Rabia asks "What can be done to make open access content more usable and understandable for frontline health workers who may not have research training?"

A few thoughts:

1. Open access content may refer to original peer-reviewed research (which is the primary focus of the current discussion) or to other forms of content (eg books, formularies, guidelines...).
2. 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.
3. The understandability of content is dependent on factors other than open/closed access. It depends on the communication skills of the original author(s), the editing skills of the editors, and the skills of peer reviewers. Editors and peer reviewers are responsible for ensuring that the content is clear and coherent (as well as many other checks). Many journals now have 'plain English summaries' as well as abstracts, or they provide a list of 'key points that this research adds to our understanding of the topic'.
4. The 'value added' of the editorial and peer review processes are important and likely to make the final version more usable and understandable than the original author's version.
5. 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](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30384-X/fulltext)

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (67) Q4 How would you design an OA system? (10) Preprints and Plan U (3)

26 October, 2025

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!

Best

David

<https://profiles.ucalgary.ca/david-cawthorpe>

HIFA Profile: David Cawthorpe is Adjunct Assistant Professor at the University of Calgary, Canada. His professional interests include: Human Development, Developmental Psychopathology, and Delivery of low bandwidth medical education curriculum. cawthorpe AT ucalgary.ca

Open access (68) Open access summary table

26 October, 2025

Having enjoyed the Open Access discussion so far, I put together an opinionated summary of some of the pros and cons of OA in the following table (converted to text here as the listserv software doesn't allow for table format). Comments and suggestions on making it more accurate would be very welcome.

General

Open Access Pros

- Provides access to international literature previously inaccessible on account of cost
- Allows access to and sharing of the results of sophisticated and expensive research
- Provides an international perspective
- Offers novel solutions to the health challenges of contemporary life

Open Access Cons

- 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

Economics of the publishing model

Open Access Pros

- Diminishes the economic burden on educational library budgets by removing many of the paywalls preventing access to essential health information (how and when depending on the kind of OA offered: Green, Diamond, Gold, Hybrid, or Bronze)
- Enables publishers to publish anything that is submitted, as the cost is covered up front

Open Access Cons

- Increases the burden on educational administrative budgets by making authors and/or their sponsoring bodies (universities, governments) pay for publication through Article Processing Charges (APCs)
- APCs: financial discrimination, when there is no sponsor
- 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
- Encourages the rise of predatory journals which will publish anything for APCs, leading to a decrease in scientific quality

Other

Open Access Pros

- Encourages wider quotation and citation
- Facilitates science communication (depending on Plans S, T, or U), encouraging self-archiving in open access repositories
- Encourages the process of going from research to policy to practice (R2P2P)

Open Access Cons

- 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

Source: Chris Zielinski, 2025

Chris Zielinski

Centre for Global Health, University of Winchester, UK and

President, World Association of Medical Editors (WAME)

Blogs; <http://ziggytheblue.wordpress.com> and <http://ziggytheblue.tumblr.com>

Publications: <http://www.researchgate.net> and <https://winchester.academia.edu/ChrisZielinski/>

HIFA profile: Chris Zielinski: As a Visiting Fellow and Lecturer at the Centre for Global Health, University of Winchester, Chris leads the Partnerships in Health Information (Phi) programme, which supports knowledge development and brokers healthcare information exchanges of all kinds. He is President of the World Association of Medical Editors. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. He also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. Chris has been a director of the UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). chris AT chriszielinski.com. His publications are at <https://www.researchgate.net/profile/Chris-Zielinski> and <https://winchester.academia.edu/ChrisZielinski/> and his blogs are <http://ziggytheblue.wordpress.com> and <https://www.tumblr.com/blog/ziggytheblue>

Open access (69) Q3 What is your experience of OA as a researcher/author?

26 October, 2025

Dear all,

Welcome to week three of our discussion on Open Access, and a huge thank you to everyone who has shared their experiences so far! To contribute, please send an email

to: hifa@hifaforums.org You can review past messages on our RSS feed here: <https://www.hifa.org/rss-feeds/17>

Here again is our landing page for further information: <https://www.hifa.org/news/hifa-announces-deep-dive-discussion-healthcare...>

This week (28 October - 2 November) we are looking at Q3: What is your experience of OA as a researcher/author?

Last week we explored healthcare professional's experiences of OA as readers of medical publications. This week, we focus on OA from the perspective of healthcare professionals as researchers and authors of medical publications.

To address this knowledge gap, we are keen to explore the following factors:

- How often do healthcare professional's 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?

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?

Please do feel free to comment on any aspect of open access that you feel is relevant to this discussion.

As a reminder, the HIFA Open Access working group proposes the following guiding questions:

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

We look forward to your contributions: hifa@hifaforums.org

Many thanks, Joanna

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HIFA profile: Joanna Donnelly DPhil is a Communications Consultant at Oxford PharmaGenesis and leads the open access working group and AI discussion forum at Open Pharma, a multi-sponsor collaboration facilitated by Oxford PharmaGenesis seeking to drive transparency in the

communication of pharma-sponsored research. She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/joanna>

Open access (70) Has open access to research ever saved a life? (6)

27 October, 2025

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...>

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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.

We invite HIFA members to give an example where an open access research paper helped to save a life, or to improve the management of an individual patient.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (71) Removing barriers between evidence and impact (9)

27 October, 2025

Rabia (Tanzania) asks: 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?

<https://www.hifa.org/dgroups-rss/open-access-25-removing-barriers-betwee...>

My response comes from the perspective of someone who believes that the availability of reliable healthcare information is dependent on the integrity of the global evidence ecosystem, and that 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>

There is always room for more collaboration across the system. 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.

All stakeholders in the system could potentially need access to the full text of a research paper. However, 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.

It would be great to hear the views of HIFA members who develop guidelines, job aids and community health materials. To what extent do you use open access research papers in your work?

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (72) Q3 What is your experience of OA as a researcher/author? (2)

27 October, 2025

Dear HIFA colleagues,

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/>

ABSTRACT

Introduction: Open access (OA) publishing rates have risen dramatically in the biomedical sciences in the past decade. However, few studies have focused on the publishing activities and attitudes of early career researchers. The aim of this study was to examine current publishing activities of clinical and research fellows and their perceptions of OA publishing and public access.

Methods: This study employed a mixed methods approach. Data on publications authored by Memorial Sloan Kettering Cancer Center fellows between 2013 and 2018 were collected via an in-house author profile system and citation indexes. Journals were categorized according to SHERPA/RoMEO classifications. In-person and telephone interviews were conducted with fifteen fellows to discern their perceptions of OA publishing.

Results: The total percentage of fellows' publications that were freely available OA was 28.6%, with a relatively flat rate between 2013 and 2018. Publications with fellows as first authors were significantly more likely to be OA. Fellows cited high article processing charges (APCs) and perceived lack of journal quality or prestige as barriers to OA publishing. Fellows generally expressed support for the National Institutes of Health (NIH) public access policy.

Conclusions: While the fellows in this study acknowledged the potential of OA to aid in research dissemination, they also expressed hesitation to publish OA related to confusion surrounding legitimate OA and predatory publications and frustration with APCs. Fellows supported the NIH public access policy and accepted it as part of their research process. Health sciences information professionals could potentially leverage this acceptance of public access to advocate for OA publishing.

EXTRACTS

'While many health sciences information professionals have been at the forefront of open publishing initiatives, the vitality of the OA movement ultimately hinges on the decisions made by authors about where they publish their work.'

'Quote: "I'd like to publish more in open access journals, but some of the fees for authors are like \$3000, \$4000. I'm on a trainee salary, living in one of the most expensive cities in the country, I've got two kids. How could I ever afford that fee? It makes it untenable. I mean, with my research, I want to be "open," but with the fees they charge, how can I?"

HIFA profile: Neil Pakenham-Walsh

Open access (73) Q3 What is your experience of OA as a researcher/author? (3)

27 October, 2025

Dear Neil,

As a researcher and author, I have actively experienced the transformative power of Open Access (OA) in my work. 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.

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.

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.

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.

Dr. Uzodinma Adirieje

CEO and Permanent Representative to the United Nations,

Afrihealth Optonet Association (AHOA) - CSOs Global Network and
Think-tank for Health, Climate Actions and Development *(Winner of the SDG

3 – Good Health and Wellbeing Champion Award).

<https://afrihealthcsos.blogspot.com/2024/03/about-afrihealth-optonet-ass...>

National Coordinator, Civil Society Partnership for Sustainable Development Goals in Nigeria (CSP-SDGs Nigeria)

HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (74) Removing barriers between evidence and impact (10) Impact of OA on the global evidence ecosystem

28 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-25-removing-barriers-betwee...>]

Rabia asks: "And perhaps most importantly — 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?"

Thank you, another good question.

I would respond to this by thinking not only about whether and how an open-access research paper might directly inform patient care. Indeed 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. (I am sure such examples exist, we just haven't identified any as yet- I'm hoping HIFA members can help, and especially welcome examples from personal experience.)

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>

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...>

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (75) Q3 What is your experience of OA as a researcher/author? (4) Author processing charges (APCs)

28 October, 2025

We look forward to hear about your personal experience of open access as a researcher. Or your observations.

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?

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?

The biggest disincentive for researchers is the APC or author processing charge. In some journals this can be several thousand dollars. What works and what doesn't work in paying these APCs? How can they be made more affordable?

Over the past several years, many HIFA members have supported the principle that, in many or most cases, research funders would pay the costs of APCs. The cost would usually be a (relatively minor) budget line on the research funding proposal.

However, some research funders don't agree. Earlier this year, for example, the Gates Foundation announced a new open access policy whereby they have stopped paying APCs. Instead, they direct researchers to post their research as preprints. The subsequent journey of the paper, including editing and peer review (which would normally be done by a journal publisher through APCs), appears now to be unsupported. The Gates Foundation maintains that they do not want to support a dysfunctional system (with, as they see it, exorbitant APCs). But it's not clear yet whether the preprint approach will meet information needs any better (or worse) than the conventional journal approach.

What do you think? hifa@hifaforums.org

HIFA profile: Neil Pakenham-Walsh

Open access (76) Author processing charges (2) Gates Foundation Open Access Policy

29 October, 2025

<https://www.hifa.org/dgroups-rss/open-access-75-q3-what-your-experience-...>

In my latest message yesterday I noted: 'The biggest disincentive for researchers is the APC or author processing charge. In some journals this can be several thousand dollars. What works and what doesn't work in paying these APCs? How can they be made more affordable?'

'Earlier this year, for example, the Gates Foundation announced a new open access policy whereby they have stopped paying APCs. Instead, they direct researchers to post their research as preprints.'

You can read more about the Gates Open Access Policy here:

<https://openaccess.gatesfoundation.org/open-access-policy/>

Here are extracts:

'Effective January 1, 2025, this policy has been expanded to apply to all published research funded, in whole or in part, by the foundation ("Funded Manuscripts"). The Open Access policy also applies to any data underlying the Funded Manuscripts... to continue our mission to improve the lives of the world's most vulnerable populations...

'It is the foundation's expectation that Funded Manuscripts shall be shared promptly in the form of a preprint...

'The Foundation Will Not Pay Article Processing Charges (APC). Any publication fees are the responsibility of the grantees and their co-authors...'

In an accompanying video, Gates Foundation representative Ashley Farley says: "Grantees must publish their research as a preprint... Preprints are free to read and free to publish. They're also journal agnostic which means the research can be evaluated in its own merit and not the journal in which it's published... this allows for the research community to quickly respond and address any issues... which will thus make it more trustworthy... We are also stopping support for APCs... this is a critical step in achieving more equitable open access business models moving forward"

In my message yesterday, I said: "The subsequent journey of the paper [preprint], including editing and peer review (which would normally be done by a journal publisher through APCs),

appears now to be unsupported. The Gates Foundation maintains that they do not want to support a dysfunctional system (with, as they see it, exorbitant APCs). But it's not clear yet whether the preprint approach will meet information needs any better (or worse) than the conventional journal approach."

I look forward to your comments.

HIFA profile: Neil Pakenham-Walsh

Open access (77) Has open access to research ever saved a life? (7) I think we can trust HIFA members more than we can trust ChatGPT!

29 October, 2025

On 21 October I asked ChatGPT: How many specific examples can you give where access to the full text of a research paper saved a life?

ChatGPT gave five examples and you can read them in full here:

<https://www.hifa.org/dgroups-rss/open-access-49-has-open-access-research...>

Here is a list of the examples and you can review my comments at the URLs shown:

1. Open Access to Research on "Early Detection of Stroke Using MRI" <https://www.hifa.org/dgroups-rss/open-access-49-has-open-access-research...>
2. Open Access to Research on "Antibiotic Resistance and Treatment Protocols" <https://www.hifa.org/dgroups-rss/open-access-51-has-open-access-research...>
3. Open Access to Research on "Early Intervention for Preterm Birth" <https://www.hifa.org/dgroups-rss/open-access-53-has-open-access-research...>

All three examples were deeply flawed. I invite you to comment.

Here is the 4th example:

4. Open Access to Research on "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.

It would be wonderful to hear of an example from YOUR experience (or observation) where open access to an original research paper helped to save a life. I think we can trust HIFA members more than we can trust ChatGPT!

HIFA profile: Neil Pakenham-Walsh

Open access (78) Q3 What is your experience of OA as a researcher/author? (5) Predatory journals

29 October, 2025

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”.

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).

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.

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.

Chris Zielinski

Centre for Global Health, University of Winchester, UK and

President, World Association of Medical Editors (WAME)

Blogs; <http://ziggytheblue.wordpress.com> and <http://ziggytheblue.tumblr.com>

Publications: <http://www.researchgate.net> and <https://winchester.academia.edu/ChrisZielinski/>

HIFA profile: Chris Zielinski: As a Visiting Fellow and Lecturer at the Centre for Global Health, University of Winchester, Chris leads the Partnerships in Health Information (Phi) programme, which supports knowledge development and brokers healthcare information exchanges of all kinds. He is President of the World Association of Medical Editors. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. He also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. Chris has been a director of the UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). chris AT chriszielinski.com. His publications are at <https://www.researchgate.net/profile/Chris-Zielinski> and <https://winchester.academia.edu/ChrisZielinski/> and his blogs are <http://ziggytheblue.wordpress.com> and <https://www.tumblr.com/blog/ziggytheblue>

Open access (79) Q3 What is your experience of OA as a researcher/author? (6) Predatory journals (2)

29 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-78-q3-what-your-experience-...>]

90% of each weekly invites are preds!

That result might be used for university promotions!

;))

HIFA Profile: David Cawthorpe is Adjunct Assistant Professor at the University of Calgary, Canada. His professional interests include: Human Development, Developmental Psychopathology, and Delivery of low bandwidth medical education curriculum. cawthord AT ucalgary.ca

Open access (80) Gates Foundation Open Access Policy (2) Should funders of research take responsibility for APCs?

31 October, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-76-author-processing-charge...>

Dear HIFA colleagues,

The Gates Foundation has decided this year to stop paying author processing charges (APCs). [<https://openaccess.gatesfoundation.org/>] I'd like to share a few reflections and invite your comments.

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.

(There are other models of payment of APCs, notably the 'read and publish' agreements between academic institutions and publishers whereby the institution pays an annual fee and authors from that institution are exempted from APCs. We can discuss these also.)

What is the Gates Foundation's position on open access? The two key points are:

1. The Gates Foundation will no longer pay APCs
2. The Gates Foundation expects all researchers to publish their findings as a preprint.

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

On their website the Gates Foundation says:

1. 'Preprints are free to read and free to publish [yes, but all open access journals are free to read and many are free to publish]
2. 'They're also journal agnostic which means the research can be evaluated in its own merit and not the journal in which it's published' [a key function of journals is to evaluate papers on their own merit]
3. 'This allows for the research community to quickly respond and address any issues [if we have a precipitation of preprints, will this help the research community to 'respond quickly'?]
4. 'Which will thus make it more trustworthy' [will we trust preprints more than journal articles?]
5. 'We are stopping support for APCs... this is a critical step in 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? - below]

Why have they 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.

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.

I recognise that many HIFA members may not agree that funders should take responsibility for APCs. I do not have special expertise in this topic and am ready to learn.

I look forward to your comments.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (81) Gates Foundation Open Access Policy (3) Should funders of research take responsibility for APCs? (2)

31 October, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-80-gates-foundation-open-ac...>]

Thanks Neil for this perspective. The Gates transition really moved the needle and has led other foundations and funders -- and indeed researchers themselves -- to reconsider their approach to publishing and open access.

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.

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.

HIFA profile: Indi Trehan is a physician-scientist and academic researcher based in Seattle, United States. He is a professor of paediatrics at Seattle Children's Hospital; adjunct professor of global health and epidemiology at University of Washington; investigator at UW Global Center for Integrated Health of Women, Adolescents, and Children; and investigator at Seattle Children's Research Institute Center for Clinical and Translational Research. He has published in many different journals, some open, some hybrid, some closed. He has run into the various issues with trying to get funding for open publishing access. He is also an editor at multiple journals and has mentored many junior researchers in both HICs and LMICs on how to navigate open access issues. He is a member of the HIFA Project on Open Access. <https://www.hifa.org/support/members/indi> indi AT alum.berkeley.edu

Open access (82) Gates Foundation Open Access Policy (4) Should funders of research take responsibility for APCs? (3)

1 November, 2025

Dear Indi and colleagues,

Many thanks for your message. You note 'it is very challenging for us as researchers to plan an accurate line-item in grants for APC fees'. I have very little experience in this, and would like to invite other HIFA members, especially those who have experience with research proposals, to share their experience. Please email to: hifa@hifaforums.org

Meanwhile I asked ChatGPT: "We are preparing a health research proposal for an international consortium of academic institutions in high-income and LMICs. The total budget is £1 million. We would like you to prepare a paragraph to highlight how we would publish and disseminate the research. We want the research to be open access and we would like the funder to cover the cost of the APC. We hope to publish the paper open-access in The Lancet but we are prepared to consider other journals if needed."

'Proposed Text for the Dissemination and Publication Plan

To ensure the widest possible impact and accessibility of the research findings, all outputs from this project will be published under open-access terms in leading peer-reviewed journals. Our primary target journal is The Lancet or one of its specialty titles, given their international reach, rigorous standards, and strong record in global health research. Should publication in The Lancet not be feasible, we will consider other high-impact open-access journals of comparable standing. We will request that the funder cover the article processing charges (APCs) to guarantee immediate and unrestricted public access to the findings. In addition to journal publications, we will disseminate results through conference presentations, policy briefs, stakeholder workshops in both high-income and LMIC partner countries, and digital media channels to reach academic, policy, and practitioner audiences globally.'

ChatGPT recommended the following budget:

Open Access APCs \$7,000

Conference dissemination \$8,000

Stakeholder workshops & policy briefs \$10,000

Digital dissemination Website updates, media engagement, video summaries, data visualizations \$5,000

Total Dissemination Budget \$30,000'.

COMMENT (NPW): 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.

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.

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

Open access (83) Introducing Q4: How would YOU design an OA system that retains the benefits - and fixes the problems! - of the current OA system?

2 November, 2025

Thanks to HIFA members for the great discussion and ideas related to open access (OA) thus far. The discussion has been enlightening and we are eager to hear even more perspectives and experiences from researchers, clinicians, patients, advocates, policymakers, funders, and everyone else with an interest in OA publishing.

We would like to conclude this deep dive discussion with one final summative question:

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!

HIFA profile: Indi Trehan is a physician-scientist and academic researcher based in Seattle, United States. He is a professor of paediatrics at Seattle Children's Hospital; adjunct professor of global health and epidemiology at University of Washington; investigator at UW Global Center for Integrated Health of Women, Adolescents, and Children; and investigator at Seattle Children's Research Institute Center for Clinical and Translational Research. He has published in many different journals, some open, some hybrid, some closed. He has run into the various issues with trying to get funding for open publishing access. He is also an editor at multiple journals and has mentored many junior researchers in both HICs and LMICs on how to navigate open access issues. He is a member of the HIFA Project on Open Access. <https://www.hifa.org/support/members/indi> indi AT alum.berkeley.edu

Open access (84) Introducing Q4: How would YOU design an OA system? (2)

3 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-83-introducing-q4-how-would...>

Dear Indi and fellow HIFA colleagues,

Thank you for introducing Q4: How would YOU design an OA system that retains the benefits - and fixes the problems! - of the current OA system?

I am really looking forward to hearing everyone's views on this key topic.

Recognising that our discussion is specifically about one aspect of open access publishing, namely open access to peer-reviewed research, here are a few personal thoughts from me:

1. 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.

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.

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. As such an ideal OA system serves to build a world where every person has access to the reliable, relevant healthcare information 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.

2. From the perspective of the global evidence ecosystem, the primary users of the full text of research papers are those who synthesise evidence: systematic reviewers and clinical guideline developers. In this discussion we have heard from two systematic reviewers. Simon Lewin (Norway) notes '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'. I agree. Unni Gopinathan (also from Norway) welcomes the fact that open access reduces the problem of accessing full text to conduct a synthesis. On the other hand he points out that OA has led to an increase in lower-quality papers that makes the work of synthesis harder. Again I agree, and I would like to hear more from those who conduct systematic reviews and, especially, those who prepare clinical guidelines.

3. Health professionals (and patients and policymakers) may also, at times, need access to the full text of original primary research papers. But 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.

4. 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.

5. In our discussion so far, two of us (Indi and I) have agreed that research funders should be responsible for paying article processing charges (APCs).

6. 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. For me, it makes much more sense for research funders to collaborate with journals rather than exclude them. Exorbitant APCs? Yes indeed, this is the case with some of the top journals, but the way forward is to negotiate, if necessary through capping of the APC budget line.

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

How would YOU design an OA system that retains the benefits - and fixes the problems! - of the current OA system?

I very much look forward to hearing YOUR views. Do you agree/disagree with any of the above? Send your thoughts to: hifa@hifaforums.org.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (85) Introducing Q4: How would YOU design an OA system? (3)

4 November, 2025

Dear Neil,

The next-generation Open Access (OA) system must retain the benefits of current OA models including free access, global knowledge sharing, and equitable dissemination; while addressing major problems such as publication costs, quality control, and sustainability. This will be guided by the following scenarios:

1. FIVE CORE PRINCIPLES

- a. Universal Accessibility: Knowledge remains freely accessible to all, globally, without paywalls.
- b. Equitable Publishing: Researchers from low- and middle-income countries (LMICs) are not disadvantaged by high article processing charges (APCs).
- c. Quality Assurance: Peer review and editorial standards are rigorous and transparent.

- d. Sustainable Funding: OA operates without shifting costs onto authors or readers unsustainably.
- e. Interoperability & Discoverability: Research is easily searchable and machine-readable.

2. FIVE KEY FEATURES OF THE IMPROVED OA SYSTEM

a. Tiered Funding Model

- i. Global OA Fund: Supported by governments, philanthropic foundations, and international health organizations, covering APCs for researchers without institutional backing.
- ii. Sliding-Scale APCs: Authors with institutional or private funding may contribute proportionally.
- iii. Institutional Memberships: Universities and organizations pay annual contributions that subsidize publications.

b. Transparent and Inclusive Peer Review

- i. Open Peer Review: Review reports are published alongside articles, improving accountability and credibility.
- ii. Diverse Reviewer Pool: Include experts from LMICs to reduce geographic and disciplinary bias.
- iii. Post-Publication Review: Community-based evaluation allows corrections and updates after publication.

c. Platform Integration

- i. Centralized OA Repository: Articles, datasets, and preprints are stored in a unified, indexed platform.
- ii. Machine-Readable Metadata: Facilitates AI-assisted discovery, citation tracking, and evidence synthesis.
- iii. Versioning System: Supports updates and corrections without losing citation integrity.

d. Incentives for Contribution

- i. Recognition for Reviewers: Peer review contributions are tracked and rewarded, promoting engagement.
- ii. Impact Metrics Beyond Citations: Incorporate social impact, policy influence, and practical implementation in evaluation.

e. Community Governance

- i. Managed by an international consortium of researchers, practitioners, and policymakers to ensure accountability, transparency, and adaptability.

3. FIVE ADVANTAGES OF THE PROPOSED SYSTEM

- a. Retains free access and broad dissemination.
- b. Reduces financial barriers for authors.
- c. Improves transparency and trust in research quality.
- d. Encourages global collaboration and inclusivity.
- e. Ensures sustainability without sacrificing equity or standards.

Dr. Uzodinma Adirieje

CEO and Permanent Representative to the United Nations,

Afrihealth Optonet Association (AHOA) - CSOs Global Network and Think-tank for Health, Climate Actions and Development (Winner of the SDG 3 – Good Health and Wellbeing

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National Coordinator,

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Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (86) Introducing Q4: How would YOU design an OA system? (4)

4 November, 2025

Dear HIFA colleagues,

Indi (on behalf of the HIFA Open Access working group) asks:

"Q4: How would YOU design an OA system that retains the benefits -- and fixes the problems! -- of the current OA system?"

I have commented on the Gates Foundation's new open access policy and their decision to stop funding APCs:

<https://www.hifa.org/dgroups-rss/open-access-80-gates-foundation-open-ac...>

You responded: "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."

I suggested it is not so challenging to do this. Of all that research funders have to consider, the budget line for payment of APC is straightforward, particularly if it is capped by the funder (and different funders may have different caps).

I have provided further thoughts on Q4 here:

<https://www.hifa.org/dgroups-rss/open-access-84-introducing-q4-how-would...>

In particular, I state:

"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. For me, it makes much more sense for research funders to collaborate with journals rather than exclude them. Exorbitant APCs? Yes indeed, this is the case with some of the top journals, but the way forward is to negotiate, if necessary through capping of the APC budget line."

So 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.

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).

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.

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).

Apart from the Gates Foundation (for which we await a proponent to explain the benefits), there are many other perspectives on the future of open access.

I am not an expert in this field and I really look forward to hear what others think.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (87) Introducing Q4: How would YOU design an OA system? (5)

5 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-58-clinician-investigator-i...>

Dear Lacey and all,

Thank you for your comment:

"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."

This refers to the new Gates Open Access Policy which has two main elements:

1. Gates-funded research should be 'shared promptly in the form of a preprint, which is a version of a manuscript hosted on a public server prior to formal peer review'.

<https://openaccess.gatesfoundation.org/open-access-policy/>

2. 'The Foundation Will Not Pay Article Processing Charges (APs)'

I expressed my reservations about the Gates Policy yesterday: <https://www.hifa.org/dgroups-rss/open-access-86-introducing-q4-how-would...>

I look forward to understand what others think.

1. '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.

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.

I invite proponents of pre-prints to comment, whether from the perspective of researchers, healthcare professionals or patients.

2. '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?

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?).

3. '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?

I look forward to further discussion on how we can build an OA system that fixes the problems and retains the benefits of the current system.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (88) Q4 How would you design an OA system? (6) Preprints and Plan U (4)

5 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-39-q4-how-would-you-design-...>

Dear Suranjana Banik and all,

You say: "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. For clinicians, especially those in evidence-based fields, preprints can offer early insights but should never be the sole basis for clinical decision-making. Perhaps HIFA could play a vital role here in promoting awareness about how to critically appraise and appropriately use preprint data in healthcare contexts."

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.

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.'

I look forward to comments from others.

'Perhaps HIFA could play a vital role here in promoting awareness about how to critically appraise and appropriately use preprint data in healthcare contexts.' HIFA's role here is to convene stakeholders across the global evidence ecosystem and thereby explore the issues.

HIFA profile: Neil Pakenham-Walsh

Open access (89) Q4 How would you design an OA system? (7) Funder-pays-APCs model

6 November, 2025

I asked ChatGPT for help to describe a model open access system. I did prompt it with my own personal biases (as I have already expressed), so there is definitely an element of ChatGPT telling me what I want to hear.

I look forward to your comments. You may like to try ChatGPT with your own prompts and biases. (I see ChatGPT as a helpful tool for brainstorming and summarising, although it would be helpful if we can let each other know when we are using it.)

This is what it replied:

Talking Points: A Practical Approach to Funding Open Access in Health Research

1. Funders should pay APCs — but wisely.

- *The cost of publishing open access is tiny compared to the overall cost of health research — often less than 1%.

- *Yet, publication is where research becomes impact. It's how evidence reaches practitioners, policymakers, and the public.

- *That's why APCs should be a standard budget line in research proposals, covered by funders up to a sensible cap.

- *This ensures predictability, fairness, and visibility of funded work.

2. Capping APCs keeps the system fair and sustainable.

- *Funders can limit reimbursement to a maximum (say, USD 1,500–2,000) and require publishers to justify their costs.

- *This helps prevent excessive pricing while sustaining the genuine services journals provide — coordination of peer review, professional editing, and indexing.

- *If publishers want to charge more, they can, but funders and authors are free to choose better-value options.

- *Competition then drives efficiency, not prestige inflation.

3. We still need journals — and peer review.

- *Preprints are wonderful for speed and transparency, but they aren't enough for healthcare.

- *Clinicians and health managers need reliable, edited, peer-reviewed evidence that's easy to read and ready to apply.

- *Preprints can complement journals, but they shouldn't replace them. In healthcare, reliability and clarity save lives.

4. Refusing to pay APCs altogether risks backfiring.

- *Some funders, like the Gates Foundation, have stopped paying APCs in protest at high costs.

- *That frustration is understandable — but abandoning APCs entirely risks pushing authors toward obscure or lower-quality outlets.

- *It's like throwing the baby out with the bathwater. The real solution is to make APCs affordable, transparent, and equitable.

5. A pragmatic “funders-pay-with-conditions” model could work.

Here's a simple, balanced formula:

- *Funders pay APCs up to a reasonable cap.

- *Publishers must disclose their costs and services.

- *LMIC and unfunded authors get automatic waivers.

- *Only journals meeting recognised quality standards (COPE, DOAJ) qualify.

*Funders reserve part of the OA budget for repositories, Diamond journals, and translation into local languages.

*This model is practical, equitable, and supports both global access and quality assurance.

6. The bottom line.

*Open access is essential — but it must also be fair, affordable, and trustworthy.

*We need the input of journals, but we need to avoid them overcharging for their input.

*By working together — funders, publishers, and researchers — we can open not just access, but impact.

I invite other HIFA members to critique the above.

What, for you, would the ideal OA system look like?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (90) Q4 How would you design an OA system? (8)

6 November, 2025

I have proposed a personal view: a conservative way forward for OA publishing, whereby research funders continue to pay APCs, but measures are taken for journals to be more transparent in their costs and avoid using APCs as a cash cow. I look forward to hearing the views of others.

Others have expressed enthusiasm for preprints. I'm in favour of pre-prints but I believe they have a limited role. They are good for rapid sharing of results among researchers, where a field is moving rapidly. But they are not very useful in general for the majority of end-users of health evidence.

There is an argument that pre-prints provide an opportunity for the paper to evolve through a process of open peer-review, whereby fellow researchers (and others) comment on the paper. Does anyone have experience of how this works?

Many pre-prints are subsequently published in peer-reviewed journals. Again, do you have experience of this? How did it work? Was it easier or harder for your preprint to be accepted in your journal of choice than it would have been if it were not previously available as a preprint.

What do journal publishers think about the way forward for OA publishing, and the role of pre-prints?

I understand that some publishers have set up their own pre-print repositories, which presumably allow open peer-review with a view to being accepted in one of the publisher's journals. How does this work? Is there a need for a two-stage peer review process, with open peer-review at the pre-print stage followed by conventional peer-review of the submitted manuscript?

Looking forward to your inputs. hifa@hifaforums.org

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (91) Q4 How would you design an OA system? (9)

6 November, 2025

Dear HIFA colleagues,

Thank you, Neil, for framing this important question.

If I were to design an Open Access (OA) system, I would focus on *equity, usability, and sustainability* as its central pillars. Open access should not only remove paywalls but also ensure that knowledge is *reachable, understandable, and usable* across different contexts - from global research institutions to the most remote health facilities.

A few thoughts for consideration:

Equity in authorship and readership: Ensure that researchers and practitioners in low- and middle-income countries can publish and access without financial barriers, possibly through global or regional APC funds supported by governments and donors.

Practical usability: Embed collaboration between journals, communities of practice, and health ministries so that open-access research is translated into guidelines, policy briefs, and frontline job aids.

Language and accessibility: Encourage multilingual abstracts and summaries to make OA content more inclusive.

Sustainability: Promote transparent APC capping and collective negotiations between funders and publishers to prevent cost escalation.

In short, an ideal OA system would combine *openness with purpose* ensuring that the global flow of knowledge leads to local impact.

Warm regards,

Rabia Khaji

Tanzania | HIFA Open Access Working Group

Ms. Rabia A. Khaji

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"Together We Are"

Hope and Life"

HIFA profile: Rabia Abeid Khaji is the Head of Monitoring and Evaluation and TB Portfolio at SHDEPHA+ in Tanzania. Her professional work is fundamentally centered on overcoming barriers to health information access, particularly for healthcare professionals and vulnerable communities in low-resource settings. Her experience includes: - Gender and Equity Focus: She recently led a comprehensive TB gender assessment for Tanzania and contributed to the national TB Gender Operational Plan, directly engaging with the challenges of equitable access

to health information and publishing.[...] She is a member of the HIFA Open Access working group. <https://www.hifa.org/support/members/rabia> rabiabeid AT gmail.com

Open access (92) Q4 How would you design an OA system? (10)

7 November, 2025

Dear Neil and colleagues,

This is such an important question and one it's great to be discussing. I would start from the premise that it's essential that systems are designed collectively and in cooperation regionally and globally.

There are many good examples of OA systems already being designed but in the development of new systems it is essential that they are underpinned by community rather than commercial principles. These principles will include equity, especially financial and transparency of processes. A further important principle is that of bibliodiversity - that is support for a multitude of publishing models.

Best wishes

Ginny

Adjunct Prof Virginia Barbour

Editor-in-Chief, Medical Journal of Australia

Co-Chair DORA

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QUT acknowledges the Turrbal and Yugara as the First Nations owners of the lands where QUT now stands. We pay respect to their Elders, lores, customs and creation spirits. We recognise that these lands have always been places of teaching, research and learning. QUT acknowledges the important role Aboriginal and Torres Strait Islander people play within the QUT community.

HIFA profile: Prof Virginia Barbour is the Editor-in-Chief of the Medical Journal of Australia and until recently was Director of Open Access Australasia. She is an Adjunct Professor at Queensland University of Technology (QUT) and was previously co-lead of the Office for Scholarly Communication at QUT. She trained in the UK in medicine at Cambridge University and University College and Middlesex Hospital medical schools, specialising in haematology. She went on to do a DPhil at Oxford University and post-doctoral research in the US on globin gene regulation. She joined The Lancet in 1999, leaving in 2004 to be one of the three founding editors of PLOS Medicine. She has been involved in many international open access, innovative scholarly communication and publication and research integrity initiatives. She was involved in the final drafting of the UNESCO Open Science Recommendation in 2021. She was previously Chair of the Committee on Publication Ethics (COPE). She is currently Co-Chair of the Declaration on Research Assessment (DORA), a Plan S Ambassador and a member of the

NHMRC-MRFF Public Health and Health Systems Committee. She was an editorial advisor to medRxiv in the first two years of the COVID-19 pandemic. [ginny.barbour AT qut.edu.au](mailto:ginny.barbour@qut.edu.au)

Open access (93) Q4 How would you design an OA system? (11)

7 November, 2025

Dear all,

Great discussion, thank you everyone for your inputs.

As Ginny Barbour said earlier today, our current question - how would you design a better OA system? - is critical.

What kind of system would you like to see in the future?

A few of us have proposed that funders should take responsibility for APCs. One option is to build on the system we already have, and focus on addressing the most unpopular aspect of OA - high APCs. In such a system, journals would continue to play a strong role, delivering quality definitive content for end-users. Funders would pay APCs, but these would be capped (what other measures could be used to keep APCs reasonable?). Preprints would continue to have a role, especially for rapid communications among researchers in fast-moving fields. AI would be harnessed with a view to improving quality while reducing publishing costs (and thereby reducing APCs).

There have been mentions of other approaches. For example, an increased focus on preprints (as proposed by Plan U) and subsequent publication in APC-free OA journals. How would this work in practice? What are the drivers and barriers?

How would YOU design a better OA system?

Please email your comments to: hifa@hifaforums.org

Here is the RSS feed to review previous messages: <https://www.hifa.org/rss-feeds/17>

Many thanks,

Neil

HIFA profile: Neil Pakenham-Walsh

Open access (94) Q4 How would you design an OA system? (12)

7 November, 2025

Dear Uzo and all,

Thank you for your thoughts on 'How you would design an OA system'.

You suggested a "global OA Fund: Supported by governments, philanthropic foundations, and international health organizations, covering APCs for researchers without institutional backing".

Would you like to say more how this would work?

My initial thinking on APCs is that research funders should take responsibility for APCs. The primary reason that some funders (notably the Gates Foundation) have decided to stop funding APCs seems to be that they are fed up with the rising costs of APCs which have clearly gone way

beyond real costs among some of the top journals. So the key challenge is to make APCs reasonable and affordable. How? Funders could simply cap the APC budget line in funding proposals.

If funders agree to take responsibility, there would be no need to have a global OA fund and we could avoid what might become a cumbersome bureaucracy.

"Sliding-Scale APCs: Authors with institutional or private funding may contribute proportionally" I'm not sure what this means, but there is a challenge here about how to reduce the inequity of some researchers being unable to afford the APC. If a reasonable APC cost could be included in every research proposal budget, this should address this problem for most researchers.

"Institutional Memberships: Universities and organizations pay annual contributions that subsidize publications." I think you refer here to the arrangements whereby some academic institutions pay an annual amount to publishers. If funders routinely covered reasonable APC costs, such arrangements should perhaps not be necessary?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (95) Q4 How would you design an OA system? (13)

7 November, 2025

Dear Neil and all,

Open access is essential for many reasons, but there are some unfortunate realities that have not been mentioned.

- In many countries, academicians -- and even students in some countries -- are required to publish research to maintain their positions or to graduate. They may not have the resources or time to conduct sufficient research for promotion or graduation, so an industry selling fake papers and authorships on accepted manuscripts has evolved, aka "paper mills."

- AI has made generating fake papers or components of research much faster and cheaper.

- Many journals are receiving many more manuscript submissions to screen and potentially peer review, taxing editorial resources.

- The APC for-profit model means journals are under pressure to publish more articles. Authors submitting fake papers will pay APCs, and in some journals the papers may not receive the scrutiny they otherwise would.

Some journals publish special issues edited by guest editors, but these have led to manipulation of the peer review system to publish articles that otherwise would be rejected.

These issues have helped drive the huge increase in article retractions over the last few years.

For journals with financial resources, publishing organizations like STM have developed tools that editors can use to screen for paper mill papers, AI-generated content, fraudulent images, and a host of other issues. Such screening tools are welcome, but journals must pay for them. Journals from LMICs with smaller or no profit margins, eg, diamond journals, cannot afford such tools. This increases the gap between HIC and LMIC journals created by lack of resources and

indexing and English dominance, among other factors. One solution would be to make such tools accessible to LMIC journals. However, the paper mill industry quickly subverts new tools and ongoing investment and updating is required.

Alternatively, the academic incentives could be changed. One approach would be to reward research transparency, including full data access, and deemphasize the number of publications, journal impact factor, and citations as a measure of research importance. Some countries are starting down that path, but many more are needed to change the research culture. If they do not, and LMIC journals don't have tools to meet these new challenges, both they and the research culture they help support, which is so important to contextualize medicine and other fields for local populations around the world, will suffer.

Best wishes,

Margaret

Margaret Winker, MD
eLearning Program Director
Trustee
World Association of Medical Editors

wame.org

WAME eLearning Program <<https://wame.org/wame-elearning-program.php>>

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HIFA profile: Margaret Winker is Trustee and Past President of the World Association of Medical Editors (WAME) and Director of the WAME eLearning Program. She is based in the US.

Professional interests: WAME is a global association of editors of peer-reviewed medical journals who seek to foster cooperation and communication among editors, improve editorial standards, promote professionalism in medical editing through education, self-criticism, and self-regulation, and encourage research on the principles and practice of medical editing.
margaretwinker AT gmail.com

Open access (96) Q4 How would you design an OA system? (14) Global Open Access Fund for APCs

8 November, 2025

Dear Neil,

Thank you for seeking further elucidation on how the GOAF would work.

It is my considered opinion that the Global Open Access Fund (GOAF) would serve as a dedicated international mechanism to promote equitable access to scientific publishing by removing financial barriers for researchers lacking institutional or grant support. Supported collaboratively by governments, philanthropic foundations, multilateral agencies, and global health organizations, the Fund would pool resources into a transparent, centrally managed platform. Eligible researchers — especially from low- and middle-income countries — could apply for coverage of Article Processing Charges (APCs) required by open-access journals.

The GOAF would operate under clear governance standards, ensuring accountability, inclusivity, and equity. Applications would be assessed based on criteria such as research quality, relevance to global development or health priorities, and financial need. Partnerships with publishers would allow for direct payment of APCs or negotiated fee reductions. The Fund's structure would include regional coordination hubs to reflect diverse research contexts and needs.

By bridging the gap between researchers and open publishing, the GOAF would democratize knowledge production, amplify voices from underrepresented regions, and accelerate the global exchange of evidence-based innovations. Ultimately, it would uphold the principle that scientific knowledge is a global public good, not limited by geography or income, thereby advancing both equitable open science and sustainable development goals.

Uzo'

Dr. Uzodinma Adirieje

CEO and Permanent Representative to the United Nations,

Afrihealth Optonet Association (AHOA) - CSOs Global Network and Think-tank for Health, Climate Actions, Environment and Sustainable Development (Winner of the SDG 3 – Good Health and Wellbeing Champion Award).

<https://afrihealthcsos.blogspot.com/2024/03/about-afrihealth-optonet-ass...>

National Coordinator,

Civil Society Partnership for Sustainable Development Goals in Nigeria (CSP-SDGs Nigeria)

Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (97) Two compilation documents to guide us for our final week of discussion

8 November, 2025

Dear HIFA colleagues,

Thank you to everyone who has shared their views so far. This has been a very rich discussion.

As we move into our final week, I have prepared two documents that you may find helpful, perhaps especially those who have joined us in the last few weeks:

1. Full compilation of all messages, in chronological order, unedited (90 pages)

<https://www.hifa.org/sites/default/files/articles/Full-Compilation-OA.pdf>

2. Selected content, organised under headings and subheadings (35 pages)

<https://www.hifa.org/sites/default/files/articles/Compilation-OA-short-e...>

#2 may be particularly helpful if you would like to review the discussion as a whole, or any particular aspect. It starts with a Contents list that hyperlinks to specific headings and subheadings, so it is easy (for example) to review what we have said about APCs.

While editing this document I noted there are a lot of unanswered questions. I propose to highlight some of these questions in the coming days in the hope that we can encourage more input on them.

Otherwise our week ahead is clear for you to discuss any aspect of OA until we officially conclude the discussion on Friday 14 November.

With best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (98) Unanswered questions (1) How important is open access publishing for healthcare professionals?

8 November, 2025

Dear HIFA colleagues,

Joanna Donnelly introduced our discussion on behalf of the HIFA Open Access working group. She asked:

1. How important is open access publishing for healthcare professionals?

Our discussion suggests that everyone appreciates the main benefit of open access publishing: that it is free to access for anyone with an internet connection. Researchers appreciate it for the increased visibility that it gives to their work.

Our discussion has focused on open access to the full text of research papers. We have not heard any examples where access to the full text of a research paper has helped to inform a clinical decision or saved a life. Arguably, the priority for healthcare professionals is to have access to evidence 'further along' the global evidence ecosystem, such as synthesised evidence (systematic reviews and clinical guidelines) and repackaged evidence (such as decision aids and formularies).

We have asked ChatGPT: Has access to the full text of research ever saved a life? ChatGPT has not been able to provide an example and we haven't yet received any examples from HIFA members.

Can anyone comment further on the importance for healthcare professionals of access to the full text of research? Has access to the full text of research ever saved a life?

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

Free access is described as the main benefit and article processing charges are the main barrier.

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

If a paper is behind a paywall, many healthcare professionals will not have access. Some of those in high-income countries have access to such content through institutional subscriptions. Some of those in LMICs have access through Hinari. The impact of not having access to the full text of individual research papers remains unclear.

We look forward to your comments on any of the above. Please email: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (99) Unanswered questions (2) How important is open access publishing for healthcare professionals? (2)

9 November, 2025

Dear Neil,

THE IMPORTANCE OF OPEN ACCESS FOR HEALTHCARE PROFESSIONALS WITHIN AFRIHEALTH OPTONET ASSOCIATION (AHOA) GLOBAL NETWORK

Access to reliable, up-to-date, and evidence-based information is vital for effective healthcare delivery and policy-making. For members of the Afrihealth Optonet Association (AHOA) — a network of health, environment/climate/energy and sustainable development professionals and

stakeholders across Africa—Open Access (OA) is not just a convenience, but a lifesaving necessity. Open Access enables doctors, nurses, researchers, and community health workers to freely access the texts of the latest research, clinical guidelines, and innovations without financial or institutional barriers.

In many parts of Africa and the Global South, subscription-based journals are prohibitively expensive, limiting the ability of health workers to make informed, data-driven decisions. Open Access removes this barrier, allowing AHOA professionals to stay current on global best practices in disease prevention, maternal health, nutrition, climate-health linkages, health-related Sustainable Development Goals (health-SDGs), and pandemic responses.

By democratizing knowledge, OA empowers healthcare professionals to translate research into action, improving patient outcomes, enhancing local innovations, and informing effective policy. Ultimately, Open Access saves lives—as it will be ensuring that no African health worker or researcher is denied life-saving information simply because they cannot afford it.

Knowledge must be shared, not sold, if we are to achieve health equity and the SDGs.

Dr. Uzodinma Adirieje

CEO and Perm. Rep. to the United Nations,

*Afrihealth Optonet Association (AHOA)** - CSOs Global Network and Thinkttank for Health, Climate Actions and Development (Winner of the SDG 3 – Good Health and Wellbeing Champion Award). *

*<<https://afrihealthcsos.blogspot.com/2024/03/about-afrihealth-optonet-ass...>

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*National Coordinator, *

*Civil Society Partnership for Sustainable Development Goals in Nigeria

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HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (100) Institutionalizing open access in LMICs

10 November, 2025

Sustainable Approaches for Institutionalizing Open Access in Africa's Depressed Economies and LMICs

Dear Neil,

Open Access (OA) must be reframed as a strategic public good in Africa and other low- and middle-income countries (LMICs). Institutionalizing OA requires sustainable financing, robust policy frameworks, capacity building, and equitable partnerships. Governments and universities should adopt clear OA mandates that prioritize repository development, green OA, and retention of author rights. Sustainable funding can be achieved by reallocating subscription budgets to support institutional repositories and by establishing national and regional OA funds that subsidize publishing infrastructure rather than costly article processing charges (APCs).

Capacity strengthening is essential. Librarians, researchers, and administrators need training in OA licensing, metadata standards, digital

preservation, and advocacy. Regional consortia can aggregate technical expertise and negotiate collective agreements with publishers while

promoting OA models that waive article processing charges by relying on institutional and governmental support. Digital infrastructure

investments—reliable repositories, persistent identifiers, and interoperable metadata—must be scaled with attention to low-bandwidth

accessibility and long-term preservation.

Equity must guide partnerships with global north institutions and funders; collaborations should transfer skills, preserve local editorial control, and avoid extractive publishing relationships. Policies incentivizing OA—promotion criteria recognizing OA publications, public visibility metrics, and rewards for data sharing—encourage researcher buy-in. Legal reforms protecting copyright exceptions for education and research will remove barriers to reuse and enable broader uptake.

Finally, sustained advocacy and community engagement are critical. Civil society, professional associations, education groups, and student movements should champion OA's societal benefits: improved healthcare, education, and innovation. Measured implementation, iterative evaluation, and sharing of best practices across Africa and LMICs will ensure OA becomes an enduring, locally governed resource that strengthens knowledge sovereignty and accelerates development. Continent-wide roadmaps with milestones, financing targets, and monitoring indicators will secure long-term viability and regional ownership, and foster inclusive digital futures, today.

Dr. Uzodinma Adirieje

CEO and Perm. Rep. to the United Nations Systems, Afrihealth Optonet

Association (AHOA);

National Coordinator, Civil Society Partnership for Sustainable Development Goals in Nigeria (CSP-SDGs);

President, African Network of Civil Society Organizations (ANCSO);

President, Society for Conservation and Sustainability of Energy and Environment in Nigeria (SOCSEEN);

Chair, Global Civil Society Consortium on Climate Change and Conference of Parties (GCSCCC).

Global Health and Dev't Projects Consultant | Conferences Organizer | Trainer| Facilitator | Researcher | M&E Expert | Civil Society Leader | Policy Advocate

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HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across

Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (102) Unanswered questions (4) Should funders stop paying APCs?

10 November, 2025

Dear HIFA colleagues,

In the past few weeks a few of us have agreed that funders should take responsibility for paying a fair price for article processing charges (APCs). But at least one person has expressed support for the Gates Foundation, which has taken the opposite view and has decided to stop paying APCs altogether.

I have invited the Gates Foundation to join us to make their case and we await their response.

Meanwhile, would anyone like to comment for or against the principle that funders should take responsibility for paying a fair price for APCs?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (103) Should funders stop paying APCs? (2) Plan S

10 November, 2025

Dear HIFA colleagues,

During our discussion we have heard about Plan U, but I don't think we have discussed Plan S.

'Plan S is an initiative for Open Access publishing that was launched in September 2018. The plan is supported by cOAlition S, an international consortium of research funding and performing organisations. Plan S requires that, from 2021, scientific publications that result from research funded by public grants must be published in compliant Open Access journals or platforms.' <https://www.coalition-s.org/>

Now that I have had time to refresh my memory about Plan S, I have reviewed the 10 principles and I am in full agreement. https://www.coalition-s.org/plan_s_principles/

Principle 4 notes:

'Where applicable, Open Access publication fees are covered by the Funders or research institutions, not by individual researchers'

and Principle 5 says:

'When Open Access publication fees are applied, they must be commensurate with the publication services delivered and the structure of such fees must be transparent to inform the market and facilitate the potential standardisation and capping of payments of fees.'

This is in complete alignment with our discussion on HIFA and the suggestion that funders should take responsibility for paying APCs, and that APCs should reflect actual costs.

OA journals continue to have a vital role to play.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (104) Should funders stop paying APCs? (3)

10 November, 2025

Dear Neil and Bill Gates Foundation,

When a research project funder like Bill Gates Foundation decides to stop paying Article Processing Charges (APCs), it can significantly affect the visibility, accessibility, utilization, and impact of funded research. Without APC support, researchers may not be able to publish in open-access journals, with the risk of limiting global access to their findings — especially in low- and middle-income regions. This decision can also create inequities between well-funded and under-resourced researchers, reducing collaboration, impeding knowledge management, and slowing scientific progress. Furthermore, it undermines the funder's commitment to knowledge dissemination, transparency, and public benefit, as valuable research outcomes risk being locked behind paywalls, restricting their contribution to innovation and evidence-based policymaking; and ultimately impeding progress the 2030 SDGs, and Africa Agenda 2063.

Dr. Uzodinma Adirieje

HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize

resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Open access (105) Should funders stop paying APCs? (4)

10 November, 2025

Neil Pakenham-Walsh writes

> OA journals continue to have a vital role to play.

They surely vitally enrich publishers. But since publishers in general don't pay reviewer---who do the actual evidence work---journals do very little to further evidence.

-- Written by Thomas Krichel <http://openlib.org/home/krichel> on his 22074th day.

HIFA profile: Thomas Krichel is Founder of the Open Library Society, United States of America. Professional interests: See my homepage at <http://openlib.org/home/krichel> Email address: krichel at openlib.org

Source link:

https://hifaforums.org/_/TBCszcwY

Author:

Thomas Krichel

Open access (106) Should funders stop paying APCs? (5)

10 November, 2025

Uzodinma Adirieje, Nigeria writes

> Without APC support, researchers may not be able

> to publish in open-access journals, with the risk of limiting

> global access to their findings — especially in low- and

> middle-income regions.

There is no such risk. Nothing prevent researchers from uploading their research to any web site and make it available there.

--

Written by Thomas Krichel <http://openlib.org/home/krichel> on his 22074th day.)

HIFA profile: Thomas Krichel is Founder of the Open Library Society, United States of America. Professional interests: See my homepage at <http://openlib.org/home/krichel> Email address: krichel at openlib.org

Open access (107) Should funders stop paying APCs? (4)

11 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-91-q4-how-would-you-design-...>

Dear Rabia,

Thank you for your thoughts on designing an Open Access system.

You suggest a focus on equity, usability, and sustainability. I agree. More specifically, I would argue a focus on the extent to which an OA model contributes to strengthen the global evidence ecosystem and thereby increases the availability and use of reliable healthcare information.

You invite us to consider to 'Promote transparent APC capping and collective negotiations between funders and publishers to prevent cost escalation'. Again I agree and several HIFA members have now expressed support for this, which is one of the principles of Plan S. Research funders should take responsibility for paying APCs, but these should be capped to reflect actual costs.

As Uzodinma Adirieje said yesterday:

'When a research project funder like Bill Gates Foundation decides to stop paying Article Processing Charges (APCs), it can significantly affect the visibility, accessibility, utilization, and impact of funded research. Without APC support, researchers may not be able to publish in open-access journals, with the risk of limiting global access to their findings — especially in low- and middle-income regions.'

Inflated APCs are already a major barrier. If researchers are not allowed to include reasonable APC costs in their research proposals, this will make publication in OA journals impossible.

By excluding support for researchers to publish in OA journals, funders are weakening the global evidence ecosystem and reducing the availability and use of reliable healthcare information. They are doing the opposite of their own mission statements.

Rabia, you also mention 'global or regional APC funds supported by governments and donors'. Uzodinma has suggested similar, saying this would be 'supported by governments, philanthropic foundations, and international health organizations, covering APCs for researchers without institutional backing'.

I'm not sure about this. Why would funders be ready to give to a central fund when they are not ready to support APC costs of their own grantees?

Again, I would encourage funders to take direct responsibility to support dissemination of their own funded research projects, with capped APC budget lines as recommended by Plan S (which the Gates Foundation is, ironically, one of the first signatories).

APC waivers for LMICs are welcome, but individual journal policies are haphazard and confusing. Also, are likely to perversely encourage funders not to pay for a dissemination budget line on the basis that the authors 'should be able to secure an APC waiver'. I believe it would be much better and simpler for funders to take responsibility for paying capped APC costs for all research projects, whether they are HIC, LMIC or international. A further point is that waiver policies by definition categorise LMIC researchers as being unable to pay the APC, which in itself is inequitable.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (108) Unanswered questions (5) Can you think of an example where access to the full text of a research paper helped you to manage a patient?

11 November, 2025

Dear HIFA colleagues,

As we enter the final few days in our in-depth discussion on open access, I hope you can fill in some gaps.

In particular, we are missing actual real-life examples where open access to health research has helped you in your work. For example, can you think of an example where access to the full text of a research paper helped you to manage a patient?

We have yet to identify any examples where open access to research has helped to manage a patient or helped to save a life.

Looking forward to your inputs. Please email to: hifa@hifaforums.org

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open accesss (105) Unanswered questions (5) Can you help with any of these 25 questions?

11 November, 2025

Dear HIFA colleagues,

I have extracted all the questions from our edited compilation document: <https://www.hifa.org/sites/default/files/articles/Compilation-OA-short-e...>

I have provisionally classified these under subheadings. Some of the questions have been partly answered, while others have yet to receive comments.

If you can help with any of these, please email: hifa@hifaforums.org

1. WHAT IS THE IMPACT OF OPEN ACCESS (OA) ON HEALTH CARE?

1.1 What is the impact of open access to health research on health care?

1.2 Who needs access to original research and why?

1.3 Do health professionals need access to the full text of research to deliver quality health care?

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

2. WHAT IS YOUR EXPERIENCE OF OA AS A HEALTHCARE PROFESSIONAL/READER?

2.1 How important is open access publishing for healthcare professionals?

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

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

2.4 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?

2.5 To your knowledge, has open access to research ever saved a life?

2.6 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?

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 ACCESS AND THE GLOBAL EVIDENCE ECOSYSTEM

5.1 What is the impact of open access to research on the global evidence ecosystem?

5.2 How can open access to research facilitate the six different components of the global evidence ecosystem?

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...?

5.3 How can OA help research and knowledge from LMICs be peer reviewed, published, translated, and disseminated?

5.4 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?

5.5 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.)

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

5.7 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?

6. PREPRINTS

6.1 What is your experience with pre-prints?

7. Article Processing Charges (APCs)

7.1 Some OA journals do not charge APCs. How do they do this?

7.2 Do all the major OA journals rely on APCs?

7.3 What are your views on APC waivers?

7.4 Should funders take responsibility for paying APCs?

8. Artificial intelligence

In what ways will AI change things? Will it reduce costs of processing articles (and thereby potentially lower APCs)?

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (110) Unanswered questions (7) Can you think of an example where access to the full text of a research paper helped you to manage a patient? (2)

11 November, 2025

Dear Neil and all,

In seeking evidence about OA and saving lives, this study would be useful to review: "The impact of COVID-19 on the debate on open science: a qualitative analysis of published materials from the period of the pandemic" <https://www.nature.com/articles/s41599-024-03804-w> The article is Open Access. The section "Clear 'line of sight' to the benefits of OS" is particularly relevant to our discussion; I won't paste the entire section here but it includes many citations that might provide a basis for a deeper discussion.

Best wishes,
Margaret Winker

Margaret Winker, MD
eLearning Program Director
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HIFA profile: Margaret Winker is Trustee and Past President of the World Association of Medical Editors (WAME) and Director of the WAME eLearning Program. She is based in the US.

Professional interests: WAME is a global association of editors of peer-reviewed medical journals who seek to foster cooperation and communication among editors, improve editorial standards, promote professionalism in medical editing through education, self-criticism, and self-regulation, and encourage research on the principles and practice of medical editing.
margaretwinker AT gmail.com

Open access (111) Unanswered questions (8) How important is open access publishing for healthcare professionals? (3)

12 November, 2025

Dear Uzo,

Thank you for your latest message "Open access (99) Unanswered questions (2) How important is open access publishing for healthcare professionals? (2)"

You state: 'Access to reliable, up-to-date, and evidence-based information is vital for effective healthcare delivery and policy-making.'

Yes, I agree. This is the rationale for HIFA. <https://www.hifa.org/about-hifa>

You say: 'Open Access enables doctors, nurses, researchers, and community health workers to freely access the texts of the latest research, clinical guidelines, and innovations without financial or institutional barriers.'

Again I agree. By definition content that is open access is freely accessible to anyone with an internet connection.

'Ultimately, Open Access saves lives — as it will be ensuring that no African health worker or researcher is denied life-saving information simply because they cannot afford it.'

I am in no doubt that free/open access saves lives when applied to derivatives of health research: clinical guidelines, formularies, training materials, manuals, decision aids.

We might assume that open access to full text of a research paper could be lifesaving.

However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making. We asked ChatGPT, who could not identify an example either.

This does not mean such examples do not exist. But it may mean that access to the full text of a research paper is rarely lifesaving.

HIFA profile: Neil Pakenham-Walsh

Open access (112) How important is open access publishing for healthcare professionals? (4) Has open access to research ever saved a life? (8)

12 November, 2025

I hope this helps...

I excerpted part of the email as a question to chat [ChatGPT] and I will give you a chat response and I will give you the question that I asked to begin with....

The question I asked chat (chatgpt and I have been friends since January 2024) and I don't exactly understand what level of access you have to chat... I have a basic account:

1) my question to chat based on your last email:

One of my colleagues made the following statement, but I was wondering if you had any insights or could answer the question with reference to published literature... for example... is there a published paper that proves open access literature helped save a patient or helped treat a patient?

It would be fine to have a body of work that is open access to influence policy in a way that saved lives—that would be an appropriate reference as well: here is the original response that I am asking you to consider an answer answering this question—

“However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making. We asked ChatGPT, who could not identify an example either.”

2) here is the reply:

Here's your response with formal references for each claim/statement:

Short answer: yes — there are published, citable examples where open-access (OA) research directly informed clinical decisions and, at population scale, saved lives.

A few high-signal cases you can reference:

#1: The first widely used COVID 19 (SARS-CoV-2) PCR protocol was published OA in Eurosurveillance on 23 Jan 2020 (Victor M. Corman et al.). Labs worldwide stood up diagnostic testing using that paper's primers/protocols—core to triage, isolation, and care.

#2: The RECOVERY trial “dexamethasone” result was released OA as a medRxiv preprint on 22 Jun 2020. Multiple studies document immediate practice change and associated mortality reduction after the OA preprint emerged (with later peer-review confirming the effect).

o Example impact documentation: an interrupted-time-series analysis found an “abrupt increase in dexamethasone use and an associated decrease in mortality” after RECOVERY's release; a Japanese nationwide analysis shows steroid prescribing pivoting specifically to dexamethasone once guidance incorporated the (OA-circulating) RECOVERY result.

#3: COVID guideline pipelines that were fully OA (for example, rapid recommendations in The BMJ; national guidance updates) show measurable prescribing shifts once OA recommendations cited the RECOVERY preprint/journal article—again underscoring that open, immediately accessible evidence changed treatment at scale. The Japanese study noted dexamethasone prescriptions rose from ~2.5 % to ~35.2 % after week 29 (July 2020) when it was formally included in guidance.

#4: Beyond single drugs, there's a peer-reviewed synthesis arguing (with case documentation) that open science / OA “saves lives” in outbreaks by accelerating methods, data and guidelines—the COVID pandemic is the clearest modern proof-of-concept.

#5 (health-system access): While it's harder to tie one patient's survival to one OA PDF, programmes built to widen OA access for clinicians—e.g., HINARI Access to Research in Health / Research4Life—have peer-reviewed evaluations showing clinicians and institutions used the

newly accessible literature in care and training across low- and middle-income countries, helping close the “know-do” gap that underpins preventable mortality.

What this means for your colleague’s claim

It’s understandable that “this one OA paper saved this one named patient” case-reports are rare—clinicians don’t usually document access modality in case notes. But there are now well-cited, peer-reviewed analyses showing that OA outputs (methods papers, preprints, and guidelines) triggered rapid changes in clinical decisions and were associated with reduced mortality at scale. That directly contradicts the assertion that no example exists of full-text access contributing to decision-making or saving lives.

If you want a compact references list for rebuttal use these four anchors:

1. Corman VM, Landt O, Kaiser M, et al. Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR. *Eurosurveillance*. 2020 Jan 23;25(3):2000045. doi: 10.2807/1560-7917.ES.2020.25.3.2000045.
2. Horby P, Landray MJ, RECOVERY Collaborative Group. Effect of dexamethasone in hospitalized patients with COVID-19 – Preliminary Report. *medRxiv*. 2020 Jun 22.doi:10.1101/2020.06.22.20137273.
3. Higuchi T, et al. The Japanese Guide affected the prescription of steroids for COVID-19 inpatients in Japan. *BMC Public Health* / pre-print. 2023. (Showed prescribing shift post-guidance).
4. Besançon L, Peiffer-Smadja N, Segalas C, et al. Open science saves lives: lessons from the COVID-19 pandemic. *BMC Med Res Methodol*. 2021;21(1):117. doi:10.1186/s12874-021-01304-y

HIFA Profile: David Cawthorpe is Adjunct Assistant Professor at the University of Calgary, Canada. His professional interests include: Human Development, Developmental Psychopathology, and Delivery of low bandwidth medical education curriculum. cawthord AT ucalgary.ca

**Open access (113) How important is open access publishing for healthcare professionals?
(4) Has open access to research ever saved a life? (8)**

12 November, 2025

Dear David,

Thanks for your message with your prompt to ChatGPT and its response. I find this interesting in two ways. First, it potentially informs us to what extent access to the full text of research might save lives. Second, it is an opportunity for us to look at the potential and the limitations of ChatGPT.

Your prompt: ‘One of my colleagues made the following statement, but I was wondering if you had any insights or could answer the question with reference to published literature... for example... is there a published paper that proves open access literature helped save a patient or helped treat a patient? It would be fine to have a body of work that is open access to influence policy in a way that saved lives— that would be an appropriate reference as well: here is the

original response that I am asking you to consider an answer answering this question—
“However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making. We asked ChatGPT, who could not identify an example either.”

My comment on the prompt: The original objective was to 'identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making'. As I said in my original message, we are not asking about free/open access to derivatives of health research: clinical guidelines, formularies, training materials, manuals, decision aids. I think we would all agree that these are vital to deliver quality health care and thereby save lives. Our query is specifically about access to the full text of a research paper in a clinical context. It would be interesting to see examples in a policy context as well, but these are outside the remit of the original query.

ChatGPT then gives five examples. It would be interesting to look at each of these in turn to see whether any of them respond to the original query.

I'll start with the first example:

"#1: The first widely used COVID 19 (SARS-CoV-2) PCR protocol was published OA in Eurosurveillance on 23 Jan 2020 (Victor M. Corman et al.). Labs worldwide stood up diagnostic testing using that paper's primers/protocols—core to triage, isolation, and care."

Helpfully ChatGPT gives us the reference: Corman VM, Landt O, Kaiser M, et al. Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR. Eurosurveillance. 2020 Jan 23;25(3):2000045. doi: 10.2807/1560-7917.ES.2020.25.3.2000045.

Here is the abstract:

Abstract

Background: The ongoing outbreak of the recently emerged novel coronavirus (2019-nCoV) poses a challenge for public health laboratories as virus isolates are unavailable while there is growing evidence that the outbreak is more widespread than initially thought, and international spread through travellers does already occur.

Aim: We aimed to develop and deploy robust diagnostic methodology for use in public health laboratory settings without having virus material available.

Methods: Here we present a validated diagnostic workflow for 2019-nCoV, its design relying on close genetic relatedness of 2019-nCoV with SARS coronavirus, making use of synthetic nucleic acid technology.

Results: The workflow reliably detects 2019-nCoV, and further discriminates 2019-nCoV from SARS-CoV. Through coordination between academic and public laboratories, we confirmed assay exclusivity based on 297 original clinical specimens containing a full spectrum of human respiratory viruses. Control material is made available through European Virus Archive – Global (EVAg), a European Union infrastructure project.

Conclusion: The present study demonstrates the enormous response capacity achieved through coordination of academic and public laboratories in national and European research networks.

My comment on #1: This study is clearly irrelevant to my original query. It does not provide an example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making.

I'll have a look at the other four examples given by ChatGPT. If you or other HIFA members would like to do the same, this would be great - we can compare notes.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (114) Has open access to research ever saved a life (9)

13 November, 2025

Dear David,

Thanks for your enquiry to ChatGPT in relation to my statement: "However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making."

ChatGPT gave five 'examples'. Yesterday I looked at the first example (detection of COVID-19 by real-time RT-CPR) and concluded it was not relevant.

Here is the second example:

#2: The RECOVERY trial "dexamethasone" result was released OA as a medRxiv preprint on 22 Jun 2020. Multiple studies document immediate practice change and associated mortality reduction after the OA preprint emerged (with later peer-review confirming the effect).

Example impact documentation: an interrupted-time-series analysis found an "abrupt increase in dexamethasone use and an associated decrease in mortality" after RECOVERY's release; a Japanese nationwide analysis shows steroid prescribing pivoting specifically to dexamethasone once guidance incorporated the (OA-circulating) RECOVERY result.

Reference: Horby P, Landray MJ, RECOVERY Collaborative Group. Effect of dexamethasone in hospitalized patients with COVID-19 – Preliminary Report. medRxiv. 2020 Jun 22.doi:10.1101/2020.06.22.20137273.

COMMENT (NPW): This research has been described by the evidence-based medicine leader Paul Glasziou. He says 'RECOVERY has been remarkable, going from first meeting to first patient recruited in a record-setting nine days, recruiting 13% of all COVID-19 hospitalised patients in the UK during the first COVID-19 wave; and a few months later giving clear answers on the effectiveness of dexamethasone.'

What was remarkable was the overall process. The publication of the pre-print was one part of a wider process. I note the researchers findings were published as an 'official' paper just a few weeks' later in the New England Journal of Medicine (<https://pmc.ncbi.nlm.nih.gov/articles/PMC7383595/>). It would be interesting to know how this was achieved (perhaps the researchers were already in contact with the NEJM during the course of their research?). The NEJM paper was accompanied by an editorial commentary by Clifford Lane and Anthony Fauci ('Research in the context of a pandemic' <https://pmc.ncbi.nlm.nih.gov/articles/PMC7383591/>).

I would argue that what would have been most useful to clinicians and policymakers was perhaps not the preprint, but the NEJM paper (which would have been edited, formatted and peer-reviewed) and associated commentary.

This is a good example in that it demonstrates how pre-prints can accelerate research communication. But it also seems to me to underline the importance of journals and their role in editing and peer-review.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (115) Has open access to research ever saved a life (10) CHatGPT example #2/#3

13 November, 2025

Dear HIFA colleagues,

I sent a comment on ChatGPT's example #2 earlier today (with thanks to David Cawthorpe). I concluded 'This is a good example in that it demonstrates how pre-prints can accelerate research communication. But it also seems to me to underline the importance of journals and their role in editing and peer-review.' But it's arguable whether it serves as an example of 'how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making'. On reflection, I don't think it demonstrates such an example. For example, we don't know of a specific health professional that sought the preprint and made a clinical decision on that basis, as compared with a specific health professional that made such a decision based on the NEJM paper and/or commentary. Indeed, while the NEJM paper was free to read at the time of the publication, it was not open-access. (If we had a situation where clinicians were unable to access the NEJM paper because it was behind a paywall, and that quality of care was reduced as a result, this would have been a good example.)

It is also notable that, by the time of publication (July 2020), leading publishers had committed (in March 2020) 'to making all of their COVID-19 and coronavirus-related publications, and the available data supporting them, immediately accessible in PubMed Central (PMC) and other public repositories. This will help to support the ongoing public health emergency response efforts'. The fact they did so suggests, in itself, that the needs of public health (particularly in emergency situations) are better served by open (or at least free) access.

If we turn our attention to #3 of ChatGPT examples, this also relates to COVID-19:

#3: COVID guideline pipelines that were fully OA (for example, rapid recommendations in The BMJ; national guidance updates) show measurable prescribing shifts once OA recommendations cited the RECOVERY preprint/journal article—again underscoring that open, immediately accessible evidence changed treatment at scale. The Japanese study noted dexamethasone prescriptions rose from ~2.5 % to ~35.2 % after week 29 (July 2020) when it was formally included in guidance.

Reference: Higuchi T, et al. The Japanese Guide affected the prescription of steroids for COVID-19 inpatients in Japan.

COMMENT (NPW): This paper (June 2023) simply showed that national guidance in Japan led to increased use of dexamethasone in that country, which is unremarkable. This paper could

hardly be an example of a paper that a health professional might seek to help in clinical decision-making for an individual patient. The 'Japanese Guide' itself was published back in March 2020. Clearly, the guide would have been used by health professionals, but this is outside the remit of our question, which is looking at the impact on healthcare of open-access, full text research papers.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (116) Can you think of an example where access to the full text of a research paper helped you to manage a patient? (3)

13 November, 2025

Re: Open access (110) Can you think of an example where access to the full text of a research paper helped you to manage a patient? (2)

Dear Margaret and All, Thank you for highlighting this interesting and most relevant paper. ["The impact of COVID-19 on the debate on open science: a qualitative analysis of published materials from the period of the pandemic" <https://www.nature.com/articles/s41599-024-03804-w>]

'Line of sight' <https://hodges-model.blogspot.com/search?q=line+of+sight>

- and variants - 'thought', 'action', 'duty', 'symmetry', 'best fit', 'demarcation' (science : non-science) .. have arisen in reflection and critique for quite a while.

Geographically - topographically, I experience this almost weekly walking along a nearby coast, a hotel, yacht racing office and 'home' alternate, literally in 'line of sight'.

It reframes in health our 'transparency' versus 'opaque'.

Note (again I think?) the diametric opposition in Hodges' model between the SCIENCES domain of knowledge; and the public's understanding of science in the SOCIOLOGICAL domain of knowledge.

I particularly like, what is essentially a purpose of Hodges' model:

'There were also moves to reframe open science conceptually, particularly in connecting science with society and addressing broader questions of equity.'

equity (equality - inequity, inequality..) <https://hodges-model.blogspot.com/search?q=equity>

Perhaps it's ironic that being onLINE can without due care and attention blur the 'lines' almost completely.

Regards

Peter Jones Community Mental Health Nurse, Part-time Tutor and Researcher Blogging at "Welcome to the QUAD" <http://hodges-model.blogspot.com/> <http://twitter.com/h2cm>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges'

model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>). h2cmuk AT yahoo.co.uk

Open access (117) Has open access to research ever saved a life (11) CHatGPT example #4

14 November, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-112-how-important-open-acce...>]

Dear David and all,

Thanks again for your message above, where you asked ChatGPT in relation to my original challenge: “However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making.”

I've looked and discounted the first three examples, all of which relate to COVID-19.

#1 <https://www.hifa.org/dgroups-rss/open-access-113-how-important-open-acce...>

#2 <https://www.hifa.org/dgroups-rss/open-access-114-has-open-access-research...>

#2/3 <https://www.hifa.org/dgroups-rss/open-access-115-has-open-access-research...>

Here is example #4:

#4: 'Beyond single drugs, there's a peer-reviewed synthesis arguing (with case documentation) that open science / OA “saves lives” in outbreaks by accelerating methods, data and guidelines—the COVID pandemic is the clearest modern proof-of-concept.'

Reference: Besançon L, Peiffer-Smadja N, Segalas C, et al. Open science saves lives: lessons from the COVID-19 pandemic. BMC Med Res Methodol. 2021;21(1):117. doi:10.1186/s12874-021-01304-y

COMMENT (NPW): Yet again, this example relates to COVID-19. The authors note: 'In response to the COVID-19 pandemic many publishers and researchers have sped up their adoption of Open Science practices, sometimes embracing them fully and sometimes partially or in a sub-optimal manner. In this article, we express concerns about the violation of some of the Open Science principles and its potential impact on the quality of research output. We provide evidence of the misuses of these principles at different stages of the scientific process. We call for a wider adoption of Open Science practices in the hope that this work will encourage a broader endorsement of Open Science principles and serve as a reminder that science should always be a rigorous process, reliable and transparent, especially in the context of a pandemic where research findings are being translated into practice even more rapidly'

On reading the text, I noted a mismatch between the title and the content. The title 'Open science saves lives' would suggest that the paper would provide evidence that open science saves lives. But saving lives was not even mentioned in the full text and no such evidence was provided. Indeed, much of the paper pointed to some major problems with preprints and rapid open access publication, as shown by these two extracts:

1. 'The scientific community has responded accordingly, with the publication of over 80,000 preprints and peer-reviewed articles on COVID-19 or SARS-CoV-2 since announcement of the emergence of a new virus on 31 st December 2019 [1]. Many of these publications have contributed to the development of a body of knowledge that has since informed practice but a considerable number of these studies suffer methodological weaknesses, limiting the interpretability of their findings [2] or leading to false claims with a potentially dramatic impact on public health.'

2. 'While the need for faster scientific dissemination during a pandemic is understandable, the possibility to publish without a rigorous and critical peer-review process is, in some circumstances, detrimental to the scientific community and the public at large. This is the case when these findings are used to inform medical practice or public health policies. For example, following concerns about the scientific validity of a study investigating the effectiveness of hydroxychloroquine, accepted for publication in less than a day after submission [33], post-publication reviews were commissioned. These reviews, published 4 months after the initial publication, [28, 62], pointed out major methodological and ethical flaws. Despite this, the paper was not retracted, on the grounds that it gives room for scientific debate'

Apart from the above, we can also note that this paper was a commentary and not a formal research paper. We can clearly see that this paper would not have been of any use in informing decision-making by a healthcare professional.

I would therefore again discount this paper in terms of the original challenge.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (118) Has open access to research ever saved a life (12) CHatGPT example #5

14 November, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-112-how-important-open-acce...>]

Dear David and all,

Thanks again for your message above, where you asked ChatGPT in relation to my original challenge: "However, to date we have been unable to identify a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making."

Finally I'd like to comment on the last example provided by ChatGPT.

'#5 (health-system access): While it's harder to tie one patient's survival to one OA PDF, programmes built to widen OA access for clinicians—e.g., HINARI Access to Research in Health / Research4Life—have peer-reviewed evaluations showing clinicians and institutions used the newly accessible literature in care and training across low- and middle-income countries, helping close the "know-do" gap that underpins preventable mortality.'

ChatGPT doesn't give a reference for this one, but most of us are familiar with Hinari and would agree that it has improved the availability and use of research papers in peer-reviewed journals.

However, Hinari is not primarily an open-access initiative. The primary benefit of Hinari is that it provides access to subscription journals free or at low cost to certain institutions in eligible countries.

The example doesn't respond to the original challenge of identifying a specific example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making.

We have now asked the HIFA community and ChatGPT for such examples. None have emerged from HIFA members. Your approach to ChatGPT yielded 5 examples, and my previous approach yielded 6 examples. However, none of these 11 examples fit our original challenge.

We can therefore conclude that 'we have been unable to identify (through the HIFA forum or through ChatGPT) a single example of how access to the full text of a research paper saved a life, or even contributed directly to clinical decision-making.'

Such examples may well exist. Absence of evidence is not evidence of absence. But for me this exercise raises questions about the importance of open access to research (as opposed to open access to derivative content) to clinical decision-making.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (119) Has open access to research ever saved a life? (13) Benefits of OA journals

Dear Neil and HIFA colleagues,

It has been a very interesting thematic discussion on Open-Access (OA) with your response from ChatGPT.

This got me interested in doing a quick PubMed search.

Interestingly, I couldn't find any OA research that directly saved a life; however, we should think of the numerous benefits of OA research in the context of public health, which saves many lives with the development of health policies and their implementation through national health plans and impacts lives, particularly in low- and middle-income countries (LMICs).

While there are predatory OA medical journals with very high article processing charges (APC) and improper review methodology, but several OA medical journals (e.g. Lancet, BMJ, PLOS, BMC, Creative Commons licences, etc.) maintain very high standards before acceptance for publication with different APC structures.

These OA medical journals benefit the lives of populations, particularly in LMICs, to enable: - Health providers to access and reproduce research in the local context. - In academia, medical trainees can publish their research most often at a faster rate. - Easy access and more frequent citations in scientific papers - Allow health providers to implement evidence-based clinical guidance at the point of care. - Global collaborative projects with interdisciplinary proposals for research and funding. - The public can access and engage in discussions with their health providers on the updated medical progress, prevention, diagnosis, and treatment. - All people to 'the right to access evidence-based medical knowledge', not only for themselves but also to engage with policymakers for equity in health. (HIFA global campaign).

Best wishes

Dr Meena Nathan Cherian, MBBS, MD (Anaesthesia) (Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland). Director, Global Health New Challenges:online courses, Geneva Foundation for Medical Education & Research (GFMER), Switzerland. www.gfmer.ch/surgery/cancer.htm Senior Advisor, Global Action, International Society of Geriatric Oncology (SIOG). Permanent Committees - SIOG Adjunct Prof.The Chinese University of Hong Kong,Shenzhen,China. <https://med.cuhk.edu.cn/en/teacher/371>

WHO-HIFA Working Group on Essential Health Services,COVID-19, Learning for Quality Health Services; mHEALTH-INNOVATE. www.hifa.org

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HIFA profile: Dr Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; she is a member of the HIFA Steering Group; HIFA Partnerships and Projects Working Group; and HIFA mHEALTH-INNOVATE Working Group. [https://www.hifa.org/support/members/meena-nathan-cherianm15 AT gmail.com](https://www.hifa.org/support/members/meena-nathan-cherianm15%40gmail.com)

Open access (120) Has open access to research ever saved a life? (14) Benefits of OA journals (2) Gates Foundation Open Access Policy (5)

16 November, 2025

Dear Meena,

Thank you for your message yesterday. <https://www.hifa.org/dgroups-rss/open-access-119-has-open-access-researc...>

It was interesting to hear that you couldn't find any evidence through a PubMed search that OA research directly saved a life. This means that we have now been unable to find any examples where open access to research has saved a life (or even contributed to quality of care) despite:

1. repeatedly asking HIFA members through this forum
2. asking ChatGPT through two approaches (one by myself and one by HIFA member David Cawthorpe), and
3. running a PubMed search.

This doesn't mean that such examples don't exist. But it does suggest that we may overestimate the potential direct impact of access to the full-text of research on patient care. On the other hand, open access has major indirect benefits as we have previously discussed.

Thank you also for listing some of the benefits of OA journals. For me, this emphasises the value-added that journals can bring in terms of quality and accessibility to different end-users.

This reminds me of Thomas Krichel's recent message in response to my assertion that 'OA journals continue to have a vital role to play'. He replied: "They surely vitally enrich publishers. But since publishers in general don't pay reviewer---who do the actual evidence work---journals do very little to further evidence." <https://www.hifa.org/dgroups-rss/open-accesss-105-unanswered-questions-5...>

I would agree that some OA journals charge excessive APCs to generate more profit. And I agree that publishers in general don't pay reviewers. But I disagree that journals do very little to further evidence. The publishing process, including editorial assessment, copy-editing, communications with authors, peer review, proofreading and final sign-off for publication add a great deal to further evidence. The publishing process is one of the six pillars of the global evidence ecosystem. <https://www.hifa.org/about-hifa> We need to strengthen the pillar, not weaken it.

Some of us (including myself) argue that research funders should take responsibility for paying APCs, but that these should reflect actual costs which should be transparent - similar to what was proposed by Plan S several years ago. This could be driven simply by capping the APC budget line. The Gates Foundation disagrees and has decided to stop paying APCs altogether, a decision that is arguably reckless. Uzo Adirieje wrote: 'When a research project funder like Bill Gates Foundation decides to stop paying Article Processing Charges (APCs), it can significantly affect the visibility, accessibility, utilization, and impact of funded research. Without APC support, researchers may not be able to publish in open-access journals, with the risk of limiting global access to their findings — especially in low- and middle-income regions.' <https://www.hifa.org/dgroups-rss/open-access-104-should-funders-stop-pay...>

Several days ago I invited the Gates Foundation to join our discussion and await their response.

Meanwhile, I would agree with one aspect of the Gates policy: that non-APC-based models should be explored. We need to understand the different business models of diamond OA journals (those that do not charge APCs) and how they work. 'Diamond open access refers to academic texts (such as monographs, edited collections, and journal articles) published/distributed/preserved with no fees to either reader or author... applied to a variety of structures and forms of publishing, from subsidized university publishers to volunteer-run cooperatives that existed in prior decades.' https://en.wikipedia.org/wiki/Diamond_open_access

We previously heard from Ruwaida Salem, managing director of Global Health Science and Practice. GHSP is a diamond OA journal that was previously funded by USAID and has recently relaunched since USAID was dismantled. You can read about their experience here: <https://www.hifa.org/dgroups-rss/open-access-34-removing-barriers-betwee...>

There has indeed been a gap in our discussion in relation to promising new models such as diamond OA journals. We are coming to the end of our official discussion time but I leave the forum open for further contributions. Please send email to: hifa@hifaforums.org

With thanks and best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (121) Can you think of an example where access to the full text of a research paper helped you to manage a patient? (4) Indirect benefits of open access

16 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-110-unanswered-questions-7-...>

Dear Margaret and all,

You wrote: In seeking evidence about OA and saving lives, this study would be useful to review: "The impact of COVID-19 on the debate on open science: a qualitative analysis of published materials from the period of the pandemic" <https://www.nature.com/articles/s41599-024-03804-w> The article is Open Access. The section "Clear 'line of sight' to the benefits of OS" is particularly relevant to our discussion; I won't paste the entire section here but it includes many citations that might provide a basis for a deeper discussion.

The abstract reads: 'This study is an analysis of the international debate on open science that took place during the pandemic. It addresses the question, how did the COVID-19 pandemic impact the debate on open science? The study takes the form of a qualitative analysis of a large corpus of key articles, editorials, blogs and thought pieces about the impact of COVID on open science, published during the pandemic in English, German, Portuguese, and Spanish. The findings show that many authors believed that it was clear that the experience of the pandemic had illustrated or strengthened the case for open science, with language such as a "stress test", "catalyst", "revolution" or "tipping point" frequently used. It was commonly believed that open science had played a positive role in the response to the pandemic, creating a clear 'line of sight' between open science and societal benefits. Whilst the arguments about open science deployed in the debate were not substantially new, the focuses of debate changed in some key respects. There was much less attention given to business models for open access and critical perspectives on open science, but open data sharing, preprinting, information quality and misinformation became most prominent in debates. There were also moves to reframe open science conceptually, particularly in connecting science with society and addressing broader questions of equity.'

The impact that is being discussed here represents part of what we have been describing over the past few weeks as the 'indirect' impacts of open access on health.

A quote from the full text: 'During the pandemic, many of its advocates saw the pandemic as finally demonstrating unequivocally the case for OS, with some going as far as to assert "Open science saves lives" (Besançon et al. 2021)' Also '[the] current pandemic makes abundantly clear that the public availability of public knowledge indeed saves lives – but it doesn't do so only now, it always does' (van Gerven Oei 2020).

I would agree that 'Open science saves lives'. Open science is more than open access. Both are drivers of the global evidence ecosystem and therefore have the potential to improve the availability and use of reliable healthcare information and save lives. In the current discussion our focus is on open access to the full text of research papers. There are of course many derivative publications (clinical guidelines, formularies, educational resources...) that are open-access, and they clearly are used extensively by clinicians to inform their decisions and save lives. What is in doubt is the extent to which original research papers directly save lives - we have been unable to identify a single case. Even if it is true that open access to research has

little direct impact, our discussion over the past few weeks has shown that open access to research has substantial indirect impacts

I would also certainly agree that 'the public availability of public knowledge indeed saves lives'. This was self-evident long before the pandemic. However, I would not use the term 'public knowledge'. Public knowledge is defined by Merriam-Webster as 'something that people know because it has been reported in the news' <https://www.merriam-webster.com/dictionary/public%20knowledge> This definition is itself not accurate, as public knowledge can also spread by word of mouth or any other medium. The main problem is that the term 'public knowledge' says nothing about the reliability of that knowledge: is it based on cumulative evidence derived from robust research? For us on HIFA, this is critical. There are many examples of so-called 'public knowledge' that are frankly dangerous, including popularly held false beliefs as well as misinformation from governments.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (122) Has open access to research ever saved a life? (15) Predicting the Probability That Open-Access Clinical Literature Saves Lives

18 November, 2025

Dear Colleagues,

Possibly this paper will present a slightly different perspective for organizing considerations about the impact of open access journals....

Further the OA platform also brings forward a relatively new style of open access publishing. One's paper is published quickly and it is immediately open to peer review. I think I mentioned Qeios to HIFA once before. Qeios has become my favorite.

Best, David

Predicting the Probability That Open-Access Clinical Literature Saves Lives. Qeios.
doi:10.32388/U2SYIR. <https://www.qeios.com/read/U2SYIR>

Abstract

Whether open-access (OA) clinical literature directly saves lives is frequently debated, yet empirical documentation is scarce because clinical notes rarely record how evidence was accessed. This study synthesizes high-impact cases of OA-enabled clinical change—most notably the SARS-CoV-2 PCR diagnostic protocol and the RECOVERY dexamethasone findings—and develops an expanded Bayesian predictive model estimating the probability that a single clinician reading one OA article saves a life. We integrate three primary evidence bases: (1) clinician-reported rates of practice change following article consultation, (2) the proportion of clinical decisions that influence short- or long-term mortality, and (3) empirically observed mortality reductions following OA-mediated dissemination of life-saving therapeutic evidence. We then extend this model by incorporating additional determinants of diagnostic and therapeutic accuracy, including medical error rates, years of clinical experience, multimorbidity-dependent diagnostic entropy, cognitive load, structural barriers, team-based reliability, guideline adherence, and electronic health record (EHR)-related error susceptibility, formalized in a multilevel Bayesian framework. The core model yields a probability range of $p \approx$

0.003–0.02 that a clinician–article encounter prevents one death, corresponding to a Number Needed to Treat (NNT) analog of approximately 50–330 clinician–article encounters. After accounting for heterogeneity in clinical acuity, multimorbidity, and the extended set of clinician and system parameters, hierarchical Bayesian extensions adjust the predictive interval to $p \approx 0.002$ –0.03 and $NNT \approx 30$ –500. The integrated analysis demonstrates that OA literature meaningfully increases the probability of life-saving clinical decisions, especially in high-acuity environments where marginal improvements in evidence latency and accuracy have large mortality consequences.

HIFA Profile: David Cawthorpe is Adjunct Assistant Professor at the University of Calgary, Canada. His professional interests include: Human Development, Developmental Psychopathology, and Delivery of low bandwidth medical education curriculum. cawthorpe AT ucalgary.ca

Open access (123) Chaos is coming for scholarly publishing: Open Journals Collective and Diamond OA journals

18 November, 2025

'Chaos is coming for scholarly publishing' - Research Professional News <https://share.google/EZ9H7LFS5mLpza507>

(with thanks to Jonathan Parker, HIFA steering group member)

Extracts

'What's certain is that the Big Five will no longer reap the obscene profit margins they've enjoyed for decades. Their multimillion-dollar agreements with artificial intelligence companies may be the last windfall.'

'The financial crisis at UK universities has left librarians needing to save hundreds of thousands of pounds each year. An obvious thing to cut is commercial publishers' journal packages— university libraries spend up to 60 per cent of their budgets on subscriptions and licensing agreements with the Big Five commercial publishers: Elsevier, Springer Nature, Wiley, Taylor & Francis and Sage...

'Diamond open access, where journals charge neither readers nor authors, has equity baked in. The international Plan S initiative defines it as “community-driven, academic-led, and academic-owned”...

'A growing number of high-profile journals have flipped to diamond open access...

'January 2026 will see a major step towards mainstreaming diamond open access, in the shape of the Open Journals Collective. This initiative replaces transformative agreements with a non-profit, community-led research infrastructure, collectively raising funds to support diamond journals.

'More than a dozen participating publishers in the UK, US and continental Europe have been announced so far. By investing in OJC-supported journals, libraries get more control over how their funding is spent and can collectively design an exit ramp from commercial big deals...

'At the Open Library of Humanities, which I co-founded in 2015, our average annual library membership of about £1,600 per year—which supports the publishing costs of more than 30 journals—wouldn't cover a single article processing charge at most commercially run journals...

'We can confront loss of access to expensive commercial journals by working together to move to a non-profit, community-governed publishing system.'

Caroline Edwards is professor of contemporary literature and culture at Birkbeck, University of London. She is co-founder and executive director of the Open Library of Humanities and a director of the Open Journals Collective.

COMMENTS (NPW): I watched a presentation by Caroline Edwards about Open Journals Collective here: <https://vimeo.com/1090554632>

What I understood:

It is led by 'academics, librarians, publishers'

'we stand united against commercialisation of research communication. We refuse to see our work exploited for profit'. 'Transformative Agreements (between academic institutions and top 5 publishers' are inequitable

The OJC appears to identify journals that are unhappy with their current arrangements with commercial publishers, and invite them into a new arrangement with OJC where academics can run their own journals

The funding model is still unclear to me. It is run on a non-profit basis and it seems that people will be able to become members by providing an annual fee. It's expected that operation would be funded by 'libraries and funding councils'.

It's interesting that the OJC explicitly describes itself as political. It is also anti-commercial and appears to be a reaction against the profits of commercial publishers.

The presenter did not discuss the role of preprints at all - they were not even mentioned. And despite embracing library and information professionals, there was no perspective on whether and how this approach might strengthen (or weaken) the quality of journal publishing and the global evidence ecosystem. It did feel that it was largely being done for the benefit of academics and librarians who are unhappy about some aspects of commercial publishing among the 'big 5'.

I think it will be challenging to get people to invest sustainably in such a way that this model would approach the size and operations of the big 5 publishers.

Capping of APCs still seems to be the easiest way forward, although I take on board Ginny Barbour's comment that we need a diversity of approaches.

I look forward to your comments.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (124) Chaos is coming for scholarly publishing: Open Journals Collective and Diamond OA journals (2) The Hidden Costs of Diamond OA

19 November, 2025

Dear HIFA colleagues,

Yesterday I shared an optimistic article on the future of Diamond OA journals.

<https://www.hifa.org/dgroups-rss/open-access-123-chaos-coming-scholarly-...>

Thanks to Margaret Winker and the WMA Newsletter, I was interested to read an opposite perspective on the SScholarly Kitchen blog. Extracts below.

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When “Free” Isn’t Fair: The Hidden Costs of Diamond OA

The “no-fee” model often conceals significant costs. Editorial labor, copyediting, typesetting, hosting, preservation — none of these are free. When no revenue is collected from subscriptions or APCs, someone must absorb the expense. Often, that “someone” is a small editorial team working unpaid, a university department stretching its limited budget, or a scholarly society relying on volunteer time.

The closure of Work Organisation, Labour and Globalisation illustrates this point starkly. Its diamond OA pivot aligned perfectly with open science principles, but without sustainable funding, the model collapsed under the weight of uncompensated work.

By contrast, some well-resourced systems are experimenting with structured funding. In 2024, the Dutch research council NWO launched grants of up to €50,000 to support journals flipping to diamond OA, recognizing that transitions are costly and require financial planning. Similar initiatives, such as NSF-funded programs at MIT, provide crucial short-term support for the transition phase. However, most of these grants last only a few years, leaving journals facing significant uncertainty once the initial funding ends. This underscores a critical gap between facilitating a transition and ensuring long-term sustainability.

Building a Fairer Future: From Celebration to Collaboration

If diamond OA is to fulfil its equity promise, it cannot rely solely on idealism. The Toluca–Cape Town Declaration (2024), emerging from the 2nd Global Summit on Diamond Open Access, calls for a coordinated global effort to strengthen the model, including sustainable funding mechanisms, shared infrastructure, common quality standards, and collaborative governance structures.

Several policy recommendations emerge from recent research:

Shared Infrastructure: Pooled publishing platforms and shared technical services can reduce costs and raise quality across many small journals.

Institutional Funding: Universities and governments should integrate diamond OA support into core research funding, rather than relying on short-term grants.

Indexing Inclusion: Repositories, indexing services, and bibliometric systems must adapt to better represent regionally focused and non-English diamond journals.

Capacity Building: Training in digital publishing, metadata standards, and editorial best practices can help journals meet global technical criteria.

==

COMMENT (NPW): It's interesting to see that Diamond OA advocates are now saying that diamond OA should be supported in core research funding. Which brings us back to where we were a few weeks ago: research funders should take responsibility for affordable APCs that reflect actual processing costs.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (125) The Hidden Costs of Diamond OA (2) Correction

20 November, 2025

[Re: <https://www.hifa.org/dgroups-rss/open-access-124-chaos-coming-scholarly-...>]

Dear Neil,

Thank you; I appreciate the shout out, but I'd like to correct that the Newsletter to which you refer is from WAME, World Association of Medical Editors, rather than WMA. [thanks for correction and apologies for the error, NPW]

Best wishes,
Margaret Winker

Margaret Winker, MD
eLearning Program Director
Trustee
World Association of Medical Editors

wame.org
WAME eLearning Program <<https://wame.org/wame-elearning-program.php>>
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HIFA profile: Margaret Winker is Trustee and Past President of the World Association of Medical Editors (WAME) and Director of the WAME eLearning Program. She is based in the US.

Professional interests: WAME is a global association of editors of peer-reviewed medical journals who seek to foster cooperation and communication among editors, improve editorial standards, promote professionalism in medical editing through education, self-criticism, and self-regulation, and encourage research on the principles and practice of medical editing.
margaretwinker AT gmail.com

Open access (126) Journal of the Medical College for Women & Hospital, Dhaka, Bangladesh (2) Diamond OA and BanglaJOL

20 November, 2025

Dear Dr Rahnuma Ahmad,

Thank you for your introduction message and welcome to HIFA! I was very interested to learn about your Journal of the Medical College for Women & Hospital, Dhaka, Bangladesh and I see that this is an open access journal and 'there is no article processing charges (APCs) or submission charges'. The Medical College for Women & Hospital (MCWH), Dhaka 'bears all the costs of publication of the journal'.

I also note that your journal is part of Bangladesh Journals Online (BanglaJOL), which was established by INASP (where I used to work up to 2005) and is now managed by Bangladesh Academy of Sciences.

'BanglaJOL uses the Open Journals System created by the Public Knowledge Project based in Canada. This software is open source and allows the journal content listed on BanglaJOL to be indexed through Open Archives Initiative search engines dedicated to research, which harvest the metadata for each journal article, making this work readily available to a global audience, and giving the journals greater visibility among the worldwide research community.'

This appears to be a successful example of a diamond OA journal that is supported by an academic institution and collaborates with other journals in Bangladesh as part of BanglaJOL.

I would be very interested to learn more about your experience with evolving the journal and working with BangaJOL.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (127) Benefits of OA journals (3)

20 November, 2025

Re: <https://www.hifa.org/dgroups-rss/open-access-105-should-funders-stop-pay...>

In response to my statement 'OA journals continue to have a vital role to play' Thomas Krichel writes:

'They surely vitally enrich publishers. But since publishers in general don't pay reviewer---who do the actual evidence work---journals do very little to further evidence.'

Yes, a minority of OA journals enrich the publisher by charging inflated APCs. And publishers in general don't pay for peer review. But I don't agree that journal publishers 'do very little to further evidence'.

Without the input of journals, research communication would be a mess. The journal publishing process is one of the six components of the global evidence ecosystem. <https://www.hifa.org/about-hifa>

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (128) Should funders stop paying APCs? (4)

20 November, 2025

We have discussed at length about APCs and the Gates Open Access Policy. A few of us have agreed that funders should take responsibility for paying a fair price for article processing charges (APCs), with one person expressing support for the policy.

I was reviewing their policy and they stipulate: 'Grantees should not pay [APC] fees out of their budget'. It does feel like the Gates policy is driven by ideology against Gold OA journals rather than pragmatism on what works best for health research communication. If the Gates Foundation and others were simply to cap APCs this would allow researchers more choice and thereby support knowledge translation and positive health outcomes. Capping APCs would also allow them to continue to explore the role of preprints, APC-free journals and other models.

Meanwhile I asked ChatGPT if it can identify any other research funders that have followed the path of the Gates Foundation. ChatGPT was unable to identify a single research funder that had taken the same decision. There are several funders that boycott hybrid journals, and this is understandable, but the Gates Foundation is the only funder that refuses to pay APCs altogether.

As Ginny Barbour has said, "I would start from the premise that it's essential that systems are designed collectively and in cooperation regionally and globally." It would be interesting to know the extent to which there is cooperation (or lack of it) among the leading health research funders. In particular it would be important to understand the research communication policies of the top 10 health research funders, listed here: <https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-...> The Gates Foundation ranks 16th.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh

Open access (129) Benefits of OA journals (4)

20 November, 2025

Neil Pakenham-Walsh writes

> In response to my statement 'OA journals continue to have a vital role to play' Thomas Krichel writes:

> > 'They surely vitally enrich publishers. But since publishers in general don't pay reviewer--- who do the actual evidence work---journals do very little to further evidence.'

> > Yes, a minority of OA journals enrich the publisher by charging inflated APCs.

My point has nothing to do with APCs being high or low. It has to do with who produces the value and who gets paid, irrespectively of the amounts being paid.

-- Written by Thomas Krichel <http://openlib.org/home/krichel> on his 22084th day.

HIFA profile: Thomas Krichel is Founder of the Open Library Society, United States of America. Professional interests: See my homepage at <http://openlib.org/home/krichel> Email address: krichel at openlib.org

Open access (130) Benefits of OA journals (5)

20 November, 2025

Neil Pakenham-Walsh writes

> Without the input of journals, research communication would be a mess.

It's already a mess with the journals. Remember the Lancet paper about Spuntik V? If the results were even approximately true, the WHO would have approved Sputnik V. It never did.

-- Written by Thomas Krichel <http://openlib.org/home/krichel> on his 22084th day.

HIFA profile: Thomas Krichel is Founder of the Open Library Society, United States of America.

Professional interests: See my homepage at <http://openlib.org/home/krichel> Email address: krichel at openlib.org