Global Journal of Medicine & Public Health

Editorial: 10th anniversary of a not-for-profit online open access journal; Critical Reflections on the development of GJMEDPH

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ABSTRACT

The Global Journal of Medicine and Public Health (GJMEDPH) is now 10 years old. From its beginnings, the journal has been a good faith effort with committed leadership: free-standing, unlinked to any other publishing entity, with limited financial but significant voluntary support. Being able to publish and access relevant research is a valid need in all world regions. Over the past decade, GJMEDPH has played a role in expanding this capacity: an online OA vehicle for sharing observations and identifying feasible interventions. The journal has published work from researchers across the development spectrum, but mostly from South Asia and sub-Saharan Africa. In accomplishing a decade of publishing, GJMEDPH has reached a relevant milestone. The aspirational vision for an even more successful new decade should be continuous quality improvement: fine tuning its performance and sharpening its focus so as to further benefit the quality of health science research and development across the Global South.

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EDITORIAL

The Global Journal of Medicine and Public Health (GJMEDPH) is now 10 years old. From its beginnings, the journal has been a good faith effort with committed leadership: free-standing, unlinked to any other publishing entity, with limited financial but significant voluntary support.

In 2012, I was invited to write an Editorial for the first issue.[1] It is now my role to recognize a decade of sustained publishing achieved since that issue. In taking stock, it is relevant to revisit the guiding principles behind GJMEDPH and some realities that affected the environment into which it was launched. Let me say at the outset that the vision, courage and perseverance to launch and sustain an online Open Access (OA) journal in itself merits admiration. This duly acknowledged, as with all initiatives across the development spectrum, opportunities for continued improvement are important to recognize.

The journal is included in the Directory of Open Access Journals (DOAJ). DOAJ defines OA as scientific and scholarly journals making all content available for free, without delay or user-registration requirement, and meeting high quality standards, notably by exercising peer review or editorial quality control.[2] An open license is used so that any user is allowed immediate free access to works published in the journal and is permitted to read, download, copy, distribute, print, search or link to the full texts of articles, or use them for any other lawful purpose.[2]

GJMEDPH was launched and developed during a period when OA journals were rapidly proliferating, in

turn provoking sceptical reactions and even adversarial views by traditional publishing interests. The emergence of electronic publishing technologies facilitated all such online initiatives.[3] Critics expressed justifiable concerns about the difficulty in meeting contemporary quality standards, which (to be fair) also apply to established non-OA journals. More than a few individuals have burnished their careers on the back of this controversy, a form of 'virtue signaling.'[4] Similarly, there is the perennial problem of confirmation bias: the tendency to emphasize and believe experiences which support one's views and ignore or discredit those which do not.[5] To illustrate, one critic opined in an interview: how could such a journal claim to be "global", the inference being that only a well-established (presumably Western) journal should hold such aspirational vision. Geographic remoteness is in the eye of the beholder, and this attitude was arrogant, insular and unhelpful. I can no longer find this interview on the internet; its apparent removal is understandable as the criticism was invalid.

It is stating the obvious to say that traditional health science journals (non-OA) have been increasingly unable to respond to a burgeoning output of research from scientists in lower income countries (LICs) which lack capacity for their own science publishing. By contrast with Western authors, LIC authors have less experience in navigating the requirements of established publishers, often write in an unconventional syntax, and enjoy less success in publishing with them. As a consequence, the health science literature continues to be driven by the priorities of higher income countries, and the evidence base remains dominated by this mostly Western bias. This has to change, especially as the quantity and quality of research from emerging economies grows, and knowledge synthesis necessarily becomes more collaborative.

Let me be clear about my view of traditional mainstream journals: many perform an essential function in advancing knowledge and promoting standards, but they all have shortcomings. Take *The Lancet* for example: its publisher Elsevier was castigated for 'predatory' practices,[6] and its article processing fees are far beyond the financial capacity of most LIC researchers. Nonetheless, its financial model facilitates its potential to achieve quality standards. However, let me also go on record that, when teaching critical skills at Dalhousie University in Canada, and later at the Aga Khan University in Pakistan, I purposely selected articles from *The Lancet*, as methodological flaws and errors of interpretation could be found in virtually any issue. Students learned that even in the ostensibly best journals, there will still be deficiencies. No offense intended: I am pleased to have published with *The Lancet* myself, but no journal is perfect.

There was a time when the established non-OA journals were perceived simply as 'scholarly', but we now recognize that all forms of publishing are driven by a business model, with their biases, vested interests, quality control and financial challenges. For example, Oxford University Press (OUP), the publishing arm of the University of Oxford, has operations in several countries, including the USA and India, and there is absolutely nothing wrong with this: I am proud to have published a book with OUP.[7] But there is a whiff of double standards when anti-OA activists then take issue with publishers in South Asia using a business address in New York (a similar model), while still looking down their noses at a legitimate LIC business address.

Being able to publish and access relevant research is a valid need in all world regions. Over the past decade, GJMEDPH has played a role in expanding this capacity: an online OA vehicle for sharing observations and identifying feasible interventions. The journal has published work from researchers across the development spectrum, but mostly from South Asia and sub-Saharan Africa. New journals such as this open up participation so that research more relevant to varying social, cultural and economic settings has a fairer chance of being published.[1] But of course there is a learning curve: one must crawl before one walk or runs.

By contrast, established journals sustain their generally higher reputations for scientific rigour through continuous quality control and robust financial management systems, mostly serving

investigators in developed countries, typically over many decades. During this long gestation they have steadily improved in quality in all respects: scientific, biostatistical, ethical and public health relevance. The editorial space does not allow for elaboration on this point but the history of scientific publishing includes a litany of unethical and incompetent studies over the decades right up to the present; all journals, established or not, must continue to learn from their mistakes. Clearly, to close any gap which may exist, new OA journals (with track records measured in mere years) must also meet quality and management norms, and lead by example.

Throughout its development, GJMEDPH has endeavoured to honour its aspirational goal: the principle that the research base for medical and public health practice must be appropriate to settings where these are applied, and their findings disseminated primarily to benefit those settings.[1] Related to this (as was argued in 2012), another principle is emerging: lessons from developing countries are of value to developed ones e.g., global disease surveillance, large scale trials of vaccines and micronutrients, community-based participatory research, and evaluation of traditional practices. But this is still not a level playing field, far from it.

Consider the Omicron variant of COVID-19: first recognized in South Africa, whose authorities quickly told the world. Yet the West promptly punished that country by imposing a ban on travel, out of unscientific fear of importation (it had already arrived) and domestic political considerations. Similarly, when South Africa (with proven research capacity) was the first to share knowledge of Omicron's lower virulence than the Delta strain, the West was initially reluctant to accept this information.[8] Stripping away the aura of pandemic management, this could be viewed as "scientific colonialism."[9] The subliminal aim of this neocolonial dynamic is to devalue what LIC scientists offer and imply that it gains legitimacy only through the sanction or validation of the colonizing entity, as whatever they stand for is inherently superior.

Also noted in 2012, and which bears repeating here, recent decades have seen a push to promote 'best practices, mostly driven by the science base of developed countries.[1] When questions arise regarding the evidence needed to assess the relevance of their adoption, in the West they are subjected to replication research to determine applicability. By contrast, Western practices are typically promoted and adopted in developing countries uncritically, often as an extension of Western-driven training and development policies, even though conditions may be different and locally developed approaches desirable.

All this duly recognized, many errors in decision-making in development settings arise from deficient local research and related policy capacity. Contexts become more complex as one moves to national levels and even more so to cross cultures or to attempt global application.[1] Publishing capacities attuned to such realities are part of the solution. Strengthening such capacities in the Global South should result in better understanding about how contextual factors, such as politics, socio-cultural norms and beliefs, and a challenging fiscal environment, can influence everything from replicability and adaptation to potential scale-up success. Knowing that an intervention works in a particular setting is not enough: one must properly explore whether it will work elsewhere, and if so, how this can be achieved.

All persons associated with the emergence of GJMEDPH and sustaining it for a decade are to be congratulated for their contribution to this achievement. The first decade has demonstrated its viability as a publishing avenue for a relevant research community. Its non-profit model, supported by modest processing charges, is admirable. Significantly, attempts by commercial publishers to buy out the operation have all been rebuffed out of concern that the journal not be drawn into any stream for which financial gain may displace the core motivation. Despite this accomplishment, the journal has scope for improvement. It must strive to improve scientific rigour, while deferring to authentic experience even when rigour may fall a little short. However, its quality can only be as good as its peer review and copyediting, and neither should be taken for granted. Voluntary support can go only so far, and must be carefully nurtured if it is to be sustained.

When peer review of quality cannot be secured in specialized areas of health science, then boundaries need to be revisited regarding what is truly feasible. Similarly, while improvements in copyediting over the past two years are noteworthy, it is important to protect this essential capacity to ensure that it does not overload those doing this highly skilled work. The Editor-in-Chief and founder of the journal is simultaneously a senior staff member of the Kashmir Department of Health. Perhaps now is the time to add a full-time, paid Managing Editor. To achieve this may require a sustaining grant, preferably from the host country, or at least from within the Global South, to strengthen the prospect of continuing sustainability. Given the voluntary nature of current roles, an alternative might be to reduce publication frequency to quarterly to help achieve higher quality, even at the loss of some articles included within the present bimonthly system. The journal could also consider enhancing its areas of emphasis: for example, more articles on how to conduct particular kinds of studies across the research spectrum. New strategic thinking may be required to explore such options.

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CONCLUSION

In accomplishing a decade of publishing, GJMEDPH has reached a relevant milestone. The aspirational vision for an even more successful new decade should be continuous quality improvement: fine tuning its performance and sharpening its focus so as to further benefit the quality of health science research and development across the Global South.

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