

SPECIAL REPORT **OPEN ACCESS**

Disparities in Global Authorship and Data Source in the *Pediatric Blood and Cancer Journal* 2011–2021: Realities and Strategies for Improvement

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Received: 9 May 2024 | **Revised:** 6 September 2024 | **Accepted:** 14 October 2024

Keywords: authorship | authorship guidelines | childhood cancer | equity | low- and middle-income countries | pediatric oncology

ABSTRACT

Background: Research expands knowledge and improves outcomes. Research is needed in all settings, but most often occurs in high-income countries (HIC) compared to low- and middle-income countries (LMICs). Publication in scientific peer-reviewed journals and authorship position are important for academic/clinical advancement. We explored the current state of global authorship and data source distribution for publications in the *Pediatric Blood and Cancer* (PBC) journal.

Procedure: LMIC-affiliated author inclusion and position in selected article categories of the PBC (2011–2021) were recorded. Articles with at least one LMIC-affiliated author (first-listed affiliation) and 5% of exclusively HIC-authored articles were verified. Descriptive statistical analysis was performed.

Results: Of 4504 articles reviewed, 593 (13%) included at least one LMIC-affiliated author (517/593 [87%] as first author and 488/593 [82%] as senior author. In a subset of articles with LMIC-sourced data, 148/675 (22%) included exclusively HIC authors. Within the LMIC-sourced data subset, 81/675 (12%) articles were mixed HIC/LMIC affiliation and 446/675 (66%) were exclusively LMIC-affiliated. The frequency of LMIC-affiliated authors as first or senior author within HIC/LMIC-affiliated collaborations was 31/81 (38%) and 9/81 (11%), respectively.

Conclusion: As more than 80% of children live in LMICs and the WHO Global Initiative for Childhood Cancer is increasingly engaged across LMICs, all researchers/clinicians must justly be given an opportunity to conduct, write, publish, and be recognized for their research. PBC is uniquely poised to promote equitable publishing practices and opportunities for professional recognition by drawing on emerging best practices for equitable authorship, including potentially restructuring authorship guidelines and requirements.

Abbreviations: ASPHO, American Society of Pediatric Hematology/Oncology; HIC, high-income country; LMIC, low- or middle-income country; PBC, *Pediatric Blood and Cancer* journal; RCT, randomized control trial; SIOP, International Society of Paediatric Oncology; WHO, World Health Organization.

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1 | Introduction

Growing calls in global health research exhort increased focus on ensuring equitable opportunities for researchers and clinicians to conduct and publish high-quality research, irrespective of country of residence. The underrepresentation of publications from low- or middle-income countries (LMICs) in pediatric literature has been previously described [1, 2]; however, literature specifically defining current global authorship distribution in pediatric oncology research is limited. Addressing these authorship disparities requires research that provides clear understanding of both current global publication rates and the structural inequities in research that perpetuate lack of diversity in the first place.

In this study, we conducted an in-depth examination of one global pediatric oncology journal, guided by the research question “What is the current state of global authorship and data source distribution in the Pediatric Blood and Cancer (PBC) journal from 2011 to 2021?” We then narrowed our authorship analysis to articles based on data from at least one LMIC to highlight our findings in comparison to the global disease burden alongside examples from global, pediatric, and pediatric oncology literature. Our objective was to provide a baseline understanding of current PBC authorship trends and identify best practices for more meaningful and accurate authorship inclusion that can inform efforts to improve authorship equity in our field.

2 | Methods

2.1 | Study Team

A global research team was recruited for regional diversity, including a PhD-prepared pediatric oncology nurse faculty (China), two PhD students (South Africa, Australia), two MD/PhD epidemiologists (Bangladesh, Australia), a masters-prepared independent researcher (Hungary), a PhD-prepared pediatric oncology nurse (USA), and a masters-prepared biostatistician (Ghana). A masters-prepared pediatric oncology nurse practitioner joined the study post-analysis to assist with data validation and manuscript writing (Canada). The team initially included a physician from Honduras, but they moved to Mexico for a pediatric oncology fellowship a few months after the study began and was unable to continue.

2.2 | Study Design

A review of articles published in PBC between January 1, 2011 and December 31, 2021 was conducted to identify authors whose first-listed affiliation was in an LMIC (stratified by low-income, lower middle-income, and upper middle-income countries). Articles were assigned to each of the reviewers by publication year. Online (recorded) video meetings amongst authors of this paper were used to discuss and finalize inclusion and exclusion criteria for screening of publications, design and finalize the data extraction form, and consider questions arising from the data extraction process.

TABLE 1 | Article inclusion by submission type.

Article category included	Article category excluded
<ul style="list-style-type: none"> • Research articles • Brief reports • Critical reviews/reviews • Special reports • Clinical practice guidelines • Supplements (peer reviewed) 	<ul style="list-style-type: none"> • Book reviews • “How I approach” • Letters to the editor • Commentaries • Correspondence and letters • Highlights • Education (introduced 2021) • Historical perspective (introduced 2014) • On children, blood, and cancer • Supplements of congress abstracts (scored, but not peer-reviewed)

2.3 | Data Selection

An Excel database was placed on Google sheets for sharing data. All data for PBC articles in eligible categories were entered into the database. Article inclusion criteria were established by consensus to include only articles that were both related to clinical practice and peer-reviewed (see Table 1).

2.4 | Data Extraction

For each eligible PBC article, the reviewers collected data using a standardized, co-created data extraction guideline and validated the data to ensure consistency. Extracted data included article title, submission type (as defined by the journal), volume, issue, publication year, article subject (disease type), study design, biomedical treatment type (if applicable), author names, and first listed country of affiliation. Countries of affiliation were then categorized by World Health Organization (WHO) region, and country economic status was determined based on the World Bank List of Countries by income for the publication year and accounting for any changes in status within the 11-year span [3].

2.5 | Data Analysis

Statistical analyses of the PBC articles were conducted with Microsoft Excel v16.8 by DO. Descriptive statistics were used to calculate the frequency and percentage for the categorical variables.

2.6 | LMIC Data Verification

Three authors (Julia Challinor, Elizabeth Sniderman, and Kathryn Burns) divided the PBC articles with an LMIC author

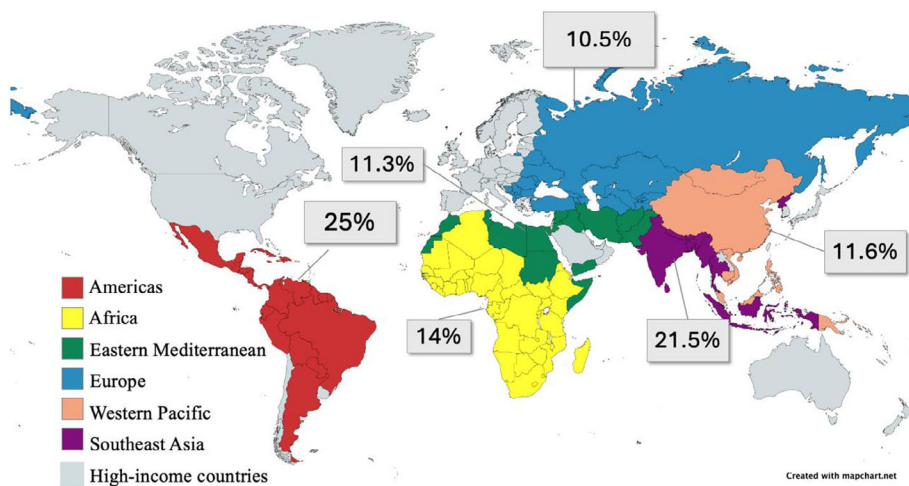


FIGURE 1 | Low- and middle-income country authorship distribution in the 593/4504 eligible Pediatric Blood and Cancer journal publications (2011–2021) by World Health Organization region (in %).

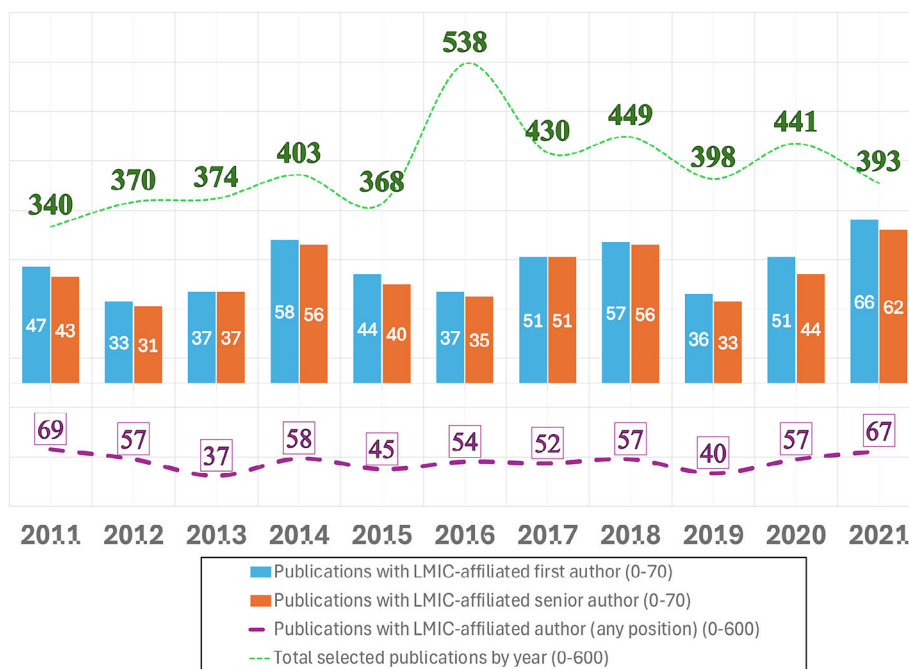


FIGURE 2 | Number of publications per year with at least one author from a low- or middle-income country (LMIC) (2011–2021).

in any position to verify each entry and ensure data validity using a decision tree developed by consensus. A total of 5% of all articles exclusively high-income country (HIC) authored were verified by a second researcher (Julia Challinor or Kathryn Burns) to ensure no LMIC author had been missed. Results showed only one article with an LMIC author had been missed, which was added to the LMIC data, so further verification was not conducted.

3 | Results

Over the course of the 11-year period (2011–2021), a total of 4504 articles in PBC meeting inclusion criteria were published. Of these, only 593/4504 (13%) included at least one author from an

LMIC (first, middle, or senior author). A total of 3911/4504 (87%) of the selected articles were written by exclusively authors from HICs. Figure 1 shows the geographic spread of articles with at least one LMIC author stratified by WHO region of the authors' first affiliation.

From an initial peak in 2011 (20.3%), the percentage of articles with at least one author from an LMIC decreased and remained relatively flat (lowest in 2013 at 9.9%) until 2021 when it increased slightly (17%) but did not exceed the initial peak. Figure 2 shows time trends for LMIC-affiliated authorship (first author, senior author, or including at least one author from an LMIC) from 2011 to 2021. The number of articles with LMIC-affiliated first authors increased marginally from 47/340 (13.8%) of the total

TABLE 2 | Geographic distribution of articles including data from at least one low- or middle-income country with only high-income country authors.

Data source	No. of articles
Tanzania—LMIC	1
India—LMIC	1
Multiple low-income countries	1
Multiple middle- and low-income countries	1
Mix of high-, middle-, and low-income countries	144
Grand total	148

articles published in 2011 to 66/393 (16.8%) in 2021, and the number of LMIC senior authors increased from 43/340 (12.6%) in 2011 to 62/393 (15.8%) in 2021. Our findings also indicated that randomized control trial studies (RCTs) including LMIC authors were rare (2%), with over 50% from a single LMIC (India).

3.1 | Articles Including LMIC-Sourced Data

Our findings demonstrated that a total of 675/4504 (15%) total published articles included data from at least one LMIC. In this subset, 148/675 (22%) articles had exclusively HIC-affiliated authorship (for geographic distribution of data source, see Table 2). The remaining 527/675 (78%) articles included at least one LMIC-affiliated author (for data source geographic distribution see Figure 3; and for detailed breakdown of articles by

country see File S1). A time trend of LMIC-affiliated authors in articles with LMIC-source data demonstrated a small increase, from a total of 51 articles in 2011 to 61 articles in 2021 (with fluctuation over time and a nadir of 31 in 2013). In a subset of 527 articles including at least one LMIC-affiliated author, 22/527 (4%) included data from a low-income country, 178/527 (34%) from a lower middle-income country, and 246/527 (47%) from an upper middle-income country. The remaining 81/527 (15%) articles had a mix of data from both HICs and LMICs.

In articles with LMIC-source data, authorship order demonstrated that most LMIC-affiliated authors were in first author position (477/675; 70%) or senior author position (455/675; 67%). However, 446/675 articles with data from an LMIC were written by exclusively LMIC authors, whereas the number of articles with mixed authorship (both HIC- and LMIC-affiliated authors) and data from at least one LMIC was only 81/675 (12%). In this mixed authorship subset, LMIC-affiliated first authors appeared in only 31/81 (38%), and senior authors appeared in 9/81 (11%) of the reported HIC/LMIC collaborations. Mixed HIC/LMIC-affiliated authors as presumed collaboration articles represented 1.8% of all selected PBC articles over the 11-year period. An additional 237/4504 (0.05%) of all selected articles did not specify a data source (i.e., primarily literature reviews).

4 | Discussion

Scientists and health professionals from multiple disciplines have called for a reconsideration of how authorship attribution is managed to better respond to opportunities for research and publishing, or lack thereof, for those based in LMICs [4–8]. According

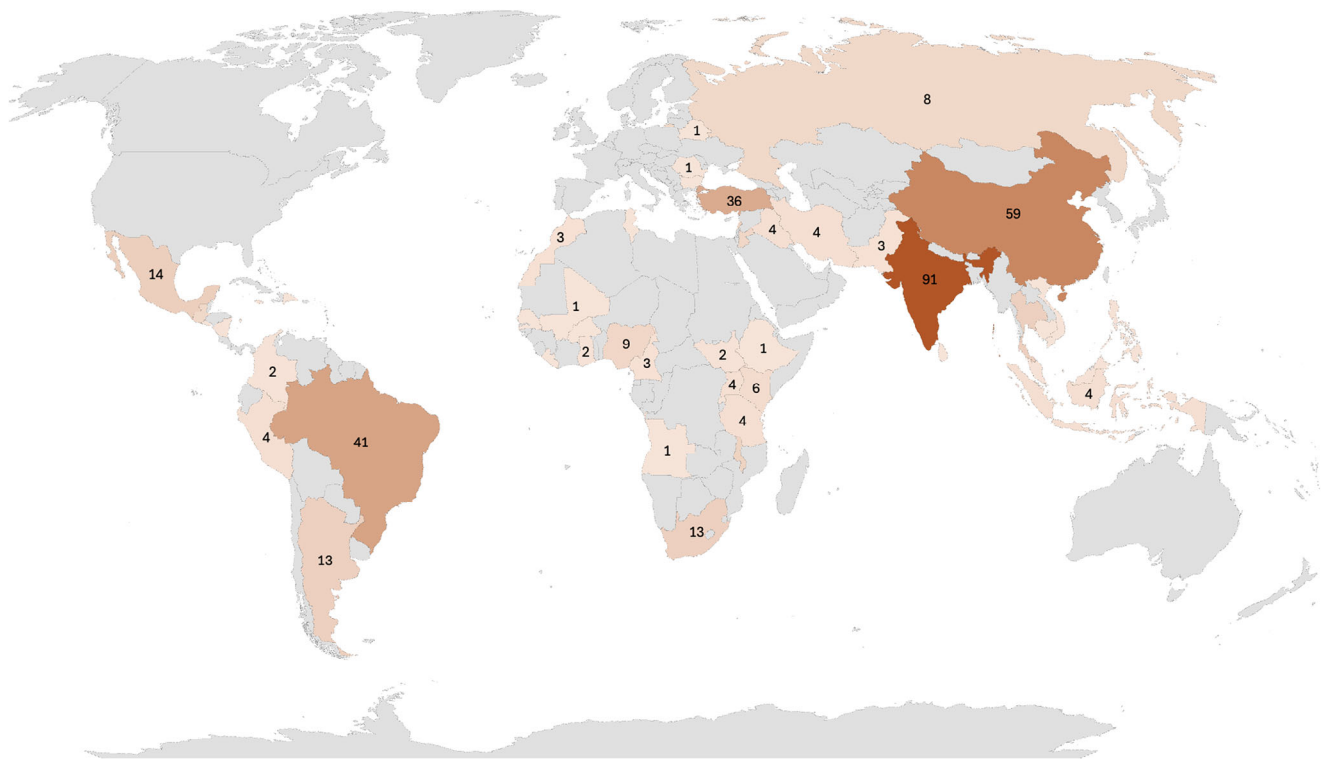


FIGURE 3 | Geographic distribution of articles including data from at least one low- or middle-income country with at least one low- or middle-income country-affiliated author.

to the International Committee of Medical Journal Editors, “Authorship confers credit and has important academic, social, and financial implications. Authorship also implies responsibility and accountability for published work” [9]. Health sciences research authorship in peer-reviewed publications frequently has implications for academic promotions, grant funding, awards, and reputation [10]. Research infrastructure, training, funding, and protected time are limited in underresourced LMIC settings where limited specialized healthcare professionals are faced with very high number of patients with advanced disease [11–14]. Although there has been a rise in publications offering data on authorship disparities and concrete measures that can be taken at all levels of the research ecosystem to compensate for the barriers faced by LMIC researchers and improve publishing rates from LMICs [15], recent studies have demonstrated that authorship parity remains woefully far from reach in global health and oncology [14, 16–21].

The findings of this study build on previous literature on authorship distribution [2], showing a significantly disproportionate representation of publications with only HIC-affiliated authors (90% of all articles and almost one quarter of those with LMIC-sourced data). The paucity of data from LMICs is a major contributor to the low overall representation of LMIC authors, as it is unlikely that an unaffiliated author from an LMIC would be included on a publication exclusively reporting data from an HIC.

However, our findings on article data sources are in and of themselves significant as they further highlight authorship disparity by global burden of disease. Less than one in five of the included PBC articles had LMIC-sourced data, making the geographic representation of publications inversely proportionate to the global disease burden of childhood cancer. The vast majority (80+%) of children diagnosed with cancer live in LMICs where mortality is high due to late diagnosis, treatment abandonment, and inconsistent access to critical chemotherapy, specialized surgery and pediatric radiotherapy, less comprehensive supportive care, and a lack of government healthcare policy prioritization [22]. As the World Health Organization Global Initiative for Childhood Cancer (GICC) is strengthening childhood cancer care infrastructure and financing through the CureALL framework and increased HIC/LIC collaborations across LMIC [23], more robust metrics must be put in place by journals to amplify publications from LMIC-affiliated authors on local research [24].

Among the limited PBC articles with data from at least one LMIC (15%), more than 20% were published without crediting a single local (LMIC) author. This likely indicates a high rate of “safari” or “helicopter” research [25] defined by Morton et al. as “conducting primary research within a host country and subsequently publishing findings with inadequate involvement and recognition of local researchers, staff, and/or supporting infrastructure” [15(p268)]. Such practices perpetuate power differentials and inequity by allowing HIC-affiliated authors to benefit from the unacknowledged labor of LMIC researchers [18, 19]. A recent editorial in *Lancet Global Health* has addressed this issue, even for secondary analysis authorship [26].

Two-thirds of the PBC articles with LMIC-sourced data were published by only LMIC-affiliated authors, whereas only 15%

included mixed LMIC/HIC-affiliated authors (presumably reflecting collaborative work). Within this subset of mixed LMIC/HIC-affiliated authorship with LMIC-sourced data, the rate of LMIC-affiliated first authorship was less than 40% and senior authorship was only just over 10% articles. This finding corresponds with previous literature on authorship that demonstrates high rates of local, LMIC-affiliated authors being “underrepresented in prime authorship positions in health-related literature about their own countries” [27(p8), 28], which ultimately means these authors are conferred less value for merit-based academic advancement [27].

The very low rate of PBC articles with LMIC-sourced data presumably crediting LMIC/HIC collaboration is likewise surprising given the documented large number of long-standing childhood cancer HIC/LMIC collaborations in multiple regions for this complex and rare disease (e.g., Groupe Franco-Africain d’Oncologie Pédiatrique [Franco-African Pediatric Oncology Group], Asociación de Hemato-Oncología Pediátrica de Centro América [AHOPCA], and World Child Cancer-NL Foundation) [13, 28, 29]. This aligns with an observation by Abimbola (2019) that existing authorship guidelines do not recognize all aspects of LMIC researcher roles, including recruiting participants, collecting and interpreting data (particularly if conducted in local languages), and often lead to LMIC authors being relegated to lower or no authorship positions, despite their contributions to the study [30].

Regarding authorship parity in pediatric research conducted in LMICs, the rates we found of PBC articles using LMIC-sourced data with (any) LMIC-affiliated authorship (78%) and LMIC-affiliated first authorship (66%) were lower than previous literature. PBC LMIC-affiliated senior authorship rates were similar to other global studies on publications using LMIC-sourced data (70%). Rees et al. reviewed 1243 pediatric publications from four high-impact journals (including PBC) from 2006 to 2015 and found that 95.9% included at least one LMIC-affiliated author [2]. In our PBC analysis, the lower percentage was particularly surprising considering a wider study design inclusion criteria included articles (e.g., case reports, literature reviews, and case series, which Rees et al. excluded). The same study by Rees et al., the authors found that the least frequent study design with only LMIC-affiliated authors were RCTs (9.8%) [2], which aligned with our findings of less than 5%. The low number of RCT reports from LMIC mirrors previous research that has demonstrated potential “...funding and publication bias against LMIC-led RCTs,” despite the fact that RCTs in LMICs “...are more likely to identify effective therapies and have a larger effect size than RCTs from HICs” [31(p379)].

Our findings must also be understood in the context of the very low rate of reported LMIC/HIC author presumed collaborations across the PBC 11-year span (as 100% of articles exclusively LMIC-affiliated had LMIC first and senior authors) and in consideration of the fact that PBC publishes only in English. In comparison, a study of global health literature published in 41 languages by Dimitris et al. (2021) found that 86.0% of publications with LMIC-sourced data had LMIC authorship (77.2% first authors and 71.2% senior author) [32]. A study of publications funded by the US National Cancer Institute involving LMICs showed even lower rates of LMIC author representation compared to PBC on this metric; 49% of publications had an LMIC-affiliated author, and

only 22% and 17% of first and last authors were LMIC-affiliated, respectively [28]. Our rates of PBC LMIC-affiliated first (38%) and senior (9.8%) authorship for pediatric research articles with mixed (LMIC/HIC) authorship for presumed collaborations were much lower for both positions than Dimitris et al., but higher than the US study for first author, while much lower for senior authorship.

A comprehensive review of pediatric oncology journal authorship was not conducted for other major pediatric oncology journals, such as the *Journal of Pediatric Hematology/Oncology* [33] or the *Pediatric Hematology/Oncology Journal* [34], and adding these journals to article-level analysis was beyond the scope of work. In a search in both journals for authorship-affiliation publications 2011–2021, none were identified. However, a recent review article by Elhassan et al. on authorship in publications with pediatric oncology data from Africa in several journals including PBC revealed an increase of African authors from 2005 to 2022 of 37–287 articles, respectively [35]. This magnitude of change did not align with our PBC results, which had a minor increase with data from a single African country (2011: 7 articles to 2021: 11 articles). Elhassan et al. also found that research output was disproportionate; the largest number of publications were from Egypt (28%) and South Africa (20%) [35]. This corresponded with our findings within 84 articles with data from a single African country; most were from Egypt (21%) and second was South Africa (15%) (see [File S1](#)).

Our results underline the ongoing critical need to improve broader systems that promote opportunities to conduct research and publish in LMICs, and change the paradigm and historical practices of authorship in scientific publishing. As Morton et al. point out, journal editors and editorial boards are part of the research ecosystem that influence authorship equity by “brokering research outputs...[and] commissions,” thus impacting research priorities and funding (see [Figure 4](#)) [15(p6)]. The authors recommend publishers consider increased diversity and inclusion of LMIC professionals on editorial boards, implement mandatory structured reflexivity statements, consider multiple joint first and senior authors, and increase open access options for HIC/LMIC collaborations with LMIC-sourced data (see [File S3](#) for further concrete recommendations) [15].

Literature points out that although authorship numbers are easily measured, quantitative indicators alone are an inadequate indication of research inclusion [32(p1), 36]. Ongoing practices of ghost-authorship (unnamed authors) or unwarranted authorship [10(p200)] and complex questions about data ownership, research priorities, and funding bring into question the definition of “contribution” [18, 19]. Barriers and challenges to research collaboration and meaningful publication authorship for LMIC-affiliated researchers and clinicians include large patient populations with a small pediatric oncology specialized team, lack of funding for direct research costs and protected time for research [37, 38], absence of local capacity for research training and mentorship [39, 40], and in many cases no official recognition or career advancement for research or publications. Academic pressure on HIC collaborators to publish for their own academic advancement can dictate authorship position, even when LMIC authors are included [41]. Securing funding is a major barrier to publishing in all settings, but is significantly harder for researchers in LMICs [42, 43]. The majority

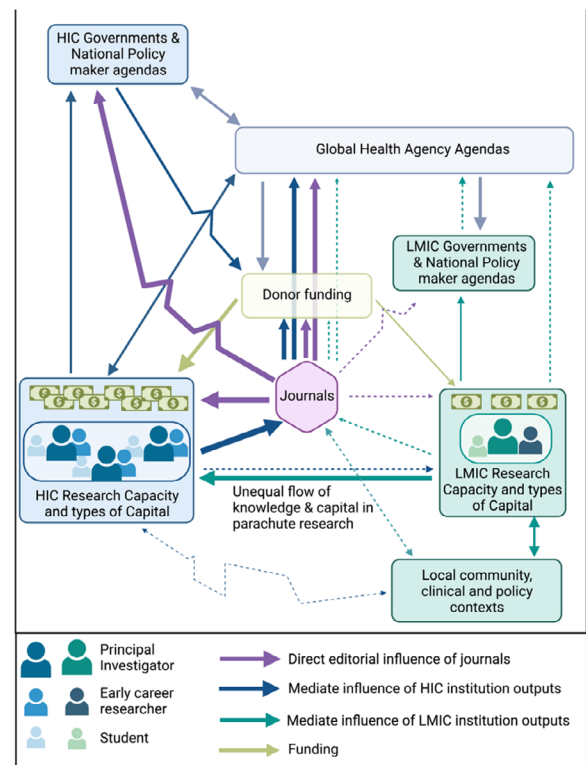


FIGURE 4 | “The position and power of journals within the global health research ecosystem. Journals influence the ecosystem by (a) brokering research outputs that are predominantly led from HIC institutions; and (b) direct editorial statements (e.g., through ‘commissions’). These journal activities influence research prioritization and funding allocation. The current predominance of HIC outputs and perspectives in journal activities further amplifies the impact of HIC perspectives on donor funding and research agendas. This can worsen existing inequities” [6(p270)].

of medical and health research funding comes from HICs, which primarily funds research in HIC [42], and the article processing charges and access costs present additional funding challenges [44].

A limitation of this study was the impossibility of determining authors’ appropriate geographic location during reported research, which has been mentioned by other publications on this topic as LMIC trainees may be in HIC settings and HIC experts may have relocated to an LMIC but retained their HIC affiliation [32, 45]. Manual data input by multiple reviewers, even with consensus on how to categorize the variables, was a threat to accuracy as methodologies were not always specified or entirely clear in the publications.

We have identified overall LMIC author inclusion and position in PBC journal over 11 years, with a particular focus on authorship in articles with data from LMIC. Our findings serve as a baseline to measure improvement in publication best practices over time. PBC, as the official journal of the International Society of Paediatric Oncology (SIOP) and American Society of Pediatric Hematology Oncology (ASPHO) has an important role in publishing global efforts in pediatric hematology/oncology, including efforts in support of the World Health

Organization GICC [46–48]. Ultimately, the responsibility for addressing authorship equity in global health research should primarily rest with HIC researchers and institutions and not with LMIC researchers and clinicians who already contend with significant structural and institutional barriers within the global health landscape. We hope that the results of this authorship review will motivate SIOP and ASPHO members, authors, the editorial board of PBC, and Wiley Publishers to engage with emerging best practices to develop more equitable publishing practices and guidelines for author recognition on submitted publications.

Acknowledgements

The authors would like to acknowledge Dr. Rina Medina, a pediatrician from Honduras, who contributed to the conceptualization of the study. We would also like to acknowledge Lusikelelwe Mkumbuzi for assistance with a figure. Alexandra Martiniuk is salary funded by an Australian National Health and Medical Research Council (NHMRC) Investigator Grant.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.