# Should UK Specialty Trainee Doctors in Obstetrics and Gynaecology have more opportunities to work in Global Women’s Health?

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# Summary

* The Royal College of Obstetricians and Gynaecologists (RCOG) has a long history of advocacy for women’s health, nationally and internationally.
* There is a demand and interest in global women’s health among a sample of junior doctors training in Obstetrics and Gynaecology in the UK.
* There is ongoing debate regarding whether this desire should be nurtured, opportunities created, and barriers addressed, both in the interest of training and as a means of addressing global health inequity.
* Global health work needs to be a mutually beneficial partnership for all involved, with work carried out sensitively and sustainably.

# Introduction

The burden of maternal mortality and morbidity is highest in low- and middle-income countries (LMIC) [1]. Many high-income countries support women’s healthcare development in LMIC settings [2], and a growing number of highly skilled medical professionals (including junior doctors) engage in voluntary work in LMIC settings. The Royal College of Obstetricians and Gynaecologists (RCOG) in the United Kingdom (UK) has a long history of advocacy for women’s health, nationally and internationally [3]. The RCOG has included global health competencies in a new clinical training curriculum and have been implementing high quality, evidence-based care packages to improve women’s lives in LMIC for many years. Furthermore, the RCOG have a long-standing relationship with Voluntary Services Overseas to enable UK based doctors to undertake long term (6 months to 2 years) placements in LMIC settings [4]. We conducted a pilot survey to assess the views and experiences of junior doctors training in Obstetrics and Gynaecology (O&G) in the UK, regarding their interest in, and understanding of, global women’s health.

# Methods

An online ten-point questionnaire was distributed by email to junior doctors training in O&G in the UK. An email reminder was sent two weeks later. Main questions included (i) level of training (ii) interest in global women’s health (iii) experiences (if any) of volunteering, (iv) motivations for volunteering, (v) barriers to undertaking a volunteering placement, (vi) and what trainees would like to see the RCOG do regarding global women’s health. All participants were asked to respond to each question individually and questions were not linked to previous answers. The questionnaire could not be submitted if any of the questions were not answered. For each question, several options were available from a drop-down menu and open text options were provided. Data was analysed using Excel 2013. This pilot study was deemed minimal risk and full institutional ethical approval for the study was not necessary as we examined the personal views of junior doctors on the RCOG mailing list as part of a scoping exercise, via an anonymized short online questionnaire. Implied consent was given through the completion of each survey.

# Results

53 trainees completed the survey. More than half of respondents (52.8%) were specialty trainees at level year three to year five (ST3-ST5), 26.4% were ST6-7 and 18.9% were ST1-2. There were responders from 11 deaneries in the UK, with many respondents (39.6%) from the London deanery. Most respondents (88.7%) expressed an interest in global women’s health, but only 32.1% had experience of volunteering in a LMIC setting. Of the respondents who had volunteering experience, 88.5% (23/26) were motivated by an interest in global health; 50.0% (13/26) were interested in teaching opportunities and 42.0% (11/26) felt they had an obligation to help. Barriers included: problems in obtaining time out of training programme (81.0%); financial reasons (71.0%); and personal or family commitments (70.0%). The majority of respondents (90.2%) would like the option of a global women’s health fellowship; 78.4% would like the RCOG to provide more opportunities to get involved in global women’s health; and 58.8% would like to be able to spend time in a LMIC setting and/or receive training for this.

# Discussion

This baseline pilot survey is the first to provide insight of the interests and aspirations regarding global women’s health of UK trainee doctors in O&G, as well as potential barriers in achieving these goals [5]. Whilst limited by numbers of respondents, this survey initiates an important discussion of how global women’s health training and engagement could be shaped.

Understanding the barriers trainees face when engaging in global women’s health will help to develop strategies to overcome them and make knowledge exchange more possible; which if conducted appropriately and sensitively, could be beneficial both to trainee doctors in high- and low-income settings. The main barrier for UK trainees regarding global women’s health opportunities appeared to be challenges with securing time and support to undertake such placements [5]. This may be a result of workforce demands on the National Health System in the UK. Whilst this represents an apparently unsurmountable challenge in many settings, it also represents an opportunity. Schemes such as the Medical Training Initiative scheme, which allows doctors from low-resource settings to work and train in the UK for a limited period under close supervision, may indeed be adapted to create North-South training exchange programmes without a net loss of workforce [6].

There is also a lack of consensus on best practice on how to conduct and support both short and long-term effective medical volunteer placements in low-resources settings to benefit both the volunteer and recipient organisation. Given the marked differences in medical practice between many high- and low-income settings, a robust framework for medical volunteering is required to ensure: a) no harm is done, b) the trainee is achieving their learning objectives, and c) the placement has contributed positively to patient care. A junior trainee may benefit most from an observatory role (short-term placement), whereas a senior trainee may become part of the clinical team (longer term placement), provided close supervision is available. Placements must be backed up by thorough pre and post-placement training, to understand why differences in clinical management exist. A prime example is the use of forceps or a vacuum to conduct an instrumental vaginal delivery, that is a daily occurrence on the labour wards of high-income countries but are not commonly conducted in low resource settings, often due to lack of training or resources [7]. A deeper understanding of how to facilitate the sharing of expertise between different health systems is required, including ensuring it is mutually supportive and sustainable over time, and that evaluation components are integrated into programs to ensure this [8]. It was beyond the scope of this survey to assess challenges experienced by UK trainees in O&G whilst on placement. A larger national survey may help. Further collaborative qualitative research in both high- and low-resource settings may indicate how best to design and implement global women’s health opportunities, including teaching and training programmes for UK based trainee doctors in O&G.

# Declarations

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**Contribution to authorship:** MMC and SS was responsible for study inception, study design and MMC wrote the manuscript. SS constructed the survey, coordinated and supervised the data collection and analysis. HW and NV have contributed the interpretation of the data and the writing of the manuscript. All authors have read, edited and approved the final manuscript for submission.

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**Data sharing statement:** No additional unpublished data from the study are available.

**Details of Ethics Approval:** This pilot study was deemed minimal risk and full institutional ethical approval for the study was not necessary as we examined the personal views of junior doctors on the RCOG mailing list as part of a scoping exercise, via an anonymized short online questionnaire. Implied consent was given through the completion of each survey.

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