2026, Volume 58, Issue 5, 363-364, e-ISSN 1938-3800

Family Medicine

NARRATIVE ESSAY

Bridging Worlds in Maternal Care: Reflections From a Family Medicine-Obstetrics Rotation in Rural Kenya

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HOW TO CITE: Mbwabi AK. Bridging Worlds in Maternal Care: Reflections From a Family Medicine-Obstetrics Rotation in Rural Kenya. *Fam Med.* 2026;58(5):363-364. doi: 10.22454/FamMed.2026.866160

FIRST PUBLISHED: May 15, 2026

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The first sound I remember hearing in the labor ward at Kakamega General Hospital, as I joined the clinical team as a visiting family medicine resident, was not chaos but urgency. Nurse-midwives were calling out fetal heart rates, requesting supplies, and updating one another on complications. It was early September, the first morning of my month-long obstetrics rotation, and I felt a familiar tightening in my chest as I adjusted to an unfamiliar clinical pace. Coming from a rural residency program in Oregon, I arrived eager to strengthen my obstetric skills while contributing within the limits of my role. What I did not anticipate was how deeply the emotional and ethical dimensions of learning in this environment would shape my approach to clinical decision-making and professional accountability.

In the months before the rotation, I had reflected extensively on cultural awareness and the ethics of short-term global health work. Standing in the ward, however, transformed those abstractions into lived responsibility. I found myself returning repeatedly to a central question: what does it mean to learn within a system that may not tangibly benefit from my brief presence? Holding that tension required a recalibration of purpose. Rather than centering my own educational objectives, I approached the work as a guest within a functioning system whose rhythms, priorities, and constraints demanded respect and accountability.

I began to see this recalibration most clearly in how teaching unfolded. Although I arrived primarily as a learner, I was at times invited to support teaching on department-identified topics, including active management of the third stage of labor and fetal heart rate interpretation. As the ward filled with active labor and emergencies, formal sessions were frequently deferred. Teaching shifted to the bedside during handoffs, brief pauses between patients, and moments of shared clinical decision-making. Working alongside interns and midwives, I reinforced evidence-based practices within existing workflows, learning how responsiveness to patient needs shaped both education and care.

That same responsiveness further shaped my role during my second week, when a patient arrived with heavy bleeding following an early pregnancy loss at home. Her hemoglobin was critically low. As we stabilized her for manual vacuum aspiration and antibiotics, my contribution shifted from structured teaching to embedded clinical collaboration. The next step, transfusion, depended on relatives traveling to donate blood, completing screening, and waiting through delays beyond the clinical team's control. Standing by the bedside, I watched the patient's eyes follow each clinician and wondered what she was experiencing: exhaustion, fear, cautious hope? I confronted the unease of knowing what was clinically indicated while accepting that it could not happen quickly. In that moment, clinical expertise yielded to coordination, patience, and shared uncertainty. The ethical weight of providing care and learning alongside such vulnerability lingered long after her condition stabilized. Encounters like this compelled me to confront not only the limits of the system, but also the limits of my own assumptions about what care should look like.

Resource limitations shaped many aspects of care, but the deeper challenge lay in recognizing how easily my own expectations could narrow my understanding of the patient experience. Many birthing individuals labored without access to regional anesthesia. My initial impulse was to interpret this absence solely as deprivation. Over time, I stepped back and observed the midwives' steady presence at the bedside-guiding breathing, offering reassurance, and helping patients reposition through long hours of

labor. These encounters reminded me that pain, endurance, and decision-making are shaped not only by constrained choices but also by the agency with which patients navigate their circumstances. Despite profound differences in resources, certain moments felt deeply familiar: the collective stillness during fetal heart auscultation, the shared vigilance around postpartum bleeding, and the quiet relief following a newborn's first cry. These moments reaffirmed the transcendent nature of responsibility borne by those who attend birth, regardless of setting.

My perspective further broadened in outpatient care when a patient presented with a painless genital ulcer. I diagnosed primary syphilis and treated them with intramuscular benzathine penicillin. Counseling on safe sex practices, partner notification, and follow-up felt routine. When the patient returned the following day febrile and distressed, I recognized a Jarisch-Herxheimer reaction and managed their symptoms. Clinically straightforward, the encounter nonetheless highlighted how destabilizing care can feel when stigma and vulnerability intersect. Sexually transmitted infections carry significant implications for reproductive health, and the patient's return was a reminder that effective care is measured not only by diagnostic accuracy but by how safely patients feel navigating uncertainty alongside us.

As the rotation progressed, my clinical instincts evolved. I relied less on technology and more on physical examination, trusting my hands for Leopold maneuvers and fundal assessments. Repeated exposure to high-acuity obstetric care sharpened my ability to anticipate complications, but the most enduring lessons came from my Kenyan colleagues whose clinical judgement had been brilliantly honed by constraint. Their decisiveness, adaptability, and commitment to patients reshaped how I understood both resourcefulness and leadership in obstetric care. Whether coordinating an emergency cesarean with limited staff or guiding a laboring patient through pain with steady reassurance, they demonstrated a form of leadership rooted in clarity, humility, and deep respect for the people they serve. By the end of the month, these lessons had become inseparable from my own developing clinical identity.

Leaving Kakamega was unexpectedly difficult, shaped by the depth of engagement with patients and colleagues that had developed over the course of the rotation. The ethical tension inherent to short-term global health remained unresolved, yet the experience clarified my responsibility to engage with humility, prioritize sustainability, and remain accountable to both the communities I serve and the systems that host me. Returning to Oregon, I carry these lessons with me-greater attentiveness to clinical judgment, patient experience, and a renewed awareness of the tenuousness of reproductive care both at home and abroad. Bridging these worlds is not an exercise in comparison, but a commitment to bidirectional learning that continues to shape my practice.