

Obstetrics and Gynecology at Naivasha County Referral Hospital in Naivasha, Kenya  
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In my third year of residency I did an elective rotation in obstetrics and gynecology at Naivasha County Referral Hospital (NCRH), in Naivasha Kenya. The University of Washington, where I am completing my residency, has a longstanding relationship across multiple departments including pediatrics, internal medicine, and OB/GYN with the hospital. This is my reflection of my time in Naivasha.

In many of the ways I expected, Naivasha, Kenya was very different from Seattle. The cedars and pines of my home were replaced by acacias, the constant drizzle by a blue sky and hot sun, and my commutes in designated bike lanes or bumper to bumper traffic were replaced by people zooming by on boda bodas and matatus. You could see zebras from the side of the road, you drove on the left, and everyone drank sweet milky tea and loved ugali. Kenya was hotter, brighter, louder, and more colorful than the gloomy gray of March in the PNW that I had left behind.

The hospital was also different. The operating rooms were called theaters, and in these theaters there were no insufflated abdomens, only open bellies. Vaginal deliveries went unmedicated, women labored in the same rooms, and mothers pushed and delivered alongside one another, separated by only a curtain. Moms recovered in a shared postpartum ward, congratulating each other on their babies. In surgery there was inconsistent cautery and limited suction. Resources that I took for granted in Seattle, things like antibiotics, narcotics, ultrasound, reagents, and imaging studies, were not always available, forcing doctors to rely more on their physical exam and patient history for most diagnoses and clinical decision making. Adverse patient outcomes across the hospital were a more common occurrence and maternal and neonatal outcomes that I had never seen or seen only rarely during residency, things like eclampsia, IUFDs, and maternal deaths, just happened more.

I expected things to be different, and they certainly were, but as I reflect on my time in Kenya, I am more struck by the similarities.

On my first day in the operating room I stood across from one of the medical officer interns, chiefing her through an abdominal hysterectomy. I talked her through the layers of the abdominal wall as she cut through the skin to the peritoneum, the exact same layers I chiefed my interns through in Seattle.

In both Seattle and Kenya the only ways to have a baby are through the vagina or the abdomen, and the antepartum period involves a constant weighing of fetal and maternal risks and benefits. Everywhere, patients put their lives and trust in your hands.

The scarcity of resources or location of the hospital does not change the love in a mother's eyes when she holds her baby for the first time, the heavy weight that drops in the pit of your stomach when someone tells you they have not felt their baby move in several days, and the devastation when you tell them that their baby has died. Whether or not there is cautery, unlimited blood products, or cell-saver, the goal is the same — to keep mom and baby safe, to stop the bleeding, prevent infection, keep from doing harm to the patient.

At hospitals in both Seattle and Naivasha you need your whole team, at every level, for things to run smoothly. You definitely want the nurses on your side, pharmacy always knows the answers to your medication questions, and there is camaraderie between the residents found in their long hours and

shared exhaustion. People have a favorite hospital food (it's the lentils and chapati in Naivasha and the tots in Seattle), and a favorite place to go after work.

Everywhere teams are made up of people who put their heart and soul into their work. A combination of people who are outraged at bad outcomes and systems issues, resigned to the way things are, and who are motivated to teach, to learn, and to improve.

Our jobs as obstetricians and gynecologists in Kenya and Seattle are fundamentally the same, what is different are the tools we are given to achieve those goals and the systems and environment that we work in. What is different are the resources and barriers patients bring to the table. In Kenya I met doctors, nurses, residents, and pharmacists who work extraordinarily hard to achieve the same goals as I do with substantially less resources. I met people eager to improve systems at their hospital, implement evidence-based guidelines, and partner with UW and other institutions to create change.

The role of foreign physicians and organizations in global health is complex and nuanced. Among the many goals of global health partnerships between institutions is an exchange of knowledge. During my time at NCRH I saw glimpses of my Seattle colleagues in the way an MO made their incision for the hysterotomy, or the way a consultant opened a window in the broad. I hope I left people with something of value, with more knowledge about the physiologic changes of pregnancy, obstetric hemorrhage, or paracervical blocks. Working in the obstetrics and gynecology wards at NCRH left me with more questions than I arrived with, but I am confident that forward progress is possible. I am eager to continue to work in global reproductive and sexual health throughout my career.

I hope to see my Kenyan colleagues on our labor and delivery ward in Seattle. What a privilege it was to work with and learn from the providers at Naivasha County Referral Hospital. What a humbling experience it was. Asante sana.