Pre-Physician Assistant Internship Program

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SUMMER 2025 ALUMNI

Where Life and Loss Shape Purpose: A Personal Reflection on Global Health and Medicine

Introduction

"Someone needs to switch with him", said the nurse managing the airway. I stood there in awe. It was May 27th, 2025, around 11pm, my second week at Coast General Teaching and Referral Hospital (CGTRH) and my very first night-shift. I had just entered the pediatrics accidents and emergency room (A&E), and in front of me was another more experienced intern performing CPR on a 2-year old boy. My heart dropped. I am CPR-certified, but I had never seen it being used nor needed to use it myself, especially not on a child. The pediatric emergency room that night was short-staffed, and every set of hands mattered. When the call came for someone to take over, another intern stepped forward. Before he could move closer, I asked him, "Are you CPR-certified? Do you know what you're doing?" He hesitated and admitted he would just try to copy what he saw, believing this is how he could help. At that moment, I made a choice. As a young woman heading not just into medicine but existing in the world around us, I've been taught to always question myself; but this was not the time for self-doubt. I knew I had the training and ability, and I wasn't going to let hesitation compromise that child's care. With confidence, I said no, stepped forward, and took responsibility. I quickly pulled on gloves, steadied myself, and took over the airway from the nurse. I focused on the rhythm of counting breaths, grounding myself in the task and pushing away the crushing reality: that this small, innocent boy's life was partially in my hands. After multiple rounds of CPR, the time of death was called. My adrenaline still surged, but the room was silent, heavy with grief. I locked eyes with the intern who had been doing compressions, and together we stepped back. Then came a sound that will stay with me forever. The anguished scream of the boy's mother. She rushed to her son's lifeless body, then turned her grief into rage, lunging toward the doctors, the nurses, towards us. Her pain was uncontainable, raw, and devastating. Nothing more could be done.

A Turning Point in Pediatrics

That night was a turning point for me. I learned that even in the most harrowing circumstances, I could step up, not timidly but with the confidence and clarity needed to help. Yet, even as I carry that lesson forward, I also carry the weight of lingering guilt. I know rationally, that everything possible was done, but part of me still replays those moments, wondering if anything could have changed the outcome. That tension between confidence and guilt is what continued to drive me throughout my two months at CGTRH. It reminded me of the gravity of this work, and of the responsibility I hold each time I step

into the hospital. Every patient interaction reinforces that responsibility, but it also fuels my drive to be a source of light in what can sometimes feel like an unbearably dark space.

Broadening Perspective through Rotations and Community Care

That night in the pediatric emergency room, during only my second week, put everything I was doing at CGTRH into perspective. It was a stark reminder that this was not just observation: this was the reality of medicine. Grateful doesn't even begin to capture how I feel when reflecting on my eight weeks (2 months) in Mombasa, Kenya. From the moment I landed on May 16, 2025, I could not have anticipated how profoundly my outlook on medicine, life, and humanity would change. Throughout my time at CGTRH, I was able to rotate through a wide range of departments, from the Accident and Emergency (A&E) and Cardiology to Surgery, Pediatrics, the Comprehensive Care Clinic (CCC), Oncology and Obstetrics and Gynecology (OB-GYN). I also gained exposure to Radiology, the Newborn Unit, the Casting Unit and even the Morgue. Each placement revealed a different side of patient care. Whether it was the urgency of A&E, the vulnerability of the newborn ward, or the complex emotions surrounding end-of-life care. Beyond the hospital walls, I joined community health initiatives, helping in our IMA sponsored community clinics with triage, pharmacy support, and nutrition counseling. Yet what left the deepest impression were the school-based health education sessions we led with primary and secondary students. Teaching hand hygiene, dental care, and personal and feminine hygiene practices, I saw how simple education could spark lasting change. Those classroom moments brought joy and hope in weeks that were otherwise some of the most emotionally demanding. I also took part in a youth mental health seminar, contributing to efforts to destigmatize a critical global issue.

While these experiences gave me invaluable clinical exposure, they also pushed me to think beyond patient encounters. Living and working in Mombasa meant witnessing first-hand how healthcare delivery is shaped by political systems, cultural values, and resource availability. Each department, each clinic, and each classroom not only deepened my medical knowledge but also highlighted the broader forces that define patient care in this context. To truly capture what my eight weeks taught me, it is important to reflect on these systemic differences, unique clinical cases, and powerful patient interactions that left a lasting impact.

Systems and Structures of Care in Kenya

While at CGTRH I was able to observe how healthcare delivery, structure, and human resources are deeply influenced by both healthcare literacy and the broader political system, factors which usually shape the patient's outcome in Kenya in ways that stand in sharp contrast to my experiences in Canada. To better understand the challenges many healthcare workers face in Kenya, I first had to grasp the idea of the different levels of integration within the healthcare system and the route that many patients must take to finally end up at the hospital. Kenya's health sector is divided into three main categories: commercial, private, public, and faith-based. CGTRH falls into the public sector, primarily government-funded and used by those less financially fortunate. While this makes it more affordable, it is also severely under-resourced and understaffed. This correlates with higher incidences of hospital-acquired infections and generally poorer patient outcomes (International Medical Aid [IMA], 2025). Limited accessibility to public healthcare compared to private care drives patient numbers at CGTRH even higher, pushing the patient-to-healthcare worker ratio to staggering levels of nearly 21 doctors and 100 nurses per 100,000 people (IMA, 2025). Despite being a publicly funded hospital, CGTRH does not provide universal healthcare. Patients are still required to pay out-of-pocket fees, and for some, even the cost of opening a patient file can be unfeasible. While private medical insurance exists, it largely serves individuals in the formal employment sector. This creates systemic inequity, as approximately 80% of Kenyans are employed in the informal sector (IMA, 2025). Though the National Health Insurance Fund (NHIF) offers subsidized coverage for as little as $5 USD a month, many families cannot afford to opt in, as food, shelter, and school fees often take precedence (IMA, 2025). This makes healthcare bills instantly unaffordable, forcing families to pursue cheaper, short-term "quick fixes" rather than sustainable, long-term solutions.

One patient story that has stayed with me was that of a seven-year-old girl in the pediatric outpatient ward (POW), who was born with biliary atresia and after an unsuccessful KASAI procedure now also has a chronic form of cholangitis. Her family had traveled to India when she was only two months old for a KASAI procedure, knowing this could be a potential permanent solution but in some cases risky. For this family it was more financially feasible than the alternative, a liver transplant. Sadly, the cost of MHC testing for family compatibility and the transplant itself made it unattainable. For years, she has been in and out of the hospital whenever her symptoms flared up. Despite these challenges, the POW staff knew her and her mother by name, and together with other mothers on the ward, they built a supportive community. I was welcomed into this circle, often sitting with her, taking her vitals, and giving her mother moments of respite. On my last day, her tearful embrace reminded me of the resilience and humanity that emerge even in resource-strained settings. Her story emphasizes how both hospitals and families must navigate systemic shortages with creativity, sacrifices, and solidarity. Her story also reminds me of my own family. My younger brother also has a chronic form of cholangitis, but in Canada, his condition has been far more manageable since diagnosis because of his medications

and consistent monitoring available to him. Thanks to this access, his liver has even begun to regenerate, declining his need for a transplant. The stark contrast between his journey and that of a little girl in Kenya highlights the reality of how geography and resources can determine health outcomes.

There is almost a dependence on outside support especially in CGTRH's reliance on international aid and donations. Free surgical camps from Canadian open-heart specialists or American pediatric teams temporarily filled gaps that the local system could not. Yet this reliance also revealed its fragility. Recently, U.S. funding cuts to international medical programs have already impacted departments like oncology, contributing to shortages in HPV vaccines and furthermore increasing the future rate of cervical cancer, which is the most prevalent cancer within East Africa (Shah, 2025). The ripple effects of global politics are felt most acutely by the patients who can least afford it.

The contrast with Canada became strikingly clear after I returned home this past summer. While working as a lifeguard, I was involved in a major first aid response where an overdose required CPR. Within seconds, we were able to hook the patron up to an AED. The device not only analyzed the rhythm but gave us real-time feedback, telling us if compressions were too shallow or too slow. Having access to such resources fundamentally changes the effectiveness of care and outcomes. In Kenya, even basic resources like functional monitors or gloves were sometimes scarce. Within my eight weeks at CGTRH I never saw a working AED being used during a code. In Canada, by contrast, advanced life-saving technology is publicly available in gyms, schools, airports, and pools. This disparity highlights how systemic investment or lack thereof, directly shapes the care patients receive, and it deepened my awareness of the privilege and responsibility I hold as I continue my path toward medicine.

To put Kenya's healthcare spending into perspective, the country invests approximately $88 USD per person annually, or 5% of its GDP, in healthcare (IMA, 2025). This contrasts sharply with the United States, which spends nearly $11,000 USD per person, 17% of its GDP, yet still struggles with equitable access. Canada falls between these two extremes, with healthcare expenditure around $4,600 USD, representing about 11-12% of GDP (Canadian Institute for Health Information [CIHI], 2024). Delivered through a publicly funded, single-payer model, Canada's system ensures that patients do not pay directly for most physician or hospital services at the point of care, unlike in Kenya, where out-of-pocket costs are the norm and often prohibitive. While Canada faces its own systemic challenges, such as longer wait times and healthcare worker shortages, it does not experience the severe supply and resource gaps I witnessed at CGTRH. This comparison sharpened my understanding of how political systems and financial priorities shape access to healthcare. In Kenya, limited government investment and a reliance on out-of-pocket costs mean families are forced into difficult choices between medical care and basic necessities. In Canada, taxation and collective funding help ensure universal access, even if delivery is not always timely. And in the U.S., despite extraordinarily high investment, unequal

access persists. These contrasts revealed to me that medicine is not only about clinical skill, but also about the systems that enable or limit its delivery.

These systemic differences in healthcare delivery became even more apparent when considering the disease burden in Kenya, where patients face a dual challenge of communicable illnesses, rising rates of non-communicable conditions, and the often-overlooked crisis of mental health, each of which I witnessed firsthand through patient interactions.

Communicable Disease Burden

One of the most striking realities in Kenya is how heavily communicable diseases continue to shape patient care. Malaria, tuberculosis, and HIV remain widespread, but what I learned is that these illnesses are often compounded by malnutrition. This was very prevalent within the pediatric ward and the pediatrics A&E; children admitted for infectious diseases were frequently also struggling with severe undernutrition, which not only weakened their immune system but also prolonged recovery. This dual burden was something I had not fully appreciated until I witnessed it firsthand. Mosquito-borne viruses were especially prevalent, with many patients only seeking care once symptoms became unmanageable without urgent medical intervention. Numerous malaria cases progressed to cerebral malaria, developed severe anemia or other hematologic complications and even liver issues. This vector-borne communicable disease represents 3% of mortalities and one of the top outpatient morbidities in Kenya (IMA, 2025). When speaking about vector-borne viruses I think it's also important to highlight chikungunya. Within the hospital I had many run-ins with all severities of this virus, from cerebral chikungunya to having it as a co-infection with another illness, it was extremely prevalent within CGTRH. During my time at CGTRH there was even a chikungunya outbreak within the pediatric ward. This is due to limited resources such as insecticide-treated bed nets, reliable diagnostic testing, and vector control programs.

Alongside malaria and other mosquito-borne illnesses, HIV remains one of the more pressing communicable diseases in Kenya, and my time in the Comprehensive Care Clinic (CCC) gave me firsthand insight into the challenges patients face in living with and managing this condition. Beyond the medical realities of antiretroviral therapy, I witnessed the weight of stigma, the barriers to consistent medication adherence, and the extraordinary resilience of patients who showed up day after day for their care. These experiences highlighted how HIV is not only a clinical diagnosis but also a social and emotional journey, one that deeply shapes both patients and their families. Within the CCC I spent most of my time in the consulting therapy rooms and the pharmacy. In consulting I was able to learn and educate myself more on the stigma around HIV, and why when working within the hospital it was referred to as RVD (retrograde virus disorder). I found that lots of patients feared being recognized

by other community members that they might know, and most were willing to travel to this CCC from other surrounding regions to avoid this. Mombasa county contributes 3.6% of the total people living with HIV in Kenya (IMA, 2025). Many would come in disguises, some women wearing full burkas even though they weren't Muslim; after speaking with one of the consulting physicians I learnt that around 10% wear a disguise so they can stay anonymous to the public. Also many, if not all, would transfer their anti-retroviral treatment medication (ART) to different pill bottles or stuff them so others around could not hear the shake of the pill bottle. These practices are created by and through more feed into the negative stigma surrounding HIV, which in result delays treatment and feeds into a negative self-image. Lots of the CCC physicians found that newly diagnosed patients would have a decline in their mental health, that's why they offer free consulting surrounding someone with a positive status. They found that most patients who accepted their status were really good at keeping up with their ART, and informed me that 98% of CCC regular patients were at low viral loads. Thanks to this, childhood cases have had an 18% decline. It was also nice to learn that they are starting to educate and destigmatize within the public schools, overall helping increase the youth of Kenya's health literacy.

The Growing Challenge of Non-communicable Diseases

At the same time, I observed the growing burden of non-communicable diseases such as cancer, hypertension, and diabetes. Unlike in Canada, where chronic conditions are supported by long-term management programs, in Kenya many families face fragmented care, limited access to medications, and the overwhelming financial toll of repeat hospital visits. These systemic gaps make non-communicable diseases especially devastating, as families often must choose between temporary fixes and the hope of a definitive treatment.

During my time at CGTRH, I spent many hours observing the oncology team; this is where I came to understand how deeply non-communicable disease, especially cancer, can impact patient care in Kenya. Cervical cancer stood out as the most prominent cancer, a trend driven largely by limited access to HPV vaccination and lack of healthcare literacy about cancer signs and symptoms (Ferlay et al., 2024). This overall caused women to present mostly in advanced stages of disease. While early detection ensures a favorable outcome and prognosis for most cancers, about 80% of reported cases in Kenya are detected at an advanced stage when very little can be achieved in terms of treatment (IMA, 2024). In these late stages, treatment is not only medically complex but also financially devastating. Even patients with health insurance frequently find that their coverage does not meet the full cost of treatment, forcing families to make impossible choices. I witnessed one particularly heartbreaking case of a woman diagnosed with both breast and cervical cancer who was financially constrained to treat only one condition. Stories like hers were not uncommon, as many patients are forced to pause or

abandon life-saving treatment due to lack of funds. These encounters made clear how structural and financial barriers can dictate survival, and how different this reality is from Canada, where universal healthcare ensures that cancer treatment is covered and patients do not have to choose between their health and financial stability.

At the same time, I also saw glimpses of hope and innovation. The hospital was running a free drug trial for patients with a specific type of red blood cell cancer, where those enrolled not only received their medication but also had the entirety of their care cost covered. For these patients, research provided an opportunity that healthcare systems alone could not afford them. One oncology consultant I worked with was deeply committed to expanding knowledge beyond hospital walls. He was engaged in outside research and organized medical camps that focused on the hidden burden of undiagnosed cancers within refugee camps. Unlike viral illnesses such as HIV or malaria, cancer often goes overlooked in these contexts, yet the suffering it causes is no less profound. Together, these experiences highlighted how non-communicable diseases are shaping Kenya's healthcare landscape in profound and complex ways. They expose systemic inequities in access to screening, treatment, and financial protection, but they also underscore the resilience and dedication of healthcare providers who are working to bridge these gaps. My time in oncology left me with a deep appreciation for the urgent need to prioritize non-communicable diseases within global health, as their impact continues to grow in places where resources remain scarce.

Mental Health and Hidden Burden

Equally important, yet often hidden in the shadows, is the burden of mental health. Mental health in Kenya remains deeply stigmatized, with many people taught to simply put their head down and endure their struggles in silence. The Kenya Mental Health policy states that 1 in every 4 is likely to suffer from a mental health illness at some point in their lifetime. This statistic translates to around 12 million Kenyans (IMA, 2025). This mindset, while born from resilience, often eats away at individuals who feel isolated in their pain. Too often, people are left unaware that it is not only acceptable but necessary to reach out for help and that they are not alone.

This silence surrounding mental health extends into other sensitive issues, most painfully sexual assault. Nationally in Kenya approximately 1 in 3 women have experienced sexual violence before the age of 18 and 38% of married women have faced physical violence (Yusuf, 2024). One of the most haunting cases I witnessed was that of a woman who had been assaulted and left at the front of the A&E department with no identification. It ended up taking days for her family to arrive, leaving her alone, a victim of both violence and abandonment. Even more devastating was the case of a three-year-old girl I had met on one of my night shifts who had been sexually assaulted. What struck me most was

that she did not even realize what had been done to her was profoundly wrong. I was fortunate enough to gain her trust, and once I did I was able to help distract her from the harsh reality she was in; trying to help give that little girl some type of comfort in a world that had already failed her. Her innocence, her willingness to laugh and play despite such trauma, was heartbreaking. Having a personal connection to the topic of sexual assault, this experience hit me in an especially raw way. It was both painful and humbling to witness the resilience of someone so young while knowing the lifelong shadow such violence can leave behind. These moments revealed how sexual violence has, in many ways, become normalized, with little discussion of consent or accountability. In Mombasa County, data from CGTRH's Gender-Based Violence Recovery Centre indicates that between 2017 and 2023, over 3,100 sexual violence survivors sought care, having the median age of 15 years old for female survivors (Olum et al., 2025). This silence echoed in the youth mental health sessions we conducted, where many adolescents asked difficult questions about safety, consent, and how to protect themselves. One female student had confided through an anonymous note that a boy continued to force sex on her despite her saying no. Her fear was not only about the violation itself, but also about how it could impact her future. She worried that an unwanted pregnancy might strip her of her chance at an education. Hearing about this raw and desperate call for help was devastating. It revealed how deeply these issues are tied to cycles of poverty, gender inequality, and systemic neglect.

Yet alongside these experiences, I also witnessed providers who deeply understood the psychological weight of illness and injury. In the casting unit especially, physicians often spoke with me about how traumatic it can be for patients, not just children, to come to the hospital. They made it a priority not only to treat physical injury, but also to ensure patients were leaving in a good headspace. They reassured them that it was okay to feel scared, but that by coming to the hospital, they had done the right thing. Watching this intentional care, acknowledging the patient's emotional wellbeing as inseparable from their physical recovery, stood in sharp contrast to the cultural stigma that often surrounded mental health outside of the hospital walls. This demonstrated how essential it is to create spaces where young people feel safe to share, to learn about their rights, and to begin breaking the silence surrounding both mental health and sexual violence.

Full Circle in Emergency Care

It was July 8th, my eighth and final week interning at CGTRH, and I found myself once again on the night shift in the accident and emergency department. It felt like a full-circle moment. My first night shift had been here, and now my last would end in the same place. Over these weeks, I had grown tremendously: I had stepped into leadership, learned when to take control, and found confidence in the unpredictability of the night. At 3am, the usual chaos of the ER had quieted, and a few of us sat at the

charge station updating notes when the PA system broke the silence: "Code blue, Obstetrics and Gynecology High Dependency Unit. Code Blue. Any available A&E staff please report." I jumped to my feet. This time, I was the experienced intern, turning to the ones beside me who were on their very first night shifts. For me, these codes had become part of the rhythm of nights at CGTRH, each one sharpening my skills and deepening confidence. A nearby nurse caught my eye and simply said "Let's go". We ran through the back lot toward the OB-HDU, where we found a woman lying unconscious on the bed. She had recently undergone a C-section, but her abdomen remained extremely swollen. The diagnosis: a severe post-surgical infection, sepsis. Gloves on, I stepped forward while another intern checked for pulse: "I have no pulse, I'm starting CPR". Immediately, I knew the drill. I directed another intern to find a bag-valve mask, and quickly got an OPA, and took charge of the airway. Around me, the doctors and nurses rushed to assess and attended to medications and equipment, much of it outdated or nonfunctional. There was no AED, and the unit was desperately under-resourced. The first bag-valve mask didn't work, so I sent an intern running to another department's crash cart for a replacement. Once we had a functional one, I stopped alternating with compression and remained in charge of the airway. The woman began vomiting bile and blood mid-code. My instincts took over: removing the OPA, turning her head, clearing the airway with my gloved hands while the nurse suctioned, then replacing the OPA, whilst becoming covered in splashes of vomit. We repeated this cycle again and again until every measure was exhausted; time of death was called.

When I looked up, the newer interns stood frozen, witnessing their first death. This time though, I did not feel the same guilt the way I had during my first code. Instead, I felt deep remorse, knowing that this woman's death was not from a lack of effort, but from a lack of resources. She was a daughter, a friend, a mother, and now she is gone.

The fragility of life in that moment forced me to pause. Am I doing something that brings light into my life, into other lives? Am I doing something that makes the world better? I knew the answer was yes. Despite the heartbreak, I knew there was nowhere else I needed to be but here, helping, learning, and stepping forward. This experience, though one of my most testing, affirmed my path. I may not be the most religious person, but in these past few months a verse from Romans 8:18 has kept finding its way to pop into my life. "The pain that you have been feeling can't compare to the joy that is coming." That night crystallized for me that medicine, though all the pain and suffering you may have to deal with, is not just a profession, but a calling. It inspires me every day to do good, to help others, and to keep driving towards the future I know I am meant for in medicine.

Conclusion

These experiences deepened my medical knowledge but also reshaped my perspective. Being able to see firsthand how systemic inequities in healthcare delivery, political priorities, and resource allocation determine patient outcomes. Yet I also witnessed resilience: mothers forming support systems, physicians creating research initiatives, and hospitals leveraging partnerships to meet overwhelming needs. In contrasting Kenya and Canada, I am left with a sharper awareness of privilege, responsibility, and the urgent need for systems that do not force families to choose between health and survival. It also illuminates not only disparities but the universal values of compassion, resilience, and hope that underpin patient care. This journey has highlighted the profound privilege it is to be able to live, to learn, and to love. Life is a gift and thanks to this incredible opportunity from International Medical Aid; I want to be able to use part of my gift to be able to continue to give back.

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