



Pre-Medicine Internship Program

Kyle Taylor

UNIVERSITY OF PENNSYLVANIA

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From Textbook to Triage: What Global Health Means to Me Now

I remember sitting in my high school biology class, flipping through a textbook when I stumbled upon a section on diseases prevalent in the developing world. It described, in vivid and unsettling detail, the symptoms of illnesses like Ebola and malaria - two diseases I had never heard of at the time. The page depicted Ebola's internal hemorrhaging and malaria's destruction of red blood cells as they burst and release parasites into the bloodstream. The section ended with a sobering note: Ebola and malaria might be curable, but little progress was being made due to a severe lack of research funding. The textbook also estimated the total cost to eradicate malaria. According to the Gates Foundation, the estimated cost to eliminate malaria by 2040 is between \$90 and \$120 billion - a sum less than the net worth of many of the world's wealthiest individuals (Renwick). That statistic stuck in my mind and has remained with me ever since: global health inequality is a solvable problem - so why aren't we doing more to solve it?

Over the following years, my interest in global health deepened, particularly as the COVID-19 pandemic exposed glaring inequities in vaccine access. I found myself inspired by frontline healthcare workers - many of whom were my own neighbors - and by the efforts to democratize vaccine availability worldwide. I trained to become an EMT, responding to medical emergencies on my college campus, and became involved in vaccine delivery research focused on developing pulsatile-release vaccines aimed at improving vaccination rates in low-resource settings. I joined a global health club on campus and worked to raise awareness of global health issues among my peers. Still, something felt missing. I didn't fully understand who I was helping. Who were these vaccines for? Who truly bore the brunt of these inequities? Why was it urgent to act now? I wanted to understand who was behind the numbers - the lives, the faces, the families.

Landing in Mombasa marked my first time outside the developed world. I remember the drive from the airport vividly. It felt chaotic, alive, and strained all at once - tuk-tuks, motorcycles, cars, and pedestrians weaving through the streets with no apparent regard for traffic rules. At every stop, people approached our windows offering fruit, nuts, or handcrafted goods, desperate to make a sale. The struggle for daily survival was tangible. I watched silently from the backseat, feeling a complex mix of awe, guilt, and anticipation for what lay ahead in the hospital.

During my first week, I was placed in the internal medicine ward, where we were introduced to Dr. Suhail, who guided us through patient rounds. One of the first patients we met was Margaret, a woman who had clearly suffered a stroke. I had been trained to recognize strokes as an EMT, but this was the first time I saw the reality firsthand: facial drooping, right-sided weakness, and expressive aphasia. Dr.

Suhail explained that Margaret had been in the ward for about a week and was showing slow signs of improvement. Margaret could understand us but couldn't speak. She lay motionless on a rusty bed, covered by a colorful blanket, with flies buzzing across her face. Her daughter, strong and vigilant, stayed at her bedside, advocating fiercely for her care - swatting flies, changing Margaret's clothes, and reading aloud to her. When I asked Dr. Suhail how long it had taken for Margaret to reach the hospital after her stroke, he explained that many patients arrive well past the "golden hour," when intervention might still reverse the damage. In neighboring Somalia, the average time to arrival for stroke patients is 16 hours (Sheikh Hassan). Many delay care due to lack of healthcare literacy or a belief that divine intervention will heal them (Kimani).

As we continued our rounds, I began to notice the silence that filled the ward. Patients sat quietly, not using phones or engaging in conversation. It wasn't peaceful - it was haunting. It felt like a collective understanding that not much could be done for them. Limited resources meant that Dr. Suhail had to prioritize only the most urgent conditions. Retroviral diseases, for instance, were often left untreated. Despite taking thorough histories and analyzing labs and imaging, there was often little he could offer by way of treatment.

One moment that struck me deeply was meeting a 20-year-old woman with stage 4 cervical cancer. She was my age. No treatment was scheduled; she was only receiving palliative care and was expected to spend her final days on a deteriorating hospital bed under the beating sun. That image stayed with me - how unjust it felt that someone my age, with a potentially preventable and treatable disease, was forced to endure such a fate. Had the cancer been caught earlier, this woman might have a better prognosis. However, like many of the other patients we saw that day, she presented with an advanced-stage illness, and the opportunity for curative treatment had already passed.

The internal medicine ward revealed a grim reality, yet within it, I also witnessed resilience and community. The patients, though suffering, created a comforting environment within the ward. They wore vibrant fabrics and their beds were covered in intricately patterned blankets. Family members looked after not only their loved ones but checked in on others in the ward as well. In the midst of helplessness, the community thrived.

My second week was spent in the surgical department. I observed an array of procedures - from the placement of a ventriculoperitoneal (VP) shunt to a coronary artery bypass graft. On my first day, I watched a double valve replacement. Dr. Iqbal, a visiting surgeon, generously spent two hours walking us through the procedure. He explained that such surgeries are often the result of untreated rheumatic fever - something nearly eradicated in the U.S. due to access to antibiotics like penicillin (Cleveland

Clinic). It was jarring to see complex, high-risk surgeries being performed for diseases that could have been prevented with basic, affordable interventions.

This theme of treating symptoms instead of root causes recurred throughout the week. VP shunts, for example, are used to treat hydrocephalus, which can arise from neonatal infections like *Streptococcus pneumoniae* (Sakurai et al.). In many African countries, these infections go untreated due to limited access to antibiotics (World Health Organization). Similarly, I observed a spina bifida surgery - another condition preventable through folic acid supplementation, a standard and inexpensive part of prenatal care in high-income countries (Mayo Foundation). The reality is stark: in Africa, families face costly, high-risk surgeries for conditions that are preventable with the right public health measures. In a country where the health expenditure per capita is just \$88.39 compared to over \$10,000 in the US, bearing the cost of expensive, preventable procedures is unconscionable (International Medical Aid). It was a painful reminder that without robust public health infrastructure, expensive hospital interventions become the last resort for preventable tragedies.

Even the operating rooms reflected the resource gap. During one open-heart surgery, a fly buzzed around the room. The presence of a fly during open-heart surgery wasn't just a nuisance - it was a symbol of how drastically under-resourced the system had become. At one point, Dr. Iqbal requested an alpha blocker only to be met with silence - it wasn't available. Instead, he instructed the anesthesiologist to improvise using a mix of saline and nitroglycerin. I later learned that Dr. Iqbal was a visiting cardiothoracic surgeon, and had only been at Coast General Hospital for three days. Many doctors at the hospital split their time between public and private hospitals to make ends meet. Coast General, the largest public hospital in the region, has only one full-time cardiothoracic surgeon.

As my time in Mombasa came to an end, I was left with a deepened sense of purpose, humility, and urgency. I witnessed physicians delivering care under unimaginable constraints, doing everything they could with the limited resources they had. I was struck by their willingness to teach and share knowledge despite the demands of their work. I returned home with renewed gratitude for the healthcare systems I had always taken for granted.

Yet, I also returned with frustration. Why are essential resources being cut from USAID-supported programs in this region? I heard stories of emergency rooms without working defibrillators, CT machines being down, patients undergoing procedures without anesthesia, and common medications being out of stock. These are all solvable problems.

Programs like PEPFAR (President's Emergency Plan for AIDS Relief) are being significantly disrupted. PEPFAR has saved over 26 million lives since its inception and cuts to the program could

put millions of additional lives at risk (UNAIDS). According to UNAIDS, the pause in US foreign assistance beginning in January 2025 had an immediate impact on the delivery of life-saving HIV medicines and the provision of HIV prevention services to millions of people whose lives depend on them (UNAIDS, 2025). Additionally, PEPFAR alone employs 41,500 healthcare workers in Kenya, many of whom are now facing layoffs (Kenya News Agency). When international aid programs are cut abruptly, the burden falls on local communities who are ill-equipped to fill the gap, exacerbating health inequities and endangering the lives of many additional people. The future of healthcare in Kenya is unstable and it has me worried. The world has the tools, resources, and knowledge to fix this, but the will to help is eroding.

This experience affirmed my commitment to global health - not just in theory, but in action. I now understand that to be a good healthcare professional is to care deeply about people and systems alike. It means advocating for equity, addressing root causes, and seeing the patient within their full human, social, and economic context. My hope is to one day contribute to the transformation of healthcare systems like Kenya's - through better infrastructure, expanded access to care, and increased healthcare literacy. I am more determined than ever to be part of the solution.

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admissions@medicalaid.org

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1629 K Street NW Suite 300

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