Pre-Physician Assistant Internship Program

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From Global Health Exposure to Purpose: My Pre-Physician Assistant Internship in Mombasa, Kenya

My passion for healthcare—particularly in underserved communities—began in high school. My journey began freshman year of college volunteering in the Dominican Republic; I witnessed firsthand the impact of compassionate care on those with limited access to medical services. However, growing up in a supportive environment, I was initially shielded from the struggles many face accessing healthcare. My time in Mombasa opened my eyes to significant disparities in healthcare delivery. It further inspired me to pursue a career as a physician assistant dedicated to bridging these gaps.

Arriving in Kenya with International Medical Aid, I was prepared to learn about healthcare delivery in a resource-limited setting; however, despite that preparation, the differences were striking. From the moment I stepped off the plane the bustling streets of Mombasa, the vibrant markets, and the warm greetings from locals set the stage for an immersive experience. Over the next four weeks, I moved through various clinical rotations, from the Newborn Unit to Radiology. I taught at various schools and had the opportunity to help with community medical clinics. The hands-on involvement and the cultural exchange were profound. Observing and participating in the care of premature infants, learning from seasoned professionals, and connecting with patients deepened my understanding of the human side of medicine. These experiences enriched my clinical knowledge and reinforced my commitment to providing compassionate and equitable healthcare.

On my first day of internship orientation at Coast General Teaching and Referral Hospital (CGTRH), I walked through bustling corridors, observed daily operations, and absorbed common rules and practices. I soon learned that patients had to pay out of pocket for basic medical supplies, including sutures, medications, and catheters. If and when they were unable to afford these essentials, they were subjected to detention within the hospital until they could settle their bills. This practice was starkly different from anything I had encountered in the United States, where such necessities are routinely provided.

Proceeding through orientation and a tour of the hospital, it seemed the aforementioned healthcare disparities only continued to grow. While healthcare inequality is an unfortunate reality throughout the world (to include back home), my work in Mombasa set into stark relief just how extreme those inequities can be. It was disheartening to see patients without rooms—separated only by thin curtains—waiting for an indeterminate amount of time to receive care due to significant staff shortages. The overburdened healthcare providers struggled to meet the overwhelming demand, resulting in long waits

and insufficient attention to individual patients. The immediate exposure to these harsh realities was a poignant reminder of the impact of systemic inequity in healthcare.

My first week in the OB labor ward at CGTRH was eye opening, and it afforded me the opportunity to engage with deeply moving work. I was inspired by the strength and resilience of the women I encountered. Despite the intense pain and fear they must have been feeling, these women endured labor and related procedures without epidurals or any form of pain relief, including episiotomies. Witnessing their courage firsthand was humbling and enlightening, and highlighted the incredible fortitude of mothers in this environment.

Parallelling and necessitating this inspirational courage, the care provided in the labor ward was markedly rushed due to chronic understaffing. The limited number of healthcare professionals available required tasks to be performed quickly, often without adequately communicating with patients. I was shocked to observe that staff did not explain procedures to women, instead performing actions (e.g., bursting the amniotic sac or making incisions) without any warning or explanation. The urgency of the situation was often conveyed through yelling at the mothers to push and (at times) even physically pressing on their stomachs to expedite the process. This sometimes-necessary approach was decidedly different from the patient-centric work I was more familiar with.

Nested with the staff challenges discussed above, much of the delivery work was carried out by student nurses. One particularly memorable moment was watching a 20-year-old student nurse perform her first solo delivery. She managed the situation with competence and confidence, a testament to her training and ability to remain adaptable in such a high-pressure environment. This reliance on student nurses was a direct consequence of the severe shortage of medical staff. Dr. Mohammed—the one doctor in the ward—was frequently needed in the operating room to handle emergency C-sections, leaving the ward under the care of these young trainees.

One night shift brought an emotional and heart-wrenching experience that I will never forget. A mother, clearly in distress, tapped me on the shoulder to get her cervix checked. Her desperation and the immediacy of her need were palpable. When she opened her legs and revealed her cervix, I saw a foot—a clear sign of breech birth for the premature 30-week-old twins. I immediately alerted the doctor, and the twins were delivered promptly. The delivery was complicated by both babies being in a breech position, requiring extraordinary efforts from the medical team to ensure a safe birth. Tragically, despite all efforts, one of the twins passed away the next day. This event made clear that in neonatal care, there is an ever-present, fragile line between life and death; this practice can take a profound emotional toll on families and healthcare providers.

Access to skilled healthcare providers and adequately stocked facilities is critical. Notwithstanding global disparities, the divide between rural and urban areas (e.g., Mombasa) domestically is similarly stark. Resources remain limited in urban centers but are relatively better than in the westernmost provinces of Kenya. By way of example, the maternal mortality ratio in Kenya "stands at 355 deaths per 100,000 live births, translating to nearly 5,000 women and girls dying annually due to pregnancy and childbirth complications. While access to skilled birth attendance has improved . . . over 80% of maternal deaths are attributed to poor quality of care" (UNFPA Kenya, 2016). Without routine care, including regular antenatal visits, ultrasounds, and blood tests, women are more likely to die from complications during pregnancy and childbirth. In the U.S., maternal and prenatal care is generally more accessible, with regular standard care practices. Most women have access to skilled healthcare providers, advanced medical facilities, and pain relief options during labor. By contrast, Kenya faces substantial challenges, including a shortage of healthcare professionals, limited medical supplies, and under-resourced facilities.

As with the previously-identified high rates of maternal mortality, the disease burden in Kenya was an ever-present reality during my time in the labor ward. HIV remains a significant health challenge in Kenya, where stigma and misinformation about the disease continue to affect many, particularly expecting mothers and newborns. According to the 2015 Kenya HIV Estimates, "women in Kenya are more vulnerable to HIV infections compared to Kenyan men, with the national HIV prevalence at 7.0 percent for women and 4.7 percent for men." This heightened vulnerability translates into considerable impacts on maternal and child health. For example, "HIV and AIDS in Kenya accounts for 20 percent of maternal mortality and 15 percent of deaths of children under the age of five" (International Medical Aid, 2024). During my time in Mombasa, I observed that healthcare staff often avoided discussing the HIV status of mothers directly, referring to it as "RVD" (retroviral disease) instead of HIV. This semantic avoidance perpetuates the stigma and prevents open conversations that are crucial for effective disease management and support. In the maternity ward, HIV-positive mothers were subject to different delivery protocols to minimize the risk of mother-to-child transmission. For instance, staff would take extra precautions such as delaying the rupture of the amniotic sac until the baby was fully delivered, reducing the baby's exposure to HIV in the birth canal. Despite these careful measures, the lack of open communication about their condition left many mothers feeling confused and isolated, unable to fully understand or engage with the necessary steps to protect their health and that of their newborns.

These anecdotal experiences underscore the immense challenges faced by the Kenyan healthcare system and the pressing need for improvements in maternal care. The courage and endurance of the mothers, coupled with the dedication of the healthcare providers working under such constraints, left a lasting impression on me. It reinforced my commitment to advocating for better healthcare resources

and practices, both locally and globally, to ensure that all women have access to the quality care they deserve.

I found one of the most important parts of my 4-week internship was engaging with the local community through hygiene clinics at children's schools, women's healthcare sessions, and free Saturday clinics. These opportunities offered me a deeper understanding of the cultural context in which healthcare is delivered. Teaching dental and hand hygiene to children, for example, emphasized the importance of preventive care and health education in improving public health outcomes. We introduced basic concepts of cleanliness and disease prevention through interactive demonstrations and activities, which were met with enthusiasm and curiosity from the children. This hands-on approach not only equipped them with essential skills, it highlighted the critical role of early education in fostering long-term healthy habits. Witnessing the children's eagerness to learn and their immediate application of these practices was a powerful reminder of the impact that simple, preventive measures can have on a community's overall health.

The cultural variations I encountered during these sessions, such as different beliefs about healthcare and varying levels of health literacy, reinforced the need for culturally sensitive and patient-centered care. For instance, in women's healthcare sessions, we discussed female anatomy, family planning, and hygiene. These discussions often revealed deeply ingrained cultural beliefs and practices that influenced women's health choices. Understanding these cultural nuances was crucial in providing relevant and respectful healthcare advice. It was evident that a one-size-fits-all approach would not be effective; instead, healthcare providers needed to tailor their communication and interventions to align with the community's values and beliefs.

With improved communication comes better community outreach, a key component to improved healthcare outcomes made evident during my work in the Saturday community medical clinic at Likoni Primary School. Many patients who attended these clinics had limited access to healthcare due to financial constraints, geographic barriers, or lack of awareness about available services. In Kenya, the current health expenditure per capita is only $88.39, compared to $10,623.85 in the United States, reflecting the vast difference in economic resources and the extent of healthcare services available. By bringing healthcare directly to these underserved communities, we were able to reach individuals who might otherwise go without necessary medical attention. This initiative emphasized the importance of accessibility and equity in healthcare delivery, particularly in a country like Kenya, where healthcare spending stands at just 5.167% of its GDP compared to 16.885% in the U.S. (International Medical Aid, 2024). This divide in health expenditure reflects the challenges faced by Kenyan communities in accessing comprehensive services. Outreach programs are critical in bridging the gap and ensuring that more people receive the medical care they need.

Through these community engagements, I also learned about the challenges faced by healthcare providers in educating and empowering patients. Many individuals struggle with literacy, making it difficult for them to understand medical advice and adhere to treatment plans. For example, one of the last patients we consulted was a 13-year-old girl with sickle cell disease; she was experiencing severe pain in her upper left abdomen, likely due to a sickle cell crisis. This condition, exacerbated by limited access to medications and healthcare resources, can lead to complications such as splenic sequestration or splenomegaly. The girl's condition showed me the unfortunate impact of inadequate healthcare infrastructure and education. Her family lacked knowledge about the importance of regular medical check-ups and the management of sickle cell disease. They were unaware of the necessity for routine blood tests, vaccinations, and the avoidance of dehydration and infections; all critical components in managing her condition. This meant that the girl often went without the necessary medications and preventive care, leading to frequent and severe pain crises. During the consultation, it was clear that her condition had been neglected not out of indifference, but due to financial constraints and a lack of awareness.

This anecdote is representative of a broader trend; most patients we consulted at community clinics were young teenagers. This demographic presented unique challenges as they were at a critical stage of development and faced various health issues, including malnutrition, infectious diseases, and reproductive health concerns. Many had limited knowledge about their health and the importance of seeking timely medical care. The doctor explained that they relied on these clinics to get the medication and care that they needed.

Most obviously, healthcare providers play an important role in treating illnesses; however, that importance is matched by the need to educate and empower patients. Effective communication and education can bridge the gap between limited resources and better health outcomes. By providing clear, simple, and culturally appropriate information, healthcare providers can help patients understand their conditions, adhere to treatment plans, and make informed decisions about their health.

These experiences have deepened my appreciation for the complexities of delivering healthcare in diverse cultural settings, teaching me the importance of adaptability, empathy, and cultural awareness in my practice. Moving forward, I will integrate these lessons into my career as a physician assistant, striving to provide compassionate, culturally sensitive, and patient-centered care to all individuals, regardless of their background or circumstances.

My time in Mombasa has solidified my interest in pursuing a career focused on global health and working in underserved communities. The resilience, dedication, and resourcefulness of the healthcare professionals I worked with have inspired me to strive for excellence in my own practice. I have

developed a specific interest in neonatal care and maternal health, recognizing the need for specialized care in these areas, especially in low-resource settings.

To this point in my professional development, my internship experience in East Africa is the cornerstone of my journey toward becoming a physician assistant. I am beyond grateful for the clinical exposure, cultural immersion, and unique challenges faced. Looking back, this time has not only enriched my knowledge and skills, it has deepened my passion for making a meaningful impact in the field of healthcare.

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