

Collaborative Care: An Observation of Mentorship and Mobile Medical Clinics in Kyrgyzstan

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Table of Contents

Acknowledgements	2
Abstract.....	4
Introduction.....	5
Background & Literature Review	7
Kyrgyz Demographics and History	7
Healthcare Since 1991	11
Financial Accessibility.....	14
Improving Access in Rural Kyrgyzstan.....	16
Mentorship	17
Mobile Medical Clinics.....	25
My Personal Experience.....	32
Getting to Rural Kyrgyzstan	32
A Typical Clinic Day	37
Facilities and Local Staffing.....	42
Demographics Served	44
Food and Lodging	45
Social Orphans	49
What I Learned and Future Applications.....	52
Personal Observations	52
Personal Applications	59
Bibliography	62

Abstract

Kyrgyzstan is a small country in Central Asia with many geographically-isolated villages and communities. After the fall of the Soviet Union in 1991, Kyrgyzstan lost the economic support that the Soviet Union provided and became responsible for establishing an independent healthcare system. This process has been tedious, and many people living in Kyrgyzstan's remote villages do not have regular access to a doctor. Mentorship programs are being implemented in Kyrgyzstan to equip young healthcare professionals with the skills they need to practice medicine in remote places. Mobile medical clinics are being paired with the mentorship programs to allow young healthcare professionals to be actively involved in providing healthcare access to people in remote areas. The focus of the analysis is a reflection on my personal experience as an American traveling with a mobile medical clinic and how my experience fits into the context of current global health research. The mobile medical clinics were greeted with extreme gratitude and excitement. However, the mobile medical clinics were also limited in their ability to make lasting changes on their own.

Introduction

When I first heard the name Kyrgyzstan, I felt awkward because I had no idea where the country was located. During the summer of 2022, I had the opportunity to visit Kyrgyzstan with my immediate family. My family wanted the chance to travel somewhere before we kids began to leave the house. We chose Kyrgyzstan because my family had friends doing humanitarian work there. This was our opportunity both to travel and to help with something for the greater good of people.

The primary purpose of the trip was to help with a series of mobile medical clinics in the rural parts of Kyrgyzstan. My family was well-suited because my dad is a registered nurse, and I am a nursing assistant. My mom and brothers were able to help with entertaining children and odd jobs to keep the clinic moving smoothly. It was extremely rewarding to be able to work as a family, and we enjoyed being completely immersed in a culture and history about which we knew little.

I had a lot of personal reasons for being excited about the trip. Medicine has been my passion since I was old enough to flip through the medical textbooks that sat on my dad's shelf. I became a nursing assistant to gain clinical experience, and now my education at WOU is preparing me for higher education in medicine. I was fascinated to see medicine being practiced in places where medical equipment, supplies, and staff were in

short supply or nonexistent. I have never had the experience of being denied access to healthcare or of care being nonexistent where I live, but cost was a huge barrier to healthcare during the first half of my childhood. Out of that, I have become interested in how I can help with improving access and quality of healthcare for people everywhere.

While working with the clinic, I got to see firsthand the excitement over being able to see a doctor. Many of the patients that came through the clinic had no regular access to a doctor for a variety of reasons, such as cost, distance of travel, and or a lack of an available provider. Still, I couldn't help but wonder if we were actually improving the situation longterm. We held a clinic in each town for one day. Many of the people needed frequent follow-up visits to manage chronic problems, and yet very few of them would see a doctor again anytime soon. This wonder is what led to the underlying question for my thesis—can healthcare professionals from high-income countries work with healthcare professionals in Kyrgyzstan to permanently improve access to healthcare in rural areas?

Background & Literature Review

Kyrgyz Demographics and History

Kyrgyzstan is a small country about the size of Nebraska in central Asia. Kyrgyzstan shares a border with China to the east and with Kazakhstan to the north. Along the southern and western borders lie Tajikistan and Uzbekistan. Roughly 90% of the country is mountainous between the Tien Shan and Pamir-Alay mountain systems. The average elevation is 9,020 ft above sea level (The World Factbook, 2023).

Figure 1:

General Location of Kyrgyzstan (Ontheworldmap.com)



Kyrgyzstan has a growing population of 7.07 million (Our World in Data, 2023). It is a diverse country made up of 73.8% Kyrgyz, 14.8% Uzbek, 5.1% Russian, and 1.1% Dungan. An additional 5.2% is made up of Uyghur, Tajik, Turk, Kazakh, Tatar, Ukrainian, Korean, and German people. Both Kyrgyz and Russian are considered state languages, but Russian continues to be the common trade language that connects many Kyrgyz people to the rest of the world. There are many other common languages and dialects spoken, especially outside of the big cities (The World Factbook, 2023).

A little more than ninety percent of the people are Muslim, mostly Sunni Muslim (Pew Research Center, 2025). In the bigger cities, people are much more casual with what they believe. Being Muslim is closely tied to their identity as a Kyrgyz, but they may not practice the tenets of Islam daily. People in the rural areas are generally more devout and practice the tenets of Islam daily. The Kyrgyz people have not always had such a deep connection to Islam. Much of Kyrgyzstan's religious history is influenced by its location on the Silk Road and the frequent conflict in geographic central Asia. Their practice of religion has evolved as they have lived in close proximity to different religions (Chotaeva, 2016).

Traditionally the Kyrgyz were a nomadic people. Instead of buying or growing feed for their sheep, goats, and cows, they allowed their animals to graze in the mountains. They lived in yurts that could be moved from place to place as they followed their animals (Biyik, 2016). As Kyrgyzstan has

developed in the 20th century, property ownership made nomadism virtually impossible. Most people now have some kind of permanent home, although many people still take their herds to the mountains for the summer (Biyik, 2016).

The most relevant politics for modern Kyrgyzstan involve the Russian Empire. In 1876, the final part of the territory of Kyrgyzstan was annexed as a part of the Russian Empire. Northern Kyrgyzstan agreed to this arrangement voluntarily because they were experiencing intertribal conflict as well as threats from the Chinese and Khazaks around them. Southern Kyrgyzstan was taken by military force. Russians began moving into Kyrgyzstan and brought a new culture with them. As land ownership was established, much of the good land was given to the Russians, and this led to uprisings of the Kyrgyz against the Russians (Chotaeva, 2016).

In 1917, the Bolsheviks came to power. The people of Kyrgyzstan were hopeful that the era of exploitation would be over, but instead they experienced persecution of religious leaders, political figures, and the wealthy. Many innocent people were killed as the Bolsheviks established their rule. However, alongside the brutality came societal structure that had never existed before. Education and written language were established and became available to everyone. Art forms, like theater and painting, were developed. Science as a discipline was established, and industry was

built up that greatly improved the socioeconomic status of Kyrgyzstan (Chotaeva, 2016).

Of important note, Kyrgyz people were also eligible for free healthcare through the Soviet Union beginning in 1918. Doctors and nurses were available in larger population centers to provide the kind of care that they needed, but there were significant fluctuations in available medical supplies, medications, and equipment. The funding dedicated to healthcare was closely tied to the politics of the World Wars (Reshetnikov et al., 2019).

On August 31, 1991, Kyrgyzstan declared its independence from the USSR. On December 21, 1991, the Kyrgyz Republic joined the Commonwealth of Independent States just before the fall of the Soviet Union on December 26, 1991. Independence of former Soviet states was immediately recognized by many countries around the world, but it signified the beginning of a very long period of building infrastructure that had never existed in these countries. Depending on the region of central Asia, the GDP decreased by anywhere from 33% to 60% (Claborn, 2020). Public health spending was no longer a priority for these countries and dropped from a range of 4 to 7% to as low as 1.1% of the GDP (Ulikpan et al., 2014).

Healthcare Since 1991

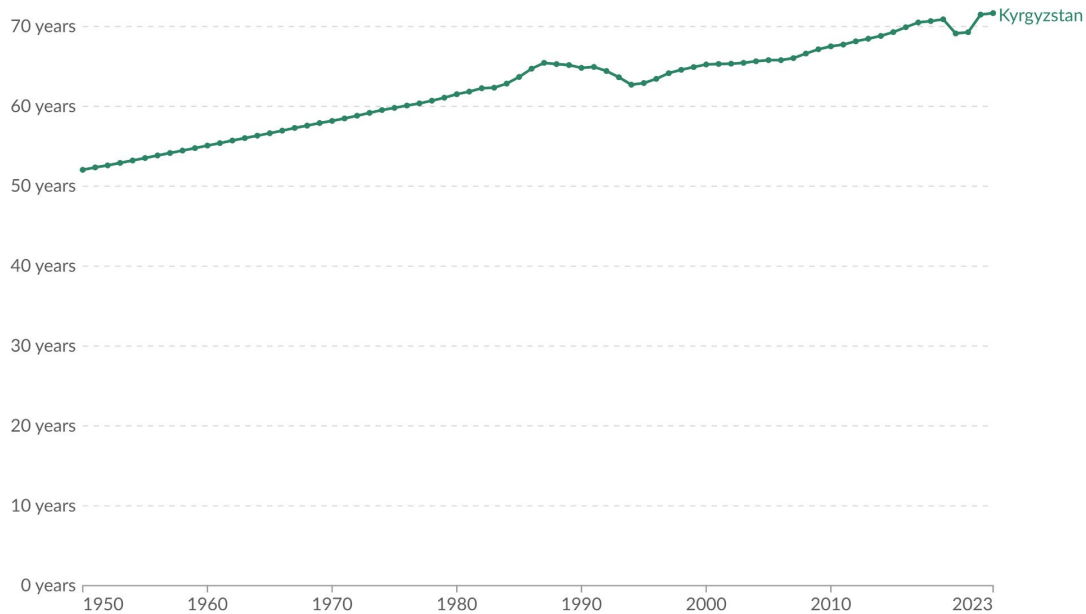
When healthcare funding through the Soviet Union was no longer available, the healthcare system implemented by the Soviet Union became too expensive to manage. Healthcare was no longer free, and there were fewer incentives for doctors to work in rural areas. In addition to free healthcare, the Soviet Union had a number of public health campaigns that promoted immunizations, infectious disease monitoring, and maternal-child health programs. These were shut down with the loss of funding. Infectious disease rates increased, and life expectancy temporarily decreased as cardiovascular disease and mental illness increased. (O'Brien et al., 2005).

Figure 2.

Life Expectancy from 1950 to 2023 in Kyrgyzstan (OurWorldinData.org)

Life expectancy

Period life expectancy¹ is the number of years the average person born in a certain year would live if they experienced the same chances of dying at each age as people did that year.



Data source: Riley (2005); Zijdemann et al. (2015); HMD (2025); UN WPP (2024)

OurWorldinData.org/life-expectancy | CC BY

1. **Period life expectancy** Period life expectancy is a metric that summarizes death rates across all age groups in one particular year. For a given year, it represents the average lifespan for a hypothetical group of people, if they experienced the same age-specific death rates throughout their whole lives as the age-specific death rates seen in that particular year.
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As Kyrgyzstan has worked to build a new healthcare system, there have been a number of specific challenges, and many of these challenges have drawn in humanitarian organizations from around the world. Kyrgyzstan has a significant urban-rural divide that makes it challenging for people to access the location where healthcare is available. About 64% of the population live in rural areas (Our World in Data, 2026). However, both physicians and facilities with advanced diagnostics are concentrated in urban areas. Compared to urban centers, rural areas have less than half

the number of doctors per capita (Kyrgyzstan: Health System Review, 2022). It has been estimated that half of the population of Kyrgyzstan lacks reasonable access to a primary care physician. If an individual needs specialized care, they will almost certainly need to travel (Fonken, et al., 2020).

In theory, family medicine doctors should be well-trained and the most easily accessible to people in rural areas. However, family medicine is not viewed as a prestigious speciality by the general public or by doctors already working in medicine. The Soviet Union placed a high level of importance on specialized medicine and compensated specialists at a higher level (Fonken et al., 2020). Many people prefer to find a specialist on their own that matches their perceived problem. As a result, there are not enough family doctors in many parts of Kyrgyzstan. After Kyrgyzstan became independent, programs associated with the Kyrgyz medical schools worked hard to retrain specialists as family doctors and tried to increase interest among new grads in choosing family medicine. Since 1998, more than 500 new family medicine doctors were trained in Bishkek, but only 10 of those doctors ever worked outside the two main cities of Kyrgyzstan. As of 2020, only one of those ten is practicing in a rural area (Fonken, et al., 2020). Studies show a consistent decline in interest in family medicine among medical students as they progress in their training.

Residents have been interviewed to determine why there is such low interest in working in rural areas. Improved working conditions was the top answer across the board (Heller et al., 2023). Aside from wanting a better career trajectory, residents cited housing with Internet access and the availability of basic medical equipment as the top examples of improving the working situation. Around the same time as the interviews were done, residents were also visited to inquire about their medical equipment. None of the residents had an otoscope of their own, and most of them were not able to access one easily (Fonken, et al., 2020).

Another common pattern among young doctors in Kyrgyzstan is to work hard to get an education and learn English for the purpose of leaving Kyrgyzstan. This pattern is not unique to Kyrgyzstan and is often referred to as the “brain drain.” The common motive for migration of healthcare workers is higher pay. Unfortunately, this migration trend puts more pressure on the doctors who continue to work in Kyrgyzstan. The number of doctors being trained has increased, but the total number of doctors practicing in Kyrgyzstan declines each year. Many of the doctors currently practicing are nearing retirement age (Japarova et al., 2024).

Financial Accessibility

Kyrgyzstan does have a mandatory health insurance program, but out of pocket costs continue to be high at 46.3% of healthcare costs in

2019, with the largest expense being medications (*The Health System Review for Kyrgyzstan*, 2022). For comparison, out of pocket costs in the United States in 2019 were only 11% of healthcare costs (Our World in Data, 2026). Between 2012 and 2018, inpatient visits cost an average of \$13.60 USD, and outpatient visits averaged \$9.00 (Iamshchikova, 2021). During the same time frame, the mean monthly salary was about \$188 USD (Our World in Data, 2021). In rural areas, salaries can be significantly less. These numbers may initially sound reasonable compared to the United States, but insurance in Kyrgyzstan does not cap out-of-pocket expenses. Instead, insurance is set up as a copayment system for services needed (*The Health System Review for Kyrgyzstan*, 2022).

Setting up an efficient structure for compensating healthcare workers continues to be an ongoing issue. Currently the fund from which healthcare workers are paid is supported by the Mandatory Health Insurance Fund and the state budget, but even together they do not provide adequate funds. As a result, informal payments are common. These are under-the table payments or gifts given by patients to healthcare providers outside the official fee. Some informal payments may be tokens of gratitude, but others serve as bribes. Wealthy people can get higher-quality care in a more efficient time frame, while low-income people may be forced to accept lower-quality care and wait longer (Japarova et al. 2024).

Catastrophic health spending is defined as out of pocket expenses that exceed the ability of the household to pay and result in economic hardship. With high rates of out of pocket spending, catastrophic health spending also tends to be high. Between 2012 and 2018, Iamshchikova (2021) estimated that somewhere between 6% and 33% of the population experienced this kind of catastrophic health spending, with the most recent estimates around 13% (Rechel et al., 2025). Not surprisingly, single-parent homes and rural regions were disproportionately affected by catastrophic health spending (Iamshchikova, 2021).

Improving Access in Rural Kyrgyzstan

This is the context into which many high income countries are trying to offer their support. The team with which I traveled chose to combine two strategies to improve access to primary care. The first strategy is mentorship. The team has designed a program where newly graduated resident doctors can work alongside highly skilled doctors to improve their clinical skills. Residency programs in Kyrgyzstan continue to improve with assessments on par with high-income countries and a much larger focus on clinical skills. Still, many doctors are not prepared to work in low-resource areas. The program gives residents the opportunities to establish relationships with these skilled doctors and find support and

encouragement rather than just competition. The goal is to prevent burnout and encourage young doctors to stay in Kyrgyzstan permanently.

The second strategy being used is mobile medical clinics. These traveling clinics are closely tied to the mentorship program. The mobile clinics are an opportunity for the residents in the mentorship program to travel to low-resource rural areas and host a clinic day with the help and support of a more experienced physician. These clinic days allow young doctors to get a glimpse of what rural practice might be like without the full commitment. The goal is for young physicians to be confident enough in their skills and committed enough to serving people to be interested in rural practice full time. The mobile clinics also give people in rural areas the chance to be seen by a doctor. These one-time visits do not resolve the need for follow-up care, but they help with addressing short-term health concerns or encouraging people to seek out further care.

Mentorship

Mentorship can be broadly defined as a relationship where “a more experienced and knowledgeable healthcare professional guides a less experienced colleague in career development” (Ellis et al., 2024). Traditionally, mentorship was the primary way that new medical professionals were trained. As formal education has standardized the training process, mentorship has become a smaller part of the overall

process of learning to practice medicine. Lectures, studying, and exams now serve as a significant part of the education process for healthcare professionals. However, mentorship is being brought back through both informal and formal programs in many high-income countries as we consider the value of personal input into the lives of young professionals (Hill et al., 2022). Many mentorship programs separate clinical mentorship from general professional development mentorship, but these lines are often blurry. In the context of mentorship in low- and middle-income countries, many young healthcare professionals have the potential to benefit from both types of mentorship.

In the United States and many other high-income countries, mentoring tends to focus heavily on research and long-term job satisfaction (Hill et al., 2022). Mentoring gives medical students or newly graduated doctors the chance to get their foot in the door in academia through their mentor's connections. The second aspect of mentorship is often job satisfaction. Issues like self-confidence and burnout can be addressed by allowing young professionals to seek guidance from more experienced professionals on how to cope. Medicine has extremely high rates of burnout and is correlated with a lack of interest in caring for one's personal health, high rates of suicide, poor bedside manner or professionalism, and poor patient care. Young physicians are particularly susceptible to burnout because they are often working very long hours with

high levels of responsibility and low levels of autonomy (Ellis et al., 2024; Rodeles et al., 2025).

In high-income countries, mentorship has consistently shown positive outcomes, provided the mentee and mentor are a good match. Students pass their competency reviews at a higher rate (Ong et al., 2018), and their chance of research publication increases (Yehia et al., 2014). Medical students and residents who participate in mentorship programs report a greater sense of purpose and autonomy in their work, more motivation to continue their work, and reduced chances of experiencing burnout (Dimitriadis et al., 2012; Spataro & Elnicki, 2025).

Mentorship programs are gradually being implemented in low- and middle-income countries (LMICs), such as Kyrgyzstan, but the focus is often more complex and less personal. While most physicians in the United States have adequate medical training in their specialty, physicians in LMICs may lack specialized training for a particular population of people or location with limited resources. Mentorship programs aim to help healthcare professionals be more proficient at providing high quality care to their patients (Schwerdtle et al., 2017). At the same time, the requirements being placed on clinical staff must be reasonable. For many locations, it is not realistic to ask staff to commit to long hours of continuing education or recommend that clinics purchase new and expensive equipment, even if it would improve long-term patient

outcomes. The mentorship needs to be done in person with real case studies that these professionals see on a daily basis in order to be practical (Hema Magge et al., 2015).

One of the most common approaches to mentorship is training someone about a topic with which many local facilities need help (Schwerdtle et al., 2017). This trained professional then periodically visits local facilities. They may observe cases, host teaching sessions, and perhaps most importantly, demonstrate how something can be done better without placing the blame on healthcare professionals who have never learned. The trained professional may also be in charge of observing the general work flow of a facility. From their observations, they may be able to recommend basic changes to improve quality of care and efficiency. These services are usually offered free of charge to the facility through either government funding or international donors. Common areas where small changes can make a significant difference in LMICs include documentation protocols and supply management (Gelane Workneh et al., 2013; Hema Magge et al., 2015).

Mentorship has been an effective tool for introducing new workflow styles or techniques. Changes in supply availability, an increase in patient load, or inadequate staffing can cause old workflows to become inefficient. This can lead to slow and low-quality care. In more extreme cases, it can be dangerous for patients. Rwanda effectively used mentorship to introduce

an algorithmic method for approaching pediatric visits that is used in over 100 countries. A single trained mentor was able to visit 21 facilities and help with didactic training, case observations, and feedback on performance. At the end of the implementation, documentation was more consistent, patients were being prescribed the correct treatment upon the first visit regularly, and counsel was being consistently offered to parents about things like appropriate levels of hydration or when to return to the clinic with concerns (Hema Magge et al., 2015).

Mentorship has also been an effective method for building confidence in providers. Lack of training in a particular area paired with inadequate supplies can cause healthcare professionals who are otherwise very competent to struggle with confidently treating patients. If specific gaps in training can be identified, mentorship can be very effective at improving the treatment process and boosting confidence. Botswana has an extremely high prevalence rate of HIV, but providers expressed a lack of confidence in their training to treat HIV. A mentorship program was established where a mentor visited facilities and taught the protocols for standard HIV treatment. This increased the confidence of the providers, and as a result, the facilities saw an improvement in monitoring viral load, correct medication dosage, and consistent patient education (Gelane Workneh et al., 2013).

Mentorship has been established as a valuable tool in developed countries and in specific settings in LMICs. The clinic that I traveled with is working to integrate both professional and clinical mentorship. There are fewer examples of healthcare workers from high income countries serving as mentors in LMICs. The concept seems to have the potential to be a powerful tool. Healthcare professionals from high income countries with dedicated support can commit themselves more fully to mentorship than healthcare professionals whose first goal is often to financially support themselves and their families. Mentors from high income countries may also be able to access more resources, such as medical equipment and medications, with less financial strain.

One of the theoretical strong points of mentorship between a high income country and a lower income country is the ability to collaborate (Finley et al., 2008). Healthcare professionals in high income countries often have access to more training and better resources. However, it is often unhelpful for healthcare professionals to try to solve the problems of LMICs without a very clear understanding of the nuance of the situation. This requires collaboration and building a professional relationship. Taking the time to listen to the problem and the context behind it will be more effective than making assumptions and offering a one-size-fits-all answer (Finley et al., 2008).

An excellent example is the project that Canada and Jordan did together to develop a protocol for improving pain management in pediatric cancer patients. After a series of collaborative conversations, they were able to identify that the Jordanian doctors were quite hesitant to prescribe pain medication for children. This was in part due to the complexity of obtaining opioids, parental concerns of opioid use in their children, the hesitancy of children to express pain around strangers, and the belief that the entire experience was part of God's will. Ultimately, more than half of the children in their care were experiencing pain on the day they were surveyed. Together, the Canadian and Jordanian researchers were able to develop a straightforward protocol for prescribing pain medication. A group of Canadian providers traveled to Jordan for teaching sessions to implement the new protocol. Once the new protocol was in place, pain was assessed regularly, opioids were being prescribed and given, and the Jordanian providers felt equipped to manage pain (Finley et al., 2008).

One of the concerns with providers coming from high-resource countries is that they will struggle to teach meaningful skills to providers who do not have access to the same level of equipment and supplies. Surveys were done to address this concern after a project was done by the Canadian military in Afghanistan (Beckett et al., 2015). The mentorship team was made up of 5 providers who had served in combat in low-resource locations previously. The goal of the project was to help Afghan

providers develop a more efficient workflow in seeing and diagnosing patients. The mentees were then surveyed to find out if they perceived the mentorship by NATO medical advisors to be beneficial. The feedback was largely positive with one primary critique. The Afghan physicians thought that the Canadian providers relied too heavily on medical technology for diagnosing that is not readily available in low-resource settings (Beckett et al., 2015). This is perhaps one of the more challenging aspects that needs to be addressed to allow mentorship to be as productive as possible.

In summary, mentorship programs in the United States have consistently shown positive results. When mentorship is adapted amongst healthcare professionals from LMICs, the quality of patient care improves. When these two pieces are combined and mentors from high income countries work with healthcare workers in LMICs, there also seems to be evidence that it could be a good strategy. It allows groups with large resources to invest in groups with low resources without directly giving away money or supplies. Instead, it allows for the investment in the healthcare workers who might be able to help make long-term changes in Kyrgyzstan. There are still concerns about cultural clashes and misunderstandings, as well as the adjustment to practicing medicine in lower-resource settings. These are concerns that should not be overlooked going forward.

Mobile Medical Clinics

Short-term medical service trips are very popular among non-profits, religious organizations, and medical organizations. These are generally trips that are organized by high-income countries to travel to LMICs and offer free or low-cost health services to underserved populations. These clinics are temporary and may be held in a town for a day, a week, or several weeks before moving on to some other location (Gomez-Virseda & Barreda, 2026).

Published research on short-term medical service trips has increased, but there is often a lack of data to allow for analysis of long-term outcomes. These trips are often organized by volunteers, and good records are not always kept or accessible for research purposes. There is a strong focus on short-term outcomes, such as the number of patients able to be seen in a day. The intentions of these organizations may be excellent, but the quality of care and ethics of short-term medical service trips may be lacking (Gomez-Virseda & Barreda, 2026).

Mobile medical clinics are often used for a variety of reasons, including short-term disaster response (Sarika Sheerazi et al., 2025). This use of mobile clinics appears obvious when there are acute needs that need to be addressed. Local healthcare services may be temporarily disrupted or

overwhelmed by an increase in patients. These situations would seem to allow temporary clinics to be effective because the infrastructure for healthcare already exists. It is just temporarily overwhelmed.

Despite their widely accepted use, little data exists to show that mobile clinics are effective in natural disaster response. The goal is to provide emergency services, nutrition and clean water support, and treatment for acute illnesses (McGowan et al., 2020). In reality, funding and coordinating these types of clinics can be a nightmare, and in some cases, these mobile clinics end up addressing the burden of disease unrelated to the natural disaster (Sarika Sheerazi et al., 2025). The concern is that these mobile clinics are sent out for emergency response and instead end up caring for patients who are unable to access healthcare regularly at any time. While better than nothing, these types of clinics may not be the most effective or efficient method of improving access to care (Sarika Sheerazi et al., 2025). However, many nonemergency mobile medical clinics go out to medically isolated areas in LMICs for this very purpose.

There are two primary ways that mobile medical clinics are being used in addition to short-term disaster response. They can be set up to provide non-acute medical services, or they can be set up to provide screening. Sometimes these services are separate, and sometimes they are combined. The overarching hope is that people will be able to access

preventative care and screening by removing barriers like distance traveled, cost, and paperwork (Yu et al., 2017).

The first way is to provide non-acute medical services. These are often connected to public health initiatives. They often include vaccines both for children and adults. Another common service is providing birth control or prenatal care, as well as education about taking care of oneself during reproductive years (Sabo et al., 2025). These types of clinics can often reach a large number of people in a single day and have the ability to provide simple, lifesaving measures to people in remote areas.

The second kind of mobile medical clinic is for screening. The types of screening vary widely. Low cost mobile clinics may offer simple services like blood pressure, blood sugar, or hemoglobin checks. Mobile clinics with more resources often provide wider laboratory and imaging services. They may be able to monitor bloodborne diseases or track blood counts. Imaging services may include cancer screenings, such as mammography, or equipment for eye exams. In some cases, the clinics may be set up to perform simple operations (Martiniuk et al., 2012). Screening clinics often have the ability to provide health education or counseling for managing chronic disease (Yu et al., 2017). Mobile medical clinics often do not have the ability to offer treatment for any abnormal results that are found, but they can encourage the patient to seek care at a higher-level facility and

sometimes even offer some resources to help with that process (Sabo et al., 2025).

There are two different types of critiques for mobile medical clinics. The first type is broader and more organizational, and the second type focuses more on patient experiences. Many mobile clinics operate with some kind of foreign organization supporting them both financially and in terms of staffing. From an organizational perspective, mobile medical clinics can be expensive and complicated to operate compared to stationary clinics. The logistics of travel and transportation of staff and supplies can be time-consuming and expensive. This calls into question the sustainability of the short term nature of mobile medical clinics (Gomez-Virseda & Barreda, 2026).

The second type of critique is more about the ethics of patient care and ensuring that patients are getting high quality care. When medical teams come from high-income countries to LMICs, there is often a significant language barrier that requires an interpreter. If an interpreter is not local or available at all times, this can be a significant hindrance when providers are trying to communicate care instructions or provide education. There can also be a lack of cultural competence that can make it more difficult for providers to connect with patients (Faktor et al., 2023;

Gomez-Virseda & Barreda, 2026). At worst, it can lead to an outright disrespect for cultural differences (Mantey et al., 2026).

Alongside difficulties in communication can come the issue of informed consent. Oversight of documentation is less strict, the daily workload is often intense, and communication with a language barrier can be difficult and time-consuming. Properly obtaining informed consent can easily be skipped over. It often is not with malicious intent, although the lack of oversight can create opportunities for abuse (Gomez-Virseda & Barreda).

Privacy also becomes a concern with mobile medical clinics. Space is often limited, and many clinics want to see as many patients as possible. This can lead to multiple patients being seen in the same space without any kind of divider. Even if partitions are in place, they may not prevent the conversation between the doctor and the patient from being heard by other people waiting in the clinic. This problem often arises out of altruistic intentions but is an ethical problem nonetheless (Gomez-Virseda & Barreda, 2026; Nkosi, 2023).

When providers from high-income countries come into low-income countries, there is a power dynamic between providers and patients and between providers and local healthcare staff. This can lead to exploitation of patients and staff (Gomez-Virseda & Barreda). Patients can feel like they

are being taken advantage of by providers who just want an ego boost for doing something good. They can also feel like they're being experimented on by providers who want the opportunity to try procedures that aren't commonly done in high-income countries. Local staff can feel like their skills are being disregarded by the mobile clinic providers, despite being very experienced (Mantey et al., 2026).

The final criticism is that mobile medical clinics struggle to make a long-term difference (Gomez-Virseda & Barreda, 2026). If a patient is diagnosed with high blood pressure and given a month's supply of medication, the patient's blood pressure will be high again once the medication is gone. Mobile clinics do not have the ability to follow up with patients who need follow-up care. Often this means the patients will not get the follow-up care they need, or it may place additional burdens on local staff to try to follow up with more patients than they have the capacity to see. Expensive medications or a lack of understanding about the seriousness of a hidden condition may discourage patients from seeking help once the convenience of the mobile medical clinic is gone (Faktor et al., 2023; Gomez-Virseda & Barreda, 2026).

While mobile medical clinics draw criticism, they also show signs of temporarily reducing health inequality. Patients who receive care generally perceive the clinics to be beneficial and the care received to be satisfactory,

even if the clinic is limited in the services available (Faktor et al., 2023). Cost, distance to be traveled, stigma, and skepticism about doctors or medicine are commonly cited barriers to accessing healthcare (Dawkins et al., 2021). The mobile clinics are able to temporarily overcome some of these barriers. Most of the clinics are either free or low-cost and will not turn anyone away for social, financial, or educational differences. Alongside cost, patients are more likely to visit a clinic that does not require travel or missing an entire day of work.

Patients may also be willing to seek out a mobile health clinic because they are not likely to know the staff. They perceive less judgment and stigma than they might from someone local (Dawkins et al., 2021). Mobile clinics cannot eliminate healthcare skepticism, but some people do not have the same level of skepticism for doctors as they do for an entire hospital experience. Mobile clinic staff generally have a reputation for being kind and polite, and this can help ease the suspicion (Faktor et al., 2023).

My Personal Experience

Getting to Rural Kyrgyzstan

In June of 2021, my family flew into the capital city, Bishkek, in the Chuy region, which is in the northern part of Kyrgyzstan. We spent a couple days in Bishkek, and then joined the clinic crew to continue traveling. From Bishkek, we flew to Osh, which is in the south central part of Kyrgyzstan. From Osh, we travelled into the Batken region by marshrutka. Razzakov is located about 180 miles from Osh, but the distance takes about six and a half hours to drive or travel by bus. Osh is the big city to which people in the Batken region travel if they are looking for educational opportunities or specialized medical care.

Marshrutkas are the most common and cheapest form of transportation from place to place outside of the big cities. A marshrutka is a large van that can be used to transport people or animals, sometimes simultaneously. Many of them run regular routes similar to buses and are cheaper than hiring a private taxi. All of the clinics were hosted in the Batken region, and our primary mode of transportation was the marshrutka.

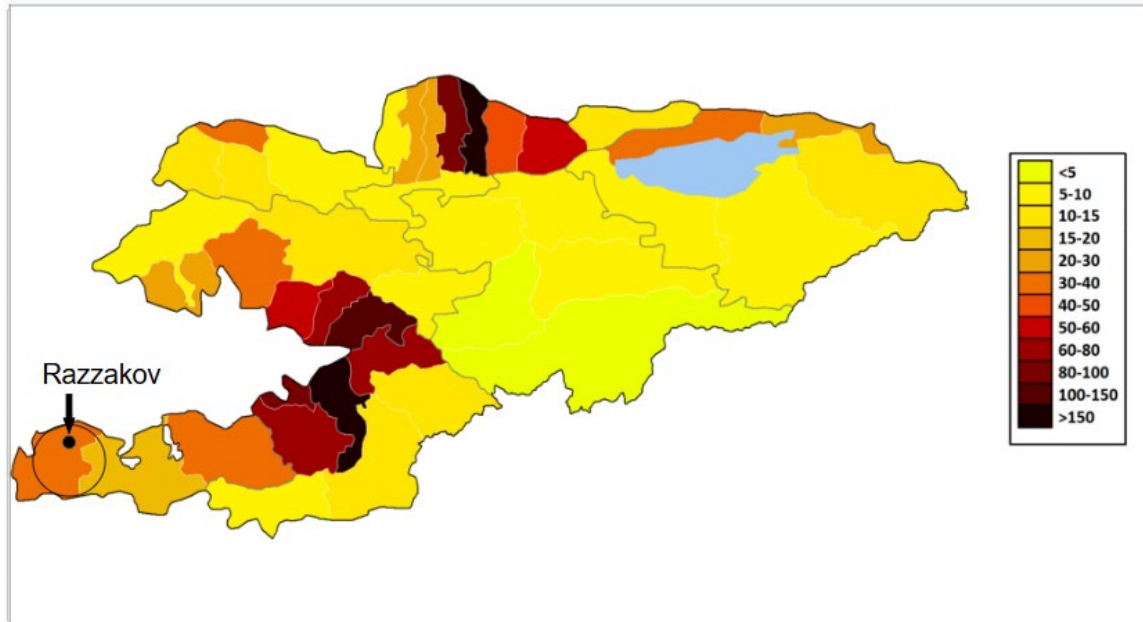
Figure 3

Regions and Significant cities in Kyrgyzstan (Ontheworldmap.com)



Figure 4

Map of Population Densities in Kyrgyzstan. The location of Razzakov is indicated by a black dot, and the black circle indicates the general area where the mobile medical clinics were held. (National Statistical Committee of the Kyrgyz Republic)



I met up with the clinic team at various points along the trip to the Batken region. In total we had 7 doctors—two Americans, one older Kyrgyz doctor, and four young doctors who participated in the mentorship program. Of the American doctors, one was an experienced pediatrician, and the other was an experienced emergency medicine physician. The older Kyrgyz doctor was experienced in pediatrics, and the four young doctors had completed general residency training and were interested in pursuing specialized training in a variety of specialties.

The mentorship program is designed to accomplish two major things: to improve clinical diagnostic skills and to encourage professional development and interest in working in rural areas. Many of the doctors in this particular cohort graduated during the COVID-19 pandemic. Instead of getting a full residency, many were immediately forced to go to work in hospital ICUs and missed out on the development of clinical skills. The mentorship program gave them the chance to go back and learn some of the critical skills for being an efficient practitioner.

Residency programs in Kyrgyzstan have been evolving for the better through the joint efforts of Kyrgyz health initiatives and multiple partnerships with Switzerland. Immediately after Kyrgyzstan's independence, residency programs were not well-structured. They focused heavily on training doctors in specialty skills without as much focus on practical applications. Both the academic curriculum and the clinical skills needed to be updated to align more closely with the standards of high-income countries (Orozalieva et al., 2021). These changes have improved the quality of education, but there is still an ongoing struggle for doctors working in rural areas with limited equipment and supplies. The medical diagnostics skills used in a hospital setting can be very different from the medical diagnostic skills used in rural settings where you cannot rely on imaging or lab tests.

We had a patient who came to the clinic with symptoms that indicated either some kind of heart problem or severe anxiety. The young doctor that saw the patient approached one of the older doctors to get guidance on how to figure out the real source of the symptoms. The young doctor was not wrong to ask for help. It can be very difficult to differentiate between heart problems and anxiety, but it was revealing that the young doctor had no idea where to even start. Medical schools and residency programs prepare students to practice medicine in one of the big cities in Kyrgyzstan, but they are far less prepared to practice medicine where there is not an entire laboratory and imaging department.

The mentorship program is hosted by a family practice clinic in Bishkek and accepts newly graduated medical residents. The new doctors are then paired with doctors who have advanced training. Most of the mentoring doctors thus far have been American. The residents participate in group meetings, case studies, clinical shadowing, and work experience with direct feedback for about a year. There is a strong focus on developing skills that will be useful in rural settings where there are limited resources.

The mobile medical clinics are then designed as a way for the new doctors to apply their newly acquired diagnostic skills in a rural setting. This gives them the chance to experience rural family medicine without committing to a long-term job in a rural area. The mobile medical clinics are organized by a combination of people living in various parts of

Kyrgyzstan, including the mentorship coordinators in Bishkek. Funding for both the mentorship program and the mobile medical clinics largely comes from donors in the United States.

A Typical Clinic Day

All clinic days were virtually identical. For each clinic day, we traveled from our base in Razzakov out to the small rural villages. The locations were coordinated ahead of time with the local nurses. Each of the clinics was held in a building in the village, an already existing clinic or school. I'm going to walk through the experience of a typical clinic from the perspective of the front desk, the medical assistant, the doctor, the lab tech, and the pharmacist. Our team consisted of 14 people most days. In most of the villages where the clinic traveled, there was already a clinic staffed by nurses. These nurses generally helped with the mobile clinic as front desk attendants.

The front desk attendant was responsible for filling out a form with patient information. It included a basic medical history, information about insurance, and a little bit of demographic information. This job had to be done by someone who spoke and wrote Kyrgyz fluently. In the rural villages, Kyrgyz was the primary language spoken, and not everyone was fluent in Russian. Local nurses often helped fill this role. The front desk attendants were in charge of making sure that people were brought into the

clinic in the same order that they arrived. Contrary to the United States, people do not form orderly lines. This was probably due to equal parts of excitement to see a doctor and basic cultural differences. After 100 patients were registered for the day, it also became the front desk attendants' job to politely turn people away.



Image 1. The table where patients registered to be seen by the doctor. The woman in the purple is doing the registration, and I am taking vitals.

The medical assistant was in charge of getting vital signs. This is the job that I often did. To keep the clinic moving, I would often take vital signs while the patients were in the process of registering. The basic information gathered was blood pressure, heart rate, weight, and height. From there, the medical assistant directed the patient to the appropriate doctor's room

based on their reason for visiting. I did not have an interpreter with me, and I do not speak Kyrgyz. So, I communicated with patients through a series of hand motions and pointing.

Instead of patients being taken to rooms and the doctor visiting each patient in their respective room, each doctor was assigned to a room. During registration, the front desk attendant would assign each patient a number and a room based on their reason for visiting the clinic. The patients then waited outside their assigned doctor's room until their number was called. The doctor's visit then proceeded like a typical doctor's appointment in the United States, with the exception that all documentation for the visit was done during the visit. Each doctor brought their own kit of basic equipment for general checkups, such as a stethoscope, otoscope, ophthalmoscope, and penlight. Most of this equipment would not have been readily available otherwise.

A number of common themes appeared amongst the patients that were seen. Many patients needed to make dietary adaptations. Many Kyrgyz people in rural areas do not get adequate protein from their diets. This leads to nutrient deficiencies. One of the most common deficiencies seen was anemia. Anemia is further complicated by the tradition of drinking black tea with every meal. Black tea can limit iron absorption and make anemia worse. Common symptoms include headache, dizziness, lightheadedness, and fatigue (Alorainy et al., 2025).

There were also a fair amount of traditional remedies seen. At one point, a child with bright blue/green spots came in. We later found out that it was some kind of remedy for a skin reaction. The doctors spent a lot of time counseling patients about making good dietary and medicinal decisions that are based on scientific evidence rather than tradition. This has to be done very carefully to avoid offending patients for their belief in traditional medicine. The goal was not to shame patients for using traditional medicine but to let them know that certain traditional remedies carry risks that may outweigh any benefit.

If the doctor decided that a lab test was necessary to confirm a diagnosis, they marked the test to be done and sent the patient to the lab technician. The lab technician had very limited supplies. The clinic was able to test hemoglobin, glucose, and dipstick urine. All of these were used extremely sparingly because there was a very limited supply. We were also very limited on the amount of gloves that were available. Many clinic activities were done without gloves, and sanitization was very carefully done between patients. All of the available lab tests had results ready in a matter of minutes. The lab tech would record the results and send the patient back to their assigned doctor for further instructions.



Image 2. The set-up for doing basic labwork. My dad is pricking this patient's finger to get a hemoglobin reading, and I am writing down the values to be given to the doctor.

The pharmacist was usually just one of the doctors on the team. If the doctors prescribed a medication, then the patient would take the prescription to the pharmacist. The pharmacist would find the medication and give the patient instructions for taking it. The medications were one of the major points of attraction for patients because a 30-day supply was offered at no cost. In Kyrgyzstan, most drugs can be purchased over the counter, including many of the common prescription drugs in the US. However, the drugs tend to be very expensive. It's not unusual for people to decide that there are other things that they need more than their medication.

Facilities and Local Staffing

Many of the mobile clinics were hosted in the local medical clinic. Many of the villages have one, but they are staffed only by nurses. All of the clinics were permanent buildings. Some of them were built as a clinic, while others were converted. Some of the clinics had no electricity, and even in the clinics with electricity, the lighting was often extremely poor. Most of the clinics had water running into the building, but not all clinics had sinks with plumbed drains. It was normal to have a bucket under the sink that had to be emptied periodically.

None of the clinics had indoor bathrooms, although there were generally separate facilities for men and women. Outside of the capital, there are no Western toilets. In rural areas, the toilets are just holes in the ground. Most of these toilets are well-maintained. However, some of them are a public health concern. If the pits are dug improperly or if the location is not chosen carefully, sewage can leach into the surrounding soil and water. This is problematic because water sources are often community wells where there are no filtration systems being used.

During the mobile clinics, there was never a local doctor present for the clinic. I am unsure if this was always because there was no doctor in the area or if the local doctor was simply visiting other communities. The nurses indicated that many of the clinics we visited have traveling Kyrgyz

doctors that are only available occasionally. They are spread very thin because there are not enough of them.

Each of the local clinics has at least one nurse, and they are essentially in charge of the clinic in the absence of the local doctor. They offer general checkups like checking blood pressure, blood sugar, and iron levels. If there are public health initiatives in the village, the nurse is the one in charge who will be out in the community talking to people. One of the common initiatives is checking for and treating anemia, particularly in women of childbearing age and young children. In Kyrgyzstan, 32.9% of women of childbearing age and 33.4% of children under the age of 5 are anemic (Our World in Data, 2026). This is double the anemia rate in women of childbearing age, and more than six times the anemia rate in children in the United States (Our World in Data, 2026).

These local nurses were always present for the duration of the mobile clinic when our team showed up. The nurses' familiarity with the needs of the community both as a whole and individual people allowed them to serve as mediators between the community and the mobile clinic team. They also helped the clinics to move smoothly by helping the team locate items and organize a work flow.

Demographics Served

The mobile clinics were open and free to anyone, and we saw a wide variety of people. The most common patients were women who were often pregnant or newly postpartum, children of all ages, and the elderly. This is the population of people in the United States that would see a doctor regularly, but in Kyrgyzstan, many of these people are not able to see a doctor regularly. There are midwives that are trained to help with prenatal care and attend to births, but they do not have the same training as an OB/GYN. Of the children that were seen, some of them were seen for childhood diseases that could be prevented with vaccines. Vaccination rates in children are fairly high (around 82%) throughout Kyrgyzstan, but among communities that are not vaccinated, childhood diseases like measles still pop up (UNICEF, 2024). In the United States, many elderly people are encouraged to see their doctor frequently in order to monitor their health. In Kyrgyzstan, many elderly patients have conditions like heart disease, high blood pressure, or diabetes but have no idea.

We also saw an ethnically diverse group of people. Depending on which border we were close to, we saw a mix of Kyrgyz, Tajik, and Kazak people. When the borders of Kyrgyzstan and the surrounding countries were drawn by the Soviet Union, there was no way to perfectly divide people according to their ethnicity. There are many ethnic Tajiks and

Kazaks who live in Kyrgyzstan. These three groups of people are similar both in appearance and culture. The primary difference in the context of the mobile clinics was language. Some of the people who came to the clinics did not speak Kyrgyz or Russian well.

Food and Lodging

The clinic team was housed in a local hotel that served as the base that we returned to each night. This was a luxury compared to some of the mobile clinics in years past. The hotel actually had running water, electricity, and indoor bathrooms. The team was responsible for our own breakfast. A pretty standard breakfast included coffee, bread, boiled eggs, cucumbers, tomatoes, and whatever fresh fruit had been picked for the day. Bread is served with every meal.



Image 3. The bedroom I shared with one of the Kyrgyz doctors. This was the base camp that we came back to each evening after the clinics. These accommodations were considered to be quite nice because there was actually electricity and running water that was pretty consistently available.

Lunch was always served by the community where the clinic was being hosted. Because some of us were American, it was considered to be a huge honor to invite us into their home and serve us food. Rarely was there a table and chairs. Instead, we were served food Kyrgyz-style on mats on the floor. Everyone sits in a circle, and the food is spread out in the center. Personal eating dishes are not common. It's normal to share a plate or bowl

with the person sitting next to you. Lunch was almost always a dish called plov. It's a rice dish cooked with a small amount of meat and veggies like onions and carrots. Plov is a common meal in rural Kyrgyzstan and an example of a meal that is low in protein content. Seasonally available fruits and vegetables were served with every meal. Tea is the one unchanging staple of every Kyrgyz meal. Everyone drinks at least two cups of black tea before the meal can be considered complete.



Image 4. One of the meals prepared for the clinic volunteers. Both the seating and the food arrangement are the traditional ways of eating. Multiple plates of food are set out to be in reach of everyone. Tea and bread will always be served at every meal along with whatever fruits and vegetables are in season. The main dish is often served as big plates that are shared between two or three people. Some of the snack-like food items are rarely touched at meals, but having a full table of food is part of the role of hosting.

We were responsible for finding our own supper. We usually went out for supper for two reasons. It allowed us to keep fewer food supplies with us, and it allowed us to support the local businesses. We often ate savory soups, a noodle dish called lagman, dumplings called manti, or shoshlik. Shoshlik is skewers of meat and vegetables and is always served with tons of onions and dill.

The water in rural Kyrgyzstan is considered unsafe to drink by foreigners and even some locals. Our team would drink the tea served to us at lunch because the water is boiled. Otherwise, we carried bottled water with us everywhere. Soft drinks are extremely prevalent with Orange Crush Fanta and Coke being the most common. Sparkling water is more commonly served in restaurants than flat water. In some places, drinks like chalap or kumis are served. Chalap is a yogurt-based drink that is very salty. Kumis is a slightly alcoholic beverage made from fermented mare's milk.

Diet plays a significant role in the health of the average rural Kyrgyz person, and we got to see it firsthand. Their diet is often very high in carbohydrates and low in protein. Plov is one of the most common meals. It's affordable and filling but lacks protein. When we were served plov, the cooks would add small pieces of meat or a couple boiled eggs. However, this was their way of treating the American with high priority. Beans and lentils can be found in the markets, but they are a less common protein

source than meat because of the nomadic tradition of gathering food. Diabetes is also common. This is likely because of a combination between diets that are high in carbohydrates and the high consumption of soft drinks when clean drinking water is not available.

Social Orphans

One of the more heartbreaking things we did while in Kyrgyzstan was visit a children's camp. The camp was extremely isolated, and there were few caregivers for the number of children living in the camp. Kyrgyzstan has a high number of children living in orphanages and children's camps, and sadly as many as 94% of the children still have a living parent (Key Drivers Contributing to Child-Parents Separation Kyrgyzstan, 2024). There are 33 state-run childcare institutions, and 4700 children live in these institutions. Kyrgyzstan is unique in that it allows for privately-owned childcare institutions. There is no data available for how many children live in these institutions. Considering Kyrgyzstan is one of many countries with a strong culture of family care and only has a population of 6 million people, these numbers are high (Key Drivers Contributing to Child-Parents Separation Kyrgyzstan, 2024). Most of these children are considered social orphans because they have living relatives but no one willing or able to care for them. Beginning in 2012, Kyrgyzstan

does have a foster care system with 114 foster parents currently caring for 250 children (Aizada KUTUEVA, 2025).



Image 5. The bridge to cross the creek on the path to the children’s camp we visited. The bridge was actually quite sturdy but definitely not what I expected to find. I’m not sure if there was any other way to access the camp.

The top contributing problems are economic hardship, parents migrating or working abroad, and family disruptions, such as alcohol or

drug abuse, that lead to domestic violence situations (Key Drivers Contributing to Child-Parents Separation Kyrgyzstan, 2024). Because of the large numbers of parents that work abroad or migrate to other countries, children are often left behind because it is logistically challenging for parents to bring their children. These children may be relinquished in hopes that they will be fed and educated. There is also a significant amount of stigma around birth defects or children born to unmarried mothers. These children may be abandoned to avoid social shame (Key Drivers Contributing to Child-Parents Separation Kyrgyzstan, 2024).

Mentoring new physicians and offering mobile medical clinics does not offer any solutions for these children. Doctors do have a responsibility to watch for signs of abuse, but beyond that, the issue is too large. In high-income countries, there are generally financial assistance programs, education options, and domestic violence shelters that help to mitigate the number of children who are given up by their parents. Many low- or middle-income countries (LMICs) do not yet have corresponding programs. This is a part of the ongoing struggle to develop social services and safety nets.

What I Learned and Future Applications

Personal Observations

Perhaps the most striking thing that I experienced in Kyrgyzstan was the sense of awe that followed us everywhere for simply being American. In Bishkek, people didn't pick us out quite as easily. There are still quite a few Russian people who live in Kyrgyzstan at least part of the year. However, in the rural villages to which we traveled, many of the local Kyrgyz people had never seen a white person before. It's also not considered rude in Kyrgyzstan to stare at people you find intriguing. We were often approached by people who simply wanted to take a picture with the Americans. That picture would then be sent off to everyone in their family to brag about what they found walking down the street. Even now, I don't know for sure how they all immediately knew we were American.

This aspect of our trip left me with a couple different feelings. It amused me because I've never wanted to be famous. I do not enjoy that kind of attention. However, it also made me aware that my nationality meant something to these people. They looked at me and saw a symbol of all the things they hope to achieve either in their lifetime or their children's lifetime. Regardless of the political feelings of people in the capital city, Americans are a symbol of wealth and abundance to the working-class

people of remote Kyrgyzstan. It was humbling to be reminded of things that I take for granted.

When I got to Kyrgyzstan, I was prepared for there to be some cultural differences, although I was unaware of what most of those differences would be. None of them were hugely problematic, but there were a few that my American mind perceived as strange or even a bit illogical. In Kyrgyzstan, it's commonly believed that cool air blowing on your skin can cause you to get sick. This means that even when it's 90° or warmer, the windows remain closed on the 15 passenger vans. It's also commonly believed that contact with the ground can cause you to get sick. It is not acceptable to go barefoot or even to sit on the steps of your house without some kind of barrier, such as a piece of cardboard. However, when we made mistakes like touching the ground, we were quickly scolded, not because it offended people, but because they were genuinely concerned for our health. I quickly came to respect these cultural differences.

In a similar line of thinking, it quickly became evident that many Kyrgyz households still operate with a combination of modern "Western" medicine and traditional medicine. An example of this was when a mother brought her young son in to be checked out by one of the doctors. His skin was covered in greenish colored spots. I was not able to be a part of the conversation, but it was explained to me afterwards that he had had either

chicken pox or perhaps hand, foot, and mouth disease. The green spots were a traditional kind of medicine that his mother put all over the rash to try to speed up the healing process. The consensus among the American doctors was that the medicine was likely not effective and may have even slowed down the healing process. Nonetheless, it was very important that the doctors were respectful and understanding of the mother's honest efforts to help her son. It was an excellent teaching moment, but it needed to be done with kindness and an appreciation for traditional medicine.

I also discovered that I went to Kyrgyzstan with an oversimplified understanding of how Americans could help the people of Kyrgyzstan. It seemed quite simple that as Americans with relative wealth, we could overcome some of the basic struggles to provide access to healthcare for people in remote areas. We could come in armed with a crew of doctors, basic diagnostic tools, common medications, and money to cover the cost of our travel to the remote villages. There is no doubt in my mind that we were able to help many people, but I also recognize that much of the help we offered was good for one day or maybe a month at best. A single mobile clinic cannot fix a system that does not provide for all its people, and it truly can't even be a bandaid. For every person who was seen in the clinic, thousands more could not be seen.

We were also extremely limited in the services we could offer. Our diagnostic tools were very limited, but we also didn't have a wide range of providers. We had pediatricians, hospitalists, and an ER doctor. There was no specialized women's health, no cardiology, no dentist, and no eye doctor. The doctors were qualified to treat the vast majority of patient concerns, but if anything requiring specialized testing and care would have come up, they would have to be referred to a bigger city.

In general the people being seen in the clinic were very happy for the chance to see a doctor. That is worth something. I did see the aspect of the clinics being expensive to run with largely short-term results. The doctors often diagnosed patients with things like diabetes or high blood pressure and offered them a 30-day supply of medication. In Kyrgyzstan, most medications can simply be bought over the counter. However, they are expensive, and for that reason alone, most of the people who were diagnosed with diabetes or high blood pressure will not purchase medication when their 30-day supply runs out. The mobile clinics do not have an obvious solution for this problem. One potential partial solution is that the diagnoses made during the mobile clinics can be shared with the local nurses. The nurses have the ability to follow-up with patients, monitor blood pressure or blood sugar, and counsel them on best practices if patients are willing to be proactive about their health.

We also ran low on all of our supplies and always had to turn people away at the end of the day. In some locations, we struggled to maintain high levels of professional care that we would expect in the United States. When we ran out of gloves, we resorted to washing our hands between patients. When the building lacked enough exam rooms, two patients were seen in a room at a time, although never for highly personal exams. And, finally, we struggled to communicate from an American perspective to a Kyrgyz perspective. It was common to inform patients that they were anemic and needed to cut down on the amount of black tea they were drinking. This concept coming from an American came across as an insult to their culture, despite the good intentions. Black tea is consumed with every meal, and the thought of not drinking black tea has far more social implications than Americans being told to cut back on coffee.

Helping Kyrgyzstan as a long-term goal has to extend beyond wanting to help patients in the here and now. When I was in Kyrgyzstan, the exciting part of the trip was the mobile medical clinics. The mobile medical clinics are a good opportunity for young Kyrgyz doctors to gain firsthand experience working in remote places. The mobile clinics introduced the young doctors to meaningful aspects of providing care to people who would otherwise not be seen by a doctor. The work is never-ending and the pay not enough, but for doctors who chose a career in medicine for the sake of helping people, rural medicine may hold some

appeal. If enough people became interested in rural medicine, the workload would gradually decrease for the handful of doctors currently serving remote Kyrgyzstan.

I did not have the chance to see the mentorship program in action. I was able to see the facility where it takes place and ask some basic questions. The young doctors who participated in the mentorship program all seemed to speak positively of their experience. The young doctors clearly respected the mentoring doctors for their clinical skills, but they also had a very personable relationship. I did not see evidence of strong tension between American culture and Kyrgyz culture in the mentoring relationships. I'm sure that differences and misunderstandings arose, but there was clearly a mutual respect between everyone in the program.

Since I have been home, the mentorship program has become more exciting to me. One of the biggest things that will drive change in Kyrgyzstan is Kyrgyz doctors who are educated and passionate about Kyrgyzstan finding healthcare solutions for people in remote areas. The mobile medical clinics do not accomplish that, but the mentorship program has so much potential. Many established Kyrgyz doctors are discouraged and struggle to see a brighter future for rural medicine. They are also spread thin and may not have the capacity to offer mentorship to young doctors. There is an opportunity for healthcare professionals from high-

income countries to share not only their skills but also their perspective that healthcare can be improved.

The end goal for the mentorship program should be a transition from Americans mentoring Kyrgyz doctors to Kyrgyz doctors mentoring Kyrgyz doctors. However, mentorship is an opportunity for high-income countries to invest in low-income countries in hopes of better long-term outcomes. Giving away medication helps for a very short amount of time. Helping doctors do their job more effectively lasts for generations.

To temper the positivity of the last paragraph, the results of the mentorship program may continue to be few and far between. During the mobile clinics, I worked with a young doctor. She was incredibly personable, had a great bedside manner, and had successfully finished the mentorship program. When she worked with the people in these rural towns, she appeared to be excited about what she was doing. However, even while working with these mobile clinics, she was applying for visas and study programs in Europe. The last I heard, she was living in Europe somewhere. Despite her love for people, the drive to leave Kyrgyzstan and find something better was still incredibly strong.

For many young doctors, the need to work for something better has been instilled in them since they were children. Many of their parents pushed them towards medicine so that they could eventually leave

Kyrgyzstan for better pay and more opportunities. Improving the number of doctors can only happen with a cultural mindset shift. The people of Kyrgyzstan have to be able to see a future for themselves and their children in Kyrgyzstan. That is a hurdle that no amount of American dollars can solve on its own.

Personal Applications

The applications section would not be complete without considering how my experience in Kyrgyzstan will affect my future as a medical professional. One of the most obvious things that I have come to recognize is how little I know about non-western healthcare perspectives. Before being in Kyrgyzstan, I had never given a significant amount of thought to non-western medicine in general. It's easy for me to forget that there are still many people who use a combination of traditional and modern medicine. As a medical professional, I want to provide high-quality, evidence-based care, but I want to do it in a way that respects other perspectives. I don't want to look down on people with different perspectives or assume that they are willfully ignorant. Instead, I want to take the time to listen and understand their perspective.

The second thing I realized is that I can't just ignore the policy aspect of healthcare. I am drawn to the human interaction that occurs between a patient and their healthcare provider. Those relationships are what

attracted me to medicine and have continued to bring me back. I would be content to never dip my toe into healthcare politics. However, Kyrgyzstan has been a good example for me to begin to understand what can happen if healthcare professionals are not actively involved in policy-making.

The final thing that my trip to Kyrgyzstan solidified in my mind is that I would love to be a part of international healthcare aid again in the future. I don't have all the answers, but I want to be a part of helping developing countries establish sustainable healthcare infrastructure. I want to use my skills to serve people in a way that won't create dependency but, instead, will encourage healthcare professionals of that country to be as educated and involved in shaping their countries' healthcare future as possible.

It was also humbling to recognize that all of the tasks with which I helped could have been done by one of the local nurses. It was great to have an extra set of hands, but I was extremely replaceable. Together as a team, we were able to see a lot of patients, but on an individual level, I had very little to offer the Kyrgyz people. I cannot sit in my lovely American home and pretend that I made an enormous impact. I cannot pretend that I was some kind of hero, and that's just fine. With the possible exception of natural disaster situations or war zones, developing countries don't need self-proclaimed heroes to come and fix their problems. With careful planning, collaboration and a lot of humility, they may benefit from

temporary assistance or mentorship that will help them develop a more sustainable healthcare system.

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