Honduras Trip Report – May 2026

Department of Family Medicine, University of Rochester

Participants	
Faculty Sophina Calderon Doug Stockman Interpreters Diego, Arlin, Esmeralda, Fatima Dental Honduran dentist for 1.3 days Cook Ana	Residents Amy Lotemplio Catherine Ramos UR Medical Student Amber Mcferren Unitarian Church None

Introduction

The Department of Family Medicine at the University of Rochester operates a Global Health Program. This year-round program travels twice a year for two weeks at a time to rural Honduras. The Department has partnered with a rural community called San Jose, San Marcos de la Sierra in the Southwestern state of Intibucá, Honduras. The needs of the target community are great and go beyond curative medicine. By listening to the concerns of the local community members and performing qualitative community assessment, we have created interventions designed to address the common problems. Below is a report from our May 2026 trip.

Travel and General Comments

The travel to Honduras went well. We got through Honduran Immigration and Customs without being stopped. There is a new government in power. It appears most of the baggage searching stations in Customs have been removed. We were not stopped or searched and promptly got on our way. Prior to driving to San Jose we were able to do banking and buy all the needed supplies for the 11 days in San Jose. We had four Honduran interpreters we worked with before join our group. They are lovely people who really appreciate all we do in San Jose, and they treat patients with the respect and compassion all people deserve. We hope they will join future trips.

Group during a hike with Gustavo being the guide

Ana did the cooking and cleaning for the group. We ate well and enjoyed not having to wash dishes. The government electricity was more stable than on other trips. Most days we had electricity for almost 24 hours.

Water access remains the biggest problem for the local people. We got to experience that ourselves this trip. We usually get our water from collecting rain. Doug noted in November 2025 that our 4,000 gallon fero-cement water tank was leaking. Included in the solar equipment shipment in February 2026 were supplies to repair the leaking tank. The villagers treated the tank in April. Rains normally start around April and May. Unfortunately, we had no significant rain during this trip so the tank was

almost empty. Therefore, water for bathing and dish washing were in short supply. We had to purchase water from outside the community and have it trucked in on the back of a pick-up truck. The water was expensive and dirty but at least we could bathe and wash dishes. During this trip Doug purchased a 1,500 gallon plastic water tank that got delivered shortly before the group returned to the US. Hopefully we can get this installed and filled with rain water before the next trip as a back up. Given most local people have to carry water for home use on their backs up a mountainside every day they are astounded at how much water the group consumes. Our group had 12 people and we used over 1,000 gallons of water in 11 days. This amount of water is one tenth what the average American uses per day in the US. Most of us don't know how good we have it.

Education & Schools

The Unitarian Church of Rochester, in collaboration with San Jose partners, has managed and funded a scholarship program so that area school children can attend school beyond the 6th grade. Below is a report by Amy Lotemplio about the scholarship program. The scholarship program currently provides financial aid for education to 26 children.

Water we purchased for bathing and dish washing

As a part of the scholarship program, each of the children receiving the scholarship is involved in community service. Traditionally, the scholarship students help us unload our bus at the house upon our arrival. When we pulled into San Jose this year, about 24 students were waiting for us with smiles, ready to help out. They were very helpful in unloading our water, food, luggage etc. While they were working, my co-resident and I distributed letters from the scholarship donors to the children who were there, taking pictures of them as we distributed. It was fun getting to meet the children.

On the second Sunday of the trip, we worked with Professor Roney, one of the local teachers who has been helping organize the scholarship program, to collect required documents from the children and their parents and to distribute funds for the next semester. We met the families at our clinic. We had a brief opening discussion with the families and Roney. Many parents and grandparents expressed deep gratitude for the scholarship program. We then distributed funds to the students who had the required documentation. It was exciting to see so many kids continue to have the opportunity to go to school when they otherwise would not have been able to. It was a privilege to get to meet the students and parents one-on-one to deliver the funds. I felt very grateful to Professor Roney, the Unitarian Church, and the interpreters who allowed me to be involved in this process.

Scholars and parents

Scholar meeting

Puberty talk intro

Small Group Education – Overview and puberty talk for girls (Amber M.)

We visited the local school to talk to the 4th, 5th, and 6th-grade classes about puberty. We began with a humorous skit modeled after a news show (complete with theme music!), using lighthearted examples about bodies changing, growing feet, clumsiness, and new body smells to introduce topics in an approachable way. The skit helped ease some of the discomfort that can come with discussing puberty. Afterward, we separated the students into boys' and girls' groups for a Q&A session. To help students feel more comfortable, we invited them to write their questions anonymously on pieces of paper. In the girls' group, many questions focused on when puberty begins and when to expect a first period, reflecting both curiosity and anxiety about upcoming changes.

Amber holding an impromtu English class

One moment that stood out was when a student asked, "Why do men hurt women?" The question was hard to hear, and even harder to answer. Of course, we should not assume too much from one question, but it certainly raised concerns that some students may have been exposed to issues related to safety or violence. It reminded us that even a simple puberty lesson can bring up much bigger topics, and that giving students a safe way to ask questions can help reveal concerns that might otherwise go unspoken.

Small Group Education – Puberty talk for boys (Amy L.)

As a part of the scholarship program, our group also spent a morning in the nearby school teaching the 4th graders to 6th graders about puberty. Our fantastic medical student, Amber, spearheaded this event. Amber wrote a very funny puberty skit, which was presented to the entire group of boys and girls to lighten the mood before we split the kids into groups of boys and girls for the more detailed puberty discussions and Q and A. Two of our interpreters, Diego and Fatuma, were the stars of the skits and made me question why they were interpreters and not on Broadway. The kids seemed to really enjoy their performance.

Amy and Diego teaching boys about puberty

After the skit, Diego and I took the boys into a separate classroom. Thinking back to my own middle school days, and my days teaching as a substitute teacher in a middle school, I was a little nervous about how the boys might act. They were, to my surprise, very well behaved and genuinely engaged in the topic. From their perspective, it must have been kind of surreal to have a Gringo lady come explain puberty and then disappear in a week.

With the help of Diego, I provided a brief overview of puberty and what the kids can expect. The kids then had the opportunity to ask any questions they wanted anonymously. Many questions were centered on facial hair. I had minimal advice regarding how to deal with facial hair, but Diego seemed to answer their questions about this, from what I can tell. Other questions were focused on asking why puberty happens at the biological level and on how and when voice changes happen. We answered all their questions as best as we could. Overall, it was fun to get to work with the kids at the school. I hope to do something like this again in the future.

Computer Education

The Honduran interpreter Arlin did a great job educating a number of children on computer use. These children are in the 8-12 year old range. The children are making great progress on learning to use a mouse, keyboard, and the basics of operating a computer. Much of this happens through game play. We had some issues with broken power strips so there was a delay in running more than one computer at a time, but we rebuilt one power strip so we finally got two computers running. The medical student Amber also did some computer education as well as teaching basic English language phrases to the children.

The middle school in San Marcos (about one hour walk from San Jose clinic) requests whenever possible that the family provide a computer for their child. Two people Doug knows well were able to raise enough money to pay Doug to bring refurbished Dell laptops. One family has a family member in the US who paid for the computer. The other person, Edis, who helps us out, is a contractor who builds houses in the area. Those two girls, around 15 years of age, received computer education on their own laptops during this trip. This was the first time they ever used a computer.

Medical Care

The medical clinic saw the usual cases and a typical amount of patients. The visit volume did not overwhelm the two residents and medical student. The clinic is organized so that two clinicians see patients and the third clinician runs the pharmacy dispensing medications and collecting nominal payments for service. The attending physician precepts every case, helps with procedures, and puts out fires as needed. This trip we had the assistance of the UR Dermatology Department. Given we have internet in the volunteer house via a StarLink satellite system we sent a couple clinical cases, including photos, to the dermatologist handling eReferrals here in Rochester. We really appreciate having their expertise. We consulted on the case of a boy who has a hypo-pigmented rash growing over most of his face, and a middle-aged woman with a large black patch on her leg that she worried might be a cancer. We borrowed a dermatoscope from HFM which helped in diagnosis.

Kat performing a knee injection

Amy performing a knee injection

Amber performing a shoulder injection

This trip, as on others, clinicians found they do more procedures in San Jose than they get to do in Rochester. Everyone did knee injections, and Amber and Amy got to perform shoulder injections. Given our interns don't usually get trained on performing blood glucose testing, it was humorous

seeing one of the clinicians struggling to do that procedure. Fortunately, the patient was good natured even after four finger pokes before a blood sugar level was obtained. The clinicians also learned how to perform urine dip stick tests, urine pregnancy tests, mix up and administer ceftriaxone injections, and perform ear lavages for impacted cerumen. They definitely learn to appreciate what pharmacists do. Working in the pharmacy when busy can be a challenge.

Clinical Care – Interesting Cases

Diabetes Case (Amy L.)

I learned a great deal during our trip about the differences between medical care in resource-rich versus resource-poor environments. One case highlighted these differences clearly.

A 48-year-old female with a past medical history significant for obesity, who was well known to the clinic, presented with multiple concerns, including increased urinary frequency, unintentional weight loss, and bilateral calf pain with walking short distances. She reported that the urinary frequency had been ongoing for approximately two months without significant progression or improvement. She expressed concern for UTI as she had suffered from UTIs in the past. She also described subjective weight loss during this period, although no previous weight measurements were available for comparison at the time of my seeing her. In addition, she reported worsening cramping pain in both calves since August 2025, occurring even while walking short distances around her kitchen, and improving with rest.

Given this constellation of symptoms, I was concerned about metabolic syndrome, particularly undiagnosed diabetes mellitus and peripheral artery disease (PAD). We performed a urine dipstick, which revealed glucose greater than 1000 mg/dL and trace proteinuria. We then obtained a fingerstick glucose measurement—which I was proud to have (somewhat painstakingly) learned how to perform during this trip—and her glucose level was markedly elevated at 424 mg/dL, highly concerning for uncontrolled type 2 diabetes mellitus. A random glucose of 424 mg/dL roughly corresponds to a hemoglobin A1c of 16.4%.

Amber and Fatima working in the pharmacy utilizing teach-back education with a patient

If this patient had presented in Rochester, she would have required initiation of insulin therapy. However, in this clinic, the only available diabetes medications were metformin and glipizide. I discussed the diagnosis of diabetes with the patient, including the importance of diet and lifestyle modifications, as well as the need for medication management. Accepting the diagnosis was challenging for her, as it felt sudden and unexpected. Ultimately, we initiated treatment with metformin, with plans to gradually titrate to 1000 mg twice daily, along with glipizide. Because our team would be leaving the following week, we referred her to San Marcos for continued diabetes management and medication titration. We also referred her for further evaluation of suspected PAD, given her symptoms and risk factors, including obesity and newly diagnosed diabetes.

This case emphasized for me how dramatically resource limitations can shape clinical decision-making. In a resource-rich setting, this patient would likely have undergone immediate laboratory testing, vascular studies, and initiation of insulin therapy. In contrast, our management options were

constrained by medication availability and limited diagnostic resources, requiring us to adapt our clinical approach while still striving to provide effective care.

Caring Companion (Amy L.)
Another case that stood out to me came at the end of one of our clinic days. An older couple approached us, with the husband explaining that he was concerned about his wife as she had been coughing for the past few days. He told us that his grandchildren had been seen in the clinic a few days ago and that they were treated for a cough. The husband was worried for his wife and encouraged her to come to the clinic. We examined the patient and found that she had subtle crackles over her left lung base. We decided to treat her for community-acquired pneumonia. When we were explaining the antibiotics to the patient, her husband was listening very intently and repeating back everything we said. We could tell he was going to continue to take good care of her.

Later that day, I saw this same couple walking home on a footpath behind our house in the rain. I saw the husband holding an umbrella above his wife to protect her. It was touching to see how caring this husband was to his wife. He set a good example for doing your best to take care of those around you.

Case Report: 12-year-old female presents for Nexplanon removal (Amber M.)
Patient D is a 12-year-old female who presented for a Nexplanon removal, accompanied by her sister. D reports that she had her first sexual encounter one month prior with an older man. The next day, the police arrested the man, and D was taken to the hospital. She states that many tests were run at the hospital, including a urine test and a blood test. According to D, the hospital forced her to get a Nexplanon implanted, but neither she nor her mother wanted her to get birth control. She was supposed to attend a follow-up visit at the hospital this past Tuesday, but the follow-up appointment did not happen.

D states that the man is now in prison, so she is no longer sexually active. Since she is no longer sexually active, she expresses the desire to have the Nexplanon removed. She also notes headaches and cramps since having the Nexplanon placed. Prior to the Nexplanon placement one month ago, D had normal periods with mild cramping controlled by homemade tea. She reports that she has not had another period since the Nexplanon was placed.


Kat enjoying teaching a school girl about heart sounds

The case presented an ethical, and potentially legal, challenge. Honduras does not have a clear age of consent for minors seeking contraceptive care, so our ability to make any changes to a contraception plan without the consent of a parent is unclear. Additionally, the patient was not endorsing any clear indication for Nexplanon removal, so we encouraged the patient to continue monitoring her symptoms, and we provided a referral to the original hospital where the Nexplanon was placed for potential removal. We informed the patient that following up with this hospital is also important because they have her original lab results. The patient also completed a urine pregnancy test in the clinic, which was negative, and we provided ibuprofen for menstrual cramps.

Chagas-Related Cardiomyopathy (Kat R.)
A 45-year-old woman came into the clinic asking for a wellness exam and to talk about her heart health. She quickly disclosed that she had been diagnosed years ago with Chagas disease. This condition is caused by the parasite Trypanosoma cruzi and transmitted by a Kissing Bug, which is common in rural Latin America; although many people clear the infection, it can quietly cause damage to the heart and other organs decades after initial infection. Our patient was diagnosed with Chagas-related dilated cardiomyopathy where she had intermittently received sporadic care by a public and private cardiologist; she explained how she was told she has a "bad heart." She had stopped seeing a cardiologist and ran out of a cardiac medicine about 1-year prior due to financial and transportation barriers on top of balancing being a busy mother.

She went on to explain at least weekly episodes of rapid heart rate, palpitations, and dizziness/weakness. These episodes were becoming more frequent especially when exerting herself and she learned the feeling would subside with rest. She asked if we could supply the unspecified medication that she was previously taking, going on to explain how she had been using an herbal supplement after she ran out of the medicine which previously prevented these episodes.
A 2-lead EKG had evidence of left ventricular hypertrophy (enlarged heart) and atrial fibrillation. There was no evidence of heart failure on exam, which was reassuring, but as a whole it was clear that she had progressing heart disease in the absence of consistent management.

It struck me when she vocalized ambivalence about the care she had received in Honduras, specifically asking if she was receiving the same standard of care expected in the United States and if she would need surgery. Based on what we understood about her care, we told her that yes, she was receiving what guidelines recommended. We told her that some people with advanced Chagas-related cardiomyopathy may eventually reach a point where a heart transplant is discussed; however, she was not there and urgently recommended returning to a Honduran cardiologist and staying on her medications consistently. We informed her about the diagnosis of atrial fibrillation and the risk of stroke if it is uncontrolled.

She carefully listened to our recommendations and asked further questions. Although agreeing to our reasoning, in the face of the financial and logistical barriers, she asked if she could "just continue taking the herbal medicine?"

<u>Young boy with facial rash (Kat R.)</u>
After lunch on the first day of clinic, the children from the school next door were crowded around the clinic windows with their faces pressed against the window bars, profuse giggling, and amusement with my broken Spanish. There was one boy who had splotchy discoloration across his face that was pushing his entire face into the window bars, asking eagerly if we had any toys or games. We didn't. Although briefly disappointed, he was entirely undeterred.

This 9-year-old boy became a fixture of the trip where he would often just appear at the clinic after school, not asking for anything in particular (except for games), where he would make small talk and goof around with the team. He visited the house after clinic hours as well for Doug's computer lessons – often also asking to play games. We taught him some English phrases that we later found out he was teaching his classmates. During the puberty talk, he was very invested in all aspects of growing a beard.

His mother brought him in for a clinic visit to discuss the patchy hypopigmentation across his face that had been worsening and made him feel like people were always looking at him. Lucky for him, this was the first trip where we brought a dermatoscope. We examined the hypopigmented areas and sent our photos to a dermatologist at URMC for further recommendations. It was most likely pityriasis alba or a fungal condition. In the US, we would've had a straightforward dermatology referral and targeted treatment plan. Here, we were able to give a steroid cream and oral antifungal to cover the most probable causes with the plan to follow up in September. He was overjoyed with the hope of his skin improving.

Dental Care

We were unable to find a US dentist to join our group. We did find 2 Honduran dentists and a dental student to work on a week end. They were able to treat 41 patients. Because of problems with the equipment they mainly extracted teeth and performed cleanings.

Our group organizing dental equipment

Plastic lawn chairs as make-shift dental chairs, with 3 patients being treated at once

Dr. Elizabeth doing an extraction

Dental vignette (Kat. R.)

A middle-aged woman came into the clinic with right ear pain which initially was concerning for an ear infection. As we did a closer history and exam, she also had facial tenderness in the right upper mouth that radiated to her ear and prominent enlarged lymph nodes on her right neck. It turned out that a tooth there had been bothering her. We diagnosed her with a probable dental abscess. We recommended she return to the clinic on Saturday to have the Honduran dental team examine her and likely extract the tooth; in the meantime, we were able to give an antibiotic and pain medicine.

She came back as hoped and the tooth was extracted. The next day, we saw her at Scholarship Day. She was there with her preteen daughter who was receiving a scholarship. I went over to ask how she was feeling where she explained that she was doing much much better and the pain had subsided. Her daughter was standing so confidently and excited about continuing school for another semester. The mother had such a big smile across her face that clearly showed how proud of her daughter she was.

Observations

Cultural Home Visit (Amber M.)

One afternoon, we visited an older woman named Cipriana who lives down the road from the clinic. She welcomed us into her home and sat with us for a couple of hours, sharing stories about her life in the village, her animals, and her community. She spoke with so much love about her family, including both her biological family and the people in her community who had become family to her. She had served her community as a midwife for years, and she told us stories about walking to homes in the middle of the night to help with deliveries.

She also told us about a close friend who passed away many years ago. On her deathbed, her friend shared that one of her biggest worries was that she would no longer be able to bring the weekly snack to her child's class. She asked Cipriana to continue bringing the snack, and Cipriana kept that promise. After her friend died, Cipriana not only continued bringing snacks to the class, but also helped raise her friend's daughter as her own.

Through her work as a midwife, friend, neighbor, and presence in the village, Cipriana seemed to embody what it means to deeply care about her community. Everyone we passed on the road seemed to know exactly where she lived and spoke of her with warmth. In Cipriana's life, service looked like showing up in the middle of the night for a birth, keeping a promise to a friend, and continuing to care for the people around her.

Across Indigenous Lands: A Navajo Physician's Journey in Honduras (Sophina C.)

[Ed. For those who don't know Sophina she is a graduate of our Residency and Global Health Program]

Serving as a family medicine attending physician in San Jose, has been one of the most meaningful experiences of my professional career. Over multiple trips, I have had the privilege of accompanying and supervising Family Medicine residents as they care for patients, learn about global health, and work alongside dedicated Honduran interpreters serving the Indigenous communities of rural Honduras. Each visit has deepened my appreciation for the resilience, generosity, and cultural richness of the communities we serve. As an Indigenous physician from the Navajo Nation, I have often reflected on the unique opportunity to work with another Indigenous population outside of the United States. While there are many differences between our communities, there are also shared values centered on family, community, tradition, and caring for one another. These connections have made my experiences in Honduras particularly meaningful.

Sophina making Frybread

During this brigade, I decided to share a small piece of my own culture with the team by making Navajo frybread. It was a simple gesture, but one that carried deep personal significance. At home in the United States, frybread is much more than a meal. As the matriarch of my household, I prepare frybread for my family as an expression of love, care, and nourishment. It is a tradition passed down to me by my mother and grandmother, who taught me not only how to make frybread but also the importance of gathering family around food and creating

lasting memories together. My husband and children consider it a special occasion whenever I make frybread. It is one of those meals that brings everyone together and reminds us of our family history and traditions. Before departing for Honduras, I told my family that I hoped to gather ingredients and make frybread for our brigade team while we were at camp. They were immediately excited by the idea and felt it would be a meaningful way to share a piece of our family's culture with the residents, students, and Honduran interpreters serving alongside me.

On the last night of our time on the brigade, in our primitive camp kitchen, I was able to coordinate making frybread to accompany a Honduran stewed meal made by our Honduran cook. The experience felt especially meaningful because earlier in the week I had given a talk to the team about the Indian Health Service and healthcare delivery within Indigenous communities in the United States. The team engaged thoughtfully with the topic, asking insightful questions and demonstrating a genuine interest in understanding both the strengths and challenges of Indigenous healthcare systems. By the end of the discussion, many had gained a greater appreciation for the historical and contemporary realities facing Native communities. Sharing frybread with the team after those conversations created a unique moment of cultural exchange. We had traveled all the way to Honduras to learn from and serve an Indigenous community, and in return, I was able to share a small part of my own Indigenous heritage with the brigade team. Around a table in a remote Honduran camp, conversations about culture, healthcare, community, and service came together over a meal that carried generations of family history.

Caring for patients in rural Honduras, teaching residents, discussing Indigenous health, and sharing frybread with colleagues reminded me that medicine is ultimately about relationships. It is about honoring the stories, traditions, and humanity of the people we serve and those with whom we work. The experience reinforced why I continue to participate in these brigades. While we come to provide medical care and education, we also leave with a broader understanding of one another and a deeper appreciation for the cultures that shape our communities. Sharing frybread in Honduras became more than a meal; it became a symbol of connection between Indigenous peoples, a celebration of service, and a reminder that some of the most meaningful lessons in medicine happen far beyond the walls of a clinic.

Politics and Land Issues

When it comes to politics, nothing is easy. National and regional elections were held in November 2025. The mayor for the county of San Marcos where San Jose is located remains contested. Additionally, there is still no president elected for San Jose Centro, where we work. This hinges on who the mayor is. It sounds like even though the people vote for their village leader the San Marcos mayor will choose who they want to run San Jose Centro and ignore the people’s vote. This means no changes are possible regarding the land dispute at this time.

Rural Development Projects

Our usual projects of cook stoves, latrines, water filters, pilas, fish farms, etc. are presently on hold due to the land dispute issue.

Solar Electricity
We were unable to install new solar systems this trip. Doug had an injury that kept him from walking to homes, and during a brigade it is often difficult to get away from the group and the clinic. Hopefully we will install more solar systems starting in September.

Agriculture
Coffee harvest starts around mid November and ends in January-February. We brought home 50 pounds of Lempira Organic, 40 pounds of Lempira, and 30 pounds of Indio. We pay Fingerlakes Coffee Roasters to roast, grind, and bag the coffee. After we pay transport fees and processing fees all remaining money (profit) is returned to the Honduran farmers. The Farm to Table approach really helps these hard working local farmers. Thank you for supporting this effort. The coffee will be for sale in mid June at Highland Family Medicine.

Update on Project Status (updated 05/21/2026)

Project	Completed	Project	Completed
Cook stoves	456	Scholarships	175+ students, 25 current scholars
Filters	608	Solar systems	62
Latrines	204	Fish farms	6
Pilas	247	Piped water systems	5 communities
Heirloom seeds	>18,000 given	Barrels and gutters	>80

Your Help is Needed
We believe in low cost, simple technology solutions that the Hondurans can learn and maintain on their own. We are doing a great job in this respect. However, even simple interventions cost money. To continue the exceptional work we are doing in Honduras, we need more funds. If you have the financial ability and appreciate the great improvements our activities are bringing to rural Hondurans, please take a minute and donate to our project. Donations are tax deductible if you itemize your taxes. We are very fortunate to have the assistance of the Department of Family Medicine and dedicated volunteers to almost eliminate overhead expenses. Therefore, your donation will reach the Hondurans and not be spent on less helpful expenses such as rent for a dedicated US office or US-based secretarial support. If you would like to donate to the San Jose project, please make a check payable to “San Jose Partners”. Mail the check to “San Jose Partners. 1170 Frawley Drive, Webster, NY 1458”. Donations can also be made using PayPal or Venmo by visiting the Donations page on www.sanjosepartners.org.

Summary
The greater Rochester Family Medicine community has touched so many lives in Honduras and the Hondurans have enriched so many of our lives. As is true for all development projects, there will be set backs. These are learning opportunities and allow us to improve future interventions. This cross-

cultural project is realizing huge benefits for everyone involved, even with setbacks. The scholarship students gain confidence as well as a chance for a path out of poverty. 62 families now have lights at night and a way to charge their cell phones because of our involvement in San Jose. Seeing the smiles and appreciation as people display their running water, new cook-stove, or water filter is so rewarding. Through these very intimate person-to-person exchanges we maintain hope that a better world will become a reality one community at a time. Thanks to everyone for their continued support to make this project such a great success.

Douglas Stockman, MD
Director, Global and Refugee Health

Front: Kat, Amber, Amy
Back: Arlin, Ana, Breesia, Doug, Fatima, Esmay, Diego, Sophina