

Opinion

Lasting Effects of Title 42 and Health Implications

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Over five years since Title 42 was reimplemented during the COVID-19 pandemic, questions about its necessity and lasting impact on the health of migrants and asylum seekers remain largely unanswered. Our analysis of the evidence yielded two critical findings: (1) Title 42 did not help control cases of COVID-19 in the U.S., and (2) Title 42 had a pronounced negative impact on the mental and physical well-being of migrants and asylum seekers and strained the healthcare systems meant to support them. These findings lead us to urge public health practitioners and policy makers to approach immigration and asylum policies through a lens of respect and dignity. Building social support as well as medical support networks, including proper and timely physical and mental health screenings, and connecting migrants to culturally sensitive care are essential. Our hope is that writing about this topic will rekindle discussions and build public and political will to advocate for fair and just policies that consider the health and wellbeing of those seeking refuge, such that the harm inflicted upon migrants and asylum seekers as a result of Title 42 and similar laws and policies will not be repeated.

Advocacy Focus and Impact on Health

How this work impacts health: Existing research and journalism describe considerable health consequences of enforcing the public health law Title 42 during the COVID-19 pandemic. Title 42 significantly increased the prevalence of depression, musculoskeletal injuries, and childhood trauma among migrants and asylum seekers coming to the U.S.

How this paper addresses advocacy/action: We advocate for the humane treatment of migrants and asylum seekers. We call for action at individual, community, and government levels of influence to ultimately apply a collective advocacy approach to migrant health. We specifically appeal to health care and public health practitioners and policy makers to approach immigration through a lens of respect and dignity.

What this work adds to the field: We describe actions that the U.S. can take, now that enforcement of Title 42 has been paused, with the hope that writing about this topic will rekindle discussions in our communities, the media, and government offices such that the harm inflicted upon migrants and asylum seekers will not be repeated.

Next steps/needed action(s): Ensuring that immigration policy focuses on the health and wellness of individuals seeking refuge and asylum will require building social support as well as medical support networks that include psychiatric screenings and systems that connect migrants to culturally sensitive care.

Now five years removed from when the first COVID-19 case was reported in the U.S., the U.S. continues to grapple with questions regarding the impact and implementation of public health measures used to address this emergency. However, the impact of public health measures taken during this time on migrants and asylum seekers has largely remained unexamined and hidden from the spotlight.

WHAT IS TITLE 42?

In March 2020, the Centers for Disease Control (CDC) issued an order to limit migration across U.S. borders to stop the spread of COVID-19. This was done under Title 42 of the United States Code, Chapter 6A, Subchapter II, Part G, Section 265, a rarely used law motivated by the need to address public health, social welfare, and civil rights in emergency situations to stop the introduction of communicable diseases (*42 U.S. Code § 265 - Suspension of Entries and Imports from Designated Places to Prevent Spread of Commu-*

nicable Diseases 1944). First introduced in the 1944 Public Health Service Act, Title 42 originally aimed to assuage concerns about U.S. soldiers returning from World War II with malaria and tuberculosis, and ultimately authorized the U.S. federal government to establish measures preventing the spread of diseases (Gostin and Friedman 2023).

Title 42 effectively granted the U.S. Surgeon General the power to deny entry to the U.S. to people who were perceived to pose a risk by carrying and spreading communicable disease. In 1966, this power was transferred to the Department of Health and Human Services, which has since delegated that power to the director of the CDC (“COVID-Related Restrictions on Entry into the United States Under Title 42: Litigation and Legal Considerations” 2023). With this authority, in 2020, CDC director Dr. Robert Redfield was directed by Vice President Mike Pence to utilize his emergency powers under Title 42 during the COVID-19 pandemic to again limit entry to the U.S., despite some disagreement from top CDC officials regarding its necessity (Dearen 2021).

In April 2022, the CDC announced that it felt there was no longer a need for the restrictions imposed by Title 42 given the efficacy of new vaccines and therapeutics (“CDC Public Health Determination and Termination of Title 42 Order” 2022), but multiple states sued and brought the case to the Supreme Court after the Biden Administration attempted to stop enforcement of the law (Ainsley 2022). Despite contentious litigation since 2020, enforcement of Title 42 formally ended in May 2023 after President Biden announced an official end to COVID-19 restrictions. From 2020 to 2023, Title 42 was used over 2.5 million times to turn away migrants and asylum seekers (Santana 2022).

WAS TITLE 42 NECESSARY?

Despite the public health justifications for reinvoking Title 42 in 2020, research conducted since that time has not provided statistical evidence that the order resulted in fewer COVID-19 cases (“Order Suspending the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists” 2020; Wong and Svajlenka 2022). When controlling for outside factors and outliers (i.e., unrelated COVID spikes), the correlation between monthly Title 42 expulsions and monthly COVID-19 rates was non-existent (Wong and Svajlenka 2022). In addition, many experts have argued that Title 42 had the intensified effect of being more detrimental to the health and well-being of migrants, largely because it unnecessarily eliminated health screenings at the U.S. border (Beckett et al. 2022). For example, the CDC typically recommends medical screenings for migrants as they arrive and await decisions on their asylum status. These screenings include checking for communicable diseases, vaccine status, physical and mental disorders, drug use, and performing routine chest radiographs (MacPherson and Gushulak 2016). However, facing immediate expulsion under Title 42, many migrants were unable to get these screenings, resulting in worse physical and mental health outcomes (Pillai and Artiga 2022).

The trauma of these denials was compounded by the fact that 16,000 unaccompanied minors (children under age 18 years who arrive at the border without a parent or guardian) were expelled under Title 42, exposing them to extremely dangerous conditions and depriving them of safety and protections (“Trump Administration Intentionally Expelled Thousands of Unaccompanied Children to Danger Under Title 42” 2024). Starting in November 2020, children traveling alone were considered exempt from the immediate expulsion rule of Title 42 (“District Court Blocks Trump Administration’s Illegal Border Expulsions” 2020). However, this still resulted in many families, who had previously been expelled and were no longer detained at the border, self-separating from their children and sending them back to the border to qualify for exemption (Montoya-Galvez 2022). While some were granted this exemption, it was widely documented that many of these children were detained and held in custody at the border in overcrowded and unsanitary conditions with no room to ensure social distancing for unlawful extended periods (Merchant 2021).

A recent assessment of the re-implementation of Title 42 shows that many individuals seeking refuge and asylum at the U.S. border were held in close proximity during detention or deportation, had limited access to needed medications, received far fewer medical screenings, and were separated from their families, resulting in preventable increases in adverse physical and mental health outcomes (Gostin and Friedman 2023). That Title 42 led to such trauma and the fracturing of so many migrant families at the U.S. border is ample evidence that it was not only unnecessary (Hathaway 2020), but was not a legitimate tool for providing safety or preventing the spread of communicable disease (Hampton et al. 2021a).

LASTING HEALTH IMPACTS

To grasp the gravity of this situation more fully, it is important to understand the motivations and experiences of migrants and those seeking asylum. Migrants are individuals who leave their home country for a variety of reasons and may be screened for asylum at the U.S. border on the basis of fear of persecution, violence, or human rights violations (Montoya-Galvez 2022). Many migrants arrive with some type of health concern, ranging from physical injuries to communicable and chronic disease (“Health Challenges for Refugees and Asylum Seekers,” n.d.). These health concerns are often a result of the poor living conditions, lack of access to healthcare, and violence in the countries they are fleeing (Ashley 2023). Families often travel for months to escape persecution in their home countries with minimal belongings and shelter, further contributing to the development and worsening of various medical conditions. Health care professionals serving these patients have reported treating conditions ranging from trench foot and musculoskeletal injuries to pneumonia, while being mindful of identifying chronic conditions that have likely been untreated for months to years (Petty 2023). Notably, many migrants also have diagnosed and undiagnosed mental health conditions such as depression, anxiety, and PTSD (“Mental

Health Facts on Refugees, Asylum-Seekers, & Survivors of Forced Displacement,” n.d.). In one instance, Physicians for Human Rights reported that among a group of 26 migrants they provided mental health screenings to, 96% screened positive for depression, 92% for anxiety, and 88% for PTSD related to family separation (Hampton et al. 2021a), further emphasizing why physical and mental health screenings at the border are so critical.

Title 42 also adversely affected children through family separation and Adverse Childhood Experiences (ACEs) associated with migration. These ACEs include a range of pre-migration traumas such as war, terrorism, natural disasters, and forced displacement; transit-related events like violence, exploitation, mistreatment by border officials, separation from family and culture, and fear of death; and post-migration stressors such as detention, fear of deportation, unsafe living conditions, lack of social support, and longing for their home and cultural identity (Hampton et al. 2021b; Ertanir, Cobb, Unger, et al. 2023). These early life adversities are known to have long-lasting negative health effects, including increases in the risk for cardiovascular disease, depression, and diabetes (Jackson et al. 2022; Ye et al. 2023; Zhu, Shan, Liu, et al. 2022).

Many migrants have experienced adverse health consequences as a result of Title 42, though this is only the case for the individuals who have survived the process of seeking refuge (Pillai and Artiga 2022). The International Organization for Migration (IOM) has graded the southern border of the U.S. as the most dangerous border crossing in the world (Gallo 2023). According to the Marshall Project, the death rate of migrants along the southern border almost doubled under Title 42 (Calderón and Dias 2021). Repeated border crossing attempts are one possible explanation for this increase in the migrant mortality rate during Title 42 (Martínez et al. 2024). Repeated attempts increase the risk of physical injury or death, such as major falls off of the 30-foot walls (Tenorio, Hill, and Doucet 2024). After being denied entry, many individuals are either forced to return to the dangerous situations they were fleeing within their home countries, such as physical and sexual violence including but not limited to kidnapping, rape, and torture, or continue waiting for asylum at the border (Pillai and Artiga 2022). For many, the high stake risks associated with crossing the border, while traumatizing, are relatively less so compared to what they have experienced in their home countries and during their migration, which is why they take such risks.

Ultimately, the lasting health impacts of Title 42, an arguably unnecessary policy, has led to much more preventable suffering and many more unnecessary deaths than it was ostensibly put in place to prevent.

MEETING THE NEEDS OF MIGRANTS

Unsurprisingly, when enforcement of Title 42 ended as the public health emergency for COVID-19 was lifted, further stress was placed on the existing U.S. healthcare infrastructure (Pillai and Artiga 2022). Facilities and providers at the U.S.-Mexico border were overwhelmed by the growing num-

ber of individuals awaiting opportunities to formally seek asylum in the U.S., which also led to unhealthy overcrowding situations. In addition, with an upwards of 100,000 migrants transported from the border to major cities via bus and plane, the awaiting healthcare infrastructures and teams of providers waiting there were also at increased risk of being inundated, leading to challenges in providing timely and quality care (Garcia 2023; “Texas Transports Over 100,000 Migrants To Sanctuary Cities” 2024). Agencies that typically provide services to asylum seekers, which are primarily private and faith-based, also reported difficulties in continuing to acquire donation-based funding during the emergency orders and many were overwhelmed (Gomez 2021).

Still, several major cities have declared themselves as safe places to defend human rights with policies that discourage law enforcement from reporting the immigration status of individuals and discriminating against individuals based on their residency status when accessing support services (Gomez 2021). State and national organizations, such as the Illinois Coalition For Immigrant and Refugee Rights and the UN Refugee Agency, have continued to partner with local organizations to provide medical services and train community health workers to address the specific health needs of migrants (“Healthcare Access” 2024; “Access to Healthcare,” n.d.). Through engaging in advocacy campaigns to influence health insurance policy expansion, providing primary care during resettlement, and becoming qualified to conduct domestic medical screenings (per CDC guidelines), health care workers continue to support migrant populations (P Iqbal, Walpola, Harris-Roxas, et al. 2022; “Refugee Health Domestic Guidance,” n.d.).

The capacity and commitment of the healthcare systems in these destination cities to accommodate an influx of new residents is critical, as is providing care that is sensitive to the cultural backgrounds of migrants. Establishing access to consistent primary care and medications for newly arrived individuals has been crucial in addressing migrants’ health care needs. Providing specialized mental health care and support to address depression, anxiety, and PTSD as well as trauma and violence is and will remain essential for these populations. However, given the well-documented overtaxed U.S. mental health care system, investing in public health strategies that promote mental health and crisis prevention will be required. Improving access to mental health screenings and early intervention, combating stigma, and advocating for increased funding while reducing barriers to care—such as documentation status—represent feasible and sustainable strategies to ensure equitable care for newly arriving migrants (“Mental Health of Refugees and Migrants: Risk and Protective Factors and Access to Care,” n.d.).

WHAT’S NEXT?

There is ample evidence that Title 42, and similar laws and policies, adversely affect the health and wellbeing of migrants (Pillai and Artiga 2022). Again, it is important to acknowledge that asylum seekers come to the U.S. be-

cause they are fleeing violence and persecution in their own country. While we must also recognize the complexities of the immigration system, it is critical that legislators consider the health of migrants and asylum seekers when making decisions about the implementation of current immigration and asylum laws and the development of future policies.

To reiterate, Title 42 is a public health law that was enforced during the COVID-19 pandemic as an emergency measure to prevent the spread of COVID-19 by requiring migrants and asylum seekers to remain at the U.S. border. Most of the focus has been on the southern border between the U.S. and Mexico, where a significant number of migrants were forced to either stay in Mexico or return to their country of origin while their cases were being reviewed (“What Does the End of Title 42 Mean for U.S. Migration Policy” 2023). While enforcement of Title 42 effectively ended on May 11th, 2023 when the public health emergency in response to the COVID-19 pandemic was lifted, the longstanding asylum law in the U.S. prior to the COVID-19 pandemic, the Immigration and Nationality Act of Title 8 of the U.S. Code, was automatically reinforced.

What is Title 8? Title 8 allows migrants to apply for asylum in the U.S., however, it also allows for the immediate deportation of those who do not qualify for asylum. Under Title 8, the Biden administration permitted individuals seeking asylum to remain in the U.S. while their case was being processed (“What Does the End of Title 42 Mean for U.S. Migration Policy” 2023). However, this was accompanied by a new policy requiring migrants seeking asylum to schedule an appointment through the CBP One app, which over time was found to have significant issues related to language access, appointment availability and technological infrastructure (“CBP One™ Mobile Application” 2024; Office of Inspector General, U.S. Department of Homeland Security 2024), adding to the difficulties faced by asylum seekers. In addition, the Biden administration issued Presidential Proclamation 10773, known as “Securing the Border,” a policy described as intending to ease pressure on the immigration system by suspending entry of migrants across the southern border into the U.S. once the weekly average reaches 2,500 encounters and until it drops below 1,500 encounters (Kanno-Youngs and Aleaziz 2024; “FACT SHEET: President Biden Announces New Actions to Secure the Border” 2024), but which ultimately delayed many individuals from seeking refuge and timely medical attention.

It also is important to note that immigration policy is regulated by the federal government through congressional legislation and executive action, and the majority of recent immigration policies have been implemented by the executive branch of the U.S. government (Lebrón et al. 2023). Therefore, immigration policy, and a law like Title 42 that is technically not an immigration law but has been applied as such, can change drastically depending on the administration elected by voters.

In the early days of the current Trump administration in 2025, the U.S. Refugee Admissions Program, the legal process for refugees to migrate to the U.S., was indefinitely suspended meaning that they would stop approving new

applications for entry (“Realigning the United States Refugee Admissions Program” 2025). Meanwhile, the CBP One app was shut down and re-established as the CBP Home app, giving migrants without documentation a way to voluntarily declare their intent to leave the U.S., facilitating departure (“CBP Launches Enhanced CBP Home Mobile App with New Report Departure Feature” 2025) but not a way to legally stay. Notably, the Migrant Protection Protocols, also known as the “Remain in Mexico” policy, was also reinstated; this requires asylum seekers to stay in Mexico while they await U.S. court proceedings (“The ‘Migrant Protection Protocols’: An Explanation of the Remain in Mexico Program” 2025). During previous iterations of this policy, thousands of migrants reported difficulty obtaining legal counsel and many faced violence, kidnapping, and assault while they waited in Mexico for their asylum cases to be considered (U.S. Committee for Refugees and Immigrants 2021), essentially giving a disingenuous name to a protocol that rather than protecting them, put more migrant lives at risk.

Beyond Title 42, these additional policies aimed at deterring migration, enforcing deportation and suspending resettlement programs contribute to the public health crisis of asylum seekers (“U.S. Department of State Abandons U.S. Responsibility for Safely Resettling Refugees” 2025). As the political landscape continues to change, new policies are likely to separate families and further prevent migrants from accessing health screenings and medical attention that are essential to address new and chronic physical and mental health conditions, as well as intensify the dangers of crossing treacherous landscapes in seek of refuge (Pillai and Artiga 2024).

EDUCATION IS FOR EVERYONE

Title 42 and the COVID-19 pandemic and the U.S. response to them both have led to increased civic participation, though with mixed reactions and impacts. For instance, these events have led to increased advocacy and awareness around immigrant rights, fostered digital mobilization via social media, and enhanced solidarity with migrant communities (Schoon et al. 2025; Shah, Miller, Yang, et al. 2023). However, they have also contributed to fear and misinformation and polarized public opinion about immigration policy and governmental mandates. Overall, the effects have varied across communities and reflected both challenges and opportunities for ongoing civic engagement (Goldsmith, Rowland-Pomp, Hanson, et al. 2022).

Education focused on the general public, policymakers, and healthcare professionals and their professional organizations will be key to changing false perceptions and combating stigma about migrants, and to ultimately providing accurate information and encouraging inclusivity. This education should encompass comprehensive curriculum reforms in K-12 schools, undergraduate and graduate institutions, and specialized training programs that highlight the contributions of migrant communities to the U.S. society, economy, and culture to foster a more nuanced understanding of their experiences and challenges. Such edu-

cational efforts can significantly impact health advocacy by equipping individuals with the knowledge and tools needed to confront biases, combat misinformation, and promote fair immigration policies (“What the End of Title 42 Means for People Seeking Safety at the US Border” 2023). Medical education in particular should also focus on cross-cultural communication and global health competencies (Gruner, Feinberg, Venables, et al. 2022); residency and fellowship opportunities in refugee health do already exist but can be strengthened (“Refugee Health Residency Programs” 2024). Workshops, community forums, and storytelling at community events can further humanize the lived experiences of migrants. Creating an inclusive community where migrants are supported can also empower them to learn more about their legal rights and engage in local programs and services to facilitate their resettlement. Listening to and including migrants in community initiatives and town halls can provide platforms to voice their needs and concerns and would contribute to integration and an overall sense of belonging.

Educational institutions and community-based organizations should collaborate to prioritize research and policies that support migrant populations and promote diversity and equity. Organizations can join local, state and national coalitions, such as the Refugee Council USA, to provide legal aid, shelter, job opportunities and healthcare to ultimately mobilize and empower individuals seeking refuge (“About Us” 2024). Health care institutions must further prioritize policies that improve access to care for the communities they serve, provide culturally sensitive outreach services, and empower their healthcare workers to identify and address health inequities in migrant communities through research (Alarcon 2022) that includes and acts on the input of those patients and communities, such as through Community Health Needs Assessments (Wright, Williams, and Wilkinson 1998). Increasing visibility for migrants and highlighting the collective efforts and resources needed to better understand their health needs through research can ultimately drive policy reform using evidence-based findings (Thiel de Bocanegra, Carter-Pokras, Ingleby, et al. 2018).

As healthcare workers are the ones providing screenings and basic health care services and supporting migrants during critical periods of resettlement, they are uniquely positioned to amplify the voices of this population. By conducting advocacy research, using social media to promote public awareness, partnering with local grassroots organizations, and directly working with policymakers at the local and state levels, healthcare professionals can generate lasting support and changes for the betterment of migrant health and well-being (Rubin 2020).

CALL TO ACTION

Treating migrants and asylum seekers with respect and dignity is not just a moral imperative but a practical one. The necessity of addressing the current migrant crisis is urgent as the dangers of crossing the southern border of the U.S. are profound, as are the consequences of the immoral policies that force individuals to remain in danger, either at the

border or in their home countries. Health care professionals who hope to serve these families and children also face moral injury when policies like these prevent them from providing care or force them to work in ways that go against their values and undermine the doctor-patient relationship (Ramasamy 2025).

The end of the enforcement of Title 42 in 2023 marked a turning point. It offered a chance to step back and consider a more compassionate way forward, one that acknowledges the complex realities that migrant communities face. While the Biden administration attempted to streamline entry and hit a pause to raids, deportations, and family separations, reinstatement of the misguided Title 42 law is once again being considered by the current administration (Pillai and Artiga 2024). While concerns about the spread of communicable diseases are understandable and COVID-19 was a particularly pivotal time, neither is there a major public health threat at this time nor is expelling migrants a solution to one (Ulrich and Crosby 2022).

Any and all advocacy efforts, whether at the personal, community and/or government levels, focused on helping to pave a humane pathway forward for immigration policy are needed for the health of our society (Earnest et al. 2023). By clearly and effectively communicating the public health challenges of migrant health, demanding policy reform, and uniting motivated individuals to call for change, a robust model of advocacy can be implemented. It is apparent that to effectively achieve the changes required to address and improve such a complex immigration and asylum system, a wide range of advocacy initiatives will be needed to inform action. Those can include but are not limited to individual or patient advocacy, in which health care professionals and patients themselves advocate for changes to address unmet social needs; adjacent advocacy, in which groups of people unite together to engage in advocacy that brings attention to and drives public and political will for change; and structural advocacy, in which individuals, groups and communities—all of society—are focused on advocating for lasting systemic changes to unjust policies and procedures that can prevent inequitable health access and outcomes in the future (Earnest et al. 2023). For lasting change to occur on these different levels, this guidance cannot remain conceptual in nature but must be met by concrete actions that can have a positive, sustained impact. Change is required, particularly when policies are unjust, and change requires that people act—even if they do not perceive that they are impacted by some policies—because they are unjust.

Overall, we need fair and just immigration and asylum policies so that people can enter the U.S. and find refuge, and we should ensure that the process itself is not such a dangerous endeavor. While that should be our long-term goal, here we focus on some of the short-term actions we can all take that can lead to those longer-term changes.

- First and foremost, a primary focus should be on reuniting families torn apart by immigration policies. Family reunification requires coordinated efforts from legal teams, community organizations and individuals to advocate for protection-focused reunifi-

cation procedures, consistently apply public pressure, and build support systems that offer information and legal assistance during the process (“Family Reunification,” n.d.).

- For those who are granted asylum in the U.S., we need to work to ensure that these historically marginalized groups have the support and resources they need to thrive in their new communities. This means providing language programs, supporting cultural integration, and promoting community organizations that can assist with resettlement (National Academies of Sciences, Engineering, and Medicine 2015). To achieve this, ongoing support for these communities and community-based organizations and service providers will be vital.
- Providing migrants with essential, equitable and accessible health care is another crucial aspect that requires more focused attention. Immigrants come to the U.S. with diverse health care needs, which are often exacerbated by cultural and language barriers that keep them from accessing care and acting on physician’s orders. To improve access and understanding for both patients and providers, it is essential to train health care providers to understand and respect these differences and develop health care information that is understandable with regards to language and literacy levels. This also means bridging the gap between immigrant communities and health care services by establishing clinics in areas with high immigrant populations, connecting asylum seekers with primary care physicians, and providing culturally competent and comprehensive health care assessments required by the U.S. government for migrants to receive health insurance benefits. Understanding that many asylum seekers have faced abysmal conditions in their home countries, during their transit and at the U.S. border, it is imperative to acknowledge and address the psychological torment that these individuals have endured. Ensuring ongoing psychosocial support is and will be critical (“What the End of Title 42 Means for People Seeking Safety at the US Border” 2023).

It is true that many of the challenges faced by migrants, including financial instability, decreased access to primary care, and low health literacy are also experienced by many U.S. citizens, which means that focusing on structural and systemic improvements to the U.S. health care system can improve health care for all groups and should be something we can all agree on. Addressing these barriers by expanding coverage in federally funded public health insurance pro-

grams and increasing resources for federally qualified community health centers (FQHCs) would not only benefit lawfully present immigrants and migrants, but also low-income U.S. citizens and all individuals who depend on governmental and not-for-profit organizations for care and services. These efforts would also reduce overall health care costs—for the medical system and for patients and families (Alarcon 2022).

It is also true that some of the changes and improvements that we have called out here are already included on some circulating lists of programs and services to be ended, defunded, cut, or removed (“Ending Radical And Wasteful Government DEI Programs And Preferencing” 2025). But this should not deter us. Active collaboration, and courage, are needed at all levels of society and all levels of advocacy, from the individual to the governmental, and are required to make a cohesive cultural shift towards equity and inclusion. These do not have to be dangerous times – but action is essential. These efforts are about building bridges, not walls, and creating a society where everyone is valued and welcomed.

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