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Advancing Reproductive Justice to Close the Health Gap: A Call to Action for Social Work

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Abstract

Reproductive justice is an intersectional social movement, theory, and praxis well-aligned with social work's mission and values. Yet, advancing reproductive justice—the right to have children, to not have children, to parent with safety and dignity, and to sexual and bodily autonomy—has not been a signature area of scholarship and practice for the field. Here, we argue that it is critical for social work to advance reproductive justice in order to truly achieve the Grand Challenge of closing the health gap. We start by discussing the history and tenets of reproductive justice and its overlaps with social work ethics. We then highlight some of the ways by which social workers have been disruptors of and complicit in the oppression of individuals, families, and communities with regard to their reproductive rights and outcomes. Finally, we end with a call to action and recommendations for social work to foreground reproductive justice in research, practice, and education efforts by centering marginalized voices while reimagining the field's pursuit of health equity.

Key words: Reproductive Justice, Health Equity, Grand Challenges, Social Work

Advancing Reproductive Justice to Close the Health Gap: A Call to Action for Social Work

"The thing about reproduction is that, more than anything else, it tells you how a society values people." -Dorothy Roberts (Brennan, 2001)

More than genetics, medical care, or individual behaviors, health outcomes are shaped by the conditions in which people are "born, grow, live, work, and age" (World Health Organization, 2008, p. 1). Social workers have long recognized that health inequities originate in the social determinants of health—the social, economic, and political conditions that influence life chances (Walters et al., 2016). Improving these conditions is squarely situated within the purview of social work. Reflecting this commitment, one of social work's Grand Challenges is to "Close the Health Gap." Closing the health gap refers to intervening at individual, community, and societal levels to not only increase access to healthcare but also to address the social determinants of health and eliminate health inequities. Health inequities—the avoidable, unfair, and unjust differences in health status that persist across racial, class, gender, and other social categories—are some of the most compelling and critical challenges to overall social equity (Whitehead, 1991). Furthermore, this Grand Challenge underscores the need to shift from the biomedical model's emphasis on individual behavior change to a social model of care that addresses root causes of health and health inequities (Walters et al., 2016). To do so, social work scholarship must draw on a rich tradition of frameworks that link a critical analysis of health inequities with an analysis of root causes in social, political, and economic forces (Spencer, Walters, & Clapp, 2016). In this paper, we argue that addressing root causes and closing the health gap will require the integration of knowledge and practice that hitherto have not been central to the social work canon—and that reproductive justice is a valuable framework to employ in service of this goal.

Rooted in human rights, reproductive justice is an intersectional social movement, theory, and praxis (Luna & Luker, 2013; Ross, 2017). Throughout the history of the U.S., white supremacy

has undergirded reproductive oppression, from the forced reproduction of enslaved women to the forced sterilization of those seen as “unfit” to reproduce (Ross & Solinger, 2017). This history animates reproductive justice, conceived of in 1994 by Black women frustrated with mainstream feminist rhetoric around individual reproductive “choice” and singular focus on abortion access. In contrast, their communities faced immense constraints in making the choice to parent due to deep-seated structural and social inequities and, as a result, contended with tremendous barriers to raising children with safety and dignity (Ross, 2017). At its core, reproductive justice is concerned with upholding the right to have children, to not have children, to parent with dignity, and to sexual and bodily autonomy. As such, achieving reproductive justice extends far beyond personal choice around abortion to fights for racial, gender, economic, and environmental justice; comprehensive immigration and prison reform; and universal access to affordable, high-quality healthcare throughout the life course.

Both social work research and reproductive justice share a commitment to furthering and shaping knowledge and practice towards a more equitable society. Moreover, reproductive justice aims to shift power and leadership to the communities most affected by reproductive oppression and to create sustainable and systemic change. Despite its pertinence and alignment with the *Code of Ethics* (NASW, 2017), social work remains largely absent from many key contemporary struggles for reproductive justice. These struggles include advocating for repealing the Hyde Amendment, which specifically restricts abortion access for publicly insured individuals, thereby perpetuating health disparities since its passage in 1976 (Adashi & Occhiogrosso, 2017).

Additionally, recent revisions to Title X—the federally funded family planning program—widen the health gap, disproportionately affecting low-income, adolescent and racial ethnic/minority patients (Hasstedt, 2019). With these revisions, Title X grantees are no longer required to provide patients non-directive pregnancy options counseling. Moreover, they are

prohibited from providing or making referrals for abortion care—a provision that led Planned Parenthood to withdraw from the program. The rule also requires that either physicians or advanced practice clinicians (e.g., nurse practitioners or physician assistants) provide all pregnancy options counseling, meaning that social workers can no longer provide this care. NASW (2018b) issued comments in opposition to this rule. However, the provision that directly affected social workers' ability to provide reproductive care was not mentioned.

Furthermore, the U.S. currently faces unconscionably high rates of adverse infant and maternal health outcomes, with Black and Native American women and their infants bearing a disproportionate burden (Lorenz, Ananth, Polin, & D'Alton, 2016; Petersen et al., 2019). A body of social work scholarship has focused on maternal and child health inequities (e.g., Hans, Edwards, & Zhang, 2018; Tabb et al., 2019; Yu & Sampson, 2016)), and social workers had an important role in reducing rates of infant mortality in the early 20th century (Almgren, Kemp, & Eisinger, 2000). Yet, as maternal health is seen as a litmus test for the overall functioning of a healthcare system (United Nations Population Fund, 2009), the level of focus on this topic in social work scholarship is not commensurate with the importance and urgency of this health gap.

Recognizing the need for additional knowledge, practice, and advocacy to advance equity, a growing body of social work scholarship calls for a greater commitment to reproductive justice within social work education and practice (Beddoe, Hayes, & Steele, In Press; Begun, Bird, Ramseyer Winter, Massey Combs, & McKay, 2016; Begun, Kattari, McKay, Winter, & O'Neill, 2017; Liddell, 2019). Here, we seek to build upon these calls from social work scholars and offer an intersectional perspective on health inequities through the lens of reproductive justice. Reproductive justice not only centers the health needs of women and gender expansive individuals but also offers a framework for gender justice. By highlighting the ways in which social work can attend to gender and health equity and advance reproductive justice, we aim to bolster social work's ability to close

the health gap, foster health equity for all people, and engage with critical aspects of the human experience that are largely neglected by the field.

Reproductive Justice: A Framework, Movement, and Praxis

Reproductive justice is a "theory of the flesh" (Moraga & Anzaldúa, 2015): a framework, movement, and praxis born out of necessity that recognizes the myriad ways certain bodies have been persistently engaged as battlegrounds of coercive, destructive, disciplinary power (Jolly, 2016; Luna & Luker, 2013). At its core, reproductive justice recognizes how multiple, shifting experiences of oppression differentially shape access and inclusion, social-ecological well-being, bodily autonomy, and deemed parental fitness—foregrounding the tensions that necessarily emerge in the fight to both bear or *not* bear children, and to raise them or *not* raise them, with safety, sustainability, and dignity (Jolly, 2016; Ross & Solinger, 2017). Both the absence and pursuit of reproductive justice are lived and viscerally felt by groups intersectionally and disproportionately subjected to structural violence: Black, Indigenous, and women of color; poor women; queer and transgender people; young women; (im)migrant and refugee women; incarcerated and institutionalized women; and women residing in rural areas, with disabilities, experiencing homelessness, and who use substances (Jolly, 2016; Ross & Solinger, 2017). Despite this marginalization, these groups have rallied to demand justice and well-being for themselves, their families, and their communities. While social workers devote much of their effort to serving these same communities, the field has failed to sufficiently center reproductive oppression as a key target for intervention and disruption (Alzate, 2009; Liddell, 2019; Smith, 2017).

One example is the intersection of reproductive and carceral (i.e., of criminal justice or imprisonment context) oppression. Ongoing, brutal criminalization and pervasively racist enforcement and judicial systems have reaped incomprehensible violence on Black and Brown communities—resistance against which has been the very genesis of the reproductive justice

movement (D. Roberts, 1997; Ross, 2017). The reproductive consequences of over-incarceration and over-policing are innumerable. Systemic over-surveillance and violence lead to chronic vigilance and fear, with adverse physiological and mental health effects (Alang, McAlpine, McCreedy, & Hardeman, 2017; DeVylder et al., 2018); to the assault and murder of family and community members; to parents bearing responsibility for controlling their "delinquent" or "at risk" children, while fighting to keep them alive, at home, and healthy under critically under-resourced conditions (Elliott & Reid, 2019; Ross, 2017). Targeted over-incarceration—enmeshed with the wars on poverty and drugs, and the criminalization of pregnancy—perpetuate reproductive oppression. Manifestations include lack of appropriate access to abortion, prenatal, and other sexual and reproductive healthcare while institutionalized; dehumanizing practices such as shackling during childbirth; and parents struggling to maintain relationships with their children due to distance and enforced child welfare involvement (Flavin, 2008; Hayes, Sufrin, & Perritt, 2020). The inequities experienced by incarcerated women of color are, of course, extensions and effects of (gendered, racist, classist, ableist) strategies of reproductive control waged against non-incarcerated marginalized women (Ahrens, 2015). For example, while incarcerated individuals have been subject to coercive sterilization and fertility control as recently as 2016 in Tennessee (Adams, 2018), other populations deemed "high-risk"—including low-income women, young women, and women of color—are steered towards long-acting reversible contraceptive methods through counseling strategies that privilege "undesirable" pregnancy prevention over reproductive autonomy (Gómez, Fuentes, & Allina, 2014).

Similarly, oppressive immigration law enforcement leads to targeted family fragmentation, denied access to abortion while in detention, exclusion from or fear of accessing health and social services, and increased adverse birth outcomes (Fleming et al., 2019; Novak, Geronimus, & Martinez-Cardoso, 2017). Early 2018 saw a devastating example of such reproductive oppression,

with the U.S. government's "malicious and unconscionable" zero tolerance immigration strategy forcibly separating thousands of children from their border-crossing or asylum-seeking families (de la Peña, Pineda, & Punsky, 2019; NASW, 2018a). While adult caregivers faced immediate criminal prosecution and deportation, children were detained under appalling conditions, without reunification plans, and required to appear unaccompanied at their own immigration hearings. U.S. social workers widely condemned the strategy as unethical, "cruel and inhumane"—collectively advocating alongside activist groups, politicians, and other professional allies for rescindment and reunification. However, such calls to action lacked a reproductive justice lens, rendering invisible a long trajectory of white supremacist, colonial, and ethnocentric reproductive control (NASW, 2018a).

Social Work and Reproductive Justice: Tensions and Opportunities

In adhering to the profession's *Code of Ethic*s, social workers are charged with centering their practice around the preservation of human rights; the pursuit of social justice; the promotion of clients' well-being and self-determination; and the provision of comprehensive, unbiased knowledge of all available resources and supports to clients (NASW, 2017). Each of these tenets is inextricably interwoven with core principles of reproductive justice. However, research suggests that many social workers lack basic knowledge of reproductive and sexual health resources and policies, even when they support abortion rights (Begun et al., 2016; Begun et al., 2017). Social workers' lack of knowledge impedes clients' awareness of—and, thus, *access* to—the array of services to which they are legally entitled, including abortion and contraceptive services, pregnancy options counseling, STI/HIV testing and treatment, and confidential services for minors.

This dearth of social workers' practice-based competencies may be explained, in part, by the lack of accreditation requirements—much less recommendations—for social work programs to include education on sexuality or sexual and reproductive health (Council on Social Work

Education, 2015), despite social workers' regular interactions with clients in this realm (Winter, Kattari, Begun, & McKay, 2016). These are crucial gaps to address, especially as research suggests that when social workers lack knowledge or perceive a topic to be morally or socially contentious, they may be more likely to advise clients based on personal values and opinions— rather than social work's professional ethics and standards—and they perceive themselves as being unlikely to be able to provide referrals for critical services, including abortion (Winter et al., 2016). As a result of these deficits, social work has faced an inability to engage in adequate advocacy in this area. For example, under the current iteration of Title X, social workers are not permitted to provide even the most basic pregnancy options counseling to clients, a standard best practice across health professions that necessarily adheres to principles of social and reproductive justice for the 3.9 million people served by the program annually (Hasstedt, 2019; Janiak, O'Donnell, & Holt, 2018; Office of Population Afffairs, 2019).

In order to foster contemporary engagement with the reproductive justice movement, social workers can draw from historical examples of social worker leadership efforts aligned with reproductive justice principles. In particular, the Settlement House model of the Progressive Era sought to improve not only the physical health of newly-arrived European immigrants but also the structural conditions that influence health outcomes (Addams, 2008). As noted in 1928 by Thyra J. Edwards—Black social worker, labor organizer, and Civil Rights pioneer—social work was uniquely positioned to link family welfare, health, and social inequity; shift blame from the individual client; and indict "the political economy that creates these conditions of mass unemployment and its attendant malnutrition, disease, overcrowding...and family disintegration" (Andrews, 2011, p. 79). To combat oppressive forces within social work and expose the structural racism behind such practices, many Black and Indigenous social workers participated in social movements such as the Black Power Movement (Bell, 2014) and the American Indian Movement

(Day & Campbell, 2015). These social workers exemplify participation in a vision for family health and well-being that uplifts families of color and dismantles structural inequities.

Further, many social workers have long understood reproductive health and rights—including maternal, child, and family well-being—as instrumental to an equitable society (Alzate, 2009). To this end, one of Hull House's first programs was a kindergarten and nursery (Addams, 2008). A separate space for mothers to rest and convene proved generative for women to participate in community advocacy, public health campaigns, trade union organizing, and lecture tours. Through this and similar programs, early social work honored and supported the reproductive lives of many poor, working-class, immigrant women at a time when their family planning decisions were surveilled, stigmatized, and policed by mainstream medical and political institutions (Bridges, 2017).

However, the historical contribution of social work in advancing reproductive justice is uneven (Alzate, 2009). Settlement Houses largely excluded Black women and families, leading Black social work leaders of the Progressive Era to form their own organizations, including Black-owned and operated hospitals. Their programs focused on addressing poverty and racism, particularly on the need for Black women and mothers to have employment opportunities, services, healthcare, and cultural programming designed for and by them. Unlike their white counterparts, these social clubs incorporated working-class, tenant farm, young, and poor women as members.

Additionally, some early social workers—even those at Hull House—were complicit or actively participated in the Eugenics movement by incorporating notions of "unfit" or "degenerate" motherhood and womanhood in social work assessment, case management, public policy, and scholarship (often on no other grounds than women being sexually active, young, poor, disabled, or non-Anglo-Saxon; Kennedy, 2008). Social workers promoted coercive contraceptive and sterilization practices in Puerto Rico between 1930 and 1970, failing to acknowledge their role in

service of U.S. imperialism and social control of poor and working-class women (Briggs, 2002). Furthermore, some social workers have relied on bias and stereotyping, instead of person-centered values, when serving as gatekeepers to health and family welfare resources—discriminatorily surveilling sexual and reproductive choices as a pretext for services. Legal scholar Dorothy Roberts (1997, 2009) notes the legacy of disproportionate involvement of children of color in the child welfare system, particularly Black and Indigenous children, exacerbated when social workers unjustly report clients' male partners to the police or unnecessarily remove children from parents. Given contemporary and historical patterns of perpetuating oppression, the reproductive justice framework provides a path forward for social work practice and scholarship that promote, instead of hinder, reproductive freedom.

The Criminalization of Pregnancy: A Key Example at the Intersection of Social Work and Reproductive (In)justice

The criminalization of pregnancy refers to the punishment of pregnant people for actions interpreted as harmful to their pregnancies (Flavin, 2008). Criminalization has become particularly pervasive in the U.S., with increasing state laws and overzealous and inappropriate enforcement measures that punish pregnant people for a range of actions, including substance use, miscarriage, experiencing violence during pregnancy, abortion seeking, and abortion outside the healthcare system (Amnesty International, 2017; SIA Legal Team, 2018). In 2019, the case of Marshae Jones, an Alabama woman who was shot in the stomach and charged with manslaughter for "initiating a fight knowing she was five months pregnant," drew national attention (Stockman, 2019). This case highlights what legal scholar Michele Goodwin (2014) describes as a "recent era of maternal policing, in addition to inspiring (and sometimes requiring) medical officials to breach their duty of confidentiality in the treatment of pregnant women" (p. 789).

Criminalization of pregnancy is proliferating in two primary ways. First, the ever-growing expansion of restrictions on abortion access increasingly seeks to punish pregnant people for seeking or obtaining abortion. As we are writing this manuscript, Ohio has proposed legislation that would make obtaining an abortion or participating in abortion provision a (potentially capital) crime, with no exception for rape or incest. The proposed law also requires doctors to re-implant an ectopic pregnancy in the uterus, a medically impossible feat (Epstein, 2019). Other states have recently proposed similar legislation that effectively bans abortion by making it illegal after six weeks, when many pregnancies have not yet been recognized (Gordon & Hurt, 2019). These types of laws have, thus far, not been allowed by the courts to stand; if such restrictions are enacted, people without financial resources to travel out of state would be left without any access to legal abortion. With increasing barriers to abortion access, pregnant people are managing abortion outside of the healthcare system. While this may invoke the image of an unsafe, "back alley" abortion, a contemporary self-managed abortion is more likely to involve ordering and taking medication abortion pills through the Internet, a practice that the best evidence suggests is safe (Aiken, Digol, Trussell, & Gomperts, 2017). States have enacted legislation specifically designating self-managed abortion as illegal, as well as used fetal harm and criminal abortion laws and other strategies to punish pregnant people for self-managed abortion (SIA Legal Team, 2018).

Second, substance use before or during pregnancy can lead to criminalization, with some states' laws designating substance use during pregnancy as child abuse, and others' relying on broader child abuse, fetal abuse, and fetal protection laws. A lack of treatment options for pregnant people facilitates punishment for substance use (Amnesty International, 2017). The criminalization of substance use during pregnancy disproportionately affects women of color—that is, it creates health and healthcare disparities (Bowers et al., 2019; Paltrow & Flavin, 2013). For example, research on prenatal drug testing finds that Black women have a higher likelihood of being tested

for drugs during pregnancy than white women; while they are no more likely to screen positive, Black infants are more likely to be reported to child protective services than white infants (S. Roberts & Nuru-Jeter, 2012).

Social workers' roles, particularly in the hospital setting, can position them as participants in this criminalization, through the reporting of clients to law enforcement and the child welfare system (Goldensohn & Levy, 2014; Paltrow & Flavin, 2013). In this way, social workers and the healthcare institutions in which they work can contribute to widening, rather than closing, the health gap. There is no legal requirement that mandates reporting of self-managed abortion, and drug testing and reporting of a positive drug test during pregnancy varies significantly by state. In both cases, however, social workers and other healthcare providers have the discretion to create scenarios where clients' physical and mental health and overall well-being is harmed, and that incentivize clients to avoid care for fear of prosecution or child welfare system involvement (Stone, 2015). For example, social workers are professionals included in networks built by prosecutors to locate pregnant people using substances, who are given the "choice" of entering substance use treatment or facing jail time (Howard, 2017). For social work, reproductive justice foregrounds the tension between participation in disciplinary surveillance and advancing social justice. In service of the latter, social workers have an important role to play in rolling back legislation that perpetuates the criminalization of pregnancy, ensuring that abortion care and substance use treatment are available to all clients, being equipped as practitioners to make necessary referrals, and understanding and intervening upon multi-level policies that exacerbate health inequity.

Advancing Reproductive Justice to Close the Health Gap: Praxis for Social Work Scholarship, Policy Advocacy, and Practice

As a theory, movement, and praxis, reproductive justice suggests an expanded vision for social work—bridging the persistent analytic and practice gaps that occur when social workers miss

the connections between reproductive freedom, family welfare, and client autonomy. Here, we offer suggestions for engaging a reproductive justice lens in scholarship and practice, as a means of bolstering the field's enduring commitment to closing the health gap.

Social work scholarship to advance reproductive justice. As noted in the opening quote of this article, the social and structural determinants of reproductive autonomy and family well-being are reflective of a society's values and priorities (Brennan, 2001). In this way, social work scholars should be leading the charge, with the field well-poised to offer solutions to advance health equity and reproductive justice (with the scope of scholarly topics outlined elsewhere; see Alzate, 2009 and NASW, 2018c). Notably, advancing reproductive justice requires privileging those voices and perspectives most impacted by reproductive oppression and countering approaches that perpetuate epistemic injustice (i.e., privileging some knowledge and knowledge production over others; Paphitis, 2018). Through the co-creation of knowledge with clients and communities, social work can develop its scholarly footprint in a way that is aligned with reproductive justice and social work values. Such scholarship requires the use of participatory, power-conscious approaches throughout the research process, including: transparency in budgeting; sharing of funding and other resources; community member participation in data collection, analysis, and interpretation; and intentional dissemination approaches that enable community-serving transformative action (Ibis Reproductive Health, 2020). Conducting research in this way ensures that knowledge about health inequities, and solutions generated from findings, are grounded in the needs and lived expertise of those most impacted by reproductive injustice. Such knowledge will allow the field's scholarship to truly advance social justice in our efforts to close the health gap.

Policy advocacy to advance reproductive justice. Social work's potential in advocating for policy to advance reproductive justice has not been realized (Beddoe et al., In Press). Without a reproductive justice lens, the traumatic roots and systemic impacts of existing policies remain

unacknowledged and unaddressed (Smith, 2017). For example, NASW (2018a) formally denounced the U.S. government's zero tolerance family separation policy as "wholly un-American." Yet, this response had the effect of obscuring a complex, brutal legacy of such practices—from the barbaric fragmentation of Black families during slavery, to the cultural genocide of Indigenous people via Indian Residential Schools, to contemporary manifestations of these same strategies through various forms of mass incarceration and child apprehension (NASW, 2018a; Williams, 2018). Furthermore, a reproductive justice lens makes critical linkages between ongoing social work advocacy efforts, such as the Grand Challenges to "Promote Smart Decarceration" and "Close the Health Gap," and informs crucial, yet notably absent, gender-based outcomes of this advocacy, such as necessary access to reproductive care while incarcerated. Although the NASW (2018c) has recently renewed its commitment to reproductive justice at the federal level, many policies that perpetuate reproductive oppression occur at the state or institutional level (e.g., restrictions on abortion access, fetal protection laws that criminalize pregnancy, sexuality education policies, refusal of Catholic hospitals to provide aspects of reproductive and transgender healthcare). Social work's engagement in advocacy to advance reproductive justice at the institutional, local, state, and federal levels would expand the field's contribution to advancing health equity, as well as bring the strength of social work's analysis to debates already engaging disciplines that do not have an explicit commitment to social justice (e.g., medicine).

Social work practice to advance reproductive justice. Social workers must address inequities in sexual and reproductive health through practice responses and policy reforms that align with the principles of reproductive justice and the *Code of Ethics* (NASW, 2017). Of utmost importance are trauma-informed, human rights-centered practice responses that mandate the provision of unbiased referrals and resources (Ely, Rouland Polmanteer, & Kotting, 2018), and promote frameworks such as structural competency—which underscore the connections between

direct practice, social and structural determinants of health, and historical injustices (Downey & Gomez, 2018). Engagement with reproductive justice can help social workers shed light on structural barriers to sexual and reproductive health, address their own biases around reproduction, and understand the legacy of reproduction oppression in the U.S. and in the field of social work. This is critical for interventions to close the health gap, as such interventions may actually perpetuate reproductive oppression. For example, racialized discourses around "teen pregnancy" (Geronimus, 2003) may lead school social workers to promote long-acting reversible contraception without consideration of students' preferences and needs (Gómez et al., 2014). A reproductive justice perspective highlights the necessity for non-stigmatizing, comprehensive sexuality education and accessible, client-centered contraceptive and abortion care, as well as structural supports for young parents to thrive. In the broad context of closing the health gap, reproductive justice also foregrounds the need for high-quality care to support dignified fertility management and childbirth—particularly in the context of increasing restrictions on abortion and contraceptive access, and the maternal mortality crisis among Black women.

Conclusion

The Grand Challenge to "Close the Health Gap" represents a timely and necessary commitment to harness social work praxis to create lasting health equity for all. Due to the absence of a gender-conscious analysis, this Grand Challenge, and associated scholarship and practice, run the risk of perpetuating reproductive oppression. This failure reflects social work's broad complacency with regards to reproductive freedom, despite the field's commitment to dignity, autonomy, and social justice. Incorporating the reproductive justice framework—which links racial, gender, and health justice with human rights—into the scholarly and practice questions of this Grand Challenge has the potential to advance the social work models (e.g., feminist, empowerment-based, anti-oppressive) that are best suited to address the health gap. Because questions of gender

and reproductive justice can be sidelined even in pursuit of overall health justice, it is imperative to incorporate a social movement and a framework that centers the knowledge and experiences of under-resourced communities. Bringing reproductive justice to bear on the Grand Challenge of closing the health gap deepens and strengthens our understanding of what it will take to truly achieve holistic health equity for all.

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