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HANDOVER DIALOGUES

UN Special Rapporteur on the Right to Health

Notes from Dialogue

Sexual health and rights: intersections with reproductive justice, gender, and gender-based violence

Panellists:
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Enid Muthoni Ndiga, Senior Vice President Center for Reproductive Rights overseeing four regional programs based in Africa, Asia, Latin America and Europe, and the Center for Global Advocacy Work at the United Nations.
Ebenezer Durojaye, Professor of Law and the head of the Social, Economic, Social Economic Rights Project at the Dullah Omar Institute, University of the Western Cape, South Africa.
Saoyo Tabitha Griffith, legal and policy expert on health and human rights, Advocate of the High Court of Kenya.
Nyasha Chingore-Munazvo, human rights lawyer and gender activist at AIDS and Rights Alliance in South Africa.

Special Rapporteurs: Tlaleng Mofokeng (current) and Dainius Pūras (former).

Moderator:
Nkatha Murungi, Center for Human Rights, University of South Africa.

Organising partners: Center for Human Rights at the University of Pretoria, Human Rights Monitoring Institute, and the Human Rights Center at the University of Essex.

Nkatha Murungi: Welcome everyone to this fourth dialogue in the Handover Dialogue series. The topic is sexual and reproductive health and rights (SRHR), and is very much anchored in the priorities of the special rapporteur, Tlaleng Mofokeng, as highlighted in her initial report to the Human Rights Council. SRHR intersects with themes of colonialism and racism and the need for substantive equality. Before our panellists present on these topics, we have opening remarks from Dainius Pūras.

Dainius Pūras: The theme of this dialogue is of crucial importance, not only to the realization of the right to health, but to human rights in general. During my first year as Special Rapporteur, the global community was preparing the 2030 Agenda for Sustainable Development, and drafting the Sustainable Development Goals. So one of my first statements to global leaders was encouraging them to do more on sexual and reproductive health rights. And I should say, they had much more to do. Throughout my tenure, I used many different tools to promote these rights, including thematic reports, for example, in my report on the right to health and adolescence, and in another on the deprivation of liberty. In almost all my 11 official country missions, and in many other meetings around the world, I raised these issues of sexual and reproductive health rights, gender-based violence, and discrimination on the basis of sexual orientation and gender identities, and the discussions were very insightful. I met not only resistance, but also passionate and courageous people like our panellists and participants today. And this is, as we know, the field of human rights defenders, even if it is health care and global health. But it is a risk-taking field and we know it should not be so. I remain convinced that the title of this mandate should be changed to the right to physical, mental, and sexual health.

Sexual health is so extremely important. During my tenure, I tried to address these rights in my own way, starting by going to schools to speak with teenagers about sexuality education. We know that in many countries there are many obstacles to the right to sexual and reproductive health, although there are also good things happening. However, many experts in these fields doubt that it would be possible now to pass the declarations of Cairo and Beijing, that were adopted 27 years ago, because there has been regress. The populist governments use the so-called “traditional family values” when they attack human rights in general. Their beliefs are against not only LGBT rights but also the rights of family members such as children and women.

So I’m happy the mandate has been passed on to Tlaleng, who, as a woman from the Global South, brings her lived experience and medical and human rights expertise to these issues.

Nkatha Murungi: I invite Enid to lead a discussion on the global context related to SRHR, particularly in the wake of responses to COVID-19. What are the opportunities and imperatives related to SRHR in the world at the moment?

Enid Muthoni Ndiga: I’ll start off by saying that at our center, we use law, policy, and human rights as tools to expand access to sexual health rights, especially in restrictive environments. But recently we have been seeing these tools used for the opposite effect. I have enjoyed a long standing and solid partnership with all the mandates on the right to health and have seen the significant strides they have made in terms of setting normative standards for the right to health and especially on SRHR. And we look forward to continue working with the mandate, particularly now, because we see many opportunities for the mandate to expand access to SRHR and to help defend our human rights defenders.

In terms of the current global context, I speak to three main things.

Firstly, the response to the COVID pandemic has resulted in backlash and regression at the global level which then permeates into regions and countries. This constrains the space for SRHR, both for recipients of services, the right holders, and also for service providers, especially the ones are offering abortions and services to adolescents. The impact of these regressions is greatest on groups that suffer intersectional discrimination: gender, disability, poverty, and other vulnerabilities. One of the biggest concerns we have right now are governments who are regressing on SRHR obligations and restricting abortion through legislative processes. Judiciaries are being co-opted to uphold anti-SRHR claims. There have always been

groups that are opposed to abortion, but their impact would not be as huge if we had governments, decision makers, and policymakers who would give judgments or decisions based on international rights standards. There have been attempts to roll back on abortion access in many countries around the world. We've seen women suffering and being incarcerated because of the absolute criminalization of abortion.

But there is global opposition to the regression and repression. This opposition is organized, united, and emboldened. It has been active in global political forums, including UN forums, and has spoken out about the rising religious fundamentalism and populism.

Another critical trend is the co-optation and instrumentalization of human rights laws and mechanisms; we are seeing the language of rights being co-opted, for example by claiming there is a "right to life" before birth. Such proponents argue that restrictions against abortion are necessary to protect women's health or to protect children. Similar arguments are used to oppose adolescents' rights to access SRHR, and these have been led in some places by religious actors, sometimes supported by foreign organizations, trying to litigate for "fetal rights".

It has also been concerning to see some regions, for example, Europe, with cases coming to the human rights mechanisms and courts asking them to allow medical professionals to refuse abortion care under the right to freedom of thought, conscience and religion. We push back on these cases and trends, but we fear these arguments will spread to other regions.

Finally, we are very concerned that women continue to die from preventable maternal death, and pregnant women continue to suffer mistreatment and abuse around the world. COVID-19 exacerbated preexisting barriers to maternal healthcare. We saw that states failed to classify SRHR services, including abortion, as essential services in the pandemic, which meant they became inaccessible, especially to the most marginalized. Those good practices which were implemented, for example, telehealth, need to continue after the pandemic. The barriers to SRHR services are always greater for girls, adolescents, Indigenous women, and Black women in America. But this also presents an opportunity to work together, to learn from each other, and to overcome these global problems.

Nkatha Murungi: I now welcome Professor Charles Ngwena, and ask him to reflect on intersectionality and abortion. We have noted the progress that has been made at the UN level, at the normative level, in relation to the issue of access to safe abortion. How can the UN, and the Special Rapporteur, push towards domestic implementation, and especially with the use of medical and self-managed abortions? Secondly, how can this mandate can promote sexual autonomy of adolescents and adults with intellectual disabilities?

Charles Ngwena: Let me begin by saying a few things about abortion, to acknowledge the work of previous mandate holders, in particular the work that they did to highlight the inequitable impact of criminalization of abortion. But I also want to reflect on what else can be done beyond working towards the decriminalization of abortion. In other words, I'm suggesting that the glass is half full. Decriminalization should remain an important goal but we need to note the enormous progress that has been made, in particular by treaty monitoring bodies, in developing a normative framework for thinking about the right to abortion as a human right. But fulfillment of these rights is missing and we need to focus on this, on what is permitted under domestic laws and on whether abortion laws are being implemented in ways that are nondiscriminatory.

For example, there are many countries that allow abortion on the grounds of risk to health. But in practice, the regulations make it very difficult for all women to access a lawful abortion, because of the discriminatory

nature of these regulations. We therefore need to focus on ensuring the current laws are implemented in ways that are non-discriminatory. We saw that COVID-19 provided opportunities to make abortion more accessible in several countries, but it was used in conservative or religious jurisdictions to restrict access to abortion, including in the United States.

Disability is an important intersection in SRHR. Women with disabilities are often denied the right to make their own decisions about reproductive health. The Convention on the Rights of Persons with Disabilities, which acknowledges in article 25 the right to sexual and reproductive health, and importantly, has provisions in article 12 about legal capacity. A challenge for the mandate would be how to operationalize the right to health to protect women and girls with intellectual disabilities from rights violations around coercion. We need tools to operationalize these rights, and especially for people with intellectual disabilities.

Nkatha Murungi: Professor Ebenezer Durojaye will now reflect on the issue of sexual violence, particularly in relation to the global and regional normative frameworks relating to sexual violence. What are these standards and how can the mandate use these mechanisms?

Ebenezer Durojaye: There are various international instruments with provisions that are useful in addressing gender-based violence and sexual violence. Each of the rights to life, health, non-discrimination, dignity, and to be free from inhuman or degrading treatment is useful. Over the years treaty monitoring bodies have developed greater clarification and guidance on this aspect of the enjoyment of sexual and reproductive health; for example, CEDAW General Recommendations 19 and 35 on violence against women. These have helped frame gender-based violence as discrimination against women, and a hindrance to their enjoyment of social rights. General Comment 30, relating to women in conflict, made a strong statement that non-state actors can be held accountable for sexual violence against women during the period of conflict, which is a radical advance on who can be considered a duty bearer.

The UN human rights system appears to be showing a greater commitment to the issue of gender-based violence. The UN special rapporteurs on violence against women, on torture, on the right to health, and more recently, the UN independent expert on gender identity and sexual orientation, have all delivered reports that link gender-based violence, sexual violence, and enjoyment of sexual reproductive rights.

In Africa the Maputo Protocol is often celebrated as one of the most valuable and progressive human rights charters. Yet at national levels, there are challenges in operationalizing it to address gender-based violence. This is where the role of civil society is very important to translate women’s rights at grassroots levels.

Nkatha Murungi: Saoyo Tabitha is invited to comment on forced sterilization.

Saoyo Tabitha: Reproductive coercion is a broader topic than forced sterilization, but because we are time limited, I will refer just to the practice of forced and coerced sterilization to demonstrate the reproductive rights violations that arise from reproductive coercion more generally. Although sterilization can be an acceptable form of modern contraception when performed with the full, free, and informed consent of the patient, it has been forced on women and populations to deny them the chance of having children. It has been used on persons living with HIV, persons living with disabilities, women of a different sexual orientation, and on indigenous people and ethnic minorities. These practices happen in societies that characterize HIV, disability, or sexual orientation as either a personal tragedy, a curse, or a medical condition that can be treated.

There are about six or seven countries in Africa where coercion is still occurring today. In Namibia and

Kenya cases have been brought against both the government and private medical practitioners. Cases are documented but not yet litigated in Uganda, and the practice is frequently documented in South Africa, Lesotho, and Swaziland.

Forced and coerced sterilization demonstrates intersectionality in terms of people's vulnerability to these violations. People living with disabilities, women living with HIV, indigenous or ethnic minorities, women of a different sexual orientation, those living in poverty, and women lacking education or unable to read are most likely to be victims of coerced sterilization. There are three conditions that increase the use of this practice: health care providers prepared to be involved in the sterilizations, no accurate information available to the women who need it, and no informed consent obtained.

Cultural issues make this practice difficult for women in Africa to talk about it. But the practice is rife and it will be challenging for Tlaleng to document it when, in Africa, talking about being barren or talking about inability to have a child is extremely difficult. It is also difficult to capture data about forced sterilization in intersex people who may have been sterilized at birth, with the decision made by a parent, a guardian, or a medical provider.

Nkatha Murungi: Finally, Nyasha Chingore-Munazvo will discuss key lessons from global health and human rights responses to HIV over the past 40 years and meeting the 2030 global HIV target.

Nyasha Chingore-Munazvo: I will start by acknowledging the progress on HIV that previous mandate holders achieved. We've seen their reports on the right to access medicines, on informed consent, criminalization of HIV, and on same sex relationships. In terms of the lessons, we have of course learned that we need to adopt a human rights-based approach to HIV and we need to address structural barriers, especially as they affect marginalized and vulnerable persons. UNAIDS has just released a report showing that countries with progressive laws and policies and inclusive human rights-based health systems have had better outcomes for HIV.[1]

The 2020 UNAIDS global update showed that new infections are highest amongst key populations. When we fail to protect vulnerable and marginalized populations, including adolescents, women, and young women, what we're choosing to do is to delay progress in ending the pandemic. The Aids and Rights Alliance for Southern Africa and our partners across 18 countries in East and Southern Africa have learned the importance of protecting the rights of bodily autonomy and integrity, that this is integral to addressing HIV. It includes acknowledging the evolving capacities of adolescents to make decisions on HIV prevention, treatment, and care. UNAIDS data tells us that adolescents aged between 15 and 19, particularly girls in Sub Saharan Africa, are extremely vulnerable to HIV. So I want to emphasize that we cannot end HIV without achieving universal access to comprehensive SRHR, including sex education, safe abortion, and addressing gender-based violence.

Despite this, some states want to separate HIV from SRHR. We know that in addition to stopping stigma and discrimination, we also need to achieve equality and equity. These two conditions really matter. We know that it was not the scientific breakthrough on ARVs that shifted the trajectory on HIV; it was making treatment affordable and accessible for communities that was the breakthrough. Interventions led by people living with HIV in key populations actually begin to shift things within communities. We need to ensure that HIV remains funded and this goes to community-led initiatives and human rights-based programs.

Addressing socioeconomic inequalities, and reducing regional disparities is critical, not just for HIV, but also for affordable and equitable access to COVID-19 vaccinations.

Nkatha Murungi: I now invite Dainius Pūras and Tlaleng Mofokeng to reflect on the issues the panellists have raised.

Dainius Pūras: The excellent presentations from the panellists have had me reflecting on the last six years and especially on the country missions, which are so important. There was, for example, a dramatic challenge during my country mission to Paraguay. At that time, there was a high-profile case of a 10-year-old girl who had been raped and was forced to maintain the resulting pregnancy and enter motherhood. I had difficult conversations with the government officials there, but even more difficult were conversations with my colleagues, medical doctors, the majority of whom supported the position of government and said the girl was doing well and that there was nothing wrong with her mental or physical health. I am not blaming my colleagues, but I was wondering why we had such different perspectives. Is it about this dual loyalty? Or is it cultural? So when I work on country mission reports, I think less about how the government will react, and more about how civil society will react. Civil society will criticize the report if it is not strong enough, not critical enough. They are usually our best allies. I am concerned about the current attacks on civil society space and the pandemic is also creating different problems for civil society: it can help revitalize universal human rights principles, including and especially SRHR. And it can sadly contribute to further regress. We have to do our best to promote universal human rights principles and sexual reproductive health rights.

Tlaleng Mofokeng: One of the issues that stands out for me is that of protecting human rights defenders. We've seen, globally, how many people have been jailed or killed for being vocal defenders of human rights. During COVID-19 some states have advanced laws that restrict abortion access, knowing that civil society has been unable to organize to oppose such changes.

The issue of refusal of care, and the idea of conscientious objection, when it comes to abortion, is a weird thing. For example, as a practicing doctor, if I decided that I'm not going to treat any people who come to the casualty with alcohol-related accidents on the grounds it is against my religion to drink, I wonder what kind of response that would get? I think the world we live in generally wants to punish a woman, for not birthing, or for being pregnant. So we see that this issue of conscientious objection based on religion features strongly in abortion care, but it's only in abortion care. In trauma, I've never heard a trauma surgeon say they won't operate on a prisoner or a person suspected of having killed an entire family from drunk driving; this doesn't happen because doctors know the rights of patients. So I'm pushing back on normalizing this language of conscientious objection when it comes to abortion, because I see it as disobedient, unethical, and unprofessional. I see my clinical care and my practice of medicine as a protection of human rights; we know so many rights violations and abuses are happening especially in the area of SRHR.

In my upcoming report, I speak about the importance of dignity and bodily autonomy as central to SRHR. If you are living in a country, in a society, that is anti-gender, that doesn't see other people as human, and is anti critical race theory, I see that as an attack on dignity and bodily autonomy. Many on the panel have in different ways spoken to this. I plan to take forward the work done by previous mandates on the lifecycle and policy approaches to SRHR.

In South Africa during COVID-19 use of telehealth services increased to enable doctors and patients to connect virtually. We now have to be vigilant that these policy changes remain. We often talk about policies that we don't want, but now we have an opportunity to support a policy that we've seen in practice.

The intersection of disability and sexual reproductive health rights is important to me. And as Tabitha was saying about forced sterilization, we know that it's not just about health status. Forced sterilization on people who are HIV positive happens in South Africa and having a disability makes people even more vulnerable. I've

been working in collaboration with experts on disability in various programs, and I think the intersectionality approach is essential. If you look at all the different groups of people who are marginalized and made vulnerable, it's usually people of minority, migration populations, people with disabilities, Black people, and people of African descent, all over the world. We know the prevalence of Afro-phobia and xenophobia and so we have to embrace non-discrimination, and put an end to coloniality because it is the basis of the obsession with controlling and policing people. We can't move forward and talk about intersectionality without looking directly at, and naming, the issues for what they are, because we know that racism impacts on the right to health and well-being. But also, racism reinforces and enables other systems of oppression and so it's very important as we talk about SRHR as a whole, to really be cognizant and remember that there are many other issues that intersect and intersectionality demands of us to firstly name those systems and dismantle them.

The African Union has been disappointing in how resolution 275 of the Maputo Protocol on sexual orientation has not found expression in national policies. There are many countries in the African continent where people suspected of being homosexual are incarcerated. So although the resolution is really amazing, what is very disappointing is that it is not being translated into legislation, policy, or practice.

We need to consider all these issues within the broader context of the world and the societies that we are trying to navigate on a daily basis. I used to find it very frustrating as a medical student, and then an intern, that Black women, young Black woman, were communicated to in ways that were very disempowering. And I was one of these people. We were not looked at as people who were inherently possessing of dignity and the ability to make decisions for ourselves. It is as if the programmers, funders, philanthropies, and governments look at women as perpetual infants, as people who do not matter, and perhaps even sometimes who deserve the types of violence that they endure on a daily basis—whether that is structural violence, physical violence, sexual violence, or economic violence.

This view of women helps justify forced contraception and forced sterilization. It has also found its way into SRHR programming – a framing that justifies a call for women to sacrifice their interests for the rest of society, and that governments are authorized to make these calls on people's behalf. The approach is sometimes called ecofascism; this ideology is not being identified adequately when we are interrogating programs around SRHR, and around HIV prevention, that are targeting people on the African continent. It is always the minority groups who are blamed for the decrease in resources, for the inability of the environment to sustain everybody, and for overpopulation. This framing helps justify forced contraception and forced sterilization.

I have been, for a long time, a sexuality health communicator and educator. I was a peer educator in medical school and I implemented a program in the local clinics. I think there is a problem about societies that don't want children who are affirmed, who don't want children to know their rights, and who don't want children to know that their bodies are theirs. Those societies are full of predators. Those are societies where patriarchy is still very dominant and it suits certain people in society to maintain power over other people. Access to information is a human rights issue. When you talk about sexual reproductive health and the right to health broadly, it includes access to information and withholding information is denial of that right. I see the absence of comprehensive sexuality education as a gross human rights violation. In South Africa I have fought to get comprehensive sexuality education into schools, but faith and cultural leaders push back on that.

I speak with a lot of young people who are still stigmatized, because every time we talk about HIV, every time we talk about HIV transmission and prevention, it is presumed we are talking about sexual transmission. But a lot of young people, especially in Africa, are born with HIV; their parents are the ones who were let down by governments and health systems that did not change to provide them with information or care. These young people were raised by their grandmothers. They are the youth of today. And now they are further stigmatized,

because everyone associates HIV diagnosis with sexual contact and promiscuity. So even globally, we must think about HIV messaging and campaigns that are not just about prevention. Because for young people born with HIV, they need to know how to negotiate their own sexuality, their own relationships, issues of disclosure, and so on.

Finally, a comment on attacks on special rapporteurs, especially when they take certain positions on issues, including SRHR. Attacks on me started on the day that my appointment was announced. I had not made any formal comments and I hadn't even received my welcome letter. And already, there were opinion pieces and all sorts of things written about me, so, one can only imagine what will happen when my reports and interventions do start coming out.

While I absolutely believe in digital health and the potential it has for SRHR in general, I also understand that technology is not neutral. We know again, that surveillance and facial recognition is rooted in policing, and it sees Black people with certain features automatically as criminals. We need to talk about who is doing the coding in these digital technologies. Because if the people themselves are sexist, racist, ablest, xenophobic, homophobic, transphobic, then we will find these views will be embedded with that technology. And in closing, I want to advise that my upcoming general assembly report, will be dealing in-depth with digital health and digital rights.

Enid Muthoni Ndiga: I have a final comment on SRHR access in humanitarian settings. We are trying to ramp up this issue at the global level, because around the world people are being increasingly displaced, through conflict or natural disasters. One of the key gaps in humanitarian responses is access to SRHR. We need to make a full package of sexual health care available, including abortion.

Saoyo Tabitha: How do we hold states accountable in a space where increasingly space for civil society is shrinking? States are now pushing back, we have rising anti-gender movements, human rights language is being misused and weaponized. So how can we hold states accountable?

Participant question about COVID-19 and abortion: The pandemic has revealed how essential sexual reproductive health services are, but the specific question in relation to abortion is, how can we support human rights standards that create a legal obligation of states to guarantee access to abortion with no restrictions? Can we discuss abortion exceptionalism?

Tlaleng Mofokeng: All COVID-19 did was compound existing deficiencies and shifted resources from other departments, including SRHR, especially abortion, to COVID-19 response. Of course, reallocation is necessary when dealing with a global pandemic. But it signals that there were not enough health care workers in the first place. In those vulnerable health systems, if one nurse got sick or got exposed and had to quarantine, entire services collapsed, because there was only one nurse trained.

A lot of countries have curfews and the militarization of the COVID-19 response was problematic, because imagine being a 17-year-old, who survived rape, who is surviving violence in the home, who must then go meet up with an army personnel down the road to try to access an abortion. In South Africa, sometimes women have to save for two months to get transport money to get to a facility, just to be told that we don't do that here. And there is no accountability or consequences for the facility.

So for me the issue of COVID-19 and abortion centers around the lack of accountability. Firstly, for health care providers who violate other people's human rights, there is no accountability, and no consequences for departments of health, who do not actually have the budget and do not include abortion when they list SRHR

services. I've been to many local clinics where, as soon as you walk in, you see a long list of services, but not abortion. And because it starts with an 'a,' you would expect it to be right at the top. But the stigma and the discrimination is so entrenched that people will not even name the procedure. And the other thing is that if we are not collecting data, if we are not quantifying the scale of the issue, it becomes very easy for politicians to say, 'Well, you know, just ignore that it doesn't exist,' which then puts more pressure on civil society to produce the evidence and the data.

So it comes back to using the courts. I don't think civil society uses the courts as much as it should. I think some form of legal challenge on these issues would make a big difference. If we take it to the courts and demand that states are held accountable for realizing human rights that they have ratified, that could really advance SRHR fulfilment.

Participant question: In terms of accessing sexual and reproductive rights, all women continue to be invisible. So under this umbrella, including issues to do with, HIV/AIDS, or rights violating practices associated with widowhood, I ask Tlaleng what are some of the issues you have encountered with regard to sexual rights of older women?

Tlaleng Mofokeng: SRHR as they relate to older women are very important. I have decided to focus on reproductive cancers because I think they've been neglected over the years, and some, such as cervical cancer affect older women, and working on this issue supports the WHO declaration to eradicate cervical cancer. However, the mandate is just me and support staff, so we have limits in terms of what we can do and how far we can reach. That's why it's important to be thinking about collaboration, and looking at other UN agencies and the work that they're doing. Another aspect of SRHR for older women is that we hardly talk about pleasure for older women. And there is a shame, silence, and secrecy around older women who are sexually active. Because women outlive their husbands, we have a lot of widows. And in some societies, there are beliefs which violate many human rights of widows. There are many women, older women, who are dealing with poor health, and not being examined adequately, or asked about issues of pleasure, or cancer screening, or issues of abuse, and all of these are very important issues.

We also have to talk about the law. The law is a weapon and I don't think we're talking enough about that. We often talk about the law as if it's something that will just protect people, but in some instances, the courts are weaponized against people who are marginalized. We must be more intentional about how we use the independent experts' reports. The special rapporteurs can work together to maximise content and inclusiveness of our reports, but we can't control how far civil societies use these reports. We can't control how member states use these reports. But it is my wish that people can see themselves and their lived experiences in these reports—that they are not just academic.

In my view, there is no justice without intersectionality. In order to move people from areas of vulnerability, we have to re-center those people who have been in the margins. That's what intersectionality is about. It's about understanding how multiple layers of oppression actually express themselves in the individual.

All of my reports start from understanding if we can't, even as a global society, as a global community, in the global health architecture, name the structural issues, we can never get to intersectionality, and we can never get to justice. And that's the elephant in the room. No one wants to talk about why certain countries in the Africa region, Asia, and Latin America, are unable to actually sustain their own development and their own healthcare systems and why they're dependent on philanthropic aid. We have to talk about the extractive nature of capitalism and colonialism and what that enabled. We have to talk about the people like myself, who grew up in an apartheid era, in a Bantustan rural area, where even the land was not fertile enough for us to have a

sustainable food supply, and how that was intentional and legalized racism. There is no way that I can speak about intersectionality as a black woman right now, in the UN, and not come from that lived experience; that's who I am. I'm not academic about these issues. I also believe we must move away from this idea that we need to save people. No one wants to be saved, nobody needs to be saved. But we do need to be honest about how we got where we got to so that we can get to justice and intersectionality. That, for me, is the bridge to get to justice, whether it's economic justice, reproductive justice, land justice, it all comes from that honesty.

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1 UNAIDS, Forty years on and new UNAIDS report gives evidence that we can end AIDS Available at: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2021/june/20210603_global-commitments-local-action