



**FEMINISTS
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VACCINE**



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**THE IMPACT OF THE EU'S
OPPOSITION TO THE WTO TRIPS
WAIVER PROPOSAL ON COVID-19
VACCINES: SWEDEN'S DUTIES
AS A MEMBER STATE AND
EXTRATERRITORIAL OBLIGATIONS
UNDER CEDAW**

**Shadow Report to the 80th
Session of the CEDAW**

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The Impact of the EU's Opposition to the WTO TRIPS
Waiver Proposal on COVID 19 Vaccines: Sweden's
Duties as a Member State and Extraterritorial
Obligations Under CEDAW

Submitted by:



on behalf of the [Feminists for a People's Vaccine Campaign](#)

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1. Executive Summary and Recommendations

COVID-19 is not only a health and economic crisis, but also a human rights crisis with disproportionate gender impacts. It needs concerted international cooperation and solidarity to ensure that everyone, everywhere is protected; the multiple crises in the wake of the pandemic are mitigated; and the pandemic itself is effectively controlled and curbed. Central to this effort is equal, non-discriminatory global access to COVID-19 vaccines, medicines, and other products, and the removal of policy and institutional barriers that block access and exacerbate the adverse gender impacts of the pandemic.

This Shadow Report, submitted in support of the Feminists for a People's Vaccine Campaign¹, focuses in particular on the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), administered by the World Trade Organisation (WTO), and the opposition by a minority of countries, including Sweden through its membership in the European Union (EU), to a waiver from TRIPS implementation of intellectual property (IP) on COVID-19 vaccines, diagnostics, therapeutics and other needed medical products. This opposition has severe and disproportionate impacts on the rights of women and girls in low and middle-income countries, raising concerns about Sweden's compliance with its:

- (a) extraterritorial obligations under CEDAW, including duties to meet the standards of substantive equality and non-discrimination when operating within the multilateral system and as a member of the EU;
- (b) duties of international cooperation and assistance, including refraining from infringing on the ability of other States to fulfill their own human rights obligations; and
- (c) commitments under its Feminist Foreign Policy.

In May 2020, the decision-making body of the World Health Organisation (WHO), the World Health Assembly, recognised the need for “**extensive immunization against COVID-19 as a public good for health** in preventing, containing and stopping transmission in order to bring the pandemic to an end [...]”. It also recognized the **need for all countries “to have unhindered, timely access** to quality, safe, efficacious and affordable diagnostics, therapeutics, medicines and vaccines, and essential health technologies, and their components, as well as equipment” to support their efforts to deal with the pandemic. It therefore called for, as a global priority, “**the urgent removal of unjustified obstacles** thereto, consistent with the provisions of relevant international treaties, including the provisions of the TRIPS Agreement and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health” (described in further detail in Part 2). To achieve this purpose the Assembly called for a spirit of unity and solidarity and intensified cooperation at all levels to control the pandemic and mitigate its impact².

1. <https://feminists4peoplesvaccine.org/#about>

2. See [World Health Assembly Resolution on COVID-19 response](#), UN Doc. WHA73.1, 19 May 2020

Similarly, the CEDAW Committee in its joint call for action highlighted the urgent need by women and girls for international solidarity and cooperation, noting that the various challenges of the pandemic that hamper these efforts may deepen poverty and inequalities, particularly in countries without robust supporting systems. The Committee has urged States to be aware of these risks and honour their duty of international assistance and cooperation³.

This duty is directly linked to a range of international human rights, including the right to enjoy the benefits of scientific progress, established by both Article 27 of the Universal Declaration of Human Rights (UDHR) and Article 15 of the International Covenant on Economic Social and Cultural Rights (CESCR)⁴, and the core obligation to ensure minimal levels of economic, social and cultural rights protected under CESCR and CEDAW. In the case of the right to health, this includes essential primary health care, essential medicines as well as prevention, treatment and control of epidemics and other diseases by making relevant technologies available and implementing and/or enhancing relevant immunization programmes and other strategies⁵. Moreover, in the context of COVID-19, the CEDAW Committee has emphasised that States “must address women’s increased health risk through preventive measures and by ensuring access to early detection and treatment of COVID-19⁶.”

The failure to meet the requirements of the right to health and ensure international cooperation and assistance in the sharing of knowledge and access to vaccines, medicines, and related products, including knowledge and technologies across countries, particularly with low and middle-income countries, adversely affects equality of access and endangers life and health, with disproportionate impacts on women and girls. The CESCR Committee has emphasised that States must combat the pandemic in a manner consistent with human rights, which includes extraterritorial obligations to support other States fulfilling their duties. In addition, it calls on States to ensure that no decision or unilateral measure obstructs access to essential goods, such as health equipment. It also cautions that any restriction based on the goal of securing national supply must be proportionate and take into consideration the urgent needs of the world’s poorest victims.⁷

Indeed, as the CEDAW Committee noted early in the pandemic, COVID-19 has been “a test for governance, leadership and democratic institutions everywhere, for keeping national and international commitments, and adhering to the principles of gender equality, non-discrimination, solidarity, both nationally and internationally.”⁸ The world’s wealthiest countries, including Sweden, are failing this test - contributing instead to the continued disproportionate adverse impacts of the pandemic and exacerbation of women’s human rights violations in low and middle-income

3. CEDAW, Call for joint action in the times of the COVID-19 pandemic: Statement adopted on 21 April 2020

4. CESCR Committee, General Comment 25 on Science and Economic, Social and Cultural Rights (article 15 (1) (b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights, E/C.12/GC/25, 30 April 2020, para 45. See CESCR, General Comment 14, article 12.2(c), paras 16, 44.

6. [CEDAW Committee, Guidance Note on CEDAW and COVID-19](#), June 2020

7. See CESCR, “Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural Rights”, para 20.

8. CEDAW, Call for joint action in the times of the COVID-19 pandemic: Statement adopted on 21 April 2020

countries by blocking equitable access to COVID-19 medicines, vaccines, and other products.

Sweden's contribution to these violations is particularly evident through its role as a member of the EU which continues to deny waiving patent access and enabling the free production of vaccines and other products - an absolutely essential step in curbing the spread of COVID-19. Sweden itself has received 9 times more vaccines than all low-income countries combined, showing the sheer hypocrisy of the EU. While poorer nations suffer, wealthy nations have bought their way out⁹.

We call into question Sweden's compliance with its obligations under Article 2 of CEDAW—read in conjunction with its duties as a State party to other international human rights treaties, including the ICESCR—to realize women's rights both within and outside its territory. These obligations include Sweden's duties:

(a) to refrain from making or contributing to the making of laws and policies which directly or indirectly result in the denial of women's equal enjoyment of their rights, extraterritorially as well as within its jurisdiction; these include refraining from supporting policies that prevent access to vaccines, medical products and treatments needed to respond to COVID-19.

(b) to cooperate internationally and create an enabling environment conducive to the universal fulfillment of women's economic, social and cultural rights by supporting the TRIPS waiver to facilitate universal and fair access to vaccines, medicines and other products needed to fight the COVID-19 pandemic.

(c) to recognise that the TRIPS framework “may have an adverse impact on prices and availability of medicines” and that intellectual property should not be a barrier to Sweden's international human rights obligations to share the benefits of scientific research widely and in furtherance of its human rights obligations¹⁰.

This review cycle is an opportunity for the Committee to ensure that women's rights are central in ongoing policy formulations —both in Sweden, within the EU, and internationally—about measures to tackle the COVID-19 pandemic, which manifests a range of structural barriers to substantive equality. The foreseeable burden that the non-waiver of patents under TRIPS and resulting lack of access to vaccines, medicines, and other products to fight the pandemic place on women implicates Sweden's extraterritorial obligations under CEDAW to ensure that its foreign policy determined actions do not contribute to, or facilitate, such infringements of women's rights.

Sweden's commitment to this principle is already demonstrated in its Feminist Foreign Policy, aimed at strengthening the rights, representation, and resources of all women and girls.¹¹

With the CEDAW Committee's assistance, this objective can be put into practice by ensuring that all necessary measures are taken to eliminate discrimination against women and girls through

9. <https://twitter.com/peoplesvaccine/status/1442822811173670915?s=08>

10. <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26484&LangID=Etement>

11. <https://www.government.se/government-policy/feminist-foreign-policy/>

equitable global access to COVID-19 medicines, vaccines, and other products.

For these reasons, we, the organisations submitting this report, suggest the following recommendations for Sweden:

- (a) to take measures to ensure that it, acting territorially or extraterritorially, as a member of the EU, is in compliance with its obligations under CEDAW, including conducting a gender impact assessment of the EU's position to oppose the TRIPS Waiver at the WTO (described in further detail in the next section);¹²
- (b) to take measures to ensure that it, acting territorially or extraterritorially, as a member of the EU within the multilateral system, including at the WTO, upholds its obligations of international cooperation and assistance, including refraining from acts or omissions that prevent or infringe on the ability of other State Parties from fulfilling their obligations under CEDAW; and
- (c) to conduct a comprehensive and participatory review of its Feminist Foreign Policy, including its Feminist Trade Policy, to ensure policy coherence and compliance with CEDAW across all areas of its international trade obligations and to ensure that its actions within WTO, including vis-a-vis its membership in the EU, recognise the primacy of its international human rights obligations over intellectual property regimes.

We also welcome the Committee's Guidance Note on COVID-19 and CEDAW and invite the Committee to expand on it by clarifying the obligations of State Parties within the multilateral system, including duties of international cooperation and assistance and their application to equitable, non-discriminatory access to COVID-19 vaccines, medicines, and other needed products and technologies.

We would further welcome a consultative process and statement by the Committee on the impact of the global intellectual property regime on women's human rights and continued exacerbation of gender inequality resulting from the failure of State Parties to cooperate at an intergovernmental level to remove the structural economic and financial barriers to the full enjoyment of women's human rights and substantive equality.

12. See [CEDAW General Recommendation No. 35: Gender-based violence, updating General Recommendation No. 19, at para. 20](#)

2. The TRIPS Agreement: Background, Proposed TRIPS Waiver, and the Opposition

The TRIPS Agreement and Doha Declaration- Brief Background

The WTO TRIPS agreement administered by the WTO came into effect on 1st January 1995, compelling WTO member states to enact and enforce intellectual property laws at the national level in accordance with new international requirements. The TRIPS Agreement signified a globalization of IP rights that protected the knowledge and technology held mostly by multinational corporations. Previously, national governments had much more freedom with respect to the scope of patents resulting in the manufacture and import of pharmaceutical products as medicines could be excluded from patent laws. During this period, lower middle-income countries (LMICs) engaged in robust trade in generic drugs¹³ that were produced in countries with no patents for those drugs. These sources of affordable pharmaceutical products were especially important for countries facing a lack of resources and local manufacturing capabilities, or public health emergencies such as the HIV/AIDS epidemic or needed treatments for life-threatening infectious diseases or chronic illnesses¹⁴.

Once the TRIPS Agreement was enforced, trading of generics was curbed, and all WTO Members had to provide for patents for all products and processes of manufacturing, deferring to the exclusive rights of patent holders. Many countries who did not have “robust knowledge-based, high-technology sectors”¹⁵ of their own had depended on the freedom afforded by pre-TRIPS in order to import life-saving medicines, while those with manufacturing capacity could build their domestic industry.

The end goal of TRIPS is purportedly to provide incentive for innovation. On the contrary, the inclusion of drugs under the TRIPS Agreement has exacerbated the problem of timely, equitable, and affordable access to life-saving medicines. Minimum IP protection standards including a 20-year patent term have enabled manufacturers to exert a market monopoly. This has inadvertently incentivised pharmaceutical companies to take advantage and charge exorbitant prices for crucial medicines and treatments, keeping them out of reach for the majority of the world’s population, largely developing countries in the Global South¹⁶. In 2021 the TRIPS Agreement has proven to be a monopolistic tool for a handful of corporations in the pharmaceutical sector.

In 2001, the 4th Ministerial Meeting at Doha, Qatar, brought forth the Doha Declaration. This re-affirmed the rights of WTO member countries, in that TRIPS “can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and,

13. A generic drug is a drug that is not branded drug but is bioequivalent to the branded/patented drug and similar in dosage, administration and performance.

14. <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-3-3#ref-CR23>

15. <https://www.e-ir.info/2013/12/23/the-arguments-for-and-against-the-trips-agreement/>

16. As early as 2001 a World Bank report acknowledged that developing countries “bear the increasing cost of the system”. Compliance with TRIPS cost developing countries an “annual \$20 billion transfer of wealth” Since then numerous assessments and reports from the UN have set out the devastating impacts of patents and other IPRs on access to medicines

in particular, access to medicines for all”¹⁷. It also reaffirmed the right of WTO members to use the provisions of the TRIPS Agreement, including TRIPS Flexibilities for public health purposes. TRIPS flexibilities are exceptions, limitations and legal mechanisms under the agreement that allow countries to formulate appropriate national IP rules, including to address public health needs¹⁸.

TRIPS Flexibilities and Their Insufficiencies

Despite the affirmations made in the Doha Declaration and the amendment that added Article 31bis to TRIPS¹⁹, there are severe insufficiencies regarding these provisions²⁰:

First, developing and least developed countries face issues with implementing TRIPS flexibilities. This stems from a lack of full understanding of the flexibilities themselves, largely caused by the constant and often inappropriate “technical assistance” and “capacity building and training” provided by the patent/intellectual property offices of developed countries. Second, there is still danger of these flexibilities being undermined by regional and bilateral trade agreements that are allowed under TRIPS. This results in many countries being disadvantaged by the “world trading system as a whole”. Third, the TRIPS Article 31bis framework entails cumbersome procedures and are therefore not effective solutions for countries with limited or no manufacturing capacity. For instance, compulsory licenses must be done on a case-by-case, drug-by-drug basis. If a compulsory license were to be issued for the ARV cocktail consisting of three separate drugs, a separate application would have to be filled for each drug, which is time consuming and costly. Finally, while the TRIPS Agreement requires transfer of technology to least developed countries (LDCs) such that they may build up manufacturing capacity²¹, these provisions have not yet been implemented.

In the context of the COVID-19 pandemic, the shortcomings of the TRIPS Agreement have starkly highlighted the growing inequality between the global North and global South²². Wealthy countries have hoarded COVID-19 vaccines to the extent that, according to a World Health Organization estimate, 75% of vaccines are going to a mere 10 countries²³²⁴. In fact, Sweden has received 9 times the supply of vaccines that low-income countries have received, put together. On the other hand, the entire continent of Africa has only been able to vaccinate 3.3% of its

17. https://dawnnet.org/wp-content/uploads/2021/06/FPV_Issue-Paper-3_An-Evaluation-of-TRIPS-Flexibilities-a.pdf

18. These flexibilities include: (1) definitions and national standards for the 3 criteria for what can be patented (“novelty”, “inventive step” and “industrial applicability”); (2) compulsory licensing, which where the state can allow manufacture or import of a product without consent of the patent holder (but with remuneration payments to the originator). This is usually when patent holding pharmaceutical companies refuse to do voluntary licensing, which as the name suggests, entails companies willingly allowing competitors to manufacture or import a product subject to royalty payments and other conditions; (3) parallel imports, wherein the same patented product can be imported from another country where it is sold cheaper, without consent of the patent holder; (4) exemption from TRIPS obligations for Least Developed Countries (LDC’s), a right contained in the agreement itself called “transition period”. There is also an additional transition period for pharmaceutical patents that runs in parallel for LDCs.

19. This amendment was made to address the issue of export under compulsory license to countries with insufficient manufacturing capacity

20. https://dawnnet.org/wp-content/uploads/2021/06/FPV_Issue-Paper-3_An-Evaluation-of-TRIPS-Flexibilities-a.pdf

21. This is specifically stated under articles 66.2 and 67 of the TRIPS Agreement, but this has not yet been implemented

22. This is with specific reference to the barriers in accessing COVID-19 vaccines, diagnostics, therapeutics and other needed medical products.

23. The EU has been able to vaccinate 60.1% of its population; the UK 64%; and Switzerland 51.9%.

24. The issue of hoarding could be offset, if manufacturing capabilities were expanded globally. However, this is not the case due to the failure of vaccine patent holders to issue sufficient voluntary licenses. In any event production has to be ramped up on a far larger scale to deal with the pandemic.

population²⁵. A handful of wealthy nations are even moving into booster shots. At the same time millions of hoarded doses have also expired and are going to waste.

The longer we delay equitable, widespread vaccination and treatment, many more lives will be lost (4.72 million thus far²⁶) and economic losses will be enormous. The cumulative cost of delaying global vaccination will amount to US \$2.3 trillion by 2025 along with serious impacts on the lives of people, especially women and disadvantaged communities. The developing world will be shouldering the bulk of that cost, being the last to receive vaccinations that would allow resumption of a fully functioning economy.

The TRIPS Waiver and EU Pandemic Treaty Proposal

In October 2020, a proposal by India and South Africa was presented at the WTO TRIPS Council, seeking a temporary waiver from the TRIPS implementation of IP on COVID-19 vaccines, diagnostics, therapeutics, and other needed medical products. The TRIPS Waiver, as it has now come to be known, will provide freedom to operate from which plural measures can be undertaken, if it is adopted by the WTO General Council²⁷. The Waiver is a more comprehensive solution compared to individual TRIPS flexibilities- which have shown to be cumbersome and impractical during a pandemic- and instead introduces a blanket legal tool that does not have to be applied on a case-by-case basis.

Support for the Waiver has been resounding and widespread, with over two-thirds of WTO members backing it, including 64 co-sponsors. However, while the opposition for the Waiver is in the minority, the few countries blocking the consensus that is needed are wealthy, Western nations, namely the EU, Switzerland, and the United Kingdom²⁸.

MEP Sara Matthieu of Belgium has articulated the EU's stance on the Waiver²⁹, highlighting a concern about increased competitor manufacturers and enabling transfer of technology as the reason for the bloc's opposition. While the Parliament has expressed support for the Waiver, the Commission is staunch in its opposition, to the point where it is attempting to downplay the Parliament's support³⁰. Additionally, the EU, of which Sweden is a member, has proposed an alternate Pandemic Treaty, which it claims would "ensure universal and equitable access to vaccines, medicines and diagnostics for pandemics". The main goal of such a treaty would be to "strengthen the world's resilience to future pandemics through better alert systems, data

25. <https://www.twn.my/title2/wto.info/2021/ti210913.htm>

26. <https://covid19.who.int>

27. The Waiver will allow open sharing of technology and knowledge in order to expand manufacturing for COVID-19 treatments. As a result, there will be rapid manufacturing where there is capacity, entrance of competitor manufacturers which will help regulate prices, and will also enable transfer of technology. Countries are free to choose whether or not they want to implement the Waiver at the national level. As of now, proponents of the Waiver have amended its text to state it will be in place for at least three years from the date of adoption with a review mechanism

28. The EU Commission has insisted time and again that there is no clash between IPR and public health goals, and that the two are "mutually supportive" of one another. There are multiple historical examples to show that this is not true.

29. [High-Level Dialogue: TRIPS Waiver- Challenges and opportunities](#)

30. In fact, the parliament's decision to support the Waiver was in the majority.

sharing, research and the production and distribution of vaccines, medicines, diagnostics and personal protective equipment”³¹.

This Pandemic Treaty acts as a counter proposal to the TRIPS Waiver and as a way to “find a solution within the given framework” of the TRIPS Agreement. However, an examination of the proposal shows that it is not offering anything new, and in fact it is viewed as a diversionary tactic. Professor Siva Thambisetty from LSE provided a clear evaluation of the Pandemic Treaty, calling it a rather “performative, reductive document that states the obvious”³². First, the EU counterproposal only applies to patents³³. Second, the proposal only covers vaccines and treatments³⁴. Third, the EU proposal relies heavily on compulsory licensing which had already proven to be impractical and limited in scope³⁵. Finally, the counterproposal is too dependent on the willingness of Big Pharma to share technology and knowledge through voluntary licensing that has proved to be untenable³⁶.

Importantly, inequalities relating to access to medicines and a favouring of intellectual property rights and private sector interests over the rights of women and girls is not specific to the COVID-19 pandemic. It is a longstanding, structural issue that leads to the preventable illness and deaths of countless women, particularly in developing countries, with those bearing the gravest consequences being women who face multiple and intersecting forms of discrimination on the basis of gender, race, class, ability, and other lines of oppression. Please refer to the attached annex for information on the history of access to medicines through a gendered lens, with recent examples relating to HIV/AIDs and breast cancer treatments.

31. <https://www.euractiv.com/section/coronavirus/news/leaders-of-23-countries-back-eus-pandemic-treaty-idea/>

32. [High-Level Dialogue: TRIPS Waiver- Challenges and opportunities](#)

33. The treaty does not address any other form of IP such as copyrights, trade secrets, data exclusivity, and so on.

34. There is no mention of other important medical equipment such as testing kits, masks, or raw materials.

35. In fact, the EU proposal also undermines existing TRIPS flexibilities for public health according to some assessments.

36. The propensity of Big Pharma’s concern for profits and not people’s health has been on display during pandemics (HIV/AIDS and SARS COV-2) and for life-threatening conditions (Hepatitis C and Breast Cancer) Voluntary licensing itself is especially problematic because it excludes those living in countries that are regarded as lucrative markets for pharmaceutical companies. Even under a voluntary license, pharma companies control where the product is manufactured and supplied. The continuing global shortages and highly inequitable access to COVID-19 vaccines are a testimony to the failure of voluntary licensing.

3. Denial of Women's Rights in the Context of the COVID-19 Pandemic' and Continuing Poor Access to Vaccines and Medicines Particularly in the Global South³⁷

The pandemic has highlighted the fragility of hard-won gains for gender equality across the globe but particularly in the global South. Notwithstanding women's biological advantage of being less susceptible to contracting SARS-COV2 infection and lower death rates as compared to men, the social and economic fall-out of the pandemic has exacerbated gender inequalities. Multi-layered intersectional identities of race, class, caste, sexual orientation and gender identities, ethnicity, age, ability, religion and migrant/citizenship status in the South (and the North) have impacted women's access to healthcare, as well as their economic and educational opportunities.

The pandemic and resultant lockdowns have heightened the deleterious economic fallout for women in many spheres of their lives. Women account for less than 40% of the global workforce³⁸, but have incurred an estimated 54% of job losses. There are several reasons for this. One, unemployment has disproportionately hit feminised sectors such as services and hospitality, where up to nine of every ten workers are women.³⁹ Two, 92% of women workers are in the informal sector. And across the globe, 56% of countries report a higher percentage of women workers than men in the informal sector⁴⁰. During the first month of the pandemic, informal workers experienced income drops of 60% globally, and 82% in Asia and Latin America.⁴¹ Three, women entrepreneurs face specific challenges with lack of financial support, increase in unpaid domestic work and constraints in mobility during the pandemic. In China, women farm-owners experienced more challenges with resource allocations, and were left more vulnerable to the long-term pandemic impacts than male farm-owner⁴².

As a result, income gains made by women over the last ten years have reduced drastically⁴³, and women are more likely than men to report a drop in income and/or in financial support⁴⁴ from family⁴⁵. Of the 96 million people that the pandemic could potentially push into poverty, a report from UN Women states that nearly half (47 million) are women and girls⁴⁶. Job losses for women, combined with an increase in domestic labour at home and care-work for their families have further reinforced barriers to economic inequality⁴⁷. Unpaid care work has increased by up to 49% among women⁴⁸.

37. This section was originally published as a special contribution in the "[Spotlight for Sustainable Development: Demanding Justice beyond Rhetoric](#)", 2021 (Chapter 1.8,p.47);

38. https://dawnnet.org/wp-content/uploads/2021/06/FPV_Issue-Paper-1_Access-to-Medicines_-Why-Should-Feminists-Care-2.pdf

39. https://dawnnet.org/wp-content/uploads/2021/04/DAWN-Discussion-Paper-32_The-Pandemic-as-a-Portal.pdf;

40. https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_711798.pdf

41. https://dawnnet.org/wp-content/uploads/2021/04/DAWN-Discussion-Paper-32_The-Pandemic-as-a-Portal.pdf

42. <https://emerge.ucsd.edu/wp-content/uploads/2021/02/covid-19-and-gender-quarterly-report-oct-dec-2020.pdf>

43. https://dawnnet.org/wp-content/uploads/2021/04/DAWN-Discussion-Paper-32_The-Pandemic-as-a-Portal.pdf

44. https://dawnnet.org/wp-content/uploads/2021/04/DAWN-Discussion-Paper-32_The-Pandemic-as-a-Portal.pdf

45. Lewis, H. (2020, April 01). [The Coronavirus Is a Disaster for Feminism](#). Retrieved June, 2020

46. <https://www.unwomen.org/en/news/stories/2020/9/feature-covid-19-economic-impacts-on-women>

47. Kenward, S. (2021, February 02). [Covid-19 vaccination strategies must ensure equity for all women](#). Retrieved April 01, 2021

48. https://dawnnet.org/wp-content/uploads/2021/04/DAWN-Discussion-Paper-32_The-Pandemic-as-a-Portal.pdf

Economic stress caused by the pandemic has impacted young girls negatively leading to gender-based exclusions. In Asia, girls have been quitting school education during COVID 19 to supplement household income in menial jobs⁴⁹ With a closure of schools, and education moving online, the exclusion of the poor, especially girls, has intensified with limited access to digital equipment like laptops and smartphones⁵⁰. Even as schools open, the combination of education budget cuts⁵¹ and families under financial strain make it likely that more girls will continue to remain out of school in order to help in domestic and care-work. Under extreme economic duress, there are reports of trafficking in girls,⁵² and an increase in child-marriages during the pandemic.⁵³

The lockdown and restrictions on movement during the pandemic has also led to an increase in domestic violence, as women were locked in with their perpetrators for long periods of time, with limited access to support services.⁵⁴ As resources are reallocated to fight the pandemic and health care services diverted to combat COVID 19, other services considered ‘non-essential’ are being affected. Among them are a range of sexual and reproductive health services⁵⁵. They include maternal health care, contraception, abortion and gynecological services that largely affect women and girls. The risk of unwanted pregnancies is especially high for girls with serious consequences for their life-opportunities⁵⁶. Within the health system, women frontline health-care and services workers constitute around 70% globally⁵⁷, and are at the lower ends of health worker hierarchies. They experience poorer work conditions, low wages and job-insecurity.

Due to vaccine shortages and delays in receiving supplies around the world, there is a likelihood of rationing in households, giving preference to males. In India, nearly 24 percent more men were vaccinated during the height of the pandemic’s second wave.⁵⁸ There are fears of domestic violence if a woman gets vaccinated before the male “head of house” does.⁵⁹ Women with disabilities face specific challenges of ‘access’ – related to a lack of sensitivity in designing physical spaces and apps for vaccination services. Similarly, women who are sex workers face discrimination, abuse and lack access to adequate information, or documentation required to receive COVID-19 vaccinations.

49. <https://theprint.in/world/girls-are-quitting-school-to-work-in-covid-hit-rural-india-nepal-other-asian-countries/506619/>;

50. [Country-level data on the gender gap in mobile ownership and mobile internet use indicate women consistently lag behind men.](#)

51. Mendez Acosta, A., & Evans, D. (2020, October 02). [COVID-19 and Girls’ Education: What We Know So Far and What We Expect.](#) Retrieved October 19, 2020

52. <https://www.indiatoday.in/coronavirus-outbreak/story/covid-19-poor-marginalised-vulnerability-child-trafficking-ngos-1812519-2021-06-08>;

53. <https://www.theindiaforum.in/article/child-marriages-during-pandemic>; <https://www.indiatoday.in/coronavirus-outbreak/story/covid-19-poor-marginalised-vulnerability-child-trafficking-ngos-1812519-2021-06-08>;

54. https://www.unescap.org/sites/default/files/20201119_SDD_Policy_Paper_Covid-19.pdf;

55. [Why a gender lens is needed for the COVID-19 response.](#) (2020, April 16). Retrieved July 31, 2020

56. Janoch, E., Rodriguez, M., & Turner, B. (2021, March 25). [Our best Shot: WOMEN FRONTLINE health workers around the world are keeping you safe FROM COVID-19.](#) Retrieved April 31, 2021

57. Linde, A., & Gonzalez Laya, A. (2020, May 9). [What the COVID-19 pandemic tells us about gender equality.](#) Retrieved October 26, 2020

58. <https://www.indiatoday.in/diu/story/fewer-women-than-men-taking-covid-shots-in-india-s-vaccination-drive-1810158-2021-06-02>

59. [Choosing to challenge gender inequity in the COVID-19 VACCINE rollout.](#) (2021, March 5). Retrieved April 02, 2021

The pattern of gendered pandemic effects in COVID-19 is broadly similar to those witnessed during the HIV/AIDS outbreak, Ebola, and Zika outbreaks. This emphasizes the need to address the “structural determinants of gender inequality—eg, political participation and economic systems”—and the “intersections with other inequities” to combat the COVID 19 and its detrimental gender impacts⁶⁰. Many countries have not reported sex-disaggregated data, critical for tracking gender impacts. According to a Lancet report, only 48% and 36% of 199 countries reported sex-disaggregated data on COVID-19 cases and death⁶¹. And few countries have data that account for gender identity and typically exclude transgender and non-binary people⁶². Disaggregated data is key for gauging the nature and extent of gender and other manifestations of inequalities during the pandemic, to design appropriate policies and programs for interventions.

The pandemic is a setback to hard won rights for women and girls, and towards gender equality. A TRIPS waiver is essential for equal access to medicines and vaccines for all, and to end the pandemic. The TRIPS waiver is a significant structural solution to stem the adverse effects of the pandemic across various dimensions of the economy and our societies, including women’s rights.

60. <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901651-2>

61. <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2901651-2>

62. <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/>

4. Sweden's Extraterritorial Obligations in Relation to the Right to Health and its Obligations Vis-a-vis its Role as a Member in the EU

Fundamental to State responses to the pandemic is to ensure that the right to health is safeguarded.

The UDHR, binding on all States, proclaims that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family...” (UDHR, Article 25.1). ICESCR, elaborates the right to health as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (ICESCR, Article 12.1) and this right is enshrined in a number of international human rights treaties. CEDAW by Article 12 calls on States Parties to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services...” and CEDAW General Recommendation 24 on women and health “...implies an obligation [on States] to respect, protect and fulfil women’s rights to health care”, noting that “States parties have the responsibility to ensure that legislation and executive action and policy comply with these three obligations.”⁶³

In the furtherance of economic, social and cultural rights, which includes the right to health, ICESCR goes on to note the duty of States to provide international assistance and cooperation across borders and requires them “...to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized in the Covenant” (Article 2 (1)).

As the CEDAW Committee made clear in General Recommendation 28, and reiterated in General Recommendation 30, “States parties are responsible for all their actions affecting human rights, regardless of whether the affected persons are in their territory.” CEDAW protections apply across all human rights including rights enshrined in the UN Charter on Human Rights and all the UN Conventions. Sweden has ratified all these treaties and is bound by its obligations under each of them including extraterritorial obligations they impose in the context of the CEDAW framework of non-discrimination and substantive equality. These include the duty to respect, protect, and take-action through international cooperation to realize CEDAW protected rights. The Maastricht Principles on the Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights Principles (Maastricht Principles) further elaborate a broad body of jurisprudence on extraterritoriality⁶⁴ pertinent to this report.

Extraterritorial obligations arise when a state exercises control, power, or authority over people or situations located outside its sovereign territory in a way that could have an impact on the en-

63. [CEDAW General Recommendation No. 24: Article 12 of the Convention \(Women and Health\)](#)

64. Maastricht Principles, at Section II, 6, princ.8. Although the Maastricht Principles are specifically intended to address the extraterritorial applicability of economic, social and cultural rights. The Principles elaborate extraterritorial obligations in relation to economic, social and cultural rights, without excluding their applicability to other human rights, including civil and political rights.

joyment of human rights by those people or in such situations (Principle 9a). All states are bound to these obligations in respect to human rights. As described in Principle 9 (b), extraterritorial obligations also arise on the basis of obligations of international cooperation set out in international law.

Extraterritorial obligations are no longer an emerging phenomenon. They have been repeatedly recognised by the Committee in multiple General Recommendations and Concluding Observations. These obligations are a key component of a global perspective on human rights, as they ensure the extension of human rights well beyond the sovereign borders of a state. This has become increasingly important given globalisation's role in extending the impact of States and their actions- or inactions- beyond their own territories. The application of extraterritorial obligations by the CEDAW Committee in Concluding Observations spans various thematic areas including business related human rights violation (Canada), extractivism and environmental degradation (Australia/Papua New Guinea), arms trade (Sweden), tax justice (Switzerland), occupation (Israel). We cannot undermine the importance and interpretation of extraterritorial obligations in the context of COVID-19 pandemic and most importantly in the production, management and distribution of vaccines.

Furthermore, in relation to involvement of private agencies in the health sector, the Committee has stated that, "CEDAW is concerned about the evidence that States are relinquishing these obligations as they transfer State health functions to private agencies. States and parties cannot absolve themselves of responsibility in these areas by delegating or transferring these powers to private sector agencies. States parties should therefore report on what they have done to organize governmental processes and all structures through which public power is exercised to promote and protect women's health. They should include information on positive measures taken to curb violations of women's rights by third parties and to protect their health and the measures they have taken to ensure the provision of such services."⁶⁵ By analogy, this same analysis applies to the obligation of States as members of intergovernmental entities, such as the EU - States cannot relinquish their CEDAW obligations to the organisations, institutions or regional blocs to which they are a member. They are required to report on how their roles within these bodies are exercised to promote and protect women's health and take positive measures to curb violations of women's rights by the larger body, with due regard to their obligations nationally and extraterritorially.

This approach is confirmed in General Recommendation No. 35, in which the Committee, recognising the transnational nature of gender-based violence, stated that "gender-based violence against women can result from acts or omissions of State or non-State actors, acting **territorially or extraterritorially**, including extraterritorial military action of States, individually or as **members of international or intergovernmental organizations or coalitions**, or extraterritorial actions by private corporations."⁶⁶

65. [CEDAW General Recommendation No. 24: Article 12 of the Convention \(Women and Health\)](#), at para. 17

66. [CEDAW General Recommendation No. 35: Gender-based violence, updating General Recommendation No. 19](#), at para. 20

The Committee will be well-aware of the “silent pandemic” of gender-based violence occurring along the economic and health crises exacerbated by the pandemic, and the connections between rising violence and pandemic-related measures, such as movement restrictions, school closures, and loss of jobs and livelihoods. This has contributed to alarming setbacks to gender equality across the globe and the loss of hard-fought gains in women’s human rights. However, this outcome was not and is not evitable. Governments have both the option and obligation to adopt a human rights-based approach to pandemic responses, including due regard to rights of women and girls outside their territorial boundaries and the adoption of all appropriate measures to remove policy and institutional barriers that prolong the spread of COVID-19 and infringe on the ability of other States to fulfill their own human rights obligations under CEDAW and other international human rights treaties. A failure by Sweden to, at minimum, assess the gender impact of the EU’s decision to oppose the TRIPS Waiver at the WTO and ensure its actions as a member of the EU comply with its obligations under the Convention, is a failure to meet the standards of CEDAW with grave impacts on the lives and rights of women and girls, particularly in low- and middle-income countries.

Indeed, the issues raised in this Shadow Report go to the heart of Sweden and all State Parties’ core obligations under Article 2 of the Convention “to pursue by all appropriate means and without delay a policy of eliminating discrimination against women”, which is inextricably linked to all other Articles of the Convention, including the right to health, and applies extraterritorially and to all activities of State Parties, whether acting individually or “as members of international or intergovernmental organizations or coalitions.”⁶⁷ As stated in General Recommendation 28,

Effective implementation of the Convention requires that a State party be accountable to its citizens and other members of its community at both the national and international levels. In order for this accountability function to work effectively, appropriate mechanisms and institutions must be put in place.⁶⁸

These mechanisms must include a requirement for State Parties to assess and report on their compliance with the Convention in the implementation of foreign policy and in their roles within multilateral and intergovernmental institutions, such as the EU. Just as governments are not permitted through delegation or devolution at the national level to negate or reduce their obligations under the Convention,⁶⁹ neither should they be permitted to negate or reduce their obligations through delegation or devolution of responsibility to regional or international bodies. Finally, to the extent that the obligations and rights discussed in this Shadow Report raise new

67. [CEDAW General Recommendation No. 35: Gender-based violence, updating General Recommendation No. 19](#), at para. 20

68. [CEDAW General recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women](#), para. 40

69. [CEDAW General recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women](#), para. 39

or emerging issues relating to State obligation under CEDAW, we note the Committee's comment in General Recommendation No. 28 that, "the spirit of the Convention covers other rights that are not explicitly mentioned in the Convention, but that have an impact on the achievement of equality of women with men, which impact represents a form of discrimination against women", and invite the Committee to explore these duties in the context of its longstanding reminders to States that international human rights obligations are paramount to and take primacy over trade and investment regimes and, in particular, over the interests of investors and the private sector in a restrictive and unequal global intellectual property system.⁷⁰

As rightly stated by the CEDAW Committee in its 2018 contribution to the High-Level Political Forum on Sustainable Development, global financial and trade processes can create heightened risks of rights violations, compounding gender discrimination with other forms of disadvantage - on the basis of socioeconomic status, geographic location, race, caste and ethnicity, sexuality or disability - and severely limiting women's and girls' opportunities and life chances.⁷¹ In the midst of a global health and economic crisis, this assessment is even more starkly felt, as is the need for the implementation of State obligations under the CEDAW Convention within these processes.

In this light, we would like to reiterate our recommendations for Sweden to the CEDAW Committee:

(a) to refrain from making or contributing to the making of laws and policies which directly or indirectly result in the denial of women's equal enjoyment of their rights, extraterritorially as well as within its jurisdiction; these include refraining from supporting policies that prevent access to vaccines, medical products and treatments needed to respond to COVID-19.

(b) to cooperate internationally and create an enabling environment conducive to the universal fulfillment of women's economic, social and cultural rights by supporting the TRIPS waiver to facilitate universal and fair access to vaccines, medicines and other products needed to fight the COVID-19 pandemic

(c) to recognise that the TRIPS framework "may have an adverse impact on prices and availability of medicines" and that intellectual property should not be a barrier to Sweden's international human rights obligations to share the benefits of scientific research widely and in furtherance of its human rights obligations.⁷²

70. See, for example, the [CEDAW Committee's Concluding Observations to Canada in 2016 \(CEDAW/C/CAN/CO/8-9\)](#); and [Germany in 2017 \(CEDAW/C/DEU/CO/7-8\)](#)

71. [CEDAW Committee, Contribution to the 2030 Sustainable Development Goals in response to a call for inputs by the High-Level Political Forum on Sustainable Development \(HLPF\), 27 April 2018](#)

72. <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26484&LangID=Etement>

ANNEX

Intersectional Gender Inequality and Discrimination: A Brief History of Access to Medicines Through a Gendered Lens

Women in particular have suffered in the past from barriers to accessing medicines and treatment, especially during past public health emergencies. During the HIV/AIDS epidemic in the 1980's and early 1990's, barriers to access were evident because of the expensive, patented antiretroviral (ARV) cocktail⁷³. Accessing treatment for HIV/AIDS was, and continues to be, a struggle for women more so than men.

First, current statistics show that in sub-Saharan Africa, one out of every five (20%) new HIV infections occurs among adolescent girls and young women. This is despite the fact that they make up only 10% of the population, highlighting a discrepancy in infection rates with respect to gender. In countries where infection rates are even higher, 80% of new HIV infections among adolescents are girls, who are up to eight times more likely to be living with HIV than adolescent boys⁷⁴.

Even though women and girls make up the majority of new cases, men are usually given preference if ARV treatment becomes too expensive. There are cases wherein the woman in a heterosexual relationship would forgo treatment if medical drugs were in limited supply or too expensive⁷⁵.

In addition to societal preference for males, women living with HIV are also faced with violence as a barrier to accessing treatment, along with greater stigma and discrimination⁷⁶. Women have also stated that their lack of autonomous decision making, care responsibilities, needing to request permission from partners/other male family members, and a lack of privacy contribute to their inability to access ARV treatment easily.

The gendered impact of access to treatment does not just stop at HIV/AIDS. Breast cancer treatment – a disease for which the female gender is the strongest risk factor – is extremely difficult to obtain, especially in lower income countries. In middle income countries financial catastrophe is documented for patients and their families within a year of treatment due to the exorbitant costs of cancer drugs. This is because the drug used for treatment- Herceptin or Trastuzumab- is patented in many countries and is very expensive⁷⁷.

Here, the Indian context has been taken as an example to demonstrate the barriers to access

73. During the HIV/AIDS epidemic, the African continent was the most affected. However, they struggled to get their hands on the antiretroviral (ARV) cocktail which was a proven and effective remedy. The ARV's were patented drugs, making it very expensive for relatively poor African nations to import. The protests and demonstrations that followed, beginning in South Africa, against the high prices of these life-saving drugs have become one of the most prominent examples of the struggles people face in accessing medicines – all because of an IPR system that keeps such crucial life-saving drugs out of reach.

74. <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/women>

75. <https://onlinelibrary.wiley.com/doi/10.1111/jwip.12123>

76. Women often cite physical, sexual, psychological, emotional, and structural violence as barriers to access. This violence comes from partners, family, community members, and employers.

77. This drug is a complex bioengineered compound and was sold for a pricey sum of US \$1,771 at one point. Such a steep price inadvertently made it inaccessible for socially and financially disadvantaged members of the population, namely women.

associated with patents⁷⁸. Herceptin was under patent in India, making it very expensive and hard to access for many women. This issue was brought to the attention of the Médecins Sans Frontières (Doctors Without Borders) Access Campaign resulting in a successful advocacy⁷⁹ with the Indian government filing for a compulsory license for the drug⁸⁰.

As a result, in 2014-15, Roche- the patent holder for the drug- withdrew its patent monopoly in India, and Biocon- an Indian competitor of Roche- began manufacturing a more affordable version of Herceptin. The resounding success in India in challenging the patent on Herceptin ignited a response in women around the globe, in order to raise awareness about the sheer unaffordability of Herceptin in other parts of the world. Despite this, Roche still refused to lower the overall price of the patented drug. In South Africa, negotiations for drug pricing went on for so long, a woman died because she was unable to access treatment. Even after that, Roche refused to lower its prices. Today, the fight for Herceptin/Trastuzumab is still ongoing in many parts of the world, demonstrating the struggle for the right to life.

78. [DAWN Talks #2: COVID-19 - Women from the South Reimagining the Intellectual Property System](#)

79. Initiated by Leena Menghaney of MSF and K M Gopakumar of Third World Network

80. India's Ministry of Health reacted and set up a committee to file a compulsory license that would grant manufacturing rights to an Indian competitor to Roche, the patent holder of Herceptin.

