FEMINISTS FOR A PEOPLE'S VACCINE

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"THE PANDEMIC IS MOST CERTAINLY NOT OVER"

BELGIUM'S OBLIGATION TO SUPPORT A GLOBAL PUBLIC GOOD APPROACH TO COVID-19 DIAGNOSTICS, VACCINES AND THERAPEUTICS

Shadow Report to the 83rd Session of the CEDAW

Shadow report to the 83rd Session of the Committee on the Elimination of Discrimination against Women

“The pandemic is most certainly not over”[1]:

Belgium’s obligation to support a global public good approach to COVID-19 diagnostics, vaccines and therapeutics

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September 2022

[1] "COVID-19 is not over", Tedros warns at the 75th World Health Assembly on May 22, 2022.

Table of Contents

"…as the impact of the COVID-19 pandemic continues to be felt, closing the [global] gender gap has increased by a generation from 99.5 years to 135.6 years."

(World Economic Forum's 2021 Global Gender Gap Report)

1. "The pandemic is most certainly not over"[2]: Intellectual property regimes with their barriers is not the answer. States must apply a global public good approach with equitable access to protect women's right to health

COVID-19 is both an economic and human rights crisis. It has disproportionate gender impacts requiring international cooperation and solidarity to ensure that everyone, everywhere is protected. Central to this effort is equitable access to COVID-19 diagnostics, vaccines and therapeutics. The removal of policy and institutional barriers such as intellectual property regimes are critical to this. These regimes block access to tests, treatments and vaccines, hamper critical care and exacerbate the adverse gender impacts of the pandemic. This is an issue of concern for the mitigation and curbing of the COVID-19 pandemic, ongoing outbreaks of Ebola in DRC, monkeypox and hepatitis across different countries as well as the threat of future pandemics.

While no individual country can resolve a global health crisis, each is obligated to cooperate internationally towards the development of solutions that, first and foremost, enable the protection of human rights and uphold the standards of non-discrimination and substantive equality. The individual obligation to comply with international human rights standards is heightened when countries like Belgium are members of powerful blocs, such as the European Union (EU), given the level of power and influence such blocs wield.

The current **intellectual property approach** adopted by Belgium,[3] the EU, and other developed countries has failed to meet this obligation. This approach places almost all

[2] "COVID-19 is not over", Tedros warns at the 75th World Health Assembly on May 22, 2022.

[3] See, for example, statements of Belgian Chamber of Representatives confirming their reliance on intellectual property rights as part of their national and global-level pandemic response: https://www.lachambre.be/doc/ccra/pdf/55/ac394.pdf at 10.02 from page 293 [in French and Dutch]; https://www.lachambre.be/doc/ccra/pdf/55/ac404.pd at 05.04 from page 10 [in French and Dutch]; https://www.lachambre.be/kvvcr/showpage.cfm?section=qrva&language=fr&cfm=qrvaXml.cfm?legislat=55&dossierID=55-B045-1193-0030-2020202108313.xml [in French and Dutch]; https://www.dekamer.be/QRVA/pdf/55/55K0045.pdf at page 293 [in French and Dutch]; https://www.lachambre.be/doc/ccra/pdf/55/ac444.pdf at 16.02 on page 25 [in French and Dutch]; https://www.lachambre.be/doc/ccri/pdf/55/ic449.pdf at 16.02 from page 71 [in French and Dutch]; https://www.lachambre.be/doc/ccri/pdf/55/ic530.pdf at 16.03 from page 75 [in French and Dutch]; https://www.lachambre.be/QRVA/pdf/55/55K0059.pdf at page 79 [in French and Dutch];

COVID-19 vaccines, medicines, treatments, and diagnostics in the hands of private, multinational pharmaceutical corporations, even when taxpayers finance a significant part of product research and development. As a consequence, these corporates can impede access in the pursuit of profits.

Belgium has stated that intellectual property (IP) creates a framework for cooperation with the private sector for the transfer of knowledge and innovation.[4] However, four years into the pandemic, this approach has failed to deliver and is (by design) incapable of ensuring equitable, non-discriminatory access to COVID-19 diagnostics, vaccines and therapeutics. Approximately 1 billion people in developing countries remain unvaccinated. Africa continues to lag far behind with only 21.2% of its population fully vaccinated. This disparity has paved the way for increased transmission and more deaths, especially among unvaccinated high-risk groups, and increased risk of new variants emerging. Decline in testing has also meant a disregard for the evolution of the virus, prompting the WHO Director-General to caution reported cases are increasing in almost 70 countries worldwide.

As a consequence, Africa in particular has been reporting rising death rates, while in stark contrast developed countries, including Belgium, have achieved over 75% in vaccine coverage. The WHO DG has called for support to ensure that all countries reach at least 70% vaccination coverage as soon as possible and noted "continued supply-side problems for tests and therapeutics" because of "insufficient funds", and "insufficient access". Most damningly, the **Committee on the Elimination of Racial Discrimination (CERD)** has rightly observed that this **"pattern of unequal distribution within and between countries … replicates slavery and colonial-era racial hierarchies; and… further deepens structural inequalities affecting vulnerable groups", including women and girls**.

The only solution that ensures compliance with CEDAW and other international human rights obligations, with the potential of dismantling structural inequalities noted by CERD, is an **equitable global public good approach**. This approach means that all COVID-19 diagnostics, vaccines, therapeutics, technologies, and other products would be public and equitably available to all countries. No person or country could thereby be excluded from accessing or benefiting from these goods. With the temporary waiver of the IP barrier as proposed by India, South Africa and co-sponsored by 63 other States in 2020, with more subsequent support, there would be no shortages in manufacture and supply. Governments would be free to expeditiously design pandemic responses that prioritize the fulfillment of international human rights obligations over commitments made under

https://www.lachambre.be/kvvcr/showpage.cfm?section=qrva&language=fr&cfm=qrvaXml.cfm?legislat=55&dossierID=55-B059-1181-0104-2020202110488.xml [in French].

[4] See footnote 3.

trade and investment agreements or to the private sector, as required by the CEDAW Committee[5]. However, this proposal was sidelined by the WTO (as described below).

Notably, Belgium has called for a more "innovative and flexible approach" to IP at the EU level, and for a global public good approach to the development, production and accessibility of vaccines[6]. However, Belgium conflates a global public good approach with an IP approach, failing to address the reality that IP barriers are designed to create and protect ***private*** property, maintaining ownership within the hands of the private sector. It must be noted that the private sector has made billions of dollars as profit riding on the pandemic. Private ownership of patents has also limited access to vaccines, diagnostics and therapeutics globally.

Belgium also fails to incorporate any comprehensive analysis of its international human rights obligations or assess the compatibility of these obligations with its current IP approach. It links innovation and research primarily to the private sector, without considering the overwhelming amount of public investment, research, and development that directly or indirectly led to the development of COVID-19 vaccines[7].

Therefore, this CEDAW review is an important opportunity to clarify Belgium's obligations and recognise an equitable **global public good approach to COVID-19 as necessary to the protection of women's human rights worldwide and, in particular, in developing and least developed countries.**

This Shadow Report, submitted in support of the Feminists for a People's Vaccine Campaign, focuses in particular on the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), administered by the World Trade Organization (WTO), and the opposition by a minority of countries, including Belgium through its membership in the European Union (EU), to a comprehensive temporary waiver from TRIPS implementation of IP on COVID-19 vaccines, diagnostics, therapeutics and other needed medical products. **This opposition has severe and disproportionate impacts on the right to health of women and girls in developing and least developed countries, raising concerns about Belgium's compliance with its:**

[5] On Germany's 2017 State review, the Committee recommended that Germany "Ensure(d) that trade and investment agreements negotiated by the State party recognize the primacy of its international human rights obligations over investors ' interests and that the introduction of investor-State dispute settlement procedures through the Comprehensive Economic and Trade Agreement does not create obstacles to full compliance with the Convention" (paragraph 16(d)).

[6] See footnote 3.

[7] See here and here.

(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) stated objective that global challenges can only be met in a multilateral framework and Belgium's membership inter alia in the Council of Europe and the International Organisation of La Francophonie (OIF).

In particular, **we call into question Belgium's compliance with its obligations under Articles 2 and 12 of CEDAW** to realise women's rights both within and outside its territory. These obligations include Belgium'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 diagnostics, vaccines and therapeutics 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 temporary TRIPS waiver to facilitate universal and fair access to diagnostics, vaccines and therapeutics needed to fight the COVID-19 pandemic;

(c) to recognise that the TRIPS framework has an adverse impact on prices and availability of medicines and that IP should not be a barrier to Belgium's international human rights obligations to share the benefits of scientific research widely and in furtherance of its human rights obligations.

Failure to comply with these core obligations has a **multiplier effect on all aspects of women's rights covered by the Convention**, including the rights to education, livelihoods and employment, and to live dignified lives free from violence. Therefore, for the reasons outlined in this report, **we suggest the following recommendations for Belgium:**

(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 opposing the comprehensive TRIPS Waiver at the WTO (described further in section 3);[8]

(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;

In particular, **we respectfully request that, in accordance with Belgium's CEDAW obligations, the Committee encourages Belgium to unequivocally:**

(a) Support the expeditious extension of the June 2022 TRIPS Decision, that was the outcome of the negotiations on the TRIPS Waiver proposal (described in Section 3 below), to cover the production and supply of COVID-19 diagnostics and therapeutics without any further conditions[9].

(b) Support the full use of existing TRIPS flexibilities such as compulsory licensing of patents and adequate exceptions to protection of undisclosed information, copyright and industrial designs.

(c) Pledge not to use the dispute settlement mechanisms of the WTO and other trade and investment agreements, or other means to stop or dissuade countries from using any TRIPS flexibilities for producing, using, exporting or importing medical technologies and products.

(d) Ensure that the EU/European Commission does not make any TRIPS Plus demands in its trade agreements and negotiations with developing countries.

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

[9] Paragraph 8 of the Decision states: "No later than six months from the date of this Decision, Members will decide on its extension to cover the production and supply of COVID-19 diagnostics and therapeutics".

2. Current state of access to COVID-19 diagnostics, vaccines and therapeutics

While there is growing complaisance that COVID-19 has now become 'endemic', we know little about the virus. There are three glaring reasons why access to COVID-19 diagnostics, vaccines and therapeutics are still needed:

(a) There is **continued inequity in vaccination between regions**. Nearly 75% of populations in developed countries are fully vaccinated, as against only 17.5% of populations in developing. Access to important COVID-19 treatments and diagnostics "remains challenging in many developing countries" partially due to IP barriers enforced by Pharmaceutical Corporates.

(b) By December 2021, **of the more than 3 billion tests reported across the world, only 0.4% had been performed in developing countries**[10] leading consequently to more undetected cases. COVID-19 excess mortality data suggest the mortality impact of the pandemic is more serious than what has been officially recorded[11]. The highest ratios of excess deaths to reported COVID-19 deaths occurred in parts of central Asia and sub-Saharan Africa. Developing countries have had the highest cumulative excess deaths due to COVID-19 since the start of the pandemic.

(c) There is evidence to show that the **virus has a greater impact on those who are unvaccinated.** As a consequence, they pose a threat to others as potential carriers and spreaders of COVID-19 variants.

(d) Those vaccinated against COVID-19 are around ten times less likely to be admitted to an intensive care unit because of coronavirus infection, making vaccine inequity a continued global concern and barrier to human rights-based pandemic responses.

Access to therapeutics

Another important area of COVID-19 treatment is therapeutics. This is particularly true in light of the 12th WTO Ministerial Conference (MC 12) decision on the TRIPS Waiver proposal (described in section 3 below). Overall, this decision does little to truly remove barriers imposed on COVID-19 vaccines and has left the question of COVID-19 diagnostics and therapeutics unaddressed.

[10] As a result, 40,000,000 more cases are reported in HICs compared to LICs.

[11] The number of excess deaths due to COVID-19 was largest in south Asia, the middle East and north Africa (MENA), and eastern Europe, according to a Lancet study.

Currently, Paxlovid - a combination drug developed by Pfizer is a promising oral therapeutic with reported efficacy of around 88% in reducing hospitalization and death in early detected COVID-19 patients.

Pfizer and the Medicines Patent Pool (MPP)[12] have agreed on a voluntary license for Paxlovid, enabling 95 countries (least developed and some developing) to purchase the generic version from manufacturers licensed by MPP. Many developing countries in the "upper middle income" range are excluded, as is common with these voluntary licenses. Thus, many countries across central and southeast Asia, the MENA region, Latin America and the Caribbean have been excluded from this license[13], thereby forcing them to rely on Pfizer directly for their expensive version.

Another limiting factor is that Paxlovid must be administered within five days of symptom onset for effectiveness. Therefore, poorer countries with low testing capacity may not detect positive cases within this 5-day window. Moreover, Pfizer had reportedly only promised ten million doses of Paxlovid to the eligible countries. Meanwhile, developed countries with high testing capacity and plenty of Paxlovid supplies are benefitting the most.

Ironically, COVID-19 treatments like oral therapeutics are precisely what poorer countries need to fight the virus and Paxlovid would save many lives. Effective and cheap therapeutics are critical to fighting new variants and for those unvaccinated due to extraneous variables[14]. Therefore, therapeutics offer an economic alternative that is easier to scale up.

The unknown impact of "long COVID" and future treatments

There is still much unknown about the COVID-19 virus, specifically the phenomenon of its long-term effects or "long COVID"[15]. Treatments for this are under research and should be equitably accessible to all.

[12] The Medicine Patent Pool is a United Nations-backed public health organization working to back access to, and facilitate the development of life-saving medicines for low and middle income countries.

[13] As a result, Latin American and Caribbean region countries will be unable to procure or produce cheaper generic versions of Paxlovid until at least 2041.

[14] For instance, in LMICs transport and vaccine delivery remains an issue due to far-flung remote areas and the absence of suitable storage conditions.

[15] Long COVID refers to "signs and symptoms that continue after acute COVID-19 disease (4–12 weeks). See more here. Theories as to why this occurs range from long-term cellular damage caused by the virus to fragments of the virus lingering in the system long after onset. See more here and here.

There is a dearth of studies on long COVID, particularly in poorer countries which account for a large proportion of COVID-19 cases globally. Further research is especially needed in regions such as sub-Saharan Africa due to their limited health system resources. Women are also associated with a higher likelihood of long COVID[16].

Racing to find treatments for long COVID, wealthy developed nations such as the US and UK have already dedicated large sums of money to research. Poorer countries cannot afford to do so. With long COVID the next critical issue, there are concerns that developed nations will continue to gate-keep research and data, preventing equitable access to effective treatments.

3. The role of the EU in trade negotiations including the WTO TRIPS Decision and its implications

TRIPS and TRIPS Plus[17] provisions in trade and economic agreements continue to be a major obstacle to timely and affordable access to COVID-19 health technologies and products.

TRIPS Plus demands by the EU hinder public health

The EU is a major *demandeur* of TRIPs Plus in negotiations with developing countries. This includes demands to adopt data/marketing exclusivity[18], patent term extension etc.[19] This serves to prolong market monopoly of IP holders with disastrous consequences for public health and populations in developing countries.

In Jordan, data exclusivity delayed the introduction of cheaper generic alternatives for 79% of medicines between 2002 and 2006 and ultimately the higher medicine prices threatened the financial sustainability of government public health programs. Consequently, medicine prices in Jordan are 800% higher than in Egypt. In Colombia, data exclusivity increased the costs to the public health system by US$396 million between 2003 and 2011. In Peru, data exclusivity is expected to contribute to an increase of about US$459 million in total pharmaceutical expenditure by 2025. In Guatemala, the

[16] See more here and here.

[17] TRIPS Plus refers to intellectual property obligations and commitments that are beyond the TRIPS requirements. These are done through bilateral, regional and plurilateral trade and economic partnership agreements. TRIPS Plus provisions essentially increase intellectual property barriers and reduce access to diagnostics, vaccines, therapeutics and other medical products.

[18] Data/marketing exclusivity prevents drug regulatory authorities from relying on clinical/text data submitted by originator companies, to approve generics for the market. Several developing countries had to introduce data exclusivity as a condition of trade agreements with developed countries. **There is no international law requiring data exclusivity to be accorded.**

[19] For example, 90 civil society organizations worldwide have called on the EU to drop all TRIPS Plus demands from the Indonesia-EU Comprehensive Economic Partnership Agreement.

data exclusivity duration of 15 years significantly reduced competition, so medicines readily available in most countries at affordable prices were simply not available in Guatemala.

WTO TRIPS Decision of 17 June 2022[20]

The widespread inequity, resulting from the pharmaceutical industry's reluctance and even outright refusal to sufficiently engage through voluntary mechanisms to allow the use of their IP, data and know-how with all possible manufacturers of COVID-19 products, led to the TRIPS Waiver proposal before the WTO in 2020. Initiated by India and South Africa,[21] co-sponsored by 63 WTO Members and receiving tremendous global support,[22] the proposal sought a waiver of at least 35 articles of the TRIPS Agreement covering patents, protection of undisclosed information, copyright and industrial designs to enable the scale up and diversification of global manufacturing of all health products and technologies for the prevention, treatment and containment of COVID-19.

After nearly 2 years of intensive discussion and negotiation, this original comprehensive TRIPS waiver proposal was replaced by the very limited and narrow conditional TRIPS Decision (the Decision) at the recently concluded WTO Ministerial Meeting (MC12). This Decision **does not waive IP** on all essential COVID-19 health technologies and is limited in scope and application. The Decision is limited to vaccines, in essence waiving only a condition attached to the use of compulsory license of patents under Article 31 of TRIPS. It provides a temporary waiver of export restrictions required by Article 31(f). The Decision is for a duration of 5 years and further contains notification and anti-diversion obligations that are against principles of public health.

The Decision reflects the obstructive positions of the UK, EU (including Belgium) and Switzerland and the US's insistence that it should be limited to vaccines. The criteria that limit which Members can use the Decision not only exclude China, a leading vaccine manufacturer and supplier, but absurdly "encourages" a binding commitment from **all developing country Members with existing capacity to manufacture COVID-19 vaccines not to avail themselves of the Decision** (Footnote 1 of the Decision). Further, applying the Decision to therapeutics and diagnostics is absolutely necessary from a public health perspective but it was the most contested and deferred to a later stage. This, despite patent filings related to therapeutics considerably outnumbering those on vaccines at an approximate 4:1 ratio.[23]

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[20] WT/MIN(22)/30)

[21] Proposal IP/C/W/669 revised in IP/C/W669/Rev.1.

[22] This included other WTO members, the World Health Organization and UNITAID, civil society, intellectual property experts, parliamentarians, Nobel laureates and former world leaders.

[23] See page 12 of WIPO's Patent Landscape Report.

The crucial role of therapeutics and diagnostics in controlling COVID-19 is undisputed, recommended by the WHO and reflect national test and treat strategies. Yet timely affordable access remains a challenge in most developing countries. “Current global outpatient treatment production is less than what is needed if 10% of the high-risk population contracts SARS-CoV-2. Using estimates of the population with at least one comorbidity for progression to severe COVID-19, a total of 1.7 billion people globally are at high-risk. If 50% of those at high-risk were infected, 872.8 million courses of outpatient treatment would be needed if there was equitable access to diagnostics and treatment. Current global production of outpatient treatment stands at 160 million courses which is currently less than the 174.6 million courses needed to treat 10% of the global high-risk population” (Airfinity data, February 2022).

Most of the limited supply of COVID-19 therapeutics has been procured mainly by wealthy countries with 16% of the global population. Even when available, they are unaffordable to most developing countries. For some products, voluntary licenses (VLs) have been offered by originator companies to some manufacturers from developing countries but are subject to various conditions often difficult to comply with. The VLs also exclude supply to many developing countries. Supply constraints are expected to continue for most of 2022 even for products where VLs exist. It is clear the broader principle of “global public good” is being severely violated due to the IP-related barriers to manufacturing and access.

4. EU and Belgium’s current position on the TRIPS Waiver leads to violations of CEDAW Articles 2, 10-12, 16, General Recommendation 35, and the duty to cooperate internationally

During Sweden’s constructive dialogue in October 2021, the Committee observed that the implicit opposition of EU Member States (Belgium is an EU Member State) to waiving WTO intellectual property rules might constitute a violation of the Convention, considering, in particular, the disproportionate effects of COVID-19 on women and girls in developing countries and the fact that this could have been prevented by the action of countries to ensure equitable access to vaccines[24].

Indeed, the Committee will be well aware that the social and economic fall-out of the pandemic has exacerbated gender inequalities with multi-layered intersectional identities of race, class, caste, sexual orientation and gender identities, ethnicity, age, ability, religion and migrant/citizenship status, especially in developing and least developed

[24] 80th Session of the CEDAW Committee, Summary of Records, Sweden Constructive Dialogue, October 2021, para. 24.

countries, impacting women's access to healthcare, as well as their economic and educational opportunities.

In particular, the avoidable prolonging of the pandemic due to inequitable access to COVID-19 diagnostics, vaccines and therapeutics has led to the following interconnected violations under CEDAW:

(a) **Articles 10 and 16 (education; family law and marriage):** Economic stress caused by the pandemic has led to gender-based exclusions. In Asia, girls have been quitting school education to supplement household income in menial jobs. School closure and resultant online education and limited access to digital equipment, excluded poor children, especially girls[25]. Women and girls were 11% more likely to drop out of school during the COVID-19 pandemic. Even as schools open, the combination of education budget cuts and families under financial strain is likely to result in more girls remaining out of school to help in domestic care work. There are reports of trafficking of girls, and an increase in child marriages due to economic stress. School closures increase child marriage risk by 25% per year. UNICEF estimated 10 million additional children before 2030.

(b) **Article 11 (employment):** A World Bank Group study found that women were 11% more likely to have lost a job during the pandemic due to multifaceted reasons including patriarchal norms and gender stereotypes.[26] Job losses for women, combined with increased domestic and unpaid care work have further reinforced barriers to economic inequality. Across 33 countries representing 54% of the global working-age population, women spent 55% of their working time in unpaid work, compared to 19% for men. In Asia Pacific, 28% of women took up unpaid care and domestic work as their main economic activity, compared to only 2% of men. Within the health system, women frontline healthcare and service workers constitute around 70% globally, and are at the lower end of health worker hierarchies, experiencing poorer work conditions, low wages and job insecurity. Their pay on average is about 24% lower than men and 20% less overall.

[25] Country-level data on the gender gap in mobile ownership and mobile internet use indicate women consistently lag behind men. https://www.gsma.com/r/wp- content/uploads/2021/06/The-Mobile-Gender-Gap-Report-2021.pdf

[26] Unemployment has disproportionately hit feminized sectors such as services and hospitality, where up to nine of every ten workers are women. Women make up 80% of domestic workers, of which 72% of domestic workers have lost their jobs as a result of the pandemic. Across the globe, 56% of countries report a higher percentage of women workers than men in the informal sector. During the first month of the pandemic, informal workers experienced income drops of 60% globally, and 82% in Asia and Latin America. Women entrepreneurs face specific challenges with lack of financial support, increase in unpaid domestic work, constraints in mobility during the pandemic and were 7% more likely to have closed their business than male entrepreneurs. In every region of the world, female-owned businesses experienced higher closure rates during the first year of the pandemic compared to male-owned businesses. Read more here and here.

(c) **Article 12 (health):** As resources are reallocated to fight the pandemic and health care services diverted to combat COVID-19, other services considered 'non-essential' are affected. These include a range of sexual and reproductive health services such as maternal health care, contraception, abortion and gynecological services affecting women and girls. Approximately 12 million women in 115 developing countries experienced disruptions in their access to contraceptive services, leading to 1.4 million unintended pregnancies in just the first year of the pandemic. The risk of unwanted pregnancies is especially high for girls with serious consequences for life opportunities.

(d) **General Recommendation 35 (gender-based violence):** The pandemic has led to an increase in domestic violence, as women were locked in with perpetrators for prolonged periods, with limited access to support services. There has been a 30% increase in reported cases of GBV globally and trends from African countries show a clear increase in GBV. Data from call centres in Zambia indicate an increase in violence against girls (27%) and against women (38%).

Moreover, **core obligations under Article 2** to eliminate all forms of intersectional discrimination are affected by vaccine shortages and delays in supplies around the world, with a likelihood of rationing in households, giving preference to males. In many developing countries, women are less likely to get COVID-19 vaccines. In Pacific Island countries women are overall less likely to complete the two-dose protocol.

In January 2022, the ratio of vaccinations in India stood at 954 women for every 1000 men, showing a gender gap in vaccination. There are fears of domestic violence if a woman gets vaccinated before the male "head of household". Women with disabilities face specific challenges of 'access' – related to a lack of sensitivity in designing physical spaces and apps for vaccination services. Women who are sex workers face discrimination, abuse and lack of access to adequate information or documentation required to receive COVID-19 vaccines.

This gendered pattern of COVID-19 impact is broadly similar to those witnessed during the HIV/AIDS, Ebola, and Zika outbreaks. This only emphasizes the need to address the "structural determinants of gender inequality—e.g., political participation and economic systems"—and the "intersections with other inequities" to combat the detrimental gender impacts of COVID-19. It also demonstrates the critical importance of **the duty of international cooperation and assistance** in redressing human rights violations that have already occurred and ensuring responses to COVID-19 and other future pandemics address structural inequalities which meet international human rights standards, including CEDAW.

In this regard, the CEDAW Committee 2020 joint call for action highlighting the urgent need of women and girls for international solidarity and cooperation remains highly relevant. Here, the Committee noted how the various challenges of the pandemic that hamper these efforts may deepen poverty and inequalities, particularly in countries without robust supporting systems. The Committee also urged States to be aware of these risks and honour their duty of international assistance and cooperation. As stated in section 1, we reiterate that **an equitable public good approach to COVID-19 is needed to ensure protection of women's right to health and other human rights.**

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 (ICESCR)[27] and the core obligation to ensure minimal levels of economic, social and cultural rights protected under ICESCR 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 strategies[28]. Moreover, in the context of COVID-19, **the CEDAW Committee has emphasized that States "must address women's increased health risk through preventive measures and by ensuring access to early detection and treatment of COVID-19."**

5. Belgium's opposition to the TRIPS Waiver is inconsistent with the findings of its Parliamentary Commission studying Belgium's colonial past

Several reports highlight the connections between racial discrimination - and its intersection with socioeconomic status - to vaccine disparity, mortality, and morbidity related to COVID-19. These disparities are exacerbated by pre-pandemic racial inequalities linked to health challenges, reduced access to health care, housing conditions, and employment in high-risk occupations. Even beyond health, the pandemic has had disproportionate impacts on racial/ethnic minorities and other marginalized communities.

[27] 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.
[28] See CESCR, General Comment 14, article 12.2(c), paras 16, 44.

In April 2021, CERD attributed the lack of equitable and non-discriminatory access to COVID-19 vaccines to "the consequences of the historical racial injustices of slavery and colonialism that remain largely unexplained today…" and reiterated its call on States to support the TRIPS Waiver.

During the WTO's 12th Ministerial Conference in June 2022, the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia, and related intolerance issued an open letter to Member States arguing that racial discrimination played a role in access to COVID-19 health technologies. This operates not only within countries but also through the "differential treatment of and outcomes for countries and territories that were subject to prolonged exploitation and degradation during the colonial era on the basis of racist theories and beliefs". **The Special Rapporteur further argued that racial discrimination is "embedded into transnational legal, economic and political structures, including the international intellectual property regime"**.

The Special Rapporteur's findings are evidenced by the disparities in vaccine access in Belgium as compared to its former colonies. For example, while Belgium has administered the COVID-19 vaccine initial protocol to 79% of its population, Burundi (0.14%) and DRC (2.7%) have remained at extremely low levels. Rwanda is a continental exception and has been able to vaccinate 78% of its population.

There have been efforts within Belgium to address the distinct and critical impact of colonialism on the lives of people in formerly colonized African countries and on those of African descent living within Belgium. The root causes of these violations have been attributed to "the lack of recognition of the true scope of violence and injustice of colonisation", as stated by the UN Working Group of Experts on People of African Descent during a visit to Belgium in 2019. Following widespread anti-racist and decolonization protests in Belgium against the backdrop of the Black Lives Matter movement, the country's federal Parliament set up a Special Commission comprised of representatives of diaspora collectives, specialists and academics to study its colonial past. This also extended the scope of the country's reparation and decolonization examination to territories Belgium once colonized[29].

The report concluded that Belgium's colonial project also had deep consequences in the post-colonial period and across all aspects of people's lives in Rwanda, DRC and Burundi. An exploitative economic relation between these countries have, on one hand, elevated Belgium to an important place in the world economy while, on the other, created structural

[29] Resolution adopted on 17 July 2020 that established the Special Commission to Examine the Independent State of Congo and Belgium's colonial past in the Congo, Rwanda and Burundi, its consequences and the appropriate steps to be taken.

issues resulting in deep inequalities within former colonies. This includes, as a result, the underdevelopment of manufacturing capacity, as established by the report[30].

Accordingly, the Commission recommends that Belgium's reparations must be dealt not only with words but also in deeds through a comprehensive approach: "Reparations - as part of a holistic approach to dealing with the past - should also aim to transform structures, inequitable power relations and unequal socio-economic conditions". It has been noted that while Belgium cannot retract its colonial past it is now necessary to address the contemporary fall out of it, and address structural inequalities that prevent the exercise of the right to health and to development of former colonies. Promoting 'quick fixes' such as vaccine dose donations or voluntary licensing of technology does little in the way of structural changes. It simply reiterates the benevolent and humanitarian discourse Belgium used during its colonial enterprise.

6. The recommendations set out in this Shadow Report are consistent with the EU's position on CEDAW compliance

Finally, the recommendations set out in this Shadow Report **(see page 8)** are consistent with the EU's position on CEDAW compliance, making it incumbent on Belgium to ensure that it and the EU bloc as a whole meets its obligations when acting in international fora, including the WTO. For example, the **European Consensus on Development, states that the EU and its Member States will proceed in accordance with the fulfillment of obligations under the CEDAW, and firmly embrace the protection and fulfillment of women's and girls' rights.**[31]

This position is further supported by the End-of-Mission Statement of former United Nations Independent Expert Juan Pablo Bohoslavsky, who reiterated that **international and multilateral institutions "are not beyond the reach of international human rights law"** and must respect these laws when making policy recommendations or setting conditionalities on their Member States. The Independent Expert extended this **exemplar to EU Member States, who were reminded that their obligations under core human rights treaties they have ratified "need to be respected as well when they affect rights holders living outside their own territory**", and similarly **any delegation of their powers to an international institution does not remove States' obligations to**

[30] Page 211.

[31] EU (2017). New European Consensus on Development: 'Our world, our dignity, our future'. Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission. OJ C 210, 30 June.

ensure that international institution will not infringe on human rights in carrying out the delegated powers.

The pandemic is a setback to hard won rights for women and girls, and towards gender equality. The TRIPS Decision adopted at the 12th WTO Ministerial Conference in June 2022 is a severely watered-down version of the original Waiver proposal put forth by India and South Africa. Hence it is not called a "Waiver" decision in the final adopted outcome. The Decision does little to ensure equitable access to vaccines for all and does not even include other essential products such as COVID-19 diagnostics and therapeutics. Without a full waiver on all the needed COVID-19 products and technologies, there is no end to unjust IP barriers on equitable access, and as a result, no end to the pandemic. Belgium must recognize that a full 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.

We also emphasize the need to strengthen a "global public goods" perspective to health, which is based on international cooperation and collaboration to improve global health, in particular the health of the poor. Global public goods are those which can consist, inter alia, of programmes, policies and services that are available to all and are "non-excludable". They are goods that can be enjoyed by anyone repeatedly without lessening their benefits to others. They are goods that are available to all and beneficial to all. In this respect, health can be considered a global public good. The benefits of such goods also accrue to future generations and merit the cost expended on them in the present. These critical public goods must be provided "by an international effort, since national governments acting individually lack the incentive [and often the means] to provide such efforts at a sufficient level for global well-being", as highlighted in the report of Working Group 2 of the WHO Commission on Macroeconomics and Health.