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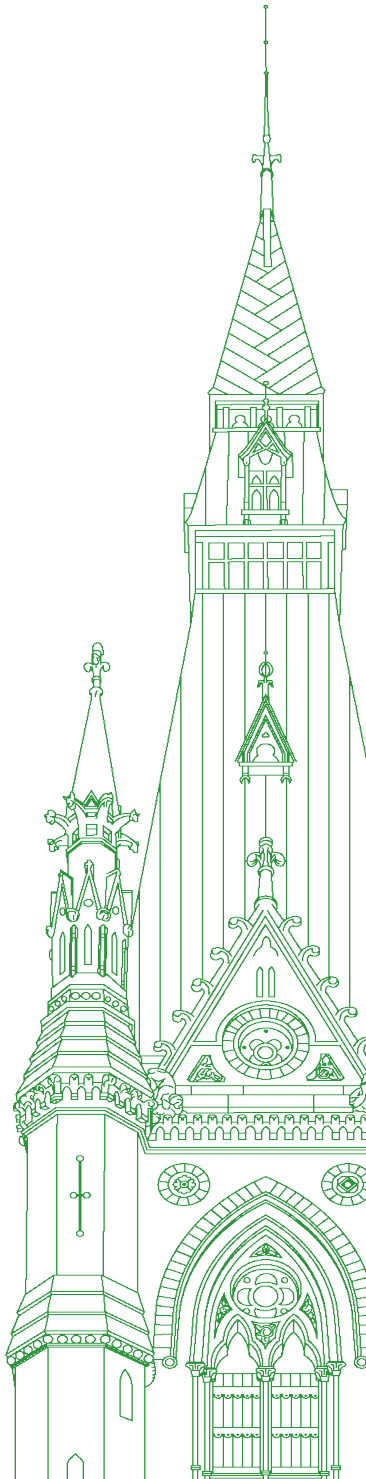

Chair: Mr. Sven Spengemann

Standing Committee on Foreign Affairs and International Development

Monday, April 4, 2022

● (1110)

[*Translation*]

The Chair (Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.)): Dear colleagues, welcome to meeting No. 4 of the Standing Committee on Foreign Affairs and International Development.

[*English*]

Pursuant to the motion adopted on January 31, the committee is meeting on its study of vaccine equity and intellectual property rights.

[*Translation*]

As always, interpretation is available at this meeting. To listen to the interpretation, just click on the globe icon at the bottom of your screen.

I would ask members participating in person to keep in mind the Board of Internal Economy's guidelines for mask wearing and health protocols.

[*English*]

I'd like to take the opportunity to remind all participants that screenshots and taking photos of your screen are not permitted.

[*Translation*]

Before speaking, please wait until I recognize you by name. When speaking, please speak slowly and clearly. When you are not speaking, your mic should be on mute.

A reminder that all comments by members and witnesses should be addressed through the Chair.

[*English*]

Colleagues, I would like to now welcome our first panel of witnesses before the committee and thank them for agreeing to spend time with us this morning.

As usual, when you have 30 seconds remaining in your testimony or questioning time, I will signal you with this yellow piece of paper, so please keep an eye on your screens.

[*Translation*]

I would now like to welcome this morning's first panel of witnesses.

First, we welcome France-Isabelle Langlois, Executive Director of Amnistie internationale Canada francophone.

[*English*]

From Oxfam Canada, we have Diana Sarosi, director, policy and campaigns; and Brittany Lambert, women's rights policy and advocacy specialist.

You'll each have five minutes for your opening statements.

[*Translation*]

I propose that we start with Ms. Langlois.

Ms. Langlois, you have five minutes for your opening statement.

Ms. France-Isabelle Langlois (Executive Director, Amnistie internationale Canada francophone): Ladies and gentlemen, good morning. Thank you for this invitation.

Amnesty International, as an organization that defends human rights, became involved from the very beginning of the pandemic in order to call for unwavering international solidarity by all states, including Canada. Along with many other stakeholders, we have been calling for vaccine equity and the temporary patent waiver at the World Trade Organization, or the WTO, for more than two years. This is the third time that I have personally appeared before a parliamentary committee on this issue. In the meantime, Canada's position has not changed, COVID-19 is still present and continues to result in deaths, although we talk about this less and less. The gap between rich and poor countries is growing, and pharmaceutical companies continue to reap huge profits.

Amnesty International wants to remind everyone that under international human rights law, governments have an obligation to provide the financial and technical support necessary to implement the right to health, particularly in light of the international spread of a disease.

Therefore, we call on Canada once again to provide strong support for the temporary waiver on intellectual property rights for health technologies related to COVID-19 proposed by South Africa and India in October 2020 at the WTO.

However we are deeply concerned about a draft text, which was leaked to the media in late March, proposing a compromise for this waiver between the European Union, the United States, India and South Africa. As written, this text will never ensure the supply and transfer of technologies necessary for equal access to health tools to combat COVID-19 and the protection of the right to life and health. We urge Canada not to endorse this text.

Initially, India and South Africa called for a waiver to the WTO's TRIPS Agreement—specifically provisions relating to intellectual property rights and trade—to democratize the production of products that combat COVID-19 until global herd immunity is achieved.

The World Health Assembly recognized the “role of extensive immunization against COVID-19 as a global public good for health in preventing, containing and stopping transmission in order to bring the pandemic to an end”.

Yet, pharmaceutical companies around the world continue to pursue a business-as-usual approach, limiting production and supply capacity.

We will have tolive with COVID-19 for years to come. Everyone must have access to vaccines, and also to treatments. We must democratize production, especially now that new treatments are becoming available.

By supporting the removal of intellectual property protections for vaccines and other products to combat COVID-19, Canada would be putting the lives of people around the world, including Canadian lives, before the profits of a few pharmaceutical giants and their shareholders.

The only way to end the pandemic is to end it globally, and the only way to end it globally is to put people before profits.

The international standards of human rights to which Canada subscribes and the regulations governing international trade clearly stipulate that the protection of intellectual property must never come at the expense of public health.

The COVID-19 crisis is also a human rights crisis. It cannot be overcome without true commitment to one of the Sustainable Development Goals: to leave no one behind. Based on the premise that “none of us will be safe until everyone is safe”, Canada has an opportunity today to make a decision that will make that goal a reality.

Amnesty International is reiterating the specific request it made to the Canadian government to support a waiver not just for vaccines but also for all necessary medical technologies, and not just for certain countries but for all those with the means to contribute to vaccine production. Nor should other discussions about other waivers be postponed for six months or more.

We are asking Canada to show exemplary leadership on international solidarity.

Thank you.

● (1115)

The Chair: Thank you very much for your opening statement, Ms. Langlois.

[*English*]

We will now turn the floor over to Ms. Sarosi from Oxfam Canada for opening remarks.

Please go ahead.

Ms. Diana Sarosi (Director, Policy and Campaigns, Oxfam Canada): Thank you, Chair. It is my pleasure to be here before the committee.

Oxfam supports long-term development, advocacy and emergency response programs in more than 90 countries around the world. The low- and lower middle-income countries we work in have suffered tremendously from the pandemic. COVID-19 has shattered the world's weakest economies, destroying livelihoods and making global hunger skyrocket. In 2021, 163 million people were pushed into poverty because of the pandemic.

These same countries have struggled to access vaccines. In 2021, more than 80% of all vaccines went to G20 countries, while less than 1% reached low-income countries. Vaccine inequality has prolonged the pandemic, and poorer countries have paid the price of vaccine inequality in economic terms and in lives. For every life lost to COVID-19 in a rich country, four were lost in lower- and middle-income countries. Globally, 4.7 million children have lost a parent or caregiver to the virus. That's a staggering four children every minute.

COVAX was supposed to deliver two billion doses to low- and middle-income nations by the end of 2021, but delivered only less than half of that because of slow donations from wealthy countries, including Canada, and delivery delays from vaccine makers. People in low- and middle-income countries should not have to rely on the charitable goodwill of rich nations and pharmaceutical corporations to fulfill their right to protection from COVID-19. That is why Oxfam has supported the calls for a TRIPS waiver.

The TRIPS waiver proposal put forth by India and South Africa in October 2020 and backed by over 100 nations was a powerful message from developing countries that they needed relief in this pandemic. By giving more companies the legal ability to reproduce COVID-19 vaccines and drugs, a waiver could help to increase supplies and pave the way for a more equitable distribution of life-saving technologies.

For 18 months, the European Union and other rich countries chose to block the TRIPS waiver and the path to an early exit from this pandemic, thus defending the interests of pharmaceutical monopolies. Large pharmaceutical companies have been the biggest winners in this pandemic. It is tragic that our global economy has proved better at creating new vaccine billionaires than at vaccinating the billions of people who need protection from this cruel disease.

A few weeks ago, a document was published, proposing a compromise agreement on the TRIPS waiver. It was negotiated by the U.S., the EU, South Africa and India. With the except of the EU, these countries have not officially endorsed the compromised proposal. It is positive that the EU has finally come to the table and acknowledged that intellectual property rules and pharmaceutical monopolies are a barrier to vaccinating the world; however, in our view, the document is only a very small step forward. The current text is narrow in scope and has considerable limitations. It does not cover COVID tests or treatments. It covers only patents and not other intellectual property barriers. It narrows geographical scope, excluding countries with significant manufacturing capacity, and it creates new, onerous barriers for countries seeking to issue a compulsory licence, rather than easing current rules.

Adopting this text without addressing its flaws would set a negative precedent and stand in the way of the world's ability to respond collectively to future pandemics. We hope that Canada will work collaboratively at the World Trade Organization to urgently remedy the limitations in the proposed text. We would also like to see Canada accelerate its delivery of surplus doses and scale up international assistance funding to support developing countries with the devastating economic fallout from the pandemic.

COVID-19's economic, social, educational and health impacts on women and girls have been particularly staggering. In 24 months, the pandemic has set back the goal of achieving gender parity by a whole generation.

COVID-19 is a transnational challenge, but our collective response so far has been short-sighted, inequitable and nationalistic. It is time to change course. The world has waited long enough.

Thank you again for the opportunity to appear here today on behalf of Oxfam.

● (1120)

The Chair: Ms. Sarosi, thank you so much for your opening remarks.

Colleagues, we will go into round one now.

I'm looking at the clock. We've had a bit of a late start. I think we have time for only this first round. I would encourage colleagues in the Conservative and Liberal parties to share their slot if they wish to do so. They are six-minute allocations.

Leading us off will be Mr. Genuis, please, for six minutes.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you, Mr. Chair, and thank you so much to the witnesses.

Could you clearly put on record what you understand to be the government's position? What's your understanding of what the government's position is right now and what we are advocating for?

Ms. Diana Sarosi: I can jump in.

That's a tricky question. That's what we're trying to find out as well. It has been very nebulous. On the one hand, they are saying they're not supporting it, but they're also not opposing it. They've basically been standing on the fence on this issue for many months now, but have also initiated an alternative third way proposal, which has further undermined the advancement of the TRIPS waiver conversations.

I would like to bring in my colleague, Brittany Lambert, who can talk a little more about the Ottawa process.

Ms. Brittany Lambert (Women's Rights Policy and Advocacy Specialist, Oxfam Canada): Yes, the government has always stated with regard to the TRIPS waiver that its goal is to work constructively to find a consensus-based solution at the WTO that would be acceptable to everybody. In reality, though, this nebulous position has made it very difficult to tell what the government's position is. It hasn't wanted to engage with us on the specifics of any clauses in the TRIPS waiver or in the compromise proposal. It's impossible to tell how constructive a role it is playing at the WTO right now.

Mr. Garnett Genuis: At the risk of sounding partisan, this sounds, sadly, typical. They have the right buzzwords out there—co-operative, collaborative, being nice, helping people—but it becomes hard to know what they actually mean by these words.

Would you say that the third way they're talking about is providing more clarity or simply more confusion about what their position is? Do you know what the substance of the third way proposals are, or is that just another set of nice-sounding concepts without clarity?

Ms. Brittany Lambert: In the third way, the Walker process, driven by the Ottawa Group, they say they're aiming to tackle issues like supply chains, export restrictions and other issues that the industry has identified as being barriers to production. Unfortunately, it contains nothing on intellectual property, so it's not seen as a viable alternative by the 100-plus countries that identified intellectual property as the biggest obstacle to their ability to secure lifesaving tools.

I would say that it muddied the waters at the WTO and that it probably did indeed postpone a consensus on the TRIPS waiver.

Mr. Garnett Genuis: Has the government articulated any reasons for not proceeding in this direction? Has that been part of the dialogue, or has it not even gotten that far?

Ms. Brittany Lambert: No, they have said that they want a consensus-based solution that works for everybody. I suspect that their reasons, much like the other wealthy countries that have obstructed the TRIPS waiver, have to do with not wanting to take a position that would be contrary to the interests of pharmaceutical companies, which obviously have a huge influence, especially when these nations themselves are depending on them to secure their own vaccines.

Mr. Garnett Genuis: How would you describe the level and nature of engagement of civil society, of human rights organizations like yours, by the government on this issue?

Ms. Brittany Lambert: The government have been responsive. They've been willing to meet with us, but as I said, their position is so nebulous that it prevents us from getting into detailed discussions with them on anything. Their speaking lines continue to be that they support consensus and that they're working behind the scenes to get that, and that's where it ends.

Mr. Garnett Genuis: Thank you.

Ms. Langlois from Amnesty, do you want to weigh in on that point, about the nature of your engagement with the government up to this point?

● (1125)

Ms. France-Isabelle Langlois: Could you repeat your question? I'm not sure I understood.

Mr. Garnett Genuis: How would you describe the nature and quality of engagement that you've had with the government on this issue? Have they been forthright? Have they been available at senior levels to discuss their position? How has that unfolded?

Ms. France-Isabelle Langlois: Thank you.

[*Translation*]

We have been having discussions with the government and different stakeholders. It has not been easy. We had to push a lot 18 months ago to have these meetings and discussions. However, we cannot say that discussions are not taking place. There are discussions, but its position does not appear to have changed.

[*English*]

Mr. Garnett Genuis: I know we have a draft.... I'm not supposed to speak about draft motions on notice, so I won't.

I have one final question. Could any of the witnesses speak to this concept of enlightened self-interest in the context of the pandemic? We want to talk about altruism, of course, being a primary value, but how does enlightened self-interest inform what we should be doing in this respect?

Ms. France-Isabelle Langlois: The question is for me?

Mr. Garnett Genuis: It's for anyone who wants to take it.

[*Translation*]

Ms. France-Isabelle Langlois: As already mentioned, we have been living with this pandemic for more than two years, and there have been delays and negotiations for more than two years. We are asking the government to demonstrate real leadership and to be constructive in order to resolve the situation. We really must go ahead with patent waivers and the democratization of technologies and the production of all treatments for COVID-19 around the world. We must create vaccine equity and equitable access to all technologies and, above all, to new medications being developed that will soon be available.

The Chair: Thank you, Ms. Langlois.

[*English*]

Thank you very much, Mr. Genuis.

We'll go to Dr. Fry, please for six minutes.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Chair. I want to thank my colleague, Heather McPherson, for bringing up this particular topic, because we all know, this is common sense, that until we can end the pandemic everywhere, we will continue to have bouts of pandemic going on, as we can see now with the BA.2, which is beginning to threaten countries in Europe and, obviously, the United States and Canada.

I think this is an important issue. We've talked about vaccines. I think the question I have is whether any of you know or understand what Canada is doing with regard to testing, with regard to diagnostics and with regard to culture? I think that is an important thing, cultural issues regarding vaccine uptake in some countries.

Ms. Brittany Lambert: I can speak to that.

Through the ACT Accelerator, there are several arms. I'm happy to see that Canada is not focusing only on vaccines, but also through the other arms and diagnostics and treatment, etc.

That being said, this TRIPS waiver compromise proposal is quite worrisome in terms of access to treatments and tests. One of its most glaring flaws is that it would apply only to vaccines. That may have been useful 18 months ago, but the context has now changed, and we're no longer in a situation of vaccine scarcity. We're now at a stage in the pandemic where regular, rapid and affordable testing and treatment are just as important, so we are concerned that this TRIPS compromise proposal, because it excludes tests and treatment, is just going to replicate the same extreme inequality that we've seen with vaccines, but in terms of access to other life-saving treatments.

Hon. Hedy Fry: I just wanted to go back to one of the pieces I asked you about in my question, which is that we know that many countries.... You take a country like Hong Kong. It obviously isn't a low-income country, but Hong Kong is finding itself now with a huge number of deaths as a result of the pandemic, when it was doing very well at the very beginning of the pandemic in term of its public health protocols.

What we're hearing, though—and I have been checking this out in a lot of medical journals—is that a lot of people in Hong Kong do not want to take vaccines because of cultural issues. They don't trust vaccines; they don't understand them. There are all kinds of reasons why many countries don't want to take vaccines or the uptake is low.

What do you think one can do about that? What's a good strategy to deal with cultural issues? You cannot make people do something if they don't want to, but is there a creative way to get people to take up vaccines? What are the ways to do that?

● (1130)

Ms. Brittany Lambert: Certainly campaigns to combat misinformation are key and vaccine hesitancy is an issue everywhere. That being said, I would say two things. I would say low supply to many places has bred hesitancy. Here, it's very mainstream. Everybody gets the vaccine, everybody talks about it. The government can credibly campaign to increase uptake, because it actually has vaccines to offer people. I think that may explain—not necessarily in Hong Kong; I don't know that situation—some of the hesitancy that we've seen in places like Africa.

Then there are other complex social factors that drive hesitancy for some communities—a history of colonial, medical, vaccine research abuse, etc.

Hon. Hedy Fry: You have no creative answers to help us to overcome some of those problems? Here in Canada, we see vaccine hesitancy. In a country like Canada and in a country like Hong Kong, which is a well enough educated country, we still see this sort of cultural barrier, but I want to move on again.

As you know, the Ottawa Group has been covering the trade and health issues. What role do you think this group can play and has it played in leading the discussion at the WTO for the 32 other members of the group? As you said, only vaccines are covered in TRIPS. How about introducing issues like treatment and testing, etc.? What role do you think the Ottawa Group can play and should play?

That's for anyone.

Ms. Brittany Lambert: I don't know the ins and outs of the Ottawa Group and everything they're doing, but I hope they can play a constructive role. I just think it's important that it not be construed as an alternative to the TRIPS waiver, because the IP barriers that developing countries have been raising are clearly important to them, and the Ottawa Group doesn't include anything to that effect.

Hon. Hedy Fry: No, and I think the thing about the TRIPS waiver is that Canada doesn't have any skin in this game, necessarily, because Canada is not a pharmaceutical country. It doesn't deliver huge pharmaceuticals. We have to get ours from other people. Europe is a big vaccine producer and the United States produces some vaccines, but my question still comes down to this: How do we get uptake? It's one thing to take a horse to water, but you have to make it drink.

The question for me is, how do we get uptake in low-income and middle–income countries that are hesitant? I know that religious reasons play a huge role in people taking vaccines and/or accepting vaccines. In other countries, cultural issues play a big role. I want to go back to this, because for me that is a big stumbling block. The TRIPS waiver notwithstanding and Canada playing a role in that, I think I agree with you on that one. The issue for me is that you could do whatever you would, but if people aren't going to take vaccines, how do we find a way around this?

Education is a long-term thing, as you know. You just don't tell people, “Oh no, no, no. Please trust us, because we think this is important for you.” What sort of way can we use to get around this? I know that some people have talked about paying people to take vaccines. I have heard that discussed in many countries. Do you think that's a valid way to get people to take up vaccines when, for various cultural and other reasons, they don't want to?

The Chair: Dr. Fry, unfortunately, that's past your time. We'll have to wait for the answer in the next round.

Hon. Hedy Fry: I'm sorry, Chair.

[*Translation*]

The Chair: Ms. Normandin, welcome to the committee.

You have six minutes.

Ms. Christine Normandin (Saint-Jean, BQ): Thank you, Mr. Chair.

I thank all the witnesses for their testimony.

My questions will be mainly for Ms. Langlois.

Ms. Langlois, I would like to talk about the letter that you sent to several parliamentarians on March 23, sharing your concerns about an amendment to the TRIPS agreement.

The second point you mentioned is that, according to the current draft, only countries producing less than 10% of global vaccines would be eligible. Would it not be more appropriate, for example, to also allow countries that produce more than 10% of global vaccine to participate, on condition that they produce vaccines for lower-income countries?

Could you talk about that, please?

● (1135)

Ms. France-Isabelle Langlois: I would first like to say that my area of expertise, and that of Amnesty International, is limited to human rights. We have concerns about the fact that the changes or restrictions requested are not consistent with the spirit of human rights or the treaties and conventions signed by Canada.

With regard to the patent waiver and intellectual property, we must bear in mind that there must be as few restrictions as possible. The process must be democratized as much as possible so that as many people as possible around the world have access to treatments and not just vaccines.

For all sorts of reasons, there is hesitancy, as Ms. Fry rightly pointed out, not only about vaccines, but also about treatments. The longer we delay, the more hesitancy there will be. When we appropriate technologies or vaccines, restrict access to them and delay sharing them with all of humanity, it sends a terrible message. For example, by sending the surplus of AstraZeneca vaccines, which we do not want, to the poorest countries, we are sending the terrible message that these vaccines are not good for us, but they are good for them.

We have to bear that in mind. We must not restrict the production of vaccines to certain countries, no matter how the restrictions come about. We must make the opportunity available to others. We must support all countries that want and are able to produce vaccines.

Canada's role is not limited to purchasing vaccines and sending them to the poorest countries. All the logistics must be established in those countries so they can administer treatments, including vaccines. The situation is complicated in the case of vaccines. Current vaccines require specific handling, especially when it comes to the cold chain. In many regions of the world, it is difficult to implement without the appropriate technology and logistics. Not only must we provide the technology and the remedies, among other things, but we must also raise people's awareness of the importance of these medications and treatments.

Ms. Christine Normandin: Thank you very much. You answered some of the questions I was going to ask you, which is why I let you have more time.

I just wanted to follow up on Dr. Fry's questions and touch on the issue of hesitancy.

The proposed changes to TRIPS only cover prevention—vaccines—and don't allow for any latitude when it comes to treatment. Doesn't that make people even more hesitant? As we know, people may be vaccine-hesitant, but when they get sick, they are much less hesitant to receive treatment.

Does the fact that treatments are not included contribute to people's tendency to be hesitant?

Ms. France-Isabelle Langlois: I'm not exactly sure why treatments were not included, but what you are suggesting makes sense to me. I think we need to keep in mind that pharmaceutical companies want to control the profits. All along, economic interests have taken precedence over the health and the lives of entire populations.

Ms. Christine Normandin: In your January 10 letter, you urged parliamentarians to ensure that human rights are included as guiding principles in the World Health Assembly's debates on a future international treaty on pandemics.

I'd like to hear your thoughts on human rights and the right to health. Is there specific wording stating that that means the right to vaccines, or does that have to be interpreted, such as by a legal opinion?

Ms. France-Isabelle Langlois: The right to health means the right to access all available treatments, regardless of what they are, and to have fair and equal access to health care, no matter what it is. We can infer that vaccines are part of health care for many diseases, including COVID-19.

Ms. Christine Normandin: Would it make sense to specify in advance what's included and what's not? That way, debates about whether or not it includes certain elements, such as treatment, could be avoided down the road.

● (1140)

Ms. France-Isabelle Langlois: Exactly. I believe Canada should support the ongoing work to establish a treaty on pandemics specifically. We can expect more pandemics, so the idea is that, when the next one comes along, we can avoid spending months or even years debating these issues as we are doing now. A treaty would give us the mechanisms to ensure greater equity in terms of treatment and prevention.

Ms. Christine Normandin: Thank you.

The Chair: Thank you very much, Ms. Langlois and Ms. Normandin.

[*English*]

Ms. McPherson, you have six minutes, please.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you, Mr. Chair.

Thank you to our witnesses for being here today. This is so important. The work you've been doing on this is vital.

Over the weekend and last week, we heard about the new development of the omicron XE variant, which is, of course, extremely worrying. It means that what we're doing here today is that much more important.

I have to start by saying that I'm extremely frustrated that we are in this position, that we are still debating and still discussing some of the issues that we're discussing today. The first time I raised this issue within the foreign affairs committee was actually on November 17, 2020, when I asked to ensure that we had an equitable way to make sure that countries around the world could access vaccines, and that they would not all be procured and snatched up by wealthy countries at the expense of global health. Obviously, when we look at the history of how vaccines have been rolled out during the COVID pandemic, that has not been the case.

I guess that's where I'll start today. Some of my colleagues have already brought up the idea that the pharmaceutical companies have been given the power to determine who gets a vaccine and who doesn't. Of course, when you leave a corporation, whose reason for being is profit, in charge of rolling out life-saving vaccines, you are not going to have an equitable rollout. We know that the profits that Pfizer, BioNTech and Moderna have made are around $34 billion in 2021, despite the fact that they received $8 billion in public funding.

Perhaps I'll ask our colleagues from Oxfam to comment first. Could you give us a little more insight on what it means when we give corporations the power to determine who is able to be vaccinated and who is able to access vaccines, rather than treating this as a public health thing that is determined in a more equitable way?

Ms. Brittany Lambert: You're right, Heather, about the pharmaceutical monopolies. The big four, if you will, have basically had exclusive patents on these vaccines that the entire world wants. That has basically enabled them to play God and decide what price they're going to sell the vaccines at and who they're going to sell them to. They have obviously prioritized contracts with the wealthiest governments, who were willing to pay more.

They've insisted that they can supply the world. They've consistently exaggerated their production capabilities. This control that they retained enabled them to artificially constrain supply at the cost of millions of lives in developing countries. The profits they're making are quite outrageous. Moderna and BioNTech have 69% profit margins. If you look at how much Pfizer, BioNTech and Moderna are making together, it adds up to profits of about $65,000 per minute.

Ms. Heather McPherson: That's per minute.

Ms. Brittany Lambert: Yes. It's quite shocking.

I think lives should be prioritized over corporate profits, when they clearly have more than enough already.

Ms. Heather McPherson: Thank you so much.

Ms. Diana Sarosi: If I could add to that, the thing is that we knew that would happen, because this is how it has happened in the past and this is just how the world works, right? That's why COVAX was set up. That's the thing about it: COVAX, in its conception, was a brilliant idea to try to avoid that kind of situation, but by then, countries had started to make side deals with these pharmaceuticals, and COVAX got completely undermined. Otherwise, it would have been COVAX purchasing for the world. These pharmaceuticals wouldn't have been able to pit countries against each other for the highest prices.

● (1145)

Ms. Heather McPherson: Exactly. One of the other things is that this is not new. We have had problems with access to essential medicines in the past. I worked with MSF on campaigns decades ago on this.

One of the other concerns I have and that I want to flag for you is that we have heard that Canada will be using vaccine doses to contribute to the calculation of official development assistance. Now, considering the impacts that COVID has had on women and girls, the food shortages we're seeing around the world right now, and the impacts on our ability to deliver on the feminist international assistance policy, what are the impacts of our using those vaccines as part of our ODA? How will that impact Canada's ability to play a meaningful role in the world with regard to humanitarian and development assistance?

Ms. Brittany Lambert: Clearly, with this pandemic and all the other crises that the world is facing—climate, the economic repercussions of the pandemic, conflict, global displacement—we need the ODA to go up to be able to support the world with the long-term fallout of this pandemic. I would strongly urge the government to ensure that any.... It's great if it can get credit for its vaccine donations, but it needs to increase ODA proportionately.

Vaccine inequality has prolonged the pandemic. It has reversed some of the fragile women's rights gains that we were making, thanks to wonderful investments like those of the feminist international assistance policy. In that sense, I would say that vaccine inequity has threatened, or is threatening, the ambitions and the achievements of the feminist international assistance policy.

It's in Canadian interests, if we don't want to see the wonderful work that we've done and invested in go to waste, to make sure that we increase international assistance rates to compensate for what's happening and the extra money we need to spend on vaccines.

The Chair: Ms. McPherson, thank you very much.

Colleagues, I'm going to correct myself. We do have time for a brief second round, albeit compressed. I would propose that we do three-minute and one-and-a-half-minute rotations. That way, we'll sneak in just past 12 o'clock, I believe.

If that's okay with colleagues, Mr. Morantz will be leading us off for three minutes.

Please go ahead.

Mr. Marty Morantz (Charleswood—St. James—Assiniboia—Headingley, CPC): Thank you, Mr. Chair.

Given the limited time, I want to focus on the Medicago vaccine company and its production of a Covifenz vaccine. I'll direct my question to Oxfam, because their representative mentioned concerns about Canada being able to meet its COVAX obligations. That was Ms. Sarosi, I think.

As you may be aware, the Government of Canada provided a SIF grant of $173 million to Medicago to produce a made-in-Canada vaccine, which was intended for a number of purposes. One was to enable Canada to meet its COVAX obligations. This was confirmed by Minister Sajjan in media articles. It was denied by the public service when I questioned the public service about it in the last meeting about vaccine equity.

Do you have any concerns about that? The WHO has said specifically that Covifenz will not be approved for emergency use. In fact, it went so far as to say that “there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests”. Why did it say that? It said that because Philip Morris International, which is a tobacco company, owns a roughly one-third stake in Medicago.

Could you comment on that situation?

Ms. Brittany Lambert: I apologize. I can't comment on that specific situation. I don't know the details.

My hope is that Canada can.... Obviously, I want to see Canada be able to donate as many vaccines that are useful to the developing world as possible, but I don't know the ins and outs and politics of that situation.

Mr. Marty Morantz: Do any of the other panellists have any knowledge of that issue? No.

I'll leave it to you to look into it. Obviously, Canada's obligations to COVAX are very serious international obligations, so it might be of interest to you to find out that Canada is going to have a lot of difficulty meeting its 200-million-dose obligation. This is because of the fact that the proper due diligence wasn't done when 173 million taxpayer dollars were invested in a company that is producing a vaccine that cannot be used outside of our borders for emergency use.

Those are my questions, Mr. Chair.

● (1150)

The Chair: Thank you very much, Mr. Morantz. Thank you for sticking to the time limits.

Mr. Sarai, you have three minutes.

Mr. Randeep Sarai (Surrey Centre, Lib.): Thank you.

I want to thank the witnesses for giving insight on this. This is an ongoing issue, and it is still a pretty pressing issue, even though we see that rates in Canada have gone down and vaccine uptake is very high.

I would like to find out if any of the witnesses can elaborate on how practical a TRIPS waiver would be, taking in the time...how long it would take to build a facility specifically for the mRNA type of vaccines, which would procure the ingredients and manufacture and deliver vaccines.

We've seen that here, even though funding support announcements were made immediately when COVID-19 happened, the facilities are just coming up now. It takes almost two years.

Even if we were to do a TRIPS waiver—if the world were able to do that—how practical would it be? Would facilities be up and running and getting ingredients? If it takes the same timeline in Canada or the western world, it would essentially take almost two years. I don't know if that has been taken into account.

Can somebody elaborate on that?

Ms. Diana Sarosi: I can jump in on this issue.

A study by MSF has already shown that about 100 companies are ready to manufacture these vaccines around the world. Obviously, nothing is going to happen overnight and there need to be adjustments made. These are companies that are already producing vaccines and medication for all kinds of other diseases, so it's really a matter of adjusting it.

The other thing to consider as part of it is the amount of time it takes to do clinical trials. Trying to manufacture a new vaccine takes a long time, because you have to spend a long time doing clinical trials. That time could really be reduced if there was a possibility to share the knowledge and the technology so that we don't have to do these extensive clinical trials anymore.

Mr. Randeep Sarai: What's the cause of the slow uptake, even in places like China, which manufactures its own vaccine and where they have a fairly robust system of delivery and procurement, and their levels are very low? We see the uptake load. It's not a matter of pure availability, but also hesitancy or other factors.

Can anyone elaborate on the Chinese situation, where it's almost one-sixth of the population of the world?

Ms. Diana Sarosi: I can elaborate on that, which also includes the situation in Hong Kong.

China has pursued a policy of zero COVID cases. From the start the Chinese policy was they're not going to let it in; they're going to focus on the testing. As soon as there was a case, they kept it isolated and took it out of society, basically. It's come down to this omicron variant for them to realize this policy is not sustainable.

In terms of hesitancy, I want to bring up one recent study by the Partnership for Evidence-Based Response to COVID-19. It showed that an overwhelming majority of people in Africa, 78% of people surveyed across 19 countries, are willing to get vaccinated.

Hesitancy is not particularly higher in developing countries than in developed countries. People want to get vaccinated everywhere, but having this charitable approach whereby countries never know when they're going to get vaccines and how soon they're going to expire makes it very difficult to get these vaccines into people's arms.

The Chair: My apologies, Ms. Sarosi and Ms. Sarai, but in the interests of time, we'll have to move on.

[*Translation*]

Thank you very much.

I will now give Ms. Normandin the floor for a very short, minute-and-a-half intervention.

Ms. Christine Normandin: Thank you very much, Mr. Chair. I will be very brief.

There has been a lot of talk about state obligations in terms of human rights and the right to health. Correct me if I'm wrong, but there are no penalties for failure to honour those obligations. Maybe that is why nothing concrete is happening. Pharmaceutical companies are powerful lobbyists and they're putting a lot of pressure on governments to not sign on to the TRIPS waiver.

Would be a good idea for a future treaty on pandemics to include sanctions against states that fail to fulfill their human rights and right to health obligations?

● (1155)

Ms. France-Isabelle Langlois: That is a good question.

Generally speaking, international obligations are not backed by sanctions. Rather, countries themselves impose their own sanctions, by which I mean that they give themselves the legislative tools to ensure they respect their international commitments.

It is after all a moral engagement. International treaties encourage compliance with commitments.

Ms. Christine Normandin: In this case, the pharmaceutical lobby is tipping the balance one way. Would it be a good idea to have sanctions to even things out?

Ms. France-Isabelle Langlois: I think it's very important to have a counterweight to the pharmaceutical companies' excessive power. Government needs to matter more than private sector economic interests. That is the main thing to work on. There are national economic interests tied to the economic interests of pharmaceutical companies, and that is the problem.

The Chair: Thank you very much, Ms. Normandin.

[*English*]

Ms. McPherson, please, you have one and a half minutes.

Ms. Heather McPherson: Thank you very much, Mr. Chair.

Again, thank you to our witnesses.

I have one very quick question for Ms. Langlois.

We are now two years into this pandemic and we're going into the third year.

Can you give me what you believe—please be blunt—to be the primary reason the Canadian government has not acted on the TRIPS waiver and has vacillated and sat on the fence for the last two years? Can you give me the primary reason for that, please?

[*Translation*]

Ms. France-Isabelle Langlois: My hunch is that it is for economic reasons. Canada, like other countries, is in negotiations with pharmaceutical companies to gain access to supply. We do not know how much each country paid for the vaccines or the treatments, but we do know that the prices are not the same from one country to the next. There are also negotiations with pharmaceutical companies to have local facilities so that we can produce our own vaccines. Unfortunately, that is hanging in the balance. On one hand, we do not want to put ourselves at odds with the pharmaceutical companies we are negotiating with; on the other hand, we should be putting much stronger political pressure on these companies.

[*English*]

Ms. Heather McPherson: In effect, you're saying that the Canadian government has enabled the pharmaceutical companies around the world to have the power over life and death and has not pushed for tools that could in fact make sure that vaccine equity is a reality around the world.

[*Translation*]

Ms. France-Isabelle Langlois: Exactly.

[*English*]

The Chair: Thank you very much, Ms. McPherson.

Mr. Aboultaif, you have three minutes.

Mr. Ziad Aboultaif (Edmonton Manning, CPC): Thank you, Chair.

I hear today that there are a lot of politics around this whole issue. One of them is using the product from Medicago, from which millions of doses were ordered for donation to COVAX. They were denied because of the involvement of a third party or an investment company in the manufacturing or in the private sector in Canada.

Isn't that also part of the politics? Do you see it in that fashion?

Why would you deny giving or accepting these vaccinations that are available for the world where they're most needed, for reasons such as these?

That question can be for any of the witnesses, such as Oxfam.

Ms. Brittany Lambert: As I mentioned in my answer to the previous question, I'm not familiar with the details of this case, so I can't comment.

Mr. Ziad Aboultaif: That's a conversation about the availability of vaccine and waiting for that, and the deaths that have taken place in many parts of the world. Oxfam is one of the organizations on the ground that are operating and trying to help these countries that don't have vaccinations available.

Isn't that part of the politics, too?

● (1200)

Ms. Brittany Lambert: It sounds like it may be, but I don't know the entire situation.

For sure, we're watching the types of vaccines that Canada is donating. I know that so far there's been more AstraZeneca. That is causing some challenges. A lot of countries are having difficulty placing them, because a lot of countries don't want them now that evidence has emerged showing that mRNA vaccines are more effective against omicron in particular.

We're also watching.... I know they have donated some Moderna. In terms of Pfizer and Novavax, there's no clarity yet on whether Canada will be donating any of those. I think many countries would like to know.

Unfortunately, I do not know the details of the Medicago case.

Mr. Ziad Aboultaif: I'd like to hear from Amnesty on that, too.

Ms. France-Isabelle Langlois: Thank you.

[*Translation*]

I do not have any knowledge of the Medicago case, so it is hard for me to answer your question.

[*English*]

Mr. Ziad Aboultaif: I'm very surprised that both organizations cannot answer that question. You're fighting for vaccinations. You're fighting for these people—the less fortunate—and you don't know the answer to that.

Thanks. I will stop right here.

The Chair: Thank you very much.

Our final intervention in this round with this panel goes back to Mr. Sarai for three minutes.

Go ahead, please.

Mr. Randeep Sarai: Thank you.

Can I get some clarity as to the numbers?

I think some of the numbers that you have of how much Canada has donated might be outdated. My understanding is that we have given close to 100 million doses through COVAX.

Can any of the witnesses maybe check that and speak on the record to that?

[*Translation*]

Ms. France-Isabelle Langlois: I think that Canada promised more than 200 million doses. However, so far only 14 or 15 million doses have been made available. At that rate, it will take a very long time.

[*English*]

Ms. Brittany Lambert: It's a bit complicated also, because Canada's 200-million commitment is a commitment to donate the equivalent of 200 million doses, so that includes actual doses, but it also includes money to buy doses through COVAX. In terms of its actual surplus doses, right now it's donated fewer than 15 million, as my colleague from Amnesty said. These are doses that it had in excess of what Canada needs and that it sent to other countries.

Mr. Randeep Sarai: Is COVAX not purchasing? Obviously, there were the two streams. There was the excess that Canada would give, and that's obviously based on what excess it had. The second part was financial, that COVAX would procure, buy or purchase in supply. Has that been slow because the money coming into COVAX has been slow, or has that been because its supply agreements are not as robust or as strong as the other countries that have had them?

Ms. Brittany Lambert: I think it's starting to speed up through COVAX. December-January was a turning point. Until then, there was scarcity in the supply globally. COVAX couldn't move, because there were no vaccines for it to buy.

Now the landscape is changing. I expect the money that goes to COVAX will be able to purchase vaccines more quickly from this point on.

Mr. Randeep Sarai: Do you not think it would be faster to immunize more people by funding those existing facilities that are now able to make excess production, rather than starting from scratch?

This is not a government position. I was just trying to see practicality. What's the fastest way to get people immunized? Would it not make sense now to just focus on that and make sure COVAX has enough financial resources to procure those vaccines and give them to those who are lacking them right now?

Ms. Diana Sarosi: I would point out in response that we have no control over what those companies charge for vaccines. Now it's this price; by next year, it could be double the amount. Keeping the pharma monopolies in power also undermines our ability, possibly in the future, to be able to purchase through COVAX, because prices keep going higher.

● (1205)

The Chair: Mr. Sarai, thank you very much.

That concludes our time with the panel.

I'd like to thank both of our witness groups for being with us today. It was a pleasure.

[*Translation*]

Thank you very much for sharing your expertise.

[*English*]

We will let you disconnect. Then we will suspend briefly to empanel our second panel and bring those witnesses on board.

Thank you so much.

● (1205)

_____(Pause)_____

● (1205)

The Chair: Welcome to the witnesses for our second panel.

I have a very brief point of housekeeping before I introduce you.

We have, in some cases, very tight time allocations. I'm going to signal you with this piece of paper when you have 30 seconds remaining in questioning or testimony time. It's a bit like a flag. If you could stick to the time limits, that would help us greatly.

We would like to welcome, colleagues, for our second panel, Shehzad Ali, associate professor and Canada research chair in public health economics at Western University; and Robyn Waite, director of policy and advocacy for Results Canada.

I will give each of you five minutes for opening remarks, beginning with Professor Ali.

Please go ahead, sir. The floor is yours.

Dr. Shehzad Ali (Associate Professor, Canada Research Chair in Public Health Economics, Western University, As an Individual): Thank you, Mr. Chairman.

Two years into the pandemic, 64.5% of the world has received at least one dose of the vaccine, but the percentage in the developing world is only 14.5%. This massive vaccine inequity is, quite frankly, an embarrassment. Companies have prioritized sales to governments that could pay the highest price, pushing low-income countries to the back of the queue. As a result, 70% of the doses produced by Moderna, Pfizer and BioNTech are going to wealthy nations, resulting in massive vaccine inequities. I think we still have an opportunity to correct course, and I will discuss two areas where Canada can play an important role.

The first is the issue of licensing and IP waivers. As we know, IP is protected under the WTO's TRIPS agreement.

There are several arguments for supporting IP waivers during the pandemic. First, much of the technology used to develop the vaccine is funded through public money. For example, Moderna received $2.5 billion and Pfizer received close to $2 billion from the U.S. government alone. Second, the current capacity of patent-holding companies and those that produce ingredients is not sufficient to get the world vaccinated in the short run. We need to pool global resources, but IPs are in direct conflict with this goal.

Canada has repeatedly referenced article 31bis of the TRIPS agreement and its operationalization via the CAMR, Canada's access to medicine regime, as an example of existing flexibility in the TRIPS agreement. However, the only time this process has been used in Canada was in 2008, for two shipments of an HIV drug that were sent to Rwanda after four years of struggle with the CAMR process. After this, Apotex, the manufacturer, decided not to go through the process again.

CAMR as it currently exists is not fulfilling its purpose. A more comprehensive and global approach is the quadrilateral TRIPS waiver initiative, which is spearheaded by India and South Africa. Some WTO members, including Canada, have pushed back on this, arguing that existing flexibilities are sufficient, but these flexibilities operate on a country-by-country and product-by-product basis. They are not sufficient at all, given the scale of the pandemic.

After 18 months of negotiation, the text of the TRIPS waiver is being developed, but early reports indicate that it has several limitations. Even the current draft of the waiver could be in danger if some countries oppose it. While in the past Canada has not actively supported this initiative, this is the time to play a role in pushing for an all-inclusive TRIPS waiver.

The second initiative that Canada can support is the WHO's mRNA vaccine technology transfer hub, which was established last year in South Africa. The aim of the hub is to facilitate the manufacture of vaccines in developing countries by transferring the technology and technical know-how to local producers. It has produced the first batch of COVID vaccines based on publicly available information, but without support from patent holders. However, many steps remain before the vaccine can be distributed, and it won't help to curb the pandemic this year.

For this hub to be effective, it is essential either that the technology used here be free of IP constraints in low-income countries or that such rights be made available to the hub through non-exclusive licences. The hub will require significant resources and technical expertise.

I think this is an opportunity for Canada to support a historic initiative to reduce vaccine dependency and inequity.

Thank you.

● (1210)

The Chair: Professor Ali, thank you very much. Also, thank you for remaining within the time allocation. It's very much appreciated.

Ms. Waite, please go ahead with your opening remarks. The floor is yours for five minutes.

Dr. Robyn Waite (Director, Policy and Advocacy, Results Canada): Thank you, Mr. Chair, and hello everyone. I'm Dr. Waite, director of policy and advocacy at Results Canada.

Results is a non-profit, grassroots advocacy organization committed to raising voices for a world free of extreme poverty. Our network of 500-plus volunteers has been advocating for vaccine equity since the start of the pandemic.

I am pleased to have the opportunity to share some of our organization's reflections on these issues, informed by our own perspectives and those of the many experts, advocacy allies and civil society partners we work with here in Canada and around the world.

Despite the relaxing of public health measures here in Ottawa, the pandemic is far from over. Around the globe, we are seeing a rise in cases, and the threat of dangerous new variants persists. A failure to coordinate a global response to the pandemic and the resulting inequity in access to COVID-19 tools is having costly consequences.

Eighty-five per cent of all COVID-19-related deaths are in countries with low access to tests, treatments and vaccines. Associated disruptions to health systems and the redeployment of resources and attention to COVID-19 have wiped out decades of development in global health progress.

Twenty-three million children missed out on basic childhood vaccines in 2020, the highest number missed since 2009. In 2021, the World Health Organization reported the first year-on-year increase in tuberculosis cases since 2005. Also, schoolchildren around the world have missed more than two trillion hours of in-person learning, the consequences of which are learning and earning losses. The global economy is projected to lose U.S. $5.3 trillion by 2027.

Now, the war on Ukraine, growing humanitarian crises and looming food and energy emergencies will exacerbate the strain on economies, peoples and systems around the world. The collision of crises of COVID, conflict and climate all unfolding and rapidly escalating in real time demands that global leaders such as Canada double down to end the pandemic. While this study is focused on vaccine equity, we should really be talking about all the tools needed to end COVID-19, including diagnostics, treatments and vaccines, plus the health system infrastructure and the people needed to roll them out.

While Canada has performed well in the interest of vaccine equity in some respects—for example, it was one of the first countries to invest a fair share in the ACT-Accelerator—it is lagging in comparison to its G7 and G20 peers in other areas, the TRIPS waiver issue being one.

Canada should step up and explicitly embrace the temporary removal of the intellectual property rights that are protected and enforced by the World Trade Organization on all COVID-19 tools, as well as actively engaging WTO members to get any compromise proposal right. It's a must for an equitable response to COVID-19; for the world's ability to respond collectively and quickly to future pandemics; for the protection of public funds and the interests of people over profits; and for global health solidarity. When high-income countries such as Canada fail to stand with less advanced economies, commitments to decolonization become mere rhetoric.

Our government often acknowledges that global challenges demand global solutions, yet Canada's international assistance envelope is woefully low. Since 1970, the UN target set under Canadian leadership has called for advanced economies to invest 0.7% of their gross national income in development assistance. Canada's levels of spending reached a near all-time low of just 0.27% of GNI in 2019, well below the rich country average.

With the onset of the pandemic, this downward trend was thankfully reversed and, moving forward, sustained increases must become the new norm, starting with getting Canada's IAE to $9 billion in budget 2022. This is critically important in continuing to respond directly to the pandemic, mitigate its knock-on effects to recover globally, and prepare for future threats.

The community has suggestions for how Canada could target resources to high-impact solutions. Results wants to see Canada continue to invest its fair share in the ACT-Accelerator and its implementing partners, such as the Coalition for Epidemic Preparedness Innovations, the Global Fund to Fight AIDS, Tuberculosis and Malaria and FIND, the global alliance for diagnostics.

There is no escaping that the world needs repairing, and it is everyone's job to educate people and raise public awareness about global solutions to global problems.

Results Canada volunteers from across the country are doing a stellar job of it. They care about vaccine equity. They are committed to taking action and want you and the Government of Canada to rise to the challenge of the modern day with the level of ambition and global-mindedness required. That means increasing investments in international assistance; squeezing all the impact possible out of each dollar; spending political capital to build political will; and a whole-of-government approach committed to international co-operation.

Thank you, Mr. Chair.

● (1215)

The Chair: Dr. Waite, thank you so much for your opening remarks.

We will go to round one. These are six-minute allocations for the members of the committee.

Leading us off will be Mr. Genuis.

Mr. Garnett Genuis: Thank you so much, Mr. Chair, and thank you to the witnesses for your presentation. I'm going to focus most of my questions on the topic of the study, of course.

Dr. Waite, could you quickly speak to the situation in Ukraine in terms of concerns about food shortages and how that might impact global health more broadly? We're hearing a lot of concerns about the global food supply and the possible implications.

Dr. Robyn Waite: Of course.

COVID-19 has reminded us that diseases know no borders and that nobody's safe until everyone is safe. We live in a globalized world. Our economies are globalized. Our food production is globalized.

We know that people living in Ukraine are being very catastrophically impacted right now by the war, and they're fleeing the country. Their fleeing is of concern for their direct health and also the global health security and stability of the world.

We know that another conflict and a collision of crises are going to put increased demand on constrained budgets, so that's significantly concerning. More resources going to COVID and Ukraine mean less resources going other ways, unless we increase that international assistance envelope that I spoke about earlier.

Mr. Garnett Genuis: Could you or other of our witnesses address the question of the distribution of unused AstraZeneca doses? This is something that has come up previously.

We're talking about vaccine hesitancy, but we're talking about that in the context that it's a vaccine that—and I don't know if I'm using quite the right language—is maybe not recommended for Canadians—or it's approved but there are other things that are preferentially recommended—and we're distributing doses. How does that impact the perception of vaccine safety and the perception of Canada's role in all this, and what are your recommendations around AstraZeneca doses?

Dr. Robyn Waite: Sure. I can go first.

Results Canada has been loosely engaged and supportive in the advocacy around dose donations. We haven't been out in front leading, one reason being that we're quite disappointed that we're in the situation of a charity approach to getting vaccines around the world in the first place.

I would say, yes, with AstraZeneca, they came online fast and early and got out the door early. Now, though, we're seeing that we're not using AstraZeneca in Canada, and that definitely does impact the demand for AstraZeneca in other countries around the world. We're already seeing that AstraZeneca is not necessarily preferred as a product in COVAX recipient countries.

I'm happy to see that Moderna and hopefully Pfizer are going to come online from Canada soon, but it definitely does impact perceptions of vaccines.

I know we have been talking a lot about vaccine hesitancy, but I want to also caution about too much of a siloed focus on that. The head of the CDC said not too long ago that “vaccine apartheid”, not vaccine hesitancy, is contributing to prolonging the COVID-19 pandemic, so we should be careful about what we're focusing on.

I'd love to talk about it maybe a bit later, but vaccine hesitancy also ultimately has to do with trust and an erosion of trust. We're seeing massive erosion of trust around the world, particularly in government institutions and leaders. Building that trust is absolutely critical to getting uptake of medical products like vaccines.

● (1220)

Mr. Garnett Genuis: Thank you.

I'd like to hear from all of our witnesses, in particular on what your engagement has been like directly with the government and what it has said about the TRIPS waiver. I think it came out in the first panel that there are a lot of nice words being said by the government, but still a lack of a sense of what it's actually doing or planning to do here, a couple of years into the process.

Tell us a bit about your engagement directly with the government and your understanding of its position and the things it's been saying to you.

Dr. Shehzad Ali: I'm happy to go first.

I have not engaged directly with the government on this particular issue, but I've seen several accounts of how Canada has engaged or not engaged in this process. In fact, last year a number of accounts emerged suggesting that the Canadian government has, in fact, been discouraging other countries from engaging with the TRIPS waiver procedure. It has been showing CAMR as a mechanism that is an alternative to a TRIPS waiver, which—as I said in my presentation—is not really the approach to take.

The other thing I would like to add is that the recent experience of Biolyse has been full of frustration. Just getting a drug on schedule 1 of the Patent Act can take several months.

Mr. Garnett Genuis: I'm sorry, but I'm almost out of time. I just want to get you to clarify one thing you said, which sounded as though you were saying that the government might be advocating against the TRIPS waiver behind the scenes. You have some reason to believe that. Is that correct?

The Chair: Could we have just a very brief answer, please?

Dr. Shehzad Ali: There have been lots of suggestions to lead one to conclude in that direction.

Mr. Garnett Genuis: Okay. Thank you.

The Chair: Thank you, Mr. Genuis.

Madame Bendayan, go ahead, please, for six minutes.

[*Translation*]

Ms. Rachel Bendayan (Outremont, Lib.): Thank you very much, Chair.

My thanks to Ms. Waite and Professor Ali.

[*English*]

Professor Ali, perhaps I'll continue in English, because I would like to pick up on that very last point you made. Obviously, we are in committee and we are on the record, sir, and many countries have acknowledged Canada's leadership in putting together the Ottawa Group. I, along with other colleagues on this committee, was part of the international trade committee's extensive study on the TRIPS waiver discussions, in which many experts weighed in on Canada's role.

If you do not have specific sources that you're willing to share with us, I would ask you to reconsider your comments regarding Canada's role to date. I would also like to point out that the United Kingdom, the EU and Norway have all opposed the TRIPS waiver at the WTO, while Canada has been trying to bring countries together in order to reach agreement. I think you would agree, Professor, that we need the European Union to agree to such a waiver for it to be effective.

Professor, over to you.

Dr. Shehzad Ali: I agree. I think the U.S. and the European Union are much bigger players than are some of the other countries. It was good to see that the U.S. last year started actively supporting vaccine waivers, and the European Union certainly has some reservations in this area as well.

While Canada certainly has provided support in different ways, if you look at the documents that have come out, I think you'll say that leadership is something we really need to see from Canada.

● (1225)

Ms. Rachel Bendayan: There are many reasons being given by the EU and the U.K. that you have just acknowledged are critical in coming to terms on a waiver at the WTO, including manufacturing capabilities, quality control and the safety of the vaccines.

In that context, and given the fact that these are important players in terms of having manufacturers in their home countries, can you perhaps give us—in a very short response—some of the reasons you are so against using the existing flexibilities in CAMR, not because I think that is necessarily a better route, but given the intransigence of countries that we need in order to reach a waiver? As you pointed out, some of these were used in 2008.

Dr. Shehzad Ali: As I pointed out, the company that used that flexibility in 2008 was extremely frustrated with the process, and the recent experience of Biolyse was not particularly different. Just getting a drug on schedule 1, as I said, takes several months, and the approach of going country to country and drug by drug is not really an efficient mechanism to respond to this crisis.

Ms. Rachel Bendayan: I understand, Professor Ali, but now we are blocked in negotiations at the WTO, which I would again insist that Canada is very much trying to unblock.

Dr. Waite, I think I will just turn to you in order to clarify some of the statistics we heard on a previous panel. I think we have very publicly stated on our government website that 14.2 million doses of vaccine have already been donated through COVAX by Canada, but it's actually 100 million doses equivalents that have been donated. Are you familiar with that statistic, Dr. Waite?

Dr. Robyn Waite: Yes, I am. That's because some of our commitment to the 200 million doses is in dollars committed, which COVAX can then use to purchase vaccines.

Ms. Rachel Bendayan: Exactly.

Wouldn't you agree, Dr. Waite, that it is a good thing to provide the flexibility to countries to choose the vaccine that they would like to purchase for their population?

Dr. Robyn Waite: Yes, and that's exactly why Results Canada has not leaned too heavily on the dose donation advocacy in and of itself, because dollars are the most helpful investment, so that COVAX can have those flexibilities and that purchasing power directly with pharmaceutical companies.

Ms. Rachel Bendayan: That's excellent. That's exactly what we are doing as a government.

I would like to point out that this puts Canada approximately in the top ten. Would you agree that we are one of the top ten counties in the world in terms of vaccine donations?

Dr. Robyn Waite: Yes.

Ms. Rachel Bendayan: You mentioned in your introduction, Dr. Waite, that two trillion hours of in-person schooling has been missed by children. I believe you mentioned it was last year. I see you nodding.

Canada is also number one or number two—perhaps you know—in supplying diagnostics like rapid tests to developing countries. Do you feel that is important, given some of the statistics you mentioned in your introduction?

Dr. Robyn Waite: I couldn't say if we're the top or not. I'm not familiar with that statistic, but I can say that investing equitably across all pillars of the ACT-Accelerator is pretty important. The ACT-Accelerator has vaccines, therapeutics and diagnostics pillars, and a health systems-strengthening connector. Canada has invested across all.

Ms. Rachel Bendayan: The ACT-Accelerator also works in order to raise awareness and fight vaccine hesitancy as well.

The Chair: Give a very brief answer, please.

Dr. Robyn Waite: Yes.

The Chair: That was very brief.

[*Translation*]

Thank you very much, Ms. Bendayan.

I will now give the floor to Ms. Normandin for six minutes.

Ms. Christine Normandin: Thank you, Chair.

Many thanks to all the witnesses.

We know that since the beginning of the crisis and the minute the vaccines were developed, the pharmaceutical companies' interest was truly a financial one. There was a pharmaceutical lobby. There was a financial interest in distributing the vaccines to countries paying the most, something the COVAX initiative was supposed to temper, in a way, to allow less fortunate countries to get vaccines.

In the meantime, we saw a type of vaccine diplomacy. For example, we saw China ally with Serbia to distribute the Sinopharm vaccines. In exchange, China wanted everyone to kowtow to it. China also intervened a great deal in Africa.

In your opinion, are COVAX and this type of vaccine diplomacy not at odds with each other or does one help the other? Should COVAX not be used to temper this type of vaccine diplomacy, which serves its own interests? On the contrary, does it help COVAX when China unilaterally decides to provide doses to less fortunate countries?

● (1230)

[*English*]

Dr. Robyn Waite: When COVAX was developed, it had big dreams and big intentions. If we had all played by the COVAX principles from the start, we'd be in a very different position from the one we are in today.

Because high-income countries such as Canada bought in to COVAX but then undermined it at the same time by procuring mass amounts of doses directly from pharmaceutical companies, we ended up with a supply constraint in the end. Ideally, we would have had a globally coordinated response to this pandemic out of the gate. Unfortunately, we're not there.

All hands on deck is pretty welcome right now. If we need to look at COVAX bilateral dose donation or anything we need to do to get to the target of vaccinating 70% of the world, we should do that at this point.

We should definitely learn lessons and try to figure out how to globally coordinate in the future, so we avoid a march of folly on a global scale like this in the future.

[*Translation*]

Ms. Christine Normandin: In other words, if COVAX had been better structured from the start, we might have avoided spending so much time on vaccine diplomacy, including by China. Did I understand your answer correctly?

[*English*]

Dr. Robyn Waite: I'd say it needed to be better supported by G20 countries, not necessarily better structured.

If all countries that were committed to the vision of COVAX had wholeheartedly backed it up by making sure COVAX had priority access to dose donations, then we could be in a different situation from the one we are in today.

[*Translation*]

Ms. Christine Normandin: You touched on the structural aspect, but also the aspect of support from G20 countries. What was the biggest thing keeping COVAX from working properly?

[*English*]

Dr. Robyn Waite: One thing that was missing was dollars and fast investment in COVAX as a mechanism, so that it could then go and purchase vaccine doses quickly. The other thing it was missing was a full commitment to its vision and mission. For example, Canada supported COVAX with investment at the AMC and the self-financing arm of it, but then we also went and procured our own dose donations directly with pharmaceutical companies, which undermined COVAX in and of itself.

[*Translation*]

Ms. Christine Normandin: Let us talk about the fact that countries received vaccine doses instead of the money to procure the vaccine. This was wasteful in some cases when some countries gave doses that were at the end of their useful cycle, that were practically expired and, once they arrived in the other countries, almost needed to be thrown out.

What needed to be improved to avoid all that?

[*English*]

Dr. Robyn Waite: COVAX is a new mechanism. It's the biggest mass deployment of vaccines around the world that we've ever seen on this scale, so it's learning as it evolves. Now we're also seeing COVAX starting to introduce minimum shelf lives for doses being donated, so that when they land in a country, they have at least a certain amount of time left to be able to turn that vaccine into a vaccination.

Those things are changing and happening in real time, because we're learning as we go.

[*Translation*]

Ms. Christine Normandin: Previous witnesses have told us that there were vaccine procurement issues at first, but that at some point there were problems with demand. In reality, the demand for vaccines in some countries was less than the number of vaccines they were sent.

In order to avoid losses, should we review the vaccine distribution algorithms in the different countries?

● (1235)

[*English*]

Dr. Shehzad Ali: I'm not sure we need very complicated distribution algorithms. There is significant demand in most countries. I think Dr. Waite or one of the earlier speakers said that vaccine demand is significantly high. Vaccine hesitancy, as it has been presented in the western world, is low, so I think it's that willingness.

Frankly, if we are considering donating only surplus doses or doses that are close to expiry—only on some occasions, I should emphasize—that does not send a good message to the world.

[*Translation*]

The Chair: Thank you very much, Ms. Normandin.

Thank you to the witnesses as well.

[*English*]

Next is Ms. McPherson, please, for six minutes.

Ms. Heather McPherson: Thank you very much, Mr. Chair, and thank you to the witnesses for joining us today for this important study.

As a member of the opposition, my role is to look at the government's response and to try to find ways to improve that response going forward. What I'm hearing from the testimony in this panel and the previous panel is that the Canadian government in effect undermined COVAX by agreeing to or by negotiating bilateral agreements with pharmaceutical companies.

In addition, the Canadian government failed to secure that intellectual property protection through the TRIPS waiver, so that other countries could produce their own vaccines.

The final piece of this is that we are seeing that the Canadian government has a system, in the form of the Canada's access to medicines regime, that does not work. It has not worked in the past, and it is certainly not up to the task of working right now. I've heard from organizations that have said the websites are down; the phones don't.... Nothing in that entire process is working.

As an opposition member, what I look at is the potential for us to have a different response if a future pandemic or a variant of COVID-19 were to happen.

I'd like to ask both our witnesses how confident they feel that the global response, particularly from a Canadian government perspective, would be different if we were to be in this situation again in the near or distant future.

Perhaps I could start with you, Dr. Ali.

Dr. Shehzad Ali: Thank you.

Vaccine nationalism is something we have seen across the globe. Canada is not the only country. The U.S. and most European countries have taken a very similar route, which is, in some ways, understandable. There is public pressure on the government, but at the same time, I hope this is really a time when we learn from the way we responded to things. We all understand that this is not the last pandemic. There will be future pandemics.

Also, I think it's important to think about global efforts. Currently, our thinking has been primarily driven by donations and by finding different mechanisms within our system to allow the manufacturing of vaccines here and then sending them abroad.

I particularly applaud the WHO's mRNA hub, which I think is an excellent mechanism to produce and propagate capacity within developing countries. This is where Canada should take a lead and really stand with the WHO because, obviously, these things will continue to happen. This, I think, is a historic moment when we really should contribute.

Ms. Heather McPherson: Thank you.

Go ahead, Dr. Waite.

Dr. Robyn Waite: Yes. I would hope that we would do things differently, because I have faith in the Government of Canada, humanity and multilateral institutions, so I'd hope that we would be learning the lessons from this experience and adapting, making the necessary changes. I know that will happen, because I'm seeing it happen in real time already. COVAX is learning in real time and adapting in real time. The Government of Canada is doing the same; the World Health Organization is doing the same.

We're starting to do studies just like this, to reflect on what worked, what didn't work, and what we need to do to make sure we are prepared for future threats, which are inevitable.

I agree with all of the oppositional remarks that you started this question off with, but I want to say that Canada is leading in some respects, too. We are one of only four countries covering the ancillary costs for every dose that we're donating through COVAX. We were one of the first G20s to invest our fair share in the ACT-Accelerator. We took a leading role in creating the COVAX donation mechanism, and Minister Karina Gould, when she was with International Development, was a co-chair of the AMC engagement group.

It's a nuanced, complex issue. In some areas we're doing well, and in some areas we're underperforming.

● (1240)

Ms. Heather McPherson: Thank you.

As much as I have other questions I'd like to ask, I have to take this time that I've been allotted to move a motion that I brought forward that has to do with this topic.

Could I, Mr. Chair, move the motion that I tabled last week? Would you like me to read it, or can I just move it right now?

The Chair: It's at your discretion, Ms. McPherson.

Ms. Heather McPherson: I would like to read it, if possible.

The Chair: You're free to do that. Please go ahead.

Ms. Heather McPherson: Thank you so much. It is very short.

The motion is:

> That, pursuant to Standing Order 108(1)(a), the committee order that all briefing notes, memos and emails regarding lobby meetings between the government and pharmaceutical companies where vaccine equity was discussed since March 2020 be provided to the committee no later than April 21, 2022; that matters of cabinet confidence be excluded from the request; and that redactions for commercially sensitive information be applied only where strictly necessary.

Thank you, Mr. Chair. I would ask for a vote.

The Chair: Thank you very much. I will now invite colleagues to intervene on the motion that's before the committee. It's properly before the committee. It was put on notice before, and it relates directly to the substance we're discussing today.

I'm going to work with our clerk to make sure that we develop an integrated list of intervenors. I can see hands raised virtually, and there may well be colleagues on the floor who also wish to intervene.

Madame Bendayan, please lead us off in the discussion of this motion.

[*Translation*]

Ms. Rachel Bendayan: Thank you very much, Chair.

I am a bit disappointed. I thought we were unanimous on the importance of this study. We are taking 20 minutes out of this meeting to deal with my colleague's motion.

That being said, I see that you have already started the debate. I will not get in the way.

Thank you.

The Chair: Thank you, Ms. Bendayan.

[*English*]

Are there other interventions from colleagues on the motion that is before us? I don't see anybody virtually.

Madam Clerk, does anybody wish to intervene from the floor? I'm going to be cautious here just in case people are still formulating thoughts.

Seeing no further debate, are colleagues prepared to vote on the motion as presented? I seem to have a consensus on taking it to a vote.

Colleagues, is there any opposition to the motion as presented by Ms. McPherson?

Ms. McPherson, I do not see any opposition to the motion. I want again to be sure that I have the reactions from the room and virtually.

(Motion agreed to)

Ms. Heather McPherson: Thank you so much.

I will cede the remainder of my time. I don't think there was much left anyway.

The Chair: Actually, we have gone a bit over. Thank you very much for that.

We will now go into what I propose to be a very compressed second round of questions to the panel.

If colleagues are okay to do what we did last time, which was three minutes and one and a half minutes, I will ask Mr. Genuis to please lead us off for three minutes.

Mr. Garnett Genuis: Thank you, Mr. Chair.

I'm at a bit of a disadvantage, being remote. If any of my Conservative colleagues want to speak, maybe they can message me in the appropriate chat.

I have questions, so I'm happy to use the time until I hear from another colleague.

The Chair: Sure. It's at your discretion, and you're free to share the time as you wish.

Mr. Garnett Genuis: Sure. I will wait for those notifications.

We were talking about a perception of different kinds of vaccines. Could either of the witnesses speak to Chinese state vaccine diplomacy? How are the vaccines manufactured in China perceived?

How does it affect international coordination around access to vaccines and intellectual property, when other actors with other strategic interests are in some sense saying they are offering vaccines, but they have another agenda or perhaps the vaccines are not of the same level of efficacy?

● (1245)

Dr. Robyn Waite: I apologize. I'm not informed enough to speak to that issue.

Dr. Shehzad Ali: Neither am I. I'm not in a good position to answer that question.

Mr. Garnett Genuis: Okay. That's no problem. We can follow it up with some other witnesses.

Dr. Waite, you didn't have a chance to answer my final question. I wonder if you could speak about your reflections on that one as well.

Dr. Robyn Waite: Yes. Results Canada has engaged Minister Ng's office, both directly and working in coalition with allied civil society organizations that want to see Canada step up and explicitly support the TRIPS waiver proposal.

I can say that most of what we're hearing or feeling is that there's a commitment to the process but no real, clear indication of whether there's a commitment to support the actual proposals from India or South Africa. It's a commitment to process negotiation, and that's pretty much the end of the conversation.

Mr. Garnett Genuis: Just to sharpen that point a bit, at the end of the day you feel that you don't really know what the government's position is. It hasn't been clear about what its position is with respect to the waiver one way or the other.

Dr. Robyn Waite: Yes. I would say that's accurate. If not much discussion is happening, it's hard to understand.

Mr. Garnett Genuis: Okay. Thank you.

If there's time left, you could also clarify why the transfer of money is preferable, as opposed to the transfer of vaccines.

The Chair: Give a super quick answer, please.

Dr. Robyn Waite: It's about COVAX being able to use the resources how they most need to use them. It's also about removing as much friction as possible from the process of getting vaccines into other countries.

When you start doing three-way negotiations between the Government of Canada, COVAX and a pharmaceutical company, for example, there's a whole set of logistics behind that, which is way more cumbersome than if we were investing dollars directly in COVAX.

The Chair: Thank you very much, Mr. Genuis.

Mr. Ehsassi, you have three minutes.

Mr. Ali Ehsassi (Willowdale, Lib.): Thank you, Mr. Chair, and thank you to our two witnesses today.

I will start with Professor Ali.

In your remarks you indicated that approximately 70% of vaccines distributed so far have been to advanced economies or wealthy countries.

Given that there is such a shortfall, if things do not change—given that we're concerned about the scale of this challenge and that it's incumbent upon members of this committee to understand the dimensions of this—how long would it take before we could see sufficient production by the big pharmaceutical companies to cover all countries?

Dr. Shehzad Ali: A number of companies have recently made announcements that they will be developing new plants based in Africa. This whole process may take a year or longer, but I think we really have an opportunity here, with the technology help that has been established by the WHO. They have the expertise.

There is significant demand. There are local producers who are willing to make the vaccine, and they have produced initial doses. They obviously now need to go through clinical trials, because they have used the sequence that was made available by Moderna—or the same formula that Moderna is using was available—but without help from the industry.

I think that if we want to make an impact in the short run in addition to COVAX, a significant major step will be to engage the pharmaceutical industry and get it to help this hub, because the technology transfer in the short term is the real solution. I think that is the process that will speed things up a lot.

We need about 10 billion doses in low-income countries. From what I understand, COVAX has committed to about a billion doses. There is a massive gap, and to meet that gap by the end of this year—70% coverage in low-income countries— seems like an impossible task given the current mechanisms that we have.

● (1250)

Mr. Ali Ehsassi: To date, have any of these big vaccine companies contributed at all to the hub? Has there been any assistance?

Dr. Shehzad Ali: I'm not privy to that information, sir. I don't know if Dr. Waite has anything to add here.

Dr. Robyn Waite: That's a great question. Can I circle back? We have the information, but unfortunately I don't have it in my spread of notes. If I can circle back with that information, I'd love to, because our allies have done some analysis as to which pharmaceutical companies are good players in COVAX and which ones aren't such great players.

Mr. Ali Ehsassi: Thank you ever so much, Dr. Waite.

The Chair: Thank you, Mr. Ehsassi.

[*Translation*]

Ms. Normandin, you have 90 seconds.

Ms. Christine Normandin: Thank you, Chair.

We know that a hundred or so countries will not meet the target of 70% vaccination coverage that we hoped to achieve by July 2022. We often hear people say that instead of providing a fourth dose here, we should be giving these doses to countries that have not met this vaccination target.

I would like to know whether the issue we should be focusing on is simply the vaccine supply aspect or if there is also a more complex problem of distribution and the administration of the vaccine. Is it a combination of the two? Is the supply dynamic changing a bit, in other words is it no longer just about providing vaccine doses, but also about a need for capacity on the ground to administer them?

[*English*]

Dr. Robyn Waite: I can take that.

Absolutely, it's not just about supply: We need vaccines to be turned into vaccinations. That requires strong, resilient health systems and people who are equipped and ready to administer those vaccinations. Last year, I guess, at the beginning of the pandemic, supply was the big, critical issue in getting the world vaccinated.

Now, it's more about the delivery of those doses. We have a lot of doses: How do we get them into arms as fast as is absolutely possible? That really comes down to strengthening health systems and investing in people.

We've seen that community-led responses are absolutely critical to getting things out the door quickly and to building trust with communities. I would recommend an investment in the frontline health heroes who are doing this critical work for us.

[*Translation*]

The Chair: Your time is almost up, Ms. Normandin. Do you have another very brief question?

Ms. Christine Normandin: I do not have enough time to ask another question, Chair.

The Chair: Okay. Thank you very much.

[*English*]

We have Ms. McPherson, please, for one and a half minutes.

Ms. Heather McPherson: Thank you, Mr. Chair, and thank you again to our witnesses.

I was going to ask my last question of Dr. Ali, if I could, on CAMR.

You spoke about how CAMR is not a process that is working right now, and I don't think it should be to the exclusion of other tools, but I would hope that you would agree this is still a tool that we should be using.

Further to that, right now, knowing where we are, knowing how long it has taken us to get to this point and knowing the pandemic is not done around the world, what are the top three things you would like to see the Canadian government do immediately to address vaccine equity?

Dr. Shehzad Ali: In my view of the top three things, the first is to support the TRIPS waiver and to take a very active role in that. Currently, I think we're waiting to see what the draft will look like. I think taking an active leadership role would be desirable.

The second thing is supporting the WHO hub, which requires significant resources and technical expertise.

The third one is to look again at CAMR and see how we can make that process efficient.

Ms. Heather McPherson: Thank you very much.

Mr. Chair, that was my question, and I'm sufficiently informed, thank you.

The Chair: Thank you very much, Ms. McPherson.

Mr. Morantz is next, please, for three minutes.

Mr. Marty Morantz: Thank you, Mr. Chair.

This question is for Dr. Ali, initially.

I don't know if you had a chance to listen in on the first hour of our meeting, but I'm particularly interested in the matter of a grant from the Government of Canada to the Medicago vaccine manufacturer, and Ms. Waite, either of you are welcome to weigh in on this in the short time we have.

This grant was given to make sure Canada had domestic production capacity but also to ensure that we could meet our COVAX obligations. In the last meeting, I asked public officials about this, and they said that the fact that the WHO had disallowed the Covifenz vaccine for international emergency use would not affect the Government of Canada's contribution to COVAX.

Subsequent to that, media reports said that the minister had confirmed that in fact it would affect our contribution to COVAX.

I see this as a failure of due diligence on the part of the Government of Canada to ensure that when it is providing a grant to a company that is partially owned by a tobacco company—in this case, Philip Morris—it does its due diligence to ensure that the product is available for emergency use outside our borders. I'm wondering if you could comment on that situation.

● (1255)

Dr. Shehzad Ali: I can't comment on the specifics and what process was followed, but I think we are in a crisis situation due to the pandemic globally.

I understand the stance that WHO has taken, given Philip Morris's 21% stake in the company, but I was asking myself, if this had been the first vaccine coming out in 2020-21, what would our position have been then?

I, for one, am someone who has been actively working in the space of smoking and tobacco, and I would not support anything that is tobacco industry-funded. However, WHO has in the past, in 2014, approved treatments for Ebola that had tobacco ties.

I don't know how things will go in this particular case, but I think we need to look at things through a different lens from the one we would use in non-pandemic situations.

Mr. Marty Morantz: Dr. Waite.

Dr. Robyn Waite: Yes. I can just chime in quickly and agree on an unfortunate failure in due diligence, but I understand that the 200 million doses committed to COVAX did not take into account any vaccines from Medicago.

It was dollars and then excess doses of the likes of AstraZeneca, Pfizer and Moderna, which we had already purchased directly from pharmaceutical companies.

Mr. Marty Morantz: You could check media reports, but the minister is on the record in the media saying that this is going to affect Canada's obligation to meet its COVAX commitments.

The Chair: Mr. Morantz, thank you very much, and thank you to the witnesses.

Our final intervention with this panel this afternoon goes to Dr. Fry, for three minutes.

Please go ahead.

Hon. Hedy Fry: Thank you. I wanted to thank this panel for some very creative solutions to some of the problems that I was trying to get to.

You're absolutely right, Dr. Waite, that it's not just about getting vaccines; it's about getting them into people's arms. I think that's an important one.

I don't have a question. I thought that the top three recommendations made by Dr. Ali made sense, so I think that at the end of the day we all know the objective is to get as many people as possible vaccinated globally so that we can get rid of this pandemic. You're absolutely right that our ability to learn from the process, the mistakes and the first set of rapid things that we tried to do, will be important for future pandemics. However, I would hope that at the end of this all, we don't simply focus on COVAX but on preparations, both in terms of infrastructure in developing countries and also in terms of finding ways to educate in the interim with regard to cultural and religious objections, so that if there's another pandemic, we're ready to roll and are prepared, having learned from our mistakes.

I want to thank both of you for very comprehensive and non-ideological sets of responses. It showed the ability to think outside the box.

Thank you.

The Chair: Thank you very much, Dr. Fry.

[*Translation*]

On behalf of all the members of the committee, I want to thank the witnesses who appeared this afternoon.

Professor Ali and Ms. Waite, thank you very much for your attendance and your testimony. We are very grateful.

● (1300)

[*English*]

Colleagues, with that, I have one very brief point of business, which is our proposed scheduled informal meeting with the UN High Commissioner for Refugees, Filippo Grandi, on Thursday morning at nine. Could you please flag with the clerk if you are planning to attend. There is a virtual option and an in-person option.

With that, I want to take a moment as always to thank our clerk, our analysts and our amazing House of Commons team for all the support they are giving us these days, not just for the regular meetings but also for a number of ad hoc extraordinary meetings as well. It really is very much appreciated.

Mr. Genuis.

Mr. Garnett Genuis: Thank you, Mr. Chair.

Could I just ask that when we have senior officials from international organizations, you offer us the opportunity of considering a formal meeting with them as well? We have done formal meetings on the record. Informal conversations are nice, but they don't have the same level of transparency that a public meeting has. We seem to be doing a lot of informal meetings, which is better than nothing at all, but I want to flag that as something that maybe should be considered when we have the opportunity.

The Chair: Mr. Genuis, it's noted and appreciated. In fact, a formal meeting in those instances is often the first option or the first consideration. In this case, because of House resources or the House order, it wasn't possible to land a formal meeting under the time frame available to the high commissioner, therefore we chose the informal option. Your point is well noted, though. It is always the priority to consider that option first.

Mr. Garnett Genuis: Okay, thank you.

The Chair: Colleagues, thank you very much.

With that, we stand adjourned. Please keep safe, and we'll see you at our next session.