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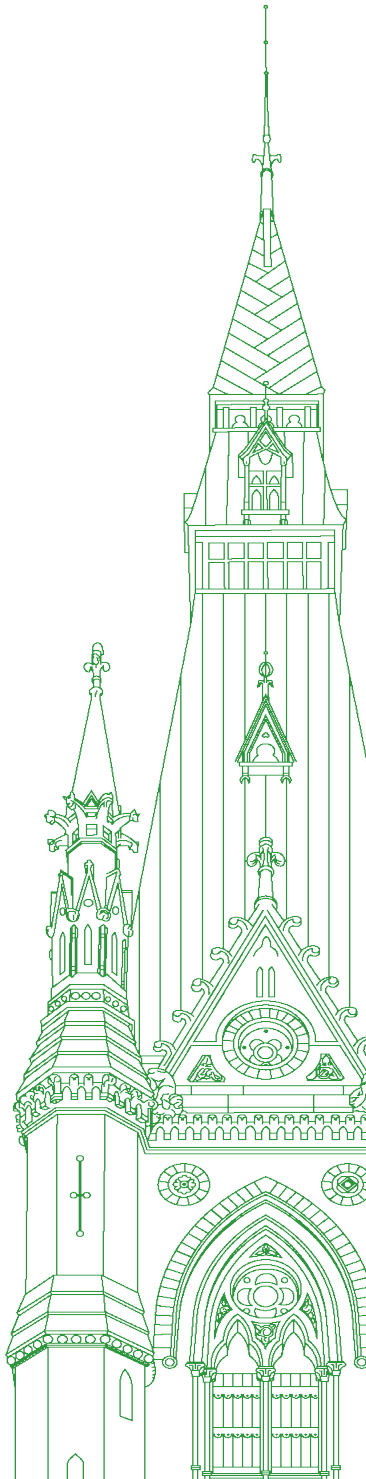

Chair: Mr. Sven Spengemann

Standing Committee on Foreign Affairs and International Development

Monday, March 21, 2022

● (1100)

[*Translation*]

The Chair (Mr. Sven Spengemann (Mississauga—Lakeshore, Lib.)): Good morning, honourable members. Welcome to meeting number 10 of the Standing Committee on Foreign Affairs and International Development. I call the meeting to order.

To ensure an orderly meeting, I would like to outline a few rules to follow.

[*English*]

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

[*Translation*]

As always, interpretation is available through the globe icon at the bottom of your screen, and for members participating in person, keep in mind the Board of Internal Economy's guidelines for mask use and health protocols.

I'd like to take this opportunity to remind all participants in this meeting that taking screenshots or photos of your screen is not permitted.

[*English*]

Before speaking, please wait until I recognize you by name. When speaking, please speak slowly and clearly. When you're not speaking, I would ask that you put your microphone on mute. I would remind members and witnesses that comments should be addressed through the chair.

Before we begin, I'd like to flag that we have a number of small housekeeping items to deal with at the end of the session. I would like to reserve some time at the end to take care of that.

Without further ado, I'd like to welcome the officials who are with us today.

From the Department of Foreign Affairs, Trade and Development, we have Stephen de Boer, ambassador and permanent representative of Canada to the World Trade Organization, and Joshua Tabah, director general, health and nutrition.

Welcome to the committee.

From the Department of Industry, we have Darryl Patterson, director general, and Mark Schaan, acting senior assistant deputy minister, strategic and innovation policy sector.

Welcome.

Mr. Tabah, I understand that you'll be making the only opening statement before the committee this morning. I will turn the floor over to you.

As customary, I will signal colleagues and witnesses with this yellow sheet of paper when you have 30 seconds remaining in your testimony or questioning. It has proven to be an effective method of keeping time, so I would ask you to keep an eye out for that.

Mr. Tabah, the floor is yours for five minutes. Please go ahead.

Mr. Joshua Tabah (Director General, Health and Nutrition, Department of Foreign Affairs, Trade and Development): Thank you, Chair.

It is my pleasure to be here before the committee. I'm joined today from Geneva by my colleague Stephen de Boer, Canadian ambassador and permanent representative to the WTO.

[*Translation*]

Building on decades of leadership in global health, Canada has been a champion of vaccine equity, contributing to a robust, multifaceted and global response to the pandemic since the very beginning.

[*English*]

Throughout the pandemic, Canada has reinforced its position as a leader in global health and equity. We've done that by championing new mechanisms for the procurement of COVID-19 vaccines and other medical products, and by working collaboratively within the international rules-based trading system to support broader access to vaccines.

Canada is committed to supporting equitable global access to COVID-19 vaccines, treatments and diagnostics. That's why we've worked hand in hand with the access to COVID-19 tools accelerator, or the ACT accelerator, and the COVAX facility towards this goal. COVAX remains the best way to ensure that all countries have equitable and timely access to COVID-19 vaccines. Canada has committed $580 million in support, and has been a key champion of the facility since its inception nearly two years ago.

● (1105)

[*Translation*]

COVAX uses a fair, transparent and equitable allocation framework based on a series of algorithms that ensure doses are distributed where they are needed most.

[*English*]

COVAX has now shipped over 1.3 billion doses to 144 countries. Despite some initial challenges in securing the supply it needed last year, COVAX has been well positioned since the fall to meet the supply needs of its members while also offering integrated end-to-end support. It is the key mechanism to help ensure that all countries have what they need to make steady progress towards the WHO's goal of achieving 70% immunization rates this year.

The donations of vaccines were critical last year when global supply was severely constrained, and they've played a major role in COVAX's effort to ensure that all countries have access. Part of Canada's contribution to the facility included $10 million specifically for the development and operationalization of COVAX's dose-sharing mechanism through which doses offered for donation by any country are matched with the countries that need them, ensuring that global efforts are coordinated.

[*Translation*]

In addition, Canada has committed to donating the equivalent of at least 200 million doses to the COVAX facility by the end of 2022. To date, more than 100 million vaccine doses have been delivered through COVAX.

[*English*]

This includes 15 million surplus doses that COVAX has shipped to 23 countries on Canada's behalf and the equivalent of 87 million doses procured through Canada's financial support.

Additionally, Canada is one of only four countries to pay the full ancillary costs for any doses donated through COVAX. This ensures that the costs for syringes, diluent and safe disposal materials don't create an additional burden on COVAX or recipient country partners.

The global vaccine supply landscape has shifted in recent months, and production and supply now exceed current demand and administration capacity. If the landscape in 2021 was supply constrained, the landscape in 2022 is evolving to be demand constrained. To help adjust this, Canada will continue to go beyond procurement. It will also reinforce vaccine delivery and strengthen health systems to ensure that countries have the support they need to turn vaccines into vaccinations.

[*Translation*]

Canada has provided $100 million to support the delivery and distribution of vaccines through COVAX's delivery program. We have made a significant investment to support the system in conjunction with the World Health Organization and Pan American Health Organization, or WHO and PAHO.

[*English*]

Canada is exploring additional ways to increase bilateral and regional support for country-level delivery and administration, including for demand generation.

While we have currently moved beyond the situation of supply scarcity we faced last year, we are committed to doing our part to ensure it doesn't happen again, by addressing barriers to production and access.

We are working with international partners to improve global capacity to manufacture vaccines for both COVID-19 and beyond. Since the onset of the pandemic, Canada has actively worked with other WTO members and international partners to identify and address concrete barriers to access, such as supply chain constraints and export restrictions.

As Ambassador de Boer is in attendance today, he can speak to Canada's engagements at the WTO and provide the latest from there.

[*Translation*]

Canada recognizes that global vaccine access and distribution depends on numerous factors that go beyond intellectual property. They include the resilience of supply chains, distribution challenges, access to technical know-how and expertise, and, of course, production capacity and funding.

[*English*]

To support more diversified vaccine production, Canada announced at the G20 summit last year an investment of $15 million to support COVAX partners and a South African consortium to set up an mRNA technology transfer and manufacturing hub in South Africa.

[*Translation*]

In conclusion, Canada remains committed to helping achieve the WHO target of vaccinating 70% of the world's population.

[*English*]

By supporting global, multilateral efforts to end the COVID-19 pandemic and complementing this with targeted, country-specific support, Canada will continue to take a leading role in helping ensure that all countries have access to the COVID-19 tools and support they require.

Thank you, Chair.

● (1110)

[*Translation*]

The Chair: Thank you very much for your opening statement, Mr. Tabah.

[*English*]

We will now begin our first round of questions. These are six-minute allocations, and leading us off this morning will be Mr. Aboultaif.

Please go ahead for six minutes.

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

Good morning to everyone, and good morning to the witness.

Thank you, Mr. Tabah, for your presentation this morning. The first question that comes to mind is this: What is meant by equivalent doses of vaccines to COVAX?

Mr. Joshua Tabah: Much of the funding that Canada has provided to the COVAX facility is for the procurement of vaccines by COVAX. COVAX purchases the vaccines and allocates them through the WHO allocation mechanism to countries in need.

As such, the 87 million doses that we have procured the equivalent of is based on a calculation used by all G7 countries to determine the equivalent dose volume that their financial contribution would provide. Therefore, Canada is calculating both the in-kind surplus doses provided to COVAX for allocation, as well as the equivalent, the number of doses that COVAX will be able to procure directly from manufacturers through the financial support provided.

Mr. Ziad Aboultaif: Thank you.

Is there any cash involved with that?

Mr. Joshua Tabah: Yes, that is through grant funding to the COVAX facility partners; as such, we work with trusted international assistance partners, like the GAVI, the global alliance for vaccines. They work with other partners to procure doses through the grant funding provided by Canada, other G7 donors and other financial supporters as well.

Mr. Ziad Aboultaif: How much was Canada's participation, in dollar terms, in this initiative?

Mr. Joshua Tabah: To date, Canada has provided $540 million to the COVAX facility.

Mr. Ziad Aboultaif: On the specifics of the equivalent, such as the one you mentioned, out of the $580 million, how much is just for the specific initiative?

Mr. Joshua Tabah: The G7 methodology agreed with COVAX takes the total support provided by a donor to COVAX in terms of unrestricted grant supports for COVAX's work and then calculates the dose equivalency based on that. For Canada, that $554 million in grant supports translates to the equivalent of 87 million doses procured and distributed by COVAX.

Mr. Ziad Aboultaif: Getting from 14 million to 200 million doses by the end of the year, as you mentioned, of course sounds challenging. It's a big jump from 14 million to 200 million. If that is cash, isn't that just the Canadian government abdicating on its commitment to donate vaccines?

Mr. Joshua Tabah: Canada works closely with COVAX to ensure that COVAX receives the support it requires to partner with developing countries and others to meet their vaccine needs. We're already at just over 100 million doses provided against that commitment of 200 million, some from the cash procurement that I mentioned and some from in-kind doses. We feel that we're on track to achieve the target of mobilizing the equivalent of 200 million doses through COVAX by the end of 2022.

Mr. Ziad Aboultaif: In that regard, what has happened to all the vaccine doses the government claimed to have contracted for?

Mr. Joshua Tabah: I'm sorry, sir, but I'm not well positioned to speak about Canada's overall procurement.

When doses are made available for donation, we offer them to COVAX, and COVAX uses its allocation framework to place them where they are most needed around the world.

Mr. Ziad Aboultaif: Would Ambassador de Boer like to participate in answering this question?

His Excellency Stephen de Boer (Ambassador and Permanent Representative of Canada to the World Trade Organization, Department of Foreign Affairs, Trade and Development): I have no knowledge of Canada's procurement policies with respect to vaccine procurement within Canada. I'm sorry, but I cannot answer that question.

Mr. Ziad Aboultaif: Thank you.

COVID-19 vaccines are available through COVAX. Would you be able to tell us what kinds of vaccines are available, what brand names are available and how many of each have been administered?

Mr. Joshua Tabah: That's an excellent question but quite a detailed one. That information is publicly available on COVAX's website. I would be happy to make sure there is follow-up for that.

At a general level, I can say that COVAX is only in position to procure vaccines that are received through the World Health Organization's emergency use listing. They strive to have a balanced portfolio that reflects the needs of its members. As you would understand, going forward that will include a large percentage of mRNA vaccines, such as Pfizer and Moderna—both vaccines within the COVAX portfolio. They are also planning to deliver significant volumes of Novavax and Johnson & Johnson as other prominent vaccines. Initially, AstraZeneca was a prominent vaccine distributed through the COVAX facility, but there has been a reduced demand for that viral vector vaccine from partner countries, and so it will feature less prominently going forward.

● (1115)

Mr. Ziad Aboultaif: I have 30 seconds left, and I have a final question.

Is there a problem with countries donating about-to-expire doses to COVAX, and how many are wasted in that they did not get used before expiration? Again, do you have any ideas on that? If you can't, of course, give me the answer now, I would appreciate a written response to the committee.

The Chair: Give a brief answer, please, in the interest of time.

Mr. Joshua Tabah: At this stage, we don't have any detailed or granular information about doses going to waste. I can assure you that no countries received doses from COVAX that they had not agreed to take. There have been no doses shipped through COVAX that have not been explicitly requested and signed off on by any recipient country.

Mr. Ziad Aboultaif: Thank you.

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

Mr. Ehsassi, please, for six minutes.

Mr. Ali Ehsassi (Willowdale, Lib.): Thank you, Mr. Chair.

Thank you, Mr. Tabah, for your explanations. They were very helpful, indeed.

My first question is a general one. As you know full well, COVAX is a creation without precedent that came together given the collaboration of numerous countries and the WHO. However, many have criticized it for having been too ambitious, and they say so without knowing all the challenges that were bound to arise. How would you evaluate the implementation of COVAX?

Mr. Joshua Tabah: It is a monumental undertaking to have designed a new multilateral mechanism for the procurement and delivery of vaccines. I would point to a few specific milestones that give us comfort and confidence in how effective the mechanism has been.

First, the COVAX mechanism was able to deliver its first doses to Ghana in February 2021, mere weeks after those doses received initial regulatory approval from the WHO. It represents the first time that a novel product in the vaccine space like this was made available so early in an equitable way around the world.

Another significant milestone earlier this year was achieving a billion doses delivered. For many of us, it was a key moment to recognize the enormity of not just the effort but also the result in progress that COVAX has made.

At this stage, with over 1.3 billion doses shipped and many more planned deliveries in the coming weeks and months, we feel that COVAX is the key platform positioned to provide support to countries that require it. It offers end-to-end integrated support, including technical assistance, planning support, cold chain assistance, and local administration and rollout support. When we set out to build this new mechanism with a number of other allies, it was important not just to position COVAX for effective procurement, but also to be able to procure safe and effective vaccines that would respond to what countries require and then to complement that with comprehensive support to strengthen immunization systems in countries.

I mentioned in my opening remarks that there were delays last spring and summer that the world faced. Production was not able to keep pace with the demand that spiked around the world. By about October or November, though, COVAX was well positioned to meet those needs of countries and it achieved a milestone of over 350 million doses delivered in December alone.

Mr. Ali Ehsassi: The latest data suggests that approximately 63% of the population of the world has received one dose. I noted during your presentation that you were talking about the milestone of 70% immunization by the end of the year. How likely is it that the WHO will hit that target by the end of this year? It would appear to me that we may very well surpass that target.

● (1120)

Mr. Joshua Tabah: There's a great deal of analysis and multiple opinions on this question. It's one the committee is likely to return to. Personally, I do think that the world is on track for an average immunization level of around 70% or even exceeding it by the end of 2022. I will note, however, that the WHO's goal is that every country achieve immunization levels of 70%, ideally by this summer. That is a much more ambitious goal. I think that there are multiple countries, in particular, fragile and conflict-affected states, that will struggle to achieve that level of immunization on that timeline.

Mr. Ali Ehsassi: Thank you. Now I'll turn to Ambassador de Boer.

Hello, Ambassador. It's great to see you before this committee. I want to ask you about the meetings and the discussions that were taking place at the WTO earlier this month. Of course, various initiatives are on the table. There is one that is led by India and South Africa and another one that is led by the European Union.

Could you tell us what Canada's perspective and views are on the merits of the two initiatives that are currently under discussion?

Mr. Stephen de Boer: I think what you're referring to are two processes. There is a proposal that was put forward by a number of countries led by India and South Africa. It was presented to the TRIPS council quite a while ago—I believe it was in October 2020—and it has been an ongoing discussion.

The other process that you're referring to is one that is led by the director general of the WTO. It's the so-called quadrilateral process that includes the U.S., the European Union, South Africa and India. That process was launched in December and is ongoing.

Mr. Ali Ehsassi: These two processes would not be either-or, but would essentially complement each other, is that correct?

Mr. Stephen de Boer: It's not clear. There are stories that there is a compromise that has now been reached, but that compromise has not been approved by the quadrilateral. My assumption is that if a compromise were reached, that would go to the TRIPS council for discussion, rather than the earlier proposal, and that members would engage on that particular text.

Mr. Ali Ehsassi: Thank you.

[*Translation*]

The Chair: Thank you, Mr. Ehsassi.

Good morning, Mr. Bergeron. You have six minutes. Go ahead.

Mr. Stéphane Bergeron (Montarville, BQ): Thank you, Mr. Chair.

Thank you to the witnesses.

Good morning to my fellow members. It's nice to see everyone again after two weeks off, which may have felt long to some and short to others.

Mr. Tabah said something in his opening statement that took me by surprise. He said that the vaccine landscape in 2021 was supply constrained, but that the situation had evolved in 2022 to become demand constrained.

I was taken aback when he said that, given the situation in a number of countries, including Haiti, where only 1% of the population is vaccinated. I'll come back to Haiti in a moment. In the Democratic Republic of the Congo and Chad, less than 1% of the population is fully vaccinated. In Papua New Guinea, just 2.8% of the population is vaccinated, and in Yemen, the number is 1.4%.

While we may be about to enter a phase where the landscape is demand constrained, the situation is very different in some African countries and in Haiti, for instance.

What, then, accounts for your rather optimistic view of the situation in 2022, Mr. Tabah?

Mr. Joshua Tabah: Thank you for that excellent question.

Low demand is not necessarily an optimistic sign. It's a complex challenge. The doses are available. If Haiti wants to access doses through COVAX, they could be there in a few weeks.

Low vaccination rates are not the result of a shortage of doses; rather, they are the result of a lack of demand and the limited health care capacity in those countries. I repeat, the doses are available. Nearly five billion doses have been made available through the COVAX facility this year. It is now necessary and urgent to work with those countries to ensure, not only that the political demand exists and logistical capacity is in place, but also that the population wants to be vaccinated against COVID-19. The misinformation and lack of demand in many communities is significant.

That is why we are working with partners such as the WHO and PAHO. We want to make sure that governments in the region, including those in Haiti and the Dominican Republic, have access to comprehensive supports so they can work with their populations. That way, when more requests for vaccine access start coming in, the necessary capacity will be in place. The doses are available now.

● (1125)

Mr. Stéphane Bergeron: I gather from Mr. Tabah's remarks that the next challenge for the international community will revolve around on-the-ground distribution and administration to populations, not so much the production and allocation of doses. I would think Canada has some work to do in that regard.

Now I want to talk about what Canada has done. Canada has donated *x* number of doses to other countries on a bilateral basis through a mechanism that is still unclear. The criteria used to determine which countries would or would not receive doses from Canada are still somewhat murky.

For example, Canada provided doses to Jamaica on four occasions, either directly or through COVAX, but did not provide any doses directly to countries like Haiti. Clearly, Haiti, one of the poorest countries in the world, is in the grip of not only a major political crisis, but also a major humanitarian crisis because of the earthquake that hit the northern part of the country. What's more, Canada and Quebec are home to a large Haitian diaspora.

What accounts for the disparity in Canada's provision of doses to countries on a bilateral basis?

Mr. Joshua Tabah: Thank you for your question.

Our offer of vaccines to the government and people of Haiti is quite clear, and our ambassador is keeping a very close eye on the situation. We are ready to work with the Haitians as soon as they tell us they need doses to administer.

We are here for our neighbours in the Americas and the Caribbean, of course. We want to make sure that Haiti has all the support it needs to strengthen its commitment to the vaccination campaign.

We have established criteria. When countries in need of doses with the capacity to administer them cannot receive doses from Canada through COVAX, we can deal bilaterally with those countries. That's what we did last year with Jamaica.

The Chair: Thank you, Mr. Bergeron.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

[*English*]

The Chair: We will now pass the floor to Ms. McPherson.

Please go ahead for six minutes.

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

I'd like to thank our guests for joining us today.

Welcome back to all of my colleagues from the weeks in our constituencies.

This is obviously an issue that's very important to me. I brought forward the motion for us to study this in this committee, so I'm looking forward to asking some questions today.

The first question I want to ask is regarding the TRIPS waiver. It recently emerged that a compromise agreement was negotiated. We heard about that earlier. This would soon be presented to the WTO. In the view of most CSOs, the document is only a small step forward as it applies only to small geographical areas and addresses the export of vaccines made under compulsory licence.

Will Canada support the TRIPS waiver at the WTO? Why has Canada been dragging its feet on the original waiver? Is any action ready to be taken on this reintroduced waiver?

One big concern that I should flag is the idea that this is so urgent. We have heard time and time again that the government is thinking about it, questioning it and looking at it, but we haven't seen the urgency.

Mr. Tabah talks about the idea that we had a very big problem in terms of supply at the beginning of the pandemic.

My questions are, will we be supporting that going forward and why didn't we support this in a more expedited way?

● (1130)

Mr. Stephen de Boer: I want to be very clear. There is no TRIPS waiver at this point. There was a proposal, as I mentioned to Mr. Ehsassi. There is now a process by which—

Ms. Heather McPherson: I'm sorry to interrupt. Does Canada intend to support the quad that is coming forward?

I do apologize for interrupting you. It's just that I have such little time.

Mr. Stephen de Boer: That's fair enough.

That is not an official waiver text either. We don't have that text.

As we understand it, a compromise was reached among the four and they have gone back to capitals to consult. The text has not been shared by the quadrilateral members with Canada or any WTO members, nor has it been shared by the DG.

I understand the plan would be that, if they agree, it would be presented to the TRIPS council as soon as possible. However, we do not have access to this particular text, so as it stands right now there is no waiver text.

With respect to your other question, Canada has never said that we would oppose a TRIPS waiver. It's been problematic in that there has not been a TRIPS waiver text. Canada has said that we are ready to engage with members on the basis of a compromised text. In this case it will have to be when that text is available and when the quadrilateral group has confirmed that this is the compromise.

I should also say—

Ms. Heather McPherson: You do know the intention of the text, though. Would Canada be finally willing to support the intention of a TRIPS waiver?

Mr. Stephen de Boer: I'm not sure why I would know the intention when this text has not been confirmed by the four quadrilateral members.

Ms. Heather McPherson: I'm going to ask another question to keep it moving.

Mr. Stephen de Boer: Sure.

Ms. Heather McPherson: Another question I have is around CAMR, which is Canada's access to medicines regime. We know there was a proposal put forward from a manufacturer in Bolivia. We heard a number of concerns about the process to access the CAMR.

How is the government addressing this? As it stands, of course, CAMR isn't working. We'd like to see it work better.

Is this a priority for the government?

Mr. Stephen de Boer: I'm not sure who you—

Mr. Mark Schaan (Acting Senior Assistant Deputy Minister, Strategic and Innovation Policy, Department of Industry): I'm happy to start on that, Ambassador.

With respect to the questions of Canada's access to medicines regime, there is a process, as you outlined, that needs to be followed to be able to move it through. Canada continues to work in international fora with respect to this and follows those dialogues and discussions. At this stage, Canada has not received a formal proposal through the CAMR process and is looking at the possibilities of how the regime would be engaged in this regard.

Ms. Heather McPherson: Wouldn't this indicate that the CAMR process is broken if they are not able to put that process forward? I understand that you're saying there is a process that needs to be undertaken, but it does seem like we are now two years into a pandemic and that process should probably be expedited.

Mr. Mark Schaan: I think it's very important to come back to the comments that were made by my colleagues in Geneva with respect to the fact that right now the problem is not one of supply—

● (1135)

Ms. Heather McPherson: It really was.

Mr. Mark Schaan: CAMR is a process by which additional supply can be brought to bear from a Canadian perspective in those countries that potentially have need. It is worth noting that that would need to be a demonstrable capacity to move that through, and as we saw, there was a significant effort from the players at the forefront of the vaccine effort to be able to tech transfer and grow capacity, which ultimately then came to bear, which is why we are now in a position where there is actually significant supply across the world.

Ms. Heather McPherson: Thank you.

The Chair: Ms. McPherson, that's six minutes spot on. You'll have a chance to follow up in subsequent rounds.

We will go to round two.

Leading us off will be Mr. Morantz, please, for five minutes.

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

I'm curious about a recent news story that said it's very likely that the WHO won't approve Medicago's COVID vaccine due to ties to the tobacco industry. As you're probably aware, the Government of Canada invested $173 million of taxpayers' dollars into Medicago for the production of the Covifenz vaccine. When they applied to the WHO for approval, the WHO did its due diligence and found out that Philip Morris, the tobacco company, owns a roughly 20% stake in Medicago, and they have a strict policy of not partnering with tobacco companies.

I'm wondering whether or not you're aware of the situation and what due diligence was done before the government parted with $173 million for a vaccine company whose vaccines can't be used outside of our borders.

Mr. Joshua Tabah: Go ahead, Mr. Patterson, I can come back on the WHO side if necessary.

Mr. Darryl Patterson (Director General, Department of Industry): With respect to the investments made in the facility in Quebec for Medicago, as with all projects that are ultimately supported through our colleagues at the strategic innovation fund within the Department of Industry—or ISED—rigorous due diligence is performed, as well as expert advice in the context of vaccine and biomanufacturing projects through the vaccine task force, which provides advice on all projects moving forward. There was a process followed and a decision made to fund in accordance with the policies and procedures that are followed for all investments made.

Mr. Marty Morantz: Thank you.

During that due diligence, did the Government of Canada look into the ownership of Medicago? Was it aware prior to the giving of the $173 million grant that Medicago was substantially owned by a tobacco company?

Mr. Darryl Patterson: I can't comment on the specific due diligence, having not been part of it, other than to say that financial due diligence is conducted, as well as corporate due diligence, on all transactions that are supported through the SIF.

Mr. Marty Morantz: Who could answer that question?

Mr. Darryl Patterson: I can take that back and report back if that's [*Inaudible—Editor*].

Mr. Marty Morantz: I would like to know whether or not the Government of Canada was aware, before it issued $173 million of taxpayers' dollars to Medicago, that the WHO had a rule that it wouldn't deal with tobacco companies. If you could respond to that question in writing, I would really appreciate it.

The article goes on to say that given this rejection of the Covifenz vaccine by the WHO, these vaccines will be excluded from contribution to COVAX. Will that hamper the Canadian government's ability to meet its obligations to supply the 200 million doses equivalents or actual doses to COVAX? Was it relying on the vaccines from Medicago to meet that goal?

Mr. Joshua Tabah: Thank you for the question. I can take that one.

No, Canada has not been relying on that specific vaccine candidate to meet the target of donating the equivalent of 200 million vaccines to COVAX by the end of 2022. As I mentioned, a key, necessary step for COVAX to add a vaccine to its portfolio is WHO EUL recognition, which, as you've noted, is likely not to be the case for Medicago.

I would simply add that countries are free to make whatever procurement and regulatory decisions they deem appropriate. The WHO's emergency use listing is an important step for COVAX, but other countries globally have their own regulator approaches and may make similar decisions to Canada in terms of providing regulatory approval for a vaccine candidate.

● (1140)

Mr. Marty Morantz: Have you had any discussions with any other countries that may simply wish to ignore the WHO rejection and actually acquire vaccines on a bilateral basis?

Mr. Joshua Tabah: We have regular discussions with countries. Many countries, including, for example, the United States, Mexico or others rely primarily on their own national regulator as opposed to decisions from the World Health Organization. The WHO's regulatory function is an important scientific and evidence base in particular for developing countries that lack stringent regulator authority themselves.

Mr. Marty Morantz: You found out that—

The Chair: Thanks very much. In interest of time we'll have to leave it there. You'll have a chance to follow up in a subsequent round.

[*Translation*]

We now go to Ms. Bendayan for five minutes.

[*English*]

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

Thank you, Ambassador, and to all the witnesses who are here before us today.

I would like to begin, however, by acknowledging where we are at.

Russia issued an ultimatum to surrender the city of Mariupol. Approximately 12 hours ago, Ukraine time, that deadline expired. The citizens of Mariupol continue to be bombed, continue to be shelled, continue to die; and they do so in the name of freedom and democracy. I think we should acknowledge that at the beginning of our meeting.

I would also like to acknowledge the leadership of my colleague, Ali Ehsassi, who returned only a few days ago from the Ukraine-Poland border.

Mr. Ambassador, I'm very familiar with the discussions about the TRIPS waiver you referred to earlier in your exchange with my colleague, Ms. McPherson. I would like to come back to that for a moment. My understanding is that the United States, India, South Africa and the European Union have held discussions, as you mentioned last week, and that there is no proposed text before WTO members, which includes Canada. Is that the current state of affairs as you see it, Ambassador?

Mr. Stephen de Boer: Yes, that is correct.

Ms. Rachel Bendayan: It is impossible for members, including Canada, to provide a clear position one way or the other.

Mr. Stephen de Boer: Yes, but I would say that Canada has signalled all along that we are ready to join a consensus on the waiver issue. We will actively engage in discussions should a text come forward, for example, with a view to reaching a compromise and reaching a solution on this issue.

Ms. Rachel Bendayan: In fact, Mr. Ambassador, Canada has played a leadership role in bringing parties together on this very topic.

Can you perhaps walk us through what Canada has done over the last many months in order to advance discussions on an IP waiver?

Mr. Stephen de Boer: What Canada did was mostly through the work of the Ottawa Group that Canada has convened within the WTO. Much of the Ottawa Group's work was animated by the DG and a process that she engaged in called the “third way”, where she looked at some of the trade impediments with respect to our response to COVID-19.

With the Ottawa Group members, Canada has put forward a trade and health initiative that would facilitate trade in and the equitable distribution of medical goods, including vaccines, therapeutics, diagnostics and vaccine production inputs, and generally promote resilient and predictable supply chains. We have been working hard to try to get support within the WTO for this initiative.

It would address export restrictions, promote efficient customs procedures and temporarily remove or reduce tariffs on these medical goods and production inputs.

Ms. Rachel Bendayan: Thank you, Mr. Ambassador.

To be clear, as you said, our government absolutely welcomes the progress that was made. We have always been in search of a multilateral solution to this issue.

Picking up on your last answer, you mentioned other medical goods. My understanding is that in addition to vaccines, we also need to provide developing countries with syringes, and other medical items in order to support their vaccination campaigns.

Can you speak to Canada's role in providing those additional materials?

● (1145)

Mr. Stephen de Boer: I'm working in the trade policy sphere, not in the procurement of goods, such as syringes.

Let me tell you, and perhaps all honourable members will recall this as well, that at the beginning of the pandemic we had issues as significant as trying to get masks, for example. The Ottawa Group and the trade and health initiative response was to try to address some of those problems. They tried to address export restrictions and increase transparency, so it would be easier to facilitate international trade in those vital but sometimes very simple goods.

[*Translation*]

The Chair: Thank you, Ms. Bendayan.

[*English*]

We'll have to leave it there.

[*Translation*]

It is now Mr. Bergeron's turn for two and a half minutes.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I want to follow up on the question about Medicago. My understanding, and correct me if I'm wrong, is that the decision by the WHO is preliminary, not final.

What, then, is Canada doing in an effort to get the WHO to change its decision? On the face of it, the decision might appear to make perfect sense, since tobacco companies don't tend to manufacture products that are good for people's health.

However, how can a tobacco company be criticized for making a significant investment in something that has enormous benefits for global health?

Mr. Joshua Tabah: I'll go first, but my colleagues may have something to add.

Health Canada determined that Medicago's vaccine was safe and effective, and that's why a decision was made to use it domestically—a sign that it is an important vaccine for the world. I would also point out that the decision is quite recent and that talks with the WHO and its partners are ongoing.

Mr. Stéphane Bergeron: In your assessment, is there reason to hope that the WHO will ultimately change its mind?

Mr. Joshua Tabah: Forgive me, Mr. Bergeron, but I'm not the right person to make those types of predictions. My area of focus is international assistance for developing countries.

Mr. Stéphane Bergeron: I understand.

I'm almost out of time, and I wouldn't want to insult you by trying to get you to answer another question in so little time. We can pick up our discussion later.

Thank you, Mr. Chair.

The Chair: How thoughtful of you, Mr. Bergeron. Thank you.

[*English*]

We'll go to Ms. McPherson, for two and a half minutes.

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

The question I have is around COVAX. The understanding was that COVAX was intended to be used as a tool to make sure that vaccines were equitably distributed.

Mr. Tabah, do you believe that it undermines COVAX's ability to do its job, when other countries develop bilateral agreements with the vaccine producers and, in effect, take the vaccines that would be available, so COVAX can't do its job?

Mr. Joshua Tabah: COVAX's plan for procurement was sound. There were delays and export restrictions from key suppliers that created a significant gap in its procurement pipeline early last year, in the spring and early summer.

● (1150)

Ms. Heather McPherson: Did that gap exist because other countries, like Canada, made bilateral agreements to take those doses, so there weren't doses available?

Mr. Joshua Tabah: That's not the analysis that we have discussed with COVAX or other partners. It really was a significant reliance on production from the Serum Institute of India, and then a very significant third wave that affected that country, which led to export restrictions.

It is worth stepping back a bit and recognizing that, since the fall, COVAX has had access to the supply that it required. As such, it has been able to ensure that it can play the part that we hoped it would for developing countries and other members.

Ms. Heather McPherson: I look at some of the profits that we're expecting Pfizer, BioNTech and Moderna to make over the course of this pandemic. We've heard estimates in the range of around $65,000 a minute.

Considering that $8 billion of public money went into the development of vaccines, do you think it is appropriate that the pharmaceutical companies are in charge of the disbursement of life-saving vaccines?

Mr. Joshua Tabah: I'll take that one from the honourable member. All I can say is we are trying to ensure that COVAX has everything it needs to respond to the end-to-end requirements of developing country partners to reach those immunization targets.

Ms. Heather McPherson: We're in a good situation, if there is another pandemic, to be able to get vaccines out more equitably. I think we can all agree that the vaccine response to COVID-19 was not strong.

Would you feel that we are well placed or in a better-placed situation for future pandemics?

The Chair: Give a very brief answer, please.

Mr. Joshua Tabah: On the one hand, we've developed mechanisms that we won't have to put in place from scratch next time, but very significant reforms to the international architecture remain, which multiple independent panels have called for. There is still work ahead of the global community to put in place some of those changes to ensure that something like this never happens again.

Ms. Heather McPherson: Thank you.

The Chair: We'll have to leave it there. Thanks very much, Ms. McPherson.

Next up is Mr. Chong, please, for five minutes.

Hon. Michael Chong (Wellington—Halton Hills, CPC): Thank you, Mr. Chair.

I want to clarify several pieces of information. As I understand it, the Government of Canada signed contracts directly with the vaccine manufacturers to provide vaccines to Canadians for over 400 million doses. I understand that about 90% of adult Canadians are vaccinated with three doses. That means we've used approximately 90 million doses, and that we have over 300 million doses left under contract that are available to Canadians.

Canada pledged 200 million doses to the COVAX facility as part of our commitment. In the earlier testimony today, I think the witnesses mentioned, Mr. Chair, that Canada's donated $540 million to this program and the COVAX facility to date, which is the equivalent of 87 million doses. That's my understanding of what we've been told here.

To clarify, is the 87-million-dose equivalent what you see this $540 million grant as? Are there any actual vaccine doses in the 87-million-dose equivalent amount?

Mr. Joshua Tabah: Yes, that's the number of doses that we have agreed with COVAX and as G7 members—

Hon. Michael Chong: No. I'm asking a very specific question. In the 87-million-dose equivalent, are there actual doses that Canada has contributed, or is it all an equivalent amount?

Mr. Joshua Tabah: Thank you. I understand now.

That is the equivalent amount from the cash contribution. Over and above that, Canada has provided approximately 15 million in-kind doses, which have been delivered through COVAX to developing countries.

Hon. Michael Chong: Thank you. That's very helpful.

That works out to roughly $6.20 a dose, Canadian. In other words, the $540 million that Canada has contributed to the COVAX facility is roughly equivalent to 87 million doses, which is roughly $6.20. Is that math accurate?

● (1155)

Mr. Joshua Tabah: That's correct. There might be a difference of cent or two if it was based on a U.S. equivalency, but yes.

Hon. Michael Chong: Okay. The working group for the OECD proposed valuating these dose equivalents at $6.72 U.S., which is $8.40 Canadian under the current exchange rate of roughly 80 U.S. cents per Canadian dollar. I take it that the G7 equivalency is different from the OECD working group equivalency. Is that correct?

Mr. Joshua Tabah: Yes, and sometimes, honourable member, I wish it wasn't. This was a G7 methodology put in place under U.K. leadership last June—

Hon. Michael Chong: Sure.

Mr. Joshua Tabah: —and you're right. The discussions at OECD are ongoing about that new one. They're in the same ballpark, but there are differences and we're trying to streamline that.

Hon. Michael Chong: On this $540 million that we have contributed, will Canada be considering that as part of its annual official development assistance goals? Will that be included in the ODA calculations for last year, this year and upcoming years?

Mr. Joshua Tabah: That's where that OECD valuation is really important, because any in-kind support provided directly to developing countries, like these dose donations, will be reported as official development assistance.

Hon. Michael Chong: Okay.

Mr. Joshua Tabah: We may donate doses through COVAX that go to middle-income countries, so we'll have to look at whether those are also reported, but certainly all those to low-income and low-middle-income countries will be reported as such.

Hon. Michael Chong: Those are all the questions I have.

Thank you, Mr. Chair.

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

Mr. Gaheer, welcome back to the committee.

You have five minutes. Please go ahead.

Mr. Iqwinder Gaheer (Mississauga—Malton, Lib.): Thank you, Mr. Chair.

Thank you to the ambassador and the witnesses for their time.

My first question is about COVAX and the fair allocation framework. The criterion is equality of coverage. That's a primary criterion. Could the witnesses please speak about how COVAX doses are directed to specific countries? Who manages the delivery and the handover to the countries, and who is responsible for the domestic rollout? We've had conversations about how COVAX gets the doses, but what happens once they have them?

Mr. Joshua Tabah: Thank you. It's an excellent question and is something that we're all placing a great deal of attention on right now.

In terms of the allocation framework, there is a hands-off independent scientific process led by the WHO to ensure that as soon as doses are made available through COVAX, they are allocated to countries on the basis, yes, of need and coverage, but also on the ability to use and other criteria, like vaccine dose preference. If a certain vaccine becomes available, but it's not what a country is looking for, it will go to someone else. That's part of the algorithm and the calculations I mentioned that go into each allocation round as new doses become available.

On the specific partners inside COVAX, Gavi is the organization that leads on the negotiation and determination of which vaccines to procure, but then UNICEF is the logistics agent that in general manages the delivery of vaccines from manufacturer to country.

In-country, the doses are traditionally handed over to the domestic health authority—the minister of health and her team, for example—and they then take responsibility for national rollout and administration. They have support from Gavi, from UNICEF and from the WHO in managing those national vaccines, but ultimately, the international community is here to support national authorities in managing their immunization campaigns.

Mr. Iqwinder Gaheer: Thank you, Mr. Tabah. That was very informative.

I'd like to jump to the TRIPS waiver proposal, which we've spoken about a bit. There seems to be significant support amongst WTO members for the TRIPS waiver proposal led by India and South Africa.

Several members, though, including the EU, Norway and the U.K., have opposed it. The U.K., on December 16, 2021, issued a statement to the WTO TRIPS council and voiced its concerns that the proposed TRIPS waiver "would not increase the number of vaccines reaching people's arms" and that it carried "risks".

Could you speak to why WTO members like the EU, Norway and the U.K. are opposed to the TRIPS waiver proposal led by South Africa and India?

● (1200)

Mr. Stephen de Boer: First of all, you're asking me to divine what the U.K. or Norway are thinking, for example. I think those are the two countries you mentioned.

Let me say this. There have been criticisms of the waiver proposal because it may not actually achieve the result, which is to increase vaccine production for a variety of reasons; but no WTO member has said that they do not wish to discuss this issue.

This goes before the TRIPS council, which is a council of the WTO, and there is a 90-day period for proposals to be discussed. Every time the 90 days has come up, the membership has unanimously agreed to continue those discussions.

What I hear from the members you have mentioned is that there is some suggestion that the proposal will not actually address what it is intended to address.

Honestly, the best people to answer that question would be those members themselves.

Mr. Iqwinder Gaheer: Great. Thank you.

Do you then share the U.K.'s pessimism with respect to reaching a consensus based on the TRIPS waiver proposal, led by India and South Africa?

Mr. Stephen de Boer: It's not at all clear, as I said earlier, that the India and South Africa proposal will continue to be viable, because we have heard that the quadrilateral discussions with the U.S., EU, India and South Africa may have reached another result. It's too early to tell, because we don't know what's in that particular proposal.

I would say that Canada is more than willing to engage in that discussion and would support a consensus with the membership, going forward.

Mr. Iqwinder Gaheer: Great. Thank you.

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

We'll now go into our third round of questions.

Leading us off is Mr. Genuis, please, for five minutes.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you very much, Mr. Chair.

Thank you to our witnesses.

What proportion of the vaccine—

The Chair: Excuse me, there is a problem with the sound.

Stand by one second, please. I'll put a pause on your time.

[*Translation*]

Mr. Garnett Genuis: I can speak in French if that's easier.

Mr. Stéphane Bergeron: It's working in French, at least.

[*English*]

The Chair: It is working now.

Go ahead, Mr. Genuis.

Mr. Garnett Genuis: Thank you.

What proportion of the vaccines that Canada is giving away or contributing through COVAX are of a type that is not recommended in Canada?

Mr. Joshua Tabah: None of them is. We would only offer, through COVAX, vaccines that we had procured. That meant they had received regulatory approval from Health Canada, and also from the World Health Organization.

Mr. Garnett Genuis: My question was not what proportion had not received regulatory approval; my question was what proportion was not recommended in Canada. For example, I understand that AstraZeneca is approved, but not recommended for use by Canadians.

Mr. Joshua Tabah: There would be other people better placed to speak about Canada's domestic strategy.

We have made AstraZeneca doses available through COVAX for donation. It is a dose that continues to be sought by some countries around the world, and we have recent information from COVAX that AstraZeneca has been allocated to countries that continue to use it as part of their national campaign.

Mr. Garnett Genuis: Thank you.

Could you answer my first question?

Mr. Joshua Tabah: On the proportion...?

Mr. Garnett Genuis: What proportion of Canada's COVAX contribution funds or distributes doses that are not recommended for use in Canada? That was my initial question.

Mr. Joshua Tabah: I can say that of the roughly 15 million doses that Canada has provided in kind, about five million have been Moderna and about 10 million have been AstraZeneca. I don't have the dose equivalents that COVAX has purchased and allocated from our financial contributions attributed down to specific vaccine types.

● (1205)

Mr. Garnett Genuis: Okay. Thank you.

Of the in-kind vaccine contributions, two-thirds of what we're giving to other countries are of a vaccine type not recommended for use in Canada.

Do you have concerns about how that might be perceived?

Mr. Joshua Tabah: I don't have any concerns. The AstraZeneca doses were the first vaccines that Canada donated to the facility, and were made available from the manufacturer. It's natural that more of those were allocated initially.

We now see that—

Mr. Garnett Genuis: Sorry to interrupt, but I have limited time here.

What proportion of the total vaccines distributed by the COVAX facility are of a type not recommended for use in Canada?

Mr. Joshua Tabah: An earlier question touched on the overall volume by name and delivery by COVAX. That information is publicly available. I don't have it at my fingertips, but I'm happy to make sure the committee has line of sight on all the vaccines allocated.

Mr. Garnett Genuis: Thank you. Please provide it to us in writing.

My sense is that about 20% of the vaccines shipped through COVAX are Sinopharm or Sinovac from China, and they are not approved for distribution in Canada. Is that correct?

Mr. Joshua Tabah: Both of those received EUL, and were available from COVAX. I understand demand was low, so I can't confirm that, but that's the overall volume that was shipped. That will be part of the information we will share.

Mr. Garnett Genuis: Thank you.

Mr. Tabah, can you comment on the use of so-called vaccine diplomacy by China, your observations around that, and the impact of that? There's some indication that the distribution of vaccines is being used as a strategic tool by the Government of China to, for instance, try to blunt human rights criticism.

Is this a phenomenon you're observing, and what is Canada doing to respond?

Mr. Joshua Tabah: Canada, like other G7 countries, is committed to ensure that there's an effective multilateral mechanism, so that countries have a choice when they are looking for a safe and effective vaccine. COVAX is now providing that.

Mr. Garnett Genuis: I don't know if that was really an answer to my question.

Are you observing the use of vaccine diplomacy as a kind of geostrategic tool by the Government of China to blunt criticism around its human rights record?

I understand your objective is to give countries a choice, but are you seeing efforts being made along those lines?

Mr. Joshua Tabah: Multiple countries attempted to pair vaccine offers with a desire for influence earlier in the pandemic, when supply was scarce. Now that supply is abundant, we hope countries will continue to choose safe and effective vaccines, and that's what COVAX offers.

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

Mr. Sarai, please go ahead, for five minutes.

Mr. Randeep Sarai (Surrey Centre, Lib.): Mr. Ambassador, could you elaborate on some of the concerns of why the TRIPS waiver would not be an effective tool to actually increase supply and affordable supply for those countries seeking it?

Sometimes people think it's a very simple way to increase supply for developing countries and continents that have a challenge, and others don't realize why.

Can you elaborate on the challenges that have been discussed?

Mr. Stephen de Boer: With all due respect, please be aware that some of this is surmising since I am not an intellectual property expert, but the issue seems to be around timing, and particularly around the timing of the production of these vaccines.

I mentioned earlier that the director general of the WTO had a third way proposal, where she talked to industries about the issues they were facing with respect to vaccine production. None of them mentioned intellectual property as the problem. They talked about other issues, like inputs, for example, and actually having the technical expertise, and the people who could deliver on the manufacturing, particularly on the mRNA, which is quite complex. Supply chain predictability was another issue.

Some of the countries that are holding the IP, I would imagine, are thinking that they should probably be spending more time addressing those issues that have been identified as the real stumbling blocks to vaccine production.

There's a range of issues not related to the IP itself.

● (1210)

Mr. Randeep Sarai: Is Canada's strategy to increase doses to those countries needing them by funding COVAX, or is it also to use some of our domestic facilities that now have been created, or are being created, that may create supply right here in Canada to help supply those countries?

Mr. Joshua Tabah: I can take that one. I would say it's a multipronged approach whereby our support to COVAX is the primary mechanism to help end the acute phase of the pandemic right now, and that's by cash financing through grant agreements and through the provision of in-kind doses that are donated from Canadian surplus.

In addition, though, we are supporting more diversified manufacturing capacity, including in South Africa with an mRNA hub. As the ambassador mentioned, developing the capacity and infrastructure to produce mRNAs is highly complex. This is a COVAX-backed initiative with WHO as a key partner to work with a consortium of producers in South Africa to ensure that it becomes the initial South African capacity for that production.

Then, going forward, as Canada brings additional manufacturing capacity online through its biomanufacturing strategy, I think there is an expectation and a hope that it could play a role in addressing global vaccine demands.

Mr. Randeep Sarai: Quickly, how is the global world, either through COVAX or otherwise, dealing with vaccine hesitancy in the developing world?

Mr. Joshua Tabah: Our understanding is that the situation differs significantly from country to country, so the responses that we are trying to support differ as well. We're working hand in hand with ministries of health and the World Health Organization to put in place vaccine competence campaigns. Sometimes that's because populations didn't have access to clear information; sometimes it's simply because they didn't have access to health services to receive the immunization.

I was in Nigeria a few weeks ago speaking with the minister of health about additional support that we could provide to ensure that the populations in remote areas receive not only access but clear and up-to-date information about the benefits of taking a COVID-19 vaccine.

There is work happening on multiple fronts at a country level, a regional level and also a global level to focus on demand generation, because that will be critical in achieving 70% immunization levels this year.

Mr. Randeep Sarai: Thank you.

The Chair: Mr. Sarai, thank you very much. Just before we go to our next intervention, I want to remind colleagues of the Board of Internal Economy health guidelines. If you're not speaking or having lunch, please continue to wear masks as set out by the Board of Internal Economy.

[*Translation*]

Go ahead, Mr. Bergeron. You have two and a half minutes.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I'd like some clarification. In response to Mr. Chong's question earlier, Mr. Tabah suggested that Canada's financial contribution to COVAX consisted in supplying the equivalent of a certain number of vaccine doses.

Does that mean that the bulk of Canada's financial contribution to COVAX will be used to purchase doses and that no part of the contribution will go towards addressing the new challenge of distributing and administering doses in recipient countries?

Mr. Joshua Tabah: That's an excellent question. We are doing our best to distinguish the various funding amounts made available to COVAX. Through that mechanism, we endeavour not only to purchase, distribute and transport doses, but also to provide cold chain and technical support to countries in need.

Dose equivalency is an issue we discuss with the G7 and OECD to ensure a consistent approach. I'm referring to the 87 million doses, the equivalent number of doses procured through COVAX with Canada's financial contribution. With the assistance of the WHO, UNICEF and other partners, we are supporting the delivery and administration of doses, which that calculation does not include.

● (1215)

Mr. Stéphane Bergeron: You said two things in your answer that really piqued my curiosity.

First, as you said earlier, the doses are made available through COVAX, but the problem has more to do with the receiving and administration side of things. Are you talking to COVAX officials about making changes to our support, to ensure better distribution on the ground?

Second, what portion of Canada's assistance is being used to address that new challenge?

The Chair: Please keep your answer brief, Mr. Tabah.

Mr. Joshua Tabah: We speak regularly with the people at COVAX. I mean daily, not just weekly. That is also true for partner countries where we would like to see an increase in vaccination coverage and the use of doses. We take that challenge seriously. We have assured the people at COVAX that we are prepared to take on a larger role to address these issues on a regional and international basis in the coming months.

The Chair: Thank you, Mr. Tabah.

Mr. Stéphane Bergeron: Mr. Chair, if I may, I'd like to ask Mr. Tabah to get back to the committee in writing with the funding amounts provided by Canada for the distribution and administration of doses in recipient countries.

The Chair: Your request has been noted, Mr. Bergeron.

Thank you.

[*English*]

Next we have Ms. McPherson for two and a half minutes.

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

Speaking of written documentation, I'm wondering whether or not it would be possible for our witnesses to provide a list of all government meetings with the pharmaceutical lobby and related companies since the beginning of the pandemic, including notes from those meetings, if possible.

My question is going to follow up on my colleague Mr. Bergeron's questions on ODA.

My concern is that if ODA is being calculated using vaccines as part of our official development assistance, we will not see the same levels in other areas. If we calculate these as part of our ODA, will there be an impact on other areas where ODA is vitally important as we recover from COVID-19?

Mr. Tabah, perhaps you could take that one.

Mr. Joshua Tabah: Yes, I'd be happy to. Thank you.

To date, all the supports we have provided to COVAX in terms of financial support, as well as the support provided more broadly to the ACT accelerator for tests, treatments and health systems, have been additional to Canada's regular ODA budget. These are extraordinary COVID-19 funds that the government has made available to support this initiative, and as such should be viewed as additional and not substituting.

It is essential to maintain our current health services for populations in need, in particular during the pandemic.

Ms. Heather McPherson: To clarify, going forward into next year's budget and into future budgets, we would expect to see that ODA would still have contributions for things like food security, knowing that the crisis in Ukraine is going to have deep impacts on food security around the world. We would still have support within our FIAP, the international assistance policy for women and girls. All of those things would not be taken from in order to account for the ODA that we've spent on vaccines.

Mr. Joshua Tabah: It's an excellent question, and one that I do not have an answer to. I can speak to what's been done to date, which is additional funding provided to the department that ensures the integrity of current reference level flows.

Ms. Heather McPherson: You mentioned earlier today that $15 million, I believe, was allocated to funding in South Africa to produce vaccines. We heard that there would be around $34 billion made by pharmaceutical companies over the course of the pandemic. I'm wondering if you feel that $15 million is sufficient to help South Africa get to a situation where they can create vaccines that are accessible to people around the world.

The Chair: We need a brief answer, please, sir.

Mr. Joshua Tabah: At this point, we're pleased to be the second most important donor towards that initiative. We're hoping that vaccines start rolling out the door next year. It will be a really important step for South Africa to be able to produce mRNA vaccines on soil.

Thank you.

The Chair: Thank you, Ms. McPherson.

Next is Mr. Aboultaif, please, for five minutes.

Mr. Ziad Aboultaif: Thanks again, Chair.

I will go back to my colleague MP Chong's question on the $540 million equivalent to 87-million doses, at $6.20 per dose.

Mr. Tabah, do you know whether this price is a universal unit cost for vaccines?

● (1220)

Mr. Joshua Tabah: These are relatively complicated policy discussions that we've had among G7 countries, and now among DAC countries, as part of the OECD, with COVAX. We've tried to provide the best estimate of an average cost. We're not privy to the specific cost paid per dose by COVAX, but we're trying to find a fair representation that would appropriately reflect, in a transparent way, the cost of procurement of the doses that COVAX has done.

Mr. Ziad Aboultaif: My issue with this is that Canada could have paid more than other countries. We've heard throughout the last two years that our unit cost was higher than what the European Union or the United Kingdom paid.

Do you have any idea on that?

Mr. Joshua Tabah: Unfortunately, no, but in terms of the valuation, it was important to find a solution that worked for all of us so that at least some simplicity and coherence were brought into the mechanism. It's related not to Canada's purchase price but rather to the equivalent that COVAX is needing to allocate per dose.

Mr. Ziad Aboultaif: COVAX has negotiated on behalf of all donors or participants in the fund to provide those vaccinations needed. Is that correct?

Mr. Joshua Tabah: What makes COVAX special is that it's a pooled procurement mechanism. It takes the demand from, say, 92 developing countries and is able to negotiate better prices and access as a result of that, and then it “bulk procures” doses to then allocate to its members.

Mr. Ziad Aboultaif: Those are the 92 countries that can benefit from COVAX. Is that correct?

Mr. Joshua Tabah: Yes. They're part of a window called the advance market commitment, which is specifically for low-income and low-middle-income countries, the ones that need the most international support.

Mr. Ziad Aboultaif: We can call this a distribution list of COVAX vaccines. Is that correct?

Mr. Joshua Tabah: Yes, it's the members of participating economies, the AMC 92. They're primarily the ones to whom those doses are being allocated.

Mr. Ziad Aboultaif: Is there information on how the distribution happened? Is that information on the public record, or do we need to obtain it through you?

Mr. Joshua Tabah: It's all publicly available on COVAX's website but also on UNICEF's, which has a very good interactive dashboard through which you can click on a country to see when shipments from COVAX came into the country, and of course it summarizes it at higher levels, as well.

Mr. Ziad Aboultaif: Canada sits at that table, I can imagine, since we're a donor country. Do we have an influence on how this distribution needs to happen or do we take the recommendation of the WHO in this case?

Mr. Joshua Tabah: We do sit and actively participate in many tables, but the allocation framework is at arm's length from donors, so it is entirely needs-based and ensures equity. That's run by the WHO with scientific experts and clear algorithms that countries understand. So, no, we do not influence the allocation of COVAX's doses to their member countries because that's a science- and needs-based decision that's run by that arm's-length committee.

Mr. Ziad Aboultaif: So we accept the recommendation and we further our commitment accordingly without having to have any influence over how vaccines are distributed, where they go and how much to pay per vaccine?

Mr. Joshua Tabah: That's right. We understand the parameters. We helped to negotiate and put them in place for this mechanism. We were a key leader of it from the beginning, so we accept how well the methodology works in terms of allocating the vaccines.

Mr. Ziad Aboultaif: When you say “we accept”, who accepts? Is it the Minister of Health or Foreign Affairs or International Development?

Mr. Joshua Tabah: When we're dealing with in-kind doses, doses that are surplus to Canadian requirements, those are deemed surplus by the Minister of Health of Canada. Then the Minister of International Development delegates to us the delivery of those doses through COVAX to wherever the fair allocation framework that COVAX manages indicates. Obviously COVAX keeps us informed. We want to ensure that our embassies on the ground are aware of incoming Canadian doses. We want to make sure that we take the advantage to ensure that they are put to use immediately and lead to immunizations in our partner countries, so it's a dynamic discussion.

The allocation process itself is at arm's length from donors in other countries like Canada and is managed by the WHO on COVAX's behalf.

● (1225)

Mr. Ziad Aboultaif: Thank you.

The Chair: Next we have Ms. Vandenbeld for five minutes.

Go ahead, please.

Ms. Anita Vandenbeld (Ottawa West—Nepean, Lib.): Thank you very much.

I want to thank you for your expertise and for being here today.

Before I get to my questions, I'd like a clarification. When Canada is providing doses, we're not just providing the actual vaccine but are also providing the things that are needed to administer that, like syringes and things like that. Is that correct?

Mr. Joshua Tabah: When we work with COVAX, as I mentioned, we're one of only four countries to ensure that we pay the full ancillary costs for any donated doses. Kudos to Ireland and a couple of other countries for being partners with us in this, but the intent is that when we donate to COVAX, we can't then create an additional financial burden on COVAX or the others. COVAX has its own agreements to procure the safe disposal of materials, the vaccines and the transport, but we ensure that it has the financing necessary so that Canada's donated doses don't create any additional cost or burden on it.

Ms. Anita Vandenbeld: Thank you.

We've talked a lot today about the actual doses, the actual vaccines, and that's the COVAX piece, but we also know that as part of the ACT accelerator there are three other pillars, and those include things that are really needed by countries, things like being able to test for COVID. Under the therapeutics pillar, we also have the needs for health systems, as we've heard from other members here, the absorption capacity of health systems and the bottlenecks. That's another pillar. Also there's making sure that there are diagnostics. I'm sorry—there are the diagnostics and the testing and then the therapeutics, which are basically treatment. It's not just a matter of getting vaccines. We also need to be able to treat COVID. We need to be able to test for COVID, and we need to be able to get those vaccines into people's arms through the health care system.

Can you tell us a little bit about what Canada is doing on those other three pillars in addition to getting the actual doses, and where we rank compared to other countries on those three pillars?

Mr. Joshua Tabah: Thank you.

Chair, you'll have to cut me off because I could speak all day about this.

The ACT accelerator covers all four of those pillars because they're essential. That 70% immunization level, if we reach it, still means that there will be 30% who are not vaccinated. They will rely on “test and treat” strategies, much as we are increasingly doing in North America, given the continued transmission of vaccines. Test and treat is essential for us to identify the evolution of this virus and then to deal with it, in particular, for people more at risk of serious illness. Canada is one of the largest donors to each of those pools.

Health systems are necessary to ensure the delivery of treatments, tests and also vaccines. It's also the legacy piece, which we hope to strengthen, that will persist after this pandemic and position us to better respond to any future threats.

The ACT accelerator took a novel approach by identifying a fair-share burden for every country. They determined what every country should pay, so that the ACT accelerator could do its work. Canada was one of the very first countries to fully meet its burden share for the ACT accelerator and one of the very few to have done so.

Canada is held in very high regard for having met its burden share and ensured a balanced approach across all four pillars. We're one of the only donors to have done so.

Ms. Anita Vandenbeld: Is it true that Canada is actually first in the world on the therapeutics pillar, the diagnostics pillar and health systems pillar?

Mr. Joshua Tabah: The needle moves around a little bit as new contributions come in, but we are a top donor. That is sometimes first, but sometimes we bump down to second or third and then we bring in additional investments.

The international system and developing country partners are very well aware of Canada's leadership in providing access to not just vaccines, but also to health systems support, diagnostic support and access to therapies.

On therapies in particular, the development of new antivirals really is the next horizon. We want to make sure that developing countries do have equal access to them just as they do for vaccines now.

Ms. Anita Vandenbeld: On a different track, I'd also like to ask about the pilot project, which is the South African technology transfer hub.

You mentioned the $15 million. Can you tell me the importance of it and why this pilot is significant in terms of potentially scaling that up in the future?

Mr. Joshua Tabah: I would point to two elements in particular that are significant. South Africa is already a regional leader in vaccine production. They have outstanding manufacturing capacity and have been working on producing generic vaccines, but there has been no mRNA vaccine production capacity in sub-Saharan Africa or in Africa more generally. This is the first WHO-backed initiative to ensure that there is African production of mRNA vaccine primarily aiming for African consumption.

The second point is that this will be a hub that will have a number of spokes across the continent where additional production will happen. This is where the core of the technology transfer and the scale-up of capability will occur. That will then be reproduced in other production facilities, so we'll get a much bigger bang for this investment than we would have by investing in competing, discrete initiatives.

We're very excited. The South Africans are very excited and, frankly, so are other stakeholders across the African continent.

● (1230)

The Chair: Mr. Tabah, thanks very much. We'll have to leave it there.

Thank you, Ms. Vandenbeld.

Colleagues, we're at 12:30. I had suggested that we set aside 15 minutes at the end of the meeting to discuss a number of housekeeping items. If it's okay with everybody I would suggest that we do four more interventions of three minutes each, one per party. That would take us roughly to a quarter to one.

If you're okay with that, we would start out with Mr. Morantz for three minutes.

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

Actually, Mr. Genuis is going to take my round.

Mr. Garnett Genuis: Thank you.

I'll just follow up on my earlier comments and put together a few things. We've been talking a bit about the challenge of vaccine hesitancy and some of the efforts to combat that. That's in a context, bluntly, where two-thirds of Canada's physical contribution to COVAX has been of a kind of vaccine that's not recommended for use in Canada.

To clarify my comments about Sinopharm and Sinovac, according to Dr. Bruce Aylward with the WHO, Sinopharm and Sinovac COVID vaccines have been shipped to 49 countries through COVAX, accounting for nearly 20% of total vaccines shipped through COVAX.

Do you think the problem of vaccine hesitancy in developing countries is exacerbated by sending vaccines that are known to have lower efficacy than other vaccines or that aren't recommended for use in the country that's sending them? Do you think that's contributing to vaccine hesitancy?

Mr. Joshua Tabah: Of the data and polling I have seen, and there has been extensive work done by WHO and UNICEF as well as the African Union and countries themselves, it appears that it was lack of access to vaccines that allowed misinformation to spread more actively.

I do expect, though, that the portfolio we offer through COVAX will continue to evolve and be much more reliant on mRNA vaccines. I wouldn't expect to see a lot more viral vector distributions, because the demand for those from countries that set their own national immunization goals is shifting away from viral vectors just as has been the case in Canada.

Mr. Garnett Genuis: As I've maybe said previously, I don't know whether that's an answer to my question. You're saying that the delays allowed misinformation to set in, but I'm sharing that it was clearly information, not misinformation, which is that Canada is choosing to distribute vaccines that are not recommended for use in Canada, and that some proportion—and we'll find out when you follow up with the written answer—of what's coming from other countries may be vaccines that aren't even approved, let alone recommended, here in Canada.

Is it not logical to wonder that people who are looking at that and saying, “People in Canada are being encouraged to choose other alternatives, and yet Canada is sending this to us” might contribute to hesitancy in terms of uptake, at least until other kinds of vaccines are available?

Mr. Joshua Tabah: I respect the decisions that our partner countries are taking about what vaccines to prioritize in their national immunization strategy. If that aligns with viral vectors, including those made available for donation by Canada, so be it, but, as we've seen increasingly, their priorities are also shifting to mRNA. They're following the science, much as Canada has.

The Chair: Thank you very much.

Mr. Genuis. I'm sorry, we'll have to leave it there.

Mr. Ehsassi, go ahead, please, for three minutes.

Mr. Ali Ehsassi: I'd like to share my time with Ms. Vandenbeld.

Ms. Anita Vandenbeld: Thank you very much.

I have a couple of final questions. There was mention earlier in the committee of what a lot of people are talking about as future-proofing the world from future pandemics. Can you talk about how the work Canada has done and our leadership role on the ACT accelerator and the COVAX mechanisms, and also the work in terms of transforming health systems, training health professionals, transportation of vaccines and cold storage, will have a multiplier effect in terms of the future so that what we're putting in right now is going to have impact going forward, not just for future variants but also for future pandemics?

● (1235)

Mr. Joshua Tabah: We have also spoken of production capacity. Diversifying and increasing production capacity is a key element, as is speeding up the sequencing of diseases once we understand that there are new outbreaks so that we can determine vaccine responses much more quickly.

The G7 has adopted a goal to try to carry out that genomic sequencing so that we can come up with new vaccine solutions within 100 days of a novel outbreak. That, married alongside increased vaccine production capacity, means that we'll be much better positioned to ensure a broad-scale vaccine rollout in the future, but as you've said, these investments we're making in health systems are to strengthen immunization capacity today but hopefully carry on in a sustainable way in the future.

That community health worker who is putting shots in arms is also the person at front lines who will be best placed to detect when there are new viral outbreaks. When they see any kind of a disease occurrence that is different from what was to be expected, by equipping these community health workers at the front line with diagnostic capacity and simple multi-variant testing capacity, we will be able to to detect much earlier what these novel outbreaks might be.

That said, the work isn't done yet. We continue to need to find better ways of managing this. The World Health Organization is in a leadership role in terms of convening us around a table to see whether there is a need to put in a new international instrument to ensure better data exchange and better management of information at the onset of a pandemic.

COVAX and ACT-A are functioning at a really high level right now, but obviously it took a very heavy lift by many of us to develop mechanisms and put them in place. We now have identified what these effective multilateral mechanisms are and can be, and they will continue to be there should the world require their kind of assistance in the event of another catastrophic novel disease outbreak.

Thank you.

[*Translation*]

The Chair: Thank you, Ms. Vandenbeld.

We now go to Mr. Bergeron for three minutes.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I want to follow up on Canada's support for certain countries since the pandemic began.

Everyone knows that we have been adamant from the start that Haiti, Taiwan and Palestine should receive special consideration. It appears, however, that the government did not heed our call, even though Taiwan helped us out in the early months of the pandemic, when we were in desperate need of medical equipment—masks and gowns, in particular. We received more than a million masks from Taiwan at the beginning of the pandemic, at a time when it was facing its own supply challenges because of the People's Republic of China. I argued that Canada should move quickly to provide Taiwan with vaccine doses.

Nevertheless, Canada has so far not delivered a single dose to Taiwan, whether directly or through COVAX. Conversely, Japan, the U.S., Poland, Lithuania, Slovakia and the Czech Republic all have. It's the same story with Palestine. If I'm not mistaken, Canada offered to give Palestine doses that were about to expire, doses that it refused—I imagine because of delivery and administration issues.

How do you explain the fact that Canada paid so little attention to those countries' needs? After all, they were in unique situations and certainly could have used swift help from Canada through bilateral arrangements.

Mr. Joshua Tabah: Thank you for your question.

Forgive me, but I'm not able to give you details about every country, but my colleagues in charge of bilateral relations with those countries are probably better people to ask.

I didn't know that Taiwan had asked Canada for doses. As far as I know, Taiwan was a model in its domestic pandemic response. It really set the standard for many countries in the world.

As for Haiti, we talked a bit about the challenges that exist there. We strongly support the Haitian people, but the recent string of political crises has certainly complicated the reception of the many doses that Canada and other countries have supplied. We have much more work to do with our partners in Haiti. It is my hope that political and technical discussions will lead to better co-operation, and make it easier to ship vaccine doses and administer them to the population.

With respect to Palestine, I don't have any up-to-date information.

● (1240)

Mr. Stéphane Bergeron: Mr. Tabah, if you would be so kind as to send us the information in writing, we would appreciate it.

Once again, thank you for being here today.

The Chair: Thank you, Mr. Bergeron.

[*English*]

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

Ms. Heather McPherson: Thank you.

I have the enviable position of being last in this committee, so I always get to ask the last question. I want to end with something.

I spoke to a doctor who has been working very hard on this work, Dr. Madhukar Pai, a professor and Canada research chair in epidemiology and global health. I asked him what he wanted me to ask the experts today. He expressed deep dismay that we are studying vaccine equity right now, but in fact we should be in a situation where vaccine equity is a reality because we are two years into this pandemic. He is deeply concerned about the BA.2 variant, the potential for future variants, the potential for impacts on Canadians and the potential for people around the world.

He has stated very clearly that Canada should have already donated our 200 million doses, that we should have already backed the TRIPS waiver and that we should have already ramped up vaccine production.

What has been the biggest impediment to Canada fulfilling its promises? We did promise the 200 million doses. We did not achieve that. We have repeatedly said that we are open to engage on intellectual property, but we have done nothing to waive intellectual property rights, even temporarily. CAMR is still inaccessible.

It's two years in. Why has Canada shown such limited understanding of the urgency of this issue with regard to the impacts on Canadians and the impacts on people around the world?

Mr. Joshua Tabah: Perhaps I can start.

I would note that increasing equity and increasing access by all populations, in particular low- and middle-income populations, has been the single overriding focus of my team for the last two years. What our partner organizations asked for as the priority was financial support and an improved coordination mechanism to work together. We delivered them the ACT-A, the COVAX facility, and fully met Canada's burden share to ensure that they had the resources necessary.

We are on track to achieve the 200-million dose commitment by the end of 2022, and right now what we're hearing from our partners is that they need more support for delivering administration at country level.

No one has sat by to analyze or to just look at things; we have acted and we have acted with alacrity and urgency since the beginning, and I think more than any other country donor.

I'll turn to Ambassador de Boer if he wants to say anything on the TRIPS side.

Mr. Stephen de Boer: Thank you.

I would say two things, the one is there isn't a waiver proposal yet on the table but it's also very important to understand how the TRIPS waiver operates.

The TRIPS waiver only allows a WTO member to enact domestic measures so as not to implement various provisions of the TRIPS agreement with regard to COVID-19. In other words, a TRIPS waiver would not, by itself, suspend patents.

The second question with respect to Canada in the domestic context is what exactly would Canada be suspending and what patents does Canada hold that go towards the vaccine production or mRNA production. I'm not aware that there are any in fact.

The waiver itself is waiving us from international obligations, not to implement those obligations domestically.

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

Colleagues, on our collective behalf I'd like to thank our officials, Ambassador de Boer and his colleagues, for being with us, for their service and for their testimony. We'll allow them to disconnect and take care of a number of housekeeping items in the next 15 minutes.

The first of these takes us to two budgets from SDIR that were distributed through the office of the clerk on March 4. The first of these was for a World Food Programme briefing in the amount of $575 and the second was a briefing with human rights organizations in the amount of $875. These are customary approvals for us for the work that's done by SDIR.

Colleagues, is there any opposition to approving those budgets as presented to you by the office of the clerk?

Some hon. members: Agreed.

The Chair: The second item is the approval of two of three work plans that were circulated also by the clerk, I believe about a week and a half, two weeks ago. The two that we would like to get approval on this afternoon to allow the analysts and clerk to move forward are the draft work plan on vaccine equity and the one on the Taiwan Strait. There's still a residual item that needs to be clarified on the Ukraine draft work plan that will come to us in a subsequent session.

Is there any discussion or objection to those draft work plans as presented by the clerk?

Mr. Chong.

● (1245)

Hon. Michael Chong: Mr. Chair, there's a witness my office had submitted for the Taiwan work plan who I would really like to have appear. His name is Doctor Steve Tsang. I'll just give other members of the committee some background on him. He is the director of the SOAS China Institute at the SOAS, University of London, England. He's a professor and an expert on politics and governance in Taiwan, China and Hong Kong, and in the foreign and security policies of China and Taiwan. He's been often quoted in leading publications in recent years.

I think he would be a valuable witness to have appear in front of our committee because of his expertise.

The Chair: Mr. Chong, thank you and noted.

Colleagues, I will just remind you that if there are discussions on witnesses and prioritization that go into more detail than the presentation of qualifications as Mr. Chong has just done, the option is at your disposal to go into an in camera session. The committee usually does that in camera but if there's a quick approval here or no objection to including that witness, then it becomes a matter of scheduling and making sure that we have enough time for the various witnesses to be put forward.

I will take Ms. McPherson next and then see if we can end this discussion without having to go in camera, but I'm in the committee's hands.

Ms. McPherson, please go ahead.

Ms. Heather McPherson: Thank you. I'll be very brief.

In terms of the vaccine equity study, I wanted to flag that the names we brought forward for the in camera portion were not included. I think it's important that we have somebody in the in camera portion, because it has to do with how we will be able to provide vaccines around the world. We put forward The Council of Canadians and somebody from Bolivia. Perhaps they could be considered.

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

If there are no additional interventions from members on this, I will ask the clerk to address briefly whether we can take those points on board without having to do a reprioritization among members.

Go ahead, Mr. Oliphant, please.

Hon. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Chair.

I have no trouble at all with adding Dr. Tsang. I don't know whether that means we have to take someone off; I will leave that decision to the clerk and analysts. I think he would be a good witness. We should try to fit him in. We are even willing to go with a lengthier meeting.

I'm fine with the other study, as well.

There are no other issues, from our perspective, with respect to these work plans.

The Chair: Thank you very much, Mr. Oliphant. That's helpful.

[*Translation*]

Go ahead, Mr. Bergeron.

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

I didn't necessarily realize that the committee would be approving these work plans today.

I'm just quickly going over my notes for the vaccine equity work plan.

I don't mean to criticize any of the witnesses that have been selected so far, but I do want to point something out to the committee. Mira Johri would be able to share some valuable insight into the pharmaceutical side of things if we were to include her in the first panel of meeting number two.

I also want to flag that, for meeting number four, panel two, no researchers in the humanitarian field were invited to appear. One of the people we would've liked to hear from is Karl Blanchet. I do want to bring that to your attention.

I'm still looking for my notes on Taiwan.

If it's all right with you, Mr. Chair, can you come back to me in a moment?

● (1250)

The Chair: Thank you, Mr. Bergeron.

[*English*]

Madam Clerk, do you have any reaction to what we've heard so far? These are questions primarily on the integration of potentially one or two additional witnesses, but nothing in terms of opposition.

What position does that put you and the analysts in, given the feedback that we've received?

The Clerk of the Committee (Ms. Erica Pereira): If members are in agreement to add these additional witnesses and are willing to let the analysts look at the work plan to see where they might slot them in, we can certainly do that.

The Chair: Does that correspond to the position of members?

I see some heads nodding.

[*Translation*]

Are you still looking for your notes, Mr. Bergeron?

Are you okay with the work plans as presented?

Mr. Stéphane Bergeron: Unfortunately, I wasn't quite listening, as I should've been. I was talking to an assistant.

I don't want to make you repeat it all, but can you tell me quickly what was said, Mr. Chair?

The Chair: Are you all right with approving the work plans, taking into account the additional comments made by members?

Mr. Stéphane Bergeron: If members' additional comments are taken into account, of course, I have no problem with that.

If I may, I'd like to comment quickly on the Taiwan work plan.

For the third meeting, Ting-Shen Lin is appearing in the second panel, but I was wondering whether that was the best panel to put him in. I don't have any objections per se. I was simply wondering whether it might be better to reverse [*Technical difficulty—Editor*].

The Chair: Pardon me, Mr. Bergeron, but the sound has cut out.

Mr. Stéphane Bergeron: Can you hear me now?

The Chair: Now, we can hear you, yes.

Mr. Stéphane Bergeron: Did you miss everything I said?

The Chair: No, you cut out for only a couple of seconds.

Mr. Stéphane Bergeron: I was wondering whether, out of consideration, we shouldn't switch the two panels, so that Mr. Wen-yi Chen, the representative from the Taipei Economic and Cultural Office in Canada, appears first.

[*English*]

Mr. Garnett Genuis: Mr. Chair, with respect to the vaccine equity study, I support the general shape of it, but I might want to send a follow-up note to the clerk on a couple of witnesses as a suggestion here and there. The general direction of it is good, thanks.

The Chair: Any objection to what Monsieur Bergeron suggested?

This is helpful. Thank you, colleagues.

We're in good shape in terms of moving this forward. It's primarily in the interest of keeping our studies on the rails, and allowing the analysts and the clerk to do the work to set up the meetings.

This takes us to a final point of housekeeping, a motion that Mr. Genuis wishes to present.

Please go ahead.

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

Shall I read the motion? What's the best process here?

The Chair: It's brief enough, and we still have a few minutes before one o'clock, so you can read it.

Mr. Garnett Genuis: Colleagues, I'm proposing the following motion:

> All written responses that have been or will be sent by witnesses to the committee arising from questions asked during public hearings, since the beginning of the 44th Parliament and going forward, shall be published on the committee's website, unless the committee has agreed or agrees in a particular case that particular responses given shall not be made public.

The rationale for this is that very often we ask for a written follow-up from witnesses on specific issues. My understanding from the clerk is that those are already deemed public documents. They're distributed to members, but not published anywhere, which means we and anyone we might send them to would have access to them. However, if somebody doesn't know us, or isn't in touch with our office, and is simply following the proceedings of the committee, and they want to find the written follow-up promised in a particular case, they have a harder time doing so. In the interest of transparency, just as our minutes and conversations are public, the written follow-ups would be automatically published on the website, as well.

We had some discussion via email about the exception, as referred to in the motion, where the committee deems that something shouldn't be made public. My suggestion would be that if the chair identifies some reason that a particular written submission should not be made public, he would delay its publication and bring the issue to the committee so that they could confirm or question the chair's decision in that case.

That would seem to me a reasonable procedure for the case where, for whatever reason, a written follow-up was something we didn't want to publish. As a default, especially when we're dealing with government officials, if there's an issue of a written follow-up, it makes sense for it to be easily accessible.

● (1255)

The Chair: Mr. Genuis, thank you very much for presenting the text of the motion, and the additional commentary.

Is there any discussion or opposition to Mr. Genuis' motion?

(Motion agreed to)

The Chair: With that, we stand adjourned until our next session.

Thank you very much, colleagues.