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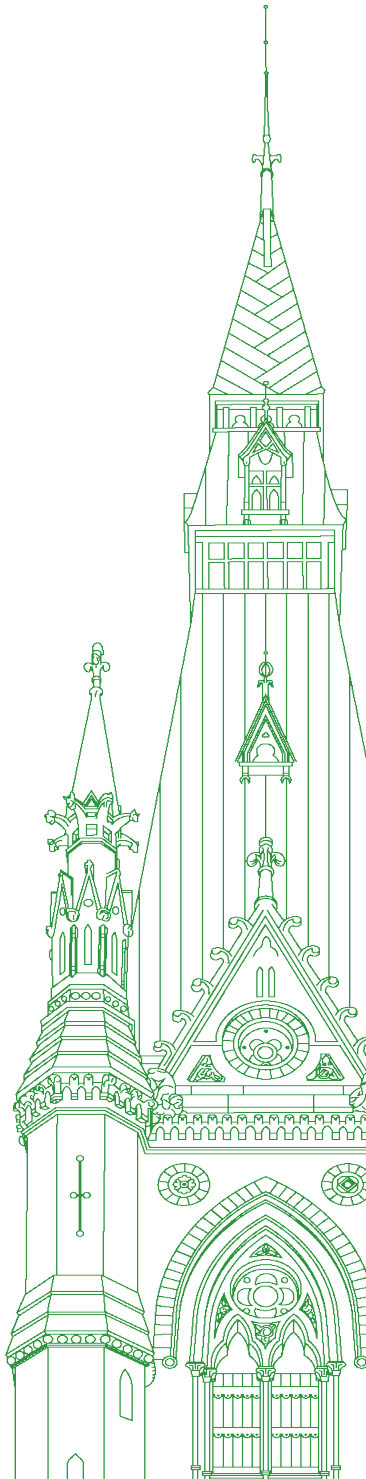

Chair: Mr. Ron McKinnon

# Standing Committee on Health

**Monday, May 10, 2021**

● (1105)

[*English*]

**The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)):** I call this meeting to order. Welcome to meeting number 36 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic, specifically today examining Canada's national emergency response landscape.

I would like to welcome the witnesses. We have from the Privy Council Office, Ms. Christyne Tremblay, deputy clerk; Ms. Thao Pham, deputy secretary to the cabinet operations; and Ms. Jodi Van Dieen, counsel to clerk of the Privy Council and assistant deputy minister, Privy Council Office legal services sector. From the Department of Public Safety and Emergency Preparedness, we have Mr. Rob Stewart, deputy minister. From the Ministry of Health of Israel, hopefully we will have later on Dr. Asher Shalmon, director, international relations division. From the Regional Municipality of York, we have Mr. Bruce Macgregor, chief administrative officer.

I will invite the witnesses to make their opening statements. We will start with the Privy Council Office and Ms. Christyne Tremblay for six minutes.

[*Translation*]

**Ms. Christyne Tremblay (Deputy Clerk, Privy Council Office):** Thank you, Mr. Chair.

Good morning.

Thank you for the opportunity to appear before this committee to discuss the federal response to COVID-19 in the context of emergency management.

My name is Christyne Tremblay, and I am the deputy clerk of the Privy Council and associate secretary to the cabinet, and the deputy minister for Intergovernmental Affairs. I am joined today by my colleagues Thao Pham, deputy secretary to the cabinet for operations; Jodie van Dieen, assistant deputy minister of Privy Council Office legal services; and Rob Stewart, deputy minister of Public Safety and Emergency Preparedness.

The Government of Canada's efforts responding to the pandemic run the gamut from federal investments in public health such as testing and contact tracing or the purchase of personal protective equipment; to providing direct financial support to individual Canadians and businesses; ensuring adequate and reliable supply of therapeutics and medical supplies across the country; maintaining effective border measures to minimize the importation and spread of COVID-19 and its variants; and purchasing and distributing vaccines to the provinces and territories.

The federal government has also worked collaboratively with the provinces, territories and indigenous communities to manage the pandemic. Public Health measures are largely within provincial and territorial jurisdiction, and the federal government sought to ensure that they had the tools and resources to exercise their jurisdiction.

Federal funding to support Canadian workers and businesses provided the space for provinces and territories to enact public health measures in their jurisdictions, tailored to their specific circumstances.

Through the Safe Restart Agreement, the federal government provided nearly $20 billion to support the provinces and territories in their efforts to deal with the pandemic. A further $7.2 billion in pandemic support was provided for provinces, territories and indigenous communities, in recognition of the ongoing pressures COVID is putting on the health care systems.

The federal government also provides PPE, medical equipment and surge capacity support to the provinces and territories. This includes the provision of testing and contact tracing supports and mobile health units. The federal government has responded to more than 70 requests for assistance, including by deploying the Canadian Armed Forces to long-term care facilities, supporting vaccinations in remote First Nations communities, and most recently deploying nurses and medical assistance teams to Ontario hospitals. My colleague Rob Stewart is responsible for coordinating these responses to requests for assistance.

Additionally, the federal government has provided health care staff and equipment to the front lines and more rapid testing and support for contact tracing thanks to teams at Statistics Canada. We have also provided additional drugs and developed laboratory testing capacity within our federal labs. Through our partnership with the Canadian Red Cross, support has been provided to long-term care facilities in several provinces, and additional nurses and physicians were recently deployed to assist in Toronto.

The Privy Council Office has played a central role supporting the Prime Minister and Cabinet throughout the COVID-19 pandemic. This includes supporting the Cabinet Committee on the Federal Response to the Coronavirus Disease, or COVID-19, which has a mandate to ensure leadership, coordination and preparedness for the response to, and recovery from, COVID-19 across Canada. The committee has also played a coordination function, working with all federal departments participating in managing the pandemic.

● (1110)

We have also played a central convening and coordination function, working with departments and agencies horizontally across government on a wide array of COVID-related priorities as well as communications through our COVID communications hub. My colleague, Thao Pham, is very much involved in this work.

Our responsibilities for Intergovernmental Affairs has also meant that the Privy Council Office has been leading engagement with the provinces and territories, including supporting 30 first ministers meetings in the past 15 months, which have focused primarily on the response to the pandemic. The last meeting was held 10 days ago and every provincial and territorial premier was in attendance.

I understand the committee is interested in discussing the legislative tools that exist at the federal level to respond to emergencies like the current public health crisis the country finds itself in. Parliament has granted the government authority to deal with emergency situations and some of these authorities have already been employed in dealing with the pandemic. An example of this is the Quarantine Act, which has been used to implement restrictions at the international border, including mandatory testing and quarantine requirements for travellers.

The Emergencies Act also exists as one possible tool for dealing with emergencies on a national scale. There are four types of emergencies that can be declared under the act: public welfare emergency, public order emergency, international emergency, and war emergency. Pandemics such as the COVID-19 pandemic are considered a public welfare emergency. The act includes a specific definition of a national emergency as urgent, critical and temporary in endangering the lives, health and safety of Canadians that exceeds the capacity of the provinces and territories to deal with. Importantly—

● (1115)

[*English*]

**The Chair:** Could you wrap up, please?

**Ms. Christyne Tremblay:** Sure. I need one second.

[*Translation*]

Additionally, the federal government is obligated to consult with the provinces and territories prior to invoking the act. As such, a cabinet decision to invoke a national emergency under the act is a measure of last resort. The Prime Minister consulted with the premiers of the provinces and territories regarding the potential need for invoking the Emergencies Act. The consensus among premiers at that time was that it was not required.

[*English*]

**Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC):** Chair, I have a point of order regarding time for questions.

[*Translation*]

**Ms. Christyne Tremblay:** Thank you.

[*English*]

**The Chair:** Go ahead on your point of order.

**Hon. Michelle Rempel Garner:** I was just wanting to make sure that we had time for questions, because the witness was going over time.

**The Chair:** Thank you, and thank you, Ms. Tremblay.

We'll go now to Mr. Stewart.

Deputy Minister, I believe you have a statement as well. You have six minutes, please.

**Mr. Rob Stewart (Deputy Minister, Department of Public Safety and Emergency Preparedness):** I will save you time by only making a few short remarks.

Obviously, emergency management has been a very large feature of the landscape over the last year. If we go back in time, we had a snowstorm in Newfoundland and we had disruptions to critical rail infrastructure before the pandemic struck, so we have been busy.

I'm here today to talk to you about the structure of the federal government's response to emergencies and how we coordinate with the provinces, the tools we've used and the situations we've responded to.

I'm at your disposal. Thank you.

**The Chair:** Thank you, Mr. Stewart.

We'll go now to Dr. Shalmon, the director of the international relations division at the Ministry of Health of Israel.

Dr. Shalmon, welcome. You didn't have a chance to test your sound, so maybe you could say a few words to make sure the interpreters can hear you properly, and then we will carry on with your statement.

**Dr. Asher Shalmon (Director of the International Relations Division, Ministry of Health of Israel):** Good morning, Ottawa.

My name is Dr. Asher Shalmon. I'm the head of the international ministry of health of Israel and I'm delighted to be here with you.

Is it fine?

**The Chair:** Thank you. Hopefully we'll get the thumbs up from the interpreters.

Mr. Clerk, are we good?

**The Clerk of the Committee (Mr. Jean-François Pagé):** Move your mike closer to your mouth, please.

Okay, Mr. Chair.

**The Chair:** Thank you, Mr. Clerk.

Dr. Asher, I invite you to make a statement of six minutes. When your six minutes is up, I'll show you the red card. Please do try to wrap up then. Thank you.

Go ahead, please, for six minutes.

**Dr. Asher Shalmon:** Thank you for inviting me. It's a pleasure to be here.

I was asked to speak about Israel's vaccination campaign, which is quite a successful one. We started early. On December 19, the Prime Minister and the Minister of Health were publicly vaccinated, and from the morning of the 20th we started to vaccinate widely all over the country.

We decided to go on a simple scheme, meaning that from the first day we vaccinated everybody who was age 60 and above, and medical personnel and first responders all over the country, with no subgrouping. Then, on a weekly basis, we dropped the age by five years, until at the point of week eight, the campaign was fully opened for the whole population over the age of 16.

We are now discussing when to start vaccinating teenagers. We have not yet authorized vaccine for ages 12 to 16, but we are working on it. I believe that at the end of next week, or the week after, that will be authorized in Israel and we'll be ready to start.

As you may know, Israel decided to take a single approach. We are using only Pfizer-BioNTech vaccines. We do have a clear deal with Pfizer regarding shipment dates and the exact terms of how the whole project is working. We were appealing to them, as we are running it as a national IT-driven operation where every case is fully registered not only with the national registry, but at the same time, registered by the recipient's HMO into their personal electronic medical record.

As I mentioned, the whole project was paperless. You had to preregister for your appointment, although if you did not register, you had a good chance to be vaccinated anyhow.

At the peak of this vaccination program, we vaccinated more than 200,000 people a day. To remind you, we have 9.25 million residents here in the State of Israel. We vaccinate everybody here: citizens, temporary residents, diplomats and foreign workers. Even asylum seekers and illegal immigrants were fully vaccinated from the first day. As well, we vaccinated our diplomatic corps around the world. We hoped to have some bilateral agreement with countries and we understood that it could not work at the pace that we were looking for, so we basically vaccinated everybody by ourselves.

Compliance was good. I think the psychology of supply and demand in the beginning was a major issue for the public. People were queuing and were trying to get it sooner rather than later. Of course, it changed as this campaign moved on, and now we are putting a lot of emphasis on the last part of the population who are hesitant or against it. We do understand that a devoted anti-vaxxer will never be convinced, so we are putting our efforts into hesitant people and into some communities that were slow in terms of the numbers, such as the Bedouin in the Negev and some of the Orthodox communities, who we are pushing ahead to be vaccinated.

It's not obligatory. You have the right not to be vaccinated, although there are some crucial working places, such as the health sector, that expect everybody who gives crucial services to the public to be vaccinated. We do not have a legal framework to force it, but it's kind of an understanding that it is what we expect from our employees.

We issue what is known as a “vaccination certificate”, which is fully electronic; it's a bar code. You get it a week after the second dose.

At this point, I might add that we decided to stick to the manufacturer's protocol and to vaccinate everybody for the second dose on day 21.

The green pass is another document, which you are entitled to receive if you are COVID-recovered or fully vaccinated. That allows you into what are known as “green pass zones” in the country, mostly restaurants and bars. Gyms used to ask for it, but now, by law, gyms are open to everybody, including public swimming pools. Large cultural events and concerts, all of them, could operate under a green pass registry, meaning that they are allowed to have much larger gatherings of people than what is known as the “purple tag”, which is a standard COVID-19 restriction for general places like supermarkets, pharmacies, hospitals, and so on.

● (1120)

Just to sum up the numbers, more than 90% of our medical personnel are vaccinated. More than 90% of those 60 and above are vaccinated. If we look at the adult population of Israel, 80% of the population were all vaccinated with, at least a single dose or had recovered. Around 9% of our population was found by PCR test to be positive in terms of carrying COVID-19 at some point during the past year.

That's where we are. I would be very happy to answer questions. I guess there will be a few.

Thank you.

**The Chair:** Thank you, Dr. Shalmon.

Before we carry on to our next statement, Ms. Tremblay, I'm advised that your mike may not be properly selected. Could you check that?

While Ms. Tremblay does that, we will carry on with Mr. Bruce Macgregor, chief administrator officer for the Regional Municipality of York.

Mr. Macgregor, please go ahead for six minutes.

● (1125)

**Mr. Bruce Macgregor (Chief Administrative Officer, Regional Municipality of York):** Thank you, Mr. Chair. As a former soccer coach, I'm a little sensitive to yellow and red cards, so I hope you won't be using them.

I'm the CAO of York Region. There are nine cities and towns that extend north of the City of Toronto to Lake Simcoe that serve as home to over 1.2 million Canadians. We are an upper tier municipality and provide 14 core services to all of our communities, ranging from courts to policing, transit, water and wastewater, to name a few.

We also deliver public health services, as one of 34 public health units in Ontario, under the direction of Ontario's chief medical officer of health, as described under the Health Protection and Promotion Act. This is a model that differs from practices in other provinces.

Our public health responsibilities are also delivered through a community and health services department in an integrated model that also includes paramedics, social services, long term care and housing, all of which have a focus on the social determinants of health.

The perspective I'll provide you today is as the CAO of a large greater Toronto area municipality where our regional council also serves as the board of health.

York Region has a comprehensive emergency management and preparedness program that is tested annually as required by legislation. Through our emergency management program, threats are assessed annually using hazard identification and risk assessment. Since SARS in 2003 and H1N1 in 2013, pandemic risks have increased in priority and focus. Formalized business continuity planning is also part of our emergency preparedness, and is centred on maintaining critical services.

On January 23, 2020, our medical officer of health, Dr. Karim Kurji, activated the public health emergency operations centre to respond to the COVID-19 pandemic threat, one month before York Region recorded its first case. On March 17, 2020, York Region activated the regional emergency operations centre, and by March 23, York regional chair, Wayne Emmerson, had declared York Region's first ever state of emergency under the Emergency Management and Civil Protection Act.

Prior to, and throughout, the pandemic response, York Region and our nine local cities and towns have worked together very closely. Our local municipalities have been an added source of assistance during York Region's mass immunization efforts.

With public health embedded in our organization, we were able to redeploy approximately 1,000 staff from within our organization to support the public health response. Additional critical internal supports were immediately redirected to enable staff working remotely. We redirected procurement to rapidly acquire personal protective equipment, human resources to quickly hire required specialized staff for long-term care and public health, and communications to ensure updates were available through multiple communications channels.

Business continuity plans documenting essential services and functions with assigned priorities helped to quickly identify services that could be suspended or reduced to shift staff resources to support the COVID-19 response while ensuring that critical core services continued uninterrupted during the pandemic.

York Region has in place robust and well-tested incident management systems that will serve emergency response efforts well into the future. We've strengthened relationships with our local municipalities, community partners and elected officials, and forged new relations with experts from various fields, such as the Red Cross, St. John Ambulance, local physicians, hospitals and pharmacies, all of which will support our future decision-making.

What we have learned through forced digital transformation will not be lost, with efficiencies and opportunities incorporated into our new normal moving forward.

Provincial and federal funding programs have enabled many Canadians to refrain from going into workplaces while enabling business to receive support during shutdowns. Without this financial support, the pandemic outcomes would have been much worse with respect to community and workplace transmission. While most of York Region's population has access to consistent and reliable broadband technologies to support remote working, there are many rural parts of our communities that experience the ongoing challenges that persist in rural areas throughout Ontario and Canada. As we optimistically shift from the response phase of the pandemic and into recovery, individuals and businesses will continue to require provincial and federal assistance and supports, hopefully with a stronger commitment and component of funding critical public infrastructure.

Through the COVID-19 experience, York Region's state of preparedness is higher than ever before, and as we look ahead to the potential of recurring infectious diseases, it will become critical to remember this experience and guard against complacency. We're hopeful for progress in three specific areas, working together with our provincial and federal partners.

● (1130)

First is encouraging domestic production and he supply of personal protective equipment and vaccines; second is investing in broadband to support all Canadians in working and schooling from home; and third is ensuring consistent and clear communication among all levels of government to educate and inform the population we serve, as a vital component of any emergency response.

Thank you, Mr. Chair, for your time this morning and for the opportunity to share York Region perspectives shaped by our organizational emergency management and public health model and experience.

**The Chair:** Thank you, Mr. Macgregor, and thank you to all the witnesses for your statements.

We will start our questioning right now. We will start with Ms. Rempel Garner, please, for six minutes.

**Hon. Michelle Rempel Garner:** Thank you.

I'll start by issuing hearty congratulations to the Government of Israel on their vaccine rollout program. I'll then direct my questions to Ms. Tremblay.

Have any of the vaccine procurement contracts been sent to the law clerk, per the October 26 motion in the House of Commons?

[*Translation*]

**Ms. Christyne Tremblay:** I just want to mention that with respect to the motion, PCO, together with all the departments, is reviewing the documents. So far more than five series of documents have been communicated including thousands of pages—

[*English*]

**Hon. Michelle Rempel Garner:** Thank you. I don't have time for this.

Have the vaccine contracts been provided to the law clerk per the motion?

[*Translation*]

**Ms. Christyne Tremblay:** The contracts have not been sent yet.

Work with the pharmaceutical companies continues.

[*English*]

**Hon. Michelle Rempel Garner:** Has the government directed you to not send these documents to the law clerk?

[*Translation*]

**Ms. Christyne Tremblay:** These documents belong to the pharmaceutical companies. We are actively working with these companies—

[*English*]

**Hon. Michelle Rempel Garner:** I would argue that they belong to the people of Canada.

You have not, then, sent the contracts to the law clerk.

[*Translation*]

**Ms. Christyne Tremblay:** We are working with the pharmaceutical companies to ensure that the appropriate documents are sent to the clerk.

[*English*]

**Hon. Michelle Rempel Garner:** Thank you.

The next question is, did the PCO provide direction or approval to any department or minister that ATIP operations should be shut down during the pandemic?

[*Translation*]

**Ms. Christyne Tremblay:** Every ATIP office in the government is open.

[*English*]

**Hon. Michelle Rempel Garner:** At the start of the pandemic, did the PCO provide direction or approval to any department or minister that ATIP operations should be shut down?

[*Translation*]

**Ms. Christyne Tremblay:** I will repeat my answer. Every ATIP office is operational.

[*English*]

**Hon. Michelle Rempel Garner:** Thank you.

Will a national proof of vaccination system be available to Canadians within the next four months?

[*Translation*]

**Ms. Christyne Tremblay:** If I may, I will ask my colleague Thao Pham to answer that question since she runs the operations of the Cabinet Committee on the Federal Response to the Coronavirus Disease, COVID-19.

[*English*]

**Ms. Thao Pham (Deputy Secretary to the Cabinet, Operations, Privy Council Office):** Good morning, Mr. Chair and MPs. I'm really pleased to be here. Thank you so much for the invitation.

Maybe I'll try to respond to Ms.—

**Hon. Michelle Rempel Garner:** I don't have time. We only have a few minutes.

Will a proof of vaccination system be available to Canadians within the next four months?

**Ms. Thao Pham:** As you know, the federal government is working very closely with provinces and territories in terms of rolling out the vaccination. Of course, the provinces and territories are the key interlocutor and are responsible for rolling out the vaccination, and therefore we will continue to work very closely with them.

**Hon. Michelle Rempel Garner:** I asked about a national proof of vaccination program. Are any plans for a national proof of vaccination system under way?

**Ms. Thao Pham:** We are working closely with all of the provinces and territories because, as you know, each province will have the specific systems, but—

**Hon. Michelle Rempel Garner:** Is it fair to say no, that there won't be a national system for proof of vaccination, then?

**Ms. Thao Pham:** Provinces and territories as you know are rolling out the vaccination program right now, and we are continuing to work with them.

**Hon. Michelle Rempel Garner:** There are no plans right now, then, for a national proof of vaccination program. It will be up to the provinces.

**Ms. Thao Pham:** We are working with the provinces and territories. As you know, the federal government has responsibility for international travel, so a number of departments are also looking at international standards with the WHO.

● (1135)

**Hon. Michelle Rempel Garner:** Will there, then, be a national system that is managed by the federal government?

**Ms. Thao Pham:** Maybe, Mr. Chair, if I may I'll just finish my answer here. The federal government has responsibility for international borders, so we are working with international partners such as the ICAO and WHO to look at those international standards. Of course, we are also continuing to work with the provinces and territories in terms of—

**Hon. Michelle Rempel Garner:** Thank you for the non-answer.

Mr. Stewart, was any advice given to the federal government that quarantine enforcement mechanisms should be fully set up at our borders and airports prior to directing a million Canadians to come home at the start of the pandemic?

**Mr. Rob Stewart:** If I understand your question well, you're asking whether or not we were enforcing the borders as we are today—

**Hon. Michelle Rempel Garner:** No, I was asking whether or not you gave advice to the government to set up quarantine and enforcement mechanisms at the border prior to directing a million Canadians to come home at the start of the pandemic.

**Mr. Rob Stewart:** The advice to the government was provided by the Public Health Agency of Canada, to be clear.

**Hon. Michelle Rempel Garner:** Are you aware whether the Public Health Agency of Canada directed the government to set up quarantine enforcement prior to directing Canadians to come home at the start of the pandemic?

**Mr. Rob Stewart:** To be clear, as things unfolded over the course of January and February of last year, we were working to bring Canadians home before we declared a pandemic and before quarantine measures were imposed.

**Hon. Michelle Rempel Garner:** Thank you.

I'll turn back to Ms. Tremblay. When did Canada begin negotiations with CanSino?

**Ms. Christyne Tremblay:** Can you repeat the question, please?

**Hon. Michelle Rempel Garner:** When did Canada begin negotiations with CanSino for the development of a vaccine?

[*Translation*]

**Ms. Christyne Tremblay:** I'm unable to answer that question.

[*English*]

**Hon. Michelle Rempel Garner:** Ms. Tremblay, I'll ask the same question to you that I asked Mr. Stewart. Did the government receive any advice to put in place quarantine measures prior to directing Canadians to come home at the start of the pandemic?

[*Translation*]

**Ms. Christyne Tremblay:** When the cabinet committee on COVID-19 usually meets the ministers talk about issues related to the borders.

[*English*]

**Hon. Michelle Rempel Garner:** Was any advice provided to the government to put in place a quarantine mechanism prior to directing Canadians to come home at the start of the pandemic?

[*Translation*]

**Ms. Christyne Tremblay:** On every issue options are always offered to the ministers for decision-making purposes.

[*English*]

**Hon. Michelle Rempel Garner:** So it was offered. A quarantine mechanism was given to the government at the start of the pandemic.

[*Translation*]

**Ms. Christyne Tremblay:** I said that options were proposed to the ministers for decision-making purposes.

[*English*]

**Hon. Michelle Rempel Garner:** Was a quarantine measure included in those options?

**The Chair:** Thank you, Ms. Rempel Garner.

We'll go now to Mr. Van Bynen.

Mr. Van Bynen, please go ahead for six minutes.

**Mr. Tony Van Bynen (Newmarket—Aurora, Lib.):** Thank you, Mr. Chair.

Thanks to our witnesses with us here today. I want to especially thank Bruce Macgregor from the Regional Municipality of York for taking time out of his busy schedule to bring a regional perspective into our discussions. I also want to thank him and his team for their work during these difficult times.

It has always been great to work with you, Bruce, and I appreciate the updates on the current situation that your team has been sending out regularly.

Bruce, in your opening statement you mentioned that throughout the pandemic the region has worked closely with the municipalities. I'm wondering if you could expand on this collaboration and share with us a bit more about the roles played by the province, the region and local municipalities, including the differences between roles.

**Mr. Bruce Macgregor:** Thank you, Mr. Chair.

It's certainly a privilege to bring the local experience to this federal table. As municipalities, we are creatures of the provinces and consequently are guided by legislation. In Ontario that legislation includes a bit of a deeper dive into what are normally services provided by the provinces elsewhere in Canada, so we deliver public health, housing and social services in partnership with the Province of Ontario, with funding, of course, as well from provincial sources. All of that can't possibly fit into a property tax bill. We do also provide services municipally and we share those municipal services with our local municipalities that are a collection of towns and cities, like Markham and Vaughan with 400,000 population each and growing, and small rural towns, relatively smaller rural areas with populations of 30,000 to 40,000.

At the regional level, we deliver the large consistent services across that area, including the provincial services. We've deliver policing. We deliver paramedic services. We deliver water and wastewater services, transit and transportation. Local municipalities deliver library services, fire and recreational services as well, so with respect to the pandemic, of course, our emergency services are connected quite tightly. Those are paramedics and police at the regional level, and fire services at the local level, with our provincial oversight bodies, of course, engaged as well.

Our medical officer of health takes direction from the provincial chief medical officer of health. Of course, there is information flowing from federal sources in the health sector as well.

Mr. Chair, that's a quick answer to that question. I hope I haven't left anything out.

● (1140)

**Mr. Tony Van Bynen:** A few weeks ago, the region's Facebook page shared a table entitled “COVID-19 Phase 1 Vaccine Rollout Rules and Responsibilities”. I was quick to share that on my page, because I think it's unclear to many Canadians, and unfortunately even to colleagues in the House, the role that's played by each level of government as more and more COVID vaccines become available. I just asked you about the role of the provinces, the municipalities and the region in this pandemic, so I won't ask you to repeat yourself, but I am wondering if you could share why the region thought it was important to share this information and where you found the information about the role each level of government plays in this pandemic.

**Mr. Bruce Macgregor:** Mr. Chair, there is tremendous anxiety amongst Canadians generally with respect to vaccination. For the most part people want to get vaccinated and want to get two rounds as recommended by the manufacturer. People are taking information from all kinds of sources. We found that it was important to manage those expectations relative to the supply of vaccines. We're not alone in the world. Vaccine shortages are even more chronic in some jurisdictions in the world. We had to make clear to our residents what we are able to control and what is controlled outside of our jurisdiction. We have clearly set out the role of the Government of Canada, the role of the Province of Ontario, the role of our municipalities, and frankly the role as well of the community, because the community has to be responsible, and we've had some wonderful responses. Two of our mass vaccination clinics are run by community practitioners, so it's a great sign when everybody comes together to not only manage expectations but also provide the best possible service in getting vaccinations into arms.

**Mr. Tony Van Bynen:** From a regional perspective, Bruce, what are some of the lessons learned and some of the gaps that were found in the responses to this pandemic, and what are some of the recommendations that you would provide us?

**Mr. Bruce Macgregor:** As I summarized at the conclusion of my comments, there are three areas where we feel there could be better preparedness for pandemics. With this last generation of municipal employees who are currently employed in our workforce, we've had three. This is our third pandemic of sorts. We've had SARS, H1N1 and now this one, which is much more significant than the others. We always look to lessons learned as we have for most prior experiences. Certainly the provision of personal protective equipment is very important, and if there was local manufacturing, that would be helpful, as we have discovered. Vaccine development and availability are important as well.

I think what we have certainly learned is that it takes all three levels of government to chip in to make this work. The funding coming from the senior levels of government has been absolutely critical to keeping our communities in a position where they can recover.

**Mr. Tony Van Bynen:** Thank you.

Thank you, Mr. Chair.

**The Chair:** Thank you, Mr. Van Bynen.

[*Translation*]

Mr. Thériault, you have six minutes.

**Mr. Luc Thériault (Montcalm, BQ):** Thank you, Mr. Chair.

Mr. Stewart, the Department of Public Safety seems to be having a hard time managing the borders. We have heard rumours of fraudulent tests.

Could you give us an idea of the extent of this problem?

What have you done to deal with this issue?

**Mr. Rob Stewart:** I would be glad to answer that question.

We are seeing a very small number of fraudulent tests at the border. I'm sorry, but unfortunately I don't have the numbers with me. I could send them to the committee after the meeting.

We are working with the Public Health Agency of Canada and the Canada Border Services Agency on monitoring travellers very closely. A very limited number of travellers have produced fraudulent tests.

● (1145)

**Mr. Luc Thériault:** Are you able to make interceptions or is this connected to the overall problem?

What exactly are you doing to detect these fraudulent tests?

**Mr. Rob Stewart:** I couldn't say exactly how the border services officers are detecting the fraudulent tests. However, we have a standard in place with respect to the documents and these officers thoroughly review every document that is presented to them.

My colleague Ms. Pham could say more about that.

**Mr. Luc Thériault:** What sort of rapport does the Public Health Agency of Canada have with the Department of Public Safety? There seems to be a communication problem there.

Between the time the variants enter the country and the time restriction measures are announced, it is already too late.

How do you explain that we have so many variants, when the government claims to have put in place some of the strictest measures in the world?

Do the agencies communicate with one another? Is there good communication of the risks so that measures at the border can be taken proactively?

**Mr. Rob Stewart:** According to our data, the incidence is minimal. In fact, roughly only 1% of travellers have contracted COVID. The Public Health Agency of Canada has very strict quarantine measures. Travellers have to be tested before they arrive at the border and then they are tested twice more once they are in the country.

**Mr. Luc Thériault:** You would agree that if the measures were so strict and effective then there would be fewer cases of variants and epidemics tied to those countries.

That being said, again with better border controls, what is Public Safety's position on a vaccine passport?

**Mr. Rob Stewart:** We will certainly need a vaccine passport for Canadians to be able to travel abroad and to know the vaccination status of people arriving in Canada.

We are in talks with the provinces and territories to find a way to determine whether people have been immunized.

**Mr. Luc Thériault:** You say vaccination status. What do you mean by that?

**Mr. Rob Stewart:** I am talking about a type of certification.

**Mr. Luc Thériault:** Okay.

You expect good communications between the territories, Quebec and the provinces in order to get the information as proof of vaccination. Is that it?

**Mr. Rob Stewart:** Yes. It is in the public interest of all Canadians so that they may travel. I am confident that with all the collaboration we are seeing we will find a way to determine vaccination status electronically.

● (1150)

**Mr. Luc Thériault:** You're recommending the vaccine passport for better border control. Is that correct?

**The Chair:** Thank you, Mr. Thériault.

**Mr. Luc Thériault:** That's what I gather.

**Mr. Rob Stewart:** Pardon? I didn't hear you.

**Mr. Luc Thériault:** You're recommending the vaccine passport for better border control. Is that correct?

**Mr. Rob Stewart:** Yes, absolutely.

**The Chair:** Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, please go ahead for six minutes.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you, Mr. Chair.

First off, on behalf of all of my colleagues, I'd like to express our best wishes to Mr. Shugart for a speedy recovery and good health.

Madame Tremblay, I'm going to read to you an excerpt from what parliamentarians were told in 1987 when they were reviewing Canada's emergency legislation landscape from a federal point of view. It said:

> The federal government has primary and ultimate responsibility to provide for the safety and security of Canadians during national emergencies. Its constitutional jurisdiction over such national emergencies stems from the power of Parliament to legislate for the "Peace, Order and Good Government of Canada" and the emergency doctrine which has evolved from it.
>
> That doctrine invests the Parliament of Canada, during times of national crisis, with temporary plenary jurisdiction to legislate on all matters, including those normally reserved exclusively to the provinces. It operates, as Mr. Justice Beetz of the Supreme Court of Canada stated in the Anti-Inflation Reference, as a "partial and temporary alteration of the division of powers between Parliament and the provincial legislatures"...which gives to the Parliament of Canada in times of national crisis, "concurrent and paramount jurisdiction over matters which would normally fall within exclusive provincial jurisdiction"...he also observed, "the power of Parliament to make laws in a great crisis knows no limits other than those which are dictated by the nature of the crisis"....

Is that your understanding of the constitutional authority of the federal government in a time of national emergency?

[*Translation*]

**Ms. Christyne Tremblay:** Thank you for the question.

The premiers discussed the matter and agreed that we were indeed in a national pandemic situation. Since the federal government wanted to prepare for every option, it considered using the Emergencies Act, but it had to meet three criteria—

[*English*]

**Mr. Don Davies:** Madame Tremblay, I'm sorry; I'm not there yet. I'm just asking about the general constitutional authority.

Do you accept what I read to you as an accurate description of the federal government's constitutional authority?

[*Translation*]

**Ms. Christyne Tremblay:** On matters of constitutional authority, I would like to ask my colleague Jodie van Dieen to answer the question.

[*English*]

**Ms. Jodie van Dieen (Counsel to the Clerk of the Privy Council and Assistant Deputy Minister, Privy Council Office Legal Services Sector, Privy Council Office):** That's a fair reflection of the federal government's legislative authority under peace, order and good government in an emergency context.

The Emergencies Act was a piece of legislation passed, relying upon the peace, order and good government emergency branch power.

**Mr. Don Davies:** Thank you, Ms. van Dieen. I appreciate it.

I'll direct my questions to you, then.

Parliamentarians were also told the following:

> Where the scale of the disaster is such that it affects more than one province, or where it occurs on territory within the federal domain, the federal government will have primary if not exclusive responsibility to provide for public safety.

My question for you is this. The scale of the disaster has obviously affected more than one province. I think we all can acknowledge that. However, it seems that the federal government has taken the opposite view, that the provinces have primary responsibility to act, with the federal government playing a supportive role, if asked. Why is that?

**Ms. Jodie van Dieen:** The Emergencies Act embodies the federal-provincial-territorial collaboration and working together, and, in fact, requires consultation with the provinces and territories, and specifically requires that invoking the Emergencies Act for a national emergency only occurs when other federal, provincial or territorial legislative measures are not sufficient.

In addition, in subsection 8(3) of the Emergencies Act, it says that where a declaration of emergency were to have been made, following such a declaration, it is, of course, anticipated that the provinces and territories would continue to act within their legislative spheres and that the federal government's actions should not unduly impair or intrude upon those actions.

I would say that the Supreme Court, since 1987, has very much spoken of co-operative federalism as a key constitutional concept, and I would say that the Emergencies Act, as passed by Parliament, reflects co-operative federalism and federal-provincial-territorial collaboration.

● (1155)

**Mr. Don Davies:** I want to give you a quote from Dr. Hardcastle who spoke to this committee last week. She said:

> It's surprising to me that in inarguably the largest emergency this country has seen since World War II that we haven't seen the federal government turn to the exceptional powers granted under the Emergencies Act, or to pass COVID specific legislation grounded in the POGG power. If the Emergencies Act was not used here, I'm not sure when it would ever be used.

My question is this. Given that Canada has now experienced three waves of the pandemic, the Canadian Armed Forces have had to be called in three times to provinces, Alberta has the worst record in North America, and there are severe serious outbreaks in Ontario and Manitoba, why hasn't the federal government used any of its emergency powers to date?

As well, is it your view that Ontario and Alberta are managing this pandemic well?

I don't know who wants to field that.

Madame Tremblay?

[*Translation*]

**Ms. Christyne Tremblay:** Thank you very much for the question.

My colleague Jodie van Dieen laid out the principle of cooperative federalism. We generally believe that the premiers must work together, that the provinces must use their capacities together, that the federal government must provide all the tools at its disposal and that together they can tackle the pandemic. It is truly a spirit of collaboration that has fuelled every level of government during this pandemic.

We had the chance to hear from a regional representative, who also described this collaborative dynamic between every level of government. The Emergencies Act states that it is to be used only if the situation cannot be managed otherwise and the provinces are unable to deal with the situation alone, without support.

[*English*]

**The Chair:** Thank you, Mr. Davies.

Committee, that wraps up our time for this panel. We're going to have to suspend and go to the next panel—

**Mr. Don Davies:** Mr. Chair, we do have a few minutes, and we did start awfully late, and we have the acting Clerk of the Privy Council here. I would respectfully suggest we have one more round of, say, one minute each because we didn't get a full hour.

**The Chair:** Fair enough. That will put pressure on our next panel, because I think we will be shoehorned there as well, but if that's what the committee wants to do, by all means we will do one-minute slots, one slot per party.

We will go to the Conservatives to start with. I'm not sure who that will be. Will that be Ms. Rempel Garner?

**Hon. Michelle Rempel Garner:** It will be Mr. Maguire.

**Mr. Larry Maguire (Brandon—Souris, CPC):** I will go ahead, Mr. Chair.

**The Chair:** Mr. Maguire, please go ahead for one minute.

**Mr. Larry Maguire:** To Deputy Minister Stewart, have you provided the government with any advice regarding using rapid tests for all persons including essential workers at our land borders?

**Mr. Rob Stewart:** Yes, sir. There is an active dialogue going on. It would not be me personally who would one providing that advice, but, yes, we are working closely with the Public Health Agency and our critical infrastructure unit to see it applied.

**Mr. Larry Maguire:** Along that same line, have you given any advice or recommendations to require any form of pre-departure testing for domestic air travellers?

**Mr. Rob Stewart:** That would be in the domain of Transport Canada, but I can tell you that no such air advice has been provided. That would be an issue of testing on a domestic level and would be the responsibility of the provinces.

**Mr. Larry Maguire:** I want to thank Dr. Shalmon from Israel for his excellent testimony.

You pretty well answered all the questions I had, Doctor, so thank you for being with us.

I think it's remarkable that you could start on December 19 and have everybody over 16 years old vaccinated by the time eight weeks were up. Obviously, you didn't have any interruptions in vaccine procurement. Was that the case?

● (1200)

**The Chair:** The witness may answer.

**Dr. Asher Shalmon:** Yes, it was well planned, and in that sense it worked well. Actually the shipments were on time. I can recall only one shipment that was late by two days from Pfizer. Otherwise, things worked well. It was unbelievable, you might say.

At no point were we in shortage, because from the beginning we kept a second dose for everybody, so we had flexibility in using those extra doses.

**Mr. Larry Maguire:** It sounds as though you had good contracts.

Thanks.

**The Chair:** Thank you, Mr. Maguire.

We go to Mr. Kelloway.

Mr. Kelloway, go ahead, please, for one minute.

**Mr. Mike Kelloway (Cape Breton—Canso, Lib.):** Thanks, Chair.

My question is for you, Dr. Stewart. You're closely involved in how the federal government has been supporting the provinces and territories, especially when it relates to emergency requests for support. I have two very quick questions.

Can you tell the committee about the kinds of support the federal government has provided to the provinces and territories? Second, what is the process now, Mr. Stewart, for a province or territory to request more and additional support?

**Mr. Rob Stewart:** The Department of Public Safety, under its Emergency Management Act responsibilities, has coordinated over 70 responses to requests for assistance either from the provinces and territories or from indigenous groups. We've provided assistance via the Canadian Red Cross and the army and have coordinated with public health delivery of drugs and human health workers, of late into Ontario in particular. We stand by with an inventory of services and help for provinces. If they wish to access it, they only have to ask.

**Mr. Mike Kelloway:** Thank you.

Mr. Chair, that's good for me. Thank you.

**The Chair:** Thank you, Mr. Kelloway.

[*Translation*]

Mr. Thériault, you have one minute.

**Mr. Luc Thériault:** Ms. Tremblay, we have been dealing with this pandemic for more than a year now. Some agencies have talked about various improvements that could be made and lessons that have been learned.

Can you give us two or three lessons that you have learned from this pandemic? What would you do in future or what should you improve from here on out?

**Ms. Christyne Tremblay:** Thank you very much for the question, Mr. Thériault.

The first lesson has to do with the capacity to work together quickly not only in a situation like the pandemic, but in any emergency situation. There also needs to be improved coordination between all levels of government and quicker responses in some cases.

My colleague, Mr. Stewart, mentioned that 70 requests for assistance made it easier to fight the pandemic. We could also find ways to speed up these processes to intervene even more quickly on the ground and respond to the needs of Canadians.

**The Chair:** Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies for one minute, please.

**Mr. Don Davies:** Thank you.

Mr. Stewart, I'll direct this to you. We learned last week that two of the four airports receiving international travellers in Canada are not enforcing federal quarantine rules. That's in Quebec and Alberta. What measures is the federal government considering to deal with that situation?

**Mr. Rob Stewart:** We have a dialogue with the provinces and territories through a federal-provincial policing table, where we are actively working with both governments and their police forces, the police of jurisdiction, to enhance enforcement of the quarantine.

**Mr. Don Davies:** Thank you.

Madame Tremblay, on November 27, the Clerk of the Privy Council, Mr. Shugart, wrote to this committee with respect to the document production order adopted by the House of Commons on October 26, 2020. He wrote, “Preliminary estimates suggest that there are millions of pages of relevant documents.”

However, according to the law clerk, only 8,166 documents have been turned over by the government to date. Can you confirm whether the government is purposely withholding documents or explain why it is being so slow to produce documents ordered by the House of Commons to this committee?

● (1205)

**Ms. Christyne Tremblay:** Thank you very much for the question. I think it's a good one.

We have to coordinate the work all across the government to make sure that there is consistency and that we can remove the duplication. As we work, the documents are more and more complex, but it's really kind of the intent to share the documents with the committee.

For the question that I got earlier about the contracts with the companies, there are seven contracts, and we are having discussions with the seven companies in order to be able to share with you the contracts as much as possible. This work is in progress.

**The Chair:** Thank you, Mr. Davies.

That really wraps up our time for this panel. I'd like to thank all of the witnesses for sharing your time, expertise and knowledge with us today. I'd particularly like to thank Dr. Shalmon for joining us all the way from Israel. Thank you, all.

With that, we will suspend and bring in the next panel.

● (1205)

_____(Pause)_____

● (1205)

**The Chair:** I call this meeting back to order.

Welcome, everyone. We are resuming meeting number 36 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic. Specifically today, we're examining Canada's national emergency response landscape.

I'd like to welcome the witnesses. We have, as individuals, Dr. Isaac Bogoch, physician and scientist, Toronto General Hospital and University of Toronto; and Dr. Peter Hotez, professor and dean of the National School of Tropical Medicine.

From the Ministry of Health of the Slovak Republic, we have Brigadier-General Dr. Vladimír Lengvarský, Minister of Health of the Slovak Republic, and we have....

Is it Dr. or Mr. Martin Pavelka, epidemiologist?

**Mr. Martin Pavelka (Epidemiologist, Ministry of Health of the Slovak Republic):** It's mister.

**The Chair:** Okay, thank you. Mr. Martin Pavelka, epidemiologist.

With that, we will ask the witnesses to present their statements. I will display a yellow card when your time is almost up and a red card when it's up. When you see the red card, do please try to wrap up.

We'll start with Dr. Bogoch for six minutes.

**Dr. Isaac Bogoch (Physician and Scientist, Toronto General Hospital and University of Toronto, As an Individual):** Thank you so much. Again, thank you for the invitation to chat today.

My name is Isaac Bogoch, and I'm an infectious diseases physician and scientist based out of the Toronto General Hospital and the University of Toronto. I sit on several provincial and federal COVID-19 committees and task forces.

Over the next few minutes, I'd like to focus on a few semi-related issues related to the pandemic response. I think it's important to frame our conversation within the current and the near-future Canadian context.

We're still embroiled in a pretty large third wave across most of the country. Provinces such as Nova Scotia and Alberta, unfortunately, have higher rates of infection than ever before, but other provinces are slowly turning the corner.

No matter what, we're far from where we need to be. With mass vaccination efforts expanding, I think it's fair to say that we're going to realize some significant benefits from this vaccination, much like other countries that are a few months ahead of us, like the United States, Israel and the U.K. We're just a couple of months behind them. With sound public health measures and ongoing vaccinations, we will likely be far better off in the near future than where we are right now.

With that in mind, I think it's important to focus on a couple of current and near-term issues, and to really start thinking about what our off-ramp looks like.

The first one is regarding border measures. Now, we know COVID-19 isn't going anywhere any time soon; it's going to be around for awhile. At least for the near future, I think it's reasonable to ensure that people travelling, and Canadians returning to Canada, demonstrate either evidence of COVID-19 vaccinations, or if people choose not to be vaccinated, they still must quarantine and show evidence of negative testing.

This virus poses a significant public health threat, and we know it disproportionately impacts our low-income and racialized neighbourhoods. Border measures like this won't be perfect, but they'll still reduce the importation of virus. Policies like this seem prudent for the near future. Longer-term strategies remain unclear.

Related to the border, I think it's also important to discuss vaccine passports. When I say “vaccine passports”, I'm referring to requiring evidence of vaccination to cross an international border. Regardless of what our personal views are of the virus or vaccinations, there's a growing list of countries globally that require proof of vaccination for COVID-19 to enter them. We should be proactive in ensuring that Canadians who choose to be vaccinated will have acceptable documentation of their vaccine status to enable international travel.

Another point is with regard to essential workers who cross the border. We know there are tens and tens of thousands of people crossing our borders daily, and many of them are essential workers, such as truck drivers bringing in vital goods to Canadians. They should have priority vaccinations. For example, we know there's a great program on the Manitoba-North Dakota border for vaccinating truck drivers. This program is exemplary, and we should see more of that.

I have a couple of other quick points.

With regard to airports, if we were going to shut down all non-essential travel to the country, the time to do it was over a year ago. The current measures are clearly not perfect, but they still buffer Canadians from importing a significant number of cases of COVID.

When we look at the current and projected pace of vaccination and the benefits afforded by vaccination, I think it's pretty clear that there are significant questions when we raise the utility and costs of further restricting already restricted travel versus the potential gains. We could also create safer travel by ensuring that those who enter the country are vaccinated and continue to quarantine, as mentioned above.

Lastly, to touch on the Emergencies Act, or other measures for federal intervention at the provincial level, a lot of this is easy to say, but I imagine it's much more challenging to operationalize. I don't think there's the capacity for the federal government to micromanage health care or public health at the provincial level, or even regional level. There would have to be very, very clear and prespecified divisions of labour to make this work effectively.

There are plenty of other COVID-19-related topics to discuss, but unfortunately I don't have a lot of time. I'd be happy to address any of these in the question period that follows.

Again, thank you for your time. I'm happy to chat.

● (1210)

**The Chair:** Thank you, Dr. Bogoch.

We will go now to Brigadier General Vladimír Lengvarský.

Sir, go ahead with your statement, for up to six minutes, please.

**Brigadier-General Vladimír Lengvarský (Minister of Health of the Slovak Republic):** Thank you.

Dear Mr. Chairman, vice-chairs, members of the standing committee on health, dear friends in Canada, I would like to extend my cordial greetings from Bratislava to all of you. I'm pleased and honoured to have this opportunity to address you. Likewise, allow me to convey my special thanks to the Honourable Michelle Rempel Garner, a great friend of Slovakia, for the invitation to share the Slovak experience with nationwide population testing.

The current pandemic is a humanitarian crisis that is threatening to leave deep social, economic and political scars for years to come. It is therefore highly desirable and responsible to adopt corresponding strategies that have the potential to relieve impacts of the pandemic.

Before the introduction of the vaccines, the testing itself was the only efficient tool for countering the pandemic. In this context, Slovakia opted for nationwide testing, which has proven to be helpful in revealing the areas hardest hit by the virus as well as in reducing the rate of incidence. This information was crucial for preparing and adjusting the corresponding region-based measures.

Overall, I perceive that it's extremely important to build synergies at the international level, including through sharing examples of best practices. Let me thank you once again for your interest in the Slovak experience related to testing. Mr. Pavelka is ready to provide you with further information on this matter.

Stay healthy and keep safe. Thank you.

● (1215)

**The Chair:** Thank you, Minister. I'd also like to acknowledge the presence of the ambassador, Vit Koziak.

Welcome and thank you.

We don't have Dr. Hotez yet, do we? There we go. Okay.

Doctor, could you say a few words for the interpreters, to make sure they can hear you properly? Then I'll ask you to start your statement.

**Dr. Peter Hotez (Professor and Dean, National School of Tropical Medicine, Baylor College of Medicine, As an Individual):** It's good to see everybody, and I appreciate this opportunity.

**The Chair:** Could you say maybe a few more words?

**Dr. Peter Hotez:** I hope everything is working out well and that I can be understood for the translation.

**The Chair:** That's excellent. Thank you.

Mr. Clerk, is that sufficient? I'm getting the thumbs-up.

Please go ahead, Doctor, for six minutes.

**Dr. Peter Hotez:** Thank you to the committee for inviting me.

Very briefly, I'm an M.D. Ph.D. pediatrician-scientist and I co-lead efforts to develop vaccines for neglected diseases of poverty in addition to coronavirus infection vaccines and a new COVID-19 vaccine. For the last two decades, we've built an academic research centre known as a PDP, a product development partnership, and we use industry practices to make the pharmaceuticals that industry generally won't produce because they mostly target diseases of the poor.

Our PDP is know as the Texas Children's Center for Vaccine Development at the Texas Children's Hospital and Baylor College of Medicine. We've now developed a low-cost recombinant protein vaccine to prevent COVID-19. Some refer to it as a people's vaccine because it could be scaled for production at extremely low cost, we think as low as $1.50 U.S. per dose, and it requires simple refrigeration. Biological E., one of the big vaccine producers, has now started to scale up production to more than one billion doses, and the Indian regulatory authority has now given us the green light to advance it to phase 3 clinical trials with the hope that there will be an emergency-use authorization in India later this summer. In parallel, CEPI, the Coalition for Epidemic Preparedness Innovations, is working with Biological E. for a global road map for phase 3 trials internationally.

There's just one other biographical piece. I do have a meaningful Canada connection. My grandfather Morris Goldberg grew up in the Jewish quarter of Paris and emigrated to Montreal around the time of World War I. Years later, he lost many family members during the Nazi occupation of Paris, so I always like to say that I exist only because of the goodness of the Canadian people who accepted my grandfather, and I've never forgotten that.

Today, I hope to raise two issues, one on COVID-19 vaccinations and the other on COVID-19 vaccines. With regard to vaccinations, according to the New York Times tracker, as of yesterday, only 3.2% of Canada's population has been fully immunized, and just under 40% has received a single dose.

In contrast, in the U.S. the numbers are 34% fully immunized and 46% having had a single dose. In the U.S. we also do have our problems though. We have a troubling blue- and red-state divide so that the real situation is that states such as Vermont, Massachusetts and Connecticut will reach the point where almost one-half of their populations are fully immunized, whereas deep red states such as Idaho and Wyoming and the mountain area in our southern states are only about one-quarter in. This disparity reflects an awful level of anti-vaccine aggression in our country.

**The Chair:** Pardon me, Doctor, could you slow down a little for the interpreters.

**Dr. Peter Hotez:** Okay. I'm sorry about that.

I'm also a bit of an expert on this anti-vax scenario because my youngest daughter, Rachel, has autism and intellectual disabilities, and I wrote a book previously called *Vaccines Did Not Cause Rachel's Autism*, which often makes me public enemy number one with the anti-vaccine group.

Regarding Canada, I've publicly expressed my concern that our U.S. government could, and should, do more to help Canada vaccinate its population, especially now, given that only 3% of Canadians are fully immunized. In my public appearances on the cable news networks and podcasts, including the CBC, I've explained why there are both practical reasons and emotional reasons for this.

On the practical side, we share an enormous border. We simply cannot slow transmission by vaccinating all of Detroit, Michigan, for instance, without doing the same in Windsor, Ontario, or Buffalo, New York, on either sides of the Peace Bridge.

On the emotional side I've stated that there are not many nations who showed the United States unconditional love—and here I recount my remembrance—in the days after the 9/11 attacks when 100,000 Canadians stood on Parliament Hill in solidarity with the American people. I would point out not many nations do such things. I've therefore stated that when it comes to providing immunizations against COVID-19, there should be no daylight between the U.S. states and the Canadian provinces.

Specifically In the area of vaccines, I also believe that Canada has the potential to do more in vaccine science and production. You're a nation of some of the world's greatest research universities and medical schools; people come from all over the world to train at UBC, Toronto, McGill, Queen's, Waterloo, Western, Alberta, just to name some. Ultimately it was the Public Agency of Canada's National Microbiology Laboratory that led to the development of the successful Ebola vaccine that stabilized the situation in the Democratic Republic of the Congo.

Our licence to Biological E. in India is not exclusive, and we'd be more than willing to transfer our technology to Canada so we could produce it for the world, if not for internal use. This might be part of a larger opportunity for the NML, the National Microbiology Laboratory, possibly in collaboration with one of Canada's research universities, to build a world-class centre for vaccines, science, development and production, doing so would propel Canada to the forefront of global vaccine diplomacy.

Thank you again for this opportunity, and I look forward to having a discussion and dialogue and answering any questions you might have.

● (1220)

**Mr. Chris d'Entremont (West Nova, CPC):** On a point of order, Mr. Chair, I think Mr. Pavelka had some further comments to go with the Slovak presentation, so if you wouldn't mind.

**The Chair:** Absolutely, I apologize.

Mr. Pavelka, I apologize, please go ahead.

**Mr. Martin Pavelka:** Dear Mr. Chairman, vice-chairs and honourable members of the Standing Committee on Health, and dear friends in Canada, it's a great opportunity to present to you the Slovak experience of rapid antigen mass testing and how it can be effectively used to suppress COVID prevalence in the population.

In the next few minutes, what I want to do is convey three key messages and present the Slovak experience, bust some myths about antigen tests and mediate the message on how to conduct effective, efficient and practical rapid antigen mass testing.

From the Slovak experience, for us, PCR testing actually was not the best test for the COVID-19 epidemic, for several reasons.

The first one was the time lost in processing. By the time you got a time slot to be able to go to a mass testing centre, the laboratory processing time or the time lost was just an opportunity for the virus to produce new generation lines.

Second, the limited laboratory capacity meant that only symptomatic people were basically favoured for the PCR tests. On the other hand, for the antigen tests, you can scale them up, and because of the low cost you can do them at high frequencies and you can actually cut more strains of transmission.

I'm going to give you some basic data about our antigen tests. Between January and April, through antigen testing, we detected almost twice as many infections as through the PCR channel. There were 250,000 infections detected in this short time period. That is 5% of Slovakia's population. Half of these infections were completely asymptomatic at the time of testing. These people would never have been detected through standard syndromic PCR surveillance.

One in 20 people were detected through antigen tests, so more or less everyone in Slovakia now knows someone from their close circle who was detected through antigen tests and who, through timed isolation, was able to basically prevent infecting their parents, their friends and their loved ones.

Slovakia did three main mass testing campaigns, one in November and then again from late January onwards. Now, every week, Slovak residents are tested, and the tests allow them to use exemptions from the stay-at-home order. You can go to work and you could go to the post office, the bank and so on.

The methodology was basically laid out by Michael Mina and Daniel Larremore. I call them the fathers of rapid antigen testing. Slovakia was one of the very first countries to actually conduct tests in cycles, so I call them the poster children of the antigen mass testing.

In our dataset, the specificity of the test is actually really massive. From a low test prevalence in our symptomatic counties, we could calculate that the specificity of the antigen tests used in our country is no less than 99.96%. From the 30 million antigen tests conducted during this period, no more than 12,000 were false positives, so really, when it comes to specificity, the false positive tests are not of concern.

When it comes to sensitivity, the tests in Slovakia have proven to very well detect infectious individuals. As I said, with the PCR test, by the time you are actually confirmed to be infectious, you may not be infectious anymore. With these antigen tests, we are in fact [*Technical difficulty—Editor*] infectious people.

As a very final point, there are three key messages or ingredients from our own experience that make a rapid antigen mass testing campaign so successful.

First of all, it's the volume. Other countries have tried it. In Austria, for example, Vienna tried it and it didn't work; only 5% of the population of Vienna turned out. That's not enough to cut transmission chains so you can flip the reproduction number below one. Regularly, one-third of the population gets tested every week. This seems to be working.

● (1225)

Second is communication. One of the misconceptions is that people don't trust antigen tests because of their lower sensitivity. Now, the point of rapid antigen mass testing is not to accurately detect the infectious status of every resident. That's not the point. It's not a clinical test. The point is to detect enough strains of transmissions, and by cutting them, you are flipping the reproduction number to below one. That's all you need. By switching that, the epidemic will be decelerating.

Communication is very important. The rapid antigen mass testing only works when you communicate the messages very clearly to the population.

Finally, the most important ingredient from our dataset is that we learned it's not enough to isolate the positive case, but to isolate the whole household. That's because of the secondary attack rate of the virus. Once it gets into a household, the member of the family will effectively infect the rest of the household members, so you need to isolate the whole household

Thank you very much. I'm ready to take questions.

**The Chair:** Thank you, Mr. Pavelka.

We will go now to our questions, starting Ms. Rempel Garner for six minutes.

**Hon. Michelle Rempel Garner:** Thank you, Chair.

I'll briefly start with Dr. Hotez.

I want to thank you for your work in vaccine advocacy and dispelling myths around the vaccine link with autism. I think it's really important, and I want to thank you for doing that.

I am going to direct most of my questions to representatives from Slovakia.

You have the benefit of three members of this committee having been to Slovakia.

The national story of rapid testing is one that really should be celebrated internationally. I think it probably saved a lot of lives, and it's one that, in Canada, we're very interested in, particularly as we wait for vaccine shipments to arrive in Canada.

Mr. Pavelka, I'll start with you.

I read your study called “The impact of population-wide rapid antigen testing on SARS-CoV-2 prevalence in Slovakia”, which found that multiple rounds of population-wide rapid antigen testing decreased COVID-19 prevalence by 58% within one week.

Can you explain, and elaborate perhaps, on how that rapid testing was able to achieve this?

● (1230)

**Mr. Martin Pavelka:** There is a slight difference between the November campaign and the current mass testing we're having now. The one key difference is back then, we didn't have the B.1.1.7 strain. Now, almost 100% of our positive samples are B.1.1.7, which is more transmissible. We are not actually achieving 58% suppression of prevalence between each round, as we did in November, when we were still dealing with the old variant.

It's still measurable. We have the same vaccine coverage as all the other members of the European Union, yet we have one of the lowest infection rates and were one of the first countries to actually get to almost the bottom very rapidly.

The key success behind that is, as I said, isolating households. When isolating the household, you're effectively cutting the chains of transmission. Especially with the B.1.1.7 strain, what we've found is that when a member of the family gets sick, the whole family eventually develops symptoms; whereas with the old Wuhan type, or the pre-existing variants, the secondary attack rate was around 20% or 30%. Now, literally the whole household gets sick.

By isolating just the positive case, you will not cut the transmission effectively. By isolating the household—

**Hon. Michelle Rempel Garner:** Thank you. I'm sorry to cut you off. My time is brief.

The other thing that was really interesting about the work that came out of Slovakia was showing the amount and the prevalence of asymptomatic cases, which likely had a significant cause of spread in many parts of the world.

In countries like Canada, we have had stay-at-home measures, and certainly in the early start of the pandemic, there may have been asymptomatic spread, but it wasn't necessarily detected. Then, I think there was this thought that, well, in the population, everything is fine, right?

Do you think there was a bit of a positive sociological impact, as well, on rapid testing? For example, when you tested the whole population, you were able to show that there was spread and this was something that the country needed to take seriously.

Do you think that perhaps helped compliance with the stay-at-home measures, and then subsequently with a desire for vaccination?

**Mr. Martin Pavelka:** This was the case in the November campaign.

Back then, we didn't test over a period of a week, but we did one round in one single weekend and then repeated it again. In those two weekends, we detected around 50,000 or 52,000 infections. This was taken by massive surprise. No one expected that, and I think that's when it hit everyone: It is everywhere, and anyone can be a carrier.

**Hon. Michelle Rempel Garner:** The other thing I would note is that I think testing is so important. You talked about myth busting. I've heard many times that PCR tests are the gold standard and that antigen tests are less accurate. But your experience has shown that the volume of the testing—testing everybody regularly—helps to stop the spread of COVID because you're catching many more cases than you would by just PCR testing symptomatic persons.

**Mr. Martin Pavelka:** Absolutely, it's exactly as you said. It's an old Soviet/hammer method, I agree. But how many PCR tests have we had? Maybe we in the government have them more often because we are exposed to many international meetings. But the ordinary citizen may have one or two PCR tests in a year. With the antigen test, you can ascertain your infectious status every week—twice a week. And this is the problem with SARS-CoV-2, because a large portion of the population is fully asymptomatic. These people would never know they are infectious. By taking the antigen test once or twice a week, I can search my infectious disease. I can find out if I am positive or not. If I'm positive, I can isolate myself much earlier to prevent new generations or propagation lines of the virus, and if I am negative, I can go to work and can send my children to school.

**Hon. Michelle Rempel Garner:** With the few remaining seconds I have left, I do want to congratulate Slovakia for your excellent work. Once I am fully vaccinated and travel is safe, I certainly look forward to visiting your beautiful country and seeing friends and family there again, so congratulations. I think there are a lot of best practices we can take as a country from your efforts in rapid testing.

**Mr. Martin Pavelka:** Thank you very much.

I have to confess I love Canada. I have many friends in Toronto, Edmonton and Vancouver, and I have travelled a lot of Canada in the past. I hope once COVID is over, I'll be back in Canada again.

● (1235)

**Hon. Michelle Rempel Garner:** Thank you.

**The Chair:** Thank you, Ms. Rempel Garner.

From Vancouver, thank you, Mr. Pavelka.

We go now to Dr. Powlowski for six minutes.

**Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.):** Dr. Hotez, I spoke to you almost a year ago on convalescent serums. Sir, I don't know if you remember. I didn't know then that you were one of the authors of the bible. I've worked a lot of years in tropical countries and before I go, I always buy the most up-to-date *Manson's Tropical Diseases*, so I'm really impressed.

I think convalescent serum has been largely replaced by monoclonal antibodies. My understanding is that the United States National Institutes of Health now strongly recommends that these be used by high-risk people early in the disease. In the United States, if you get sick and you're high risk, you go to a website and the government directs you to where to go for your treatment.

In Canada, basically we don't use monoclonals. First, I want to get your opinion on that. Second, your government nicely surprised me, anyhow, with the Biden announcement that it would back the WTO waiver on intellectual property rights related to COVID. What is your response to that? Do you think it will work, and if you can answer quickly enough, I would like to also get Dr. Bogoch's response to both those questions.

Thanks.

**Dr. Peter Hotez:** I think the patent waiver could be useful. I have an article that just came out in Foreign Affairs this morning that basically says that the patent waivers are a good development but are insufficient to solve the problem because the problem with vaccines is that they are more complicated than small-molecule drugs. For instance, if you have the structure of an antiretroviral drug for HIV/AIDS, the likelihood is that you can bring together organic chemists and formulation experts and produce that drug; the only thing standing in the way is the patent. Vaccines are far more complicated. It takes years to know how to create and build vaccines and do it under a quality umbrella for quality control and quality assurance, having the regulatory authority in place. Just waiving patents will not be sufficient to solve this problem.

What we need is the help from the U.S. government to actually make a lot of vaccine for the world. Look at the scale that we're talking about. There are 1.1 billion people in sub-Saharan Africa, 650 million people in Latin America and about 500 million people in the smaller, low-income countries of Asia. When you add up those numbers times two doses, we're talking about five to six billion doses of vaccine. Where's that going to come from?

The mRNA technology is still new. It's a great technology—I got the Pfizer-BioNTech vaccine, and I'm grateful for it—but can we scale that up, and what will a patent waiver do for that? It's the same with the adenovirus vector vaccines, and we have our vaccine. For instance, with regard to our vaccine, we have Biological E. making a billion doses. Who's going to make the other four to five billion doses? I think there seems to be.... There's not an adequate foreign policy for producing vaccine at the scale that we need and in the time frame that we need. We really need it now.

We have the added problem, of course, that the whole game plan for the global vaccinations relied heavily on India to be the big producer between the Serum Institute and Biological E. Now those vaccines are not being exported because they're being kept within India, so it's like a domino effect and the whole thing is kind of falling apart.

I worry that there's not an adequate structure. The COVAX sharing facility was well-thought-out, but the vaccines simply aren't there right now. The key message, I think, for the Biden administration is this: “Thanks for the patent waiver. It's a good first step, but now what are you doing to do?”

**The Chair:** Thank you, Doctor.

I'm obliged at this point to notify the committee that the bells in the House are ringing. We require unanimous consent to continue. May I suggest to the committee that we carry on through the end of this first round? Is there agreement to do that?

**Some hon. members:** Agreed.

**The Chair:** Dr. Hotez, I believe your answer was over.

Dr. Powlowski had asked Dr. Bogoch to step in on this.

**Mr. Marcus Powlowski:** Maybe, first, quickly, I'll ask Dr. Hotez about the use of monoclonal antibodies and the fact that they're used widely in the States. We don't use them.

● (1240)

**Dr. Peter Hotez:** They both work by the same principle. The idea is that the convalescent serum provides virus-neutralizing antibodies, and the monoclonal antibody works that same way. The advantage of the monoclonal antibody, of course, is that there's better quality control, so you know exactly how much antibody you're providing. With the convalescent plasma, there could be enormous variability. That's why you're getting very inconsistent results, as well.

If you have very high titre levels of convalescent antibody, it could work quite well, but a lot of places don't adequately measure it, so there is all that variability. Of course, the problem with both of those products is that you have to give them very early on in the course of the illness, when you're still interfering with virus replication. Remember, there are two components to COVID-19. There's the virus replicating phase, and then there's the host inflammatory response. Once you delay and allow that host inflammatory response to continue, it's clear that the monoclonal antibodies and the convalescent serum are not working very well, so you have to give it early on in the course. It's certainly no substitute for vaccination.

I don't quite understand why monoclonal antibodies are not more widely available. In the U.S., too, there's been a problem. For instance, when my daughter-in-law got COVID-19, she was living in Arizona and wanted to get her monoclonal antibody, and the infectious disease attending at the medical centre there gave me a list of about a hundred criteria why she couldn't get it. They've made it so fussy and complicated and have limited the criteria so that, at least for the last few months—maybe it's gotten better now—it was almost impossible to actually get it used for anybody.

**The Chair:** Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have six minutes.

**Mr. Luc Thériault:** Thank you, Mr. Chair.

I would like to thank our witnesses from Slovakia for sharing their experience with us.

Doctor Bogoch, I watched you react when witnesses from Slovakia were intervening. What do you think of how we used tests here in Canada?

Why is there resistance to using PCR tests instead of rapid tests and tests that are better suited to daily life, for example?

Isn't there a lesson here that would help us improve our screening operations?

[*English*]

**Dr. Isaac Bogoch:** I'd like to thank our friends and colleagues from Slovakia for discussing their tremendous innovation and work.

I completely agree with the sentiment that you suggest and with the sentiment brought up by Ms. Michelle Rempel Garner earlier. These are excellent tests that have been underutilized in Canadian settings. We have access to them; we just haven't deployed them as broadly as we should have.

I think there is some general confusion among many Canadians as to the difference between a diagnostic test and a screening test. The PCR tests are very good for diagnostics. If you get sick and you want to know if a person coming into the hospital or clinic has COVID-19, you'd use a PCR test. We're talking about rapid testing to help keep workplaces safe. An example was given earlier: I'd much rather use a rapid test to detect most of the people coming in who are positive for COVID-19 by using these rapid tests than detect zero people coming in by not using any rapid tests. It's kind of a no-brainer, and they have been underutilized.

What's very interesting in Canada is that the business community figured this out first. While many of us in the medical and scientific community were debating back and forth, the business community just quietly went ahead and started integrating rapid testing, and created much safer work environments. This was most impressive. Here in Ontario, John Ruffolo is a well-known local business leader. He started pushing this forward, and we were applauding him from the sidelines.

I completely agree that we could utilize these tests much more significantly. There's room to do so. Quite frankly, this virus ain't going anywhere; it's going to be around for a while. Even with mass vaccine efforts in place, we still need to create safer workplaces. Given the way that point-of-care rapid testing was described by our Slovakian colleagues, it is a very smart way to do this.

● (1245)

[*Translation*]

**Mr. Luc Thériault:** If I understand correctly, we will likely have to live with the virus. All these health measures, that are essential, but restrictive, are having a major impact on mental health and the economy.

When we want to relax the measures and start lifting the lockdown order, no matter how minimally or progressively, wouldn't it be best to use these tests?

[*English*]

**Dr. Isaac Bogoch:** Yes, I would agree completely. I've spoken publicly on this. I've published in the academic medical literature on this. I think they are underutilized in Canadian settings.

There's certainly a much greater role for expanding the use of these tests. They're good. Again, you have to use the right test in the right place and interpret it in the right manner, but of course, I think in general they have been underutilized in Canada. There is plenty of room for expansion.

[*Translation*]

**Mr. Luc Thériault:** Doctor Hotez, I would like you to say a few words about waiving the vaccine patent. Earlier you talked about the COVAX program, which allowed 53 million people to be vaccinated. That is not a lot when you consider that eight billion people need to be vaccinated. I would like your opinion on that.

Could you also tell us what your vaccine could add to the frantic race to the vaccine? At first, we noticed that the science was open and everyone was collaborating, but as soon as a solution was discovered, everyone retreated to their own corners. Some countries even withheld vaccines. I would also like to know what you think of that.

Could you talk about the impact that your vaccine might have?

[*English*]

**Dr. Peter Hotez:** Unfortunately, I missed the beginning of that question, and my French is just not good enough. Maybe the English translator could just briefly summarize the beginning part?

[*Translation*]

**Mr. Luc Thériault:** I'm not sure if that's possible.

[*English*]

**Dr. Peter Hotez:** Well, one thing is that we actually did not file any patents for our vaccine. It's free and open to anybody who wants to scale it up and produce it. We do this for practical reasons, because the filing of patents is so expensive, and our biggest concern is access. We provide non-exclusive licence for our vaccines for just a minimal licensing fee, and then you have the opportunity to scale it up and produce it. We put everything in the public domain, meaning we publish every step of the way, so that nobody can actually block us either. It has worked very well for us for our global health vaccines for schistosomiasis and Chagas disease, and we've taken the same approach for COVID-19 vaccines.

Again, intellectual property for us is not the biggest barrier. It's the fact that most countries just don't have the resources and trained human capital to scale it up. That's why I say, with respect to waiving intellectual property around mRNA vaccines, do not expect that all of a sudden you're going to see lots of mRNA vaccines around. There is an enormous learning curve that's required in order to produce it. If you were serious about having other groups starting to make mRNA vaccines, you would have to ask the Pfizer and Moderna people who have the experience now in scaling this up to actually enter into plants with organizations to help them learn how to produce this at that large scale. That's why I say that waiving the patents could be useful in the long run and it may even have some short-term use, but if I were to rank the top five priorities right now for vaccinating the world, I don't even know that waiving the patents would be in the top five.

● (1250)

[*Translation*]

**The Chair:** Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, go ahead for six minutes, please.

**Mr. Don Davies:** Dr. Hotez, I know that the U.S. federal government developed a national vaccination plan. I think I recall seeing that last November. Can you briefly describe to us what that national vaccination plan looked like and what role the U.S. federal government played in developing that plan?

**Dr. Peter Hotez:** Well, unfortunately, in the last administration, the vaccination plan was mostly about providing and ensuring that there would be adequate supply of vaccine. That was clearly important, but it became clear when the new administration took over that the plan and the logistics were largely focused on making certain that the boxes of vaccine would be kept without temperature incursions and delivered via FedEx and UPS and all of those usual mechanisms.

It was good that it happened, but there was really not an adequate plan to vaccinate the American people. The initial plan relied heavily on pharmacy chains and some of the hospital systems, and I think they did the best they could, but especially in some of the low-income neighbourhoods across the U.S., they're pharmacy deserts, and there was no mechanism for vaccinating, especially in low-income neighbourhoods or even in a lot of rural areas.

I think that there the contribution of the federal government was to put a new plan in place in order to scale up vaccinations very rapidly. That evolved as well, because when the Biden administration took office, they said that they were going to deliver 100 million immunizations in 100 days.

That made sense, I think, in January, until we realized that the B.1.1.7 variant from the United Kingdom was accelerating as fast as it was. A number of us in the scientific community said, "Well, it's great that you made that commitment, but it's not adequate, and you're going to have to triple that." That was I think one of the more impressive things about the administration in 2021: how they regrouped to triple the rate of vaccination. That's why we're doing so well. There was that all hands on deck....

We still have problems now, because we do have—

**Mr. Don Davies:** Dr. Hotez, I have limited time, and I have a few other questions I want to get to, if I could.

**Dr. Peter Hotez:** Okay.

**Mr. Don Davies:** You sort of anticipated where I was going. I know that early in his term President Biden made a series of changes to the plan he inherited. That included setting up federally managed mass vaccination sites and deploying armed forces personnel—I think even national guardsmen—to assist with managing them.

Can you describe the role the U.S. federal government played in actually delivering vaccinations?

**Dr. Peter Hotez:** Well, they always have to work with the states, but I think it was in the planning and the coordination of helping to create the sites, helping with the use of the military and the National Guard and making recommendations to the states in terms of opening up some of the big sports arenas, for instance, to do this in a high-throughput way.

**Mr. Don Davies:** You've already talked about the comparative numbers of full vaccinations and partial vaccinations between the U.S. and Canada. Roughly, your numbers are that something over 40% of Americans have been fully vaccinated versus somewhere around 3% of Canadians, so it seems to me that the U.S. has gone for more of a full vaccination strategy. Can you briefly touch on how that has come to be and why that is?

**Dr. Peter Hotez:** They've also provided quite a number of single doses. The numbers overall in the U.S. are 46% single dose and 34% two doses, but in the high-performing states, it's more like 60% and 45%. The reason you could do it was the vaccine supply. There was enough vaccine available from the two mRNA vaccines, less so the J & J vaccines. That was what made it possible: the procurement of vaccines at that scale.

● (1255)

**Mr. Don Davies:** Thank you.

In a recent interview with The Canadian Press, you noted that you had assumed that Canada had essentially been keeping pace with the U.S. in terms of getting our citizens vaccinated, until you looked at the numbers. You were quoted as saying: "I was really astonished—only about a third of the country has received a single dose, and essentially no one's gotten fully vaccinated." Do you attribute that solely to supply?

**Dr. Peter Hotez:** I think that's probably the biggest barrier: not having an adequate amount of vaccine. The good news is that I do see the numbers picking up for the single dose. It's now heading towards about 40% single dose, so that's better, but still, in terms of full vaccination, the numbers that I see are at only about 3%, so that rounds off to zero.

I think what I would like, and this is why I made the recommendation for the Biden administration to help to a greater extent.... If it looks as though vaccine supply will continue to be low for the next few months, let's help the provinces as much as we can, for both the pragmatic and the emotional reasons that I mentioned earlier.

**Mr. Don Davies:** Thanks.

President Biden recently set a new goal for vaccinations in America, calling for 70% of the U.S. adult population to have at least one shot and 160 million Americans fully vaccinated by July 4. In doing so, he announced his administration's plans to implement initiatives to bring the vaccine to people who are less eager to get vaccinated. Can you provide this committee with an overview of what those initiatives might look like?

**Dr. Peter Hotez:** Yes. There were two problems early on that we noticed back in December. Two groups were highly vaccine hesitant. One was black and brown communities, and then conservative groups. There were four news polls, one from PBS NewsHour and others from Monmouth University, Quinnipiac University and Kaiser showing that about 40% to 50% of Republicans said they would refuse vaccinations.

So I started doing two things. One, I began going on a radio podcast and a radio program that reached black and brown communities, and hesitancy really started going down. I was on one very interesting one with one of the historic black churches in Richmond, Virginia. A pediatrician from the church invited me together with the pastor. I said to the pastor that the numbers looked like they were going down. What did he attribute that to? He said that part of it was that doctors like me were reaching out but also that the clergy in black churches really work together to help make that happen. I think he's right. I think that made a big difference. But now the problem is more access in low-income communities than hesitancy. However, with the conservative groups, it still a rip-roaring problem. You're seeing it reflected now in this disparity between blue and deep red states.

My fear is that we're going to reach some of those benchmarks in the blue or blueish states and the Democratic strongholds—and that's already starting to happen. We're already reaching numbers that will look like Israel's numbers, but in the deep red states, we're still greatly underperforming and underachieving. I worry about ongoing virus transmission there. We have to do a better job reaching out to conservative groups. I'm trying to go back on Newsmax and Fox News and stations like that to do what I can. But it's been really tough.

**The Chair:** Thank you, Mr. Davies.

Members, that pretty much brings our questions to a close.

I'd like to thank all ofthe witnesses, particularly our visitors from the Slovak Republic, for their presence here, and thank you once again to Ambassador Koziak for his attendance.

I would also like to extend my appreciation on behalf of the committee to all of the House of Commons staff, particularly today when we've had guests from all over the world. It's quite difficult sometimes to wade through the technical issues. Thank you for that—and as well to the interpreters. It's a challenging job at the best of times, but in times like this, it's even more so. Thank you to everyone.

With that, the meeting is adjourned.