DÁIL ÉIREANN

AN COMHCHOISTE UM GHNÓTHAÍ EACHTRACHA AGUS COSAINT

JOINT COMMITTEE ON FOREIGN AFFAIRS AND DEFENCE

Dé Máirt, 9 Feabhra 2021

Tuesday, 9 February 2021

Tháinig an Comhchoiste le chéile ag 10 a.m.

The Joint Committee met at 10 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Cathal Berry,	Catherine Ardagh,
John Brady,	Gerard P. Craughwell,
Sorca Clarke,	Joe O'Reilly,
Barry Cowen,	Niall Ó Donnghaile.
Gary Gannon,	
James Lawless,	
Brian Leddin,	
David Stanton.	

Teachta / Deputy Charles Flanagan sa Chathaoir / in the Chair.

Distribution of Covid-19 Vaccines to Developing Countries: Discussion

Chairman: The purpose of our engagement this morning is to examine the international response and actions that Ireland can take in respect of the distribution and roll-out of Covid-19 vaccines to developing and low- and middle-income countries. On behalf of the committee, I welcome Dr. Kieran Harkin and Dr. Aisling McMahon who represent Access to Medicines Ireland, and Ms Winnie Byanyima, executive director of UNAIDS. We will be joined later in the meeting by Dr. David Nabarro, the special envoy on Covid-19 for the World Health Organization, WHO. They are welcome to our engagement.

I remind witnesses of the long-standing parliamentary practice to the effect that they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable, or otherwise engage in speech that might be regarded as in any way damaging to the good name of the person or entity. If statements are potentially defamatory in respect of an identifiable person or entity, witnesses will be directed to discontinue their remarks. It is imperative that compliance with any direction be observed. For witnesses attending remotely outside of the Leinster House campus, there are some limitations in respect of parliamentary privilege and, as such, they may not benefit from the same level of immunity from legal proceedings as witnesses who are physically present. In this regard, witnesses who are participating in this committee meeting from a jurisdiction outside the State are advised also that they should be especially mindful of the domestic law in the jurisdiction from which they speak and how it may apply to the evidence that may be given.

Members are reminded, and I thank the witnesses for their forbearance, of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the Houses or an official either by name or in such a way as to make that person identifiable. I also remind members that they are only allowed to participate in the meeting if they are physically located on the Leinster House complex, either here in the Dáil Chamber or remotely from offices within the precincts of the Houses. For anybody watching this meeting online, some Oireachtas Members and witnesses are accessing this meeting remotely. Due to these unprecedented circumstances and the large number of people attending the meeting remotely, I ask everybody to bear with us should any issues of a technical nature arise. In anticipation of a successful engagement, I express my appreciation to those people in the background, comprising our broadcasting team, sound engineers and everybody associated with what, on the face of it, seems a straightforward engagement. A lot of work has gone into this meeting and I am very grateful to members for their attendance and for the efforts of everybody involved.

I call Dr. Harkin to give his opening statement. He will be followed by Dr. McMahon and Ms Byanyima. I will then ask members to participate by way of a question-and-answer session, starting with Deputy Brady.

Dr. Kieran Harkin: We are grateful for the opportunity to attend the committee and address the issue of equitable global access to Covid-19 vaccines. We would like to explain why we believe that Ireland should formally endorse the World Health Organization's, WHO's, Covid-19 technology access pool, C-TAP, without delay. I am a GP based in Dublin. I am joined by Dr. Aisling McMahon, an assistant professor of law at Maynooth University with a special interest in patent and health law. Access to Medicines Ireland is a membership group, an organisation

of relevant workers. We are honoured to be joined by Ms Winnie Byanyima, executive director of the Joint United Nations Programme on HIV/AIDS, UNAIDS, and a leading advocate of the People's Vaccine Alliance.

To date, more than 3,600 people have died from Covid-19 in Ireland, and more than 2.3 million people have died globally. The global economic cost of Covid-19 has been estimated at $3.4 trillion per year. Furthermore, Oxfam has calculated that the economic impact of the virus could push 500 million people into poverty and nearly half of all jobs in Africa could be lost, according to UN estimates. While the arrival of effective vaccines has brought an expectation that the pandemic can be brought under control, that is threatened by an inadequate supply of vaccines. Most lower income countries are not expected to be vaccinated until 2023 or later. Vaccine scarcity and slow roll-out will ensure a prolongation of the pandemic as outbreaks re-emerge due to travel between and within countries. Even more worrying is the risk that variants of the virus will emerge, which will be more infectious, more dangerous and resistant to current vaccines, as we have seen in South Africa in recent days.

Ongoing research into identifying and addressing these problems before they arise is essential. For these reasons, efficient mechanisms for scientists to collaborate and accelerate research and to achieve faster global roll-out of effective vaccines is essential. The reality is that the current vaccine scarcity is artificial and can be resolved by increasing production capacity globally. However, to do so, companies must share their know-how and intellectual property rights to expedite research and enable others to produce vaccines. Given the extent of the extraordinary health crisis and a significant public investment that has supported the creation of many Covid-19 vaccines, this is not an unreasonable expectation. As Dr. Mike Ryan of the WHO said:

> We have got to get it together as a society. Social justice is only a dream if we don't put health justice at the centre ...

Rapid, equitable, global access to vaccines must be a key priority and to achieve this, we urge the Government to endorse the WHO's C-TAP. I will hand over to Dr. McMahon who will detail this model.

Dr. Aisling McMahon: In May 2020, the WHO initiated the solidarity call to action, launching its support for the C-TAP and urging key actors, including governments, to take action. Put simply, the C-TAP is a platform to facilitate the sharing of intellectual property rights, data, know-how and cell lines related to Covid-19 technologies, including vaccines. Its end goal is to increase equitable access. The C-TAP model is needed because production capacity for vaccines, medicines and diagnostics for Covid can be increased globally but, in order to do this, more companies must license and share intellectual property rights, know-how and technologies to enable others to produce them. The C-TAP sets up a mechanism to facilitate this. It is a voluntary model that is subject to the agreement of such companies. Participation, depending on the context, could include compensation in the form of royalties where appropriate.

Countries must learn from the past. The use of intellectual property rights in a manner which hindered access to medicines has had devastating impacts previously, particularly in the HIV-AIDS crisis, with many millions of lives lost as a result. We must ensure that in this health crisis, that does not happen again. In short, supporting the C-TAP provides a way to achieve global equitable access to vaccines. It would maximise the manufacturing capacity globally by enabling more companies to make vaccines. It would accelerate the development of new technologies by encouraging the sharing of data and know-how, thereby increasing transparency. It would facilitate more accessible access. The C-TAP works in collaboration with the

existing UN-backed Medicines Patent Pool, which has extensive experience in pooling intellectual property rights for public health. Furthermore, support for the C-TAP aligns with the European Commission's recently published intellectual property strategy and the Word Health Assembly's Covid-19 response resolution, both of which encourage voluntary pooling and licensing of intellectual property for Covid-19. Addressing vaccine inequality in this way also gives us a better opportunity to ensure that the core values and intentions of Irish Aid's policy, A Better World, are put into practice, reaching the furthest behind first and leaving no one behind, which is Ireland's approach to realising the UN sustainable development goals. It is fully consistent with Ireland's foreign policy goals of openness, global solidarity and a commitment to multilateralism.

The C-TAP is also vital if COVAX, the vaccine pillar of the WHO's Access to Covid-19 Tools, ACT, Accelerator is to be a success. C-TAP and COVAX are complementary to each other. On 5 February, Dr. Tedros Ghebreyesus of the WHO, in discussing COVAX's first interim vaccine distribution forecast, cautioned that:

> Countries are ready to go but the vaccines aren't there... We encourage all manufacturers to share their data and technology to ensure global equitable access to vaccines.

However, it must be emphasised that the C-TAP will only be a success if more Governments and companies support it. On the other hand, if voluntary mechanisms like the C-TAP do not achieve sufficient support, then mandatory measures for suspending intellectual property rights under the WTO Council for Trade-Related Aspects of Intellectual Property Rights, TRIPS, waiver proposal will be needed, and should be supported, to encourage and achieve change.

Access to Medicines Ireland is joined by ActionAid Ireland, the Irish Global Health Network, the INMO, Médecins Sans Frontières Ireland and Oxfam Ireland in calling on the Government to support the C-TAP. To date, 40 countries worldwide, including five European countries, have endorsed it. Furthermore, last September, the President, Mr. Michael D. Higgins, indicated his support for the WHO's global solidarity call to action in his speech at the UN General Assembly. Most recently, on 3 February, Dr. Anthony Fauci said that rich countries had a moral responsibility to help countries unable to access vaccines. This could include supplementing their own ability to produce vaccines with co-operation from the pharmaceutical companies regarding relaxation of some of the patent situations.

The bottom line is that we have got to get the entire world vaccinated. Global multilateral action is needed and Ireland can and should be a leading voice in this regard. Access to Medicines Ireland encourages the Government to endorse formally the global solidarity call to action and the Covid-19 Technology Access Pool as soon as possible and to take action at an EU level to encourage greater support for the C-TAP. Alongside this, we urge the Government to increase financial support for the WHO's ACT Accelerator. We thank the committee for granting us this opportunity to share our views.

Chairman: I thank Dr. Harkin and Dr. McMahon for their presentations. Ms Byanyima has joined us and is very welcome. I invite her to make her opening statement. I apologise for my-----

Ms Winnie Byanyima: I thank the Chairman.

Chairman: Ms Byanyima is very welcome. She joins us from Geneva, I understand.

Ms Winnie Byanyima: Yes. My name is Winnie Byanyima. I lead the United Nations joint programme on HIV-AIDS. It is called UNAIDS. I am grateful for this opportunity to address the Joint Committee on Foreign Affairs and Defence on the critical issue of Covid vaccine equity. I am also happy to let the committee know that I am the proud daughter of Irish missionary sisters of St. Francis.

In the early years of the AIDS response, millions of lives, as Dr. McMahon said, were needlessly lost because life-saving treatment remained out of reach for people in poor countries as people in rich countries benefited from antiretroviral treatment and went on to live long, healthy lives. In poor countries 9 million people died waiting for the prices to come down. It was a deeply painful lesson that many of us know very personally and one that the world, it seems, is having to learn again.

Ten months ago world leaders declared that any Covid-19 vaccine would be a global public good, a people's vaccine, but we now face a situation that the South African Government has called a new global apartheid. Nine in ten people in the poorest countries are set to go without a vaccine this year. A small group of rich countries representing just 14% of the global population have bought up most of the supply of the Covid vaccines that are available until the end of 2021. I am sure the committee is as shocked as I am that pharma companies are charging developing countries more than they are charging rich countries, in some cases more than double. My country, Uganda, will pay $7 per dose of the AstraZeneca vaccine and South Africa will pay just over $5 whereas the European Union will pay just over $2 per dose.

The problem is not only one of money or unfair allocation; it is also that not enough vaccines are being made. Even rich countries face challenges over production quantities in this year. What the European Union is experiencing now is deeply troubling, and we empathise. It is a taste of what Africa, Asia and Latin America have been experiencing. This is why approaching vaccination as a competitive race between countries and regions means that everyone loses out. What Europe thought was defending Europe was really defending the profits of the owners of big pharmaceutical companies. The vital decisions of production, supply and price and, therefore, who gets the vaccine and when have been left in the hands of big pharmaceutical companies. How is that right? Our best chance of all staying safe from Covid-19 is to have vaccines, tests and treatment available for all, for the whole world. As the Irish President, Michael Higgins, noted when he and I spoke on the same platform at the UN last year, "Unless such medical tools are fully accessible to all on an equitable basis, the world remains at risk." Right now, however, big pharma is protecting its monopolies, technology and intellectual property and thus restricting production. We know how to solve this problem: it is to open up production. Maximising global production can happen only if all companies that can produce vaccines have access to the vaccine technology, know-how and intellectual property. Pharma companies will not share unless pressed to do so. Governments have that leverage and there is a mechanism to enable the sharing that Dr. McMahon described, namely, the WHO's C-TAP. It is a one-stop-shop for pooling all data, know-how, biological material and intellectual property and then licensing production and technology transfer to other potential producers. So far, pharma companies have not joined C-TAP and the proposal presented by the Governments of South Africa and India at the WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights, TRIPS, council for a temporary waiver of certain TRIPS obligations has been blocked by the rich countries that host the pharma companies with a vaccine.

This is not only about access for the poor. The longer the virus is left to ravage developing countries, the longer people in rich countries will remain at risk. The virus is mutating, as Dr.

Harkin stated. This threatens the efficacy of vaccines, as we have seen with the so-called South African variant. Yesterday, the South African Government had to postpone its roll-out of the AstraZeneca vaccine because, having bought millions of doses, it realised that the vaccine did not have efficacy against the variant. The slow pace of vaccination everywhere means that we risk seeing more dangerous variants developing. As Dr. Mike Ryan of the WHO, a wonderful Irishman, often remarks, no one is safe until everyone is safe.

The economic cost is also great. New research from the International Chamber of Commerce predicts that delays to vaccine access in poorer countries will cost the global economy an estimated $9 trillion, with nearly half of that being the cost to wealthy countries. These vaccines were developed with public money and these companies depend on government support. Whenever we raise the question of leverage over companies, though, we are told by rich countries' governments that there is COVAX. While support for COVAX is welcome, it cannot solve the supply problem on its own. Indeed, COVAX can only complement C-TAP.

We need to ensure that constraints on licensing and know-how no longer obstruct mass production of Covid vaccines. We must make companies take part in C-TAP. It is their governments that can make that happen. We also need to speed up agreement on a waiver at the WTO, especially if C-TAP does not work. I hope that the Irish Government will consider joining C-TAP. I join Dr. Harkin and Dr. McMahon in urging the committee's parliamentarians to ask their Government to do so.

Like AIDS, Covid is revealing the underlying fissures of inequality, how they hurt all of us and how outdated rules and approaches obstruct us from overcoming them. Fixing them is a policy choice. It is a moral, public health and economic imperative to ensure that everyone gets vaccinated in 2021 and that no one is left behind.

I thank the committee for the opportunity to speak.

Chairman: I thank Ms Byanyima for her presentation and for agreeing to stay with us for our questions and answers session. Since my understanding is that we have not been joined by Dr. David Nabarro yet, I will commence the questions and answers session with the three witnesses who have already contributed. I call Deputy John Brady.

Deputy John Brady: I thank all our guests for their very insightful contributions, containing important information and statistics that are shocking and alarming. As we face into the ongoing commitment for global solidarity and social justice, the contributions are very timely. Unfortunately, the big pharmaceutical companies continue to profiteer on the backs of people throughout the world. I believe one of the witnesses said countries are ready to go but the vaccines are not there. That is the call from throughout the world. It is very clear that the pandemic can only be ended by protecting all nations. It is interesting to hear the comment that no one is safe until everyone is safe. That is the only way we will get on top of this global emergency. No pharmaceutical company should profit from the pandemic. We need to ensure widespread availability across all nations. It is shocking that nearly 70 countries will only be able to vaccinate approximately 10% of their populations next year.

Another shocking figure that was given related to the cost of one of the vaccines. The term "morally corrupt" springs to mind when some countries are being charged €7 per vaccine. South Africa is being charged €5, but some of the better off countries in Europe are only being charged €2 per vaccine. That clearly shows everything that is wrong with the roll-out of the vaccines.

Wealthy countries will have enough vaccine to protect all their citizens three times over in 2021 and yet some of the poorer underdeveloped countries are struggling to vaccinate their citizens. Lessons need to be learned from the AIDS crisis. I believe 9 million people in African countries alone died of AIDS while they were screaming out for access to the medication to help with AIDS.

I believe five European countries, Belgium, Luxembourg, Norway, Portugal and the Netherlands, have signed up to support the Coronavirus Treatment Acceleration Program, CTAP, along with 40 countries globally and a list of organisations that were mentioned earlier. Several Irish experts, including Professor Luke O'Neill, Dr. Sam McConkey and many others, support it. Sinn Féin fully supports the programme.

We also support another initiative and I might ask for views on this. I refer to the Right to Cure initiative, a European citizens' initiative that was launched last year, which proposes to put public health before private profit, and to make anti-pandemic vaccines and treatments a global public good, freely accessible to everyone. As we need 1 million signatures to move that initiative forward, I appeal to anyone who is listening to sign up to support it. There is significant crossover in the objectives of CTAP and that particular initiative to ensure intellectual property rights and patents do not hamper the accessibility or availability of any future Covid-19 vaccine or treatment, and to ensure that EU legislation on data and market exclusivity does not limit the immediate effectiveness of compulsory licences issued by members. There are a number of other points there as well. Is this something our witnesses also support? I have a question relating to the failure of countries to support C-TAP and the dire consequences of that. Do we have expectations or analysis of what the impact will be? We see some of the financial impacts, which are shocking, and how it will affect some poorer countries. When we speak about people and individuals, how will the failure to introduce C-TAP affect them?

It is unbelievable that the Irish Government has not signed up to support this. What engagement, if any, has taken place between Access to Medicines Ireland and the Government? What do the witnesses feel as organisations, doctors and people about this issue? What are the largest obstacles blocking C-TAP? Are there particular interest groups such as shareholders?

Chairman: There are a number of questions from Deputy Brady that he has not directed at any one individual but perhaps I might get a brief response from Dr. Harkin, Dr. McMahon and Ms Byanyima.

Dr. Kieran Harkin: I am very pleased to hear the endorsements from Deputy Brady. We have been disappointed in some sense that no more than four EU countries have supported it to date. There will probably be much greater interest now that the US Administration has been led and encouraged by Dr. Fauci to take an interest in it and move in the direction of supporting C-TAP. While the UK Government has not formally endorsed C-TAP, it has certainly made a number statements suggesting that it agrees with the principles underlying it and in reality, is not too far away from supporting it. Every day, it is becoming more and more clear that the current system is failing and that we cannot rely on the pharmaceutical industry to guide us through this pandemic as its eye is clearly directed towards its shareholders rather than public health. That is the way the industry is set up.

Dr. Aisling McMahon: We really appreciate the endorsement in terms of C-TAP. In terms of the Deputy's question about the failure to support C-TAP, we are seeing the consequences of it since the vaccines have been approved, particularly since they have started to be rolled out. It is fantastic that we have these vaccines but, unfortunately, we do not have enough of them.

That is becoming more and more clear for Ireland and other European countries and all over the world. C-TAP would facilitate the manufacturing of vaccines and the ability to make more. There is an artificial scarcity because the rights holders are simply not sharing intellectual property data and know-how. Know-how, data and intellectual property are needed to make these vaccines. Rights holders could be willing to come on board, take the opportunity to share and realise that we are in an extraordinary crisis and pandemic and need to bring it under control and that the only way to do that is increase the production of these vaccines. C-TAP is a direct avenue that would facilitate that. We support the COVAC scheme but, unfortunately, the target is that they would have enough vaccines for 20% of populations, which is nowhere near the figure we would need to achieve herd immunity or a population-wide spread of vaccination. The consequences of not supporting C-TAP are that we will at best achieve 20% and that is assuming we even have a supply to achieve that. C-TAP can deliver more vaccines for the likes of COVAC and facilitate that so it is important to stress that C-TAP would provide a mechanism to deliver more vaccines if it was supported but it needs support.

Ms Winnie Byanyima: We have a situation where the rules that regulate business and trade, which have been in place for the past 30 years or so, have had an impact on our minds to the extent that we think that the right to profit is equal to the right to health and the right to life. We have a mindset that is completely taken over by the notion that profit is as important as health and life. It is a big problem for all of us that we have developed a mindset that justifies profits coming before life. The second issue is that the rules themselves, which we should be challenging, are not being challenged. Why is that? It is because shareholders in this modern world of trade have become so important in businesses that their voice is more important than that of workers, communities and ordinary people. We had a form of trade and business 30 years ago that allowed profits to be ploughed back into workers' wages, research and community development. Shareholders took only 10% of profits in the UK, for example, but today, shareholders take 70% of total profits. The voice of shareholders is so dominant in the politics of our countries. Their voice is heard before the voice of ordinary people, including consumers and workers and that is part of the problem.

We would like to see countries that do not host the pharmaceutical companies that produce the vaccines joining C-TAP because they do not have anything to lose. We salute Belgium, the Netherlands, Portugal and Norway for supporting C-TAP, as well as many other developing countries. Of course, countries like Germany, the USA and the UK oppose C-TAP because the pharmaceutical companies and their shareholders have a powerful voice in those countries. We would like the countries that do not have a stake in the companies producing the vaccines to come together and insist on fairer rules that allow sharing of the technology. We urge them to back the WTO waiver that is being requested at the TRIPS Council or to join C-TAP. These are two avenues that will assist in maximising vaccine production for the world. The interests of big companies and their shareholders are blocking progress towards justice and equity in access to vaccines.

Chairman: We are joined by Dr. Nabarro from the WHO, who is welcome. Given the time constraints, I propose to go to Deputies Stanton and Leddin next, to direct their questions or observations to the relevant witnesses and then go to Dr. Nabarro.

Deputy David Stanton: I take the opportunity to welcome our guests and thank them for joining us to discuss this very important issue. Approximately 40 countries, including Belgium, the Netherlands, Portugal and Norway in Europe, have supported the WHO's solidarity call to action and C-TAP. Can our guests give us any insights into why other countries have not done

so? I also note what Dr. McMahon said earlier about the fact that we are very fortunate in now having a number of vaccines that seem to be effective. When the virus emerged initially, there was concern that it might take a very long time to develop vaccines to combat it. Thankfully, this has happened very quickly within a year. We are all concerned about the possibility, and the fact, that the virus is mutating and is changing and has the potential to change into something even more deadly. I note Dr. Nabarro is also online and I welcome him. Perhaps when he speaks he might comment on questions such as access to non-government controlled areas of Syria. There is no guaranteed channel for vaccines for people in this area. There are other areas of conflict in the world such as Tigray, Mozambique, Libya and Rohingya in Bangladesh, and places with many refugees in Uganda and Lebanon. Will our guests comment on the possibility of these people getting vaccinated? I am also interested in hearing the views of our guests on whether these areas could become centres for more changes to the virus, leading to deadlier strains, if the people in them are not vaccinated.

It is also quite interesting to note the Government here has not said "No" to joining the call for action, but if some of the recent responses from the Minister are to be considered, is examining the situation fairly strongly. I hope we will be in a position to do so before too long. This time last year, this issue was just starting so things have moved very quickly.

The AIDS epidemic was absolutely catastrophic. I take on board in particular what has been said by the director of UNAIDS. This pandemic is even more deadly because it is even more transferable and has the potential to really and truly cause devastation throughout the world. The Government here should sign the solidarity call to action as soon as possible. I note a number of other European countries have done so.

Throughout the world, is there a lot more capacity to produce the vaccines to the standard required? I stand to be corrected but in Ireland we have many pharmaceutical companies but I am not aware of our companies producing any vaccine.

Deputy Brian Leddin: I thank Dr. Harkin, Dr. McMahon and Ms Byanyima for their contributions, which were very insightful and enlightening. My Green Party colleague has written to the Department of Foreign Affairs, which provides the lion's share of Ireland's overseas development assistance, to request that Ireland uses its seat on the UN Security Council to advocate on behalf of the countries worst affected and least capable of overcoming the pandemic. In addition, Deputy Ó Cathasaigh has written to the Minister, Deputy Coveney, inquiring as to whether he will support C-TAP. Our party believes further avenues of international co-operation and assistance in addition to COVAX should be explored and leveraged to maximise equitable access and distribution of vaccines in developing countries now and in the longer term.

With respect to international efforts, the fast response of Gavi, the Coalition for Epidemic Preparedness Innovations and the WHO in initiating and leading of the work of COVAX should be applauded. It is an important demonstration of collaboration and solidarity to support vulnerable developing countries as they work to overcome Covid-19. It is important that Ireland supports this initiative to the greatest extent possible through funding and our knowledge and experience of public health emergencies. It is also welcome to see the aim of the COVAX initiative is to protect at least 20% of each participating population by the end of the year. Given the task at hand, this is no small feat but the efforts of COVAX will not be sufficient to fully address the challenge and its various aspects. Some issues and questions that come to mind are technical, operational and political. Could the witnesses address whether health services will be sufficiently staffed and trained to administer vaccines in a timely manner and how we can ensure the safety of access in countries that are politically fragile? There is a question about

adequate storage and transport facilities and how we put those in place for the distribution of vaccines at centres and hospitals. I thank the Chairman for bringing me in early.

Chairman: I thank Deputy Leddin. Before I call Dr. Nabarro, I want to revert to the panel with the questions from Deputies Stanton and Leddin. I refer to Dr. McMahon's response to the points raised by Deputy Stanton. Could I put it to her that the herd immunity through vaccination that we thought was possible late last year and early this year is now unlikely to be possible because of the emergence of further and new variants such as, for example, the strains in South Africa and, we suspect, South America? Does she agree that we are seeing a movable feast or shift in the projected goalposts, which adds to the challenge involved?

Dr. Aisling McMahon: I thank the Chairman. I will start by answering some of the questions raised. On Deputy Stanton's question on why other countries have not joined the CTAP initiatives, 40 countries worldwide have done so, as was noted, including five European countries. In terms of why others have not, that is the question we are also asking. In our minds, CTAP will facilitate more access to vaccines. I can only speculate as to why countries have not signed up so far. I wonder if perhaps it is only now that as vaccines have thankfully come on board, we are seeing gaps in terms of access, supply chain issues and that do not have as many vaccines as we initially thought we would. Now would be an opportune time for people to reflect on that and countries to put themselves behind some of the initiatives such as CTAP which will, if it is supported, facilitate more people being able to make these vaccines.

Another important point was raised, which relates to the Chairman's point on the new variants that are arising. It is a worrying time. Others are more qualified to speak on those points and I am sure we will hear from Dr. Nabarro later on this. In terms of the intellectual property perspective, one of the obstacles to having access to vaccines is intellectual property, data and the sharing of know-how, in particular. This also relates to the point on the safety of the production of vaccines. We need companies to share their know-how to facilitate and enable others to produce vaccines of the same quality standard. CTAP would facilitate that. If we had more vaccines, we could deliver more vaccines. That would mean more people could be vaccinated and, it is to be hoped, reduce the number of new variants emerging. I will not speak on that. I am sure others can speak later on it.

On whether there is excess capacity in the system, we have looked at some of the research produced by other groups such as Knowledge Ecology International, KEI. It suggested that there is untapped potential. We know there are various different pharmaceutical companies, including in Ireland, who could facilitate and help with the production of vaccines. In recent times, some pharmaceutical companies have entered into voluntary licensing deals where they have agreed to help in the production of vaccines. For example, as far as I am aware, Pfizer and BioNTech recently reached an agreement with Sanofi to help to increase its production. We are calling for more of this.

Reference was made to shareholders. The traditional shareholder model involves a focus on profit. Some of the work we are now doing suggests that a small group of shareholders see themselves as stewards of resources. Actions are being taken in other countries, such as the US, where there have been shareholder motions, in particular in a pandemic context, to state that profits should not be the main priority and instead other goals such as delivering global equitable access should be prioritised. We must consider who the shareholders are, which in some cases are pension fund or investment companies. There is potential for the public to leverage their voices by saying that in this pandemic we must see a change and the sharing of intellectual property and data to facilitate this.

Ms Winnie Byanyima: I will reply to some of the questions that were raised. There was a question about refugees and internally displaced people, whether they will be catered for, and if not, whether the communities of refugees and internally displaced people could turn out hosting new and dangerous variants of the virus. This is the case but there are some good practices. For example, in Jordan, one in every four people is a refugee. It is rolling out its vaccination programme to include refugees and it has the support of the United Nations High Commissioner for Refugees. We also heard from the International Federation of the Red Cross and Red Crescent Societies last week, which launched a plan to help vaccinate 500 million people globally. There is a need to pay attention to those people with weak citizenship rights and have them vaccinated.

We have looked carefully at the question of capacity in the People's Vaccine Alliance, estimating that the three biggest vaccine producers - Moderna, Pfizer-BioNTech and Oxford AstraZeneca - are producing enough vaccines for only 1.5% of the global population, which tells us how small is the supply. We are looking at how much capacity is being used by the other big vaccine producers. When we started probing, we saw some of the production companies moving very fast to try to conclude agreements with some of the major vaccine producers in Europe and America to license them. They have really been holding on to their technology and know-how to first try to scoop as much profit as possible before they license others. That is why we need the pressure.

The capacity is there and we will estimate those figures. This capacity is not only in Europe and North America.; there is also capacity in the emerging economies. There is huge capacity in India, with some companies licensed to produce the AstraZeneca vaccine, for example. There are other Indian producers with capacity that is sitting there. There is also capacity in Indonesia, China, Russia and so on. There is capacity and we will estimate those figures but we must put pressure on those companies.

I also wanted to speak to the question of the pandemic being really more devastating than HIV/AIDS. I agree. In developing countries like ours in Africa, the economic devastation is worse than the health devastation. For some reason our people have not had as many deaths or even infections as in Europe. Perhaps it is because the populations are younger or we have suffered many infectious diseases previously but nobody knows yet. Infection rates are lower and deaths are fewer. Nevertheless, the economies had to be closed completely so the economic devastation is huge. People have lost jobs and their income so they have nothing to eat. It is devastating. The need to recover is global and this pandemic is more damaging than HIV. Every life is important.

Many countries and governments support CTAP, but they have not yet signed up to the Costa Rica resolution. I think that has to do with some fear of the pharmaceutical companies because this is now about survival of the fittest and booking supplies with a few companies. I suspect that some governments did not show up to sign up to the common technology access pool because that would be seen as perhaps "anti" the pharmaceutical companies. I suspect one is seen as in conflict with the other. While some governments have signed on to the People's Vaccine Alliance and the People's Vaccine Alliance is demanding support for C-TAP, the same governments have not signed up to C-TAP or the Costa Rica resolution. That tells us they will sign onto the People's Vaccine Alliance, which is campaigning for C-TAP, but they will not go to the WHO pool. Something there suggests that one is in conflict with the other.

Chairman: I am going to move on to our fourth guest. I am pleased that we are joined this morning by Dr. David Nabarro, the special envoy on Covid-19 from the World Health Or-

ganization. I thank Dr. Nabarro for joining us. I trust that he will make a brief submission to our committee and will be in a position to stay with us until approximately 12 noon. Several members have offered for questions. I am pleased that Dr. Nabarro has joined us for this formal public session and I call on him to commence his contribution.

Dr. David Nabarro: I am here as the WHO envoy. There is a requirement as we go into the evidence process for me to state that, although this is a formal meeting of the committee, my representation of the WHO has to be seen as informal. It cannot be, we respectfully suggest, an alternative to the formal governance process of the WHO through the UN World Health Assembly or other similar mechanisms.

I wish to start by acknowledging the incredible work being done by Dr. Kieran Harkin, Dr. Aisling McMahon and Ms Winnie Byanyima. I may have got the order wrong but that was the order I was given. What the committee has been hearing this morning is really important. I was proud to be able to join and hear Dr. McMahon and Ms Winnie Byanyima talking and explaining their points of view, and I am pleased indeed to be here.

I want to talk about three things. The first is Covid-19 and the pandemic. The second is the way in which efforts are being made to improve access to vaccine through something called COVAX, which the contributors have been describing. The third thing I want to talk about is improving access to technologies through initiatives like the People's Vaccine initiative and C-TAP.

We will start with the pandemic. I imagine everyone in Ireland knows but perhaps I will say it again. This pandemic is nowhere near finished. This is nowhere near the end. Some people say there is light at the end of the tunnel but from my point of view, I am not sure how far away that light is. I have no idea how long it will take to reach the end of the tunnel. I am prepared to say to committee members that I believe there are some really difficult and rocky periods ahead of the world to get through it.

This is a new virus that has appeared and entered into the human ecosystem, just as HIV did some decades ago. The world needs to adapt to a new virus. That adaptation process takes time, especially given that the virus will change. Humanity's response to the virus will change as well. The adaptation will be continuous. Right now, we are in a phase where the incidence of reported new cases of Covid-19 in Europe has gone into a decline. This is in particular since the beginning of January and is super-welcome news. It has gone into decline because of the extraordinary effort by the people of Europe and, increasingly, the people of North America to take this virus seriously by maintaining physical distancing, wearing face protection, practising incredible hygiene, self-isolating when ill and protecting the most vulnerable. These are the tried-and-tested measures through which people can reduce their risk. That has to be accompanied with well functioning public health systems that can detect people with the disease, enable them to isolate in a decent way, trace their contacts and enable those contacts to isolate and, when necessary, deal rapidly and robustly with outbreaks that occur.

These are big shifts happening in humanity. We are all working out how to come to terms with it. We have had various moments when we have been able to learn: the first acceleration in March and April of last year; the second acceleration at the end of the summer months of last year; and the dramatic third acceleration towards the end of last year and over the new year period. We have been learning such a great deal, perhaps most importantly that the virus is the adversary and people are the solution. There is a requirement to enable people to be strong, connected and empowered to fight the virus despite the fact that this entails massive social and

economic dislocation. It hits poor people the worst and it often hits people who have different ethnicity from the dominant ethnicity in western European countries the worst. Dealing with Covid in Ireland and elsewhere in Europe means empowering people to respond and enabling those most affected, particularly the poorest and those with least access to resources, to be strong.

Having said that, there are ways in which it is possible to help people. The ways to help include all those I have mentioned and now we can add vaccines. Who should be receiving vaccines now? In our view, it is clear that it should be the people who are at risk: older people and people with simultaneous illnesses; and those who are most exposed to the virus, namely, people dealing with Covid in their professional work all the time, particularly in healthcare, residential care, dentistry or other professions where one is in contact with the exhalations of people with the virus. If the vaccine is helpful in protecting people, there is one priority for the world, as stated clearly by the Director-General of the WHO and the Secretary-General of the UN. That priority is to make sure everybody in need of the vaccine can access it on the basis of need first, not on the basis of geographical location or nationality. Right now, the people who must be a priority for any vaccine are health workers, older people and people with concomitant illness, wherever they live.

That is why at the request of the different member states of the WHO, the COVAX scheme was set up as part of the access to Covid-19 tools, ACT, accelerator. COVAX is a scheme to enable the pooled purchase of vaccines at a negotiated price, ideally a low price. The vaccines can then be made available to countries to purchase with their own funds or, if their GDP is low, to purchase with aid funds. It is an advance purchase scheme like what we have used for other vaccines around the world to enable everybody to get the lowest possible price. By negotiating with the producers, we are able through COVAX to get the price low. In order for that to work, there has to be vaccine in the system and there is not enough for COVAX to work right now. Anybody who criticises COVAX needs to be clear about what he or she is criticising. Is it that it does not have enough vaccine coming through or is it because it has design flaws? At the moment, the people who run COVAX tell me they want more vaccine in, which means, first, expediting the regulatory approval of existing vaccines that are currently on the edge of COVAX but not in it because COVAX can distribute only vaccines that have an emergency use licence from the WHO advisory committee on vaccination. Second, we have to get some of the new vaccines properly into the COVAX portfolio, that is, the ones that use messenger RNA. These are very exciting vaccines. At the moment, they have to be kept super cold, which makes them a real challenge to use, but the technology will improve and we have to get them in.

Third, countries that have purchased their own vaccine through bilateral deals and have some to spare should give it to COVAX immediately. It should become a movement everywhere that whenever there is some spare, it is given over. The key question is what is spare. My colleagues and I are asking whether, given the current availability of vaccines, any country should be planning to vaccinate all its adults against Covid or whether they should carry out vaccination of the at-risk groups and then share the rest with COVAX so that it can go to other countries where it is needed. Moreover, COVAX needs to take on new products and new vaccine production needs to come in.

Another key question is what is the hold-up. What could allow there to be more vaccines? I certainly agree that the resolution produced by Costa Rica before last year's World Health Assembly, which led to the C-TAP proposal and the associated medicines patent pool being set up, is very important. It is a mechanism that has worked for voluntary licensing for vaccines

and treatments for other products, and it is surely the right way to go in the long term. In the meantime, let us try at least to get existing schemes working as effectively as possible while, at the same time, exploring possibilities for upgrading the C-TAP system. To get vaccines moving now, we need not only more vaccines coming in but also to scale up the potential of different manufacturers working to the full. When that happens, each scale-up has to be individually licensed by the WHO system. That is absolutely essential for quality assurance, safety and efficacy. Let us ensure that all the approval processes happen quickly.

It will not be possible to get vaccines into the arms of people everywhere without an enormous global support programme for vaccine administration throughout the world. Without that, we might end in the embarrassing scenario of vaccines becoming available more and more, particularly during 2021, with the inability to implement them. For polio, we have had to have a global immunisation programme, while for measles and other childhood illnesses, there are strong global programmes. There will need to be the global support of countries so that they can implement the vaccines.

Some of that is available through COVAX but, frankly, I know from experience that the world will have to get behind poorer countries to help them carry out their immunisation programmes. That is where we will need continued commitment from the G7, the G20, the UN Security Council, the UN General Assembly and other global bodies to ensure that the money moves. That is absolutely the key. Colleagues have made that point and I endorse it. COVAX will work if it gets the support it needs from rich countries; it will fail if countries go round the back, do not give it enough money or discredit it. Let us work together to make COVAX a success. In the longer term, let us use the C-TAP system and other medicine patent pools to increase the availability of supplies in poor countries where they are needed.

Chairman: I thank Dr. Nabarro for his contribution. Before we return to questions, I remind members that the clock is ticking and we have to conclude our deliberations by 12 noon, in accordance with the Covid-restricted atmosphere in our Parliament. I will group the questions, therefore, which I am sure they will assent to. I will call Senator Joe O'Reilly, to be followed by Deputy Berry and Deputy Gannon, and will then come back to the panel. The four witnesses are now in attendance. On the next round, I will start with Deputy Clarke.

Senator Joe O'Reilly: I thank the Chairman. I will do my best to heed his suggestion that members try to be efficient. I welcome the witnesses. I congratulate Dr. Harkin and Dr. McMahon on their voluntary and moral leadership. It is important. I also congratulate Ms Byanyima. It was great to hear from Dr. Nabarro as well.

As I stated at a previous committee meeting, it is interesting that we have a case where self-interest and the morally correct thing to do coincide. They often do not coincide, but in this instance they do. As Dr. Mike Ryan would say, no one is safe until everyone is safe. It is very scary that 2.3 million people have died globally. Dr. Nabarro's interpretation of the future is also frightening. The economic cost of €3.4 trillion per year is shocking. Basically, we need the global south, the developing world and all other parts of the world to be on board. As the world is now a global village, one cannot assume that because what are, from our perspective, isolated areas are not covered, we are safe. As a result of the prevalence of travel, we are not safe. The issue of variants then arises.

I refer to two stark and frightening figures. The first is that it will be 2023 before several countries are looked after. The other figure, if I picked it up correctly - I may be corrected if I did not - is that only 1.5% of the global population would be covered by the existing supply of

vaccines. Those are stark figures.

My colleague, Deputy Stanton, raised the issue of capacity. We should have reassurance in that regard. I intuitively think there would be far more capacity available if there was a will to use it, but I would like to hear more on the issue. Ireland now has a particular role in the context of the UN. The Government must join and sign up to the international statements on this issue and use our position in the EU and the UN.

I recently had a discussion with the Palestinian ambassador to Ireland. She explained that the Palestinian people have particular difficulties with access. I ask the witnesses to comment on that. Of course, that links to the issue of refugees. It is obvious that where there is a density of people, such as in refugee settlements, etc., and indeed in places such as Gaza, there is a greater spread. I would like the comments of the panel on that but I think it is a pretty basic point. One assumes the spread is more difficult to halt in the normal ways.

I ask Dr. Nabarro to address the issue of the Russian vaccines and what is happening there. I have been told that the Russian vaccine is very effective. We in this western part of Europe do not know much about it. I ask him to comment on that issue and how the vaccine is being used internationally. I ask the witnesses to comment on the issue of capacity and the Palestinian question specifically.

I was here all day yesterday, when there was a full Seanad sitting at which many important issues were discussed. I am sure many important issues were also discussed in the Dáil in recent days. However, without being ridiculous or melodramatic, I believe this is probably the most important meeting that has been held in these buildings for many months. The issue we are discussing is the most serious in terms of morality, expediency, the economy of the world and the lives of people. This is of mammoth importance. I am certainly unequivocal in my support of what our guests are doing. I am very proud to have the opportunity to say that.

Deputy Cathal Berry: I thank our guests for their very informed commentary and testament. As a Member of Parliament hundreds of whose constituents are currently deployed overseas as UN peacekeepers in resource-poor countries and are themselves awaiting vaccination, I can completely identify with the issues the witnesses have highlighted and rightly raised this morning. The case they put forward is compelling. They have our full attention in Dublin this morning.

I have three questions. First, while the case the witnesses made is compelling, is there any way we can strengthen it further. For the benefit of the committee, maybe one or two of the panel could outline diseases for which the patents on vaccines or medications have been waived in the past. If there was a list of diseases for which medicine patents had been waived in the past, it would certainly strengthen their case because precedents are important. Second, have the three pharmaceutical companies that make Covid vaccines formally declined to become involved or are we still awaiting a response?

My third question is perhaps a technical one to which the witnesses may not have an answer. When countries in the EU signed up to this new mechanism, the C-TAP, that has been described, did their minister for health sign off on it or was there a motion on the floor of parliament? What technical mechanism was used? Is there a document to sign or does one merely have a press conference and make a formal pledge across the airwaves?

I will summarise my questions. Have the pharmaceutical companies formally said "Yes" or

"No" at this stage? What technical mechanism was used at parliamentary level to sign up to the pledge? Is there a list of diseases for which vaccine or medication patents have been waived before they had elapsed?

Chairman: I will take Deputy Gary Gannon in this round and then return to the panel.

Deputy Gary Gannon: Gabhaim buíochas leis an Chathaoirleach. I will keep my questions brief.

My first question pertains to wealthier countries which are hoarding vaccines. Canada, a high-income country, currently has enough vaccines to vaccinate its population several times over, yet it is hoarding some of its vaccines. It still intends to secure 1.9 million vaccines through the COVAX system. Will the witnesses comment on wealthier nations hoarding vaccines? What can we do to stop that practice and what will be the outcome if it persists?

As part of the COVAX initiative, pharmaceutical companies have pledged that no country will receive vaccines for more than 20% of the population until every country has enough supply to vaccinate 20% of its population. Currently, we are well off target, with 16% of the world's population having received 60% of the vaccine supply. Pfizer has only supplied 2% of its vaccines to COVAX. I ask Ms Byanyima or Dr. Nabarro what steps are being taken to ensure that pharmaceutical companies fulfil their pledges to the COVAX initiative.

Many international NGOs, including Médecins Sans Frontières, MSF, have called for a relaxation of intellectual property rights on Covid-19 vaccines and technologies to ensure the scaling up of production and access in the global south. What steps should the Government be taking, be that independently, as part of the EU or through our role on the UN Security Council, to press pharmaceutical companies to open up intellectual property or support initiatives such as the C-TAP?

Chairman: Perhaps we will start with Dr. Harkin, who has not contributed for some time. Members asked a number of specific questions. I ask that we focus to some extent on Ireland's role, as highlighted by Deputy Gannon. Dr. McMahon spoke of the Government's leverage in this matter. Having regard to the fact that we are all agreed that the concept of vaccine nationalism is somewhat disturbing, what role could Ireland have, as a member of the EU, UN and UN Security Council? I suggest we address the questions posed by members under that umbrella.

Dr. Kieran Harkin: In reply to some of Deputy O'Reilly's questions on capacity, it is worth bearing in mind that this time last year, there were no Covid vaccines available. We have come a long way in a relatively short time. While the mRNA vaccine is a very sophisticated vaccine, some of the advantages are that it can be produced quite quickly and the manufacturing set-up can be done in a relatively short time, within three months. It is interesting that Knowledge Ecology International, KEI, an international organisation, has identified more than 100 plants capable of producing Covid vaccine. Six of those are in Ireland, four from Merck, which had attempted to develop its own vaccine which failed recently. Two of the plants are in Cork, one in Carlow and one in Swords.

On what Ireland should do on the waiver on the national stage, our priority would be for Ireland to support CETA but we would also suggest that the waiver or the suspension of intellectual property rights in relation to Covid-19 products as proposed by the Indian and South African governments also warrants support.

On when a patent has been suspended and used from before, it has happened a number

of times. It is what brought an end to the HIV epidemic in Africa when the pharmaceutical industry and the governments which support them caved in under pressure and relented and allowed HIV drugs to be produced and manufactured generically. Notable times this happened was when the US Government was threatened by anthrax and overnight brought in a law lifting patents on ciprofloxacin, the only antibiotic that would have been effective. There are other examples which I do not have to hand.

Dr. Aisling McMahon: This is a situation where the self-interested, pragmatic, and moral things to do are the same. Unless we get more vaccines to more people globally and equitably, it is not in anyone's interest. It is correct to emphasise that.

My colleague, Dr. Harkin, spoke on the capacity issues. We also know there is capacity because we see the pipeline of vaccines. We see other companies are working on vaccines, both mRNA and other vaccines. Thankfully, there is a great number of them, which indicates capacity.

Given that there has not been voluntary sharing or co-operation, there is a need to share intellectual property. To get that, some countries propose that there would be a waiver or a suspension of intellectual property. The preference would be for companies simply to share but if that is not achieved, there has to be support for mechanisms such as the waiver.

The AIDS HIV crisis is one example of where intellectual property has been relaxed. There was ongoing petitioning from civil society organisations and developing countries for years. Several years were lost while that petitioning was going on because it simply was not being heard. Eventually it led to an announcement and a declaration under the Agreement on Trade-Related Aspects of Intellectual Property Rights, TRIPS, which is the overarching laws on intellectual property, that public health would also have to be prioritised and that intellectual property would have to be used in a way that was compatible. There are certain measures within that framework that allow, for example, for compulsory licences for a certain period of time which would allow a third party to make a drug without the intellectual property holder's permission. That is perfectly legal and provided for within TRIPS under certain circumstances. It was one of the key mechanisms during the HIV AIDS crisis that facilitated access. It was 7 February 2001, so 20 years ago nearly to the day, that Cipla, the Indian generic company, made the announcement, and it was such a striking announcement, that it could produce HIV-AIDS antiretrovirals for less than $1 a day. That was a game changer in this context.

Since then, the Medicines Patent Pool, which is the body that works with C-TAP, has produced generic products for more than 141 countries worldwide. On top of this, some of the statistics from the Medicines Patent Pool suggest that those generic products have facilitated 38.75 million patient years of treatment. Those generic products are being facilitated through the pooling of IP and they work for HIV-AIDS but also hepatitis C, TB and various other diseases. The pooling of intellectual property rights is a system that has worked before. C-TAP in particular is, in our view, a key mechanism. Not only does it share IP, but in the vaccine context it shares know-how and know-how is particularly crucial for producing these vaccines. We call on companies and governments to support this.

On the question regarding whether companies have refused to sign up to C-TAP, I cannot answer that. It is not my knowledge that they have refused. I do not have that information to hand. I would encourage companies to consider supporting this and countries to encourage companies to support these initiatives.

Chairman: I invite Dr. Nabarro to respond to the remaining questions, with particular reference to Senator Joe O'Reilly's question on the Russian vaccine.

Dr. David Nabarro: I will answer as best I can. The WHO has had a number of exchanges with the manufacturers of the Russian vaccine, the Gamaleya company, and it is continuing to seek from the very co-operative Russian manufacturers all the data that are needed for an emergency use authorisation. It is complex. For this process to go through, first one has to look at the vaccine and the results of the phase 1, 2 and 3 trials of the vaccine. Second, under the WHO rules that have been approved and requested by the national Governments of the member states of the WHO, a certificate of good manufacturing practice is requested from the manufacturer. All of these issues are being looked at. In regard to other vaccines that are going through this system, I cannot tell the committee when the effort will be completed. In regard to Gamaleya and Sputnik V, this is a work in progress that is being done with the greatest possible speed while at the same time maintaining the requirements for quality assurance, safety and efficacy.

Senator Joe O'Reilly asked about ensuring access for refugees and other disadvantaged people. It is important to stress that the COVAX scheme has been designed such that it includes capacity to ensure that when vaccines are available they get to disadvantaged and refugee communities. Deputy Berry asked about the situation where patents have been waived, to which I think Dr. McMahon gave a pretty good answer. I do not want to add to it. In 2002, I was working with the director general WHO and the Secretary General of the UN. The key issue is that company CEOs came to us. As a result of an environment which created some pressure, they came to us and I recall that eight of them said they were going to find a way to reduce their prices and to deal with the various concerns raised previously around doing so. The rest is history. What a transformative change.

On the question regarding whether pharma companies have agreed to voluntary licensing in regard to Covid vaccines, the answer is that they have. The agreement between AstraZeneca and Serum Institute of India or between Sanofi and BioNTech are examples of where this is happening. The key question that we all need to ask is what can be done to speed up things and make sure that the right amount of vaccines are available.

That brings me to Deputy Gannon's questions. He asked if wealthy countries were hoarding vaccines. I checked that with people who have the answers when I was getting briefed for today's meeting. It is not that wealthy countries have got a lot of vaccine. In fact, each of the wealthy countries that has a mass vaccination programme under way, including the United Kingdom and countries in the European Union, are short of vaccine. They are worried about supplies because they have made advance purchase commitments, which means they got an option on vaccine with the manufacturers but there is such competition for supplies among governments that have made pledges to vaccinate large proportions of their population as well as those who have made pledges to support COVAX. There is a terrible competition under way and I cannot underestimate the severity of this competition. One just has to look at newspapers in European countries right now to see, for example, the frustration being expressed towards European leaders that there is not more vaccine becoming available. That is creating a competition with COVAX. Quite simply, that is what is happening now. It is because the countries that are committed to vaccinating all their populations for the very good reason that they see this as the best way out of the pandemic are putting such huge pressure on the very limited supply that availability of COVAX is always in question. That is our difficulty.

Deputy Gannon brought up this point by asking if wealthy countries are hoarding. I do not want to use the term "hoarding" but they are certainly putting immense demands on the manu-

facturers in the current vaccine shortage to take vaccines away from COVAX so that they can fulfil pledges they have made to their citizens for widespread vaccination. This situation is very difficult. If a political leader has said his or her people will be vaccinated and after they have done the people most at risk - the health workers - they will go to teachers, then first-line responders like ambulance workers and then essential personnel like security guards, who have a lot of contact with people and we know have a higher incidence, it can be seen that the political pressure in Europe is huge, yet at the same time here are we, with COVAX, saying, as we have heard even in what has been going on here today, that the situation for health workers in poor countries is desperate. Thousands of health workers have died as a result of Covid-19 in the past year. Yes, we want to protect these health workers but there is this terrible conundrum, and I believe everybody sees it. Unfortunately, increasing the licensing and using the Medicines Patent Pool and C-TAP will not deal with the acute problem right now. The problem right now is that there is limited capacity. We are in a shortage situation. It should get better in the coming weeks and months but the competition for this small amount of vaccine right now is huge.

Deputy Gannon's question, and I do not want to answer it exactly as written, was how to get Pfizer to fulfil its responsibilities to COVAX. Pfizer has got responsibilities to a number of different groups which have made advance purchase agreements. It has also got shortages of production because, when vaccines are being produced, things do not work smoothly. Batches go wrong. Whole batches have to be thrown away. Pfizer has licensed the Serum Institute of India, a Korean company. It has also got its own plants in Europe and they are not all able to produce what is needed. Given the demand that is coming, often backed by lawyers from European governments and from the European Union as well as from the UK and, I am sure, from other countries in the world, and it is building up, it is super hard to understand precisely what is going on. One concern is that COVAX works if there is transparency about pricing, delivery dates and to what degree the company is able to say that it did its best but could not deliver. Right now, we do not have full transparency, which makes life difficult.

In response to Deputy Gannon, the lack of transparency makes this difficult. What steps should the Government take to support the matters we are talking about? Everything that has been said in the chamber is right. This requires political action, not just within the nation but also across Europe and through the UN Security Council. There is a core question that comes back to members here, representing the Irish people, which is what the Irish people want. My colleague, Dr. Mike Ryan, who is the greatest Irishman working on infectious diseases, works as head of emergencies at the WHO. He talked to me last weekend as I was preparing and said that it is difficult because politicians believe that it is their job to always fight for the interests of their constituents, which, right now, is for as many people as possible to be vaccinated with a safe, effective and functional vaccine as quickly as possible.

Is there any way that we can get a message to politicians that perhaps the population of Ireland is prepared to look at an alternative proposition, which is for high-risk people in Ireland to be vaccinated now with whatever spare vaccines are available being shared with other countries in the world so that they can vaccinate their high-risk population? Once we have all high-risk populations vaccinated, then we can complete the vaccination of the adult population. This is a political dilemma. I do not know how one gets to know the mood of the population but there surely needs to be a test of what the people of Ireland and other European countries want right now, whether it is fairness for the world or trying to get as much vaccine as possible for people in the country.

Chairman: I thank Dr. Nabarro. While as politicians, the likelihood is that we will seek

to prioritise our constituents, we know, as has been said here this morning and repeatedly over the last weeks and months, that nobody is safe until everybody is safe and that it is not a question of engaging in a type of vaccine nationalism. Unless the EU, US and UN work together to ensure that everybody is lifted and has access to vaccinations, then our constituents will not be safe themselves.

Deputy Sorca Clarke: I thank the witnesses for their time, for their honest words and for putting Covid into a more global perspective than a national perspective. I find it morally reprehensible for any pharmaceutical company to engage in extortion of poorer countries by price gouging. I cannot think of a worse action by any company at a time like this. Dr. Nabarro is correct that people are the solution, but we will only be the solution if we are willing to take on the role of being global champions and ensuring equal and proper access to all vaccines and treatments used to save the lives of those affected by Covid.

There is another issue that has not been touched on. EU member states, like other countries, have contributed billions of euro and dollars to the pharmaceutical companies over past years, through taxpayer funds, research and development funds or other tax breaks. This is not the time for anybody to be getting into a bickering match over intellectual property rights; it is the time to simply step up, stick on the big girl pants and do the right thing.

My questions are quite simple. One concerns C-TAP and COVAX. In the opening statement, 2023 was given as the year when people in some poorer countries will be vaccinated. Is there a tipping point whereby that target could be moved out further or brought closer depending on the level of buy-in to C-TAP? Other contributors have spoken about manufacturers refusing to engage. Have manufacturers been asked to engage? Have potential producers in other countries being directly asked to sign up to and support the programme?

On the companies based in Ireland that could manufacture the vaccine, do we know whether there is a relatively available supply of what they would need to facilitate their doing so? I believe there are half a dozen such companies. What engagement has taken place with them to determine whether they would come on board to engage in manufacturing if the conditions were right?

I understand certain countries have either overbought or over-ordered based on their populations. I stand to be corrected but I believe New Zealand either over-ordered or overbought not for its own population but for neighbouring territories that may not have been best placed to order for themselves. Is this a global trend? Is there more evidence of this solidarity or is New Zealand very much an isolated case? Of the countries that have over-ordered or overbought, how many have made an offer under the COVAX system?

We have touched on conflict zones, refugee movement and the vital job the Red Cross is doing. Regarding occupied territories, who is present to ensure people were most vulnerable are vaccinated?

Senator Gerard P. Craughwell: I thank the witnesses for attending. It strikes me that the appalling mix of the animal instincts of capitalism is meeting up with competitive races. The competitive race is not just that towards vaccination as it concerns individuals themselves. As an individual sitting here, I watch every day to see how close my age group is to the next stage of vaccine roll-out in Ireland. That is human nature. All of us want to be vaccinated. We want all the vaccines to be shared equally, but not just now. It is a case of saying, "I am all for it. As soon as I have been vaccinated, let us get the rest of the world vaccinated." That is a human

response. The animal instincts of capitalism are driven by the ownership of the intellectual property rights. When we talk about declaring something a global public good, we are saying to the shareholders of the drugs companies and manufacturers that we do not want them to have super-normal profits, which is what they normally earn from the development of a drug of one type or another. There are two ways of dealing with that. One is that national governments would tax the shareholders to take the super-normal profits off them in order that the drug could be redistributed globally along the global network, but that is highly unlikely to happen because we are politicians and we ultimately answer to our local constituencies. The other solution, therefore, is that we cough up and pay the super-normal profits to the manufacturers to have a free licence throughout the world to get manufacturing done. I would be interested in the panel's view on that.

We have heard about occupied territories and war-torn areas around the world such as Syria and Yemen. Where a totalitarian government is in place, do the witnesses believe, or is there any evidence to suggest, the denial of access to a vaccine may become another form of human rights abuse?

The other terrible term I heard this morning, which is quite frightening and I believe is happening in the United States, is "vaccine chasing". People are moving from one geographical area to another because the roll-out of the vaccine is faster in the second area. I am quite concerned about that.

I must ask this question today with respect to Covid-19. Part of the argument or solution is vaccination, the other part is in testing. There is a reluctance in Ireland to use antigen testing, which many European countries have taken up and are using to see schools and manufacturing plants open up. What is the panel's view on the antigen roll-out?

The final question goes back to the issue of interpersonal competition for vaccine. My colleague, Deputy Berry, referred to Defence Forces personnel who are going into extremely testing conditions. Under normal circumstances, they are exposed to all sorts of infections, but in this particular instance they are exposed to Covid-19 on top of everything else. I fully support what Deputy Berry is talking about. Yesterday, however, we had a debate in this Chamber on special education. The question arose as to whether those who are on the front line and will have to visit five or six houses a week now qualify as front-line workers. The quite natural instinct is to stretch out the definition in order that we can bring more groups under the term "front-line workers". I would love to hear from the panel as to how we might tie down what in fact constitutes a front-line worker and then work to that definition.

Senator Niall Ó Donnghaile: I have a specific question. Having discussed it with my Seanad colleague, Senator Higgins, I know she would have intended to ask this question if she could were it not for the Covid-19 restrictions. She understands and appreciates that.

Building on Senator O'Reilly's question to our panel, there are public health concerns internationally, specifically around Israel's unequal distribution of vaccines and access to vaccines for Palestinians in the occupied territories. As our panel will know, the Palestinian human rights group, Al-Haq, joined by more than 100 Palestinian human rights and civil society organisations, called Israel's vaccine policy discriminatory and unlawful due to its complete disregard for its obligations toward Palestinian healthcare. I believe one of our earlier contributors spoke to global apartheid with regard to the vaccines. Article 56 of the Fourth Geneva Convention stipulates that the occupier has a duty to ensure the application of necessary preventive measures to combat the spread of diseases and epidemics.

So far, more than 172,000 Palestinians in the occupied territories have tested positive for Covid-19 and there have been more than 1,900 deaths. As other members have said, I note the Government is contributing to COVAX. In keeping with the Chairman's advice, however, I have a specific question. Not least in the context of Ireland's often-cited and often-lauded soft power on the global stage, whether that is in the context the of the EU, UN, the Security Council or our historic and long-standing links with North America, will the panel give us their views on what more could be done specifically by Ireland and this State to support Palestinian equitable access to vaccinations?

Chairman: Before I go back to the panel, I want to ask about the immediate way forward. In the past we have seen, for example, UN-convened and sponsored pledging conferences where money has been raised on the international stage. My understanding is that up to approximately $40 billion will be required to secure in excess of 2 billion vaccines. Is there optimism, for example, or any signs coming from the US where the Biden Administration might wish to see the manifestation of its engagement on the multilateral stage? How soon does this need to happen? Are there signs that it is happening? If there is a pledging conference, how do we ensure that the pledges are ultimately implemented and given?

We may not get a further round. I would like to hear concluding remarks from Dr. Harkin, Dr. McMahon and Dr. Nabarro. Deputy Clarke has indicated. I will let her in with a very quick, specific and brief question.

Deputy Sorca Clarke: Perhaps the panel could update us on the current discussion with the World Trade Organisation regarding the Agreement on Trade-Related Aspects of Intellectual Property Rights, TRIPS, waiver proposal. What stage is that at?

Chairman: Perhaps we could start with Dr. McMahon.

Dr. Aisling McMahon: On the current state of affairs with the TRIPS waiver proposal, this was discussed before Christmas. If my recollection serves me right, it was put forward by countries in October and it has been discussed since then. There were informal discussions again, I think, last week, and as far as I am aware there will be further discussions. In March, there will be more discussions within the formal meeting context on the TRIPS situation, so it is still ongoing.

In response to some of the other questions, the C-TAP initiative is a voluntary system. It does not suspend and instead encourages companies to share their intellectual property rights. They retain those rights. It is also a non-exclusive system so they would still be able to have licensing agreements. That is the key difference between the two. The other difference is that C-TAP encourages the sharing of know-how, which is crucial within the vaccine context. Both of those measures are ongoing and, as we have said, both are ones that we support.

On the first question that Deputy Clarke asked about the figures that we mentioned earlier of nine out of ten people not being able to get vaccines, and some of those figures are for Oxfam and other groups, our hope is that is based on projections around the current vaccine situation. We hope that with agreements like C-TAP or, indeed, if more companies are willing to engage in voluntary licensing, that would either increase the capacity, because we are going to have more and more manufacturers producing these vaccines, or it would build capacity. It would mean new manufacturers coming on board to produce those vaccines. Our hope is that that would then increase the numbers available and bring the figures down, thus making sure we have a more equitable spread because, essentially, the aim is to produce more and have more

manufacturers doing more.

In terms of IP, that currently is tricky. If companies have intellectual property and if they are not sharing the know-how, then other manufacturers cannot come on board because it would be in breach of intellectual property rights, but also they may not have the know-how to do that. They need the know-how and the sharing.

On who else supports or whether any pharmaceutical companies support the C-TAP measure, there is news that 18 generic companies, that is, 18 companies that could produce generic products, have come on board and are supportive of the C-TAP arrangement. As I have said, I am not aware of the current picture and to what extent they are coming on board, although I am sure they are, and there are negotiations between the WHO and the pharmaceutical companies that have some of the rights at the moment. Certainly, generic companies are coming on board, and the latest figure is that there are 18 companies that are generic producers and that are willing to do that.

In terms of Senator Craughwell's questions, one was very important as it mentioned the idea of human rights. This is something we have touched on briefly. It has to be said and must be emphasised, however, that there is a human right to life and there is also a human right to health protected both under the Universal Declaration of Human Rights and under international agreements such as the International Covenant on Economic, Social and Cultural Rights. All countries that are party to those would have obligations to protect and promote human rights, and not just a legal obligation, although clearly there is one, but also a moral obligation in terms of these issues.

I know, given the time, we may not get the opportunity to say more on the following, so we would like to thank the committee again today, but one of the things that I would ask for is that there would be consideration given to or discussion of formal endorsement of C-TAP. It is very important. Others have mentioned Ireland's place on the international stage. It is not enough just to support C-TAP. We certainly support that and hope that the Government would do that, but also, if possible and ideally, the Government should be advocating for C-TAP and other mechanisms at an international level, particularly at the EU level but also, given its role internationally in terms of the UN Security Council, being an advocate and being a part of that. The other thing is to encourage other pharmaceutical companies to join. Some companies, it must be said, have already engaged in and entered into voluntary licensing deals and I know this has been mentioned. These include Pfizer and BioNTech with Sanofi, AstraZeneca with the Serum Institute of India. More of that needs to happen and C-TAP, if they supported it, could facilitate that at a larger scale. The idea of whether a Dáil motion might be something that would be possible was also mentioned earlier. We would particularly welcome a Dáil motion or Seanad motion tabling these types of issues if it was something Members were willing to consider, particularly an endorsement of the C-TAP initiative, but also the other initiatives such as the waiver or other proposals to facilitate equitable global access.

Chairman: I thank Dr. McMahon. Dr. Harkin may wish to make a brief comment.

Dr. Kieran Harkin: I have nothing to add to that except to sincerely thank the Chairman for having us today and giving us an opportunity to present our case.

Chairman: I thank Dr. Harkin. I leave the final word to Dr. Nabarro.

Dr. David Nabarro: First, Deputy Clarke asked when the tipping point is, given the predic-

tion that poorer countries will only be immunised in 2023. Speaking as a public health professional, as well as an envoy for the WHO, the tipping point is now. There is no time down the road. We are watching extraordinary and dramatic damage occurring to the fabric of human society everywhere as a result of Covid. It is very active now; there are a lot of issues all over the world, including deepening inequities and real frustration and anxiety on the part of millions of people. Now is the time when the leaders in the rich world must take the initiative and must focus on equity. All that has been said by Dr. McMahon, Dr. Harkin and Ms Byanyima is so right. I say do not wait.

The second point is how many countries are doing what New Zealand has done in terms of actually taking advantage of their skills in dealing with Covid and postponing an option they have got on a vaccine? I have not heard of any others and it is time we had a vaccine solidarity challenge where heads of government, through their legislators, are invited to indicate what are the circumstances under which they will be ready to share. Of course, they will all say they are worried about variants but the whole world is worried about variants. Variants can affect poor countries just as badly as they can affect rich ones. The key thing is to protect those who are most at risk. The responsibilities of occupiers, as was brought out by Deputy Clarke, and the responsibilities of governments are well set out. Dr. McMahon is much better qualified than me to talk about it but again, as a public health professional, I am really concerned when groups of people inside a national border are denied, for some reason or other, an opportunity to access a vaccine and I am sure that those who have occupational responsibilities will do everything possible to be transparent about how they are dealing with it.

Senator Craughwell raised many points and I got five of them down. I feel I have the responsibility to deal with the third question, on vaccine sharing. I stress that one of the things we all must work on at the moment is vaccine hesitancy. There are people who are not quite sure about whether they want to take the vaccine. It is really important that in all societies they are given a second, third or fourth chance if they are uncertain when first asked. Thus I am kind of advocating for a really tolerant approach and for offering people, as I said, a chance to think about things and not requiring them to make a decision now on the basis that otherwise they will not get a chance. On testing, I stress that while there are concerns about the reliability and positive predictive value of some of the antigen tests available, the committee should watch this space. I believe that more reliable rapid tests will come on stream. That will make such a difference. We do not talk so much about testing. I believe that access to rapid and reliable tests is absolutely key to an equitable response.

On the question of the definition of "front-line personnel", countries could really take advantage of the opportunities they have in the international system through the UN to debate these things.

The Chairman said something that is very important about the money that is needed. The Chairman asked where the impetus will come from for a real initiative in this regard. There have been calls for a vaccine summit involving the new US Administration and perhaps involving the G7. It is very important that we go beyond just saying there needs to be a summit. World leaders have got to come together in a constant format to deal with this crisis as a global crisis now. It cannot be dealt with by individual national leaders working on their own, which is bound to cause terrible problems. The kinds of issues we are discussing today need solidarity in the responses. The WHO and the UN Secretary-General are constantly asking for greater and more joined-up leadership by leaders. I propose not just a summit but a global Covid response programme that deals with all of the issues such as access to tests, access to treatment, access to

vaccines, travel issues, the problems of obligations of occupiers and all the other problems we are talking about. This needs ongoing attention now because we do not know what a failure to deal with Covid in a joined-up way worldwide will lead to. We do know that 2020 was a year like no other. Who knows what will happen in 2021 and 2022 if we do not deal with this as the global emergency that it is?

Chairman: I thank Dr. Nabarro. On behalf of the committee I thank our panellists for meeting with the committee this morning. It was a very interesting meeting. The committee will meet in private session next week. We will gather the information we have and then the committee will take steps as appropriate.

I thank Ms Byanyima and Dr. Nabarro for joining us this afternoon from Geneva. The committee and I offer them our continued best wishes and success in their roles in ensuring the international community plays its part for those most in need of assistance in battling this pandemic and with regard to vaccine distribution. It is clear from our engagement that we will return to this issue as the weeks go by. We will keep an agenda meeting open for such over the next months.

I thank Dr. Kieran Harkin and Dr. Aisling McMahon for their attendance today. I ask them to keep in contact with the committee.

In thanking members for their engagement, I also thank the logistics personnel and members of the broadcasting unit. It was quite a feat to be here in the Dáil Chamber and to have people contributing remotely from within the precincts of Leinster House to have a most successful engagement with our panellists and witnesses from Ireland and from Geneva.

We will adjourn until the private meeting at 11.30 a.m. on Thursday, 18 February. If any issues of an urgent nature arise in the meantime, my door is open.

The joint committee adjourned at 12.05 p.m. *sine die*..