FEMINISTS FOR A PEOPLE'S VACCINE

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Serious Concerns Over Norway's Position in WHO Negotiations on the Pathogen Access and Benefit Sharing (PABS) System

19 March 2026

Esteemed Prime Minister Støre,

We, the undersigned civil society organisations from around the world, are writing to express serious concerns regarding Norway's current positions in the ongoing World Health Organization (WHO) negotiations on the Annex to the Pandemic Agreement concerning the Pathogen Access and Benefit-Sharing (PABS) System.

Norway has long portrayed itself as a champion of equity, multilateralism, and responsible global governance. As a party to the Convention on Biological Diversity (CBD) and its Nagoya Protocol on Access and Benefit-Sharing (ABS), it has also been a strong supporter of the access and benefit-sharing principles enshrined in those instruments.

Against this backdrop, Norway's positions in the PABS negotiations are difficult to reconcile with its longstanding commitments. Norway is opposed to proposals aimed at strengthening transparency, accountability, legal certainty, and alignment with international law. These proposals are central to ensuring that the sharing of pathogen materials and sequence information results in fair and equitable benefit-sharing.

As a result, Norway's stance is increasingly inconsistent with its reputation as a defender of equity and fairness in global health governance. In fact, Norway is blatantly backtracking on elements agreed in Article 12 of the

Pandemic Agreement concerning the development of the PABS system and is deliberately undermining the Pandemic Agreement objective of preparing for and responding to a pandemic, guided by equity.

First and foremost, Norway opposes operationalising access and benefit-sharing through standard contractual arrangements with every recipient of PABS biological materials and sequence information. It also resists requiring recipients to agree to ABS conditions prior to gaining access.

This position runs counter to well-established global ABS principles, which recognise that access to biological resources — over which States exercise sovereign rights — must be subject to mutually agreed terms. Both the CBD and its Nagoya Protocol, as well as widespread national and international practice makes clear that a functioning ABS system is grounded in contractual agreements concluded before access is granted.

There is over 15 years of positive experience within WHO using standard contracts under the Pandemic Influenza Preparedness (PIP) Framework for sharing influenza viruses with pandemic potential. These agreements have demonstrated that contractual arrangements can facilitate rapid access to pathogens while ensuring clear benefit-sharing commitments. Similar practices are common domestically in Norway as well, where biological materials are routinely transferred under standard contracts concluded before access is granted.[1]

Against this background, Norway's position that access should be granted without predefined obligations is difficult to justify. Such an approach risks enabling free riders and undermining fair and equitable benefit-sharing — the core objectives of the CBD and the Nagoya Protocol while weakening due diligence and accountability in the use of shared resources.

Second, it is outrageous that Norway is promoting databases that permit anonymous, unaccountable, illegal access to pathogen sequence information under a flawed, selective, interpretation of "open access."

This position obligates States to share genetic data publicly, yet does not obligate users to share benefits fairly and equitably arising from the use of such data. Further, if access is anonymous how can users be identified and required to contractually commit to fair and equitable benefit sharing.

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[1] E.g. https://www.nhm.uio.no/english/collections/dna-bank/mta/nhmo-dna-bank-mta1-provision-of-material-170112.pdf

Norway's position is in direct contradiction with the CBD Decision that recognizes the right of countries to fair and equitable benefit-sharing arising from the use of digital sequence information on genetic resources.

Norway's position is also hypocritical. While opposing developing country proposals that would require sequence data of pathogens to be deposited in databases implementing user registration and data access agreements, Norwegian researchers routinely deposit pathogen sequences exclusively in GISAID—a platform that requires user registration, acceptance of a data access agreement, and prohibits onward sharing to users who have not accepted the same terms. As at 31 October 2025, Norway had submitted at least 81,000 SARS-CoV-2 sequences exclusively to GISAID, and yet Norway shamelessly opposes adopting similar safeguards within the PABS system. It has even resisted proposals to establish a multilaterally governed sequence database under the auspices of the WHO.

It therefore appears that Norway is promoting the continued reliance on databases that lack transparency and accountability, allowing users of sequence information to access and use such data without traceability or enforceable benefit-sharing obligations. And to advance its flawed position Norway is circulating misleading information on the issue with the intent to confuse other delegations and complicate an already sensitive negotiation process.

Norway's approach risks facilitating digital biopiracy and undermining the principles of fair and equitable benefit-sharing recognised in international law. There are also significant biosecurity risks attached to Norway's position as highlighted in a letter signed by scientists and scientific organizations such as the European Network of Scientists for Social and Environmental Responsibility, the Federation of German Scientists, and Testbiotech, alongside civil society groups to Member States on 10 February 2026[2].

Third, Norway's persistent opposition to benefit-sharing proposals from developing countries is deeply troubling. It has resisted proposals to reserve a share of vaccines, therapeutics and diagnostics (VTDs) for the WHO to deploy during early outbreaks and during a Public Health Emergency of International Concern (PHEIC).

Without such arrangements, vulnerable developing countries risk being left without timely access to essential medical tools before a pandemic is declared. Past outbreaks — including COVID-19, mpox, and Ebola — have shown that wealthy countries often secure supplies early through advance purchase agreements or premium pricing, leaving developing countries behind.

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2 https://itforchange.net/sites/default/files/add/SCIENTISTS%20LETTER%20ABOUT%20BIOSECURITY%20ISSUES%20IN%20PABS.pdf

Developing country proposals aim to correct this imbalance by ensuring that WHO's needs, and those of the most at-risk countries, are addressed from the outset at the same time as Norway's needs. Yet Norway has opposed reserving supplies for WHO and has also resisted measures to rapidly expand supplies during health emergencies through licensing to more manufacturers in the global south.

Finally, Norway's position is ultimately against its own interests. By opposing measures that guarantee compliance with the PABS system and fair and equitable benefit sharing that is meaningful from each user of the system, pathogens with pandemic potential will spread unchecked, putting Norwegians themselves at greater risk. Without safeguards being applied to the sharing of sequence information of dangerous pathogens, in the current era of artificial intelligence, Norwegians will face increased biosecurity risks.

Its international reputation is also on the line: once seen as a global champion of fairness, equity, and respect for international law, Norway now risks being perceived as a backtracker, enabler of biopiracy, undermining its credibility as a reliable partner for developing countries and global public health.

We therefore respectfully urge you to instruct Norway's delegation to:

- Ensure legal certainty: This requires all recipients of materials and sequence information of pathogens with pandemic potential to be identified and sign standardised contracts with WHO prior to access, ensuring compliance with PABS requirements. This will minimise biosecurity risks and operationalise ABS under the CBD and Nagoya Protocol.
- Ensure accountable databases: Only sequence databases that require mandatory user registration and verification, and PABS agreed data access agreement should host PABS sequence information.
- Support a WHO-governed database: Develop a multilaterally governed WHO database that ensures non-discriminatory access, accountability, transparency, and effective benefit-sharing, ensuring compliance with the PABS system.
- Robust governance: Establish mechanisms to monitor sharing and use of PABS materials and sequence information.
- Enforceable benefit-sharing: Require every recipient to provide meaningful, enforceable benefit-sharing, including binding commitments for VTD developers and manufacturers to reserve portions of real-time production and stockpiles for WHO-coordinated distribution during early outbreaks and PHEIC, and to issue production licenses to manufacturers in the Global South to rapidly expand supplies during health emergencies.

- Equitable access over monopolies: Move away from intellectual property-based monopolies that restrict access, and promote models supporting equitable access, such as mandatory licensing.

Signed,

Global organizations

1. AIDS Healthcare Foundation - AHF
2. Association For Promotion of Sustainable Development
3. Brot für die Welt
4. Development Alternatives With Women for a New Era - DAWN
5. Disability People's Forum Uganda
6. Flux
7. Geneva Global Health Hub - G2H2
8. Health Action International - HAI
9. International Treatment Preparedness Coalition - ITPC Global
10. Madhira Institute
11. Masimanyane Women's Rights International
12. Medical Impact
13. Medicus Mundi International - Network Health for All (MMI)
14. Oxfam
15. Policies for Equitable Access to Health - PEAH
16. People's Health Movement
17. Public Services International (PSI)
18. Social Watch
19. Society for International Development
20. Third World Network
21. Wemos

Regional organizations

22. Acción Internacional para la Salud Perú
23. Afya na Haki
24. AIDS Action Europe - AAE
25. AIDS and Rights Alliance for Southern Africa
26. European Federation of Public Service Unions - EPSU
27. Global Humanitarian Progress
28. Health Action International Asia Pacific - HAIAP
29. Jesuits Development Office

30. Medicinas para la Gente Latinoamérica - PMA LAC
31. Pharmaceutical Accountability Foundation - PAF
32. Project on Organization, Development, Education and Research - PODER
33. Red Latinoamericana por el Acceso a Medicamentos - RedLAM
34. Salud y Fármacos
35. Southern Africa Miners Association - SAMA

National organization

36. Access to Medicines Research Group, China
37. Action Against AIDS, Germany
38. Asociación Programa de Soporte a la Autoayuda de Personas Seropositivas - PROSA, Peru
39. Association Burkinabé d'Action communautaire - ABAC, Burkina Faso
40. Brazilian Interdisciplinary AIDS Association - ABIA, Brazil
41. Cancer Alliance, South Africa
42. Cellule Associative des Femmes Actives pour la Gouvernance, les Droits Humains et le Bien-Être - CAFAGB, Cameroun
43. Centre for Community Water Resources Management - CCWRSAN, Malawi
44. Centre for Governance Accountability and Leadership, Zambia
45. Centre for Health Science and Law, Canada
46. CER Consulting Services, Colombia
47. Chartered Institute of Forensics and Certified Fraud Investigators, Nigeria
48. Coalition for Health Promotion and Social Development - HEPS, Uganda
49. Comité de Derechos Humanos Pasco CODEH-PASCO, Peru
50. Consumers' Association of Penang (CAP), Malaysia
51. Egyptian Initiative for Personal Rights (EIPR), Egypt
52. Federación Sindical de Profesionales de la Salud - FESPROSA, Argentina
53. Fundación de Estudios e Investigación de la Mujer - FEIM, Argentina
54. Forum for Protection of Public Interest (Pro Public), Nepal
55. Friends of the Earth, Malaysia
56. Fundación Grupo Efecto Positivo, Argentina
57. Fundación IFARMA, Colombia
58. Gabungan Darurat Iklim Malaysia Berhad, Malaysia
59. Health Justice Initiative (HJI) South Africa South Africa
60. Hope for Future Generations, Ghana
61. Human Rights Research Documentation Center - HURIC, Uganda
62. iCHANGE, Côte d'Ivoire
63. IDEALS, Inc. - Lawyering for Development, Philippines
64. Indonesia for Global Justice - IGJ, Indonesia

65. Initiative for Social and Economic Rights - ISER, Uganda
66. Innovations for Development, Uganda
67. Just Treatment, UK
68. Kenya Female Advisory Organization, Kenya
69. Kenya Legal & Ethical Issues Network on HIV and AIDS - KELIN, Kenya
70. Khulumani Support Group, South Africa
71. Land of Free Boys and Girls, Peru
72. Malaysian Food Sovereignty Forum - FKMM, Malaysia
73. Malaysian Women's Action for Tobacco Control and Health - MyWATCH, Malaysia
74. Medicus Mundi, Spain
75. Misión Salud , Colombia
76. National Network of People Living with HIV and AIDS Pernambuco - RNP+, Brazil
77. Nexus Research Cooperative , Ireland
78. Parti Sosialis, Malaysia
79. People's Health Movement, Kenya
80. People's Health Movement, South Africa
81. People's Health Movement, Tanzania
82. Prayas Center for Health Equity, India
83. Promoting Group for Monitoring the Supply of Antiretroviral Medicines - GIVAR, Peru
84. Pink Triangle Foundation, Malaysia
85. Shine Africa Teso - Saf-TESO, Uganda
86. Salud por Derecho, Spain
87. Sandvik Health Empowerment Foundation , Nigeria
88. SENTRO Labor Union, Philippines
89. Sí, da Vida, Peru
90. Soul Palliative Care, India
91. Swaziland Migrant Mineworkers Association - SWAMMIWA, Eswatini
92. The Humsafar Trust, India
93. The People's Matrix, Lesotho
94. Trade Justice Pilipinas, Philippines
95. Uganda National health Users/Consumers' Organization - UNHCO, Uganda
96. VIHve Libre, Mexico
97. Women and Media Collective, Sri Lanka
98. Women Law and Development, (MULEIDE), Mozambique
99. Working Group on Intellectual Property - GTPI, Brazil
100. WomanHealth, Philippines