Tidsskriftet Tidsskrift for Den norske legeforening

Protecting the vulnerable is protecting ourselves: Norway and the Coalition for Epidemic Preparedness Innovation

GLOBAL HELSE

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Norway has played a critical role in the recent launch of the new Coalition for Epidemic Preparedness Innovation, revealing Norway's powerful position in global health. But how will Norway help put the coalition's governance principles – political legitimacy, representation and accountability – into practice? And how will a more security-based approach impact Norwegian global health policy and research?

On January 19, 2017, a new Coalition for Epidemic Preparedness Innovation entered the global health architecture. Launched at the World Economic Forum by Norwegian Prime Minister Erna Solberg and Bill Gates, the coalition aims to finance the development of vaccines against emerging infectious diseases. In the coalition's own words, its objective is nothing short of "outsmarting epidemics" and giving the world "an insurance against epidemics" (1).

The coalition is designed as a public-private partnership with representation from governments, philanthropies, non-governmental organisations, pharmaceutical companies, research institutes, regulatory bodies and multilateral organisations (box 1). Although branded as a global initiative, it is very much "made in Norway," with its creation highlighting Norway's financial and agenda-setting power as a major global health actor.

Box 1: Who supports the CEPI (10)?

- **The founding partners:** Norway, India, the Wellcome Trust, the Bill and Melinda Gates Foundation, the World Economic Forum
- **The investors:** Norway, Japan, Germany, the European Commission, India, the Bill and Melinda Gates Foundation, and the Wellcome Trust
- **The interim board members (with voting rights):** United Kingdom, Australia, the United States, Norway, the European Union, India, South Africa, Liberia, Ethiopia, the Wellcome Trust, the Bill and Melinda Gates Foundation, Merck, GSK, the Serum Institute, Pax Vax, Médecins sans Frontières, and three "independents" connected to the World Economic Forum, the US National Academy of Medicine, and the London School of Hygiene and Tropical Medicine.
- **CEPI's coalition partners, advising the board:** donors (including Norway), research institutes, pharmaceutical companies, regulatory and normative bodies (among others, the World Health Organization and the US Academy of Medicine), procurement and distribution partners (for instance, Gavi, the Vaccine Alliance) and non-governmental organisations (including those that are part of the No More Epidemic Campaign, such as Save the Children and International Medical Corps).

A Norwegian diplomatic success

The idea to establish a new coalition to develop vaccines against emerging diseases can be traced back to the Ebola crisis of 2013–2015. The Norwegian Institute of Public Health then cooperated with the World Health Organization (WHO) on a collaborative vaccination trial in Guinea, which found the vaccine to be 100% effective (2). Following the Ebola crisis, many reports and panels called for global action to prevent similar epidemics, including setting up mechanisms to ensure the development of vaccines against emerging diseases (3)-(5). Based on their experience during the Ebola crisis, the Norwegian Ministry of Foreign Affairs and the Norwegian Institute of Public Health took

the initiative to convene a working group in Oslo in April 2016 to address this issue (6). Shortly afterwards, the Coalition for Epidemic Preparedness Innovation was created as an international non-profit association under Norwegian law.

The coalition's organisation reflects Norway's decisive influence (box 2). It is a diplomatic success for the Norwegian government, which, since the mid-2000s, has continued to make global health one of its foreign policy priorities (7). At the same time, the coalition is indicative of a shift in emphasis during the past fifteen years away from Norway's historically strong commitment to addressing health through the multilateral UN system in favor of new-public-private partnerships for health (8). Much of the increase in Norwegian funding to global health during this period has been support to public-private partnerships, including Gavi, the Vaccine Alliance, and the Global Fund to fight AIDS, TB and malaria, often in partnership with new philanthropic foundations, notably the Bill and Melinda Gates Foundation. Tore Godal, a leading Norwegian health diplomat, has even been described as the "founding father" (9) of Gavi, whose innovative institutional and financing models certainly influenced the creation of the Coalition for Epidemic Preparedness Innovation. The coalition is thus an expression of not only Norway's financial power, but also its recognised expertise and moral authority, deriving from its long involvement in the field.

Box 2: Norwegian influence in the CEPI (10)

- **Interim CEO (until April 2017):** John Arne Røttingen, current Director of the Research Council and former Director of the Division for Infectious Disease Control at the Institute of Public Health
- **Interim Secretariat**: hosted at the Norwegian Institute of Public Health, Oslo
- **Board**: Norway holds one of the five seats allocated to high income countries
- **Financial contribution**: NOK 1 billion, second largest after Japan

Power dynamics and governance principles

From the outset, the coalition has been explicit about defining its core governance principles (10), espousing commitment to "political legitimacy" and "public interest representation", "accountability", "independence and neutrality", and "transparency". As the coalition is operationalised and develops, it will be important to clarify and monitor what these principles mean, and how Norway will make use of its power to put them into practice. Already, some important questions are evident.

Political legitimacy and public interest representation

The coalition claims to strive for “political legitimacy”, but what does this mean, and from where does its claims to legitimacy derive? Are its founders appealing to normative democratic criteria such as representativeness, in the sense of “democratic legitimacy” (11)? Or do they assume a less normative definition of legitimacy that assesses audiences’ views about which values they believe give an institution legitimacy? The initiative’s formation has been justified with reference to a global consensus following the Ebola crisis on the need for new mechanisms to develop vaccines against emerging diseases. But who shaped this consensus in the first place? Does this global interest reflect only the interests of donor countries or those of the low-income countries who were affected by the Ebola epidemic as well? It is striking that two of the most influential commissions drawing lessons from Ebola were funded by high-income countries and rich foundations and hosted by European and American institutions, such as the London School of Hygiene and Tropical Medicine, the Harvard Global Health Institute and the US National Academy of Medicine (4, 5). Experts from donor countries clearly played a major role in drafting these commissions’ recommendations (12), but the role of their low-income country counterparts is less clear.

The participation of a wide range of actors on the coalition’s board could be another source of legitimacy. However, among the board’s 19 seats, five are reserved for high income countries, four for low- and middle-income countries, two for philanthropic organisations, four for private companies, three for “independents” (individuals invited to sit on the board because of their personal merits, not their institutional attachments) and only one seat for civil society (fig 1). This low level of representation for low- and middle-income country governments and civil society raises doubt about public interest representation. In theory, multilateral organisations such as the World Health Organization could represent the public interest, but the World Health Organization has only observer status on the board and thus has no formal power within the new coalition.

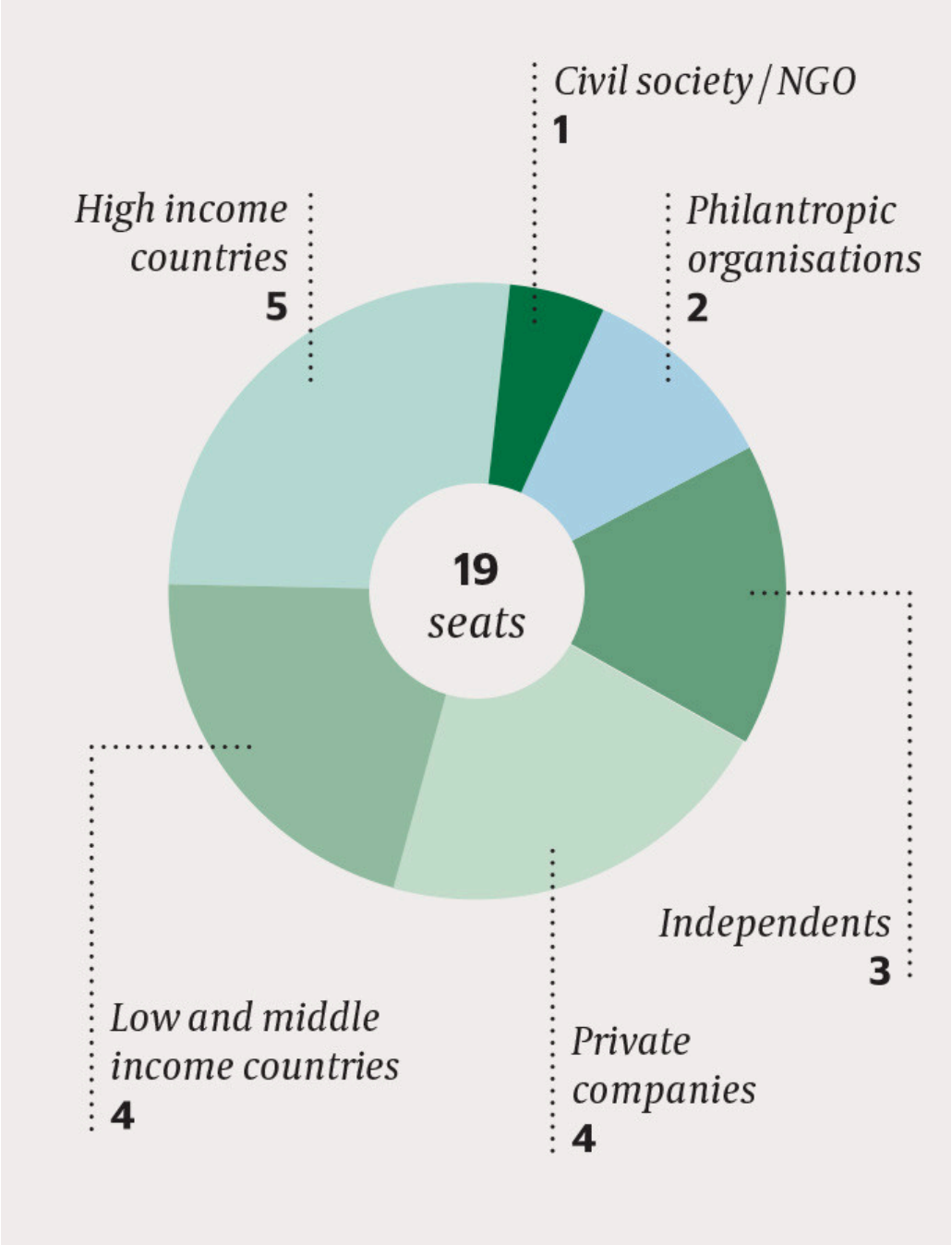

Figure 1 Composition of CEPI's interim board

Accountability

In its governance principles, the coalition espouses the value of accountability, though without defining what this means. To whom is it accountable? *To its donors* – high-income countries, India and philanthropic organisations? The donors do hold a substantial share of the votes on the board, and they even have a clear majority with the independents, representing the London School of Hygiene and Tropical Medicine, the US National Academy of Medicine and the World Economic Forum – three institutions located in high income countries likely to hold policy views on global health security similar to those of the donors. Or is the coalition accountable to *its intended beneficiaries*, the vulnerable populations located in low-income countries? The beneficiaries have

a very limited number of seats on the board, although their interest is seen as specifically important in the coalition's preliminary business plan with the intended development of a policy for questions related to vaccines' affordability and availability (10). Or is it accountable to *its partners*, the pharmaceutical companies receiving support to develop vaccines? These companies are guaranteed coverage of all the direct and indirect costs involved in the vaccine development process and have secured almost a quarter of the seats on the board. The partners may also benefit from the support of their home countries, many of which are represented on the board (the United States, the United Kingdom and India). The industry is thus, as is often the case in public-private partnerships (13), in a position of power with a win-win outcome for its involvement: its costs are covered (companies might even profit financially from the cooperation), and in case of success, businesses can use their involvement for public relations purposes.

"Independence and neutrality"

Behind the concepts of independence and neutrality can be read a normative understanding of global health policies, strongly advocated by the Gates Foundation and increasingly adopted by Norway (8, 14). The coalition's claims of independence and neutrality are indeed symptomatic of a technical, vertical approach to global health issues. Within this approach, vaccines – delivered through top-down programs designed to be applicable everywhere – have been cast as the ultimate cost-effective global health panacea. At the same time, the weak health systems and surveillance mechanisms that would help diagnose, treat and isolate patients before the epidemic gets too large have been relatively neglected (4, 12). The aim seems to be having a technological tool ready for the next crisis, no matter how bad the situation becomes before an epidemic strike.

"Public trust", "transparency" and "no conflicts of interest"

The coalition plans to elaborate policies to promote transparency and prevent conflicts of interest. Such policies are indispensable to ensure public trust, and we encourage the coalition to be very strict when developing and applying them. A future assessment of these policies will give insight into the Norwegian interim administration's capacity to promote these norms within the organisation.

The Securitisation of the Norwegian Global Health Policy

The Norwegian contribution to the Coalition for Epidemic Preparedness Innovation has been framed by Prime Minister Erna Solberg as a contribution to the Sustainable Development Goals, the United Nations's 2030 development agenda (1).

Traditionally, Norway has approached development from a humanitarian perspective – its aim being to help others. However, these goals paved the way for a new conception of development, more centered on win-win projects, as every country (including the wealthiest ones) is due to report its policies to meet the goals and targets. The coalition is clearly framed as one of these win-win projects. Solberg has justified it by declaring that "*protecting the vulnerable is protecting ourselves*" (1).

The coalition, meanwhile, frames its contribution as providing *the world* an insurance against emerging infectious disease outbreaks. Norwegian support for the initiative is thus motivated by multiple concerns: showing solidarity with the most vulnerable, ensuring national security and securing diplomatic gains.

Norway has used global health as a foreign policy tool for a long time, as a way to gain status and diplomatic recognition and to secure a seat at the table (15). It is, however, a relatively new development to include national security considerations in global health – a tendency that extends to other fields of development, as demonstrated, for instance, by the aid provided to Afghanistan. An assessment of the ongoing development of the coalition's governance principles and underlying promise to promote affordable and available vaccines for everyone will indicate if a balance has been found between these different, and potentially competing, objectives.

Finally, the blurring between security and solidarity in initiatives such as the Coalition for Epidemic Preparedness Innovation raises ethical questions about their financing: will they be financed solely with the aid budget? If so, this would signal a securitisation in Norway's humanitarian policy, meaning that security concerns would be integrated in projects framed as altruistic and humanitarian, potentially trumping the ambition to help the most vulnerable.

We would like to thank Sidsel Roalkvam, Ekaterina Bogatyreva, Sonja Kittelsen, Ann-Louise Lie, Maren Kloster and Hanneke Pot from the Global Health Politics and Culture research group at the Centre of Development and the Environment, University of Oslo, for their very valuable insights and feedback.

This article is part of the series 'Global Health in the Era of Agenda 2030', a collaboration between Norad, the Centre for Global Health at the University of Oslo and The Journal of the Norwegian medical association. Articles are published in English only.

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Publisert: 26 June 2017. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.17.0208
Received 28.2.2017, first revision submitted 29.3.2017, accepted 24.4.2017.