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SYMPOSIUM ON GLOBAL HEALTH AT A CROSSROADS PART II

GLOBAL HEALTH LAW: PANDEMIC RESILIENCE THROUGH A RULES-BASED INTERNATIONAL HEALTH COOPERATION?

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Global health law seeks to empower individuals and communities; however, the field largely operates according to a charity-based approach. The COVID-19 pandemic and the announced withdrawal of the United States from the WHO highlighted existing tensions, amplifying skepticism toward international health cooperation. This essay analyzes opportunities for global health law to transition to a self-reliance model by examining the revised International Health Regulations and the new Pandemic Agreement. The essay considers whether and how these amended and new instruments could advance a rights-based, resilience model of international health cooperation.

Introduction

The COVID-19 pandemic exposed critical weaknesses in international health cooperation and governance through vaccine nationalism,[1] disproportionate travel bans,[2] and limited collaboration in investigating SARS-CoV-2's origin.[3] In response, the World Health Organization (WHO) has undertaken two major legal reforms: the 2024 amendments to the International Health Regulations (IHR) of 2005,[4] which entered into force for most state parties in September 2025, and the Pandemic Agreement,[5] the main text of which was adopted in May 2025, pending negotiation of the Annex. The Pandemic Agreement is only the second treaty adopted under WHO Constitution Article 19 in seventy-six years, marking an unprecedented moment for global health governance by embedding equity and solidarity principles into binding international health law.[6] This essay examines how these twin legal reforms may signal a new era of international health cooperation. It analyzes whether these reforms could improve the rules-based global health security framework by building resilience through empowerment—strengthening countries' legal, regulatory, and research capabilities to respond to health emergencies, and sharing technical know-how.

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[1] Caroline E. Wagner et al., *Vaccine Nationalism and the Dynamics and Control of SARS-CoV-2*, 373 SCIENCE eabj7364 (2021).

[2] Roojin Habibi et al., *Do Not Violate the International Health Regulations During the COVID-19 Outbreak*, 395 THE LANCET P664 (2020).

[3] Helen Davidson, *China Refuses Further Inquiry into Covid-19 Origins in Wuhan Lab*, THE GUARDIAN (July 22, 2021).

[4] World Health Organization, International Health Regulations (2005), A/77/A/CONF./14 (June 1, 2024).

[5] Resolution WHA78.1. Agenda Item 16.2. WHO Pandemic Agreement (May 20, 2025).

[6] *Id.*

International Health Cooperation: Between Charity and Security

The United Nations (UN) system is founded upon international cooperation through global governance. Within this framework, international health cooperation can be distinguished into two models: charity and global health security. The charity model positions wealthy nations as benevolent providers of assistance to low- and middle-income countries, reinforcing unequal power dynamics by allowing donor countries to unilaterally determine priorities and implementation approaches. This approach creates problematic dependencies,[7] fragmented health interventions,[8] and lacks financial and political sustainability once donor attention shifts.[9] In comparison, the global health security model frames infectious diseases as threats to national and international security.[10] While it successfully mobilizes resources and political will, this approach primarily serves wealthy nations' interests by focusing on containment and surveillance instead of addressing structural inequities that create disease vulnerability. The model overlooks the interconnected social, economic, and environmental determinants of health that require holistic, equitable solutions rather than merely securitized responses. Despite different framings and objectives, both models share a critical flaw: they lack mechanisms to empower aid recipient countries. Both models operate within power structures that either prioritize donor interests or high-income nations' security concerns over recipient country autonomy, agency, and leadership. Moreover, states tend to be inconsistent in their commitments to international cooperation.[11] Instead, states primarily prioritize strategic interests over collective health goals, selectively complying with or withdrawing from international obligations when cooperation conflicts with national interests, undermining predictability and reliability in global health governance. International cooperation also faces structural obstacles due to opposing sovereignty concerns, financing gaps, domestic political constraints, competing priorities, and resource limitations.

Notwithstanding the prevailing models of charity and security, international human rights law is clear about the obligation to cooperate in international health. For instance, Articles 2(1) and 22–23 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) obligate all state parties[12]—particularly those with economic and technical capacity—to take steps toward fully realizing the rights enshrined in the ICESCR. This can be done individually or through international assistance and cooperation, including treaties, recommendations, and technical assistance. The Committee responsible for interpreting the ICESCR has stated that states have an obligation, subject to available resources, to "facilitate access to essential health facilities, goods and services in other countries, wherever possible, and [to] provide the necessary aid when required."[13] The ICESCR thus provides an additional legal basis for countries to cooperate in regional and health system strengthening and diversification of pandemic-related goods.

[7] Olusoji O. Adeyi, *Misguided Charity: The Bane of Global Health*, 8 BMJ GLOB. HEALTH e013322 (2023).

[8] Neil Spicer et al., *"It's Far Too Complicated": Why Fragmentation Persists in Global Health*, 16 GLOB. HEALTH 60 (2020).

[9] Adeyi, *supra* note 7.

[10] David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325 (2005).

[11] Nina Schwalbe, Susanna Lehtimaki & Elliot Hannon, *The Pandemic Treaty: A Forensic Review of Process and Pitfalls*, 20 GLOB. PUB. HEALTH 2522916 (2025).

[12] Comm. on Econ., Soc. and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the International Covenant on Economic, Social and Cultural Rights), para. 11, UN Doc. E/1991/23 (Dec. 14, 1990).

[13] *Id.*

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Notably, the UN Charter prioritizes cooperation during global health crises such as COVID-19.[14] Other areas of international law have underspecified the duty to cooperate internationally.[15] This ambiguity similarly appears in global health law instruments adopted under the WHO, leaving the IHR (2005) equally vague. Yet global health commits to addressing social determinants of health—the external conditions that influence and affect health and quality-of-life outcomes—through the law.[16]

Structural Limitations of the World Health Organization and the IHR (2005)

WHO's legal instruments have significant limitations in facilitating international cooperation. The organization's historical reluctance to exercise its normative authority and its preferred top-down approach raise questions of coordination.[17] Moreover, WHO's legal approach to international infectious disease control has typically been reactive rather than proactive in global health crises such as SARS and HIV-AIDS. Amendments to the IHR (2005) have primarily been driven by responses to previous pandemic events. While WHO is constitutionally mandated to act as the directing and coordinating authority,[18] critical limitations in its governing authority have been evident long before COVID-19 emerged. The agency's indecisiveness was witnessed early both during the HIV/AIDS pandemic[19] and the West African Ebola outbreak of 2014.[20]

The IHR 2005's main objectives are enshrined in Article 2: to prevent, prepare for, protect against, and provide a public health response to the cross-border spread of disease whilst avoiding unnecessary interference with international traffic and trade. The IHR 2005 also obligate states to develop minimum core capacities.[21] Article 5 requires states to have the infrastructure to promptly detect the emergence of new or re-emerging diseases and assess their risk of international spread. States must also notify WHO within twenty-four hours of completing that assessment. This establishes the foundation for ensuring all states parties can detect disease-related events and inform the international community through WHO.

The IHR 2005 require state parties to cooperate in building core health capacities.[22] However, the form this cooperation should take—whether research and information sharing, technical assistance, or financial and material support—remains unspecified. This vagueness has hindered international health cooperation for infectious disease control, despite WHO's coordinating role.[23] Over a century ago, academic literature identified insufficient capacity building as a key reason for the ineffectiveness of the IHR 1969, the predecessor to the

[14] Schwalbe, Lehtimaki & Hannon, *supra* note 11.

[15] Rüdiger Wolfrum, *Cooperation, International Law of*, Oxford Pub. Int'l L. (Apr. 2010).

[16] Lawrence O. Gostin, Global Health Law (2014).

[17] Thana C. de Campos-Rudinsky & Daniel Wainstock, *Subsidiarity as a Structural Principle of Global Health Law*, 120 AJIL Unbound __ (2026).

[18] World Health Organization (WHO), Constitution of the World Health Organization (1946).

[19] Marcos Cueto, Theodore Brown & Elizabeth Fee, The World Health Organization: A History 203 (2019).

[20] Adam Kamradt-Scott, *WHO's to Blame? The World Health Organization and the 2014 Ebola Outbreak in West Africa*, 37 Third World Q. 401 (2016); *see also* Tsung-Ling Lee, *Making International Health Regulations Work: Lessons from the 2014 Ebola Outbreak*, 49 Vand. Transnat'l L. Rev. 931 (2021).

[21] WHO, International Health Regulations, Art. 5(1) (3d ed. 2005) [hereinafter 2005 IHR].

[22] *Id.*

[23] WHO Const., *supra* note 18.

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IHR (2005).[24] This situation persists today: during the COVID-19 pandemic, an official IHR Review Committee highlighted the vague nature of collaboration and assistance obligations under the IHR (2005).[25]

In turn, the COVID-19 pandemic once again exposed WHO's limited ability to coordinate an effective global response amid competing national interests. For example, South Africa alerted the world about the Omicron variant as required by Article 7 of the IHR 2005 but faced scientifically questionable border closures by Global North countries.[26] These measures were disproportionate to WHO's specific recommendations, lacked a scientifically sound public health rationale, and undermined the organization's authority—despite IHR (2005) obligations to avoid such practices. Additionally, nations negotiated bilateral vaccine contracts with confidential clauses,[27] bypassing the WHO-led COVAX initiative, designed to ensure equitable global vaccine distribution.

Revising the International Health Regulations: From Cooperation to Commitment?

The persistent inability of state parties to meet critical capacity-building obligations of the IHR (2005) left many countries inadequately equipped to prevent, detect, and respond effectively to the COVID-19 pandemic.[28] In the recent 2024 reform of the IHR, which entered into force in September 2025, for most WHO member states,[29] states amended Article 44, central to states' obligations to cooperate. Previously, Article 44 required states to "collaborate with each other, to the extent possible"[30] on health security matters, including detection, assessment, and response to public health emergencies of international concern. These obligations are not accompanied by concrete commitments to provide support, whether financial or otherwise, to other states. The new Article 44*bis* introduced a Coordinating Financial Mechanism under the World Health Assembly to identify and mobilize resources for implementing the IHR 2005, particularly strengthening states parties' core capacities for preventing, detecting, and assessing disease-related events. The Mechanism also encourages voluntary contributions to non-WHO organizations supporting this goal. However, governments made no commitment to additional budgetary resources. Financial contributions under Articles 44 and 44*bis* remain voluntary without benchmarks. Collaboration obligations remain vague and hortatory, suggesting compromise wording enabled the 2024 amendments' adoption.

Moreover, the newly created States Parties Committee for the Implementation of the IHR (2005) (Article 54*bis*) offers an opportunity to open debates on how best to realize the commitments to collaborate with each other. Since the Committee's terms of reference remain to be defined, states parties could examine individual assistance requests more thoroughly. Such requests could invoke a human rights rationale, framing IHR (2005) implementation support as necessary to respect, protect and fulfill the right to health. Committee deliberations would reveal the reasoning behind accepting or rejecting requests, helping identify political

[24] See overview in Pedro A. Villarreal, Roojin Habibi & Allyn Taylor, *Strengthening the Monitoring of States' Compliance with the International Health Regulations*, 19 INT'L ORG. L. REV. 215, 228 (2022).

[25] World Health Org., Report of the Review Committee on the Functioning of the International Health Regulations (2005) During the COVID-19 Response, 48, A74/9 Add. 1 (May 5, 2021).

[26] Lawrence O. Gostin et al., *Human Rights and the COVID-19 Pandemic: A Retrospective and Prospective Analysis*, 401 THE LANCET 154 (2023).

[27] Alexandra L. Phelan et al., *Legal Agreements: Barriers and Enablers to Global Equitable COVID-19 Vaccine Access*, 396 THE LANCET 800 (2020).

[28] Giulio Bartolini, *The Failure of "Core Capacities" Under the WHO International Health Regulations*, 70 INT'L & COMP. L. Q. F. 233 (2021).

[29] Excluding Argentina, Austria, Brazil, Canada, Czech Republic, Germany, Israel, Italy, the Netherlands, the Philippines, and the United States. Four state parties, Iran, the Netherlands, New Zealand, and Slovakia, have rejected the 2022 amendments, which means the 2024 amendments will enter into the force for them in September 2026.

[30] WHO, *supra* note 4.

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obstacles hampering collaboration obligations under the amended IHR (2005). This Committee mechanism could support the parallel legal reforms through the Pandemic Agreement, which signals a broader shift in global health governance.

Pandemic Agreement: Toward an Empowerment Model?

Recent legal reforms show promise. The Pandemic Agreement formally recognizes equity and solidarity principles, and it represents an emerging consensus to address pandemic cycles more comprehensively. This Agreement advances beyond previous reactive IHR framework by expanding its scope to encompass strengthening health systems and considering the interrelated health of humans, animals, and the environment.

The Pandemic Agreement also takes a different approach to cooperation by emphasizing empowering countries through sustained health system development and strengthened regulatory frameworks during non-pandemic periods. States are encouraged to invest in a more robust healthcare workforce, and sustainable, diversified local production of pandemic health products.

Importantly, the Pandemic Agreement bridges global health security and Universal Health Coverage (UHC), establishing health systems as essential infrastructure for both pandemic preparedness, prevention, and response, as well as for population health.[31] By emphasizing health system strengthening during inter-pandemic periods, the Agreement shifts from reactive responses to proactive investment, addressing all phases of pandemic cycles and encouraging sustained commitment to health infrastructure. This approach extends beyond the IHR core capacities for disease detection and response (listed in Annex 1 of the IHR) to encompass broader health system strengthening. By formally recognizing UHC—which embodies the right to health—as part of the binding global health security framework, this integration could drive actionable international cooperation and catalyze a fundamental shift in infectious disease control toward a rights-based approach.

Similarly, the Pandemic Agreement requires state parties to take appropriate measures to develop, strengthen, protect, safeguard, retain, and invest in a multidisciplinary, skilled, trained domestic healthcare workforce. This workforce must be adequate to prevent, prepare for, and respond to health emergencies, including in humanitarian settings, while maintaining essential health care services and essential public health functions and during pandemic emergencies and otherwise (Article 7).

Building on this workforce foundation, the Agreement focuses on achieving sustainable and geographically diversified local production of pandemic-related health products (Article 10). This approach could significantly strengthen regional and national resilience during public health emergencies by ensuring domestic access to critical medical supplies when global supply chains face disruption. It could catalyze broader economic development through creating skilled jobs, attracting investment, and fostering increased global competition that drives innovation.

Encouragingly, by establishing diverse knowledge production centers throughout different regions, this strategy aims to create more resilient innovation ecosystems where scientific discoveries can emerge from a wider spectrum of cultural perspectives and regional expertise. These varied viewpoints often lead to novel solutions that might otherwise remain undiscovered in more homogeneous research environments.

Challenges to Global Health Law Reforms

The Pandemic Agreement faces several critical implementation challenges. The most pressing is the unresolved issue of equitable pathogen and benefit sharing, which has been deferred to an annex with a

[31] Md Zakiul Hassan et al., *From Reaction to Resilience: The WHO Pandemic Agreement as a Blueprint for Global Health Equity*, 158 INT'L J. INFECTIOUS DISEASES, Art. No. 107944 (2025).

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May 2026 deadline at the time of writing and is a condition for opening the Agreement to signature.[32] Beyond this, effective implementation will require building technical capacity in resource-limited settings,[33] aligning domestic regulations with international obligations, meaningfully engaging civil society, and addressing the widening Global North-South divide. Geopolitical tensions and competing national priorities compound these challenges, as does the absence of transparent, mandatory evaluation mechanisms to track progress.[34]

The Agreement is also hampered by three key structural deficiencies: the use of hortatory language ("should" rather than "shall") to express legal obligations, the failure to frame equity and solidarity as legal obligations.[35] the absence of robust enforcement mechanisms, and a lack of substantive commitments to sustainable health financing. These weaknesses could collectively diminish the Agreement's ability to drive transformative change despite its ambitious aims. Ultimately, these implementation challenges reflect a fundamental tension in international law: the need to operate within a Westphalian governance structure rooted in state sovereignty while pursuing cosmopolitan goals that address inherently transnational issues.[36] Respect for sovereignty has been enshrined as a cornerstone principle in the Pandemic Agreement, reflecting member states' determination to preserve national autonomy while engaging in international health cooperation. Yet, an overemphasis on sovereignty could undermine this cooperation. Rising populist nationalism has deepened distrust globally, leading nations to prioritize perceived self-interest over collective action in critical health security decisions.

Conclusion

The legal framework for global health security is evolving. An empowerment model focused on international cooperation and sustainable financing may achieve more equitable global health outcomes. While the Pandemic Agreement and the 2024 amendments to the IHR (2005) fall short of directly empowering individual states to foster claims against other states in case of insufficient international health collaboration, it does offer some building blocks for that purpose. By embedding equity and solidarity principles, both instruments give states legal grounds to justify supporting other nations, potentially steering WHO and national decisions on financing core capacities and health system strengthening. These standards also enable non-state actors—academia, civil society, and individuals to hold governments accountable for disregarding these obligations. In the end, even though legal developments certainly cannot override prevailing political will, the provisions in these legal instruments offer a blueprint toward an empowerment of individual states in the rules-based global health security.

[32] Kerry Cullinan, *"Critical" to Complete Pandemic Agreement by UN Meeting in 2026*, HEALTH POL'Y WATCH (Sep. 15, 2025).

[33] WHO, Seventy-Eighth World Health Assembly, Intergovernmental Negotiating Body to Draft and Negotiate a WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response, A78/10 (May 14, 2025).

[34] Priti Patnaik, *At the Cusp of Change: Agenda Setting in Global Health Law by Emerging Economies*, 120 AJIL UNBOUND __ (2026).

[35] Benjamin Mason Meier, Judith Bueno de Mesquita & Sharifah Sekalala, *Human Rights Limitations in World Health Organization Reforms: Strengthening Human Rights Obligations in Global Health Law to Ensure Global Health Equity*, 120 AJIL UNBOUND __ (2026).

[36] Clare Wenham, Mark Eccleston-Turner & Maike Voss, *The Futility of the Pandemic Treaty: Caught Between Globalism and Statism*, 98 INT'L AFF. 837 (2022).

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