

SYMPOSIUM ON GLOBAL HEALTH AT A CROSSROADS PART I

AMENDMENTS TO IHR 2005: TOWARD DECOLONIZING INTERNATIONAL HEALTH EMERGENCY REGIME?

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Introduction

The entry into force of the amendments to the International Health Regulations 2005 (IHR 2005), on September 19, 2025, represents a pivotal moment in global health emergency governance history.¹ The COVID-19 crisis revealed the inability of both developed and developing nations to protect their populations from the pandemic. Developing nations experienced disproportionate impacts due to insufficient financial resources and manufacturing capacity to obtain necessary health products for pandemic response.² The neoliberal emphasis on economic efficiency and enforced trade liberalization through the World Trade Organization (WTO) framework, particularly mandatory product patent protection under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) widened inequities in access to vaccines, therapeutics and diagnostics (VTDs), and increased dependency of developing countries on developed countries for this access.³

Two primary reform initiatives were launched to address future challenges in international health emergency governance: the WHO Pandemic Agreement and the IHR amendments. The North-South divide became evident during this process, with the Global North emphasizing legal requirements for enhanced information sharing and surveillance, while the Global South focused on establishing predictable access to health products.⁴

The amendment process began when the United States submitted multiple proposed amendments in 2021. Two of them concerned the entry into force of IHR amendments and were adopted by the World Health Assembly (WHA) in 2022. Following WHA75 in 2022, a Working Group on Amendments to IHR 2005 was established and other member states were invited to make IHR amendment proposals. An IHR Review Committee established by WHO director-general to review these proposals. After extensive textual negotiations both in the working group and Health Assembly, member states adopted amendments during WHA78 in 2024.

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¹ WHO Press Release, [Amended International Health Regulations Enter into Force](#) (Sept. 19, 2025); WHO, [International Health Regulations \(2005\) as Amended In 2014, 2022 and 2024](#) (Sept. 19, 2025).

² Deborah Gleeson, Belinda Townsend, Brigitte F. Tenni & Tarryn Phillips, *Global Inequities in Access to COVID-19 Health Products and Technologies: A Political Economy Analysis*, 83 HEALTH & PLACE 103051 (2023).

³ K. M. Gopakumar, *TRIPS@30: Thirty Years of Widening Inequities in Access to Medicines*, 363 THIRD WORLD RESURGENCE 11 (2025); K. M. Gopakumar & Renga Sengupta, *Economic Liberalisation and Its Faults*, THE HINDU (May 27, 2020).

⁴ K. M. Gopakumar & Nithin Ramakrishnan, *WHO: Developing Countries Focus on Equity in IHR Amendment Proposals*, TWN INFO. SERV. HEALTH ISSUES (Jan. 11, 2023).

A significant feature of these amendments is provisions enabling equity. Various analyses published regarding the amendments argue that they either maintain the *status quo*⁵ or transform IHR 2005's technocratic character, by incorporating equity-related provisions.⁶ This essay examines the potential of these equity-related amendments to decolonize the international health emergency regime. The second section offers a developing country perspective on IHR2005 and the health emergency regime it tries to manage. The third section unpacks recent amendments aiming to operationalize equity, and the fourth section analyzes the potential of these amendments to decolonize the international health emergency regime, considering implementation challenges.

IHR: A Developing Country Perspective

IHR 2005 remains the sole legal instrument until the Pandemic Agreement is adopted, that governs public health emergencies of international concern (PHEICs). While IHR 2005 facilitated information transmission regarding outbreaks, no corresponding responsibilities exist for WHO or state parties to contain outbreaks. This approach mirrored the International Sanitary Regulations (ISR), IHR's predecessor. Following this approach, IHR 2005 required state parties to notify outbreaks of specific diseases, then permitted other state parties to implement protective measures for their populations without unnecessary interference with trade and travel.⁷

While maintaining the previous approach, IHR 2005 introduced five significant responsibilities. First, it broadened notification requirements from three diseases to all health events with cross-border spread potential, including non-communicable diseases from chemical or nuclear incidents.⁸ Second, to enable timely notification, state parties were required to maintain core public health surveillance and response capabilities.⁹ Third, IHR 2005 empowered WHO to gather information on disease outbreaks from non-state actors and enabled the WHO director-general to declare PHEICs without concerned member state cooperation.¹⁰ Fourth, the WHO director-general issues temporary recommendations to address PHEICs, which remain non-binding.¹¹ Fifth, IHR 2005 permitted member states to implement additional measures beyond WHO recommendations. Sixth, it acknowledged cooperation needs and required parties to collaborate with WHO and each other for smooth implementation, particularly assistance for developing nations.¹²

Core capacity requirements were to be fulfilled within a five-year transition period, subject to extension of two additional years. However, the WHA extended the deadline further in 2015 based on IHR Review Committee recommendations, since several states had not met the requirements.¹³ Limited financial resource availability, especially considering other competing health priorities of developing countries, was the primary reason for

⁵ David P. Fidler, *The Amendments to the International Health Regulations Are Not a Breakthrough*, THINK GLOB. HEALTH (June 7, 2024).

⁶ Roojin Habibi, Mark Eccleston-Turner & Gian Luca Burci, *The 2024 Amendments to the International Health Regulations: A New Era for Global Health Law in Pandemic Preparedness and Response?*, 53 J. L. MED. & ETHICS 47 (Suppl. 1, 2025).

⁷ David P. Fidler, *From International Sanitary Conventions to Global Health Security: The New International Health Regulations*, 4 CHINESE J. INT'L L. 325 (2005); N. Howard-Jones, *Origins of International Health Work*, 1 BRIT. MED. J. 1032 (1950).

⁸ *International Health Regulations* (2005), Art. 6, 2509 UNTS 79.

⁹ *Id.* Arts. 5, 13.

¹⁰ *Id.* Art. 9.

¹¹ *Id.* Art. 12.

¹² *Id.* Art. 44.

¹³ WHO, *Implementation of the International Health Regulations (2005): Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*, EB136/22 Add.1 (Jan. 16, 2015).

inadequate core capacity implementation.¹⁴ Although IHR 2005 acknowledged assistance needs and required WHO to provide such support, this proved ineffective without implementing mechanisms and resources. Article 44 and the WHA resolution for IHR 2005 adoption required WHO to mobilize financial resources “to the extent possible” to assist developing countries. Nevertheless, some note the absence of “assistance” in the text of Article 44, and argue that the provision largely provides flexible collaboration options.¹⁵ Furthermore, Article 44 fails to clearly specify developed countries’ differentiated responsibilities for providing assistance, resulting in non-implementation.

IHR 2005 does not explicitly require WHO or other state parties to facilitate access to necessary health products after a PHEIC declaration. Since health products’ development remain concentrated in few state parties, particularly in developed countries, developing nations experiencing outbreaks have limited incentives to report. Additionally, state parties notifying disease outbreaks risk facing unilateral travel and trade restrictions. These unilateral measures often function as penalties for information sharing.¹⁶ The IHR originally designated the WHA as the forum for IHR implementation discussions. Nevertheless, the WHA’s typically overcrowded schedule provides inadequate time for focused IHR implementation deliberations.

From a developing country viewpoint, IHR 2005 operated as a system for providing information through WHO to developed countries to protect their citizens. Historically, ISR’s purpose was addressing threats of diseases such as cholera, yellow fever, and plague spreading to the West due to colonial trade routes, without affecting trade and population movement.¹⁷ IHR 2005 reinforced this colonial approach by requiring developing countries to maintain core capabilities without guaranteed financial assistance commitments.

Further, to prevent state parties’ non-cooperation due to fears of consequences of notification through unilateral actions, IHR 2005 allows WHO director-general to collect information from non-state actors, such as the Global Outbreak and Response Network (GOARN), and determination of PHEIC.¹⁸ In pursuance of Article 6 read with Article 46, a state party, reporting public health events, facilitates transport of diagnostics specimens and other biological materials for verification and public health purposes. These specimens and information are often used for further development of health products such as diagnostics and vaccines. Thus, IHR 2005 not only reinforces but also advances colonial approaches to data and resource extraction, but without corresponding obligations to provide equitable access to health products and/or guaranteed financial assistance.

Assistance provided during Ebola or recent mpox outbreaks occurred outside the IHR 2005 framework as charitable aid. Following the 2024 mpox PHEIC determination, Canada and Switzerland declined to share mpox vaccines from their stockpiles.¹⁹ Vaccine donations proceeded slowly and significantly below required demand. Under IHR 2005, no obligations existed for WHO or state parties with stockpiles to facilitate mpox vaccines to other state parties facing outbreaks.²⁰

¹⁴ Mikael Broberg, *A Critical Appraisal of the World Health Organization’s International Health Regulations (2005) in Times of Pandemic: It Is Time for Revision*, 11 EUR. J. RISK REG. 202, 208 (2020); Giulio Bartolini, *The Failure of “Core Capacities” Under the WHO International Health Regulations*, 70 INT’L & COMP. L. Q. 233, 241 (2021).

¹⁵ Margherita Cinà et al., *The Stellenbosch Consensus on the International Legal Obligation to Collaborate and Assist in Addressing Pandemics: Clarifying Article 44 of the International Health Regulations*, 19 INT’L ORG. L. REV. 158 (2020).

¹⁶ Carly Jackson et al., *Between Rules and Resistance: Moving Public Health Emergency Responses Beyond Fear, Racism and Greed*, 7 BMJ GLOB. HEALTH e009945 (2022).

¹⁷ Fidler, *supra* note 7; Howard-Jones, *supra* note 7.

¹⁸ *International Health Regulations* (2005), *supra* note 8, Art. 9.

¹⁹ Chetali Rao & K.M. Gopakumar, *To Fight Mpox, Release Vaccine Stockpiles*, GENEVA HEALTH FILES (Aug. 28, 2024).

²⁰ John Cohen, *African Countries Fall Far Short of Mpox Vaccination Targets*, SCI. (June 4, 2025).

Amendments to Operationalize Equity

Given this background, particularly inequitable access to COVID-19 vaccines, therapeutics, and diagnostics, incorporating equity became essential for IHR amendments. The Executive Board (EB) Decision 150 (3) on IHR Amendments states:

Such amendments should . . . address specific . . . challenges—including equity, technological or other developments—or gaps that could not effectively be addressed otherwise but are critical to supporting effective implementation and compliance of the International Health Regulations (2005) . . . in an equitable manner.²¹

However, many viewed amendment proposals as altering IHR 2005's technical character. For instance, the Review Committee on IHR amendment proposals remarked regarding equitable access proposals: "remains unclear how WHO could discharge the unprecedented set of new responsibilities attributed to it relating to health products and know-how under this proposed amendment, as these may arguably exceed its constitutional mandate."²²

Article 3.1 has been modified to declare: "These Regulations shall be implemented with complete respect for human dignity, rights, and fundamental freedoms, while fostering equity and solidarity." This represents the first inclusion of equity and solidarity concepts within the IHR framework. Nevertheless, additional sections in Articles 13, 44, and the newly introduced Article 54bis convert equity concepts into practical measures. The following paragraphs examine these amendments' significance:

Equitable Access Provisions: Three supplementary paragraphs, numbered 7, 8, and 9, have been incorporated into Article 13. Paragraph 7 was added to create clear authority for WHO to assist state parties upon request or when WHO assistance is accepted. The provision states:

WHO shall support States Parties, upon their request or following acceptance of an offer from WHO, and coordinate international response activities during public health emergencies of international concern, including pandemic emergencies, after their determination pursuant to Article 12 of these Regulations.²³

Additionally, paragraph 8 establishes five specific responsibilities for the WHO director-general to eliminate barriers and ensure prompt, equitable access to relevant health products for state parties following PHEIC declarations, including pandemics. These five duties encompass:²⁴ conducting assessment of public health needs such as availability and affordability of necessary health products; facilitating access to essential health products; supporting state parties in diversifying production of essential health products; sharing health product authorization with states; and supporting system strengthening amongst states for research, development and domestic production.

Further, paragraph 9 mandates that state parties collaborate upon request, to provide mutual assistance or support WHO-coordinated response activities. State parties must execute four specific actions: supporting WHO in implementing Article 13 provisions including Sections 7 and 8; engaging domestic stakeholders to assist WHO in executing outlined actions; collaborating with relevant stakeholders within their jurisdiction to promote fair

²¹ WHO, [Strengthening WHO Preparedness and Response to Health Emergencies: Report of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies](#), Doc. EB150/3 (Jan. 26, 2022).

²² WHO, [Report of the Review Committee Regarding amendments to the International Health Regulations \(2005\)](#), Doc. A/WG1HR/2/5 at 55 (Feb. 6, 2023).

²³ [International Health Regulations \(2005\) as Amended In 2014, 2022 and 2024](#), *supra* note 1, Art. 13.7.

²⁴ *Id.* Art. 13.8 (a)–(c).

access to essential health products; and including provisions in publicly funded research agreements to advance equitable access during PHEICs and pandemics.²⁵

Financial Support: Article 44.2 of the amendments introduces three responsibilities for state parties. First, state parties must enhance domestic resources for IHR implementation, including through international partnerships. Second, state parties must collaborate to reform governance models of existing financing entities to be regionally representative and responsive to developing countries' needs. Third, financial resources must be identified through the Coordinating Financial Mechanism to equitably address developing countries' priorities.

A new Article 44*bis* creates a Coordinating Financial Mechanism (CFM). The CFM's objectives are to mobilize new and additional financial resources, and maximize financing availability for implementation of states' implementation needs and priorities, particularly, developing countries. The CFM's functions include leveraging voluntary monetary contributions to support states with developing, strengthening and maintaining core capacities. While no dedicated IHR implementation fund is specifically referenced, these provisions establish clear mandates for resource mobilization to fulfill responsibilities.

Implementation Committee: From a governance perspective, IHR 2005's most critical weakness was the absence of a dedicated mechanism for discussing and monitoring implementation, including technical and financial support. The new Article 54*bis* establishes a States Parties Committee for the Implementation of the International Health Regulations (2005) to facilitate the effective implementation, particularly of Article 44 and 44*bis*. This constitutes the first institutional mechanism dedicated to examining matters related to IHR implementation. An explanation for scope of limiting clauses such as "extent possible" in Article 44 is currently subject to WHO and state parties' interpretation.

Toward Decolonization Through Equity

Amendments to Articles 13 and 7 clearly establish equitable access as a fundamental pillar of IHR. They create obligations/mandates for WHO to implement measures facilitating timely and equitable access to relevant health products. Furthermore, they mandate that the WHO director-general:

make use of WHO-coordinated mechanisms, or facilitate, in consultation with States Parties, their establishment as needed, and coordinate, as appropriate, with other allocation and distribution mechanisms and networks that facilitate timely and equitable access to relevant health products based on public health needs.²⁶

This provision offers possibilities for transforming existing mechanisms like the International Coordination Group on vaccine provision²⁷ from charitable operations to clear legal mandates and accountability. Additionally, it requires the director-general to consider equitable access as an essential element when issuing temporary recommendations.²⁸ These amendments thus possess potential for establishing *quid pro quo* arrangements in exchange for providing disease outbreak information.

Beyond recognizing equitable access, these new sections grant WHO an explicit mandate to implement measures ensuring equitable and timely access through local production. Thus, WHO can operate without legal constraints in promoting local production, including through technology transfer. Contrasting significantly with WHO Pandemic Agreement, where there is no mandate for WHO to work on technology transfer.

²⁵ *Id.* Art. 13.9 (a)–(c).

²⁶ *Id.* Art. 13.8(b).

²⁷ International Coordinating Group (ICG) on Vaccine Provision (last visited Sept. 21, 2025).

²⁸ International Health Regulations (2005) as Amended, *supra* note 1, Art. 17(*dbis*).

Unlike earlier financial assistance provisions, the objectives of CFM encompass new resource mobilization, offering possibilities for establishing a dedicated IHR implementation fund. The CFM and the implementation committee offer possibilities for holding state parties accountable with regard to financial and technological resources, particularly those in the Global North. However, implementing these provisions could be compromised by WHO's weaknesses which is currently functioning with substantial voluntary contributions often establishes priorities based on donor preferences rather than international public health needs. Another significant structural deficiency is the failure to incorporate common but differentiated responsibilities²⁹ (CBDR) within IHR, which provides excuses for developed countries to avoid historical responsibilities.

Additionally, IHR amendments focused more on equitable access obligations post-PHEIC determination by WHO, neglecting early outbreak response which is vital. Another missing element involves extraction of genetic materials or pathogen-related information causing PHEICs or potential PHEICs without sharing any benefits to developing countries.

Conclusion

The IHR amendments mark a significant shift in the health emergency regime, challenging colonial frameworks that offered little equitable access to health products for developing countries. For the first time, WHO is explicitly mandated to provide such access, transforming the IHR (2005) from a technocratic instrument of surveillance into a tool for equity. Some critics argue the amendments distort the IHR's technical character by adding policy issues like access to health products and health financing, while lacking sanction-based enforceability. Yet these concerns are not new; the "technical instrument" argument was central during earlier negotiations, enabling wealthier states to preserve colonial approaches. In sum, the amended IHR offer a chance to move toward a regime grounded in cooperation and can achieve equity, rather than extraction and profiteering.³⁰

²⁹ Chang Wang & Yi Zhang, *Common But Differentiated Responsibilities and Respective Capabilities as a Guiding Principle in International Health Law in Times of Pandemics*, 51 NETH. Y.B. INT'L L. (2020).

³⁰ Andraž Zidar & Živa Cotič Zidar, *Amended WHO International Health Regulations for Better Global Pandemic Governance?*, 24 MED. L. INT'L. 297 (2024).