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COMMENTARY

The 2025 IHR Amendments: A Partial Fix and Three Lingering Structural Challenges

BY NOVANTUM ADVISORY GROUP

> The amendments to the International Health Regulations that entered into force on 19 September 2025 represent the most significant structural change to the IHR since its 2005 revision and they deserve to be evaluated as such, neither dismissed by critics nor overstated by advocates. The analytical tool this commentary applies is a five-pathology diagnostic framework drawn from the empirical record of IHR failure in fragile, conflict-affected, and climate-stressed settings. Against that framework, the 2025 reforms achieve partial progress on two of five structural pathologies, leaving three unaddressed.

PART I: THE FIVE PATHOLOGIES DIAGNOSTIC FRAMEWORK

The IHR has been evaluated exhaustively at the implementation level, looking at compliance rates, JEE scores, core capacity gaps. What the post-COVID literature has not done is apply a structural diagnostic: not whether countries are complying with the IHR, but whether the IHR's architecture is designed to produce compliance in the settings where it fails most catastrophically. The following five pathologies are derived from that structural analysis.

STRUCTURAL PATHOLOGY	PRIMARY EVIDENCE	IHR 2025 AMENDMENTS	WHO PANDEMIC AGREEMENT	VERDICT
Assumption of Institutional Continuity: The framework treats State Parties as functionally sovereign, administratively capable actors	*Khairuddin et al. (2024): catastrophic simultaneous failure across all six WHO building blocks in FCAS settings (2,704 records, 635 primary sources)*	Not addressed: both instruments continue to address State Parties as legally equivalent governance actors	Not addressed: no provisions for sub-state or non-state delivery where the state is the governance failure	**UNRESOLVED**
Absence of Crisis-Adaptive Architecture: Static compliance obligations do not activate differently in crisis conditions	*WHO JEE Analytics Platform (accessed February 2026): all 19 technical areas below 60% adequacy globally; biosafety 40%, health emergency management 49%*	Partially addressed: new 'pandemic emergency' tier creates a formal legal threshold at which accelerated response obligations activate	Partially addressed: provisions for expedited access and benefit-sharing during declared emergencies introduce conditional differentiation	**PARTIAL**
Sector Siloing: Health ministries bear IHR obligations without binding integration of climate, economic, or security governance	*Bascolo et al. (2020): PAHO EPHF confined to health ministries, with 'weak participation from other government sectors, civil society, and the private sector'*	Not addressed: no cross-sectoral coordination obligations; health ministers remain the sole obligated actors	Not addressed: Pandemic Agreement is a health sector treaty; no binding obligations on other government ministries	**UNRESOLVED**
Compliance Without Enforcement: IHR obligations carry no binding enforcement mechanism and no consequence for non-compliance	*Fidler DP (Chatham House, 2015): Ebola Review Committee found IHR's compliance architecture fundamentally inadequate; IPPPR*	Partially addressed: coordinating financial mechanism links resources to core capacity development, creating conditional	Partially addressed: equity and benefit-sharing provisions create reciprocal obligations that may generate compliance pressure	**PARTIAL**

STRUCTURAL PATHOLOGY	PRIMARY EVIDENCE	IHR 2025 AMENDMENTS	WHO PANDEMIC AGREEMENT	VERDICT
	(2021, The Lancet): repeated same finding post-COVID	financial incentive for compliance		
Universalism-Differentiation Mismatch: Identical legal obligations applied to states with radically different institutional capacity	*Bartolini G (2021, Int'l and Comparative Law Quarterly): IHR imposes 'unconditional obligations' that 'pay no heed to structural and economic differences between States'*	Not addressed: amended IHR applies identical obligations to Afghanistan (IHR preparedness score ~35) and non-FCS regional mean (78); no differentiated compliance pathway for FCAS settings	Not addressed: Pandemic Agreement applies uniform obligations across 124 signatory states regardless of institutional capacity	**UNRESOLVED**

PART II: WHAT THE 2025 REFORMS ADDRESS AND THE PRECISION OF THAT PROGRESS

Credit must be given precisely where it is due. The 2025 IHR amendments and the WHO Pandemic Agreement represent genuine improvements over the 2005 framework. Being specific about what they achieve is as important as being specific about what they do not.

On crisis-adaptive architecture: The new 'pandemic emergency' tier is the most structurally significant change. The 2005 IHR operated on a binary logic: a Public Health Emergency of International Concern (PHEIC) was declared or it was not, and all IHR obligations applied uniformly regardless of outbreak trajectory. The pandemic emergency tier introduces a gradient, a formal legal threshold between routine preparedness and full PHEIC activation, at which a defined subset of accelerated response obligations activates. This is a meaningful structural improvement. It acknowledges that health emergencies have trajectories, and that governance responses should scale with those trajectories. It is, however, not the same as an adaptive architecture: the tier is a new threshold in the same static compliance system, not a mechanism for continuous adaptive response.

On compliance without enforcement: The coordinating financial mechanism is the second genuine improvement. The 2005 IHR's compliance architecture was almost entirely relational. Member states were expected to meet core capacity obligations because they had signed the treaty, not because non-compliance had consequences. The financial mechanism, by formally linking resource access to core capacity development, introduces a conditional structure: countries that demonstrate progress receive resources; countries that do not face reduced access. This is not enforcement in the legal sense; it does not impose penalties for non-compliance. But it converts a pure obligation into a conditional exchange, which is a structural improvement over the prior architecture.

These two improvements address the same two pathologies partially, not fully. The pandemic emergency tier acknowledges crisis trajectories but does not create a continuously adaptive mechanism. The financial mechanism creates resource conditionality but does not create enforcement consequences for treaty violation. Both represent movement in the right direction. Neither closes the pathology it addresses.

PART III: THE THREE UNRESOLVED PATHOLOGIES AND WHY THEY MATTER MOST FOR FCAS SETTINGS

The universalism-differentiation mismatch is the most consequential unresolved pathology for fragile states. Every single one of the 19 IHR technical areas falls below the 60% adequacy threshold in global JEE averages, with biosafety at 40%, legal instruments at 41%, health emergency management at 49%, financing at 49% (WHO JEE Analytics Platform, accessed February 2026). These global averages conceal a structural distribution problem: the gap between high-capacity and low-capacity member states is far larger than the average suggests. In the WHO Eastern Mediterranean Region, the IHR capacity differential between fragile and conflict-affected states (FCS mean: 46.6) and non-FCS states (mean: 78.0) is 31.4 percentage points (WHO EMRO, 2025). The amended IHR continues to apply identical

obligations to both. No differentiated compliance pathway, no tiered obligation structure, no FCAS-specific capacity support mechanism is created by either instrument. The 29 FCAS settings (out of 82 LMICs as of 2022 World Bank classification) that face the most severe implementation barriers are offered the same obligations as member states with four times their preparedness capacity.

Sector siloing remains structurally intact. The defining characteristic of contemporary health emergencies, documented by Khairuddin et al. (2024) across 635 primary sources is that they are not health sector events. They are intersections of health system failures with climate displacement, economic contraction, and political instability. The IHR 2005 was a health sector treaty. The 2025 amendments are a revised health sector treaty. The WHO Pandemic Agreement is a new health sector treaty. None of the three creates binding obligations for climate authorities to integrate health emergency preparedness. None creates binding obligations for finance ministries to maintain health emergency financing floors during fiscal crises. None creates binding obligations for security authorities to protect health infrastructure. In Gaza/Palestine, 54% of health facilities are non-functional and 89% are partially or fully damaged (HeRAMS, 2024). In Sudan, 38% of facilities are non-functional. These are not health sector failures. They are cross-sectoral failures for which health sector treaties carry no remedy.

The assumption of institutional continuity is the most fundamental unresolved pathology and the most invisible. Both the amended IHR and the Pandemic Agreement address State Parties, sovereign member states with functioning administrative systems capable of meeting treaty obligations. The empirical record documented in the Khairuddin et al. (2024) synthesis and the WHO EMRO recovery paper (2025) establishes that in the settings where IHR failure is most acute, state institutional continuity is precisely what cannot be assumed. In Yemen, parallel governance structures mean that IHR obligations notionally apply to a state that does not exercise administrative control over the majority of the territory where those obligations would need to be implemented. In Somalia, the IDSRS evaluation found 15% progress on financing against 79% on technical components the institutional substrate for translating technical capacity into funded implementation does not exist. Neither the IHR amendments nor the Pandemic Agreement creates mechanisms for sub-state or non-state delivery where state institutional continuity has failed. They offer no governance architecture for the settings that need them most.

PART IV: THE IMPLICATION FOR HEALTH GOVERNANCE INVESTMENT

The 2025 reforms are an incremental improvement to an architecturally mismatched framework. They make the IHR somewhat less static and somewhat less toothless. They do not make it adaptive, cross-sectoral, or differentiated by institutional capacity. The three properties that the empirical record of FCAS health system failure establishes are essential for governance frameworks serving volatile-region health systems.

The practical implication is a gap that no treaty revision will close in the medium term: FCAS-specific health governance investment at the district level, the subnational level, and through civil society contracting mechanisms where state institutional continuity has failed cannot wait for the IHR to become the instrument that FCAS settings need. That instrument may eventually be built. In the settings where 212.6 maternal deaths per 100,000 live births occur against a non-FCS regional mean of 34.2 (WHO EMRO, 2025), the wait is not a policy option.

The five-pillar adaptive governance framework described in the accompanying report "*Structuring Resilience: A Blueprint for Adaptive Health Governance"* published by the Novantum Advisory Group, addresses the three unresolved pathologies directly. Decentralized decision authority with governance co-conditions addresses the institutional continuity assumption by creating resilient subnational structures that do not depend on state-level functionality. Real-time surveillance with pre-authorized response protocols addresses the crisis-adaptive architecture gap at the operational level. Civil society contracting mechanisms address the sector-siloing gap by creating accountability channels outside the state-ministry structure. These are not substitutes for IHR reform. They are the investments that fill the gap the IHR, even amended leaves open.

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