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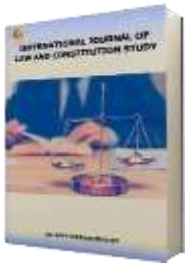

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THE GLOBAL PANDEMIC AND REFORM OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

Abd. Rahman Alwi Pase, Cintami Grece Novita Ramadani, Nurlila Pratiwi, Muhammad Priandani

Islamic Criminal Law Program, Faculty of Sharia and Law, State Islamic University of North Sumatra, Indonesia

rahmanalwi0205232055@uinsu.ac.id, cintami0205232046@uinsu.ac.id, nurlilapratiwi0204232057@uinsu.ac.id, Muhammadpriandani83@gmail.com

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ABSTRACT

The COVID-19 pandemic exposed weaknesses in the International Health Regulations (IHR) 2005, such as weak enforcement, slow outbreak reporting, and global health inequities. This study aims to analyze post-pandemic IHR reforms and their implications for Indonesia. The method used is normative legal research with a legislative and conceptual approach through a literature review. The results indicate that the 2024 IHR amendments and the 2025 WHO Pandemic Agreement strengthen the global health system through early detection, international coordination, and the principle of health equity. These reforms also introduce the category of "pandemic emergency" as a mechanism for the global pandemic response. In Indonesia, policies such as PSBB, PPKM, international travel protocols, and 3T have been in line with the 2005 IHR. However, strengthening surveillance, reporting systems, and national health resilience remains necessary to face future pandemics.

Corresponding Author: Abd. Rahman Alwi Pase				
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INTRODUCTION

The COVID-19 pandemic has served as a catalyst for significant change in global health management, as it has revealed that the international health architecture remains far from prepared to address disease threats that transcend national borders. The massive and rapid spread of the virus has exposed various fundamental weaknesses, ranging from poor coordination among countries, slow outbreak reporting mechanisms, sharp disparities in the distribution of vaccines and medicines, to the limited health response capacity faced by many developing countries. These various issues ultimately sparked serious criticism of the effectiveness of the 2005 International Health Regulations (IHR) as the international legal framework that should serve as the primary guide in managing global health emergencies (Organization, WHO Official, 2024).

In response to the lessons learned from the COVID-19 pandemic, member states of the World Health Organization (WHO) approved amendments to the IHR at the 2024 World Health Assembly. These changes are intended to strengthen pandemic preparedness, accelerate early warning systems, improve coordination among countries, and prioritize the principles of equity and solidarity in the distribution of global health resources. Additionally, these amendments introduce the term “pandemic emergency” as a new category within the international public health emergency framework to clarify the mechanisms for the global response to future pandemics (Habibi, Eccleston-Turner, & Burci, 2025).

On the other hand, the reform of the IHR has sparked various debates regarding national sovereignty, the authority of the WHO, and the implementation of international health policies at the national level. Some countries argue that strengthening global regulations is crucial to prevent a recurrence of coordination failures, such as those that occurred during the COVID-19 pandemic. However, others are concerned that such policies could open the door to interference in each country’s domestic policies. This debate demonstrates that IHR reform is not solely about health issues but also encompasses political, international legal, and inter-state relations aspects (Zidar & Zidar, 2024).

For Indonesia, the reform of the IHR is a critical issue because Indonesia is part of a global community with a high level of vulnerability to the spread of infectious diseases and high population mobility. Strengthening international health regulations requires the government to be prepared to enhance surveillance capacity, disease reporting systems, the resilience of the national health system, and the alignment of national policies with WHO international standards. Therefore, a study on global pandemics and the reform of international health regulations (IHR) is essential to understand developments in global health governance and their application to national health policies in Indonesia (Klafki, 2024).

METHOD

This study employs a normative legal research methodology, utilizing both a statutory approach and a conceptual approach. The legal materials used include primary legal materials in the form of international legal instruments, such as the IHR 2005, its 2024 amendments, the WHO Constitution, and official documents of the World Health Assembly; secondary legal materials in the form of scientific journals, books, and relevant prior research; and tertiary legal materials in the form of legal dictionaries and encyclopedias. All legal materials were collected through library research.

The collected legal materials were analyzed qualitatively using a prescriptive-analytical method, which not only describes existing norms but also evaluates the structural weaknesses of the IHR 2005 that were exposed during the COVID-19 pandemic and assesses the extent to which the 2024 IHR amendments and the 2025 WHO Pandemic Agreement can address these weaknesses. The analysis also covers the alignment of Indonesia's mitigation policies—such as PSBB, PPKM, international travel health protocols, and the 3T policy—with Indonesia's obligations as a State Party to the 2005 IHR, in order to formulate normative recommendations for strengthening the national public health legal system in the future.

RESULTS AND DISCUSSION

1. Definition of a Global Pandemic

A global pandemic is a situation in which an infectious disease spreads on a massive scale, crossing national borders and reaching all corners of the world almost simultaneously. The WHO defines a pandemic as a situation in which a new disease

spreads worldwide and the majority of the population has not yet developed immunity to it (Organization, 2020). From an epidemiological perspective, a pandemic can be distinguished from an epidemic based on its geographic scope; an epidemic is defined as a sudden surge in disease cases confined to a specific community or region, while a pandemic describes a much wider spread that crosses national borders (Last, 2001).

An outbreak can be classified as a pandemic if it meets certain criteria, namely: the pathogen causing the disease is a new agent or has undergone significant enough mutations that the human body has not yet developed immunity to it; the disease is capable of spreading effectively among humans; and its spread is occurring simultaneously across multiple countries or continents (Morens, Folkers, & Fauci, 2009). The declaration of a pandemic does not depend solely on the severity or virulence of a disease, but is determined more by its ability to spread rapidly and reach various parts of the world on an international scale.

Throughout modern history, humanity has faced several major pandemics that have had a profound impact on human life, including the 1918 influenza pandemic—known as the Spanish flu—the HIV/AIDS pandemic that began to spread in the early 1980s, and the COVID-19 pandemic, which was officially declared by the WHO on March 11, 2020 (Organization, 2020). The COVID-19 pandemic is considered one of the largest pandemics in modern history, with impacts felt not only in the health sector but also in various other areas, such as the economy, social life, and the global political landscape (Nicola & al, 2020).

2. History and Development of the International Health Regulations (IHR)

The international community's awareness of the urgency of cooperation in combating the spread of infectious diseases has, in fact, been growing since the 19th century. Before the era of international collaboration emerged, each country implemented its own quarantine policies as a response to the threat of diseases entering from abroad. However, the increasing intensity of trade and cross-border mobility—particularly the repeated waves of cholera epidemics that struck Europe—demonstrated that a national approach was no longer sufficient to address these challenges. It was this realization that ultimately led to the convening of the first International Sanitary Conference in 1851, which would later become the foundational milestone for the establishment of multicultural health cooperation.

The fundamental motivation behind this cooperation was essentially protective: to shield Europe and North America from the threat of diseases perceived to originate from the southern regions and Asia, while ensuring the smooth flow of international trade was not hindered by quarantine practices deemed excessive. After a series of international sanitation conventions, all these provisions were finally codified into the First International Sanitation Convention in 1892, which was later revised in 1969 and renamed the International Health Regulations (IHR).

A new chapter in international health governance began with the establishment of the World Health Organization (WHO) in 1948. The WHO Constitution marked a fundamental paradigm shift: health was no longer viewed solely as a matter of national interest, but was recognized as a fundamental human right—that is, a state of complete physical, mental, and social well-being for every individual, regardless of any differences. Pursuant to Articles 21 and 22 of the WHO Constitution, the World Health Assembly (WHA) is granted the authority to establish regulations that are binding on all member states, except for those that explicitly declare their refusal. This mechanism paves the way for the creation of a universally applicable international legal instrument, thereby ending the fragmentation left by previous sanitation conventions. This development went hand in hand with the emergence of various other complementary international legal frameworks, including the right to health codified in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), and the public health exception clause in the 1960s GATT, which also had significant implications for the broader protection of human health.

The IHR 1969 was designed to strengthen the principles of international public health security by requiring countries to report certain diseases to the WHO and to maintain adequate public health capacity at ports and airports. However, over time, the effectiveness of the IHR 1969 has declined significantly. Many countries assessed that the reporting obligations stipulated in the 1969 IHR did not provide benefits commensurate with their national interests, so compliance with these regulations gradually weakened. By the 1990s, a consensus had emerged within the global health community that the 1969 IHR contained three major weaknesses: first, the scope of covered diseases remained very limited; second, the failure of contracting states to submit outbreak reports to the WHO in a timely manner; and third, the non-compliance of contracting states in implementing trade and travel restrictions in a proportionate

manner in accordance with applicable provisions. On the other hand, the emergence of new disease threats such as the Ebola virus and dengue fever, coupled with the escalating HIV/AIDS crisis—which was further accelerated by the intensifying tide of globalization—increasingly underscored that the existing regulatory framework was no longer adequate to address the evolving challenges of global health.

The most decisive impetus for a comprehensive revision of the 1969 IHR came from the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003. The SARS outbreak clearly revealed how vulnerable the international response system was in the face of cross-border infectious diseases capable of spreading at an extremely rapid pace. The WHO capitalized on this momentum by organizing a series of regional consultations and intergovernmental negotiation sessions attended by more than 500 delegates from over 150 member states. The negotiation process was lengthy and marked by intense debate, particularly regarding the proposed obligation for states to provide information, materials, and samples if there were indications of the release of biological, chemical, or radiological agents. This provision caused a divide between countries that wanted the IHR to include the dimension of weapons of mass destruction and those that opposed it. After a long and dynamic negotiation process, an agreement was finally reached on May 14, 2005, and the WHA officially adopted the revised International Health Regulations, subsequently known as the IHR 2005. This legal instrument is binding on the 194 WHO member states and remains the primary foundation of global health governance in addressing the threat of transboundary diseases (Kurniaty, 2021).

3. Post-COVID-19 Reform of the IHR

The COVID-19 pandemic prompted the World Health Organization (WHO) to update the International Health Regulations (IHR) 2005 with the aim of strengthening the global health architecture to anticipate potential future pandemic threats. This reform was driven by various shortcomings identified during the pandemic, including weak international coordination, delays in outbreak reporting, and striking disparities in access to health services among countries (Organization, WHO Official). One of the key elements of the IHR reform is the strengthening of the early warning system . Within this framework, WHO member states are required to report any disease outbreak or health threat to the WHO promptly, transparently, and accurately, so that the spread of disease can be immediately addressed and controlled. This reform is

fundamentally aimed at improving the effectiveness of early detection of potential pandemics at the global level (Klafki, 2024).

In addition, the IHR reform introduced a new category known as a “pandemic emergency.” This status is intended to identify public health emergencies with the potential to spread globally and requiring a faster and better-coordinated international response. With the introduction of this category, the WHO is expected to be able to take more effective and responsive measures in addressing pandemic situations (Zidar & Zidar, 2024). Furthermore, the IHR reform also emphasizes the importance of strengthening the capacity of national health systems in each member state. Each country is encouraged to strengthen various essential components of its health system, including disease surveillance systems, public health laboratory capacity, the availability of medical personnel, the adequacy of health facilities, and preparedness to address public health emergencies. Strengthening national health capacity is considered crucial so that every country has the adequate capability to manage outbreaks more independently and is prepared to face various health threats that may arise (Habibi, Eccleston-Turner, & Burci, 2025).

In addition to these points, the IHR reform also emphasizes the importance of the principles of solidarity and global justice in the distribution of vaccines, medicines, and health technologies. The experience during the COVID-19 pandemic has clearly demonstrated that developing countries often face serious obstacles in gaining access to adequate health services and resources. Therefore, one of the fundamental goals of the IHR reform is to achieve a more equitable and just distribution of health resources for all countries, regardless of their level of economic development (Organization, WHO Official, 2024).

4. The Implications of Implementing the IHR in Indonesia for Pandemic Response

In the wake of the COVID-19 pandemic, the Indonesian government has implemented policies to address the pandemic in accordance with the 2005 International Health Regulations (IHR), which outline the mandatory public health measures that must be implemented. The various policies implemented by the government to mitigate the spread of COVID-19 include, among others:

1. Large-Scale Social Restrictions (PSBB) and the Enforcement of Community Activity Restrictions (PPKM)

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Pursuant to Article 15 of the IHR 2005, it is stipulated that in circumstances designated as a Public Health Emergency of International Concern (PHEIC), the WHO has the authority to issue recommendations in the form of containment measures that must be implemented by its member states, one of which includes the implementation of health quarantine. As a WHO member state, Indonesia has also implemented these recommendations through two policy measures: Large-Scale Social Restrictions (PSBB) and the Enforcement of Community Activity Restrictions (PPKM).

The PSBB policy itself encompasses the implementation of community quarantine as well as the adoption of online learning and remote work (Work From Home), as regulated by Government Regulation No. 21 of 2020 on Large-Scale Social Restrictions for the Acceleration of COVID-19 Response. Article 2, Paragraph (1) of the regulation stipulates that PSBB grants the government the authority to restrict the movement of people and goods entering or leaving a specific province, regency, or city.

2. International Travel Health Protocols

The implementation of health protocols is a crucial aspect of efforts to curb COVID-19, particularly in the context of international travel, which is one of the main factors in the transmission of the virus. As part of mitigation measures, the Indonesian Government issued Circular Letter No. 8 of 2021 from the COVID-19 Task Force regarding Health Protocols for International Travel During the COVID-19 Pandemic, which essentially tightens entry and exit requirements for Indonesian and foreign nationals. The circular also sets out various administrative and health requirements that must be met by foreign nationals as a condition for visiting or transiting through Indonesian territory.

From an international law perspective, the measures taken by the Indonesian Government are consistent with the provisions of Article 23 of the IHR 2005. This provision essentially stipulates that, in the interest of a country's public health, the relevant state may request information

regarding the purpose and travel plans of visitors prior to their arrival, to ensure and minimize potential health risks that may arise. In certain situations, the country may also take additional measures as provided for in Article 43 of the IHR to protect the health of its territory, including by imposing restrictions on travelers from other countries.

3. Implementation of the 3T Approach (Testing, Tracing, and Treatment)
   Pursuant to Article 18(1) in conjunction with Article 15 of the 2005 IHR, the WHO has the authority to recommend a number of measures that must be implemented by its member states. These include tracing travel history in areas affected by the disease, checking health documents, conducting health screenings, implementing quarantine measures, tracking close contacts of patients, and denying entry to patients into a country's territory. These provisions are implemented by Indonesia through the application of the 3T policy—Testing, Tracing, and Treatment—which fundamentally focuses on three main aspects: health screenings for individuals suspected of exposure, tracking and monitoring of close contacts of patients as well as the patients themselves, and comprehensive medical care for those confirmed positive. This policy also establishes mechanisms for authorized officials to notify communities in affected areas to remain vigilant against potential transmission. In its implementation, this process requires the participation and collective behavior of all segments of society as an integral part of the success of pandemic mitigation efforts (Jonathan & Dewi, 2021).

Discussion

1. In their study titled "Reforming Global Health Security After COVID-19," published in the 2023 edition of The Lancet, Gostin, Katz, and Phelan conducted a comprehensive review of the 2005 IHR's inability to effectively manage the COVID-19 pandemic. In that study, Gostin et al. argued that the IHR 2005 contains fundamental structural weaknesses, particularly regarding law enforcement, given that the WHO lacks sanctions that can be imposed on countries that neglect their reporting obligations. The relevance of this study to the journal under review lies in the similarity of their focus, namely the

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inadequacy of the IHR 2005 as an instrument of international law in addressing global health emergencies (Gostin, Katz, & Phelan, 2023).

2. Habibi et al., in their study titled “Do Not Violate the International Health Regulations during the COVID-19 Outbreak,” published in The Lancet in 2020, examined how countries fulfilled their obligations under the IHR during the early stages of the COVID-19 pandemic. The study criticized the travel and trade restrictions unilaterally imposed by several countries, which were deemed contrary to the provisions of Article 43 of the 2005 IHR, as that article only permits the implementation of restrictions beyond standard measures if supported by strong and adequate scientific evidence. The relevance of this study to the journal under review is evident in the similarity of the issues discussed, particularly regarding the implementation of health protocols in the context of international travel in Indonesia (Habib & al, 2004).
3. In his book titled “Global Health Governance: International Law and Public Health in a Divided World,” published by the University of Toronto Press, Aginam chronologically outlines how international health regulations have evolved from the first International Sanitation Conference in 1851 to the establishment of the WHO and the current IHR framework. In his analysis, Aginam emphasizes that the initial impetus behind the emergence of international health cooperation was driven more by self-protection than by humanitarian spirit, as European nations essentially sought to fortify themselves against perceived disease threats originating from the Global South and Asia. The historical perspective presented by Aginam aligns with the discussion in the journal under review, particularly in the section examining the historical background and the dynamics of IHR regulatory development (Aginam, 2004).

CONCLUSION

The COVID-19 pandemic has exposed structural weaknesses in the International Health Regulations (IHR) 2005, such as weak enforcement, slow early warning systems, and global health inequities. In response, reforms have been implemented through the 2024 IHR amendments and the adoption of the 2025 WHO Pandemic Agreement to strengthen early detection and the principle of global health equity. For Indonesia, these reforms have significant implications because national pandemic

response policies have been aligned with the IHR, although strengthening surveillance, reporting, and the resilience of the health system remain priorities in preparing for future pandemics.

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