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Commentary

The US Withdrawal From the WHO: A View From Latin America and the Caribbean on Multilateral Fragility, Reciprocal Benefit, and Regional Resilience

Comment on "The U.S. Withdrawal From the World Health Organization: Implications and Challenges"

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Abstract

The 2025–2026 withdrawal of the United States from the World Health Organization (WHO) represents one of the most consequential disruptions to global health governance in the postwar era. In the Americas, its effects are already visible: The Pan American Health Organization (PAHO) is facing delays and funding cuts; the Region lost its measles-free status in November 2025; and President's Emergency Plan for AIDS Relief (PEPFAR)-supported HIV services have been reduced in Central America and the Caribbean. Additionally, the United States also benefits from multilateral cooperation through disease surveillance, vaccine strain selection, and the early detection of threats. Recent outbreaks outside the region demonstrate that weaknesses in international surveillance can become risks within its own borders. Therefore, we propose reforming WHO governance, diversifying its funding, strengthening regional institutions, and establishing clear frameworks for private-sector participation in global health.

Keywords: World Health Organization, United States, Global Health Governance, Latin America and the Caribbean, Health Equity

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The editorial by Yazdi-Feyzabadi and colleagues provides a timely and rigorous analysis of the implications of the United States withdrawal from the World Health Organization (WHO) in January 2025.[1] The authors rightly identify the structural vulnerabilities this decision exposes, from financing gaps to weakened pandemic preparedness, and call for governance reform and renewed multilateral engagement. We write as researchers based in Latin America who have previously examined this crisis from a global health equity perspective,[2] and whose region depends heavily on WHO- and the Pan American Health Organization (PAHO)-led programmes yet remains peripheral to the policy debate the decision has provoked. We extend the editorial's analysis in two directions that we consider underdeveloped: first, by grounding its global argument in measurable consequences for the Region of the Americas; and second, by examining what the United States itself stands to lose, a question largely absent from the current literature.

The United States as a Strategic Partner: A Legacy Under Threat

For decades, the United States has occupied a singular position in the international order, not merely as the world's largest economy or its preeminent military power, but as a foundational guarantor of collective security and a reliable partner to vulnerable nations. The architecture of the postwar international system was built, in substantial part, on the premise that American power would be exercised not exclusively in self-interest, but in service of a broader vision of stability, development, and shared prosperity. Nowhere has this been more consequential than in the Western Hemisphere. Through frameworks such as the Inter-American Treaty of Reciprocal Assistance, the Organization of American States, and decades of bilateral security cooperation, the United States positioned itself as the indispensable anchor of regional solidarity in the Americas, the powerful partner to whom smaller, more vulnerable nations could turn in moments of crisis. This role generated asymmetric but genuine interdependence: the region's stability has benefited from US engagement, and US strategic interests have been served by a hemisphere that is, however imperfectly, integrated, cooperative, and oriented toward democratic governance.

What has been insufficiently appreciated is that global health has functioned, for nearly eight decades, as one of

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the most durable expressions of this same strategic logic. The United States' founding role in the WHO in 1948, its sustained financial contributions, and its technical leadership in confronting HIV/AIDS, tuberculosis, malaria, polio, and pandemic influenza were not acts of philanthropy disconnected from geopolitical reality, they were the health dimension of US global leadership. Just as the US sought to unite the Americas around shared principles of security and democratic governance, it built a global health architecture premised on the idea that a disease contained anywhere protects people everywhere. The WHO was, in this sense, an extension of the same strategic vision: the recognition that the powerful have both the capacity and the interest to protect the vulnerable, and that doing so ultimately strengthens the protector as much as the protected. The current withdrawal represents a departure not only from institutional membership, but from this foundational strategic logic, one whose abandonment carries costs that will be borne most acutely by those least able to absorb them, and eventually, by the United States itself.

The Asymmetric Geography of Consequence

While the editorial correctly emphasizes the impact of the US withdrawal on low- and middle-income countries broadly, the specific consequences for Latin America and the Caribbean merit closer examination. Many countries in the region rely on WHO technical assistance for epidemiological surveillance, vaccine regulatory guidance, and implementation of the International Health Regulations. The PAHO, as the WHO's regional office for the Americas, serves as the primary conduit for this technical cooperation, and any structural weakening of the WHO's financial base risks cascading into regional procurement inefficiencies and reduced technical capacity. As we documented previously, the US accounted for 19.77% and 13.96% of WHO expenditures in 2022 and 2023, respectively, contributing a total of US $1.284 billion in the 2022–2023 biennium,[2] figures that converge with those reported by Yazdi-Feyzabadi et al, and collectively underscore the magnitude of the fiscal void generated by the withdrawal.

These consequences are not limited to the WHO's central budget. PAHO, founded in 1902 and the oldest international health agency in the world, is simultaneously the WHO regional office for the Americas and a treaty-based organization of the inter-American system, of which the United States remains a member. This dual status has not insulated the region. The United States, historically PAHO's largest single contributor, has accumulated substantial arrears in assessed contributions for the 2024–2026 period[3]; in September 2025 approximately US $45 million in previously appropriated allocations were rescinded, and PAHO's programme budget has contracted from more than US $1.14 billion in 2022–2023 to planned spending of US $762 million for 2026–2027.[4] The functions most exposed are precisely those on which the smaller economies of Central America and the Caribbean depend: laboratory and surveillance networks, regulatory strengthening, and the pooled procurement mechanisms of the Revolving Fund for Access to Vaccines and the Strategic Fund for essential medicines.

The epidemiological consequences are already documented. In November 2025, PAHO announced that the Region of the Americas had lost its verification as free of endemic measles transmission, reversing an achievement first certified in 2016 and making the Americas the first WHO region to lose measles elimination status.[5] In 2025 alone, 14 891 confirmed cases and 29 deaths were reported across 13 countries, an approximately 32-fold increase relative to the previous year, with transmission continuing into 2026 and the regional public health risk assessed as very high.[6] Measles does not respect the boundaries of the withdrawal: outbreaks in the United States, Mexico, and Canada have been epidemiologically linked, and the United States has recorded its highest annual case counts since 1991. A regional programme sustained for three decades by shared surveillance, laboratory confirmation and pooled vaccine procurement is faltering at the precise moment when the architecture that supported it is being defunded.

A Deteriorating Situation: The 2026 WHO Statement

The gravity of this situation has deepened since the initial withdrawal announcement. On January 24, 2026, the WHO issued a formal statement following the US notification of definitive withdrawal, acknowledging that the decision makes both the United States and the world less safe.[7] This formal rupture, now proceeding through the WHO Executive Board and the World Health Assembly, represents an institutional inflection point the international community cannot afford to treat as routine diplomatic friction.

What the United States Gains: The Reciprocity of Multilateral Health Cooperation

The editorial, like most of the surrounding literature, documents what the WHO loses when the United States departs. The reciprocal question—what the United States obtains from membership—is rarely posed, yet it is decisive for any realistic appraisal of the decision. It is answered most clearly by instances in which US domestic health protection depends on institutions the country has now left or defunded.

Seasonal influenza is the clearest example. Since 1952 the WHO Global Influenza Surveillance and Response System has operated the longest-standing global platform for systematic disease surveillance, comprising some 150 national influenza centres and seven collaborating centres, one of which is hosted by the US Centers for Disease Control and Prevention (CDC).[8] Twice each year, WHO consultations analyze these data and issue the recommendations on vaccine composition that national regulatory agencies and manufacturers use to produce the following season's vaccines.[9] The United States contributes to this system, but it is also among its principal beneficiaries, since the strains selected for US influenza vaccines are identified largely from viruses collected outside US borders. US experts participated, virtually, in the February 2026 consultation for the 2026–2027 northern hemisphere season, weeks after the withdrawal took formal effect[10]—an implicit acknowledgement that this dependency cannot be legislated away.

Measles offers a second, regionally specific illustration. Elimination status in the Americas is verified not by national

authorities but by PAHO's Regional Monitoring and Re-Verification Commission, which is scheduled to review the status of the United States and Mexico in November 2026.[11] The credibility of a landmark US public health achievement is therefore certified by a regional multilateral body, on the basis of surveillance and genomic data contributed by neighbouring countries.

Beyond these examples the benefits are structural: advance epidemiological intelligence on threats that will reach US ports and airports; access to pathogen sequences and biological materials shared through WHO frameworks; regulatory convergence that lowers barriers for US-manufactured vaccines, diagnostics and biologics; and the diplomatic standing that accrues to the country that convenes and finances collective action. To frame assessed contributions to the WHO as expenditure rather than as investment in domestic health security is to misread the nature of the transaction.

Financing Architecture and the Philanthropy Trap

The editorial raises important concerns about the rising role of private philanthropies in filling the vacuum left by the US withdrawal. From the perspective of recipient countries in the Americas, the philanthro-capitalist model carries inherent risks: priority-setting driven by donor preferences rather than local epidemiological burden, verticalization of disease programmes at the expense of horizontal health system strengthening, and accountability gaps that bypass democratic governance. Latin America has experienced these dynamics firsthand. In Peru, reliance on Global Fund financing for HIV prevention delivered largely through non-governmental organizations, in the absence of commensurate government stewardship, produced parallel structures whose continuity became uncertain once the country ceased to be eligible for external grants.[12] Comparable transitions elsewhere in the region illustrate a recurrent pattern: vertical programmes rarely leave behind the horizontal capacity required to sustain their own results.

The Cascading Consequences for Vulnerable Populations

Among the most measurable consequences of US disengagement is the impact on President's Emergency Plan for AIDS Relief (PEPFAR)- and the United States Agency for International Development (USAID)-funded programmes. Before its dismantling, USAID administered more than US $35 billion in annual programme funding, supported activities in approximately 130 countries, and accounted for a substantial share of humanitarian assistance tracked globally.[13] Its dismantling has resulted in the cancellation of an estimated 25% of international cooperation programmes. PEPFAR-funded HIV care programmes in El Salvador, Guatemala, and Haiti have been suspended or severely curtailed, with the Joint United Nations Programme on HIV and AIDS estimating significant increases in transmission risk and treatment discontinuation.[14] The regional profile of this disruption is distinctive: Latin America finances most of its antiretroviral treatment domestically, but prevention, testing and community-based services for key populations depend heavily on external funding, and it is these components that have been interrupted.[15] Within 90 days of the funding freeze, global estimates projected up to four million unintended pregnancies and at least 8000 additional maternal deaths.[16]

These consequences have materialized in real time. As of May 2026, the WHO reported more than 170 deaths and nearly 750 suspected cases of the Bundibugyo Ebola strain in the Democratic Republic of the Congo, a variant for which no specific vaccine or treatment exists, and warned the true scale was likely considerably larger.[17] The outbreak circulated for weeks before detection because local testing capacity was unavailable and samples had to be transported over a thousand miles to Kinshasa for confirmation. Aid workers attributed this delay directly to layoffs of USAID-funded health workers and the erosion of surveillance infrastructure.[17] A CDC expert on the ground described the agency as "incredibly short-staffed across the board," with the State Department having withheld approximately US $700 million from the CDC's PEPFAR allocation in 2026.[17] The mechanism, however, is not specific to Africa: outbreak detection depends on laboratory and surveillance capacity that is externally financed and regionally coordinated, and the same dependency characterizes arbovirus, measles and antimicrobial resistance surveillance across Latin America and the Caribbean.

The impact has not been confined to Africa. In May 2026, a hantavirus outbreak aboard an international cruise ship carrying passengers from 23 countries exposed the surveillance blind spots created by the US withdrawal. American public health authorities were no longer embedded in the real-time WHO information networks through which the CDC would ordinarily have received advance epidemiological data and participated in viral sequencing.[18] American passengers dispersed across four US states before any CDC public briefing had been issued, prompting the National Public Health Coalition to warn that the withdrawal "puts people in the US at higher risk." These episodes confirm that the consequences of US disengagement are neither abstract nor geographically confined: they are measurable, immediate, and increasingly visible within US borders (Figure). For the Americas the episode is doubly instructive, since the networks through which US authorities would ordinarily have been alerted are the same ones through which PAHO member states exchange early warning under the International Health Regulations.

Regional Resilience and Distributive Justice

Structural reform of the WHO is necessary but insufficient without parallel investment in regional health governance. The COVID-19 pandemic demonstrated that regional solidarity, through mechanisms such as COVAX, can partially compensate for global failures.[19] The WHO's Investment Round,[20] expanded contributions from the European Union, China, and the BRICS nations, and South-South scientific collaboration represent essential components of a more resilient, multipolar global health architecture. The editorial suggests the US withdrawal may serve as a "wake-up call." We concur, while underscoring that the populations bearing the cost of this lesson did not cast the votes that

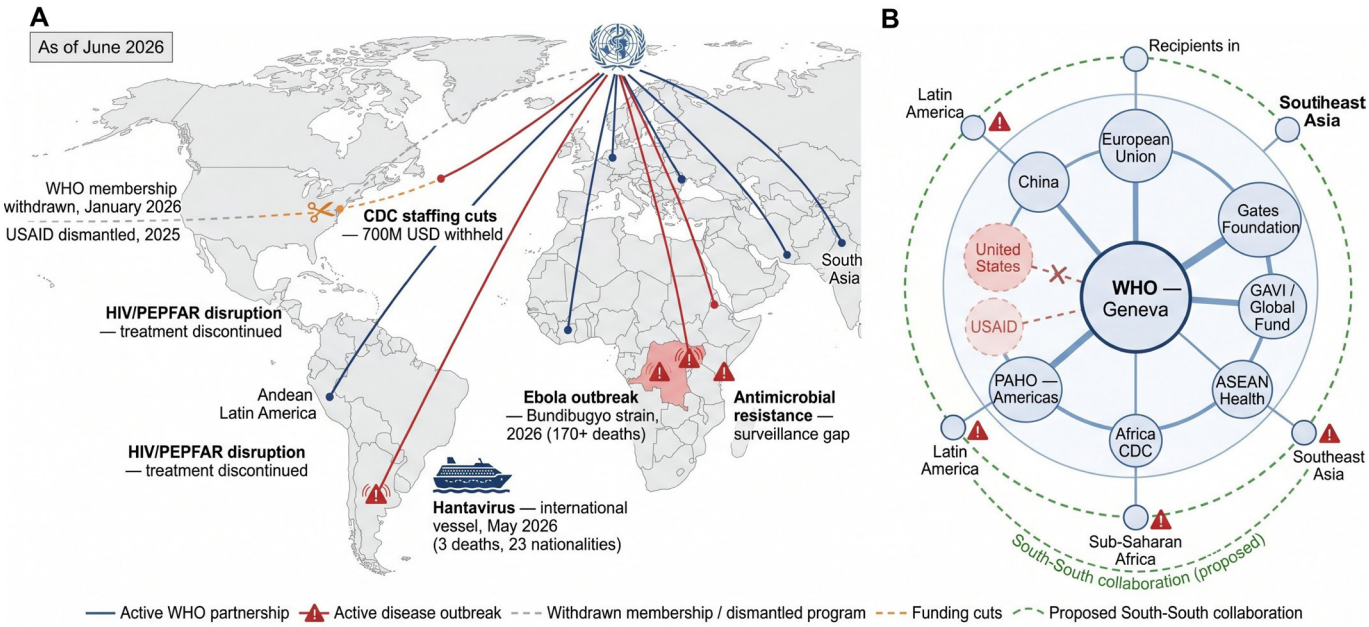

Figure. Global Health Governance Fragmentation Following the United States Withdrawal From the World Health Organization and the Dismantling of the United States Agency for International Development (2025–2026). Panel A: Geographic distribution of active WHO technical partnerships and current disease outbreak alerts as of May–June 2026. Navy blue lines indicate regions with active WHO technical missions; red lines with warning triangles indicate regions affected by active public health emergencies, including the Ebola outbreak caused by the Bundibugyo strain in the Democratic Republic of the Congo (170+ deaths as of May 2026), the hantavirus outbreak aboard an international vessel in the South Atlantic (May 2026, 3 deaths, 23 nationalities affected), antimicrobial resistance surveillance gaps in East Africa, and HIV/PEPFAR program disruption in Latin America and the Caribbean. The dashed grey line toward the United States indicates severed institutional partnerships following WHO membership withdrawal (January 2026) and USAID dismantlement (2025); the dashed orange line indicates funding cuts to the Centers for Disease Control and Prevention, including the withholding of approximately US $700 million from PEPFAR allocations. Panel B: Conceptual network diagram of the current multilateral global health governance architecture. The United States and USAID nodes appear disconnected (dashed red lines, ×) from the WHO center node. Outer recipient regions (Latin America, Sub-Saharan Africa, Southeast Asia) display active outbreak alerts. The dashed green outer ring represents proposed South-South direct collaboration as a resilience strategy. Abbreviations: ASEAN, Association of Southeast Asian Nations; CDC, Centers for Disease Control and Prevention; GAVI, Global Alliance for Vaccines and Immunization; PAHO: Pan American Health Organization; PEPFAR: President's Emergency Plan for AIDS Relief; USAID: United States Agency for International Development; WHO: World Health Organization.

precipitated it. The burden is asymmetrically distributed, and that asymmetry is itself a matter of global justice. In the Americas this architecture already exists and is underused: PAHO's Revolving and Strategic Funds, the joint negotiation of medicine prices by the Council of Ministers of Health of Central America and the Dominican Republic, the Caribbean Public Health Agency, and the Andean Health Organization offer institutional platforms capable of absorbing part of the technical and procurement functions now at risk, provided that member states are willing to finance them.

Conclusion

The withdrawal of the United States from the WHO is a consequential and strategically self-defeating decision. It threatens pandemic preparedness, health equity, and the legitimacy of multilateral governance, and its earliest measurable effects in the Americas—a region that has lost measles elimination, a regional office facing arrears and budget contraction, and interrupted HIV prevention services—show how quickly institutional retreat becomes epidemiological loss. The United States built its global standing on the credibility of being the partner that shows up, extending its power in service of collective security and the protection of the vulnerable, above all in this hemisphere. That logic applies to health with unusual force, because the benefits are reciprocal and demonstrable: the composition of US influenza vaccines, the verification of US elimination achievements, and the early warning that precedes imported threats all depend on institutions the country has now left or defunded. The unfolding crises in the Democratic Republic of the Congo and aboard an international vessel are not hypothetical warnings; they are evidence that this departure carries costs measured in lives. We endorse the calls by Yazdi-Feyzabadi et al for governance reform, financial diversification, and renewed US engagement, and add our own: invest in regional health architectures, strengthen South–South and intraregional collaboration, and establish binding governance frameworks for private sector participation in global health. In an interconnected world, no population is secure until all are protected.

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The authors used a large language model for language editing only. All scientific content, interpretation, and references were produced and verified by the authors, who take full responsibility for the final text.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

Disclaimer

The views expressed in this commentary are those of the author and do not

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