

The US withdrawal from the WHO and the assault on public health

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On January 22, 2026, the United States formally completed its withdrawal from the World Health Organization (WHO), ending a 78-year relationship that began with the agency's founding in 1948. This rupture comes at a moment of heightened global risk. As the COVID-19 pandemic enters its seventh year and domestic outbreaks of measles and other preventable diseases rise to levels not seen in decades, peer-reviewed research shows that the forces driving pandemic emergence are accelerating rather than receding.

A major 2022 study led by Colin Carlson of Georgetown University's Department of Biology and published in *Proceedings of the National Academy of Sciences* found that climate change alone is expected to trigger thousands of new cross-species viral transmission events in the coming decades, sharply increasing the likelihood of novel human infections. By withdrawing from the WHO, the United States has weakened its access to coordinated global disease surveillance and early warning systems at precisely the moment when scientific evidence indicates that new pandemic threats are becoming more frequent and harder to contain.

In a joint statement announcing the withdrawal, Health and Human Services Secretary Robert F. Kennedy Jr. and Secretary of State Marco Rubio justified the decision by accusing the WHO of mishandling the COVID-19 pandemic and failing to implement what they described as necessary institutional reforms. The statement asserted that the WHO delayed declaring a global health emergency, minimized the risks of asymptomatic and airborne transmission, and offered praise for China's early response despite later evidence of reporting delays and data gaps.

WHO technical leadership, independent epidemiologists, and peer-reviewed research documented early warnings about human-to-human transmission and airborne spread and emphasized the limits imposed by incomplete and evolving data in the first weeks of the outbreak. Nevertheless, the administration presented disputed claims as settled conclusions, reinforcing a political narrative that portrays the WHO as compromised by state influence rather than as a multilateral scientific body operating under the constraints of its member states.

The initial response to COVID-19

By all credible accounts, the global response to COVID-19 unfolded under unprecedented conditions. In late December 2019, clinicians in Wuhan began reporting clusters of pneumonia cases of unknown cause, prompting local investigations as health authorities worked to identify the pathogen and determine whether sustained human-to-human transmission was occurring. On January 3, 2020, after several days of internal assessment, Chinese health authorities formally notified the United States and the WHO of the outbreak through established public health channels,

as the virus began spreading beyond the initial cluster.

Within days, Chinese scientists had sequenced the virus and identified it as a novel coronavirus, and the genetic sequence was shared publicly in mid-January, allowing laboratories worldwide to begin developing diagnostic tests. As evidence of international spread mounted, the WHO declared the outbreak a Public Health Emergency of International Concern on January 30, 2020. By early February, senior US officials already understood that the virus posed a serious airborne threat. In a recorded interview on February 7, 2020, then-President Donald Trump told journalist Bob Woodward that the virus "goes through the air," acknowledging privately what had not yet been communicated clearly to the public. This assessment reflected information available through internal briefings from public health agencies and intelligence reporting, even as official messaging continued to minimize the danger.

As the pandemic escalated globally, communication continued at the highest political levels. On March 27, 2020, Trump and Chinese President Xi Jinping spoke by phone about the spread of the virus, with both governments publicly describing the call as focused on cooperation and information sharing.

Rather than treating the early uncertainties of the outbreak as a scientific problem requiring sustained international coordination, the Department of Health and Human Services moved to recast them as evidence of institutional failure. HHS officials increasingly promoted the lab-leak hypothesis as a settled explanation for the pandemic's origins, arguing that the WHO had failed to act independently of what they described as inappropriate political influence from member states. This critique centered on the WHO's origins report, which had not endorsed a laboratory origin based on the evidence available at the time, although it had not discounted it either. The administration used this framing to justify withdrawing from the WHO and replacing multilateral engagement with an "America First" global health strategy built around bilateral arrangements and partnerships with private and faith-based organizations.

The consequences of the United States' formal withdrawal from the WHO have now begun to unfold. In response, WHO Director-General Tedros Adhanom Ghebreyesus described the decision as a loss "for the United States, and also a loss for the rest of the world," warning that it ultimately makes the US less safe. While the WHO has maintained that the withdrawal is technically incomplete until the United States settles substantial financial arrears, estimated at nearly \$200 million in unpaid assessed contributions for 2024 and 2025, the agency has nonetheless been forced to move ahead with deep structural cuts. These include a budget reduction of roughly 22 percent and significant workforce reductions to offset the loss of its largest historical donor. Tedros described the U.S. exit as a major factor in one of the most difficult years in the organization's history, while stressing that international cooperation and solidarity against shared biological threats remain more important than financial disputes.

The U.S. departure has triggered a fiscal crisis within the WHO, forcing

the agency to cut its 2026–2027 budget to approximately \$4.2 billion and eliminate nearly one quarter of its global workforce. Despite a 20 percent increase in assessed contributions from other member states, the organization continues to face a projected funding shortfall of about \$1.05 billion, worsened by the US refusal to pay between \$200 million and \$278 million in outstanding arrears. According to reporting by *Politico*, the WHO's long-term stability, and any prospect of renewed US engagement, is now tied to the impending leadership transition, as Tedros is set to step down in 2027 due to term limits.

While some observers have characterized the transition as a potential reset in relations, the Trump administration has reportedly pushed for an American Director-General or Inspector General, complicating the prospects for widely discussed candidates such as Hanan Balkhy and Hans Kluge. Although the United States will have no formal role in the selection process, the outcome is likely to shape whether the WHO can stabilize its operations or whether the current geopolitical rupture becomes entrenched.

The funding shock triggered by the US withdrawal has placed several core WHO functions at immediate risk, weakening the global systems that detect, contain and prevent disease outbreaks.

One of the most consequential losses is the destabilization of the Global Influenza Surveillance and Response System, the international network of 152 national influenza centers that tracks how flu viruses evolve across regions and seasons. This system underpins the annual selection of vaccine strains and serves as an early warning mechanism for pandemic influenza. With the United States no longer participating fully, access to shared viral samples and coordinated analysis is diminished. At the same time, the global system loses the analytical capacity of US laboratories. The result is a mutual weakening of surveillance that leaves countries less able to anticipate dangerous mutations and respond before outbreaks spread.

The withdrawal has also intensified the crisis facing the Global Polio Eradication Initiative, a decades-long effort that has brought the world to the brink of eliminating the disease. The initiative is now confronting a funding gap of approximately \$440 million and has been forced to implement a 30 percent budget cut for 2026. These reductions threaten vaccination campaigns and surveillance in the few remaining regions where polio transmission persists, increasing the risk that the virus could resurge in areas previously declared polio-free.

Global public health efforts undermined

In conflict and humanitarian settings, the loss of US funding has weakened the Early Warning, Alert and Response System, which operates in places such as Syria, Somalia and South Sudan where the health infrastructure has collapsed. This system is often the only means of detecting outbreaks of cholera, measles or Ebola before they escalate into regional emergencies. Reduced support limits the ability to identify and respond to these threats quickly, increasing the likelihood that localized outbreaks will spread across borders.

Beyond individual programs such as maternal and child health services, neglected tropical disease elimination and chronic disease surveillance, the withdrawal has hollowed out the WHO's technical capacity itself. The elimination of more than 2,300 positions, roughly one quarter of the organization's workforce, represents a severe loss of institutional memory and specialized expertise. This includes scientists and regulators who coordinate vaccine development, laboratory diagnostics, and international standards for new medicines. The departure of US-embedded experts has created gaps in the global health architecture that are difficult to replace

and leaves dangerous blind spots in systems designed to protect populations from emerging biological threats.

The US withdrawal from the WHO is not a stand-alone foreign policy move. It reflects a parallel dismantling of public health at home.

Inside the United States, the federal government has abandoned the longstanding principle that the state bears responsibility for limiting disease, replacing it with a doctrine of "individual choice" that disregards how infectious threats spread. This shift was formalized one year ago, when the administration elevated the lab-leak hypothesis to official doctrine, rejected natural spillover as a working framework, and recast the global public health system as the source of the crisis rather than a mechanism for containment. Since then, domestic health institutions have been reshaped accordingly. With Kennedy spearheading the wrecking operation, DHS has overhauled leadership and advisory structures at the CDC, NIH and FDA, removed experienced experts, sharply reduced routine childhood immunization schedules, and repopulated scientific oversight bodies with ideological opponents of public health intervention.

The consequences of this "America First" health strategy are already visible in the United States. The country is experiencing its twelfth wave of COVID-19 alongside a severe influenza season that has already claimed the lives of 44 children. Preventable diseases once thought to be under control are resurging at an accelerating pace. By late January 2026, 416 confirmed measles cases had been reported across 14 jurisdictions, already exceeding totals from the unprecedented surge seen in 2025.

In public remarks addressing the outbreaks, Ralph Abraham, the principal deputy director of the CDC and the agency's second-highest ranking official, suggested that measles transmission was largely driven by imported cases, framing the resurgence as a border-related problem. Abraham has emerged as a key figure in the Kennedy-led Department of Health and Human Services, where public health guidance has increasingly been subordinated to political messaging.

Because of the current upsurge, the US is likely to lose its status as a country where measles has been eliminated. Abraham, asked if he viewed this as a significant event, replied, "Not really." A physician who formerly served as Louisiana's surgeon general, Abraham continued, "You know, it's just the cost of doing business, with our borders being somewhat porous [and] global and international travel."

As reported by *STAT News*, recent policy changes under HHS and the Centers for Medicare and Medicaid Services rolled back federal requirements for standardized reporting of vaccination status during outbreaks, limiting the CDC's ability to assess how immunity gaps are driving domestic spread. In this context, Abraham's remarks politicize what is fundamentally a public health imperative, shifting attention away from declining vaccination coverage and weakened prevention efforts toward scapegoating the world outside the United States.

The damage from this shift is already evident inside the United States' core scientific institutions. At the National Institutes of Health, pandemic preparedness has been reframed in ways that break with decades of epidemiological research and the historical record of mass death from infectious disease. Diet, exercise and individual health are being elevated as the primary defense against pandemics, a position that runs counter to the scientific consensus built through generations of study on airborne transmission, vaccination and population-level prevention.

The attack on vaccination

NIH officials Jay Bhattacharya and Matthew Memoli have argued that the traditional pandemic response, including testing, vaccination and public health mandates, created a false sense of security. In its place, they

have promoted what they describe as making the population healthier through individual behavior.

In a January 2026 editorial published in *Science*, former Global Vaccine Alliance (GAVI) chief executive Seth Berkley warned that such “magical thinking will not prevent future pandemics or improve public health,” stressing that highly transmissible pathogens cannot be controlled through personal health measures alone. Berkley noted that while general health is important, it offers little protection against viruses that spread through shared air and contact, pointing to historical pandemics such as the 1918 influenza and smallpox, which disproportionately killed millions of young adults who were otherwise healthy.

This rejection of scientific precedent is most clearly reflected in changes to federal vaccine policy. Under new leadership, the Advisory Committee on Immunization Practices has shifted away from its long-standing role of prioritizing population-wide protection. Its chair, Kirk Milhoan, a pediatric physician, has stated that a parent’s individual right to refuse vaccination supersedes risks to the broader community. He has argued that mandatory vaccination undermines informed consent and has treated the return of diseases such as measles and polio as acceptable consequences of individual choice. This reasoning abandons the central premise of public health: that individual decisions cannot contain threats that spread through shared spaces, shared air and shared vulnerability.

While officials present these policies as a restoration of liberty, their impact on children tells a different story. A recent study by the Centers for Disease Control and Prevention found that children with Long COVID are two and a half times more likely than their peers to experience chronic school absenteeism, often accompanied by memory impairment and persistent fatigue. These outcomes stand in direct contrast to the administration’s insistence on a rapid return to normalcy. Together, they expose the practical meaning of the claim that the cure cannot be worse than the disease. In prioritizing economic activity and political ideology over biological risk, the federal government has effectively accepted widespread infection, long-term disability and preventable death as tolerable outcomes of its policy choices.

The dismantling of the World Health Organization alongside the erosion of domestic health agencies constitutes a direct assault on the social gains won by the working class over the past century. The public health infrastructure that dramatically extended human life through sanitation, disease surveillance, and vaccination was not bestowed from above. It emerged from collective struggle and the disciplined application of scientific knowledge. That infrastructure is now being deliberately dismantled by an administration that treats mass infection and the loss of measles elimination status as acceptable outcomes, described openly as the cost of doing business. As institutional expertise is stripped away and scientific standards are subordinated to claims of individual choice, the state is abandoning its responsibility to protect the population from biological threat, replacing evidence-based governance with policies that place profit above human life.

This destruction of public health is therefore not a technical failure but a class question with direct consequences for democratic rights. The normalization of mass illness and premature death has accelerated a widening gap in life expectancy, as those with wealth retain access to private protection while working families are left exposed to preventable disease, long-term disability, and early death. The defense of science and public health cannot be entrusted to institutions that have been repurposed to legitimize this outcome. It must be taken up as a political struggle, rooted in the defense of collective life itself. A globally coordinated, scientifically grounded public health system is not optional. It is inseparable from the right to live.



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