Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Institutional Exit and Practical Autonomy: U.S. Withdrawal from WHO and the Option Value of Global Health Institutions

Jing Ge

jge003@fiu.edu

Florida International University

Research Article

Keywords: institutional exit, global health governance, practical autonomy, surveillance capacity

Posted Date: July 9th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10148172/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

This paper examines when withdrawal from an international organization increases rather than weakens state autonomy. By using the U.S. withdrawal from the World Health Organization (WHO) as a theory-building case, this paper develops a function-level framework of institutional option value. The paper argues that institutional exit should not be evaluated only at the level of membership in an organization. It should be assessed at the level of specific institutional functions, because the same organization can contain low-cost technical platforms, high-value but politically contested governance bodies, marginal forums, and autonomy-costly legal commitments. The paper operationalizes two dimensions—option value and autonomy cost—and applies them to WHO-related functions using public documentary evidence from official U.S. and WHO sources, public-health institutional materials, and secondary scholarship. The analysis shows how broad organizational exit may reduce practical autonomy through information loss, rule-making vacancy, burden shifting, and credibility volatility. In the conclusion, the paper reframes autonomy as the preservation of useful choices under interdependence and shows why institutional exit should be analyzed by function rather than by organizational label.

Introduction

Global health governance turns distant outbreaks into domestic policy questions. A respiratory signal in one region, a hemorrhagic-fever cluster across a border, or a zoonotic infection in an animal reservoir can affect clinical alerts, travel guidance, vaccine preparation, laboratory protocols, and emergency planning in the US. The institutions that organize these signals are part of the health-security infrastructure. They do not simply express international cooperation. They help determine how quickly governments see a threat, how confidently they interpret it, and how costly the response becomes once the threat moves across borders.

However, the US withdrawal from WHO places this infrastructure at the center of an institutional-exit debate. On January 20, 2025, President Trump signed Executive Order 14155, directing the US to withdraw from WHO and to pause the transfer of US funds, support, and resources to the organization (White House 2025). In January 2026, HHS announced that the US had completed the withdrawal and had begun shifting activities previously conducted with WHO toward direct bilateral engagements with other countries and organizations (HHS 2026). The US government also rejected the 2024 amendments to the International Health Regulations, arguing that they created unacceptable sovereignty risks (HHS and State Department 2025).

As a treaty platform, a technical agency, a convenor of expert networks, a public-health intelligence hub, a connector of laboratories, and a site where governments negotiate the rules and expectations of emergency response, WHO’s functions include the International Health Regulations (IHR), which structure global early warning and notification; the Global Influenza Surveillance and Response System, which supports influenza monitoring and vaccine-strain recommendations; GOARN, which connects

outbreak-response expertise; and EIOS, which organizes epidemic intelligence from open sources (WHO 2026a).

Although the US leaves the WHO, it still needs outbreak intelligence, pathogen samples, sequencing information, laboratory interpretation, emergency recommendations, vaccine-composition assessments, and channels to compare signals with other governments. Although direct bilateral engagement can replace some channels, and domestic agencies can build parallel capacity, those substitutes cannot provide the same information, speed, reach, and credibility at an acceptable cost.

Global health governance scholarship has long shown that infectious disease blurs the boundary between domestic policy and international order. SARS helped transform older sanitary conventions into a broader legal and institutional framework for managing cross-border health risk (Fidler 2004). The revised IHR expanded expectations of rapid reporting, surveillance capacity, and international notification, even though compliance has remained uneven (Kamradt-Scott and Rushton 2012). Global health institutions can both protect populations and create political disputes over authority, sovereignty, and whose security receives priority (Rushton 2011).

In this context, the paper examines under what conditions withdrawal from an international health organization increases or weakens US practical autonomy. Practical autonomy refers to the capacity to preserve useful choices under conditions of interdependence. In global health, that capacity depends on early warning, expert access, laboratory networks, data interpretation, emergency coordination, and the ability to shape rules before they become embedded in international practice. A government can formally exit an institution and still face the risks, rules, and information demands produced by the same transnational disease environment.

The paper argues that institutional exit should be evaluated by function. Withdrawal can increase autonomy when it removes commitments that impose high legal, financial, or domestic-policy costs while producing little usable information or coordination value. Withdrawal can weaken autonomy when it separates the US from low-cost systems that generate early warning, technical assessment, and crisis coordination. WHO illustrates both possibilities because it contains high-value information platforms, reformable governance functions, marginal activities, and potentially costly legal commitments in the same organizational space.

The paper is divided into eight parts. The first reviews existing scholarship on international institutions, institutional authority and exit, and global health governance, identifying the gap that motivates the analysis. The second develops the theory of institutional option value and presents the typology. The third explains the research design and case selection. The fourth applies the typology to WHO. The fifth identifies the mechanisms through which broad exit can reduce practical autonomy. The sixth discusses implications for institutional selectivity. The final section concludes by reflecting on what the WHO case reveals about autonomy in global health governance.

Literature Review

Existing literature on international institutions provides the first foundation for answering this question. Institutional theory shows that states create and use international organizations because they reduce transaction costs, generate information, stabilize expectations, and make cooperation less costly than repeated ad hoc bargaining (Keohane 1984). Later work on institutional design adds that organizations vary because states design institutions to solve different cooperation problems, including uncertainty, distributional conflict, enforcement, and coordination (Koremenos et al. 2001). This literature explains why information-producing and coordination-providing organizations can remain useful even when states distrust the broader political environment.

Some scholars emphasize institutional authority, delegation, legitimacy, and pathology. International organizations can develop bureaucratic routines, expert authority, and organizational preferences that diverge from the preferences of member states (Barnett and Finnemore 1999). Delegation can help states solve technical and informational problems, while also creating agency slack and accountability concerns (Hawkins et al. 2006). The growing authority of IOs also generates politicization when domestic actors begin to see international bodies as constraints on democratic control or national discretion (Zurn et al. 2012). This work explains why skepticism toward WHO and similar bodies cannot be dismissed as irrational anti-institutionalism.

Others examine institutional exit and contested multilateralism. Withdrawal can function as a bargaining tool, a signal of dissatisfaction, or a strategy for institutional change (von Borzyskowski and Vabulas 2024). States may also move across forums when existing institutions become blocked, creating overlapping venues and strategic alternatives (Morse and Keohane 2014). In this sense, exit is more than abandonment. It can be part of a broader institutional strategy when states possess credible alternatives and can preserve the functions they still need.

In addition, work on SARS shows how infectious-disease politics pushed international law beyond older sanitary conventions and toward broader governance of cross-border risk (Fidler 2004). The 2005 IHR revision marked a legal shift from state-by-state sanitary control toward a wider global health-security framework (Fidler 2005). The revised IHR expanded the logic of global public-health surveillance by emphasizing notification, assessment, and information exchange rather than only border measures (Baker and Fidler 2006). Legal and public-health scholarship treats the IHR as a central framework for global health security because it creates procedures for notification, assessment, and international coordination during cross-border health events (Gostin and Katz 2016). Research on disease diplomacy and global health security also shows that health institutions operate simultaneously as technical systems and political arenas (Davies et al. 2015). The security framing of health can focus policy attention, while also narrowing priorities and shifting attention toward threats that affect powerful states (McInnes and Lee 2006). Critical work on global health security asks whose security is protected when health risks are framed as security problems (Rushton 2011). Existing literature on oversecuritization further warns that emergency language can distort priorities and reduce space for broader public-health objectives (Wenham 2019). These provide the empirical foundation for treating WHO as more than a symbolic multilateral body.

Nevertheless, the existing literature leaves three gaps that this paper addresses. First, the institutional exit literature usually analyzes withdrawal at the level of the organization or treaty, while this paper disaggregates a single organization into functions. WHO contains early-warning networks, laboratory systems, emergency coordination channels, treaty processes, budgetary politics, and low-salience diplomatic forums. Each function creates a different combination of option value and autonomy cost. Second, the institutional design literature explains why information and coordination are useful, while this paper applies that insight to the replacement problem after exit. The main question is whether the US can replace WHO-linked functions at equal reliability and lower cost. Third, the global health governance literature explains the value and limits of WHO, while this paper connects that literature to a broader theory of practical autonomy.

The paper develops the concept of institutional option value. Option value refers to the value of remaining present in a body, network, or process because presence preserves future choices that would be slower, more expensive, or less reliable to recover after exit. The concept does not assume that international organizations are inherently beneficial. It asks whether a given institutional function preserves information, bargaining access, technical influence, or burden sharing at a lower cost than unilateral substitution. A function with high option value and low autonomy cost should be preserved. A function with low option value and high autonomy cost should be cut or rejected.

Theoretical Framework

The paper develops a typology, which separates institutional functions along two dimensions: option value and autonomy cost (see Table 1). Option value is high when participation preserves information, rule-making access, technical influence, partner coordination, or crisis-response capacity that would be costly to rebuild after exit. Autonomy cost is high when participation imposes legal, budgetary, bureaucratic, or political constraints that reduce US discretion without producing equivalent benefits. The typology is a diagnostic framework, not a causal mechanism. It classifies institutional functions so that the later mechanisms–information loss, rule-making vacancy, burden-shifting, and credibility volatility–can be traced more precisely.

Combining the two dimensions produces four types of institutional participation. The framework evaluates specific functions inside an organization. WHO, for example, contains Type I, Type II, Type III, and Type IV functions at the same time. This is why a single stay-or-leave position is analytically weak. The relevant object of analysis is not WHO as a label, but the particular function being preserved, reformed, downgraded, or rejected.

The typology is built from the same problem emphasized in institutional design theory: cooperation failures differ across issue areas, so institutional arrangements should be evaluated by the specific function they perform (Martin and Simmons 1998). In some domains, the dominant problem is uncertainty and information; in others, it is distributional conflict, legal constraint, monitoring, or domestic accountability. A function-based typology is therefore more precise than a general position for

or against WHO membership. It asks what each component does, what it costs, and what the US would need to replace if it left.

This approach also draws on research showing that IO authority varies across organizations and policy domains. Some organizations possess strong legal or administrative authority; others operate mainly through information, expertise, and coordination (Hooghe et al. 2019). WHO contains both kinds of activity. Its emergency declarations, standards, and legal instruments raise issues of authority and accountability, while its surveillance networks and collaborating centres mainly create informational and epistemic value. Distinguishing those functions allows the analysis to avoid treating technical information systems and autonomy-costly commitments as if they were the same kind of institutional involvement.

Table 1
A Typology of Institutional Participation

Type	Option value	Autonomy cost	Institutional function	Preferred policy
Type I: Option-preserving platforms	High	Low	Technical networks, surveillance systems, standards, early warning, data access, expert channels	Remain and contest narrowly; preserve technical participation and agenda-setting influence
Type II: Conditional reform bodies	High	High	Valuable institutions with governance, budget, political, or accountability problems	Remain conditionally; tie funding and participation to audits, transparency, mandate discipline, burden sharing, and reform benchmarks
Type III: Discretionary low-stakes forums	Low	Low	Symbolic meetings or marginal activities with little strategic effect and limited cost	Downgrade, consolidate, monitor, or delegate to lower-level participation
Type IV: Autonomy-eroding commitments	Low	High	Commitments that impose legal, fiscal, or policy constraints without offsetting information, rule-making, or burden-sharing benefits	Exit, reject, suspend funding, or replace with narrower coalitions and bilateral tools

Type I: Option-Preserving Platforms

Type I functions are the strongest cases for continued technical access. They give the US a seat inside information and rule-making systems that will continue regardless of US government participation. In global health, IHR surveillance, GISRS, GOARN, WHO collaborating centres, Disease Outbreak News, and Epidemic Intelligence from Open Sources all fit this logic to varying degrees. They create channels through which governments and laboratories share signals before a threat becomes a crisis (WHO

2026a). Their outputs shape practical decisions: which pathogen is watched, which laboratory sequence requires attention, which emergency is escalated, which vaccine strain is recommended, and which clinicians receive alerts.

The autonomy cost of these platforms is often modest because they are technical and informational. Participation allows US experts to see information earlier, challenge assumptions, contribute data, and shape technical language while leaving domestic policy choices in US hands. For a cost-sensitive state, this can be a bargain: a limited investment in expert presence may reduce the likelihood that the US later needs to respond through emergency appropriations, travel restrictions, ad hoc bilateral pressure, or domestic crisis spending.

Type II: Conditional Reform Bodies

Type II functions combine high value with high cost. WHO as an organization often belongs here. It provides information and coordination functions that no country can easily reproduce by itself, while its governance pathologies remain significant. WHO relies heavily on voluntary and earmarked contributions; in the 2024–2025 budget period, voluntary contributions accounted for about 83% of revenue, and WHO itself has argued that inflexible funding hampers operations (KFF 2026). The organization also faces the classic IO problem that bureaucratic authority can help solve coordination problems and can also produce mission creep, insulation from accountability, and politicized priorities (Barnett and Finnemore 1999).

A Type II classification supports conditional reform. The US government can preserve high-value technical access while tying money, governance participation, and political support to auditability, transparency, emergency-performance benchmarks, independence of technical assessment, and clearer separation between science and advocacy.

Type III: Discretionary Low-Stakes Forums

Type III functions are low-value and low-cost. In WHO and the wider UN health ecosystem, these may include meetings, declarations, campaigns, or side initiatives that are diplomatically pleasant while doing little to affect US security, market access, disease intelligence, or crisis response. A selective policy should avoid spending major diplomatic capital on them. Downgrading participation, sending technical staff rather than cabinet officials, consolidating meetings, or requiring periodic review may be enough.

This category reduces overreaction. Treating every marginal forum as an existential intrusion on sovereignty wastes attention that should be reserved for institutions with real strategic consequences. The goal is to prioritize attention and resources.

Type IV: Autonomy-Eroding Commitments

Type IV functions are the cases where exit or rejection is justified. These commitments impose high autonomy costs while producing little offsetting option value. In global health, the clearest candidates are treaty or regulatory provisions that could create open-ended funding obligations, vague legal duties, intrusive domestic-policy constraints, or weakly accountable allocation mechanisms. The 2024 IHR amendments and 2025 Pandemic Agreement became politically controversial in part because critics feared that emergency language, equity obligations, or future pathogen access-and-benefit-sharing rules could constrain national discretion without sufficient accountability (HHS and State Department 2025).

This typology directs the US to distinguish between IHR early warning as a Type I information platform, WHO as a Type II reform body, low-salience meetings as Type III, and open-ended or poorly defined legal commitments as Type IV. The practical rule is straightforward: cut commitments that erode autonomy and preserve the low-cost tools that strengthen it.

Case Study

This paper uses a single-case research design to examine the functional consequences of institutional exit. The purpose of the case is not to treat WHO as representative of all international organizations. It is to use a complex and contested organization to show why exit should be evaluated at the level of institutional functions rather than at the level of organizational labels.

WHO is an unusually good test case because it is politically contested, technically important, and directly connected to the 2025–2026 US withdrawal. It is also a hard case for both sides. Supporters of withdrawal can point to COVID-19 controversies, perceived Chinese influence, bureaucracy, funding distortions, and disputed treaty negotiations (White House 2025). Critics of withdrawal can point to disease surveillance, influenza vaccine composition, GOARN, technical collaborations, and the costs of fragmented alternatives (KFF 2026).

Existing literature on WHO's institutional design helps explain why this case cannot be reduced to a single verdict. WHO's federal structure and powerful regional offices have produced recurring tensions between central direction and regional autonomy (Hanrieder 2015). Its authority also depends heavily on expert credibility, agenda-setting, and the ability to convene actors it does not command (Youde 2012). These features make WHO simultaneously useful and frustrating. It can coordinate expert networks that no single state controls, while also producing the governance problems that make conditional reform necessary.

The history of IHR reform reinforces this point. The revised IHR helped socialize states into a broader norm of rapid reporting and shared responsibility for health threats, even though compliance has remained uneven (Kamradt-Scott and Rushton 2012). Disease diplomacy research shows that outbreaks can drive legal and normative change because pathogens expose the limits of purely national control (Davies et al. 2015). Therefore, the US withdrawal decision occurred in a field where rules and expectations continue to develop even when the US government rejects some of them.

The case conducts a functional analysis. WHO is simultaneously a political body, a treaty platform, a technical agency, an emergency coordinator, a laboratory network connector, and a source of health information. Treating WHO as one object obscures the variation among its functions. The rest of this section applies the typology to the WHO case in four steps.

The administration's own withdrawal statement illustrates the substitution problem. HHS and State stated that the US had begun pivoting activities previously conducted with WHO to direct bilateral engagements with other countries and organizations (HHS 2026). The statement concedes that many WHO-linked functions persist after exit and require replacement. The cost and reliability of the replacement determine whether exit increases autonomy.

Type I in Practice: WHO as an Option-Preserving Information Platform

The first practical application begins with early warning because it sits upstream from every later policy choice. The International Health Regulations are often discussed as legal obligations, and one of their core functions is informational. WHO describes the IHR as requiring it to maintain a global public-health surveillance system, assess public-health events, and notify states about risks that may spread internationally (WHO 2026a). The value of this function does not depend on treating WHO as a domestic regulator. It depends on whether the US receives usable signals early enough to act before a foreign outbreak becomes a domestic emergency.

For the US, the early-warning function serves concrete national interests. It reduces uncertainty before a threat reaches US territory. A Bundibugyo Ebola signal from Ituri or Kampala can affect US clinical alerts, traveler guidance, and laboratory readiness (CDC 2026e). A zoonotic-influenza signal from Guangdong can matter because WHO has previously reported severe human avian-influenza infection from Guangdong Province in China after poultry exposure (WHO 2023). A Cambodia H5N1 signal can alter US risk assessment because recent human H5N1 cases in Cambodia form part of the global avian-influenza picture (CIDRAP 2026). A European wastewater signal can help interpret cross-border infectious-disease trends because ECDC now treats wastewater surveillance as part of EU/EEA-level infectious-disease monitoring (ECDC 2025). Earlier information can prevent larger interventions later. Exiting an information platform may reduce formal obligations while increasing the chance that the US learns of threats later or through narrower channels.

One of the clearest examples is the Global Influenza Surveillance and Response System (GISRS). GISRS is the global laboratory and surveillance network that supports international virological and epidemiological surveillance of influenza, shares candidate viruses, and feeds into WHO's twice-yearly vaccine composition recommendations (WHO 2026b). The 2026–2027 Northern Hemisphere influenza vaccine composition recommendations were released by WHO on February 27, 2026, after consultations linked to GISRS (WHO 2026c). Those recommendations shape manufacturers, regulators, and national

immunization planning. If the US loses coordinated participation in this system, the effect is diplomatic; it can affect vaccine preparedness.

GISRS also connects to pandemic influenza preparedness. WHO's Pandemic Influenza Preparedness Framework is built on virus sharing, benefit sharing, and governance; member states share influenza viruses with pandemic potential through GISRS, which supports risk assessment and development of pandemic vaccines (WHO Europe 2024). This Type I function preserves options. Participation gives US scientists and regulators better access to data, viruses, and technical discussions before decisions are locked in while leaving domestic vaccine policy under US control.

H5 bird flu shows why global and domestic surveillance cannot be separated. According to the CDC, since early spring 2024, it has used multiple approaches to track H5 bird flu in the US, including national flu surveillance, targeted H5 monitoring, wastewater surveillance, and emergency-department information (CDC 2025). CDC's current situation summary notes continued outbreaks in birds and other animals and sporadic human cases (CDC 2026b). A CDC global H5N1 summary reports that since 1997, more than 1,000 sporadic human infections have been reported from 25 countries and roughly 48 percent have died, while illness severity has ranged from mild to fatal (CDC 2026c).

Those examples show why US autonomy depends on information outside US borders. Avian influenza evolves through animal reservoirs, migratory birds, poultry systems, dairy cattle, and occasional human infections. WHO regional guidance emphasizes that avian influenza viruses do not currently transmit easily from person to person, while ongoing circulation in poultry remains concerning because the viruses can mutate and become more contagious (WHO Western Pacific 2026). US agencies need domestic surveillance, international reporting, sequence sharing, and technical comparison. The policy choice concerns whether US agencies receive broad, timely signals or must piece them together through slower bilateral arrangements.

Moreover, WHO-linked networks provide rapid response and public-health intelligence. GOARN is a technical partnership coordinated by WHO for rapid identification, confirmation, and response to public-health emergencies of international importance; WHO's Western Pacific description notes that GOARN comprises more than 300 technical institutions and networks globally (GOARN 2026). CDC describes itself as having been a crucial partner of GOARN for more than two decades and describes the network as helping rapidly identify, confirm, and respond to international public-health emergencies (CDC 2026d).

EIOS performs a different but related function: it gathers information from official and unofficial open electronic sources to support epidemic intelligence (WHO 2025a). WHO's 2024–2026 EIOS strategy describes it as a coordinated approach to strengthening public-health intelligence through the WHO Hub for Pandemic and Epidemic Intelligence in Berlin. WHO Disease Outbreak News provides curated outbreak reports that are now sufficiently systematic that researchers are building epidemiological knowledge graphs from them (Consoli et al. 2025). WHO collaborating centres provide another channel of technical influence: WHO describes more than 800 collaborating centres across more than 80

member states, and CDC's National Centre for Health Statistics hosts the US WHO-FIC collaborating centre for ICD and ICF work (WHO 2026d).

Above all, these are central information assets for global health security. Their value is greatest before a crisis is obvious. By the time a pathogen is already in US hospitals, the marginal value of earlier global signal detection becomes visible only in hindsight. Hence, Type I functions are easy to underfund and easy to dismiss politically since their success often looks like nothing happened.

The 2026 Bundibugyo Ebola outbreak in the Democratic Republic of the Congo and Uganda illustrates the information-loss problem with unusual clarity. On May 17, 2026, WHO determined that an Ebola disease outbreak caused by Bundibugyo virus in DRC and Uganda constituted a Public Health Emergency of International Concern. WHO reported that, as of May 16, eight laboratory-confirmed cases, 246 suspected cases, and 80 suspected deaths had been reported in Ituri Province across at least three health zones, with two laboratory-confirmed cases, including one death, reported in Kampala, Uganda, among people traveling from DRC (WHO 2026e). CDC issued a Health Alert Network advisory on May 19, 2026, alerting US clinicians, public-health practitioners, and travelers; it repeated the DRC figures and assessed the risk of spread to the US as low at that time (CDC 2026e). ECDC's page, updated June 2, 2026, stated that the Bundibugyo outbreak continued to affect both DRC and Uganda and provided case definitions and laboratory guidance for European preparedness (ECDC 2026a). On June 2, 2026, WHO had reduced suspected DRC Ebola cases to 116 after hundreds were ruled out, with 321 confirmed cases and 48 deaths, while Uganda reported additional cases among contacts of confirmed patients (Reuters 2026a).

This episode has three strategic implications. First, outbreak numbers change rapidly. Initial suspected cases can be revised downward after investigation; laboratory confirmation can separate Ebola from other febrile illnesses; travel-associated cases can change regional risk assessments. Second, the information must move across multiple institutions: national ministries, WHO, CDC, ECDC, IOM, laboratories, clinicians, and border-health authorities. Third, the problem extends beyond whether the disease reaches the US. CDC's own advisory was issued because US clinicians and travelers needed situational awareness even when US domestic risk was low (CDC 2026e).

In this context, the US withdrawal from WHO is serious. Because the US is currently outside WHO and coordinating only in a limited fashion to effectuate withdrawal, it needs another route to equivalent real-time access to WHO-led assessments, field reports, laboratory interpretation, and emergency discussions (HHS 2026). Bilateral agreements may help, while Ebola outbreaks still cross bilateral boundaries. The 2026 outbreak involved DRC, Uganda, travel, cross-border movement, laboratories, and international guidance. Information loss in such a case means slower, narrower, less trusted, or less institutionally embedded information.

However, such a unilateral substitute is costly since it must collect signals, maintain relationships, deploy experts, validate laboratory findings, coordinate with ministries, issue clinician guidance, and keep allies informed. Those tasks may be possible, yet they require funding, personnel, and standing

relationships. If WHO membership and technical participation provide a lower-cost access point to those functions, leaving may reduce dues while increasing total cost. That is the burden-shifting mechanism in its simplest form.

Type II in Practice: Reforming WHO Without Destroying Useful Tools

If Type I functions make a strong case for technical presence, Type II functions make a strong case for conditional reform. WHO's weaknesses are real. The organization's COVID-19 performance became deeply contested; critics argue that emergency action was too slow, that the organization was too deferential to China, and that subsequent reforms did not adequately solve independence and transparency problems (White House 2025). Scholars of global health law had already criticized IHR implementation after the West African epidemic, arguing that the IHR were a nearly universal legal framework but had failed to ensure sufficient preparedness and rapid response (Gostin and Katz 2016).

The funding structure reinforces these concerns. KFF reports that WHO revenue comes from assessed contributions and voluntary contributions, with voluntary contributions comprising about $5.9 billion, or 83% of total revenue, in the 2024–2025 budget period (KFF 2026). Earmarked voluntary funding can make WHO less flexible in emergencies and more responsive to donor priorities than to general organizational strategy. WHO member states have approved increases in assessed contributions and reform efforts designed to improve predictability and reduce reliance on earmarked money, but the reform process remains incomplete (WHO 2025b).

However, a cost-conscious approach should ask for audit trails, transparent budgets, independent evaluation of emergency performance, measurable reform benchmarks, clearer separation between technical assessment and policy advocacy, and narrower mandates. It should also distinguish fixed assessed contributions from voluntary project funding. The US can cut or condition low-value voluntary funding while maintaining technical participation in high-value networks. This is a more precise instrument than exit from the entire organization.

The same thing applies to the 2025 Pandemic Agreement and 2024 IHR amendments. WHO states that the Pandemic Agreement, adopted by the World Health Assembly on May 20, 2025, sets out principles and tools for better coordination on pandemic prevention, preparedness, response, and access to vaccines, therapeutics, and diagnostics (WHO 2025c). The 2024 IHR amendments entered into force on September 19, 2025 and introduced a new pandemic emergency alert level (WHO 2025d). The US government rejected the IHR amendments in July 2025 (HHS and State Department 2025). Implementation of the pandemic treaty faced delay because of unresolved negotiations over pathogen access-and-benefit-sharing rules (Reuters 2026b). A treaty provision that improves early warning, data exchange, and technical interoperability without imposing vague domestic policy obligations may preserve US options. A provision that imposes open-ended commitments, weak accountability, or poorly defined benefit-sharing duties may justify rejection.

Type III and Type IV in Practice: Downgrade What Is Marginal, Reject What Is Costly

Type III activities include low-stakes forums whose outputs do little to shape US disease intelligence, vaccine preparedness, emergency response, market access, or core health security. These may be useful for symbolic diplomacy while remaining strategically unnecessary. The US can reduce delegation size, use observer participation where available, rely on embassies or technical staff instead of cabinet-level representation, and require sunset review for recurring meetings. Downgrading low-value activities is prioritization.

Nevertheless, if a proposed WHO-linked rule would require open-ended financing, vague domestic-policy changes, or legal exposure without improving US access to information or reducing crisis costs, the US should reject it. The administration saw the amendments as sovereignty constraints with technical implications (HHS and State Department 2025), that is, does the disputed provision create enough option value to justify its autonomy cost?

The typology permits a policy combination that looks inconsistent only on the surface: remain connected to GISRS, GOARN, EIOS, collaborating centres, and outbreak intelligence; condition funding and governance participation on reform; downgrade low-value forums; and reject or renegotiate provisions that impose high autonomy costs.

Mechanisms: How Broad Exit Can Reduce Practical Autonomy

Information Loss

Information loss is the mechanism most directly connected to the institutionalist claim that organizations reduce uncertainty. Surveillance networks allow governments to compare signals, identify anomalies, and act before an event becomes politically visible (Haas 1992). In global health, that informational function is especially important because early signals are often incomplete, politically sensitive, and distributed across laboratories, clinicians, border agencies, and foreign ministries. Exit weakens autonomy when it interrupts access to the networks that make those signals interpretable.

Also, outbreak intelligence is cumulative. A case report from a provincial hospital, a laboratory sequence, a travel history, an animal-health report, a wastewater signal, a clinician alert, and a WHO Disease Outbreak News notice each provide partial information. Institutions such as WHO aggregate weak and geographically dispersed signals into a shared risk picture. The IHR page describes surveillance and information sharing as part of WHO's global early-warning function (WHO 2026a). EIOS adds open-source epidemic intelligence to that system (WHO 2025a). The 2026 Bundibugyo outbreak illustrates the mechanism. On May 17, 2026, the initial WHO account reported laboratory-confirmed cases, suspected cases, and suspected deaths across several health zones in Ituri Province (WHO 2026e). By June 2, WHO had revised suspected cases sharply downward after hundreds of suspected cases were ruled out

(Reuters 2026a). That revision showed why embedded access to evolving assessments is valuable: the signal changed as laboratories, field investigations, and ministries clarified the outbreak.

For the US, this case is also a clinical and travel-risk problem. CDC issued a May 2026 Health Alert Network advisory, giving US clinicians and public-health officials guidance on risk assessment, infection control, diagnostic testing, and travel-related vigilance (CDC 2026e). ECDC likewise maintained an updated page on the DRC/Uganda outbreak as information changed (ECDC 2026a). The US needs reliable channels for knowing when an outbreak could affect American travelers, military personnel, aid workers, clinicians, laboratories, or supply chains. If federal withdrawal weakens the channels through which that information arrives, the US government may have to compensate with more expensive bilateral collection and emergency response.

The 2026 Andes hantavirus cruise-ship cluster shows the same issue in a setting directly connected to travel risk. On May 2, 2026, an Andes virus outbreak on a cruise ship was reported to WHO, raising the possibility of imported cases to the US; CDC then issued clinician guidance while emphasizing that no confirmed US cases associated with the outbreak had been reported as of May 18 (CDC 2026f). WHO's Disease Outbreak News later described contacts being traced from the cruise-ship outbreak, and ECDC noted that the vessel included passengers and crew from multiple countries (WHO 2026f). In this kind of event, information value comes from cross-border coordination: identifying exposed passengers, linking clinical symptoms to travel history, sharing laboratory confirmation, and updating national risk assessments. A purely bilateral model can work only if the US maintains many bilateral channels at once.

Other disease domains show different forms of information dependence. In 2024, WHO declared the mpox upsurge a Public Health Emergency of International Concern because of the DRC outbreak and spread to other African countries (WHO 2024b). In 2026, CDC continued to report avian-influenza activity in animals and sporadic human cases, requiring comparison between domestic surveillance and international animal-health signals (CDC 2026b). The cruise-ship cluster required travel-linked testing and multinational notification rather than a single domestic report (CDC 2026f). Each example points to a different information channel: emergency declaration, animal-human surveillance, and cross-border travel investigation.

Therefore, information loss is a loss of interpretive position. When US experts participate in networks, they receive reports and help ask questions, define case categories, compare diagnostic methods, evaluate uncertainty, and influence how signals are prioritized. Outside monitoring can still read public reports, but it offers less access to informal expert judgment and less influence over how evidence is assembled.

Rule-Making Vacancy

Rule-making vacancy follows from the fact that IOs help define categories, procedures, and expectations before formal enforcement begins. Regimes can shape behavior by structuring what information is collected, how problems are classified, and which responses are treated as legitimate (Krasner 1983). In global health, categories such as PHEIC, pandemic emergency, variant monitoring, and vaccine-composition recommendations influence how partners organize their own decisions. US absence does not stop those categories from developing; it changes how much influence the US government has over their technical and political meaning.

Institutions collect information and define categories, procedures, and expectations. In global health governance, rules can determine when an event becomes a PHEIC, how states report unusual outbreaks, how pathogen samples and sequence data are shared, how vaccine-strain recommendations are made, and how national authorities interpret WHO technical advice. These rules are often formally softer than treaty commands, and they still shape procurement, licensing, laboratory practice, donor behavior, and political expectations. If the US exits a rule-making arena, other states, secretariats, expert groups, regional organizations, and private actors continue to define the field (Bradford 2020).

On the one hand, the Pandemic Agreement demonstrates rule-making vacancy. The World Health Assembly adopted the agreement in May 2025, while KFF notes that 124 member states voted to approve it and the US and some other countries did not participate (KFF 2026). In 2026, a key pathogen-sharing annex remained unresolved, meaning that the most consequential implementation debates continued after the US withdrawal process (Reuters 2026b). Other governments can continue negotiating access-and-benefit-sharing rules with reduced US presence in the process that may shape future expectations for pathogen samples, countermeasure access, and emergency cooperation.

On the other hand, influenza vaccine composition serves as another example. WHO issues vaccine-composition recommendations twice a year, drawing on GISRS surveillance and expert consultations; in February 2026, WHO made recommendations for the 2026–2027 northern hemisphere influenza season, including specific H1N1, H3N2, and B/Victoria lineage viruses for egg-based and cell-based/recombinant/nucleic-acid vaccines (WHO 2026b). These recommendations guide national regulatory agencies and manufacturers. A country can formally reject WHO authority while still operating in a vaccine market shaped by WHO-linked data and expert processes. If the US is absent or marginal in these processes, it may still face the downstream products of rules it did less to shape.

Furthermore, the 2024 IHR amendments introduced, among other changes, a pandemic-emergency category and strengthened expectations around national capacity, information sharing, and international coordination; the amendments entered into force in September 2025 for states that accepted them (WHO 2024a). The US rejected the amendments, yet the categories can still influence how partners classify events and what they expect from other governments (HHS and State Department 2025). Exit can protect formal consent while reducing agenda-setting power.

Rule-making vacancy also creates strategic space for competitors and for regulatory diffusion. The Brussels Effect shows how large markets can export regulatory preferences beyond their formal

jurisdiction (Bradford 2020). In health governance, the European Union, China, middle powers, regional organizations, and philanthropic donors all have incentives to shape technical expectations, financing norms, and emergency-response procedures. If the US government leaves the room, it may later find that US companies, laboratories, and allies must adapt to standards developed elsewhere. The core question is whether presence gives the US a cheaper way to contest, revise, or block rules before they harden.

Moreover, formal organizations can be inefficient, but they also pool administrative costs and reduce the need for states to negotiate separately with every partner (Abbott and Snidal 1998). When the US government exits a shared platform and then recreates parts of the same function through bilateral channels, the budgetary saving from withdrawal can be offset by the staff, legal, diplomatic, and technical costs of replacement (HHS 2026).

The US can sometimes prefer bilateral channels. They may offer more control, closer alignment with specific partners, and clearer accountability. However, in an outbreak involving multiple countries, a bilateral model multiplies the number of relationships that have to be activated. The 2026 Andes hantavirus cruise-ship cluster involved passengers and crew across many jurisdictions, which made travel history, testing, and notification a network problem rather than a single bilateral exchange (ECDC 2026b). Replacing a hub-and-network system with a series of bilateral links may increase transaction costs precisely when speed is most valuable.

Moreover, subnational workarounds after federal withdrawal illustrate the persistence of demand for network access. For example, in February 2026, Illinois would join GOARN after California, and New York City joined a U.N. health network after the federal withdrawal; these steps were framed as efforts to preserve access to outbreak information and expertise (Reuters 2026c). Their participation reveals a gap left by federal exit. If the federal government withdraws while major jurisdictions seek direct links to WHO-related networks, the need for those networks has been decentralized rather than eliminated.

Decentralization can produce resilience and unevenness. Some states and cities have the resources, laboratories, and legal capacity to maintain international ties; others do not. A patchwork may give California, Illinois, or New York City better access while leaving other jurisdictions dependent on secondhand information. It can also weaken US bargaining power: WHO and partner governments face a fragmented set of American actors rather than a coordinated federal position. This can become government by duplication: federal agencies rebuild bilateral channels, states seek direct participation, and domestic institutions create parallel systems to replace a function that had previously been pooled.

In terms of fiscal, if a modest contribution to a multilateral system gives the US access to surveillance, technical experts, outbreak updates, and pooled response capacity, the relevant comparison is dues versus the cost of unilateral replacement. The WHO budget and US contributions have often been criticized, and those criticisms may be valid (KFF 2026). A cost-conscious strategy should ask about total cost. A policy that reduces a visible international line item while increasing hidden costs in CDC staffing, bilateral diplomacy, emergency stockpiles, travel screening, redundant data platforms, and crisis response may be fiscally misleading.

Credibility Volatility and Institutional Fragmentation

Credibility volatility works through repeated interaction rather than formal alliance credibility. Research on institutional legitimacy shows that member-state support, expert authority, and public contestation shape whether organizations can sustain cooperation over time (Tallberg and Zurn 2019). Abrupt exit can weaken the predictability that technical communities need for routine exchange. Also, repeated cycles of exit, workaround, and partial reentry can make US participation less coherent for the partners and domestic actors that rely on stable channels.

In US strategy, credibility includes whether laboratories, ministries of health, regulators, state agencies, and allied governments can expect the US to remain a predictable participant in mutually beneficial information-sharing and standard-setting work. When the Trump administration abruptly exits or rejects many institutional processes at once, partners may hedge by investing in alternative networks, giving more weight to other powers, or proceeding without US technical input.

Federal withdrawal was followed by continued US clinician alerts based on international outbreaks, efforts to shift work into bilateral channels, state and city attempts to join WHO-related outbreak networks, and continued reliance on global information channels for public-health practice (CDC 2026a). The result is a mixed posture: the federal government withdraws from the institution while American laboratories, hospitals, states, and cities still need information from the environment the institution helps maintain.

Volatility can also reduce allied coordination. When the US government leaves rather than organizes a reform coalition, like-minded states have less US leverage behind transparency, budget discipline, emergency-declaration reform, or clearer separation between technical assessment and political advocacy. Exit can weaken the reform agenda it claims to advance. Exit pressure can produce adaptation, and the effect depends on credibility, sequencing, alternatives, and whether other members prefer to accommodate the exiting state or route around it (von Borzyskowski and Vabulas 2024).

Credibility volatility also has domestic consequences. When federal policy oscillates, agencies, states, universities, hospitals, and private firms face uncertainty about which international channels they can use. WHO collaborating-centre relationships, laboratory exchanges, vaccine-strain consultations, and emergency networks depend on repeated interaction, not one-off announcements (CDC 2024). If US actors expect these channels to be repeatedly opened and closed by executive decision, they may either underinvest in them or create informal substitutes outside federal strategy. Both outcomes reduce coherence. A cost-sensitive state should prefer stable, narrow, accountable channels over cycles of broad exit followed by improvisation.

Implications

Accountable engagement offers an alternative to broad withdrawal. The policy should begin with an audit that classifies WHO-related functions by option value and autonomy cost. The audit should

separate membership, funding, data access, technical participation, emergency coordination, treaty commitments, and voluntary project support. These are different instruments and should be separated rather than bundled into one yes-or-no decision.

First, the US should preserve Type I technical access. Even outside formal WHO membership, the US government should seek mechanisms that maintain participation or equivalent access in GISRS, GOARN, EIOS, outbreak intelligence, relevant collaborating-centre work, and influenza vaccine composition processes. If formal membership is politically unavailable, the US should negotiate narrow technical arrangements with clear deliverables. The goal is to preserve US access to information and influence that would be costly to recreate.

Second, the US should convert Type II participation into conditional reform. Funding should be tied to performance metrics: emergency-declaration timelines, independent after-action reviews, budget transparency, data-access standards, whistleblower protection, and separation of technical assessment from political advocacy. Voluntary contributions should be reviewed by strategic value. The US should coordinate with like-minded states to reform governance rather than rely only on exit threats.

Third, Type III activities should be downgraded. Low-stakes meetings and symbolic declarations should receive senior-level attention only when they shape concrete US interests. Agencies should be required to explain what information, access, or burden-sharing value each recurring engagement provides. If the answer is weak, downgrade it.

Fourth, Type IV commitments should be rejected or renegotiated. The US should avoid treaty language that creates vague domestic-policy obligations, open-ended financing, or legal exposure without clear reciprocal benefits. Rejection should be clause-specific whenever possible. A blanket rejection of an entire institutional ecosystem can sacrifice useful surveillance functions because of objections to a separate legal provision.

Fifth, exit should be sequenced. If the US government decides to leave or reject a commitment, it should specify the defect, the reform demanded, the alternative mechanism, and the conditions for reentry. Exit without a substitute creates vulnerability. Exit after failed reform, with a clear replacement and reentry path, can create leverage (von Borzyskowski and Vabulas 2024).

Therefore, accountable engagement gives the US government a way to use that institutional competition deliberately. It preserves access where existing platforms remain useful, creates pressure for reform where institutions have drifted, and reserves exit for commitments whose costs outweigh their option value.

Conclusion

A successful withdrawal expands the range of viable choices available to the US government. A poorly designed withdrawal narrows those choices by forcing the US to rebuild information channels, technical

relationships, and coordination mechanisms after they are already needed. Practical autonomy is secured by keeping the tools that reduce future dependence and discarding the commitments that create avoidable constraint. In that sense, the central question is not whether the US should stay or leave. It is whether a given institutional move increases the country's capacity to act deliberately when the next crisis arrives.

Selective participation offers a more durable understanding of autonomy. It requires a disciplined assessment of function, cost, reversibility, and replacement value. The US can reject open-ended obligations, pressure institutions that drift beyond their mandates, and downgrade low-value activities while preserving access to networks that provide information, technical coordination, and agenda-setting influence. This approach treats institutional presence as a tool to be evaluated, not as a loyalty test.

The broader implication is conceptual as well as practical. Autonomy is often imagined as distance from institutions. In practice, many external constraints are produced upstream, in the technical spaces where risks are named, evidence is standardized, alerts are circulated, and expert judgments become the basis for public action. A government that leaves those spaces still faces the world they help organize. The difference is that it encounters the results later, with fewer channels for shaping them and fewer trusted relationships through which to respond.

Therefore, this paper has treated withdrawal as a question of institutional function. A membership decision becomes analytically misleading when it treats a complex organization as a single object. The same institution can contain weak political forums, costly mandates, useful surveillance systems, technical standard-setting processes, and negotiable legal commitments. The policy problem is to separate these functions before choosing the instrument. A state that exits without this separation may reduce visible entanglement while weakening the quiet forms of access that make independent action possible.

Declarations

Conflict of interest

The author declares that there is no conflict of interest.

Data availability statement

No original dataset was generated or analyzed for this study. The analysis is based on publicly available documentary materials, including official U.S. government documents, WHO materials, public-health institutional sources, and secondary scholarly literature cited in the reference list. All sources used in the study are publicly accessible through the cited publications or institutional websites.

Author contribution statement

The author is solely responsible for the conception and design of the study, collection and interpretation of documentary materials, theoretical framework development, analysis, drafting, revision, and final approval of the manuscript.

Funding

The author received no financial support for the research, authorship, or publication of this paper.

Acknowledgements

The author would like to thank anonymous reviewers for their insightful comments and suggestions. The author also gratefully acknowledges the fellows at the Cato Institute for their helpful feedback on earlier versions of this manuscript.

Ethics Approval and Consent to Participate

The research project was reviewed and approved by the Social and Behavioral Institutional Review Board of Florida International University, under protocol number IRB-24-0310, on 06/18/24. However, this manuscript does not report data collected through interviews, surveys, experiments, or other direct interactions with human participants. It relies exclusively on publicly available secondary data and documentary sources. Therefore, consent to participate was not applicable to this manuscript. The research was conducted in accordance with the ethical standards of the approving institutional review board and relevant guidelines for responsible research practice.

References

1. Abbott KW, Snidal D (1998) Why states act through formal international organizations. J Conflict Resolut 42(1):3–32. https://doi.org/10.1177/0022002798042001001
2. Baker MG, Fidler DP (2006) Global public health surveillance under new International Health Regulations. Emerg Infect Dis 12(7):1058–1065. https://doi.org/10.3201/eid1207.051497
3. Barnett MN, Finnemore M (1999) The politics, power, and pathologies of international organizations. Int Org 53(4):699–732. https://doi.org/10.1162/002081899551048
4. Bradford A (2020) The Brussels Effect: How the European Union Rules the World. Oxford University Press, New York. https://doi.org/10.1093/oso/9780190088583.001.0001
5. CDC (2024) WHO-FIC collaborating centre in the United States. National Center for Health Statistics, 29 May. https://www.cdc.gov/nchs/icd-usacc/about/index.html. Accessed 25 Jun 2026
6. CDC (2025) CDC activities and accomplishments to date in 2024–2025 H5 bird flu response. 17 January. https://www.cdc.gov/bird-flu/spotlights/h5n1-response-01172025.html. Accessed 25 Jun 2026
7. CDC (2026a) United States completes WHO withdrawal. CDC Newsroom, 22 January. https://www.cdc.gov/media/releases/2026/united-states-completes-who-withdrawal.html.

Accessed 25 Jun 2026

8. CDC (2026b) A(H5) bird flu: current situation. 6 March. https://www.cdc.gov/bird-flu/situation-summary/index.html. Accessed 25 Jun 2026
9. CDC (2026c) Global human cases with avian influenza A(H5N1), 1997–2026. 29 May. https://www.cdc.gov/bird-flu/php/surveillance/chart-epi-curve-ah5n1.html. Accessed 25 Jun 2026
10. CDC (2026d) Our partnerships: global health protection. 2 March. https://www.cdc.gov/global-health-protection/php/programs-and-institutes/partners.html. Accessed 25 Jun 2026
11. CDC (2026e) Ebola disease outbreak in the Democratic Republic of the Congo and Uganda. Health Alert Network HAN00530, 19 May. https://www.cdc.gov/han/php/notices/han00530.html. Accessed 25 Jun 2026
12. CDC (2026f) 2026 hantavirus outbreak: testing for potential infection. Health Alert Network HAN00529, 18 May. https://www.cdc.gov/han/php/notices/han00529.html. Accessed 25 Jun 2026
13. CIDRAP (2026) WHO reports H5N1 death among variant zoonotic flu cases seen this year. Center for Infectious Disease Research and Policy, 29 April. https://www.cidrap.umn.edu/avian-influenza-bird-flu/who-reports-h5n1-death-among-variant-zoonotic-flu-cases-seen-year. Accessed 25 Jun 2026
14. Consoli S, Coletti P, Markov PV, Orfei L, Biazzo I, Schuh L, Stefanovitch N, Bertolini L, Ceresa M, Stilianakis NI (2025) An epidemiological knowledge graph extracted from the World Health Organization's Disease Outbreak News. Sci Data 12:970. https://doi.org/10.1038/s41597-025-05276-2
15. Davies SE, Kamradt-Scott A, Rushton S (2015) Disease Diplomacy: International Norms and Global Health Security. Johns Hopkins University, Baltimore
16. ECDC (2025) ECDC framework to guide the integration of wastewater-based surveillance into infectious disease surveillance at the EU/EEA level. 10 December. https://www.ecdc.europa.eu/en/publications-data/ecdc-framework-guide-integration-wastewater-based-surveillance-infectious-disease-surveillance-eueea-level. Accessed 25 Jun 2026
17. ECDC (2026a) Ebola disease outbreak in the Democratic Republic of the Congo and Uganda. Last updated 24 June. https://www.ecdc.europa.eu/en/ebola-outbreak-democratic-republic-congo-and-uganda. Accessed 25 Jun 2026
18. ECDC (2026b) Andes hantavirus outbreak in cruise ship. Epidemiol Update, 26 May
19. Fidler DP (2004) Germs, governance, and global public health in the wake of SARS. J Clin Invest 113(6):799–804. https://doi.org/10.1172/JCI21328
20. Fidler DP (2005) From international sanitary conventions to global health security: the new International Health Regulations. Chin J Int Law 4(2):325–392. https://doi.org/10.1093/chinesejil/jmi029
21. GOARN (2026) GOARN. Official website. https://goarn.who.int/. Accessed 25 Jun 2026

22. Gostin LO, Katz R (2016) The International Health Regulations: the governing framework for global health security. Milbank Q 94(2):264–313. https://doi.org/10.1111/1468-0009.12186
23. Haas PM (1992) Introduction: epistemic communities and international policy coordination. Int Org 46(1):1–35. https://doi.org/10.1017/S0020818300001442
24. Hanrieder T (2015) The path-dependent design of international organizations: federalism in the World Health Organization. Eur J Int Relat 21(1):215–239. https://doi.org/10.1177/1354066114530011
25. Hawkins DG, Lake DA, Nielson DL, Tierney MJ (eds) (2006) Delegation and Agency in International Organizations. Cambridge University Press, Cambridge. https://doi.org/10.1017/CBO9780511491368
26. HHS (2026) United States completes WHO withdrawal. 22 January. https://www.hhs.gov/press-room/united-states-completes-who-withdrawal.html. Accessed 25 Jun 2026
27. HHS and State Department (2025) The United States rejects amendments to International Health Regulations. 18 July. https://www.hhs.gov/press-room/state-department-hhs-rejects-amendments-to-international-health-regulations.html. Accessed 25 Jun 2026
28. Hooghe L, Lenz T, Marks G (2019) A Theory of International Organization. Oxford University Press, Oxford. https://doi.org/10.1093/oso/9780198766988.001.0001
29. Kamradt-Scott A, Rushton S (2012) The revised International Health Regulations: socialization, compliance and changing norms of global health security. Global Change Peace Secur 24(1):57–70. https://doi.org/10.1080/14781158.2012.641284
30. Keohane RO (1984) After Hegemony: Cooperation and Discord in the World Political Economy. Princeton University Press, Princeton
31. KFF, the World Health Organization (2026) The U.S. government and. 17 March. https://www.kff.org/global-health-policy/the-u-s-government-and-the-world-health-organization/. Accessed 25 Jun 2026
32. Koremenos B, Lipson C, Snidal D (2001) The rational design of international institutions. Int Org 55(4):761–799. https://doi.org/10.1162/002081801317193592
33. Krasner SD (ed) (1983) International Regimes. Cornell University Press, Ithaca
34. Martin LL, Simmons BA (1998) Theories and empirical studies of international institutions. Int Org 52(4):729–757. https://doi.org/10.1162/002081898550734
35. McInnes C, Lee K (2006) Health, security and foreign policy. Rev Int Membr 32(1):5–23. https://doi.org/10.1017/S0260210506006905
36. Morse JC, Keohane RO (2014) Contested multilateralism. Rev Int Organ 9(4):385–412. https://doi.org/10.1007/s11558-014-9188-2
37. Reuters (2026a) WHO says suspected Ebola cases drop to 116 after hundreds ruled out. 2 June
38. Reuters (2026b) WHO delays pandemic treaty amid pathogen-sharing dispute. 1 May
39. Reuters (2026c) Illinois will join WHO's outbreak response network in defiance of Trump. 4 February

40. Rushton S (2011) Global health security: security for whom? Security from what? Polit Stud 59(4):779–796. https://doi.org/10.1111/j.1467-9248.2011.00919.x
41. Tallberg J, Zurn M (2019) The legitimacy and legitimation of international organizations: introduction and framework. Rev Int Organ 14(4):581–606. https://doi.org/10.1007/s11558-018-9330-7
42. von Borzyskowski I, Vabulas F (2024) When do member state withdrawals lead to the death of international organizations? Eur J Int Relat 30(3):756–786. https://doi.org/10.1177/13540661241256951
43. Wenham C (2019) The oversecuritization of global health: changing the terms of debate. Int Affairs 95(5):1093–1110. https://doi.org/10.1093/ia/iiz170
44. White House, World Health Organization (2025) Withdrawing the United States from the. Executive Order, 20 January. https://www.whitehouse.gov/presidential-actions/2025/01/withdrawing-the-united-states-from-the-worldhealth-organization/. Accessed 25 Jun 2026
45. WHO (2023) Avian influenza A(H3N8)-China. Disease Outbreak News, 11 April. https://www.who.int/emergencies/disease-outbreak-news/item/2023-DON456. Accessed 25 Jun 2026
46. WHO (2024a) Q&A: International Health Regulations: amendments. 1 October. https://www.who.int/news-room/questions-and-answers/item/international-health-regulations-amendments. Accessed 25 Jun 2026
47. WHO (2024b) WHO Director-General declares mpox outbreak a public health emergency of international concern. 14 August. https://www.who.int/news/item/14-08-2024-who-director-general-declares-mpox-outbreak-a-public-health-emergency-of-international-concern. Accessed 25 Jun 2026
48. WHO (2025a) Epidemic Intelligence from Open Sources (EIOS) strategy 2024–2026. 11 September. https://www.who.int/publications/i/item/B09476. Accessed 25 Jun 2026
49. WHO (2025b) Financing and implementation of the programme budget 2024–2025. A78/19, 6 May. https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_19-en.pdf. Accessed 25 Jun 2026
50. WHO (2025c) World Health Assembly adopts historic Pandemic Agreement. 20 May. https://www.who.int/news/item/20-05-2025-world-health-assembly-adopts-historic-pandemic-agreement-to-make-the-world-more-equitable-and-safer-from-future-pandemics. Accessed 25 Jun 2026
51. WHO (2025d) WHO Pandemic Agreement. WHA78.1, 20 May. https://apps.who.int/gb/ebwha/pdf_files/WHA78/A78_R1-en.pdf. Accessed 25 Jun 2026
52. WHO (2026a) International Health Regulations. Official health topic page. https://www.who.int/health-topics/international-health-regulations. Accessed 25 Jun 2026
53. WHO (2026b) Global Influenza Surveillance and Response System. Official initiative page. https://www.who.int/initiatives/global-influenza-surveillance-and-response-system. Accessed 25 Jun 2026

54. WHO (2026c) Recommendations for influenza vaccine composition for the 2026–2027 Northern Hemisphere season. 27 February. https://www.who.int/news/item/27-02-2026-recommendations-for-influenza-vaccine-composition-for-the-2026-2027-northern-hemisphere-season. Accessed 25 Jun 2026
55. WHO (2026d) Collaborating centres. Official WHO page. https://www.who.int/about/collaboration/collaborating-centres. Accessed 25 Jun 2026
56. WHO (2026e) Epidemic of Ebola disease caused by Bundibugyo virus in the Democratic Republic of the Congo and Uganda determined a Public Health Emergency of International Concern. 17 May. https://www.who.int/news/item/17-05-2026-epidemic-of-ebola-disease-in-the-democratic-republic-of-the-congo-and-uganda-determined-a-public-health-emergency-of-international-concern. Accessed 25 Jun 2026
57. WHO (2026f) Hantavirus outbreak linked to cruise ship travel, Multi-locations. Disease Outbreak News, 28 May. https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON604. Accessed 25 Jun 2026
58. WHO Europe (2024) Pandemic Influenza Preparedness (PIP) Framework. Official WHO Europe page. https://www.who.int/europe/news-room/fact-sheets/item/pandemic-influenza-preparedness-(pip)-framework. Accessed 25 Jun 2026
59. WHO Western Pacific (2026) Avian influenza. Official WHO Western Pacific page. https://www.who.int/westernpacific/health-topics/avian-influenza. Accessed 25 Jun 2026
60. Youde J (2012) Global Health Governance. Polity, Cambridge
61. Zurn M, Binder M, Ecker-Ehrhardt M (2012) International authority and its politicization. Int Theory 4(1):69–106. https://doi.org/10.1017/S1752971912000012