



GLOBAL HEALTH INSIGHT

TRUMP II ADMINISTRATION:

THE NEW GLOBAL HEALTH
STRATEGY DECIPHERED

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The members participate in the group in their personal capacity and not on behalf of their respective organizations. This document is the result of collective work within the group. It does not engage nor reflect the individual views of each member.

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EXECUTIVE SUMMARY

GENERAL CONTEXT

In September 2025, the United States released a new global health strategy entitled *America First Global Health Strategy*, marking a major shift in its international positioning on global health. In a context of ongoing reconfiguration of the global health architecture, the Trump II administration explicitly signals its intention to break with traditional multilateral approaches.

The strategy now prioritizes bilateral relationships with partner countries, combined with conditional and targeted financing, primarily focused on infectious diseases. These funding mechanisms are accompanied by new requirements, including substantial co-financing by recipient countries, increased state accountability in implementation, and a reduced role for non-governmental organizations.

One of the defining features of this strategy lies in the announced speed of its implementation. U.S. authorities committed to negotiating and signing, within very short timeframes, formalized bilateral agreements with partner countries, departing from the customary timelines of international health cooperation.

STATE OF IMPLEMENTATION

The timeline announced in the strategy released in September has been broadly adhered to. As of 29 January, 15 MoUs have been signed.

OBJECTIVES OF THIS DOCUMENT

This document aims to:

- Draw the attention of relevant stakeholders to an ongoing development that remains insufficiently visible but may prove structurally significant for global health;
- Recall the main components of the U.S. strategy of September 2025 in order to provide a shared analytical framework;
- Shed light on the current situation based on available information regarding the MoUs, by identifying the main areas of uncertainty;
- Highlight the strategic challenges raised by this development and examine its implications for France and for civil society actors.

In addition to this briefing note, the think tank is publishing a position paper containing policy recommendations addressed to French and European decision-makers.¹

¹ Santé mondiale 2030 (February 2, 2026). [Policy brief following the global health insight document on the](#)

[new global health strategy of the Trump II administration.](#) [online].

1. THE U.S. GLOBAL HEALTH STRATEGY (2025)

1.1. Introduction

The second inauguration of Donald Trump at the White House marked a decisive and rapid turning point in the foreign health policy of the United States of America. In less than one year, this shift has entailed the dismantling of the United States Agency for International Development (USAID), a drastic reduction in budgets allocated to global health, withdrawal from major multilateral bodies such as the World Health Organization (WHO) on 22 January 2026, and the suspension or revision of several flagship programmes, including the *President's Emergency Plan for AIDS Relief* (PEPFAR). These decisions have plunged the entire global health community into profound uncertainty for several months.

In this context, the publication and (initial) implementation of a U.S. global health strategy constitutes a major development. It sets out an explicit political direction, enabling global health stakeholders to understand U.S. priorities and to position themselves accordingly.

It is therefore essential, for anyone concerned with international health governance, to grasp the orientation that Washington intends to give to its global

health policy in the coming years. It is from this perspective that this paper proposes an analysis of the 2025 U.S. global health strategy, as it is expected to apply, barring policy reversals or internal inconsistencies, until the end of President Donald Trump's term of office.²

1.2. Strategy's Political Rhetoric

To fully grasp the new global health model promoted by the United States, it is first necessary to understand the political rhetoric in which it is embedded.

The situation is presented through a structured narrative, summarized here around three quotations drawn from the letter addressed to the American people by Secretary of State Marco Rubio, included in the U.S. global health strategy:

« **The United States is the world's health leader.** »

According to the strategy, the United States remains the global leader in health. The text recalls the historical achievements of U.S. programmes, whether by design or through financing, over the past 25 years: more than 26 million lives saved through PEPFAR;

² White House (September 18, 2025). *America First Global Health Strategy*. [online].

millions more through initiatives targeting polio, malaria, and tuberculosis; and 7.8 million children born to mothers living with HIV who were protected from infection. The strategy also emphasizes that the United States has prevented “thousands of epidemics” from reaching its shores, thereby strengthening national security. Within this narrative, U.S. health assistance is framed as both an instrument of national protection and a tool of international influence.

« Our foreign assistance programs are deeply broken. »

The strategy then adopts a critical stance toward the existing global health system, which it portrays as inefficient, costly, and poorly oriented. According to the document, the current aid model relies primarily on non-governmental organizations, which are accused of having created parallel structures and of fostering a culture of dependency among recipient countries. The report puts forward specific figures to support this assessment: less than 40 percent of U.S. assistance is said to reach frontline supplies and personnel, while 60 percent of funds are absorbed by management, technical assistance, and administrative costs. This imbalance is presented as a key explanation for the loss of effectiveness of the U.S. system and for the perception of a bureaucratic and wasteful apparatus. This diagnosis reflects a broader intention to rethink the role of U.S. assistance, no longer as open and multilateral support, but as a

policy refocused on results and on the direct accountability of partners.

« We must keep what is good about our health foreign assistance programs while rapidly fixing what is broken. »

Finally, the strategy calls for preserving past successes while correcting the shortcomings of the current system. The Trump II administration asserts its intention to maintain U.S. engagement in global health, but within a more selective and conditional framework, more closely aligned with national interests. In other words, this does not constitute a withdrawal, but rather a reorientation. Health programmes will continue, but according to principles of cost-effectiveness, performance, and sovereignty. Under the new strategy, global health is now conceived as a strategic investment, contributing simultaneously to the protection of U.S. citizens, the strengthening of bilateral relations, and the support of the country’s economic prosperity.

1.3. Three Pillars

The new U.S. global health strategy is structured around three main pillars.

SAFE

Safeguarding national health security constitutes an absolute priority of the strategy. The objective is to prevent epidemics from reaching the United States by strengthening global surveillance and rapid response capacities in geographical areas identified as

high risk. Within this approach, global health is no longer conceived as an international public good, but primarily as a tool of national protection, serving territorial security and domestic stability.

STRONG

The strategy seeks to advance national interests through strengthened bilateral partnerships. U.S. health assistance is now positioned as a strategic instrument of foreign policy. The United States commits to concluding multi-year bilateral agreements with beneficiary countries, aimed at advancing national priorities while supporting partners in building sustainable and resilient health systems.

PROSPEROUS

The emphasis is placed on innovation and support for U.S. companies. Global health projects financed by the United States are expected to prioritize the procurement, distribution, and promotion of products originating from domestic industry, including medicines, equipment, and diagnostics. Global health is thus framed as an economic lever combining diplomacy and industrial policy, while simultaneously protecting the national economy from the consequences of international health crises.

1.4. Bilateral agreements

The strategy proposed in 2025 introduces a new model of international assistance, based on the signing of

multi-year bilateral agreements between the United States and beneficiary countries of U.S. health aid. According to the document, these agreements aim to make partner health systems more autonomous, while ensuring that epidemic threats are contained before reaching U.S. territory.

Each bilateral agreement is expected to specify a set of elements:

- Joint priorities defined by Washington and the recipient country;
- Performance indicators against which programme success will be measured;
- Modalities for co-investment between the two governments;
- Steps for transitioning the partner to financial and operational autonomy.

The State Department aimed to finalize all agreements by 31 December 2025, with operational launch scheduled for April 2026.

However, no overall budget figures are provided at this stage, nor is there a detailed breakdown between U.S. and national contributions.

Funding will now be strictly performance-based.

Each disbursement will depend on achieving measurable objectives, such as vaccination coverage, epidemiological surveillance capacity, or the speed of response to health emergencies.

This model is accompanied by a significant reduction in the role of international NGOs, which have until now been central to U.S. health aid implementation. They will be largely replaced by government channels, and in some cases by private sector actors or certain faith-based organizations. U.S. assistance will focus exclusively on so-called frontline resources, with indirect costs and programme management expenses («overhead costs») excluded from funding.

To ensure implementation of the agreements, the strategy foresees the presence of U.S. teams in the field, primarily in areas of high epidemic risk, to support programme monitoring, evaluation, and surveillance. This presence

is primarily intended to ensure compliance with commitments and to allow for a rapid response in the event of a health threat.

Each agreement will include a precise transition timeline, outlining the stages of progressive U.S. disengagement and the increasing responsibility of partner governments. Ultimately, these governments will be expected to assume full management and financing of the strengthened health systems.

This approach represents an ideological shift: global health is no longer seen as a field of international solidarity, but as a contractual space of mutual responsibility, where every dollar spent must contribute to U.S. security and prosperity.

1.5. Comparative Analysis with the 2024 Strategy

The table below summarizes the main changes implemented within a few months by the Trump administration and how they differ from the previous administration.

Theme	<i>U.S. Government Global Health Security Strategy (2024, Biden)</i> ³	<i>America First Global Health Strategy (2025, Trump)</i>
Overall Objective	Global health security	Serve U.S. interests: national health security, diplomatic and commercial interests
Diplomatic Approach	Affirmed multilateralism (WHO, regional partnerships)	Bilateral partnerships

³ White House (April 16, 2024). *U.S. Government Global Health Security Strategy 2024*. [online].

Implementation	NGOs, multilateral agencies	Partner governments, private sector, and faith-based organizations
Aid Logic	Accountability, but predictable and continuous	Conditional and transactional disbursements
Funding Style	Focused on structural capacities	Primarily limited to frontline products and services
Scope of Action	Centered on global health security	Broadens the concept of global health to openly include economic, commercial, and diplomatic interests
Priorities	HIV treatment and prevention, malaria and tuberculosis, maternal and child health, nutrition, neglected tropical diseases, health system strengthening, innovation and vaccine R&D, pandemic preparedness and prevention	Surveillance, prevention, and pandemic preparedness (the only explicitly stated thematic priority in the strategy, although operational reality observed in the signing of MoUs appears broader)
Ideology	Aligned with Biden policies: inclusion, equity, liberal values	Aligned with conservative Republican policies and values

While a significant amount of data is publicly available on the Biden administration's global health expenditures, publicly available data for the first months of the Trump 2025 administration are very limited. The strategy contains no numerical estimates, and the only concrete financial commitments are those arising from the Memoranda of Understanding signed to date, which are detailed later in this note. Thematic and channel-specific breakdowns, as well as the total projected amount for all countries targeted by the U.S. global health strategy, have not been published, making any overall quantitative comparison partial and uncertain.

2. IMPLEMENTATION OF BILATERAL AGREEMENTS

The strategy published in September 2025 announced the rapid conclusion of a significant number of bilateral agreements by December 2025. This objective has been largely achieved. Implementation is proceeding at a sustained pace, reflecting a U.S. determination to move quickly and unilaterally.

2.1. Signing of Agreements (January 2026)

As of this date, 15 agreements have been formally signed between the United States and partner countries, all concluded for a five-year period. The information presented below is drawn entirely from press releases issued by U.S. embassies in the countries concerned.

Partner country (date of signature)	Total agreement amount (USD)	US contribution over 5 years (USD)	Partner country co-financing (USD)	Main thematic areas mentioned
Kenya (12/04)	2.5 billion	1.6 billion	850 million	SPRI, HIV/AIDS, TB, malaria, MCH, Polio
Rwanda (12/05)	228 million	158 million	70 million	SPRI, HIV/AIDS, malaria
Liberia (12/09)	176 million	125 million	51 million	SPRI, HIV/AIDS, malaria, MCH
Uganda (12/10)	2.3 billion	1.7 billion	500 million	SPRI, HIV/AIDS, TB, malaria, HSS
Lesotho (12/10)	364 million	232 million	132 million	SPRI, HIV/AIDS, HIS, HRH
Eswatini (12/12)	242 million	205 million	37 million	SPRI, HIV/AIDS, HIS
Mozambique (12/15)	-	1.8 billion	Increase of domestic expenditure on healthcare as a percent of government budget by nearly 30%	HIV/AIDS, malaria MCH

Cameroon (12/18)	850 million	400 million	450 million	SPRI
Nigeria (12/21)	5.1 billion	2.1 billion	3 billion	SPRI, HIV/AIDS, TB, malaria, Polio, MCH
Madagascar (12/23)	175 million	134 million	41 million	SPRI, malaria, Polio, MCH
Sierra Leone (12/23)	173 million	129 million	44 million	SPRI, HIV/AIDS, malaria
Botswana (12/23)	487 million	106 million	381 million	HIV/AIDS, SPRI
Ethiopia (12/23)	1.5 billion	1 billion	450 million	SPRI, HIV/AIDS, TB, malaria, Polio, MCH
Côte d'Ivoire (12/30)	937 million	487 million	450 million	SPRI
Malawi (01/14)	936 million	792 million	143.8 million	HIV/AIDS, TB, malaria, Polio, MCH, SPRI

TB: Tuberculosis / **MCH:** Maternal and Child Health / **SPRI:** Surveillance, Preparedness and Response to Infectious Diseases / **HSS:** Health System Strengthening / **HRH:** Human Resources for Health / **HIS:** Health Information System

U.S. authorities specify in their official communications that the amounts committed by the United States are spread over five years and are intended to gradually decrease. Conversely, the share of co-financing provided by partner countries is set to increase progressively, reaching the levels agreed upon in the respective agreements by the end of the period.

This financial trajectory is presented as a lever to promote autonomy, sustainability, and ultimately the independence of beneficiary countries from U.S. assistance.

2.2. Content of Signed Agreements

The MoUs that have been signed are not publicly accessible as of January 2026. However, a draft MoU circulated in the press appears to have served as the basis for negotiations of

the signed agreements, as well as for potential ongoing negotiations with other countries.

Two clauses in this preliminary document raise particularly important questions.

The clause below indicates that the United States now conditions part of its bilateral global health assistance on the systematic sharing of data and

biological samples related to pathogens with epidemic or pandemic potential. Under the MoU model, partner countries commit not only to transmit all available information on these pathogens but also to sign a separate agreement for the sharing of biological samples and genetic sequencing data.

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- The United States and [INSERT COUNTRY NAME] plan to enter into a specimen sharing agreement substantially in the form of Appendix 4 for the purpose of providing physical specimens and related data, including genetic sequence data, of detected pathogens with epidemic potential to the United States within five (5) days of detection. Both parties intend this specimen sharing agreement will continue for [twenty-five (25)] years.

Source : Health Policy Watch (November 7, 2025).
US Ties Global Health Aid to Data Sharing on Pathogens – Undermining WHO Talks. [online].

This agreement on the sharing of biological samples could extend over a period of 25 years, while the U.S. financial assistance linked to the MoU covers only five years. To date, no explicit provision foresees a mechanism for sharing the benefits derived from the use of these data or samples, particularly regarding access to vaccines, treatments, or diagnostic tools developed from this information.

This bilateral approach is in tension with ongoing negotiations led by the WHO on the Pathogen Access and

Benefit Sharing (PABS) mechanism, one of the last unfinished components of the WHO Pandemic Agreement.⁴ Furthermore, questions remain regarding the potential for these data to be shared with the U.S. pharmaceutical industry and whether such sharing would be exclusive.

In addition, a second clause mentioned in the press (without available excerpts) provides for the sharing of data on the long-term performance of the MoU, intended to allow partner countries to receive subsequent

⁴ World Health Organisation (May 20, 2025). *WHO Pandemic Agreement - Global.* [online].

tranches of funding.⁵ This provision, which also extends over 25 years while financial assistance is scheduled for

only five years, remains vague. It notably raises the question of whether it implies U.S. access to the entirety of the partner country's health data systems.

3. KEY POINTS OF ATTENTION

3.1. On the United States' General Approach to Global Health

► Challenge to Multilateralism

The shift toward bilateralism represents a profound break with 25 years of multilateral cooperation. It remains to be determined whether this model can genuinely ensure coherent global health coverage or whether it will lead to fragmentation of international governance, creating uncovered zones. The strategy appears to link bilateralism with efficiency, but this assumption has never been demonstrated in programmes of this scale.

► Risks of Narrowing the Global Health Scope

The U.S. strategy involves a marked refocusing on a few priorities (pathogens, surveillance, HIV, TB, malaria), to the detriment of sectors historically supported but now almost entirely absent: vaccination, nutrition, community health, prevention of non-communicable diseases, and sexual and reproductive health. There is a tangible risk of backsliding on health gains achieved over the past 20 years if other actors and mechanisms do not step in.

► Potential Effects of NGO Withdrawal and Exclusion of Indirect Costs

The de facto dismantling of NGO networks and the exclusion of indirect costs could undermine operational capacities in certain countries, including logistics, supervision, data collection, and monitoring and evaluation. It is important to consider whether effective action can occur without their participation. Furthermore, the faith-based

⁵ Health Policy Watch (November 7, 2025). [*US Ties Global Health Aid to Data Sharing on Pathogens – Undermining WHO Talks*](#). [online].

NGOs that the new U.S. administration intends to continue funding are often socially legitimate but politically aligned, with potential effects on priorities related to rights, gender, and sexual and reproductive health.

When PEPFAR was launched in 2003, the Bush administration had similar intentions; however, in practice, U.S.-operated NGOs and local recipients successfully implemented HIV/AIDS programmes without strict limitations. In other words, the principle of pragmatism prevailed. It is far from certain that the same will be true under this administration, given the much smaller number of NGOs likely to be selected.

➤ **Financial Sustainability and Viability of the Proposed Model**

The strategy mentions “mandatory co-investments” by partner countries, without specifying the expected levels or accompanying mechanisms. Do these countries have the financial means to provide them? What would happen if they are unable to meet these requirements? Would countries be allowed to co-finance with other international donors, including through other bilateral or multilateral agreements

➤ **Governance, Transparency, and Accountability**

The shift from a multi-actor system (NGOs, multilateral organizations, diverse donors) to a bilateral system dominated by Washington reduces the multiplicity of checks and balances. It remains unclear what mutual oversight mechanisms will be in place, which indicators will be used, and how performance will be verified. There is a risk that accountability becomes a unilateral process, focused on U.S. priorities rather than on national health needs.

➤ **Geopolitical Consequences**

The explicit refocusing on U.S. interests could encourage other powers (China, India, Gulf States) to strengthen their own bilateral health offerings, triggering a form of geostrategic health competition and/or diluting international health cooperation.

➤ **Selective Approach to Science**

In the United States, there is an increasingly selective approach to science, with political choices influencing the use or distancing from certain scientific recommendations. For example, the 2025 global health strategy refers to epidemiology for surveillance and epidemic

response but does not mention nutrition science or maternal health, fields historically considered consensual in global health.

Moreover, recent changes in domestic vaccine policy, where the U.S. Department of Health removed six vaccines from the list of mandatory childhood immunizations, raise questions about U.S. commitment to vaccines internationally and the scientific standards it promotes.⁶

3.2. On the Negotiation and Signing of Bilateral Agreements

While negotiations and the signing of MoUs continue at a sustained pace, within a framework marked by low transparency, it is necessary to anticipate a number of structural questions. The rapid deployment of these agreements, in line with the objectives set out in the U.S. strategy, limits the analytical and reactive capacities of partner countries as well as other global health actors.

► Data on Pathogens and Scientific Sovereignty

The mandatory sharing of samples and sequences included in the draft MoUs raises major international biopolitical questions: ownership of data and equitable access to derivative products (vaccines, treatments). The exceptional duration (25 years) for data sharing contrasts with the brevity of financial assistance (up to 2030), creating a benefit asymmetry.

Moreover, questions remain regarding the potential existence of national preference clauses, for instance favoring the procurement of U.S. products or technologies. While this is not explicitly mentioned in the draft MoUs, it is an implicit element of the U.S. strategy that could advantage the U.S. pharmaceutical industry. If such provisions were implemented, they could limit the choices of partner countries, particularly due to the higher cost of U.S. products compared with alternatives from Indian or Chinese markets.

Over time, these developments could profoundly reshape health markets. Until now, falling prices for generic medicines and biosimilar products have relied on purchase volumes and collective negotiation. Reduced volumes and market fragmentation would weaken these mechanisms, forcing countries and international organizations that

⁶ *Aux Etats-Unis, le ministère de la santé retire six vaccins de la liste de recommandations pour les enfants, une mesure sans précédent.* Le Monde. January 6, 2026. Only available in French. [online].

continue to procure to negotiate in smaller and less competitive markets, with direct cost implications.

► Alignment with the Pandemic Accord

These bilateral agreements also raise questions about their compatibility with ongoing multilateral negotiations on the WHO Pandemic Accord, to which the United States is not a party, particularly regarding the Pathogen Access and Benefit Sharing (PABS) mechanism, whose technical annexes on data sharing are still under discussion.

The existence of bilateral frameworks imposing strict sharing obligations, without an explicit mechanism for benefit sharing, could undermine efforts to establish common and balanced rules at the multilateral level and may set precedents that negatively influence ongoing negotiations. At this stage, there is no indication that the United States requires that all data be transmitted exclusively to it, but the design of certain MoUs could favor centralization or priority access by U.S. agencies, which warrants attention.

► Power Dynamics in Negotiations

The highly transactional nature of the MoUs places many partner countries in a disadvantageous negotiating position, particularly those whose HIV/AIDS, tuberculosis, or malaria programmes are heavily dependent on U.S. funding. This structural dependence de facto limits their ability to refuse or renegotiate certain terms of the agreements.

The central question remains the real room for maneuver of the countries concerned: do they have the financial, technical, or political alternatives necessary to oppose clauses deemed unbalanced? If not, what support would they need to strengthen their position in negotiations?

► National Responses and Regional Dynamics

Available information mainly concerns African countries, the only ones for which details have emerged in the press at this stage. National positions appear heterogeneous. Some countries contest certain clauses, notably those related to pathogen data sharing, while others seek to limit their scope to the themes explicitly financed by the United States. Conversely, some states have chosen to sign the first agreements rapidly, responding to immediate financial imperatives, political

considerations, or a desire to present themselves as privileged partners.

The U.S. strategy also indicates particular interest in certain Asian countries. The current lack of data does not preclude future developments, and similar dynamics could emerge in other regions. A key question is whether collective responses may emerge. The formation of regional or interregional common fronts, via the African Union, could theoretically help rebalance power dynamics. However, the opacity surrounding ongoing negotiations limits information flow and, consequently, the ability of countries to coordinate their positions.

► African Union Response

It is worth noting that the Africa Centres for Disease Control and Prevention (Africa CDC) has not remained passive in response to the U.S. global health strategy and its implementation. A communiqué from African heads of state and government supported the institution, constituting an important political signal.⁷ This text, adopted during an extraordinary session on the sidelines of the United Nations General Assembly, expresses explicit concern regarding the new U.S. strategy, particularly regarding the removal of Africa CDC from the list of U.S. funding beneficiaries. The heads of state reaffirm the importance of a unified African approach to global health, as well as the centrality of existing partnerships with international organizations and research institutions, notably citing Fiocruz, a deliberate choice in the context of alliance reshaping.

Although this position has not, at this stage, influenced U.S. orientations, it may affect future regional coordination dynamics.

► Response of France and the European Union

The evolution of the U.S. stance raises questions about the positioning of other international donors: will they align, compete, or strengthen multilateral approaches? What will be the implications of these choices for partner countries? In this context, what levers can France and the European Union mobilize? A strategic question arises: how can partner countries be supported so that they are not forced to

⁷ Africa Centers of Disease Control and Prevention (Africa CDC). Communiqué from Africa CDC on the Committee of Heads of State and Government Extraordinary Session on the Margins of UNGA 80 – Africa CDC. September 22, 2025 [online].

accept unbalanced bilateral agreements due to a lack of viable alternatives?

CONCLUSION

The changes in U.S. global health policy over the past twelve months, as formalized in the new strategy published by the Trump II administration last September, represent an unprecedented break due to the speed of implementation, the scale, and the radical shift from previous policy orientations. These inflections call into question the very foundations of the global health architecture that had gradually taken shape since the beginning of the 21st century.

As in other areas of U.S. foreign policy, the announced decisions appear to be immediately translated into action, leaving little time for concerned actors to adapt. In the face of this dynamic, the reactive capacity of the most exposed countries, particularly those in the Global South, appears limited. The United Nations system, and the World Health Organization in particular, finds itself in a state of signifi-

cant institutional paralysis. The European Union, beginning with France, is currently struggling to produce consolidated strategic analyses and, even more, to formulate credible and coordinated counter-proposals.

This fragility is further reinforced by the fact that the majority of major donors outside the United States, with few exceptions, have reduced their official development assistance, including in the health sector. This contraction of international financing mechanically reduces the manoeuvring space of aid-receiving countries and weakens their negotiating capacity vis-à-vis the United States, thereby reinforcing power asymmetries in global health governance.

In this context of rapid and uncertain restructuring, the think tank intends to continue this work of analysis throughout 2026.



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