https://doi.org/10.37723/jumdc.v16i4.1366

*J. Univ. Med. Dent. Coll.2025;Vol.16(4): v-vi*
*ISSN (Print) 2221-7827, ISSN (Online) 2310-5542*
https://www.jumdc.com

***Editorial***

Open Access

# The impact of global funding cuts on World Health Organization (WHO) and what it means for global health security

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***How to cite this:*** *Tariq S, Tariq S, Malik A. The impact of global funding cuts on World Health Organization (WHO) and what it means for global health security. Journal of University Medical & Dental College. 2025;16(4):v-vi.*



In an era when global health threats are rising, the looming workforce cuts at the World Health Organization (WHO) are a dangerous reversal, and the world ought to wake up to what's at stake. In recent weeks, the WHO has announced plans to shed 2,371 posts by mid-2026, reducing its global workforce by nearly a quarter [1].

Why does this matter? Because WHO is not just another UN agency for many low- and middle-income countries (LMICs), it is the backbone of disease surveillance, outbreak response, maternal and child health programmes, immunisation drives, and emergency support. The funding gap forcing this downsizing is staggering: a projected shortfall of over US$1 billion for 2026–2027 [2].

Meanwhile, global health financing is contracting at a disturbing rate. Official Development Assistance (ODA) for health, which surged during the COVID-19 pandemic, is projected to decline by up to 29% in 2025 compared to 2024. The consequences are already evident: a recent WHO survey of 108 LMICs found that critical services, such as maternal care, vaccination, emergency preparedness, and disease surveillance, have been reduced by up to 70% in some countries [3].

This double shock, shrinking financing and shrinking workforce, threatens to reverse decades of progress in global public health.

**The practical solutions can be:**

Governments and funders should develop a more coherent approach to funding for health emergencies; this will involve raising the priority of health systems as part of health emergency preparedness, moving towards multi-year, predictable funding based on decent minimum capacities with complete transparency in responsibility for financial management.

Empowered regional institutions like the Africa CDC or the UK Health Security Agency model could assist LMICs in building their own surveillance and response capabilities. This involves risk distribution, developing local expertise, and the necessity to keep systems operational even if global staffing collapses.

Long-term effort involves shifting from response-driven aid to prevention, outbreak assurance, maternal safety, and prescribing readiness training in medical and nursing curricula, such as using simulation platforms like Open WHO or prescribing safety programs like the SCRIPT Program.

If WHO loses close to 25% of its workforce, the answer isn't nostalgia, it's preparedness and ownership. Governments must:

1.Co-finance surveillance and maternal safety infrastructure.
2.Decentralise capacity into strong regional hubs.
3.Invest in digital and AI decision systems.
4.Embed training through platforms that update evidence in real time.

Global institutions, philanthropies, and academic partners should prioritise pooled climate-safety-maternal work packages, long-term research collaborations, and hybrid models combining arts-based simulation, data science, and policy translation. This approach protects lives today while building systems that can absorb future shocks without needing to "fight fires forever."

**ACKNOWLEDGEMENT:** None.
**CONFLICT OF INTEREST:** None.
**GRANT SUPPORT AND FINANCIAL DISCLOSURE:** None.

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