

raises serious concerns about potential regional spread, including towards neighbouring Angola.

At the same time, DR Congo is experiencing one of the most severe cholera outbreaks of the past decade, with a total of 48 139 cases and 1443 deaths reported between Jan 1 and Aug 24, 2025, resulting in a case fatality rate of 3%.³ By epidemiological week 33, high case fatality rates were reported in the provinces of Kwilu (76 cases, 26 deaths; 44%), Sankuru (42 cases, 6 deaths; 14%), and Equateur (224 cases, 19 deaths; 8%).³

DR Congo also continues to be the global epicentre of mpox. Between Jan 1 and Sept 14, 2025, DR Congo has reported 16 879 confirmed mpox cases and 43 deaths.⁴ Response efforts have been challenged by factors such as persistent endemic conditions, gaps in surveillance, and poor access to vaccines.

Measles also continues to pose a serious public health threat in DR Congo, with 36 150 cases and 565 deaths reported between Jan 1 and June 29, 2025, corresponding to a case fatality rate of 1.6%. The most affected provinces by epidemiological week 26 were Haut-Lomami (671 cases and 27 deaths), North Kivu (190 cases and 1 death), Maniema (178 cases and 13 deaths), and South Kivu (159 cases and 4 deaths).⁵

The simultaneous epidemics affecting DR Congo illustrate a syndemic dynamic, where overlapping health crises exacerbate each other. The response to Ebola virus disease has diverted attention and crucial resources (eg, human, material, and financial resources) from other pressing health threats. Conflict-driven population displacement and inadequate water and sanitation infrastructure have accelerated the spread of cholera. Furthermore, the resurgence of mpox underscores the urgent need for an integrated and multisectoral approach based on the One Health principle.⁶

In a country marked by a structurally weakened and underfunded health

system that is facing chronic staff shortages, these crises can no longer be addressed in isolation or through reactive measures alone. There is an urgent need to move towards comprehensive, coordinated, and sustainable response strategies. This shift includes strengthening disease surveillance and routine immunisation programmes; expanding decentralised diagnostic capacity; making sustainable investments in safe water, sanitation, and hygiene infrastructure; and fostering robust community engagement in prevention, particularly in underserved rural areas. Without increased commitment and a long-term vision, DR Congo risks remaining trapped in a cycle of recurring and preventable epidemics. Investing now in prevention and systemic resilience will not only ensure better health security for DR Congo in the future, but also safeguard the broader region.

We declare no competing interests.

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Africa leads, multilateral health organisations support

At birth, parents must do everything to support their child, but as children mature, the parental role shifts from providing full care to providing guidance, support, and resources when asked.¹ Africa's public health institutions have undergone a similar journey. Yet, the multilateral health organisations that surround them too often behave as if African institutions were still in their infancy.

When multilateral organisations began operating in Africa in the 1940s, most states were not yet independent. In 1960, a year in which many African countries gained independence, only 13 medical schools existed in eight countries. By 1980, there were 51 medical institutions, although many nations still lacked public health schools and trained professionals, making external leadership indispensable.² Today, the landscape has transformed through sustained investment in education, research, and health systems. By 2009, Africa had 168 medical schools, with most countries hosting at least two schools.³ African scientists now lead global institutions, while the Africa Centers for Disease Control and Prevention (Africa CDC) has become a continental public health powerhouse since it was established in 2016, coordinating incident management structures, advancing local manufacturing, shaping health financing, and building health workforce capacity.

The successful response to the mpox outbreak of 2024–25 epitomises this shift. On Aug 13, 2024, the Africa CDC declared mpox a public health emergency of continental security and rapidly reorganised the response under the Four Ones principle: one team co-led with WHO, one plan covering 29 countries and 28 partners, one budget of US\$599 million that mobilised over \$1.2 billion and 6 million vaccine doses, and one monitoring and evaluation framework.⁴ For the first time, Africa led a continental response while partners aligned behind a single strategy. It was African leadership exercised, with global solidarity in support.

The lesson is clear: the era when multilateral organisations led, convened, and implemented in Africa is ending.⁵ Continuing to do so duplicates effort, fragments responses, and weakens the very systems Africa has built. The Lusaka Agenda (2023) and Gavi Leap (2025) both affirm a new order: Africa must be in the driver's seat, setting priorities and leading implementation, while multilateral organisations provide respectful, enabling support.

The future role of multilateral health organisations in Africa must be redefined around four actions: (1) co-develop and uphold evidence-based norms and guidelines with and through African institutions, tailored to continental and national contexts; (2) facilitate technology transfer and regulatory capacity to enable sustainable African production of vaccines, diagnostics, and therapeutics; (3) invest selectively in workforce capacity strengthening, especially in epidemiology, genomics, emergency response, and health economics; and (4) enable effective resource mobilisation and deployment, aligning donor priorities with African-led strategies, brokering innovative financing, and ensuring equitable access to health products.

This is not about ending global partnerships but redefining them.

Africa is now a proactive architect of health care infrastructure, not a passive recipient. Multilateral organisations that continue directing risk irrelevance and those that enable and empower remain essential. Their greatest contribution is strengthening African institutions to deliver the future.

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Community-controlled research for disruption-resilient partnerships

In the USA, the termination of over 1500 research grants totalling approximately US\$7.5 billion revealed the vulnerabilities in traditional academic–community research partnerships.¹ These abrupt terminations targeted research focused on marginalised populations and showed how political shifts can destroy decades of trust-building between researchers and vulnerable communities while creating immediate disruptions in health care access and services.

Community-controlled research models offer a resilient alternative to

traditional partnerships. Communities maintain ownership over research processes, data, and products through co-led research centres or partnerships, with contractual protections extending beyond individual grant funding. Unlike traditional academic–community partnerships in which academic research institutions hold the resources and decision-making power, community-controlled approaches ensure research continuity even when external funding or political support disappears.

For example, in Kenya, community-led HIV research cooperatives have sustained multiyear studies through political and social unrest by maintaining community governance.² When government funding fluctuated, communities mobilised local resources and international partnerships to continue research and maintain essential health services. Similarly, Indigenous research and data sovereignty movements in Canada and Australia show how communities can successfully control research while maintaining scientific rigour.^{3,4} Tribal organisations in these countries govern research protocols, data analysis, and dissemination, creating resilience against political interference while building internal research capacity and expertise. In these examples, community ownership ensures that research priorities remain aligned with community needs and assets.⁵

Academic research institutions can implement community-controlled approaches through several practices, including community advisory boards with budgetary oversight and decision-making power, community-led data analysis training, community-appointed positions on institutional boards of directors and trustees, and shared ownership of research products that can create community assets that persist despite changes in research funding and other resources.

Implementing these models will require fundamental shifts in the culture of academic research. Rather than extractive and opportunistic