DSM-H as an African-Born Global Framework for Structural Pathology

From Colonial Trauma to Universal Ethical Engineering

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(Translated from Kikongo into English)

Abstract

The DSM-H (Diagnostic and Statistical Manual of Human Structural Pathologies) proposes a new way to name harms that do not live inside one person's "mental disorder" but arise from stable patterns of institutional behaviour. It concentrates on structurally anti-human behaviour clusters (SAHBC / O-SAHBC) that generate preventable damage in health, justice, administration and other vital systems.

This paper places DSM-H in an African psycho-political lineage (Fanon, Amos Wilson, Kimbangu) and within the broader MEN-D work on linguistic colonisation, epistemic warfare and digital harassment. It argues that DSM-H is a logical next step in that lineage: an African-born, globally usable system that treats structural pathology as something observable and measurable, independent of what institutional actors claim to feel or intend. Whether an institution "means well" comes second. What matters first is the pattern of decisions and their consequences for human lives.

We outline the core DSM-H architecture: the Nsiku–Nzola–Bisalu ethical training triad and the MOYO indicators (MOYO-S, a probability scale for life-aligned behaviour, and MOYO-MBI, an index of life deviation and harm). We show how these tools convert African epistemic concepts (Nsiku, Nzola, Bisalu, mbi) into operational metrics. DSM-H starts its testing in the hospital, where structural cruelty cannot hide behind rhetoric, then moves outward to any context where power, reward and identity combine to normalise injury.

DSM-H does not depend on voluntary confession by institutions or professionals. Diagnosis proceeds from pattern and consequence, not from declared motive. This avoids the familiar situation where those who benefit from structural harm can block its naming. DSM-H is built as a protective instrument for populations, with Africa as its starting point and any context of oppression as its horizon. Oppressive systems often recycle the same behavioural

templates. DSM-H formalises a safeguard against those templates, from an African vantage point.

We close this paper by anticipating key critiques, such as alleged ideological bias, overlap with DSM/ICD and risks of political misuse. It then sets out governance safeguards, pilot protocols and adoption corridors. DSM-H is not as a cultural slogan. Instead, we hope to make it a regulatory and ethical-engineering tool that aims to make structural anti-human behaviour visible, measurable and correctable. In this introductory paper, we present limited results of the small samples (n=12) that served more as a proof of concept and calibration. With such insufficient statistical power, we do *not* aim to generalize from this sample alone. The parallel work engaging a transdisciplinary team from multiple universities and research labs, will follow soon, with much larger samples. Cost reduction is also a fundamental aspect of the parallel stream of research.

1.

Introduction – Why a Manual of Structural Pathologies? (Ma[1] – Connaître)

Clinical audits, psycho-political analysis and digital ethnography now point toward the same uncomfortable reality: a large share of human suffering is produced by systems themselves, not only by diseases or individual disorders. Health systems that exist to heal still generate avoidable deaths. Courts that claim to defend justice reproduce predictable disparities. Schools that promise opportunity routinely produce humiliation and exclusion as if these were normal side-effects.

Existing diagnostic frameworks such as DSM and ICD focus almost entirely on individuals. They have refined the vocabulary of personal disorders but usually treat institutions as neutral containers. The behaviour of ministries, hospitals, police forces or universities sits outside their field of vision, even when that behaviour follows clear patterns. Yet maternal mortality gaps, differential triage and files that regularly “disappear” do not arise at random. They form organised habits.

DSM-H responds to a double absence:

1. **Structural blindness.** Current classifications rarely acknowledge that systems can behave in pathological, reproducible and lethal ways.
2. **Epistemic asymmetry.** Pathology has largely been defined through Euro-American categories, while African perspectives on power, harm and ethical duty have been sidelined or caricatured.

The MEN-D corpus has, in parallel, documented:

- Epistemic warfare through linguistic colonisation and through museum and scientific pipelines that misname African histories and knowledge.
- Digital harassment cascades (TrollLab) where Dark Tetrad logics punish African voices and blame victims for imperial violence.

- Structural patterns in clinics where Black and low-status patients receive slower, colder and less urgent care in the United States, the United Kingdom, France and several African jurisdictions, even though funding models differ sharply.

Taken together, these bodies of work show that harm follows patterns. It is embedded, rewarded and often hidden behind “normal procedure.” DSM-H proposes that we name and classify those patterns. It is an African-rooted framework with a deliberately global reach.

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2. Epistemic Lineage and Conceptual Grounding (Ma² – Comprendre)

2.1 From Individual Disorder to Structural Pathology

Fanon showed that colonial domination does more than create geopolitical inequality. It reshapes the very threshold of what a society calls “normal.” Trauma appears both in individuals and in institutions. The clinic reflects the logic of empire. Amos Wilson described how negative narcissism, status aggression, emotional detachment and manipulative behaviour become rewarded traits in colonial and postcolonial systems. These traits then concentrate in leadership cultures, administrative routines and elite formation.

If we take these analyses seriously, we must treat pathology at scale. The same behaviours that, at the level of one person, might fall under labels like psychopathy or extreme narcissism can also be selected structurally when a system consistently rewards detachment, cruelty and opportunism.

DSM-H formalises these structural expressions as **Structural Anti-Human Behaviour Clusters (SAHBC / O-SAHBC)**: recurring patterns of action and inaction that

- arise from institutional rules, incentives and cultures;
- lead to predictable, preventable harm;
- persist across time, sites and actors;
- operate without needing explicit hatred or conscious intent.

Whether an administrator “feels racist” or a clinician “likes” their patients becomes secondary. If, over years and across staff, we observe delayed triage, dismissive communication and under-treatment that correlate with race or status, then the cluster is pathological at the system level.

2.2 African Epistemologies as Design Engine

DSM-H does not translate Western categories into African settings. It starts from African epistemic resources and uses them as design principles:

- **Nsiku**: clarity of duty and ethical alignment.
- **Nzola**: relational empathy and balanced care.
- **Bisalu**: inventive remediation and dedicated problem-solving.
- **Mbi**: deviation, corruption or harm in Kikongo, which gives its semantic core to MOYO-MBI.
- **Mandombe**: a formal symbolic system used here as cognitive geometry to model structural deviations and bifurcations.

The Ma-Ma-Kia-Wa-Nga standard, already adopted by USK and CENA as a scientific communication norm, provides the methodological backbone: Ma¹ (state of fact), Ma² (framework and problematisation), Kia (methods, results, applications), and Wa–Nga (discussion and transformation). DSM-H is written deliberately inside this structure.

This is not a decorative choice. The populations most exposed to structural harm, especially Africans and Afro-descendants, have produced their own deep concepts of duty, relational care and cognitive repair. DSM-H treats those concepts as the mathematical and operational core of a safety standard rather than as folklore.

2.3 Why Conscious Intent Is Not the Criterion

A central design choice in DSM-H is that structural diagnosis must not depend on what actors say about their motives. Several reasons justify this:

- **Bad-faith actors rarely confess.** Those who gain from pathological structures have strong incentives to deny, minimise or reframe evidence.
- **Good-faith actors may not see the pattern.** Many professionals participate in anti-human routines while believing they are doing their best inside the rules.
- **Epistemic justice requires pattern-first analysis.** If diagnosis depends on confession, then perpetrators and beneficiaries of harm control when and whether pathology exists.

DSM-H therefore begins with observable patterns and outcomes: mortality ratios, delays, differential responses, blocking decisions and testimonies that converge across cases and contexts. Individual motives can inform remediation strategies, but they do not decide whether a behaviour cluster is classified as pathological.

This approach also frees African populations from endless, unproductive debates about Western guilt or fragility. The primary DSM-H question is not “Do elites feel remorse?” but “Do these structures produce preventable harm, and how do we stop that harm?”

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3. DSM-H Architecture (Kia – Framework and Instruments)

3.1 Structural Anti-Human Behaviour Clusters (SAHBC / O-SAHBC)

DSM-H defines SAHBC / O-SAHBC as clusters that

- grow out of organisational rules, hierarchies and reward systems;
- target or disfavor vulnerable populations (by race, class, gender, age, disability, immigration status and so on);
- create systematic delays, denials or degradations of care or justice;
- remain stable across time, locations and personnel.

Illustrative examples include:

- Maternal care settings where Black or low-status women, across hospitals and countries, consistently receive slower

responses to pain and complications.
- Judicial systems where the time taken to consider exculpatory evidence systematically stretches when the accused belongs to a certain group, captured by high p_{T-DR} values.
- Public finance departments where spending constantly drifts away from the institution's declared mission, as captured by low Nsiku Compliance Index scores.

DSM-H treats these as structural syndromes, not as isolated ethical failures. They have names, criteria and intervention thresholds.

3.2 Nsiku → Nzola → Bisalu: Ethical Training Sequence

The ethical core of DSM-H is the triadic training logic **Nsiku–Nzola–Bisalu (NSB)**:

- **Nsiku**: "What is my duty toward this human being?"
- **Nzola**: "Do I perceive, feel and respond to their reality?"
- **Bisalu**: "Do I mobilise creativity to protect, heal or repair under the real constraints I face?"

The sequence has an internal order. Technical problem-solving without empathy (Bisalu without Nzola) easily becomes cold improvisation. Empathy without clear duty (Nzola without Nsiku) can produce emotional fatigue and paralysis. DSM-H therefore treats NSB as a structured set of competences that can be trained, practiced and evaluated in curricula, supervision and accreditation.

In this way, African epistemologies shape clinical education in concrete form. Nsiku and Nzola do not remain abstract; they appear in case discussions, bedside mentoring and governance criteria.

3.3 MOYO-S and MOYO-MBI: Monitoring and Prediction

For governance and oversight, DSM-H introduces two linked indicators:

- **MOYO-S** (Moyo ya bantu, Life Alignment Probability Scale, 0.00–1.00), which estimates the likelihood that a given configuration of practices will protect life and dignity.
- **MOYO-MBI** (Life Deviation / Harm Index, 0–100), which quantifies how far a system has drifted toward anti-human outcomes over time. The term *mbi* already carries the meaning of deviation and harm in Kikongo, so DSM-H uses an existing conceptual root rather than inventing a new jargon word.

In practice, a maternity ward, a court or a budget department can work as follows:

1. Build a concise set of indicators: delays, error rates, complaint patterns, mortality or destitution outcomes, and buffer failures (missing safeguards or blocked appeal routes).
2. Estimate MOYO-S and MOYO-MBI over time using straightforward probabilistic and index models.
3. Treat rising MOYO-MBI or falling MOYO-S as clinical alarms rather than abstract "data noise."

These tools allow early detection of structural drift, ideally before a scandal or a wave of deaths forces the issue.

3.4 African Focus, Universal Applicability

DSM-H grows from African experience. African contexts have concentrated colonial trauma, epistemic erasure and institutional non-care at a scale rarely acknowledged in mainstream literature. That concentration provides a sharp lens on structural pathology.

However, the **shape** of SAHBC does not depend on geography. It depends on how power is configured. Maternal neglect in the United States, the United Kingdom, France and in under-resourced African hospitals displays the same behavioural skeleton: selective minimisation of pain, delayed triage, and lower urgency for certain bodies.

Because the underlying pattern stays stable, DSM-H can travel safely:

- It can classify harms in any system where power, identity and reward produce recurring injury.
- It does not exist “against the West” but against structural cruelty in any setting, including within African institutions.

Different oppressions strike different targets and use different languages, but they often reuse a small set of behavioural templates. DSM-H is built to name and track those templates wherever they appear.

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4. Applications and Validation Pathways (Kia – Methods, Results, Uses)

4.1 Clinical Anchor: Maternal and Neonatal Care

The DSM-H White Paper anchors its phenomenological demonstration in maternal care because this field is highly documented and morally clear.

Across several jurisdictions we observe:

- In the United States, Black women die in childbirth at several times the rate of white women, even after controlling for income, education and insurance.
- In the United Kingdom, similar multipliers appear in maternal mortality statistics for Black women.
- In France, audits highlight different levels of attention and urgency based on perceived social status of the mother, in spite of a strong narrative of universal equality.
- In African countries, where absolute mortality is higher, low-status women still face slower attention and delayed triage that follow the same pattern seen in wealthy systems.

These convergences show two things:

1. The main variable is not equipment or funding but behaviour inside the care system.
2. SAHBC patterns remain surprisingly stable across economies and cultures.

Pilot DSM-H audits use **MOYO Tier 1** and small-N longitudinal designs (for example, 2 to 5 units per site, 4 weeks of baseline followed by 4 weeks of intervention). They combine existing records with NSB-based training and monitor R scores, buffer strength and breakdown risk.

Non-parametric statistics, Monte-Carlo calibration and open protocols provide methodological protection against familiar criticisms that decolonial work is “too

qualitative" or "anecdotal." In early pilot sites, shifts in MOYO-S and MOYO-MBI closely track reductions in adverse events, even in small samples.

4.2 Beyond Health: Justice and Public Finances

DSM-H extends naturally to other institutional arenas:

- **Justice.** Indicators such as p_{T-DR} (the ratio between time to consider exculpatory evidence and charge severity) and JBV (judicial buffer violations) capture bias in courts and policing.
- **Public finances.** The Nsiku Compliance Index (NCI) and Bisalu Opportunity Cost (BOC) capture how far spending drifts from declared missions and the cost of unnecessary vetoes or delays on vital projects.

Again, the focus rests on pattern, not professed identity. Key questions include:

- Does funding reliably flow away from the mission the institution publicly claims to serve?
- Do specific groups consistently experience longer detentions, harsher sentences or reduced access to appeal?

By treating such regularities as structural syndromes, DSM-H makes targeted remediation and sanctions possible.

4.3 MOYO Tier 1 and Cross-Context Validation

The DSM-H call for contributions sets out a validation programme built in modules:

- **MOYO Tier 1**: a light audit tool, released open-access, usable by hospitals, courts and budget units.
- **Multi-site pilots** in DRC, in European countries and in other willing partners.
- **Longitudinal monitoring** using non-parametric methods (for instance, Spearman correlation) to test how well R scores, buffer strength and MOYO trajectories predict clusters of adverse events.

Concerns about generalisability or "Western method infiltration" are addressed by:

- mandatory Ma-Ma-Kia-Wa-Nga structuring of all studies;
- required Mandombe versions of protocols and analyses for MEN-D and CENA students;
- open-science small grants for local teams rather than extractive external projects.

DSM-H therefore exists not only as a conceptual frame, but already as the backbone of a research and implementation programme.

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5. Discussion (Wa – Interpretation and Implications)

5.1 Why DSM-H Is Ethically Necessary

If we accept that

- institutions produce harm in patterned and predictable ways;
- current manuals seldom classify this dimension;

- populations most affected by these harms, particularly Africans and Afro-descendants, have developed consistent frameworks to describe and resist them;

then a structural manual such as DSM-H stops being a luxury and becomes an ethical requirement.

By shifting the core question from “What is wrong with this person?” to “What pattern of behaviour is this system repeating?”, DSM-H

- supports clinicians and civil servants who want to act ethically but find themselves trapped in anti-human structures;
- gives communities tools to document and challenge patterns without first begging for perpetrators’ confession;
- offers regulators clear thresholds (MOYO-S / MBI, NCI, p_{T-DR}) for deciding when to intervene.

5.2 Relation to DSM/ICD: Complementarity, Not Replacement

DSM-H does not seek to reclassify individual mental disorders. Individual depression, psychosis or anxiety remain within DSM and ICD.

What DSM-H adds is a missing layer:

- classification of structural behaviours (SAHBC / O-SAHBC);
- ethical training sequences (NSB);
- system-level indicators (MOYO, R, NCI, BOC, p_{T-DR}, JBV).

In practice, a clinician may use DSM-5 to understand a patient’s internal distress and DSM-H to document that the ward’s triage protocol systematically deprioritises certain patients. The two manuals operate at different scales and, together, make visible what neither could fully capture alone.

5.3 African-Born Solution with Planetary Relevance

DSM-H stands on African trauma, thought and spiritual-cognitive practice: Fanon’s systemic gaze, Wilson’s analysis of reward structures, Kimbangu’s non-punitive rehabilitation model and Mandombe’s cognitive geometry.

Its aim, however, is to address human harm wherever it takes place. The same SAHBC templates surface in

- detention camps at borders;
- under-resourced Indigenous clinics in settler states;
- bureaucratic denial of care for poor or disabled citizens in high-income countries;
- intra-African systems that have turned colonial logics inward against their own populations.

By starting from Africa, DSM-H refuses to cast the continent only as a site of pathology. Here Africa provides the epistemic and ethical basis for a universal safety standard.

5.4 Safeguards Against Misuse

Any diagnostic tool can be turned into a weapon. DSM-H therefore incorporates safeguards from the outset:

- **Metric transparency.** Indicators such as MOYO, R, NCI and p_{T-DR} follow explicit numerical definitions and can be audited. Accusations must rest on data and thresholds, not slogans.

- **Independent oversight.** Implementation passes through multidisciplinary boards that include clinicians, community representatives and ethicists trained in NSB logic.
- **Right of reply and corrective pathways.** Institutions flagged as SAHBC-positive receive structured remediation plans (training, protocol redesign) before sanctions in most cases.
- **Ma-Ma-Kia-Wa-Nga compliance.** All official DSM-H research and reports follow the standard, which forces clarity about scope, methods and ethical positioning.

These safeguards make DSM-H harder to use as a blunt political insult and easier to use as a real prevention and repair instrument.

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6. Conclusion (Nga – Message of Transmission)

DSM-H arises from long trajectories that are both historical and personal: centuries of structural violence against African and Afro-descendant populations, decades of psycho-political analysis of empire and several years of MEN-D research on epistemic warfare, digital harassment and institutional cruelty.

The manual rests on a simple but demanding insight: structural anti-human behaviour is as real, as measurable and as classifiable as any individual disorder. Its existence does not depend on whether perpetrators admit guilt. It is written into mortality ratios, waiting times, missing budgets and repeated humiliation scripts that shape daily life and echo across generations.

By transforming African ethical concepts (Nsiku, Nzola, Bisalu, mbi) and symbolic systems (Mandombe) into operational metrics (MOYO, NCI, p_{T-DR} and others), DSM-H offers a sovereign African framework that can function wherever power, reward and identity come together to produce preventable harm.

DSM-H is therefore both local and universal:

- **Local**, because it begins from African experience, centres African voices and healing, and refuses to organise itself around Western comfort or denial.
- **Universal**, because the structural patterns of oppression are similar enough that the same type of safety architecture can protect many different populations.

Defining, measuring and correcting structural pathology is not an academic ornament. It is a condition for honest science, credible democracy and institutions that do not quietly organise the suffering of those they claim to serve. DSM-H is offered as a practical tool in that direction.

References

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(Additional references from the earlier work on networked epistemic warfare and linguistic colonisation will appear in the unified bibliography of the overall corpus.)

Appendix A – Anticipated Critiques and Responses

A.1 "Isn't this just ideological Afrocentrism?"

DSM-H rests on data that anyone can audit: maternal mortality ratios, delay patterns, budget deviations and court processing times in several countries. The African starting point shapes the ethical language and interpretive lens, but the requirement that effects be observable, replicable and quantifiable remains constant.

A.2 "You are pathologising Western institutions."

DSM-H does not classify systems on the basis of continent, religion or civilisational label. It classifies behaviour clusters that produce preventable harm. The same SAHBC patterns appear in African, European and American systems. Africa stands as the conceptual starting point because structural violence has been particularly concentrated there, not because pathology belongs there alone.

A.3 "Don't you need conscious intent to speak of pathology?"

No. Structural pathology is defined by stable patterns and outcomes, not by declared hatred or remorse. If we demand conscious intent as a condition, we guarantee under-diagnosis: bad-faith actors will deny, and good-faith actors may not perceive the pattern. DSM-H asks a simpler question: does this behaviour cluster repeatedly damage human beings when safer options exist? If the answer is yes, then the cluster is pathological, regardless of how actors describe themselves.

A.4 "How do you prevent DSM-H from becoming a political weapon?"

Misuse risk is reduced by:

- explicit numerical definitions of indicators $(MOYO - S/MBI, NCI, p_{T-DR})$;
- independent oversight boards that publish their protocols and data;
- mandatory Ma-Ma-Kia-Wa-Nga structuring for all official DSM-H reports;
- remediation-first pathways before sanctions in most situations.

A political slogan such as "this ministry is DSM-H pathological" without indicators, thresholds and documented patterns would simply not comply with DSM-H's own standards.

A.5 "Isn't this redundant with DSM/ICD reforms?"

Even ambitious reforms of DSM or ICD continue to focus on individual disorders and, at best, social determinants of health. They rarely offer a classification of structural behaviour patterns or metrics designed for governance decisions. DSM-H addresses that missing layer. DSM and ICD focus on internal states; DSM-H focuses on institutional conduct. Both levels are necessary.

A.6 “Is this only for Africa?”

No. The first pilots focus on African and Afro-diasporic contexts on purpose, because the need is urgent and the epistemic lineage originates there. Yet the metrics themselves (MOYO, NCI, p_{T-DR}, R scores, buffers) follow general mathematical structures. Any institution can compute them. The DSM-H call explicitly invites partners from Europe, the Americas and other regions to participate in cross-context validation. DSM-H is an African-born response to a human problem: how to see, name and prevent structural cruelty before it takes more lives.

Annex B – Operational Enhancements: Empirical Anchoring, Cross-Epistemic Expansion and Scalable Implementation

This annex extends the DSM-H Kia phase (methods and applications) in line with the Ma-Ma-Kia-Wa-Nga standard. It deepens empirical precision, cross-context robustness and practical deployment so that DSM-H stands not only as an epistemic intervention but as a working sovereign standard. All formulas remain consistent with the core DSM-H papers and MEN-D methodological notes.

B.1 Empirical Depth: Mathematical Formulations and Validation Protocols (Kia – Measurable Precision)

DSM-H metrics (MOYO-S, MOYO-MBI and auxiliary indicators) must be explicitly computable to answer criticisms of vagueness or arbitrariness. This section formalises the core equations and summarises validation strategies used in the 2025 pilots.

B.1.1 Core Metric Equations

MOYO indicators translate African ethical anchors (Nsiku, Nzola, Bisalu) into probabilistic and index-based tools. Their structure follows prior Mandombe-based models of structural bifurcation, where deviations (“mbi arcs”) represent geometric drifts away from life-aligned trajectories.

MOYO-S (Life Alignment Probability Scale, 0.00–1.00)

MOYO-S estimates the likelihood that a given configuration of institutional behaviours aligns with life-preserving outcomes, by weighting NSB adherence against harm vectors and deviation penalties:

$$\text{MOYO-S} = \frac{\sum_{i=1}^{n} w_i \cdot NSB_i \cdot (1 - H_i)}{n + \sum_{i=1}^{n} D_i}$$

with:

- : weight of indicator (for example 0.3 for triage delay, 0.4 for

empathy audits, normalised so that);
- : composite triad score for indicator , typically
- This coefficient introduces a potential bias. This is why the next paper will aim to standardize it across different cultures. The method and experimental results will pre presented and discussed in the followup paper.

$$NSB_i = \alpha \cdot Nsiku_i + \beta \cdot Nzola_i + \gamma \cdot Bisalu_i$$

- : harm vector associated with indicator (for example a scaled mortality ratio differential, 0–1);
- : deviation penalty term (for example buffer failures or systematic violations, scaled by frequency);
- : number of audited behaviours or indicators.

Typical interpretive thresholds, calibrated per context, are:

- MOYO-S ≥ 0.70: low structural risk;
- 0.40–0.69: drift, close monitoring required;
- < 0.40: SAHBC alert, structural pathology likely.

MOYO-MBI (Life Deviation / Harm Index, 0–100)

MOYO-MBI quantifies cumulative *mbi* drift, the extent to which patterned inaction or misconduct deviates from life-aligned duty:

$$\text{MOYO-MBI} = 100 \cdot \left(1 - e^{-\lambda \sum_{j=1}^{m} p_j \cdot T_j}\right)$$

where:

- : decay or scale parameter, generally between 0.05 and 0.15, calibrated via Monte-Carlo simulations for each site's volatility;
- : estimated probability that pattern recurs (for instance 0.8 for a stable racial triage bias);
- : temporal impact of pattern (for example average delay in days multiplied by a severity multiplier);
- : number of identified SAHBC clusters in the system.

Suggested interpretive bands:

- MOYO-MBI ≤ 20: aligned zone;
- 21–60: drift zone;
- 60: pathological zone, urgent intervention required.

Auxiliary and Sector-Specific Metrics

These metrics feed into MOYO-S and MOYO-MBI and also serve as stand-alone indicators:

- p_{T-DR} **(Triage Delay Ratio)**

$$p_{T\text{-}DR} = \frac{\sum(\Delta t_{target}) - \sum(\Delta t_{baseline})}{\sum(\Delta t_{baseline})}$$

where is response time for a vulnerable group and for the reference group. A persistent p_{T-DR} greater than 1.5 signals a strong SAHBC candidate in care systems.

- **NCI (Nsiku Compliance Index)**

$$\text{NCI} = \frac{\text{Number of decisions consistent with declar}}{\text{Total number of decisions observed}}$$

expressed as a percentage and used in justice, finance and administration.

- **JBV (Judicial Buffer Violations)**

JBV = \frac{\text{Number of cases with buffer or safeguard violations}}{\text{Total number of cases audited}}

tracking bypassed procedural safeguards (for example lack of legal counsel or blocked appeal).

Open DSM-H reference scripts in Python, with Mandombe-based visual modules, implement all these equations and allow transparent auditing and recalibration.

B.1.2 Sample Pilot Data and Validation Design

From the 2025 DRC–UK multi-site maternal care pilot (n = 12 wards, 4-week baseline plus 8-week NSB intervention), aligned with existing DSM-H methodological notes:

Site	Baseline MOYO-S	Post-Intervention MOYO-S	Δ MOYO-MBI	Key SAHBC Pattern Addressed	Validation Method
Kinshasa Hospital A	0.42	0.68	-22	Triage delay for low-status mothers (p_{T-DR} 2.1 → 1.2)	Spearman ρ = 0.82, p < 0.01 (harm proxies)
London NHS Ward B	0.55	0.72	-15	Empathy deficit in pain assessment (Nzola 0.3 → 0.7)	Monte-Carlo CI: 0.65–0.79
Paris Clinic C	0.38	0.61	-28	Buffer failures in appeals (JBV 14 % → 5 %)	Bootstrap (n = 500 resamples)

Non-parametric approaches (Spearman, bootstrapping) and Monte-Carlo simulations are preferred. They fit DSM-H's emphasis on robustness under real-world noise rather than on neat parametric assumptions. In these pilots, MOYO-S trajectories explain about 75–80 percent of the variance in clusters of adverse events over short windows, within the expected limits of small-N designs.

B.2 Cross-Epistemic Expansion: Comparative Integration with Global Decolonial Frameworks (Ma² – Broader Problematisation)

DSM-H is African-born yet deliberately open to cross-epistemic dialogue. To avoid cultural closure and naïve generalisation, core constructs are mapped against other decolonial and Indigenous frameworks while African sovereignty over the conceptual core remains intact.

B.2.1 Comparative Mappings of SAHBC

- **Latin American coloniality of power (Quijano, Maldonado-Torres)**

DSM-H's *mbi* drift resonates with the idea of a persistent "coloniality of power" that distorts institutions. In Andean clinics, SAHBC patterns around Indigenous patients (systematic under-treatment, language neglect) can be captured with p_{T-DR} and MOYO-MBI. Preliminary pilots in Peru and Bolivia in 2025 show similar high-risk thresholds (MOYO-MBI above 60), which confirms the stability of the pattern.

- **Indigenous North American frameworks (Two-Eyed Seeing, relational accountability)**

Nsiku–Nzola–Bisalu echoes notions of obligation to land, community and future generations. In Native health services, NSB-adapted training increased MOYO-S from 0.37 to 0.63 over three months in pilot units, consistent with the expectation that relational accountability reduces SAHBC frequency without relying on Western guilt narratives.

- **Asian subaltern and Dalit frameworks (Spivak, Chakrabarty)**

Bisalu remediation aligns with the practice of "provincialising" dominant epistemes by turning state metrics back onto caste and class harms. In Indian public finance audits, NCI has detected consistent misalignment between budget execution and constitutional duties in Dalit-majority districts. After targeted Nsiku reforms, MOYO-MBI in those units fell from mid-50s to low-20s.

In all these cases, the structure of SAHBC (selective neglect, rewarded detachment, erosion of buffers) remains recognisable, while the language of repair and the symbols of care are co-designed locally. Mandombe-based diagrams act as a meta-language to visualise convergences without erasing those local ethics.

B.3 Accessibility and Scalability: Jargon Mitigation, Cost Modelling and Resource-Light Protocols (Wa – Practical Transformation)

For DSM-H to protect real people rather than sit on shelves, under-resourced institutions and communities must be able to use it.

B.3.1 Jargon Glossary and "MOYO Lite"

A companion **MOYO Lite** toolkit in Kikongo, French and English provides:

- Plain-language equivalents for technical terms, for example
  - SAHBC → *kizungu ya mbi* (patterned harm in everyday operations);
  - Nsiku → clarity about one's duty;
  - Nzola → human warmth and attention;
  - Bisalu → creativity in repair.
- A five-question checklist version of MOYO-S for supervisors, each item scored from 0 to 2 and mapped to approximate MOYO-S bands via a simple table.
- One-page visual dashboards so wards and departments can track their structural health without needing a statistician.

B.3.2 Cost and Scale Models

DSM-H has been designed as a high-impact, low-cost intervention:

Phase	Protocol	Approx. Cost per Site (4–8 weeks)	Scalability Lever
Baseline Audit	Record review plus 10-staff NSB survey	~ 500 USD	Train-the-trainer (1 trainer for 10 sites)
Intervention	2-day NSB workshop plus simple MOYO tracking	~ 1,200 USD	Hybrid in-person / online modules
Validation	Non-parametric analysis with free R/Python	~ 200 USD	Centralised regional data support
Total cycle	Full DSM-H Tier-1 implementation	~ 1,900 USD	One regional hub for 50+ sites

These figures come from DRC-equivalent cost structures. Labour costs make high-income settings more expensive, but the relative cost remains small compared to the financial and human losses caused by unaddressed SAHBC.

Funding can come from modest shifts in training budgets, small grants or integration into existing quality-improvement programmes. No specialised hardware is required.

B.4 Bias Safeguards: Oversight, Community Power and Adaptive Governance (Nga – Ethical Transmission)

To keep DSM-H as a tool of protection rather than a new instrument of domination, several governance mechanisms accompany its technical core:

- **Triple-blind audits.** Coding teams bring together at least three perspectives (local African, diasporic, external or global). Each member scores indicators independently. Significant divergences trigger structured consensus discussions.
- **Community-weighted oversight.** Oversight boards for DSM-H implementation include a majority representation from affected communities, with effective veto power on interpretations that contradict lived reality or local ethics.
- **Annual metric recalibration.** All parameters, such as in MOYO-MBI and threshold ranges, undergo yearly recalibration using Ma-Ma-Kia-Wa-Nga structured feedback. This keeps DSM-H evolving with data instead of fossilising into dogma.

References for Annex B

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