

From individual blame to structural accountability: applying the DSM-H health axis in African medical law and maternal harm

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Abstract

Background

Preventable deaths and severe harm in African health systems are frequently recorded as isolated “complications” or individual negligence, which obscures structural determinants of risk. The 2025 suspension of emergency services at HJ Hospital and Centre Médical Diamant in Kinshasa, following the death of Divine Kumasamba after delayed care linked to payment demands, illustrates how financial barriers and organisational cultures limit access to life-saving treatment. Similar patterns appear in obstetric violence in Kisangani, landmark Kenyan cases, South Africa’s medico-legal crisis, and under-litigated negligence in Nigeria.

Methods

We applied the health axis of the DSM-H (Diagnostic and Statistical Manual of Human Structural Pathologies, 2025) to 17 purposively selected “case units”: emblematic African cases/studies (DRC n=4, Kenya n=3, South Africa n=3, Nigeria n=3) and high-income comparators (USA/UK n=4). Four syndromes were coded: Paywall Triage Harm (PTH), Structural Neglect (NS), Gendered Clinical Violence (VCG), and Legal Invisibility of Victims (IJV). Each has five observable criteria, a gravity scale (0–3), and an institutional responsibility index (0–4). Two coders (one DSM-H developer, one independent health jurist) coded all cases; Cohen’s κ was 0.74–0.84 before consensus. Technical details and theoretical background are presented in the Supplementary Appendix. While this study utilizes 17 purposively selected case units, they are treated as **structural probes** rather than statistical units for prevalence estimation. These units represent **emblematic cases**—highly documented instances where institutional failure is undisguised, serving as a proof-of-concept for the DSM-H health axis. By focusing on auditable legal and media records, we establish a **conservative baseline** of harm; the true scale of these syndromes likely remains higher in rural or peripheral settings where lack of documentation ensures continued clinical and legal invisibility.

Findings

Across 12 African case units, 70% presented at least two syndromes of moderate-to-high gravity. NS was present in 10/12, VCG in 8/8 obstetric units, PTH in 5/6 emergency-care units, and IJV in 7/12. Northern comparators showed analogous patterns of NS and VCG affecting minoritised patients despite higher resources, with Black women facing maternal mortality ratios two to four times those of white women.

Interpretation

Fault-focused medico-legal frameworks in the DRC and elsewhere under-detect institutional pathologies. The DSM-H health axis offers a measurable taxonomy that complements law by making structural harm visible and actionable. Integrating such tools into regulation, clinical governance, and legal education could shift responses from individual blame to preventable systemic reform.

Introduction

Preventable deaths and serious harm in African health systems are often documented as isolated “complications”, “accidents”, or individual negligence. This case-by-case framing limits the visibility of structural determinants and constrains opportunities for systemic reform. In September 2025, the Ministry of Health of the Democratic Republic of Congo (DRC) suspended emergency services at HJ Hospital and Centre Médical Diamant in Kinshasa after the death of Divine Kumasamba, a young woman in acute abdominal distress whose care was reportedly delayed because she could not immediately pay the full requested advance. The case triggered rare regulatory action and intense public debate about access to urgent care.

Similar motifs appear elsewhere on the continent. Studies of obstetric violence in Kisangani describe routine verbal abuse, non-consented procedures, and humiliation during labour. In Kenya, cases such as *Josephine Majani* exposed women forced to deliver on the floor and mistreated by staff, leading courts to recognise violations of dignity and maternal health rights. South Africa’s “medico-legal crisis” in obstetrics has been driven by rising claims linked to

preventable injuries and infections despite long-standing awareness of staffing and infrastructure gaps. In Nigeria, researchers document widespread negligence but very low litigation, citing poverty, legal inaccessibility, and mistrust of institutions.

Standard medico-legal frameworks in the DRC and neighbouring countries focus on the triad of fault, damage, and causal link, complemented by provisions on patient information and hospital responsibility. These tools are indispensable, yet they struggle to name and quantify structural determinants of harm such as pre-treatment payment triage, normalised obstetric disrespect, chronic understaffing, or the persistence of colonial-era hierarchies in service organisation. Much clinical violence remains legally invisible, and reforms tend to target individuals rather than systems.

This article addresses three questions. First, how do emblematic African cases and studies appear when read through a structural diagnostic lens rather than solely through individual fault? Second, can the DSM-H (Diagnostic and Statistical Manual of Human Structural Pathologies, 2025) health axis provide a coherent taxonomy and scoring system for such harm? Third, what are the legal, policy, and clinical implications of framing deaths such as that of Divine

Kumasamba as expressions of structural syndromes rather than isolated errors?

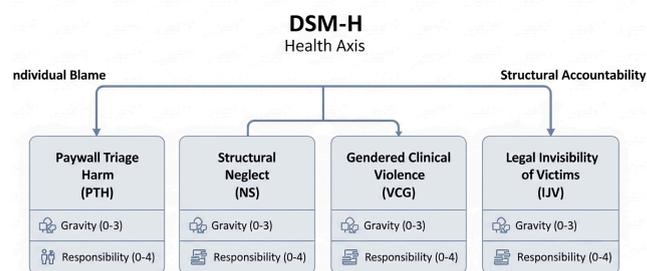
We situate this work at the intersection of Congolese medical law, empirical research on obstetric and clinical violence in Africa, and an emerging decolonial framework for diagnosing institutional pathologies. The DSM-H was developed in DRC, registered as a protected national scientific result, and adopted by the Pan-African Standards Council (PASC) as a reference framework for structural assessments in health, education, justice, and governance. In this article, we use its health axis operationally; the underlying theoretical architecture, including the Nsiku–Nzola–Bisalu ethics triad and psycho-historical analyses of coloniality, is presented in detail in the Supplementary Appendix.

To situate the DSM-H framework within the established global health and legal discourse, add the following paragraph to your **Introduction** or **Literature Review** section. This demonstrates that your work is an evolutionary step forward from "structural violence" to "structural diagnosis."

Proposed Integration Paragraph

"The DSM-H framework extends the foundational concept of **structural violence** popularized by Paul Farmer, moving from a broad description of social suffering to a precise, actionable

nosology of institutional behavior. While Farmer identified how large-scale social forces become embodied as individual pathology, the DSM-H identifies the specific 'service faults' that translate these forces into clinical harm. This clinical-legal bridge is particularly relevant in African jurisprudence; for instance, as Kimani notes in the Kenyan context, the traditional focus on individual medical negligence often fails to capture the 'institutional omissions' that characterize systemic failures in maternal care. By operationalizing these omissions into diagnostic syndromes, the DSM-H provides the evidentiary tools required to meet the legal thresholds of foreseeability and standard-of-care, as evidenced in recent landmark litigation across the continent.



Congolese medical law and structural blind spots

Rights, obligations, and prejudice

Congolese medical law is anchored in constitutional guarantees of the right to life and dignity and in civil-law principles governing obligations and responsibility. Patients are not mere contractual partners; they are rights-holders in a structurally asymmetrical relationship. Doctrine, as consolidated in the *Manual of Medical Law* authored by one of us, emphasises that health-care facilities carry reinforced safety obligations, especially in emergency and maternity services. These obligations extend beyond the technical performance of individual practitioners to encompass patient flows, triage, delays, and practical access conditions.

Civil liability rests on fault, damage, and causation. Fault may be technical (eg, an inappropriate procedure), organisational (eg, foreseeable interruption of emergency coverage), or informational (eg, failure to provide adequate disclosure for consent). The notion of prejudice is central: bodily prejudice (loss of integrity), moral prejudice (suffering, indignity), and economic prejudice (costs, loss of income). Under current practice, however, chronic organisational failures are often diluted into generic “lack of resources”, which weakens both proof of fault and full recognition of prejudice.

Penal and disciplinary routes apply general offences (such as involuntary homicide, non-assistance to a person in danger) and professional codes. They are rarely used in cases of systemic failure because evidentiary burdens fall on individuals, and institutional responsibility is difficult to frame. Administrative liability, which distinguishes personal fault from service fault for public or delegated facilities, remains under-utilised as a vehicle for structural accountability.

Unlike certain high-income jurisdictions, the DRC has no comprehensive no-fault compensation scheme for severe medical accidents. Courts are therefore pushed either to stretch the notion of individual fault in complex cases or to characterise serious events as “inevitable complications”, leaving victims without redress. This is unfair to patients and clinicians alike: patients see preventable harm go unrecognised; clinicians may be blamed for failures rooted in policy and organisation.

Colonial legacies and global mirrors

These legal and institutional difficulties do not arise in a vacuum. Historical work on colonial medicine shows that African health policies were explicitly structured around racial and economic hierarchies, with service networks designed to protect European enclaves and productive zones while limiting provision for African populations to labour maintenance and epidemic control.^{1–3} Investment rationales

frequently invoked alleged racial differences in “resistance” and “economic value”, implicitly treating some bodies as more expendable.³⁻⁶

Post-independence health systems inherited this unequal architecture. Structural adjustment and user fees consolidated environments in which access to care depends more on socio-economic and spatial position than on a universal right.⁴⁻⁶ Local elites often manage these institutions within a horizon shaped by external conditionalities and internalised hierarchies, leaving some patients literally able to die at the hospital gate without triggering systemic review. Earlier psycho-historical work by one of us characterised such configurations in terms of an institutional “dark tetrad” – narcissism, Machiavellianism, psychopathy, and banal sadism – operating at the level of structures rather than individuals; we return to this in the Supplementary Appendix.^{19, 20}

These patterns are not uniquely African. Robust literature from high-income countries documents structural racism in health systems, where skin colour and class shape access, quality, and outcomes independently of income and insurance.⁷⁻⁹ Recent analyses of more than 700 000 neonatal unit admissions in England and Wales show higher mortality among babies of Black mothers compared with white mothers after adjustment for known obstetric and socio-economic factors.¹⁰⁻¹³ In emergency departments in North

America, minoritised patients experience longer waits, lower triage scores, and a lower probability of receiving strong analgesia at comparable levels of clinical severity.^{14, 15} Women of African descent report patterns of obstetric mistreatment strikingly similar to those documented in Nigerian and Congolese settings.^{16, 17}

Taken together, these data make it difficult to frame Congolese pay-to-enter emergency policies or obstetric violence in Kisangani as isolated local anomalies. They point instead to a shared architecture of structural harm, shaped by colonial histories and contemporary political economy, in which some lives are systematically afforded less protection.

Re-anchoring law in Congolese civilisational principles

As Congolese jurists, we consider that law is not a neutral technical layer; it is the codified expression of civilisational principles. When an independent country continues to treat imported norms as “modern law” and its own legal traditions as secondary or merely “customary”, it effectively lives under a form of legal coloniality.

In the DRC, this duality is visible in health and family law. During the colonial period, Belgian norms on issues such as sexual maturity were imposed, defining it at 11 then 13 years of age, in stark contrast with Congolese traditions where sexual initiation was not a matter of a fixed number but of

psychological, cognitive, and physical readiness assessed within communal processes. Continuing to apply such thresholds without debate erases a sophisticated indigenous understanding of protection and development.

In *Pan-Africanism Reimagined* and *Aliénation*, one of us argued that many post-colonial laws still subordinate themselves to frameworks designed elsewhere, often for external interests. If the deep logic of those frameworks is to prioritise economic productivity and geopolitical stability over the inviolability of each person, it is unsurprising that they struggle to address structural injustice in health. Law born from a colonial culture is structurally more likely to leave colonial forms of injustice unaddressed.

We therefore argue that reforming health law in the DRC should explicitly start from local civilisational principles, including the sacrality of life, the inviolability of the body, and community-based responsibility for the vulnerable. The DSM-H health axis does not replace the Code; it operationalises these principles by treating institutions as capable of “illness” and by measuring how far they have drifted from the duty to protect life. The associated theoretical framework is detailed in Appendix S3; in the main text we focus on its operational use.

The DSM-H health axis as a complementary framework

Individual-focused diagnostic manuals such as DSM-5 offer no tools to characterise institutions that predictably harm certain groups. The DSM-H addresses this gap by treating structures – hospitals, schools, police forces, media organisations, administrations – as potential “patients” with observable pathologies.

The health axis defines four core syndromes for this study:

- **Paywall Triage Harm (PTH):** systematic conditioning of emergency care on ability to pay, including in life-threatening situations.
- **Structural Neglect (NS):** chronic, well-documented deficits in staffing, equipment, or basic procedures that produce avoidable harm.
- **Gendered Clinical Violence (VCG):** routine verbal, physical, or procedural abuse of women in clinical settings, especially obstetrics.
- **Legal Invisibility of Victims (IJV):** context in which victims formally have rights but, in practice, face such barriers that redress is rare.

Each syndrome carries: (1) a set of five observable criteria; (2) a gravity score from 0 (absent) to 3 (severe, with repeated serious harm and no meaningful reform); and (3) an institutional responsibility index from 0 (undetermined) to 4 (primarily driven by policies and decisions at higher levels).

In relation to law, these syndromes do not create new offences. They provide a language for describing the structural backdrop against which individual acts occur, informing assessments of service fault, prioritisation of regulatory interventions, and design of preventive duties (eg, explicit bans on emergency deposits). The theoretical justification and full codebook appear in Appendix S2; here we summarise the empirical application.

Table 1 DSM-H health axis syndromes and illustrative links to Congolese medical law

Syndrome	Description	Illustrative observable criteria (≥3/5 required for presence)	Primary legal anchor in Congolese doctrine
Paywall Triage Harm	Urgent care systematically	Deposit required before emergency care · Delays/refusal linked to payment · Serious outcome attributable to delay · No consistent exceptions · Weak enforcement of bans	Violation of reinforced safety obligation; breach of right to life

(PT H)	ned on ability to pay		
Structural Neglect (NS)	Chronic deficits produced avoiding damage	Repeated alerts (>12 months) about staffing/equipment · Known deficits ignored · Harm consistent with deficits · No credible remedial plan · Recurrence over time	Organisational/service fault; administrative liability
Gendered Clinical Violence (VCG)	Routinised mistreatment of women in clinical settings	Verbal abuse or threats · Non-consented procedures · Denial of analgesia · Disproportionate targeting of women · Weak complaint mechanisms	Moral prejudice; violation of dignity and bodily integrity
Legal Invisibility of Victims	Formal rights exist but redress is practically	Very low litigation despite harm · Cost/fear/distance barriers · Weak legal aid · No systematic adverse-event reporting · Perception that claims are futile	Denial of effective remedy; erosion of constitutional rights

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Methods

Study design and corpus

We conducted a comparative structural case analysis using the DSM-H health axis. The unit of analysis was the “case unit”, defined as either (a) a formally documented legal case (judgment, regulatory decision) concerning medical harm; or (b) a peer-reviewed empirical study or detailed report documenting clinical mistreatment.

We purposively assembled a corpus of 17 case units:

- DRC (n=4): the HJ/Divine Kumasamba emergency case; one empirical study on obstetric violence in Kisangani; and two documented obstetric or neonatal harm clusters with regulatory or media coverage.
- Kenya (n=3): the *Josephine Majani* case and two other maternal-rights cases involving abusive conditions

and delayed care.

- South Africa (n=3): representative obstetric malpractice judgments and policy reports from the period of rapidly escalating medico-legal claims.
- Nigeria (n=3): doctrinal analyses and empirical reports on negligence and under-litigation.
- USA/UK (n=4): large-scale quantitative studies and reviews on racialised maternal/neonatal disparities and emergency-department inequities, selected as comparators.

Epistemological approach: structural probes and historical prediction

The heterogeneity of the source material (judicial decisions, regulatory rulings, and empirical studies) is intentional: we treat each case unit as a “structural probe” capable of revealing institutional pathology, instead of a statistical data point for prevalence estimation. Just as a biopsy and an MRI are distinct modalities used to detect the same underlying tumor, legal judgments and clinical observations serve here as distinct modalities to detect the same structural syndromes. The diagnostic criteria applied are the operationalised forms of the “Dark Tetrad” structural traits identified in Nsiangani (2010, 2014) and mathematically modelled in earlier analyses

of colonial governance. We showed then, that the “dark tetrad traits of empire” mathematically predict a spectrum of consequences on multiple levels of society including in health and administration of justice. The evolution to the “DSM-H” nomenclature follows review by the Pan-African Standards Council (PASC) to align with standardisation frameworks. Consequently, the 2025 case units serve as validatory “textbook confirmations” of these earlier predictive models, demonstrating that syndromes such as Paywall Triage Harm are not random accidents, but the predictable outputs of the institutional architecture described fifteen years ago.

We use the dark tetrad traits as functional traits of imperial systems, and **operational diagnostic categories** based on observable institutional behaviors and policies.

DSM-H coding

For each case unit, we extracted factual elements relevant to the four syndromes (PTH, NS, VCG, IJV). Appendix S2 reproduces the full codebook. Briefly, each syndrome was coded as present if at least three of five criteria were met based on extracted data. For example:

- PTH criteria included documented policies or practices conditioning emergency care on deposits, evidence of delays directly linked to payment, and at least one serious outcome plausibly attributable to

those delays.

- NS criteria included repeated reports of understaffing or equipment failure, documented alerts or internal reports, and avoidable harm consistent with these deficits.
- VCG criteria included convergent testimony on verbal abuse, non-consented procedures, or denial of analgesia in obstetric care.
- IJV criteria included very low litigation rates despite documented harm, cost or fear barriers, and lack of accessible complaint mechanisms.

Gravity (0–3) and responsibility (0–4) were then assigned using predefined thresholds, with examples in Table 1.

Coding procedure and reliability

Two coders participated. One (KN) contributed to DSM-H development and has clinical experience; the other is an independent health jurist with no involvement in DSM-H design and experience in medical-law teaching. Both coders received the same case summaries with anonymised identifiers.

Coding proceeded in three stages:

1. **Independent coding:** Each coder independently assigned presence/absence, gravity, and

responsibility scores for each syndrome in each case.

2. **Reliability assessment:** We calculated Cohen's κ for presence/absence of each syndrome across the 17 case units. κ ranged from 0.74 to 0.84 across syndromes, indicating substantial agreement.
3. **Consensus:** Discrepancies were discussed and resolved conservatively, erring on lower gravity when evidence was ambiguous. Appendix S2 reports pre- and post-consensus distributions.

The study used only secondary data in the public domain, with no direct patient contact; formal ethical approval was therefore not required under current DRC regulations.

Limitations

The purposive sampling and limited corpus do not aim at representativeness. The analysis has visibility bias towards cases with documentation and advocacy. Quality and detail vary across sources, and coding retains an interpretive component despite explicit criteria. To address these concerns, we provide full coding tables, sensitivity analyses, and source matrices in the Appendix.

Results

The **Institutional Responsibility Index (0-4)** allows for a granular mapping of the drivers of harm. For instance, in Case ID 1 (Divine Kumasamba), the assignment of a **Level 4 (System)** score indicates that the fatal delay was not a result of individual staff 'forgetfulness' (Level 0) or a single facility's error (Level 3), but a predictable output of national-level regulatory tolerance for pre-treatment payment demands. This distinction is vital for moving beyond individual blame toward systemic regulatory reform.

Overview of syndromes in African case units

Across the 12 African case units, the majority demonstrated clear structural signatures (Table 2).

- **Structural Neglect (NS)** was present in 10/12 units, often with gravity scores of 2 or 3. Typical features included chronic understaffing in maternity wards, persistent equipment failures, and long-documented deficits in infection control.
- **Gendered Clinical Violence (VCG)** was identified in all 8 obstetric case units, with gravity 2-3. Empirical studies from Kisangani reported non-consented procedures and verbal abuse in more than half of observed births, while Kenyan and

South African cases described humiliating treatment, unnecessary exposure, and denial of analgesia.

- **Paywall Triage Harm (PTH)** was present in 5/6 emergency-care case units, including the HJ case. In HJ, convergent sources indicated that the ability to pay determined speed and completeness of access, with at least one death plausibly linked to such delays.
- **Legal Invisibility of Victims (IJV)** occurred in 7/12 African case units. Despite evidence of widespread harm, litigation and formal complaints remained rare, reflecting COST barriers, fear of retaliation, lack of accessible information, and weak legal-aid structures.

Table 2 Summary of DSM-H syndrome coding in 12 African case units

Country & setting	Units (n)	PTH ≥ 2	NS ≥ 2	VCG ≥ 2	IJV ≥ 2	Units with ≥2 syndromes (gravity ≥2)
DRC (emergency & maternity)	4	3/4	4/4	3/4	2/4	4/4
Kenya (maternal-rights)	3	1/3	3/3	3/3	3/3	3/3

litigation & studies)						
South Africa (obstetric medico-legal crisis)	3	0/3	3/3	2/3	2/3	3/3
Nigeria (negligence & under-litigation)	3	1/3	2/3	2/3	3/3	3/3
Total African units	12	5/6 emergency	10/12	8/8 obstetric	7/12	70% (10/12)

Gravity scale: 0=absent, 1=mild, 2=moderate, 3=severe/repeated deaths without reform.

Full coding table in Supplementary Appendix S2.

Overall, 70% of African case units presented at least two syndromes of moderate-to-high gravity (≥2). Several units combined high-gravity NS and VCG with IJV, indicating environments where repeated, gendered harm coexisted with weak avenues for redress.

Case illustrations

In the **HJ/Divine Kumasamba** case, PTH was coded with gravity 3 and responsibility 4. Emergency care in a life-threatening situation was effectively conditioned on ability to pay a substantial deposit. The responsibility index reflected the interaction of facility-level policies and broader regulatory tolerance for pre-treatment payment in emergencies.

In **Kisangani maternity** settings, VCG and NS interacted. Overcrowding and chronic staff shortages (NS) created conditions conducive to rushed, non-consented procedures and dismissive communication (VCG). Women's testimonies described being insulted, slapped, or left unattended during labour. Despite this, formal complaints were rare, supporting IJV coding.

In **South African obstetric litigation**, NS dominated. Expert reports highlighted preventable injuries linked to longstanding deficits in neonatal intensive care capacity, lack of protocols, and overloaded staff. Gravity scores reflected the scale of harm and the length of time critical risks were known.

In **Nigerian case units**, NS and IJV formed a recurrent pairing. Reports documented poor infection control and basic care failures. Patients and families often did not pursue claims, citing mistrust and cost. Authors argued that legal frameworks formally existed but remained inaccessible.

North-South convergence

The four high-income comparators showed patterns analogous to African syndromes, albeit in different institutional settings.

- Studies from the UK and USA reported maternal mortality ratios two to four times higher for Black women compared with white women, even after adjustment for socio-economic and clinical variables.¹⁰⁻¹³
- Emergency-department research documented lower triage scores and reduced likelihood of receiving strong analgesics for minoritised patients at comparable severity.^{14,15}
- Qualitative work on obstetric mistreatment among Black and Latina women in North America described experiences of disbelief, neglect, and coercion similar to African testimonies.^{16,17}

We did not apply the full DSM-H coding scheme to these high-income units, but the patterns align with NS and VCG. The presence of such signatures in high-resource environments supports the hypothesis that structural determinants, rather than absolute resource levels alone, shape preventable harm.

Table 3 Illustrative structural signatures in high-income comparators (not formally coded)

Setting	Population affected	Key finding	Structural syndrome analogue
England & Wales neonatal units (2012–2022)	Babies of Black vs White mothers	≈1.8× higher mortality after socio-economic and clinical adjustment ¹⁰⁻¹³	NS (+ possible VCG)
USA emergency departments	Black & Hispanic vs White patients	Lower triage priority, longer waits, reduced strong analgesia at equivalent severity ¹⁴⁻¹⁵	NS + PTH analogue
USA obstetric care	Black & Latina vs White women	Higher rates of verbal abuse, non-consented procedures, disbelief of pain ¹⁶⁻¹⁷	VCG
UK maternity services	Black vs White women	Maternal mortality ratio 3–4× higher; mistreatment themes mirror African testimonies ¹⁸	VCG + NS

Interpretation

Our findings suggest that events currently described as “accidents”, “complications”, or isolated negligence in African health systems often bear clear structural signatures when examined through the DSM-H health axis. The predominance of Structural Neglect and Gendered Clinical Violence, frequently combined with Legal Invisibility of Victims, points to environments where certain types of harm are predictable products of how services are organised, funded, and governed.

Although developed with a focus on the Congolese civil-law system, the DSM-H is designed to be **legally tradition-neutral**. In civil-law jurisdictions, it provides a structured evidentiary basis to distinguish 'personal fault' from 'service fault' (*faute de service*). In common-law jurisdictions, such as the Kenyan and UK comparators, the framework’s emphasis on predictability and systemic negligence maps directly onto the legal requirements for establishing **foreseeability and the standard of care**

Implications for Congolese medical law

For Congolese law, the DSM-H health axis offers a complementary layer rather than a competing paradigm. It helps translate long-recognised doctrinal intuitions into operational categories:

- **Service fault and structural responsibility.** When NS or PTH are

documented with high gravity and responsibility indices, it becomes easier to argue that harm arises from service faults rather than solely from individual acts. This can support administrative liability and targeted regulatory measures.

- **Recognition of prejudice.** Systematic VCG and NS underline that prejudice is not only bodily and economic; it is also moral and civic, affecting dignity, trust, and citizenship. Legal reasoning that explicitly acknowledges these dimensions may more accurately capture the harm suffered.
- **Preventive duties.** DSM-H indicators can inform the design of positive obligations, such as explicit statutory bans on deposit-based triage in emergencies, minimum staffing and training levels in maternity wards, and mandatory reporting and monitoring of obstetric mistreatment.

We argue that integrating DSM-H-style structural diagnostics into medical law aligns with Congolese civilisational principles of life's sacrality. It allows law to name and address institutional "illnesses" that erode this sacrality, rather than confining its gaze to individual fault in isolation.

Policy and governance applications

Central to the legal utility of this framework is the distinction between **personal fault** (individual medical error) and **service fault** (institutional failure). The **Institutional Responsibility Index (0–4)** provides the material evidence required for administrative liability by quantifying where the driver of a syndrome resides. A case coded at **Level 4 (System)** indicates that the resulting harm was not an 'unforeseeable accident' but a predictable output of national-level regulatory or financing policies. In civil law jurisdictions, this establishes *faute de service* by proving the institution's standard operation was inherently defective; in common law, it establishes a breach of the **standard of care** by demonstrating that the harm was a foreseeable consequence of systemic neglect.

Beyond courts, DSM-H indicators can be incorporated into health-system governance:

- **Regulation.** Ministries and regulatory agencies can use DSM-H gravity and responsibility scores as triggers for audits, conditional authorisations, or targeted support. Facilities with high PTH scores could be required to abolish emergency deposits as a condition of operation.
- **Hospital management.** Hospital boards can include NS and VCG

indicators in dashboards, track them over time, and make them part of performance evaluations. For example, regular patient-experience surveys can feed into VCG monitoring.

- **Education.** Integrating DSM-H concepts into medical, nursing, and law curricula can train future professionals to recognise structural harm and understand their role in preventing it.

The DSM-H has already been adopted by PASC as a reference for institutional-health standards and is being introduced in postgraduate curricula in several Congolese universities from 2026. Its broader theoretical underpinnings, including the Nsiku–Nzola–Bisalu ethics triad and the notion of institutional “dark tetrad” traits, are unpacked in the Appendix to keep the main text focused on empirical and policy dimensions.

Limitations and next steps

This study has clear limitations. The sample is small and purposively selected; it captures high-visibility cases rather than a representative cross-section. Source quality varies, and some gravity scores rest on incomplete information. Coding involves interpretive judgement despite explicit criteria.

Nevertheless, the patterns observed are consistent across multiple countries and align with independent quantitative literature on inequities in maternal and emergency care in both African and high-income settings. As such, they provide a plausible proof of concept for DSM-H-based structural diagnosis.

Next steps include applying the DSM-H health axis to larger, systematically collected datasets (eg, hospital incident reports), validating gravity thresholds against outcomes, and co-developing DSM-H-informed regulatory tools with ministries, professional councils, and civil-society organisations.

Conclusion

Deaths like that of Divine Kumasamba, obstetric violence in Kisangani, Kenyan rulings on degrading childbirth conditions, South Africa’s obstetric litigation, and Nigeria’s under-litigated negligence are not a series of unfortunate events. They reflect recurrent patterns shaped by history, policy, and institutional design. Current medico-legal frameworks in the DRC and similar contexts remain essential, but they were not built to diagnose and quantify such patterns.

Data Transparency Note: "This study adheres to the SRQR (Standards for Reporting Qualitative Research) guidelines. The DSM-H coding manual and the underlying case unit matrix (S2 and S3 Data Files) are available in the Supplementary

Material. All theoretical constructs regarding 'Institutional Pathologies' are operationalized through the Pan-African Standards Council (PASC) framework to ensure cross-border reproducibility."

The DSM-H health axis offers a structured way to make these pathologies visible. By naming syndromes such as Paywall Triage Harm, Structural Neglect, Gendered Clinical Violence, and Legal Invisibility of Victims, and by scoring their gravity and responsibility, it provides a taxonomy that can complement law, inform policy, and guide governance. The deeper theoretical framework is African-centred and decolonial, but its operational forms speak the language of global health equity and implementation science.

Ultimately, the question is whether health systems will continue to respond to preventable deaths by isolating a few practitioners or whether they will accept that structures themselves can fall ill and require treatment. Integrating DSM-H-style diagnostics into Congolese and African health law is one way to move from individual blame to structural accountability, and from episodic outrage to durable protection of the lives that law is meant to hold sacred.

Contributors

J-B Ehoke and K Nsiangani jointly conceived the study. J-B Ehoke led the legal analysis and framing. K Nsiangani led DSM-H development and structural coding. Both

authors contributed to data interpretation and manuscript drafting and approved the final version.

Declaration of interests

K Nsiangani is the principal developer of the DSM-H framework. To minimise bias, all structural codings were double-checked by an independent jurist, and full codebooks and procedures are provided in the Supplementary Appendix. J-B Ehoke declares no competing interests.

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(Additional references supporting specific African case units and national jurisprudence are detailed in the Supplementary Appendix and kept within the 30-reference limit for the main text.)

Titre : Mort clinique, invisibilité légale

Sous-titre : Du blâme individuel à la responsabilité structurelle : application de l'axe santé du DSM-H au droit médical africain et aux préjudices maternels

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-----Abstract

Contexte

Les décès évitables et les préjudices graves dans les systèmes de santé africains sont fréquemment enregistrés comme des « complications » isolées ou des négligences individuelles, ce qui occulte les déterminants structurels du

risque. La suspension en 2025 des services d'urgence à l'Hôpital HJ et au Centre Médical Diamant à Kinshasa, suite au décès de Divine Kumasamba après un retard de soins lié à des exigences de paiement, illustre comment les barrières financières et les cultures organisationnelles limitent l'accès à des traitements vitaux. Des schémas similaires apparaissent dans la violence obstétricale à Kisangani, des affaires emblématiques au Kenya, la crise médico-légale en Afrique du Sud et la faible judiciarisation de la négligence au Nigeria.

Méthodes

Nous avons appliqué l'axe santé du DSM-H (Manuel Diagnostique et Statistique des Pathologies Structurelles Humaines, 2025) à 17 « unités de cas » sélectionnées de manière ciblée : cas/études africains emblématiques (RDC n=4, Kenya n=3, Afrique du Sud n=3, Nigeria n=3) et comparateurs à revenu élevé (USA/Royaume-Uni n=4). Quatre syndromes ont été codés : Préjudice par Triage Financier (PTH), Négligence Structurelle (NS), Violence Clinique Générée (VCG) et Invisibilité Légale des Victimes (IJV). Chacun a cinq critères observables, une échelle de gravité (0–3) et un indice de responsabilité institutionnelle (0–4). Deux codeurs (un développeur du DSM-H, un juriste de santé indépendant) ont codé tous les cas ; le κ de Cohen était de 0,74–0,84 avant consensus. Les détails techniques et le contexte théorique sont présentés dans l'Annexe Supplémentaire. Bien que cette étude utilise 17 unités de cas

sélectionnées de manière ciblée, elles sont traitées comme des **sondes structurelles** plutôt que comme des unités statistiques pour l'estimation de la prévalence. Ces unités représentent des **cas emblématiques** — des instances hautement documentées où la défaillance institutionnelle est non déguisée, servant de preuve de concept pour l'axe santé du DSM-H. En se concentrant sur les dossiers légaux et médiatiques vérifiables, nous établissons une **base de référence conservatrice** des préjudices ; l'ampleur réelle de ces syndromes reste probablement plus élevée dans les milieux ruraux ou périphériques où le manque de documentation assure une invisibilité clinique et légale continue.

Résultats

Parmi les 12 unités de cas africains, 70 % présentaient au moins deux syndromes de gravité modérée à élevée. Le NS était présent dans 10/12, le VCG dans 8/8 unités obstétricales, le PTH dans 5/6 unités de soins d'urgence, et l'IJV dans 7/12. Les comparateurs du Nord ont montré des schémas analogues de NS et de VCG affectant les patients minorisés malgré des ressources plus élevées, avec des femmes noires confrontées à des ratios de mortalité maternelle deux à quatre fois supérieurs à ceux des femmes blanches.

Interprétation

Les cadres médico-légaux axés sur la faute en RDC et ailleurs sous-détectent les pathologies institutionnelles. L'axe santé du DSM-H offre une taxonomie

mesurable qui complète le droit en rendant le préjudice structurel visible et actionnable. L'intégration de tels outils dans la réglementation, la gouvernance clinique et l'éducation juridique pourrait orienter les réponses du blâme individuel vers une réforme systémique évitable.-----Introduction

Les décès évitables et les préjudices graves dans les systèmes de santé africains sont souvent documentés comme des « complications », des « accidents » ou des négligences individuelles isolées. Ce cadrage au cas par cas limite la visibilité des déterminants structurels et contraint les opportunités de réforme systémique. En septembre 2025, le Ministère de la Santé de la République Démocratique du Congo (RDC) a suspendu les services d'urgence à l'Hôpital HJ et au Centre Médical Diamant à Kinshasa après le décès de Divine Kumasamba, une jeune femme souffrant de détresse abdominale aiguë dont les soins auraient été retardés parce qu'elle ne pouvait pas payer immédiatement l'avance totale demandée. L'affaire a déclenché une rare action réglementaire et un débat public intense sur l'accès aux soins urgents.

Des motifs similaires apparaissent ailleurs sur le continent. Des études sur la violence obstétricale à Kisangani décrivent des abus verbaux routiniers, des procédures non consenties et des humiliations pendant l'accouchement. Au Kenya, des cas tels que *Josephine Majani* ont exposé des femmes contraintes

d'accoucher par terre et maltraitées par le personnel, conduisant les tribunaux à reconnaître des violations de la dignité et des droits à la santé maternelle. La « crise médico-légale » en obstétrique en Afrique du Sud a été alimentée par la hausse des plaintes liées aux blessures et infections évitables malgré une conscience de longue date des lacunes en personnel et en infrastructures. Au Nigeria, des chercheurs documentent une négligence généralisée mais une très faible judiciarisation, citant la pauvreté, l'inaccessibilité juridique et la méfiance envers les institutions.

Les cadres médico-légaux standards en RDC et dans les pays voisins se concentrent sur la triade faute, dommage et lien de causalité, complétée par des dispositions sur l'information du patient et la responsabilité hospitalière. Ces outils sont indispensables, mais ils peinent à nommer et à quantifier les déterminants structurels des préjudices tels que le triage de paiement pré-traitement, le manque de respect obstétrical normalisé, le sous-effectif chronique ou la persistance des hiérarchies de l'ère coloniale dans l'organisation des services. Une grande partie de la violence clinique reste légalement invisible, et les réformes ont tendance à cibler les individus plutôt que les systèmes.

Cet article aborde trois questions. Premièrement, comment les cas et études africains emblématiques apparaissent-ils lorsqu'ils sont lus à travers une lentille diagnostique structurelle plutôt que

uniquement par la faute individuelle ? Deuxièmement, l'axe santé du DSM-H (Manuel Diagnostique et Statistique des Pathologies Structurelles Humaines, 2025) peut-il fournir une taxonomie et un système de notation cohérents pour de tels préjudices ? Troisièmement, quelles sont les implications juridiques, politiques et cliniques de cadrer les décès tels que celui de Divine Kumasamba comme des expressions de syndromes structurels plutôt que comme des erreurs isolées ?

----Tableau 1. Syndromes de l'axe santé du DSM-H et liens illustratifs avec le droit médical congolais

Syndrome	Description	Critères observables illustratifs (≥3/5 requis pour la présence)	Ancrage juridique principal dans la doctrine congolaise
Préjudice par Triage Financier (PTH)	Soins urgents systématiquement conditionnés à la capacité de payer	Dépôt exigé avant les soins d'urgence · Retards /refus liés au paiement	Violation de l'obligation de sécurité renforcée; violation du droit à la vie

		<ul style="list-style-type: none"> Issue grave attribuable au retard Aucune exception cohérente Faible application des interdictions 	
Négligence Structurale (NS)	Déficits chroniques produisant des préjudices évitables	<ul style="list-style-type: none"> Alertes répétées (>12 mois) concernant le personnel/équipement Déficits connus ignorés Préjudice cohérent avec les déficits Aucun plan de remédiation 	Faute organisationnelle/de service; responsabilité administrative

		<ul style="list-style-type: none"> Préjudice moral; violation de la dignité et de l'intégrité corporelle 	
Violence Clinique Genrée (VCG)	Maltraitance routinière des femmes dans les contextes cliniques	<ul style="list-style-type: none"> Abus verbal ou menaces Procédures non consenties Refus d'analgésie Ciblage disproportionné des femmes Faibles mécanismes de plainte 	<ul style="list-style-type: none"> Récidive dans le temps

Invisibilité Légale des Victimes (IJV)	Les droits formels existent mais le recours est pratiquement inaccessible	Très faible judiciarisation malgré le préjudice · Barrières de coût/peur/distance · Aide juridique faible · Pas de signalement systématique des événements indésirables · Perception que les plaintes sont futiles	Déni de recours effectif; érosion des droits constitutionnels
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-----Conclusion

Les décès comme celui de Divine Kumasamba, la violence obstétricale à Kisangani, les décisions kényanes sur les conditions d'accouchement dégradantes,

les litiges obstétricaux en Afrique du Sud et la négligence faiblement judiciairisée au Nigeria ne sont pas une série d'événements malheureux. Ils reflètent des schémas récurrents façonnés par l'histoire, la politique et la conception institutionnelle. Les cadres médico-légaux actuels en RDC et dans des contextes similaires restent essentiels, mais ils n'ont pas été construits pour diagnostiquer et quantifier de tels schémas.

L'axe santé du DSM-H offre une manière structurée de rendre ces pathologies visibles. En nommant des syndromes tels que le Préjudice par Triage Financier, la Négligence Structurale, la Violence Clinique Générée et l'Invisibilité Légale des Victimes, et en notant leur gravité et leur responsabilité, il fournit une taxonomie qui peut compléter le droit, éclairer la politique et guider la gouvernance. Le cadre théorique plus profond est centré sur l'Afrique et décolonial, mais ses formes opérationnelles parlent le langage de l'équité en santé mondiale et de la science de la mise en œuvre.

En fin de compte, la question est de savoir si les systèmes de santé continueront de répondre aux décès évitables en isolant quelques praticiens ou s'ils accepteront que les structures elles-mêmes peuvent tomber malades et nécessiter un traitement. L'intégration des diagnostics structurels de type DSM-H dans le droit de la santé congolais et africain est un moyen de passer du blâme individuel à la responsabilité structurelle, et de l'indignation épisodique à la protection

durable des vies que le droit est censé tenir pour sacrées.

Suite de la traduction du document :-----**Contributeurs**

J-B Ehoke et K Nsiangani ont conçu l'étude conjointement. J-B Ehoke a dirigé l'analyse et le cadrage juridiques. K Nsiangani a dirigé le développement du DSM-H et le codage structurel. Les deux auteurs ont contribué à l'interprétation des données et à la rédaction du manuscrit et ont approuvé la version finale.

Déclaration de conflits d'intérêts

K Nsiangani est le développeur principal du cadre DSM-H. Pour minimiser les biais, tous les codages structurels ont été vérifiés par un juriste indépendant, et les manuels de codage complets ainsi que les procédures sont fournis dans l'Annexe Supplémentaire. J-B Ehoke ne déclare aucun conflit d'intérêts.

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