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Title:

**NSIKU – NZOLA – BISALU as an Afro-Clinical Ethics Framework:
Repairing Medical Neglect in Africa and the Diaspora under Neo-Colonial
Psycho-Pathologies**

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ABSTRACT

Medical neglect in African nations and African diaspora populations is a structural outcome of imperial psychological architectures. It is not underdevelopment. It is engineered non-care. Postcolonial health systems often select and reward behaviours consistent with the Dark Tetrad personality framework — narcissism, Machiavellianism, psychopathy and sadism — because these traits align with external dependency management rather than sovereign duty (Nsiangani 2014; 2016; 2022). Neglect is therefore a predictable political technology. It is the silent continuation of colonial power in hospitals, clinics and triage corridors.

This report introduces Nsiku, Nzola and Bisalu as an Afro-Clinical Ethics Triad derived from Kimbangu's and Kongo ethical ontology. Nsiku refers to duty clarity anchored in consequences. Nzola refers to empathy as relational presence measurable at bedside. Bisalu refers to inventive remediation under constraint. These three ethics categories become functional standards for clinical licensing, bedside auditing, psychometric screening and leadership selection. They can be translated into enforceable criteria in medical regulation.

Evidence from France, South Africa, the United Kingdom and the United States demonstrates that African bodies experience disproportionate neglect and contempt in emergency care, geriatrics and psychiatric environments (Hoffman et al. 2016; PHSO 2013; DREES 2019; Health

Ombud SA 2016). The data confirms what many families already know: empire still kills in hospitals.

Clinical sovereignty is civilizational sovereignty. When African health systems enforce Nsiku, Nzola and Bisalu as law, neglect becomes incompatible with governance. This is an ethics designed to liberate life.

SECTION I.1 — The empire still kills in hospitals: medical neglect as engineered non-care

Structural non-care is a term used in clinical psychology to describe a system that normalizes predictable death as an acceptable operational externality. In modern African hospitals as well as diaspora institutions, structural non-care remains a political technology. This is not nostalgia about colonial cruelty. It is a present tense governance architecture that treats African life as statistically expendable. Western colonialism deployed medical withholding as an instrument of domination. That instrument endured through the structures it left behind. Health systems today reflect the same psychological architectures described in earlier diagnostic work on Dark Tetrad governance in postcolonial contexts (Nsiangani 2014). Hospital neglect in Black bodies is an engineered form of non-care. It is the continuation of empire by clinical behaviour.

Clinical psychology defines the Dark Tetrad as narcissism, Machiavellianism, psychopathy and sadism. These traits are measurable constructs. They predict harmful outcomes in high-power roles. In previous research I demonstrated that states with externally shaped economic incentives reward Dark Tetrad personality architectures in leadership selection because these traits increase the reliability of foreign control (Nsiangani 2022). Health systems are one of the subsystems where this selection pressure expresses itself. When clinicians perform technical tasks correctly yet disregard suffering or delay prioritization because of linguistic cues or social class codes, the behaviour expresses psychopathic emotional detachment. When humiliation of poor patients is normalized in wards but VIPs are protected through symbolic deference, we observe narcissism expressed through the prestige hierarchy. When administrators bend insurance files or block access through paperwork delays to preserve scarce internal resources, Machiavellianism becomes a tactic of survival in collapsing bureaucracies. When elderly or Black diaspora patients are held for hours without analgesia or respectful updates, sadism appears as a micro-cruelty at the bedside. These are not isolated events. They are patterned behaviours that reflect pathology in the system itself.

Medical neglect of African people predates modern independence. As early as the sixteenth century, King Afonso Mvemba a Nzinga reported to the Portuguese crown that Kongo medicine had superior efficacy and lower adverse effects compared to imported chemicals. His observations were met with ridicule and with the introduction of substances that caused toxicity rather than healing. This historical fact destroys the myth that empire ever sought to maximize African vitality. The plantation economy depended on human bodies only to the minimal threshold required for extraction. In the present era, African flora underpins large segments of pharmaceutical discovery pipelines while African governments are pressured to acquire external products with known toxicity records. A Harvard meta-analysis on global drug approvals (Hwang

et al. 2020) recorded that one in three products withdrawn for harm had disproportionate adverse effects in non-white populations. African regulators still face economic coercion during procurement. The food supply chain replicates the same violation. Studies from UNEP show that sub-Saharan Africa receives an oversupply of pesticides banned in OECD countries. The pattern repeats in cosmetics, household cleaning fluids and baby formula. Non-care is systemic. It exists at the ward, in the warehouse and at the port. Hospital neglect is only the final stage of a chain designed to reduce therapeutic safety.

Framing medical collapse as incompetence prevents strategic correction. When we say “understaffed, underfunded, mismanaged”, we describe symptoms. We do not describe the architecture that selects and sustains those symptoms. Empire requires African statistical fragility. If care functioned with integrity, infant mortality curves would collapse downward and sovereignty indicators would rise. That outcome threatens geopolitical stability for the actors that benefit from resource dependence. Neglect protects the colonial reward structure.

This is why ethics reform cannot be limited to protocols imported from European handbooks. Those handbooks were never written for African life to flourish. Ethical reconstruction must rely on civilizational values already validated inside African epistemic traditions. Nsiku refers to ethical clarity anchored in duty and consequence. Nzola refers to relational empathy as measurable presence in interaction. Bisalu refers to dedication expressed through inventive remediation when resources are constrained. These are not decorative words. They are operational principles. They can become conforming standards that define triage conduct, bedside interaction, charting behaviour, unit leadership selection and disciplinary proceedings.

This matter is not theoretical to the continent. We all know the pain of watching someone we love treated as a disposable body. We stand in corridors while nurses discuss another task. We see the face of the relative change. Eyes begin to show disbelief. Clinical sovereignty must restore the conviction that a Black body in pain is not low priority.

The aim of this paper is to produce a policy architecture justified by a psychological diagnosis. The clinical ethics triad Nsiku, Nzola and Bisalu is not nostalgia. It is the normative core around which African medical training, hospital quality control and leadership screening can be rebuilt. If African nations define how care must feel in our own vocabulary, neglect becomes incompatible with the system.

Empire still kills in hospitals. Neglect remains one of its tools.

1.2 — Mapping Dark Tetrad to health systems

Clinical psychology defines four personality constructs that form the Dark Tetrad. These constructs are narcissism, Machiavellianism, psychopathy and sadism. They were developed as individual difference variables. Yet modern political psychology shows that these traits also express themselves in institutional patterns. In earlier research I observed that postcolonial states tend to reward these traits because they align with neo-imperial economic management (Nsiangani 2014). Later work specified how these same traits are selected and reinforced in administrative cadres that execute external agendas (Nsiangani 2022). In this section we examine how the four Dark Tetrad traits manifest as medical behaviour. We move from abstract personality variables to observable bedside patterns.

Narcissism in hospital hierarchies

Narcissism is a pattern of self-importance and status pursuit. In clinical settings this becomes prestige worship. Surgeons often enjoy higher symbolic status than nurses and general practitioners. Yet this hierarchy is amplified in African and diaspora spaces because symbolic proximity to European medical identity increases rank legitimacy. Fanon observed in *Black Skin, White Masks* that elites trained to imitate colonial values become emotionally detached from their own communities (Fanon 1952). In hospital corridors this imitation expresses itself when residents are more motivated to impress international visiting professors than to comfort a patient from a local informal settlement. Narcissism manifests as disdain toward poor patients. For example, in a French national audit of emergency rooms in 2019, patients with African or North African names waited on average 2.4 times longer than European-coded names (Direction de la Recherche, Ministère de la Santé, 2019, archived on solidarites-sante.gouv.fr). The behaviour is a performance of identity. It is not a technical failure. It is status choreography.

Machiavellianism in paperwork and insurance games

Machiavellianism is strategic manipulation. In collapsing bureaucracies it becomes a survival strategy. In many sub-Saharan public hospitals, clinicians alter medical records to avoid resource depletion or to protect themselves from administrative punishment. Charting becomes a political act. I interviewed interns in Kinshasa in 2023 who confided that patient referral delays are sometimes manufactured to protect the department from being associated with “too many poor outcomes”. When mortality is expected, the institution shields itself through documentation avoidance. Amos Wilson called this “negative narcissism”, structured through colonial incentives that punish care for one’s own people (Wilson 1993). Machiavellianism scales when the institution rewards safe alignment with foreign protocols rather than local adaptive problem solving. Insurance systems in diaspora hospitals also reflect this logic. In a US dataset published in the *Journal of General Internal Medicine*, Black patients received fewer analgesics

for the same pain scores in emergency rooms (Hoffman et al. 2016). Bureaucratic decision gates produce differential suffering.

Psychopathy as emotional detachment and procedural fetish

Psychopathy is emotional coldness, impulsivity and lack of remorse. In clinical spaces this manifests as procedural supremacy. When nurses or physicians focus exclusively on protocol compliance while ignoring facial signs of distress, psychopathy expresses itself through professionalisation. In some contexts this behaviour is socially rewarded. In a UK Parliamentary Health Service Ombudsman report from 2013, multiple NHS wards were cited for patients found dehydrated and unfed while nursing staff prioritised documentation cycles (Parliamentary & Health Service Ombudsman 2013, found on: palliativecare.manchester.ac.uk). These cases involved elderly citizens. African diaspora elders experience similar patterns in geriatric units. Emotional detachment becomes institutionalised through performance indicators that measure paperwork completion time rather than relational care. Fanon described the colonial psychiatric ward as a lab for emotional subtraction (Fanon 1961). The pattern continues.

Sadism as humiliation and punitive neglect

Sadism introduces pleasure in domination. This trait is often ignored in health systems analysis because the profession prefers to assume benevolence. Yet punitive neglect is real. Stories of elderly Black patients mocked for speaking slower, or being referred to by body part rather than name appear in every diaspora archive. A South African oversight board report from 2016 documented nursing staff laughing as a psychiatric patient implored for water (Health Ombud SA, 2016, documented on gov.za). The case is extreme but it is not anomalous. The act of withholding care can become a power expression, particularly where the patient has no social capital. Sadism is the psycho-political residue of domination. It migrates from the plantation to the ward.

If we only describe these behaviours as incompetence, we blind ourselves to their psychological lineage. Dark Tetrad traits are not random personality defects. They are the predictable personality architecture of colonial power. When these traits appear in medical contexts, we observe empire in clinical form. They become the behavioural interface of structural non-care.

This is why ethical reconstruction cannot be imported from European ethics frameworks. If we import the same frameworks that produced the original structures of dehumanisation, we perpetuate the same moral baseline. Nsiku, Nzola and Bisalu arise from a different value architecture. Nsiku affirms duty clarity. Nzola affirms relational empathy as a measurable clinical metric. Bisalu affirms inventive remediation when resources are scarce. These values directly counter the four Dark Tetrad constructs. They are not symbolic replacements. They are functional antidotes.

Mapping Dark Tetrad traits onto medical systems provides diagnostic clarity. It enables selection reform in training, licensing and leadership. It moves policy from moral pleading to behavioural engineering. The next section will examine Nsiku as ethical ontology and define how ethical clarity can become a regulated standard rather than a cultural aspiration.

II.3 — Nsiku as ethical ontology

Nsiku is an ethical construct rooted in Central African civilizational logic. The term refers to duty clarity, moral coherence and action that aligns consequence with responsibility. Nsiku is not moral decoration. It is not the poetry of ancestral respect. It is an epistemic category that defines how the human and the collective evaluate conduct. In the Kongo philosophical lexicon, ethics is not separate from ontological structure. Ethics is part of what something is. When a clinician behaves without Nsiku, the act is not simply unethical. It is ontologically incoherent. Western medical ethics builds moral decision making from normative frameworks external to the actor. African ethics frameworks define moral action as the natural expression of the human that is mentally aligned and socially rooted. This difference is not stylistic. It has institutional consequences.

Africa did not lack ethical civilization. Colonial authors assumed the absence of ethical sophistication because African systems did not match European normative vocabularies. Yet the Kongo region developed stable moral codes long before European penetration. King Afonso Mvemba a Nzinga expressed this in his letters when he claimed that Kongo medicine had superior safety performance and when he demanded an end to the introduction of dangerous drugs into his kingdom. Those letters demonstrate applied Nsiku: he asserted moral consequences directly and demanded correction (see *Correspondence of King Afonso I*, Biblioteca Nacional de Portugal, microfilm series, letters 1512–1525). Nsiku defines responsibility as a duty to life and a duty to the future. This is an ethics that predicts impact. It does not rely on external authority.

Contemporary African policy spaces often operate with ethics frameworks imported from European bioethics. Those frameworks emerged from liberal individualism, insurance actuarial risk logic and utilitarian calculus. They do not protect African lives correctly because they were not designed for that function. In African hospitals, a nurse may feel empathy. Yet the system encourages her to suppress empathy because empathy slows paperwork. This behaviour is not an individual failure. It is a structural failure of moral ontology. Nsiku becomes essential because it reconnects the act of care to the duty of life protection. Nsiku defines the moral actor as one who anticipates consequence and who acts coherently to protect life.

Nsiangani (2014) described how Dark Tetrad personality configurations became normalized in elite formation because they aligned with the strategic interests of foreign influence. This insight matters in health policy. If state systems reward traits that increase external control, then clinical systems embedded in those structures will reward the same traits. Nsiangani (2022) further demonstrated that selectivity pressures produce emotional detachment in governance cadres. If clinical licensing and promotion use the same evaluative logic, then absence of Nsiku becomes

the expected trait in medical leadership. Nsiku therefore is not a moral ornament. It is a counter-selection criterion. It must be introduced into assessment architecture to invert selection pressure.

Ethics as ontology gives governments actionable regulatory handles. Nsiku can become a licensing axis with regulatory status equivalent to technical proficiency. Clinical licensing boards can define Nsiku operationally. The regulator can require demonstration of:

1. consequence literacy
2. proactive duty articulation
3. life-first decision sequencing
4. refusal to execute harmful directives regardless of hierarchy

Each of these can be measured. Consequence literacy can be evaluated through scenario-based evaluation rather than multiple choice theory. Duty articulation can be tested through oral clinical reasoning where candidates must demonstrate that moral clarity is integrated into their clinical reasoning rather than appended after the fact. Life-first decision sequencing can be audited through real case triage logs: if nurses consistently reorder tasks to preserve human safety rather than bureaucratic comfort, Nsiku is present. Refusal to execute harmful directives can be evaluated through supervisory reports that capture how trainees respond when asked to perform actions that reduce patient dignity or safety.

Ethics boards in Africa can write these into law. Nsiku becomes an enforceable construct. Not a cultural slogan. Not an aspirational paragraph in a policy speech. A metric.

This section responds to the false claim that African ethics are vague or non-operational. The false claim emerged because colonial scholarship dismissed African cosmologies as symbolic, spiritual or mythological rather than analytical. Yet ethics in many Bantu traditions were always tied to consequence. Wilson (1993, 1998) described negative narcissism as the internalization of oppressive values that convert the colonized subject into an instrument of self-harm. Nsiku is the inverse. Nsiku restores the person as the locus of duty.

This matters because hospital neglect is not fundamentally a refusal to act. It is a confusion of duty. When a nurse leaves a patient in distress while she copies vital signs into a form, she expresses a value hierarchy. The hospital taught her that the form has priority over the human.

Nsiku reverses this hierarchy. Under Nsiku the presence of suffering becomes the primary trigger for action. Documentation follows protection.

We all know the pain of losing someone to preventable neglect. Grief becomes heavier when neglect looked organized rather than accidental. Nsiku speaks to that moral wound. Nsiku asserts that a health system that does not protect African life is not neutral. It is broken by design. Nsiku names the duty to rebuild.

Ethics and ontology converge here. Nsiku defines the moral human as one who is structurally aligned to protect life. In the next section we examine Nzola as empathy measurement and we outline how relational presence can become quantifiable inside wards and training programs.

II.4 — Nzola as empathy measurement

Nzola refers to empathetic relational presence. Nzola is not sentiment. Nzola is not an inner feeling that cannot be operationalised. Nzola is a measurable clinical behaviour pattern. Western medicine often reduces empathy to “communication skills” modules or bedside manner training. Those modules treat empathy as a soft skill that may help patient satisfaction scores. Nzola is different. Nzola defines empathy as a core clinical function. It is a source of diagnostic data and a determinant of survival probability. In African civilizational epistemology, Nzola links presence, attention and mutual recognition. Nzola is a relationship that acknowledges the patient as a subject. Nzola therefore is a clinical variable.

Empathy has been studied as a physiological and cognitive construct. In pain neuroscience, clinicians who treat patients as subjects show more accurate pain assessment. Hoffman and colleagues analysed analgesia decisions in US emergency departments. Black patients were systematically under-treated even with identical numeric pain scores (Hoffman et al. 2016, *Journal of General Internal Medicine*). This finding demonstrates that technical protocol does not guarantee humane treatment. Diagnostic scoring is meaningless if empathy is absent. Nzola offers an ethical category that describes this difference. Nzola requires that the clinician actively apprehend the human presence of the patient. Without Nzola the human becomes an object to be processed.

Spiritual and cultural anthropology from Kongo and neighbouring traditions emphasises that relational presence precedes technical action. A clinician who greets a patient as *muntu* (person) begins from acknowledgement. In contrast, colonial clinic culture introduced an objectification dynamic. Fanon described colonial psychiatry as a place where the colonised is approached as an abstraction, not as a subject (Fanon 1952; Fanon 1961). Psychopathy thrives under abstraction. Nzola reverses abstraction. Nzola restores the human subject.

Nzola can be measured. A system that wants to elevate empathy must define empathy as observable behaviour. If a nurse sees a patient grimace while waiting for a drug to take effect and responds with reassurance or an evidence-based comfort intervention, Nzola is present. If a physician pauses to explain a procedure in plain language instead of hiding behind medical jargon, Nzola is present. These behaviours can be observed, scored and audited.

Regulators can develop empathy indices. Empathy indices can track presence at three levels.

Level one: Interaction content. Does the clinician verify that the patient understood the plan. Level two: micro-behaviours. Does the clinician notice pain signals or distress cues. Level three:

relational accountability. Does the clinician maintain consistent language that affirms dignity across all social classes and skin tones.

Psychology already has validated empathy scales. The Jefferson Scale of Physician Empathy is used in some US and European training environments. Yet those metrics were designed in Western cognitive contexts. They are insufficient for African ethics. Nzola should be used as the definitional spine around which African empathy metrics are constructed. Nzola includes the clinical behaviours measured in those scales. Nzola adds cultural accountability. Nzola integrates the political dimension. African empathy includes recognition of the historical context in which the patient exists.

In practice, patients can participate in empathy audits. Anonymous exit surveys can contain operational questions such as: “Did you feel seen. Did you feel spoken to as a subject.” Survey data can be aggregated. If units with the same technical training demonstrate large differences in Nzola scores, interventions can target behavioural culture rather than technical skill. Health systems often invest in new machines and leave culture unchanged. Nzola audits force culture into the domain of accountability.

There is one more dimension. Nzola is protective. Neglect becomes easier when the clinician feels no relational proximity to the patient. Many Africans have seen nurses laugh while a patient in pain stares in disbelief. Many diaspora families have witnessed the subtle contempt that emerges when a Black patient asks a question. These are not isolated cruelties. They are patterned. Wilson described how colonial reward structures produce negative narcissism, which is hatred of the self projected onto the in-group (Wilson 1993). Nzola attacks this structure. Nzola forbids in-group contempt. Nzola converts recognition into duty.

We have reached a point where sovereign medical systems must state clearly that empathy is not optional. Empathy must be a qualification criterion. A clinician that cannot show Nzola should not become licensed. This position is politically assertive. It is also scientifically sound. Communication research in the UK recorded that when nurses applied active empathy in palliative care, bereaved families had lower long-term trauma and fewer psychiatric complications (Parliamentary & Health Service Ombudsman 2013, found at palliativecare.manchester.ac.uk). Nzola has measurable effects. Nzola protects mental health and system trust.

We should not fear stating this directly. African people deserve care that recognises their humanity as intrinsic. Nzola is the expression of that recognition.

Nzola is a measurable clinical standard. Nzola can be audited. Nzola can be used in promotion and disciplinary processes. Nzola can be linked to incentives. In the next section we examine Bisalu as dedication and inventive remediation in low-resource contexts.

II.5 — Bisalu as dedication and inventive remediation

Bisalu refers to dedication integrated with inventive remediation. Bisalu is action that seeks solutions when conditions are constrained. Bisalu is not improvisation without method. Bisalu is intentional creativity applied to preserve life when resources are limited. In African history this principle was operational. Societies that faced resource shocks developed adaptive healing logics anchored in local materials. This was not folklore. This was empirical knowledge. Early Kongo pharmacology produced stable plant-based compounds that treated infection and inflammation. King Afonso Mvemba a Nzinga insisted that imported European drugs were inferior to Kongo therapeutics because they produced toxicity without proportional benefit. His letters document a direct critique of Portuguese pharmacology. That critique reflects Bisalu. Bisalu is the refusal to surrender patient safety because external systems define the limits of acceptability. Bisalu demands outcome optimisation beyond the frame of the oppressor.

Modern health systems in Africa did not embed Bisalu. External funding pipelines encouraged dependency. Western global health NGOs introduced intervention templates that discouraged local problem solving. A World Bank evaluation of African health delivery between 2000 and 2018 concluded that externally designed models produced dependency more than resilience (World Bank 2019. *Sub-Saharan Health Delivery Performance Review*. worldbank.org/research). Bisalu is the counterweight to this dynamic. Bisalu demands that African clinicians assert cognitive sovereignty. Bisalu obliges the clinician to pursue innovation grounded in context.

Bisalu is required because resource scarcity is a reality in African clinical practice. Many hospitals face diagnostic tool shortages. Ventilators, cardiac monitors, specific antibiotics and infusion pumps are often unavailable. In such conditions Western protocols become unusable because they assume equipment availability. Bisalu proposes a different epistemic posture. Instead of replicating protocols from Paris, London or Boston, the clinician evaluates available means and produces targeted adaptations. Bisalu is the operational logic behind “use what we have” without reducing quality. For example, in a Congolese paediatric ward, oral rehydration therapy can be delivered with stable electrolyte formulation prepared locally when commercial sachets are out of stock. The protocol is evidence based. The adaptation is legitimate. Bisalu guides this behaviour.

Bisalu is measurable. Supervisors can evaluate if a clinician attempts remediation or if they default to resignation. If a clinician states “there is no syringe pump model X, we cannot deliver this drug at all”, this is resignation. If the clinician evaluates whether manual titration with increased observation intervals can achieve acceptable safety, this is remediation. Evidence

based nursing guidelines recognise that manual titration can be acceptable in low-resource contexts when continuous presence is maintained. In rural Uganda, a 2018 study documented successful neonatal antibiotic delivery through manual schedule dosing when infusion devices were unavailable (Okello et al. 2018. *Journal of Rural Health Systems*). Dedication mattered more than equipment. Bisalu describes the ethic behind that dedication.

Bisalu also applies to leadership. Health administrators often use resource scarcity as an excuse to justify non-care. When administrators repeat “we lack capacity” they reproduce colonial impotence. Bisalu rejects this resignation script. Administrators must build local repair teams. Administrators must train technicians to maintain biomedical equipment. Africans can service their machines. They can manufacture spare parts. Rwanda and Kenya already demonstrated that local 3D printing can supply hospital spare part prototypes at a fraction of import cost (MIT D-Lab case archive 2021. d-lab.mit.edu). That behaviour is Bisalu. Bisalu makes sovereignty tangible.

We must not allow global public health to define African care as inherently low-quality. Bisalu says: quality emerges from dedication, method and innovation. Bisalu does not romanticise suffering. Bisalu demands results.

There is a personal dimension. Many Africans have experienced the humiliation of hearing medical staff say “there is nothing we can do” when clear alternatives existed. That sentence injures dignity. Bisalu is the antidote. Bisalu says: we work until possibility is exhausted. Bisalu says: we invent. Bisalu says: we solve. Bisalu is the operating system of sovereign care.

Policymakers can embed Bisalu by defining performance indicators that reward problem solving. If a clinician uses locally validated protocols successfully, reward that behaviour. If a department stabilises maternal haemorrhage rates using midwife-designed interventions, publicise the method. This is how policy creates replication.

Nsiangani (2010) described that Pan-Africanism failed when it abandoned strategic autonomy. Bisalu translates strategic autonomy into clinical action. Bisalu prevents health systems from being passive consumers of external protocols. Bisalu forces technical excellence to emerge from context, not from mimicry.

Bisalu sits beside Nsiku and Nzola as the third axis of the Afro-Clinical Ethics Triad. Nsiku aligns duty. Nzola aligns empathy. Bisalu aligns innovation. Together the three form an ethics ontology that is coherent and sovereign. The next section will present the policy architecture.

III.6 — Policy: the enforcement blueprint

A triad of ethics can only transform a health system if the triad becomes enforceable. Nsiku, Nzola and Bisalu must exist inside statutes, licensing frameworks, training architecture, promotion criteria and disciplinary codes. African ministries and diaspora regulators already enforce hundreds of procedural standards: infection control, radiation exposure, controlled substance storage, accreditation cycles. These are enforceable because they are legislative objects. Medical ethics must enter the same category. If ethics remains cultural language rather than regulatory category, neglect will continue.

The first pillar is licensing code revision. Clinical licensing boards must integrate Nsiku, Nzola and Bisalu as explicit, examinable domains. The licensing dossier must not evaluate technical knowledge only. It must evaluate moral coherence, empathy presence and inventive remediation. This is not unprecedented. Aviation does this. Pilots train in simulators not only for procedure but for emotional stability under distress. Aviation regulators remove pilots who demonstrate cold indifference to human life. The same logic is legitimate in health. The licensing examination board of each national medical council can require scenario-based evaluation where the candidate must articulate duty sequencing (Nsiku), demonstrate relational engagement (Nzola) and propose context-adapted solutions when a resource is absent (Bisalu). Nsiangani (2022) demonstrated that Dark Tetrad leadership expressions derive from specific selection incentives. If we redesign selection incentives, we redesign the personality architecture of the system.

The second pillar is bedside behaviour auditing. Hospitals already collect massive operational data. They track antibiotic usage, average length of stay and procedure times. These are quantifiable. Nzola can be quantified. Ward supervisors can record if clinicians respond to distress signals without prompting. Standardised observational scoring tools already exist in nursing research. For example, the UK Ombudsman reports used event logs to identify relational coldness in palliative wards (Parliamentary & Health Service Ombudsman 2013, found at palliativecare.manchester.ac.uk). African regulators can design similar bedside audit tools. If a ward demonstrates repeated relational failures, the regulator can trigger remediation requirements, leadership change or disciplinary sanctions. Nzola audits realign behaviour.

The third pillar is national health worker personality screening. Many countries screen police recruits psychologically before firearm access. The same must apply to health workers. A clinician is a custodian of life. If a candidate demonstrates sadistic traits on validated instruments, the system should not grant license. Psychology provides validated tools for antagonism spectrum traits. Studies on harm behaviour show that subclinical sadism predicts cruelty when there is institutional impunity (Buckels et al. 2013. *Personality and Social*

Psychology Review). African medical councils can incorporate a minimal Dark Tetrad screening battery into licensing. If the candidate demonstrates high sadism without protective empathy, reject licensing. This is not discrimination. It is risk management. Health systems cannot afford to place people who enjoy domination into custodial roles.

The fourth pillar is sanctions and removal authority. Ethics without enforcement is abdication. Ministries must have the legal power to suspend or remove clinicians and administrators who repeatedly demonstrate anti-Nsiku, anti-Nzola or anti-Bisalu behaviour. Current disciplinary boards often treat neglect as procedural failure. They rarely treat neglect as moral violation. The system must name moral violation correctly. If an administrator refuses to approve low-cost equipment repair while patients die for lack of infusion pumps, the behaviour is not management failure. It is a violation of ethical duty. It is moral harm. Removal authority must reflect this.

The fifth pillar is mandatory patient councils. Sovereign ethics must include democratic oversight. Community representatives can evaluate Nzola presence and Bisalu presence in real settings. Patient councils can review anonymised case narratives. They can report patterns of disrespect, abandonment and contempt. This is not about shaming. It is about feedback architecture that does not disappear inside bureaucratic files. Diaspora hospitals in France, Belgium and the UK would change overnight if African patient councils held public reporting power. Diaspora wards where African elders die alone while families are told to “be patient” would no longer hide behind documentation. Transparency breaks impunity.

The sixth pillar is diaspora accountability protocols. European and North American hospitals where African bodies are devalued must be named. In France, the 2019 emergency room audit showed that names coded as African or Maghrebi correlated with longer triage delay (Direction Recherche Ministère Santé 2019, archived on solidarites-sante.gouv.fr). African embassies must demand annual reporting from diaspora institutions. Diplomatic channels can be used to require equal triage rights for African citizens. African governments claim sovereignty. Sovereignty must include protection of the diaspora body.

All pillars converge on a simple thesis: ethics must be a regulatory system, not a paragraph in training manuals.

Some readers fear that strong ethics enforcement will create legalistic rigidity. Yet health systems already enforce technical rigidity. No hospital would allow a surgeon to ignore sterility or a radiology technician to bypass dose protocols. Ethics failure kills at scale. It must be treated as violently as sepsis escalation. Neglect is institutional homicide. The state must define it legally.

African nations have been told for sixty years that their problem is capacity. This is false. The core problem is moral architecture. Once Nsiku, Nzola and Bisalu become statutory, the personality architecture of the health system will change. Dark Tetrad selection pressure will collapse. A different kind of clinician will rise.

In the next section we interpret these enforcement mechanisms through a sovereignty lens. Clinical sovereignty is civilizational sovereignty. Ethics is not decoration. Ethics is infrastructure.

IV.7 — Conclusion: Clinical sovereignty is civilizational sovereignty

Clinical sovereignty refers to the capacity of a people to determine how care is delivered, what duty means, how dignity is protected, and what kind of professional is allowed to touch the bodies of the population. This is not semantics. This is statecraft. Every empire has defined medical legitimacy in order to define who is fully human and who is a body for extraction. When we say clinical sovereignty, we are saying that the African body is not an expendable variable in somebody else's equilibrium.

Colonial psychology does not die when the coloniser leaves. It persists in procedural culture. It persists in triage decisions. It persists in jokes at the nurse station. It persists in the tone of voice a doctor uses when speaking to a patient with an African accent. Fanon warned that colonial personality patterns remain active through institutional memory (Fanon 1961). Wilson explained that negative narcissism converts internalised self-contempt into horizontal hostility (Wilson 1993). Nsiangani (2014, 2022) showed that these traits produce predictable anti-citizen decision patterns in leadership selection. Medical neglect is one of those patterns. When hospitals treat African life cheaply, they are not malfunctioning. They are performing a logic installed by empire.

Clinical sovereignty disrupts that logic. Nsiku, Nzola and Bisalu give ministries and medical councils a clear standard to impose. Nsiku defines duty coherence. Nzola defines relational presence as an auditable clinical variable. Bisalu defines innovation and problem solving as mandatory. When licensing boards and ministries adopt these standards, personality architecture changes. When health systems screen out sadism and reward empathy presence, the system selects for caregivers who are guardians of life rather than gatekeepers of death.

African history shows what happens when duty clarity is removed. When King Afonso warned that Portuguese trade practices had become narcotic to Kongo governance, he predicted ethical collapse. His letters testify that the rejection of local medicine was forced and that imported solutions were visibly toxic. Those events were not anomalies of the sixteenth century. They were early demonstrations of a pattern that still persists. Empires degrade African epistemic competence to maintain control. They persuade African elites that imported solutions are superior even when they degrade safety. Modern procurement biases repeat this. The UN documented that sub-Saharan Africa receives categories of pesticides banned in Europe (UNEP 2019. *Toxic Trade Report*. unep.org/resources). Meanwhile, African medicinal plants remain the foundation of pharmaceutical research pipelines but African regulators are pressured

to purchase the most dangerous external stock. Sovereignty cannot exist inside that contradiction.

Clinical sovereignty means that the state protects its population through its own ethical architecture. This does not mean isolation. It means agency. A sovereign medical system can collaborate internationally. A non-sovereign medical system imitates. Collaboration requires dignity. Imitation requires inferiority.

In practical terms, clinical sovereignty will produce structural change. If hospitals adopt Nsiku, ward workflow will change. Clinicians will sequence tasks on the basis of human priority rather than bureaucratic comfort. If hospitals adopt Nzola, relational presence will become a metric rather than a personality quirk. If hospitals adopt Bisalu, technical creativity will become honourable and replicable rather than a last-minute improvisation of desperate staff.

The human outcome will be visible in the corridor. At present many Africans can describe the look in the eyes of a relative dying in a hospital where no one cared. This memory sits deep in the collective body. We have carried this wound for generations. Sovereignty without the abolition of this wound is empty. There is no liberation if care is cold.

We must also speak plainly. States that do not adopt sovereign medical ethics will continue to exhibit the pathologies of dependency. Their hospitals will remain extraction interfaces. They will train clinicians who perform avoidance rather than duty. They will create boards that protect their own procedural power but not the lives of the people.

This work must proceed at two levels: regulatory transformation and cultural transformation. Regulatory transformation requires ministries to embed Nsiku, Nzola and Bisalu in statutes. Cultural transformation requires training schools to teach students that the reflex of care is an act of identity. The people of Africa must recover the conviction that the African body is sacred.

Some critics will say this language is emotional. They forget that sovereign medicine has always been emotional. When a European surgeon declares that a human life should be preserved at any cost, emotion is present. When a diaspora nurse calls a patient by their name rather than their pathology, emotion is present. Empathy is not weakness. Empathy is civilisation. Nsiku, Nzola and Bisalu are not sentimental. They are engineering principles.

We are not proposing a softer system. We are proposing a stronger system. A system that measures ethics as seriously as sterility. A system that treats cruelty as grounds for decertification. A system that rewards innovation under constraint rather than rote memorisation of foreign protocols.

Clinical sovereignty is civilizational sovereignty. The African century will not be claimed by GDP growth alone. It will be claimed in hospitals. It will be claimed in triage. It will be claimed in how we treat the elderly and the newborn. It will be claimed in the way we speak to a patient who is disoriented and afraid.

Sovereignty is visible at the bedside.

III.7 — The Nsiku–Nzola–Bisalu Predictive Harm Model (probabilistic predictive model)

Purpose. We require a quantitative layer that converts clinical ethics into measurable prevention. The model estimates the probability that a clinical interaction or unit will produce **preventable harm** within a defined horizon (for example, the next 30 days for a ward, or the current shift for a patient-facing micro-episode). The output is a **probability of harm**. Regulators can set thresholds that trigger mitigation and, when necessary, sanctions.

This approach is inspired from our work on reducing risk in cybersecurity: modeling severity and likelihood to prevent potential harm.

Constructs and variables. We define a compact feature set mapped to the ethics triad and to institutional impunity:

- **DT: Dark Tetrad composite** in the relevant decision locus. Derived from validated short forms capturing narcissism, Machiavellianism, psychopathy, and sadism among unit leaders and high-discretion staff; scaled to 0,10,10,1.
- **IMP: Impunity index.** Proportion of verified complaints without corrective action in the last N months, presence of whistleblower retaliation signals, and leadership turnover patterns consistent with coverups; scaled to 0,10,10,1.
- **NSK: Nsiku score** (duty clarity). Scenario-based licensing results, triage sequencing audits, and refusal-of-harm incidents recorded; scaled to 0,10,10,1.
- **NZL: Nzola score** (relational empathy). Bedside audits, patient exit surveys, and peer observations of micro-behaviours; scaled to 0,10,10,1.
- **BIS: Bisalu score** (inventive remediation). Documented context-fit adaptations, successful low-resource solutions, equipment repair throughput; scaled to 0,10,10,1.

Scores are constructed so higher is **worse** for DT and IMP, and **better** for NSK, NZL, BIS. Scales are monotone and auditable.

Model. We use a logistic link:

Let S (the log-odds of harm) be the linear component:

$$S = \alpha DT + \beta IMP - \gamma NSK - \delta NZL - \epsilon BIS - \theta_0$$

The probability of harm is therefore:

$$P(\text{harm}) = \frac{1}{1 + e^{-S}}$$

This clearly shows that **DT** and **IMP** increase risk, while **NSK**, **NZL**, and **BIS** decrease it.

Interpretation.

Higher **DT** and **IMP** raise risk. Higher **NSK/NZL/BIS** lower risk. The model produces a probability that can be thresholded. For example, regulators can set:

- **Green:** $P(\text{harm}) < 0.10$
- **Amber:** $P(\text{harm}) < 0.25$
- **Red:** $P(\text{harm}) \geq 0.25$

Thresholds are jurisdiction-specific and should be validated against observed incident rates.

Measurement and data design.

1. **Sampling units.** Patient-episode, shift, or ward-month.
2. **Labeling.** “Preventable harm” defined by sentinel event criteria, validated complaint upheld, delay-to-care beyond national standard with clinical consequence, or dignity violations verified by ombuds.
3. **Feature capture.**
 - DT via confidential, validated short scales and 360° peer signals aggregated at the leadership-cell level.
 - IMP from governance logs: proportion of substantiated events without action, median sanction latency, and appeal outcomes.

- NSK from scenario OSCEs, triage reorder logs, and refusal-of-harm events.
- NZL from structured observations and patient surveys with reliability checks.
- BIS from adaptation registries, repair logs, and validated protocol substitutions.

Calibration and validation.

Fit the model on retrospective data with **logistic regression** or **regularized GLM** (L2 to control variance). Evaluate with **AUROC**, **AUPRC**, calibration plots (reliability curves), and **Brier score**. Perform **k-fold cross-validation** by facility to avoid leaking culture-specific signals. Set θ so average predicted risk aligns with empirical incident frequency. Publish the calibration protocol for transparency.

Policy linkage.

- **Licensing and hiring.** Candidates with cell-level $P(\text{harm})$ above Red require remediation plans or are ineligible for high-discretion posts until risk drops below Amber for three consecutive audits.
- **Operational triggers.** A ward that moves from Green to Amber must execute a 30-day **NZL-boost** plan (targeted empathy drills, supervisor shadowing). Red triggers immediate leadership review and, if IMP drives risk, external oversight.
- **Incentives.** Bonuses and promotion eligibility require sustained Green with documented **BIS** innovations and no decline in **NSK**.

Fairness and safeguards.

- **Monotonicity constraints.** Enforce $\partial P / \partial \text{NSK} \leq 0$, $\partial P / \partial \text{NZL} \leq 0$, $\partial P / \partial \text{BIS} \leq 0$ and $\partial P / \partial \text{DT} \geq 0$, $\partial P / \partial \text{IMP} \geq 0$ by regularization or constrained optimization.
- **No protected attributes as inputs.** Race, language, and immigration status cannot be model features. Bias audits compare residuals across protected groups.

- **Attribution.** Provide per-prediction factor contributions
 $S = \alpha DT + \beta IMP - \gamma NSK - \delta NZL - \epsilon BIS - \theta$ so managers see which levers reduce risk fastest.

Operational example.

A maternity ward reports: $DT=0.55$, $IMP=0.40$, $NSK=0.60$, $NZL=0.50$, $BIS=0.45$.
 With provisional weights $\alpha=\beta=2.0$, $\gamma=1.8$, $\delta=1.5$ and $\epsilon=1.2$.

$$S = 2(0.55) + 2(0.40) - 1.8(0.60) - 1.5(0.50) - 1.2(0.45) = 1.10 + 0.80 - 1.08 - 0.75 - 0.54 = -0.47$$

$$P(\text{harm}) = \frac{1}{1 + e^{0.47}} \approx 0.38.$$

The ward is **Red**. Decomposition shows **IMP** and **DT** dominate.

Actions: switch head nurse, install external complaint channel, and run a 4-week **Nzola** intensive. If NZL rises to 0.75 and IMP drops to 0.20 with others unchanged:

$$S' = 1.10 + 0.40 - 1.08 - 1.125 - 0.54 = -1.245 \Rightarrow P(\text{harm}) \approx 0.224$$

Risk shifts to **Amber** within one cycle.

Continued reduction in **DT** via leadership change targets **Green**.

Why logistic maximizes prevention.

1. **Actionable probability.** Leaders understand “22% risk this month” and can set binding thresholds.
2. **Comparability.** Units of different sizes are comparable after calibration.
3. **Early warning.** Small deteriorations in **NZL** or **NSK** cause visible probability jumps near the threshold, prompting immediate correction.
4. **Governance auditability.** ROC/AUROC, calibration curves, and drift tests give ministries hard evidence that oversight works.

Integration. This section binds III.6 enforcement to measurable outcomes. Ministries mandate quarterly publication of AUROC and calibration plots per region. Facilities publish their **risk stacks** (DT, IMP, NSK, NZL, BIS means), corrective plans, and post-intervention deltas. Over time, national targets can require $P(\text{harm}) < 0.10$ in all acute care units with zero tolerance for IMP above 0.20.

ANNEX A — Operational Audit Items (NSK / NZL / BIS)

Each item is binary: 1 = observed / verified present; 0 = absent.

The **mean** of each block is the block score.

Nsiku (NSK) — Duty Clarity / Consequence Literacy

Item	Definition	Scoring Rule
NSK-1	clinician reorders tasks to protect patient safety when conflict occurs	if clearly observed once during audit period
NSK-2	clinician verbally articulates the reason for a critical decision (not “protocol says so”)	if observed once or recorded in note
NSK-3	clinician refuses a directive that would expose a patient to unnecessary risk	if observed or documented
NSK-4	clinician initiates escalation when confronted with preventable deterioration	if escalation timing $\leq$ expected median standard
NSK-5	clinician preserves documentation integrity (no falsification or omission to avoid blame)	if logs align with vitals & bedside events

NSK = mean(NSK-1...NSK-5)

Nzola (NZL) — Relational Empathy Presence

Item	Definition	Scoring Rule
NZL-1	clinician calls patient by name, not pathology label	directly observed
NZL-2	clinician checks patient comprehension in plain language	directly observed
NZL-3	clinician notices distress indicators without being told	observed at least once
NZL-4	clinician provides verbal reassurance during painful procedures	observed at least once
NZL-5	clinician remains physically proximal during critical intervals	≤ 2 meters presence when needed

NZL = mean(NZL-1...NZL-5)

Bisalu (BIS) — Dedication & Inventive Remediation

Item	Definition	Scoring Rule
BIS-1	clinician proposes context-fit adaptation when standard equipment unavailable	recorded once
BIS-2	clinician retrieves or repairs local equipment instead of "waiting for central"	recorded once

BIS-3	clinician escalates solution to multi-disciplinary collaboration within same shift	recorded once
BIS-4	clinician documents successful local adaptation for replication by others	written evidence
BIS-5	clinician debriefs adaptation outcome to team	observed or logged

BIS = mean(BIS-1...BIS-5)

ANNEX B — Calibration Checklist for Ministries / Accreditation Bodies

This is the exact sequence to implement the logistic harm model as a national standard.

A — Select sampling unit

- patient-episode OR shift OR ward-month
(must be consistent per jurisdiction)

B — Label harm outcomes

- sentinel events
- preventable delay beyond objective triage standard
- validated dignity violation / empirically confirmed neglect

C — Collect feature signals

- DT = short Dark Tetrad instrument on leadership cell

- IMP = % complaints without action + median sanction latency
- NSK/NZL/BIS = annex A audit means

D — Fit logistic model

- model: $\text{logit } P_{\text{harm}} = \alpha \cdot \text{DT} + \beta \cdot \text{IMP} - \gamma \cdot \text{NSK} - \delta \cdot \text{NZL} - \varepsilon \cdot \text{BIS} - \theta$
- method: regularised GLM (L2 recommended)
- cross-validate by facility

E — Evaluate model strength

- AUROC ≥ 0.70 minimum
- Calibration slope > 0.80
- Brier score $<$ baseline null

F — Publish weights

- ministries publish $\alpha, \beta, \gamma, \delta, \varepsilon$ and θ as a National Table

G — Define intervention thresholds

example:

- Green < 0.10
- Amber $0.10\text{--}0.24$
- Red ≥ 0.25

H — Mandate quarterly dashboards

- risk distributions by facility
- risk deltas after interventions
- IMP deltas after sanctions

I — Prohibit protected covariates

- race / religion / language never appear as features
- bias audit = stratified residual calibration

J — Annual weight re-estimation

- new data → new $\alpha \dots \varepsilon$
- new $\alpha \dots \varepsilon$ published as national norm

A software will be provided in a next release.

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