Insights into a United States of America-based Congolese Diaspora Organization's Initiative to Establish and Operate a Health Center for a Community of Internally Displaced Persons in the Democratic Republic of the Congo: Motivators, Milestones, Facilitators and Inhibitors

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BACKGROUND

Members of the African Diaspora (AD) based in Western countries have been lauded as significant contributors to the economy of their countries of origin, notably through their financial remittances. According to Newland, *The Global Development Finance Annual Report* shows around US$ 100 billion as the magnitude of the flow of remittances to developing countries in 2003 (Newland 2004: 67). Little is known however about the social roles that members of the African Diaspora collectively endorse and play as initiators and operators of humanitarian organizations in their countries of residence and also as creators and operators of health care facilities in their respective countries of origin or in a particular community within their countries of origin. In addition to being scarce, information about such social roles and health initiatives is not also fuzzy, generally non-organized, and often only anecdotally presented outside of any clear conceptual framework. It is important to explore these realities to understand their characterization and to promote greater and more effective involvement of the African Diaspora in African health affairs. Although we cannot pretend to fulfill this vision in the limited context of this case study, we advocate for quality documentation of and research on this work. This documentation will yield several benefits for the pursuit of public health work in Africa where some health interventions by Western/Eastern actors/stakeholders have been increasingly criticized and blamed due to their perceived insensitivity to and disrespect of the rights of Africans and where the initiatives genuinely conceived by the African diaspora are more likely to be more sensitive and more respectful of the rights of the African peoples. Moreover, the majority of health project by members of the African Diaspora targets the under-served African communities where government and private lucrative health facilities generally do not exist. The propagation of information on this work will stir much interest and involvement of the members of the African diaspora, uncover and promote the adoption of best practices and expose and eliminate repetition of ineffective practices, if any.

SYNOPSIS ON HEALTH INFRASTRUCTURE DEVELOPMENT BY THE AFRICAN DIASPORA

Many Africans in the Diaspora have created not-for-profit health care facilities in Africa. Seven cases illustrate this phenomenon:

a) **ETHIOPIA**: 171 Ethiopian physicians in the US have pledged money and time to the EADG's project to build a state of the art hospital in Addis Ababa (ERIN, 2014). "This was an idea that was initially conceived by 12 doctors, and now that number has risen much more; we now have members from Europe as well as Africa." According to the chairman of EADG, the main objective is to avert people from wandering abroad searching for a better treatment. (https://www.voanews.com/a/diaspora_doctors_to_start_specialized_hospital_in_ethiopia/1608344.html)

b) **SOMALI:** Almost every member of the Somali diaspora sends money home to their family, to help with food, rent, school fees and other daily expenses. But *clan and hometown groups also collect money to build schools and clinics, even hospitals and universities, and to repair damaged infrastructure* (ERIN, 2012).

c) **KENYA**: Daylight, a St. Paul nonprofit organization, hopes to raise $75,000 for the materials and labor needed for a project aimed at building Larson's Breuer house replica in Kenya. But this will serve as a clinic. Kenyan Michael Kimpur, a graduate of Bethel University in Arden Hills, and Minnesota native and fellow Bethel grad Nathan Roberts co-founded Daylight Center and School in Kapenguria, Kenya, a city near the edge of the nomadic lands in Kenya.

d) **SUDAN**: A Sudanese pastor, the Rev. Zachariah Jok Char who moved to the U.S. in 2000 at the age of 19 and who paid his way through college in Michigan, working as a dishwasher and at a meat factory, and earned a bachelor's degree in social work and biblical studies, now works in the refugee department at Bethany Christian Services in Grand Rapids, Michigan, and has served as pastor of the Sudanese Grace Episcopal Church in the Episcopal Diocese of Western Michigan since 2007. He is reported as visiting South Sudan in December 2013 when the conflict erupted, forcing him to abandon his mission to build a medical clinic in his home village of Duk Padiet.

e) **UGANDA**: An Ugandan medical doctor (Dr. Nandawula Kanyerezi Mutema) is reported as a Diaspora Returnee who recently opened a state of the art clinic at the Village Mall in Kampala. This is a partnership.

f) **LIBERIA**: After working many years in the USA, a Liberian woman (Mary Moore Kieh) has single-handedly erected a 21-Bedroom Clinic in Johnsonville outside of Monrovia. As a mid-wife by profession, she was moved by the dire need for a medical center in Johnsonville. The clinic is named in honor of her late brother, Robert Moore, who was very dear to her life but got sick and died. She has returned to Liberia from the United States to manage the clinic whose official opening was scheduled in January 2017 and was due to be attended by Liberian President and many other distinguished guests.

g) **THE DEMOCRATIC REPUBLIC OF THE CONGO**: (1) NBA Hall of Famer and humanitarian Dikembe Mutombo established the Biamba Marie Mutombo Hospital which operates since 2007. (2) A France-based organization known as "Aide Médicale au Congo, has funded the construction of a « Dispensaire » in the village of MULUKU in the Bandundu Province. (3) Created as a US-Based humanitarian organization, Leja Bulela, INC has built the Kalala Muzeu Health Center for the community of internally displaced persons (IDPs) in Cibombo Cimuangi in the outskirt of Mbuji Mayi.

AIM OF THE STUDY

- This study reviews, **from an insider's perspectives** and within the broader framework of the stalled democratization process of the Democratic Republic of the Congo (DRC), the motivations and genesis of the creation of LEJA BULELA, INC (LB), a United States of America-based Congolese Diaspora organization.
- It describes the efforts LEJA BULELA has deployed to establish and operate a health center in favor of a community of internally displaced persons (IDPs) in the Eastern Kasai Province of the DRC.
- It explores the facilitative and inhibitive factors LEJA BULELA has encountered in the establishment and operation of the aforementioned health care facility.

COMBINATION OF THREE METHODS

- Participant-Observation
- Documentary Analysis
- Appreciative Inquiry

RESULTS

GENESIS/MOTIVATORS OF LEJA BULELA INC. AND OF KALALA MUZEU REFERRAL HEALTH CENTER

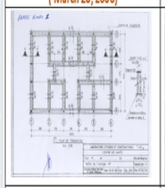
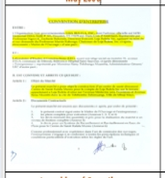
Ethnic-based Persecution and Suffering Leading to the Creation of Leja Bulela (LB)

- For the survival of his political regime, Mobutu resorted to various tactics, one of which was the incitation of feelings and acts of prejudice and hostility towards the Luba ethnic group.
- To weaken his main political opponent Dr. Etienne Tshisekedi, cling to power and delay the democratization process, Mobutu orchestrated with his political allies, an ethnic cleansing scheme which caused a second wave of persecution against peoples of Kasai origin in various cities of the Katanga province. The first wave had taken place in the early 1960s.
- About one million Kasaians either fled the country or became "internally displaced peoples" (IDPs). The latter moved to other places in the then Zaire (now DRC) such as Kinshasa, Eastern Kasai and Western Kasai.
- A portion of these IDPs went to the Eastern Kasai Province where they either merged into existing communities or formed brand new communities.
- One such a brand new resettlement community is the Cibombo Cimuangi community, located on the outskirt of the city of Mbujimayi
- There were no public infrastructures to accommodate these IDPs. There were no medical or school facilities. Higher morbidity and mortality rates were recorded, prompting several stakeholders to seek and plead for the intervention of international humanitarian organizations.
- Informed and moved by this crisis, in 1993, a small group of Luba-Kasai individuals in the Congolese diaspora in the U.S.A. convened a meeting to explore some collective actions in favor of the victims.
- LB was created in 1993 in Detroit by the participants who initially wanted to name their organization "NEVER AGAIN". This name was discarded in favor of a more meaningful, luba name, "LEJA BULELA".
- "Leja Bulela" means "show that you care" in the Tshiluba language of the Luba-Kasai people
- Leja Bulela was incorporated and registered in the State of Iowa as a not-for-profit humanitarian organization

Early Life of Leja Bulela and Steps toward the Establishment of the Kalala Muzeu Health Center

- Since its inception, LB has convened and held its annual meetings each year in a city selected during a vote by its membership at their previous meeting
- LB started the second decade of its existence at the start of its 2003 annual General Assembly in Boston.
- At this meeting, the General Assembly noted that LB was losing its motivation, compassion, and solidarity, which were at the foundation of its creation. Many lamented that LB seems to sleep on its laurels.
- While it was generally recognized that LB had many accomplishments, there was still a general feeling that L had to do more than what it had accomplished so far in its first ten years of existence.
- Therefore, discussions were initiated in Boston for a solid project capable of uniting all of its membership as well as any other supporters and sympathizers of the Luba cause.
- During the General Assembly, the idea of having a solid presence in Mbuji-Mayi was seriously considered. It was in this spirit that the idea of building a health center in Mbuji Mayi was born and of baptizing this Center in the name of Kalaka Muzeu or of calling it simply Leja Bulela Health Center.
- Kalala Muzeu was a dedicated LB member and founder. He lost his life in a car accident while driving from Indianapolis (place where he had just participated in the third annual meeting) to New York (his residence).
- Apreliminary needs assessment - - done in Boston during the General Assembly in 2003 – had established that with a minimum of $15,000 (fifteen thousand American dollars), LB can build a health center.
- In the exact wording of this preliminary assessment, it was envisioned/revealed that:"This amount may be shared by Leja Bulela members. LB has approximately 20 members who can be considered as loyal.
- If each one of them is committed to contribute about $500, this amount may be assembled by the time of the Annual General Assembly that will be held next year in Atlanta.
- When the amount is assembled, the national president of Leja Bulela may solemnly launch the construction project during this General Assembly.

MAJOR MILESTONES

Blue-Print Design (March 20, 2006)	Foundation achieved October 2006	Main Infrastructure completed without Roof October 2006
		
Building Agreement Signed May 2006	Follow-up/ Claim by Builder due to Price Increase of Cement March 2007	Other Contruction Steps between 2007 and 2010
		➢ Grass Planting ➢ Roofing in 2008 ➢ Flooring in 2009 ➢ Water Storage in 2009 ➢ Flooring in 2009
Launching of Operations 2010	Solar Suitcase Installation Project -2012 & Incinerator Construction	Bathroom and Shower Upgrade Project 2015-Present
		

FACILITATORS/CHALLENGES

GOVERNANCE & MANAGEMENT FACILITATORS/CHALLENGES
- DEDICATION OF BOARD MEMBERS TO THE VISION AND INITIAL CAUSE
- FOCUS ON A SINGLE COMMUNITY
- PRESENCE OF A PATRIARCHAL FIGURE WHO COMMANDED RESPECT
- STABILITY OF GOVERNANCE STRUCTURE EXCEPT FOR 2015-2017 PERIOD
- ALTHOUGH LATE IN COMING, MORE INCLUSIVENESS OF FEMALE AND YOUNGER MEMBERS
- KNOWLEDGE OF CULTURAL NORMS AND PRACTICES
- INCLUSION OF A LOCAL CLERGY MEMBER FAMILIAR WITH HEALTH FACILITY CONSTRUCTION PROJECTS
- UNDERESTIMATION OF THE AMOUNT OF INVESTMENT NEEDED
- GRAPEVINE LEADING TO DISTRUST/DISCOURAGEMENT OF CONTRIBUTIONS
- DISAPPEARANCE OF PATRIARCHAL FIGURE WHO COMMANDED RESPECT
- ETHICAL LAPSES AND LEADERSHIP CONFLICTS PARTICULARLY DURING 2015-2017 PERIOD

MEMBERSHIP FACILITATORS/CHALLENGES
- EXISTENCE AND COMMITMENT OF A CORE GROUP OF 20-22 MEMBERS
- MORE YOUNGER PEOPLE JOINING, FOLLOWING IN THE STEPS OF THEIR PARENTS
- SMALL SIZE OF MEMBERSHIP
- DEATH/LOSS OF 3 VERY LOYAL AND INFLUENTIAL MEMBERS
- NEGATIVE CHARACTERIZATION OF LB MEMBERSHIP BY OUTSIDERS (AS INDICATIVE OF ONE'S "TRIBALISM")?
- CONFLICTS CREATED BY SOME NEW MEMBERS COMING WITH "GRANDIOSE" VISIONS
- LIMITED ABILITY TO ATTRACT AND RETAIN NEW MEMBERS
- DORMANT MEMBERS WHO DO NOT SHOW UP AND WHO DO NOT CONTRIBUTE FOR YEARS
- REQUIREMENT OF EXTRA MONTHLY CONTRIBUTION TO SUPPORT STAFF SALARIES AND BENEFITS

MARKETING & FUNDRAISING FACILITATORS/CHALLENGES
- MARKETING CAMPAIGN FOCUSING ON MEMBERSHIP
- REGULARITY OF REMITTANCES FROM CORE MEMBERS
- ACCESS TO LIMITED EXTERNAL CONTRIBUTIONS
- TOO MUCH RELIANCE ON MEMBERS' CONTRIBUTIONS TO MEET GROWING NEEDS
- FEW MEMBERS ARE ABLE TO RAISE FUNDS FROM EXTERNAL SOURCES
- TOO MUCH DEMAND WEIGHING ON A SMALL NUMBER OF MEMBERS

BUILDING CONSTRUCTION FACILITATORS/CHALLENGES
- ABILITY OF LEVERAGE RESOURCES FROM OTHER SOURCES TO ADVANCE LB PROJECTS
- WILLINGNESS TO USE PERSONAL RESOURCES TO ADVANCE LB PROJECTS
- REASONABLE COST OF LAND NEEDED AND REASONABLE COST OF CONSTRUCTION LABOR COSTS
- RELATIVE EASE OF SECURING LAND ACQUISITION PAPERS
- RELATIVE EASE OF SECURING CONSTRUCTION PERMIT
- NEGOTIATION OF A MULTI-PHASED CONSTRUCTION CONTRACT
- COMMITMENT OF BUILDER (DO, BUT NOT LIVING IN THE COMMUNITY)
- INABILITY OF LOCAL OFFICIALS TO PROVIDE PROMISED FREE PLOT OF LAND
- CUMBERSOME BUREAUCRATIC PROCESSES
- INCREASING COST OF BUILDING MATERIALS LEADING TO PRICE REVISIONS
- DELAYS IN PAYING BUILDER DUE TO CASH FLOW ISSUES
- DELAY IN THE COMPLETION OF THE CONSTRUCTION

HUMAN RESOURCES MANAGEMENT FACILITATORS/CHALLENGES
- AVAILABILITY OF TRAINED AND INTERESTED CANDIDATES IN THE DRCONGO
- EXISTENCE OF AN OVERSEEING MEDICAL COMMITTEE
- CPACITY IN RECRUITMENT PROCEDURES
- WRONG PRIORITY IN RECRUITMENT OF SUPPORT STAFF INSTEAD OF CLINICAL STAFF

CONCLUSIONS

- This case study has unveiled the motivations, milestones and facilitative and inhibitive factors in the creation of the Kalala Muzeu Health Center.
- Created in 1993, Leja Bulela, Inc (LB) has survived significant challenges for over 24 years. It is poised to celebrate the 25th anniversary of its creation in July 2018.
- LB has assembled a limited core of 20-22 members. LB members have accomplished a daunting project of erecting the infrastructure of an expanding Health Center.
- It took about ten years for LB to make the construction decision. LB members were prompted and encouraged by the vision of few members.
- Elected at the inception of the project, LB leaders and executives who belong to the health care professions have played a key role in translating this vision into a reality.
- While it was a positive step in the life of LB, this construction decision was not followed by a smooth, successful internal fundraising campaign.
- One major impediment was a smear campaign, alleging that the "clinic" was going to be the individual property of the chair and of the executive director.
- This rumor has discouraged many members who have refrained from contributing. It took almost 5-6 years to erect the facility and almost one additional year to complete the payment of the total cost to an angry builder.
- More elaborate research would need to be carried on regarding the humanitarian work of the African Diaspora. However, to be credible from a research/academic perspective, credible investigation of the praxis of African diaspora humanitarianism should be based on an explicit conceptual framework.
- This is crucially needed to meaningfully understand AD humanitarianism, build its measurement tools and methodological approaches, identify and describe its correlates, and describe the patterns of AD initiatives.
- Findings stemming out of this research will promote best practices and facilitate achievement of quality at the inception, establishment and operational stages of these health projects by the African Diaspora.

RECOMMENDATIONS

- Information on the work, challenges and accomplishments of Leja Bulela, INC and other AD organizations in terms of construction and management of health care facilities in Africa needs to be assembled and organized to form and be analyzed as an intrinsic part of the repository of global human activity.
- One reason for doing this is to stimulate learning by and involvement of many other AD organizations for the betterment of African health care infrastructures and outcomes.
- These AD initiatives create new roles and prompt many members of the AD to step into these newer, sometimes unfamiliar social roles.
- Some AD members are being called to assume for the first time the responsibilities of board members, board chairs, executive directors, treasurers, executive secretaries, committee chairs, etc…
- In some of these roles, they are called to play the challenging duties of spokespersons, negotiators with diverse stakeholders and compliers with various regulations which have been enacted and are enforced by various regulatory bodies in the western world and in the country of origin where their health care facilities are located.
- In these regards, these organizations can be identified as social entrepreneurs, collective builders, trans-national employers, transnational organizational providers of health care.
- To enable their officers to properly fulfill these roles and to avoid any misunderstanding and violations of regulations, AD organizations would need to invest in governance and executive management capacity development.