A couple of kilometres outside the district capital Fort Portal, along the road to DR Congo, is a small, private clinic. On the door is a sign that says: Kisakye Medical Centre & X-Ray Service/Ultrasound.

We are in the far west of Uganda, in the former kingdom of Toro. The doctor, after whom the clinic is named, is waiting inside: Peter Kisakye, with his stethoscope still around his neck. A form explains exactly which services he provides: gynaecology services, general medicine, surgery and paediatrics.

The friendly doctor is popular in the area and falls under the “too good for this world” category. He often allows his patients to pay according to their means and doesn’t make problems if they pay late—or not at all.

Kisakye wanted to be a doctor when he was a child and studied medicine between 1989 and 1995. Next year he celebrates his silver jubilee in the profession, but he doesn’t think there’s any reason to celebrate: “I will never advise my children to become doctors. You don’t get what you deserve.”

At least: not in Uganda. Most of Kisakye’s fellow students work abroad, mainly in Europe and neighbouring Rwanda. In the wider surrounding area of Fort Portal there are just three qualified gynaecologists. Recently there was a woman who had to travel almost a hundred kilometres to reach him and had bled to death before he could get her on the operating table.

Such—unnecessary—deaths and unsafe abortions frustrate Kisakye the most, but the inadequate facilities are also a problem. “The hospital in Fort Portal was built in 1930,” he says, “and nothing has changed since then, while the population has increased dramatically. When I started working in the hospital in 1995, women were always able to stay a couple of days after giving birth, so we could provide them with proper aftercare. Now they are only able to stay one night; there is just no space.”

On paper Uganda’s healthcare policy looks excellent and well-thought-out, Kisakye explains, but appearances can be deceiving. “The salaries of doctors and other medical personnel barely rise, there are hardly any jobs created for new doctors who complete their studies, and the promised medicines and facilities simply do not materialize.”

He worked as a Medical Officer in the district hospital for ten years, during which he earned 940,000 Ugandan shillings (220 euros) a month. According to the normal course of events he should have progressed to Medical Officer Special Grade followed by Special Consultant, with an increasing monthly wage of up to 850 euros.

“All year myself and a couple of other young doctors heard the promise that we would be promoted,” Kisakye says, “but the government never created senior jobs in the hospital.”

Meanwhile, Kisakye had a family of his own, and children, and was barely able to manage: hence the decision to set himself up as a self-employed doctor and gynaecologist. Now he just about manages, but there is no money to save and the toll is high: he can no longer count how operations and births he has performed. Kisakye and his two fellow gynaecologists recently experienced a peak period of 154 births in seven days. “In fact, I am subsidising our government,” he remarks. “My colleagues and I perform the heavy lifting and the government is the real winner, because it doesn’t have to pay us a shilling out of the government budget.”

And he adds, somewhat ironically: “What the government does, often together with foreign donors, is organise workshops on, for example, mother and infant mortality. They always take place in fancy hotels.”

“For me,” he says, “it would be lucrative to attend all those workshops because you are paid a sitting allowance. I earn more for attending a workshop than for operating on a patient.”

In 2030, forty million more people worldwide will work in the care sector, double the number today. Yet there’s an expected shortage of eighteen million jobs, especially in low- and middle-income countries. Donors and national governments do not yet view the creation of medical jobs as a priority, they even make up arguments for not investing in them. “President Museveni wants to build roads first; we need economic growth.” But a healthy population pays for itself.
Peter Kisakye’s story brings the issue very much to life. A great deal of medical care is needed, but the profession is not made appealing. According to the World Health Organisation (WHO) in 2010, forty million jobs will be needed worldwide in the healthcare field. At the same time, in that year, the WHO expects a shortage of eighteen million medical jobs, especially in low- and middle-income countries. Something doesn’t add up. How can we avoid this impending disaster?

It is a subject that worries Mariëlle Bemelmans on a daily basis. She is director of Wemos, obtained her PhD in the subject of health-care personnel, and has worked “in the field” in Africa for years. Would she advise young people in low-income countries to follow a study programme related to healthcare? She thinks carefully before replying: “When you look at the needs in the world and see how interesting the profession is, I would wholeheartedly say ‘yes’. However, from a career perspective it looks more gloomy right now.

"On the one hand, there’s a huge demand for new jobs in health-care and it will only increase—all the lights are green. On the other hand, there is a clear paradox because of the high unemployment among people with a medical background in Africa.

“Moreover, the work pressure is tremendous, salaries are low, and people often have to work extra hours on the side in a private clinic just to earn a living wage.”

Bemelmans has worked in Malawi, known for the mass exodus of medical personnel abroad mostly because the government has failed to create enough jobs for them.

"The senior official that was responsible for nurses and midwives once cynically told me that it would make more sense to move her office to the airport, because there she would see more nurses and midwives pass by than anywhere else in Malawi.

"I find it unacceptable to see all those medical people pour out of a country where there are so many shortages and where maternal mortality is the highest in the region.”

According to Bemelmans, it is necessary for governments and donors to realise the importance of investing in healthcare, including in creating employment opportunities. She has a battery of arguments ready to back up her plea.

“The impact is huge,” she says. “High mortality figures can be directly avoided if more hands are available. If you have more midwives and obstetricians to supervise safe births, you immediately see an improvement in maternal and infant mortality.”

"The International Labour Organisation (ILO) calculated that a single job in the healthcare sector creates two to three other jobs in adjoining sectors because support services are needed to ensure the work can be carried out, such as drivers, cleaners or technicians in diagnostics and laboratories. Therefore, the effect is broader.”

It sounds logical, but it doesn’t happen enough. It seems that, in Bemelmans’ view, something is slightly off in all parts of the chain; it starts right at the top with the national authorities.

“According to international recommendations,” she says, “a government should invest around five percent of GNI in healthcare, and a minimum of 86 dollars per inhabitant each year. This is hardly ever the case in low-income countries. Kenya, Tanzania and Zambia spend just two percent and Uganda just one percent on healthcare. This is sometimes because the health sector is not a priority compared with other sectors like education or agriculture. But often it’s a question of a lack of money in an absolute sense: the government budget is just too small. It is an extremely bitter pill to swallow when you think that so much money is sluiced abroad, including by means of tax shelters and illegal money flows.

“In Uganda five hundred million euros disappears across the border every year and Malawi loses a lot of money from the uranium sector. If you could invest that money in social and public sectors, these countries would benefit a lot more.”

And then there’s the International Monetary Fund (IMF), that still has a major influence on the financial policy of many African countries. Bemelmans: “The IMF continues to propagate the policy that a Ministry of Finance must keep a tight grip on its purse strings.

“As a result, governments are still very strict in budgetary terms when it comes to how much money can be allocated to the public sectors, including healthcare. And consequently personnel hiring in the medical sector is regularly frozen.”

But other donors, such as “regular” development organisations, are holding back a solution to the problem. “They often adopt the principle that their funding may not be spent on recurring cost items, such as wages.”

This means there are many reasons why insufficient numbers of additional jobs are created in the medical sector. Bemelmans believes that the only way to break the vicious circle is to tackle everything at the same time. Wemos and other organisations are busy with lobbying and advocacy to make progress on this issue.

“It’s mainly about creating a different image,” Bemelmans explains. “We are trying to change the narrative of healthcare as a cost item into a new narrative which demonstrates that investing in healthcare and creating new jobs is also economically appealing.

“Investing in a healthy population ensures greater productivity and increased economic growth. Studies conducted between 2000 and 2011 reveal that a quarter of economic growth in low- and middle-income countries resulted from advances in public health. For every dollar you spend on healthcare, you get nine dollars in return. The return on the investment is extremely high.

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public health system always depends on the type of leader in power. He refers to Ethiopia, which he considers a textbook example of how things should be organised on the African continent. “With the turn of the century, in 2000, Uganda and Ethiopia were in the same starting position in terms of healthcare. Uganda decided to focus entirely on economic growth, the Ethiopian Prime Minister Meles Zenawi decided to focus investments in healthcare in addition to agriculture. The current top man of the WHO, Tedros Adhanon, was his Minister of Health during those years.”

Omaswa believes that this strategy is still paying off today. “Every year thousands of doctors graduate in Ethiopia, as do midwives and nurses. The government encourages them to first get experience abroad and then come back. Jobs are subsequently created for them. They have left us far behind.”

It is a different story in Uganda. “Here there has been a struggle between economists and social scientists for years. Economists see education and healthcare as cost items and primarily want to invest in infrastructure and productive sectors, such as farming, to promote economic growth. Only then will they allocate money for investment in social sectors.”

Unfortunately, the mantra of “economic growth above all else” has become widespread on the African continent, Omaswa says. “But what does it achieve for us, when you see that in spite of this growth inequality is increasing and people don’t have any money for healthcare and education? You see this happening in Europe and elsewhere in the world too. Greed has gotten the upper hand.”

He believes that the challenge lies in changing the mindset, in which humane thinking takes priority over profit. He reduces the topic to one simple question: “Do you opt to build roads or create jobs for midwives?”

Omaswa regularly feels as though he is talking to a brick wall, as in his meetings with President Yoweri Museveni. “Every time we talk to him, he asks us to be patient. He then explains that he first wants to build roads and is going to construct dams, which will generate extra power so that the economy can grow. And that we will have money to create new jobs in the health sector after that.”

“My reply is always the same: Mister President, it is not better to first invest in the population and its health? Then we can build our roads themselves, without help from the Chinese. But the conversation stops there. It is also a rather delicate matter, because of Chinese interests in our country.”

There are times when he is almost driven to despair. As a number of years ago when the American aid agency USAID signed an agreement with the Ugandan government to pay the wages of two thousand nurses and midwives for a period of three years. Uganda would take over paying the wages after this period. “But we never kept our side of the bargain,” Omaswa says.

Last year was another low point. “Uganda’s State budget included an amount of 490,000 euros for recruiting doctors and nurses. The amount was not distributed, because they were not recruited.

“It was a question of placing an advertisement in the newspaper, conducting interviews and finding suitable posts for these people, who are desperately needed. The government even fails in taking such a small step. I can assure you, that it doesn’t fail to recruit personnel to help construct roads.”

Despite the fact that he has reached an age at which most people are retired, Omaswa will continue to strive for better health policy in Africa and in Uganda in particular. The only thing he believes will help is a constant pressure of lobbying and advocacy. “First and foremost,” he says, “aimed at people surrounding the President: his Ministers, advisors and MPs. If he also hears the people in his immediate environment talking of how important it is to invest in healthcare, then he might be convinced.

“We will also continue to lobby funding bodies and try and convince them that they should invest in personnel for our healthcare sector—that’s much more effective than sending us money for malaria medications.

“I do not consider the popular argument put forward by funders, that paying wages is not sustainable, to be valid at all. Even roads are not sustainable, because you need to retrofit them after ten years.”

He still has one trick up his sleeve. “There are presidential elections in Uganda next year. Let’s all ensure that healthcare is an important issue on the political agenda.

“Let it become the hot topic of the day in the street. We have a shortage of healthcare workers and medicines: how do the candidates plan to solve this problem?”

“Mister President, is it not better to first invest in the population and its health?”

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waiting room in a clinic in Tanzania

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Job Champions

The spirit of entrepreneurship is alive and kicking in the Global South. This series of portraits reveals six inspiring, home-grown ‘job champions’—women and men, young and old. These are energetic pioneers, who have broken into difficult markets and created valuable jobs for their communities, sometimes in impressive numbers. They have demonstrated that they can lead the change in their countries. Here they are.

**Ramil Mouzawak**

**Country:** Lebanon

**Company:** Souk el Tayeb

**Sector:** farming and catering & hospitality

**One hundred employees, income for a thousand people**

"Make food, not war" is the motto of Souk el Tayeb, a popular outdoor market and restaurant chain. After completing his studies in graphic design, the founder Ramil Mouzawak, a farmer’s son, returned to his passion: organic food. He travelled through Lebanon and wrote a guide and a series of articles about Lebanese food. Mouzawak, charismatic and with a good sense of humour, became a cookery teacher and made a weekly appearance on the Lebanese TV programme Sohbat lil _Bahr_ (or: your health on your plate). In 2004, he founded Souk el Tayeb, the first food market in Beirut, where farmers from the surrounding area could sell their produce and so have a more stable income.

Mouzawak wanted to use food to build bridges in a country that has been repeatedly torn apart by conflict. The smouldering tensions between Muslims and Christians unleashed the Lebanese Civil War in 1975, which was to endure for fifteen years. In addition to Palestinian refugees, the country is now also home to many Syrians.

"In Lebanon there are many different religious sects that apparently have nothing in common, apart from food," Mouzawak told _The New York Times_. "Take the example of the mamoul, a butter biscuit. Christians eat it at Easter, Muslims during Eid al-`Fitr, or the Festival of Breaking the Fast."

Souk el Tayeb has now grown to become a renowned market and restaurant chain. It has six branches and five guest houses throughout the country. One branch is in the Bourj el-Barajneh refugee camp, just outside Beirut. In total Souk el Tayeb has about a hundred permanent employees and provides income for around a thousand farmers and producers, including Lebanese women in the countryside, and Palestinian and Syrian refugees.

The large farmers’ market is organised in Beirut twice a week all year round, where farmers can sell their produce to eating chefs from Lebanese villages are paid directly for their ingredients and services in the restaurants. In 2009, Mouzawak was named ‘social innovator in the Arabic world’ for his connecting role.

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**Ashok Soota**

**Country:** India

**Company:** Mindtree and Happiest Minds

**Sector:** ICT

**22,400 employees**

Ashok Soota (76) is the uncontested job champion of the Indian ICT sector. Along with nine friends he set up Mindtree, which is now India’s largest ICT multinational with over twenty thousand employees in seven countries.

The year was 1999, the era of the Internet was still in its infancy. Soota had resigned from his job as vice president of Wipro Infotech, one of the largest Indian software companies, where he had made a name for himself by turning India into a “software back office” for large American companies. Mindtree leased a small office in Bangalore and focused on e-business: instead of coding software, its intention was to build good computer networks and services for companies.

With courage—and, in their own words, a little arrogance—the men soon reeled in two large clients from the US: Lucent Technologies and Avis, a car rental firm. They delivered great work, after which Mindtree flourished. It developed pioneering technologies, such as Bluetooth for telephones.

Nowadays, Mindtree is engaged in the fight for women’s participation in the workforce. Fewer and fewer Indian women work: currently 26 percent, compared with 36 percent in 2005. Experts cite multiple reasons for the low participation percentage; one is that gender stereotypes lead to mothers working less. Therefore, Mindtree, where women make up a third of the company’s workforce, has set up a childcare facility in its headquarters in Bangalore. Employees can have their children looked after there at a reduced price.

Soota took a new step in 2011 when he founded Happiest Minds, the first “mindful” ICT company in India. “The marriage between ICT and mindfulness is clear on the website, where the firm’s core values are listed as follows: ‘Be attentive, non-judgemental and empathetic in everything you do.’ Every employee devotes at least sixty minutes a week to yoga and meditation. Happiest Minds now has 2,400 employees and operates in six countries, including the Netherlands.

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‘Job champions’—women and men, young and old. These are energetic pioneers, who have broken into difficult markets and created valuable jobs for their communities, sometimes in impressive numbers. They have demonstrated that they can lead the change in their countries.