

Report 4

Intermediate standardized

SALARY SUPPORT/ INCENTIVES

Payment scales for civil servants and health workers

S O M A L I L A N D



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Foreword

The Ministry of Health and Labour is pleased to present this first edition of the ***Intermediate Standardized “Salary Support/Incentive” Payment Scales for Civil Servants and Health Workers - Somaliland***

The Republic of Somaliland has struggled for over 15 years to establish itself as an independent nation. Upon declaration of independence in 1991, the nation was left with nothing in terms of institutions or infrastructure. Today, we have the rudiments of a functioning public health system.

But the public system is largely staffed by under-trained, under-supervised and under-paid staff, struggling to provide some services to their people. The system functions on donations from international agencies (such as the UN, NGOs and Islamic charity funds). Given the low levels of financing and management, the fact that the public health system exists is a triumph. Nevertheless, we know from surveys that less than 15% of the rural population is able to use the public system for regular complaints and that there are major barriers to access and utilization in both rural and urban areas. The public system contributes only marginally to improved health status of the general population and equity of access for the poor. It is imperative that the public system be developed to be of greater utility to the people of Somaliland.

Delegates from the MoHL to the September 2007 Health Systems Strengthening workshop in Nairobi, financed by the EC and organized by UNICEF, stressed the urgent need for investment in human resources, institutional development of the Ministry of Health and Labour but first and foremost the development of an *Essential Package of Health Services*.

In conjunction with the EPHS, this document presents the first major initiative to take on the issue of health staff reform which is critical to health sector reform. Together these two documents form the nuts and bolts of the first stages of public health system reform and development.

A recent survey¹ indicates that service delivery is poor in all sectors and is rated as being poor by the citizens of Somaliland (less than 20% of the population has access to services across the board). Some 60% of staff was found to be under-qualified to allow them to provide effective services to the population. Staff in general is de-motivated, in part due to low salaries and delayed payments. This is particularly relevant to the health

sector where under-skilled staff has a major impact on the quality of care and can make the difference between life and death.

The ultimate solution is to establish proper skills training and certification, competitive job applications, proper supervision and management and opportunities for promotion. In addition, such developments need to be accompanied by a package of benefits including realistic salaries, incentives (for example to work in hardship posts), opportunities for advancement and a pension or retirement compensation. All this needs to be worked out with the national Civil Service Commission as part of an overall package of reform.

Without reform of the health workforce it will not be possible to improve in any meaningful way the performance of the public health system and hence the efficiency by which all money invested in the public system is used.

Currently, many health workers are supported or subsidized by international agents through incentives schemes. Incentives schemes can form an effective part of a total rewards package – but when provided alone and many times higher than salaries, they can be disruptive and destructive to the efficient organization of health services. We commit to work on the broader process of human resource administrative reform with other arms of government – but in the meantime it is imperative that we begin to pay realistic salaries to ensure we can attract qualified professionals to work full time in the public health sector. And payment must be linked to performance². This salary support package has been designed to take into account market prices for essential commodities and the market wage in the private sector. These guidelines aim to provide realistic wages to all staff and at a rate comparable (but slightly less) than the private sector pays. The wages are for a full working days week (42 hours) and should be discounted or increased depending on the time actually worked.

This document serves as an important tool to guide donor, NGO and government positions – reducing transaction costs and enhancing coherence and coordination to reach greater efficiencies in the use of finances in the public health system. I fully endorse this document and thank all Somalilanders, NGOs and UN agencies who participated in the development of this tool. In particular we would like to thank UNICEF and the EC for their assistance in supporting this process. We commit to trying to implement this tool and sincerely beseech all partners to follow suit and work with us according to these standards to assist in the construction and reformation of an effective and equitable public health system in Somaliland.

Best Regards

Hon. Abdi Halim Mohamed
Minister of Health and Labour



Preface

In a workshop to launch the EC Lot 3 funded UNICEF health systems development project, human resources was defined as the single highest priority system wide issue. Most actors recognised the need for improved quality and coverage of basic services as the greatest issues to be addressed – but that without some progress in human resource development, administration and management, little could be done to improve service delivery.

In various fora, even humanitarian NGOs have highlighted the absolute lack of trained staff and the impact this has on their capacity to offer quality services in the short term. The continuing lack of human resources means that any plans for service improvement in the short term or health sector reform cannot be fulfilled and creates a situation in which reform becomes contingent on HR development – which is contingent on overall health sector investment and reform. The continuing lack of official standards means NGOs operate in a regulatory vacuum with high transaction costs and frequent security concerns arising out of employer- employee relations. Each actor must therefore establish their own systems and then try and make them work.

In an effort to contribute to the problems of staff management in the absence of a regulatory framework – the UNICEF Lot 3 coordinator embarked on an extensive survey of NGO practice in an effort to try and define what would be a positive contribution; and if there were areas of overlap to begin to formulate an

interim set of standardised norms to reduce transaction costs between actors and local communities and staff; to establish transparent working relations with local authorities and to reduce competition between employers and develop rational employment systems to aid health service management in the field. The resultant work presented here in this report was based on:

- civil service regulations
- market data on wage labour rates
- market data on cost of living
- common practice of NGOs and private service providers operating in Somaliland in the health sector.

The resultant recommendations were presented extensively in the field through various rounds of consultations and meetings – leading to an iterative process of adaptation (many suggestions from Somaliland public and private sector professionals were adopted). The final recommendations were endorsed by the Ministry of Health and Labour, Somaliland. The recommendations were also endorsed by the Health Sector Committee (the health coordination platform supported by the Somali Support Secretariat in Nairobi) and recommendations were forwarded to adopt a similar approach across all other sectors (education is adopting a similar approach) – and hopefully to harmonize recommendations across sectors.

Austen Davis - UNICEF Health Sector Development Coordinator

Acronyms

COOPi	-	Cooperazione Internazionale (Italian NGO)
COSV	-	Coordinating committee for the organizations of voluntary service (Italian NGO)
DFID	-	Department for International Development (UK)
DSA	-	Daily Subsidy Allowance
EC	-	European Commission
HR	-	Human Resources
MoHL	-	Ministry of Health and Labour
NCSC	-	National Civil Service Commission (of Somaliland)
NGO	-	Non-Governmental Organization
PHC	-	Primary Health Care
RHB	-	Regional Health Board
SC-UK	-	Save the Children UK
SRCS	-	Somali Red Crescent Society
UN	-	United Nations
UNICEF	-	United Nations Children's Fund
WVI	-	World Vision International
HR	-	Human Resource

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Discussion

1A. Introduction/background

Health care systems are complex, employing a vast number of employees with varying levels of education, required experience and responsibilities, hence a *differentiated, performance-based hierarchical salary system* is an important management tool to allow creation and reinforcement of varied levels of health service delivery and management. Salary systems are necessarily complex, so as to meet the requirement of distinguishing between persons, and differentially rewarding:

- qualifications
- experience
- position (responsibility – both managerial and technical)

The authorities of Somaliland have neither resources nor capacity to deliver effective and efficient health services to all the citizens of Somaliland, hence the majority of health services are offered through the largely unregulated private market or through partnerships between the MoHL and UN / not-for-profit NGOs.

- The MOHL uses approximately 70% of its overall budget on supporting salaries of health workers in the public health service in both hospitals and clinics (with the rest being spent on transportation and Ministry support costs).

- Not all employees of current operational health facilities are on the official payroll.
- Some health facilities and institutions are supported by NGOs, while others are not.
- Otherwise, health facilities and institutions raise finances through charity grants, contributions from the diaspora, and from local businesses, support from local communities, and fees for services and drugs. Health care facilities are frequently under local management and require local financing, blurring the distinction between public and private health services and undermining standardization and public health authority. In this context, different facilities reimburse their staff in different, unpredictable ways. There is no set of standards and performance-based management is consequently extremely difficult, even for entirely Somali-based institutions (e.g. Hargeisa Group Hospital)

Health facilities and institutions are often fully staffed or over-staffed, but frequently with staff who are under-qualified. The 1,300 health care workers on the civil service salary payroll in Somaliland include far too few managers, doctors and qualified nurses, and too many auxiliaries and unskilled workers. The availability of qualified staff to fill higher positions is low and inequitably distributed (mainly in urban centres), and those in these positions are frequently unqualified for the job. Without sufficient leadership and middle

management, the vast numbers of low and unskilled workers are inadequately managed and health system outputs are extremely poor, even if considering the low levels of investment.

For health sector reform to result in improved performance of the public health system, the regularization, management and productivity of health workers is a key issue and THE most complex one to address; but without progress in this regard, little advancement can be achieved.

1B. The problem

In a divided and institutionally weak environment, public institutions have neither the resources nor technical capacity to develop complex and effective reward systems for health care workers, nor the capacity to implement them. Consequently, public systems collapse or function perversely, and private not-for-profit actors become essential partners in re-establishing some basic functioning. One of the major challenges is to define effective reward systems and to ensure they are implemented, i.e. professionals regularly receive sufficient remuneration to keep them effectively engaged in providing public services.

In Somaliland there is an official administration with an official budget. The MoHL has a budget of roughly 1 million USD per year (3% of the total official public budget), of which over 70% is committed to salaries for health workers and civil servants. The MoHL claims to support over 1,300 staff. The following may be noted with regard to official civil service salaries:

- they are extremely low (frequently below subsistence levels);
- they are irregularly paid;
- not all staff are on the payroll;
- differentiation between posts/levels is inadequate, not linked to job descriptions or responsibilities, which undermines effective management; and
- salaries tend to be orders of magnitude below what professionals can obtain on the private market for medical skills.

These factors result in insufficient numbers of skilled professionals employed in poorly-defined jobs, with incoherent responsibilities, offering part-time inputs (as they top up their incomes through other means), adding to deeply inefficient and ineffective provision of public health services. In addition, there are large numbers of un(der)skilled staff making a questionable contribution to health service delivery on the public wage bill, adding to confusion, poor management and low performance output of health systems.

Consequently, when non-public (international or local NGOs or UN) actors intervene, an important aspect of their programmes is to negotiate a set of “incentives” to increase the regularity and absolute levels of compensation of professional and unskilled health service workers, and/or to ensure they perform specific core tasks.

Box 1 Salaries, incentives and stipends/top-ups

A **salary** is “a form of periodic payment from an employer to an employee, which is specified in an employment contract... A salary is coming to be seen as part of a “total rewards” system which includes variable pay (such as bonuses, incentive pay, and commissions), benefits and perquisites (or perks), and various other tools which help employers link rewards to an employee’s measured performance” (Wikipedia). *And so is an important management tool in defining, structuring and achieving performance in health systems.*

Incentives are “any factor (financial or non-financial) that provides a motive for a particular course of action, or counts as a reason for preferring one choice to the alternatives. Since human beings are purposeful creatures, the study of incentive structures is central to the study of all economic activity (both in terms of individual decision-making and in terms of co-operation and competition within a larger institutional structure)” (Wikipedia).

Stipends are “a fixed sum of money paid periodically for services or to defray expenses” (Merriam Webster online dictionary). **A stipend** is a form of payment or salary, such as for an action, work experience, food and/ or accommodation. Universities usually refer to money paid to graduate research assistants as a stipend rather than wages, to reflect complementary benefits (Wikipedia). Stipends are generally paid for a fixed short term, to cover costs and provide incentives to do specific tasks (for example to complete a course of study).

Incentives are in theory a relatively small top-up to a base salary to direct attention to specific tasks. Nevertheless, where salary levels are unrealistic (low) and salary structures deficient, incentives are often used as compensation. This results in incentive levels many times higher than salaries, and incentive structures that compete with the logic behind salary scales, leading to confusion between the concept of salary and incentives. If incentives are relatively high and drive towards specific functions, they can undermine commitment to the overall job (as remuneration is insignificant) and disrupt the overall job performance and overall system performance (perverse functioning).

Incentive levels are often negotiated locally between the NGO and local counterparts, both of whom may have very different motives from each other in why they wish to offer incentives, what the structures of incentive systems are and what they might expect in return. The confusion between salaries, stipends and incentives (and locus of responsibility) can be a major bone of contention and tension between external (NGO/ UN) providers/employers and staff and between local providers and the public authority.

The over “incentivization” of systems can lead to perverse functioning and system fragmentation. When trying to encourage system reconstruction and overall system productivity, it is critical to try and create total reward systems that incorporate realistic salaries and relatively small incentives, in order to attract professionals back into the public system; differentiate between levels allowing management and **reward people according to performance of their full job responsibilities.**

Externally driven programmes will tend to continue to incentivize or provide stipends in the absence of strong central leadership providing realistic guidance on:

- affordable salary scales in relation to external budgets and longer term projections of state ability to adopt such pay scales;
- sufficiently differentiated salary scales to allow formation of an effective management structure to ensure productivity;
- salaries linked to standardized job descriptions; and
- rigorous certification of employees to ensure employees meet job description requirements.

Salary systems/reward packages must be considered within the frame of national civil service conditions, reinforcing the authority and responsibility of the Ministry of Health as the principal employer of staff.

On the one hand rewards have to be set high enough to ensure adequate skilled personnel are attracted to public positions, allowing them to concentrate their efforts on their jobs (implying competition with the private market, particularly as skilled health personnel are in such scarce supply).

On the other hand, this means top-ups can be set so high that they appear to dwarf official salary scales and to undermine the role of the Ministry of Health as the employer, which may undermine long-term sustainability of health service delivery. When donor funds withdraw, the public purse will be unable to sustain remuneration levels required to maintain a professional and differentiated workforce, and the MoHL will have limited commitment to bodies of staff employed outside their remit.

Furthermore, differential salary rates between agencies (both absolute amounts and differentials between types of employee) initiate a never-ending discussion with staff, affecting motivation and perceptions of justice. This provides major challenges:

1. For external (NGO/UN) providers to provide realistic staff motivation packages allowing recruitment and retention of sufficiently skilled staff to provide effective and efficient services;
2. In coordinating external reward systems with longer term civil service reform (at least to minimize harm); and
3. To reduce the negative impact of competition between agencies.

Given strong and reasonable central leadership on these issues, grounded on shared understandings of sustainability and overall civil service reform, it is possible to move sector inputs from uncoordinated

short-term incentives towards salaries/stipends and full reward packages. This will provide incentives for staff to perform their **full jobs**, relocating responsibility back to local authorities as well as setting norms and standards to reduce transaction costs (constant negotiation), reduce tension (fair, transparent, endorsed norms and standards are applied) and to bring authorities into support of partner payment activities.

1C. Setting realistic intermediate salary levels

1C.1 Cost of subsistence

Cost of living analysis by the FSAU has indicated that a minimum nutritional food basket for a family costs roughly 25 USD per month. The basket does not include any meat or luxury food items and is aimed at what it would cost to nutritionally sustain a poor household (FSAU, 2007) IF the family understood exactly what commodities to buy and in what proportion, to maximize nutritional value against costs.

The basket does not contain non-food items such as housing, clothing, education, transport, etc. Research by an NGO in the South has indicated that the costs of living (including education and housing costs) would be nearer to 100 USD per month. Costs of living have been increasing rapidly in the past few months, and will impact on all salary level recommendations.

The cost of living is variable by region and season, but is more expensive in the North. **Hence, public salaries for nurses (with four years of professional training) of approximately 40 USD/month, and doctors of roughly 60 USD/month, are obviously below subsistence levels and cannot generate effective commitment by employees to the public system. Unskilled workers cannot survive on these official salary rates, whereas skilled workers will want to earn extra money to guarantee a minimal standard of living.**

1C.2 Daily wage analysis for day labourers

Wages for daily labourers vary, reflecting different local market conditions in terms of supply and demand. Daily rates tend to be higher in the North than in the crisis-affected South.

Table 1. Variation in daily wages over the country (source FSAU, 2008)

Location	Approx. wage (USD)
Burao	2.5
Hargeisa	3.2

The daily wage rates indicate casual labourers need to work 10 days per month *just to meet minimal food needs of their families* (if they purchase nutritionally) AND must then find extra days of work to meet other needs.

Assuming a 24-day working month in Somaliland; a casual labourer able to get 24 days of work would earn 60 – 75 USD per month (depending on the area). *Again, this analysis tends to point to the inefficiency of paying qualified nurses 40 USD per month if one expects full service.*

1C.3 Salary scales in credible Somaliland private medical institutions

Private medical institutions must generate an effective profit, even if they have some non-profit and/or societal motives. They must provide the best mix of service for cost that they can, meaning that a private service should find good professional staff, pay them competitively and offer quality high-demand services. Some renowned Hargeisa-based private medical institutions with excellent reputations pay the following salary levels:

Table 2. Salary Scales in credible private medical institutions in Hargeisa

Function	Facility A (USD) (2006)	Facility B (USD) (2008)
Full-time regional expat doctor	\$1100 – 1200 (+accommodation, food and flights)	\$2000
Full-time regional expat matron	\$800 (+accommodation, food & flights)	This facility lacks technical leadership & management & does not have this level as yet.
Local Doctor		\$800 *
Nurse (locally qualified)	\$150 - \$210	\$150 – \$250
Nurse tutor (locally qualified)	\$200 - \$250	
Midwife	\$200 - \$250	\$150 – \$250
Auxiliary	\$60	\$100
Cleaner	\$30 - \$35	\$50 - \$80
Accountant **	\$400	\$200
Administrator **		\$200 - \$300
Driver	\$120 - \$170	\$150
Guard	\$50 - \$55	\$50 - \$80

* Specialist surgeons are paid on a fee per intervention basis (paid by families to the hospital and the MD reimbursed at end of month according to number of interventions); exemption costs born by the hospital.

** The major variation in rates between the classes and different institutions probably reflects the great differences in job descriptions, responsibilities and levels.

1C.4 Initial research on NGO incentives

Data on incentive systems paid by different NGOs was collected by the EC and DFID. UNICEF collected a number of other salary scales to compliment this work.

Findings from an initial comparison of incentive systems indicated that:

1. Incentive systems are very different between Central-South and Somaliland, reflecting the relative peace and order in Somaliland.
2. Somaliland has a proposed civil service salary system, but cannot implement it due to restrictions on the available budgetary resources and inadequate professionalization of the civil service.
3. All professional health staff are officially civil servants.
4. There are a range of other institutions, especially medical training ones, where employees are officially on the state payroll and receive salaries according to civil service payment practices.
5. Gaps between private market salary opportunities and current public wages (and even proposed wages) are substantial, implying that professional health staff might dedicate only some of their time and energy to public positions, and possibly operate private practices.
6. Workers in the public health system have access to extra income through means other than official salaries; DSA paid for training and workshops by the UN and NGOs, fees for service, private practice, sale of pharmaceuticals, and contributions from RHBs, private business, etc. If these non-regularized and unpredictable sources of income were withdrawn, either the public system as it is would cease to function due to too many people being paid too small amounts to do anything, or the Ministries would have to reduce the employment roster and hire fewer staff to provide services through limited facilities. The former is the most likely scenario, though not the preferred one.
7. There are few standard job descriptions and most staff are uncertified, so it is hard to compare across programmes; differences in top-up levels may represent differences in quality or responsibilities.
8. There does not appear to be a logical hierarchical salary scale, with senior persons being paid more. Instead, top-up scales frequently reward technicians more highly than administrators, managers and/or leaders, reflecting the highly localized market - who is required for the programme, who is available and what is their worth to the private market.
9. Top-up systems vary in their differences between high and low salaries and the civil service scales, reflecting local pressure (inflate salaries for higher cadres).
10. DSAs and travel allowances vary but all follow a similar logic and could be standardized if it was felt to be useful.
11. It was more difficult to get information on top-ups paid to MoH staff (central and regional) as well as to parastatal staff.
12. There is a booming private medical market with which public salaries cannot compete, hence public salary reform must be linked to broader conditions of service and civil service reform.

1C.5 Intermediate incentives for core functions

All NGOs provide remuneration to workers in facilities (SRCS, COOPi, SC-UK, WVI). The lack of certified staff, standard job descriptions and/or performance management make it difficult to develop a standard set of incentives. Nevertheless, for *a core set of medical staff functions*, incentives paid were not vastly different.

The first conclusion was to differentiate PHC from hospital staff; the second conclusion was to focus on a core set of functions.

1C.6 Core functions: Hospitals

Table 3 Incentives paid at NGO-supported public hospitals (USD)

Core function	Agreed levels	Agency contribution
Hospital Director	450	398
Hospital Doctor	400	348
Medical Officer	275	
Matron	250	208
Head Nurse	120	
Nurse/Midwife	110	
Auxiliary Nurse	90	
Lab Technician	120	
Lab Assistant		
Hospital Administrator	275	233
Accountant/ secretary		
Pharmacist		
Support Staff	65	

1C.7 Core Functions: Primary health facilities

Table 4 Incentives paid by NGO-supported MCHs and Health Posts (USD)

Core Function	Agency a	Agency b
Head Nurse	120	
Nurse/Midwife		100
Outreach Nurse		
Auxiliary Midwife	120	
Auxiliary	80	75
HP auxiliary		

It would seem possible to define standard job descriptions for a core set of MCH and HP staff and to set fixed base incentive levels. Standard salary rates should be tied to civil service salary scales

1D. National Civil Service proposals

In 2005 the National Civil Service Commission made a study of civil service remuneration packages. They recommended a temporary scale according to current budgetary constraints, and a proposed scale for future

implementation. The proposed scale allowed for more grades and levels within grades to increase the range of differentiation between posts (management tool) as well as a major increase in salaries. The proposed scale also suggested increments every two years so that salaries increase in step with job experience.

The NCSC proposed civil service salary levels have never been implemented due to constraints in the budget. Nevertheless, external salary support needs to be linked to officially proposed salary scales and upgraded in view of the discussion above.

Table 5 NCSC recommended salary levels – Somaliland (USD)

Grades	2008 recommended salaries NCSC	2008 recommended salaries NCSC (USD)
A1	1,543,000	257.17
A2	1,403,000	233.83
A3	1,275,000	212.57
A4	1,150,000	191.66
A5	1,054,000	175.67
A6	958,000	159.67
A7	871,000	145.17
A8	792,000	132.00
A9	720,000	120.00
B6	958,000	159.67
B7	871,000	145.17
B8	792,000	132.00
B9	720,000	120.00
B10	650,000	108.33
C7	871,000	145.17
C8	792,000	132.00
C9	720,000	120.00
C10	650,000	108.33
C11	570,000	95.00
D12	390,000	65.00
D13	355,000	59.17
D14	323,000	53.83
D15	294,000	49.00

• Exchange rate 6,000 SLsh per USD.

Table 5 shows recommended salary scales (NCSC), which have not been realized due to budgetary problems. A major problem in the proposed rates is the high degree of overlap between the different levels (so that A6=B6, etc).

In order to bring these rates to levels that are reasonable according to current market conditions¹, that will attract and maintain a professional workforce in full-time employment, it will be important to recognize the high demand for skilled labour and hence the relatively higher rates that can be commanded by better-skilled cadres in the current workplace.

Given the high degree of overlap between grades A, B, C and D, which do not allow sufficient differentiation between different professional cadres, as well as the higher levels of pay commanded by those with professional skills in the market and lower levels for the unskilled due to high levels of unemployment, we recommend a temporary readjustment of the NCSC-suggested salary levels to ensure REALISTIC, COMPETITIVE, DIFFERENTIATED total wage levels.

The recommendation is to multiply the recommended official scales by

A= x 3

B= x 2.0

C= x 1.5

D= x 1.25

to reflect current studies on costs of living and reasonable expectations for long term macro-economic state budgets, as well as competitive packages in relation to the market.

1. The current state of affairs in Somaliland (significant levels of instability and civil strife in Sool and Sanaaq) imply that the state is not functioning normally. It is reasonable to assume that if Somaliland reached greater stability either as part of or separate from a stable Somalia, the economy would improve and be increasingly regulated. Numbers and levels of professional staff available would increase and competition for trained staff and hence salaries might decline.

Unfortunately, there are numerous irregularities:

- The different levels are not used within the grades.
- Most personnel do not hold the qualifications required for their jobs and performance is not managed, so salaries are not tied to conditions of performance by the employee.
- Hence:
- Salaries should be downgraded for unqualified staff, paying them according to the grades they are qualified to hold.
- Salaries should be downgraded proportionally to hours worked against the standard 42-hour working week.
- Practical ways should be found to use the full range of grades and scales within grades so as to differentiate between posts and levels of responsibility.
- Incentives should be used to reward exceptional performance, but overall incentive packages should be relatively small compared to salary baselines.

The proposed scales are in line with levels of pay commensurate with attracting professional staff to **full-time posts**. The proposed scales are an intermediate step in terms of harmonizing pay rewards for public service staff, but ultimately there needs to be full a review of the total rewards package in the context of overall civil service reform.

The official scales do not reflect managerial responsibility (medical directors, etc). It is recommend that cadres with management responsibility should receive total remuneration 20% higher than the appropriate scale for the cadre - so for example, a medical director would work at the scale of a medical doctor *120/100.

1E. Proposal for action

- This paper presents a proposal for intermediate reform of salary support to: civil servants in central ministries (MoHL), regional administrations, public institutions (e.g. training) and health facilities (anyone who is eligible to be paid a public wage according to civil service regulations).
 - The job should be rewarded according to a standard salary rate – international agencies should move towards standardized salary top-ups over uncoordinated DSAs and incentives.
 - The proposed scales are in line with levels of pay commensurate with attracting professional staff to full time posts (42 hours per week).
 - Top-ups should be calculated according to what is already paid (total salary – salary already paid).
 - Incentives can be used to reward specific performances, but should not exceed 15% of the salary level and should require additional inputs above and beyond full job performance (i.e. not replacement of working hours).
 - This paper proposes a logic behind calculating salary top-ups and calculates suggested levels for 2008.
- Proposed salary top-ups need to be recalculated periodically to reflect (1) changes in base salaries paid by the government, and (2) inflation and other changes in the cost of living.
 - This paper does not propose that these new guidelines be implemented overnight - they will need to take into account funding cycles (NGOs may have to apply for new funds or wait until the next funding cycle to rearrange budgets for funding of civil servants). Rather, if the MoHL, NCSC/ government, UN agencies and donors all agree on this proposal, it establishes a path to move towards regularization, restructuring and management for performance of the public health system in lieu of implementation of proposed civil service reform (critical in the longer term).
 - Proposed salaries are for full-time employment of qualified staff; this proposal should be urgently followed up by defining a core list of standard jobs. New appointments should be made with focus being on attracting qualified persons to jobs.
 - Payments should be on the basis of the proportion of professional time dedicated to the remunerated position (i.e. two days' work per week in the public system -> one third of the proposed salary).

2

Proposal for intermediate implementation

2A. Proposal: civil servants in ministries or governmental institutions

- All civil servants targeted for support should be supported by salary top-ups. Members of ministries paid as consultants or given incentives for specific tasks should be phased out.
- Salary top-ups should be realistic enough to attract quality workers into the public sector, but not be unrealistically high.
- Support should be given to civil servants to fulfil their total responsibilities.
- Salary support should be given with strict conditions for performance, adhering to civil service codes and working times. Staff is paid for **full time** employment, i.e. a 42 hour working week. If working hours are less or productivity is unsatisfactory, part or all of the salary support should be withheld (proportionally).
- Staff to be supported should be managed by those to whom they are accountable within the government bureaucracy; management reports should be provided to the support agency, and performance evaluations verified before salary support is transferred.
- Staff to be supported should continue to receive their government wages; if not, then salary support should not be forthcoming.
- If a person's qualifications do not match the job responsibilities, he/she should be graded according to qualifications and receive lower levels of salary support.
- All staff to be supported should be graded according to standard civil service criteria by the NCSC; salary support should be proportional to NCSC recommendations and policies.
- Incentives should make up a relatively small proportion of overall remuneration (<15%).

Table 6. Suggested full-time salaries

Grades	2008 recommended Salaries NCSC	2008 recommended salaries NCSC (USD)	2008 recommended salaries
			Grade A: Recommended Salaries NCSC *3.0
A1	1,543,000	257.17	775
A2	1,403,000	233.83	700
A3	1,275,000	212.57	640
A4	1,150,000	191.66	575
A5	1,054,000	175.67	530
A6	958,000	159.67	480
A7	871,000	145.17	435
A8	792,000	132.00	395
A9	720,000	120.00	360
			Grade B: Recommended Salaries NCSC *2.0
B6	958,000	159.67	320
B7	871,000	145.17	290
B8	792,000	132.00	265
B9	720,000	120.00	240
B10	650,000	108.33	215
			Grade C: Recommended Salaries NCSC *1.5
C7	871,000	145.17	215
C8	792,000	132.00	200
C9	720,000	120.00	180
C10	650,000	108.33	165
C11	570,000	95.00	145
			Grade D: Recommended Salaries NCSC *1.25
D12	390,000	65.00	80
D13	355,000	59.17	75
D14	323,000	53.83	65
D15	294,000	49.00	60

* Exchange rate 6,000 SLsh per USD.

Top-ups provided by international donors should be according to the above recommended salaries, taking into account current salary payments from the government which must be continued as a condition of salary support.

Table 7. Salary support, or top-up levels

Scales	2007 actual salary	2007 USD (a)	Proposed total salaries (b)	Top-up at today salary* (= b-a)
A1 (DG)	423800 + 600,000 = 1,023,800	170.63	775	605
A2 (Head Dept.)	423,800 + 200,000 = 623,800	103.97	700	600
A3	423,800	70.62	640	570
A4	423,800	70.62	575	505
A5	423,800	70.62	530	460
A6	423,800	70.62	480	410
A7	423,800	70.62	435	365
A8	423,800	70.62	395	325
A9	423,800	70.62	360	290
B6	345,800	57.62	320	260
B7	345,800	57.62	290	230
B8	345,800	57.62	265	270
B9	345,800	57.62	240	210
B10	345,800	57.62	215	155
C7	266,500	44.41	215	170
C8	266,500	44.41	200	155
C9	266,500	44.41	180	135
C10	266,500	44.41	165	120
C11	266,500	44.41	145	100
D12	156,000	26	80	55
D13	156,000	26	75	50
D14	156,000	26	65	40
D15	156,000	26	60	35

* exchange rate used = 6,000 SL shillings/1 USD

Periodic Re-evaluation

- Total salaries (and therefore top-ups) need to be upgraded every two years on the job by a factor of 5%, to reflect experience and seniority (capped after 10 years or five upgrades).
- Total salaries (and therefore top-ups) need to be upgraded periodically to reflect inflationary pressure (based on FSAU market data), to be calculated at an agreed periodicity.
- DSA and meeting attendance rates need to be downgraded or even eradicated, as staff are now paid and part of their “job” responsibilities are to attend important meetings.

2B. Medical facility workers

2B.1 Hospitals

- The proposal for hospital staff is to support generic medical professional cadres and unskilled or semi-skilled non-medical functions.
- The salary levels do not including allowances for skilled diaspora, housing/hardship allowances, training, workloads. These need to be worked out in the context of longer term recommendations to the staffing of the public health system (intermediate solutions may need to be agreed upon to ensure staffing of isolated facilities or hardship facilities). They should be agreed upon between all agencies in a region through regional coordination mechanisms and supported by local authorities.
- The grades reflect total remuneration levels, so if the MOHL or the community pays some of the fee, then the NGO should only make up the difference to ensure the total remuneration level is met. If the employee does not work full time then the rates should not be provided in full.
- Grades are for a 42 hour working week. Hospitals must run on a shift basis offering round-the-clock professional care. If staff work more or less than the 42 hours their salaries should be discounted according to the hourly rates indicated in table 7.

Table 8. Recommendations for remuneration of Somaliland hospital staff (USD)

Grade	Basic function	Basic salary	Overtime hourly rate
A1	Hospital Director (MD)	\$775	\$4.25
A2	Senior Consultant - Specialist	\$700	\$4.00
A3	Senior MD – head of ward (with 2+ MDs and 4+ nurses under supervision)	\$640	\$3.50
A6	Junior MD	\$480	\$2.75
A7	Hospital Manager (university degree/MBA)	\$435	\$2.50
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B6	Clinical Officer*	\$320	\$2.00
B7	Matron – Tutor	\$290	
B8		\$265	
B9	Senior Nurse	\$240	\$1.50
B10	Nurse midwife Pharmacist Lab Tech	\$215	
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C11	Auxiliary Nurse Aux Midwife Aux Pharmacist Aux Lab Tech (certified)	\$145	\$0.85
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D12	Driver Electrician	\$80	\$0.45
D14	Guards	\$65	\$0.40
D15	Cleaner Cook	\$60	\$0.35

* A clinical officer is considered here to be a medically qualified nurse or midwife with two years post-basic training, able to perform diagnostic and curative interventions to a reasonably high level. The CO may be trained and used for specific functions in a hospital setting (anaesthesia, caesareans), or may serve in a more general function in a health centre as a senior medical professional in lieu of a medical doctor. *This cadre currently does not exist or is not well defined.*

2B.2 Primary Health Care facility staff

Table 9. Recommendations for remuneration of Somaliland PHC staff

	Base Salary
Qualified nurse or midwife	\$215
Auxiliary nurse/ midwife	\$145
Auxiliary/CHW	\$80
Unskilled staff	\$60-65

No additional factors required to be factored in

