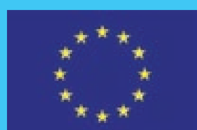
Report 5

Intermediate standardized

SALARY SUPPORT/ INCENTIVES

Payment scales for civil servants and health workers

SOMALIA



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Foreword

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 recognized 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 standardized 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 in workshops in Puntland and to MoH officials in the Puntland and CSZ MOHs. The proposals were discussed, adapted and approved by both administrations. Final versions were endorsed by officials from the MOH TFG for the Central and South Zone. While the proposals were officially approved by officials form the MoH Puntland – an official endorsement was never finally received.

The recommendations were also endorsed by the Heath 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.

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Acronyms

COSV	Committee for the Coordination of Volunteers (Italian NGO)
CS(Z)	Central South (Zone)
DFID	Department for International Development (UK government)
DSA	Daily Service Allowance
EC	European Commission
FSAU	Food Security Analysis Unit
HR	Human Resources
MCH	Maternal and Child Health (clinic)
MD	Medical Doctor
MoH	Ministry of Health
NGO	Non-Governmental Organization
PHC	Primary Health Care
TFG	Transitional Federal Government
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USD	United States Dollar

1 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 the varied levels in health service delivery and management. Salary systems are necessarily complex so as to meet the requirement to distinguish between persons and differentially reward:

- Qualifications
- Experience
- Position (responsibility – both managerial and technical)

The authorities of Somalia have neither the resources nor other capacities to deliver effective and efficient health services to all their citizens. Hence the majority of health services are offered through the largely unregulated private market or partnerships between the MoHs and UN/not-for-profit NGOs.

- The MOH in CSZ has no official budget and cannot exercise practical administrative authority over the regions of CS Somalia. The MOH Puntland does exercise practical authority over the region of Puntland (some areas are disputed with Somaliland – Sool and Sanaaq) and has an official budget. However the budget is very low and there is no official policy or scales for salaries of civil servants and public health system employees.
- Not all employees of current operational health facilities are on the official pay-roll.
- Some health facilities and institutions are supported by NGOs and others not.
- Otherwise, health facilities and institutions raise finances through charity grants, diaspora contributions, collection of contributions from local business, 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 ways and unpredictably. There is no set of standards and performance based management is consequently extremely difficult even for entirely Somali based institutions.

Health facilities and institutions are often fully staffed or over-staffed – but frequently with under-qualified staff. There are far too many un-skilled and under-qualified staff; too few higher level clinicians and professional staff and almost no managerial class of staff. The availability of qualified staff to fill higher positions is low – and those in position are frequently not qualified

for the job. Without sufficient leadership and middle management the vast numbers of low and unskilled workers are not adequately managed and hence health system outputs are extremely poor (even considering the low levels of investment).

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

1B. The Problem

In a divided and institutionally weak environment, public institutions have neither the resources nor the technical capacity to develop complex and effective rewards system for health care workers – (and to implement them). Hence 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 general health workers salaries are:

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

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

The inadequate remuneration and need to earn an income means that all health facilities are forced to charge high formal or informal charges for consultations, diagnostics and drugs at point of use which serves as probably the most significant barrier to access of public health services (especially for the rural and urban poor).

Consequently when non-public (international or local NGOs or UN) actors intervene it is an important aspect of their programmes that they 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 as wages, to reflect complementary benefits. (Wikipedia) Stipends are generally paid for a fixed short term. Stipends are given 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 to compensate. This results in incentive levels many times higher than salaries and incentive structures that compete with the logic behind salary scales. Then the concept of the salary and incentives can become confused. 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 counter-parts that may have very different motives from each other in why they wish to offer incentives, what are the structures of incentive systems and what they 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,
- With rigorous certification of employees to ensure employees meet requirements of job descriptions;

Salary systems/reward packages must be considered to reinforce the authority and responsibility of the MoH as

the principal employer of staff.

+ On the one hand rewards have to be set high enough to ensure adequate skilled personnel are attracted in to public positions and sufficiently high to allow them to concentrate their efforts into 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 the long term sustainability of health service delivery (as when donor funds withdraw, the public purse will not be able to sustain the levels of remuneration required to maintain a professional and differentiated workforce and the MoH will have limited commitment to bodies of staff employed outside their remit).

Furthermore, differential salary rates between agencies sets up a never ending discussion with staff and effects motivation and perceptions of justice (absolute amounts as well as differentials between types of employee). Therefore there is a major challenge:

1. For external (NGO/UN) providers to provide staff motivation packages that are realistic and allow them to recruit and keep sufficiently skilled staff to provide effective and efficient services.
2. To coordinate external reward systems with longer term civil service reform (at least to minimize harm).
3. To reduce negative impact of competition between agencies.

Given strong and reasonable central leadership on these issues – grounded in 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 – to "incentivize" staff to perform their ***full jobs*** and to relocate responsibility back to local authorities (as well as to set norms and standards to reduce transaction costs (constant negotiation), reduce tension (fair transparent endorsed norms and standards are applied) and bring authorities into support of partner payment activities).

1C. Setting Intermediate Realistic Salary Levels.

1C.1 Cost of Subsistence

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

The basket does not contain non food items such as housing, clothing, education, transport etc. A full basket including housing and education has been costed for Low Shabelle (Merka) by COSV and estimated to be roughly 100 USD per family per month.

The cost of living is variable by region and by season – but if anything is more expensive in the North. *Hence public salaries for nurses (4 years professional training) etc. of roughly 20 USD and doctors of roughly 60 USD per month are obviously below subsistence levels and cannot generate effective commitment by employees to the public system.*

1C.2 Daily Wage Analysis for Day Labourers

Wages for daily labourers vary between 1 USD and 4 USD per day (see Table 1), reflecting different local market conditions in terms of supply and demand. Daily rates tend to be higher in the North than in crisis affected south, indicating the impact of crisis on the possibility of employment and subsistence in times of crisis for the poor.

Table 1. Daily wages are variable over the country (source FSAU 2008):

Location	Rough wage (USD)
Burao	2.5
Hargeisa	3.2
Bosasso	2.5
Garowe	3
Galkayo	2.5
Belatweyne	3.5 (?)
Luuq	1
Baidoa	1.25
Jowhar	1.5
Marka	1.75
Jammame	1.25

The daily wage rates indicate casual labourers need to work 10 – 25 days per month *just to meet minimal food needs of families* (if they purchase nutritionally) AND then must find extra days of work to meet other needs.

Assuming 24 day working months in Somalia; a casual labourer could earn 30 – 75 USD per month (if he could get enough work days). *Again this analysis tends to point to the inefficiency of paying qualified nurses 20 USD per month (if one expects full service).*

The cost of living is variable by region and by season – and is currently rapidly changing in the face of increased insecurity, drought and increased global fuel and food commodity prices. *Hence public salaries for nurses (4 years professional training) etc. of roughly 20 - 40 USD and doctors of roughly 60 USD per 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 – and skilled workers must earn extra money to guarantee a minimal standard of living.*

1C.3 Salary Scales in Credible Somali Private Medical Institutions.

Private medical institutions must generate an effective profit (even if they have some non-profit/societal motives) – they must provide the best mix of service for cost they can. This means a private service should seek to find good professional staff and seek to pay them competitively – and offer quality services for which there is a high demand.

Some renowned private medical institutions (Hargeisa based) with excellent reputation pay the following salary levels:

Table 2. Salary Scales in Credible Private Medical Institutions

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 and flights)	This facility lacks technical leadership and management and does not have this level as yet.
Local Doctor		$800 *
Nurse (local qualified)	$150 - $210	$150 – $250
Nurse tutor (local 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 family 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:

1. Incentive systems are very different in the central South and in Somaliland reflecting the relative peace and order in Somaliland.
2. Somaliland has a proposed civil service salary system – Puntland and Central South Zones do not.
3. All professional health staffs are officially civil servants.
4. There are a range of other institutions – especially medical training institutions which have historically been regarded as public and where employees were officially on the state payroll and received salaries according to civil service payment practices.

5. Gaps between private market salary opportunities and current public wages (and even proposed wages) are substantial. This implies professional health staff would only dedicate some of their time or energy to public positions and will operate private practice.
6. Workers in the public health system have access to extra income through other means than official salaries – DSA paid for training and workshops by the UN and NGOs, fees for service, private practice, sale of pharmaceuticals, contributions from RHBs, private business etc. If these non-regularized and unpredictable sources of income were withdrawn the "public system" as it is would cease to function. Public systems are largely privatized or rely on charity.
7. There are few standard job descriptions and most staff is not certified 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 paid more. Rather top up scales frequently reward technicians more highly than administrators, managers and leaders. Top ups reflect 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 – reflecting local pressure (inflate salaries for higher cadres).
10. DSAs and travel allowances vary but all follow similar logics and could be standardized if felt useful.
11. It was more difficult to get information on top ups paid to MoH staff (central and regional) as well as para-statal staff (mainly paid by UN agencies).
12. There is a booming private medical market – public salaries cannot compete with the market – 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. The lack of certified staff, standard job descriptions and 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:

Core Functions: Hospital (USD)

Table 3 Incentives paid in NGO supported public hospitals

Core Function	Agency a	Agency b	Agency c	Agency d
Hospital Director	1200	1300		1300
Hospital Doctor	1000	1000		780
Medical Officer			765	
Matron	250	304	310	300
Head Nurse	250	175	310	220
Nurse/Mid Wife	200	150	175	195
Auxiliary Nurse	150	100	120	
Lab Technician	200	172	176	220
Lab Assistant		116	120	
Hospital Administrator	450	500		300
Accountant/ secretary		100	176	
Pharmacist	200	150	176	220
Support Staff		75		

Additional factors

If the staff (especially MDs) are DIASPORA (defined as recent returnees and foreign trained and experienced) they get a roughly 50% increase in salary.

- Some wish to create performance related pay in which case one could consider extra incentives for higher workload.
- Some recognize professional staff living in their home town work short hours and have private business opportunities – compared to staff asked to move away from home and work in the bush where they have limited private opportunities to supplement their wages. So, base remuneration packages need to be proportional to a base working week (42 hours), and there is a need for a hardship or relocation factor.

Core Functions: Primary Health Facilities (USD)

Table 4 Incentives paid in NGO supported MCHs and Health posts

Core Function	Agency a	Agency b	Agency c	Agency d	Agency e
Head Nurse	150	175	176	120	150
Nurse/Mid-wife					120
Outreach Nurse					
Auxiliary Mid-wife	130	110	?	120	
Auxiliary	110	100	120	80	
HP auxiliary		100			

Again 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 for CSZ and Puntland.

2

Proposal for intermediate implementation

2A. Proposal for Action

- This paper presents a proposal for intermediate reform of salary support to: civil servants in central ministries (MoH), regional administrations, public institutions (e.g. training institutions) 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.
- 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 (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, (2) inflation and changes in the cost of living.
- This paper does not propose these new guidelines be implemented overnight – and 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 MoHs, governments, 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 with definition of a core list of standard jobs. New appointments should be made with focus on attracting qualified persons to the job.
- Payment should be on the basis of the proportion of professional time dedicated to the remunerated position (i.e. 2 days work per week in the public system -> 1/3rd of the proposed salary).

2B. Proposal for Civil Servants Working in Ministries or Governmental Institutions

- All civil servants targeted for support should be supported in the form of 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 unrealistically high.
- Support should be given to civil servants to fulfill their total responsibilities.
- Salary support should be given with strict conditions for performance (adhering to civil service codes and work times). Staffs are paid for full time employment which is a 42 hour working week. If working hours are less or productivity is unsatisfactory part or all of the salary support should be with-held (proportionally).
- Staff to be supported should be managed by those to whom they are accountable in the government bureaucracy – management reports should be provided to the support agency and performance evaluations verified before salary support is transferred.
- In Puntland, staff to be supported should continue to receive their government wages – if not then salary support should not be forthcoming. This should be a condition for CSZ when public officials begin to receive public remuneration.
- If the person's qualifications do not match the job responsibilities they should be graded according to their qualifications and receive lower levels of salary support.
- All staff to be supported should be graded according to standard criteria as developed in the start-up package defined by UNDP.

Recommended Civil Service Wage Levels

Macro-economic projections and analysis of salaries for professionals indicate that the salary scales paid by donors to some civil servants are realistic in the right range: Indicating that civil service grades should get this order of remuneration and that this would be feasible to maintain given longer term macro-economic projections, political will and reduced military expenditure in a post-conflict stable environment:

In the CSZ stipends should be commensurate with the start up package as defined by UNDP. Salaries are to be paid as detailed below:

Table 3 TFG Start-up Package Salary Levels

Position	Renumeration (salary)	Donor 75% (2008)
DG	1000	750
Head of Department	700	525
Technical officers – professional level	500	375
Clerical staff	250	187.5

Lot 3 will advocate regional health civil servants to be remunerated according to a standard rationale:

Table 5 Regional Salaries in CSZ

Position	Renumeration Rate (total levels) USD	Puntland Official Salaries	Puntland Top-Ups
Director General	750	115	635
Regional Medical Officer/Head of Department	525	70	455
Technical officer	375	?	
Clerk	188	?	
Auxiliaries	113	?	
Unskilled staff	65	?	

These suggested salary levels are total remuneration packages:

- Intl. support should aim to top up current salaries to these levels.
- Personnel need to have the required qualifications and to work full time. If qualifications do not meet job descriptions OR staffs do not work full time, salaries should be reduced proportionally (to matching grade of qualifications or a proportion of the working week filled).

2C. Medical Facility Workers

Hospitals

The proposal for hospital staff is to support roughly 10 generic medical professional cadres and 5 unskilled or semi-skilled non-medical functions. These different generic functions are clustered into a set of 7 pay grades and each pay grade can be differentiated according to differences in qualifications and experience.

Table 5. Generic Medical Job Grades:

Grade	Definition	Generic Jobs in Grade
1	University level – Full basic training + >6 years professional training	Medical Doctor
2	9-10 yrs basic education + 5 - 6 years professional training	Clinical Officer/Medical officer
3	9-10 years basic education + 3 – 5 years professional training	Qualified Nurse, pharmacist, Lab Tech.
4	6 – 9 years basic education + 2 yrs professional training	Auxiliary nurse, auxiliary midwife, microscopist
5	6 years basic education + <1 year professional training	CHW, TBA, Assistant pharmacist, Lab assistant
6	Untrained – skilled	Electrician, driver, accountant
7	Untrained - unskilled	Guard, cook, cleaner

An additional 30% of the core function incentive is proposed as an additional incentive for team leaders or managers of a cadre taking on leadership roles and managing personnel and resources among their peers.

Table 6 Proposed basic incentives for hospital workers in Puntland and Central South Zones

	Basic salary Scale	**Management position** = (salary * 130/100)
Grade 1	$900 (Medical Doctor)	$1200 (Hospital Director)
Grade 2	$750	
Grade 3	$200	$260 (Matron, Head Nurse)
Grade 4	$125	$160
Grade 5	$80	$105
Grade 6	$100	N.A.
Grade 7	$60	N.A.
Hospital Administrator	$450	

In addition it is recognized there is a crucial non-medical function in the Hospital Administrator who needs to be qualified and trusted (a indicative salary is suggested but if the administrator has an MBA then we would expect them to be graded as grade 1 or 2).

- The salary levels do not including allowances for skilled diaspora (+50%), housing/hardship allowances, training, workloads. These have to be formulated at the project or regional level and should be transparent and consistent across grades and related to a percentage of base remuneration rates. 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 MOH 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 increased or discounted according to hourly rates.

Primary Health Care Facility Staff

Table 7 Proposed salary levels for PHC facility workers in Puntland and Central South Zones

	Base Salary	**Team leader =(salary *130/100)**
Qualified nurse or mid-wife	$140	180
Auxiliary nurse/ mid-wife	$125	
Auxiliary	$100	
Certified CHW at Health Post Level	$80	
Non-skilled staff	$60	$75

No additional factors required to be factored in

2D. Periodic Re-Evaluation

- Total salaries (and therefore top-ups) need to be upgraded every 2 years on the job by a factor of 5% to reflect experience and seniority (capped after 10 years or 5 up-grades).
- 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 agred periodicity.
- DSA and meeting attendance rates need to be down-graded or even eradicated as staff are now paid and part of their "job" responsibilities are to attend important meetings.

unicef

unite for children