# Support to donor working group on Human Resources for Health – Remuneration, HR and payroll process issues related to the introduction of the 'medium scenario'

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Client: DFID Somalia

FINAL

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# Executive summary

### Governments have made progress on implementing HR and payroll process improvements and investing more in health staff remuneration, while partners have made progress toward the 'medium scenario'; however, there has not been the coordinated plan of action envisaged a year ago

In early 2013, Charlie Goldsmith and Ahmed Mohamed, in their 'Review of Compensation, Salaries, Incentives and Benefits for Health Personnel in Somalia,' set out three scenarios for the future remuneration of Somali health staff based on an 'incremental "win-win": more resources, and higher pay, if zones will commit resources and increase accountability.'

The 'medium scenario' was accepted at the March 2013 Health Sector Committee (HSC) and Health Advisory Board (HAB) meetings. Since then:

- Governments have made progress on HR and pay reforms and increasing their share of the funding burden. Examples from the last 12 months include work toward populating HR Management Information Systems HRMIS, increasing the health salary budget, and improving payment execution methods by using mobile money.
- Health sector implementing partners and donors continue to use different pay scales; the Joint Health and Nutrition Programme (JHNP) has mandated the medium scenario for all its implementing partners, but these contracts are not yet in action; a number of key implementing partners have applied or are moving toward applying medium scenario rates (intentionally or not) and others have increased Lot 3 rates, but not as far as the medium scenario; some donors, notably the Global Fund, have committed to fund rates that vary from the medium scenario, but which implementing partners can then choose to top up, e.g. to the medium scenario, through other sources.
- The coordinated programme of remuneration and system reform proposed in 2013 has not occurred. Specifically, we are not aware of the catch-up actions agreed at the HSC in September 2013 having taken place.

### Partners fund remuneration for around 4,000 Somali health service delivery staff, at a cost of around US$ 13.5 million per annum; governments fund around 3,200 for around US$ 3 million per annum, which is expected to rise to over 4,000 and US$ 5 million per annum in 2014

We have gathered information on the number of Somali health service delivery staff being funded by donors and implementing partners, and have analysed this to quantify how much partners currently spend on remuneration and how this relates to the overall funding of the sector for all expenditure items (i.e. remuneration, drugs, infrastructure, etc.). Based on submitted data and further extrapolation as needed, it is estimated that, across the three zones, approximately 4,000 Somali health service delivery staff, including in that number posts due to be funded by JHNP with imminent effect, are funded by non-government partners, to a cumulative amount of approximately US$ 13.5 million per annum. Approximately 3,200 staff are presently paid by governments, which spend in the order of US$ 3 million per annum on their remuneration, which is expected to rise to over 4,000 and US$ 5 million per annum in 2014 upon the Parliament in Mogadishu passing the draft Budget 2014.

Overall, we expect that the three zones will in total spend approximately US$ 6 million on health in 2014: thus, remuneration will take up as much as 80% of their annual budgets. We estimate that partners spend around US$ 13.5 million per annum on the remuneration of Somali health service delivery staff, as compared to total spend on the Somali health sector in the order of US$ 70 million. Thus, spend on Somali health service delivery staff makes up approximately 20% of total partner spend on the Somali health sector. Clearly, this is an average figure, and there is considerable variation – for example, the Global Fund cite 40% spend on human resources on one grant (not clear if this is Somali health service delivery staff only or all staff). These overall proportions suggest that claims that implementing the medium scenario is 'unaffordable' are not logical particularly not from the perspective of DFID, looking across its role as a contributor whether through bilateral or multilateral programming, to all the major Somali health programmes.

It is not clear from the data provided which staff are paid by both government and partners and which are paid solely by government or solely by partners. Clearly, this increases the risk that an individual could be receiving materially more or less than is intended/required to motivate them.

Government HR and payroll systems are currently being improved in all three zones,[1] principally on the impetus of the zones themselves. Partners should capitalise on this development. We have provided some examples of appropriate practices within the country and in the region that could be adapted by health sector partners in Somalia.

**We propose a complementary progress of practical improvements to HR and payroll systems to give governments and partners more assurance, and work to agree a costed trajectory for governments to take up most of the remuneration burden of Somali health service delivery workers within five years**

Detailed recommendations to the Human Resources for Health (HRH) Working Group are made. In summary, these involve:

- A draft 'roadmap/transition workplan' with a view to its agreement through the HSC and HAB, which involves immediate steps such as:
    - Evolving the 'medium scenario' to support further implementation of HRH systems – principally by adding grading increments building on Trócaire's successful work;
    - Reaching agreements on benchmarks to provide assurance to both government and partners on the detail and accuracy of HRH data, and the operation of HRH administrative systems; and
    - Agreeing a trajectory for government to take on an agreed increased share of the funding burden over a five-year period.
- Levelling up the HR and payroll systems used by government and partners and working through government systems to the maximum extent at each stage – as per

[1] We have not had the opportunity to discuss the detailed intended arrangements for the possible role in managing health services of the Juba Interim Administration, or the relationship of Puntland as a Federal State to the Government of Somalia. All the proposals made about practical HR and payroll tools are intended to be transferable to any conventionally organised decentralised government within the three zones, and any provision of health services conventionally organised in terms of tertiary/secondary/primary care.

previous recommendations, i.e. 'on government, potentially on budget, but not yet on Treasury'. Specifically:
    - We propose the introduction of a standard, harmonised, basic set of HR and payroll tools to be used by governments and all partners to record data about HRH and to process and report payroll, so that data on HR and pay processes are held in a consistent and readily analysable format. Such tools could be delivered and implemented within six months.
- Partners and governments will need to reach and document an understanding on benchmarks and targets to monitor progress on key systems improvements.
- Recommendations are made that are specific to individual partners such as the Global Fund and JHNP, where key opportunities exist.
- We recommend that a technical and policy focal point person from the donor/partner side should maintain monitoring and overall visibility of HR and payroll issues, at least for the period of the workplan set out. There should be a single high-level professional who can personally coordinate this subject area over the next two to three months, while the priority actions are carried out, and ideally over a sustained period. They should be able to act as a trusted broker between all parties and, given DFID's role as funder of all the main bilateral and multilateral mechanisms in the Somali health sector, must specifically enjoy their confidence.
- Further recommendations are reiterated which were in the 2013 Review of Compensation, which cover five key areas: HR Policy; HR/Personnel Records and HR Information System (HRIS); Payroll processing; Payment Execution; and Attendance Monitoring.

# 1. Background to the medium scenario in the 2013 'Review of Compensation, Salaries, Incentives and Benefits for Health Personnel in Somalia'

In late November 2012, partners of the Somali Health Sector commissioned a short consultancy study to gather information on the remuneration of health staff and to make recommendations concerning future remuneration levels. The key findings of this study were that government rates for the pay of public sector health staff were below living standards and the market, and that harmonisation of remuneration could lead to more efficient use of resources and a more coordinated sector. Three remuneration scenarios (low, medium and high) were proposed, to be linked to a menu of reform commitments from the government side. In each scenario, a unified set of rates intended to be applicable across all areas of Somalia was proposed.

The medium scenario was intended to be an "incremental 'win-win': more resources, and higher pay, if zones will commit resources and increase accountability." The report was reviewed by the HSC and HAB meetings in March 2013 with all stakeholders endorsing the dual commitment, involving a revised salary scale as well as strengthening accountability systems.

Neither side of the bargain has been fully delivered. Partners have made some progress in terms of implementing or approaching the medium scenario rates, while zones – both at health sector and cross-sectoral level – have made progress on HR and pay systems. Cross-sectoral progress is an opportunity, in that health will not be held back by problems in cross-sectoral systems it cannot avoid interfacing with; however, it also makes it harder for health systems to move quickly and unilaterally.

The report contained a roadmap of **priority systems reforms** in the following areas:

- HR Policy;
- HR/Personnel records;
- Payroll processing;
- Payment execution; and
- Attendance monitoring.

The report urged funders and implementing partners to generalise successful examples of entrusting government (i.e. both Ministries of Health (MoHs) and Regional Health Offices (RHOs)) with monthly payroll processing and payment execution responsibility, i.e. "on government, potentially on budget, but not yet on Treasury". . The report pointed to successful examples across the three zones of government processing and executing pay for health service delivery staff at levels ranging from primary through to tertiary, and including management staff at each level.

In addition, the rates proposed in the medium (and high) scenarios were presented alongside the following points:

- Rates are for Somali health service delivery staff. The report used the term 'Somali health service delivery staff' to refer to people of Somali nationality or origin who are working within the main system of health service delivery (thus, typical

workstations would be Health Posts, MCHs, Referral Hospitals), and are typically permanently appointed. This is by contradistinction from NGO's 'own staff'. To this we would now add the clarification that those in the administration of the Somali health system, at District, Regional and Zonal level, are, for the avoidance of doubt, included in that definition.

- Rates were target total remuneration rates, which could be transparently funded from more than one source.
- Rates were for 2013; a 10% inflation escalator was proposed to be applied at 1 January 2014 and annually (see sections 7 and 10.1.5 of the 2013 report for the detailed rationale on this).
- For rural/hard to serve locations, it was proposed that "the existing norm of up to 30% for most remote/hard to serve locations should be generalized."
- A specific statement was made in the 2013 Review: 'Senior management: proposed rates for Directors and DGs could be a floor.' In general, since senior positions tend to be more varied due to the differences in qualifications and length of service, the proposed rates were meant to be seen as a starting point.
- At the time of developing the medium scale, there was insufficient time or resources to develop and broker agreement to a full scale with 'increments' within grades/pay rates for a given job/role. Such increments give flexibility in hiring to reflect previous experience and remuneration to a degree, and can provide an incentive for staff remaining in a job/role, e.g. through an annual pay rise, reflecting the additional skills and experience acquired over time. The addition of increments would not be difficult to generate from the agreed rates, and would facilitate the alignment of scales between partners and convergence toward the 'medium scenario'.
- The medium scenario rates were to be the total rates paid to staff, and not 'top-up' rates to be paid by partners alone.
- Additionally, the 'high scenario' asked governments to take up the majority of the salary funding burden by 2016. A trajectory for transition of the funding burden should now be agreed, and we make proposals for a five year trajectory below in light of the current and projected cycle of donor assistance.

## 2. Objectives of the consultancy

The purpose of this short consultancy was to support the HRH Donor Working Group to review the implications of the introduction of the medium-level pay scale for health workers on each of the programmes they fund (with a focus on the Global Fund, GAVI, JHNP, Health Consortium for the Somali People (HCS), and UNICEF).

The following text is taken from the terms of reference:

1. 'The **aim** of this TA is:
   (i) To support the HRH working group to review implications of the introduction of the medium level pay scale for health workers on each of the programmes they fund (focus on GFATM, GAVI, JHNP, HCS, UNICEF)
   (ii) To compile full list of positions funded by donors (top ups and full pay), and payment arrangements in place, state amount of top-up being paid by the donor/ programme in relation to the agreed salary and what is being paid by government
   (iii) To draw together and document the full implications and estimate the collective costs of introducing the medium scale
   (iv) To help identify the requests that should be made on government (ie policy, records, payroll, government contribution/percentage) etc.
   (v) To propose common position on remuneration to be agreed on, including short term measures and longer term measures'.

This was to be done through the following core activities:

- **Review progress:**
  - Review the recommendations of the health remuneration report and assess the progress made to date;
  - Identify steps agreed at the 2013 HSC and HAB meetings, reviewing how this is being interpreted;
  - As far as possible, compile a list of positions funded by donors (top-ups and full pay) and payment arrangements in place, stating the amount of top-up being paid by the donor/programme in relation to the agreed salary and what is being paid by government;
- **Identify implications:**
  - Draw together and document the full implications and estimate the collective costs of introducing the medium scale;
  - Document the costs and impact on how salaries, incentives and benefits for health personnel in Somalia are funded;
  - Identify lessons learned so far from the way the sector currently funds its personnel and how this can be improved. Capture any innovations that can be shared with the wider Somali health sector;
- **Make recommendations:**
  - Help identify the requests that should be made of government (i.e. policy, records, payroll, government contribution/percentage, etc.). Propose common position on remuneration to be agreed on, including short-term and longer-term measures ;
  - Identify the steps needed to ensure consistency in the remuneration support provided by donors through various programmes so as to reduce inefficiencies, to eliminate any double funding and to improve the longer-term sustainability of this support to the MoH;

- Propose a common donor position for support to HRH for the short term and medium term;
- Provide any additional recommendations, stemming from this consultancy, that relate to systems strengthening of HRH, for the MoH to lead on with WHO support.

# 3. Methodology

Charlie Goldsmith Associates was sub-contracted through the Health and Education Advice and Resource Team (HEART) Framework, administered by a consortium led by Oxford Policy Management and funded by DFID, for this review. Charlie Goldsmith and Erin Chu Felton had 17 person days assigned between them. Both were well acquainted with the 2013 Review because Charlie led it and Erin conducted analysis on the data received by all partners.

The activities for this consultancy involved:

- Consultations/meetings with key stakeholders, including government, donors, partners, and implementing agencies (NGOs);
- Review of written materials and minutes from previous HSC and HAB meetings to understand the agreements made and the actions proposed;
- Collation of all available datasets from implementing agencies, donors and partners on pay and top-up payment lists;
- Analysis of datasets against current and medium scenario payscales to calculate the overall 'wage bill' of the health sector;
- Production of a written report, submitted first to DFID in draft form (alongside a PowerPoint and recommended 'transition workplan') and then followed by a final report. While both consultants were in Nairobi for key meetings, DFID planned for them to present draft findings to the HRH Donor Working Group since its members were already gathered for meetings. This meeting provided an opportunity to gather further information for the final report and recommendations.

## Limitations

Time and resources were not available for travel to Mogadishu and Garoowe under this assignment (although Charlie had been to Mogadishu twice recently for work under a cross-sectoral payroll review funded by the EC). Consultations were held in Hargeisa, Somaliland and in Nairobi, Kenya. However, the timing of the consultancy was such that the consultants were present in Nairobi when partners were already gathering for a number of meetings with the three health authorities. This allowed for access to the health authorities as well as the donors/partners, but as the JHNP and Global Fund both had full-day meetings already scheduled there was a practical limit to the amount of information that could be gathered in the time with the Zonal authorities – although the consultants are grateful for the highly productive time they were able to spend with the authorities.

Another limitation in data analysis was the variation in the availability and completeness of datasets on salaries and top-ups from governments, donors, partners, and implementing agencies. In the case of obtaining available data, DFID made the initial introduction between the partners and the consultants and the request for information. In most cases, follow-up requests for data and information were granted. Where data were not available to us, we have made estimates based on general information received by the agency itself or other partners involved. This limitation was flagged prior to the start of the consultancy; from the outset it was acknowledged that a final 'paysheet' of all health workers, roles, and amounts would not be possible, but that best and overall estimates would be provided.

## Definitions

For the avoidance of doubt, some terms need to be defined in an area in which stakeholders do not always use them consistently:

- Somali health worker/health service delivery staff: Consistent with the 2013 report, this definition includes, unless otherwise stated, all staff of Somali nationality or origin that work within a health facility (skilled health workers as well as support stuff such as cleaners and guards) as well as health management and administrative staff at the district, regional and Zonal levels. This category excludes, unless otherwise stated, staff of NGOs or other agencies whose predominant function is for project management and/or training, even if they are typically located within Somalia. It further excludes staff typically not located in Somalia. In other words, we consider 'health service delivery staff' as those who are a part of the 'Somali health service' – if external assistance were to be removed, they would logically remain.
- Government systems: We use this term to refer to government systems in general – those of the Government of Somaliland, the Government of Puntland State, the Government of Somalia, and, to the extent they are formalised, the governments of Federal States under the Government of Somalia. We also intend the term to cover the full range of government institutions, including specifically Ministries of Finance, Civil Service Commissions, Ministries of Health, and the full range of decentralised institutions, including, as applicable Regional and District-level institutions.
- Partner: This term is used to refer to all agencies that work with government to either implement or fund activities in the health sector: it thus includes funding partners, notably aid donor governments, international organisations (including UN Agencies), and implementing partners, including NGOs.
- Donor: Also referred to as 'funder': entities such as DFID and the Global Fund that provide funding to the health sector.
- Implementing agency: Entities such as NGOs that are funded by donors or that work with partners to deliver health services.
- Programmes: Refers to mechanisms such as the JHNP and also broader funding mechanisms such as the Global Fund.
- Remuneration: The sum of all funds a worker receives for doing their job, including basic salary, allowances, and 'top-ups'.
- Top-up: An amount of money, funded from a different source to the basic salary, which is intended to increase an existing salary to meet a certain standard.
- Allowance: An amount of money given in addition to a base salary for a specific reason, typically related to extra costs or risks involved in the job (e.g. hardship, housing, transport, etc.). These are normally predictable amounts, based on a set of standards to determine who receives them, and are paid regularly.
- Incentive: We use this term when referring to specific amounts that tend to be given outside the normal salary cycle and which are not guaranteed to be predictable or paid regularly. Examples include one-off payments for participating in a short-term project or extra money for carrying out a specific short-term task. This is normally given by partners.
- 'Double-dipping': We use this term to refer to the practice of one person illegitimately and/or covertly taking double remuneration for the same (or even different) full-time job(s): thus, to take a salary plus allowances and top-ups is not illegitimate, while to take two salaries for different full-time jobs is demonstrably fraudulent, since one person cannot do two such jobs. Moreover, to take two salaries for the same job, usually without the full knowledge of one or both of the parties, or in a situation where both parties believe they are paying the 'basic salary', is typically a breach of contract with at least one of the parties.

## 4. Current situation: salary scales and remuneration

### Government contributions and systems progress has improved across all three zones

Overall we expect that the three zones will in total spend approximately US$ 6 million per annum on health in 2014, according to the budgets of each zone (however, note that the Central South Somalia (CSS) Zone budget was only passed in May 2014). We estimate that, broadly consistently with proportions in the last three years, US$ 5 million, or about 80% of that, will be for the remuneration of over 4,000 staff.

**Table 1 Comparison of Zonal progress on health policy, HR, pay, systems and payment, March 2014 versus January 2013**

| Geographic Zone | Health Budget 2014 | No. of health workers on payroll | Health staff pay | HR systems | Payroll | Payment execution |
|---|---|---|---|---|---|---|
| North West | US$ 1.85m | 2,370 | 20% pay increase; hired 320 additional health staff | Health workforce survey/ census underway, HRIS database and personnel records also being improved with support from THET (HCS) | Cross-sectoral: development of payroll module of SaFMIS (see CSS below) | No change from 2013 – manual paysheets created and funds sent in Somaliland Shillings via Central Bank |
| North East | No change: US$ 1.1m for health | 785 | No change (but increased teachers) | No change | No change | Sahal M-money now used for paying salaries in US dollars |
| CSS | Pending approval for US$ 3m, significant increase over 2013 ($1.8m for all social services, health not disaggregated but estimated to have been around US$ 200k) | 70 | No change (potential to increase materially, depending on budget: we have not seen a disaggregation of the $3m, but based on other zones and number of staff currently working on informal/fee-based basis, we would expect at least $2m to go on pay) | Cross-sectoral clean-up of HR data and preparation for implement-ation of an HRIS | Cross-sectoral development of payroll module of SFMIS | No change for government staff; The Ministry of Education (MoE) pays 1,400 Global Partnership for Education (GPE)-funded teachers via M-Money/EVC/ Dahabshiil |

There has not been significant coordinated progress on attendance monitoring, despite it being one of the 2013 recommendations, so we have not included it in the table above.

### North West Zone has increased staffing and raised payrates in 2014

In comparison to 2013, Somaliland has increased its budget in 2014 to US$ 1.85 million, up from US$ 1.15 million in 2013. Across all civil servants, the salary scale has increased by 20% for all grades[2] (note that allowances for senior grades have not changed). The MoH has also increased its staffing, with 2,370 staff now on its payroll, up from 2,050 in 2013. Of the total new recruits for 2014, the majority are in skilled and technical cadres, including 25 doctors, 120 nurses, 20 lab technicians, 15 public health officers, 60 auxiliary nurses and 15 nutritionists, while just 65 of the 320 are support staff. This is in the context of a wider programme of increased staffing for basic services, with education having hired teachers at a similar rate, maintaining the rough proportion of two education staff per one health staff.

In terms of HR, pay and payment execution, Somaliland continues to use a basic HR database and a spreadsheet paytool. Some payment execution delays continue. This was observed in Hargeisa when Erin was trying to meet with the Admin and Finance Director, but she was unavailable because she was 'behind schedule in paying salaries'.

At the time of the review, a health workforce headcount/census was underway by THET supported through UKAid-funded HCS, which would cover both the public and private sectors; the survey was due to be complete by May and the full report ready by June 2014. This data will be used to populate the HRIS database, of which half had already been completed. We do not have details on how the headcount is being done or on the extent to which the Civil Service Commission is involved.

Somaliland runs a basic database FMIS, termed SaFMIS, which uses the same architecture as the SFMIS used in CSS.

### North East Zone has maintained staffing and payrates at 2013 levels in 2014, and is now successfully using M-Money for payment execution

The budget for 2014 in Puntland did not change from 2013. Out of a total budget of US$ 50 million, the health budget was US$ 1.1 million. Government salary scales did not change for health workers, nor were any additional staff hired (785 staff remain on payroll). The principal change in the budget for 2014 was an increase in the number of teachers hired. Colleagues from Puntland indicated that the cost of the 2013 elections had reduced opportunities to increase resources to health.

A key change is in regard to payment execution, as Sahal M-Money is now successfully used by the MoH for payment execution for both government and partner-funded salaries, making transfers in US dollars. This provides significantly more secure payment execution than payment in cash, and is, by virtue of the more valuable denominations available, less physically arduous to administer.

[2] As reported to us by the Somaliland Health Authority.

### CSS is looking forward to scaling up staffing, and has volunteered to be a pilot implementer for the cross-sectoral HRIS and payroll work that is now getting started

Budget 2014 was being discussed in Parliament in mid-April; it is believed it will include US$ 3 million for health, which would allow significant scale-up. In 2013, CSS had a higher salary scale than the other zones, and there has been no change in this regard: this means that, with Somaliland having increased its wages, there has been some convergence of the zones.

CSS is paying 69 health staff as civil servants, plus some as project staff (government funded but off-budget). This would increase significantly if Budget 2014 were passed at the proposed amounts for health.

In terms of HR and payroll, there is significant activity: there is current cross-sectoral work ongoing to clean up the National Civil Service Commission's HR data holdings, to design and implement a basic synchronising HRIS (not yet fully funded), and to implement a payroll module for SFMIS (funded, with work ongoing on requirements specification). The MoH has expressed that it is eager to serve as pilot implementer. In terms of payment execution, CSS has acknowledged that the current payment execution approach, with the Central Bank of Somalia (CBS) paying out cash to staff, is not sustainable. The recent confirmation of the appointment of the Governor of the CBS gives an opportunity for the Bank to confirm its approach to licensing banks, which it currently regards as on the critical path to moving to more scaleable and robust payment execution methods.

### Cross-sectoral reform activity

A material change in the context from a year ago is the increase in cross-sectoral reform activity, and of the pace of change in other sectors. In particular, the MoEs in the three zones have continued to staff up and pay more teachers, with both government and GPE funds. For example, the education budget in the North East Zone increased by 6% from 2013 to 2014, while in CSS the MoE administers pay for around 1,400 teachers, funded by GPE.

In the last year, there has been considerable progress on cross-sectoral public financial management (PFM) reform, with the implementation of the SFMIS in Mogadishu and implementation of systems in the same family in Somaliland (SoFMIS) and, upcoming, in Puntland, through PFM reform work funded by DFID and implemented under the management of the World Bank. Stage two of this work, including a payroll module for the system, will answer some of the needs identified by the 2013 Compensation Report, and is now ongoing. A priority is to support that development with progress on the HR information systems that provide assurance that the right people are being paid, and on payment execution systems: in CSS, work has progressed on specifying cross-sectoral HRIS processes, and cleaning personnel data.

The Norwegian-funded Special Financing Facility (SFF) provides funding for 3,200 core staff in CSS; 69 are in the health sector. It should be noted, however, that this 3,200 across sectors in CSS should not be confused with the 3,200 health staff funded by governments across the three zones. The SFF is not presently active in Somaliland or Puntland. The SFF funds are released to government (i.e. they are on budget and on Treasury) on a periodic reimbursement basis, based on accountability provided for monthly payroll staff. Although the 69 staff paid are central administrators rather than front-line health service delivery staff,

there is discussion that the next phase of such support, building on this model, could fund staff within health facilities.

There is thus a potential window of opportunity for health to make progress not as a sector alone but as a pathfinder for cross-government systems. This is clearly highly desirable in terms of overall PFM progress and also reduces the risk of health taking a step that later might prove to be incompatible with wider government systems. This may particularly influence choices made in the HRIS area, e.g. between the iHRIS open source health sector HRIS used in some countries and a more general cross-sectoral solution, which we would strongly support, in terms of user-friendliness, integration of the health sector with the rest of government, and the resilience of, for example, system support.

The Zonal health authorities were clear when we met them in Nairobi on the importance of being part of, not isolated from, cross-sectoral reforms. The MoH in Mogadishu has explicitly requested to be the pilot institution for new cross-sectoral HR and payroll systems.

# 4. Review of progress – partners

## Datasets submitted and assumptions made for further analysis

Datasets were received from implementing partners and donors in varying formats. The data was cleaned and aligned so that key fields could be aligned where possible, i.e. location, name, job designation, workplace, number of staff (where cumulative figures were given, rather than data by individual), salary from government, total top-up amount, and total support per month. A final column was created to indicate if the staff position was considered a Somali health service delivery staff, in line with the definition above.

Table 2 below summarises the data sources we analysed.

### Table 2 Summary of data sources available to consultants and included in analysis

| Partner/ implementing agency | Donor | Type of information included |
|---|---|---|
| UNFPA | JHNP | Top-ups for approx. 15 positions related to reproductive health |
| Coordinating Unit/ UNICEF | JHNP | Government health management posts to be funded per zone and region, with a maximum number and type of post eligible for funding. Implementing partners were to be contracted from April 2014, and to pay and manage Somali health service delivery staff in facilities in the areas they supported, but there have been some delays. Estimates for facilities were based on narrative shared. The plans are to fund 28 staff per zone at zonal level, for all three zones, and eight staff per region at regional level, in nine regions (i.e. three regions in each zone), seven staff in health posts and two staff in mobile clinics. The salary scale used is referred to as the 'EPHS scale', which is generally understood to be intended to mean the 'medium scenario' |
| THET – HCS | DFID | Top-up salary figures only (some including extra allowance) by name and job designation. Zone level only (North West Zone) |
| PSI – HCS | DFID | Three staff at central MoH Somaliland are paid by PSI. Only top-up salary figures provided |
| HPA – Global Poverty Action Fund programme in Hargeisa | DFID | Pay for performance 'top-up' for health workers. Noted that additional incentives are given by the World Food Programme, but details not included in the calculation |
| HPA – HCS (Sahil, Berbera Hospital) | DFID | 'Performance-based salary' paid via MoH RHOs; data provided as gross and net amount (after taxes). It is not easy to distinguish government salary from top-up |
| Save the Children – HCS | DFID | MoH salary amounts provided with separate top-up amounts from Save the Children. Useful data which were also used to cross-check reports of government salary scale |

| | | |
|---|---|---|
| Trocaire – HCS | DFID (EC) | Payroll (including grades and steps) for two facilities shared. Additional information shared that they were funding 248 health staff (205 employed by five District Health Boards (DHBs)), at a total cost of US$ 45,000 per month. The dataset provided only 50+ staff in two locations. However, as the pay grade was included in the paysheets, we were able to back-calculate the pay scale being used |
| Global Fund – UNICEF as Principle Recipient for HIV and Malaria. World Vision is Principle Recipient for Tuberculosis | Global Fund | Pay data provided for approx. 2,800 staff. Our analysis is that, of these, approx. 1,800 would qualify as 'health service delivery staff'.[3] The Global Fund's own 'recommended rates' were shared as a separate scale, which they have proposed for use between all principal and sub-recipient staff as maximum amounts that the Global Fund will fund, and that partners can then supplement with additional funds |

Table 3 below sets out the estimated spend on remuneration by each programme/partner, the number of staff supported, and the relationship of the estimate annualised amount spent on remuneration by each partner to the total funds that programme/partner spends.

The table shows that the US$ 13.5 million spent on an annual basis on just under 4,000 Somali health service delivery staff makes up about 20% of total partner spend on the Somali health sector: this suggests that claims that implementing the medium scenario is 'unaffordable' are not logical, particularly not from the perspective of DFID looking across its role as a contributor to all the major Somali health programmes, whether through bilateral or multilateral programming. Specifically, we believe it would be affordable and operationally straightforward for DFID to offer HCS partners contract amendments to enable them to align their pay with the medium scenario where this has not yet been done.

The argument that one partner has made that there is insufficient supply of quality staff available to justify the medium scenario rates also does not seem to match the logic of the approval of the 'medium scenario' by HAB, specifically the desire to raise rates to a level that offered a credible incentive to hire and retain adequate quality staff.

The argument that other partners have made that increases in remuneration would, under fixed budgets, be at the cost of other items need to be supported by a clear account of what other investments in, for example, operational supplies, drugs or infrastructure would be

[3] This analysis was on the basis of information provided by World Vision (the Principal Recipient of the Global Fund Tuberculosis grant); we used the following 'rules' to identify the positions to those that would fit the 'service delivery' description: any staff position based outside of Somalia; staff who were paid more than US$ 1,000 per month and were not government focal points as part of national entities for Malaria, Tuberculosis or HIV, as these job types were mainly described as management, and thus under the sub-recipient's own staff. Community educators and mobilisers were also not counted, as the payments were at an incentive level (e.g. US$ 25 per month), and would not normally be salaried positions. In addition, the data provided lumped monthly and annual unit amounts. We assumed that any unit amounts above US$ 5,000 would be annual amounts and thus these figures were divided by 12 to find the monthly unit amount for that position.

lost. This is necessary if they are not to provoke challenges from the Zonal health authorities regarding the balance of partner spend between direct implementation costs and indirect costs, including costs not incurred in Somalia.

### Table 3 Detail of partner known and expected support to Somali health service delivery staff remuneration

| Partner/Donor | Currently/ expected funding | Estimated cost per year toward Somali health service delivery staff remuneration (US$) | Scale used | Proportion of funds to health salaries compared to estimated annual average total funding to Somali health sector from programme/ partner |
|---|---|---|---|---|
| JHNP EPHS | 172 (total approx. 1,000 expected to fund) | US$ 1.7m (+ additional US$ 3m based on estimates for implementing partner contracts due to be signed), totalling US$ 4.7m | Commitment to medium scenario for expected programming through implementing partners (was intended to begin April 2014). Funding estimates have been based on 80% of supported staff being funded from JHNP funds | 27%<br><br>(based on anticipated US$ 63m total spend over 5 years) |
| Global Fund | 1,848 | US$ 6.2m | Set a 'recommended rate' which is higher for some scenarios than others. Some sub-recipients topping this funding up from own funds to be able to pay staff as per medium scenario | 17%<br><br>(numerator based on current programmes denominator total spend of US$ 37m per year, based on US$ 112m ceiling for the next three years) |
| HCS/DFID | 650 (total 850 including additional Trocaire supported staff) | US$ 2.4m (includes estimated Trocaire contributions) | Most using Lot 3 scale, with some additional increment; Trocaire using medium scenario. All implementers plan to use the medium | 17%<br><br>(based on US$ 57m over five years) |

| | | | | |
|---|---|---|---|---|
| | | | scenario for new programmes, but say they are constrained about what can afford under legacy contracts. This figure includes approx. 120 staff funded under DFID GPAF programme (implemented by HPA) | |
| WHO/GAVI | 142 | US$ 250k | WHO Somaliland figures only. Lot 3 scale used; programme due to end | 22%<br><br>(based on US$ 11m 2014 funding) |
| Total (including estimates) | 3,812 | US$ 13.5m | | 20% (average) |

For the avoidance of doubt, the estimate of US$ 70 million annual partner spend is only for 'conventional donor' partner expenditure; it does not include out-of-pocket expenditure, nor diaspora, nor private sector spend.

## Datasets provided were largely based on paysheets: comparing these across partners shows little consistency in top-ups paid

Only one dataset from partners included any type of pay grade, although most of the data sets were based on actual pay sheets used for payment execution (see Table 4 below). Rather, sheets simply listed pay against individual job titles. This makes it difficult to compare job designations and remuneration as like-for-like, especially among the nursing and director/administration categories. It is desirable that common job classifications and pay grades, such as the alphanumeric ones set out in the 2013 report, should be generally used.

At this time it is not possible to say what type of payment each donor is making, i.e. whether it is for the whole salary, a top-up, incentive or allowance, as the data provided did not always split the amounts in an obvious way to facilitate this analysis.

## Many partners are paying rates close to the medium scenario

A shared assumption was heard among many health partners interviewed that achieving the medium scenario would drastically overstretch existing budgets. However, a closer look at specific partners shows that, for the majority of cadres, the rates used for payment of top-

ups are not far from the medium scenario when both government and top-up payments are considered together – see Table 4 below for an example.[4]

The medium scenario was intended to set a total remuneration level. Our impression, which cannot yet be fully proven with the current level of information provided, is that health workers who receive both a government salary and a top-up will generally receive more than the medium scenario rate. In the case of Save the Children in Puntland, shown in Table 4 below, the gap between the total remuneration received and the medium scenario rates for senior posts is of course *not* inconsistent with the proposal that the medium scenario rates at senior level should be a 'floor', recognising the specificity of skills and competing offers in the market for some of these posts.

**Table 4 Example of salary scale comparisons between government and partner scales (Save the Children through HCS funding, Puntland), US$**

| Job Designation | Govn't salary (Puntland) | SC top-up | Total monthly remuneration | Medium scenario comparison | Difference (total -med) | Medium scenario note on rate used for comparison |
|---|---|---|---|---|---|---|
| RHO Officer | 200 | 800 | 1,000 | 950 | 50 | Chief RHO |
| Hospital Director | 80 | 680 | 760 | 775 | -15 | |
| Doctor | 1,000 | 800 | 1,800[5] | 750 | 1,050 | General Doctor |
| Hospital Administrator | 80 | 460 | 540 | 500 | 40 | |
| DRHO | 167 | 633 | 800 | 500 | 300 | RHO |
| PHC Officer | 167 | 633 | 800 | 500 | 300 | PHC |
| Qualified Midwife | 80 | 320 | 400 | 475 | -75 | |
| Nurse In-Charge | 80 | 320 | 400 | 459 | -59 | Senior Nurse |
| Qualified Nurse | 80 | 320 | 400 | 400 | 0 | |
| Pharmacy Technician | 80 | 200 | 280 | 300 | -20 | |
| Lab Technician | 80 | 240 | 320 | 300 | 20 | |
| Community Midwife | 50 | 200 | 250 | 250 | 0 | |

[4] This analysis was conducted only for Save the Children Puntland because they provided data on the level of government contribution. Other partners did not (although in the case of Trocaire, the reasons may be that there was no government contribution, although we did not assume this for cases where it was unknown).
[5] This is an expatriate doctor, and only one is contracted and paid at this rate.

| | | | | | | |
|---|---|---|---|---|---|---|
| Aux Nurse | 50 | 160 | 210 | 230 | -20 | |
| Female Health Promoter PH | 50 | 60 | 110 | 200 | -90 | Community Health Worker |
| Driver | 120 | 120 | 240 | 100 | 140 | |
| Guard | 50 | 80 | 130 | 80 | 50 | |
| Cleaner | 50 | 80 | 130 | 80 | 50 | |

As set out in the 2013 report, given that the gap between the Lot 3 rates (the current *de facto* floor) and the medium scenario ranged from a few percent for lower cadres (who are most numerous) to a maximum of 100% for higher cadres (with one exception), we do not believe that implementing the medium scenario would cost those partners not yet using it much more than a 25% increase in their remuneration bill. This would therefore be of the order of 5% of their total annual budget, which effectively represents the rough price of harmonisation that partners would need to determine whether they feel represents value to them.

### Case study: Trocaire in Geddo, CSS, moved quickly to apply the medium scenario rates, using increments to give granularity

Trocaire is a member of the DFID-funded HCS and works predominately in Geddo in CSS, funding approximately 250 staffs remuneration in full as there is no formal government MoH presence there at present. It also receives a relatively small amount of funds through the European Commission, as well as having access to funds through its own private institutional funds (two districts are inaccessible due to insecurity[6]).

After the approval of the medium scenario salary rates by the HAB, Trocaire successfully aligned its scales with the medium scenario in September 2013. This process was completed over two months of working through the old and new scales to ensure that DHBs[7] were in agreement. Translation of the medium scenario's salary grades from English to Somali was the first step taken, so that the DHB could review and understand the exercise. Increments were added to the new scale (with typically 3–4% between 'points'), which allowed an entry point for each staff member to transition from the old to the new scale. The starting rates between the old and new scales were not very different; in cases where the medium scenario rates were actually lower, Trocaire was able to use the increments to put the staff on the appropriate rate, which was equal or higher on the new scale. For all cadres, there were no difficulties in applying the new scale. One specific person was mentioned where the job function did not relate exactly to the job role within the new scale, but a small adjustment was made for this.

[6] Trocaire is not allowed to use donor funds to support operations in these two districts, so private funds are used.

[7] DHBs are community organisations supported by Trocaire; they are not official government or NGO bodies. Twelve members are elected by the community, against a set of very basic guidance such as having a balance of male and female members. Health staff are contracted, recruited and managed by the DHBs who handle all HR matters and have been trained on administrative procedures.

In addition, Trocaire works through the DHBs for payment execution via Dahabshiil. Community members and one staff member are present each month for this exercise. As far as is possible, the DHBs work with local authorities, as they are invited to review programmes together and deal with operational issues. In the absence of a formal government counterpart at the time, Trocaire built relationships with local bodies through the DHBs, presenting a transition path toward future government arrangements.[8]

Trocaire is the sole contributor to health worker salaries in the areas in which it works, i.e. the workers are not on a government payroll so there was no chance of overlapping salary provisions with another agency or government. Despite this, lessons can be learned from their example by all partners in terms of engaging the local health governance bodies, adapting the medium scale to include increments, and applying the new scale, all within a short timeframe.

[8] This report does not attempt to recommend what local governance structures will need to be aligned and formalised within the different levels of authorities.

### Table 5 Trocaire's revised salary scale based on the medium scenario

| Position | Ref: medium scenario | Grade [9] | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 10+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aux. Nurse | 230 | Cb | 230 | 237 | 244 | | | | | | | | |
| Cleaner | 80 | Dd | | | | | | 140 | | | | | |
| Cook | 80 | Dd | | | | | | 140 | | | | | |
| Data Clerk | 200 | Cc | | | 212 | | | | | | | | |
| DHB Hospital Administrator | 300 | Bg | | | | 328 | | | | | | | |
| Lab Assistant | 250 | Ca | 250 | | 265 | | | | | | | | |
| Lab technician | 300 | Bf | | | | | | | | | 380 | | |
| Logistician | 300 | Bg | | | 318 | | | | | | | | |
| Matron | 500 | Ba | | | | | | | | 574 | | | |
| Midwife | 300 | Bf | | | | | | | | | 380 | | |
| Pharmacy Technician | 300 | Bf | 300 | | | | | | | | | | |
| Plumber | 100 | Da | | | | | | | 161 | | | | |
| Qualified Nurse | 450 | Bc | | | | | | | | 517 | | | |
| Qualified Nurse | 300 | Bf | 300 | 309 | | | | | | | 380 | | |
| Tutor | 450 | Bc | | | | | | | | | | | 557 |
| Watchman | 80 | Dd | | | | | 134 | 140 | | | | | |

The data above have been back-calculated from information provided based on January 2014 payroll data provided from two facilities. Where salary figures are present, this represents the actual amount paid to staff at that grade and level. There may be some variation across the five total payrolls, but the overall purpose of the table is an example of how the medium scenario grades and increment scales can be applied more broadly.

[9] Grade as assigned and used by Trocaire, based on the medium scenario grade references.

## 5. Review of progress – synthesising data from governments and partners

The compiled data show that the estimated current wagebill for all health service delivery staff is US$ 16.5 million per annum, expected to rise to US$ 18.5 million per annum in 2014. Government funds over 3,000 health posts, expected to rise to 4,000 in 2014, and partners fund (or will fund once JHNP comes on stream) just under 4,000.

### Table 6 Health service delivery staff: estimated total numbers and cost supported

| | Total number of staff receiving salary/top-up | | | Total cost of staff salary/top-up | | | |
|---|---|---|---|---|---|---|---|
| **Zone** | **Govn't (current)** | **Partner (known)** | **Partner (est)[10]** | **Govn't (current)** | **Partner (known)** | **Partner (est)[11]** | **Total cost (USD/yr)** |
| North West | 2,370 | 624 | 300 | 1,850,000 | 1,901,081 | 1,440,000 | 5,191,081 |
| North East | 785 | 330 | 300 | 1,100,000 | 1,231,921 | 1,440,000 | 3,771,921 |
| CSS | 70 | 198 | 400 | 70,000[12] | 1,388,186 | 600,000 | 2,058,186 |
| Undefined | | 1,660 | 0 | | 5,494,483 | | 5,494,483 |
| Total | 3,225 | 2,812 | 1,000 | 3,020,000 | 10,015,672 | 3,480,000 | 16,515,672 |

The 'partner (estimate)' columns above incorporate what JHNP is expected to fund at an assumed rate of US$ 400 per officer per month at the facility level (information was provided that seven staff at the facility and two mobile health staff would be funded). Other Zonal and Regional staff funded by JHNP are included in the 'partner (known)' figures.

There is quite large variation in the top-ups given for positions at the higher end of the salary scale (especially between Doctors and Directors). This may be because there are more

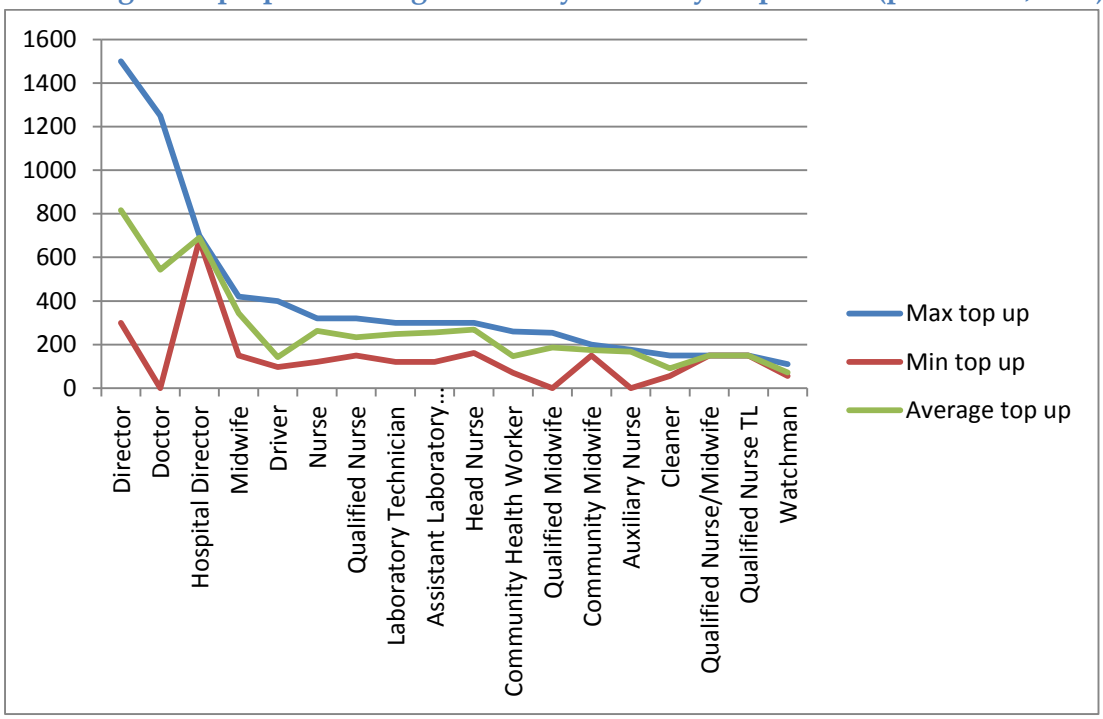
[10] JHNP estimates are not yet known for facility-based staff. Figures have been estimated that an additional 300 staff in the North West and North East zones will be supported by JHNP at an average of US$ 400 per month. An additional 150 staff are included in CSS at the same rate (the balance of staff being from Trocaire, as figures were provided in summary form). JHNP funded staff in zones and regions are accounted for in the known column by the 28 and eight people each in the respective three zones and nine regions.

[11] See above comment. These are the total estimated costs based on the calculations and information provided as above.

[12] Estimate of 1,000 on average per member of staff funded by government. CSS's current health budget is pending, which would increase this figure to US$ 2 million.

cases where the higher-paid staff receive a top-up as a supplement to the government salary compared to those at the lower end. Partners will need to be clearer if they think they are paying a salary or a top-up in addition to a government salary.

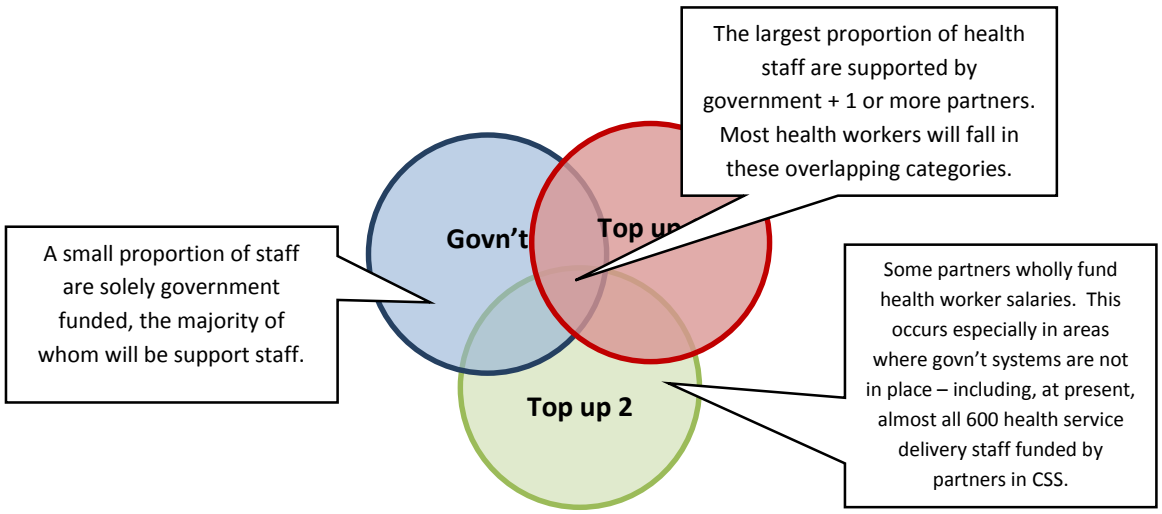
**Figure 1 Range of top-up amounts given to key cadres by all partners (per month, US$)**




**We do not know the extent to which government salaried and partner paid staff overlap: the number of staff funded by each cannot be simply summed together, as some will be funded by a combination of government and partners, as set out in Figure 2 below.**

In some of the cases where partner remuneration is in addition to government salary, we believe that the total will exceed the medium scenario rates.

**Figure 2: Possible combinations of remuneration sources**



The exercise undertaken in this consultancy did not (and was not expected to) produce the exact proportions and amount of overlaps. Overall, where we received data on what government is paying in addition to partners, 25% of the total salary bill was being paid by government. With Save the Children in Puntland, government is paying partial salaries for over 250 staff; this means that, on average, 30% of the total staff pay is government funded (the proportion ranges from 10% to 55% depending on the cadre). In the initial JHNP data shared from Somaliland pay data collection, approximately 140 staff are paid partially by government at the Zonal level. On average, government is paying 20% of its zonal staff salaries there, at rates based on the medium scenario. In some cases, partners are paying the entire salary bill, as in the case of Trocaire in Geddo. Furthermore, partners are paying nearly all the 600 health service delivery staff in CSS.

In terms of fiduciary risk, the biggest risk to funders and partners is thus illegitimate or unintended 'double-dipping'. Improved visibility of remuneration data across government and funding partners is thus key to providing funders assurance on this point. Part of this can be delivered by systems; in some cases, improvement of data quality (such as the health workforce survey in Somaliland) is needed to be able to draw clearer conclusions.

Based on lessons learned in other contests, it may not be possible, or even tactically desirable, to establish the level of double-dipping at the outset; as further described in the recommendations section, it is often a better strategy to capture all relevant information in full – and enable systems to 'self-correct' – before it can be 'judged' (i.e. assessments on whether or not the payments are correctly calculated, disbursed, etc.). The consequences for applying judgements before or during this type of data collection can result in people trying to provide the 'right answer' instead of the truth.

# 6. Implications of the current state of remuneration and HR systems

Key features and implications of the operational system we have described are: elements of fiduciary risk, particularly in regard to uncertain 'double-dipping'; lack of sustainability of top-ups/incentives paid without visibility to government; disharmony and potential resentment caused by the use of different salary scales; lack of coordination, exit strategy, and consideration of government ownership; and the risk of a drop-off in support, with a number of programmes due to end in the period 2014–2016 without clear successors and thus an increasing risk of a 'gap'. The current situation regarding staff remuneration was acknowledged by nearly all partners to be unsustainable, and in some ways irresponsible.

## The opposite of harmonised salary scales in a non-market sector can be churn of staff and dissatisfaction within what is meant to be a system

Using different salary scales and providing top-ups and allowances at different rates, within the same physical area or for the same implementing partner or intervention in different areas, has the potential to create churn, conflict and tensions. This goes against the principles of 'do no harm' as it does not protect against potential negative consequences around unharmonised salary payments that differ from one another, and potentially undermines the systematic operation most development partners seek to support.

## Use of community and government systems is a logical part of most exit strategies

Some implementing partners have already begun to set themselves up for a more sustainable environment, working with government and communities in order to build local capacity and legitimacy around health services. Clear examples of this are found among the agencies that pay staff through government or community systems, through DHBs as in the case of Trocaire, through the RHO as does Health Poverty Action, or the MoH as do partners such as THET, Merlin (now Save the Children) and GAVI. These agencies have created the building blocks for an exit strategy, strengthening government systems and building confidence by putting money through them. This strategy not only strengthens the capacity of local and government administrative functions but also increases the perception that the service, responsibility and function is led by government – at a given level – rather than by external agencies.

## Coordinating with cross-sectoral initiatives to work with cross-government systems and market developments

Other sectors are making progress on improving HR and payroll processes and working through government systems, as described above. Progress in other sectors can set precedents that the health sector can follow. It can also entail the health sector needing to contribute to a multi-sectoral initiative – e.g. administrative, or further to recent evolutions in Somaliland, in terms of pay and grading – move at its speed, and be bound in to its consequences.

Other sectors can also change the market in which health sector remuneration operates – for example, the GPE's support to 1,400 teachers' wages in CSS not only has set a standard for accountability, as provided by the MoE, but has changed the market, by establishing the primary teacher's wage as an effective floor for literate/skilled staff (in this case, particularly clearly, since the MoE has struggled to recruit a full cohort).

In all three zones, a basic requirement is thus that the MoH *and its partners* should interact regularly at policy as well as working level with respective Ministries of Finance and *Civil* Service Commissions.

## Most current programmes supporting health staff remuneration will be closed in or before 2016

In a fragile context, the exit of external partners needs to be predictable and not rushed. At present, DFID/HCS is due to end in 2015, GAVI in 2014, the Global Fund in 2017, and JHNP in 2016. Considering the length of time for funding cycles to be approved, and the already apparent delay in some programmes such as JHNP (implementation was due to start 1 April 2014 for some implementing partners), the consequences for the health sector could be quite damaging. There has been some suggestions of SFF or its successors (SFF2/MPTF) taking on core funding of health staff salaries: we are not up to date with the progress of these discussions, nor about the possibility of this support reaching Somaliland and Puntland, nor about the likely contributors to such a 'basket fund' and, specifically, to what extent DFID might or might not choose to route its funds through such a vehicle.

## 7. Examples from Sierra Leone and South Sudan

Prior to presenting recommendations for the Somali health sector, we describe two examples from countries with a history of conflict and damage to systems that are working to overcome similar challenges in the health sector, where partners and donors were involved in managing and paying health staff and where weak HR and pay systems needed to be strengthened.

### Sierra Leone: since 2010, the Global Fund and DFID have provided tapering support to health workers' salaries through reimbursement in arrears, as well as technical assistance to support HR, payroll and attendance systems nationally

Key similarities to Somalia include the efforts by government and willingness on the part of donors to support higher salaries for health workers. The key difference is that all eligible health workers were contracted – either originally, or through a rapid recruitment process – as civil servants and paid by government though a centralised payroll system. Moonlighting (with NGOs or private practice) was occurring in some cases, but generally those who were not happy with public service salaries had left for private practice long ago (although not necessarily all giving up their public service salaries when doing so). Sierra Leone did not have the potential overlap of payments from different sources as is the case in Somalia. The key risk for partners supporting the Government of Sierra Leone (GoSL) was the quality of payroll information being collected and ensuring that those who had retired, were deceased, or not showing up to work were consequently not paid. Payroll records were not being updated and expensive measures were being taken to collect data on an ad hoc basis. Lessons to be learned from Sierra Leone are from the systems put in place to regularly monitor the payroll and implement an attendance monitoring system, as well as the strong partnership between government and partners in joint decision making around funding support to salaries.

Sierra Leone launched a free health care initiative for target groups in 2010, creating an impetus to raise salaries on the basis that health workers would then stop charging user fees at the point of service. Steps were taken to improve health worker salaries, with key cadres receiving pay increases of as much as 500%, and "clean the payroll," subsequently implementing steps to ensure that payroll reforms were sustainable: namely through an extended programme of attendance monitoring, including sanctions for those who did not show up for work for a given time period. Payroll process improvements ensured people were paid according to their correct grade and scale, and an oversight committee (referred to as the Health Payroll Steering Committee) comprised of key government ministries and development partners met regularly to monitor the integrity of the payroll system, starting out every two months and moving to a quarterly basis. A set of indicators and benchmarks were established early on and then tracked on a monthly basis. The indicators included such things as: level of absenteeism of health workers, percentage of salaries paid that match their pay grade, the known workplace and job function of each health worker on the payroll, etc.

On the basis of the number of key targets met, donors have disbursed funds to the GoSL on the basis of reimbursement in arrears. A tripartite Memorandum of Understanding was signed between DFID, the Global Fund and GoSL that set out a payment schedule and the overall targets that needed to be met prior to the release of funds. DFID and the Global Fund both committed five years of budget support for salaries to the GoSL; with both donors, the budget support was tapered, so that the GoSL would take a larger share of the funding

burden, which would reach 100% by 2015. Effectively, the donors purchased a sustained increase in remuneration at the price of temporary support for its costs.

Key lessons for Somalia are that donors like DFID and the Global Fund do have a precedent for working with government systems and channelling funds through them, even in FCAS contexts. Although this depends on the 'risk appetite' determined in each country, it is possible to work in ways that strengthen and increase ownership on the part of the government. As in Sierra Leone, there should be a formal mechanism and agreement in Somalia with the authorities that states the path forward, with specific milestones and priorities set, and an exit plan for government to steadily take more responsibility over time, both in terms of administration and, specifically, in terms of a trajectory for sharing the financial burden.

### South Sudan: implementing partners within the Health Pooled Fund, covering six of 10 states, commit to using a common, government-mandated payroll tool and to use a harmonised NGO salary scale, ahead of government pay rates also aligning

The starting point in South Sudan within the health sector is similar to Somalia in that a number of partners are involved in providing sustained support to front-line health service delivery, and have done so for many years (in some cases, more than 20). NGOs hire and contract staff locally, some of whom, at facility level, function as if on the government payroll; incentives and salaries have been paid out haphazardly and through a non-harmonised scale.

The MoH, as part of a 'service delivery framework' to regularise the policy environment for service delivery (parallel to other service delivery frameworks in education and WASH), set up 21 operational benchmarks to monitor improvements in practical PFM, with a read-across to systems used by implementing partners. These benchmarks include categories around budget planning, execution, timeliness, use of payroll and attendance systems, reporting and accountability, audit controls, etc. They are intended to provide a focused path around priority administrative areas, with targets and milestones to be achieved collectively among all implementing partners, with government in the position to lead. They are monitored at six-monthly intervals.

One specific action was the mandating by government, in Summer 2013, of a 'harmonised salary scale' for NGO staff. This was successfully rolled out across NGO partners throughout the 10 States, in tandem with the mandating by government of a common payroll tool, with reporting via email so that data on NGO and government pay can be analysed in a common form. NGO reporting was monitored monthly by the three main fund/programme managers.

The key lesson from this exercise has been the importance of coordination between the payroll systems, the HRIS, and HR policy (specifically, the salary scale harmonisation process), in order for all three to be effectively implemented. The benchmarking process was useful to ensure that achievements and progress could be monitored. Somalia can learn from this, especially as there are opportunities to make improvements on multiple fronts, as was the intention of the medium scenario.

# 8. Overall recommendations and observations based on consultations and data analysis on staff remuneration

These general recommendations are based on the following key observations and principles for Somalia:

## Build trajectory toward working through government systems by implementing the medium scenario and paying through government where possible

Consistent with the New Deal for Somalia, there should be a trajectory toward working through government systems. Specifically, this means the following: 1) implementing the medium scenario recommendation that was endorsed, with donors providing flexibility where possible to allow partners to realign budgets in order to do so; 2) greater clarity about the remuneration paid by partners (see third recommendation below), so that partners can be confident staff have been remunerated at the intended medium scenario rates; and 3) that implementing partners should wherever possible work through government to pay Somali health service delivery staff. There were already in 2013 good experiences of partners in the health sector of entrusting government, at zonal and regional level, with responsibility for payroll processing and payment execution on which to build upon, and now these have been replicated in the education sector. This means that partners can work with the zonal and regional levels, enabling them to have their funds 'on-government' and possibly 'on-budget', and help generate progress, for example via reimbursement approaches like that taken by the SFF, toward full 'on-Treasury'.

Clearly, there will be a range in how quickly this transition can proceed: there is already substantial precedent in Somaliland and Puntland, and we think that most partners there could transition to working through government systems – specifically, with the MoH and RHOs and at minimum for payment execution – during 2015. This will be undertaken with a view to moving progressively toward going on-budget and eventually on-Treasury in subsequent years.

There is a wider variation of government penetration across CSS: a key first step is the current resourcing of much of the wagebill of the MoH in Mogadishu by the SFF, and the planned funding of the RHO teams in the three JHNP Regions. It will be vital for equity/do no harm that RHO teams across all the CSS Regions are funded and stood up as quickly as possible.

## Improve coordination among partners and with government by identifying a key focal point who can 'champion' the HR and payroll reform agenda

Progress around HR reforms has been discussed often in coordination forums in the last year, but actions have not always been taken or followed up.

We recommend that a key focal point person or agency from the donor/partner side should maintain monitoring and overall visibility of HR and payroll issues. The health systems analysis teams (HSATs) working under the JHNP have been proposed as candidates in this regard by some partners. We think it will be important, if that is the route chosen, for HSATs to have a single high-level professional on them who can coordinate in this area over a sustained period.

This role might equally sit well with an agency that had a technical interest but was not a significant funder or recipient of funding of Somali health service delivery staff remuneration– and this would reduce the risk of conflict of interest that some of the major programmes might face.

A point person(s) within each health authority should also be identified to coordinate and work specifically on the HR and payroll issues at an operational level. This person may need to be guided by a Director or equivalent but, ideally, there would be someone appointed to, for example, collect and compile HR and pay data from partners on a monthly basis, and who eventually could be trained to manage data.

### Implement standard tools for HR and pay that can be used by all partners and government, so that data are then compiled centrally and shared among relevant partners

It is demonstrably inefficient to have many partners using many tools to do the same task. However, this is what is happening for the processing of pay of Somali health service delivery staff, even though they are being paid in increasingly standard ways and at increasingly standard rates. This consultancy exercise in itself revealed the difficulty in the task when there are variations in the same process. None of the information provided to us corresponded exactly to what it was set out to provide when the terms of reference and call for data were first sent out by the donor HRH working group. Sharing data regarding what partners are paying, at what levels, and what the corresponding government payment is for those same staff should not be – and is not in itself – a difficult task. However, it requires a standard template and guidelines to report it on a timely basis.

The data from this exercise can provide a starting point for future data collection and reporting. However, specific technical expertise will be required to provide support on HRIS and payroll processes that will be ready to work with other sets of data as they become available. There are many systems strengthening/functional tasks to be done in the Somali health sector (e.g. Health Management Information System (HMIS), pharmaceuticals supply chain, HR/payroll, etc.), in each of which strong cross-zonal alignment is desirable and positively sought by the zonal health authorities.

It is highly desirable that HRIS+Payroll Processing+Payment Execution is kept together as an end-to-end package of tasks (rather than, for example, brigading HRIS with training and human resource production). This is to ensure an efficient flow through of data in the monthly process and, in particular, efficient processing of changes. Partners sometimes assume that HR and payroll work is entirely covered by, in the case of Somaliland, THET (who have worked on HR records management, policy and other HR strengthening initiatives), but this leaves out the essential connection with payroll processing and payment execution, which is not covered by their mandate.

Key steps toward improving the payroll processing and HRIS information in the immediate future would be to:

- Issue standard basic tools (initially, a standardised Excel spreadsheet would suffice), to have information shared monthly, to give monthly visibility at the level of individual names of who is getting paid what and by whom: this will significantly

reduce the risk of 'double-dipping'. The JHNP Payment Operations Tool[13] is a step along this road, but the same tool needs to be used by all partners and ideally by governments too.

- Transition toward a permissioned synchronising database solution including all health staff, whether government, partner, or jointly funded, and a solution that is compatible with the cross-sectoral direction of travel of government.
- References should be standardised – e.g. a standard set of job descriptions and pay grade references should be produced, making clear whether a position is in the EPHS scope.

## Specific partners have voiced difficulty to align to the medium scenario rates and systems. A few specific recommendations have been made for Global Fund, HCS partners, JHNP

The key point here is that the recommendation to align to the medium scenario is not for each partner to reach alone but is rather a collective measure taken by both government and funding partners. As mentioned in previous sections, the difference between current remuneration and medium scenario levels for many of the job roles on the medium scenario scale are not out of reach when government and other funding sources are considered in total. Furthermore, an addition of increments should smooth over those positions where partners have been paying at a higher rate than the medium scenario.

The key challenge for the Global Fund is that, within its three programmes, there are nearly 50 partners to manage. As mentioned previously, the first step is to identify those agencies that are paying Somali health delivery staff, and in the same way as other partners are recommended to use the single payroll tool these partners would also do so for health delivery staff. The funding scale which the Global Fund has recommended as capped rates for its partners can be developed for use within the tool itself, so as to further streamline scales and also encourage its use within the Global Fund's partners. Concerns around different pay systems being used by different partners should not be major issues if the Somali health service delivery staff are identified as a discrete category, and if there is an agreement to populate the single payroll tool with the relevant information. Thus, the proposed payroll tool would be used as a tool to share information, make automated calculations, and ideally manage payment execution, based on a standard scale. The payroll tool provides a platform from which the government can easily consolidate standard fields from all partners. We do not find credible the suggestion that partners will find it impossible to use such a tool at local level: such a tool is clearly not incompatible with the global accounting systems typically used by NGOs, any more than any other local receipt would be, and it is unlikely to be incompatible with any global HR systems. Furthermore, some of the sub-recipients may already be working closely with and through government, and the

[13] This tool developed for the JHNP was a simple Excel-based table that requested each zonal health authority suggest posts that would be funded by JHNP. The guidelines provided by JHNP were that 28 staff from the zone and eight staff from the region would be eligible, based on EPHS positions. For each position, the government was requested to state what compensation was agreed for each post, as well as what was already being provided from government and other donors. We found that most zonal health authorities had trouble filling in this information, as well as in choosing which health posts were to be funded (as in most cases some existing posts were not found within the EPHS approved positions and quantities).

strength of working through a partnership like the Global Fund is that lessons can be shared and applied across partners.

JHNP and other UN partners, including GAVI, have established a payment system that sends salary funding to government on a quarterly basis for Zonal and Regional staff. The UN partners then require basic accounting and programme reports prior to the next tranche of funds being approved. JHNP has already committed to use the medium scale rates; a single payroll tool will support them to apply and coordinate with government on payment execution and management of pay data and reporting. Ideally, JHNP would in due course build outwards, so that payroll processing and payment execution for Somali health service delivery staff at facility level transition across to the same government-implemented method.

HCS partners each have different means of working with government, at Zonal and Regional level, based on the different authorities and contexts, but similarly a single payroll tool – which the HCS Consortium team report they are already developing for their member NGOs, and which we would encourage be generalised more widely – will enable the consortium to standardise the reporting and sharing of pay information with DFID as their donor, as well as with government. Partners like THET and HPA do not always distinguish clearly between the payments provided by government and those provided by themselves. If the government payment amounts for these positions are zero, it should be stated as such so that the gap is clear between the current pay and the medium scenario rates. As described above, we believe there is a particular opportunity, by virtue of the bilateral and streamlined nature of the HCS arrangement, for DFID to allow budget flexibility to HCS partners, within existing funding totals, in order to implement the medium scenario where they have not already done so.

## 9. Roadmap/transition workplan

The MoHs have expressed their intention to us both separately and together in Nairobi to proceed in a highly harmonised fashion that respects the respective autonomy of their authorities.

On that basis, we propose a roadmap of practical actions, which is accompanied by a corresponding working draft document in Annex 2. The final workplan will require agreement between relevant health partners and government. Specific activities have been shared as a potential way forward, which should and are likely to be refined by the appointed lead (a step recommended to be set as a first action). The following practical activities should be prioritised, and can be what is monitored at the outset going forward on in-depth systems reforms. We would expect that most of the following tasks could be completed within six to eight weeks:

- We recommend that a technical and policy focal point person from the donor/partner side should maintain monitoring and overall visibility of HR and payroll issues, at least for the period of the workplan set out. There should be a single high-level professional who can personally coordinate this subject area over the next two to three months, while the priority actions are carried out, and ideally over a sustained period. They should be able to act as a trusted broker between all parties and, given DFID's role as funder of all the main bilateral and multilateral mechanisms in the Somali health sector, must specifically enjoy their confidence. HSAT, which had been suggested as a location for this role by some partners, is regarded by others as less suitable, on the grounds that the role needs independence from UNICEF, which itself concluded that it could not resource the role. We therefore suggest that this role should either be a stand-alone 'programme-funded' consultancy or might sit with the HCS Secretariat.

1. Government should also identify one or two person(s) per health authority as a lead and operational focal point, who would also lead on coordination with respective ministries of finance and CSCs. These people would typically be at director or deputy director level in either the planning and budgeting or admin and finance function.
2. A formal agreement should be made to guide how government and partners will work together. A trajectory should be set for partners to take on less of the funding and management burden of the current scale of human resources while government takes on more over time. We suggest, in view of the scale of spend on remuneration of government and partners respectively, and the current cycle of programmes, that a five-year trajectory would be reasonable. Such a timeframe would give governments the confidence to plan into the middle of the next cycle of donor funded-programmes (assuming further three–five-year programmes as the norm), as well as some buffer time toward the end of those putative programmes. In relation to this, a practical step would be that donors be clearer about what they are contributing to zones in terms of remuneration, and when. It was difficult to gather this information within this consultancy, but it should be readily available if a realistic trajectory is set for government to take the funding burden on over time.
3. Increments should be included in the medium scenario rates (the example of Trocaire is worth using as a starting point). Cross-sectoral activities should also be consulted

in any systems or salary scale developments. Consultancy input may be required for this activity, or it could be conducted by the identified focal point.

4. Develop and issue a standard template for payroll processing and standard deadlines for monthly submission. Initially, an Excel template and submission to a central email address for each zone would be sufficient. Ideally, a central payroll aggregator should be developed that can be owned by government but used by all payers to create standard paylists. These processes should be developed in order to be compatible with HRIS and future IFMIS/pay systems likely to be used cross-sectorally. Technical assistance may be needed for the aggregation and for taking this process beyond a basic Excel template.
5. Communications to Somali health service delivery staff should be coordinated and delivered in a way that clearly explains the new scale and how certain posts fall into it based on job function, norms and previous pay. The intention in this regard is to avoid misunderstandings and build common doctrine.
6. Once the majority of pay information is compiled for each zone, governments together with partners will have the opportunity to agree on a timeline to begin aligning payments with the agreed medium scale, and preferably paying through government systems. This will likely require a more detailed timeline aligned with steps in the broader reforms set out below.

With these priority activities underway, government and partners should agree specific actions and timescales (see Annex 2) to complete activities in the five systems reforms areas mentioned in the 2013 Review (i.e. HR Policy, HR/Personnel Records and HRIS, Payroll processing, Payment Execution (building on Puntland's success in this area in moving toward mobile money), and Attendance Monitoring). For ease of reference they are listed here with some updates:

1. HR Policy: Clear basic HR policies should be set out, to cover norms of behaviour and practice, and to set out expectations in regard to attendance and output. If cross-sectoral HR policies are being put in place, health should fit with these, but is likely to need some sector-specific policies.
2. HR/Personnel records: basic documents should be collated – or generated, if they do not yet exist – for each staff member, at a minimum including: i) birth certificate/assessment of age; ii) letter of appointment; iii) letter of last promotion; iv) qualifications; v) any medical certificates; and vi) end of service documentation, when that time comes. It would be desirable for staff to be issued individual contracts setting out their posting, remuneration, and terms of employment. Somaliland has made good progress in this area (also in terms of populating the HRMIS) and THET have sought to codify this in a format that can be transferred to other areas.
3. Payroll processing: calculation of payroll (including salaries, allowances, and deductions) should be automated; payrolls should clearly set out the name, job title, workstation and grade. The immediate use of the single payroll tool as listed in the above priorities will be an essential step toward this.
4. Payment execution: given the extensive use of Mobile-Money across the three zones, the continuation of cash payment execution in Somaliland and CSS is an anachronism that adds only risk and cost, reducing transparency of payments. It is clear that payment by bank or mobile money transfer should be the norm. This has been successfully implemented by the Puntland MoH and by a number of partners in all zones.

5. Attendance monitoring: A basic attendance monitoring system, whether paper or SMS based, should be put in place, and its results fed back to ensure the list of employees held in HR/personnel and payroll records remains accurate and that non-attendance is followed up.

In terms of the trajectory toward a medium-term 'stable state', we suggest that the following summary table may be relevant:

**Table 7: Summary table of trajectory of functional areas from January 2013 through April/May 2014 toward a medium-term stable state**

| Functional area | Jan 2013 | Apr-May 2014 | Medium term (2015 unless stated) |
|---|---|---|---|
| Pay scales | Wide variation in partner and government practice. | *Government:* Puntland (PL) remains low. Somaliland (SL) has converged part way toward medium scale. CSS was already close. Partners: converging toward medium scenario | Government: Current EC/World Bank assignment on pay and grading being performed by Charlie Goldsmith Associates offers a forum for pay and grading reform, where the medium scenario's pay and grading proposals offer a clear template for other sectors to follow |
| HR Policy | SL: MoH HR policies and contract documents developed with support from THET. PL and CSS looking to transpose across. | More active CSCs working with UNDP on cross-sectoral HR policy options | All government and partner staff should have basic contracts. For government staff, these should be according to a cross-sectoral standard for general HR issues, with MoH HR teams progressively focusing on HRH production, certification and QA |
| HR Information Systems | SL: basic MoH access database. PL and CSS – ad hoc Excel. Partners: various. | Partners: various | Government: standardised cross-government tools (standard within a government, harmonised across zones). Partners: harmonised HR/payroll tool |
| Payroll preparation | Government and | Moving toward | Government: |

| | | | |
|---|---|---|---|
| | partners: mostly ad hoc Excel tools. | cross-sectoral standards | standardised cross-government tools (standard within a government, harmonised across zones) at ministry, department, agency and regional level, feeding into cross-government SFMIS/SoFMIS/PMIS<br>Partners: paying through government where possible, or using harmonised HR/payroll tool where not |
| Payment execution | SL and PL: cash (Somali shillings)<br>CSS: cash (US dollars<br>Partners: various | SL: cash (Somali shillings)<br>PL: m-money<br>CSS cash (US dollars)<br>Partners: mostly m-money | M-Money for all |
| Who pays how much | Not analysed | Government: US$ 3–4m<br>Partners: US$ 13.5m, some executed through government systems | By 2016, substantially all Somali health service delivery staff to be paid (payment execution) through government systems. By 2018, government to be funding in the order of US$ 10m |

## Annex 1: List of interviews and discussions

| Affiliation and name | | Position/role | Organisation | Date/venue |
|---|---|---|---|---|
| Zonal health authorities | Dr Osman Warsame | Director General | Somaliland | 8 April/Nairobi |
| | Faiza Ibrahim | Director of Planning | Somaliland | 3 April/Hargeisa |
| | Abdulahi | Director, HMIS | Somaliland | 3 April/Hargeisa |
| | Abdirisaak | Director of Planning | Puntland | 8 April/Nairobi |
| | Dr Farah | AG Director General | Federal | 8 April/Nairobi |
| | Abdihamid | Director of Planning | Federal | 8 April/Nairobi |
| | Mohamed Abdi | Director of Public Health | Federal | 8 April/Nairobi |
| HCS | Katie Bigmore, Irene Kagure, Karen Stephenson, Mercy Oduor | HCS Funder | DFID | 1, 8 April/Nairobi |
| | Saba Khan | HCS Technical Adviser | HCS | 9 April/Nairobi |
| | Donato Gulino | Country Representative | PSI | 2 April/Hargeisa |
| | Rohit Odari and Yasmin | Country Representative, Programme Manager | HPA | 2 April/Hargeisa |
| | Emilien Nkusi | HSS Adviser | THET | 3 April/Hargeisa |
| | Ombretta Mazzaroni | Health Programme Manager | Trocaire | 8 April/Nairobi |
| Global Fund Principal Recipients | Dr Vianney Rusagara | GF Tuberculosis Principal Recipient | World Vision | 7 April/Nairobi |
| | Dr Wessam el Beih | GF HIV/Malaria Principal Recipient | UNICEF | 8 April/Nairobi |
| JHNP | Dr Raza Zaidi, Esther Waters-Crane | Programme coordination | JHNP | Met Raza/ Email |
| | Achu Lordfred | Maternal Health Adviser | UNFPA | Email |
| GAVI | Asia Abdi | Health team | WHO Somaliland | 3 April/Hargeisa |
| Other | Marina Madeo | Health Adviser and former Somali Health Sector Coordinator | Swiss Agency for Development and Cooperation | 7 April/Nairobi |

Additionally, at the HRH Donor Working Group at which the consultants gave an initial debriefing of a 'direction of travel' for the consultancy, Amy Clancy and Carin-Marie La Cock from the Global Fund were present and provided comments.

## Annex 2: Proposed draft workplan

| Goal | Activity | Anticipated duration (not only time on task, but inclusive of coordination) | Requirements/ dependencies | Deadline |
|---|---|---|---|---|
| **Immediate tasks (do not need to be consecutive; could be completed within 6–8 weeks)** | | | | |
| Improved coordination and action on priority reforms | Identify a partner or person from the donor side to take the lead on HR and payroll reforms. Government also should identify one or two person(s) per health authority as a lead and operational focal point | Two weeks | | TBD |
| | Initial formal agreement between government and partners on detailed workplans and milestones to be met | Three weeks | | TBD |
| | Include increments within medium scenario rates. Review discrepancies and finalise grading scale | Three weeks | May require technical assistance | TBD |
| | Issue a standard template for payroll processing and standardise deadlines for monthly submission to central focal point | Two weeks | May require technical assistance | TBD |
| | Communicate HR and pay reforms to health staff regarding basic HR policies, data collection, changes to salary scales, and upcoming reforms | Two weeks | Revised grading scale | TBD |
| | Agree on a timeline (may require a detailed workplan) between donors and government on aligning to the medium scale, and paying through government as far as possible | Two weeks | Revised grading scale | TBD |
| **Ongoing activities (to begin if not already started, in line with tasks above)** | | | | |
| Clear HR policy | Clear basic HR policies should be set out, to cover norms of behaviour and practice and to set out expectations of attendance and output | Four weeks | May require technical assistance | TBD |

| | | | | |
|---|---|---|---|---|
| Updated HR/personnel records | Collate – or generate, if they do not yet exist – for each staff member, at minimum including: i) birth certificate/assessment of age; ii) letter of appointment; iii) letter of last promotion; iv) qualifications; and v) end of service documentation, when that time comes | Three weeks (to set up systems) | May require technical assistance for part of implementation and system set-up | TBD |
| | Issue individual contracts setting out their posting, remuneration, and terms of employment. Somaliland has made good progress in this area, also populating data into HRMIS, which can be replicated in other areas | Two months | May require technical assistance | |
| | Establish an HRMIS system within and between zones, populated with data from above processes | Two months | May require technical assistance | |
| Improved payroll processing | Implement a standard tool to automatically calculate payroll (including salaries, allowances, and deductions) and paysheets that instruct and record payment. Populate payroll information that sets out name, job title, workstation and grade | Three weeks | May require technical assistance | TBD |
| | Collate monthly payroll information from all implementing partners and government, within and between all zones, which is shared between government and relevant partners | Three weeks (incl. with above) | May require technical assistance | |
| Improved payment execution | Set out feasibility for m-money systems to be used as default mechanism for payment of salaries against other options. Ensure the payroll tools are compatible with m-money system requirements to feed in payment sheets | Four weeks | May require technical assistance | TBD |
| Improve attendance monitoring | Establish a basic attendance monitoring system, whether paper or SMS based. Its results should be fed back to ensure the list of employees held in HR/personnel and payroll records remains accurate, and that non-attendance is followed up | Two months | May require technical assistance | TBD |