IBP Guide

Improving Program-Based Budgeting in Kenya

Jason Lakin and Vivian Magero

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1 Background

The National Treasury of Kenya presented its annual budget in a program-based format for the third time in April 2015. This is in line with international best practice and the requirements of Kenya's own Public Finance Management Act 2012, which also initially required all of Kenya's counties to shift to program-based budgets (PBB) in the 2014/15 financial year (FY 2014/15).

Unfortunately, few government officials know much about how to prepare a PBB, and few citizens know how to read a PBB. Lack of information about how to prepare and use the new budget format could lead to reduced transparency and undermine confidence in budget information. Indeed, Kenya's first national PBB in 2013/14 actually limited public and parliamentary access to key budget information substantially, due to poor design. Thankfully, the 2014/15 Budget rectified a number of the flaws in the government's initial attempt to shift to PBB and there were some additional modest improvements in 2015/16. However, there is still more work to be done to make the new format deliver on its promise of more and better public finance information. There is also a need for a broader understanding of what PBB is meant to achieve if we are to get useful versions of program budgets at the county level.

In light of this, we decided that it was important to prepare a guide that would inform both those who prepare the PBBs and those who use them. It is intended to speak to executives at national and county level, as well as oversight bodies, such as legislatures, auditors, civil society organizations, and the Controller of Budget.

This guide begins by explaining the difference between program-based budgeting and line-item budgeting. We then look at how Kenya's 2015/16 PBB compares to the 2014/15 and 2013/14

PBBs. We proceed to look at budgeting in South Africa and Uganda. To make the discussion concrete, we use examples from the presentation of the health budget across our various years and cases. The guide provides information to allow both deeper interrogation of the PBB, and to encourage continued improvement in Kenya's budget presentation at both national and county levels. It is highly relevant as we review the 2015/16 budget estimates, which have been tabled at the National Assembly, and as we prepare to kick off the 2016/17 budget process sometime in August this year.

2 What is a Program-Based Budget and Why Use It?

2.1 Line-Item Budgeting

Traditional line-item budgets (including Kenya's budget until 2013/14) focus on providing details on what the government spends money on. This can lead to voluminous data on specific inputs. For example, a line-item budget will provide information on spending on stationery, fuel, hospitality, training, travel, and so on. Figure 1 and Figure 2 are examples of how information is organized in a line-item budget, taken from Kenya's 2012/13 health budget.

Figure 1: 2012/13 Health Budget for Subhead Physiotherapy Services

VOTE R111 Ministry of Medical Services....Cont'd

II. RECURRENT EXPENDITURE SUMMARY 2012/13 AND PROJECTED EXPENDITURE ESTIMATES FOR 2013/14 - 2014/15

II. Heads and Items under which this Vote will be accounted for by the Ministry of Medical Services

Head Code	Unit	Item	Title	Estimates 2012/13	Projected Estimates 2013/14	Projected Estimates 2014/15
				KShs.	KShs.	KShs.
0004			**0004 Physiotherapy Services**			
	01		**Headquarters**			
		2210300	Domestic Travel and Subsistence, and Other Transportation Costs	700,000	1,500,000	2,000,000
		2210700	Training Expenses	200,000	300,000	500,000
		2210800	Hospitality Supplies and Services	140,000	300,000	400,000
		2211100	Office and General Supplies and Services	700,000	1,050,000	1,400,000
		2211200	Fuel Oil and Lubricants	80,000	150,000	200,000
		2220200	Routine Maintenance - Other Assets	100,000	150,000	200,000
		3111000	Purchase of Office Furniture and General Equipment	240,000	450,000	500,000
			NET EXPENDITURE FOR HEAD 0004	**2,160,000**	**3,900,000**	**5,200,000**

Source: Ministry of health budget for the year 2012/13

Figure 2: Kenyan Health Budget for Subhead National Aids Control Program 2012/13

0008			0008 National Aids Control Programme			
	01		Headquarters			
		2110100	Basic Salaries - Permanent Employees	14,581,463	14,873,093	15,170,555
		2110300	Personal Allowance - Paid as Part of Salary	14,018,568	14,018,568	14,018,568
		2110400	Personal Allowances Paid as Reimbursements	250,000	250,000	250,000
		2210200	Communication, Supplies and Services	60,149	75,250	75,250
		2210300	Domestic Travel and Subsistence, and Other Transportation Costs	233,589	416,092	416,092
		2210500	Printing , Advertising and Information Supplies and Services	353,372	354,557	354,557
		2210800	Hospitality Supplies and Services	34,384	66,900	66,900
		2211000	Specialised Materials and Supplies	46,432	46,836	46,836
		2211100	Office and General Supplies and Services	97,326	122,657	122,657
		2220200	Routine Maintenance - Other Assets	47,183	48,200	48,200
		3111000	Purchase of Office Furniture and General Equipment	3,919	7,700	7,700
			NET EXPENDITURE FOR SUBHEAD 01	**29,726,385**	**30,279,853**	**30,577,315**

Source: Ministry of health budget for the year 2012/13

These two examples illustrate the difficulty of understanding how the inputs listed (the "line items") actually add up to the provision of physiotherapy services or controlling the spread of HIV/AIDS. For example, both units spend substantial amounts on travel, hospitality, routine maintenance, and office furniture. But how do these inputs yield the desired outputs? One of the main differences between these two units is the fact that physiotherapy services has no salary costs. How is this fact linked to final results? Is it possible to provide physiotherapy without any staff, while AIDS control requires permanent employees? Perhaps it is (e.g., if the staff providing these services are trained by this unit but paid by another unit), but it is difficult to understand precisely how a unit delivers services from the information presented in a line-item budget.

A traditional line-item budget has little or no information about objectives. Reviews of line-item budgets tend to focus on whether or not the money allocated for inputs was used (did you spend the money we gave you for stationery or not?) rather than whether services were delivered effectively (did you reduce the spread of HIV/AIDS or not?). Kenya's traditional line-item budget provided no narrative information to explain the tables and figures in the budget, and no information about how inputs were related to service delivery objectives.

2.2 Program-Based Budgeting

In contrast, program-based budgets (PBB) organize the budget around objectives rather than inputs. A PBB presents a set of programs and (usually) subprograms with clear policy objectives. Each program has a set of indicators, which measure whether objectives are being achieved, and time-bound targets, which are related to each indicator and measure progress toward achieving these objectives. While it is focused on outputs, a PBB does not eliminate information on inputs. It does normally provide less detail on inputs, however.

Typically, a PBB is based on an economic classification that clearly identifies the different categories of expenditure, such as that dedicated to personnel, goods and services, or infrastructure. Each of these can be broken down further to illuminate the connection between spending on these categories and the objectives of related programs.

An effective PBB arranges the budget around a set of programs and objectives that are clear and specific. The indicators and targets must also be concrete, realistic, and have credible baselines and timelines. For example, we may have a program/sub-program focused on improving the lives of people living with HIV/AIDS. One indicator for this program/sub-program might be the share of the population living with HIV/AIDS that is consistently receiving antiretroviral treatment. A target for this indicator might be extending antiretroviral treatment to 70 percent of the population living with HIV/AIDS, and our baseline might be 50 percent. For our target to be meaningful, we must be trying to achieve it over a fixed period of time, such as three years. Table 1 below shows how this information may be presented in an effective PBB.

Table 1: Sample Program-Based Budget for Improving the Lives of People Living with HIV/AIDS

Program: PREVENTIVE AND PROMOTIVE HEALTH SERVICES TO AT RISK POPULATION
Sub-program: Antiretroviral treatment provision
Objective: To improve the lives of people living with HIV/AIDS

Subprogram	Indicator	Baseline 2013/14	Targets 2014/15	Targets 2015/16	Targets 2016/17
Improving Lives of PLWHA	% of population living with HIV/AIDS (PLWHA) that is receiving ARV treatment	50% of PLWHA receiving ARV treatment	55% of PLWHA receive ARV treatment	60% of PLWHA receive ARV treatment	70% of PLWHA receive ARV treatment

Author note: ARV refers to antiretroviral

The primary point of using PBB is to change the way that people use the budget: from a focus on accounting for money to an emphasis on accountability for service delivery. By presenting information on outputs and service delivery objectives, citizens and oversight bodies can review the budget according to what is most important: whether public money is providing the goods and services we expect.

3 Has the Shift to Program-based Budgeting Improved Budget Presentation and Transparency?

Having described some of the theoretical advantages of PBB, we now turn to look at whether Kenya's PBB has actually improved budget presentation and transparency. We start by comparing the PBB in 2013/14 to the 2012/13 line-item budget. We then look at the 2014/15 PBB, which brought a number of improvements. We will finally look briefly at the 2015/16 budget estimates that have been tabled recently.

3.1 The 2013/14 Program-Based Budget

Kenya's first attempt at PBB in 2013/14 fell short of expectations. A considerable amount of information was eliminated and the new narrative information on programs, indicators and targets was inadequate. For example, while the information presented in the 2012/13 line-item budgets for the National Aids Control Program and Physiotherapy Services as shown in figures 1 and 2 above did not help us understand how inputs were converted into outputs, the 2013/14

PBB simply eliminated all spending information about these units. The 2013/14 PBB introduced only three programs related to health: Curative Health, Preventive and Promotive Health Care Services, and Disaster Management. Table 2 shows the information provided on each of these programs.

Table 2: Programs and Objectives in the 2013/14 Budget

Programs	Objectives
Curative Health	Improve the health status of the individual, family and community by ensuring affordable health care services
Preventive and Promotive Health Care Services	To increase access to quality and effective promotive and preventive health care services in the country
Disaster Management	A safe and resilient society responding adequately to disasters

Source: Ministry of Health Program-Based Budget for the year 2013/14

As these programs were not broken down further into sub-programs, it is very difficult to know how the various departments that existed in the two ministries responsible for health services in FY 2012/13 were rearranged among these three programs in 2013/14.

Furthermore, given the program names and broad objectives, it is not easy to distinguish which services were covered by the first program and which by the second. While it is likely that the "Preventive" program was more focused on preventive measures, it is hard to tell which activities and outputs were produced by each program and how these differ. Logically, the indicators and targets suggest that the curative program provided antiretroviral treatment to HIV patients, while the preventive program provided them to mothers to prevent transmission. Surprisingly, however, drugs seem to be important only for the preventive program, and health worker training only for the curative program (See table 3).

Furthermore, the object of the "Disaster Management" program was "A safe and resilient society responding adequately to disasters."[1] However, the only indicator for this program was "Decrease in HIV/AIDS related deaths." It is therefore hard to understand what this program

[1] This program, with the same objective, is included in other ministries as well, where it is meant to achieve very different things.

was meant to do or how it related to the other two programs, particularly the curative program which also includes HIV-related services.

Table 3: The 2013/14 Health Budget Showing Performance Indicators with No Targets, Baselines, or Timelines to Achieve Those Indicators

	PROGRAMME NAME	PROGRAMME OUTCOME	EXPECTED OUTPUTS	MEDIUM TERM PERFORMANCE INDICATORS AND TARGETS
1.	Curative Health Care Services	Reduced incidents of curable diseases and ill health	- Patients getting curative interventions - Trained health personnel - Hospitals inspected and accredited - Patients receiving specialized curative interventions	- No. of patients treated - No. of eligible inpatients on ARVs - Proportion of inpatient malaria mortality - Proportion of fresh still birth - No. of trained health personnel - No. of health facilities inspected and accredited
2.	Preventive and Promotive Health Care Services	Reduced incidents of preventable diseases and ill health	- Children under1yr immunized. - New TB cases detected and treated. - Pregnant mothers receiving LLITN's in endemic districts - Eligible pregnant women receiving preventive ARVs - Health Commodities available at the health facilities - National radioactive waste management facility	- % of children under 1 yr immunized - TB detection rate and TB treatment completion rate. - % of pregnant women receiving LLITN's in endemic districts - % of eligible pregnant women receiving preventive ARVs - Drugs fill rates at primary health facilities - radioactive waste management facility in place
3.	Disaster Management	- Decrease in HIV/AIDS related deaths	- Increased ART services to persons living with HIV/AIDS.	- No. of persons under ART services

Source: Ministry of Health Program-Based Budget for the year 2013/14

4 Progress and Challenges in Program-Based Budgeting in Kenya

For this analysis, we looked more systematically at a number of areas of budget presentation and compared the 2013/14 PBB to the 2014/15 PBB and the 2015/16 PBB. Our summary findings are captured in Table 4 below.

Table 4: Difference in Information Available in Kenya's 2013/14, 2014/15, and 2015/16 Program-Based Budgets (using Ministry of Health example)

	2013/14 (Program Based Budget)	2014/15 (Program Based Budget)	2015/16 (Program Based Budget)
Narrative information Narrative should: 1. Explain overall mission and objectives. 2. Be clearly linked to priorities and program allocations. 3. Explain changes over time in allocations/expenditure. 4. Relate challenges and objectives in the sector to budget allocations and how the challenges would be addressed.	1. Some narrative available on the mandate of the health ministry, programs and objectives. 2. Not clearly linked to program priorities and allocations. 3. N/A 4. Does not relate challenges and objectives in the sector to changes in budget allocation. No information on how past challenges will be addressed in the current financial year.	1. Narrative information available on mandate of health ministry, programs and objectives. 2. Some allocations mentioned, but most are not described. No clear link to program priorities or allocations. 3. Some information provided on allocation trends as well as achievements in the last financial year, but not expenditure. 4. Does not relate challenges and objectives in the sector to changes in budget allocation. No information on how past challenges will be addressed in the current financial year.	1. Narrative information available on mandate of health ministry, programs, performance and achievements in the last financial year. 2. Not clearly linked to program priorities or allocations. 3. Some information on allocation trends and reasons for changes in allocation at ministry but not program level. 4. Does not relate challenges and objectives in the sector to changes in budget allocation. No information on how past challenges will be addressed in the current financial year.
Programs with clear objectives Budget should have programs that:	1. Program objectives are vague and overlapping, making it hard to know how each program uses its funds to advance a distinct objective.	1. Program objectives are still vague and overlapping, but the addition of sub-program information helps to clarify what each program actually does.	1. Program objectives no longer overlap. For example, curative services and promotive services do not overlap, because one provides preventive and the other specialized services. Sub-

1. Are clear and with clear objectives that do not overlap. 2. Have objectives that look at outputs and outcomes.	2. Curative program's objectives are focused only on outcomes (improved health status) while preventive program objectives are focused only on outputs (access to services). This leads to lack of clarity about differences between two programs.	2. Programs objectives are mostly focused only on outcomes. For instance, "reduce incidences of preventable disease and ill health." However, lack of outputs make it difficult to understand what programs actually do.	programs also help to clarify distinct program activities. 2. Objectives are now focused more at output than outcome level. They no longer overlap but it is less clear what the ultimate purposes of the programs are.
Indicators, targets, and timelines Each program or sub-program should have: 1. A set of sensible indicators with baselines and targets that relate to program objectives. 2. Consistent over time. 3. Updated to reflect changes in baseline over time.	1. Indicators are not in line with ministry objectives and have no baselines and lack targets. 2. N/A 3. N/A	1. Indicators improved from last budget as targets were introduced. However, some targets are incoherent and do not have baselines. For example, there is an indicator for "% of facility based maternal deaths" which has a target of 100%, which is both unclear and does not align with Health Sector Working Group target from 2015/16.[2] 2. Many new indicators with new targets. There was also a huge dropout of indicators that were used in the	1. Improved clarity of indicators with targets to some extent but still no baselines. Some indicators that were not clear in the last budget were dropped, leading to reduced number but more focused. For instance, "% of facility based maternal deaths." 2. Many indicators and targets have been dropped, with some being replaced without any explanation. For instance, in the health promotion subprogram, under the delivery unit – environmental health services, the indicator used in 2014/15

[2] Republic of Kenya, "Health Sector Working Group Report, MTEF for the period 2015/16-17/18"

		2013/14 budget that did not appear in the 2014/15 budget. For instance, in the health sector, there was an indicator "% of pregnant women receiving LLITN in endemic districts" which is no longer in the budget. 3. Most indicators did not have baselines. Many from previous year lacked targets.	was % of HH with latrines and with a target of 70% by the year 2015/16. The same unit now has a new indicator – National Aflatoxin Management with no target for the year 2015/16. 3. No updated information about changes in the baseline or whether targets for previous year achieved.
Subprograms and further disaggregation Subprograms should: 1. Be about 2-5. 2. Have clear objectives and be related to the program under which they fall. 3. Be consistent over time.	1. N/A 2. N/A 3. N/A	1. Two to five subprograms. 2. The subprograms do not have objectives but have indicators and targets. 3. N/A (new item).	1. Between 3 and 9 subprograms under each program. 2. The subprograms do not have objectives but have indicators and targets (though not fully consistent with last year). 3. There is a drop in the number of subprograms, with some being replaced. For instance, in 2014/15, the preventive and promotive subprogram had 5 subprograms, now there are only three subprograms. Curative health program had 3 subprograms – national referral hospital, mental and spinal injury which has now been combined into only one program National referral services.

4. Have clear indicators and targets. 5. Broken down by economic classification that is clear	4. N/A 5. Generic economic classification with vague categories of "other recurrent" and "other development" at program level.	4. Have somewhat clear targets and indicators, but as above, not entirely consistent and coherent. 5. Subprograms have been broken down into an economic classification. However, the economic is generic with use of vague categories such as "other recurrent" and "other development."	4. Have somewhat clear targets and indicators, but as above, not entirely consistent or coherent. 5. Broken down by economic classification. However, there is still use of vague classification which takes major share of allocations.
Personnel and costs There should be information: 1. Beyond "compensation to employees" at program or subprogram level. 2. On number of staff, job group, emoluments and costs.	1. No information beyond single figure for "compensation" at program level, with only 3 programs. 2. No information on number of staff, job group, emoluments and cost, unlike in 2012/13.	1. No information beyond single figure for "compensation for employees" but now this information is at program and subprogram level (increase in detail due to increase in programs from 3 to 5, plus 19 subprograms, but still less than 2012/13.). 2. No information on number of staff, job group, emoluments and cost.	1. No information beyond single figure for "compensation for employees" at subprogram level. 2. No information on number of staff, job group, emoluments and cost.

Appropriation in Aid (AiA) Information should be broken down to: 1. Type of donor, the amount and type of grant. 2. Where the money is coming from i.e. donor or user fees 3. Where the money is going to, which ministry, department etc.	1. No information on the type of donor and type of grant, only the total amount of AIA. 2. No information. 3. Information at vote and program level.	1. None 2. None 3. None	1. None 2. None 3. None
Link between program-based budget and line-item budget	The 2013/14 budget eliminated former administrative units and no information was provided that would allow for a link to the old classification to be established.	The 2014/15 PBB has some link with the old administrative units in the 2012/13 budget. It now has "delivery units" which can be linked back to the old line item budget, and the line-item classification was released along with the PBB. For example, "control of malaria and communicable disease control" delivery units appear under the sub-program "communicable disease control," with codes 108008900 and 108011800 respectively. These are the same as the codes in the line-item budget for the same units.	Same as 2014/15, with delivery unit codes allowing comparison between line-item and PBB budgets.

On balance, Kenya's shift to PBB has made more information available. However, it also reduced the level of information available on wage costs and external funding. The narrative, indicators, and targets are still weak. In many cases, the sub-program breakdown does not allow a reader to fully understand what a sub-program does or how it uses public money to achieve specific objectives. We elaborate on each row of Table 4 below.

4.1 Narrative Information

A key advantage that a PBB has over a line-item budget is that it provides a fuller narrative explanation of budget allocations.

The 2013/14 PBB introduced a few paragraphs of narrative, but these were not very closely connected to the budget figures, tables, or program objectives. For example, the 2013/14 health budget mentions a number of key initiatives in the sector, such as the provision of free maternity health, improving immunization coverage, and medical equipment. This appears in the 2013/14 PBB as follows:

"The financial year 2013/14 Budget would give priority to scaling up the policy interventions aimed at enhancing the equitability of access to medical services. Such measures will include: provision of FREE maternal health care and ensuring that most deliveries are conducted under the care of skilled health attendants, **equipping public health facilities** [emphasis added] and provision of adequate medical supplies, improving immunization coverage for children, and reducing morbidity and mortality from malaria, HIV/AIDS, tuberculosis and non-communicable diseases."

However, it is not possible to link the above narrative to expenditure because it is not clear which programs these initiatives fall under. The initiatives mentioned do not clearly match program objectives (see table 2), nor do they align with the program breakdown. For example, under which program would we expect to find "equipping public health facilities"? The budget does not tell us. Even if we surmise that it should be under the "Curative Health" program, we would not be able to see it, as the curative program breakdown uses only a generic economic classification (see table 5 below).

Table 5: Summary of Expenditure by Program in the Ministry of Health budget 2013/14

040100 Curative Health			
Economic Classification	**Estimates**	**Projected Estimates**	
	2013/2014	**2014/2015**	**2015/2016**
Current Expenditure	**17,109,067,289**	**17,962,893,062**	**18,003,744,441**
Compensation to Employees	1,259,160,177	1,297,300,309	1,336,222,928
Use of Goods and Services	1,077,247,111	1,333,005,462	1,333,183,722
Current Transfers to Govt. Agencies	14,598,865,601	14,980,585,601	14,982,335,601
Other Recurrent	173,794,400	352,001,690	352,002,190
Capital Expenditure	**3,207,729,312**	**3,833,513,901**	**3,943,513,901**
Acquisition of Non-Financial Assets	448,310,514	460,500,000	460,500,000
Capital Grants to Govt. Agencies	507,700,041	1,016,900,081	1,016,900,081
Other Development	2,251,718,757	2,356,113,820	2,466,113,820
Total Expenditure	**20,316,796,601**	**21,796,406,963**	**21,947,258,342**

Source: Ministry of Health Program-Based Budget for the year 2013/14

The quantity and quality of the narrative were both moderately improved in the 2014/15 budget. First, the narrative was expanded to include the vision, mission, performance overview, and background of program funding; the challenges faced by the ministry in implementing the budget; and the focus of spending for the upcoming year (see Figure 4).

Figure 4: Narrative Section from the 2014/15 Health Budget

PART C. Performance Overview and Background for Programme(s) Funding

Budgetary allocations for the sector increased from Kshs. 57.6 Billion in FY 2011/12 to Kshs. 87.8 Billion in FY 2012/13. In FY 2013/14 the budget allocation was KSh.36 Billion. The reduction is on account of Ksh.64 Billion which was transferred to the Counties to cater for the County healthcare functions.

Achievements for the Ministry during the period under review include; Kenya Health Policy 2012 – 2030 which outlines the country's long term aspirations in attaining the overall health goals, construction of 210 Model health centres in 210 Constituencies at a cost of Kshs 4.2

During the ensuing MTEF period, 2014/15- 2016/17, the Ministry will focus on scaling up policy interventions aimed at enhancing the equitability of access to Health care. This will include: Continued provision of free maternal health care at a cost of Kshs 4.040 billion, increased access to Primary Health care in Public Health Centres and Dispensaries through removal of users fees with a long term objective to introducing free primary healthcare, and equipping all public health facilities at an estimated total cost of KSh.45 billion over a period of 10 years. In FY 2014/15, Kshs.3 billion has been allocated for equipping 94 hospitals and KSh.300 million for upgrading facilities in Slum areas. The Ministry will also focus on training

Source: Ministry of Health Program-Based Budget for the year 2014/15

The 2014/15 PBB also provides a link between the narrative and the program/sub-program objectives. For instance, the highlighted section in Figure 4 shows that the health ministry will focus on providing free maternal healthcare at a cost of Ksh 4.04 billion. This can be linked with summary table figures of the maternity subprogram, as shown in Figure 5 below.

However, there are some figures mentioned in the narrative which are quite difficult to link to a program or sub-program. For instance, the narrative mentions that the health ministry will focus on upgrading facilities in the slum areas, at a cost of Ksh 300 million. This spending cannot be linked to a specific program or found in the budget summary table.

Figure 5: Maternity Sub-Program in the 2014/15 Health Budget

040502 SP. 5.2 Maternity

Economic Classification	Estimates	Projected Estimates	
	2014/2015	2015/2016	2016/2017
Capital Expenditure	**4,040,000,000**	**3,963,000,000**	**3,938,000,000**
Capital Grants to Govt. Agencies	4,040,000,000	3,963,000,000	3,938,000,000
Total Expenditure	**4,040,000,000**	**3,963,000,000**	**3,938,000,000**

Source: Ministry of Health Program-Based Budget for the year 2014/15

The 2014/15 budget narrative discusses performance in 2013/14; it provides a brief overview of the achievements (Figure 4) and the challenges the health ministry faced in implementing the previous year's budget.

For instance, page 192 of Kenya's 2014/15 Ministry of Health Budget narrative states:

"Despite the achievements, the Ministry experiences the following challenges: (i) Many Health facilities are not adequately equipped according to norms and standards. (ii) Most public health facilities are old and dilapidated and (iii) Inadequate budgetary provision for the procurement and distribution of Essential Health Products and Technologies. **In addition, there is a high prevalence of Preventable Communicable diseases and rising incidence on Non Communicable Diseases e.g. Cancer, Cardiovascular diseases and Diabetes** [emphasis added]."

This is a substantial improvement over the 2013/14 narrative. However, it is not entirely clear how the proposed initiatives and allocations for 2014/15 respond to the challenges identified. For example, from the challenges listed above, we might expect more funding to go to "essential health products and technologies" but we would have a difficult time identifying any such increase in the budget allocations.

The narrative allocations that are mentioned are also hard to link to the indicators or the actual allocations in the budget tables. Equipping 94 hospitals at a cost of Ksh 3 billion is also mentioned in the narrative. But the indicator tables do not refer to these hospitals. There is instead an indicator that refers to the rehabilitation of 23 hospital over three years (10 in the

first year) under the "Administration" program, "Health Policy" sub-program. That sub-program has a budget of Ksh 4.2 billion in 2014/15, which might include Ksh 3 billion for 10 hospitals in the first year, but it is clearly difficult to know how these figures align with the narrative claim of equipping 94 hospitals. The narrative may refer to the Ksh 3.3 billion equipment leasing scheme that is mentioned in the Budget Highlights document, but this is not referenced in the PBB at all. The Ksh 3 billion in the narrative and the Ksh 3.3 billion figure in the Highlights also do not match precisely.

The narrative could do more to illuminate expenditure trends and tradeoffs in each sector. It is difficult to identify areas of greater and lesser focus and how this is changing over time. In some cases, quantitative information about absorption is provided, which is an improvement. However, the link between the general discussion in the narrative and the budget tables is often weak. Given the numerous challenges with the quality of the narrative identified here, we recommend that some minimum standards be developed to guide the contents of all budget narratives.

In 2015/16, the narrative challenges continue largely as in 2014/15. The narrative still fails to illuminate expenditure decisions at the program or subprogram level, and it is not possible to identify priority allocations mentioned in the narrative, such as the Health Insurance Subsidy Program (HISP), in the budget tables. The 2015/16 budget also lacks some information that was available in 2014/15 on sector allocations over the last few years. There is also no explanation of the reorganization of programs and subprograms since 2014/15, leading to considerable confusion about whether priorities are changing or just moving from one part of the budget to another.

4.2 Programs with Clear Objectives

The creation of new programs and subprograms in FY 2014/15 substantially increased the transparency of the budget. Subprograms did not exist in the 2013/14 budget, and the number of programs was also highly aggregated, with little detail provided on the purpose of each program. Moreover, the objectives of many of these programs were unclear (see Table 2). For example, it seems that the objective of the "Preventive" program (access to preventive

services) would also be an input to the objective of the "Curative" program (better health status). As we saw, there are various other activities highlighted for each program that could potentially overlap, such as the training of health workers or supply of drugs. It is therefore unclear how these programs work in different ways to achieve different objectives.

The 2014/15 budget format continues to suffer from unclear objectives at program level, but the addition of sub-program information helps to clarify what the program is actually doing. We saw that the objective of the "Preventive and Promotive" program in the 2013/14 budget was to "increase access to quality and effective promotive and preventive health care services in the country." In FY 2014/15, the new objective is "to reduce incidence of preventable diseases and ill health" (see Figure 6). This is a marginal improvement, with a greater focus on outcomes, but still leaves a lot of questions about what the program does and still overlaps with the "Curative" program. However, we can see from the sub-program data that the program is responsible for "health promotion", "non-communicable and communicable disease control," and "the government chemist."

The 2015/16 budget creates a stronger distinction between these programs: curative health now focuses on specialized care, while preventive and promotive focuses on prevention of disease. However, neither program objective clarifies the outcomes of the program, focusing instead at output level. Thus we now have clarity about the kinds of services in each, but not the ultimate objectives of the programs. In spite of apparent similarities in the names of programs and subprograms between 2014/15 and 2015/16, there are also confusing shifts in what they do. For example, part of immunization was under promotive health in 2014/15, but it has now been removed and placed under the Maternal and Child Health program without explanation. There have also been substantial shifts in budget lines from Non-Communicable Disease Control to Communicable Disease Control (e.g., budget lines for HIV, TB, Malaria), raising questions about whether budgets are properly classified within programs.

Figure 6: Preventive and Promotive Health Services Program in the 2014/15 Budget

Programme	Objective
040100 P.1 Preventive & Promotive Health Services	To reduce incidence of Preventable Diseases and ill Health.
040200 P.2 Curative Health Services	To improve health status of the individual ,family and community
040300 P.3 Health Research and Development	To increase knowledge through research findings and capacity building
040400 P.4 General Administration, Planning & Support Services	To improve service delivery and provide supportive function to government agencies under the health sector.
040500 P.5 Maternal and Child Health	To reduce martenal and child mortality

Programme: 040100 P.1 Preventive & Promotive Health Services

Outcome: Reduced incidence of preventative diseases

Sub Programme: 040101 SP. 1.2 Health Promotion

Delivery Unit	Key Output (KO)	Key Performance Indicators (KPIs)	Targets 2014/2015
108003200 Nutrition	Dewormed children	% of school age children dewormed	49%

Source: Ministry of Health Program-Based Budget for the year 2014/15

4.3 Indicators, Targets, and Timelines

The 2013/14 budget included many indicators that lacked targets, baselines, and timelines for achieving objectives. While the narrative included some precise targets, none had timelines as can be seen below:

"The budget further seeks to reduce health inequalities and to reverse the downward trend in health related outcomes and impact indicators. Reduce malaria case fatality in hospitals from 21% to below 10%, increase number of mothers attending ante-natal clinic delivered in hospitals from 51% to 72%, increase the number of eligible patients on ARV from 56% to 63%, improve customer satisfaction from less than 60% to 64%, reduce infant mortality from 74

deaths to below 52 per 1,000 live births, reduce child mortality from 115 deaths to below 74 per 1000 live births."[3]

The narrative above shows that the health ministry was planning to reduce the number of malaria fatalities in hospitals (indicator) from 21 percent (baseline) to below 10 percent (target). However, the timetable for achieving this was not provided. Was this the target to be achieved in FY 2013/14, or sometime later? On the other hand, the section on formal indicators and targets (Table 6), shows that many indicators also lacked targets.

Table 6: The 2013/14 Health Budget Showing Performance Indicators with no Targets, no Current Status and no Set Period of Time that they will Achieve those Indicators

	PROGRAMME NAME	PROGRAMME OUTCOME	EXPECTED OUTPUTS	MEDIUM TERM PERFORMANCE INDICATORS AND TARGETS
2.	Preventive and Promotive Health Care Services	Reduced incidents of preventable diseases and ill health	• Children under1yr immunized. • New TB cases detected and treated. • Pregnant mothers receiving LLITN's in endemic districts • Eligible pregnant women receiving preventive ARVs • Health Commodities available at the health facilities • National radioactive waste management facility	• % of children under 1 yr immunized • TB detection rate and TB treatment completion rate. • % of pregnant women receiving LLITN's in endemic districts • % of eligible pregnant women receiving preventive ARVs • Drugs fill rates at primary health facilities • radioactive waste management facility in place

Source: Ministry of Health Program-Based Budget for the year 2013/14

Moreover, the 2013/14 budget included some performance indicators which did not relate to the program. For instance, the "Disaster Management" program's objective, "A safe and resilient society responding adequately to disasters," had a performance indicator "[Number] of persons under [antiretroviral] services" which did not relate to the program (see Table 3). This information had already been captured in the curative and promotive health programs.

[3] Ministry of health budget 2013/14

The 2014/15 PBB improved the presentation of targets and indicators. However, indicators still had no baseline and some targets were not informative. Most indicators and targets are at the level of the subprogram, and many targets are simply set for 2014/15 and future years, but we do not know the current status (baseline) of these indicators and therefore how realistic the targets are. This is particularly problematic when the targets mentioned are at odds with other government figures.

For example, the 2014/15 health budget set a target of 44 "[percent of] births conducted by skilled attendant," to be achieved during FY 2014/15. However, prior to the introduction of the government's flagship free maternal health program in 2013, the government estimated that 44 percent of births took place at a health facility, all of which were presumably attended by a skilled attendant.[4] In May 2014, the "Beyond Zero Campaign," an initiative spearheaded by Kenya's First Lady, claimed that "free maternity services helped increase the number of women delivering in hospitals from 44% to 66%."[5] This means that the target for 2014/15 is below what has already been achieved. Moreover, the 2015/16 target is 60 percent; and the 2016/17 target is 65 percent. This means the target for 2016/17 has already been achieved.

Similarly, the indicator for "% of facility based maternal deaths," has a target of 100 percent. It is hard to understand what this means – is the goal to ensure that all mothers who die do so in a facility? This is a surprising indicator and target. It also does not match the indicator used by the Health Sector Working Group, which looks at the absolute number of in-facility maternal deaths per 100,000 live births and is targeting a decline to 111 (baseline of 114 in 2013).[6]

In 2015/16, some of the uninformative or contradictory indicators, such as "facility based maternal deaths" have been dropped. However, other indicators that seemed important have also been dropped. For example, in 2014/15 there was an indicator for under 5 year old mortality which has been dropped in 2015/16. It is not clear why. At the same time, new indicators have been introduced that also contradict other sources as was the case for the

[4] Nicole Bourbonnais, 6 November 2013, Implementing Free Maternal Health Care in Kenya.

[5] See http://www.president.go.ke/beyond-zero-campaign-a-timely-idea-says-health-cs

[6] Republic of Kenya, Health Sector Working Group Report, MTEF 2015/16-2017/18, p. 15.

maternal death indicator. For example, the 2015/16 target for Kenyatta National Hospital for "Average Length of Stay" has already been exceeded in 2014/15, according to the Health Sector Working Group Report.[7]

Figure 7: Program Output and Performance Indicators in the 2014/15 Health Budget

PART E. SUMMARY OF PROGRAMME OUTPUTS AND PERFORMANCE INDICATORS FOR 2014/2015 - 2016/2017

108003300 Family Planning Maternal and Child Health	Maternity health services	% deliveries conducted by skilled attendant	44%	60%	65%
		% of facility based maternal deaths (per 100,000 live births)	100%	100%	100%
		% of facility based under five deaths (per 1,000 under 5 outpatients)	60%	20%	15%
		% of Newborns with low birth weight	10%	6%	5%

Source: Ministry of Health Program-Based Budget for the year 2014/15

4.4 Subprograms and Further Disaggregation

The 2013/14 budget had few programs and no subprograms. The main programs were actually ministries under the previous government which were then combined into a single, larger Ministry of Health. As a result, these programs did not provide much detail about what was happening within the ministry.

The 2014/15 budget improved upon this. More programs were included, programs were further broken down into between two and five subprograms, and there was even further disaggregation (delivery units) into what previously used to be administrative heads in the 2012/13 line item budget. For instance, the outcome of the "Preventive and Promotive Health Services" program was to "reduce incidences of preventative diseases." This was further broken down into subprogram: "Health promotion," "Non communicable disease prevention & control," "Government chemist," and "Radiation protection and Communicable disease control." Each of these has delivery units contributing to its outputs. For example, under the

[7] Ibid.

"Health promotion" sub-program, there are five delivery units with key outputs, indicators and targets.

Figure 8: The 2014/15 Health Budget Showing Program and Subprogram Breakdown

Programme: 040100 P.1 Preventive & Promotive Health Services

Outcome: Reduced incidence of preventative diseases

Sub Programme: 040101 SP. 1.2 Health Promotion

Delivery Unit	Key Output (KO)	Key Performance Indicators (KPIs)	Targets 2014/2015	Targets 2015/2016	Targets 2016/2017
108003200 Nutrition	Dewormed children	% of school age children dewormed	49%	85%	90%
108007800 Environmental Health Services	Good Hygiene practises	% of households with latrines	34%	70%	70%
108009000 Kenya Expanded Programme Immunization	Immunisation and vaccination	•% of fully immunized children.	79%	90%	90%
108014900 Nutrition and Care for HIV/AIDS Affected People	Nutritional suppliments	No of Households covered	80,000	80,000	80,000
108100200 National Aids Council	Advocacy and awareness creation on HIV and AIDs	Awarenes status of community members	16 %	47 %	47 %

Source: Ministry of Health Program-Based Budget for the year 2014/15

Beyond the number of programs and subprograms, PBBs should provide a classification of expenditure. While all budgets do this, the key question is how much detail they provide. The 2013/14 PBB divided spending using standard economic classifications: compensation to employees, goods and services, transfers, and development. These economic classifications persist in the 2014/15 PBB, but they provide more information because they are now at the level of subprograms. However, the budget still uses categories such as "other recurrent" and "other capital" which are vague. These require further breakdown. At best, such residual categories should be used to aggregate a few minor expenditures rather than describe large allocations. For example, when most of the budget for the Preventive & Promotive Health Program goes to "other development," this leaves us wondering what this program is actually doing with its allocation.

The 2015/16 budget is very similar to the 2014/15 budget in terms of subprograms and further disaggregation. One notable improvement is the addition of a column in the budget tables showing 2014/15 approved budget by subprogram, allowing comparison between the two years. However, as we have already seen, some of the underlying activities in each

program/subprogram have actually moved to new programs/subprograms, creating confusion that undermines the usefulness of this column and can only be partially rectified with reference to the line-item budget. Subprograms still lack objectives. The economic classification in the budget continues to use "other recurrent" and "other development" to classify substantial amounts of spending with no further details.

4.5 Information on Personnel and Costs

The budget does not provide comprehensive information on staff, wages, or benefits. The 2012/13 line-item budget includes extensive details about the wages and benefits of staff in each ministry. This information was eliminated in the 2013/14 PBB, the only information on wage costs was a single line for "compensation to employees" at program level.

The 2014/15 PBB improves upon this by providing information on "compensation to employees" down to the sub-program level. We are able to find 19 pieces of information about compensation to employees because of the breakdown. However, there is still no breakdown to allow us to know how many, or what type of, employees are in each ministry, or how much they are paid either individually or by job group, as was the case in the line item budget.

There is no additional information provided about staff in 2015/16 beyond what was available in 2014/15.

4.6 Information on Appropriations in Aid

Appropriations in Aid (AiA) is a revenue source, and it consists primarily of two things: donor funds that go directly to various agencies; and fees collected by agencies that are normally retained by those agencies for their operating costs.

The 2012/13 budget provided extensive information about AiA within each ministry, including the administrative unit that received the funds and whether the funds came from donors or were internally generated.

The 2013/14 PBB provided information about AiA aggregated by program, with medium-term projections. Each program had an overall figure for AiA, but it was unclear if these were donor funds or user charges, or what they were used for.

The 2014/15 PBB no longer contains critical information related to AiA. Aggregate information is provided in the "Budget Highlights" companion to the budget, but this lacks information on AiA by ministry, program, or subprogram.

Unsurprisingly, neither the 2013/14 PBB nor the 2014/15 PBB formats contain information on external revenues. External revenues are similar to external AiA, but are generally given to Treasury directly to pass through government financial systems; AiA may be given directly to a ministry or agency without passing through Treasury. Information on external revenues was provided in the line-item budgets but is lacking from both PBBs.

The 2015/16 PBB still lacks information about AiA and external revenues.

4.7 Link between PBB and administrative classification (line-item budget)

In 2013/14, there was no way to link the 2013/14 PBB format to the 2012/13 line-item budget. One could only make a guess as to where to find specific units or ongoing initiatives in the new budget. The 2014/15 PBB attempted to correct this by introducing a link between programs and "delivery units" that are recognizable as administrative units in the old line-item budget format. A transition from one budget format to another should be accompanied by a "crosswalk" that helps people link the information in the two budgets and this was an improvement in the 2014/15 PBB.

In 2015/16, the PBB continues to use delivery units at the subprogram level, allowing a connection back to the line-item budget.

4.8 Changes in the PBB presentation

There are inevitably going to be changes to the PBB as it is implemented and improved over time. Nevertheless, the introduction and disappearance of programs from year to year can make it difficult to understand and monitor spending over time. Between FY 2013/14 and

2014/15, there were substantial changes to program names, objectives, and financing. This makes it difficult to track spending for similar areas. For example, the health ministry had a "Disaster Management" program in 2013/14; this has disappeared in 2014/15. What happened to what was being financed under that program? How do we track what has happened to it over time?

Instability in programs can undermine the PBB's original purpose of providing greater clarity about government objectives and how spending is organized to achieve those objectives. Ideally, programs should be tweaked rather than completely overhauled to better represent sets of activities of government oriented toward common objectives. This will be less disruptive to readers of the budget. Major changes should also be accompanied by explanations, allowing readers to connect the old way of doing things to the new approach.

The same logic applies to the changes we have mentioned in 2015/16. The decision to move certain expenditure items between programs and subprograms creates confusion in the absence of a detailed narrative explanation of these changes.

5 Comparing Kenya, Uganda and South Africa's Budgets for Health in FY 2014/15

In this section of the paper, we compare Kenya's PBB trajectory with two countries: South Africa and Uganda. We focus our analysis on the key issues we identified earlier, particularly: narrative information, clarity of outputs and objectives, targets/indicators, breakdown of information, and program and subprogram level of breakdown.

The South African budget, which is a PBB, is considered one of the most transparent budget presentations in the world. [8] Uganda uses an output-based budget approach, which is similar to PBB, but with some important differences. [9] It also ranks as a more transparent budget than

[8] See http://www.treasury.gov.za/documents/national%20budget/2014/default.aspx

[9] See http://www.budget.go.ug/budget/national-budgets-documents

Kenya, according to the Open Budget Survey 2012.[10] Both the South African and Ugandan cases allow us to probe the logic of shifting from a focus on inputs to a focus on outputs, and demonstrate that this can be done in different ways that both deserve consideration as Kenya continues to reform. Generally, the Kenyan PBB is more similar to the South African approach. However, the Ugandan approach also has benefits, and in some ways is more wholly committed to focusing on outputs and outcomes than either Kenya or South Africa. At the same time, the Ugandan approach also has weaknesses and introduces considerable complexity.

Table 7 summarizes the differences between the budgets of the three countries, using the health budget as an example.

Table 7: Comparison of Kenya's 2014/15 Program-Based Budget with Uganda's and South Africa's 2014/15 Budgets (using Ministry of Health example)

Area	Kenya 2014/15	South Africa 2014/15	Uganda 2014/15
Narrative information	Narrative information provided on mandate of health ministry, programs and subprograms, objectives, expenditure trends, and achievements in the last financial year. The narrative is not clearly linked to allocations.	More extensive and coherent narrative and details are provided compared to Kenya. This includes information on expenditure trends, major spending priorities, performance over the last year. Narrative can be clearly linked to allocations, the budget figures, and why certain priorities are being funded.	Detailed budget narrative with overview of sector expenditures and how each sector contributes to the national development plan. Information about the sector outcomes, the challenges faced during the budget year, and plans to improve the outcomes. Narrative can be linked to allocations and outcomes. No explanation of how priorities change over time.
Programs with clear objectives	Five programs broken down into economic classification. Program objectives are vague and overlapping, but sub-program information helps to clarify what each program actually does.	There are six programs with clear and distinct objectives, with further program details provided. The program objectives are focused only on outputs of the	The vote functions, which are similar to programs, do not have clear objectives, but are each linked to a sectoral outcome (of which there are 3 in the health sector) through their outputs. This can be found both in the national budget framework

[10] See http://internationalbudget.org/what-we-do/open-budget-survey/

	For instance, the preventive and promotive program objective is not totally clear: "reduce incidences of preventable diseases and ill health". But the inclusion of subprogram "health promotion" helps clarify how the objective will be met. Other programs, like the curative health program lack clear objectives and have remained the same as those in the 2013/14 PBB. For example, "Improve the health status of the individual, family and community."	department, rather than the ultimate outcomes. For example, "Program 5, Hospitals," "Tertiary Health Services," and "Human Resources Development" each focus on hospitals. But the objective is mostly a set of activities and deliverables from the department without reference to the broader purpose of investing in hospitals, such as improved health status.	document and the public investment plan document. For instance, in the health sector budget framework paper under the vote: ministry of health, there is a vote function: Clinical and Public Health tied to a sector outcome: "children under one year protected against life threatening diseases." The vote function helps to achieve this outcome through, for example, provision of immunization services. Several vote functions together, producing multiple outputs, yield broad outcomes.
Indicators, targets, and timeline	There is improvement in the indicators and targets presentation from 2013/14. Most indicators are clear and have numerical targets. However, some targets are incoherent. For example, "% of facility based maternal deaths" has a target of 100%. Indicators and targets lack clear baselines.	Detailed information is provided on the goals to be achieved, the indicators used to measure these, the baseline, the targets, and the timeframe for achieving these goals. However, some objectives lack targets and timeframe. For instance, the goal to "combat HIV and AIDS and decrease the burden of disease from tuberculosis" does not show the target or the timeframe. Nevertheless, on balance the indicators, targets, and timeframes are superior to those in the Kenyan and Uganda budgets.	Indicators and targets at sector level and output level, but not program level, are provided. Each sector outcome shows the timeframe for achieving the targets, and most have a baseline that shows the current status. For instance, for Outcome 1 (increased deliveries in facilities), there is an outcome indicator, "Proportion of Health Centres with approved posts that are filled by trained health workers." This has a baseline of 56 (2009) and targets of 75 in FY 2014/15 and 80 in the medium-term forecast (2015). In addition, outputs also have targets. For example, the output "clinical health services provided" has an indicator for number of health workers trained, and a target of 5000 for FY 2014/15. No baseline is provided, but information about previous year target and achievement is given.
Subprograms and further disaggregation	Each program has two to five subprograms. However,	Programs into subprograms are further broken down, and	Information is broken down beyond the vote and vote function to projects, and sub-

	subprograms lack clear objectives. Subprograms have been broken down into an economic classification, and each have indicators and targets. The economic classification is basic – compensation to employees, use of goods and services, acquisition of non-financial assets and capital grants to government agencies. This has not improved from the previous year. There is still no further breakdown and vague categories such as "other recurrent" and "other development".	their own set of objectives to achieve. For instance, the HIV and AIDS, TB, and Maternal and Child Health programs, each have four subprograms. Information on funding is provided for each subprogram. The basic economic classification is similar to Kenya's (following IMF "Government Finance Statistics"), but there is a further breakdown for staff, goods and services, administration fees, advertising fees, etc.	programs, and linked to a set of outputs. For example, Vote - Ministry of Health Vote function - Health Systems Development Project - Health Systems Strengthening Detail-Hospital Construction/Rehabilitation. The economic classification remains basic – wage, non-wage, Government of Uganda development and External financing. Classification of "other goods and services" in both recurrent and development classifications also remains vague.
Information on personnel and costs	No information beyond single figure for "compensation for employees" but this is now provided at program and subprogram levels. There has been a substantial increase in detail from 2013/14 due to increase in programs from 3 to 5, plus 19 subprograms	Information on staff according to their salary level and details on the number of added and planned posts at the program level. Information on the costs for the current year as well as those for the medium term and average growth rate is provided.	The Uganda budget does not provide detailed information about wages. It only provides different classifications under employee costs such as general staff salaries, emoluments and other costs.
Appropriations in Aid (AiA) and/or external funding	AiA information eliminated altogether.	Shows the amount received from donor funds with information on the type of donor; the amount of money received; the name or type of project; and the departmental program that receives the funding.	Uganda's budget has information on external financing at vote function level (development). Further details are availed at project level for capital projects, including name of the donor, the amounts for past two fiscal years, the current year as well as medium term projections. For example, under the TB Laboratory Strengthening project in the health sector public investment plan, the donor named is International Development Association (IDA).

Link between PBB and administrative classification (line-item budget)	The 2014/15 PBB has some link with the old administrative units in the 2012/13 budget. It now has "delivery units" which can be linked back to the old line item budget, and the line-item classification was released along with the PBB. For example government chemist, special Global Fund and control of malaria have the same codes/chart of accounts in both the old administrative units and the new delivery units.	N/A	N/A

5.1 Narrative information: South Africa

South Africa provides more extensive and more coherent narrative detail than Kenya. The narrative explains the tables, as well as the figures in the tables, and provides information on focus areas. It also identifies major spending priorities and it is possible to link the narrative to expenditure items, programs, and subprograms.

For example, Figure 9 shows how the table and accompanying narrative on expenditure estimates looks in South Africa's 2014/15 budget. Information is provided on why the focus during FY 2014/15 would be on hospitals, tertiary health services and the human resource department followed by the Prevention and Treatment of HIV and AIDS and Tuberculosis program. Reasons are also given for why there is a projected increase over the medium term. There is a direct link between the narrative and the budget figures in the table and this information helps readers to identify which priorities are being funded and why.

Figure 9: Expenditure estimates and trends for South Africa Budget with Explanatory Narrative

Expenditure estimates

Table 16.2 Health

Programme	Audited outcome			Adjusted appropri-ation	Revised estimate	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate		
R million	2010/11	2011/12	2012/13	2013/14		2010/11 - 2013/14		2014/15	2015/16	2016/17
Administration	263.0	317.6	380.2	405.7	405.7	15.5%	1.3%	399.7	426.4	449.7
National Health Insurance, Health Planning and Systems Enablement	97.2	164.1	294.7	491.8	288.8	43.8%	0.8%	621.3	620.0	650.1
HIV and AIDS, Tuberculosis, Maternal and Child Health	6 471.3	7 916.0	9 169.0	11 042.0	11 045.0	19.5%	32.6%	13 049.9	14 728.6	16 299.5
Primary Health Care Services	82.3	97.3	111.0	102.6	102.6	7.6%	0.4%	93.5	98.1	103.7
Hospitals, Tertiary Health Services and Human Resource Development	15 065.7	16 700.1	17 395.9	17 722.4	17 522.4	5.2%	62.8%	18 925.8	19 693.3	20 761.0
Health Regulation and Compliance Management	540.7	517.8	548.2	763.7	763.7	12.2%	2.2%	865.3	1 064.8	1 123.7
Total	**22 520.3**	**25 712.8**	**27 898.9**	**30 528.2**	**30 128.2**	**10.2%**	**100.0%**	**33 955.5**	**36 631.3**	**39 387.7**
Change to 2013 Budget estimate				(178.5)	(578.5)			31.1	(53.9)	(249.5)

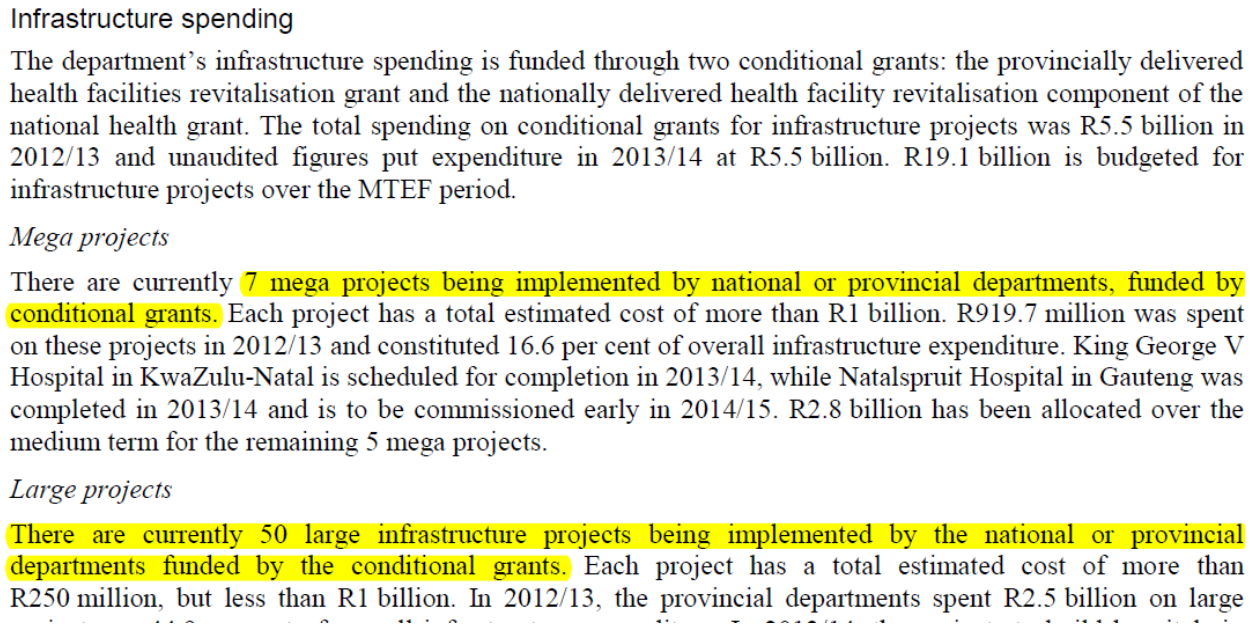
Expenditure trends

The spending focus over the medium term will continue to be on increasing life expectancy and reducing the burden of disease by revitalising hospitals, providing specialised tertiary services, and preventing and treating HIV and AIDS. Thus, the bulk of the department's budget over the medium term is allocated to transfers of: the health facility revitalisation, national tertiary services, and health professions training and development grants in the *Hospitals, Tertiary Health Services and Human Resource Development* programme; and the comprehensive HIV and AIDS conditional grant in the *HIV and AIDS, TB, Maternal and Child Health* programme. Spending on the HIV and AIDS conditional grant is set to increase over the medium term to allow the department to put 500 000 new patients on antiretroviral treatment each year. The 2014 Budget provides a further Cabinet approved additional allocation of R1 billion in 2016/17 for the department to continue to provide the public greater access to antiretroviral treatment, which explains the significant increase projected in spending in the *HIV and AIDS, TB, Maternal and Child Health* programme in that year. In addition, the programme receives a Cabinet approved additional allocation of R200 million in both 2014/15 and 2015/16

Source: South Africa ministry of health program-based budget for the year 2014/15

South Africa also provides information on priorities in capital expenditure. For instance, there is a section providing information on the planned infrastructural plans for FY 2014/15. There is information on the funding amount, the "mega projects," and large projects to be completed in the medium term (see Figure 10).

Figure 10: South Africa's Health Budget with Information on Infrastructure Spending



Infrastructure spending

The department's infrastructure spending is funded through two conditional grants: the provincially delivered health facilities revitalisation grant and the nationally delivered health facility revitalisation component of the national health grant. The total spending on conditional grants for infrastructure projects was R5.5 billion in 2012/13 and unaudited figures put expenditure in 2013/14 at R5.5 billion. R19.1 billion is budgeted for infrastructure projects over the MTEF period.

Mega projects

There are currently 7 mega projects being implemented by national or provincial departments, funded by conditional grants. Each project has a total estimated cost of more than R1 billion. R919.7 million was spent on these projects in 2012/13 and constituted 16.6 per cent of overall infrastructure expenditure. King George V Hospital in KwaZulu-Natal is scheduled for completion in 2013/14, while Natalspruit Hospital in Gauteng was completed in 2013/14 and is to be commissioned early in 2014/15. R2.8 billion has been allocated over the medium term for the remaining 5 mega projects.

Large projects

There are currently 50 large infrastructure projects being implemented by the national or provincial departments funded by the conditional grants. Each project has a total estimated cost of more than R250 million, but less than R1 billion. In 2012/13, the provincial departments spent R2.5 billion on large

Source: South Africa ministry of health program-based budget for the year 2014/15

5.2 Narrative Information: Uganda

Uganda produces more than one budget document that links the activities of the government to outputs and outcomes, including the Background to the Budget, the National Budget Framework Paper, and the Public Investment Plan (the latter contains information about development projects). These documents provide some narrative to complement the budget, but this could still be improved.

Uganda generally fails to provide adequate narrative to explain the budget figures and tables, although, for some specific projects, detailed narrative is provided. Aside from these specific projects, there is more narrative at the outcome and output level than at the vote function (program) level. The narrative provided has details on the implementing agencies, total expenditure costs, performance indicators, period of implementation, as well as the planned outputs and objectives of the project.

Figure 11: Summary of Medium Term Budget Allocations for the Health Sector

Vote Public Investment Plan

Vote Function: 08 02 Health systems development

Development Project Profiles and Medium Term Funding Projections

Project : 0216 District Infrastructure Support Programme

Implementing Agency:	Ministry of Health - Health Infrastructure Division
Responsible Officer:	Permanent Secretary
Location:	Selected Health facilities countrywide
Total Expenditure (UGX bn):	26.120
Previous Expenditure (UGX bn):	24.870
Total Planned Expenditures (UGX bn):	26.120
Funds Secured (UGX bn):	26.120
Funding Gap (UGX bn):	0.000
Start Date:	01/07/2010
Completion Date:	30/06/2015

Background:

Following the political, economic and social events of the 1970's and 1980's, the state of the health system was severely damaged with dilapidated and poorly maintained structures. As a result, concerted effort is required to improve the quality and availability of health infrastructure throughout the country. With the development of the health sector strategic plan and the concept of health sub districts, new structures is required to strengthen the district level health

Expected Outputs:

- District Health facilities Rehabilitated/constructed
- District Health facilities equipped
- Ambulance trucks and station wagons vehicles procured

Performance Indicators:

- Number of District Health facilities rehabilitated
- Number of District Health facilities equipped
- Number of District Health facilities constructed

Technical description of the project:

The project has two components:
1. Primary level of health care services involving procurement of equipment and vehicles for the Health Sub-District and rehabilitative work at District Hospitals.
2. Tertiary level of health care services involving procurement of equipment for Regional Referral Hospitals and improving infrastructure at the health facilities.

Source: Uganda's ministry of health program-based budget for the year 2014/15

The example below shows a section of the narrative describing the sector outcomes, performance and plans to improve the sector outputs. However, the budget makes it difficult to link this narrative to the allocation figures.

Figure 12: Uganda Budget Showing Sector Outcome Indicators and Performance over the First Quarter of 2013/14

S2: Sector Performance and Plans to Improve Sector Outcomes

This section describes past performance and plans to improve sector outcomes. For each outcome it sets out outcome indicators, key sector outputs and actions to improve sector performance. It then sets out analysis of the efficiency of sector allocations and major capital investments.

(i) Outcome 1: Increased deliveries in health facilities

Status of Sector Outcomes

The table below sets out the status of sector outcomes in terms of key sector outcome indicators.

Table S2.1: Sector Outcome Indicators

Outcome 1: Increased deliveries in health facilities

Outcome and Outcome Indicator	Baseline	2014/15 Target	Medium Term Forecast
Proportion of Health Centres with approved posts that are filled by trained health workers	56 (2009)	75	80 (2015)
Proportion of Deliveries in health facilities(Health Centres and Hospitals, Public and Private Not For Profit)	33% (2009)	60	70 (2015)
Proportion of approved posts that are filled by trained health workers	56 (2009)	75	80 (2015)

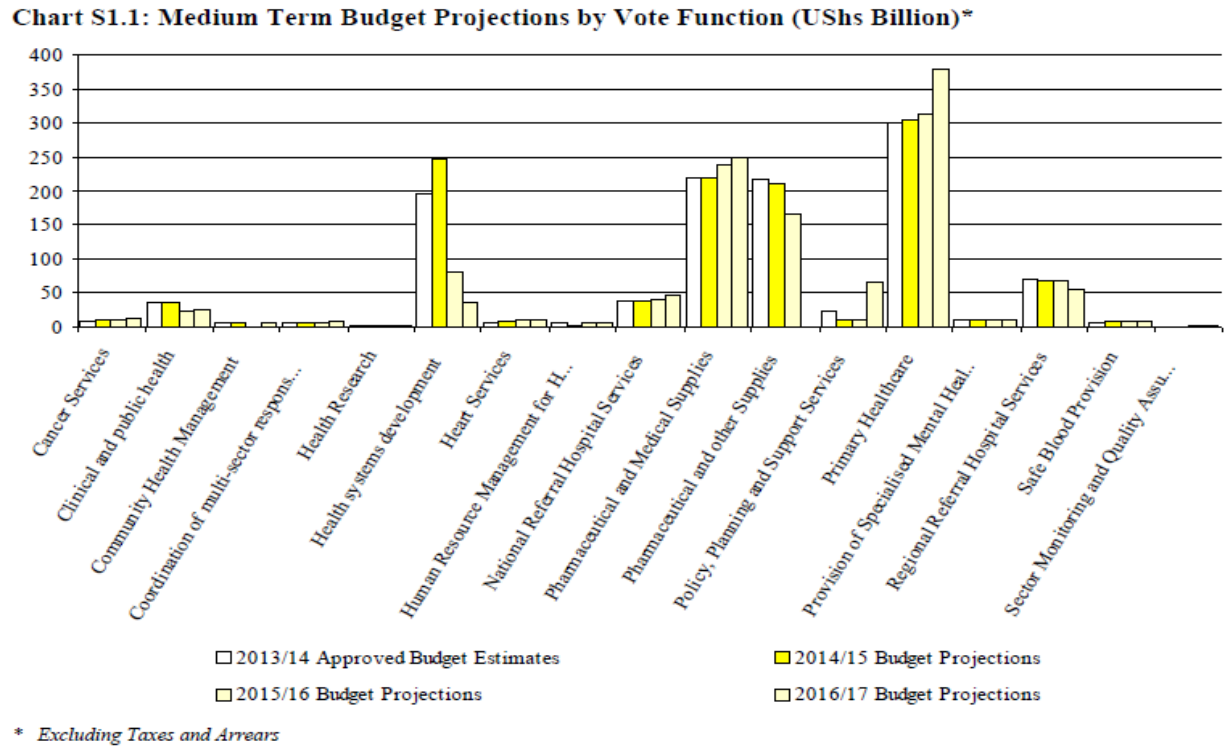
Performance for the first quarter of the 2013/14 financial year

Under Health Systems Development contracts were signed for renovation of 9 Hospitals under Phase 1 namely: Mityana, Nakaseke, Anaka, Moyo, Entebbe, Nebbi, Moroto RRH, Iganga & Kiryandongo. A request for additional funding of US$ 90 million was initiated from the World Bank for renovation of an additional 13 Hospitals and 27 HCIVs under UHSSP under Phase II namely Pallisa, Kitgum, Apac, Bugiri, Abim, Atutur, Kitagata, Masindi, Buwenge, Bukwo, Itojo, Mubende and Moroto: The request is expected to be approved by the World Bank Board in February 2014.

Source: Uganda's ministry of health program-based budget for the year 2014/15

The Uganda budget identifies spending priorities in the health sector, but provides little explanation of why these are prioritized or how this is changing over time. As shown in Figure 13 below, the biggest share of funds will go towards primary health care, followed by pharmaceutical and medical supplies, and regional referral hospitals, but no explanation for this is provided.

Figure 13: Uganda Budget Framework Paper Showing Sector Performance for the Ministry of Health



(i) The Total Budget over the Medium Term

The budget provision for FY 2014/15 for the health sector including NTR is Ushs 1,217.892 bn while that of FY 2015/16 and FY 2016/17 is 1002.184bn and 924.908bn respectively.

(ii) The major expenditure allocations in the sector

Primary Health Care at the decentralized level with shs. 293.79bn followed by Pharmaceutical and Medical supplies under NMS, which accounts for shs. 218.37 Bn. Regional referral services take shs 71.35 Bn

(iii) The major planned changes in resource allocations within the sector

Table S3.2: Major Changes in Sector Resource Allocation

Source: Uganda's ministry of health program-based budget for the year 2014/15

In addition, Uganda provides information on what the ministry of health will focus on in FY 2014/15. Table S3.2 is mentioned in the Budget Framework Paper, which would show the major changes in the sector allocation. However, there is no such table in the paper. While there is no explanation of tradeoffs in the Budget Framework Paper, it does contain a final section showing areas that were not funded and require additional funds. This provides a sense of some of the

tradeoffs that were made in the budget proposal, as well as guiding potential amendments to the overall budget proposal that would free up funds for the sector.

Figure 14: Snippet from Budget Framework Paper Showing Unfunded Outputs by the Government

S4: Unfunded Outputs for 2014/15 and the Medium Term

This section sets out the highest priotrity outputs in 2014/15 and the medium term which the sector has been unable to fund in its spending plans.

The sector faces the following major challenges:

1. Human Resources for Health

- Attraction and retention of health workers: The sector faces a challenge of attracting key human resources for health. This has caused a persistent service delivery gap in health facilities. No funds have been

provided for wage enhancement for the other health workers except Medical officers at Health Centre IIIs and Ivs. Low salaries also lead to increased absenteeism and reduced productivity as workers are forced to consider supplementary sources of income. Ushs. 129bn is required for salary enhancement for all staff in the sector annually.

- Wage provision for bonded health workers: In an attempt to solve the Human Resource challenge the Ministry of Health working with development partners offers scholarships to persons pursuing courses in selected medical fields. Some of these trainees are bonded and are expected to serve in the sector at the end of their training. Many of the bonded personnel have now completed their training and are waiting to be absorbed into the service. The challenge however is that there is no wage provision made for recruitment of these persons. Failure to absorb the health workers may lead to further loss as a result of brain drain. Ushs 2.4bn is required to recruit and pay those that have completed.

There are vacant posts at the ministry of health that are constraining service delivery. Ushs 346 million is required to cover 28 critical posts that require to be filled urgently. The vacancies arise out retirement and therefore recruitment will be on replacement basis.

Source: Uganda's ministry of health program-based budget for the year 2014/15

5.3 Programs with Clear Objectives: South Africa

The South African budget has six program with clear and distinct objectives, which reduces the potential overlap between program objectives we observed in the Kenyan budget. Moreover, further program details are provided below the section on programs in the South African budget that further clarifies their function (see Figure 15).

Figure 15: South Africa's Health Budget Programs and Purposes

Programme purposes

Programme 1: Administration

Purpose: Provide overall management of the department and centralised support services.

Programme 2: National Health Insurance, Health Planning and Systems Enablement

Purpose: Improve access to quality health services through the development and implementation of policies to achieve universal coverage, health financing reform, integrated health systems planning, reporting, monitoring and evaluation, and research.

Programme 3: HIV and AIDS, TB and Maternal and Child Health

Purpose: Develop national policy, and coordinate and fund health programmes for HIV and AIDS and sexually transmitted infections, tuberculosis, maternal and child health, and women's health. Develop and oversee implementation of policies, strengthen systems, set norms and standards, and monitor programme implementation.

Programme 4: Primary Health Care Services

Purpose: Develop and oversee the implementation of legislation, policies, systems, and norms and standards for a uniform district health system, environmental health, communicable and non-communicable diseases, health promotion, and nutrition.

Programme 5: Hospitals, Tertiary Health Services and Human Resource Development

Purpose: Develop policies, delivery models and clinical protocols for hospitals and emergency medical services. Ensure alignment of academic medical centres with health workforce programmes.

Programme 6: Health Regulation and Compliance Management

Purpose: Regulate the procurement of medicines and pharmaceutical supplies, including food control, and the trade in health products and health technology. Promote accountability and compliance by regulatory bodies for effective governance and quality of health care.

Source: South Africa ministry of health program-based budget for the year 2014/15

Figure 16: South Africa's Health Budget Program on HIV and AIDS, Tuberculosis, and Maternal and Child Health; with the Objectives

Programme 3: HIV and AIDS, TB, and Maternal and Child Health

Objectives

- Advance a combination of HIV and AIDS prevention interventions to reduce new infections by:
  - increasing the distribution of condoms
  - expanding medical male circumcision services to reach a minimum of 600 000 eligible males per year
  - offering provider initiated HIV and AIDS counselling and testing to reach 10 million people per year.
- Improve the quality of life of people living with HIV and AIDS by providing an appropriate package of care, treatment and support services to at least 80 per cent of people living with HIV and AIDS and their families by 2014.
- Reduce infant, child and youth morbidity and mortality by:
  - maintaining national immunisation coverage for children under 1 year of age at 90 per cent and above
  - improving the national measles immunisation second dose coverage from 85 per cent in 2010/11 to 90 per cent in 2013

Source: South Africa ministry of health program-based budget for the year 2014/15

Although the South African program structure is more advanced than that of Kenya, it still suffers from some deficiencies. For example, Kenya's PBB manual argues that programs objectives should not only state outputs, but also state intended outcomes of the program. Arguably, most of the South African program objectives shown in Figure 16 are focused on outputs of the department, rather than the overarching outcomes of the program. For

example, Program 5 in figure 15 above focuses on hospitals, but the objective is mostly a set of activities and deliverables from the department without reference to the broader purpose of investing in hospitals, such as providing curative interventions to improve health status.

5.4 Programs with Clear Objectives: Uganda

Uganda's budget is organized differently from both the South African and the Kenyan budget. The focus is not on program in the same manner as Kenya or South Africa's budgets. Instead, it is organized around sector outcomes and outputs. Each sector has votes (ministries and agencies), vote functions (like program), key outputs contributed to by vote functions, and then program and projects below the vote function level. For instance, under the health sector, the health ministry (vote) has six vote functions. Vote functions are groups of related services and capital investments. They are sometimes further broken down into projects or programs, e.g. 0802 Health Systems Development (vote function) has project 0216 "District Infrastructure Support Programme."

Vote functions have key outputs which are strategically important services that contribute directly to the vote's overall objective. They also contribute to the sector's key outcomes (in health, all outputs contribute to one of the three sector outcomes). See Table 8 below.

Table 8: Uganda Budget Showing Vote Function Expenditure and Allocations

Table S3.1: Past Expenditure and Medium Term Projections by Vote Function

	2012/13 Outturn	2013/14 Appr. Budget	2013/14 Spent by End Sept	Medium Term Projections 2014/15	2015/16	2016/17
Vote: 014 Ministry of Health						
0801 Sector Monitoring and Quality Assurance	0.639	0.805	0.027	0.805	1.601	2.200
0802 Health systems development	4.222	190.267	0.057	247.219	79.612	35.000
0803 Health Research	1.746	2.413	0.185	2.413	2.952	3.000
0804 Clinical and public health	22.415	35.216	1.060	34.016	21.501	25.000
0805 Pharmaceutical and other Supplies	5.150	210.327	23.562	210.327	164.984	0.000
0849 Policy, Planning and Support Services	12.418	23.363	1.007	9.954	10.213	64.277
Total for Vote:	**46.588**	**462.391**	**25.899**	**504.734**	**280.862**	**129.477**
Vote: 107 Uganda AIDS Commission						
0851 Coordination of multi-sector response to HIV/AIDS	5.140	5.448	0.942	5.448	5.844	6.404

Source: Uganda's ministry of health program-based budget for the year 2014/15

Figure 17: Uganda Budget Showing the Vote Functions, Projects, and Programs

Sector: Health		**319.18**	**72.69**	**391.87**	**316.70**	**78.69**	**395.39**
Vote: 014	**Ministry of Health**	**20.42**	**11.94**	**32.36**	**19.22**	**11.94**	**31.16**
VF: 0801	*Sector Monitoring and Quality Assurance*	*0.704*	*0.000*	*0.704*	*0.704*	*0.000*	*0.704*
Programmes							
03	Quality Assurance	0.704	0.000	**0.704**	0.704	0.000	**0.704**
VF: 0802	*Health systems development*	*0.000*	*4.797*	*4.797*	*0.000*	*4.797*	*4.797*
Projects							
0216	District Infrastructure Support Programme	0.000	1.398	**1.398**	0.000	1.398	**1.398**
0232	Rehab. Of Health Facilities in Eastern Region	0.000	0.000	**0.000**	0.000	0.000	**0.000**
1027	Insitutional Support to MoH	0.000	1.049	**1.049**	0.000	1.049	**1.049**
1094	Energy for rural transformation programme	0.000	0.200	**0.200**	0.000	0.200	**0.200**
1123	Health Systems Strengthening	0.000	0.400	**0.400**	0.000	0.400	**0.400**
1185	Italian Support to HSSP and PRDP	0.000	0.100	**0.100**	0.000	0.100	**0.100**
1187	Support to Mulago Hospital Rehabilitation	0.000	1.650	**1.650**	0.000	1.650	**1.650**
1243	Rehabilitation and Construction of General Hospitals	0.000	0.000	**0.000**	0.000	0.000	**0.000**
VF: 0803	*Health Research*	*1.461*	*0.000*	*1.461*	*1.461*	*0.000*	*1.461*
Programmes							
04	Research Institutions	1.219	0.000	**1.219**	1.219	0.000	**1.219**
05	JCRC	0.242	0.000	**0.242**	0.242	0.000	**0.242**
VF: 0804	*Clinical and public health*	*18.252*	*0.100*	*18.352*	*17.052*	*0.100*	*17.152*
Programmes							
06	Community Health	2.165	0.000	**2.165**	2.165	0.000	**2.165**
07	Clinical Services	7.465	0.000	**7.465**	7.865	0.000	**7.865**
08	National Disease Control	8.512	0.000	**8.512**	6.912	0.000	**6.912**
11	Nursing Services	0.110	0.000	**0.110**	0.110	0.000	**0.110**
Projects							
1148	Public Health Laboratory strengthening project	0.000	0.100	**0.100**	0.000	0.100	**0.100**
1218	Uganda Sanitation Fund Project	0.000	0.000	**0.000**	0.000	0.000	**0.000**
VF: 0805	*Pharmaceutical and other Supplies*	*0.000*	*7.042*	*7.042*	*0.000*	*7.042*	*7.042*
Projects							
0220	Global Fund for AIDS, TB and Malaria	0.000	3.842	**3.842**	0.000	3.842	**3.842**

Source: Uganda's ministry of health program-based budget for the year 2014/15

The Public Investment Plan document contains detailed information of development projects of the vote function and goes further to give a number of specific outputs and objectives. For instance, under the vote function "0802 Health Systems Development", the project "0216 District Infrastructure Support Programme" has the following objective, expected output and link to the National Development Plan.

Figure 18: Vote Function 0216 District Infrastructure Support Program in the Public Investment Plan document

Vote: 014 Ministry of Health

Vote Public Investment Plan

Vote Function: 08 02 Health systems development

Development Project Profiles and Medium Term Funding Projections

Project : 0216 District Infrastructure Support Programme

Objectives:

The central objective of this project is to improve the infrastructure of the health system by purchasing essential equipment and undertaking rehabilitation of Regional and District health facilities.

Link with the NDP:

The project contributes to objective 4 of the NDP which relates to increasing access to quality social services through provision and utilization of promotive, preventive, curative and rehabilitative services. Specifically the project will strengthen health systems and ensure universal access to the Uganda National Minimum health Care Package (UNMHCP) in order to achieve the sector objectives to reduce morbidity and mortality from the major causes of ill health and premature death. The project will improve three sector outcomes namely; increased deliveries in health facilities, children under one year old protected against life threatening diseases, availing adequate stocks of essential medicines and health supplies to facilities.

Expected Outputs:

- District Health facilities Rehabilitated/constructed
- District Health facilities equipped
- Ambulance trucks and station wagons vehicles procured

Planned activities for FY 2014/15:

- Completion of construction and equipping of Kisozi HC III
- Completion of construction and equipping of Buyiga HC III
- Paying of retention funds for Kapchorwa and Masafu Hospital projects.
- Carry out monthly technical supervision for health infrastructure developments at 13 RRH,3GH,and 20 selected district health facilities
- Carry out a detailed health facilities inventory and condition assessment for HC II – IV for the whole country
- Maintain vehicles
- Print and bind reports and inventories and procure stationary

Source: Uganda's ministry of health program-based budget for the year 2014/15

The project outputs mentioned in the Public Investment Plan document above correspond to the numbered outputs in the Health Sector Budget Framework Paper as shown in Table 9 below.

Table 9: Project 0216 District Infrastructure Support Program in the Health Framework Budget Paper Showing Outputs

Table S2.7: Major Capital Investments

Project Vote Function Output *UShs Thousand*	2013/14 Approved Budget, Planned Outputs (Quantity and Location)	 Actual Expenditure and Outputs by September (Quantity and Location)	2014/15 Proposed Budget, Planned Outputs (Quantity and Location)
Vote: 014 Ministry of Health			
Vote Function: 0802 Health systems development			
Project 0216 District Infrastructure Support Programme			
080280 Hospital Construction/rehabilitation	•Kisozi HCIII: Completion of Construction and equipping carried out. •Buyiga HCIII: Completion of Construction and equipping carried out. Retention for Kapchorwa and Masafu Hospital retention paid	The activities of this project were sheduled for the next quarters	- Buyiga HCIII: Completion of Construction and equipping carried out. Initial allocations were not sufficient to complete the works.
Total	**1,247,000**	***0***	**700,000**
GoU Development	***1,247,000***	***0***	***700,000***
External Financing	***0***	***0***	***0***

Source: Uganda's ministry of health program-based budget for the year 2014/15

While the Public Investment Plan lists additional activities for FY 2014/15, these are not all reflected in the plan. For example, we can only see "Completion of Construction and equipping carried out" of Buyiga HCIII planned for the year 2014/15 while the Public Investment Plan document also mentions Kisozi HCIII.

5.5 Indicators, Targets, and Timeline: South Africa

South Africa provides detailed information on the goals to be achieved, the indicators used to measure these, the baseline, the targets, and the timetable for achieving these goals. South Africa provides information on selected performance indicators with details on the project or activity under each program, as well as the timeframe with both the past, present, and projected expenditure. Not all objectives are this detailed, however. For instance, the goal to "combat HIV and AIDS and decrease the burden of disease from tuberculosis" does not show the target or the timeframe. Nevertheless, on balance the indicators, targets, and timeframes are superior to those in the Kenyan budget.

Figure 19: South Africa Health Budget Strategic Goals and Selected Performance Indicators

Mandate

The Department of Health derives its mandate from the National Health Act (2003), which requires the department to provide a framework for a structured uniform health system within South Africa. The act sets out the functions of the three levels of government as they relate to health services. The department contributes directly to achieving the government outcome which calls for a long and healthy life for all South Africans.

Strategic goals

The department's strategic goals over the medium term are to:

- increase average male and female life expectancy at birth to 70 years in 2030
- decrease maternal mortality ratio from estimated 310 per 100 000 to 270 (or less) per 100 000 live births by 2014
- decrease child mortality ratio from current 42 deaths per 1 000 live births to 38 deaths (or less) per 1 000 live births by 2014
- combat HIV and AIDS and decrease the burden of disease from tuberculosis
- strengthen the health system's effectiveness by focusing on reengineering primary health care and improving patient care and satisfaction, health infrastructure availability, human resources for health, and healthcare financing through the implementation of the national health insurance and strengthening health information systems.

Selected performance indicators

Table 6.21 National Health Laboratory Service

Indicator	Programme/ Activity/Objective/ Project	Past			Current	Projected		
		2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Turnaround times: CD4 conducted within 72 hours	Laboratory tests	86%	86%	85%	87%	88%	90%	90%
(volume of CD4 tests)			(2614 032)	(3 933 642)	(4 130 324)	(4336 840)	(4 553 682)	(4 781 366)
Turnaround times: Viral load within 4 days	Laboratory tests	41%	52%	87%	85%	90%	90%	90%
(volume of viral loads tests)		(437 060)	(605 002)	(1 394 743)	(1 464 480)	(1 537704)	(1 614 587)	(1 695 319)
Turnaround times: Tuberculosis microscopy within 48 hours	Laboratory tests	60%	95%	94%	90%	90%	90%	90%
(volume of TB microscopy tests)		(4 909 075)	(4 911 621)	(5 228 438)	(5 489 859)	(5 764 352)	(6 052 569)	(6 355 198)
Turnaround times: HIV polymerase chain reaction test within 5 days	Laboratory tests	55%	67%	85%	85%	90%	90%	90%
(volume of HIV polymerase chain reaction test tests)		(124 630)	(160 133)	(317 347)	(333 214)	(349 875)	(367 369)	(385 737)

Source: South Africa ministry of health program-based budget for the year 2014/15

5.6 Indicators, Targets, and Timeline: Uganda

Uganda provides indicators for the three priority sector outcomes of the health sector. These are generally broader than the vote functions and link to the national development plan objectives. Each outcome indicator has targets and shows the timeframe for achieving them, including a baseline showing current status. For instance, the outcome on increasing deliveries in health facilities has an indicator "proportion of deliveries in health facilities."

Figure 20: Sector Outcomes in Health Facilities and Contribution to Sector Outomes in the Uganda budget

(ii) Sector Contributions to the National Development Plan

Following the National Development Plan results chain, the three health sector outcomes in the budget framework paper are;

1. Increased deliveries in Health facilities
2. Children under one year old protected against life threatening diseases
3. Health facilities receive adequate stocks of essential medicines and health supplies (EMHS).

The above listed outcomes are mapped to the NDP objectives and sector interventions as follows.

Increased deliveries in Health Centres is mapped on the NDP Strategic Objective of strengthening the organisation & Management of Health Systems comprising the following interventions:

This section describes past performance and plans to improve sector outcomes. For each outcome it sets out outcome indicators, key sector outputs and actions to improve sector performance. It then sets out analysis of the efficiency of sector allocations and major capital investments.

(i) Outcome 1: Increased deliveries in health facilities

Status of Sector Outcomes

The table below sets out the status of sector outcomes in terms of key sector outcome indicators.

Table S2.1: Sector Outcome Indicators

Outcome 1: Increased deliveries in health facilities

Outcome and Outcome Indicator	Baseline	2014/15 Target	Medium Term Forecast
Proportion of Health Centres with approved posts that are filled by trained health workers	56 (2009)	75	80 (2015)
Proportion of Deliveries in health facilities(Health Centres and Hospitals, Public and Private Not For Profit)	33% (2009)	60	70 (2015)
Proportion of approved posts that are filled by trained health workers	56 (2009)	75	80 (2015)

Source: Uganda's ministry of health program-based budget for the year 2014/15

As can be seen in Figure 20, the Uganda budget lacks detailed information on progress over time, showing only the baseline from the year 2009. It could be improved by including more recent information about the indicator, whether recent targets were met, and projections of the target for more than one additional year. As with the Kenyan budget, there are some indicators that lack actual figures. It is therefore impossible to know whether any progress has been made against these. For example, the figure below is not clear on the status of the fencing or rehabilitation of the sewer line. Baseline information is also missing and one does not know when these targets will be achieved.

Figure 21: Uganda Budget Showing Indicators that Lack Actual Figures and Baseline Information

Vote, Vote Function Key Output	2013/14 Approved Budget and Planned outputs	2013/14 Spending and Outputs Achieved by End Sept	2014/15 Proposed Budget and Planned Outputs
Output: 085680	**Hospital Construction/rehabilitation**		
Description of Outputs:	Construction of lagoon.	construction on going	Hospital lagoon completed
	Fencing of the Hospital		
	Rehabilitation of sewer line		
Performance Indicators:			
No. reconstructed/rehabilitated general wards	0	0	0

Source: Uganda's ministry of health program-based budget for the year 2014/15

5.7 Subprograms and Further Disaggregation: South Africa

The South African breaks all of its programs into subprograms, which each have their own set of objectives (see Figure 22).

Figure 22: South Africa Health Budget with Information on Subprograms

Subprogrammes

- *HIV and AIDS* is discussed in more detail in the section below.
- *Tuberculosis* develops national policies and guidelines, and sets norms and standards for tuberculosis. In line with the 20-year vision outlined in the new 2012-2016 national strategic plan for HIV and AIDS, sexually transmitted infections and tuberculosis, core interventions will be scaled up, including intensified case finding and the rollout of rapid diagnostics using Gene Xpert technology. This subprogramme had a staff complement of 24 in 2012/13.
- *Women's Maternal and Reproductive Health* develops and monitors policies and guidelines, and sets norms and standards for maternal health and women's health. Over the medium term, key initiatives will continue to be implemented to reduce maternal mortality, using the recommendations from the ministerial committees on maternal mortality and the South African branch of the campaign to accelerate the reduction of maternal mortality in Africa. Interventions will include: deploying obstetric ambulances, strengthening family planning services, establishing maternity waiting homes, establishing Kangaroo Mother Care facilities, taking essential steps in managing obstetric emergency training for doctors and midwives, intensifying

Source: South Africa ministry of health program-based budget for the year 2014/15

Four subprograms are presented in the HIV and AIDS, Tuberculosis, and Maternal and Child Health programs. The amount of money that goes into each subprogram is also presented. For selected subprograms each year, a further breakdown of the subprogram's budget is provided.

Figure 23: South Africa Health Budget with Information on Estimates Under one Program

Expenditure estimates

Table 16.9 HIV and AIDS, TB, Maternal and Child Health

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Exp ditu to Aver
R thousand	2009/10	2010/11	2011/12	2012/13	2009/10 - 2012/13		2013/14	2014/15	2015/16	2012/13 - 2015/	
HIV and AIDS	4 851 645	6 404 279	7 852 898	9 205 928	23.8%	99.1%	10 968 950	12 804 566	14 481 069	16.3%	99.
Tuberculosis	16 378	15 822	16 592	25 710	16.2%	0.3%	26 042	26 729	28 113	3.0%	0.
Women's Maternal and Reproductive Health	10 267	11 826	15 521	17 574	19.6%	0.2%	17 158	17 613	18 465	1.7%	0.
Child, Youth and School Health	45 161	39 410	29 893	15 359	-30.2%	0.5%	16 984	17 766	18 617	6.6%	0.
Total	**4 923 451**	**6 471 337**	**7 914 904**	**9 264 571**	**23.5%**	**100.0%**	**11 029 134**	**12 866 674**	**14 546 264**	**16.2%**	**100.**
Change to 2012 Budget estimate				(27 977)			(52 104)	50 371	1 140 411		

Table 16.9 HIV and AIDS, Tuberculosis, Maternal and Child Health

Economic classification	Audited outcome			Adjusted appropri-ation	Average growth rate (%)	Expen-diture/ total: Average (%)	Medium-term expenditure estimate			Average growth rate (%)	Expen-diture/ total: Average (%)
R thousand	2010/11	2011/12	2012/13	2013/14	2010/11 - 2013/14		2014/15	2015/16	2016/17	2013/14 - 2016/17	
Current payments	**284 112**	**258 215**	**219 485**	**305 394**	**2.4%**	**3.1%**	**533 116**	**565 949**	**386 303**	**8.1%**	**3.2%**
Compensation of employees	48 821	52 967	59 447	63 892	9.4%	0.7%	64 404	67 350	70 985	3.6%	0.5%
Goods and services	235 291	205 248	160 038	241 502	0.9%	2.4%	468 712	498 599	315 318	9.3%	2.8%
of which:											
Administration fees	–	–	–	*316*	–	–	*330*	*345*	–	*-100.0%*	–
Advertising	*42 758*	*19 827*	*6 040*	*11 902*	*-34.7%*	*0.2%*	*46 258*	*21 668*	*13 322*	*3.8%*	*0.2%*
Assets less than the capitalisation threshold	*270*	*691*	*335*	*1 456*	*75.4%*	–	*1 545*	*1 653*	*392*	*-35.4%*	–
Catering: Departmental activities	*1 279*	*814*	*656*	*2 794*	*29.8%*	–	*2 913*	*3 049*	*887*	*-31.8%*	–
Communication	*479*	*406*	*626*	*643*	*10.3%*	–	*683*	*737*	*731*	*4.4%*	–
Computer services	*22*	*5*	*1*	*115*	*73.6%*	–	*129*	*144*	–	*-100.0%*	–
Consultants and professional services:	*6 122*	*2 800*	*9 505*	*25 145*	*60.1%*	*0.1%*	*16 511*	*20 066*	*29 522*	*5.5%*	*0.2%*

Source: South Africa ministry of health program-based budget for the year 2014/15

5.8 Subprograms and Further Disaggregation: Uganda

Uganda's budget provides extensive detail about outputs. When it comes to further detail about activities within vote functions, this is limited to the capital side of the budget (usually called "projects"). Figure 24 shows the details beyond the vote function "clinical and public health."

Figure 24: Uganda Budget Showing Details Beyond Output Level of Projects

Vote Function: 0804 Clinical and public health				
Project 1148 Public Health Laboratory strengthening project				
80472 Government Buildings and Administrative Infrastructure	Architectural plans developed, 4 satellite laboratories (Arua, Mbale, Mbarara, and Lacor) and NTRL construction at Butabika initiated Consultancy services to procure and install ventilation system on the new NTRL procured	The stage of drawing floor diagram for4 satellite laboratories (Arua, Mbale, Mbarara, and Lacor) for been locked down to allow move on to the next stage of drafting architectural designs by AMHOLD Bids for constructing NTRL were evaluated and the Best Evaluated Bidder was notified after a No Objection from the TTL. The Contract has been submitted to the SG for his opinion.		Architectural plans developed, 4 satellite laboratories (Arua, Mbale, Mbarara, and Lacor) and NTRL construction at Butabika initiated Consultancy services to procure and install ventilation system on the new NTRL procured
Total	**11,380,790**	*0*		**11,380,790**
GoU Development	*0*	*0*		*0*
External Financing	*11,380,790*	*0*		*11,380,790*

Source: Uganda's ministry of health program-based budget for the year 2014/15

5.9 Economic Classification: South Africa

A summary of the estimates by economic classification (current payments to staff, goods and services, transfers and subsidies, payments for capital assets, and payments for financial assets) is provided in the South African budget. Each economic classification is also further broken down. For instance, under "Current Payments" in the South African budget, there is a further breakdown of goods and services, which includes administration fees, advertising, assets etc (see Figure 25).

Figure 31: South Africa Economic Classification Breakdown

Economic classification												
Current payments	**1 089.7**	**898.0**	**1 083.4**	**1 373.9**	**1 258.9**	**4.9%**	**4.5%**	**1 638.8**	**1 837.6**	**1 933.6**	**15.4%**	**5.2%**
Compensation of employees	333.0	353.7	409.7	486.6	486.6	13.5%	1.7%	538.4	567.9	596.9	7.1%	1.7%
Goods and services	756.7	544.4	673.7	887.4	772.4	0.7%	2.9%	1 100.4	1 269.7	1 336.7	20.1%	3.5%
of which:												
Administration fees	*0.2*	*0.2*	*0.2*	*6.2*	*6.2*	*200.5%*	*0.0%*	*2.0*	*1.0*	*1.0*	*-44.7%*	*0.0%*
Advertising	*95.2*	*49.1*	*34.0*	*57.9*	*17.9*	*-42.7%*	*0.2%*	*23.7*	*58.5*	*39.4*	*30.1%*	*0.1%*
Assets less than the capitalisation threshold	*2.2*	*1.5*	*3.4*	*13.7*	*13.7*	*85.1%*	*0.0%*	*16.2*	*17.2*	*18.0*	*9.5%*	*0.1%*
Audit cost: External	*31.6*	*16.1*	*22.2*	*18.5*	*18.5*	*-16.3%*	*0.1%*	*29.4*	*27.5*	*29.3*	*16.6%*	*0.1%*
Bursaries: Employees	*0.9*	*1.0*	*1.5*	*1.4*	*1.4*	*12.8%*	*0.0%*	*1.4*	*1.5*	*1.6*	*4.5%*	*0.0%*
Catering: Departmental activities	*2.5*	*3.7*	*3.0*	*7.2*	*7.2*	*41.6%*	*0.0%*	*8.4*	*7.8*	*8.2*	*4.4%*	*0.0%*
Communication	*16.0*	*17.3*	*17.5*	*25.5*	*25.5*	*17.0%*	*0.1%*	*27.6*	*23.8*	*25.1*	*-0.6%*	*0.1%*
Computer services	*31.3*	*12.9*	*30.9*	*21.1*	*20.1*	*-13.7%*	*0.1%*	*21.7*	*23.1*	*24.3*	*6.6%*	*0.1%*
Consultants and professional services: Business and advisory services	*39.1*	*69.2*	*110.9*	*188.8*	*158.8*	*59.5%*	*0.4%*	*150.3*	*146.9*	*138.2*	*-4.5%*	*0.5%*
Consultants and professional services: Laboratory services	–	–	–	*0.1*	*0.1*		*0.0%*	*0.1*	*0.1*	*0.1*	*17.0%*	*0.0%*
Consultants and professional services: Legal costs	*1.7*	*0.7*	*35.0*	*1.0*	*1.0*	*-16.2%*	*0.0%*	*1.1*	*1.1*	*1.2*	*4.9%*	*0.0%*
Contractors	*15.7*	*18.8*	*6.6*	*20.9*	*20.9*	*10.0%*	*0.1%*	*313.0*	*443.0*	*464.1*	*181.0%*	*1.0%*
Agency and support / outsourced services	*12.6*	*11.2*	*9.0*	*18.7*	*17.7*	*12.0%*	*0.1%*	*19.4*	*15.0*	*15.8*	*-3.8%*	*0.1%*
Entertainment	*0.2*	*0.2*	*0.1*	*0.8*	*0.8*	*55.8%*	*0.0%*	*0.8*	*0.9*	*0.9*	*6.7%*	*0.0%*
Inventory: Fuel, oil and gas	*0.3*	*0.3*	*0.1*	*0.5*	*0.5*	*14.7%*	*0.0%*	*0.5*	*0.5*	*0.6*	*4.8%*	*0.0%*

Source: South Africa ministry of health program-based budget for the year 2014/15

5.10 Economic Classification: Uganda

Uganda provides a different breakdown of its economic classification. For instance, the national budget framework document provides extremely limited breakdown of the budget into recurrent and development allocations. The recurrent budget is further broken down into wage and non-wage information, and the development budget is broken down by source (government or external). This information is only available at the vote level. The approved budget estimates provide six categories of economic classification for both development and recurrent expenditure (payments to personnel, employer contribution, fixed assets, arrears and taxes, transfer and other goods and services). However, this information is only provided fir the overall budget but is not even broken down to vote level.

Table 10: Sector Expenditures in the Uganda Budget Framework Paper with Economic Classification

(i) Snapshot of Sector Performance and Plans*

Table S1.1 and Chart S1.1 below summarises the Medium Term Budget allocations for the Sector:

Table S1.1: Overview of Sector Expenditures (UShs Billion, excluding taxes and arrears)

		2012/13 Outturn	2013/14 Approved Budget	2013/14 Spent by End Sept	MTEF Budget Projections 2014/15	2015/16	2016/17
Recurrent	Wage	238.722	305.666	66.366	305.666	305.666	365.838
	Non Wage	316.861	331.499	86.170	333.799	359.953	373.886
Development	GoU	63.207	75.380	12.406	80.374	94.809	97.913
	Ext. Fin.	0.204	416.668	23.931	460.017	230.380	75.650
GoU Total		**618.790**	**712.546**	**164.941**	**719.840**	**760.428**	**837.638**
Total GoU+Ext Fin. (MTEF)		**618.994**	**1,129.214**	**188.872**	**1,179.857**	**990.808**	**913.287**
Non Tax Revenue		*0.000*	*17.295*	*4.839*	*18.366*	*11.376*	*11.621*
Grand Total		**618.994**	**1,146.510**	**184.034**	**1,198.223**	**1,002.184**	**924.908**

Source: Uganda's ministry of health program-based budget for the year 2014/15

The Ugandan Public Investment Plan document provides a detailed breakdown of inputs into different projects. However, these are not aligned to a clear economic classification (see Figure 26).

Figure 26: Summary Project Estimates by Item from Uganda 2014/15 Ministry of Health Public Investment Plan document

Summary Project Estimates by Item:

Thousand Uganda Shillings	2013/14 Approved Budget				2014/15 Draft Estimates			
	GoU	External Fin.	A.I.A	Total	GoU	External Fin.	A.I.A	Total
1123 Health Systems Strengthening	***5,400,000***	***107,420,000***	***N/A***	***112,820,000***	***550,000***	***80,610,000***	***N/A***	***81,160,000***
211103 Allowances	60,000	0	N/A	60,000	60,000	0	N/A	60,000
221001 Advertising and Public Relations	40,000	0	N/A	40,000	0	0	N/A	0
221003 Staff Training	90,000	0	N/A	90,000	72,000	0	N/A	72,000
221007 Books, Periodicals & Newspapers	3,001	0	N/A	3,001	7,000	0	N/A	7,000
221009 Welfare and Entertainment	8,000	0	N/A	8,000	0	0	N/A	0
221011 Printing, Stationery, Photocopying and Binding	10,000	0	N/A	10,000	0	0	N/A	0
224001 Medical and Agricultural supplies	0	500,000	N/A	500,000	0	4,500,000	N/A	4,500,000
224002 General Supply of Goods and Services	0	700,000	N/A	700,000	0	0	N/A	0
225001 Consultancy Services- Short term	0	400,000	N/A	400,000	0	500,000	N/A	500,000
227001 Travel inland	63,000	0	N/A	63,000	60,000	0	N/A	60,000
227002 Travel abroad	75,000	0	N/A	75,000	30,000	0	N/A	30,000
227004 Fuel, Lubricants and Oils	0	0	N/A	0	120,000	0	N/A	120,000
228002 Maintenance - Vehicles	50,999	0	N/A	50,999	51,000	0	N/A	51,000
231001 Non Residential buildings (Depreciation)	0	92,618,354	N/A	92,618,354	0	69,610,000	N/A	69,610,000
231004 Transport equipment	0	1,000,000	N/A	1,000,000	0	0	N/A	0
231005 Machinery and equipment	0	6,701,646	N/A	6,701,646	0	0	N/A	0
231006 Furniture and fittings (Depreciation)	0	2,500,000	N/A	2,500,000	0	0	N/A	0
282103 Scholarships and related costs	0	3,000,000	N/A	3,000,000	0	6,000,000	N/A	6,000,000
312204 Taxes on Machinery, Furniture & Vehicles	0	0	N/A	0	150,000	0	N/A	150,000
312206 Gross Tax	5,000,000	0	N/A	5,000,000	0	0	N/A	0
Grand Total Vote 014	**5,400,000**	**107,420,000**	**N/A**	**112,820,000**	**550,000**	**80,610,000**	**N/A**	**81,160,000**
Total Excluding Taxes, Arrears and A.I.A	*400,000*	*107,420,000*	*0*	***107,820,000***	*400,000*	*80,610,000*	*0*	***81,010,000***

Source: Uganda's ministry of health program-based budget for the year 2014/15

5.11 Information on Key Personnel and Costs: South Africa

South Africa provides information on staff salary levels and the number of added posts at the program level (see Figure 27). Costs for the current year and for the medium term are provided, as is average growth rate. However, it should be noted that the presentation does not allow for a distinction to be made between administration staff and service delivery staff.

Figure 27: South Africa's Health Budget with Information on Personnel According to the Salary Level

Personnel information

Table 16.6 Details of approved establishment and personnel numbers according to salary level[1]

	Number of posts estimated for 31 March 2014		Number and cost[2] of personnel posts filled / planned for on funded establishment													Number	
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate							Average growth rate (%)	Salary level/total: Average (%)
			2012/13			2013/14			2014/15			2015/16			2016/17		2013/14 - 2016/17
Administration			Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost	Number	Cost	Unit Cost		
Salary level	**530**	**10**	**498**	**137.4**	**0.3**	**530**	**167.1**	**0.3**	**488**	**161.6**	**0.3**	**488**	**170.5**	**0.3**	**488**	**180.0**	**0.4**	**-2.7%**	**100.0%**
1 – 6	270	6	267	39.4	0.1	270	41.8	0.2	246	41.7	0.2	246	44.0	0.2	246	46.3	0.2	-3.1%	50.6%
7 – 10	161	1	140	41.6	0.3	161	51.9	0.3	146	49.4	0.3	146	52.0	0.4	146	55.3	0.4	-3.2%	30.0%
11 – 12	49	1	50	25.0	0.5	51	29.6	0.6	54	32.4	0.6	54	34.1	0.6	54	36.3	0.7	1.9%	10.7%
13 – 16	48	2	39	27.7	0.7	46	40.1	0.9	40	34.2	0.9	40	36.3	0.9	40	37.8	0.9	-4.6%	8.3%
Other	2	–	2	3.7	1.8	2	3.7	1.8	2	3.9	1.9	2	4.1	2.1	2	4.3	2.2	–	0.4%

1. Data has been provided by the department and may not necessarily reconcile with official government personnel data.
2. Rand million.

Source: South Africa ministry of health program-based budget for the year 2014/15

5.12 Information on Key Personnel and Costs: Uganda

The 2014/15 Uganda budget does not provide detailed information about personnel type, nor job group beyond overall wages. The Budget framework paper categorizes recurrent allocations into wage and non-wage at the vote function level. The Public Investment Plan document is further broken down into general staff salaries and allowances. The overall thrust of the Ugandan budget is to focus almost exclusively on outputs and outcomes, so there is fairly limited input data, such as that on wages.

Figure 28: Uganda's 2013/14 Health Budget Showing Wages Broken Down

Programme 07 Clinical Services

Thousand Uganda Shillings	2012/13 Approved Budget			2013/14 Approved Estimates		
Outputs Provided	**Wage**	**Non-Wage**	**Total**	**Wage**	**Non Wage**	**Total**
Output:080402 Clinical health services provided (infrastructure, pharmaceutical, integrated curative)						
211101 General Staff Salaries	1,028,245	0	**1,028,245**	1,021,000	0	**1,021,000**
211103 Allowances	0	50,751	**50,751**	0	61,250	**61,250**
221002 Workshops and Seminars	0	38,170	**38,170**	0	50,050	**50,050**
221003 Staff Training	0	18,500	**18,500**	0	25	**25**
221007 Books, Periodicals and Newspapers	0	3,300	**3,300**	0	400	**400**
221008 Computer Supplies and IT Services	0	19,230	**19,230**	0	500	**500**
221009 Welfare and Entertainment	0	19,566	**19,566**	0	7,750	**7,750**
221010 Special Meals and Drinks	0	6,600	**6,600**	0	3,300	**3,300**
221011 Printing, Stationery, Photocopying and	0	80,471	**80,471**	0	37,850	**37,850**
221012 Small Office Equipment	0	0	**0**	0	7,500	**7,500**
224002 General Supply of Goods and Services	0	16,656	**16,656**	0	34,700	**34,700**
227001 Travel Inland	0	239,766	**239,766**	0	338,400	**338,400**
227002 Travel Abroad	0	10,673	**10,673**	0	88,524	**88,524**
227004 Fuel, Lubricants and Oils	0	30,269	**30,269**	0	91,600	**91,600**
228002 Maintenance - Vehicles	0	34,198	**34,198**	0	17,200	**17,200**
228003 Maintenance Machinery, Equipment an	0	66,500	**66,500**	0	395,000	**395,000**
228004 Maintenance Other	0	0	**0**	0	600	**600**
Total Cost of Output 080402:	***1,028,245***	***634,649***	***1,662,894***	***1,021,000***	***1,134,649***	***2,155,649***
Total Cost of Outputs Provided	**1,028,245**	**634,649**	**1,662,894**	**1,021,000**	**1,134,649**	**2,155,649**

Source: Uganda's ministry of health program-based budget for the year 2014/15

Figure 29: Wage Spending by Vote Contained in the Uganda Background to the Budget

Table 35 cont'd: Medium term expenditure framework (excluding energy savings, arrears and non-VAT) , billion shl

		FY 2015/16 Budget Projections				
	Sector/vote	**Wage**	**Non-Wage Recurrent**	**Domestic dev't**	**External Financing**	**Total excl. External Financing**
Security						
001	ISO	24.65	9.58	0.66	-	34.89
004	Defence (incl. Auxiliary)	416.04	367.35	104.64	204.36	888.02
159	ESO	8.16	4.10	0.40	-	12.66
	Sub total- security	**448.86**	**381.02**	**105.69**	**204.36**	**935.57**
Health						
014	Health	6.37	28.95	13.23	227.32	48.55
107	Uganda Aids Commission(Statutory)	1.48	4.02	0.13	-	5.62
114	Uganda Cancer Institute	2.07	1.10	7.19	-	10.36
115	Uganda Heart Institute	2.29	1.48	5.57	-	9.33
116	National Medical Stores	-	222.74	-	-	222.74
134	Health Service Commission	0.93	2.41	0.35	-	3.70
151	Uganda Blood Transfusion Service (UBTS)	2.01	4.19	0.37	-	6.58
161	Mulago Hospital Complex	21.56	13.48	5.08	-	40.12
162	Butabika Hospital	3.96	3.67	1.83	-	9.46
163-176	Regional Referral Hospitals	42.29	16.00	13.48	-	71.76
501-850	District NGO Hospitals/Primary Health Care	-	17.54	-	-	17.54
501-850	District Primary Health Care	266.08	16.16	30.44	-	312.68
501-850	District Hospitals	-	6.06	3.24	-	9.30
501-850	District Health Sanitation Grant	-	2.25	-		2.25
122	KCCA Health Grant	2.73	1.35	0.13	100.14	4.21
	Sub-total Health	**351.76**	**341.40**	**81.04**	**327.46**	**774.20**

Source: Ministry of Finance, Planning and Economic Development

Source: Uganda's ministry of health program-based budget for the year 2014/15

5.13 Appropriation in Aid (AiA): South Africa

South Africa provides information about donor funding, including the amount of funds received from donors; which type of donor; the name or type of project; and the departmental program that receives the funding.

Figure 30: South Africa 2013/14 Health Budget Showing Summary of Donor Funding

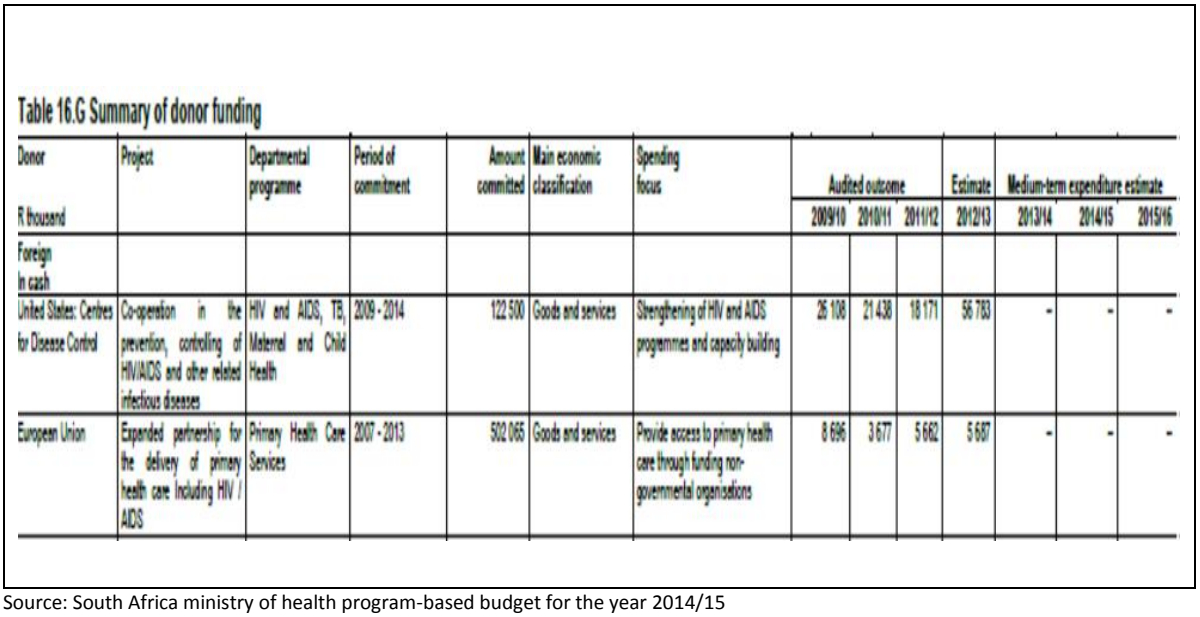


Table 16.G Summary of donor funding

Donor	Project	Departmental programme	Period of commitment	Amount committed	Main economic classification	Spending focus	Audited outcome			Estimate	Medium-term expenditure estimate		
R thousand							2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Foreign in cash													
United States: Centres for Disease Control	Co-operation in the prevention, controlling of HIV/AIDS and other related infectious diseases	HIV and AIDS, TB, Maternal and Child Health	2009 - 2014	122 500	Goods and services	Strengthening of HIV and AIDS programmes and capacity building	25 108	21 438	18 171	56 783	-	-	-
European Union	Expanded partnership for the delivery of primary health care including HIV / AIDS	Primary Health Care Services	2007 - 2013	502 065	Goods and services	Provide access to primary health care through funding non-governmental organisations	8 696	3 677	5 662	5 687	-	-	-

Source: South Africa ministry of health program-based budget for the year 2014/15

5.14 Appropriation in Aid (AiA): Uganda

Uganda's budget on the other hand has information about external financing which is contained in both the PIP document and the budget framework document. In the PIP, one can find the name of the donor, the amount of donor funding to be received and the medium-term projections. In the budget framework paper, donor funding at the vote function level is provided, but not by specific donor source.

Figure 31: Uganda Budget Showing Information About Donor Funds Including Information About the Allocations

External Financing to Vote

Projected Funding Allocations (UShs billion)	2012/13 Budget	2013/14 Budget	MTEF Projections 2014/15	2015/16	2016/15
0220 Global Fund for AIDS, TB and Malaria					
436 Global Fund for HIV, TB & Malaria	20.874	142.575	**255.800**	96.948	0.000
0232 Rehab. Of Health Facilities in Eastern Region					
523 Japan	0.660	2.640	**0.000**	0.000	0.000
1123 Health Systems Strengthening					
410 International Development Association (IDA)	79.320	107.420	**80.610**	3.000	0.000
1141 Gavi Vaccines and HSSP					
451 Global Alliance for Vaccines Immunisation	57.120	60.710	**48.290**	56.940	0.000
1145 Institutional Capacity Building					
504 Belgium	5.290	13.903	**9.616**	0.000	45.637
1148 TB laboratory strengthening project					
410 International Development Association (IDA)	15.052	13.430	**5.110**	0.000	0.000
1185 Italian Support to HSSP and PRDP					
522 Italy	3.520	4.760	**0.000**	0.000	0.000

Project Funding Allocations:

Projected Funding Allocations (UShs billion)	2012/13 Budget	2013/14 Budget	MTEF Projections 2014/15	2015/16	2016/15
Domestic Development Funding for Project	0.000	0.000	**0.000**	0.000	0.000
Donor Funding for Project	0.000	0.000	**43.580**	0.000	0.000
Total Funding for Project	**0.000**	**0.000**	**43.580**	**0.000**	**0.000**

Source: Uganda's ministry of health program-based budget for the year 2014/15