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# SECOND MEMORANDUM TO NATIONAL TREASURY SUGGESTED IMPROVEMENTS TO 2015/16 PROGRAM-BASED BUDGET

**This memorandum summarizes our recommendations for improving the presentation of the national Program-Based Budget. We also attach handouts that clearly explain our suggestions for improvement, with an example from the Ministry of Health Budget as well as examples at the county level on good practices. For further information, please contact Dr. Jason Lakin at 0729937158 or jason.lakin@gmail.com**

## SUGGESTED IMPROVEMENTS TO PROGRAM-BASED BUDGET FOR 2015/16

1. **We recognize and applaud the efforts of the National Treasury to greatly improve the transparency and accessibility of the Program-Based Budget (PBB) since 2013/14.** The 2014/15 PBB was a major advance over the 2013/14 version, and the 2015/16 budget builds on these advances.
2. **We highlight two major improvements in 2015/16:** introduction of information about prior year spending down to the program level for all ministries, and an enhanced budget summary document with more information about loan guarantees and loans to state corporations. This summary also includes a table showing changes in sector ceilings introduced since the Budget Policy Statement with explanations of these

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changes (though the figures for 2015/16 estimates do not match the actual figures in the estimates). Though the budget summary is not part of the PBB, it continues the trend of Treasury providing extra documents to help clarify what is in the PBB.

3. **While recognizing these achievements, we believe the 2015/16 budget could have gone farther to improve transparency.** We make some very specific suggestions for further improvements in 2016/17.
4. **Our suggestions relate to the following areas, which we explain below:** Enhanced summary tables; clear links between narrative and budget data; program and sub-program clarity; quality of indicators and targets; information on AIA/external funding; and further breakdown of economic classification, including wage data.
5. **The final section of this memo identifies challenges in the production of PBBs at county level for the year 2015/16, where greater technical support from National Treasury may be necessary.** These challenges overlap with those we identify at national level, but in some cases are more severe. At the same time, there are some good examples from the counties that could even inform the national budget presentation (see attached).

## A. Enhanced Summary Table

- **The quality of summary tables in a budget is a key indicator of how easy the budget is to use.** Summary tables should draw attention to the key choices that are being made in the budget. In Kenya's budget process, those choices are at the program and subprogram level, because the sector and ministry figures were meant to be set by the Budget Policy Statement earlier. Thus summary tables should help to illuminate key choices at the program level and below.

- **The summary table that is currently at the beginning of the budget should show prior year allocations at program level, and should be accompanied by a table showing subprogram allocations as well**. In order to facilitate an understanding of how the proposed budget differs from last year's budget, the summary table must show major shifts from year to year. Currently, to see the biggest shifts at program and subprogram level requires one to go ministry by ministry.

> **Good Practice At County Level** - Elgeyo Marakwet County produced a budget summary table at subprogram level, and the national government can do the same. While this table does not have prior year data, it is a good start in helping users to see the big choices in the budget estimates.

- **The summary table within the ministry shows "approved estimates" but it is not clear whether these are gross or net.** From an examination of the Ministry of Health, it appears that they are gross estimates, which makes them difficult to compare with the

net figures presented in the line item budget. It is confusing to present "approved estimates" in two different ways but call both of them simply "approved estimates". It would be better to ensure comparison could be done for both net and gross figures, which would require the PBB to have information about Appropriations in Aid, a point we make below.

## B. Clear links between narrative and budget data

- **The essence of a program budget narrative should be to illuminate spending choices at program level**. If the narrative does nothing else but explain the government's priorities for the coming year at the program and subprogram level, it will serve its purpose.

- **In the current budget presentation, by contrast, it is generally difficult to link the narrative to the priorities and budget allocations for the programs.** For example, the narrative in the health budget ministry on page 190 mentions "Equipping and developing health infrastructure of 94 Hospitals (2 per county) on a Managed Equipment Service (M.E.S) contract framework" as a priority, but it is not clear what program this is attached to and details of the same cannot be traced easily in the budget figures provided.

- **Several significant changes at subprogram level are not described at all in the narrative.** For example, there is a substantial increase in funding for the Health Policy sub-program, increasing from 8 to 12% of the total ministry budget, but this is not mentioned in the budget narrative at all. At the same time, items mentioned in the narrative, such as the Health Insurance Subsidy Program (page 189), cannot be found in the budget allocations. It is therefore hard to understand the choices that are being proposed in the sector.

- **The narrative does not explain changes in the organization of the budget to help us understand whether priorities are indeed changing or not.** Shifting of expenditure items ("delivery units") between programs and sub-programs has created the impression that priorities are shifting when in fact much of this is simply due to reorganization of the budget presentation. For example, there is a nearly 30% decline in the budget for the Preventive & Promotive Program, which is driven by a large drop in the Health Promotion sub-program. This appears to be due to a shift of all immunization spending (KEPI) from the Health Promotion sub-program into the Immunization sub-program in the Maternal Program. This in turn has resulted in a big increase in that program, but not any actual shift in priorities. The same seems to be true for the two subprograms – Non-Communicable Disease (NCD) and Communicable Disease Control

(CDC), where some items in the NCD subprogram like HIV, maternal health, TB and malaria have now been moved (probably correctly) to CDC, which has led to an increase in its allocation due to reorganization, but no actual change in priorities.

- **Finally the narrative does not relate challenges and objectives in the sector to changes in budget allocation**. There is no information on how past challenges will be addressed in the current financial year. For example, page 189 of the 2015/16 PBB mentions the existence of regional disparities in the distribution of existing health workers, where arid and semi-arid areas are disadvantaged with less staff being a challenge. But there is no further discussion of this in the narrative, and it cannot be linked to any particular allocations.

## C. Program and sub-program details

- **The 2015/16 budget has shifted programs, program objectives and subprograms since the 2014/15 budget, which is confusing but has led to some improvements.** For example, curative services and promotive services program objectives no longer overlap, because one provides preventive and the other specialized services. The subprograms also help to clarify distinct program activities.

- **However, sub-programs still lack clear objectives and we must guess what they are trying to achieve based on their indicators and targets, which are often confusing.** For example, the NCD subprogram has indicators related to cancer and to HIV, but HIV is a communicable disease (and is also covered under the CDC program as mentioned above). The Health Policy, Planning and Financing SP has "number of people accessing primary healthcare" as a key indicator, but this doesn't sound like an appropriate indicator for a policy/planning subprogram.

## D. Indicators and targets

- **Indicators and targets should have clear baselines and targets that relate to program objectives, should be consistent over time and should adjust as new baselines are established and targets are updated.**

- **In 2015/16 budget, most indicators and targets continue to be less useful than they should be. They still lack baselines making it impossible to know how realistic the targets are.** For example, if the target for number of people accessing primary healthcare in 2015/16 is 35 million, how realistic is that? This would depend on how many are already accessing primary healthcare in 2014/15.

- **There is an introduction of new indicators and targets over the years, with some being dropped and replaced without any explanation.** For example, in the health promotion

sub-program, under the delivery unit "environmental health services," the indicator used in 2014/15 was "% of households with latrines," and the target was 70% by the year 2015/16. However, that has been dropped this year and the same unit now has a new indicator – National Aflatoxin Management, with a target of developing a policy in 2016/17 and no target for 2015/16. Why was the previous indicator dropped and replaced with this one?

- **Many of the targets in the 2015/16 budget are inconsistent with other government sources. Some of these sources, including sector working group reports, show that the budget targets were already met last year.** For instance, the average length of stay (ALOS) in Kenyatta National Hospital for inpatient decreased from 10.7 days in FY 2012/2013 to 9.5 in FY 2013/2014, according to the Health Sector Report for the year 2014/15. However, the budget still has an ALOS of 10.7 days as the target for 2015/16. In addition, a look at KMTC in the ministry of health's narrative below (from page 189) shows that we are already graduating almost 22,000 workers, but the target for the 2015/16 budget year is only 21,000. The lack of seriousness in setting indicators/targets makes it difficult for Parliament to exercise oversight over whether spending is leading to service delivery objectives.

Figure 1: Snippet from the ministry of health budget estimates 2015/16

> In its core mandate of Training health workers,Kenya Medical Training College graduated 21,853 health workers of different cadres while its student population increased from 19,000 to 23,000. KMTC has now 34 campuses countrywide.

## E. External funding

- **Both 2014/15 and 2015/16 PBBs lack information on Appropriations in Aid, meaning there is no information on external funding of the budget.** Given an increase in external funding apparent from the line-item budget this year of over 80% (an over Ksh 160 billion increase), this is a major omission from the PBB. Information on external funding is important for several reasons, including the fact that sectors with heavy external funding tend to have more trouble actually spending their budgets. The health sector is slated to receive a total of Ksh 11B in AIA for health in the development budget this year, but these funds cannot be seen in the PBB.

## F. Breakdown of economic classification including wage data

- **Both 2014/15 and 2015/16 PBBs lack adequate breakdown of economic classification, including information about staff compensation.** The budget provides only a gross figure for staff compensation at the sub-program level, and no information on the number, type of employees or job group is provided. This information is provided in some other PBBs. For example, see the table below from South Africa which provides summary information on staff salary levels and the number of added posts at the

program level. Kenya could go farther than this to provide information about administrative versus service delivery staff, but this is at least a good start.

Table 1: 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.*

- **The continued use of vague categories, such as "other development" and "other recurrent," for major allocations undermines transparency.** These are intended as residual categories but sometimes take the largest share at subprogram level. For instance, in the health budget the subprogram "Forensic and Diagnostics" carries a huge "other development" allocation of Ksh 4.8B, which accounts for more than 80% of the total funding for the subprogram. There is no narrative explanation of what this spending is for.

**0402040 SP. 2.4 Forensic and Diagnostics**

| Economic Classification | Approved Estimates 2014/2015 | Estimates 2015/2016 | Projected Estimates 2016/2017 | Projected Estimates 2017/2018 |
|---|---|---|---|---|
| | KShs. | KShs. | KShs. | KShs. |
| **Current Expenditure** | **159,953,318** | **564,177,780** | **588,345,584** | **599,290,649** |
| Compensation to Employees | 26,113,000 | 228,412,919 | 239,878,841 | 243,453,906 |
| Use of Goods and Services | 133,840,318 | 303,401,521 | 318,726,743 | 325,596,743 |
| Current Transfers to Govt. Agencies | - | 1,723,340 | 1,740,000 | 1,740,000 |
| Other Recurrent | - | 30,640,000 | 28,000,000 | 28,500,000 |
| **Capital Expenditure** | **3,660,350,000** | **5,092,960,000** | **5,638,500,000** | **6,033,500,000** |
| Acquisition of Non-Financial Assets | 304,350,000 | 309,960,000 | 511,000,000 | 604,500,000 |
| Other Development | 3,356,000,000 | 4,783,000,000 | 5,127,500,000 | 5,429,000,000 |
| **Total Expenditure** | **3,820,303,318** | **5,657,137,780** | **6,226,845,584** | **6,632,790,649** |

## COUNTY CHALLENGES

**Our review of county budgets for the year 2015/16 revealed that they share a number of the weaknesses of the National government.** We draw out issues arising from five counties: Elgeyo-Marakwet, Nyeri, Lamu, Nairobi, and Taita Taveta. We summarize key challenges below. We believe that Treasury could play a role in providing more technical support to the counties in order for their budgets to be more transparent.

1. **The budget narrative is not linked to program allocations and does not explain the trends adequately.** All the five counties are experiencing this challenge.

2. **Many programs have unclear objectives; the sub-programs lack objectives.** Most programs across the county have vague or overlapping objectives. All the five county budgets lack sub-program objectives.

3. **All the five counties put all their staff costs under an administrative program, rather than service delivery programs.** This reflects a fundamental misunderstanding of PBB, as these budgets tend to put all recurrent costs under an "administration" program, rather than allocating them to the programs and objectives to which these costs contribute. For example, see below Elgeyo Marakwet Health Budget 2015/16.

**Part G. Summary of Expenditure by Programme, Sub-Programme and Economic Classification (Kshs. Millions)**

| Expenditure Classification | Supplementary Estimates 2014/15 | Estimates 2015/16 | Projected Estimates | |
|---|---|---|---|---|
| | | | 2016/17 | 2017/18 |
| **Programme 1: General administration, planning and support services** | | | | |
| **Current Expenditure** | | | | |
| Compensation to Employees | | 1,585,169,839 | 1,664,428,331 | 1,747,649,747 |
| Use of goods and services | | 429,127,549 | 450,583,926 | 473,113,123 |
| Current Transfers Govt. Agencies | | | | |
| Other Recurrent | | | | |
| **Capital Expenditure** | | | | |
| Acquisition of Non-Financial Assets | | | | |
| Capital Transfers to Govt. Agencies | | | | |
| Other Development | | 271,492,571 | 285,067,200 | 299,320,560 |
| **Total Expenditure** | | **2,285,789,959** | **2,400,079,457** | **2,520,083,430** |
| **Sub-Programme 1: Administration, Planning and general support services** | | | | |
| **Current Expenditure** | | | | |

| | | | | |
|---|---|---|---|---|
| Compensation to Employees | | 1,585,169,839 | 1,664,428,331 | 1,747,649,747 |
| Use of goods and services | | 272,092,393 | 285,697,013 | 299,981,863 |
| Current Transfers Govt. Agencies | | | | |
| Other Recurrent | | | | |
| **Capital Expenditure** | | | | |
| Acquisition of Non-Financial Assets | | | | |
| Capital Transfers to Govt. Agencies | | | | |
| Other Development | | 62,107,200 | 65,212,560 | 68,473,188 |
| **Total Expenditure** | | **1,919,369,432** | **2,015,337,904** | **2,116,104,799** |
| **Sub-Programme 2: Health Services** | | | | |
| **Current Expenditure** | | | | |
| Compensation to Employees | | | | |
| Use of goods and services | | 157,035,156 | 164,886,914 | 173,131,259 |
| Current Transfers Govt. Agencies | | | | |
| Other Recurrent | | | | |
| **Capital Expenditure** | | | | |
| Acquisition of Non-Financial Assets | | | | |
| Capital Transfers to Govt. Agencies | | | | |
| Other Development | | 209,385,371 | 219,854,640 | 230,847,372 |
| **Total Expenditure** | | **366,420,527** | **384,741,553** | **403,978,631** |

4. **In addition, with the exception of Nyeri, there is no staff breakdown into job group, type and salary costs.** As at national level, this makes it difficult to understand how money is being used to generate services.

5. **Indicators and targets are weak or non-existent. Some targets have no baseline and there is no timeline for achieving the targets.** For example, in Taita Taveta, there are a number of indicators with no targets at all.

6. **The standard economic classification is vague, with no breakdown of major items such as staff or capital spending.** The counties continue to use "other recurrent" and "other development" for major, rather than residual, spending.

# Annex 1: Good practices in 2015/16 county Program-Based Budgets

**1.** Summary table at both the program and subprogram level (Elgeyo Marakwet budget)

**SUMMARY OF PROGRAMMES AND SUB PROGRAMMES ALLOCATION 2015/2016**

| | | | | | |
|---|---|---|---|---|---|
| **Health Services** | **1,160,995,973** | P.1 Planning and Administrative Services<br>P.2 Preventive & Promotive Health Services | 994,142,835 | SP 1.1 Health Administration | 952,367,235 |
| | | | | SP 1.2 Health Monitoring and Information Management | 4,000,000 |
| | | | | SP 1.3 Health Sector Support | 37,775,600 |
| | | | 12,000,000 | SP 2.1 Community Health Services | 6,500,000 |
| | | P.3 Curative and Rehabilitative Health Services | 84,853,138 | SP 2.2 Environmental Health and Sanitation Services | 4,500,000 |
| | | | | SP 2.3 Maternal Child Health and Nutrition Services | 1,000,000 |
| | | | | SP 3.1 Pharmacy Services | 75,253,138 |
| | | | | SP 3.2 Clinical Services | 1,000,000 |
| | | | | SP 3.3 Nursing and Ambulance Services | 8,600,000 |
| | | P.4 Healthcare Infrastructural Development | 70,000,000 | SP 4.1 Healthcare Infrastructural Development | 70,000,000 |

2. Budget broken down into items under programs; combining line item and program provides additional information that is useful (Lamu budget)

**PART G: HEADS AND ITEMS UNDER WHICH VOTES WILL BE ACCOUNTED FOR BY PROGRAMMES**

| Sub Item Code | Sub Item Name | Budget 2015/2016 | General Administration, Planning, M&E | Curative Health Services | Preventive & Promotive | Environmrntal Health & Sanitation |
|---|---|---|---|---|---|---|
| 2210300 | Domestic Travel and Subsistence, and Other Transportation Costs | 11,900,000 | 4,050,000 | 4,130,000 | 2,470,000 | 1,250,000 |
| 2210301 | Travel Costs(Airlines, Bus, Railways) | 2,130,000 | 950,000 | 200,000 | 530,000 | 450,000 |
| 2210302 | Accommodation - Domestic Travel | 6,790,000 | 2,400,000 | 2,750,000 | 1,040,000 | 600,000 |
| 2210303 | Daily Subsistence Allowances | 2,980,000 | 700,000 | 1,180,000 | 900,000 | 200,000 |
| 2210500 | Printing , Advertising and Information Supplies and Services | 2,723,000 | 2,123,000 | - | 400,000 | 200,000 |
| 2210502 | Publishing and Printing Services | 1,800,000 | 1,500,000 | - | 100,000 | 200,000 |
| 2210503 | Subscription to Newspapers, | - | - | - | - | - |
| 2210504<br><br>2210599 | Advertising awareness Printing, Advertising - Other | 300,000<br><br>623,000 | -<br><br>623,000 | -<br><br>- | 300,000<br><br>- | -<br><br>- |

3. Summary table on allocation shares of the total budget, including ranking of allocations (Elgeyo Marakwet)

| DEPARTMENT/SECTOR | ALLOCATION | % OF TOTAL ESTIMATE | ALOCATION RANKING |
|---|---|---|---|
| **Office of the Governor** | 84,188,392 | 2.5 | 11 |
| **Administration** | 24,228,562 | 0.7 | 13 |
| **County Assembly** | 429,000,000 | 12.7 | 2 |
| **Finance & Economic planning** | 171,987,110 | 5.1 | 7 |
| **Roads, public works & Transport** | 284,450,597 | 8.4 | 4 |
| **Youth, Sports, Culture, Gender** | 98,274,473 | 2.9 | 9 |
| **Education and Technical Training** | 300,387,496 | 8.9 | 3 |
| **Health Services** | 1,160,995,973 | 34.4 | 1 |
| **Water, lands, Housing & planning** | 272,085,450 | 8.1 | 6 |
| **Trade, Tourism, Cooperatives & Wildlife** | 91,331,526 | 2.7 | 10 |
| **Agriculture** | 281,306,807 | 8.3 | 5 |
| **ICT & Public service** | 146,040,660 | 4.3 | 8 |
| **County Public Service Board** | 35,046,948 | 1.0 | 12 |
| **Total** | **3,379,323,994** | **100.0** | |

# Annex 2: Difference in Information Available in Kenya's 2013/14, 2014/15 and 2015/16 Programme Based Budgets (using Ministry of Health example)

| | 2013/14 (Program Based Budget) | 2014/15 (Program Based Budget) | 2015/16 (Program Based Budget) |
|---|---|---|---|
| **Narrative information**<br><br>Narrative should:<br><br>1. Explain overall mission and objectives<br><br>2. Be clearly linked to priorities and program allocations<br><br>3. Explain changes over time in allocations/expenditure<br><br>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.<br><br>2. Not clearly linked to program priorities and allocations.<br><br>3. N/A<br><br>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.<br><br>2. Some allocations mentioned, but most are not described. No clear link to program priorities or allocations<br><br>3. Some information provided on allocation trends as well as achievements in the last financial year, but not expenditure.<br><br>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.<br><br>2. Not clearly linked to program priorities or allocations.<br><br>3. Some information on allocation trends and reasons for changes in allocation at ministry but not program level.<br><br>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**<br><br>Budget should have programs that:<br><br>1. Are clear and with clear objectives that do not overlap | 1. Program objectives are vague and overlapping, making it hard to know how | 1. Program objectives are still vague and overlapping, but the addition of sub-program | 1. Program objectives no longer overlap. For example, curative services and promotive services do not overlap, because one provides |

| | | | |
|---|---|---|---|
| 2. Have objectives that look at outputs and outcomes | each program uses its funds to advance a distinct objective.<br><br>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. | information helps to clarify what each program actually does.<br><br>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. | preventive and the other specialized services. Sub-programs also help to clarify distinct program activities.<br><br>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**<br><br>Each program or sub-program should have:<br><br>1. A set of sensible indicators with baselines and targets that relate to program objectives | 1. Indicators are not in line with ministry objectives and have no baselines and lack targets. | 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.[1] | 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. Consistent over time | 2. N/A | 2. Many new indicators with new targets. There was also a huge dropout of indicators that were used in the 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. | 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 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. Updated to reflect changes in baseline over time | 3. N/A | 3. Most indicators did not have baselines. Many from previous year lacked targets. | 3. No updated information about changes in the baseline or whether targets for previous year achieved. |

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

| | | | |
|---|---|---|---|
| **Subprograms and further disaggregation**<br><br>Subprograms should:<br><br>1. Be about 2-5<br><br>2. Have clear objectives and be related to the program under which they fall<br><br>3. Be consistent over time<br><br>4. Have clear indicators and targets<br><br>5. Broken down by economic classification that is clear | 1. N/A<br><br>2. N/A<br><br>3. N/A<br><br>4. N/A<br><br>5. Generic economic classification with vague categories of "other recurrent" and "other development" at program level | 1. Two to five subprograms.<br><br>2. The subprograms do not have objectives but have indicators and targets<br><br>3. N/A (new item)<br><br>4. Have somewhat clear targets and indicators, but as above, not entirely consistent and coherent<br><br>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". | 1. Between 3 and 9 subprograms under each program<br><br>2. The subprograms do not have objectives but have indicators and targets (though not fully consistent with last year)<br><br>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.<br><br>4. Have somewhat clear targets and indicators, but as above, not entirely consistent or coherent.<br><br>5. Broken down by economic classification. However, there is still use of vague classification which takes major share of allocations. |

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|---|---|---|---|
| **Personnel and costs**<br><br>There should be information:<br><br>1. Beyond "compensation to employees" at program or subprogram level<br><br>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.<br><br>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.)<br><br>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.<br><br>2. No information on number of staff, job group, emoluments and cost. |
| **Appropriation in Aid (AiA)**<br><br>Information should be broken down to<br><br>1. Type of donor, the amount and type of grant<br><br>2. Where the money is coming from i.e. donor or user fees<br><br>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<br><br>2. No information<br><br>3. Information at vote and programme level | 1. None<br><br>2. None<br><br>3. None | 1. None<br><br>2. None<br><br>3. None |

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| **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. |


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