HERAF
Health Rights Advocacy Forum

MENTAL HEALTH BUDGET ALLOCATION

An Analysis of Mental Health Budgetary Allocations for 2016-2020

Health Rights Advocacy Forum (HERAF)
Ring Road, Kilimani
P.O Box 100667 – 00101, Nairobi, Kenya
Tel: +254735333007
Email: info@heraf.or.ke | **Website:** www.heraf.or.ke
Facebook: Heraf Kenya | **Twitter:** @HERAF_Kenya

OPEN SOCIETY FOUNDATIONS

With financial support from Open Society Foundation through the Open Society for East Africa (OSIEA)

TABLE OF CONTENT

List of Abbreviations 04
1.0 Introduction 05
2.0 Socio-economic determinants of Health Status 06
3.0 Comparing Country 08
4.0 Steps in Planning and Budgeting for Mental Health 09
5.0 Financing Kenyan Mental Health Care 10
6.0 Kenyan Mental Health Care Resources 12
7.0 Summary and Conclusions 16

LIST OF TABLES

Table 1: Mental Health Budget compared to Aggregate Health Budget, FY 2013/14 to 2018/19 12
Table 2: Budget Allocations for Mental Health programs 14

LIST OF FIGURES

Figure 1: Socio-economic Determinants of Health Status 07
Figure 2: Mental Health Spending Share of Total Health Spending (%) 08
Figure 3: Empirical Planning and Budgeting Cycle for Mental Health 09
Figure 4: National Health Budget compared to Total National Government Budget 11
Figure 5: County, National and Total Health Budgets over Total Government Budget (%) 11
Figure 6: Mental Health Recurrent and Development Budget Allocations 13
Figure 7: Recurrent budgets for Mathare Teaching and Referral Hospital for FYs 2014/15 and 2016/17 15

ACKNOWLEDGMENT

Health Rights Advocacy Forum (HERAF) appreciates all those who contributed to this report in one way or another. This report presents the findings of an analysis of Kenya's government commitment to international, regional and national funding commitments on Mental Health. The study was conducted by HERAF with financial and technical support from Open Society for East Africa (OSIEA).

This project benefited in great manner from the information and data posted online and in organisation's websites. Indeed, these sources provided a wealth of data and information by mere click of a mouse. As much as possible we have tried to acknowledge each source in our references. We feel indebted to each one of you for the rich literature and the ease of access.

We appreciate the expertise of Maureen Asembo who researched, analysed and compiled the report. We are also grateful to George Ooko, Sammy Kihiu and Jemimah Muthoni who critiqued, reviewed, aligned and edited the report.

LIST OF ABBREVIATIONS

AIE	Authority to Incur Expenditure
AU	African Union
COK	Constitution of Kenya
FY	Financial Year
GDP	Gross Domestic Product
GNP	Gross National Product
KES	Kenya Shillings
MoH	Ministry of Health
O&M	Operations and Maintenance
PFM	Public Finance Management Act
WHO	World Health Organisation

1.0 INTRODUCTION

This report reviews the status of budgeting for mental health in Kenya, touching briefly on the potential implications of various options in the future. A significant challenge in managing mental health is the concept problem, relating to the complexity of its definition. Many societies only pay attention to Schizophrenia, ignoring the stages of psychosis that many citizens go through. This concern is also reflected in the persisting confusion between attention to health (status) instead of health care. Indeed, the Constitution of Kenya 2010 (COK 2010) designation of health as a constitutional and human right – to which we return below. The second challenge around mental health management is the stigma traditionally associated with mental illness, causing varying ostracisation degrees. Thus, the people living with mental illness in many households have been locked up instead of seeking health care for them. This problematic attitude permeates decision-making at the very highest levels of government, undermining strategies against mental illness. These two realities mean that it is difficult to assess the extent of the disease in society, which complicates the design of remedial interventions and planning and budgeting.

Various governance frameworks underscore the government's varied obligations at sub-national and national levels and individuals, households, communities, and their development organisations. According to Article 1 of the Constitution, sovereignty belongs to the people to be enjoyed directly or through their elected representatives, such as parliamentarians. Article 10 lists the national values and principles of governance in general, which Article 232 interprets in relation to the public sector. The importance and principles primarily focus on ameliorating any disadvantage that might impinge on members of society enjoying the rights and privileges readily available and enjoyed by others. The constitution defines 'disability to include mental illness so that persons suffering mental illness are targeted by Articles 27specifically and Articles 24, 25, 28 and 29, and most notable, Article 43 (1)(a) on quality health care. The Constitution's Articles 2 (5) and (6) recognise that Kenyan frameworks might not immediately provide for various rights and duties that are generally recognised globally, and therefore commit the country to such frameworks.

Consequently, the sub-articles define the expectations of rights holders – wananchi and the obligations of duty-bearers – the government. Thus, programming for mental illness should go beyond the expectations of affected persons and their families to what is generally provided globally; but the service providing government should also go beyond its evident 'means' to what is usually offered globally.

1. The Constitution (2010) and all Kenyan legislation are found at http://kenyalaw.org:8181/exist/kenyalex/index.xql
2. Article 2 (5) states that: "The general rules of international law shall form part of the law of Kenya," while sub-article (6) provides that: "An treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution".

2.0 SOCIO-ECONOMIC DETERMINANTS OF HEALTH STATUS

As far as 1948, the World Health Organisation's (WHO) constitution defined 'health' as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." It sees the highest attainable health as a human right that may not be subjected to discrimination and (therefore) a fundamental determinant of peace and security. All governments must be committed. In both the definition above and its operationalisation as a commitment, the issue is health status, not health care. Studies have indeed shown that healthcare–medicine–makesamodestcontributiontohealthstatus.Thusincreasingly,thefocushasshiftedfrom medical care to 'social determinants, that is, the conditions in which people are born, grow, live, work and age'. [3]

Figure 1 relates the various social and economic issues surrounding the generation of health, whether the end product is good or bad health. It is important to note where health care fits in the framework in Figure 1. The first set of determinants are very personal to the individual. Whatever genetic makeup one inherits at birth is significant for one following foundational health status.

But individual lifestyle factors are also important, such as taking alcohol, smoking, chewing miraa, or promiscuity. The context of birth and upbringing presents the second tier of determinants: traditional rites of passage, for example, can have sex-specific impacts.[4] Among the third-tier factors, health care is only of the eight areas presented in this formulation.

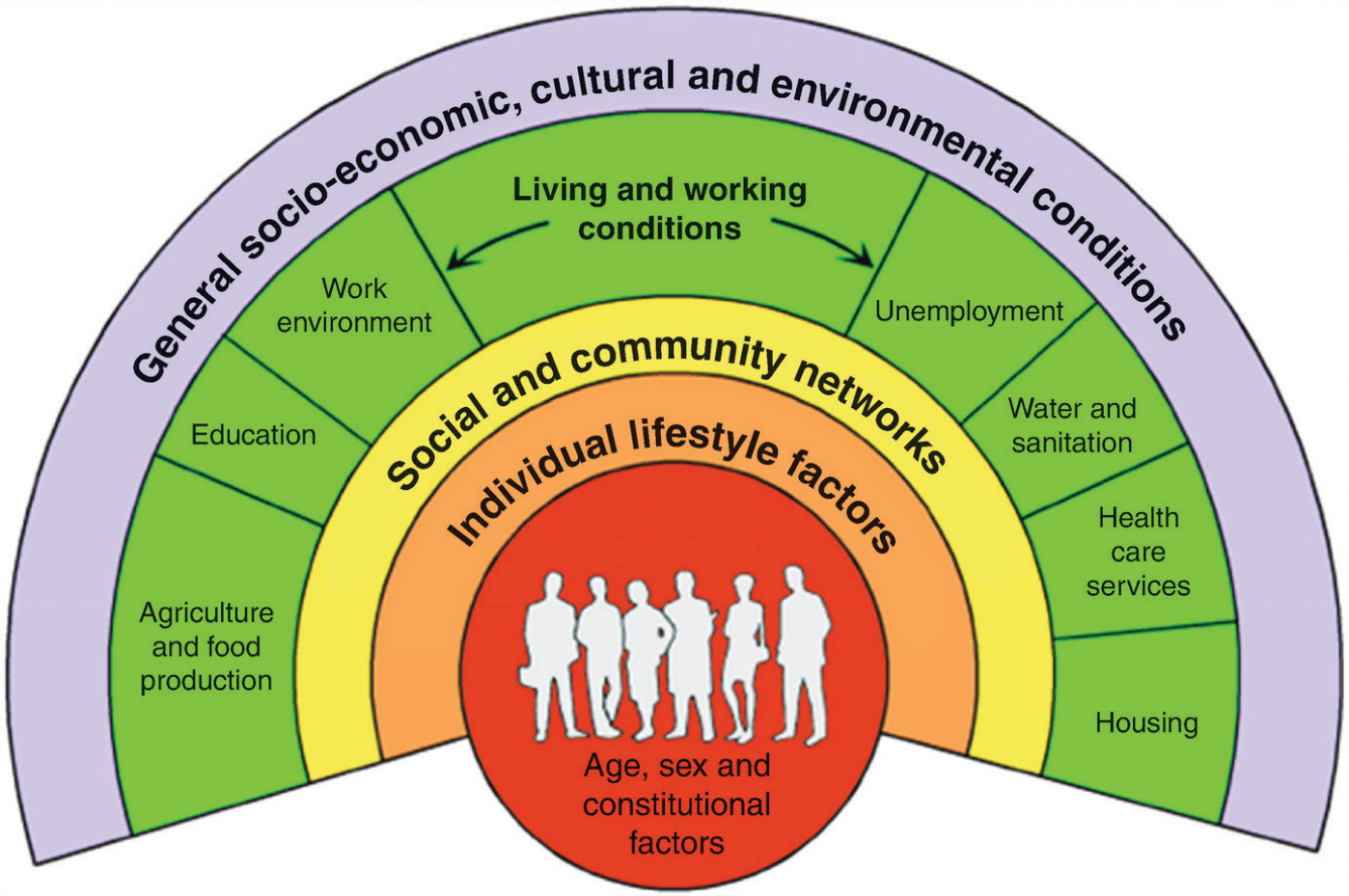
Box 1: WHO Constitution

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Source: https://www.who.int/about/who-we-are/constitution

3. See Artiga, Samantha and Elizabeth Hinton (2018), Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. At https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

4. Traditional circumcision – female genital mutilation – complicates childbirth; but male circumcision reduces HIV infection risk.



Source: Dahlgren and whitehead 1991

Figure 1: Socio-economic Determinants of Health Status

The take away from the preceding is that health is a broad-based phenomenon that should not be equated to illness or absence. Understanding mental illness and its management require such a broad-based approach. Mental illness is managed by paying attention to its social determinants, as well as to medical care when it is necessary. Resource-constrained countries would do well to heed the primary health care approach that emphasises the more cost-effective community-integrated preventive and promotive interventions over facility-based curative care.

5. See Chisolm, D. et al (2019), Mental health financing challenges, opportunities and strategies in low- and middle-income countries: findings from the Emerald project. BJPsych Open.2019 Sep; 5(5): e68. Published online 2019 Aug 6.doi:10.1192/bjo.2019.24

3.0 COMPARING COUNTRY

In budgeting for health care – whether preventive and promotive or curative, it is critical to know how much need there is for that care and its costs to deliver the care (unit cost). Typically, developed countries are better at determining both preliminaries. They have more experience in such endeavours, accompanied by better resources to undertake the estimations. Fortunately for developing countries, institutions such as the WHO, and individual researchers and other institutions regularly undertake such work, meaning that developing country policy-makers have ready-made solutions. Such work is illustrated by the WHO's EMERALD, which has undertaken extensive research on managing mental health using country-level evidence.[5]

Guided by spending norms established by WHO and other research, the higher income countries will have larger health budgets which translate into higher spending per person, often above globally-set spending norms. Conversely, the lower-income countries will have smaller allocations to health, which invariably translate into even smaller per head expenditure allocations, often far below globally set norms.

Box 2: Explaining Country Income Levels

Income per head – also income per capita, is simply each individual in the population's share of the money value of national income/production, were it divided equally across the whole population. 'National Income' is the value of all production in an economy during a single year.

Measured as Gross Domestic Product (GDP), this includes all production within the boundaries of a country, whether the producers are nationals or not. However, Gross National Product (GNP) only considers production by all nationals whether they are at home or abroad. Lupita's earnings are part of our GNP but not part of our GDP, and of USA's GDP but not its GNP.

Figure 2 compares mental health spending as a share of total health spending across four-country income per head groups. The chart does not show complete health care or mental care spending, but the picture would be pretty similar to what is reflected here. The chart shows that the high-income countries allocate an average of 5.1% of their total health care budgets to mental health care. Conversely, the lowest income countries give one half of 1% of their total health care budget to mental health care. Lower middle-income countries like Kenya allocate just under 2% of their health budget to mental health. In absolute terms, WHO has previously estimated the global average mental health spending to be US$ 3 per capita per year, with the rate being as low as US$ 0.25 per capita per year in low-income countries.[6]

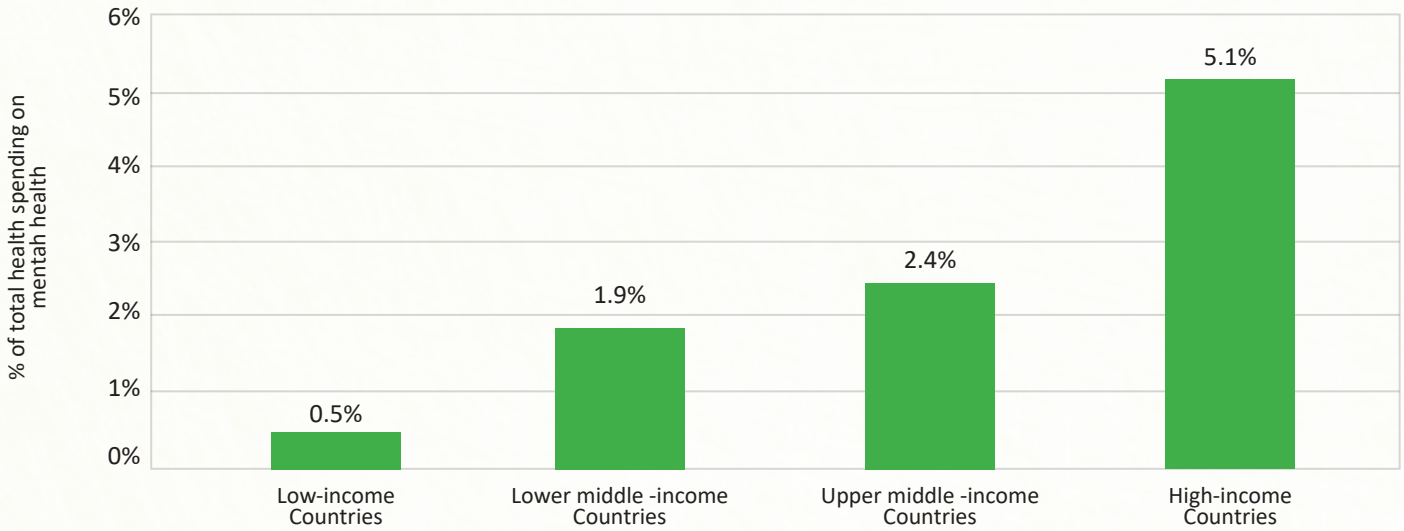


Figure 2: Mental Health Spending Share of Total Health Spending (%)

Source: WHO (2003)

6.See WHO (2012), Mental Health Atlas 2011. https://www.who.int/mediacentre/news/notes/2011/mental_health_20111007/en/

To put **Figure 2's** numbers in perspective, the African Union (AU) governments resolved in 2000 the Abuja Declaration allocate at least 15% of their budgets to health care to meet the Millennium Development Goals' health targets. Since 2000, barely 5 of Africa's 54 countries have ever met that 15% target, and some have even fallen below the share they had in 2000. Concerning the Abuja Declaration, Kenya has been under-performing.

4.0 STEPS IN PLANNING AND BUDGETING FOR MENTAL HEALTH

The EMERALD studies on planning and budgeting for mental health care resulted in the 'Mental Health Policy and Service Guidance Package' to assist policy-makers and planners to:

- Develop policies and comprehensive strategies for improving the mental health of populations
- Use existing resources to achieve the most significant possible benefits
- Provide adequate services to those in need
- Assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

The guidance package of 2003 remains the definitive document and includes the following modules: (i) The Mental Health Context; (ii) Mental Health Policy, Plans and Programmes; (iii) Mental Health Financing; (iv) Mental Health Legislation and Human Rights; (v) Advocacy for Mental Health; (vi) Organization of Services for Mental Health; (vii) Quality Improvement for Mental Health; and ((viii) Planning and Budgeting to Deliver Services for Mental Health.

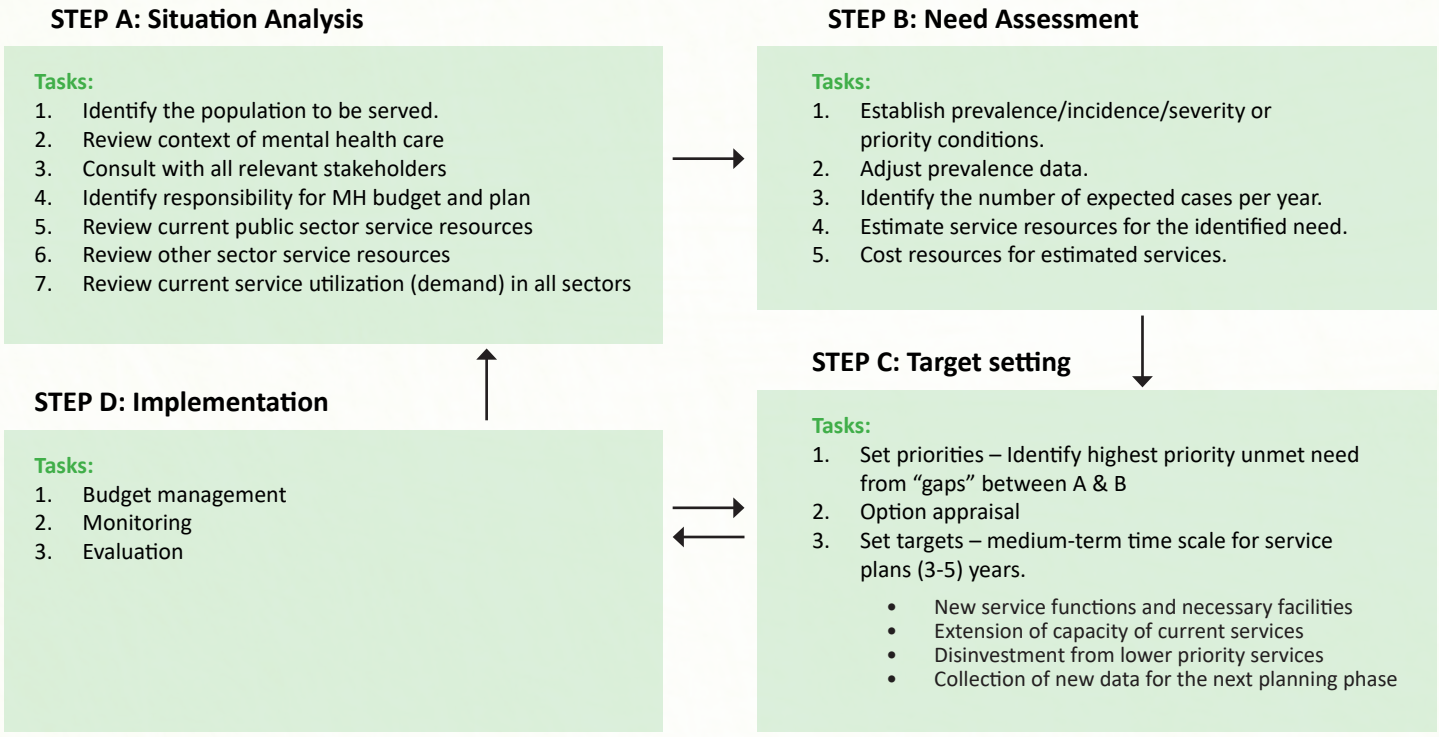


Figure 3: Empirical Planning and Budgeting Cycle for Mental Health

7. See WHO (2013), Investing in Mental Health: Evidence for Action. https://apps.who.int/iris/bitstream/handle/10665/87232/9789241564618_eng.pdf;jsessionid=2449597423D95617ECB80CB295B46A96?sequence=1

The mental health planning and financing process's conceptual aspects are discussed in Investing in Mental Health: Evidence for Action. The publication, for instance, rationalises the value bases concerning social choices and decisions surrounding investing in mental health, considering arguments for public health, economic welfare, growth and productivity, equity, culture and politics. Eventually, the EMERALD project provides the empirical framework of **Figure 3,** covering the steps in the needs assessment, planning and budgeting.

To illustrate the previous frameworks' actualisation, we cite the 2019 WHO study for which data were collected in six sub-Saharan African and South Asian countries, namely Ethiopia, India, Nepal, Nigeria, South Africa and Uganda. Data collection employed a multi-methods approach involving three steps: a quantitative and narrative assessment of each country's disease burden profile, health system and macro-fiscal situation; in-depth interviews with expert stakeholders; and policy analysis of sustainable financing options. This section concludes by citing that study's summarised results:

"Key challenges identified for sustainable mental health financing include the low level of funding according to mental health services, widespread inequalities in access and poverty, although opportunities exist in the form of new political interest in mental health and ongoing reforms to national insurance schemes. Inclusion of mental health within planned or nascent national health insurance schemes was identified as a key strategy for moving towards more equitable and sustainable mental health financing in all six countries."

It concludes that:

"Including mental health in ongoing national health insurance reforms represent the most important strategic opportunity in the six participating countries to secure enhanced service provision and financial protection for individuals and households affected by mental disorders and psychosocial disabilities."

5.0 FINANCING KENYAN MENTAL HEALTH CARE

This discussion of **Figure 4**[9] should be against the backdrop of the realities of **Figure 2.** The data show that the Kenyan national budget has grown by 165% between financial year (FY) 2014/15 and FY2018/19, from KES 1.2 trillion to KES 3.0trn. Since 2013, constitutional reforms introduced devolution. Kenyan health policy and the national referral hospitals remained exclusive National Government functions. At the same time, medical care became a county-level function primarily. The figure shows the Ministry of Health (MoH) budget has grown from KES 47 billion(bn) in 2014/15 to KES 90.0bn in 2018/19, a 91% change that is well below the national budget difference. However, these allocations exclude respective county government allocations to their health care activities.budget difference. However, these allocations exclude respective county government allocations to their health care activities.

8. See Chisolm et al. (2019).
9. The flowing discussion draws extensively on the data contained in the NGEC background paper
10. The Constitution's Fourth Schedule provides this division of largely mutually exclusive functions, with any function not listed being a National Government function.

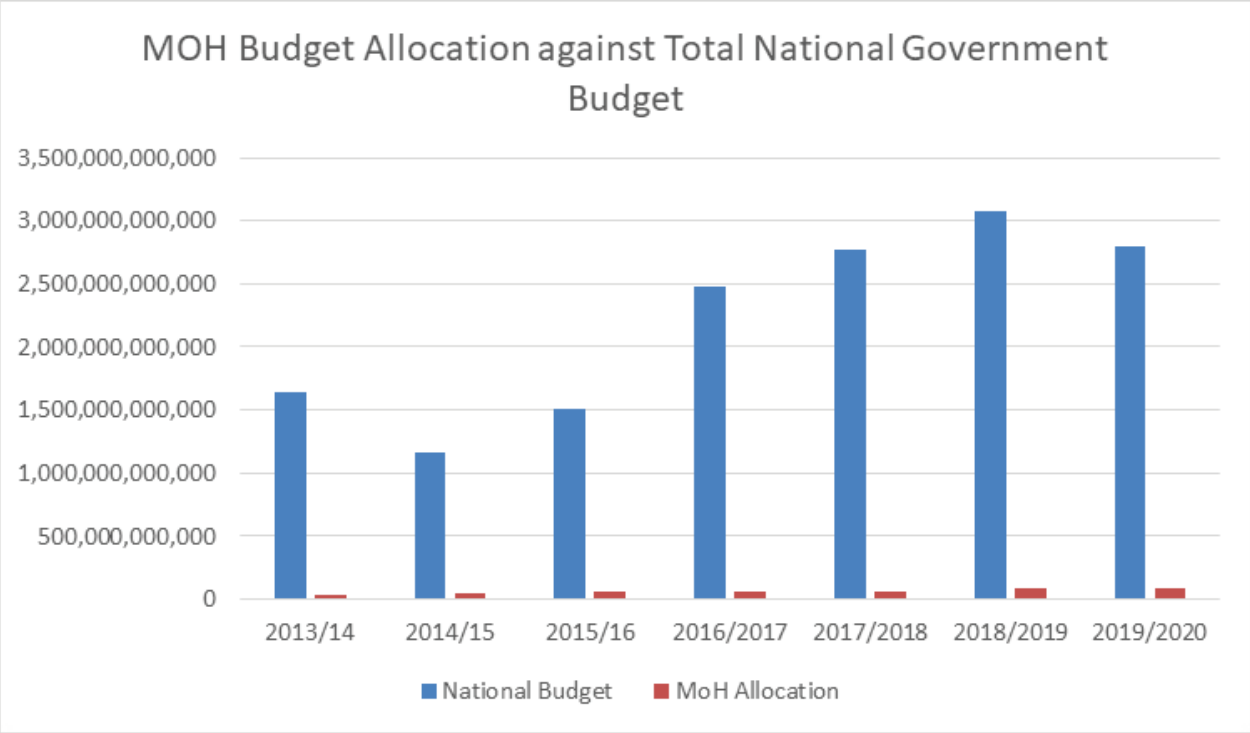


Figure 4: National Health Budget compared to Total National Government Budget
Source: MOH: National and County Health Budget Analysis

Figure 5 provides a better picture of Kenya's performance against the Abuja Declaration's 15% share of national budgets. The chart shows that for FY 2013/14, the last FY during which the whole health budget was located in MOH, the share against the national budget stood at 7.8%, a mere half of the 13-year-old Abuja Declaration's 15% budget target. The chart reflects an exciting impact of devolved health care budgeting: The County Governments immediately allocate a significant 5.5% share of the national budget to health care, which, together with MOH's 3.4% share, raises the aggregate to 13.5 the national budget. In subsequent FYs, the MH shares remain below 4% while the County Governments' share rise steeply. The county governments' share doubles above the FY 2013/14 without significantly pulling up the combined share of the national budget suggests that the county governments' equitable share of national revenues has not grown significantly.

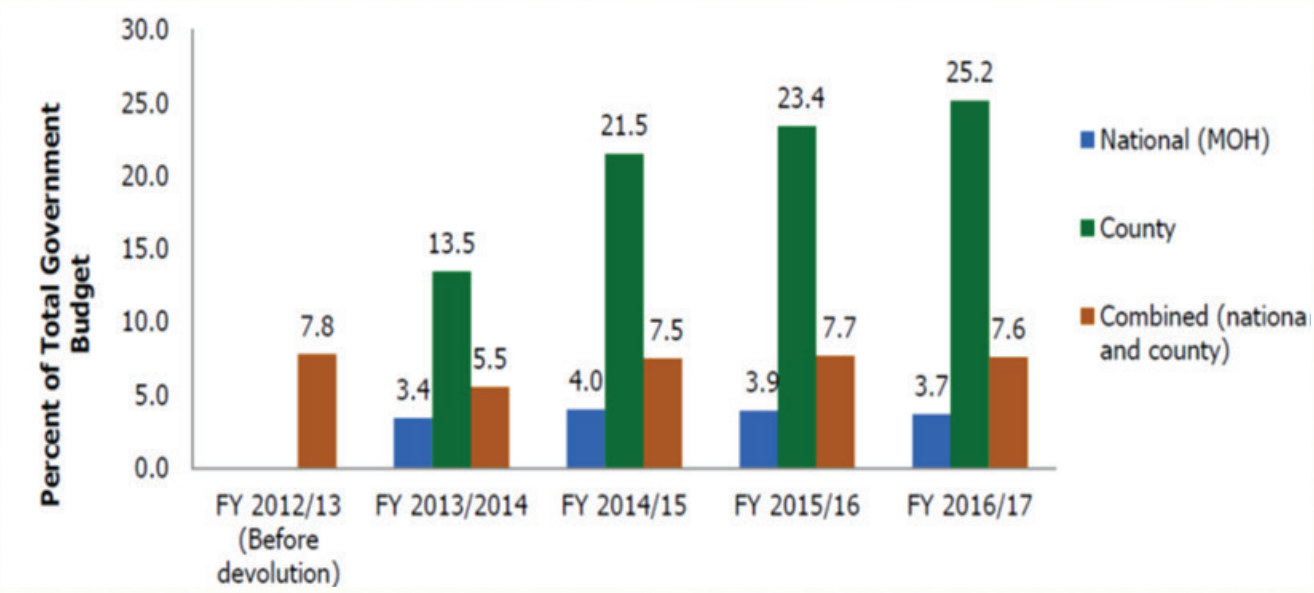


Figure 5: County, National and Total Health Budgets over Total Government Budget (%)
Source: National and County Health Budget Analysis FY 2016/2017

6.0 KENYAN MENTAL HEALTH CARE RESOURCES

Table 1 compares budget allocations to mental health compared to the aggregate Kenyan health budget between FYs 2013/14 and 2018/19. The aggregate budget change over the six FY period was 47%, closing at KES 211bn. During the same period, the mental health budget was unstable, dropping in the first FY by 47%. It rose by 155%, before increasing to KES 0.81 bn in FY2018/19. This fluctuation in budgets makes mental health care delivery unsustainable. The levels are so high as to make impossible the financing of Operations and Maintenance (O&M) year on year, including wages/salaries, allowances, rents, utilities, stationery, fuel, etc.

Financial year	Total health budget including national and county government (KES in Billions)	Total mental health budget (KES) in Billions)	Total mental health budget as a % of the total health budget national and county (KES in Billions)
2013/14	93.08	0.55	0.59%
2014/15	110.14	0.29	0.27%
2015/16	128.89	0.74	0.57%
2016/17	152.3	0.55	0.36%
2017/18	161.60	0.71	0.44%
2018/19	211.00	0.81	0.83%

Table 1: Mental Health Budget compared to Aggregate Health Budget, FY 2013/14 to 2018/19
Source: National and County Health Budget Analysis

Budgeting distinguishes the Recurrent budget from the Development or Capital budget. Recurrent spending essentially maintains the status quo while Development spending provides room for changing 'how things are done. The 2010 accession of a rights-focused constitution required 'business unusual. In place of the sigma previously associated with mental illness, the new constitutional dispensation attention needed for such individuals is right. Indeed, Article 19 (2) provides that:

"The purpose of recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings."

Article 20 (2) provides that "every person shall enjoy the rights to the greatest extent possible". In contrast, Article 21 (1) makes the 'observance, respect, protection, promotion and fulfilment of rights' a 'fundamental duty of the State and every State organ.'

Section 15(2)(a) of the Public Finance Management Act (2012) (PFM Act 2012) provides that 'in the medium term a minimum of 30% of national and county budgets shall be allocated to development expenditure.' This principle seeks transformational planning and budgeting to address Kenya's excessive wage bill share of public spending. Yet, Figure 6 does not hint at curtailed wages and salaries, given the more than four-fold dominance of Recurrent over Development spending between **FY 2013/14 to 2019/20.** This persisting bias suggests little or no 'business unusual' to address the constitutional rights imperatives cited above in relation to previous mental health management mismanagement. In keeping with the constitutional division of health sector labour between the National and County governments, medical care of the mentally ill is a county government function. Yet, these budget numbers seem exclusive national-level numbers, as was the case in **Figure 4.**

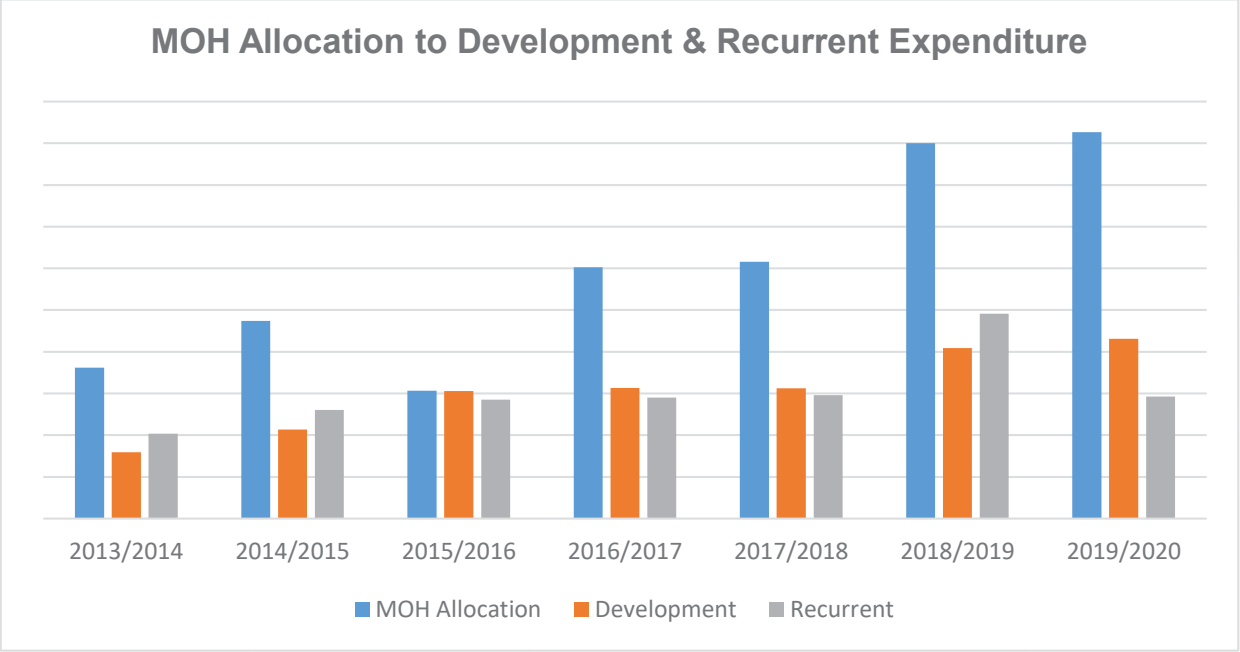


Figure 6: Mental Health Recurrent and Development Budget Allocations
Source: Budget Estimates for recurrent and development expenditures (2013/14 to 2019/20), MOH: National and County Health Budget Analysis

Table 2 disaggregates the admittedly outdated Recurrent and Development mental health budgets to specific authorities to Incur Expenditure (AIE). This brief note has neither explored the global or, indeed, Kenyan unit costs of managing mental health/illness, nor the prevalence and severity of mental illness in Kenya – the 'need' of **Figure 3.** Therefore, the note does not evaluate the adequacy of the specific monies allocated and instead restricts itself to a mere critique of the budget structure. More than any of the issue earlier in this note, **Table 2** illustrates Kenyan mental health budgeting's inadequacies. Firstly, the table represents the facility-based focus of mental health spending. The national Mathari Teaching & Referral Hospital averaged a 93% share throughout the period. Despite health care being a devolved function, there is no evidence of any attention to facilities outside Mathari Hospital.

11. Budgets allocate money across the government, which is disbursed in four tranches around the FY. However, departments must await KRA's collection of revenue. The AIE is the authorization to department heads to proceed with spending.
12. The budget numbers suggest that the slump into FY 2014/15 was promptly compensated by the sharp rise into FY 2015/16, evening the allocations just above Kshs 552mn throughout.

FY	Vote Head	Amount Allocated		Total Allocation
		Development	**Recurrent**	
2019/2020	Mathari Teaching & Referral Hospital	65,200,000	711,649,951	776,849,951
	Division of Mental Health		36,656,806	36,656,806
	Kenya Board of mental health		7,000,897	7,000,897
	Total			**820,507,654**
		Development	**Recurrent**	
2018/2019	Mathari Teaching & Referral Hospital	61,600,000	711,659,400	773,259,400
	Division of Mental Health		35,893,128	35,893,128
	Kenya Board of mental health		7,138,597	7,138,597
	Total			**816,291,125**
		Development	**Recurrent**	
2017/2018	Mathari Teaching & Referral Hospital	18,750,000	655,666,739	674,416,739
	Division of Mental Health		28,125,868	28,125,868
	Kenya Board of mental health		7,138,597	7,138,597
	Total			**709,681,204**
2016/2017		**Development**	**Recurrent**	
	Mathari Teaching & Referral Hospital	30,000,000	476,718,877	506,718,877
	Division of Mental Health		33,662,815	33,662,815
	Kenya Board of mental health		4,933,582	4,933,582
	Total			**545,315,274**
2015/16		**Development**	**Recurrent**	
	Mathari Teaching & Referral Hospital	**101,000,000**	**578,803,454**	**679,803454**
	Division of Mental Health		**48,746276**	**48,746276**
	Kenya Board of mental health		**6,560,000**	**6,560,000**
	Total			**735,109,730**
2014/15		**Development**	**Recurrent**	
	Mathari Teaching & Referral Hospital	**51,000,000**	**187,960,246**	**238,960,246**
	Division of Mental Health		**48746276**	**48746276**
	Kenya Board of mental health		**6,560,000**	**6,560,000**
	Total			**294,266,522**
2013/14		**Development**	**Recurrent**	
	Mathari Teaching & Referral Hospital		**510,927,227**	**510927,227**
	Division of Mental Health		**41,243,182**	**41,243,182**
	Total			**552,170,409**

Table 2: Budget Allocations for Mental Health programs
Source: Budget Estimates for recurrent and development expenditures

The second concern with **Table 2** is the consistently low allocations to development spending when mental health should also be subject to **Figure 1's** principle that medical care is a third 'tier' determinant of health status, after person characteristics and context upbringing. As a constitutional right, mental health requires supportive, transformational business unusual interventions, reflected in increased Development budgets.

Figure 7 illustrates a further need for continually reviewing disaggregated rather than aggregated data. These data are recurrent budgets for Mathari Teaching and Referral Hospital for FYs 2014/15 and 2016/17. As previously noted, recurrent budgets target maintenance of the status quo, primarily through the payment of salaries and allowances and utilities. The budget grew by a commendable 154 percentage points to close at KES 476.7mn. However, the period saw the 'Basic Salaries and Personal Allowances' share double from 31% to 76%, with 'Utilities supplies and Service' share dropping from 66% to 23%. Thus, while the salaries budget grew from KES 58mn to KES 362mn, the utilities' budget enabling their work fell from KES 124mn to KES 105mn. The travel budget also decreased for the presumably increased employee numbers.

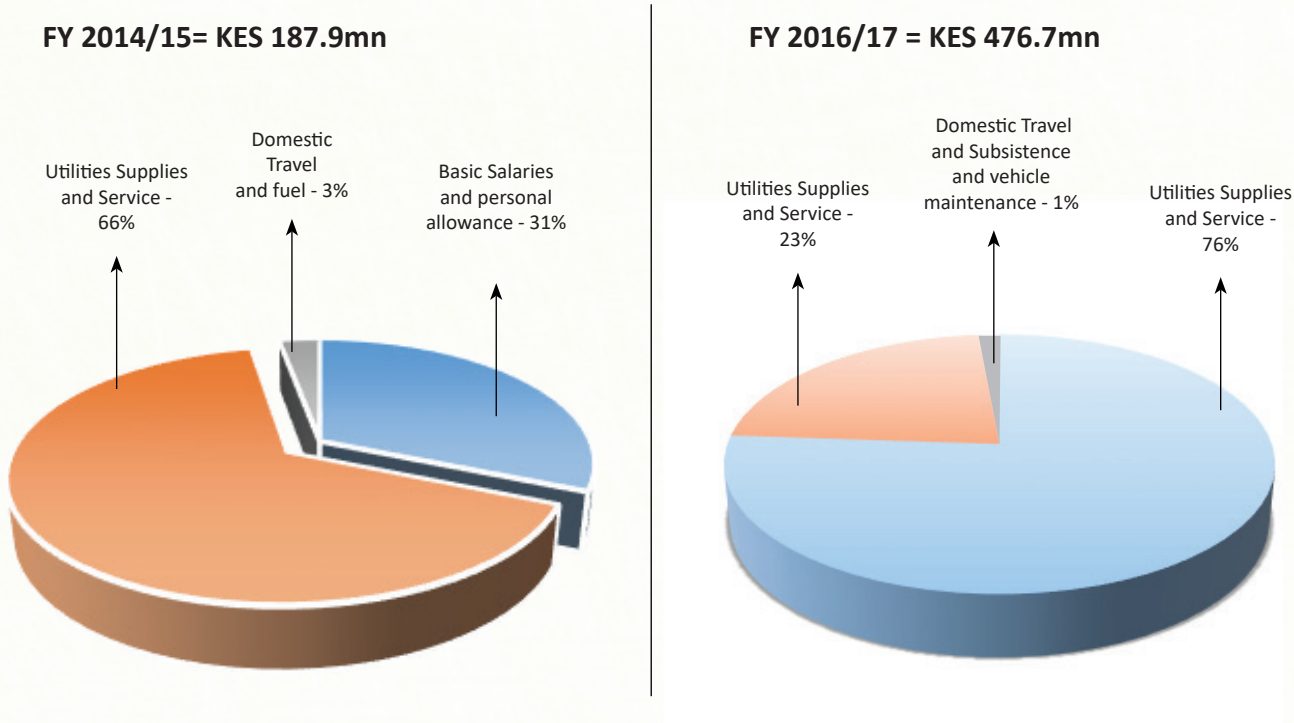


Figure 7: Recurrent budgets for Mathare Teaching and Referral Hospital for FYs 2014/15 and 2016/17

7.0 SUMMARY AND CONCLUSIONS

Traditional societies including in Kenya, have perpetuated a stigma around mental illness, meaning that sufferers have always been hidden from the public view, and in the process, denied care or left to wander and deteriorate. Kenya's transformative constitution (2010) makes health a human right and makes it a 'fundamental duty of every State and State organs to observe, respect, protect, promote and fulfil the rights.'

Starting with WHO's 1948 definition of 'health' as more than just the absence of illness, the recognition has been that health depends on more than just medical care. Approaching mental health in such a holistic manner is essential for comprehensive, sustainable, cost-effective interventions. Consequently, WHO has partnered with researchers to develop norms for planning and budgeting for mental health management.

Just as the global resource commitment to health has been modest, so has resource commitment to mental health care. Higher-income countries have larger health budgets and can commit more mental health resources in absolute and per capita terms. Lower-income countries commit absolutely and proportionately less to health and mental illness.

Within the Africa Union, the year 2000 saw the Millennium Development Goals prompt an aspiration to ring-fence at least 15% of public spending for health; but compliance remains weak 20 years on. Kenya has fared no better, posting shares that never rose above 7%. However, Kenya's 2013 accession to devolved governments with responsibilities for health care has raised the health share of budgets consistently above 20%.

Notwithstanding that achievement, Kenya seems not to have espoused an integrated approach to mental health management, seemingly focusing resources on facility-based strategies, with little or no evidence of allocations to community-based initiatives. A deeper look at the mental health management resources points to a bias towards Recurrent spending at the expense of the Development spending necessary to implement the country's transformative constitution that sees health – and by extension, mental health, as a human right.

In conclusion, Kenya needs to understand better the contexts within which mental illnesses arise and estimate the same disease burden. Subsequently, it is essential to identify sustainable, cost-effective interventions at all levels of society, emphasising preventive and promotive care without ignoring curative care. An approach to integration is to, for instance, include mental health issues in the education curricula at all levels.

HERAF
Health Rights Advocacy Forum

Health Rights Advocacy Forum (HERAF)
Ring Road, Kilimani
P.O Box 100667 – 00101, Nairobi, Kenya
Tel: +254735333007
Email: info@heraf.or.ke | **Website:** www.heraf.or.ke
Facebook: Heraf Kenya | **Twitter:** @HERAF_Kenya