Promoting Breastfeeding as a Human Right in Kenya

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1.0 Background to the Study on Legal Measures Promoting Breastfeeding in Kenya

Breastfeeding in Kenya and Africa as a human right and Breast Milk Substitutes (BMS) imports raise important questions in law, science technology, and innovation (LSTI) yet they have received insufficient attention in the law, policy and literature. It is perceived as a "lifestyle choice" to be dealt with in the private sphere. Thus, for a long time, Breastmilk Substitutes (BMS) have been perceived to be the biggest threat to breastfeeding.

In 1973 the World Health Organization (WHO) noted that Nestle Corporation was aggressively marketing its infant formula to poor third world countries which lacked adequate cash resources and sanitary infrastructure to make the formula a viable infant feeding option.[1] The use of infant formula was believed to have escalated the already high infant mortality rate. As a result of the limited access

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[1] J. Law, "The Politics of Breastfeeding: Assessing Risk, Dividing Labor," (The University of Chicago Press 2000)
Volume 25 No 2 < https://www.jstor.org/stable/3175561 > (accessed 7 January 201) 436.

to sanitary water to create the formula and facilities to sterilise feeding bottles, infants in these developing countries were prone to neonatal infections.[2]
In addition to this, the use of infant formula resulted in the diversion of the already scarce resources into the purchase of Breast Milk Substitutes (BMS) and hence directly enriching Western transnational companies at the expense of impoverished people in the third-world countries. Moreover, when mothers used infant formula, it resulted in accelerated population growth since consistent lactation was no longer a viable birth control method.[3]

In 1974 the World Health Assembly (WHA) noted a worldwide decline in breastfeeding.[4] Aggressive promotion and marketing of BMS led to a decline in the breastfeeding rate. As a result, they urged member states to review sales, and promotion of baby foods, and introduce corrective measures. This would entail creating codes of practice regulating the promotion of BMS and in some extreme cases legislation.[5]

In 1978 the WHA continued to urge member states to prioritize the issue regarding the prevention of malnutrition in infants and young children by supporting breastfeeding. This was to be done by taking social action or legislative steps to encourage breastfeeding, especially by working mothers, and regulation on the promotion of BMS.[6] The WHO and the United Nations Children's Fund (UNICEF) joined forces to collaborate and deal with the issue of infant and young child feeding.

In 1979 a meeting was convened in Geneva, attended by 150 representatives of WHO member states, organizations of the United Nations system, other international organisations, non-governmental organisations, professional associations, scientists, and the infant food industry. This culminated in a

[2] *Ibid*.
[3] *Ibid*.
[4] S. Shubber, "The International Code of Marketing of Breast Milk Substitutes". (International Digest of Health Legislation 1985) volume 36 No 4. 880.
[5] *Ibid*.
[6] *Ibid.*

recommendation that the WHO and UNICEF in consultation with relevant parties draft an international code regulating marketing breast milk substitutes.[7]

The Director-General in consultation with member states and other relevant parties developed a draft code and presented it to the Executive Board during the sixty-seventh session in 1981. The Board in turn, unanimously recommended that the Thirty-fourth WHA adopt the draft code. On 21 May 1981, the WHA adopted the International Code of Marketing of Breast Milk Substitutes (the Code) with 118 votes in favour and three abstentions. [8]

According to the WHO status report, as of March 2016, 135 countries had put in place measures related to some form of provision of the code. However, only 39 countries have comprehensive legislation or other legal measures reflecting all or most of the provisions of the Code.[9] Kenya is one of the countries that has adopted legal measures incorporating all of the provisions in the Code. The adoption of the Code's provision was through the Breast Milk Substitutes (Regulation and Control) Act. [10] The then Minister of Public Health and Sanitation Mrs Beth Mugo sponsored the Act. Before the enactment of the Act, the Kenya Bureau of Standards (KEBS) regulated BMS as a standard. However, it did not regulate marketing or promotion or institute penalties for violations.

Mrs Mugo argued that the rationale behind the Bill was to increase the child survival rate, which was an indicator of a country's development. She restated Kenya's commitment to meeting the fourth Millennium Development Goal (MDG)[11], which was to reduce the under-five mortality rate by two-thirds by 2015. This would be in line with Kenya's Vision 2030 goal of developing into a medium-income country where citizens enjoy a high quality of life.[12]

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[7] *Ibid*.
[8] *Ibid*.
[9] WHO, UNICEF & IBFAN, "Marketing of Breast-milk Substitutes: National Implementation of the International Code. Status Report 2016, (WHO 2016). <https://apps.who.int/iris/bitstream/handle/10665/206008/9789241565325_eng.pdf?ua=1> (accessed 11 May 2019) 17.
[10] Act no 34 of 2012.
[11] MDGs have now been superseded by the Sustainable Development Goals (SDGs)
[12] Member of Parliament: Beth Mugo (Contribution she made on: the Breast Milk Substitutes (Regulation and Control) Bill Second Reading (12 September 2012).

In addition to this, she argued that poor feeding practices were a hindrance to social and economic development. Moreover, that breastfeeding was not only beneficial to the child but strengthened family ties and saved money. She proceeded to delve deeper into the numerous benefits of breastfeeding. She pointed out that the Bill had no intention of restricting the manufacture or sale of BMS, designated products, or complementary foods but instead regulating the promotion and marketing of the aforementioned products. This would ensure that aggressive marketing and promotion of BMS and designated products would not unduly influence a mother's decision to breastfeed.

The Bill received overwhelming bipartisan support from the female members of Parliament who included. Cecily Mbarire, Jebii Kilimo, Rachel Shebesh, Joyce Laboso, and Millie Odhiambo, among others.[13] The BMS Act was assented to by the President Mwai Kibaki on 11 October 2012 and commenced operation on 17 December 2012.

Significantly, WHO recommends exclusive breastfeeding for the first six months of an infant's life to ensure optimal growth, development, and health. After nutritious complementary food can be introduced with breastfeeding continuing up to 24 months. [14] The BMS Act is meant to regulate the marketing and distribution of BMS. Furthermore, the Act is meant to provide safe and adequate nutrition for infants through the promotion of breastfeeding and the use of BMS where necessary.[15]

However, the BMS Act seems to solely focus on regulating the promotion and distribution of the BMS and does very little to promote breastfeeding. Aggressive promotion and marketing of BMS were predominantly blamed for the decline in the breastfeeding rate. Consequently, the BMS Act was enacted. Remarkably, an estimated 44% of the population of Kenya lives below the poverty line[16], therefore

<http://www.kewopa.org/wp-content/uploads/2015/04/September-2012-Hansard.pdf> (accessed 21 December 2018). 18.

[13] *Ibid.*

[14] WHO, "Exclusive Breastfeeding for Six Months Best for Babies Everywhere," (WHO 2011). <https://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/> (accessed 21 December 2018).

[15] Preamble BMS Act.

[16] UNICEF, " Kenya at a Glance"(UNICEF),

a majority of the Kenyan population cannot afford the luxury of using commercial BMS and other related items such as feeding bottles.[17] Most commercial BMS such as infant formula have a price range of between Ksh 1,000 to Ksh 2,000. A majority of Kenyans rely on other indigenous substitutes such as cow's milk, water, porridge, and fruit juice, which are not regulated.

In Kenya, approximately three in five children under six months exclusively breastfeed. On average, Kenyan children are breastfed for 21 months and exclusively breastfed for 4.3 months[18]. This correlates with the fact that female employees are entitled to three-months paid maternity leave.[19] Often mothers will choose to combine the three months of maternity leave with their twenty-one working days of annual leave. This roughly adds up to 4.3 months. This would suggest that the greatest threat to breastfeeding is not the marketing and distribution of BMS but rather the ability of working mothers to consistently access their infants.

The BMS Act's primary objective seems to be centred on controlling the interaction between consumers of BMS and designated products and the manufacturers and distributors. The Act goes in as far as to control the communication between manufacturers and distributors and health workers, who typically have direct access to consumers. This interferes with manufacturers' and distributors' right to commercial speech, for example through advertisement, monetary and sales promotion. This inadvertently affects sales and profit margins. Since manufacturers are restricted from advertising and promoting BMS and designated products, this inadvertently negatively affects manufacturers' and distributors' sales and profit margins.

<https://www.unicef.org/kenya/overview_4616.html> (accessed 21 December 2018).

[17]Pathfinder International, "Preventing Mother-to-Child Transmission of HIV in Kenya. Pathfinder International's
Experience: 2002-2005," (Pathfinder 2005).
<http://www2.pathfinder.org/site/DocServer/Pathfinder.PMTCT4lite.pdf?docID=4041> (accessed 21 December 2018) 6.

[18] KDHS, "National Bureau of Statistics-Kenya and ICF International 2014". (KDHS 2015).
<https://www.dhsprogram.com/pubs/pdf/sr227/sr227.pdf> (accessed10 January 2019).

[19] Employment Act, Chapter 226, Section 29.

As a result, the Kenya Association of Manufacturers (KAM) has opposed the Act. Betty Maina, the former CEO of KAM, asserted that the BMS Act's provision, which restricts advertising is a threat to constitutionally guaranteed rights such as freedom of expression[20] and public participation.[21] Despite the Constitution guaranteeing the right to public participation, the BMS Act did not comply with to this requirement during the debate of the Bill.[22] There was a concern that private sector stakeholders were not allowed to substantially participate in the formulation of the Bill[23].

Public participation was restricted to the Government and Non-Governmental Organizations (NGOs). Private stakeholders were only allowed to participate when the Bill was before the Parliamentary Committee on Health [24]. KAM admits that though this helped to weed out initial problems with the bill, it was not sufficient in addressing all the issues.

The BMS Act establishes the National Committee on Infant and Young Children Feeding Committee, which serves an advisory role to the Cabinet Secretary. The Committee's composition deliberately excludes vital stakeholders such as manufacturers and distributors, citing the reason as a conflict of interest. This, however, denies the Committee an opportunity to receive feedback or input from the very institutions it is attempting to regulate.

[20] Article 33 Constitution of Kenya 2010.
[21] Article 118 Constitution of Kenya 2010.
[22] Betty Maina, "Breastfeeding Law unfair to makers of infant formula". (The East African, 6 October 2012) <https://www.theeastafrican.co.ke/oped/comment/Breastfeeding-law-unfair-to-makers-of-infant-formula/434750-1526676-lfy7gnz/index.html> (accessed 21 December 2018).
[23] Ben M. Sihanya (2013) "Public participation and public interest lawyering under the Kenyan Constitution: theory, process and reforms," Vol. 9 (1), *Law Society of Kenya Journal,* 1–32.
[24] *Ibid.*

2.0 Conceptualizing and Problematizing Breastfeeding as a Reproductive Right in Kenya and Transnationally.

What is the scope of breastfeeding as a right in Kenya and internationally?

2.1 Breastfeeding as a Reproductive Right in Kenya

Reproductive rights applicable to Kenya recognize that all couples and individuals have a right to freely and responsibly number, and space the timing of their children and have access to information on how to do so. Moreover, couples and individuals also have the right to access the highest standard of sexual and reproductive health. Decisions on reproductive rights should be made freely and without coercion and violence.[25]

However, reproductive rights are centered around obstetrics and contraception while breastfeeding is relegated to the margins. Breastfeeding is perceived as an individual woman's choice or a lifestyle decision. Mothers are expected to make personal sacrifices to accommodate breastfeeding. In the case of *L.G* v. *ICC,*[26] the Complainant was expected to make such a personal sacrifice to enable her to breastfeed. According to the Administrative Instruction ICC/AI/2010/001 of 21 September 2010, field duty stations were divided into two: family duty stations and non-family duty stations. The aforementioned categories were based on the level of security. Non-family duty stations prohibited employees from traveling with family members to such locations.

The Complainant was working at the Trust Fund for Victims in Kampala which was labeled as a family duty station. As part of her duties, she was expected to at times travel to family non-family duty stations. As of February 2012, when she became pregnant, she was exempted from traveling to non-family duty stations. In fact, due to the inadequate medical facilities in Kampala, she was allowed to work from Europe from 28 June 2013 until the start of her maternity leave[27].

[25] International Conference on Population and Development (ICPD), Program of Action, Un Doc A/CONF.171/13 1994 para 7.3.
[26] Judgment No. 3861 International Labour Organization Administrative Tribunal.
[27] Of maternity leave under section 29 of Kenya's Employment Act, 2007, practice and case Law.

At the end of her maternity leave the complainant informed her supervisor that because she was breastfeeding, she would only be able to travel to family duty stations. Consequently, she could not undertake activities that would involve her traveling to non- family duty stations but she was open to the possibility of telecommuting. The Complainant's supervisor then requested her to take at least one year of unpaid special leave to enable her to breastfeed her child.

The Complainant submitted a request to the Registrar of the ICC to convert her special leave without pay to special leave with pay. However, the Registrar argued that the review was time barred. Therefore, the Complainant filed an appeal with the Appeal Board. The Appeal Board members dismissed the case[28]. The Complainant then filed a complaint with the ILO Administrative Tribunal once again reiterating her previous claims.

The Tribunal held that international organizations owed their employees a duty of care and were expected to operate under the principle of good faith. Therefore, they were expected to treat their employees with due consideration to avoid causing them undue injury. The Tribunal held that by not exempting the complainant who was a breastfeeding mother from travelling to non-family duty stations the Respondent had breached their duty of care. The Tribunal ordered that the Complainant's unpaid special leave be converted to special leave with pay. Moreover, the ICC was ordered to pay the complainant one symbolic Euro for moral and professional injury. Further to this, the Tribunal ordered the Respondent to adjust the Complainant's traveling duties to exclude non -family duty stations.[29]

Relatedly, the third annual Breastfeeding and Feminism Symposia held in 2007 came up with a few underlying principles. First, breastfeeding should be considered a social and biological process in which a woman enjoys the right to self-determination. Second, breastfeeding is at the core of maternal and child health care and should be categorized as a reproductive right.

[28] *Ibid*
[29] *Ibid* 8.

Third, there is a need to shift how breastfeeding is perceived. Breastfeeding is often perceived as a "lifestyle choice". However, it should instead be viewed as part of reproductive health, rights, and social justice. This, in turn, ensures that social, economic, and political structures are put in place to facilitate breastfeeding.[30]

3.0 International and Regional Legal Framework Safeguarding Reproductive Rights (what are the regional and international legal framework on reproductive rights applicable to Kenya?)

3.1 Convention on the Elimination of all Forms of Discrimination against Women

Kenya ratified Convention on the Elimination of all forms of Discrimination against Women (CEDAW) on 9th March 1984.[31] CEDAW is the core human rights document catering to women's rights. Nevertheless, it does not provide a robust legal framework for protecting the right to breastfeed. CEDAW places an obligation on the State to ensure women have access to proper services during pregnancy, confinement, and postnatal period and where necessary grant free services. Furthermore, State Parties have a responsibility to provide adequate nutrition during pregnancy and lactation.[32]

CEDAW recognises the right to work as an inalienable human right and therefore places an obligation on State Parties to eliminate all forms of discrimination against women in the field of employment.[33] The Convention also provides for additional rights to women, for example, paid maternity leave, freedom from discrimination based on marital status or pregnancy. The treaty also provides additional protection for pregnant women in regard to work, which has been proven to be harmful.[34] Aside from this, State Parties are expected to create social

[30] M.H. Labbok, P.H. Smith and E.C. Taylor, "Breastfeeding and Feminism: A Focus on Reproductive Health, Rights and Justice," (International Breastfeeding Journal, 2008) 4.
[31] UN, "United Nations Treaty Collection."
<https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&clang=_en>(accessed 11 November 2019).
[32] Article 12 Convention on the Elimination of all Forms of Discrimination against Women.
[33] Article 11 (1) Convention on the Elimination of all Forms of Discrimination against Women.
[34] Article 11 (2) (a) & (b) Convention on the Elimination of all Forms of Discrimination against Women.

services that enable parents to fulfill their family and work obligations and be able to participate in public life. A State Party is expected to achieve this particular goal through the development of a network of child-care facilities.[35]

CEDAW protects reproduction rights centred on obstetrics (or childbirth and midwifery). Breastfeeding rights are vaguely protected through the provision of maternity leave. The Convention fails to recognize that breastfeeding is an ongoing process that will continue beyond the stipulated maternity leave period. Hence the need for provisions that protect breastfeeding in the workplace such as nursing stations and breaks.

Moreover, CEDAW prohibits discrimination based on marital status and pregnancy but does not include grounds such as breastfeeding. Consequently, it relegates breastfeeding to the private sphere[36]. Breastfeeding is perceived as a woman's individual choice and responsibility rather than a process that requires robust support from all levels of society. CEDAW. Therefore, it offers minimal protection in regard to breastfeeding at the workplace.

Unlike CEDAW, the UN Convention on the Rights of the Child, 1989 (CRC) directly promotes breastfeeding by stipulating that all segments of society in particular children and parents have access to information that promotes the advantages of breastfeeding.[37] Consequently, breastfeeding is considered more as a children's right than a women's rights issue.

3.2 *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*

Kenya ratified the Protocol to the African Charter on Human and Peoples' Rights on the rights of Women in Africa (Maputo Protocol) in 2010. The Maputo Protocol recognizes breastfeeding as a right worth safeguarding. The Protocol

[35] Article 11(c) Convention on the Elimination of all Forms of Discrimination against Women.
[36] Cf the constitution of Kenya, prescription of discrimination on the following grounds under article 27: 4; race, sex, pregnancy, marital status, health status, ethnic or social origin, color, age, disability, religion, conscience, belief, culture, dress, language or birth
[37] Article 24 United Nations Convention on the Rights of the Child, 1989 (CRC).

calls on the state to ensure that measures are taken to ensure that women who breastfeed are not subjected to the death penalty.[38]

The Maputo Protocol also recognizes breastfeeding as a health and reproductive right hence it places an obligation on the state to undertake steps to ensure that both pregnant and nursing mothers can access adequate prenatal, delivery, and postnatal health and nutritional services[39]. The Protocol further recognizes breastfeeding mothers as a vulnerable group in need of special additional protection. The Maputo Protocol provides that states are under an obligation to ensure that nursing mothers are kept in an environment that is suitable for their condition and are treated with dignity.[40]

4.0 Breastfeeding and the Rights of the Child in Kenya and Africa

The United Nations Convention on the Rights of the Child (the CRC) is the leading human rights treaty, which sets out the rights of the child. It is therefore not surprising that Kenya ratified the CRC on 30th July 1990.[41] The CRC does directly promote breastfeeding by providing that State Parties have the mandate to ensure all segments of society have access to information that supports the basic knowledge of child health and nutrition and the advantages of breastfeeding.[42]
The CRC provides that states must ensure that every child enjoys the right to the highest attainable standard of health.[43] Moreover, State Parties should take measures to diminish infant and child mortality.[44] State Parties also have a responsibility to combat disease and malnutrition.[45]

[38] Article 4 (2) (j) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[39] Article 14 (2) (b) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[40] Article 24 (b) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[41] UN, "United Nations Treaty Collection."
<https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-11&chapter=4&lang=en> (accessed 11 November 2019).
[42] Article 24 (2) (e) United Nations Convention on the Rights of the Child.
[43] Article 24 (1) United Nations Convention on the Rights of the Child.
[44] Article 24 (1) United Nations Convention on the Rights of the Child.
[45] Article 24 (2) (c) United Nations Convention on the Rights of the Child.

The African Charter on the Rights and Welfare of the Child has similar provisions to the CRC. The African Charter places an obligation on the State Parties to take measures to ensure that all sectors of the society are informed and supported in the use of basic knowledge of child health, nutrition, and the advantages of breastfeeding. [46] What is more, the African Charter also provides that the State parties must take steps to reduce the infant and child mortality rate.[47]

According to the African Charter State parties also should ensure the provision of adequate nutrition and safe drinking water. [48] State parties must also put in place measures to combat diseases and malnutrition within the framework of primary health care through the application of appropriate technology.[49]The African Charter also provides that every child has a right to enjoy the best attainable state of physical, mental, and spiritual health.[50]

Both the CRC and the African Charter on the Rights of the Child predominantly focus on education and information campaigns meant to sensitize people on the importance of breastfeeding. However, there are very concrete economic, social, or political measures that have been put in place to promote breastfeeding.

The Children Act[51] does not have any provisions which refer directly to breastfeeding. However, it does provide that every child has an inalienable right to life and the Government and the family have the responsibility to ensure the survival and development of the child.[52] The Act provides that the parents have a responsibility to provide an adequate diet.[53]

Child survival is dependent on two factors: nutrient intake and the ability of the child to ward off infections.[54] Breast milk is a significant source of nutrients.

[46] Article 14 (2) (h) African Charter on the Rights of the Rights and welfare of the Child.
[47] Article 14 (2) (a) African Charter on the Rights of the Rights and welfare of the Child.
[48] Article 14 (2) (c) African Charter on the Rights of the Rights and welfare of the Child.
[49] Article 14 (2) (d) African Charter on the Rights of the Rights and welfare of the Child.
[50] Article 14 (1) African Charter on the Rights of the Rights and welfare of the Child.
[51] Chapter 141 Laws of Kenya.
[52] Section 4 Children Act.
[53] Section 23 (1) Children Act.
[54] S.L. Huffman and B.B. Lamphere, "Breastfeeding Performance and Child Survival," (Population and Development Review 1984) Vol.10

Breast milk is composed of both nutritional composition and non-nutritive bioactive factors. Bioactive factors include cells, anti-infectious and anti-inflammatory agents, growth factors, and probiotics.[55]

Breast milk protects infants against illness in one of two ways. The first method is directly protecting the infant against specific diseases. The second method is by stimulating and strengthening the infant's immature immune system.[56] Moreover, numerous studies have indicated that breastfeeding has numerous benefits to the infant. These include reduction on the risk of bacterial infection, botulism, diarrhoea, respiratory illness, viral infection, allergies, and sudden infant death syndrome. These benefits of breast milk are even more pronounced in developing countries like Kenya that lack adequate access to non-contaminated foods which can be used as a substitute for breast milk. The chances of infections are higher, and the health care system is underdeveloped. [57]

The benefits of breastfeeding go well beyond the infancy stage; children who have been breastfed enjoy improved vision, cognitive functioning, educational achievement, and speech development.[58] Breastfeeding also promotes proper teeth and jaw development. When compared to BMS, breast milk reduces the risks of obesity, cancer, adult cardiovascular diseases, and diabetes.[59] Breastfeeding also extends the duration of the mother's postpartum anovulation, therefore, lengthening the period between births. Studies have indicated that extended birth intervals have increased the rate of child survival.[60]

<https://www.jstor.org/stable/2807957> (accessed 23 April 2019) 93.

[55] O. Ballard & A.L. Morrow, "Human Milk Composition: Nutrients and Bioactive factors," (Pediatrics Clinics of North America 2013) Volume 60 Issue 1. 49-74. <https://www.sciencedirect.com/science/article/pii/S0031395512001678?via%3Dihub> accessed 23 April 2019.

[56] IBFAN,"Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health." <https://www2.ohchr.org/english/bodies/crc/docs/CallSubmissions_Art24/InternationalBabyFoodActionNetwork.pdf> (accessed 23 April 2019) 1.

[57] S.L. Huffman and B.B. Lamphere, "Breastfeeding Performance and Child Survival,". *Op. cit*

[58] H.W Christup, "Litigating a Breastfeeding and Employment Case in the New Millennium." (Yale Journal of Law and Feminism 263, 2000) 265.

[59] IBFAN, "Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health." *Op. cit*

[60] S.L Huffman and BB Lamphere, "Breastfeeding Performance and Child Survival. *Op. cit*

The consensus in the scientific community promotes exclusive breastfeeding for the first six months followed by the introduction of appropriate complementary food with the continuation of breastfeeding until two years- that this increases the chances of child survival and proper development[61]. According to a 2013, *Lancet* Study, optimal breastfeeding is the most efficient technique in preventing infant and child mortality. The study indicates that optimal breastfeeding can prevent up to 800,000 deaths of children under five in developing countries.[62] Moreover, breastfed children have a higher chance of survival than their non-breastfed counterparts. The figures indicate that an exclusively breastfed child is six times less likely to die before their half birthday than a non-breastfed child. [63]

The central theme in international, regional, and national legal frameworks concerning children is that any action taken concerning a child must always be in the child's best interest[64]. A review of the benefits of breastfeeding indicates that breast milk is essential for the survival and growth of infants. Hence it is inconceivable that breastfeeding does not feature prominently as a right of the child in the international, regional, and national legal framework. There seems not to exist an aggressive legal framework to safeguard a child's right to breastfeed.

However, it is important to note that Kenyan courts have continuously upheld decisions which advocate that breastfeeding as a child's right. In *Refugee Consortium of Kenya & Another* v. *Attorney General and 2 Others* [65], the 2nd Petitioner was Congolese registered refugee who resided in Kasarani, Nairobi. She was forcefully transferred to Dadaab Refugee Camp leaving her children behind. The 2nd Petitioner was a mother of six children, who were all under the age of 15. The petition had been brought on behalf of the six children. The youngest of the six children was still breastfeeding and as a result of the 2nd Petitioner's detention the infant had developed health problems associated with pre-mature disruption of breastfeeding.

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[61] BFAN, "Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health." *Op. cit* .

[62] UNICEF, "Nutrition." <https://www.unicef.org/nutrition/index_24824.html> (accessed 23 April 2019).

[63] *Ibid.*

[64] See Children's Act, 2022 and in Civil Appeal No. E026 of 2021, Eklr

[65] High Court of Kenya at Nairobi Constitutional and Human Rights Division Petition no 382 of 2014, (2015 eKLR).

The Court held that the separation should only be in the case of the best interest of the child and this was not the case. That by separating the breastfeeding infant from her mother the child had been exposed to malnutrition. Moreover, the child had been denied her right to parental care and family. The Court made an order of *mandamus* compelling the 2nd Respondent to unite the 2nd Petitioner and other affected children with their mother. Similarly in *MMA* v. *KM (2017)*, the Court held in this case that certain functions such as breastfeeding can only be performed by a mother. Subsequently, no one is allowed to stop a mother from breastfeeding.

5.0 Women's Reproductive Versus Productive Role in Kenya

Women's reproductive and productive roles at times may seem to be in conflict. Breastfeeding directly affects a woman's freedom in regards to employment, mobility, and her ability to carry out day -to -day tasks. Some scholars have argued that the increase in participation of women in the workforce and public life in the early 1900s was primarily a result of the introduction of the infant formula. This is because the influx of women into the workforce coincided with the creation of the formula. Over the years, very little has been done to address the structural barriers that inhibited women from exercising both their reproductive and productive roles.[66]

Studies have indicated that breastfeeding mothers are more likely to reduce working hours than mothers who feed their infants formula.[67] This is because breastfeeding is more time-consuming than preparing the formula. Moreover, the mother's presence is required during breastfeeding, unlike formula feeding, whereby the mother's presence is not necessarily required as a caregiver can prepare the formula. The formula also digests slower than breast milk. Hence formula -fed children need fewer feedings than breastfed infants.[68] In addition to

[66] PLF Rippeyoung & MC Noonan,"Is Breastfeeding Truly Cost Free? Income Consequences of Breastfeeding for Women." (American Sociological Review 2012) Vol 77. No 2. 247.

[67] *ibid* 248.

[68] I. Zararija- Grkovic & T. Burmaz, " Effectiveness of the UNICEF/WHO 20-hour Course in Improving Health Professionals' Knowledge, Practices, and Attitudes to Breastfeeding: A Before/After Study of 5 Maternity Facilities in Croatia." (Croat Medical Journal 2010) Volume 51 (5) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2969134/> (accessed 11 April 2019).

this, research also indicates that nursing mothers are more likely to extend maternity leave or quit working as compared to their counterparts who formula - feed their children.[69]

The hiatus from work can be detrimental to the woman's finances, especially if the mother takes on additional unpaid leave. Moreover, the woman may miss out on promotions that are based on work experience. Women also suffer the risk of re-entering the job market only to find that their skills are no longer compatible with workforce expectations.

Breastfeeding is the most basic form of parental care and can only be performed by women. There are numerous benefits to breastfeeding, which are not only enjoyed by the infants but also by the community as a whole. This is mainly because healthy children grow up to be healthy adults who not only contribute to the growth of the resources in the community but also do not cause a strain on the health sector. The Kenyan Government acknowledges that the future of the nation is dependent on the health of the children.[70]

Millenium Development Goals (MDG) number 4 was to reduce child mortality by two-thirds between 1990 and 2015 for children under the age of five years old[71]. In addition to this, Sustainable Development Goals (SDG) number 3 advocates for good health and well-being.[72] Two of the biggest threats to children's health are acute respiratory illness and dehydration due to extreme diarrhoea.[73] These ailments can be prevented by breastfeeding.

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[69] *Ibid*.

[70] Ministry of State for Planning, National Development and Vision 2030, "Millennium Development Goals Status Report of Kenya 2011." (Ministry of State for Planning, National Development and Vision 2030, 2011) 14.

[71] *Ibid.*

[72] SDGF, "Sustainable Development Goals," (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs- sdgs> (accessed 11 April 2019).

[73] J. Otieno, "Situation of Children and Women improves." (UNICEF 2010) < https://www.unicef.org/kenya/health_5736.html > (accessed 8 July 2019).

MDG number 1[74] promoted the eradication of extreme poverty and while SDG number 1[75] calls for an end to poverty. A 2012 economic survey revealed that approximately 2,127,700 out of a possible 39.5 million people in Kenya were unemployed in Kenya. This would, therefore, indicate that there is a large section of the population that rely on a few breadwinners. [76] This situation is further aggravated by the fact that some women have no choice except to quit their jobs to breastfeed their babies.

The Kenyan Government recognizes that the empowerment of women is the key to eliminating poverty, hunger, disease and sustainable development and therefore, the introduction of MDG number 3. MDG number 3 advocates for the promotion of gender equality and the empowerment of women.[77] In the same way SDG number 5 aims to achieve gender equality and empower all women and girls.[78] Therefore, laws that safeguard women's productive roles contribute to the increase of women in the workforce. Pursuing and achieving MDG and SDG contributes to building the nation.

There needs to be a shift in how women's reproductive role is perceived. Maternity leave should not be dismissed as time spent away from work and therefore not productive. Instead, it should be perceived as a form of social production that involves caregiving for the next generation or building human capital or human resource development[79] Women's reproductive role should be treated with the same reverence as their productive role.

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[74] Ministry of State for Planning, National Development and Vision 2030, "Millennium Development Goals Status Report of Kenya 2011." (Ministry of State for Planning, National Development and Vision 2030, 2011) 4.

[75] SDGF, "Sustainable Development Goals" (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs-sdgs> (accessed 11 April 2019).

[76] Ministry of State for Planning, National Development and Vision 2030, "Millennium Development Goals Status Report of Kenya 2011." (Ministry of State for Planning, National Development and Vision 2030, 2011) 5.

[77] *Ibid*10.

[78] SDGF "Sustainable Development Goals," (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs-sdgs> (11 April 2019).

[79] M. Swaminathan, "Breastfeeding and Working Mothers: Laws and Policies on Maternity and Child Care," (Economic and Political Weekly, May 1993,) Vol 28 No 18. 889.

For women's reproductive role to have the same importance as their productive role focus should not only be on the creation of a legal framework restricting the promotion and marketing of BMS. There needs to be an introduction of a secondary support system that promotes breastfeeding. A mother's output as a caregiver should be valued to the same extent as her output as an employee and receive just as much protection. The legal framework should protect women well beyond pregnancy and should include breastfeeding[80].

Women's productive and reproductive roles need to be supported equally. Women should not be forced to choose one role over the other. Reproductive and productive roles do not necessarily rival each other. With the proper structural changes, both roles can co-exist. A holistic approach that involves the Government's intervention through laws and policies is needed. Employers should also create workplace policies that support women's dual role.

The protective legal framework relating to breastfeeding has garnered considerable opposition. Some opponents argue that the "protectionist" approach will be detrimental to women since employers will opt to employ fewer women. This is a legitimate concern given the current capitalist climate where the emphasis is on the reduction of cost and maximization of worker output[81]. However, opponents of these arguments have come up with arguments supporting affirmative breastfeeding policies in the workplace.

First and foremost, the composition of the workforce has slowly changed with the influx of women into the workforce. With the increase of women in the workforce, it is necessary to have in place regulations and policies which safeguard fundamental rights such as breastfeeding. Furthermore, having measures that accommodate women's right to breastfeed is a cost-effective investment that increases employee morale. It also reduces absenteeism because breastfeeding improves the child's overall health. [82]

[80] See the debate in African, radical and liberal feminism
[81] Or what are the parts of consequences and divergence among Western Liberal Capitalism, Eastern Socialism, and African communitarianism?
[82] International Labour Organization, "Maternity Protection Resource Package. From Aspiration to Reality for All.

Moreover, employee turnover is reduced since female workers resume duty after maternity leave. Hence the organization does not suffer the loss of valuable skills and experience and also it reduces the cost of recruitment and retraining. In research commissioned by Vodafone, a KPMG analysis estimated that the cost of training new employees to replace mothers who have quit after childbirth comes to about 47 billion dollars every year. Whereas the cost of offering working mothers 16 weeks of fully paid maternity leave would be 28 billion dollars.[83]

Affirmative breastfeeding policies have at least enabled working mothers to smoothly transition back to their work routine after resuming duty from maternity leave. First, employer-employee relations are improved, resulting in higher employee loyalty. Second, favourable breastfeeding policies also boost the organisation's overall image to outsiders. Moreover, it is a bonus recruitment incentive for prospective female employees. It will also result in a healthier future workforce. Third, a favorable breastfeeding policy is a recognition of women's dual role in productivity and reproduction.[84]

CEDAW and the Maputo Protocol fail to adequately safeguard breastfeeding as a reproductive right. The focus predominantly seems to be on reproductive rights centred on obstetrics (or childbirth and midwifery). Provisions in CEDAW do not directly safeguard the right to breastfeeding, but instead focus on protecting women from discrimination against grounds such as pregnancy. Provisions relating to maternity leave are beneficial to working mothers who choose to breastfeed. However, they ignore the fact that breastfeeding continues well beyond the maternity period. Hence women who choose to resume work duty after maternity leave do not enjoy any legal protection against discrimination due to breastfeeding.

Module 10: Breastfeeding Arrangements at Work," (ILO 2012), <http://mprp.itcilo.org/allegati/en/m10.pdf> (accessed 18 April 2019) 10-12.

[83] L. Hooker, "Vodafone Offers Global Maternity Equality," (BBC News 6 March 2015), <https://www.bbc.com/news/business-31761572> (accessed 11 June 2019).

[84] *Ibid*.

The Maputo Protocol does directly safeguard the right to breastfeeding specifically in situations relating to the death penalty. However, the Protocol fails to protect breastfeeding mothers from the most obvious and common barrier to breastfeeding which is work obligations. There are no provisions which protect working mothers who choose to exercise their productive and reproductive role.

The CRC and the African Charter on the Rights of the Child predominantly focus on educational and information campaigns and therefore do very little to actually safeguard breastfeeding as a children's right. These legal instruments ignore the greatest barrier to breastfeeding which is the inability of mothers to access their children. The Children's Act does not directly refer to breastfeeding as a right of the child but has provisions that could be interpreted to allude to this right.

5.1 Kenyan Constitution 2010 in Breastfeeding and Reproductive Rights

Reproductive rights are deemed invaluable in that they are protected in the Constitution. The Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.[85] Reproductive rights are further reinforced by Article 27 of the Constitution which prohibits the state from directly and indirectly discriminating against pregnant women[86]. However, the Constitution fails to provide further protection and promotion of the interests of women who are breastfeeding.

5.2 Health Act 2017 on Breastfeeding and Reproductive Rights

Section 1 of the Health Act[87] defines breastfeeding as the act of feeding an infant directly from the female breast. Expressing milk is defined as the act of extracting human milk from the breast by hand or through a pump into a container.
The Health Act places an obligation on employers to establish a lactation station in the workplace. The lactation station should have necessary facilities such as hand washing equipment, refrigeration or cooling system, electrical outlets for breast pumps, a small table, and comfortable seats. Furthermore, lactation stations

[85] Constitution of Kenya 2010 Article 43 (1) (a).
[86] Quoted and discussed in part three above
[87] No 21 of 2017.

should not be located in restrooms. Employers have a further responsibility to ensure that no form of promotion and marketing of infant formula and Breast Milk Substitutes (BMS) is done within the lactation station.[88]

Nursing employees are entitled to interval breaks to enable them to breastfeed or express milk. These intervals are in addition to the regularly scheduled meal breaks. However, the break should not be more than one hour for every eight-hour working period.[89]

The companies with breastfeeding stations include Safaricom, Kenya Women Microfinance Bank, Nestle, Mabati Rolling Mills, International Medical Corps and Kenya Red Cross, World Vision, World Agroforestry Center (ICRAF), EKA Hotels, Seven Seas Technologies, Isuzu East Africa, Davis & Shirtliff among others.[90] Although the list is not conclusive, the majority of the organizations listed above are transnationals or large enterprises.

Ironically, the National Assembly drafted and approved the Health Act yet there are no breastfeeding rooms within Parliament buildings, including the National Assembly and Senate. This is despite the Members of Parliament (MPs) 2013 passing a motion directing the Parliamentary Service Commission (PSC) to create a breastfeeding station within Parliament. In August 2019, the Kwale Women's Representative, Zuleika Hassan was forced to attend a National Assembly session with her five -month-old baby because no breastfeeding station existed.[91]
However, the provisions relating to breastfeeding stations are, not inclusive. This is because large and medium-sized enterprises often have adequate resources whereas small-sized enterprises may not have enough resources to fulfill the requirements of the provisions. Moreover, this provision mainly caters for white

[88] Health Act no 21 of 2017 Section 71.
[89] Health Act no 21 of 2017 Section 72.
[90] L. Baraza, "Breastfeeding Stations a Must CS tells Kenyan Employers." (Citizen Digital 12 August 2018) <https://citizentv.co.ke/news/govt-asks-all-employers-to-set-up-breastfeeding-stations-208635/> (accessed 4 April 2019).
[91] S. Owino, "Kwale Woman Rep Zuleika Hassan ejected for bringing baby to Parliament," (7th August 2019 Daily Nation.)<https://www.nation.co.ke/news/politics/Kwale-woman-rep-Zuleika-ejected-for-bringing-baby-to-Parliament/1064-5226382-p1frm0/index.html> (accessed 13 November 2019).

collar jobs and may be challenging to implement for female blue-collar employees. Blue -collar employees such as domestic workers rarely get nursing breaks. This is a result of most domestic workers not having scheduled work hours; the workload often determines their working hours. Nursing mothers who are employed as live-in housekeepers or nannies are not able to access their infants regularly. Therefore, the expressed breastmilk may go to waste.

It may also be challenging to implement for enterprises that rely on casual labourers since the employers must ensure that the lactation stations can accommodate the nursing mothers. Casual labourers are not consistent in attendance; hence, it is difficult to ascertain how many nursing mothers are employed. Consequently, in terms of logistics, it is difficult to make adequate preparations.

In addition to this, nursing breaks can be a disadvantage to female employees whose salary is dependent on output or time. The provisions do not cater to nursing mothers who work outside the office such as cleaners contracted to clean office buildings or even salespersons. In some situations, it may be highly impractical to have a lactation station for example in airplanes. Airlines purchase or lease planes and the structure of some planes may not accommodate private lactation stations. Therefore, nursing airline crew are forced to express milk in the restroom.

Legislators purported to include nursing breaks that would enable mothers to breastfeed their infants. This provision seems highly impractical in Kenya, especially in urban settings. Most employees are not fortunate enough to live near their places of work. Urban centers such as Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Nyeri, Machakos and Kakamega are plagued with persistent traffic jams. Furthermore, the public transport system is chaotic. Hence it would be very challenging to ferry an infant back and forth for nursing breaks. Moreover, the Act does have a time restriction on nursing breaks, and therefore, a nursing mother would also find it difficult to travel back and forth.

Women in the horticultural sector have expressed concern over the implementation of the provision above. Some nursing mothers in flower farms in Lake Naivasha and elsewhere admit that even though they are given nursing breaks, there are no creches available. Therefore, this means women have to travel back home to nurse their babies or express milk and employers do not pay transport costs; hence, most women opt not to take nursing breaks.[92] Ideally, this provision would work for a nursing mother who lived near her workplace or had access to private means of transport.

The above provision, would have been more practical if the Act had required for creches at workplaces. However, some of the challenges discussed earlier such as limited resources for medium and small-sized enterprises may also prove to be a barrier. The provisions in the Health Act therefore, ideally cater to nursing mothers who are employed in white collar jobs and are stationed in their office building. Consequently, the provisions predominantly cater to the upper -class, highly educated nursing mother who is not a representative of the majority of women in Kenya.

5.3 Employment Act, Chapter 226 on Breastfeeding and Reproduction Rights in Kenya

According to the Employment Act, 2007 female employees are entitled to three months of paid maternity leave. The maternity leave is not inclusive of annual leave. The female employee has a right to return to the position she previously held before going on maternity leave. In the alternative, the female employee should be able to return to a suitable job on terms and conditions which are not less favourable.[93]

To begin with, this provision falls short of World Health Organisation (WHO) standards which advocate for infants to be exclusively breastfed for six months. Consequently, this leads to a clash between working mother's reproductive and productive roles in society.[94] Even though the Employment Act makes provisions

[92] J. Chimbi, "Women Working in Flower Farms Often Denied Maternity Leave." (18 March 2019 HIVOS) <https://east-africa.hivos.org/news/women-working-in-flower-farms-often-denied-maternity-leave/> (accessed 9 April 2019).

[93] Employment Act, Chapter 226 Section 29.

[94] WHO, "Exclusive breastfeeding for six months best for babies everywhere."

for unpaid maternity leave, this is not a viable option for single mothers or women from low-income households.

Non-compliance in the implementation of this provision is often noted. A study conducted by the Kenya Human Rights Commission (KHRC) in the horticultural industry noted non-compliance. The study indicated instances of unpaid maternity leave in Aquila and Sunbird Farms. Moreover, irregularities in the implementation of the provisions were noted in Fairtrade-certified companies where pregnant women were forced to proceed on their annual leave and maternity leave at least two months before their expected date of delivery. Therefore, this would, limit the post -delivery break to less than two months.[95]

Female casual labourers do not benefit from provisions relating to paid maternity leave. Another disenfranchised group is domestic workers. There are approximately over two million domestic workers in Kenya [96] A majority of the domestic workers are dismissed when their employers discover they are pregnant.[97] Although domestic workers are entitled to paid maternity leave due to the informal nature of their work contract, they often fear exercising this right. Moreover, some are not even aware of their rights. Domestic workers who are aware of their rights do not have enough resources to legally address the violation of their rights. Lack of resources such as money to hire an advocate and adequate savings or alternative sources of income to mitigate the loss of possible employment hinder their pursuit of justice.

Once again, the provisions of the Employment Act primarily benefit educated women who work in white collar jobs and have a high income. The

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<https://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/> (accessed 22 March 2019).

[95] KHRC, "Wilting in Bloom," (Kenya Human Rights Commission 2012). <https://www.khrc.or.ke/mobile-publications/economic-rights-and-social-protection-er-sp/63-wilting-in-bloom-the-irony-of-women-s-labour-rights-in-the-cut-flower-sector-in-kenya/file.html> (accessed 9 April 2019).

[96] G. Owidhi, "Analysis of Working Conditions and Wages of Domestic Workers in Kenya," (Central Organization of Trade Unions Kenya February 2017) <https://alrei.org/education/analysis-of-working-conditions-and-wages-of-domestic-workers-in-kenya-by-george-owidhi-economist> (accessed 10 July 2019).

[97] *Ibid.*

aforementioned class of women are aware of their rights and have resources to enable them to legally pursue their cases in Employment and labour courts.

5.4 National Policy on Maternal, Infant, and Young Child Nutrition in Kenya

The National Policy on Maternal, Infant, and Young Child Nutrition in Kenya (the National Policy) was adopted on 1 August 2012.[98] The National Policy's primary objective is to advocate for breastfeeding. However, it has provisions that restrict the use and promotion of BMS.

The National Policy stipulates that all pregnant and lactating women, pregnant women, and their partners to be made aware of the benefits and management of breastfeeding[99] The National Policy recognises the essential role partners play in promoting and enabling breastfeeding. Hence includes partners as part of the target audience.

In addition to this, the National Policy supports the initiation of breastfeeding within the first hour of birth.[100] This is ordinarily possible if the woman has undergone a non-complicated vaginal delivery. However, this may be difficult in a situation where the delivery was via cesarean section or had some other complications which make the mother unavailable for breastfeeding.

Moreover, mothers are encouraged to feed newborns breastmilk exclusively and to avoid feeding newborns any other food or drink unless medically advised to do so. [101] Similarly, according to the National Policy mothers are to be shown how to breastfeed and maintain lactation even if they are not in constant contact with their infants.[102] This provision recognises that there may be situations where the mother cannot access the infant which is especially the case with mothers working away from home.

[98] Ministry of Public Health and Sanitation, "National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[99] Paragraph 3, "National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[100] Paragraph 4, "National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[101] Paragraph 5, "National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[102] Paragraph 6, " National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).

Remarkably, Paragraph 15 of the National Policy stipulates that artificial teats or use of bottles should not be used to feed children. This is problematic because ordinarily mothers who cannot access their children express breastmilk, which is fed to infants through artificial teats and feeding bottles. Consequently, paragraphs 6 and 15 of the National Policy contradict each other.

The National Policy supports the promotion of rooming in to allow infants to remain with the infants for 24 hours.[103] Rooming in allows the mother to have constant access to the child. Nevertheless, in some scenarios such as newborns who have been admitted to Neonatal Intensive Care Units rooming-in is not an option. In Kenya, it is also not uncommon due to inadequate funding of government hospitals to find mothers sharing beds in the wards. [104]As a result, rooming- in is almost impossible.

Paragraph 8 of the National Policy encourages breastfeeding on demand. Additionally, Paragraph 10 advocates for exclusive breastfeeding for infants for up to six months. The provision mentioned above does not seem to take into account the current reality of working Kenyan women. It is difficult for mothers who work away from home to breastfeed for six months exclusively. The current Kenyan employment and labour laws only provides for three months of paid maternity leave.[105] Consequently, mothers who come from lower-income backgrounds or are not highly educated bear the brunt of these conflicting policies and laws.

Paragraphs 13, 14, 15 and 16 of the National Policy echo the provisions of the BMS Act. There is a restriction on accepting free BMS samples, advertising BMS and a ban on manufacturers of BMS interacting with health workers[106].

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[103] Paragraph 3, "National Policy on Maternal, Infant and Young Child Nutrition." (August 2012).
[104] P. Mwangi, " Agony as Expectant mothers at JM Kariuki Hospital Forced to Share beds" (Citizen Digital 8 January 2019) <https://citizentv.co.ke/news/agony-as-expectant-mothers-at-jm-kariuki-hospital-forced-to-share-beds-225980/> (accessed 10 July 2019).
[105] Employment Act, Chapter 226 Section 29.
[106] Sihanya (n 1).

One of the biggest challenges to the promotion of breastfeeding in Kenya has been the Human Immunodeficiency Virus (HIV) pandemic. The risk of mother-to-child transmission of HIV through breastfeeding has been hindered by a significant number of HIV-infected mothers from breastfeeding.[107] The National policy gives an in-depth guideline on infant feeding and HIV.

The national legal framework established to promote breastfeeding largely focuses on regulating the use of BMS and related products. The BMS Act provisions mirror the provisions of (the Code) and it is therefore not surprising that it fails to actually promote breastfeeding and instead unreasonably regulates BMS. As discussed elsewhere in this article, the international and regional legal framework focuses on information and education campaigns. The BMS Act takes a similar approach with no concrete measures provided to actually deal with the factors that inhibit breastfeeding.

The biggest challenge to breastfeeding is the inability of mothers to access their infants due to work obligations. The provisions in the Health Act and Employment Act acknowledge this challenge and attempt to promote breastfeeding through maternity leave, nursing breaks, and breastfeeding stations. However, the flagrant breach of these provisions by the employers including Kenya's National Assembly and Senate is an obstacle to promoting breastfeeding. Furthermore, the provisions cater to mostly women who are employed in white-collar jobs, educated, and have access to adequate financial resources.

6.0 Conclusion and Recommendations on the Legal Measures that Promote Breastfeeding in Kenya

Breastfeeding is a natural process that ensues after pregnancy and should be recognised as a reproductive right. Reproductive rights should not be centered on obstetrics and family planning. Reproductive rights should go beyond protecting women only when pregnant and should, therefore, extend to women who choose

[107] Ministry of Public Health and Sanitation, WHO & UNICEF, "National Strategy on Infant and Young Child Feeding" <https://extranet.who.int/nutrition/gina/sites/default/files/KEN%202007%20National%20Strategy%20on%20Infant%20and%20Young%20Child%20Feeding.pdf> (accessed 21 March 2019).

to breastfeed. Women who choose to breastfeed should receive as much protection as when they are pregnant.

Breastfeeding has countless benefits for the mother and the child. Breastfeeding helps reduce infant mortality and increases the survival rate of infants. Therefore Breastfeeding isnot only a reproductive rights issue but also a children's rights issue and is essential for attaining food security for infants.

Breastfeeding should not be perceived as a private issue and hence place the burden on individual women to make adjustments in their lives to accommodate breastfeeding. Breastfeeding should be regarded as a public health issue, and hence, there is a need for policies and regulations which will promote breastfeeding.

The policies and regulations attempting to promote breastfeeding primarily focus on limiting the marketing and distribution of BMS and related products. Lawmakers seem to be under the illusion that the biggest threat to breastfeeding is the aggressive marketing and distribution of BMS. This is not entirely false since aggressive marketing and distribution of BMS do play a role in undermining the promotion of breastfeeding.

Moreover, improper use of BMS can especially be harmful in developing countries such as Kenya where resources are limited, and a significant portion of the people live below the poverty line. Problems such as access to clean drinking water have at times led to contamination of BMS. Moreover, due to the costly nature of BMS, over-dilution is also a risk. Contamination and dilution put infants at risk diarrhea and malnutrition.
However, the focus should not be solely on the restriction of BMS. There needs to be a more in-depth analysis of factors that push women to use BMS instead of breastfeeding. There needs to be an earnest discussion on the promotion of breastfeeding that does not center on the restriction of BMS. Creating restrictions that prevent mothers from accessing BMS while not creating a secondary support system that creates a conducive environment for breastfeeding is detrimental to women for at least three (3) reasons.

First and foremost, it denies mothers an easy and accessible alternative solution when it comes to feeding their infants. Second, it prevents legislators and policymakers from addressing other vital factors which inhibit breastfeeding. Third, focus and resources are predominately directed to limiting access to BMS. The creation of a practical secondary is vital in promoting breastfeeding. The support system should be as inclusive as possible and be able to cater to a diverse group of women, taking into account disparities in education, income, and occupation.

One of the biggest challenges to breastfeeding is work obligations. Consequently, there needs to be the creation of a secondary support system in which a woman's reproductive and productive role in society can coincide. A mother's reproductive and productive role should be able to exist in harmony. The burden should not be placed on the individual mothers to devise ways to reconcile these two roles. A working mother in Kenya should also not be forced to make personal sacrifices or chose between these two roles.

The National and County government of Kenya as well as in institutions or organizations has a duty not only to protect these two rights but to also actively place measures that will allow women to thrive in these two roles simultaneously. Breastfeeding is critical in securing the survival, competitiveness, and sustainable development of the Kenya and next generation and should, therefore, be perceived as building the Nation.