UNIVERSITY OF NAIROBI SCHOOL OF LAW

ASSESSING THE LEGAL MEASURES THAT PROMOTE BREASTFEEDING IN KENYA

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A Thesis Submitted to the University of Nairobi in Partial Fulfilment of the Requirements for the Award of the Degree of Master of Laws (LLM)

Supervisor

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DECLARATION

I Nelly Muthoni Kiragu hereby declare that this is my original work and has not been presented for the award of a degree or any other award in any other University. Where works by other people have been used, references have been provided.

Nelly Muthoni Kiragu

G62/6820/2017

Signature:

Date:

APPROVAL

This thesis titled *Assessing the Legal Measures that Promote Breastfeeding in Kenya* has been done under my supervision and has been submitted to The University of Nairobi, School of Law for examination with my approval as the candidate's supervisor.

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DEDICATION

This thesis is dedicated to my children Arya and Zoey who will forever be my greatest achievement. Arya and Zoey thank you for allowing me to experience the greatest kind of love. This thesis is also dedicated to the millions of mothers in Kenya who are continually trying to create a better future for their families; may they get the consistent support they rightfully deserve.

ACKNOWLEDGEMENTS

I want to express my heartfelt gratitude to my husband, Njoro, who has persistently encouraged me throughout this period. Thank you for holding the fort down and enabling me to pursue my dreams. I would also like to thank my parents for raising me to be the person that I am today. Last but not least, I would like to thank my supervisor, Dr Agnes Meroka Mutua, for her input and patience while supervising me. I would also like to thank the reader, Professor Ben Sihanya for supervising and assisting in the correction process and the Sihanya Mentoring Group for logistical support.

LIST OF INTERNATIONAL AND REGIONAL CONVENTIONS AND REGULATION

African Charter on the Rights and Welfare of the Child (1990).

Convention concerning the revision of the Maternity Protection Convention (Revised), 1952 (Entry into force: 07 Feb 2002).

International Code of Marketing of Breast Milk Substitutes.

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

United Nations Convention on the Elimination of All Forms of Discrimination against Women, 1979.

United Nations Convention on the Rights of the Child, 1989.

LIST OF KENYAN STATUTES, BILLS AND OTHER LEGISLATIVE INSTRUMENTS

Constitution of Kenya 2010.

Breast Milk Substitutes (Regulation and Control) Act. No. 34 of 2012.

Employment Act, Chapter 226.

Health Act No. 21 of 2017.

Breastfeeding Mother Bill 2017

STATUTES AND OTHER LEGISLATIVE INSTRUMENTS OUTSIDE KENYA

Political Constitution of the Republic of Guatemala (as Amended by Legislative Decree No 18-93 of 17 November 1993).

Belgium Inter-industry-wide CBA of 27 November 2001 that was generally rendered binding by Royal Decree of 21 January 2002 (Official Gazette, 12 February 2002).

LIST OF ABBREVIATIONS AND ACRONYMS

BAI	Breastfeeding Advocacy Initiative
BMS	Breast Milk Substitutes
CEDAW	United Nations Convention on the Elimination of All Forms of Discrimination against Women
CRC	United Nations Convention on the Rights of the Child,
IBIFAN	International Baby Food Action Network
ILO	International Labour Organization
KAM	Kenya Association of Manufacturers
KEBS	Kenya Bureau of Standards
MDGs	Millennium Development Goals
NGOs	Non- Governmental Organisations
SDGs	Sustainable Development Goals
The Code	International Code of Marketing of Brest Milk Substitutes
UN	United Nations
UNICEF	United Nations International Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation

CHAPTER 1
INTRODUCTION TO LEGAL MEASURES WHICH PROMOTE BREASTFEEDING IN KENYA

1.1. Background to the Study on Legal Measures Promoting Breastfeeding in Kenya

For a long time, BMS has been perceived to be the biggest threat to breastfeeding. In 1973, the World Health Organization (WHO) noted that that Nestle Corporation was aggressively marketing its infant formula to poor third world countries which lacked adequate cash resources and sanitary infrastructure to make formula a viable infant feeding option.[1] Use of infant formula was believed to have escalated the already high infant mortality rate. As a result of the lack of 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 multinational companies at the expense of impoverished people in third world countries. Moreover, when mothers used infant formula, it resulted in the 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 the decline of the breastfeeding rate. As a result, they urged member states to review sales, 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

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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.
[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*.

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, culminated in a 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. 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 Beth Mugo sponsored the Act. Prior to the Act, Kenya Bureau of Standards (KEBS) regulated BMS as a standard; however, it did not regulate marketing or promotion or institute penalties for violations.

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), 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.[11]

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[6] *Ibid.*
[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] Member of Parliament: Beth Mugo (Contribution she made on: the Breast Milk Substitutes (Regulation and Control) Bill Second Reading (12 September 2012).
<http://www.kewopa.org/wp-content/uploads/2015/04/September-2012-Hansard.pdf> (accessed 21 December 2018). 18.

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 to instead regulate 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 support from the female members of parliament who included. Cecily Mbarire, Jebii Kilimo, Rachel Shebesh, Joyce Laboso, Millie Odhiambo, among others.[12] The BMS Act was assented on 11 October 2012 and commenced operation on 17 December 2012.

WHO recommends exclusive breastfeeding for the first six months of an infant's life to ensure optimal growth, development and health. After which nutritious complementary food can be introduced with breastfeeding continuing up to 24 months.[13]The BMS Act is meant to regulate the marketing and distribution of BMS. Furthermore, the Act is meant to provide safe and adequate nutrition of infants through the promotion of breastfeeding and the use of BMS where necessary.[14]

The BMS Act, however, seems to solely focus on regulating the promotion and distribution of the BMS and does very little to actually promote breastfeeding. Aggressive promotion and marketing of BMS was predominately blamed for the decline in the breastfeeding rate. Consequently, the BMS Act was enacted.

However, an estimated 44% of the population of Kenya live below the poverty line, [15] therefore a majority of the Kenyan population cannot afford the luxury of using commercial BMS and other related items such as feeding bottles.[16] Most commercial BMS such as infant formula have a price range of between Ksh 1,000 to Ksh 2,000. Supporters of the BMS Act fail to acknowledge that a

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[12] *Ibid*.
[13] 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).
[14] Preamble BMS Act.
[15] UNICEF, " Kenya at a Glance"(UNICEF), <https://www.unicef.org/kenya/overview_4616.html> (accessed 21 December 2018).
[16] 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.

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.[17]This correlates with the fact that female employees are entitled to three-months paid maternity leave.[18] Often mothers will choose to combine the three months of maternity leave with their twenty-one working days 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. This inadvertently affects sales and profit margins. Since manufacturers are restricting from advertising and promoting BMS and designated products, this inadvertently negatively affects manufacturers and distributors sales and profit margins.

As a result, the Kenya Association of Manufacturers (KAM) has opposed the Act. Betty Maina, 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[19] and public participation[20]. Despite the Constitution guaranteeing the right to public participation, the BMS Act did not adhere to this requirement during the debate of the Bill.[21] There was a concern that private sector stakeholders were not given an opportunity to substantially participate in the formulation of the Bill.

Public participation was restricted to the government and Non-Governmental Organizations (NGOs). Private stakeholders were only given an opportunity to participate when the Bill was before the

[17] KDHS, "National Bureau of Statistics-Kenya and ICF International 2014". (KDHS 2015). <https://www.dhsprogram.com/pubs/pdf/sr227/sr227.pdf> (accessed10 January 2019).
[18] Employment Act, Chapter 226, Section 29.
[19] Article 33 Constitution of Kenya 2010.
[20] Article 118 Constitution of Kenya 2010.
[21] 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).

Parliamentary Committee on Health. [22]KAM admits that though this helped to weed out initial problems with the bill, it was not sufficient in addressing all the issues.

Furthermore, 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 conflict of interest. This, however, denies the Committee an opportunity to receive feedback or input from the very institutions it is attempting to regulate.

1.2. Research Problem

The BMS Act's objective is to provide safe and adequate nutrition for infants through the promotion of breastfeeding and proper use of BMS. However, in reality, the Act predominantly focuses on restricting the marketing and promotion of the BMS while failing to address the factors that hinder mothers from breastfeeding.

The BMS Act fails to offer a secondary support system to facilitate breastfeeding, thus violating the constitutional/human rights of mothers and infants. This dissertation seeks to discuss breastfeeding as a reproductive right and ways in which the BMS Act and additional secondary support system can promote breastfeeding without compromising the rights of the mother or the child.

1.3. Significance of the Study

This dissertation will contribute to the available literature on the subject which can be used by other researchers to further the knowledge in this area. This thesis will also provide an insight to policymakers and legislator on the shortcomings of the BMS Act. Furthermore, it will highlight possible solutions on how to effectively promote the breastfeeding rate using a secondary support system. In addition to this, breastfeeding is at the core of infant nutrition. Consequently, infant nutrition plays a crucial role in reducing infant mortality, which is one of the Millennium Development Goals and Sustainable Development Goals.

1.4. Research Objectives

The general objective of this research is to critically analyse the adequacy and effectiveness of the BMS Act in achieving its goal of promoting breastfeeding. The first specific objective, is to illustrate the challenges faced in implementing the BMS Act. The second objective, is to assess ways in which a lack of a secondary support system has been harmful to mothers and children. The third objective, is

[22] *Ibid*.

to discuss breastfeeding as a reproductive right. The fourth objective, is to recommend practical solutions that will promote breastfeeding.

1.5. Research Questions

The dissertation explores breastfeeding as a reproductive right and how the current international, regional and national legal framework safeguards this right. The research focuses on the BMS Act as the primary national legislation purporting to promote breastfeeding. At the end of the dissertation the following questions will be answered; first and foremost, how does the BMS Act regulate the sale, distribution and promotion of BMS and its related products? Secondly, why does the BMS Act fail to promote breastfeeding? Lastly, how can secondary support measures be implemented to promote breastfeeding?

1.6. Hypotheses

This research is premised on the following three hypotheses. First and foremost, the current legal framework regulating marketing and distribution of BMS does not promote breastfeeding. Secondly, there is a need for secondary support measures to promote breastfeeding. Lastly, breastfeeding is a reproductive right and should be safeguarded.

1.7. Scope of the Research

This dissertation will focus on regulatory tools put in place it to regulate BMS and its related products and their effectiveness in promoting breastfeeding in the context of Kenya. It will also highlight the various rights contravened by the aforementioned regulations. Moreover, this dissertation will discuss the various secondary support systems needed to promote breastfeeding. This dissertation is conducted within the context of Kenya; however, there is a comparative study on secondary support systems put in place in other jurisdictions.

1.8. Conceptual and Theoretical Framework

The Conceptual framework will highlight key terms referred to in the thesis. For the sake of clarity BMS refers to as any food that is marketed or represented as a partial or total replacement of breast milk whether suitable or not for that purpose. [23] Both the Code and the BMS Act share a common definition of the term BMS.

[23] International Code of Marketing of Breast Milk Substitutes Article 3 and Breast Milk Substitutes (Regulation and Control Act) 2012 Section 2.

To further avoid ambiguity, the term breastfeeding refers to a method of feeding an infant directly from the female breast.[24] Whereas, expressing milk means to extract human milk from the breast by hand or by pump into a container.[25]

In the context of this dissertation the term infant formula refers to milk or milk like product of an animal or plant origin formulated industrially in accordance with the *Codex Alimentarius* standard for infant formula to satisfy the nutritional requirements of a child of up to six months. This includes all infant formula for special medical or nutritional purpose.[26] According to the Code Infant formula is not restricted to commercially manufactured formula but can also include infant formula prepared at home which is described as "home- prepared".[27]

Chapter 2 will discuss the conflict between women's reproductive role and productive role. Consequently, it is important to define these two roles. Women's reproductive role relates to pregnancy, confinement and breastfeeding whereas the productive role refers to working for pay.28

This thesis' theoretical framework will be primarily rooted in Liberal feminism. Liberal Feminists assert the importance of individual rights. Liberal feminists argue in favor of a variety of personal freedoms which are not subject to state interference except when in a situation assertion of said rights causes harm to others.[29] There exists multiple schools of thought within Liberal feminism, the discussion below will outline the key components that relate to women's reproductive and productive role and how they intertwine with the right to breastfeed.

Majority of feminists have often focused on women's reproductive rights and motherhood. Until fairly recently, there existed very little literature analyzing breastfeeding from a feminist perspective. Majority of the literature, laws and policies regarding breastfeeding are centered on the child's needs. Liberal Feminist question the claim "breast is best", they ask, "best for whom?" Feminists do not dispute the numerous benefits breast milk provides for infants. They, however, challenge the narratives

[24] The Health Act 2017 Section 2.
[25] *Ibid*.
[26] Breast Milk Substitutes (Regulation and Control) Act 2012 Section 2.
[27] International Code of Marketing of Breast Milk Substitutes Article 3.
[28] N. Harooni, "Maternity Protection at the Workplace."
< http://waba.org.my/pdf/MaternityProtectionattheWorkplace-final.pdf> (accessed 11 November 2019).
[29] R.Wacks, *Understanding Jurisprudence. An Introduction to Legal Theory.* (Oxford University Press 2012) 302.

which center on the promotion of breastfeeding and chastises formula feeding. These narratives ignore women's experience, views and struggles with breastfeeding.[30]

Some facets of liberal feminism argue that an analysis of laws, policies and programs that relate to breastfeeding expose some common themes. Firstly, breastfeeding is "natural" and the "best" and "purest "source of nutrition for infants. Secondly, a child-centred ideology where the mother is placed as the primary caregiver and breastfeeding is a mother's moral responsibility. Thirdly, breastfeeding is seen as a woman's individual choice and fails to acknowledge external social and economic factors which affect her decision on whether to breastfeed or not.[31]

The common perception is that breastfeeding is regarded as natural. Consequently, every woman can breastfeed with little or no difficulty. Only a few exceptional situations are women unable to breastfeed. According to Liberal feminist, this approach is problematic as it often results in the trivialization of challenges women face during breastfeeding. It also does not reflect the reality of the situation. A significant number of mothers are unable to breastfeed for the recommended six months exclusively; let alone continue breastfeeding until the infant's second birthday. Furthermore, this misconception creates an unrealistic expectation for mothers if they are unable to breastfeed. Consequently, resulting in a feeling of guilt, shame inadequacy and dejection.[32]

By perpetuating the notion that breastfeeding is a matter of individual choice and ignoring the economic, social and cultural factors which influence a mother's decision on breastfeeding; society transfers its responsibility to deal with such challenges to the individual woman. Infant nutrition and health are perceived as a public health crisis hence the need for legislation and policy promoting breastfeeding whereas social, cultural and economic factors that affect women's decision to breastfeed are relegated the private domain. These difficulties are seen as a matter of personal management of time, emotion and of the body. The challenges women face are therefore seen as secondary and trivial.[33]

In today's society, the majority of the mothers play a dual role of both mother and productive workers.[34] Many working mothers find it challenging to balance the demands of working and raising

[30] K. Zoe and A. Caente, "Breast is Best? A Feminist Re-Reading of Breastfeeding Policies and Practices in the Philippines." (*Philippine Quartley of Culture and Society 2014*) Vol 42. No 3/4. <https://www.jstor.org/stable/44512017> (accessed 9 January 2018) 119.
[31] *Ibid*. 124.
[32] *Ibid*. 127-128.
[33] *Ibid* 133.
[34] See chapter 2.3.

a child and the issue of infant feeding is at the core of this dilemma. This dilemma is further exacerbated by literature which overestimates the benefits of breast milk and risks of BMS such as formula. [35]

Some Liberal Feminists call for the recognition of the vital role women's reproductive role serves in society. For decades maternity leave has been perceived as an absence from economically productive work. Feminist are now calling for a shift from this mentality, whereby maternity is no longer seen as an absence from productive economic work but instead as the social and economic cost of raising the future generation or building capital or human resource development.[36] Moreover, liberal feminists argue that in order to bring about equality, women should not be forced to choose between their reproductive and productive roles.

In addition to this, Liberal Feminist theory argues that laws, regulations and policies which primarily seek to restrict access to BMS without providing a complementary positive social support system are detrimental to women. Women are forced to make the painful decision between work and their children. Liberal Feminist support a more holistic approach that caters for both the rights of the mother and the child.

Moreover, Liberal feminist note that studies in regards to breastfeeding often focus on the benefit of breast milk to the infant. This is observed even in health advice given to women to eat healthy and indigenous food to increase milk supply rather than to benefit the mother's health. While the scientific community apportions significantly lesser resources to the research of the detriments of breastfeeding to women such as undernourishment and depletion of calcium. Liberal Feminist argue that society often prioritizes breastfeeding since it only makes demands on a woman's body and labor, whereas commercial BMS will make demands on the family's, often the men's, income.[37]

Liberal Feminists disregard breastfeeding advocates who often perceive women and their children as a single biological entity. Therefore, disregard the fact that at times, the child and the mother may have conflicting interests. For example, breast milk advocates will often create an adversarial relationship between breastfeeding and a woman's participation in the wage economy.[38] Consequently, the majority

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[35] J. Law, "The Politics of Breastfeeding: Assessing Risk, Dividing Labour," (The University of Chicago Press 2000) Volume 25 No 2. 405 < https://www.jstor.org/stable/3175561 > (accessed 7 January 2019).

[36] M. Swaminathan, "Breastfeeding and Working Mothers: Laws and Policies on Maternity and Child Care." (Economic and Political Weekly, May 199) Vol 28 No. 18. 887, <https://www.jstor.org/stable/4399677> (accessed 2 November 2018).

[37] *Ibid* 438.

[38] *Ibid* 429.

of the mothers who can breastfeed for an extended duration enjoy the luxury of having partners who can financially support the family solely on a single salary.

1.9. Research Methodology

This dissertation uses qualitative research methods. The research will examine the current legal framework regulating BMS and challenges faced in achieving the legal framework's objective of promoting breastfeeding. The final chapter will suggest legal reforms. The dissertation will not only take into consideration the social factors that affect the legal framework but also the social impact of the legislative framework.

The dissertation will be a desk-based review of primary and secondary sources of data. The research will include a textual analysis of the legal framework regulating BMS such as the Breast Milk Substitutes (Regulation and Control) Act and the International Code of Marketing of Breast Milk Substitutes. Moreover, the Constitution of Kenya, the Employment Act and Health Act will also be examined. In addition to this, other documents such as textbooks, periodicals, journals, newspaper, articles and internet sources will be utilized. A comparative analysis will also be undertaken in 4. This will be a comparison of the legal framework between Kenya and other jurisdictions in regards to BMS and secondary support system for breastfeeding.

1.10. Literature Review

1.10.1. Factors Leading to the Decline of the Breastfeeding Rate

The WHO Status Report indicates that as of March 2016, 135 out of 194 countries had some form of legal framework regulating the marketing of BMS in line with the provisions of the Code. [39] Moreover, 39 countries have comprehensive legislation incorporating all or most of the provisions of the Code.[40]

Despite all the strides which have been made to create a legal framework regulating BMS, the WHO status report indicates that two out of three infants under six months are not breastfed exclusively. [41] To make matters worse, the rate has not improved in the last twenty years. The report notes that in high-income countries, only one out of five infants are breastfed for a year. In low income and middle-income countries, two out of three children between six and twenty-four months receive any breast milk at all.[42]

[39] WHO, UNICEF and IBFAN, "Marketing of Breast Milk Substitutes: National Implementation of the International Code. Status Report 2016." (WHO 2016) 17.
[40] *Ibid* 17.
[41] *Ibid* 7.
[42] *Ibid*.

The data would, therefore, seem to indicate that despite the existence of a legal framework regulating BMS and related products, breastfeeding rate has not risen significantly over the last twenty years. The WHO report fails to acknowledge that other factors besides the aggressive marketing of BMS may have affected the breastfeeding rate.

International Baby Food Action Network (IBFAN) outlines the obstacles that hinder mothers from breastfeeding. At the top of its list is aggressive marketing of BMS and related products. According to IBFAN, incorrect and biased information disseminated by BMS manufacturers and distributors play a crucial role in persuading mothers not to breast-feed exclusively. IBFAN argues that there is a need to rewrite the narrative so that breastfeeding once again becomes the norm and BMS the exception.[43]

Shubber, a Senior Legal Officer at the WHO, recognizes the impact early feeding of an infant has on the child's development and growth and consequently on the social and economic development of the society as a whole. Shubber asserts that improper use of BMS may often lead to sickness or death of infants. He supports this argument by quoting data presented by Derrick Jelliffe, a leading expert on pediatrics nutrition who asserts that the approximately 10 million cases of infectious diseases and infant malnutrition are directly linked to improper bottle feeding.[44]

Shubber argues that there is a correlation between the widespread, aggressive marketing of BMS and the decrease in the breastfeeding rate, especially in developing countries in both rural and urban settings. Mothers have now opted to use BMS instead of breastfeeding and that this has been detrimental to infants.

Shubber, however, fails to acknowledge that a significant proportion of the population in developing countries are living below the poverty line and are barely able to meet their basic needs. On the other hand, commercial BMS are quite costly and therefore are a luxury most families cannot afford. Most families rely on non-commercial indigenous products such as cows' milk, porridge, grains to substitute breast milk. These indigenous non- commercial products are not subjected to legislation.

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[43] IBFAN, "Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health," (Contribution to the General Comment on the Child's Right to Health). <https://www2.ohchr.org/english/bodies/crc/docs/CallSubmissions_Art24/InternationalBabyFoodActionNetwork.pdf> (accessed12 February 2019).

[44] S.Shubber, "The International Code of Marketing of Breast Milk Substitutes," (International Digest of Health Legislation 1985) volume 36 No 4. 879.

Shubber discusses how the Code should be implemented. Article 11.1 of the Code gives member states the discretion of determining the most appropriate manner to implement the Code based on the member states' social and legislative framework. The implementation may be done through national legislation, regulations or other suitable measures. This, therefore, indicates that implementation is flexible and to be determined by the member states.

Shubber, however, fails to account for the role WHO and UNICEF play in the determination of how the Code is implemented, primarily in developing countries. The reality on the ground in developing countries is that the method of implementation is often not solely at the discretion of the member states. WHO and UNICEF often sponsors legislative bills aimed at implementing the Code. Consequently, it is not surprising that the countries with the highest comprehensive legislation in regards to the Code are located in South East Asia at 36 % and Africa at 30%. Whereas developed countries in the Americas, western Pacific and European regions register the lowest proportion of countries with comprehensive legislation.[45]

Ideally, the method of implementation should be based on the member states assessment of the economic, cultural, social and legal environment. WHO and UNICEF interference has often led to the enactment of Codes which are incompatible with the economic, cultural, social and legal environment in third world countries. Take for example, the BMS Act of Kenya. It is important to note that the most developed countries have often shunned away from imposing restrictive legislation and have instead focused on creating policies which allow breastfeeding mothers to have more access to their infant or infants to have easier access breast milk.

Whereas Shuber squarely blames the decline of the breastfeeding rate on aggressive marketing of BMS and other related factors; Coluthur Gopalan asserts that other forces may be at play. Coluthur Gopalan [46]refers to a study conducted by the Nutrition Foundation of India which focused on the use of infant feeding practices specifically on the use of commercial infant foods in three major regions of India; Maharashtra, West Bengal and Tamil Nadu. It was observed that 65% of low-income families in West Bengal were spending more than 10% of their monthly income on commercial infant food as compared to 27% of families in Maharashtra. [47]

[45] WHO, UNICEF and IBFAN, "Marketing of Breast Milk Substitutes: National Implementation of the International Code Status Report 2016." (WHO 2016).
[46] C. Gopalan, "Infant Nutrition in West Benegal- Insights from Recent Studies." (Bulletin of Nutrition Foundation of India Volume 6 Number 2), <http://nutritionfoundationofindia.res.in/pdfs/BulletinArticle/Pages_from_nfi_04_85_1.pdf> (accessed 9 January 2018).
[47] *Ibid.*

Gopalan noted that there was no indication that the promotion of commercial milk foods was more aggressive in Bengal than other areas such as Maharashtra. Gopalan proceeds to offer an alternative explanation for the increased use of commercial infant foods in Bengal as compared to other areas such as Maharashtra. The increased use of commercial infant foods in Bengal is as a result of early termination of breastfeeding among Bengal mothers. Majority of the poor mothers in Bengal are unable to exclusively breastfeed beyond the third month.[48]

Nutrition and health challenges significantly affected lactation capability of poor women in Bengal. Gopalan refers to an early study which indicated that the heights, weights, and mid-arm circumference of women in West Bengal were lower than those of women in Maharashtra. In addition to this, Bengal had a higher percentage of women below the international accepted 'risk level' for body weight and height than Maharashtra.[49]Moreover, Gopalan also refers to a UNICEF study that showed that a large number of women in the Bengal area also suffered from iron deficiency anemia, which could affect breast milk output considerably.

Consequently, poor nutrition and health have led to an increase in the use of commercial infant products. The solution, therefore, does not lie with creating legislation banning the promotion and marketing of BMS. Gopalan argues that it is unreasonable to expect stunted, undernourished, anemic, overworked and harassed mothers to exclusively breastfeed their infants for the recommended six months successfully. Hence calls for the government to provide nutritional support to mothers.[50]

Though Gopalan research was conducted in India and over thirty-three years ago, it is plausible to extrapolate his findings to relate to most developing countries today. Poor nutrition and health are a challenge to breastfeeding mothers in most developing countries, including Kenya; with the bulk of the women affected coming from low-income backgrounds.

Like her counterpart Gopalan, Rebecca Kukla attributes low breastfeeding rates to other factors besides aggressive marketing of BMS. Kukla notes that in the USA, mothers who have low incomes and mothers from minority communities generally exhibit lower breastfeeding rates than upper-class white women. Though, the continuation rate of breastfeeding among upper-class white women has also

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[48] *Ibid*.
[49] C. Gopalan, "Maternal Health, Fertility Control and Child Nutrition," (Bulletin Foundation of India Vol 6 No 1) <http://nutritionfoundationofindia.res.in/pdfs/BulletinArticle/Pages_from_nfi_01_85_1.pdf>. (accessed 9 January 2019).
[50] C. Gopalan, "Infant Nutrition in West Benegal- Insights from Recent Studies," (Bulletin of Nutrition Foundation of India Volume 6 Number 2) 3.

declined.[51] Breastfeeding advocates have solely attributed this decline to the failure of information and educational campaigns. Kukla argues that such assumptions are dangerous as they prevent breastfeeding advocates from truly investigating other factors that may hinder women from breastfeeding.

Kukla points out that it is almost comical to observe the Advertising Council in America switch from their previous slogan " Breast is Best" to "Babies Were Born to Be Breastfed" in a misguided belief that a more compelling slogan would solve the problem. She outlines factors such as hostile maternity leave policies, a privatised daycare system, absence of workplace regulations supporting breastfeeding as factors contributing to the decline of the breastfeeding rate as compared to other developed countries. Instead, breastfeeding advocates focus most of their resources on educational campaigns. Even though mothers who fail or prematurely discontinue breastfeeding their babies are well aware of the benefits of breast milk.[52]

Kukla asserts that women who are members of vulnerable groups are unlikely to breastfeed since breastfeeding is not a liveable choice. Consequently, educational campaigns have no effect on such groups or in the alternative can prove to be extremely damaging. She further asserts that the inability of mothers to breastfeed goes well beyond selfishness and lack of education. [53]

Kukla notes that women from low-income backgrounds and ethnic women who especially live in a communal or crowded set up are unlikely to breastfeed as they lack a safe place to do so. These women are more prone to sexual abuse or being charged with the offence of improper sexual display. These risks are significantly lower for white women who come from a privileged background.[54]

Kukla investigates how breastfeeding advocates rarely discuss the challenges of breastfeeding, such as difficulty in let down or mastitis. Breastfeeding is often seen through rose-tinted glasses, which describes breastfeeding as a joyful, fulfilling, blissful experience. Difficulties in breastfeeding are often trivialised since they are only inconvenient to the mother and not the infant.

In addition to this, educational campaigns primarily target mothers and not other groups such as fathers and employers who have the potential of making breastfeeding a safe and comfortable experience for mothers. Kukla notes that the majority of the educational campaigns lodged by the breastfeeding

[51] R. Kukla, “Ethics and Ideology in Breastfeeding Advocacy Campaigns,” (Hypatia 2006) Vol. 21. No.1, <https://www.jstor.org/stable/3811083> (accessed 13 February 2019) 160.
[52] *Ibid* 162.
[53] *Ibid* 163.
[54] *Ibid* 164.

advocates solely deals with dangers the infant is exposed to if not breastfed. In the alternative, Kukla, suggests that educational campaigns should also disseminate information such as how to: access milk banks; use breast pumps; access lactation support and address challenges to breastfeeding.

While Kukla acknowledges that breast milk is the healthiest source of nutrition for infants, she also discusses infant formula as a substitute. This is especially the case in developed countries where clean, safe water is readily available. She notes that the majority of the adverse effects associated with formula feeding are mostly attributed to external factors such as low income, parental smoking, inadequate regular primary care and other social vulnerabilities.[55] Shubber, however, does not make this distinction and argues that irrespective of environment infant formula is harmful.

J Stolzer[56] discusses breastfeeding in the 21st Century and possible factors which may affect the breastfeeding rate. Stolzer asserts that since time immemorial human infants have been sustained by human breast milk. According to Stolzer, breastfeeding does not occur in a vacuum; various factors affect the initiation and duration of breastfeeding. [57]

Stolzer asserts that a mothers' microsystem, which comprises of her family, friends and other interpersonal relationship affects the breastfeeding rate. Stolzer asserts that breastfeeding has been affected by the lack of breastfeeding role models. In the past, the art of breastfeeding was often passed down from grandmother, aunties, mothers and cousin. Women were often exposed to mothers breastfeeding their infants, and as a result, it has become part of what was expected of a mother. However, in the present day society, women's value is denoted by their financial earning ability. Individual autonomy and success are prioritized.[58]

In addition to this, in the past, a woman's success was appraised on the health and wellbeing of her family. This is no longer the case in the 21st century. Currently, women are valued more as workers than as mothers. The workplace takes a central role; family obligations are structured around work place responsibilities. Majority of the women now work outside the home.

Moreover, Stolzer notes that in western culture, doctors are expected to be able to advise patients on the lactation process. However, a review of the medical syllabus indicates that lactation process is

[55] *Ibid* 174.
[56] J. Stolzer, "Breastfeeding in the 21st Century: A theoretical perspective," (International Journal of Sociology of the Family, 2005.) Vol.31. <https://www.jstor.org/stable/23029709> (accessed 13 February 2019).
[57] *Ibid* 41.
[58] *Ibid* 43.

often neglected in medical school. Hence doctors unable to adequately offer advice to patients who have lactation-related problems such as insufficient milk and failure of infants to lurch.[59]

Stolzer postulates that biologically, the function of mammary glands is to feed infants. In a significant number of cultures, breasts have no sexual significance. However, in Western culture, mammary glands have been sexualised. Westerners now engage in activities that disrupt the lactation process. The plastic surgery industry in the West is thriving with millions of women undergoing surgeries to enlarge and lift their breasts. Breasts are no longer perceived as life-sustaining glands but rather as a means to draw sexual attention. The over-sexualisation of breasts has also resulted in closet nursing, whereby women as expected to nurse their babies solely in private spaces.

Stolzer does admit that the infant formula industry has played a role in the decline of the breastfeeding rate. Infant formula companies are consistently attempting to make infant formula which can resemble the genetic makeup of breast milk. Furthermore, infant formula companies aggressively market infant formula. The industrial revolution has also affected people's perception. New technological advances such as infant formula being perceived as better, whereas breastmilk regarded as outdated.

The literature supporting the Code does not take into consideration that the world is not homogenous, and there exists a variety of economic, political, cultural and social variations. These differences significantly affect how legislation curbing promotion and marketing of BMS will be implemented. Especially in an environment like Africa, where culture plays a significant role in most facets of life like infant nutrition. This research will question the effectiveness of introducing foreign norms in an african domestic settings without due regards to the desires and interests of the indigenous community.

The paper will explore the critical role public participation plays during the creation of the legal framework. Initiating dialogue between the creators and implementers of the legal framework and the people whom the law affects is crucial. It is vital to allow citizens to make a meaningful contribution to how the laws are shaped hence bring about effective transformation. A meaningful participatory process will be inclusive and will not only focus on people from urban settings but will also voice the concerns of the disenfranchised rural community.

The Code ignores the African perspective. This paper will discuss the need to supplement the protection mechanism offered by the Code with a pan- African centered protection mechanism. An

[59] *Ibid*.

alternative pan African centered protection mechanism could possibly offer a healthier and sustainable environment which would promote breastfeeding.

Furthermore, a significant portion of the literature entirely focuses on the restriction of marketing and promotion of BMS. This paper will investigate whether the Code and the BMS Act are ineffective or harmful to the cause of promoting breastfeeding if a secondary support system is absent. This paper will explore the secondary support system put in various jurisdictions. It will also investigate the need to put in place secondary support system which complements Africa's social, cultural and economic makeup.

In addition to this, the majority of the available literature does not highlight the mother's rights, which are contravened by the legislation which restricts the promotion and marketing of BMS. The legislation is primarily focused on the infant's rights. Thus this paper will highlight the veiled risks the Code and the BMS Act pose to women and will also make recommendations which seek to balance the interests of mothers and infants.

Breastfeeding is a complex process, and in order to promote breastfeeding, numerous factors which act as a barrier to breastfeeding must be examined. Gopalan, Stolzar and Kukla have examined various barriers aside from aggressive marketing of BMS, which affect the breastfeeding rate. These factors have, however, been discussed within the context of jurisdiction such as India and the USA. This paper will discuss some of these barriers in the context of the Kenyan jurisdiction and sought to come up with practical solutions to overcome these challenges.

1.10.2. Breastfeeding from a human rights and feminist perspective in Kenya

Ben Sihanya, argues that there are certain decisions which are so vital to a community as a whole that a body cannot be said to have reached a rational, legitimate or reasonable decision if it does not take into account public opinion. Sihanya asserts that the Breast Milk Substitutes (Regulation and Control) Bill 2012 failed to meet this standard owing to the minimal participation from key stakeholders such as consumers, industry players and experts. This could have inevitably resulted in the Acts shortcoming. [60]

[60] Prof B. Sihanya, "Public Participation and Public Interest Lawyering Under the Kenya Constitution Theory, Process and Reforms," (The Law Society of Kenya Journal 2013 Volume 9) 5. Ben Sihanya (forthcoming 2019) "Participation and Representation in Kenya and Africa," in Ben Sihanya (2019) *Constitutional Democracy, Regulatory and Administrative Law in Kenya and Africa* Vol. 1: *Presidency, Premier, Legislature, Judiciary, Commissions, Devolution, Bureaucracy and Administrative Justice in Kenya*, Sihanya Mentoring & Innovative Lawyering, Nairobi & Siaya.

Sihanya rightly points out that from a scientific perspective, BMS are deemed safe. Moreover, there are scenarios in which the use of BMS and related products are necessary. Especially in the case of orphans, working mothers and preterm babies. In addition to this, statics indicate that Kenya's breastfeeding rate stands at 32% with the sale of BMS only accounting for 1.2%. Whereas in Nigeria, where the BMS and related products are heavily regulated, the breastfeeding rate is 13%. Furthermore, in the UK, where laws relating to BMS are liberal, the breastfeeding rate is even higher. [61]

Sihanya also argues that advertisement and marketing of other products such as alcohol, cigarettes and genetically modified foods are regulated as opposed to banned. One can argue that alcohol and cigarettes pose more danger than BMS, yet the marketing and advertising of BMS are banned rather than regulated.[62]

According to Sihanya, the BMS Act also contravenes several provisions of the 2010 constitution. First and foremost, the right to public participation. The drafters of the legislation failed to conduct consultations in good faith with critical stakeholders. Other rights the BMS Act contravenes include freedom of commercial expression guaranteed in Article 33, and 34 of the Constitution. Provisions in the BMS Act also contravene the right to information and consumer rights which are protected under Article 35 and 46, respectively. [63]

The BMS Act credits its origin from the WHO International Code of Marketing of Breast Milk Substitutes. Sihanya points out the fact that the Code is a recommendation and not a regulation treaty. Article 21 of the WHO constitutions bestows on the WHA authority to draft regulations dealing with advertising and labelling of biological pharmaceutical and similar products moving in international commerce. The WHO Code is a recommendation which has no binding effect.

This begs the question of why Kenyan legislators felt the need to enact a law prohibiting BMS and related products while they were under no international obligation to do so. One is left to wonder whether it would have been more prudent to focus resources towards formulating policies that would create an enabling environment which allowed mothers to have greater access to breastfeeding infants. However, Shubber argues that the recommendations of the WHA do carry moral or political weight since it is a recommendation emanating from the highest international body dealing with health.[64]

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61 *Ibid*.
62 *Ibid*16.
63 *Ibid* 17.
64 S. Shubber, "The International Code of Marketing Breast Milk Substitutes," 884.

Alison Stuebe argues that breastfeeding advocates do not consider breastfeeding in the context of women's lives. She argues that often enough the arguments centre on motherhood or career; breast or bottle; which distracts from the addressing the underlying issue of societal structures in place which prevents women from succeeding. Stuebe argues that often breastfeeding advocates focus on individual mothers rather than systematic barriers.[65]

Stuebe asserts that breastfeeding advocates often perceive breastfeeding as a choice rather than a right. Consequently, the entire burden of breastfeeding is placed on the individual mother and not on society. Therefore weakening the legal framework protecting breastfeeding.[66]Stuebe refers to Maxine Eichner's arguments that breastfeeding should be regarded as a related medical condition to pregnancy. Consequently, falling with the purview of reproductive rights; which in most cases receive strong legal protection. The perception that breastfeeding is a choice rather than part of reproductive rights allows employers to escape the responsibility of putting up measures at the workplace which support breastfeeding. [67]

Stuebe notes that women who can breastfeed exclusively usually typically from highly educated and upper-middle-class backgrounds. This is because they have control over their time and bodies; unlike women who come from poor backgrounds, families who require two incomes, hourly workers, blue collar workers. Essentially making breastfeeding a class-based privilege. [68]

Jacqueline H. Wolf, [69] argues that women's health reform has primarily focused on obstetrics, contraception, abortion and breast cancer. She criticises the feminist movement for often ignoring the breastfeeding issue. In her article, she explores the lack of support in the medical community. This argument is supported by an investigation of the medical school curriculum, which frequently does not include lactation physiology, human milk composition and clinical aspects of breastfeeding. Therefore, a doctor's ability to give accurate advice in regards to breastfeeding is based on personal experience from a breastfeeding doctor or a doctor whose wife is breastfeeding. As a consequence of a lack of education on lactation, doctors often give inappropriate advice.

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[65] A. Stuebe, "What does Feminism Have to do with Breastfeeding?" (Breastfeeding Medicine 2010), <https://bfmed.wordpress.com/2010/06/12/what-does-feminism-have-to-do-with-breastfeeding/> (accessed 4 February 2019).
[66] *Ibid*.
[67] *Ibid*.
[68] *Ibid*.
[69] J.H .Wolf, "What Feminists Can Do for Breastfeeding and What Breastfeeding can do for Feminists," (University of Chicago Press 2006) Vol 31. No. 2.

Wolf criticises breastfeeding advocates such as La Leche League who declared in their earlier literature that mothering was the paramount activity in women's lives. Consequently, ignoring the fact that a significant percentage of mothers worked outside the home. In 1981, La Leche League revised its literature to meet the needs of the contemporary working mother by offering advice to mothers who wished to continue breastfeeding after they returned to work. However, the league was still of the opinion that a mother's place is at home. This was demonstrated by the quote in its literature urging mothers to stay at home: "The early months and years set the course for the rest of your child's life and they can never be recaptured."[70]

Penny Van Esterik rightfully argues that breastfeeding is not only a feminist issue but a human rights issue. She asserts that women who wish to breastfeed but unable to do so due to inadequate support from family, health workers or workplace constraints are oppressed and exploited. Moreover, women are empowered when both their reproductive and productive work is valued. Women should never, therefore, be forced to choose between working and being a mother.[71]

Mina Swaminathan, correctly asserts that legislation geared towards restricting BMS solely focuses on the welfare of the child. This approach often ignores the dual roles women often hold as mothers and productive workers. She calls for a balance between the needs of the child and those of working mothers. She calls for a holistic approach in solving the breastfeeding dilemma whereby the solution is not only centered on legislation but also on government policies and a change to workplace norms and conventions.[72]

Mina does not dispute that breastfeeding is vital to the child's development. However, she does dispute an approach centered on restrictions on BMS rather than solutions which will allow the mother to have access to the child. Hence focus should be on solutions such as paid maternity leave.

Feminists rightfully advocate that breastfeeding should be considered a human right rather than a choice. However, their arguments are centered on the experiences of women in developed countries. Women's experiences are not monolithic, and there is s a danger in lumping women's experience in a single class. This dissertation intends to highlight similar arguments; however, through the lens of women living in Kenya. Other factors such as access to resources, education level and culture will also contribute to a better understanding of different women's lived reality.

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[70] La Leche League International. [1963] 1987. 190.
[71] P.V. Esteterik, "World Alliance for Breastfeeding Action," (WABA Activity Sheet 4) <http://www.waba.org.my/resources/activitysheet/acsh4.htm> (accessed 4 February 2019).
[72] M. Swaminathan, "Breastfeeding and Working Mothers: Laws and Policies on Maternity and Child Care," (Economic and Political Weekly, May 1993) Vol 28 No 18. 887.

1.11. Thesis Structure

Chapter 1 has provided a general introduction and brief background to the research. It has set the stage for the discussion of breastfeeding as a human right and the ineffectiveness of the Code and BMS Act as the predominant instruments safeguarding the right to breastfeed.

The second chapter will discuss breastfeeding from a human rights perspective both as a reproductive right and as children's rights. It will further go on to discuss the various international law safeguarding breastfeeding. It will also explore women's reproductive role vis a vis productive role.

Chapter three extensively discusses the provisions of the Code. In addition to this, this chapter also discusses the Kenyan BMS Act, which is a domestication of the Code at the national level. Lastly, the Chapter will also delve into various provisions contained in statutes that aim to promote breastfeeding at the national level.

Chapter 4 will highlight secondary support systems in other jurisdictions which have promoted breastfeeding. Lastly, Chapter 5 will outline the summary of findings, provide various recommendations which can be implemented to solve the problem and conclusion to the study.

CHAPTER 2

BREASTFEEDING AS AN INTERNATIONAL AND KENYAN HUMAN RIGHT

This chapter will discuss breastfeeding from a human rights perspective both as a reproductive right and as children's rights. It will further go on to discuss the various international law ratified by Kenya safeguarding breastfeeding. It will also explore women's reproductive role vis a vis their productive role.

2.1 Breastfeeding as a Reproductive Right

Reproductive rights 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 pertaining to reproductive rights should be made freely and without coercion and violence.[73]

Reproductive rights are, however, 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*[74] 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 travelling with family members to such locations.

The Complainant was working at the Trust Fund for Victims in Kampala which was labelled as a family duty station. As part of her duties she was expected to at times travel non- family duty stations. As of February 2012 when she became pregnant she was exempted to from travelling 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.

At the end of her maternity leave the complainant informed her supervisor that due to the fact that she was breastfeeding she would only be able to travel to family duty stations. Consequently, she could not be able to undertake activities that would involve her travelling to non- family duty stations but

[73] International Conference on Population and Development (ICPD), Program of Action, Un Doc A/CONF.171/13 1994 para 7.3.
[74] Judgment No. 3861 International Labour Organization Administrative Tribunal.

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. The Registrar however argued that the review was time barred. The Complainant therefore filed an appeal with the Appeal Board. The Appeal Board members dismissed the case. 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 travelling duties to exclude non family duty stations.[75]

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

Lastly, 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.[76]

[75] *Ibid* 8.
[76] 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.

2.1.1 International and Regional Legal framework Safeguarding Reproductive Rights

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

On 9th March 1984, Kenya ratified Convention on the Elimination of all forms of Discrimination against Women (CEDAW).[77] 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.[78]

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.[79] The Convention goes on to provide 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 regards to work, which has been proved to be harmful.[80] Aside from this, State Parties are expected to create social services that enable parents to fulfil their family and work obligations and be able to participate in public life. The State Party is expected to achieve this particular goal through the development of a network of child-care facilities.[81]

CEDAW clearly protects reproduction rights centered on obstetrics. Breastfeeding rights are vaguely protected through the provision of maternity leave. The Convention fails to recognize that breastfeeding is an ongoing process which 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, relegating breastfeeding to the private sphere. 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, offers minimal protection in regards to breastfeeding at the workplace.

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[77] 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).

[78] Article 12 Convention on the Elimination of all Forms of Discrimination against Women.

[79] Article 11 (1) Convention on the Elimination of all Forms of Discrimination against Women.

[80] Article 11 (2) (a) & (b) Convention on the Elimination of all Forms of Discrimination against Women.

[81] Article 11(c) Convention on the Elimination of all Forms of Discrimination against Women.

Unlike CEDAW, the CRC directly promotes breastfeeding by stipulating that all segments of society in particular children and parents have access to information which promotes the advantages of breastfeeding.[82] Consequently breastfeeding is considered more as children's right than a women rights issue.

2.1.1.2 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 calls on the state to ensure that measures are taken to ensure that women who breastfeed are not subjected to the death penalty.[83]

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.[84]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.[85]

2.2 Breastfeeding and the Rights of the Child

The United Nations Convention of 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.[86]The CRC does directly promote breastfeeding by providing that State Parties have a 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.[87]

[82] Article 24 United Nations Convention on the Rights of the Child, 1989 (CRC).
[83] Article 4 (2) (j) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[84] Article 14 (2) (b) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[85] Article 24 (b) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.
[86] 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).
[87] Article 24 (2) (e) United Nations Convention on the Rights of the Child.

The CRC provides that states must ensure that every child enjoys the right to the highest attainable standard of health.[88] Moreover, State Parties should take measures to diminish infant and child mortality.[89] State Parties also have a responsibility to combat disease and malnutrition.[90]

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. [91] What is more, the African Charter also provides that the State parties must take steps to reduce the infant and child mortality rate.[92]

According to the African Charter State parties also should ensure the provision of adequate nutrition and safe drinking water. [93] 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.[94] The African Charter also provides that every child has a right to enjoy the best attainable state of physical, mental and spiritual health.[95]

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

The Children Act[96] 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 has the responsibility to ensure survival and development of the child.[97] The Act provides that the parents have a responsibility to provide an adequate diet.[98]

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88 Article 24 (1) United Nations Convention on the Rights of the Child.
89 Article 24 (1) United Nations Convention on the Rights of the Child.
90 Article 24 (2) (c) United Nations Convention on the Rights of the Child.
91 Article 14 (2) (h) African Charter on the Rights of the Rights and welfare of the Child.
92 Article 14 (2) (a) African Charter on the Rights of the Rights and welfare of the Child.
93 Article 14 (2) (c) African Charter on the Rights of the Rights and welfare of the Child.
94 Article 14 (2) (d) African Charter on the Rights of the Rights and welfare of the Child.
95 Article 14 (1) African Charter on the Rights of the Rights and welfare of the Child.
96 Chapter 141 Laws of Kenya.
97 Section 4 Children Act.
98 Section 23 (1) Children Act.

Child survival is dependent on two factors: nutrient intake and the ability of the child to ward off infections.[99] Breast milk is a significant source of nutrients. 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.[100]

Breast milk protects infants against illness in one of two ways. The first method is through directly protecting the infant against specific diseases. The second method is by stimulating and strengthening the infants' immature immune system. [101] Moreover, numerous studies have indicated that breastfeeding has numerous benefits to the infant such as 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 which lack adequate access to non-contaminated foods which can be used as a substitute to breast milk; the chances of infections are higher, and the health care system is underdeveloped. [102]

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.[103] 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.[104] 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.[105]

The consensus in the scientific community is that exclusive breastfeeding for the first six months followed by the introduction of appropriate complementary food with the continuation of breastfeeding until two years; increases the chances of child survival and proper development.[106]According to a 2013, Lancet Study, optimal breastfeeding is the most efficient technique in preventing infant and child

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[99] S.L. Huffman and B.B. Lamphere, "Breastfeeding Performance and Child Survival," (Population and Development Review 1984) Vol.10 <https://www.jstor.org/stable/2807957> (accessed 23 April 2019) 93.
[100] 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.
[101] 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.
[102] S.L. Huffman and B.B. Lamphere, "Breastfeeding Performance and Child Survival,". *Op.cit*
[103] H.W Christup, "Litigating a Breastfeeding and Employment Case in the New Millennium." (Yale Journal of Law and Feminism 263, 2000) 265.
[104] IBFAN, "Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health." *Op. cit*
[105] S.L Huffman and BB Lamphere, "Breastfeeding Performance and Child Survival. *Op.cit*
[106] BFAN, "Breastfeeding and the Right of the Child to the Highest Attainable Standard of Health." *Op. cit*
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mortality. The study indicates that optimal breastfeeding can prevent up to 800,000 deaths of children under five in developing countries.[107] To boot, breastfed children have a higher chance of survival than their non- breastfed counterparts. In fact, the figures indicate that an exclusively breastfed child is six times less likely to die before their half birthday than a non-breastfed child. [108]

The central theme in international, regional and national legal framework concerning children is that any action taken concerning a child must always be in the child's best interest. 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 exists an aggressive legal framework to safeguard a child's right to breastfeed.

It is however important to note that Kenyan courts have continuously upheld decisions which advocate that breastfeeding as a child's rights. In *Refugee Consortium of Kenya & Another* v. *Attorney General and 2 others* [109],the 2nd Petitioner was Congolese registered refugee who resided in Kasarani. 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 Petitioners detention the infant had developed health problems associated with pre- mature disruption of breastfeeding.

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 children.

Similarly in *MMA* v. *KM (2017)* [110] the Court held in this case that there are certain functions such as breastfeeding that can only be performed by a mother. Subsequently no one is allowed to stop a mother from breastfeeding.

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[107] UNICEF, " Nutrition." <https://www.unicef.org/nutrition/index_24824.html> (accessed 23 April 2019).
[108] *Ibid*.
[109] High Court of Kenya at Nairobi Constitutional and Human Rights Division Petition no 382 of 2014, (2015 eKLR).
[110] High Court of Kenya at Kisii Civil Appeal No 36 of 2012, (2017) eKLR .

2.3 Women's Reproductive Versus Productive Role

Women's reproductive and productive roles at times may seem to be in conflict.[111]It goes without saying that 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 as a result of the introduction of formula. This is because the influx of women into the workforce coincided with the creation of 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.[112]

Studies have indicated that breastfeeding mothers are more likely to reduce working hours than mothers who feed their infants' formula.[113] This is because breastfeeding is more time consuming than preparing 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. Formula also digests slower than breast milk; hence formula fed children need fewer feedings than breastfed infants.[114] In addition to 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.[115]

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 which 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. Since 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

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111 See Chapter 1.8 on definition of women's reproductive and productive role.

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

113 *ibid* 248.

114 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).

115 *Ibid*.

Kenyan Government acknowledges that the future of the nation is dependent on the health of the children.[116]

MDG number 4 was to reduce child mortality by two-thirds between 1990 and 2015 for children under the age of five years old.[117]In addition to this, SDG number 3 advocates for good health and well-being.[118] Two of the biggest threats to children's health is acute respiratory illness and dehydration due to extreme diarrhoea.[119] These ailments can be prevented by breastfeeding.

MDG number 1[120] promotes the eradication of extreme poverty and similarly SDG number 1[121] 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 which rely on a few breadwinners. [122] 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 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.[123] In the same way, SDG number 5, aims to achieve gender equality and empower all women and girls.[124] Therefore, laws which safeguard women's productive roles contribute to the increase of women in the workforce. Consequently, MDGs and SDGs goals are achieved, and this 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

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[116] 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.
[117] *Ibid*.
[118] SDGF, "Sustainable Development Goals," (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs-sdgs> (accessed 11 April 2019).
[119] J. Otieno, "Situation of Children and Women improves." (UNICEF 2010) < https://www.unicef.org/kenya/health_5736.html > (accessed 8 July 2019).
[120] 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.
[121] SDGF, "Sustainable Development Goals" (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs-sdgs> (accessed 11 April 2019).
[122] 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.
[123] *Ibid*10.
[124] SDGF "Sustainable Development Goals," (Sustainable Development Goals Fund) <http://www.sdgfund.org/mdgs-sdgs> (11 April 2019).

perceived as a form of social production which involves caregiving for the next generation or building human capital or human resource development. [125]Women's reproductive role should be treated with the same reverence as their productive role.

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 a secondary support system which 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.

Both 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 which involves the government's intervention through laws and policies is needed. Employers should also create workplace policies which 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. 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 which accommodate women's right to breastfeed is a cost-effective investment which increases employee morale. It also reduces absenteeism because breastfeeding improves the child's overall health. [126]

[125] 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.
[126] International Labour Organization, " Maternity Protection Resource Package. From Aspiration to Reality for All. Module 10: Breastfeeding Arrangements at Work," (ILO 2012), <http://mprp.itcilo.org/allegati/en/m10.pdf> (accessed 18 April 2019) 10-12.

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 reduces the cost of recruitment and retraining. In a research commissioned by Vodafone, 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 actually be 28 billion dollars.[127]

Affirmative breastfeeding policies enable working mothers to smoothly transition back to their work routine after resuming duty from maternity leave. What is more, employer-employee relations are improved, resulting in higher employee loyalty. Furthermore, favourable breastfeeding policies also boost the organisation's overall image to outsiders. Further to this, it is a bonus recruitment incentive for prospective female employees. On top of that, it will also result in a healthier future workforce. Last but not least, a favourable breastfeeding policy is a recognition of women's dual role in productivity and reproduction.[128]

Both CEDAW and the Maputo Protocol fail to adequately safeguard breastfeeding as a reproductive right. Focus predominately seems to be on reproductive rights centered on obstetrics. 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.

The Maputo protocol does directly safeguard the right to breastfeeding specifically in situations relating to death penalty. The Protocol however fails to protect breastfeeding mothers from the most obvious and common barrier to breastfeeding which is work obligations. There exists 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. Both protocols 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 which could be interpreted to allude to this right.

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

As highlighted in the cases discussed the courts have over the years inferred that breastfeeding is the right of the child and is in the child's best interest. As outlined in this chapter the international and regional legal regime have failed to adequately safeguard breastfeeding as reproductive right. Chapter 3 will highlight legislation at the national level which purports to promote breastfeeding and its effectiveness.

CHAPTER 3
INTERNATIONAL AND KENYAN LEGAL FRAMEWORK PROMOTING BREASTFEEDING

The International Code of Marketing Breast Milk Substitutes is the fundamental international regulation which extensively attempts to promote breastfeeding. Kenya is among the numerous countries that have adopted the Code. Consequently, Chapter 3 extensively discusses the provisions of the Code. In addition to this, this chapter also discusses the Kenyan BMS Act, which is a domestication of the Code at a national level. Lastly, the Chapter will also delve into various provisions contained in various statutes that aim to promote breastfeeding at the national level.

3.1 The International Code of Marketing of Breast Milk Substitutes

This Section will briefly discuss the events which led up to the drafting of the Code. Moreover, it will also highlight the rationale behind the Code being a recommendation rather than a regulation.

3.1.1 History Behind Drafting of the International Code

The WHO and UNICEF had, for many years, supported breastfeeding as the primary method of improving health among children and infants. Even though a variety of factors influence the initiation and duration of breastfeeding; the twenty-seventh WHA zeroed in on BMS as the reason for the decline breastfeeding rate.[129] The WHA concluded that aggressive marketing and promotion of BMS was the greatest threat to breastfeeding. A resolution was passed urging member countries to review sales promotion activities on infant foods and introduce corrective measures which included advertising codes and legislation.[130]

In 1979, the WHO organized a meeting with key stakeholders who included representatives of member states, organisations of the UN system and other intergovernmental bodies, NGOs, infant food industry and experts in the related disciplines.[131] The meeting had five main agendas: promotion of breastfeeding; support of time appropriate weaning with the use of indigenous food, promotion of education, training and information on infant and young children nutrition; promotion of women's health and social status in relation to infant and young children health and nutrition; and appropriate marketing and distribution of BMS.[132]

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[129] WHO, "International Code of Marketing of Breast Milk Substitutes," (WHO 1981) 4.
[130] Resolutions WHA 27. 43 (Handbook of Resolutions and Decisions of the WHA and the Executive Board, Volume II, 4th Edition. Geneva, 1981) 58.
[131] WHO, "International Code of Marketing of Breast Milk Substitutes," (WHO 1981) 4.
[132] *Ibid*.

During the thirty-third WHA in 1980, a resolution was passed requesting the Director-General to draft an international code regulating the marketing of infant formula and other BMS related products.[133] WHO and UNICEF consulted all significant stakeholders and included the points which had been agreed on during the 1979 meeting.

In January 1981, the Executive Board of the WHO reviewed the fourth draft of the Code and approved it. The Executive Board recommended that the thirty-fourth WHA adopt the text as a recommendation rather than as a regulation.[134] On 21 May 1981, the draft code was adopted as a recommendation[135] with one hundred and eighteen votes in favour, one against and three abstentions.[136]

Despite the adoption of the Code, the BMS industry is still thriving, global sales of BMS amount to US$ 44.8 billion and are expected to rise to US$ 70.6 billion by 2019.[137] The WHO status report indicates that only two out of three infants below six months are exclusively breastfed. These figures are particularly disappointing since the rate has not improved in two decades despite the Code being adopted. Statistics indicate that less than one in five infants are breastfed for beyond twelve months in high-income countries. In middle and low-income countries, only two out of the three children between six and twenty-four months are breastfed.[138]

3.1.2 Adoption of the International Code as a Recommendation versus Regulation

Promotion of breastfeeding and matters dealing with the health, growth and development of infants and children falls within the mandate of the WHO. Consequently, drafting of the Code is within the WHO mandate. WHO Constitution provides that the organisation can take specific measures to protect interests within its purview. These three measures include: treaties [139] regulation [140] and recommendations.[141] Even though the WHO has the mandate to create treaties since its inception in 1948, it has never created treaties to deal with matters concerning public health.[142]

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133 WHA resolutions 33.32 (23 May 1980).
134 Resolution EB 67. R12 (28 January 1981).
135 WHA Resolution 34.22 (21 May 1981).
136 S. Shubber, "The International Code of Marketing of Breast Milk Substitutes" *op. cit.*
137 N.C. Rollins, N. Bhandari, N. Hajeebhoy et al, "Why Invest, and what it will take to Improve Breastfeeding Practices?" (Lancet 2016) 491-504.
138 WHO, UNICEF & IBFAN, "Marketing of Breast-milk Substitutes: National Implementation of the International Code. Status Report 2016" WHO 2016) 7.
139 Article 19 of the WHO Constitution.
140 Article 21 of the WHO Constitution.
141 Article 23 of the WHO Constitution.
142 S. Shubber, "The International Code of Marketing of Breast Milk Substitutes" (International Digest of Health Legislation 1985) volume 36 No 4.881.

Article 21 of the WHO Constitution gives the WHA the power to adopt regulations that deal with safety, purity, potency, advertising and labelling of biological, pharmaceutical and similar products moving in international commerce. BMS are considered as "similar products" hence can be regulated by WHO. Regulations are quasi-legislative as they can only bind member states who have consented to be bound by them.

During its deliberations, the Executive Board was torn between proposing the Code as a regulation or as a recommendation. To provide a united front, the Executive Board unanimously proposed that the Code be regarded as a recommendation.[143] Ordinarily, recommendations are not binding in effect; however, recommendations of the WHA carry moral and political weight because it is a judgment on a health issue from the highest international body dealing with health.[144] During his address to the thirty-fourth WHA, the representative of the Executive Board discussed the rationale of making the Code a recommendation rather than a regulation. The Board believed that a unanimous recommendation would be more persuasive than a regulation that did not receive the full support of the member states.[145]

3.1.3 Provisions of the Code and Critic

This section will outline the salient provisions of the Code and will also analyse the merits of said provisions based on how practical they are in contemporary Kenyan Society.

3.1.3.1 The scope of the Code

Article 2 of the Code outlines the Scope of the Code as regulating the marketing and practices of designated products. These designated products governed by the Code include BMS such as infant formula, other milk products, foods and beverages including bottle-fed complementary foods when marketed or represented as a partial or total replacement of breast milk. Also included are feeding bottles and teats.

The inclusion of the teats and feeding bottles as designated products is somewhat problematic. This is because the WHO recommends that exclusive breastfeeding continue up to six months and partial breastfeeding may continue for up to twenty- four months. However, due to work commitments or

[143] *Ibid* 883.
[144] *Ibid* 884.
[145] Excerpts from the Introductory Statement by the Representative of the Executive Board to the Thirty-Fourth World Health Assembly on the Subject of the Draft International Code of Marketing of Breast Milk Substitutes (WHA 34/1981/ REC/3).

other engagements which deny women constant access to their infants; it is difficult for women to breastfeed for such long durations.

Most women have no other option except to express breast milk and bottle feed their infants with the expressed breast milk. Hence feeding bottles and teats are not exclusively used for BMS. Moreover, from six months, infants are weaned, and other foods besides breastmilk are introduced. These foods may include water and fruit juices, which may require a feeding bottle. Therefore this provision is rather impractical.

3.1.3.2 Information and Educational Materials on Infant and Young Children Feeding

Article 4.1 bestows on the government the responsibility of ensuring objective and consistent information concerning infant and young children nutrition is provided to families and persons in the field related to infant and young children nutrition. The information should highlight the benefits and superiority of breastmilk.[146]

According to a WHO Status report, fifty-five per cent of countries have provisions in their laws which provide for educational materials that contain information on the benefits and superiority of breast milk.[147]Scholars such as Rebecca Kukla have rightfully argued that breastfeeding advocacy which solely focuses on education and information campaigns is not effective.[148]This is because the majority of women are already well aware of the vast benefits of breastmilk to infants and young children.

Women, however, face other social, economic and cultural barriers which restrict the initiation and continuation of breastfeeding. Thereby, by solely focusing on the educational and informational campaigns; barriers which restrict breastfeeding are never dealt with. Consequently, women who are willing but unable to breastfeed due to these barriers are left feeling guilty.

Informational and educational campaigns also primarily target mothers to the exclusion of fathers and employers. Fathers and employers have the potential of making breastfeeding easier for mothers. However, the burden of breastfeeding is solely left to the mother with no additional support from her partner or her employer.

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[146] Article 4.2 of the International Code of Marketing of Breast-milk Substitutes.
[147] WHO, UNICEF & IBFAN, " Marketing of Breast-milk Substitutes: National Implementation of the International Code. Status Report 2016." (WHO 2016) 23.
[148] See chapter 1.10

3.1.3.3 Promotion of BMS to the General Public

The Code forbids the promotion of designated products to members of the public.[149] To boot, manufacturers and distributors are not allowed to indirectly or directly distribute to pregnant women, mothers or their families samples of the designated products.[150] Point of sale advertising, special sales, loss-leaders and tie-in-sales for designated products are also precluded.[151]

Majority of mothers, particularly from developing countries like Kenya are from low-income backgrounds with limited resources. Due to a variety of barriers, they may be unable to initiate or continue breastfeeding. They, therefore, rely on BMS and related products such as feeding bottles and teats. Commercial BMS are quite costly, and facilities such as sales, samples, discounts assist such women in alleviating the financial burden to a small extent. Currently, BMS and related products can only be easily accessed by women from high-income backgrounds.

3.1.3.4 Promotion of BMS in Health Facilities

The health authorities in member states are expected to promote breastfeeding and the provisions of the Code.[152]However, where necessary, healthcare workers can demonstrate the preparation or use of manufactured or home prepared infant formulas. The Article does not, however, expound on what situations would be regarded as necessary for the use of infant formula.

3.1.3.5 Promotion of BMS to Health Workers

The Code places a responsibility on health workers to promote breastfeeding and the provisions of the Code.[153] Given the close contact and influence, health workers have to pregnant women and mothers of infants and young children.

Health workers such as doctors often possess limited in-depth knowledge on lactation. This is as a result of the medical curriculum glazing over the lactation topic. Doctors are therefore unable to offer their expertise in the area. This has led to the emergence of lactation experts.

Lactation experts can offer the much needed medical advice breastfeeding women require. However, in developing countries such as Kenya, a significant number of women are not able to access lactation

[149] Article 5.1 of the International Code of Marketing of Breast-milk Substitutes.
[150] Article 5.2 of the International Code of Marketing of Breast-milk Substitutes.
[151] Article 5.3 of the International Code of Marketing of Breast-milk Substitutes.
[152] Article 6.1 of the International Code of Marketing of Breast-milk Substitutes.
[153] Article 7.1 of the International Code of Marketing of Breast-milk Substitutes.

experts due to limited financial resources. Moreover, most private health insurance policies do not cover the cost of consulting lactation experts. In addition to this, in most government health facilities, there are no lactation experts, especially in smaller clinics.

3.1.3.6 Labelling of Infant Formula

The manufacturer and distributor of infant formulas have the responsibility of placing legible labels in an appropriate language indicating the superiority of breastmilk. The label should also advise the user to consult a health worker before using the product and the proper use of the product. Also included in the labelling should be the guidelines on proper preparations and a health hazard warning. The labels should not include terms such as "humanised" or "materialized." Moreover, the label should not include pictures of infants or images which idealise the use of infant formula.[154] The labels should also not in any way convey a message discrediting breastfeeding.[155]

The Code fails to provide a provision that compels manufacturers and distributors to indicate on the label the age for which the product is best suited. This can be problematic in that without an age recommendation parents or caregivers are not sure if the product is age appropriate.

The Code indicates that the labels should be in an appropriate language. This would suggest that the language used in the label should be widely spoken and understood in the locality the infant formula is being sold. The problem comes in that most manufacturers and distributors are located in developed countries; hence the labels are bound to be in the manufacturers' or distributors' native language. When the infant formula is exported to other countries, especially developing countries, there is a need to translate the label to the locals' native language. This is an extra cost which is transferred to the end consumer hence making the product even more costly and inaccessible to people in low-income homes.

3.1.4 Implementation and monitoring of the Provisions of the International Code

Governments have a responsibility to implement the principles of the Code, which complements its existing social and legislative framework. Implementation can be through national legislation, regulation or other suitable measures. The governments can opt to partner with UN Agencies such as UNICEF, WHO.[156]

[154] Article 9.2 of the International Code of Marketing of Breast-milk Substitutes.
[155] Article 9.1 of the International Code of Marketing of Breast-milk Substitutes.
[156] Article 11.1 of the International Code of Marketing of Breast-milk Substitutes.

As of March 2016, a total of 135 countries had at the very least some form of legal measures implementing some provisions of the Code. This was an improvement from 2011, where only 103 countries had implemented some provisions of the Code.[157] Thirty-nine countries have implemented all or most of the provisions of the Code into their national legal framework. Whereas, at least thirty-one countries have implemented most of the provisions of the Code and sixty-five have implemented a few provisions. Forty-nine countries have no legal measures set up to implement the provisions of the Code.[158]

Majority of the countries with comprehensive legislation are located in South East Asia and Africa. Whereas, countries with the minimal legal framework are located in the Americas, Western Pacific and Europe regions.[159] In Kenya, the provisions of the Code were wholly implemented through the Breast milk Substitutes (Regulation and Control) Act. No. 34 of 2012.

Monitoring is critical as it allows the government to be able to detect violations and take the necessary actions to remedy the situation. The governments of WHO member states are responsible for monitoring the application of the Code.[160] The WHO submits to the WHA reports indicating the status of the Code. The reports are based on data provided by the member states.[161]

According to the WHO 2011 status report, only fifty-five countries submitted relevant information, and only thirty-two countries indicated that they had a set up a monitoring mechanism. Unfortunately, only six countries had allocated a budget towards financing the monitoring and enforcement mechanism.[162]

The WHO/UNICEF Baby-Friendly Hospital Initiative has also been critical to the application and monitoring of the Code in maternity facilities. All maternity facilities which are rated as "Baby-Friendly" have an obligation to adhere to the provisions of the Code.[163]UNICEF and WHO have

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[157] 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> (accesed 11 May 2019) 1.
[158] *Ibid*.
[159] *Ibid*18.
[160] Article 11.2 of the International Code of Marketing of Breast-milk Substitutes.

[161] WHO, " Country Implementation of the International Code of Marketing of Breast- Milk Substitutes: Status Report 2011" (WHO, 2013) <https://www.who.int/nutrition/publications/infantfeeding/statusreport2011/en/> (accessed 10 March 2019) 3.
[162] 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) 2.
[163] *Ibid* 8.

teamed up with other groups to create the Breastfeeding Advocacy Initiative (BAI) which pushes for more significant support for breastfeeding. BAI has urged countries to not only implement the Code, but to also monitor enforcement and in cases where violations are detected; to ensure sanctions are meted.[164]

The WHO, in collaboration with UNICEF, has created the Global Network for Monitoring and Support for Implementation of the Code (the Netcode). The Netcode offers support to countries and civil society in the enforcement and monitoring of the Code. The Netcode receives additional support form NGOs such as IBFAN, Hellen Keller International and Save the Children.[165]

3.1.5 Additional Support of the Code by UN Human Rights Bodies

United Nations human rights bodies such as the Committee on the Rights of the Child have called for the implementation of the Code and subsequent WHA resolutions.[166] Similarly, the Committee on the Elimination of all forms of discrimination against women has urged countries to take up the responsibility of regulating the marketing of BMS and implementing the Code.[167]The Human Rights Council in a bid to eliminate child mortality has also called for the regulation of private actors such as producers and marketers of BMS and the implementation of the Code.[168]

3.1.6 Challenges Implementing, Enforcing and Monitoring the Code

The Code has faced numerous challenges in implementation, enforcement and monitoring. One of the biggest challenges is the low rate of implementation. Out of the 135 member states, only 39 states have adopted a comprehensive legal framework incorporating all if not most of the provisions of the Code. This only represents 29% of the WHO member states.[169]

Furthermore, even among the countries which have implemented all or some of the provisions of the Code into their national legal framework; implementation and monitoring is at times a challenge. Lack of sanctions has often resulted in the widespread and systematic violation of the Code's provisions.[170]

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164 *Ibid* 9.
165 *Ibid* 9.
166 Committee on the Rights of the Child, General Comment No. 15 (2013).
167 Committee on the Elimination of All Forms of Discrimination Against Women, General Recommendation No 34 (2016).
168 Office of the UN High Commissioner for Human Rights, Technical guidance on the application of a human rights-based approach to the implementation of policies and programmers to reduce mortality of children under five years of age. A/HRC/27/31 (2014).
169 WHO, UNICEF & IBFAN, " Marketing of Breast-milk Substitutes: National Implementation of the International Code. Status Report 2016." (WHO 2016). 1
170 *Ibid* 41.

As can be expected, implementation, enforcement and monitoring of the Code is a resource-intensive endeavour. WHO status report indicates that only 19% of the countries have a dedicated budget or funding. This has particularly proven to be a challenge in developing countries where resources are already limited.[171] Consequently, such countries over-rely on external funding from UN agencies.

Pushback from manufacturers and distributors has also been a significant challenge to national implementation and enforcement. Distributors and manufacturers have been using World Trade Organization Agreements and trade and investment agreements to argue against technical barriers to investment and intellectual property rights.[172]

Technological advancement has also brought about a shift in the way distributors and manufacturers of BMS promote their products. Conventional means such as advertising in retail outlets and mainstream media have become outdated and have been replaced internet and social media. It is therefore much more difficult to restrict distributors and manufacturers from having access to the general public in particular pregnant women, mothers to infants and health workers.[173]

3.2 Breast Milk Substitutes Regulation and Control Act of Kenya

Kenya is one of the countries that has adopted legal measures incorporating all of the provisions in the Code. Adoption of the Code's provision was through the Breast Milk Substitutes (Regulation and Control) Act. [174] The then Minister of Public Health and Sanitation, Beth Mugo sponsored the Bill. Prior to the Act, KEBS regulated BMS as a standard; however, it did not regulate marketing or promotion or institute penalties for violations.

The Breast Milk Substitutes (Regulation and Control) Bill (the Bill) received criticism from the manufacturers of BMS. The provision banning the marketing of BMS to health workers was particularly controversial.[175] Despite numerous attempts to water-down the provisions of the Bill, it received overwhelming support from the female members of parliament amongst other members. The BMS Act was assented on 11 October 2012 and commenced on 17 December 2012.

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171 *Ibid* 33.
172 *Ibid* 41.
173 *Ibid*.
174 Act No. 34 of 2012.
175 J. Ngirachu, "The Interest at Play in Baby Milk Debate." (Daily Nation 22 September 2012) <https://www.nation.co.ke/news/The-interests-at-play-in-baby-milk-debate-/1056-1514946-uat53wz/index.html> (accessed 10 July 2019).

The BMS Act preamble highlights that the primary function of the Act is to provide for appropriate marketing and distribution of BMS. Furthermore, ensure that infants have access to safe and adequate nutrition through the promotion of breastfeeding and proper use of BMS where necessary.

3.2.1 Provisions of the BMS Act

This Section will briefly highlight the major provisions of the BMS Act, compare some of the provisions of the Act and the Code. It also discusses the shortcomings of the Act.

3.2.1.1 Designated Products

Designated products refer to the products which fall under the purview of the BMS Act. BMS are defined as any food that is marketed or otherwise represented as a partial or total replacement of breastmilk. [176]A complementary food product is defined as food suitable or represented as a suitable complement to breastmilk from the age of six months to twenty-four months.[177] While the Code places no age limits on the definition of complementary food, the Act is specific and has placed an upper age limit of twenty-four months.

The Act has a broader range of designated products than the Code. Infant formula, feeding bottles and teats feature in both the Code and the Act. [178]However, Act has gone a step further and included pacifiers, cups with spouts and breast milk fortifiers. The Code includes both industrially and home-prepared infant formula[179]; whereas the Act only refers to industrially prepared infant formula. The Act predominately targets commercial BMS.

3.2.1.2 The BMS Act Regulatory Body

The BMS Act establishes the National Committee on infant and young child feeding (the Committee). The Committee's core functions are policy and regulation development.[180] The Committee comprises of government officials, representatives from the medical field and experts in the field of child nutrition. [181] The BMS Act bans explicitly the appointment of persons who have an affiliation or interest in the manufacturing, distribution, marketing, advertising or promotion of a designated or complementary product.[182]

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[176] *Ibid*.
[177] *Ibid*.
[178] Section 2 (1) Breast Milk Substitutes (Regulation and Control) Act.
[179] Article 3 of the International Code of Marketing of Breast-milk Substitutes.
[180] Section 5 (1) Breast Milk Substitutes (Regulation and Control) Act.
[181] Section 4 (2) Breast Milk Substitutes (Regulation and Control) Act.
[182] Section 4 (6) Breast Milk Substitutes (Regulation and Control) Act.

This provision was contentious and was opposed by KAM during the Bill's debate. KAM argued for the inclusion of a representative chosen by the manufacturer. Their suggestion was however rejected, and the Bill's proponent argued that having a representative who represented manufacturers' interest would be tantamount to having an industry insider set rules for themselves.[183]

The inclusion of a manufacturer representative would have, however, actually been beneficial to the regulatory body. The manufacturer's representative would have provided insight from a manufacturer's perspective. Moreover, the regulation would have been most likely more efficient if the bodies being governed were allowed to have some form of participation in their regulation. The participation can be limited, however meaningful. Take for example the Public Benefit Organization Act[184] whereby the Chairperson of the Governing Board of the public benefit organisations federation is a member of the Board of authority. To the contrary, the BMS industry was allowed to participate in drafting the Code.

It is essential to acknowledge that the concern that a manufacturer's representative participation in the regulatory body can be problematic. Naturally, the manufacturer's representative will promote the manufacturers' interest. However, the impact will not be substantial since the government, medical and nutritional experts still outnumber the manufacturers' representative.

3.2.1.3 Advertising and Promotion of BMS

The BMS Act was enacted relatively recently, and at a time where technological advances had been made hence, it refers to advertising through modern means such as the internet. This is significant in that unlike the Code which was drafted in the 80s, and some of the provisions have failed to keep up with the changing times.

Unlike the Code, the BMS Act specifically has a provision that describes what advertising means in the context of the Act. Advertising is described as making a representation by any means for the purpose of directly and indirectly promoting the sale or use of a designated or complementary food product. The provisions list a variety of means such as written publications, television and radio

[183] J. Ngirachu, "Firms Barred from Advertising Baby Milk," (Daily Nation 21 September 2012).
<https://www.nation.co.ke/news/politics/Firms-barred-from-advertising-baby-milk/1064-1513406-1kgnmrz/index.html> (accessed 10 July 2019).
[184] No. 18 of 2013.

broadcasts, film, or electronic transmissions, internet video or telephone, displays, signs, symbols, colours, billboards or notices, the exhibition of pictures or models.[185]

The BMS Act restricts the use of sale devices such as special discounts, tie-in-sales, provisions of premiums and rebates, discount coupons, loss leaders, gifts and free samples. The Code has a similar provision, and as discussed earlier , these provisions restrict mothers from accessing BMS and other designated products at a lower price.[186]This can limit the access of mothers with limited resources and who are in dire need of BMS and related products.[187]

In addition to this, the BMS Act bans manufacturers and distributors from offering employees who are dealing with the marketing of designated or complementary products remuneration, incentives and bonuses in relation to the volume of sales. The Act restricts manufacturers and distributors from directly and indirectly offering any support to health workers. This includes gifts such as fellowship, study grants, funding for training, financial assistance.

3.2.1.4 Interaction between Health workers and Manufacturers and Distributors of BMS

The BMS restricts the interaction between the manufacturers and distributors of designated products and complementary food products and health workers. Health workers are not allowed to accept gifts, financial assistance, fellowships, scholarships, research grants and funding for trainings.[188] Furthermore, health workers are not allowed to distribute or display designated products. Moreover, health workers are prohibited from demonstrating the use of designated products unless in certain circumstances prescribed by the cabinet secretary.

The rationale behind these provisions is that health workers have direct contact with pregnant and nursing women. Hence it is important to ensure that there exists no conflict of interest that would prevent a health worker from fulfilling their duty to promote breastfeeding in lieu of promoting BMS.

[185] Section 2 (1) Breast Milk Substitutes (Regulation and Control) Act.
[186] See chapter 3.1.3.
[187] Section 6 (2) (b) Breast Milk Substitutes (Regulation and Control) Act.
[188] Section 8 (a) Breast Milk Substitutes (Regulation and Control) Act.

3.2.1.5 Labelling of BMS Products

The packages of designated products should have notices and warnings which promote breastfeeding and proper use of BMS in the wording, size and manner prescribed by the Cabinet Secretary.[189] Unlike the Code which places the burden on manufacturers and distributors; the BMS Act is not clear on which party has an obligation to ensure the labelling is done in accordance with the provisions of the Act.

In addition to this, since labelling needs to be done in accordance with the manner prescribed by the Cabinet Secretary, BMS products which are imported may not meet these standards. Hence they will be a need to relabel the products according to the cabinet secretaries specifications. The consumer usually bears this additional cost.

3.2.1.6 Educational and Informational materials

Dissemination of educational material concerning infant and young child feeding is subject to the Cabinet Secretary's approval. The exception is research articles and public presentation which disclose the financier, sponsor or facilitator and which are promotional in nature of designated products.[190]

3.2.1.7 Enforcement of the Provisions in the BMS Act

The Cabinet Secretary has the mandate to appoint authorised officers through gazette notice to enforce the provisions of the Act.[191]The authorised officer has the mandate to enter any premises he has reasonable grounds to believe that a designated product or complementary food product has been produced, manufactured, stored, packaged, sold or used.[192]

Similarly, authorised officers may enter a premise if they have reasonable grounds to believe that any item used or information pertaining to the production, manufacture, testing, packaging, promotion or sale of a designated or complementary food product is within the premises. [193]Additionally, any premise believed to be occupied by any person contravening the provisions of the BMS Act.[194]

[189] Section 9 Breast Milk Substitutes (Regulation and Control) Act.
[190] Section 10 Breast Milk Substitutes (Regulation and Control) Act.
[191] Section 11 (1) Breast Milk Substitutes (Regulation and Control) Act.
[192] Section 12 (1) (a)Breast Milk Substitutes (Regulation and Control) Act.
[193] Section 12 (1) (b) and (c)Breast Milk Substitutes (Regulation and Control) Act.
[194] Section 12 (1) (d) Breast Milk Substitutes (Regulation and Control) Act.

Section 13 of the BMS Act further bestows an authorised officer with the power to examine a designated product; order a person in charge to produce for inspection a designated product; take samples, conduct tests and analyses. Furthermore, an authorised officer may seize designated products believed to be in contravention of the BMS ACT.[195]

3.2.2 Critique of the Kenya Breast Milk Substitutes Act

The BMS Act core function is to provide safe and adequate nutrition for infants through the promotion of breastfeeding and BMS where necessary. In addition to this, the Act is supposed to regulate the appropriate marketing and distribution of BMS. While the BMS Act does regulate the marketing and promotion of BMS; it does very little actually to promote breastfeeding. The BMS Act was enacted under the notion that the greatest threat to breastfeeding in Kenya is the aggressive marketing and promotion of BMS. Therefore, other threats to breastfeeding such as working mothers' inability to access their children and mother's health and nutrition, for example, are not addressed.

The BMS Act primarily restricts mothers from easily accessing information about BMS and other designated products. It does not provide a secondary support system which is necessary for enabling mothers to deal with barriers to breastfeeding. Instead, it makes it difficult for mothers who are unable to breastfeed, and therefore relay on BMS and other designated products, to access information and subsidised BMS.

Whereas the BMS Act primarily advocates for exclusive breastfeeding for the first six months, there is no complementary labour legislation which would make it possible for working mothers to breastfeed exclusively. The reality of the situation is that a majority of working mothers opt to express breastmilk which a caregiver will feed the infant. The infant is usually fed using artificial teats and feeding bottles. However, these products fall under the ambit of the Act, and therefore, marketing and promotion of these products are restricted. Consequently, some of the provisions of the BMS Act seem to be impractical to the needs of working mothers.

The WHO guidelines recommend exclusive breastfeeding for the first six months and the introduction of complementary nutritious food alongside breastfeeding from six months to two years.[196] The BMS Act attempts to regulate complementary food products given to infants from the age of six months to twenty-four months. This appears to be contradictory since the WHO guidelines appear to recommend

[195] Section 20 Breast Milk Substitutes (Regulation and Control) Act.
[196] WHO, "Exclusive breastfeeding for six months best for babies everywhere" <https://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/> (accessed 22 March 2019).

infants feed on nutritious complementary food. Therefore the restriction in the Act seems to single out industrial complementary food. There is no indication that industrial complementary food is not nutritious. Therefore it seems unnecessary to regulate complementary food products meant for children who are six months and older.

Furthermore, the Act focuses solely on commercial BMS. The Act ignores the fact that the majority of the households in Kenya cannot easily access commercial BMS hence, newborns are usually fed on indigenous foods. Feeding of indigenous foods can at times be a threat to breastfeeding, especially if the infant is below six months. The Act does not address this issue.

3.2.3 Additional Regulation in Kenya Safeguarding the Right to Breastfeed as a Reproductive Right

The national legal framework safeguarding reproductive rights is centered on obstetrics. There is little doubt that the courts will safeguard women's right not to be discriminated against on account of pregnancy. In *Claudine Wanjiku Mboce* v. *Exon Investments Limited and another*[197] the Claimant alleged that she had been unfairly dismissed while on maternity. The question before the court was whether the Claimant had been discriminated against on account of her pregnancy. Moreover, whether she was entitled to damages as a result of discrimination based on pregnancy. The Court held that the claimant had a right to return to work under section 29 (2) of the employment Act. In addition to this the Claimant's right under Article 27 (5) of the Constitution to not be discriminated against directly or in directly on the grounds of pregnancy. The Claimant was awarded general damages.

In order to ensure a consistent supply of breastmilk, mothers are required to breastfeed or express at regular internals. Employment outside of the home is the most significant barrier to breastfeeding. Currently, there is no comprehensive legal framework specifically safeguarding women's right to breastfeed at work. The piecemeal regulations which exists and will be discussed below.

3.2.3.1 Kenyan Constitution 2010

Reproductive rights are deemed as invaluable 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.[198] Reproductive rights are further reinforced by Article 27 of the Constitution, which prohibits the state against directly and

[197] Employment and Labour Relations Court at Mombasa Cause No. 619 of 2015, (2017) eklr
[198] Constitution of Kenya 2010 Article 43 (1) (a).

indirectly discriminating against pregnant women. However, the Constitution fails to provide further protection to women who are breastfeeding.

3.2.3.2 Health Act 2017

Section 1 of the Health Act[199] 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 should not be located in restrooms. Employers have a further responsibility to ensure that no form of promotion and marketing of infant formula and BMS is done within the lactation station.[200]

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.[201]

The companies with breastfeeding stations include Safaricom, Kenya Women Microfinance Bank, Nestle, Mabati Rolling Mills, International Medical Corps and Kenya Red Cross, World Vision, ICRAF, EKA Hotels, Seven Seas Technologies, Isuzu East Africa, Davis & Shirtliff among others.[202] Though the list is not conclusive, the majority of the organizations listed above are multinationals or large enterprises.

Ironically, the National Assembly drafted and approved the Health Act yet there exist no breastfeeding rooms within the parliamentary buildings. This is despite the Members of Parliament in 2013 passing a motion directing the Parliamentary Service Commission to create a breastfeeding station within parliament. In August 2019, the Kwale Women's Representative, Zuleika Hassan was forced attend a

[199] No 21 of 2017.
[200] Health Act no 21 of 2017 Section 71.
[201] Health Act no 21 of 2017 Section 72.
[202] 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).

national assembly session with her five month old baby due to the fact that no breastfeeding station existed.[203]

The provisions relating to breastfeeding stations are however, 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 predominately caters for white 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 as 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 which rely on casual labourers since the employers have an obligation to 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 and Mombasa 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 the nursing breaks, and therefore, a nursing mother would also find it difficult to travel back and forth.

[203] 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).

Women in the horticultural sector have expressed concern over the implementation of the provision above. Nursing mothers in flower farms admit that even though they are given nursing breaks, there are no creches available. This, therefore, 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.[204] Ideally, this provision would work for a nursing mother who lived near her workplace or had access to private means of transport.

The provision as mentioned above, would have been more practical if the Act had provided for creches at workplaces. However, some of the challenges earlier on discussed 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 predominately cater to the upper class, highly educated nursing mother who is not a representative of the majority of women in Kenya.

3.2.3.3 Employment Act, Chapter 226

According to the Employment Act, 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.[205]

To begin with, this provision falls short of WHO standards which advocate for infants to be exclusively breastfed for six months. Consequently, this leads to a clash between working mothers reproductive and productive roles in society.[206] Even though the Employment Act makes provisions for unpaid maternity leave, this is not a viable option for single mothers or women from low-income households.

Non-compliance in implementation of this provision is often noted. A study conducted by the Kenya Human Rights Commission in the horticultural industry noted non-compliance. The study indicated instances of unpaid maternity leave in Aquila and Sunbird Farms. On top of this, irregularities in the implementation of the provisions were noted with Fairtrade certified companies where pregnant

[204] 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).
[205] Employment Act, Chapter 226 Section 29.
[206] WHO, "Exclusive breastfeeding for six months best for babies everywhere." <https://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/> (accessed 22 March 2019).

women were forced to proceed on their annual leave and maternity leave at least two months before their expected date of delivery. This would, therefore, limit the post delivery break to less than two months.[207]

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. [208] Majority of the domestic workers are dismissed when their employers discover they are pregnant.[209] Domestic workers are entitled to paid maternity leave; however, due to the informal nature of their work contract, they are often fearful of 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 source 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 aforementioned class of women are aware of their rights and have resources to enable them to legally pursue their cases in Labour courts.

3.2.3.4 National policy on Maternal, Infant and Young Child Nutrition

National policy on maternal, infant and young child nutrition (the National Policy) was adopted on 1 August 2012.[210] The National Policy primary objective is to advocate for breastfeeding; however, it has provisions which restrict the use and promotion of BMS.

The National Policy calls for all pregnant and lactating women, pregnant women and their partners are made aware of the benefits and management of breastfeeding. [211]The National Policy recognises the essential role partners play in promoting and enabling breastfeeding. Hence includes partners as part of the target audience.

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[207] 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).

[208] 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).

[209] *Ibid*.

[210] Ministry of Public Health and Sanitation, "National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).

[211] Paragraph 3, " National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).

In addition to this, the National Policy supports the initiation of breastfeeding within the first hour of birth. [212]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 caesarean 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 [213] Similarly, according to the National Policy mothers are to be shown how to breastfeed and maintain lactation even if they are not in constant conduct with their infants.[214] 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.

However, Paragraph 15 of the National Policy prohibits the use of artificial teats or use of bottles 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, paragraph 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.[215] 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.[216]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 labour laws only provides three months of paid maternity leave[217]. Consequently, mothers who come from lower-income backgrounds or are not highly educated bear the brunt of these conflicting policies.

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[212] Paragraph 4, " National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[213] Paragraph 5, " National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[214] Paragraph 6, " National Policy on Maternal, Infant and Young Child Nutrition" (August 2012).
[215] Paragraph 3, "National Policy on Maternal, Infant and Young Child Nutrition." (August 2012).
[216] 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).
[217] Employment Act, Chapter 226 Section 29.

Paragraph 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.

One of the biggest challenges to the promotion of breastfeeding in Kenya has been the HIV pandemic. The risk of mother to child transmission of HIV through breastfeeding was hindered a significant number of HIV infected mothers from breastfeeding.[218] 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 the it fails to actually promote breastfeeding and instead regulates BMS. As was discussed in Chapter 2, the international and regional legal framework focus 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 this provisions by the employers who include the National Assembly is an obstacle in promoting breastfeeding. Furthermore, the provisions cater to mostly women who are employed in white collar jobs, educated and have access to adequate financial resources.

Chapter 4 will therefore highlight secondary support systems established outside the Kenya jurisdiction which promote breastfeeding. The support systems discussed are inclusive and attempt to cater to a diverse group of women.

[218] 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).

CHAPTER 4
COMPARING THE SECONDARY SUPPORT SYSTEMS IN KENYA AND FOREIGN JURISDICTION

Since we have discussed the various shortcomings of predominately focusing on the Code and the BMS Act as the primary tools of promoting breastfeeding; this chapter will investigate the need for a secondary support system. Chapter 4 will, therefore, highlight various secondary support systems established in other jurisdictions to promote breastfeeding. This chapter will also highlight specific countries which have excelled in implementing these measures.

4.1 Parental Leave System

One of the biggest challenges to breastfeeding is a mother's work obligations. A study conducted in 38 low income and middle come income countries indicated that a month increase in the statutory duration of paid maternity resulted in a 7.4 % increase in the prevalence of early initiation of breastfeeding; a 5.9% increase in the prevalence of exclusive breastfeeding and a 2.2-month increase in breastfeeding duration.[219]

Majority of countries have some form of legal framework safeguarding maternity protection. However, only 42 countries[220] have put in place legal measures which surpass the minimum recommendation of ILO for 18 weeks of paid maternity leave.[221] As was discussed in Chapter 3, the Kenyan Employment Act provides pregnant women with only three months paid maternity leave.[222]

In Sweden, parental leave, which can be shared between the mother and father, is for 18 months. The parent is entitled to 90% of their salary, which is paid by the national health system for 15 months.[223] The Norwegian government provides 42 weeks full pay and in the alternative 52 weeks at 80% pay.[224] In the Czech Republic, mothers are entitled to maternity leave of 28 weeks and 69% of the mother's salary. In a situation where the mother has other children or is a single mother, the maternity leave is extended to 37 weeks. Moreover, for three years after birth, the employer must guarantee employment in the same organisation at the same salary level.[225]

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[219] Y.Chai, A. Nandi, and J. Heymann, "Does extending the duration of legislated paid maternity leave improve breastfeeding practices? Evidence from 38 low-income and middle-income countries," (BMJ Global Health, 2018). 3

[220] WHO "Breastfeeding in the 21Century" <https://www.who.int/pmnch/media/news/2016/breastfeeding_brief.pdf> (accessed 29 May 2019) 3.

[221] Article 4 (1) Convention concerning the revision of the Maternity Protection Convention (Revised), 1952 (Entry into force: 7 February 2002).

[222] See Chapter 3.2.3.3

[223] UNICEF, "Breastfeeding: Foundation for a Healthy Future"
< https://www.unicef.org/publications/files/pub_brochure_en.pdf> (accessed 8 May 2019) 9.

[224] *Ibid*.

[225] *Ibid*.

4.2 Breastfeeding at the Work Place

As was discussed in Chapter 3, breastfeeding continues beyond maternity leave. Consequently, there needs be laws and policies which enable women to continue breastfeeding after resuming work duty. This section identifies measures set up to enable women to continue breastfeeding and work outside the home simultaneously.

4.2.1 Nursing Breaks and Reduction of Working Hours

WHO recommends that a child is breastfed for up to two years. As earlier discussed the majority of countries provide for up to 18 weeks maternity leave. Therefore it is necessary to put in place measures which allow working mothers to continue breastfeeding or express breastmilk even after resuming work duty

Convention concerning the revision of the Maternity Protection Convention [226] provides that a woman shall be entitled to one or more nursing breaks or a daily reduction of hours of work to enable her to breastfeed her child. The breaks and reduced working hours shall be perceived as working time, and therefore, she shall be compensated.[227]The Kenyan Health Act does make provisions for nursing breaks although compliance by employers is an obstacle.[228]

Studies have indicated that paid nursing breaks for at least six months resulted in an 8.9 per cent increase in exclusive breastfeeding. Moreover, a study conducted in the USA indicated that nursing breaks and lactation rooms resulted in a 25 per cent increase in breastfeeding.[229] Consequently, there is a need to create a conducive work environment which accommodates breastfeeding.

4.2.1.1 Nursing Breaks in Belgium

In Belgium, the government has put in place legal measures which safeguard women productive and reproductive role. CBA NO 80 of 27 November 2001[230] introduced the right to nursing breaks. Nursing mothers are entitled to up to nine months post-delivery nursing breaks at work. If an employee works for a duration shorter than 7.5 hours, she is entitled to a thirty-minute nursing break. In the

[226](Revised), 1952 (Entry into force: 7 February 2002).
[227] Article 10 Convention concerning the revision of the Maternity Protection Convention.
[228] See Chapter 3.2.3.2.
[229] WHO, "Breastfeeding in the 21Century" <https://www.who.int/pmnch/media/news/2016/breastfeeding_brief.pdf> (accessed 29 May 2019) 3.
[230] Inter-industry-wide C.B.A. of 27 November 2001 that was generally rendered binding by Royal Decree of 21 January 2002 (Official Gazette, 12 February 2002).

event, an employee works for more than 7.5 hours they are entitled to two thirty minutes nursing breaks; which can be taken consecutively or at different times.[231] Each month the nursing employee is expected to provide a statement from a medical center for infants or a medical certificate as evidence that she is breastfeeding.[232]

In Belgian, the burden of paying the employee during the breastfeeding breaks is shifted from the employer to the government. Public Health system is responsible for paying allowances to the employees during their nursing breaks.[233] Therefore the government does play a pivotal role in supporting breastfeeding through the social insurance and public funds system.

The breastfeeding employee receives additional legal protection in that an employee is protected from dismissal. The employer is restricted from dismissing the breastfeeding employee until at least one month after the expiration of the last medical certificate or statement from the medical center. However, she may be dismissed for reasons not related to breastfeeding. In such a case, the burden of proof is placed on the employer to demonstrate that the dismissal is not related to breastfeeding. In the event, the employer is found guilty of contravening this provision they are liable to pay the employee a protection indemnity of six months in addition to severance pay.[234]

In addition to the maternity leave, employees are also eligible to parental leave up to when the child turns 12 years old. There exist different forms of parental leaves. An employee may opt for full parental leave, which entails a full suspension of the employment contract for four months. Another option available to employees is a reduction of working hours to half time for eight months. The third option is the reduction of working hours by a fifth for twenty months. The Belgian Unemployment office remits allowances to the employees who choose to opt for the additional parental leave.[235]

Once more, the employee receives additional protection in that the employer is banned from dismissing the employee as from the date of the request for the parental leave until three months after the end of the leave. Dismissal can only be on legitimate grounds such as grave misconduct.[236] Other protective

[231] J.Aubertin, *The Littler Mendelson Guide to International Employment and Labour Law,* (Littler Mendelson 5th edition, 2017). 54
[232] *Ibid*.
[233] *Ibid*.
[234] *Ibid*.
[235] *Ibid*.
[236] *Ibid*.

measures include restrictions limiting pregnant and breastfeeding women from working overtime save for women in a position of confidence or management.[237]

4.2.1.2 Nursing Breaks in Guatemala

In Guatemala, the Constitution recognises that a working mother is entitled to at least two sessions of special rest during the workday. This rest period can be extended to accommodate a woman's physical condition, but it must be subject to a medical prescription.[238] A nursing mother in Guatemala may opt to combine her two nursing breaks of thirty minutes each and either report to work hour later or leave work one hour earlier. The nursing period is for ten months, starting from the time the mother reports back to work after her maternity leave.[239]

4.2.2 Childcare Facilities

One of the biggest challenges of lactation stations and nursing breaks as earlier discussed in Chapter 3 is the inability of mothers to access the infants during such breaks easily. Child care facilities at the workplace or near the workplace is a feasible solution. In Kenya very few employers provide child day care facilities. As discussed in Chapter 3.2.3.2 the inability of women to access their children during nursing breaks is an obstacle to breastfeeding.

4.2.2.1 Mobile Creches in India

Mobile Creche is an Indian NGO established in 1969. The NGO predominately focuses on the advocacy of the rights of marginalised children. [240] Mobile Creche offers daycare for children of migrant workers living on construction sites. The children's age group usually range from newborn infants to 14-year-olds. The NGO has been able to assist over 100,000 children in 270 construction sites[241]

The Mobile crèche employees identify construction sites which may have at least twenty-five children living in them. The Mobile Creche staff then hold discussions with the construction company's management and obtain consent to establish a creche at the construction site. The creches offer a variety of childcare services depending on the child's age and needs. Once the construction is complete, they move on to another site.[242]

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[237] Article 44 Belgian Labor Act of March 1971.
[238] Article 102 (k) Political Constitution of the Republic of Guatemala (as Amended by Legislative Decree no 18-93 of 17 November 1993).
[239] ILO, "Maternity Protection Resource Package: From Aspiration to Reality for all. Module 10: Breastfeeding arrangements at work," (ILO 2012) 11.
[240] Mobile Creche <https://www.mobilecreches.org/our-story> accessed 3 June 2019.
[241] Mumbai Mobile Creche <http://mumbaimobilecreches.org/our-model/> (accessed 3 June 2019).
[242] Mumbai Mobile Creche <http://mumbaimobilecreches.org/our-model/> (accessed 3 June 2019).

The creches play a vital role in the community as they allow nursing mothers to access their children easily during their breaks. The construction workers typically comprise of migratory labourers who were it not for the non-profit nature of the mobile creches established would not have the resources to engage commercial creches.

4.3 Milk Banks

The WHO estimates that approximately over 20 million infants weigh less than 2.5 kg at birth. Over 96% of these births are in developing countries. Children with low birth weight are more prone to suffer from early growth retardation, infectious disease, developmental delay and death during infancy and childhood.[243]

A study conducted by WHO has indicated that feeding infants who have low birth weight human milk has more positive short term and long term effects than when the infant is fed on infant formula.[244] In addition to this, it is more cost effective to feed the infant human milk as compared to formula. The WHO recommends that infants with low birth weight, which includes children with low birth weight who cannot be fed with their own mothers' milk be fed using human donor milk.[245]

4.3.1 Milk Banks in Brazil

Brazil has made substantial progress in eliminating child mortality. The country experienced a drop of the infant mortality rate from 61 in 1990 to 16 in 2015 hence meeting the MDG no 4.[246] Brazil's success has been attributed to its public health policy, which encourages breastfeeding as the primary solution to reducing infant mortality. The first milk bank in Brazil was opened in 1943, and later in 1998, the Brazilian Network of Human Milk was established.[247]

Brazil hosts the highest number of human milk banks in the world. Out of the 301 human milk banks in the region, 218 are in Brazil.[248] As compared to Kenya which only hosts one milk, located in Pumwani. In Brazil hospital and clinics administer human milk banks. Potential donors are expected

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[243] WHO, "Donor Human Milk for Low Birth Weight Infants" (WHO 2019) <https://www.who.int/elena/titles/donormilk_infants/en/> (accessed 4 June 2019) 9.
[244] *Ibid*.
[245] *Ibid*.
[246] UN Interagency Group for Child Mortality Estimation, " Levels & Trends in Child Mortality. Report 2015" (UNICEF 2015) <https://www.unicef.org/publications/files/Child_Mortality_Report_2015_Web_9_Sept_15.pdf> (accessed 4 June 2019).
[247] Economic Commission for Latin America and Caribbean, "Human Milk Banks," (ECLAC 2018) < https://www.cepal.org/en/notes/human-milk-banks> (accessed 4 June 2019).
[248] *Ibid*.

to undergo a medical examination to ensure they are in good health. The donated milk is usually pasteurised and refrigerated and dispensed according to infants need.

4.4 Friendly Breastfeeding Public spaces

Exclusive breastfeeding requires a mother to be able to breastfeed on demand. Women exist outside the realm of office and home, and therefore, there should be safe spaces where women can breastfeed. Cultural, legal, social and religious factors influence a mother's decision to breastfeed in public. A negative attitude towards breastfeeding in public has often resulted in the decline of breastfeeding rates.[249]

In some cultures, breasts are perceived as sexual organs and as a result, breastfeeding in public spaces has often been seen as controversial. By treating public breastfeeding as a controversial issue, it may convey the message that breastfeeding is undesirable, unnatural or even illegal.

4.4.1 Breastfeeding Zones in Japan

In Japan, breastfeeding in public spaces is met with a positive attitude. The Japanese government recognises that breastfeeding mothers often spend a significant portion of their day outside the home or office. Therefore, to accommodate mothers need to nurse, the government has created safe spaces where women can comfortably breastfeed. Free nursing rooms can often be found in trains, shops, airports and official buildings.[250] The rooms are spacious and can even accommodate strollers, sinks with hot water. In some cases, the rooms may also have a play area to accommodate older children.[251] Apps such as Milpas enable parents to be able to locate the nearest nursing station.

In Kenya, there exists very few safe and comfortable places outside a woman's home or work place where she can breastfeed or express breast milk. However, the proposed Kenyan Health Bill has provisions that will enable women to access safe breastfeeding zones. This will be discussed in greater detail in Chapter 5.8.1.2.

4.5 Anti-discrimination laws in Australia

The Kenyan legal framework does not have any specific provisions which safeguard the right to breastfeed. As discussed in Chapter 3.2.3, there exists piecemeal provisions in various statutes which

[249] E. Komodiki and four others, "Breastfeeding in Public: A Global Review of Different Attitudes Towards It," (Journal of Pediatric & Neonatal Care 2014) Volume 1 Issue 6.
[250] J. Phelan, "These are the best places to be a breastfeeding mother," (Global Post 2015) <https://www.pri.org/stories/2015-08-06/these-are-best-places-be-breastfeeding-mother> (accessed 7 June 2019).
[251] *Ibid*.

compel employers to provide female employees with nursing rooms and breaks. However, there are no laws safeguarding breastfeeding women from discrimination.

In Australia, the legislation exists to safeguards women's rights to breastfeed in public. Australia has enacted laws such as the Discrimination Act 1991, the National Anti-discrimination Legislation 2010, Sex Discrimination Act 1984. The Sex Discrimination Act of 1984 has been especially instrumental in safeguarding women rights to breastfeed in public spaces.

In 2011, the Sex Discrimination Act was amended to the Sex and Age Discrimination Legislation Amendment Act.[252] The amended Act includes breastfeeding as a separate ground for discrimination. This means that the law not only protects women when they are pregnant but also during the post pregnancy period of breastfeeding. The Act also defines breastfeeding as including expressing.[253]

The Act forbids any person from imposing any condition, requirement and practice that is likely to have an adverse effect on a breastfeeding woman.[254] Moreover, the law also forbids any person from treating breastfeeding women less favourably as they would have treated someone who is not breastfeeding.[255]

The secondary support systems discussed above have been crucial in promoting breastfeeding. By putting up such measures these countries are acknowledging that there are factors beside BMS which inhibit breastfeeding. The government and in some cases NGOs in the countries discussed above have recognized that breastfeeding is not a lifestyle choice confined to the private realm but rather a public health issue. Hence the need for the government, NGOs and employers to set up laws, regulations and policies which enable women to easily access their infants. The measures put in place allow women to exercise both their reproductive and productive role.

Consequently, having reviewed the best practices in other jurisdictions, Chapter 5 will recommend measures that can be put in place to promote breastfeeding. The measures will take into account Kenya's political, economic, social and cultural set up.

[252] No. 40, 2011.
[253] Article 7 A (3) Sex and Age Discrimination Legislation Amendment Act.
[254] Article 7 A (2) Sex and Age Discrimination Legislation Amendment Act.
[255] Article 7 A (1) Sex and Age Discrimination Legislation Amendment Act.

CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS ON LEGAL MEASURES THAT PROMOTE BREASTFEEDING IN KENYA

5.1 Introduction to the Summary of Findings, Conclusion and Recommendations

This chapter will give a brief overview of the findings discussed in the thesis as they relate to the research problem, research objectives, research questions and hypotheses. Based on the findings, Chapter 5 will provide a conclusion to the thesis. Finally this chapter will outline various recommendations which can be set up to promote breastfeeding in Kenya.

5.2 Research problem on the Legal Measures that Promote Breastfeeding in Kenya

The research problem sought to identify whether the BMS Act actually promotes breastfeeding. Furthermore, the research problem focused on the need to recognize breastfeeding as a reproductive right. The findings of the thesis are that the BMS Act does not promote breastfeeding but instead focuses on regulation of marketing and distribution of BMS. In addition to this, breastfeeding is not recognized by international, regional or Kenyan Law as a reproductive right. Legal measures in place focus primarily on reproductive rights such as pregnancy hence offers minimal protection to breastfeeding women.

5.3 Research Objectives on the Legal Measures that Promote Breastfeeding in Kenya

The thesis main objective was to critically examine the BMS Act and how the Act promotes breastfeeding. The research has identified that overall, the BMS Act does very little to promote breastfeeding. Moreover, various provisions in the Act are impractical to the Kenyan set up and instead frustrate breastfeeding women.[256]

The Second objective was to assess ways in which absence of a secondary support system has been detrimental to mothers and children. The findings indicate that without a secondary support system Kenyan women have been forced to make personal sacrifices to accommodate breastfeeding. This has been especially been explored in great detail in regards to women's reproductive versus productive role. [257]

[256] See Chapter 3.1.3
[257] See Chapter 2.3

The third objective was to discuss breastfeeding as a reproductive right. The research has outlined several arguments from various authors who have argued for the inclusion of breastfeeding as a reproductive right.[258] Arguments for the recognition of breastfeeding as a reproductive right have also been supported by various facets of Liberal Feminism.[259]

5.4 Research Questions on the Legal Measures that Promote Breastfeeding in Kenya

The thesis has successfully answered the three research questions posed in Chapter 1. The thesis has discussed the various provisions in the BMs Act which regulate the distribution and promotion of BMS. Secondly, it has also evaluated the reasons and ways in which the BMS Act fails to promote breastfeeding. Lastly, Chapter 5 has highlighted practical secondary measures that can be set up in Kenya to promote breastfeeding.

5.5 Hypotheses on the Legal Measures that Promote Breastfeeding in Kenya

The thesis identified three hypotheses which have been extensively examined. The first hypotheses hypothesized that the BMS Act does not promote breastfeeding in Kenya. Chapter 3.2 has examined the BMS Act in its entirety and has concluded that the BMS Act provisions do not substantially promote breastfeeding.

The second Hypotheses postulates that there is a need to set up a secondary support system in Kenya to promote breastfeeding. The thesis has identified that BMS are not the greatest threat to breastfeeding and that other social, economic and cultural factors, in particular women's productive role, hinder breastfeeding. The thesis has found that without a practical secondary system there exists a conflict between Kenyan women's productive role and reproductive role. However, a secondary support system enables women's to fulfil both their reproductive and productive role simultaneously.[260]

The third hypotheses suggests that breastfeeding should be safeguarded as reproductive right. The thesis has proved that breastfeeding is a reproductive right and should receive legal protection internationally and in Kenya.[261]

[258] See Chapter 2.1.
[259] See Chapter 1.8.
[260] See chapter 4.
[261] See Chapter 2.1.

5.6 Summary of Findings on the Legal Measures that Promote Breastfeeding in Kenya

There is no doubt that breastfeeding is the best nutritional option for infants and is vital for children's development and growth. The research carried out in this paper has established that BMS and related products are not the biggest threat to breastfeeding in Kenya. A significant proportion of the Kenyan population live below the poverty line and commercial BMS products are a luxury they simply cannot afford. Majority of low income homes relay on indigenous BMS such as cow's milk, juices and porridge which are not regulated. Yet the BMS Act primarily focuses on the regulation of marketing and promotion of commercial BMS.

The Code and BMS Act primarily focus on regulating the marketing and promotion of BMS and ignore other key factors which affect the initiation and continuation of breastfeeding. The greatest challenge to breastfeeding is the inability of mothers to access infants due to work obligation. Furthermore, the Code and BMS Act provisions are centered on breastfeeding advocacy such as education and information campaigns and ignore addressing key challenges such as mothers competing work obligations.

While reproductive rights such as pregnancy are safeguarded in the international, regional and national legal framework; breastfeeding as human right receives next to no legal protection. Breastfeeding is perceived as a "lifestyle choice" to be dealt within the private sphere. By treating breastfeeding as a "lifestyle choice," the burden of facilitating breastfeeding falls squarely on individual women. Women are forced to devise ways in which breastfeeding is a workable option. In some instances, women are forced to make sacrifices in order to cater to their reproductive role.

Breastfeeding is a matter of public health policy and benefits society as a whole. Therefore, it should be viewed as a right which is legally safeguarded. Breastfeeding should be termed as a reproductive right as it is a natural biological process occurs as a result of pregnancy. Moreover it is a parental right as it enable women to offer their infants breastmilk which has the most nutritional value.

5.7 Conclusion on the Legal Measures that Promote Breastfeeding in Kenya

Breastfeeding is a natural process which 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 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. Breastfeeding is, therefore, not only a reproductive right issue but also a children 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 therefore, there is a need for policies and regulations which will promote breastfeeding.

The current 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 does play a role in undermining the promotion of breastfeeding.

Moreover, improper use of BMS can especially be harmful in third world 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. Further to this, due to the costly nature of BMS, over-dilution is also a risk. Contamination and over dilution puts 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 which push women to use BMS instead of breastfeeding. There needs to be an earnest discussion on promotion breastfeeding that does not center on the restriction of BMS. Creating restrictions which prevent mothers from accessing BMS while not creating a secondary support system which creates a conducive environment for breastfeeding is detrimental to women.

First and foremost, it denies mothers an easy and accessible alternative solution when it comes to feeding their infants. Secondly, it prevents legislators and policymakers from addressing other vital factors which inhibit breastfeeding. 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 obligation. 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 should also not be forced to make personal sacrifices or chose between these two roles.

The government 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 of the next generation and should, therefore, be perceived as building the Nation.

5.8 Recommendations on the Measures that can be set up in order to Promote Breastfeeding in Kenya

This Segment of the thesis will discuss various measures that measures that can be set up to promote breastfeeding. The recommendations will be take into consideration Kenya's economic, cultural and political makeup.

5.8.1 Legislation

This Section will highlight legal measures that can be put in place to promote breastfeeding.

5.8.1.1 Enforcement of Legislation

Chapter 3 discusses the conventions, and national laws which safeguard breastfeeding there is need to ensure that the laws are implemented. Currently, there still numerous organisations which are yet to comply with regulations requiring them to set up lactation stations or implement nursing breaks.[262]

The government needs to set up measures to ensure that there is an enforcement mechanism set up to ensure that these regulations are adhered to. The enforcement mechanism will no doubt need financial backing and is therefore critical that the government actually include such expenses in the national budgetary allocation.

5.8.1.2 The Breastfeeding Mother Bill

Currently, national legislation safeguarding the right to breastfeed is piecemeal. There is a need for comprehensive legislation safeguarding the right to breastfeed. The proposed Breastfeeding Mothers

[262] See Chapter 3.3.

Bill's objective is to outline employers obligation towards breastfeeding mothers in the workplace and baby changing facilities for use by the public. [263]

The Bill establishes the right to breastfeed and express milk at the workplace[264]. The Bill places an obligation on the employer to set up a lactation station and further outlines the minimum facilities that should be available in the lactation station[265]. In addition to this, the Bill proposes that the introduction of more prolonged breastfeeding breaks not exceeding forty minutes for every four hours. [266]The Health Act only provides for a nursing break, not exceeding one hour for every eight hour working period.[267] The Bill goes on further to provide longer breaks for babies who require a more extended period to breastfeed.[268]

The Bill proposes the introduction of flexible work arrangements which can be used by nursing mothers to alter the work hours, workload and work station in order to accommodate the mother's new responsibility of breastfeeding.[269]

Moreover, the Bill seeks to introduce baby changing facilities in public buildings which have the possibility of hosting more than 30 occupants. The Bill outlines the necessary facilities that should be present.[270] A person who contravenes the provisions outlined in the Bill risks incurring a fine not exceeding Ksh 500,000 or a prison sentence not exceeding one year or both.[271]

The Bill introduces provisions which offer greater protection to the right to breastfeeding both at work and public spaces. However, despite the introduction of the Bill to the Members of Parliament in 2017, the Bill has not been passed. The Bill should be treated as a matter of urgency and passed, and implementation should begin as soon as possible.

5.8.1.3 Recognition of Breastfeeding as a Reproductive Right

CEDAW and the Constitution should recognize breastfeeding as a reproductive right. Breastfeeding is a natural process and should be safeguarded to the same extent as other reproductive rights such as pregnancy.[272] Expressly providing for breastfeeding as a reproductive right offers greater protection to

[263] Kenya Gazette Supplement no 37 (National Assembly Bills No 13).
[264] Section 3 The Breastfeeding Mothers Bill 2017.
[265] Section 4 The Breastfeeding Mothers Bill 2017.
[266] Section 5 (3) The Breastfeeding Mothers Bill 2017.
[267] Health Act no 21 of 2017 Section 72.
[268] Section 5 (4) The Breastfeeding Mothers Bill 2017.
[269] Section 6 The Breastfeeding Mothers Bill 2017.
[270] Section 7 The Breastfeeding Mothers Bill 2017.
[271] Section 8 The Breastfeeding Mothers Bill 2017.
[272] See Chapter 2.1.

nursing mothers. The onus now falls on the State to protect the right and prevent women from enduring discrimination on this ground.

Expressly providing that acts of discrimination against breastfeeding women amount to an offence punishable by a fine or imprisonment is critical in promoting breastfeeding. This is because it shifts the burden from the individual woman filing a suit against the offender; to the State prosecuting the offender on behalf of the woman. This is particularly helpful as in most instances; the State has more resources to pursue justice than the woman who has been victimized.

5.8.2 A balance between Women's Reproductive and Productive Role

Recognition that women have a dual role in reproduction and productivity is critical. Both roles are vital to the growth of the Nation. As discussed in the previous chapters, the most significant impediment to breastfeeding is the competing work and family obligations.[273] The State has a critical role to play as it has an obligation to set up laws and policies which will ensure that women can fulfil their reproductive and productive roles. Employers also have a duty to promote and protect women's dual roles by setting up policies and creating a work culture which promotes both roles.

5.8.2.1 Maternity leave

The WHO recommends that women should exclusively breastfeed for six months. However, the current legislation in Kenya only provides for three months of paid maternity. The laws relating to maternity leave should be amended to increase paid maternity leave to a minimum of at least six months. One of the biggest challenges to revising maternity laws has been concerns raised by the majority of Kenyan employers. The Federation of Kenya Employers has in the past, rejected the proposal to double the current stipulated maternity period. They have argued such an extension will be detrimental to women's careers and job opportunities as most employers cannot afford to meet the cost of six months paid maternity leave.[274]

As discussed in previous chapters, breastfeeding reduces cases of infant mortality, which in turn allows Kenya to meet SDG no 3. Consequently, the government has a responsibility to promote breastfeeding. The government should enact laws to increase paid maternity leave to six months. However, to avoid

[273] See Chapter 2.3

[274] L. Igadwahi, "Employers reject Bill to double maternity leave." (Business Daily, 9 May 2017) <https://www.businessdailyafrica.com/news/Employers-reject-Bill-to-double-maternity-leave/539546-3920310-92aneo/index.html> (accessed 9 June 2019).

employers forming a bias against female employers, the government through the public health insurance system should cater for the partial cost of the paid maternity leave.

Moreover, as discussed in previous chapters,[275] there are numerous benefits to longer maternity leave. Consequently, there needs to a shift in employers attitude towards maternity leave. Maternity leave should not be seen as time away from work but rather as a woman exercising her reproductive role and nurturing the future generation.

Despite the current State of maternity leave legislation, there are some companies such as EABL which are set to introduce paid maternity leave to a period of six months. [276]Nestle Kenya has also provided female employees with up to six months, paid maternity leave.[277]Microsoft Kenya has also increased maternity leave to five months.[278]These changes have been instigated by a global shift in how breastfeeding is perceived.

The aforementioned companies have revised their maternity policies to mirror the policies set up by their parent companies abroad. This is of particular significance as it illustrates the significant role private actors can play in promoting breastfeeding even in cases where the State is unwilling or unable to act.

5.8.2.2 Flexible Working Arrangements

Introduction of six months of flexible working arrangements for breastfeeding mothers in addition to the paid maternity leave can play a vital role in promoting breastfeeding. Flexible work arrangements include part-time duty, job sharing, working from home and compressed work week.

One of the challenges impeding breastfeeding is that working mothers frequently experience fatigue after resuming work duty and as a result, are too tired to breastfeed when they get home. Flexible working arrangements for breastfeeding mothers allows the mother to gradually adjust to the work environment without overexerting themselves physically, which can be detrimental to breastfeeding.

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[275] See Chapter 2.3

[276]P Alushula, "EABL new mums to get 6-month maternity leave." (Business Daily 28 May 2019) <https://www.businessdailyafrica.com/corporate/companies/EABL-new-mums-to-get-6month-maternity/4003102-5134670-wotrdn/index.html> (Accessed11 June 2019).

[277]Nestle, "Maternity Protection Policy." (Nestle 2015) <https://www.nestle.com/asset-library/documents/library/documents/people/nestle-policy-maternity-protection.pdf> (accessed 11 June 2019).

[278] F Obura, "Microsoft enhances paternity leave to six-week." (Standard Digital 22 November 2017) <https://www.standardmedia.co.ke/article/2001259136/microsoft-kenya-office-now-offers-five-month-paid-maternity-leave) (accessed 11 June 2019).

Furthermore, it allows nursing mothers to have greater access to their infants and hence, more opportunities to breastfeed.

Once again, despite the absence of legislation specifically catering for flexible working arrangements, there are companies which have unprompted by the law introduced these measures. Safaricom has reduced working hours from 40 hours to 30 hours for the first six months post maternity leave period for its female employees.[279] Nestle employees are entitled to flexible work arrangements such as job sharing and part-time employment.[280] Both Mabati Rolling Mills and Kenya Women Micro Finance Bank have introduced flexible working hours whereby mothers are allowed to report to work later and check out of work earlier.[281]

5.8.3 Human Milk Banks

Human milk banks not only offer a more nutritious alternative to infant formula but are also affordable. In Kenya, there is currently only one human milk bank located in Pumwani. Although this is progress, there needs to be an increase in the number of human milk banks across the country. The government needs to make sufficient budgetary allocations to enable the construction of human milk banks in all government hospitals.

A significant portion of the resources should be dedicated to the construction of the facilities, which include testing and pasteurization centers. Capacity building is also crucial in ensuring that personnel are adequately trained in testing and processing the breastmilk. There is also a need to train donors on appropriate steps to take during collection and storage in order to avoid contamination. Further to this, donation centers should provide adequate breastmilk pumps to enable mothers to express the breastmilk.

In addition to this, the government needs to create awareness of the vital role human milk banks serve. The African Population and Health Research Centre conducted a study in Nairobi in 2016, in which 91% of the participants had no objection to mothers donating milk, but only 51 % would allow their

[279] L. Igadwahi "Employers reject Bill to double maternity leave," (Business Daily, 9 May 2017) <https://www.businessdailyafrica.com/news/Employers-reject-Bill-to-double-maternity-leave/539546-3920310-92aneo/index.html> (accessed 9 June 2019).
[280] Nestle, "Maternity Protection Policy" (Nestle 2015) <https://www.nestle.com/asset-library/documents/library/documents/people/nestle-policy-maternity-protection.pdf> (accessed 11 June 2019).
[281] KEPSA, "Better Business Practices for Children: Documentation of Best Practices 22 February 2017" <https://kepsa.or.ke/better-business-practices-for-children-documentation-of-best-practices-22nd-feb-2017/> (accessed 11 June 2019).

child to be fed on donated milk. [282]The study indicated that one of the major concerns among the participants of the study was the risk of transmission of diseases.[283] There is, therefore a need for the government to undertake an awareness campaign educating people on the critical role the human milk banks serve. In addition to this, the government needs to reassure the people that after the milk has undergone testing and pasteurization, it is safe for consumption.

5.8.4 Health Systems and Services in Kenya

This Section will look into the health structures in Kenya and possible ways of improving the system in order to promote breastfeeding.

5.8.4.1 Lactation Consultants

Some mothers who attempt to breastfeed experience difficulty. As discussed earlier in Chapter 3, health workers such as doctors are usually not equipped with sufficient knowledge to deal with difficulties relating to lactation.[284] Lactation consultants are health workers who are specially trained to deal with issues relating to breastfeeding.

Lactation consultants play a vital role during breastfeeding since the information the consultant provides can influence a mother's feeding choice. Furthermore, lactation consultants are also trained to provide clinical management of complex problems which arise during breastfeeding and provide positive reinforcement.[285]

Results related to studies investigating the effect of lactation consolation on the duration of lactation vary. However, the majority of the studies support the conclusion that mothers who interacted with lactation consultants were more likely to breastfeed for longer durations.[286]

In Kenya, the cost of lactation consultants in most cases is not covered by private health insurance and the national health system. Consequently, this cost is directly incurred by the breastfeeding woman. This, in turn, limits the number of women who can engage in such services. The cost of lactation consultants should be met by the national health system to enable a vast number of breastfeeding mothers to have access to lactation consultants. Moreover, the government needs to station lactation

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[282] African Population and Health Research Centre, "Integrating Human Milk Banking with Breastfeeding Promotion and Newborn Care: is Kenya Ready?" <http://aphrc.org/wp-content/uploads/2017/07/Human-Milk-Bank-Project-Briefing-Paper-APHRC.pdf> (accessed 17 June 2019).
[283] *Ibid*.
[284] See Chapter 3.1.3.5.
[285] J. Leiter, J. Nagele and L.Wallkey, "The Effect of Lactation Consultation on the Duration of Breastfeeding in New Mothers: A Systematic Review, " (Honors Research Projects 2018) <https://pdfs.semanticscholar.org/8e51/9ef81e425cb40f285d71afd5bc6f8b9966e5.pdf> (accessed 4 June 2019) 4.
[286] *Ibid* 17.

consultations in government hospitals and clinics. Therefore, women do not have to travel great distances to access this service.

5.8.4.2 Review of the Medic Curriculum

It is essential to recognize that healthcare providers play a vital role in influencing mothers to initiate, continue and manage challenges linked to breastfeeding. However, the medic curriculum more often than not does not provide in-depth training related to the physiology of breastfeeding. This has resulted in a gap in knowledge and skills which would have been critical in helping doctors offer the much needed medical intervention and support relating to breastfeeding. It is therefore crucial that the medic curriculum is altered to include in comprehensive training relating to lactation management. This will enable doctors to be better trained to support women through the journey of breastfeeding.

5.8.5 Family and Community Intervention

As the saying goes, “it takes a village to raise a child”. Breastfeeding not only benefits the mother and the child but is also beneficial to the whole family and community. Breastfeeding mothers require consistent support from their family and community at large. Female family members such as mothers, grandmothers, aunties are often in a position to advise and assist mothers who are breastfeeding.

Fathers can also contribute by supporting mothers in fulfilling household duties such as cooking, cleaning and taking care of older children. This alleviates the mother's burden at home and gives her the time and energy to breastfeed. The emotional support offered by the mother’s family more often than not culminates to the mother having an overall positive breastfeeding experience.

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