African Population and
Health Research Center
Transforming lives in Africa through research.

AUGUST 2025

Liquid Gold
Breastfeeding Saves Lives

Facts on Breastfeeding in Kenya

World Breastfeeding Week 2025

QUICK FACTS ON BREASTFEEDING IN KENYA

1.5 MILLION BABIES

Approximately 1.5 million babies are born in Kenya every year

60%

Only 60 % of those are exclusively breastfed for the first 6 months of life

65%

Of children aged 12–23 months are still breastfeeding

SUMMARY

This work presents a collection of stories illustrating both the challenges and progress in promoting and supporting breastfeeding in Kenya. The key messages include:

Working women, both in formal and informal sectors, face practical and systemic barriers to breastfeeding–such as inadequate maternity leave, unsupportive workplaces, and fear of job loss.

African Population and Health Research Center (APHRC) is tackling structural and economic barriers to breastfeeding in Kenya through research, advocacy, and community-based interventions.

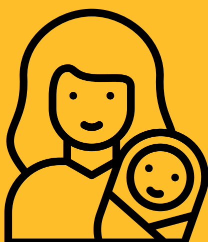
Is Kenya ready for human milk banks?

Kenya's breastfeeding journey is a story of progress but sustaining success will require continued investment, workplace transformation, and firm implementation of the legal frameworks already in place.

BENEFITS OF BREASTFEEDING

For children

- Boosts brain development
- Reduces child mortality
- Enhances immunity and reduces infections
- Protects against obesity and metabolic diseases
- Protects against premature deaths later in life



For mothers

- Lowers the risk of breast and ovarian cancer
- Reduces maternal stress
- Promotes faster loss of excess weight
- Protects against conception
- Saves money on infant food and healthcare

Society

- Contributes to better educational outcomes
- Promotes productivity and economic growth.
- Environmental sustainability and climate resilience

INTERVENTIONS TO PROMOTE BREASTFEEDING

Individual level: nutrition counseling, peer support, and home visits

Health facility level: human milk banking, early initiation of breastfeeding, training health workers in lactation support and Infant and Young Child Feeding, nutrition counselling of mothers

Community level: public campaigns

Structural/policy: workplace support for breastfeeding, maternity leave laws, enforcement of the code of marketing of breast-milk substitutes

FOREWORD

Across the world, child mortality remains a major development challenge. Although the global under-five mortality rate fell from 12.6 million deaths in 1990 to 4.9 million deaths in 2022, this average reduction conceals stark disparities across regions, countries and sub-regions within countries. According to the United Nations Inter-Agency Group for Child Mortality Estimation, sub-Saharan Africa remains the region with the highest under-five mortality rate in the world, with the risk of death before the fifth birthday being 15 times higher than in high-income countries. In a 2019 report, the UN Agency highlights that infants accounted for about 75% of under-five deaths in 2018, with mortality risk being highest during the neonatal period. In Kenya, the Kenya National Bureau of Statistics reports that the under-five mortality rate stood at 41 deaths per 1,000 live births, while the infant mortality rate was 32 deaths per 1000 live births in 2022 (Kenya Demographic and Health Survey). The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) have recommended exclusive breastfeeding (EBF), among other actions to reduce child mortality.

Globally, breastfeeding rates have increased significantly. In 2023, the global breastfeeding rate was 48%, close to the World Assembly 2025 target of 50%, according to UNICEF. In Africa, exclusive breastfeeding rates were at 45% in 2021, with 67% of women continuing to breastfeed their children up to one year, based on World Health Organization data. These encouraging figures at the global and regional level are attributed to breastfeeding support offered to mothers through policies, regulations, programs, and strategies that create an enabling environment for breastfeeding. However, more efforts must be put in place to ensure more women are breastfeeding.

Over the past decade, the African Population and Health Research Center (APHRC) has contributed significantly to building the evidence base around breastfeeding in Kenya—from urban informal settlements to rural villages, and from community-led interventions to workplace policy innovations. This booklet is a reflection on that journey. It brings together blogs, publications, and lessons from the past ten years, showcasing both what has been achieved and what remains undone.

Kenya's progress is notable. Exclusive breastfeeding rates have increased significantly over the years, rising from 32% in 2008 to 61% in 2014, however, they have stagnated at 60% in 2022, according to the Kenya Demographic and Health Survey. This increase can be attributed to the implementation of policies and strategies such as the Breast Milk Substitutes Act of 2012 which regulates the marketing and promotion of products that interfere with breastfeeding, the Health Act 2017, which requires the establishment of lactation spaces for women in the workplace, including guidance on the minimum standards of lactation spaces. Implementing the Baby Friendly Hospital Initiative (BFHI) aims to create a conducive environment within maternity facilities that protects, promotes, and supports exclusive breastfeeding. Other policies include the implementation of the Baby Friendly Community Initiative (BFCI), which extends follow-up and care of the mother and child to the community to ensure mothers receive

comprehensive nutrition at the community level, and the establishment of a Human Milk Bank to ensure that vulnerable infants have access to human milk.

But as this year's World Breastfeeding Week theme, "Prioritize Breastfeeding: Create Sustainable Support Systems", reminds us that the work is far from complete. Many women still face systemic barriers that make sustained breastfeeding difficult: precarious informal employment, lack of maternity protection, inadequate workplace support, harmful myths and misconceptions, and social norms that isolate mothers. Yet, breastfeeding saves lives—nourishing babies, protecting mothers, easing family costs, and strengthening national economies.

This collection of articles, blogs and stories documents research and honors the mothers, health workers, community leaders, and policy advocates who have advanced breastfeeding as a right and a public health priority. It is also a call to action: for stronger systems, for inclusive policies, and for an environment in which every mother can nourish her child without compromising her dignity or livelihood.

Liquid Gold: Breastfeeding Saves Lives: These words reflect what we've learned: breastfeeding is liquid gold—but it doesn't flow in a vacuum. It thrives when mothers are supported and falters when systems fail. When done well, it saves the lives of both mother and child.

Dr. Elizabeth Wambui Kimani-Murage, BSc, MPH, PhD, LL.B, PGDL

Senior Research Scientist; Lead - Nutrition and Food Systems Unit | Head - Health and Wellbeing Theme, APHRC

BREASTFEEDING & WORK

Can mothers feed and earn?

Structural barriers leave Kenyan working women struggling to breastfeed

Breastfeeding is a natural way of providing nutrition to a child, while allowing mother and child an opportunity to bond. Yet for many women in Kenya juggling the demands of work and motherhood, breastfeeding is not a choice freely made. It is a constant compromise. Research by APHRC shows that women in both formal and informal employment are struggling to breastfeed optimally for reasons that are as practical as they are systemic: unpaid or short maternity leave, lack of breastfeeding-friendly workplaces, limited time and privacy to nurse or express milk, and the ever-present fear of losing their job.

Why optimal breastfeeding matters

Optimal breastfeeding, as recommended by the World Health Organization (WHO), is defined as exclusive breastfeeding for the first six months of a child's life, followed by continued breastfeeding for up to two years or beyond, alongside complementary feeding. It includes:

- Initiating breastfeeding immediately after birth
- Feeding on demand
- Exclusive breastfeeding for six months
- Continued breastfeeding for at least two years

The benefits are substantial. Breastmilk provides all the nutrients an infant needs, boosts brain development, enhances immunity, and can prevent up to 12% of all child deaths and 10% of common illnesses in children under five.. For mothers, it lowers the risk of breast and ovarian cancer, and speeds up postpartum recovery. For families, it saves money on infant food and healthcare. At a national scale, optimal breastfeeding contributes to better educational outcomes, productivity, and economic growth.

The reality for mothers in informal work

In Kenya's informal economy—comprising traders, domestic workers, and casual laborers—breastfeeding is especially difficult. Most of these women do not receive maternity leave by virtue of the informality of their work. Taking time off means losing income or even their jobs. In households that survive day-to-day, staying home to breastfeed isn't feasible.

The excerpts below are picked from conversations relating to this issue with community members and quotes in this story have been edited for clarity.

> "Babies are given food early because the mother needs to go look for work or run her small business. She simply does not have the time to sit and breastfeed, especially if no one else is providing for her. Even if she has a spouse, he might be a drunkard who only comes home with a hundred shillings—and you know, a hundred shillings is barely anything these days. So, she feels it is better to go back to washing clothes and start teaching the baby to eat early."

Religious Leader, Key Informant Interview, Viwandani – Nairobi

> "She—meaning the breastfeeding mother—leaves at 8am to go sit in someone's compound until 6 in the evening, waiting for the boss to return. Imagine all those hours the baby hasn't breastfed; instead, the baby is given other foods while waiting. Most employers don't want you bringing your baby to work. They feel that if you bring your baby, you'll focus more on the child than on the job."

Focus Group Discussion, Community Health Workers, Vihiga

> "Mothers don't breastfeed according to the doctor's guidance. They breastfeed when they have the time. Many go out to look for casual jobs, so the baby might miss breastfeeding at the right times. The child feeds only when the mother is around. In most places where they work, mothers are not allowed to bring their babies, so the children are not breastfed as they should be."

Focus Group Discussion, Older Mothers, Kwale

Formal employment does not guarantee support Even women in formal jobs, who qualify for the mandated three-month maternity leave, face obstacles that include the lack of access to private, hygienic spaces to express milk. Some are forced to pump in washrooms or cars, and store milk in handbags—constantly fearing spills or spoilage.

> "People are very busy. They have to return to work after just two months, so the baby is introduced to NAN formula and cow's milk. Since the mother cannot come home to breastfeed, the baby is left with the house help and given water. I would say that only about 50 percent of mothers here practice exclusive breastfeeding."

Focus Group Discussion, Community Health Workers, Kiambu

> "We do not have a breastfeeding room. I have seen my colleague expressing milk in the toilet, and over time that becomes uncomfortable... you eventually give up."

Focus Group Discussion, Employed Middle-Income Mothers – Nairobi

> "When you are working, it is not possible to breastfeed the baby exclusively for six months. So, we started with breast milk and water, then added some fruits. My wife was working, so we had to introduce other foods. She would breastfeed at lunchtime, but we had to supplement so the baby wouldn't suffer during the long hours she was away."

Community Dialogue, Machakos

> "I felt it would be weird expressing breast milk in the server room. And then there was the issue of storage – I used to keep it in the car, but I constantly worried: what if it spoils?"

In-depth Interview, Working Mother, Middle-Income – Nairobi

Rural mothers face cultural and logistical hurdles

In rural areas, mothers spend long hours in the fields and often cannot bring their babies with them due to safety, distance, or weather. Expressing milk remains uncommon—cultural taboos persist, and awareness is low.

"Our women do not express milk here," said a father from Kwale." We have been told it helps, but it has not caught on."

"A mother goes to the farm early and stays long," said a villager from Vihiga." She misses feeding hours, and eventually we introduce cow's milk."

What needs to change?

To promote optimal breastfeeding and ensure good child health and nutrition, it is essential to address the work-related challenges faced by breastfeeding mothers. Studies show that supportive workplace policies are associated with reduced absenteeism among breastfeeding mothers and lead to improved productivity.

Evidence suggests that providing breastfeeding rooms in workplaces enables mothers to express milk more comfortably and successfully. Furthermore, the implementation of breastfeeding-friendly policies and laws can save lives and reduce national healthcare costs.

The Innocenti Declaration and the International Labour Organization (ILO) recommend at least 14 weeks of maternity leave. In Kenya, the Labour Law grants mothers 90 calendar days (approximately three months) of maternity leave, with a guarantee of job security upon return. However, across both urban and rural settings in Kenya, women continue to encounter barriers to optimal breastfeeding due to work demands.

Workplace support from employers and colleagues is vital and highly recommended. This support may include:

- Granting the legally required three months of maternity leave.
- Providing breastfeeding rooms equipped with clean water and milk storage facilities.
- Allowing breastfeeding breaks.
- Offering emotional and physical support as needed.

In addition, employers should extend similar support to women in informal and casual

employment by ensuring they too receive the minimum three months of maternity leave. For women working on farms or in rural areas, practical support could include breastfeeding or baby-friendly shelters near work areas and scheduled breaks to facilitate breastfeeding.

Support from the community and family is equally important. Providing breastfeeding shelters and flexible schedules in agricultural settings can significantly improve the ability of rural mothers to breastfeed optimally.

A collective approach—encompassing legal, institutional, community, and familial support—is critical to overcoming the barriers that working mothers face in breastfeeding their children successfully.

INEQUALITY & THE URBAN POOR

Breastfeeding in broken systems: Mothers' struggles to nurture in informal Nairobi settlements

Despite its benefits, many women in Nairobi's informal settlements are unable to breastfeed optimally due to structural and economic barriers– a gap the APHRC is addressing through evidence, advocacy, and community-based support.

Nutrition in the first two years of life is critical for child growth, development and survival. Optimal breastfeeding– defined as exclusive breastfeeding for the first six months of a child's life, followed by continued breastfeeding for up to two years or beyond, alongside complementary feeding–during this period is therefore critical. The WHO and UNICEF recommend exclusive breastfeeding in the first six months of life and sustained breastfeeding for up to two years or beyond, coupled with appropriate complementary feeding for optimal growth and development and survival of children (WHO 2003).

Breastfeeding is associated with a multitude of benefits to the child and the mother, both short-term and long-term. For the child, breastfeeding reduces infections and mortality in children, improves mental and motor development, and protects against obesity and metabolic diseases and premature deaths later in the life course. Evidence actually indicates that 13% of deaths in children under the age of five years could be prevented by just ensuring mothers exclusively breastfeed their children for the first six months of life. For the mother, breastfeeding results in faster recovery after delivery, reduced blood loss following delivery, reduced maternal stress, faster loss of excess weight, protection against conception especially during exclusive breastfeeding and reduced risk of breast and ovarian cancer (Lanigan and Singal 2009, Victora et al. 2008, Grantham-McGregor et al 2007).

Despite the confirmed importance of breastfeeding, many children in Kenya, and particularly in the urban slums are not breastfed according to the WHO and UNICEF recommendations (Kimani-Murage et al. 2011). Research conducted by the APHRC in two slums in Nairobi (Korogocho and Viwandani) indicate very poor breastfeeding practices. For example, only about 2% of children are breastfed exclusively for the first six months while about 15% of children stop breastfeeding by the end of the first year. On further investigation, residents in these slums illustrate various factors affecting breastfeeding thus making actualization of the WHO/UNICEF recommendations impractical. These include poverty and food insecurity, ignorance and misconceptions for example with regards to breastfeeding and family planning and breastfeeding in pregnancy, lack of social support, exclusive social policies, biological and medical factors including HIV and socio-cultural factors.

Poverty, hence food insecurity, systematic exclusion with regards to government policies and services and lack of support for a breastfeeding urban poor mother top the list of the perceived limiting factors. Extreme poverty in the slums mean that breastfeeding mothers lack adequate food to eat (quotes in this story are edited for clarity):

> "If you go to her house, she has nothing to eat. So even if you tell her to breastfeed, first of all that milk is not there because there is no food in that house."

(FGD, Village Elders, Viwandani).

Limited livelihood opportunities mean that women have to strive to make ends meet. Newly delivered mothers have to resume work shortly after birth to fend for themselves and their families.

> "Some women breastfeed for only two months, and then you hear someone saying, 'I have to go to work.' You're supposed to breastfeed, yet you're also supposed to go to work. But with how hard life is nowadays, you're forced to fend for yourself whether you have a baby or not. So, you have to leave the baby."

(FGD, Mothers, Viwandani).

In the cash-based economy characteristic of slum settings, casual labor, particularly domestic work and work in industries is almost the only decent option that an urban poor woman has. Maternity leave for at least three months, familiar for non-slum residents who usually have formal employment and as protected within the Kenyan law with respect to child rights, does not apply to mothers in the urban slum settings as portrayed by study respondents:

> "Most people here are casual laborers, like fetching water and they are paid like one hundred shillings per day, so maternity leave does not apply."

(FGD, Community Health Workers, Korogocho).

The labor system therefore systematically excludes them from the government policy on maternity leave. Working women in the slums, often regarded as "hustlers" are therefore said to often return to work after barely two weeks following delivery, having no other form of livelihood to rely on, and often to protect their jobs as it is "survival for the fittest" in the slums.

Additionally, baby-friendly work policies such as mothers being allowed to carry babies to work do not apply to these mothers. Research by APHRC has also found that about half of women deliver without skilled birth-attendance, with a third actually delivering at home. While many reasons are responsible for this, one key reason is poor access to skilled attendance given limited public health facilities within the slum settings.

This systematically excludes urban poor women from accessing counseling and support regarding breastfeeding often given to mothers in hospitals around the time of delivery. Social support culturally offered to recently delivered mothers by the extended family, friends and neighbors in the form of advice and help with work to allow the mothers enough time to recover and to adequately breastfeed is often not true for urban poor women.

Though social networks may also be poor for other urban slum residents, while non-poor urban residents may afford paid help, urban poor women have to struggle with daily chores of taking care of their families shortly after birth as illustrated by respondents in Korogocho:

> "most women here wake up and work and forget they have a baby. So by the time they remember they have a baby, there is no milk in the breast."

(FGD, Community Health Workers, Korogocho).

It is clear that interventions are needed to support urban poor mothers to optimally breastfeed. The recent policy on free maternity care at public health facilities is a great step in ensuring access to breastfeeding counselling and support offered in hospitals around the time of delivery. However, with the limited public health facilities accessible to urban poor women, more is definitely required.

Baby friendly community initiatives that bring counselling and breastfeeding support closer to mothers, often at their door-step may break the barrier of health care access. The government is in the process of piloting implementation of such initiatives in Kenya with an aim of scaling their implementation nationwide.

With this respect, APHRC in collaboration with the Division of Nutrition and other stakeholders tested the effectiveness of one such initiative in urban slums in Nairobi. Other options that may benefit breastfeeding mothers may include:

- Economic empowerment through availing baby-friendly income generating activities that allow women to work and breastfeed especially during the first six months after delivery.
- Social protection measures e.g. cash transfers to mothers (conditional or non-conditional) at least for the first six months of the babies life.
- Adjustment in labor policies and enforcement for example to allow maternal leave for casual laborers such as those who work in industries; to improve work conditions for example to allow women to carry children to work; and to protect jobs for newly delivered mothers in casual labor as happens in formal labor.

SYSTEMS THAT WORK

Breastfeeding Takes a Village: How Kenyan Communities Are Helping Mothers Overcome Barriers

Exclusive breastfeeding for the first six months is one of the best ways to give a baby a healthy start in life. But for many mothers, especially first-time moms, it can be overwhelming. Figuring out how to breastfeed, keep up milk supply, and manage breastfeeding while away from the baby is not always easy.

In line with recommendations from the World Health Organization, Kenya adopted the Baby-Friendly Community Initiative (BFCI, which aims to protect, promote and support optimal maternal and infant and young child feeding practices and improve child survival, as a strategy to promote and support exclusive breastfeeding and continued breastfeeding alongside complementary foods. In Kenya, it aligns with national maternal and child nutrition policies and is now showing promise at scale.

To test how this works in everyday life. The APHRC conducted two studies; one in urban informal settlements in Nairobi (Korogocho and Viwandani) and the other in a rural setting in Koibatek sub-County, Baringo to help inform its customization in Kenya. What we found was: when mothers are supported by trained community health volunteers, peer groups, families, and neighbors, exclusive breastfeeding rates go up and the entire community benefits—with a social return on investment as high as $71 for every dollar spent.

The initiative relies on trained community health volunteers (CHVs) and mother support groups to provide mothers with the tools, knowledge, and support they need to breastfeed exclusively.

Through APHRC's efforts, CHVs visited homes, guided mothers on latching techniques, and offered counsel on feeding and maternal health. In rural areas, mother support groups allowed women to lean on each other during this critical period.

Community members observed positive changes at individual, household, and community levels.

> "I did not know about clinic visits and breastfeeding exclusively for six months. My other child was often sickly because of this, but now I know better," said one mother.

With improved knowledge on breastfeeding, complementary feeding, and hygiene, she and many others reported more rewarding experiences with exclusive breastfeeding.

Mothers shared that counselling from CHVs helped them reduce risky behaviours such as smoking and improved their understanding of maternal and child nutrition. Fathers also

noted changes—becoming more supportive of their breastfeeding partners, participating in childcare, and getting involved in family planning. Grandmothers, often key caregivers, spoke of learning better childcare practices and providing more informed support.

The interconnected system – from hospitals implementing the Baby-Friendly Hospital Initiative to CHVs reinforcing messages in the community – was central to the program's success.

A key strength of the intervention was the consistent, community-based messaging led by CHVs, which complemented guidance from health facilities. The Baby-Friendly Hospital Initiative launched at the point of delivery was effectively extended into communities through the BFCI, creating a continuum of care.

Findings from the project implemented by APHRC and partners in Korogocho and Viwandani showed a social return on investment of $71 for every $1 spent. The community demonstrated that breastfeeding is not just a mother's duty—it is a shared responsibility.

Despite the gains, mothers still faced difficult trade-offs. Some had to choose between returning to work or continuing to breastfeed. One mother mentioned that understanding her child's nutritional needs meant higher food costs. Another struggled with weaning, saying her child fell ill during the transition from exclusive breastfeeding.

Even so, the message is clear: when the village supports a mother, she is more likely to breastfeed – and both she and her baby are healthier for it.

INNOVATION & FUTURE SOLUTIONS

Is Kenya Ready for Human Milk Banks?

As Kenya begins to seriously explore the potential of human milk banking, research by the APHRC shows strong public interest in the concept. However, it also highlights cultural concerns, safety fears, and health system gaps that must be addressed before milk banks can be embraced widely.

Why human milk matters

Breast milk is nature's perfect food for infants as it contains all the nutrients a baby needs for the first six months of life, along with immune-boosting antibodies that protect against illness. According to the World Health Organization (WHO), breast milk continues to meet about half of a child's nutritional needs up to one year, and a third up to two years.

WHO also notes that children who are breastfed tend to score higher on intelligence tests and face lower risks of obesity and type 2 diabetes later in life.

But when mothers die during childbirth, fall critically ill, or are unable to breastfeed for other reasons, the question arises: what next?

Donor milk as a life-saving alternative

Infant formula, typically made from soy or cow's milk, is modified to resemble the nutritional profile of human breast milk. However, despite these adjustments, it still lacks the natural anti-infective properties that help protect infants from disease. Likewise, animal milk, even when home-modified, does not provide the antibodies that help build infants' immune systems. Because of this, donor human milk (DHM), collected and processed through human milk banks (HMBs), is recommended when a mother's own milk is not available.

Human Milk Banking (HMB) involves collecting breast milk donated by healthy, lactating mothers, pasteurizing it for safety, and distributing it to infants who lack access to their own mother's milk.

DHM is breast milk expressed by a mother, then pasteurized and stored at a milk bank for use by infants who are not her own. While informal milk sharing has long existed in communities, it lacks the safety protocols of HMBs, including pasteurization and screening, which are crucial for minimizing health risks (Kimani-Murage et al., 2019). In this article, DHM does not refer to this informal milk sharing.

Scientific evidence supports the safety and feasibility of HMBs. A study by APHRC at Pumwani Maternity Hospital in Nairobi found that donor milk was well-tolerated by newborns and helped reduce their time in the neonatal unit (Wilunda et al., 2024). Another study in Nairobi showed that while only 23% of participants had heard of HMBs, an overwhelming 91% had a positive attitude toward them. Many

community members saw milk banks as a practical, affordable way to support orphans and other vulnerable infants with the nutritional and immune-boosting benefits of breast milk.

In that same study, 59% of mothers said they would be willing to let their child be fed donor milk if they themselves were unable to breastfeed. This willingness was higher among low-income mothers (64%) than among high-income mothers (58%). Still, safety remained a top concern: most mothers emphasized the importance of proper screening and sterilization of donor milk and milk bank equipment.

Community support for milk banking

> "We would have reduced child mortality rates, especially for children who have lost their mothers in infancy, because they would get proper food,"

Key Informant Interview (Religious Leader)

> "We usually give them cow milk and Nan [infant formula], and I don't even know what Nan is made of. If I hear that [donated milk] is truly from a human being, I will be happy. I know for sure that what I'm giving the baby is mother's milk—natural, not full of chemicals."

Focus Group Discussion (Mothers)

Barriers and concerns

Despite general support, some respondents voiced concerns. The most cited fear was the risk of transmitting HIV or other infections through donor milk. Others raised objections based on hygiene, culture, religion, or beliefs about how DHM might affect mother-child bonding.

> "We are not ready for human milk banking in Kenya. We have a generalized AIDS epidemic. As a health professional, I wouldn't give human milk from a bank to a baby with certainty that there is no HIV virus there."

Key Informant Interview (Health Professional)

> "A child breastfed by another woman is not supposed to have a relationship, like marriage, with another child breastfed by the same woman."

Key Informant Interview (Religious Leader)

Other barriers cited include limited financial, human, and technological resources, as well as a lack of political will to scale up milk banks nationwide.

What's next for Kenya?

Kenyan policymakers recognizing the potential of HMBs and have acknowledged the need for a safe, structured way to provide donor milk to infants who cannot be breastfed by their mothers. With support from the African Population and Health Research Center (APHRC) and PATH, they assessed the feasibility of establishing HMBs in the country and helped in developing local guidelines to ensure safety, acceptability, and effective implementation. The initial pilot project was conducted at Pumwani Maternity Hospital. Building on this success, PATH, in partnership with the Ministry of Health and Nairobi County, has recently launched a new initiative to scale up human milk banking in three additional health facilities in Nairobi.

For HMBs to be successful and widely trusted, the following steps are crucial (Fang et al., 2021):

- Regulatory framework: A strong national policy to govern the operation of milk banks, ensuring safety, accountability, and non-interference with maternal breastfeeding.
- Quality control: Rigorous standards for donor screening, milk pasteurization, storage, and distribution.
- Ethical safeguards: A rights-based approach that protects both donors and recipients, ensures fair access, and promotes transparency.
- Continued breastfeeding support: HMBs should not replace maternal breastfeeding but support it when needed, especially for preterm and orphaned infants.

More public awareness and education are needed to address misconceptions and build public trust in donor milk and milk banks. The evidence is clear: human milk banking, if done safely and ethically, could be a life-saving solution for Kenya's most vulnerable babies.

POLICY MOMENTUM IN KENYA

From Policy to Practice – Kenya's Breastfeeding Journey

Kenya's breastfeeding journey is a story of progress, grounded in policy and community efforts but sustaining and growing that success will require continued investment, workplace transformation, and firm implementation of the legal frameworks already in place.

Breast milk is often referred to as liquid gold and for good reason as it offers unmatched nutritional and immunological benefits for babies, while also protecting mothers' health. One of its most powerful advantages is its ability to shield infants from diseases, preventing an estimated 600,000 child deaths globally each year (WHO & UNICEF, 2025). For mothers, breastfeeding reduces the risk of ovarian and breast cancers, among other health benefits.

Kenya's progress in promoting breastfeeding

Over the past two decades, Kenya has made remarkable strides in supporting breastfeeding. Exclusive breastfeeding rates have increased from a mere 13% in 2003 to an impressive 60% by 2022. This surpasses the World Health Assembly's target of 50% by 2025 and the global average of 48% recorded in 2023.

This progress is no accident. It reflects years of sustained efforts and policy interventions designed to protect, promote, and support breastfeeding. Some of the key initiatives include:

The Breastfeeding Mothers Bill, 2024

Passed by Parliament, this progressive legislation ensures that working mothers can breastfeed or express milk in the workplace. Key provisions include:

- Establishment of lactation spaces in workplaces
- Designated break times during working hours for breastfeeding
- Flexible work arrangements for nursing mothers
- Protection against discrimination for breastfeeding women
- Rights for all women, working or not, to breastfeed in public
- Provision of baby changing facilities at work

The Breast Milk Substitutes (Regulation and Control) Act (2012, revised 2022)

This law ensures appropriate marketing and use of breast milk substitutes and promotes safe infant nutrition. It prohibits advertising breastmilk substitutes and restricts health workers from accepting gifts from manufacturers. It also mandates all labels on breastmilk substitutes to not only indicate the proper usage of those products, but to also encourage breastfeeding.

The Health Act, 2017

This act reinforces the rights of breastfeeding mothers at work by urging employers to establish well-equipped lactation stations. It also prohibits marketing of breastmilk substitutes within these stations and supports break times for mothers to breastfeed or express milk.

National Policy on Maternal, Infant, and Young Child Nutrition, 2013

This policy outlines Kenya's commitment to creating environments that support breastfeeding. It aims to protect, promote, and support exclusive breastfeeding for the first six months and continued breastfeeding for two years or more.

The Baby-Friendly Hospital Initiative (BFHI)

Kenya adopted the global BFHI developed by UNICEF and the World Health Organization to ensure that hospitals support mothers and babies through the Ten Steps to Successful Breastfeeding. The Ten Steps, include:

1. Support mothers to initiate breastfeeding within the first hour of birth.
2. Allow immediate and uninterrupted skin-to-skin contact between mother and baby.
3. Train health workers to help mothers with breastfeeding.
4. Keep mothers and babies together 24/7 (rooming-in).
5. Avoid giving newborns food or drinks other than breast milk unless medically necessary.
6. Teach mothers to recognize when their baby is hungry and respond to those cues.
7. Avoid bottles, teats, and pacifiers when possible.
8. Talk to pregnant women and families about the importance of breastfeeding.
9. Provide continued support after discharge.
10. Follow the International Code of Marketing of Breast-milk Substitutes to protect families from aggressive formula promotion.

By 2008, 70% of hospitals in the country had been declared baby-friendly. However, only 11% maintained active baby-friendly status by 2010, highlighting sustainability challenges.

The Baby-Friendly Community Initiative (BFCI)

BFCI extends breastfeeding support to communities, advocating for exclusive breastfeeding in the first six months and continued breastfeeding alongside complementary feeding for at least two years. Kenya has developed a comprehensive BFCI package, including training materials, implementation guides, communication tools, and assessment frameworks.

What more needs to be done?

Despite the encouraging achievements, Kenya's exclusive breastfeeding rate has plateaued at 60% in recent years. To build on current progress and improve outcomes further, the following steps are critical:

Implementing a baby-friendly workplace initiative

Although legal frameworks support breastfeeding at work, many women still encounter barriers when they return from maternity leave. Some workplaces lack lactation rooms or fail to offer flexible working hours, forcing mothers to abandon exclusive breastfeeding (Ickes et al., 2021; Kamau et al., 2022).

Implementing a baby-friendly workplace initiative can help to resolve this challenge. Evidence from a study in a tea plantation in Kericho, Kenya, shows that implementing such initiatives is both feasible and effective. The initiative, which included sensitizing managers and creating breastfeeding-friendly policies, led to increased breastfeeding rates, higher worker retention, and improved job satisfaction among nursing mothers.

Increasing investment in breastfeeding support

The government can scale up breastfeeding by investing in supportive programs. For example, providing grants to help establish lactation stations in small businesses or informal workplaces would ensure more women benefit. Additionally, offering financial support to mothers working in the informal sector could extend the benefits of maternity leave to them as well.

Enforcing existing laws

Laws that support breastfeeding are only effective if enforced. Employers who fail to meet legal obligations – such as providing lactation spaces or discriminating against nursing mothers – must be held accountable. Stronger enforcement and consequences for non-compliance will help normalize supportive environments for breastfeeding mothers.

Sources Cited in This Booklet

1. BREASTFEEDING & WORK

- https://pubmed.ncbi.nlm.nih.gov/18207566
- https://publications.aap.org/pediatrics/article-abstract/125/5/e1048/72534/The-Burden-of-Suboptimal-Breastfeeding-in-the?redirectedFrom=fulltext
- https://www.who.int/health-topics/breastfeeding
- https://pubmed.ncbi.nlm.nih.gov/10500022/

2. INEQUALITY & THE URBAN POOR

- Breastfeeding in broken systems: Mothers' struggles to nurture in informal Nairobi settlements https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-016-0092-7
- https://pmc.ncbi.nlm.nih.gov/articles/PMC6860346/

3. SYSTEMS THAT WORK

- Breastfeeding Takes a Village: How Kenyan Communities Are Helping Mothers Overcome Barriers https://aphrc.org/wp-content/uploads/2015/03/BABY-FRIENDLY-COMMUNITY-INITIATIVE-DESK-REVIEW_FINAL-2014-1.pdf

4. INNOVATION & FUTURE SOLUTIONS

- (WHO, 2020) https://www.who.int/publications/i/item/9789240058262
- https://www.path.org/our-impact/media-center/path-kenya-and-partners-launch-mother-baby-friendly-initiative-plus/
- https://onlinelibrary.wiley.com/doi/pdf/10.1111/mcn.13594
- https://aphrc.org/wp-content/uploads/2019/07/Human-Milk-Bank-Project-Briefing-Paper-APHRC.pdf

5. Policy Momentum in Kenya

- https://healthynewbornnetwork.org/resource/2017/country-experiences-baby-friendly-hospital-initiative/
- https://pmc.ncbi.nlm.nih.gov/articles/PMC6635904/
- https://knowledge.unicef.org/child-nutrition-and-development/resource/global-breastfeeding-scorecard-2024
- https://www.sciencedirect.com/science/article/pii/S0022316623086492?via%3Dihub
- https://pubmed.ncbi.nlm.nih.gov/33949782/
- https://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2024/TheBreastfeedingMothersBill_2024.pdf
- http://kenyalaw.org:8181/exist/rest//db/kenyalex/Kenya/Legislation/English/Acts%20and%20Regulations/B/Breast%20Milk%20Substitutes%20(Regulation%20and%20Control)%20Act%20-%20No.%2034%20of%202012/docs/BreastMilkSubstitutes(RegulationandControl)Act34of2012.pdf
- https://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf

- http://www.nutritionhealth.or.ke/wp-content/uploads/Downloads/National%20Maternal,%20Infant%20and%20Young%20Child%20Nutrition%20Policy%20Guidelines%20-%20August%202013.pdf
- http://www.nutritionhealth.or.ke/wp-content/uploads/Downloads/Baby%20Friendly%20Community%20Initiative%20-%20May%202016.pdf
- https://www.unicef.org/media/94081/file/Field-Report-Nutrition-Kenya-Final.pdf

About this Booklet

This booklet is part of the African Population and Health Research Center's (APHRC) efforts to improve nutrition and health across Africa. It contributes specifically to the work of our Nutrition and Food Systems Unit, under the Maternal, Child, and Adolescent Nutrition program.

About APHRC

APHRC is a premier research-to-policy institution, generating evidence, strengthening research and related capacity in the African research and development ecosystem, and engaging policy to inform action on health and development. The Center is Africa based and African-led, with its headquarters in Nairobi, Kenya, and a West Africa Regional Office (WARO), in Dakar, Senegal. APHRC seeks to drive change by developing strong African research leadership and promoting evidence-informed decision-making (EIDM) across sub-Saharan Africa.

Our Nutrition and Food Systems Unit focuses on two key areas: improving maternal, child, and adolescent nutrition—especially in the first 1,000 days—and transforming food systems to be healthy, inclusive, equitable, resilient, sustainable, and climate-resilient through an evidence-based and human rights-based approach.

All Photos Courtesy Shutterstock

© 2025 African Population and Health Research Center. All rights reserved.

This booklet is published under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License. To view a copy of this license, visit https://creativecommons.org/licenses/by-nc-nd/4.0/.