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Discourse and breastfeeding practice in urban communities in Indonesia: A Foucauldian perspective

Hetti Mulyaningsih^{*)}, Bagong Suyanto, Rahma Sugihartati
Universitas Airlangga

Dharmawangsa Dalam Street, Surabaya, Indonesia

Email: hetti.mulyaningsih-2016@fisip.unair.ac.id, Phone +62315014015

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Abstract Breastfeeding coverage in Indonesia is under government target. Several works of literature illustrate that mothers in Indonesia face three classic problems. First, inadequate regulation to protect breastfeeding practices, second, the massive promotion of infant formula and breast-milk substitutes, and third, discrepancies in health services. This article aimed to explore the experiences of breastfeeding mothers and to relate it to broader discourse. The study was conducted in two metropolitan cities in Indonesia, Jakarta, and Surabaya. Both locations were chosen because the two cities share similar characteristics, namely urban communities with dense, heterogeneous populations and rapid changes. The study is a critical discourse analysis using the Foucauldian perspective to help examine the discourse and the social practices of breastfeeding. Data were collected with semi-structured interviews on 36 research subjects. The results confirmed that all subjects recognised the benefits of breastfeeding discourse. However, the practice of infant feeding was not always related to health recommendations. The study also found three issues concerning breastfeeding practice, namely: discourse on breastmilk and biopower, failed mothers, and mothers' negotiation. The discourse on breastfeeding is recognised as a biopower discourse which is an extension of affected mothers' identities. Mothers who fail to breastfeed feel guilt, frustration and shame. They tried to negotiate this condition by asking health workers for help and arguing that the identity of the mother is not only influenced by the practice of breastfeeding. Therefore, a constructive biopower discourse is needed to implement breastfeeding practices and discourses to normalise breastfeeding practices.

Keywords: breastfeeding mothers; breastfeeding practice and discourse; biopower

^{*)} Corresponding Author

INTRODUCTION

Breast-milk should be given to babies exclusively for the first six months of life to achieve optimal growth, development, and health (WHO, 2001a). However, there are still various obstacles to breastfeeding practices. The obstacles include regulation, massive promotion of infant formula, and breast-milk substitutes. Not to mention the disparities in health practices which may cause biased information. The problems mentioned above can affect the practice of breastfeeding in Indonesia. This article linked the experience of breastfeeding mothers with the three significant issues, various problems of daily breastfeeding practices for mothers living in urban areas, and the characteristics of urban society.

Data from the Health Ministry showed that the Early Initiation Breastfeeding rate in 2017 was 57.8 per cent, and the coverage of exclusive breastfeeding reached 35.7 per cent in the same year. This figure was still a long way from the government's target of 90 per cent (Juniman, 2018).

International and national regulations protect the practice of breastfeeding. The superiority of breastmilk compared to other baby foods is non-debatable. Breast-milk is the ideal baby nutrition and has various health benefits for mothers and babies (NABA, 1997). Various researches that favour breast-milk prompted the World Health Organisation (WHO) to recommend a revision in exclusive breastfeeding time, from 4 months to 6 months (WHO, 2001b). WHO recommends four gold standard in infant feeding that involves breastfeeding, early initiation of breastfeeding, six months of exclusive breastfeeding, the combination of breast-milk and appropriate food at six months, and breast-milk until up to 2 years of age (DINKES, 2015).

There was a transnational social movement to boycott Nestle, the largest infant formula company in the world, in 1977-1984. This movement aimed to oppose the unethical marketing of infant formula. The first Nestle boycott was carried out in the United States by INFAC (Infant Dina's formula Action Coalition) in 1977 and then spread to various countries namely Australia, Canada, New Zealand, United Kingdom, Sweden, West Germany, France, Finland and Sweden (Waring et al., 2016). This situation led the WHO to hold its 34th World Health Assembly (WHA) meeting in 1981 to resolve the issue of Nestle's boycott. The meeting formulated the International Code of Marketing of Breast-milk Substitutes, also known as WHO CODE. A total of 118 countries voted to implement the WHO CODE internationally, except for the United States (Van Esterik, 1989).

The WHO CODE is the ethical foundation that governs marketing and practices related to breast-milk substitutes manufactures (including infant formula), other dairy products, baby food, and drinks. It also includes the use of pacifiers and milk bottles marketed or represented suitable for use as substitutes for breast-milk

either entirely or in part (WHO, 1981). Until today, the 1981 CODE has never been revised. However, there have been several World Health Assembly (WHA) resolutions that have been adopted since 1981 which refer to the marketing and distribution of breastmilk substitutes and clarify or extend issues covered the CODE (World Health Organization, 2017). Nevertheless, the CODE still adopted until now.

Indonesia has legal instruments that adopt the WHO CODE. The first regulation that adopted a portion of the WHO CODE was the Regulation of the Minister of Health of the Republic of Indonesia No. 240/MENKES/PER/V/1985 concerning Breast-milk Substitute, which since then, has been followed by other regulations. However, at present, existing regulations only cover infants aged 0-6 months, based on the definition of infant formula in Government Regulation number 33 of 2012 or PP 33/2012. Research by Fikawati et al. revealed that early initiation of breastfeeding and exclusive breastfeeding policies is still minimal. They studied the Kepmenkes No. 237/1997, PP No. 69/1999 and Kepmenkes No. 450/2004. The advocacy coalition framework analysis confirmed the weak aspects of external systems and subsystems in the development of exclusive breastfeeding policies (Fikawati et al., 2010). According to the WHO report, the implementation of the law on breastfeeding in Indonesia is still lacking. In addition, there are attempts by infant formula companies to encourage the provision of breast-milk substitutes for babies from an early age (WHO, 2014).

The second issue about breastmilk in Indonesia is the massive promotion of infant formula and other milk products. The Government Regulation on No. 33 of 2012 states that infant formula is milk specifically formulated as a substitute for breastmilk for infants up to 6 months old. This definition is still being debated by breastfeeding support groups in Indonesia because it means that only infants under six months are protected from the promotion of infant formula. Nevertheless, it is recognised that the promotion of infant formula is still quite massive in Indonesia. Therefore, it can be inferred that the promotion of other milk products (intended for babies over six months) may be more massive. Manufacturers of breast-milk substitutes (infant formula and other milk products) allegedly do not comply with the WHO CODE. In 2015, the results of a Global Index investigation revealed that there are violations of WHO CODE by producers of baby food substitutes circulating in Indonesia and Vietnam (ATNI, 2016).

A study found that health workers, breast-milk substitute manufactures, and company representatives were guilty of violations of the WHO CODE and recommended a regular monitoring system to ensure compliance and enforcement of WHO CODE. The same study also confirms that health workers and representatives of breast-milk substitutes companies in Indonesia are working together (Hidayana Et al., 2017). Infant formula and other breast-milk substitutes are latent threats for breast-milk supporters in Indonesia. It is a complex

problem, considering that Indonesia has a large market share for infant formula and other breast-milk substitutes. The large population, high birth-rate, and weak regulation make the business of infant formula and other substitutes for breastmilk quite attractive. In 2016, the business value of infant formula and other substitutes for breastmilk reached IDR 25.8 Trillion (Estimated up to SGD 24 Million) (UNICEF, 2016).

A study by Titaley et al. found that poor breastfeeding practices in Indonesia were related to environmental, socioeconomic, pregnancy characteristics, and maternal health service factors. Therefore, comprehensive efforts are needed to promote breastfeeding practices (Titaley et al., 2014). The Paramashanti et al. study in breastfeeding mothers in Indonesia showed that the early breastfeeding initiative supports the success of exclusive breastfeeding (Paramashanti et al., 2016). Knowledge of breastfeeding is a factor that affects the duration of breastfeeding. Barriers to breastfeeding are influenced by the swelling of the mothers' breasts, feeding infant formula immediately after birth, and lack of support from grandmothers to practice exclusive breastfeeding (Aristiati & Hamam, 2014)

Nestle Boycott was one of the historical pieces of evidence that breastfeeding practices need to be protected. Breastfeeding practice and discourse in Indonesia showed that regulations that protect breastfeeding practices are still lacking. Based on the ATNI report in 2016, violation of the WHO CODE in Indonesia was higher than other Southeast Asian countries. Hidayana et al (2017) also found a hidden relationship between health workers and breast-milk substitutes manufactures. Aristiati and Hamam's research found supporting and inhibiting factors for breastfeeding mothers in quantitative socio-cultural aspects (Aristiati & Hamam, 2014). The studies above show that breastfeeding practices and discourse are problematic in terms of regulation, health workers, promotion of breast milk substitutes, and breastfeeding mothers. Even so, previous studies have not examined in more depth the perspective of the experience of breastfeeding mothers, as objects and subjects of breastfeeding practice and discourse. Therefore, the current research fills that gap by looking at the experiences of breastfeeding mothers based on a Foucauldian approach. This approach places breastfeeding practices and discourses involving biopower as aspects that influence the contestation of breastfeeding practices. It also provides an opportunity to examine the success and failure of breastfeeding as a social product that can be reinterpreted and seek new alternative ideas free from the dominant regime.

METHODOLOGY

This study was conducted in two cities in Indonesia, Jakarta, and Surabaya. Surabaya is the capital city of East Java Province. The total population in Surabaya is 2.765.487 people with a population density

level of 8462 km². The total population growth in Surabaya is 0,62 per year. The total household is 768.932, and the average household member is 3,62. The number of registered birth in 2018 was 32.585 (BPS Kota Surabaya, 2019).

Meanwhile, Jakarta is the capital city of Indonesia. The total population of Jakarta is 10.467.629 with a population density of 15.804 km². Total population growth is 1,7 % per year. It has 2.509.980 of total household with an average household member of 3,83. The number of registered baby birth in 2018 was 141.669 (BPS DKI Jakarta, 2019). Being one of the major cities in Indonesia, Surabaya and Jakarta are also the centres of industrialisation and education, which attract urbanisation. Urban societies are characterised by rapid urbanisation and widespread globalisation. Big cities face challenges in the complexity of resources, migration, infrastructure and economic-based needs (Freire & Stren, 2001). Urban individuals need to negotiate their ways of thinking and acting between traditional and modern (Paxson, 2004). This condition brings up questions about the position of mothers in this massive change.

Research subjects were thirty six people consisting of breastfeeding mothers, doctor, breastfeeding counsellors, and breast-milk support group, namely "Sentra Laktasi Muslimah" (Muslimah Lactation Centre) and "Bunda Harapan Indonesia" (Indonesian Hope' Mother). This study focused on the experience of breastfeeding mothers and explored the issue through semi-structured interviews. Critical discourse analysis was chosen as a research method. This research follows Norman Fairclough's opinion that the focus of analysis is the process of articulation of texts. The text, in this case, is a social practice that contains power, knowledge, etc.; and which at the same time, reflects a difference. Texts are analysed dialectically and linked to other situations to find ways of working, identifying, and representing certain social practices (Fairclough, 2001). The primary texts in this study were interview results which were used to identify the constraints and deviations in the ideology, discourses, and practices of breastfeeding in everyday lives in Indonesia.

RESULTS AND DISCUSSION

Discourse on Breastmilk and Biopower

Since the establishment of WHO CODE 1981, there has been international attention to protect breastfeeding practices. This CODE limited the marketing and promotion of breast-milk substitutes. Consequently, this code also influences the promotion of healthy diets for infants by health workers and raises the ideology of infant feeding. On the other hand, the controversy beyond breastmilk and infant formula remains until today. Breastfeeding discourse strengthens the regulation and medical discourse but, raises practical problems. Breastfeeding is indeed natural, but it does not depend solely on biological processes. It is not an easy process since different mothers

may experience different levels of difficulty. Many factors are involved in this process, such as psychological and social factors, as well as environmental factors.

Breastfeeding practices are discussed in various health-related institutional channels. Posters about breastmilk are displayed in various health facilities. One of the implementations of the WHO CODE in Indonesia was Government Regulation PP No.33/2012 concerning Exclusive Breastfeeding. This regulation prohibits health workers and health facilities from promoting and providing infant formula and other milk products that can impede exclusive breastfeeding programs unless there are medical indications. However, the experience of breastfeeding mothers revealed a different practice.

One of the breastfeeding mothers, UMN, experienced childbirth without early breastfeeding Initiative and infant formula feeding at a health facility. An interview with UMN (20 March 2019) revealed that she gave birth at a private practice midwife at an independent cost. After delivery, there was no Early Breastfeeding Initiative. The health facility staff also gave infant formula for the baby. UMN did not have any complaints regarding the infant formula. She even continued to give infant formula at home, combined with breastfeeding. According to her, her baby could drink both. The infant formula replaced breastmilk when she was away from home. However, currently, she no longer gives infant formula to her baby because she feels that her baby does not want to drink infant formula and only want breastmilk.

TR, another breastfeeding mother, had a different experience. She and her husband both work in Jakarta. She chose to give birth in Surabaya, where her parents live. Before giving birth, she sought information from her friends and online media about pro-breastfeeding hospitals in Surabaya. She believes that breastmilk is very important. She had also bought all the equipment needed for breastfeeding, such as pumps, storage bottles, cup feeders etc. TR had a vaginal delivery and breastfed her baby right after in the hospital. Based on the information she collected, the hospital should be a breastfeeding-friendly hospital. However, unfortunately, she was not treated in the same room as her baby. Even so, TR was persistent that she wanted to breastfeed her baby. She also regularly pumps her breastmilk to prepare when she had to go back to work. However, over time, TR began to feel difficulty in breastfeeding. She felt that her baby was not satisfied with drinking breastmilk directly from her nipples. TR's mother then suggested her to feed her baby breastmilk through bottles, to which TR agreed. Her mother also suggested TR give infant formula to her baby. It was a situation that made TR uneasy: she had to choose between her mother's advice to use infant formula and her hope of exclusively breastfeeding her baby. All the while, she thought that her baby is not satisfied with her breastmilk (Interview 1 November 2019)

In another case, LN, a young mother who gave birth to a second child, had a severe medical condition during pregnancy known as preeclampsia pregnancy. This medical condition is a pregnancy complication characterised by high blood pressure and signs of damage to the organ systems. In her first labour, she also had preeclampsia. However, the second labour involved a more complicated pregnancy problem, where she also had placenta accretes. Based on the recommendation from a doctor, she was forced to have accelerated labour through Caesarean method at 28 weeks gestation. Her baby was born prematurely with low body weight, only 900 gram. Amid medical conditions that hindered her breastfeeding, LN still tried to give breastmilk to her baby, despite combining it with infant formula. However, her baby was diagnosed with infant formula intolerance. The doctor then suggested that the baby should only be given breastmilk. However, LN could not breastfeed her baby the caesarean procedure. Therefore, she tried to find a donor breastmilk for her baby while still trying to breastfeed her baby herself. She gave breastmilk to her baby through pacifiers and milk bottles. She did not directly breastfeed her baby because she thought that her milk was not enough and did not satisfy her baby (Interview 17 August 2019).

Biologically, the process of breastmilk production is influenced by prolactin and oxytocin hormones. The pituitary gland produces Prolactin in the brain, which affects physiological function. Meanwhile, the oxytocin hormone acts as a chemical messenger in the brain to push out or let the milk out. Oxytocin is also called 'love hormone' because it works according to mothers' mood. Environment plays a role in stimulating mothers' mood and feeling, and thus could easily obstruct the practice of breastfeeding. Adequacy of breastmilk is measured by the frequency of urination and defecation per day and weight gain per month. Babies must urinate a minimum 6-8 times a day with a minimum weight gain of 0.5 kg per month. There is much misinformation regarding breastfeeding practices. Breast-milk production is often associated with nipples' shape, baby refusing to be breastfed, or other factors without regards to the standard requirements mentioned before. It is not right to say that breastfeeding is a biological issue because it is also dramatically influenced by information bias.

On the other hand, health institutions aggressively promote breastfeeding as the best nutrition for babies. However, unfortunately, not all of these practices are accompanied by information on nursing skills. Although mothers are recommended to breastfeed their babies right after childbirth, mothers and families do not get an education when they get their pregnancy checked in health facilities. Some mothers even learn about breastfeeding techniques right after they deliver their babies. One of the breastfeeding mothers' subjects gained knowledge about breastfeeding during her pregnancy by attending a paid pregnancy class at one of the mothers and child hospitals (RSIA).

She stated that the class was beneficial because she could gain new knowledge about breastfeeding her baby:

In the beginning, I could not produce breastmilk, ma'am... It's rather difficult to produce breastmilk. But because I have joined seminars and pregnancy exercises, I tried to be more patient. For example, people around me told me that if I cannot produce breastmilk, I should give infant formula for my baby. I refused to do that. I did not want to do that. No matter what I must not give infant formula for my baby. (RP interview, 13 July 2019)

Mothers often become the main object of breast-milk discourse. Some mothers feel that their families do not support them. Besides TR, RP also had a similar experience. RP stated that her husband asked her to give infant formula since her breastmilk was not enough. The husband thought that her breastmilk was not adequate since the baby was always crying as if the baby did not get enough breastmilk. This situation made saddened her. She tried to prove that she could breastfeed her baby by looking for breastfeeding counsellors and researching breastfeeding practices online.

Indeed, the breast-milk discourse has caused intense academic debate. The breast-milk discourse is biased, and subtly enters the mothers' emotional aspects. This private discourse is becoming a public discourse, where women's bodies are heavily regulated. Mothers' knowledge about breastfeeding often became a dominant factor in stimulating breastfeeding practice (Septiani et al., 2017). Not to mention the possibilities that health workers and health facilities are still involved in the marketing of infant formula. Thus, the breastfeeding discourse is indeed a representation of the biopower discourse.

The idea of biopower originates from Foucault. It is a set of technology, knowledge, and discourse used to analyse, monitor, and regulate the human body and population (Foucault, 2013). The 'normal' and 'abnormal' body standard in modern society are caused by population pressure due to urbanisation and the need for industrial capitalism (Jacky, 2015). Health knowledge is one of the keys to biopower discourse. Health institutions have the absolute ability to supervise every individual to produce an obedient body and knowledge-based discipline. Therefore, this idea is inseparable from the power relations established by social institutions (White, 2016). As a biopower discourse, breastfeeding influences the identity of mothers in terms of acceptable and unacceptable behaviours. In the United States, there once a breast-milk campaign with the slogan "Breast is Best". It raised a serious debate. This discourse contributes to the rise of 'total motherhood,' makes mothers as the centre of childcare morality code, and contribute to fuelling a culture of risk. Total motherhood regulates women's reproductive authority through knowledge, culture, and public health institutions. Therefore, mothers must be discipline and normalised.

Meanwhile, risk culture places mothers as subjects and babies as an extension of the perceived identity of mothers who are vulnerable to health risks. (Zivku, 2016). Wolf asked, "Is breast best?" as a response to the "Breast is Best" campaign in the United States. This campaign urges women to give breastmilk for the first six months exclusively. Wolf argued that this health promotion campaign is spreading fear, ignoring ethical principles with weak evidence, and framing the message and cultural sensitivity in health campaigns. Supposedly, health promotion of breastfeeding practices should be more educative rather than stressing on risky message frames (Wolf, 2007).

Reid's study showed the positive construction of biopower in breastfeeding discourse. In the case of the high infant mortality rate in Derbyshire, England, the state took maternal solutions rather than overcoming structural and political inequalities. Health visitors have proven to be successful in promoting breastfeeding and supporting safe feeding through the encouragement of breastfeeding to survive amid poor sanitation among women workers. Biopower is not necessarily harmful in this context (Reid, 2017). The medicalisation of breastfeeding practices also contributes to the culture of mothers in breastfeeding. The high rates of breastfeeding in both countries are supported by medical discourse and health professionals as the leading authority and are associated with the morality and parenting norms of contemporary society (Andrews & Knaak, 2013).

In Indonesia, health workers and health facilities still have many gaps in assisting breastfeeding mothers. Therefore, the breastfeeding practices continue to burden mothers even though in reality, it has been recognised that breastfeeding also required supports. Early initiation of breastfeeding practices certainly needs health workers. At the first hour after the baby's birth, it is expected that the baby is placed on the mother's stomach because it will help with the overall success of breastfeeding in the next months. Failure of exclusive breastfeeding in the first three days of birth is allegedly caused by factors other than maternal knowledge (Fikawati & Syafiq, 2003). Most exclusive breastmilk and early initiation of breastfeeding policy studies in Indonesia discussed the lack of optimal early initiations of breastfeeding facilitation. However, in terms of regulation, there is no definitive study of early initiation of breastfeeding policies (Fikawati & Syafiq, 2010).

Other studies also confirmed that there are non-compliance of health workers and health facilities in Indonesia with the WHO CODE (Hidayana et al., 2017). In fact, research in several Southeast Asian countries exposed that Indonesia and Vietnam are the top violators of the WHO CODE. This violation occurred from many sides, including the producers of food products to substitute breast-milk, health workers, and existing health facilities (ATNI, 2016). Even so, the health industry is a market because there is a need for mothers to breastfeed their

babies. The presence of health workers and pro-breastfeeding health facilities has a market value for women who are willing to have successful breastfeeding experience. Nursing counsellors are present to provide support and assistance for mothers who experience difficulties in breastfeeding. In urban areas, breastfeeding mothers could easily access various choices of breast-milk assistance facilities. Friendship, online media, and promotion of the facility itself become a catalyst for mothers who are actively seeking for information.

The complexity of the urban community also creates its own space where mothers are faced with a more personal battle over the discourse of breastfeeding and infant formula discourse. Simpler urban families make more personal and private decisions. Sometimes the family becomes a hindrance when they do not support the breastfeeding practices. However, support from the outside of the family is easier to obtain because breastfeeding mothers in urban areas have easier access to technology, health information, and community or friends who have the same goals through online and offline media.

The discourses on breastfeeding biopower in Indonesia are still unable to regulate social institutions. The practice of breastfeeding has not become a social culture where every individual has the function of supervising, regulating, and disciplining themselves and others. However, the discourse on breastfeeding influences the construction of mothers on breastfeeding practices. Breastfeeding is becoming the hope and aspiration that every mother is supposed to achieve. Discourses and practices that focus on the role of the mother make the position of the mother vulnerable. Unsupportive situations can also affect the emotional side of the mother. In this sense, the discourse on breastfeeding creates a space that makes mothers more responsible for childcare. The practice of breastfeeding is a burden, not a mother's right. The existing space creates a dilemma between the discourse and practice of breastfeeding.

Failed Mother

Some breastfeeding mothers feel that they are failing to provide breastmilk for their babies. The findings of the study data indicate that this failure is assessed by the mother's interpretation of breast shape, the infant's reaction to breastfeeding, and an evaluation of the production of breastmilk itself.

SN, one of the subjects of breastfeeding mothers, stated that her breast-milk production was hindered. The baby did not show much excitement nor appetite during the breastfeeding process. SN also tried to give infant formula, but her baby refused and wanted to continue breastfeeding. She believed that small and unusual breast shape was the cause of the problem. She also felt that she had failed to breastfeed her first child because, even then, she thought her milk production was minimal. She only breastfed her child until she was

eight months old. She felt fortunate because her first child got breast-milk donor from relatives who also had babies. However, the situation did not last long because she gave her first child infant formula thenceforward. When she was pregnant with the second child, SN did not want to repeat a similar breastfeeding failure just like her first child. She wanted to breastfeed until her child is two years old. Based on the advice of a friend, she sought breastfeeding counsellors from online media. She then looked for breastfeeding counsellors were able to home visit and provide breastfeeding assistance (Interview, 6 September 2019).

Subject VN felt the same thing. This young mother lives with her husband, far from her extended family. She is a mother who actively learns about babies and breastfeeding since her early pregnancy through online media. She has an enormous desire to give her baby breastmilk exclusively. Due to jaundice, the baby had to be treated in hospital. Based on a doctor's recommendation, breastfeeding could be done by combining it with infant formula since VN only produces almost ten millilitres of breastmilk. The following is her statement:

"Three days. I took my baby home for three days. I sun-bathe my baby, and I realised that my baby looked a bit yellow. It was not yet time to visit the doctor. The visit was supposed to be Saturday, but I went to the hospital on Wednesday. The doctor checked my baby, and she found that the yellowness has spread to the thigh. She recommended phototherapy, and we spent four days in the hospital. During the therapy, I did not produce enough breastmilk. I tried to pump it, but I only produced ten ccs. It was obviously not enough. Phototherapy was very hot. The baby needed to drink much milk. So, I was advised to combine my breastmilk with infant formula. The hospital staffs gave the infant formula. But they used a special bottle that looked like a cup feeder, like a cup. They used that. After that, the therapy was completed. We were allowed to go home. My baby was not sick anymore and not yellow anymore. A month later, I was not able to fulfil the breastmilk need as recommended for the baby's age. My baby had gained some weight, but not much. For instance, the weight was just four and half kilos when it was supposed to be more of a certain weight. [the baby] just gained a little bit. That is why we continued to use milk infant formula. However, with certain calculation, one fifty millilitres for 24 hours and I was not supposed to use a bottle. It is up to me how to portion the milk, but I felt like it was not enough. My breastmilk was not enough. So, we added more infant formula. Then, during a doctor visit, we found out that my baby had reached over the maximum weight." (Interview, 5 December 2019)

Another subject, RR, also experienced the same thing. She felt that she could only produce little breastmilk even after she pumped it. This affected her interpretation of breast-milk production. So, she decided to give infant formula, fearing that her milk production could

not meet the needs of her baby. The decision to give infant formula was decided at her own discretion, and her husband supported it. Her decision, which was supported by her family, also made RR in a state of uncertainty. She wondered whether it was the right decision or not to give infant formula to her baby. For her first child, she was able to provide exclusive breastmilk until her child reached the age of two years old.

There were many experiences of breastfeeding practice that has influenced mothers' interpretation. However, some difficulties looked normal for health professionals. EL, a doctor who is also a breastmilk counsellor, stated that mothers must learn about how breastfeeding works. According to EL, measuring breastmilk with breast-milk pump will only make the mother depressed. EL's explanation is stated below:

"Regarding breastmilk itself, if for instance, we are in a situation where we have not yet come out from the hospital, then it is normal. A new-born baby's stomach is as big as a marble. So, assume that the stomach is this large. It is the size of marbles, more or less. Only as big as a marble! This will last from the first 1 to 4 days. So, for example, if you are pregnant, then you have given birth if the breastmilk has not yet come out while you are in the hospital, or even only a drop comes out, it is okay. Say, praise to God, *Alhamdulillah*. A drop has come out. It means you already have breast-milk talent, and you still have the capability. 99% of women in this world can definitely breastfeed. They can successfully breastfeed. Do not measure the milk with a pump." (Interview, 30 November 2019).

There was a knowledge gap between breastfeeding mothers' subjects and health professional subjects about the breastfeeding process. The opinion of health professional subjects was based on scientific knowledge while breastfeeding mothers were basing their opinions on their experiences when breastfeeding. The shape of breastmilk, nipple shape, crying babies and amount of breastmilk pumped were used as the basis for the interpretation of adequate breast-milk production. In addition, people around the mothers influenced their decision in breastfeeding practices. When a mother is unable to breastfeed, she will feel confused and frustrated. They always try to do the best for their babies based on their own judgment. This is a consequence of the mother as a nurturing cultural centre. When mothers feel unable to breastfeed, they are in a vulnerable position. This is where mothers need special attention and support from experts (Larsen & Kronborg, 2013). WHO also recognises that although breastfeeding is natural, the way it operates requires the responsibility of the state, international organisations and various interested parties (WHO, 2001).

In the discourse that contains biopower, the truth is present in every power relation. The truth that is present in the context of this power relation is a manifestation of the truth game (Burchell,

Davidson, & Foucault, 2008). In any formal rules game, only truth can legitimise the establishment of right and wrong differences. This truth is historically cultural, where each truth game determines its autonomy. In specific games, the value is the difference between right and wrong. Biopower has an affirmative goal that groups personal and interpersonal levels. Self-ethics is designed to be a point of existence in the power of discipline and at the same time to strengthen the truth (at the public level). The power relation here plays a vital role because it actively works to preserve, produce, and expand the truth. Power relations are also regulated by a series of mechanisms that are political and institutional in everyday life, which require the presence of apparatus and the process of continuous supervision on the field and something anonymous (Lorenzini, 2015).

In this perspective, failure to breastfeed is not only a personal matter of the mother, but there is a structural failure where discourse cannot manifest in the pulses of social life. There has not been a comprehensive and synergic effort to make breastmilk discourse the responsibility and practice of each individual. Therefore, it is necessary to expand public responsibility, educate information dissemination, and increase the presence of apparatus to create biopower discourse in the realm of social practice. Alliamoghaddam et al. studied the role of health professionals in promoting exclusive breastfeeding in New Zealand. They confirmed the benefits of the presence of a health visitor for assisting breastfeeding mothers in supporting practical skills for breastfeeding without making mothers feel compelled and place it as a strength training in carrying out the mother's role (Alliamoghaddam et al., 2017).

Mothers' Negotiation

The final discussion about the discourse of breastfeeding in breastfeeding practice is the mother's resistance to the stigma of failure. This failure is interpreted as a mother who is unable to provide breastmilk optimally. Resistance to failure is the mother's effort to fight for her identity as a mother despite failing to give optimal breastmilk.

RK is a mother who feels failed to breastfeed. She had given her infant formula for the first month after the baby was born. The reason for infant formula feeding was because there were medical indications so that the mother should get intensive care after birth delivery. This condition hampered the breastfeeding process for the baby. However, after she surpassed her health problems, she was faced with the desire to breastfeed. She felt frustrated and failed, which encouraged RK to seek expert help. Some experts made her even more desperate because she felt the failure to breastfeed. However, encouragement and support from the mother made RK confident that she was capable of breastfeeding her baby. She also rearranged the practice of breastfeeding and relaxation, where the

mother tried to breastfeed again after failing to breastfeed. She also succeeded. RK even became a donor mother for two other babies. This achievement made her feel that she had resisted breastfeeding failure (Interview, 20 January 2020).

KF experienced different events. Through the hashtag #sufor on Instagram, she voiced out about mothers who are giving infant formula for their babies. According to her, the way mothers feed their babies does not reduce their identity as mothers. Mothers who give infant formula are also mothers who wish their children well. Infant formula must also be given with health considerations for the baby. What KF campaigning for was her personal experience when she failed to breastfeed her child.

“Oh ... so I was only 24 (years) old when I gave birth to my first child. Incidentally, I gave birth in a hospital that was not pro-breastfeeding. My child was born and was immediately given infant formula by her hospital staff. So yes, our baby was given infant formula by the hospital for one week. My breastmilk also did not want to come out ... I pumped, I did whatever I could, yet still, nothing came out, not even a single drop. When I have arrived at home, maybe my baby was already getting used to drink the infant formula, so when the baby was given a bottle of it [the baby] just drank it. Finally, I did not give the baby any breastmilk ... certainly ... because of breastmilk... people said that infant formula is fake milk. They said that the babies are equal to calves ... or whatever... all negative stuff. They mocked me... they said, my breasts are big but empty... Something like that. Then there were these myths ... they said if a pregnant lady often lifts pliers or usually do some heavy lifting, then the breastmilk is blocked up.” (Interview, 8 November 2019).

Failure to breastfeed causes embarrassment to what she considers a failure. This arises from deviations in biopolitical ideology, where the idea of breastfeeding practices is part of the goals of the state, which are produced and reproduced by the community (Hanell, 2017). The impact of breastfeeding discourse on breastfeeding mothers also causes guilt and regret, especially when they are unable to breastfeed. Holcomb’s research in the United States shows mothers who fail to breastfeed use three strategies to maintain their identity: infant formula is not an option, recognition of efforts to breastfeed and focus on health and happiness (Holcomb, 2017). What happened and what KF did reveal the discourse contestation between formula-feeding mothers and breastfeeding mothers. This contestation results in the judgment of good mothers or bad mothers. The mother’s identity is reduced to what the mother does or what food she gives her baby. This shows the dominance of discourse on breastfeeding in certain social groups. The strong internalisation of the goodness of breast milk compared to formula milk increases the expectation of mothers to breastfeed successfully. This condition again questions the dominance

of the discourse on breastfeeding. In this regard, we can learn what Wolf's criticism of the breastfeeding campaign in the United States is. The breastfeeding campaign has even spread fear for mothers who have yet to give birth to their babies. Wolf argues that breastfeeding campaigns often use inconsistent research evidence and ignore the role of parents as the object of the campaign (Wolf, 2007).

Wolf's argument is shared by other researchers that there are serious ethical problems in the practice of breastfeeding. When mothers try to breastfeed their babies, health workers, or health facilities that help deliver births provide infant formula to the newborns. The practice is not only detrimental to the baby's health but also to the breast-milk production and the mother's ability to breastfeed (Hopkinson, 2007). Other studies also question the target of the breastfeeding discourse since it puts mothers in breastfeeding rhetoric. Critically, this discourse becomes a binding dogma and reducing the mothers' flexibility in certain social groups (Friedman, 2009). In New Zealand, which is a model for gender equality and where breastfeeding rates are high, mothers who fail to breastfeed are not discouraged in the context of gender equality and the oppression of maternal norms (Símonardóttir & Gíslason, 2018).

CONCLUSION

The breast-milk discourse is recognised as a biopower discourse, where the human body is set at the population level, especially the mother's body. Every breastfeeding discourse has its own problems in practice. This discourse expansion affected the mother's identities. Mothers who failed to breastfeed tend to be felt guilty, frustrated and ashamed. They felt that they have failed to provide the best nutrition for their babies. Mothers negotiate through seeking assistance from health professionals or breastfeeding counsellors for breastfeeding practices and trying to voice the practice of breastfeeding cannot reduce that mother's identities. This finding showed that the practice of breastfeeding was central to the ideology of good maternal identity. The identity of a mother who failed to breastfeed becomes more vulnerable and prone to oppression, including by herself. Constructive biopower discourse is needed to implement breastfeeding practice and discourse. This implementation requires accurate breastfeeding information, protection and support from health facilities, assistance from health professionals and broad community support as well as normalisation of breastfeeding practices.

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