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**Deconstructing the *breastmilk* Discourse on the Practice of Breastfeeding in Urban Communities**

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**Abstract.** Breastmilk coverage in Indonesia is still relatively low. Mothers in Indonesia often face classic problems such as weak regulation of protection of breastfeeding, the massive promotion of formula milk and breast milk substitutes, as well as discrepancies in health services. This article aimed to explore the experience of breastfeeding mothers and relate it to the broader discourse. The study was conducted in two metropolitan cities in Indonesia, Jakarta and Surabaya. Both locations were chosen with consideration that the two cities had similar characteristics with urban communities which is characterised by dense, heterogeneous populations and rapid changes. The study was conducted with the critical discourse analysis using the Foucauldian perspective to help examine the discourse and the social practices of breastmilk discourse. Data collection was conducted by semi-structured interviews on 36 research subjects. The results showed that all subjects recognised the benefits of breastfeeding discourse. However, there were differences in breastfeeding mothers' experiences when breastfeeding their babies. This study found three categories, namely the discourse of breast milk and biopower, mothers who failed to breastfeed, and mothers who resisted failure. This finding indicates the hegemony nature of breastmilk discourse and its influence on maternal identity in urban society.

**Keywords:** Breastfeeding Mothers, breastmilk Discourse, Urban Society, Foucauldian Perspective

**INTRODUCTION**

Breastmilk is recognised as the best nutrition for babies. However, there are still many obstacles for those whi practice breastfeeding. The obstacles include regulation, massive promotion of baby formula and breast milk substitutes. Finally, the disparity in health practices. These three problems can affect the practice of breastfeeding in Indonesia. This article linked the experience of breastfeeding mothers with the three major issues above, various problems of daily breastfeeding practices for mothers living in urban areas, and the characteristics inherent in urban society.

Data from the Health Ministery showed that the Early Breastfeeding Initiation (IMD) rate in 2017 was 57.8 percent, while the coverage of exclusive breastfeeding reached 35.7 percent in 2017. This figure was still far from the government's target of 90 percent (Juniman, 2018).

The practice of breastfeeding is protected by international and national regulations. Now, nobody debates the superiority of breast milk compared to other baby foods. Breast milk is the most optimal baby nutrition and has various health benefits for mothers and babies (NABA, 1997). Various reseaches that favor breastmilk prompted WHO to recommend a change from exclusive breastfeeding for 4 months to exclusive breastfeeding for 6 months (WHO, 2001b). WHO recommendations about the 4 gold food standard infants also involve breastfeeding, namely Early Breastfeeding Initiation (IMD), exclusive breastfeeding at the age of infants 0-6 months, providing complementary feeding (MPASI) starting at 6 months of age, and continuing breastfeeding until the baby is aged 24 months (DINKES, 2015).

History records that there was a trans-national social movement to boycott Nestle, the largest formula milk company in the world, in 1977-1984. This movement aims to protest the marketing of unethical formula milk. The first Nestle boycott was carried out in the United States by INFACT (Infant 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, Latif, Boyd, Barber, & Elliott, 2016). This situation led WHO to hold its 34th World Health Assembly (WHA) meeting in 1981 to resolve the issue of Nestle's boycott. The meeting produced the International Code of Marketing of Breastmilk Substitutes, also known as WHO CODE. A total of 118 countries voted to implement the WHO CODE internationally, only the United States did not approve it (Van Esterik, 1989).

The WHO CODE is the ethical foundation that governs marketing and practices related to breast milk substitute products (including formula milk), other dairy products, baby food and drinks including the use of pacifiers and milk bottles marketed or represented suitable for use as substitutes for breast milk either in whole or in part (WHO, 1981). Indonesia is a country that 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 was then followed by other regulations. But at present, existing regulations are only able to protect infants aged 0-6 months. Not to mention the issue of synergy between regulations that support the implementation of exclusive breastfeeding, such as maternity leave, maternity leave, and working mothers. According to the WHO report, the implementation of the law on breastfeeding in Indonesia is still poor. In addition, there are efforts by formula milk companies to encourage the provision of breastmilk substitutes for very young babies (WHO, 2014). Research by Fikawati et al shows that exclusive IMD and breastmilk policies are incomplete and not comprehensive. Therefore, it needs to be updated according to the content, context and process (Fikawati et al., 2010).

The second issue about breast milk in Indonesia is the massive promotion of formula milk and other milk products. Republic of Indonesia Government Regulation No. 33 of 2012 states that formula milk is milk specifically formulated as a substitute for breast milk for infants up to 6 months old. This definition is still debated by breastfeeding support groups in Indonesia because it only provides protection from the promotion of formula milk only until the baby is 6 months old. Nevertheless, it is recognised that the promotion of formula milk is still quite massive in Indonesia. Therefore, promotion of other dairy products (babies over 6 months) may be more massive. Manufacturers of breast milk substitutes (formula milk and other milk products) allegedly did not comply with the WHO CODE. In 2015, the results of a Global Index investigation reported non-compliance with producers of baby food substitutes circulating in Indonesia and Vietnam to implement the WHO CODE (ATNI, 2016).

A study found that violations of the WHO code were carried out by health workers, breast milk replacement companies, and company representatives. This study recommends the need for a regular monitoring system to ensure compliance and enforcement of WHO CODE. This study also confirms the relationship between health workers and representatives of food replacement companies for breastmilk in Indonesia (Hidayana, Februhartanty, & Parady, 2017). Formula milk and food products substituting breast milk is a latent threat for supporters of breast milk in Indonesia. This problem is complex, considering that Indonesia has a large market share for formula milk and breast milk substitutes. The large population, high birthrate and weak regulation make the business of formula milk and food substitutes for breastmilk attractive. In 2016, the business value of formula milk and food substitutes for breastmilk reached Rp. 25.8 Trillion (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, Loh, Prasetyo, & Ariawan, 2014). The Paramashanti et al study in breastfeeding mothers in Indonesia shows that the Early Breastfeeding Initiative supports the success of exclusive breastfeeding (Paramashanti, Hadi, & Gunawan, 2016). Knowledge of breastfeeding is a factor that affects the duration of breastfeeding. Barriers to breastfeeding are affected by swelling of the mother's breasts, formula feeding after delivery, and a lack of grandmother's support to practice exclusive breastfeeding(Aristiati & Hamam, 2014)

The explanation above is a structural problem faced by breastfeeding mothers in Indonesia. At present there are many quantitative studies on breastfeeding practices, but there are still few qualitative studies that discuss breastfeeding practices from the perspective of mothers in Indonesia. A qualitative approach is needed, considering the role of the mother is very important in the discourse of breast milk. Research and health promotion programs about breastfeeding often place mothers as passive objects that have resources that need to be optimised for the success of breastfeeding practices. However, there is no research that discusses the position of mothers in the midst of the confines of breastfeeding discourse and its relationship with weak support and protection in these practices. This condition is problematic and puts the mother in a complicated position. Therefore, the urgency of research from the perspective of breastfeeding mothers based on daily experience is needed to gain a comprehensive understanding and bridge the relationship between discourse and breastfeeding practices. This study chose the Foucauldian approach to understand how the breastmilk discourse works and what its implications are for social practice. This study approves the Foucauldian analysis conducted by Robyn Lee, that the practice of breastfeeding is shaped by the discourse of power that limits who practices it but also opens up new possibilities for how we understand the body, care, kinship in a broader context. (Lee, 2018).

**METHODOLOGY**

The study was conducted in 2 big cities in Indonesia, Jakarta and Surabaya. The characteristics of urban society are characterised by rapid urbanisation accompanied by widespread globalisation. Big cities face challenges in the complexity of resources, migration, infrastructure and economic-based needs (Freire & Stren, n.d.). Urban individuals need to negotiate their ways of thinking and acting between traditional and modern (Paxson, n.d.). This condition questions the position of the mother in a large flow of change.

Research subjects numbered 36 people consisting of breastfeeding mothers, health workers, breastfeeding counselors, and breastmilk support groups. The focus of the study was the experience of breastfeeding mothers explored 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, 1999; 2001).

**RESULTS AND DISCUSSION**

The results showed that all study subjects recognised the medical benefits of breast milk. However, the practice of feeding infants is not always connected to health recommendations. The study also found three categories with regard to breastfeeding practices, namely: Discourse on breastmilk and Biopower, failing mothers, and fighting failure.

**Discourse on breastmilk and Biopower**

Since the entry into force of the WHO CODE (1981), breastmilk has received international attention to protect its practice. The practice of breastfeeding is discussed through various institutional channels related to health. Posters about breastmilk are displayed in various health facilities. One of the implementation of the WHO CODE in Indonesia is Government Regulation No.33 of 2012 Concerning Exclusive Breastfeeding. This regulation prohibits health workers and health facilities from promoting and providing formula milk and other milk products that can inhibit exclusive breastfeeding programs, unless there are medical indications. However, the experience of breastfeeding mothers shows a different practice.

Assistance for childbirth without an Early Breastfeeding Initiative and formula feeding at a health facility was experienced by UMN, one of the breastfeeding mothers subject. An interview with UMN (March 20, 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 formula milk for the baby. However, UMN did not mind. She even continued giving formula milk at home combined with breastfeeding. According to her, the baby can drink both. Formula milk could replace breast milk when she is not with her baby. Currently, she only breastfeeds her baby. This action was done based on the baby's will. She felt that the baby did not want formula milk, and only wanted breastmilk.

TR, the subject of breastfeeding mothers, found a different experience. She and her husband both work in Jakarta. She chose to deliver in Surabaya, in the city where her parents lived. Before giving birth, she sought information from her friends and online media about a pro breastmilk hospital in Surabaya. She felt that breast milk is very important. She bought all the tools needed to give milk to her baby. Breast milk pumps, breast milk storage bottles, cup feeders etc. TR ended up having a normal delivery and IMD in a hospital that, based on the information it collected, was pro-breastfeeding. But unfortunately, she was not treated in the same room as her baby. Even so, TR is persistent in giving breast milk. She also pumps breastmilk to supply breastmilk later when she works. But over time, TR began to feel difficulty breastfeeding. She felt the baby was not satisfied to suckle. Her mother's insistence on breastfeeding through milk bottles was finally accepted. In fact, her mother also suggested giving formula milk to her baby. TR is in a situation that makes her uneasy, between her mother's advice encouraging formula feeding, the hope of breastfeeding and a baby she thinks is not satisfied with breastfeeding (Interview 1 November 2019)

Another case with LN, a young mother who gave birth to a second child, who has certain medical conditions. In her first labor she also experienced the same condition. But the second delivery is more severe. On the recommendation of a doctor, she was forced to accelerate labor by Caesarean at 28 weeks gestation. Premature babies born with low body weight, only 900 gr. In the midst of medical conditions that hinder breastfeeding, LN is still trying to give milk to her baby, although it must be accompanied by formula milk. Apparently, the baby was diagnosed with infant formula intolerance. The doctor also suggested that the baby only be breastfed. LN also tried to find a donor breast milk for her baby, while still breastfeeding herself. She provides breast milk through pacifiers and milk bottles. She does not breastfeed her baby directly because she feels that her milk is not enough and does not satisfy her baby (Interview 17 August 2019).

The discourse of breastmilk becomes important for mothers when connected with other discourses. It is very difficult to link breastfeeding as a natural thing. Health institutions aggressively promote breastfeeding as the best nutrition for babies. But unfortunately, not all of these practices are accompanied by information on nursing skills. Although mothers are recommended to breastfeed their babies after childbirth, they do not get education when checking their pregnancies in health facilities. Some other mothers learn breastfeeding techniques after delivery. One subject of breastfeeding mothers gained knowledge about breastfeeding while pregnant by attending a paid pregnancy class at one of the maternal and child hospitals. She admitted that the class was very helpful in breastfeeding when she experienced breastfeeding barriers, as expressed by WL (Interview, 13 July 2019):

“in the beginning, I could not produce breast milk, ma’am…it’s rather difficult to produce breast milk. But because I have joined a seminar and pregnancy exercise, I tried to be more patient. So for example, people around me told me that if I can not produce breastmilk, I should have given formula milk for my baby. I refused to do that. I did not want to do that. No matter what I must not give formula milk for my baby.”

Mothers are often the main object of breastmilk discourse. Some mothers feel they don't have the support of their immediate family. Besides TR, RP speakers also experienced the same experience. The RP source stated that her husband told her to give formula milk if her milk was not enough. The adequacy of breast milk is seen from the baby who seems to have not had enough breast milk. This made her feel sad and tried to prove that she could breastfeed her baby by looking for breastfeeding counselors and find out about breastfeeding practices online.

Admittedly, the breastmilk discourse has caused intense academic debate. The breastmilk discourse is biased and subtly enters the emotional aspects of the mother. This private discourse has also become a public discourse, where women's bodies are regulated. Much literature shows that breastfeeding has long been the target of regulating women's bodies and creating a normative assessment space for being a mother. Not to mention the problem of health workers and health facilities that are still involved in marketing formula milk. So, the breastfeeding discourse is indeed a representation of the biopower discourse.

The idea of biopower originates from Foucault which means a set of technology, knowledge and discourse used to analyze, monitor and regulate the human body and population (Foucault, 2013). The normal and abnormal body rules in modern society are triggered 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 the mother in terms of acceptable and unacceptable behaviors and hence demands In the United States, the breastmilk campaign using the slogan "Breast is Best" sparked serious debate. This discourse contributes to triggering total motherhood, mother as the center of childcare morality code and contributes to triggering a culture of risk. Total motherhood regulates women's reproductive authority through knowledge, culture and public health institutions. Therefore the need for discipline and normalisation of the mother. 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 asks, Is breast best? As a criticism of health promotion that spreads fear, ignores ethical principles with weak evidence, and frames the message and cultural sensitivity in health campaigns. Supposedly, health promotion of breastfeeding practices is more educative than campaigning in risky message frames (Wolf, 2007).

Other studies show 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 negative in this context (Reid, 2017). 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 main 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 a lot of gaps not to provide assistance to breastfeeding mothers. Therefore, the practice of breastfeeding continues to be borne by the mother. In fact, it has been recognised that this practice also needs support. IMD practices certainly need health workers. The first hour the baby is placed on the mother's stomach immediately after birth will help the success of breastfeeding in the next period. Failure of exclusive breastfeeding in the first 3 days of birth is thought to be caused by factors other than maternal knowledge (Fikawati & Syafiq, n.d.). Most exclusive breastmilk and IMD policy studies in Indonesia discuss the lack of optimal IMD facilitation. However, in terms of regulation, there is no explicit study of IMD in policy (Fikawati et al., 2010).

Other studies also confirm 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 ASIA countries shows that Indonesia and Vietnam are the countries that most violate the WHO CODE. This violation occurred from the side of the company as a substitute for breast milk food products, health workers, and existing health facilities (ATNI, 2016). Even so, the world of health is also able to create a market that meets the needs of mothers to breastfeed their babies. the presence of health workers and pro-breastfeeding health facilities has a market value for women who want breastfeeding to have been successful from the start. Nursing counselors present as a profession that can provide support and assistance for mothers who have difficulty breastfeeding. In urban areas, breastfeeding mothers easily access various choices of breastmilk assistance facilities. Friendship, online media, and promotion of the facility itself become a catalyst for mothers who are actively seeking 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 formula milk discourse. Simpler urban families make more personal and private decisions. Sometimes the family becomes a barrier when they do not support the breastfeeding process. However, support outside the family will be 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.

As a discussion, the breastmilk biopower discourse in Indonesia still seems not able to regulate social institutions or agencies. The practice of breastfeeding has not become a social culture where each individual has the function to supervise, regulate and discipline himself and others. However, breastmilk discourse affects the construction of mothers in the practice of breastfeeding. Giving breastmilk becomes hopes and ideals to be achieved related to a mother. Discourse and practice that is based on the mother makes the mother's position vulnerable. Unsupportive situations can also affect the emotional side of the mother. In this case, the breastmilk discourse creates a space that makes mothers assume more responsibility in care. The practice of breastfeeding becomes a burden and not a right that emancipates maternal freedom. The existing space creates a dilemma between discourse and breastfeeding practices.

**Failing mothers**

Some breastfeeding mothers feel failed to give milk to their babies. The findings of the data in the field show that this failure is assessed from the mother's interpretation of the shape of the breast, the reaction of the baby when breastfeeding, and the mother's evaluation of her own milk production.

SN, one subject of breastfeeding mothers stated that her milk was not smooth. The baby is like not satisfied suckling. She also tried to give formula milk, but the baby refused and wanted to continue breastfeeding. She argues that the small and incomplete breast shape makes her believe that the milk it produces is not sufficient. She also felt she had failed to breastfeed at the time of the first child because even then she thought her milk production was small. She only breastfed her child until she was 8 months old. She felt fortunate because her first child got donor milk from relatives who both had babies. But the situation did not last long. The rest, she gave her first child formula milk. When pregnant with the second child, SN does not want to repeat the failure of breastfeeding in the first child. She wants to breastfeed until her child is two years old. On the advice of her friend, she sought breastfeeding counselors. she is looking for breastfeeding counselors who can come to her house and provide breastfeeding assistance through online media (Interview, 6 September 2019).

The same thing is felt by VN. This young mother lives with her husband, far from her extended family. She is a mother who actively learns about babies and breastfeeding since pregnancy through online media. Her desire to give breastmilk is very big. The baby had experienced jaundice so had to be treated in hospital. On the recommendation of a doctor, breastfeeding is combined with formula milk because it only produces 10 cc of breast milk.

“3 days*.. I took my baby home for three days. I put my baby in the sun and I realised that my baby looked a bit yellow. It was not yet time to visit the docter. It 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. The doctor recommended photo theraphy, it took four days in the hospital. Photo theraphy. During the theraphy, I did not produce enough breast milk. I tried to pump it, but I only produced 10 cc. It was obviously not enough. Phototheraphy is very hot. The baby needed to drink a lot of milk. So I was advised to combine my breastmilk with formula milk. The hospital staffs gave the formula. But they used a special bottle, that look like a cup feeder, like a cup. They used that. After that, the theraphy 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 fulfill the breastmilk need as recommended for the baby’s age. My baby had gained some weight, but not much. For example 4,5, when it was supposed to be a certain weight. Just gained a little bit. That’s why we continue the milk formula. But with certain calculation, 150ml for 24 hours. And I wasn’t supposed to use bottle. It’s up to me how to divide the milk, but my I felt like it isn’t enough. My breast milk is not enough. So we add more formula milk. Then, during a doctor visit, we found out that my baby had gone over the maximum weight.*”

(Interview, 5 Desember 2019)

RR, the subject of the mother also experienced the same thing. She felt the results of breast milk that was pumped slightly. This affects her interpretation of breastmilk production. So, she then decided to give formula milk for fear that her milk production could not meet the needs of her baby. The decision to give formula milk was decided at her own discretion supported by her wife. Her decision, which was supported by her family, also made RR in a state of uncertainty, whether the choice to give formua milk was right for her baby. In the experience of the first child, she can give breastmilk up to 2 years.

Breast pump is present between the body of the mother and baby. An interview with a member of one of the breastmilk support groups, DH, stated that the breastfeeding process should be carried out skin to skin. In this process, mothers breastfeed their babies. The phenomenon of pumping breast milk will become a new problem because it reduces the essence of bonding between mother and baby (Interview, March 23, 2018).

EL, a health professional who is also an breastmilk counselor, states that mothers must learn about how breastfeeding works. Measuring breast milk with breast milk pump will only make the mother depressed.

*"Regarding breastmilk itself, if for example we have not come out from the hospital, it's normal. Because for the first time, a new baby's stomach is as big as a marble. So, assume the stomach (stomach) is large. It's this big (marbles), a new born baby is this big, more or less. Its sise is only as big as a marble. This is the first 1 to 4 days. So, for example, if you are pregnant, you will give birth, if the milk in the hospital has not yet come out, only a drop comes out. Say, praise God, Alhamdulillah. A drop has come out. Means you already have breastmilk talent, you still have the ingredients. And 99% of women in this world can definitely breastfeed. Can successfully breastfeed. Do not measure the milk with a pump. Not how much should we target? No. is enough for the baby. Breastfeeding is foremost. So the first key is that you breastfeed, not take the pump. Because so many people make that mistake, first giving birth, people are busy carrying a pump, not coming out. Up to three hours pumped will not come out. Stress "*

*(November 30, 2019).*

There is a difference in perception between breastfeeding mothers and professional subjects about the presence of pumps as a connecting medium. This shows a knowledge bias between mothers and health professionals. When the mother is unable to breastfeed, she will be confused which method to choose, whether to pump or give formula milk. It will be difficult to find answers without asking for expert help. They always try to do the best for their babies based on their own judgment. 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 scientific, 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 valve 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 an important 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 pulse of social life. There has not been a comprehensive and synergic effort so that the breastmilk discourse becomes 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. Research confirms the benefits of the presence of a health visitor for assisting breastfeeding mothers in providing effective skills support for breastfeeding without making mothers feel compelled and place it as a strength training in carrying out the mother's role (Alianmoghaddam, Phibbs, & Benn, 2017).

**Fighting Failures**

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 breast milk optimally. Resistance to failure is the mother's effort to fight for her identity as a mother despite failing to give optimal milk.

RK is a mother who feels failed to breastfeed. She has given her baby formula milk for the first month after delivery. The reason for formula feeding is because there are medical indications that the mother should get intensive care after delivery. This inhibits breastfeeding for the baby. But after she surpassed her health problems, she was faced with the desire to breastfeed. She felt frustrated and failed. RK seeks expert help. Some experts make her even more desperate because she feels failed to breastfeed. Encouragement and support from the mother makes RK confident that she is able to breastfeed her baby. She also rearranged the practice of breastfeeding, relactation, where the mother tried to breastfeed again after failing to breastfeed. She also succeeded. RK even became a donor mother for 2 other babies. This achievement made her feel she had resisted breastfeeding failure (Interview, 20 January 2020).

Different events experienced by KF. Through the hashtag #sufor on Instagram she voiced about mothers giving formula milk. According to her the way mothers feed their babies does not reduce their identity as mothers. Mothers who give formula milk are also mothers who wish their children are healthy. Formula milk must also be purchased with health considerations for the baby. What KF is campaigning for is her personal experience when she fails to breastfeed.

"Oh ... so I was only 24 (years) when the first child was born. Incidentally I gave birth in a hospital that was not pro-breastfeeding. My child was born and was immediately given formula milk by her hospital staff. So yes, our baby was given formula milk by the hospital for one week. My breastmilk also doesn't want to come out ... I pump, I do whatever it doesn't come out at all. Not a drop comes out. Arriving at home, maybe my baby is enjoying fomula milk, the baby is given a bottle, just drink it. Finally do not drink breast milk ... certainly ... because of breast milk ... people say it is fake formula milk. They say calves ... whatever ... the negative ones. Mocked ... she said, my breasts are big but empty ... well that's how it is. Then there are myths ... when pregnant often lift pliers or heavy lifting. So the breastmilk is blocked up "

(Interview, 8 November 2019)

Failure to breastfeed causes embarrassment to what she considers to be 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 for mothers who are unable to breastfeed. Holcomb's research in the United States shows mothers who fail to breastfeed use 3 strategies to maintain their identity: formula milk is not an option, recognition of efforts to breastfeed, and focus on health and happiness (Holcomb, 2017). What happened and what KF has done shows the contestation of discourse between mothers who give formula milk and mothers who give breast milk. This contestation results in an assessment of being a good mother or a bad mother. The mother's identity is reduced from what the mother does to choose food for her baby. This shows the dominance of the discourse of breastfeeding in certain social pockets. The strong internalisation of the goodness of breastfeeding rather than formula milk makes the expectation of success for mothers to breastfeed increase. This condition again questions the dominance of the discourse of breastfeeding. In this case, we can learn what Wolf criticised in the breastfeeding campaign in the United States. The breastfeeding campaign has even spread fear in mothers who have not yet given birth to their babies. She argues, often breastfeeding campaigns use inconsistent research evidence and ignore the role of parents as campaign objects (Wolf, 2007). Wolf's argument was responded by other researchers that there were serious ethical issues here. When mothers try to breastfeed their babies, health workers or health facilities that help deliveries even give milk to new mothers. This not only damages the baby's health but also damages the production of breast milk and the ability of breastfeeding mothers (Hopkinson, 2007). Other research also questions who the discourse for breastfeeding is about. Because this discourse product puts the mother in breastfeeding rhetoric. Critically, this discourse becomes a binding dogma while reducing the flexibility of mothers in certain social groups (Friedman, 2009). In New Zealand, where breastfeeding rates are high as well as being a model of gender equality, mothers who fail to breastfeed are not discouraged in the context of gender equality and are oppressive in relation to maternal norms (Símonardóttir & Gíslason, 2018).

**CONCLUSION**

The breastmilk discourse is recognised as a biopower discourse, where the human body is set at the population level, especially the mother's body. The breastmilk discourse creates its own problems in practice. Weak regulation and health workers and facilities that are not yet pro-breastfeeding contribute to the failure of mothers to breastfeed their babies. But on the other hand, pro-breastfeeding health markets are growing as a new form of capitalism to absorb the market for mothers who want to practice breastfeeding optimally. On the other side of the discourse of breastmilk, social networks emerge where the discourse of breastmilk dominates and corners the failure of breastfeeding mothers. The breastmilk discourse needs to be reorganised in the realm of practice and its implementation in everyday life by considering the role of the mother as the subject as well as the object of breastmilk discourse. This discourse also needs to be expanded as a form of public responsibility and not to burden the mother only. Meanwhile, alternative discourses are needed that place breastfeeding as an option, not a space to judge maternal identity.

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