

Lived Experiences of breastfeeding in Jogjakarta, Indonesia: Forms of authority beyond the law

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Dedication

For Klenam and Senam

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Table of Contents

Dedication.....	iii
Acknowledgements.....	iv
Abstract.....	ix
Introduction.....	1
Context.....	7
Research in Jogjakarta.....	11
Overview of thesis	16
Chapter 1. Literature Review	
The benefits and critiques of breastfeeding.....	20
Islam and breastfeeding.....	30
Breastfeeding practices and Employment.....	32
Public breastfeeding.....	37
Conclusion.....	39
Chapter 2. Theoretical perspective	
Embodiment.....	41
Biopower.....	54
Chapter 3. Methodology	
Ethnographic Fieldwork.....	61
Recruitment of participants.....	64
Research Participants.....	64
Description of participants.....	65
The choice of and training of research assistant.....	72
Participant observation.....	73
Interviews.....	75
Photo Novellas.....	77
Data Analysis.....	78
Conclusion.....	81

Chapter 4. Breastfeeding: Women's voice on the ground	
Forms of authorities evoked as part of the decision to breastfeed.....	82
Who takes part in shaping women's preparation towards breastfeeding.....	86
Waking up to an alarm clock to breastfeed.....	92
Mothers' experiences after they returned from the hospital.....	92
Navigating breastfeeding difficulties after the mothers returned home.....	96
Baby is old enough to start eating.....	100
Infant Weaning practices.....	105
Conclusion.....	108
Chapter 5. Family contributions to breastfeeding	
Men shaping and shaped by the breastfeeding experience of their partners	
serving as sources of support.....	110
The role of the grandmothers.....	117
Conclusion.....	128
Chapter 6. Working and Breastfeeding Practices	
Breastfeeding shaping mothers' work decisions.....	132
Work shaped by and shaping breastfeeding experiences of mothers.....	135
Conclusion.....	144
Chapter 7. Islamic faith as a form of authority influencing women's experiences	
Women's interpretations of private and public places.....	148
Hiding the breast in public.....	150
Breastfeeding in public spaces.....	153
Breast milk kinship in Islam.....	161
Conclusion.....	167
Conclusion.....	170
Appendix.....	177
References.....	188

List of Illustrations

Figure 3.1. A map of different neighborhoods of the families.....	65
Figure 3.2. Researcher played with a baby in the field.....	74
Figure 4.1. Infant food: Natural and healthy.....	104
Figure 6.1. Ambar expressed her milk in the washroom at work.....	136
Figure 6.2. Juleha's freezer was packed with expressed milk at home.....	139
Figure 6.3. Siti's freezer packed with expressed milk.....	141
Figure 6.4. Manual pump and warmer.....	142
Figure 7.1. A mom used a hijab to cover breasts while nursing.....	152
Figure 7.2. Breastfeeding dresses sold by Nadja.....	153
Figure 7.3. A mom demonstrating how she breastfed her daughter while driving motorbike...	156
Figure 7.4. Lactation room at Ambarukmo Plaza.....	157
Figure 7.5. Lactation room built by SGM.....	158

List of tables

Table 1.1. Pattern of breastfeeding infants aged 0-5 months by age group.....	177
Table 1.2. Pattern of breastfeeding in Indonesia.....	177
Table 1.3. Pattern of breastfeeding infants aged 0-5 months by characteristics.....	178
Table 1.4. Places where mothers give births.....	179
Table 3.1. Summary of the forms of authority that mothers spoke of.....	180
Table 4.1. Duration of breastfeeding and weaning.....	185
Table 6.1. Mothers' work status, place of work and length of maternity leave.....	186

Abstract

In 2009, the Indonesian government passed a breastfeeding law to address the problem of malnutrition, infant mortality and mortality of children under five years old. The law mandated mothers to breastfeed their babies exclusively for the first six months of their lives and continue for two years, except in cases where medical problems prevent mothers from breastfeeding. I aim to tease out women's experience of breastfeeding in Jogjakarta, Indonesia, five years after the law was passed. Ultimately, I am interested in understanding how do women's breastfeeding experiences embody different forms of authority. I drew upon data from ethnographic fieldwork that was carried out from June 2013 until October 2014. I argue that the breastfeeding law is remote and distant from the everyday breastfeeding practices and experiences of the women and their families. The women who take part in the study neither draw on the law nor public health as forms of authority to shape their breastfeeding experiences. Rather the women draw on their Islamic faith, families, personal experiences, finance, work and media to shape their breastfeeding experience

Introduction

My interest in breastfeeding first emerged while I was working on a *jamu*¹ project in Jogjakarta in 2013. During the *jamu* research, I observed that women often buy *jamu* drinks made from papaya leaf called *uyup-uyup*. I became curious about it and began to ask my Javanese friends why women would drink *jamu uyup-uyup*. The answer I received from my friends was that *jamu uyup-uyup* enhanced the production of breast milk. This was fascinating to me because I have always thought that as a child sucks her mother's breast, milk is produced. I never knew that some women experience low supply of milk and had to drink *jamu* to increase milk production. Many of my friends thought I was crazy to research breastfeeding since it is mainly in the domain of women. But I was determined to carry out this study because I was breastfed as a child and I know that maternal and child welfare is a concern for all people. Hopefully, this endeavor will provide original insights into women's experiences and practices of breastfeeding, as well as become a way of encouraging other men to offer support to women who can or cannot breastfeed.

When I came back to Canada, I started reading more of the breastfeeding literature and found two further reasons why studying women's experiences of breastfeeding might be significant. First, breastfeeding has received much more attention in the public health discourse than in the social sciences. In the public health literature, much attention is paid to the health risks and benefits of breastfeeding for infants and mothers (Howie, 1990; Mitchell, 1992; Dewey, 1993; Newcomb, 1994; Lawrence, 1995; Golding et al. 1997; Scariati et al., 1997; Labbok, 1999; WHO, 2003; American Academy of Pediatrics, 2005). However, the public health literature has not been interested in women's actual experiences of breastfeeding notwithstanding aiming to apply policies and regulations that police women who breastfeed. It thus seemed to me

that these policies, based on quantitative public health research, carried out far from where the policies were being implemented in the Indonesian case, might not translate into meaningful practices in the field, but rather become unrealistic or constraining, leading women to disregard them. This is the reason I turned towards the social sciences, where some studies have looked at diverse aspects of women experiences of breastfeeding (Baumslay & Michel, 1995; Murphy, 1999; Britton, 2000; Dykes, 2005; Septiari, Februhartanty & Bardosono, 2006; Britton et al. 2006), albeit not in Jogjakarta, Indonesia. My research thus contributes to these works as well as adds to them by studying how breastfeeding occurs in a new context.

The second major issue why exploring women's experiences of breastfeeding might be important is linked with the first and is particular to Indonesia. Upon doing more research on the topic of breastfeeding in Indonesia, I learned from my second supervisor (Rippey) that the Indonesian government had enacted Health Law No. 36 in 2009. The law mandates mothers to breastfeed their babies exclusively for the first six months of their lives and continue for two years, except in cases where medical problems prevent mothers from breastfeeding (Better Work Indonesia, 2013). The law provides a fine up to 100 million rupiahs (equivalent to \$11,000) or one-year jail term for any person (including employers, grandmothers, husbands, etc.), who hinders exclusive breastfeeding². The law is not intended to jail women for not breastfeeding, but to monitor and punish other people (e.g. family members, employers, and medical personnel) who would infringe on women's possibilities to breastfeed. The law aims to provide support to women to breastfeed at workplaces and public space. The law also aims to address the problem of malnutrition, infant mortality and mortality of children under five years old as indicated in statistical studies (Table 1.1 to 1.3 show patterns of breastfeeding by age and characteristics). Although the law was applauded by breastfeeding advocates, for instance, AIMI³ in Indonesia, as

a win-win situation for mothers and babies, such an official and punishing constraint coming from government policies seemed extreme and perhaps not meaningful in people's lives. I thus became interested in understanding the law and how it translates into people's lives or not. For instance, I wanted to explore if people were even aware of this law and, if so, did they conform to it (or not) or did the law conflict with other Indonesian cultural practices of breastfeeding. Thus, the law becomes an entry point for me in trying to understand the women's experience of breastfeeding.

My research therefore aims to shed light on women's experience of breastfeeding in Jogjakarta, Indonesia, five years after the law was passed. My research question is; how do women's breastfeeding experiences embody forms of authorities? Authorities are understood not as power from the above but I use it broadly in terms of power/knowledge relations as defined by Foucault (1982, p. 786), namely, as the possibility of certain people or groups of people to say and to act upon the actions of others. In other words, I aim to understand how some forms of authority shape and are shaped by women's breastfeeding experiences, beyond the law. The forms of authority include biopolitical, religious Javanese, work, media and household.

Law and public health campaigns are made within the biopolitical framework. Public health campaigns are based on demographic data and algorithms linking breastfeeding to poor health. Public health and epidemiological studies using statistical data have established that babies who are formula-fed have a higher risk of getting sick than infants who are breastfed. These statistics are presented to families to help them make an informed decision about breastfeeding with the aim of lessening the risks of not breastfeeding. So, in the hospital, public health nurses teach women how to breastfeed but how this knowledge is taken home and used may transform or be transformed by women's realities.

While Foucault provided a perspective to understand the law and public health interventions in the context of Indonesia, it is important that we understand how the law works in people's everyday lives. There are several competing ideas about what law is and how people use and think about the law in their everyday lives. While legal positivists may view the law as autonomous, discrete, rational, neutral, impartial, objective, and source of social change, scholars like Geertz (1983), Bourdieu (1987), Ewick & Silbey (1998), Sarat & Kearns (1998), argued that law as social relation cannot be absolute, determinate or omnipotent. The law is not separate from the realm of social life nor is it discontinuous and distinctive. Rather for these scholars, the law is always invented, negotiated, made, challenged, resisted, reconstituted and modified in the everyday life of people. The law can be embodied or disregarded. The Indonesian breastfeeding law, for instance, can be understood as a form of biopower. Foucault (1978) did not suggest that the development of biopower leads to the disappearance of law. Rather he argues that the "law operates more and more as a norm and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory" (p. 144). I alluded to the idea that the law as a social relation and practice are interwoven with the everyday lives of people. It would be naïve to think that punishing those who hinder women from breastfeeding (without resolving the difficulties that women face) will translate into an expected social change, as is the case of breastfeeding laws in Indonesia. People in many aspects of their lives do not think about the law until they are implicated by the law. People go about their daily lives – caring for families, work, giving births, breastfeeding without thinking of the presence of the law. As Ewick & Silbey (1998) suggested, the law may seem to be remote, distant, and often irrelevant to matters that concern us in our daily lives.

The law as social practices and social relations is embedded in the everyday lives of people. As Geertz (1983) pointed out, the law is one way that humans make sense of the world and of creating meaning in the minds of people. The law is not in antagonism to everyday life, as Engel (1993) puts it “everyday life is not opposed to law, nor does it exist merely by insinuating itself into the interstices of the law. Everyday life constitutes law and is constituted by it” (p. 126). Engel’s analysis showed the importance of contextual analysis of law and everyday life experience. Thus, the law is continuously shaping and reshaping social practices and individual actions, but these practices, relations, and actions are also shaping law by altering what is socially desirable, politically feasible and legally legitimate (Mezey, 2001). According to Bourdieu (1987), “law is the quintessential form of ‘active’ discourse, able by its own operation to produce effects. It would not be excessive to say that it creates the social world, but only if we remember that it is this world which first creates the law” (p. 839). Bourdieu (1987), Geertz (1983), Ewick & Silbey (1998), Sarat & Kearns (1998) all depart from the external and normative conception of the law and move towards viewing law as meaning making. As Sarat & Kearns (1998) have highlighted, the law permeates through our social life, and we are not merely pushed or pulled by the law that is imposed on us from the outside. Rather we internalize and embody law’s images and meanings so much that they become part of us.

In the case of the Indonesian breastfeeding law, I envisaged that some women would not be aware of the law while others may be aware of the law yet would not conform to the law since it conflicts with other cultural practices of breastfeeding. Mothers may also not report any of their family members to the law enforcers because doing so will mean a financial loss to the family which may indirectly affect the household income. Some mothers may see the law as a form of control over their bodies – so they may be against the power of the law. So, in sum, the

law as a form of biopower is lived, negotiated, modified and resisted by the mothers to reconcile with their daily breastfeeding experience. Biopolitics is just one form of authority, but there are other multiple layers of authority which shape women's experiences of breastfeeding.

Religious Javanese comprised of some forms of Islam and jamu medicine, is another form of authority. In Java, animist, Hindu, Buddhist, Islamic, and Catholic prevail as governing forces in diverse shapes, forms and layers. As Geertz (1960) pointed out, Java is a “balanced integration of animistic, Hinduistic and Islamic elements-check quote” (p. 5). In other words, I became interested in ways that breastfeeding emerges in the city of Jogjakarta, a place in which the governor working within the Indonesian republic is a Sultan living in the Javanese Palace, this situation already attesting to a multiplicity of forms of authorities that might conflict with a recent public health law. I am not referring to the Sultan as having authority over his people, but what I am talking about is the knowledge that is linked with the Sultanic Javanese ways of life which is given legitimacy that might supersede biopolitics. In Jogja, Islam, Javanese, Hinduism and Buddhism are deeply interconnected. While the Quran requires women to breastfeed for two years, women drink popular Javanese drink jamu to increase the quantity and improve the quality of their breast milk. Islam and Javanese highly value the importance of breastfeeding.

The next form of authority is the household. By household I mean the family and the personal experiences that women acquire over the course of time. The family includes a couple, children, grandparents and other relatives. The husband has an obligation under the Quran to encourage his wife to breastfeed. Grandmothers who have extensive cultural knowledge on infant nutrition helped women to increase breast milk using *jamu*. For women that drink *jamu* and it works for them, jamu becomes personal knowledge that they rely upon in their daily lives.

Work is another form of authority that shapes women's experience of breastfeeding. I conceptualize work as any activity that brings income to the mothers. In the corporate world, there are policies that govern the behavior of employees. For example, duration of paid maternity leave, break time to accommodate breastfeeding, access to lactation room and refrigerators. In workplaces where breastfeeding is not tolerated, some women have to change their job or resign in order to accommodate breastfeeding. The law could in these instances become useful to allow women to breastfeed at the workplace without losing their jobs, however this does not seem to be applied in practice.

The media also plays an essential role in shaping women's experiences. By media, I am referring to both the traditional and social media of dissemination information. Examples of the media include newspapers, televisions, radio, YouTube, breastfeeding blogs, websites, billboards, Facebook, WhatsApp, Blackberry Messenger (BBM), etc. In Indonesia, the popular breastfeeding website is AIMI. The media provide large complex narratives of breastfeeding and formula feeding which shape and transform women's perception and reinforce or challenge dominant ideologies about breastfeeding. Facebook for instance, allows women to share their experiences of breastfeeding and learn from the experience of other mothers who are within or outside Indonesia. The narratives written in the media target different audiences. All these forms of authority are not disconnected but entangled. In the analytical section, I try to bring the entanglement of the forms of authority in the narratives of the women.

To understand the forms of authority (law, public health, religion, family, work, media), I followed the breastfeeding experiences of eleven women as part of a cluster of relations with their newborns, their spouses and different members of extended family. During the field work, the women and their husbands guided me into ways of understanding how breastfeeding was

lived in relation to the forms of authorities that appear in their everyday life experiences. With this line of questioning and approach, I privilege their experiences or the ways forms of authorities are embodied and acted upon (or not). By listening to mothers' stories, their experiences, and doing participant observation, I came closer to knowing how breastfeeding mothers and their families embodied diverse forms of authorities. This approach to learning from the mothers brings forth the complexities (i.e. breastfeeding problems) that women have to deal with in relation to varying forms of authorities playing into their possibilities to breastfeed as they want and as they can. As I came into this topic in part with an interest in a national breastfeeding law, this broader setting is useful to explain in its recent histories.

Context

Indonesia declared its independence in 1945 after a lengthy Dutch (1602-1942) and short-term Japanese (1942-1945) occupation. Though Indonesia is widely diverse (i.e. this diversity is explained in the next section), the fight for independence led to the creation of national unity (Pringle, 2010). Sukarno became the first president of the newly independent Indonesia, and he promulgated the Pancasila as a philosophical foundation to unite the diverse archipelago (Krier, 2011). The Pancasila refers to five fundamental principles: nationalism, humanism, democracy, social justice and monotheism (Krier, 2011). The belief in one God is not only about Indonesians believing in one Supreme Being but every Indonesian believing in his or her own God (Elson, 2008). The belief in one supreme God was to guarantee non-discrimination of people based on religious grounds. Sukarno held political power for over twenty years when Major-General Suharto seized power in 1965.

Suharto's New Order (1965-1998) was known for its rapid economic growth, notably in rural areas, opening up trade with Western countries, and introducing neoliberal policies. Under

the guidance of American-trained Indonesian economists, known as the “Berkeley Mafia,” Suharto, “launched programs that boosted rice production, expanded the nation’s decrepit transport infrastructure, lifted literacy rates from 40 to 90 percent of the population, and implemented one of the developing world’s most successful family planning programs” (Hefner, 2000; p, xii). Pringle (2010) also found that during Suharto’s regime, the number of Indonesians living below the official poverty line dropped three-quarters, yet income inequality increased. Over his 30 years in power, the economy grew at the rate of 6-7 percent each year (Hefner, 2000, p. 6). Infant mortality rates fell sharply, and life expectancy increased (Radelet, 1998, p. 1). Although Suharto’s regime was noted for its remarkable economic achievement, there was also widespread corruption.

While many Indonesians seem to have enjoyed the economic boom from the 1970s to the early part of the 1990s, the economy collapsed unexpectedly in the latter part of 1997 and early part of 1998 because of a wider Asian financial crisis (Hefner, 2000, p. 6; Krier, 2011, p. 19). The collapse of the economy contributed to millions of Indonesians living in relative poverty. The economic crisis resulted in a political crisis in May 1998, where urban riots erupted in Jakarta, killing approximately 1,300 people (Pringle, 2010, p. 112; Radelet, 1998, p. 1). The political crisis forced President Suharto to resign after three decades in power. His Vice President Habibie immediately succeeded him as the interim President, and stayed in power for seventeen months (Pringle, 2010, p. 113) His presidency lifted Suharto’s restriction on political parties, promoted decentralization in local government and establishment of press freedom (Pringle, 2010).

Under both the Old and the New Order in Indonesia, the political power of Islam was repressed (Hefner, 1993; Brenner, 1996; Pringle, 2010). Sukarno, for instance, banned the

Reformist Islam Party Masyumi in the 1960s for wrongdoing in the Outer Islands Rebellion. After the fall of Sukarno, pressure from the Masyumi Reformists was put on Suharto to allow the Masyumi Reformists gain its place in a political setting (Pringle, 2010, p. 89). Though in 1968 Suharto allowed the Reformists to rebuild themselves as the Indonesian Muslim Party, he refused to let the old leaders of Masyumi participate in the new party (Pringle, 2010, p. 89). Further, Suharto also declined to acknowledge the Jakarta Charter as the preamble of the national constitution (Pancasila), thereby crushing the hopes of Muslims that the State would carry out Islamic law (Hefner, 1993). As Brenner (1996) argued, “the state has attempted to maintain a delicate balance, acknowledging and in certain respects encouraging Islam's religious and cultural influence among the population while restraining its political influence by alternately co-opting and suppressing potential sources of Islamic political power” (p. 676).

Islam in contemporary Indonesia is organized into two groups; the Muhammadiyah and the Nahdlatul Ulama (Pringle, 2010). Muhammadiyah is considered as the reformists who are devoted to purifying Islam of animism and Hindu-Buddhist practices that had come to be attached to it such as making offerings at graves, praying to ancestors for blessings or consulting healers for magical cures (Krier, 2011, p. 21). The Muhammadiyah doctrine is based on Sunni Islam. It was founded in Jogjakarta in 1912. Its population estimates was around twenty-five to thirty million. The Nahdlatul Ulama, which is the traditionalist Sunni Islam was established in 1926 as a reaction the growing number of the Muhammadiyah. The Nahdlatul Ulama was estimated to be the biggest Islamic group with a population size of thirty-five to forty million (Pringle, 2010, p. 114). The Nahdlatul Ulama were based mainly in East Java and were described as traditionalists who accept animist practices. Geertz (1960) who did his ethnographic study in

East Java has referred to the Nahdlatul Ulama as *abangan*. Abangan are nominal Muslims whose religious faith allow them to include some elements of local cultural practices (Geertz, 1960).

Currently, the State legal system is not based on the understanding of Sharia law nor a “monopolistic fusion of religious and political authority” (Hefner, 2000, p. xviii). Thus, the Indonesian legal system is based on a civil law system that is fused with the customary law (*adat*) and the Dutch-Roman law. Further, out of the 34 provinces of Indonesia, only one province, Aceh, imposes Islamic law on its people (Zambardino, 2014). Having discussed the political, economic, religious and legal framework of Indonesia very succinctly in a broader context, I now shift my attention to the city in which I carried out my fieldwork.

Research in Jogjakarta

Jogja, as the city is affectionately called, was historically and culturally part of the province of Central Java. It was the first capital of the Republic of Indonesia but now the capital city of the Special Region of Jogjakarta (Daerah Istimewa Jogjakarta DIY). The city has approximately three and half million people (Badan Pusat Statistik, 2010). As Ferzacca (2001) pointed out, Jogja has multiple identities; it is called *Kota Revolusi*, the evolutionary city; *Kota Perjuangan*, the city of struggle; *Kota Pelajar*, the student city; *Kota Budaya*, the city of culture. As a student city, it has the first established University after independence, Gadjah Mada University. It was founded in 1949 and has approximately 55,000 students and 1,187 international students. While I was in Jogja, I was affiliated with the Department of Anthropology, Gadjah Mada University, through a transcultural exchange with the Department of Sociology and Anthropology at the University of Ottawa, as well as part of a broader Social and Humanities Research Council (SSRHC) project. As Ferzacca (2001) highlighted, the

establishment of Gadjah Mada University after independence was the beginning of Jogja's placement in the global arena of science and academy.

Java is the only region in Indonesia that is governed by the pre-colonial monarchy, known as the Sultan of Jogjakarta. The Javanese Palace (Kraton) is the center of Jogja's traditional culture. The Kraton was built in 1755-1756, and its name was derived from the Sanskrit Ayodhya, the capital city of Rama in the Ramayana epic, thus the design of the cosmic Indic city (Ferzacca, 2001, p. 28). Walls were built around the Kraton as a form of fortification. The walled city was referred to as a "town within a town" (Ferzacca, 2001, p. 31). There were about twenty-five thousand people in the Kraton of which one thousand of them were *abdi dalem* (employees) who provided services to the Sultan (Laplante, 2016, p. 2). For example, some employees prepared *jamu* for the Sultan, others cleaned the Kraton, and cared for the horses. Geertz (1960) who conducted an ethnographic study in Javanese village states that Java has been civilized longer than England and over the course of centuries it had seen Indians, Arabs, Chinese, Portuguese and Dutch come and go. Geertz (1960) also explained that the first Malayo-Polynesian people that would have arrived on the Java Island had knowledge of agriculture, a practice that has become a vital sector of the Indonesian economy.

Statistics shows that approximately 87 percent of Indonesians self- identify themselves as Moslems (CIA, 2014). The remainder were Animists, Catholics, Hindus, Buddhists and Protestants. Geertz (1960) argues that these statistics are simple ways of understanding the complexity of religions in Indonesia. According to him, before the Hindus arrived at Java around 400 A.D., the earliest religion was animism, which is based on ancestral worship, spirits, magic and sorcery, divination and witchcraft. Islam only came to Indonesia in the thirteenth century or before. According to Saleh (2001), Islam did not spread to all part of Indonesia at the same time.

At first, it flourishes in areas that were not affected by Hindu-Buddhist traditions, such as Aceh, Banten, and West Sumatra. In areas where Hindu-Buddhist civilization dominated, Islam was forced to adapt itself, and in the process lose its doctrinal rigidity (Saleh, 2001, p. 18). For example, early Islamic architecture like the mosque in Kudus, Central Java, often reflected Hindu-Buddhist prototypes (Pringle, 2010, p. 129). Over the course of centuries, Java was remarkably able to absorb elements of both Hindu-Buddhist and Islam, and some elements of western civilization lately (Geertz, 1960; Berg, 1955). Abram (1996), who also conducted fieldwork in the Island, understood Bali as “enlivened with indigenous animism appropriating Hindu Gods and goddesses by the more volcanic, eruptive spirits of the local terrain” (p. 14-15). So, Java is a mixture of animism, Islam, Hinduism, Buddhism, and Western civilization. This combination of religions into one syncretized element is shown in the everyday lives of some Javanese. For example, when I was in Jogja in 2013, five of the Indonesia students who assisted us during the fieldwork claimed to be Muslims, but some of them did not strictly follow the principal canons of Islam. During the Ramadan period, John, who was one of the research assistants claimed to be fasting, but he drinks coffee and smokes. Also, I observed that they did not pray five times daily as required by Islam. I had never seen my research assistant attend the Friday mosque service. This is being Javanese (*kejawen*), the Javanese way of doing Islam in all sorts of ways.

In an ethnography study conducted by Laplante (2016) in Java, she found that the Tengger village located in East Java appealed more to Buddhist practices, while Hindu practices flourished in Bali, showing yet another multiplicity of layers. In a photographic ethnography, Bateson and Mead (1942) focus on the various aspects of life (such as dancing, sleeping,

standing, eating, breastfeeding) of a Buddhistic Brahman family in the village of Batocan, arguing that every village, district in Bali differ from one another.

Ferzacca (2001), who worked in Jogja especially on healing, argues that “the Javanese philosophy of embodiment outlines a universe of elements, substances, desires, aesthetic sentiments, and sensual textures that coexist in a world of practice and destiny. Illness, disease, and other signs of disequilibrium and imperfect fits make clear the general dimensions of this phenomenology of fluid signs and copious flows that saturate Javanese selves” (p. 200-201). So in Jogja, health care practices are fluid and pluralistic. The Demographic and Health Survey (2012) of Indonesia compare health facilities in which women gave birth (see Table 1.4 in the Appendix). The women give birth either in a public or private hospitals or at home. In the villages, women may be delivered by *Bidan di Desa*, village midwife or *Dukun Bayi* traditional birth attendants who delivered for women at home. *Bidan di Desa* was a biomedically trained midwife who was placed in village in Indonesia to manage birth centers. The *Bidan di Desa* program started in 1989, and its goal was to place a midwife in every village birth center in order to improve maternal and child health. In many villages, this goal has yet to be achieved (Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia, 2013). The *Dukun Bayi* uses *obat tradisional*, traditional medicine or *jamu* made from various plants and ingredients to heal the woman after birth. The *dukun bayi* also blessed the mother and the child by invoking the blessings of the ancestors, animism that many anthropologists who worked in Java discussed. None of the women who took part in the study delivered at home; they either gave birth in private hospitals or public hospitals although they do consume *jamu* to increase their breast milk. The *Dukun Bayi* may collect the plants from her household backyard or buy the ingredients from the Malioboro market. Mothers who delivered in the hospital also consumed *jamu* to heal

themselves when they returned home. This is Javanese ways of blending animism and biomedicine.

Jamu is prepared and sold mainly by women on the streets and marketplaces on a daily basis. *Jamu* is made from a mixture of spices, rhizomes, roots, leafs, chunks of woods, lemon, tamarind, chilies, beras (powdered rice), honey, and eggs, which is used to energize the body, treat disease and promote beauty. For example, some Jogja women used *jamu* to regulate their menstruation, increase breast milk, tighten their vagina for the sexual satisfaction of husbands, treat sexually transmitted infections, enhance beauty, and for prenatal and postnatal care. Krier (2011) who did her Ph.D. dissertation on *jamu* industries, women's health and Islam in Jogja found out that Muslim women used *jamu* to regulate menstruation in order to fast in the holy month of Ramadan (p. 228). Retsikas (2012) who did an extensive studies in East Java observed that mothers consume *jamu Pejjeen* three times a day throughout the first forty days after birth. The *jamu Pejjeen* "turns the mother's blood into breast milk, making it appropriate for baby food" (Retsikas, 2012, p. 97). Ferzacca (2001) suggested that "*jamu* as a spontaneously made and consumed liquid is simply one other flow that passes through the human body, that also nurtures the complex whole of flows and winds which constitute the nature of human life" (p. 151). He explained the Javanese conceptual framework of a body as winds and flows. The mixture of the ingredients of *jamu* depends on the type of illness, gender, age and taste. Like Western pharmaceuticals, *jamu*'s efficacy is measured by the degree of bitterness.

There were many public and private hospitals in the city. The notable hospitals where women give birth in Jogja include Dr. Sardjito hospital (State owned), Bethesda hospital (private), Panti Rapih hospital (Catholic) and Muhammadiyah (Islam). Bethesda was the first hospital built in Jogja, and it was founded in 1899 by a Dutch with support from Sultan

Hemengkukuwono VII. Dr. Sardjito hospital which was not far away from where I was living in Jogja has a traditional medicine unit which operates alongside with the biomedicine. The doctors who practice in the traditional medicine unit are trained in both biomedicine and traditional medicine. Patients who visit the hospital had a choice to be examined by a physician or a traditional doctor. The traditional doctors only prescribe traditional medicine that was scientifically approved by the Indonesian government. In 2013, I accompanied my supervisor to interview one of the traditional doctors in the hospital. While we were in his office exchanging greetings, I had a severe abdominal pain. The traditional doctor quickly examined me and referred me to the biomedical unit, which is three minutes away from his office. The establishment of traditional medicine unit within a public hospital is one way that the Indonesian government promotes and develop traditional medicine in Indonesia.

Overview of the Thesis

Chapter one offers a broad overview of work that has been done on the topic of breastfeeding. The themes that predominately emerged from the literature included Islam's recognition of breastfeeding, health benefits and risks of breastfeeding in public health literature, feminists' critiques of breastfeeding campaigns and breastfeeding practices and employment.

From this review of the literature, in Chapter two I propose a particular theoretical approach in anthropology that addresses experiences in breastfeeding and how these are lived within the scope of different kinds of authorities. Foucault's analysis of biopower helps us to understand how the law was instituted and how public health interventions as a form biopolitics is used to govern life. In the Indonesia context, we need to go beyond a biopolitical framework as the law on breastfeeding is technically in place but not really brought into practice and this can be discussed in more depth through the phenomenological approaches I proposed. Under the

phenomenological approach in anthropology, I use different overlapping concepts such as “embodiment,” (Csordas, 1990) “habitus,” (Bourdieu, 1977) and “knowing from the inside” (Ingold, 2012) to understand women’s experiences of breastfeeding without assuming any pre-existing entities.

Chapter three explains the methodology I followed in light of the theoretical approaches I used. I followed the everyday experiences of breastfeeding with eleven women and their families in Jogjakarta from June 2013 to October 2014. After my return to Canada, I contacted the women through my research assistant. I used interviews, participant observation, and photo novella methods to learn from their experiences.

Chapters four to seven offer an analysis of my observations and the women’s narratives. Chapter 4 is descriptive, and it talks about the different authorities that women evoked as part of their decision to breastfeed. It also focuses on when, how, and why babies were weaned off breastfeeding.

Chapter five addresses fathers and grandmothers’ contribution to breastfeeding practices. Fathers and grandmothers are important social actors that influence breastfeeding decisions and experiences. To explore this, I spent time interacting with five of the partners of the mothers who took part in the study. Fathers discuss the important roles they played in supporting their wives to breastfeed successfully. Despite fathers’ contributions to breastfeeding, some mothers suggested that their partners were unsupportive of them. Grandmothers who have extensive cultural knowledge of infant nutrition and mother-child dyads played the role as advisors and trainers of young women when they have their first child. The family forms of authority imbued a mixture of Javanese-animist-Islamic.

In chapter 6, I discuss work as a form of authority that shaped women's experiences of breastfeeding. Women have three months paid maternity leave yet the Health Law mandates them to breastfeed exclusively for six months and continue breastfeeding for two years. Mothers deal with these regulations by expression of milk as a way of managing a return to paid work. I argued that work regulation and labor laws on maternity leave shape mothers' breastfeeding experiences, but there was disjuncture between the demands of the law and the demands of work regulations.

Chapter 7 investigates Islam as a form of authority in shaping women's experiences of breastfeeding. The holy Quran require women to breastfeed for two years. It also socializes them to be modest in dressing in public place. However, how these public places are defined, interpreted, experienced, and negotiated by women varied once they became mothers. The home which was often regarded as a safe and private place could become a public place when male guests were around. Through the narratives of the eleven mothers, I explore how breastfeeding is done in public. Because of the women's faith in Islam, some of them avoid breastfeeding in public in order not to be labeled as indecent woman.

The conclusion brings together what I have learned from women's experiences and practices of breastfeeding and the law. Although the law was intended to increase breastfeeding rates and duration and give some form of protection on women to breastfeed, the law is remote from the women. Only one woman in the study had heard of the law but did not know how the law works. Other forms of authorities that shape women experiences include public health, Islam, media, work regulations and the family.

Notes

1 The *jamu* research explored the interlinkages between informal gender entrepreneurship economy, local knowledge systems in traditional medicine and urban development. The research was funded by Social Sciences and Humanities Research Council of Canada (SSHRC). My research was financed through the *jamu* research. My research was financed through the *jamu* research

2 The World Health Organization defined exclusive breastfeeding as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for the first six months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines) WHO (1991).

3 AIMI stands for Asosiasi Ibu Menyusui in Indonesia, which translates into Breastfeeding Mothers Association. The members are all mothers. They assisted each other by offering advice and support on breastfeeding through Facebook, Twitter, and Blackberry Messenger. For instance, some mothers who had difficult breastfeeding experiences shared it on Facebook and mothers who went through similar difficulties provided advice on how they were able to resolve the problem and continue breastfeeding. Thus, the association aims to provide information, knowledge and support for mothers to breastfeed exclusively for six months and continue until two years and beyond. Further, the association aims to increase the percentage of exclusively breastfed babies in Indonesia. AIMI is mainly centered at Jakarta but it has a [Facebook Page](#) which makes it easy for mothers outside of Jakarta to join.

Chapter 1

Literature Review

This chapter reviews previous research that has been done on breastfeeding in the field of public health, sociology, anthropology, women and gender studies and feminist studies. The themes that predominately emerged from the literature included, the health benefits and critiques of breastfeeding of breastfeeding promotion, Islam and breastfeeding, breastfeeding practices and employment, and public breastfeeding. Embodiment and lived experience of breastfeeding are linked to the problems that women faced during breastfeeding.

The benefits and critiques of breastfeeding

Healthy food is important for the growth of infants and breast milk is said to provide the best nutrition for infants (Schulze & Carlisle, 2010). The composition of breast milk changes with infants' needs throughout the lactation period. Minchin (1987) explained that breast milk changes within a feeding and between feedings in relation to infants' behaviors and environmental conditions. She gave an example that if a baby is born prematurely, the milk the mother makes will be higher in many of the growth factors and other nutrients the baby needs for adequate growth. If the mother is living in cold weather, the milk will be fattier to give energy to the baby, and in a hot climates, the milk will be watery to prevent dehydration (p. 26). Breast milk is therefore considered superior to other infant feeding alternatives.

Within the public health literature, it is suggested that breastfeeding has positive health benefits for both child and mother in the short and long term (WHO, 2003; American Academy of Pediatrics, 2005). For the child, it is argued that prolonged breastfeeding reduces the incidence of many illnesses including respiratory and gastrointestinal infections and diarrhea (Howie, 1990; Aniansson et al. 1994; Scariati et al., 1997; Arifeen et al., 2001; Bachrach et al. 2003;

Quigley et al. 2007; Omotomilole et al. 2015), otitis media (Scariati et al., 1997; Jackson & Nazar, 2006), asthma (Golding et al., 1997; Cushing et al., 1998; Oddy et al., 1999, Infante-Rivard et al. 2001; Miller 2001), fever (Pisacane et al., 2010), childhood and adolescent obesity (Gillman et al., 2001; Grummer-Strawn & Mei, 2004), eczema (Lawrence, 1995; Golding et al. 1997), sudden infant death syndrome (Mitchell, 1992; Golding, 1993), type I and type II diabetes mellitus, celiac disease, inflammatory bowel syndrome, leukemia, and lymphoma (American Academy of Pediatrics, 2005). Breastfeeding is not only associated with decreased risk of illnesses, but it is also linked to positive health outcomes including denser bones in childhood and adulthood (Gibson et al., 2000), lower blood pressure (Martin, Gunnell & Smith, 2005), and visual acuity (Makrides, Neumann, Simmer, Pater, & Gibson, 1995). Because of the health risks, public health experts encourage mothers to breastfeed their babies exclusively for at least the first six months of their child's life.

Research has also shown that breastfeeding holds many direct health benefits for mothers as well. Mothers who breastfeed their babies have greater postpartum weight loss, decreased incidence of premenopausal breast cancer, reduced incidence of ovarian cancer, decreased blood loss after birth, reduced risk of osteoporosis and reduced risk of hip fractures later in life (Dewey, 1993; Cumming & Klineber, 1993; Rosenblatt & Thomas, 1993; Newcomb, 1994; Labbok, 1999; American Academy of Pediatrics, 2005). Pesa and Shelton (1999) maintained that women who breastfeed their babies engage in healthier lifestyles which in turn leads to better health outcomes.

Public health often uses the risk of not breastfeeding as state apparatus to govern women's bodies to breastfeed. Women are provided with guidance that will help them simultaneously produce the right quantity and quality breast milk and also reduce the risk of

child and maternal disease. In Indonesia, the health benefits of breastfeeding and the risks associated with not breastfeeding have led to the enactment of a law mandating women to breastfeed.

Though dominant discourse of breastfeeding suggests that breast milk is a superior form of infant nutrition, critics argued that in contrast to the way bottle feeding is associated with a host of illnesses, the empirical evidence supporting the health benefits of breastfeeding is inconclusive (Law, 2000; Wolf, 2007; Rosin, 2009). Wolf (2007), for example, asserts that much of the research on the health benefits and risks of breastfeeding for both child and mother lacks statistical or substantive significance and adequate control for plausible confounding variables such as the role of parental behavior and other health outcomes. Also, Smith (2004) claims that, “much cultural knowledge of the health risks of artificial feeding, and the proper skills for breastfeeding are based on inaccurate and, in some cases, based information from two or three decades ago” (p. 371). Other methodological flaws mentioned in the literature included failure to account for small samples with potential for unspecified biases, and failure to clearly define feeding and outcome variables (Scariati et al., 1997).

There are also critiques that breastfeeding promotion is based on biological determinism, ignoring the difficulties that women face when breastfeeding (Blum 1999; Hausman, 2003; Barston, 2012). The over-emphasis on the health benefits of breastfeeding ignores and potentially stigmatizes mothers who cannot successfully breastfeed their babies. Murphy (1999) argued that mothers who formula fed their babies were often regarded as bad mothers who placed their needs, preference or convenience above their babies’ welfare. Further, Barston (2012) argued that although breastfeeding may be a beneficial act, it may not necessarily be the right choice for every mother and every child, whether for medical, psychological, or

professional reasons. The concern for Barston (2012) and Murphy (1999) was the pressure on women to breastfeed even when they face difficulty in doing so. Indeed, these critics are not against breastfeeding entirely, what they seek to do is to advocate a supportive environment for all feeding types. The right to breastfeed targets individual women without looking at the social context under which women make the decision to breastfeed or not. As Blum (1993) explains, “as an experience of intense interdependence between mother and infant, the present social context makes breastfeeding extremely difficult for many women” (p. 291). She further states that “in privileging breastfeeding, I argue for a transformed social context for mothering, one in which the pleasurable physical and emotional aspects can be widely available, genuine choices for women” (Blum, 1993, p. 306). Because of the difficulties that confront breastfeeding mothers, some studies have begun to investigate the actual lived experiences of breastfeeding mothers, but most of these studies are in the West.

Apart from the health benefits of breastfeeding for mother and child, breastfeeding advocates argue that breastfeeding also presents many economic benefits to families, employers and the health care system. To the family, it is argued that parents would be able to save money by staying away from purchasing infant formula for the first year of birth. For example, Baumslag and Michels (1995) estimated that families in the United States who breastfed their babies could save between \$1200 and \$2700 in expenditure on infant formula each year. Indirect breastfeeding benefits included saved time and wages lost from attending to sick children. Some researchers pointed out that formula-fed babies were more likely to be sick than babies that are breastfed. Hence, employed breastfeeding mothers are more likely to miss lesser days of work to care for their sick children compared to formula feeding mothers (Cohen, Mrtek, & Mrtek, 1995;

Ball & Bennett, 2001). In other words, breastfeeding could have a positive effect on women's wages, particularly for mothers who are paid on an hourly basis.

Further, studies in the United States estimated that governments would be able to reduce substantial amounts of health care costs if women were supported to breastfeed their babies (Riordan, 1997; Ball & Bennett, 2001; Weimer, 2001; Bartick & Reinhold, 2010). A 1997 study examined the health care costs of diarrhea, respiratory syncytial virus, insulin-dependent diabetes mellitus and Otitis media, as a direct result of breastfeeding avoidance. It was found that the U.S. government could save an estimated 1 billion dollars in health care cost each year by promoting breastfeeding (Riordan, 1997). A recent study conducted by Bartick and Reinhold (2010) revealed that the United States could save \$13 billion annually from reduced direct and indirect health costs and the cost of premature deaths if 90% of US families exclusively breastfed their babies for six months. If 80% of U.S. families exclusively breastfed, \$10.5 billion dollars could be saved annually, with 741 deaths prevented (Bartick & Reinhold, 2010, p. 1052). From the two studies indicated above, the suggestion seems to be made that formula feeding is costing the American health care system billions of dollar and killing hundreds of children each year.

The above studies on economic benefits of breastfeeding have been heavily criticized for the methods used to arrive at the healthcare cost estimates and projected costs families would save from breastfeeding. Bartick and Reinhold's study has questionable methods where they make all kinds of estimates based on extrapolations and guesses between types of illnesses formula fed children were more likely to suffer from and projected costs if families breastfeed. For instance, Barston (2012) criticized Bartick and Reinhold for presenting distorted data on the cost analysis of breastfeeding. She argued that Bartick and Reinhold did not critically examine whether breastfeeding prevents disease. According to her, what Bartick and Reinhold did was to

pull ten diseases that were linked to breastfeeding from the 2007 Agency for Healthcare Research and Quality (AHRQ). Bartick and Reinhold then calculated the healthcare cost associated with treating the diseases including both direct (doctor's visit to medications) and indirect (parent work absences) cost of each disease as well as the cost of premature deaths. Bartick and Reinhold also failed to mention how they calculated the number of premature deaths.

Rippeyoung and Noonan (2010) criticized Cohen et al. (1995) study on maternal absenteeism and infant illness rate among breastfeeding and formula feeding women. They argued that although Cohen et al (1995) found “a statistically significant difference in the number of sick days reported between formula-feeding mothers and breastfeeding mothers, the modal categories of sick days were one and zero, with formula feeding mothers missing one day of work and breastfeeding mothers missing no work” (Rippeyoung & Noonan, 2010, p. 4). Rippeyoung and Noonan (2010) argued that although breastfeeding advocates suggest that bottle feeding mothers miss more work than breastfeeding mothers because of sick children, there is also the potential for lost work time and wages for the time required to express milk at the workplace. They estimated that if a woman spent an hour each day at workplace expressing her milk, five times per week, for the recommended two years of breastfeeding, she, “would equal 120 hours of lost work time due to breastfeeding. Assuming an 8-hour workday, that translates into 15 missed workdays. Even compensating breastfeeding women with one less sick day than their non-breastfeeding counterparts are faced with on average... breastfeeding women would lose the equivalent of 14 workdays during their child's first six months of life” (p. 6).

Rippeyoung and Noonan (2012) dismissed the argument that breastfeeding was free. They argued that women who breastfed for six months or longer experienced steeper income declines than women who breastfed for shorter durations or formula fed. This is because they

were more likely to reduce their work hours or leave the labor force permanently to breastfeed their babies. Thus, breastfeeding costs time, money and patience to endure the difficulties that come with it.

Also, breastfeeding is thought to have environmental benefits. Breast milk is a renewable natural resource that has a complete set of nutrients for babies. Breastfeeding helps in reducing pollution and waste from production, packaging, and the transportation of infant formula (van Esterik, 1989, U.S. Department of Health and Human Service, 2011). While some formula containers are recycled, many are deposited in the landfills (U.S. Department of Health and Human Service, 2011). Since breast milk does not require any container for packaging, no paper, no fuel to prepare, and no transport for delivery, it reduces carbon footprints (U.S. Department of Health and Human Service, 2011).

Breastfeeding is also claimed to enhance a child's cognitive development. A meta-analysis by Anderson, Johnstone and Rembley (1999) on the differences in cognitive development between breastfed and formula fed children found that breastfeeding was associated significantly with a higher score for cognitive development than formula feeding. Horwood and Fergusson (1998) showed that prolonged breastfeeding was correlated with a higher score in math, IQ and reading ability. Further, Evenhouse and Reilly (2005), using sibling comparisons to reduce sample selection bias found that there is a causal link between breastfeeding and cognitive ability. Also, Kramer et al (2008) who conducted a cluster randomized trial in the Republic of Belarus found that prolonged and exclusive breastfeeding improved children's cognitive development as measured by IQ, and teachers' academic rating.

Some scholars are unconvinced about the cognitive benefit of breastfeeding (Drane & Logemann, 2000; Jain, Concato & Leventhal, 2002; Rey, 2003; Der, Batty & Deary, 2006). Der

et al. (2006) who used the U.S. national longitudinal survey of youth 1979 found that while breastfeeding has many benefits for both child and mother, it has little or no effect on intelligence in children. Similarly, Jain et al. (2002) concluded that evidence supporting the effect of breastfeeding on intelligence is less persuasive. Rey (2003) also showed that research on breastfeeding and cognitive development were methodologically flawed and failed to account for variables such as maternal IQ, socioeconomic status, and maternal education.

Furthermore, studies showed that breastfeeding enabled maternal bonding or closeness to the child (Anderson et al., 1999; Arora et al., 2000; Cernadas et al., 2003). According to Kennell and Klaus (1998), the term bonding refers to the emotional tie between mother and infant. Thus, the bonding hypotheses that the earliest hours and days of the relationship between a mother and a child, are strongly associated with a child's future development and also had long-term consequences for their emotional well-being (Moncrief & Evan, 1953; Bowlby, 1969; Klaus and Kennell, 1976). For example, Moncrief and Evan (1953) stated that, "the relations established between mother and child during the early days and weeks of life set a pattern which may be of value for the later development of the child" (p. 61), and the power of the attachment "enables mother and father to make many sacrifices necessary for the care of their infant" – attending to the child when crying, protecting the child from danger, feeding the child in middle of the night, despite parents own need for sleep (Kennell & Klaus, 1998, p. 4). Lampe, Trause, and Kennell (1977) went further to suggest that failure to bond immediately after birth could lead to child abuse or mothering disorders. Elkins (1978) suggested that, "the separation of mother and baby *after birth*, (emphasis mine), for a period as short as one to four hours may result in disturbed mothering patterns" (p. 204).

From the 1970s to early 1980s, scholars argued that for optimal bonding to develop between mother and infant, there should be physical contact between the mother and infant during the critical early hours of birth (Klaus & Kennell, 1976; Klaus & Kennell, 1982; Fildes, 1986). Klaus and Kennell (1982), for instance, stated that, “there is strong evidence that at least 30 to 60 minutes of early contact in privacy should be provided for every parent and infant to enhance the bonding experience” (p. 56). Similarly, Fildes (1986) stated that the critical bonding period for mother and infant “begin in the first minutes after birth and last for about 12 hours; the longer the separation, especially on the first day of life, the greater the chance of emotional rejection of the child by his mother” (p. 90). Early separation of infant from mother is thought to be the cause of depression in infants, emotional coldness, and indifference in the mother (Fildes, 1986). According to Kennell and Klaus (1998), maternal oxytocin is at its peak within an hour of birth. The release of oxytocin after delivery predisposes mothers to form bonds with their babies (Kennell & Klaus, 1998). Breastfeeding is therefore seen as critical to the bonding process between mother and child.

Kennell and Klaus (1998) suggested that poor women in France in the 19th century who breastfed for at least eight days hardly abandoned their babies. Additionally, Wiesenfeld et al. (1985) pointed out that mothers who breastfed, tended to be more receptive to their babies. In a large birth cohort of over 1,000 children studied, Fergusson and Woodward (1999) found that breastfed children tended to report secured parental attachment, increased perceived maternal care and less maternal overprotection compared to children who had been bottle fed. Further, in a qualitative case study of women who had adopted children who had been abused or neglected, Gribble (2006) found that breastfeeding promoted the development of child-maternal attachment

relationships in vulnerable adoptive dyads via the provision of regular intimate interaction between mother and child.

There were other empirical studies that did not support bonding. For instance, Else-Quest, Hyde, and Clark (2003) found that breastfed babies may show earlier and stronger mother-infant attachment compared to bottle feeding dyads who were ranked slightly lower in terms of the quality of relationships with their mothers. They argued that mothers may benefit from stronger attachment in the early postpartum months, but the benefits are absent by the first birthday. Early breastfeeding may have an impact on maternal bonding, but the impact is a short term one. Similarly, Eyer (1992) claimed that early contact between mother and child has no enduring effects on maternal bonding, but may sometimes have short term effects on some mothers in some circumstances. Britton, Britton and Gronwalt (2006) also conducted research on the relationship between breastfeeding and attachment security but found no direct relationship. However, they did find an association between breastfeeding and maternal sensitivity.

Critics also argued that there were conceptual and methodological errors in the bonding theory and the critical period of bond formation shifted from one study to another (Law, 2000). In a review of the literature on breastfeeding and maternal bonding, Jansen, Weerth and Riksen-Walraven (2008) found that out of 41 papers, 22 of them made, “general statements on the positive effect of breastfeeding on either facet of the mother-infant relationship without reference to empirical studies supporting this claim” (p. 510). They examined the papers that provided evidence supporting these claims and came to the conclusion that breastfeeding promotes maternal bonding. Maternal bond may be affected when mothers have negative breastfeeding experiences. It is, therefore, important to note that not all breastfeeding mothers have wonderful bonding experiences. For some women, studies have shown that they do not enjoy breastfeeding

because of the negative experiences such as nipple pain, insufficient milk, mastitis, emotional discomfort, or embarrassment (Dykes, 2005; Barston, 2012). Martin (1987) also argued that the over-emphasis on bond formation immediately after birth shifts our attention away from the medicalization of women's bodies to the mother-child relationship. The over-emphasis on developing a maternal bond within an hour of birth puts unendurable stress on the mother.

In sum, there is evidence of health effects of breastfeeding, but that they are disputed. Health is not the only reason why women breastfeed. Women also breastfeed because of their faith in religion.

Islam and breastfeeding

Breastfeeding has religious recognition in Islam. The holy Quran required a mother to suckle her child for two year. In a study conducted in Australia among twenty-five Afghan women, Tsianakas and Liamputtong (2007) found that the breastfeeding duration for both boys and girls differ. They found that in Islam boys were breastfed for two years while girls were breastfed for two and half years. They explained that the difference in breastfeeding duration was due to the physical strength between boys and girls. Girls were considered weaker to boys, so need more breastfeeding.

The child's father has the obligation to support and encourage his wife to breastfeed. According to the Quran, when there is divorce, the father must still provide clothing, food and shelter to the mother for as long as the mother still breastfeed the child. In circumstances where the mother cannot breastfeed or the child is adopted, the parents must mutually agree to look for another mother to nurse their child (Ertem, 2011). A woman who nursed another woman's child becomes the milk mother. In Islam, a mother who breastfed her child is blessed by Allah. The Hadith stated that "when a women delivers, not a mouthful of milk flows from her and not an

instance of child's suck, but that she receives, for every mouthful and for every suck, the reward of one good deed. And if she is kept awake by her child at night, she receives the reward of one who frees seventy slaves for the sake of Allah" (Tsianakas & Liamputtong, 2007, p. 250).

Muslims are expected to fast during the month of Ramadan. However, pregnant women, breastfeeding mothers and women menstruating are exempted from fasting as they are considered weak. These women fast at a later date or pay back in a form of charity if they cannot fast at all (Ertem, 2001).

In Islam, when a mother breastfeeds another woman's child, it constitutes a milk kinship relation. As El-Khuffash and Unger (2012) explained, milk kinship is established between the donor of the milk and the recipient of the milk. Thus, the children of the donor mother and the infant receiving the milk have become siblings, and are prohibited from getting married in the future (Clarke, 2007; El- Khuffash & Unger 2012). Any marriage between the children of the donor mother and the recipient infant will be considered incestuous. Different Islamic schools of thought have argued about how milk kinship is established. Ghaly (2012) drew upon the teachings of four Sunni Schools and two Shi'ite schools of Islamic law to explain how milk kinship is established. According to Ghaly, the Ja'fari school within Shi'ite tradition argued that only direct suckling at the breast constitutes milk relation, but not when giving breast milk through a bottle, cup or tube. Concerning the amount of milk, the Ja'fari and Shi'ite jurists agreed that recipient child must be breastfed ten consecutive times to constitute a milk relationship. There is, however, no consensus among the Sunni jurists about the amount of milk to feed a child to establish milk kinship. Some Sunni jurists argued that the child must be breastfed at least five times, while others opined that a small quantity is enough to constitute milk kinship. Despite the differences in interpretation about how milk kinship is constituted,

Islamic scholars agreed that milk must reach the child's stomach and the child must be less than two years for milk kinship to be constituted (Thorley, 2014).

Different scholars have described the importance of milk kinship. For example, Cevese (2015) who conducted her study among Moroccan women living in Italy argued that milk sharing practices are used to control social relations, to create, strengthen or avoid friendship and affective bonds. For Moroccan women “the connecting power of breast milk is still great, but it is impossible for them to control the “milk relation”, so they refuse to donate their milk to the banks” (Cevese 2015, 108). El Tom (2015) who did his study among the Berti of Northern Darfur of Sudan highlighted the importance of milk kinship. First, he argued that parents establish milk kinship to override oppressive cross- cousin marriage that is powerful in Islamic societies. He explained that parents who do not want their children to marry their cousins, entice their sisters-in-law to breastfeed their children, thus making them unmarriageable to their cousins in the future. Secondly, he explained that milk sharing is used to ease gender relationships among certain individuals.

Breastfeeding practices and Employment

Many studies have shown that women who chose to work as well as breastfeed had difficulties juggling the demands of work and breastfeeding (van Esterik & Menon, 1996; Blum, 1999; Fairbank et al., 2000; Galtry, 2003; Witter-Green, 2003; Dykes, 2005; Rippeyoung & Noonan, 2009;). In Thailand, for instance, Yimyam, Morrow and Srisuphan (1999) argued that breastfeeding becomes “increasingly complex when women are employed especially outside the home” (p. 957). In a study among employed women in Chiang Mai, Thailand, Yimyam and Morrow (1999) found that, “at 6 months postpartum, women who worked inside the home breastfed more than those working in the formal sector at jobs with inflexible hours (home 80%;

public sector 37%; private sector 39%)” (p. 225). Yimyam and Morrow (1999) therefore concluded that women who worked outside the home for a long time or had shift-work jobs faced many problems in continuing to breastfeed, as many of them abandoned breastfeeding within a month after returning to paid work. In African countries such as Ghana, Malawi, and Nigeria, studies have shown that economic pressure has forced many women to go back to paid work soon after giving birth in order to support their families (Mensah, 2011; Agunbiade & Ogunleye, 2012). As Dykes (2005) pointed out, globally, increasing numbers of women are returning to paid work during early motherhood. This pattern, Dykes (2005) suggested “creates many dilemmas for women as they juggle the demands upon their time and bodies” (p.2291).

Witter-Green (2003) reported that in the United States, many women discontinued breastfeeding upon returning to work because of the lack of institutional supports and organizational policies. The United States is the only industrialized country that has no paid maternity leave. Corporate policies such as limited time for breaks, no access to private rooms to accommodate pumping, and frequent travel for work were seen as barriers to breastfeeding (Allerton, 1997; Boswell-Penc & Boyer, 2007). Witter-Green (2003) also found that employers did not support breastfeeding at work because it interfered with work, brought schedule conflicts, as well as conflicted with customers’ needs, and also attracted harassment from other employees. Also, Blum (1999) and Ryan et al. (2006) reported that little progress has been made in the United States regarding the creation of friendly breastfeeding workplaces. Puwar (2004), Gatrell (2007), Boyer & Boswell-Penc (2010) went further to argue that the lack of institutional supports for breastfeeding mothers in both the US and the UK not only resulted from employers’ lack of knowledge about breastfeeding, but also occurred because mothers’ bodies set them apart from the ideal worker norm which is based on male managerial standards. Edward and Wajcman

(2005), observed that the spirit of managerialism is dominated by a masculine ethic of rationality. Thus, Edward and Wajcman (2005) equated management to masculinity. Puwar (2004) reported that male bodies have dominated the workplace and female bodies were seen as “space invaders” because they deviated from male embodied norms. Women further departed from the male embodied norms because of their lactating body and excretion of bodily fluid. As such Gatrell (2007) pointed out that breastfeeding mothers often hid their “leaky lactating bodies” from their employers and peers.

Contrary to research findings suggesting that paid work decreased breastfeeding, some studies revealed that maternal employment enhances prolonged breastfeeding. In a study conducted among Navajo women, Wright, Clark, and Bauer (1993) found that women who returned to work after three months introduced formula feeding later and breastfed longer than others, including unemployed women. They further suggested that women who worked outside the home had a higher motivation to breastfeed longer than unemployed women because breastfeeding provided a means of maintaining bonding with the child after separation during the day. Finally, they argued that if breastfeeding was firmly established before mothers returned to work, paid work may not affect the breastfeeding duration. In a literature review of eighty-one studies, van Esterik and Greiner (1981) found that work was rarely cited by mothers as the reason for not initiating breastfeeding, for choosing bottle-feeding or terminating breastfeeding (p. 185). They argued that work as a reason for the decline in breastfeeding has been over exaggerated.

For working mothers to combine breastfeeding with work, women are actively encouraged by breastfeeding advocates and public health agencies to express a significant amount of breast milk for their babies using breast pump technology. Proponents of breast

pumps argued that breast pumps provided direct benefits for babies in terms of health benefit (immunological benefits, fewer problems with diarrhea and ear infections) as well as indirect benefits for mothers because their children were sick less frequently, meaning fewer sick days (Boyer & Boswell, 2010). Further, expressing breast milk facilitated shared parenting in infant feeding and greater freedom for women (Morse & Bottorff, 1992; Dykes, 2005).

Some feminist critics have argued that pumping at work is not the same as breastfeeding a child (Hausman, 2003; Lucas & McCarter-Spaulding, 2012). These feminists argued that pumping treats breast milk as a product and women as a vessel, thus moving away from breastfeeding as a relational process (van Esterik, 1996; Lucas & McCarter-Spaulding, 2012). There is also a tendency on the part of communities to see breast pumps as a feminist technology that decreases emotional and psychological aspects of care (Blum, 1993; Hausman, 2003). Further, breast pumps reduce women's self-confidence as it is a sheer reliance on a piece of technological equipment. Van Esterik (1996) therefore suggested that the best way to remove milk from the breast is through breastfeeding.

Scholars have also argued that pumping is a time-consuming task for many women (Avishai, 2004). This is because for women to pump their milk at workplaces, they have to set up the pump, close curtains, and doors, partially undress, wait for the body to cooperate and let down, clean the pump after use, and store the milk. Due to this elaborate process of pumping, Avishai (2004) argued that pumping cuts heavily into the workday. Pumping was also thought of to be an exhausting and an unpleasant exercise as it drained women physically and emotionally (Avishai, 2004).

A woman's ability to effectively combine work and breastfeeding is dependent on the characteristics of work (Morse, Bottorff, & Boman, 1989). According to Morse et al. (1989), the

proximity of the infant to the workplace, the flexibility of working hours and the structure of the workplace were essential characteristics to the success of the mother's ability to combine breastfeeding and work. Similarly, Yimyam (1997) argued that employment *per se* may not be the important factor to breastfeeding among employed women but inflexible hours of work and separation from the infant were crucial. Studies have shown that women who are involved in agriculture were more likely to initiate breastfeeding during the first hour of birth (Thapa & Williamson, 1990; Adhikari, Khanal, Karkee, & Gavidia, 2014). For instance, Adhikari et al. (2014) found that women who are in paid work are less likely to initiate early breastfeeding because they have access to financial resources, and due to modernity and urbanization they are likely to be receptive to formula. They further argue that women in paid work are able to afford caesarean birth, a factor linked with delay in early initiation of breastfeeding. Research also showed that women who worked in professional, managerial, salaried or autonomous occupations were more likely to breastfeed than women who worked in small companies or on an hourly basis or in low-income jobs (Yimyam, 1997; Lucas & McCarter-Spaulding, 2012). This is because women working as professionals had greater flexibility and more control over their work environment (Yimyam, 1997, p. 32). Also, low-income women often could not afford an electric pump and would rely on hand expression, which took a longer time and made them less likely to continue. Lucas and McCarter-Spaulding (2012) highlighted how socioeconomic differences in employment patterns were significant in contributing to the socioeconomic disparities in breastfeeding initiation, duration, and exclusivity.

Additionally, other studies have shown an interconnection between maternity leave and breastfeeding (Baker & Milligan, 2008; van Esterik & Greiner, 1981; Rippeyoung & Noonan, 2012). Baker and Milligan (2008) who conducted a study of maternity leave provisions in

Canada found that an increase in the maternity leave duration is positively related to the breastfeeding duration among Canadian working mothers. In a study conducted in Italy, Romito and Saurel-Cubizolles (1996) indicated that the longer the maternity leave, the longer women were more likely to breastfeed.

Public Breastfeeding

A public place is defined as out of the home while private is regarded as home (Britton, 2000). This definition is not clear-cut as a public place like a park may become supportive when women are breastfeeding in a group, or difficult for breastfeeding when a woman is breastfeeding alone (Dowling, Naidoo, & Pontin, 2012). Likewise, the home may become a public place when there are male strangers in the house (Britton, 2000). Carter (1995) who did her research in the North of England among women who breastfed from the 1920s to 1980s suggested that “households are a complex mixture of private and public space, although they are often characterized as if they were the private world” (p. 107). So, women’s experience of public and private spaces depends on what they feel about the place and how they interpret it. Studies in North America, Australia and England showed that some women found it embarrassing to breastfeed their babies in public places (Carter, 1995; Dowling et al., 2012; Britton, 2000; Sheeshka et al. 2001; Stearns, 1999).

In recent years, there have been some cases in which women who were breastfeeding their children were asked to stop or leave public spaces (Gram, 2009; Hess, 2011; Tomori, 2015). Breastfeeding in public is often seen as “overstepping the limits of propriety” (Sheeshka et al., 2001). In the West, the breast is often viewed as a sexual object rather than one that provides motherly care for a child. Being asked to leave a place because of breastfeeding can be stressful and disheartening to many women. To avoid the embarrassment or shame that comes

with breastfeeding in public, some women either fed their babies with expressed breast milk or formula milk, or hid at home to breastfeed their children (Stearns, 1999; Dowling et al., 2012). There is the perception that decent women do not breastfeed in public (Carter, 1995). As Carter (1995) demonstrated,

Breasts are acceptable in public if they are presented (clothed or not) in ways which correspond to non-reproductive (hetero) sexuality. Links between motherhood and sexual breasts are clearly disturbing unless firmly held within a discourse of mothering in a 'private' place. These dichotomies intersect with each other so that women's bodies are constantly scrutinized, by themselves, and others, to make sure that they neither deny sexuality nor flaunt it. It is through the daily construction of femininity that women's bodily experiences are mediated (p. 128).

Given that breastfeeding in public is not an accepted behavior especially in the West, Stearns (1999) explored the lived experience of women who breastfed in public in Sonoma County, California, United States. Although none of the mothers in Stearns' study mentioned that they had been asked to leave a public place, she argued that women carefully managed their performance of breastfeeding in public by learning to breastfeed discretely. Stearns concluded from her study that the perceived need to hide breastfeeding and to proceed with discretion kept some women at home and out of public life more than they would have otherwise.

Also, societal ideas about bodily fluids shaped people's understanding of places where women should breastfeed their newborns. In some societies, bodily fluids are viewed as something that must be kept private. Bodily fluids emanating from women's reproductive functions are seen as more dangerous and disgusting than bodily fluids coming from men (Gatrell, 2007). Further, Morse (1990) argued that women might be asked to go to the bathroom

to breastfeed or express their milk because breast milk was considered to be dirty. Also, Callaghan (2007) suggested that midwives who helped lactating women were expected to wear protective apparel. For example, a midwife may wear gloves and protective eyewear when assisting lactating women as there was a risk that the milk may sprinkle on her. In an analysis of the concepts of pollution and taboo, Douglas (1966) pointed out that bodily fluids such as blood, saliva, or pus from a wound are sources of impurity while tears are regarded as pure. She argued that tears are pure because they cleanse and bathe the eyes. Kristeva (1982) who drew on Douglas' work classified tears and sperm as pure and menstrual blood as impure. So, the notion of dirt is defined by Douglas (1966) as "matter out of place" (p. 35). She argued that "shoes are not dirty themselves, but it is dirty to place them on the dining table; food is not dirty in itself, but it is dirty to leave cooking utensils in the bedroom, or food bespattered on clothing; similarly, bathroom equipment in the drawing room; clothing lying on chairs; out-door things in in-doors; upstairs things downstairs; under-clothing appearing where over-clothing should be and so on" (p. 35). In this context, breast milk in itself is not dirty, but it is the act of breastfeeding in public that is considered as inappropriate or indecent behavior. A woman may breastfeed in a private place, but milk stains on her dress in public may be regarded as dirty. Within the Javanese philosophy, menstrual blood is viewed as dirty and women drink *jamu* to clean this fluid and purify the body.

Conclusion

Breastfeeding practices remain a contentious issue within the literature and in public health practice. Within public health literature, breastfeeding is strongly advocated to mothers because of scientific claims of its superiority in relation to health, cognitive development as well as the emotional well-being for mother and child. The health benefits of breastfeeding have been

profoundly challenged by Smith (2004) and Wolf (2007). Both argued that the health benefits of breastfeeding are vastly overstated and that the breastfeeding only has minimal health effects. This chapter thus shows that external regulations can shape women's experiences of breastfeeding in multiple ways. I find that it is in these experiences that we can learn more on the ways these can be lived in a variety of ways and my case study aims to show how this is the case with eleven women in Jogja. To do so, I further develop approaches in anthropology that deal with embodiment and biopower.

Chapter 2

Theoretical Perspective

The aim of this chapter is to explain the theoretical approaches I have found most useful to understand women's experiences with breastfeeding. I use different overlapping concepts such as 'embodiment' (Csordas, 1990), 'habitus' (Bourdieu, 1977) and 'knowing from the inside' (Ingold, 2013) to understand women's experiences of breastfeeding without assuming any pre-existing entities. I then delve into Foucault's analysis of biopower, which help to understand the framework in which the law was instituted as well as how it can make sense to understand certain practices within hospitals in Indonesia. I explain how law as social practice is lived, negotiated and resisted in everyday life. Below I explain these theoretical approaches and how they help me to understand breastfeeding practices in Jogjakarta, Indonesia.

Embodiment

Breastfeeding as an embodied practice "establishes a specific kind of relation between the mother and the infant through the mother's body thus demonstrating a radical embodiment in which two individuals share a physiological relation" (Hausman, 2003, p. 192). The embodiment approach to breastfeeding not only looks at the biological bodies of the breastfeeding mothers but also on how the social and cultural environment, interacts with others in the world influencing mothers to breastfeed or not. Thus, the mind is not separated from the body.

The term embodiment has many meanings depending on the discipline from which it is used. My understanding of embodiment is rooted in the anthropological analysis of the phenomenological body. Csordas (1994) referred to embodiment as an "indeterminate methodological field defined by perceptual experience and mode of presence and engagement in the world" (p. 12). Embodiment as a methodological field belongs to phenomenology. I

understand phenomenology the same way as Csordas explained it as a way of being-in-the-world. Being in the world means the “world is always ‘already there’ before reflection begins” (Merleau-Ponty, 1962, p. VII), therefore we are in relation with the world and other beings. So the body, in the phenomenological sense as understood by Csordas in anthropology, is understood as the “existential ground of culture” – “not as an object to be studied in relation to culture” but as “the subject of culture” (Csordas, 1990, p. 5). Csordas (1990) maintained that “our bodies are not objects to us. Quite the contrary, they are an integral part of the perceiving subject” (p. 36). Csordas’s (1990) argument enables us to see the body as a site of knowing while admitting that we are capable of objectification through cognitive activity, referring to Bourdieu’s notion of habitus (theory of practice)- which he tied in with Merleau-Ponty (1962) to propose embodiment as a paradigm for anthropology. The argument also implies that the body should not only be seen as a site of experience that is controlled by the mind but it should be seen in itself as a source of knowing always working in tandem with the mind.

Merleau-Ponty’s (1962) phenomenology of perception offered a particular notion of perception which differs from the one usually accepted within the experiment. Experiment ignores the continuous movement of the body in the world and prior experiences. For instance, the experiment would not take into consideration the interaction between the act of breastfeeding, mother and baby in the inhabited world. For Merleau-Ponty (1962), the body is central to what we come to know in the world. He argued that we come to understand our relation in the world through the positioning of our bodies in the world. According to Merleau-Ponty (1964), the body is much more than an instrument or object in the world; it is the body that gives us our expression in the world. In other words, the body is not just a vehicle or container with which we come to experience the world, but rather it is through the body that we come to

see the world, understand the world and become part of the world. The body is actively implicated and not a passive object receiving information - bodies make meaning. Since the body is actively implicated in the world, we know things by doing and relate to objects in the world. As Gieser (2008) mentioned, “we never perceive only the pure object but always the object located in the world, surrounded by other objects, objects invested with meanings which link them to one another” (p. 302). So the relationship of the body to the world which it inhabits is fluid and continuously transformed.

For Merleau-Ponty (1962) human experience is bodily experience, which makes the body a requirement for consciousness to develop:

Consciousness is being-towards-the-thing through the intermediary of the body. A movement is learned when the body has understood it, that is when it has incorporated it into its ‘world’ and to move one’s body is to aim at things through it; it is to allow oneself to respond to their call, which is made independently of any representation.

Motility then, is not, as it were a handmaid of consciousness, transporting the body to that point in space of which we have formed a representation beforehand. In order that we may be able to move our body towards an object, the object must first exist for it (Merleau-Ponty, 1962, p. 159-161).

Thus, the body and consciousness are not separated. Rather, there is a close synergy of body and consciousness, which is only understood as a whole (Gieser, 2008).

Following Merleau-Ponty (1964), I would argue that we can measure the reality that mothers can feed their babies, but we cannot measure the effect of breastfeeding because these women are in the world at different moments, depending on prior experience. Mothers and infants do breastfeeding in various ways because of their physiology and also because of their

broader relations in the world. Thus, breastfeeding is a relational act done in the world continuously negotiated between mother, child, father, grandmothers, employers, communities, etc. A woman breastfeeding is doing so in the present, yet also in relation to prior experiences and as she can project herself into the world in this new situation. To Merleau-Ponty (1964), it is the movement of the body in space that is crucial to lived experience and perception. As such, Merleau-Ponty (1964) pointed out that “our body is not in space like things, it inhabits or haunts space” (p. 5).

The relationships between a mother and an infant during breastfeeding invoke emotion. For instance, the joy of a mother carrying her baby in her arms and seeing the baby latch on and the reciprocal gesture of the child smiling at the mother. The mother’s emotion can also include the pain of not having sufficient milk to feed the baby, the embarrassment of feeding in front of others and the distress of breastfeeding the baby at night. These experiences that are embodied at different moments in the world are reflected throughout the narratives of women in the study. This emotion affects the way the lactating body is experienced. Emotion in our everyday discourse means hidden inward feeling, however, following Merleau-Ponty, I prefer understanding them as visible in practice. In an attempt by Merleau-Ponty to understand emotion from a phenomenological approach, he argued that:

If I try to study love or hate from inner observation, I will find very little to describe: a few pangs, a few heart-throbs – in short, trite agitations which do not reveal the essence of love or hate... In fact, young children understand gestures and facial expressions long before they can reproduce them on their own: the meaning must, so to speak, adhere to the behavior. We must reject that prejudice which makes inner realities out of love, hate or anger, leaving them accessible to one single witness: the person who feels them. Anger,

shame, hate and love are not psychic facts hidden at the bottom of another's consciousness: they are types of behavior or styles of conduct which are visible from the outside. They exist on this face or in those gestures, not hidden behind them (Merleau-Ponty, 1964, p. 52-53).

Merleau-Ponty's statement clearly indicates that emotions are expressed in practice. For Merleau-Ponty, there is no such thing as inner feelings. As Geiser (2008) mentioned, emotion must be understood by "taking into account the whole being-in-the-world of a person" (p. 304).

In a qualitative study of twenty-five Australian first-time mothers, Schmied and Lupton (2001) found that for some women, the experience of breastfeeding was "pleasurable and intimate, a vital means of emotional connection to their infants, but for others, it was difficult, unpleasant and disruptive" (p. 239). Likewise, in a randomized controlled trial from Melbourne, Australia, Forster and McLachlan (2010) presented women's stories and experiences of breastfeeding. Forster and McLachlan (2010) found that women used positive words or phrases such as "worthwhile", "excellent", "positive", "fantastic", "rewarding", "convenient", "wonderful", "easy", "good", "enjoyable", "natural", "I love it", and "I really enjoy it", to express their positive feeling about breastfeeding. The typical negative comments were, "I just didn't like it", "it was very difficult" and "it's just not for me". Some women in Forster and McLachlan's (2010) study also expressed both positive and negative feeling about breastfeeding. For example, a woman was quoted to say "it's amazing, and it's good for them but a lot of work...exhausting." (p. 119). In a United States study which utilized telephone interviews, Grossman et al., (1990) asked two hundred and twenty women about their positive and negative breastfeeding experiences. Positive experiences mentioned by the women were feelings of closeness with their children, the convenience of breastfeeding and breast milk being the best.

Negative experiences included nipple/breast problems, the mother feeling tied down, insufficient milk supply, and that the mother alone had to take all the responsibility for baby care. So, words, gestures are intimately linked with emotions for Merleau-Ponty.

While Bourdieu (1977) may not have used the term embodiment, he contributed to the paradigm in anthropology since Csordas (1990) built this concept by joining Merleau-Ponty's (1962) phenomenology of perception with Bourdieu's theory of practice. It was through Bourdieu's concept of habitus in the *Outline of a Theory of Practice* that Csordas proposed an understanding of embodiment together with Merleau-Ponty's phenomenology. The concept of habitus may be traced back to Aristotle's notion of 'hexis', and reworked by Thomas Aquinas in his approach to learning and memory. Yet, Bourdieu's notion of habitus was built on the work of Marcel Mauss, Norbert Elias and Erwin Panofsky. In the essay *Techniques of the Body*, Mauss (1935) argued that bodily habit that may seem natural such as a child sucking her mother's breast or a person sleeping, "do not just vary with individuals and their imitations, they vary especially between societies, education, proprieties and fashions, prestige" (p. 73). To Mauss, the process by which people acquire the body technique is through socialization. The habitus is those aspects of culture that are embedded in the everyday practice of people which mirrors the norms of societies.

For Elias, the habitus was associated with the social and mental structures that determine tastes and habits. Elias (1987) saw habitus as "self-image and social make-up" of individuals (p. ix). He articulated the habitus as "soil from which grow the personal characteristics through which an individual differs from other members of his society. In this way, something grows out of the common language which the individual shares with others and which is certainly a component of the social habitus – a more or less individual style, what might be called an

unmistakable individuals handwriting that grows out of the social script” (Elias, 1987, p. 182). As Dunning and Mennell (1996) mentioned in their preface, the habitus for Elias represented the “second nature” or “embodied social learning” (p. ix) Like Bourdieu, the use of the concept social habitus enabled Elias to escape division (either/or approach) in relation to the individual and society that has characterised sociological discussion (Elias, 1987). Erwin Panofsky also influenced the ideas of Bourdieu on his notion of habitus. Panofsky used the concept of habitus to discuss Gothic architectural styles and what he called ‘mental habits’ that fashioned various art styles in particular historical periods and settings. In the *Postface to Erwin Panofsky, Gothic, Architecture, and Scholasticism*, Bourdieu (2005) himself recognized the influences of Panofsky on his notion of habitus.

Bourdieu (1977) described habitus as “systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively regulated and regular without in anyway being the product of obedience to rule, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this collectively orchestrated without being the product of the orchestrating action of a conductor” (p. 72). Bourdieu’s definition of habitus is complex to comprehend, but Calhoun (2014) did an intelligent work of breaking it down into ordinary language.

First learning is not all explicit and mediated by language, but often tacit and embodied. Second, he stresses that action is generally not produced by rule-following but by improvisation. Third, the capacity to produce such improvisations—and thus actions—is developed through lengthy processes of learning which are simultaneously processes of

“inculcation” by society and social fields and active self-creation. Fourth, they are simultaneously structured and structuring, because they are embedded in the repetition and occasionally innovation of action through time. Fifth, they are efficacious without conscious orientation to ends because they have been produced out of a nearly infinite number of iterations of similar actions (and reactions) and trial and error learning reinforces the effective actions. Sixth, though, they may be transposed into new circumstances, where they may be more or less effective but will in any case shape the production of actions (and responses) and thus new learning (p. 15).

Bourdieu saw habitus as enabling people to cope with unexpected and dynamic situations, yet he sets some limits to cultural predisposition. The habitus is socially constructed and acquired from childhood. Thus, the habitus is shared among individuals who have similar social and cultural backgrounds. Although habitus is a shared behavior, there are variations in the ways individuals experienced and embody things. In Bourdieu's estimation, it is important to abandon all theories that directly or indirectly view the practice as a mechanical function since habitus is both the result of practice (i.e. *opus operatum*) and the modes of practice (i.e. *modus operandi*). Thus, people do not function mechanically in terms of pre-established assemblies – models or roles, instead disposition guides practices as the basis for the “intentionless invention of regulated improvisation” (Bourdieu, 1977, p. 79). This ties up with Foucault's approach as biopower is embodied in varying ways, which I will discuss in the next section. Disposition is the likelihood of taking up shared ways of behavior in a community. Bourdieu (1977), therefore, suggests that people's ‘action and work are products of a *modus operandi* of which people are not producers and have no conscious mastery’ (p. 79).

Following Bourdieu, women may learn how to breastfeed correctly at the hospital, but this may not translate into action at home because mothers' behaviors towards breastfeeding are influenced by social environment and interaction with others in the world. Tomori (2015) who did her ethnographic anthropological study of breastfeeding in the United States maintained that breastfeeding is learned primarily from hospitals under the supervision of medical personnel and then practiced at home for a relatively short duration. The decision by women to quickly introduce bottle feeding when they were at home stemmed from the fact that their embodied experience does not match what is depicted in breastfeeding promotion campaigns that breastfeeding is pleasurable. Many of the studies in the West suggested that women discontinued breastfeeding and bottle fed their babies because of nipple pain, fatigue, discomfort with the breast, and mistrust in their bodies to produce sufficient milk (Earle, 2000; Dykes, 2005; Murphy, 1999; Blum, 1999; Gatrell, 2007; Avishai, 2007). Groleau and Rodriquez (2009) who conducted ethnographic interviews among forty-two French Canadian mothers living in poverty in Quebec between 2004-2007 used Bourdieu's concepts of habitus, fields and symbolic capital to understand the complexities of maternal embodied experiences performed in social spaces as well as the underlying social process involved in the abandonment of breastfeeding. Groleau and Rodriquez (2009) argued that choosing to breastfeed in a social environment where formula feeding is the habitus has implications for power relationships.

Breastfeeding is an embodied practice that is not done in isolation. Mothers are constantly negotiating breastfeeding with their babies, husbands, peers, grandmothers, and health professionals. Women have diverse understandings of their body, that in this case, largely go beyond the "biological body"; as in the paradigm of embodiment, bodies in Indonesia are understood as open-ended and in continuous emergence. The Javanese philosophies of the body

speak to bodies of winds and flows (Ferzacca, 2001), thus enhancing these possibilities in the Indonesian context.

There is evidence that men play a significant role in influencing women's decision and experiences of breastfeeding (Bar-Yam & Darby, 1997; Rempel & Rempel, 2010; Rippeyong & Noonan, 2012; Sherriff, Hall, & Panton, 2013). For instance, Bar-Yam and Darby (1997) found that fathers influenced the breastfeeding decision, assistance at first feeding, duration of breastfeeding and risk factors for bottle-feeding. In a study conducted in North Jakarta, Septiari, Februhartanty and Bardosono (2006) found that fathers strongly influenced their wives to introduce formula to babies before six months. They argued that fathers were afraid that their wives did not have sufficient breast milk to feed their babies. Other studies looked at the lack of social support from fathers to breastfeeding mothers. Rippeyong and Noonan (2012) who looked at the impact of breastfeeding on fathering found in the United States that fathers of children who were breastfed for six months and longer were less likely to put their children to sleep, soothe their children, and take their children to the doctor when they were sick.

Ferzacca (2001) who spoke about the Javanese philosophies of the body described it as a logic of fluid signs, involving the ideas of flow of winds through people, notions of bitter versus sweet tastes, the use of body massaging and the ingestion of elixirs. Breast milk, semen, blood, water, amniotic are examples of fluids that flow. Ferzacca (2001) gave an example of common practices that indicate a logic of fluid of signs. For example, Javanese who want relief from an illness are given pieces of paper on which passages from the Quran are written. The paper is put into a glass of water, and the water is drunk transposing the Quranic text into the fluid which helps in the restoration of health. This speaks to the intertwinement between Javanese and Islam.

In the case of breastfeeding, women who have insufficient breast milk are given *jamu* to drink to increase milk supply.

Javanese know that in order to maintain good physical health, the wind must be prevented from entering the body. My research assistant's mother in-law explained to me that to avoid the wind from getting the body, some Javanese wear jackets in hot afternoon when temperature range between 30 to 35 degree Celsius¹. According to her, people also drink *jamu* to maintain a balance between hot and cold humorism. My research assistant who gave birth recently rubbed her child with wind oil called *Minyak telon*² before bed to protect him against the wind penetrating his body. When wind enters the body, it creates maladies, and the most common of all is *masuk angin* which translates to the common cold (Ferzacca, 2001). According to Ferzacca (2001), the common treatment of *masuk angin* was *kerokan*, the practice of scraping the skin horizontally across the back with the edge of a coin to allow the penetrating wind trapped in the body a path to escape, so that the body can return to feeling fresh.

In this same line of inquiry, Ingold (2013) following Merleau-Ponty offered a persuasive approach to “knowing from the inside”. He argued that knowing is not transmitted across generations as a ready-made corpus of information, but instead, it goes through the continual process in which learners practically engage with their environment. Further, he pointed out that the only way that one can know things is from the very inside of one's being and not a mere accumulation of information in one's mind. Knowing, therefore, is active engagement, participation, and movement. Ingold explained that the awareness of the sense of self-movement in the world lies in the experience of kinaesthesia. In Europe and North America, we are under the impression that there are only five senses – sight, hearing, smell, taste, touch and ignorant of

the kinaesthesia (Sheets-Johnstone, 2016). The classical Javanese conceptual framework of the senses include sight, hearing, smell, taste and *rasa*.

In Javanese, touch strictly speaking indicates what one touches while *rasa* is feeling which has broader meaning (Farrer & Whalen-Bridge, 2011). *Rasa* translates into inner feeling or the ability to express or perceive feeling within the body (Benamou, 2010). According to Geertz (1960), *rasa* has two primary meanings: feeling and meaning. As a feeling, it is part of the traditional five senses. However, there are “three aspects of the feeling that our view of the five senses separates: taste on the tongue, touch on the body, and emotional feeling within the heart – sadness, happiness, and the like” (Geertz, 1960, p. 238). For instance, the taste of breast milk is a *rasa*; a pain emanating from an engorgement is a *rasa*, a mother feeling guilt for not breastfeeding is *rasa*. As meaning, *rasa* indicates “both the meaning of events in the *lair*, the external behavioral world of sound, shape and gesture, and in the far more mysterious *batin*, the fluid inner world of life” (Geertz, 1960, p. 239). The *lair* is the physical level in which human interacts and the *batin* is the inner life. According to Huges-Freeland (1997) “*lair* is ‘birth’, by extension the physical body and the exoteric conditions arising from one’s birth; *batin* is the esoteric, questing, transformative and creative inner self. Both are equally real in terms of human experience. *Lair* concerns rules imposed by others, such as status, physical desires and so forth; *batin* refers to self discovery” (p. 57). Conjoining *lair-batin* is making the inner and the outer correspond. *Rasa* therefore informs social practices in Java, and it is similar to Bourdieu’s rhythm or tempo in every day life (Huges-Freeland, 1997).

For Ingold (2000), engagement cannot be reduced to formulae. Rather, attentive engagement is learned through doing, paying attention to one’s movement in the world – what he calls “skill”. When Ingold (2000) spoke about skill, he was not talking about skill as “techniques

of the body”, but rather “the capabilities of action and perception of the whole organic being (indissolubly mind and body) situated in a richly structured environment” (p. 5). Skills, in his perspective, are not transmitted intergenerationally instead they are always being done, integrated into the *modus operandi* of human organism through training and experience in the performance of particular activities. Ingold’s, (2013) understanding of knowing, therefore, challenged positivists’ claims that we come to know through scientific method that is objective and detached from observation, the particularity of the knower, and cultural context. So, mothers may learn the act of breastfeeding from a hospital, but they develop the skill of breastfeeding as they practice at home.

Ingold differed from Csordas (1990) and Bourdieu (1977) because he found no pre-existing cultural conditions to describe. Ingold (2016) disagreed with the notion of embodiment because it gives the impression of a container of experience being kept in the body. Sheets-Johnstone (2016) described the notion of embodiment as a “lexical band-aid covering over a still suppurating three hundred and more year-old wound” (p. 119). She argued that we do not experience ourselves as packages within which practice are wrapped up. Thus, the body is not a “sink into which movements settle like a sediment in a ditch” (Ingold, 2013, p. 94). Rather we experience ourselves and others as “alive, moving and being moved in and by the world around us” (Sheets-Johnstone, 2016, p. 119). We as living organisms are not just moving beings but “we are our movements; therefore the knowledge we have of ourselves is inseparable from the sense we have of our movements” (Ingold, 2016, p.10). As Ingold wrote, “our task is not to take stock of its contents” [but rather to follow] “what is going on, tracing the multiple trails of becoming, wherever they lead” (Ingold, 2011, p.14).

The phenomenological approach in anthropology is suitable for understanding ways of knowing life in practice through attentive engagement, participation and movement as well as through lived experience. Ingold (2000, 2013) and Csordas (1990) gave an interpretation of phenomenology of perception from Merleau-Ponty (1962). The notion of an embodiment that I intend to follow is the one that is fluid and continuously engaging in the world which corresponds with ways bodies are generally understood in Java. In the next section, I discuss Foucault's biopower which help to understand how a specific breastfeeding law was developed and how certain public health interventions are used to govern the body in Jogja.

Biopower

Foucault (1978) described biopower as a bipolar dimension of power over life that emerged during modernity in France. The first pole of power was anatomo-politics, meaning knowledge accumulated on biological bodies where the human body is disciplined and treated like a machine. The second pole is the biopolitics of population. Foucault (1978) claimed that the two poles of biopower which emerged in the seventeenth and eighteenth century seek to "invest life through and through" (p. 139).

Anatomo-politics refers to "the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the disciplines; an anatomo-politics of the human body" (Foucault, 1978, p. 139). Anatomo-politics disciplines individuals through institutions such as prison, mental health asylums, military camps, schools, and hospitals. The placement of the individual within these confined places ensures better monitoring and adherence to strict social order. However, the confinement of a person to a facility is not sufficient in assuring disciplining

of the body. To safeguard adequate surveillance, Perron, Fluet and Holme (2005) argue that partitioning is established within these institutions. That is, each individual is confined to a particular unit within the facility. For example, in hospitals, newborns without complications are placed in neonatal units while newborns with complications after birth are sent to neonatal intensive care units. Mothers are moved from the labor unit to birthing units where they are monitored and provided training by nurses on how to care for themselves and their newborns. So, the anatomo-politics is the disciplinary dimension of bio-power that aims at transforming individual bodies through training.

The second pole of power is the biopolitics of the population which existed in the eighteenth century in Europe. Bio-politics aim at the administration of bodies based upon the management and regulation of the population. Foucault (1978) referred to biopolitics as “the species body: the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity” (p. 139). The management of these demographic characteristics through state policies become ways of regulating human life. As Hewitt (1983) points out, the state uses social policy to manage the politics of life in order to shape the social in accordance with the tasks and constraints faced by the State. He argued that “social policy plays a co-ordinating role in forming ‘the social’. It promotes and organizes knowledge, norms, and social practices to regulate the quality of life of the population – its health, security and stability” (p. 67). In Indonesia, where breastfeeding rates are relatively low (for example, 15.3% in 2010), the State passed a breastfeeding law which came from World Health Organization recommendation that babies should exclusively be breastfed for six months of life, with continued breastfeeding along with

appropriate food for two years. The WHO recommendation came out of long scientific and epidemiological research, which become the basis at which populations are governed.

Biopower or power over life designates “what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life” (Foucault, 1978, p 143). Though, much has changed since Foucault defined biopower. Rabinow and Rose (2006) pointed out that biopower in the contemporary era has taken a different form, and it would be misleading to project forward Foucault’s analysis as a guide for the present, future and its possibilities, even more so to project it to Indonesia. Rabinow and Rose (2006) suggested that biopower involved “one or more truth discourses about the ‘vital’ character of living human beings; an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals work on themselves in the name of individual or collective life or health” (p. 195).

Power is exercised not through coercion, but rather through persuading individuals to understand that certain ways of behaving are appropriate for them to promote good health. For example, public health agencies use state apparatuses to collect statistical data on the health risks of not breastfeeding babies. These statistics are presented to mothers so that they can make informed decisions about minimizing these risks. By internalizing these forms of governance, mothers cultivate the habits of self-regulating and self-monitoring their own behaviors. Thus, mothers become morally responsible for the good health of their children. Public health messages which is within biopolitical framework is one of the forms of authority that shape women’s experiences of breastfeeding. In the later part of the section, I discuss other forms of authority and how they are entangled.

In the *Birth of the Clinic*, Foucault (1973) described how medical professionals gain power through the knowledge they have acquired. According to Foucault (1980), knowledge is closely linked with power, and there is no power without a corresponding field of knowledge. In the analysis of power and knowledge, Foucault observed that the body of scientific knowledge acquired by medical physicians gives them a particular medical gaze from which they define what is deviant or normal behavior (Foucault, 1973). Medicine defines which human conditions, behaviors, or bodies deviate from the norm and what medical procedures and technologies may be used to regulate and discipline the body. For example, exclusive breastfeeding for six months of an infant's life is promoted because epidemiological studies have established statistically significant relationships between infant formula and a host of diseases including gastrointestinal and respiratory infections (Howie, 1990), eczema (Lawrence, 1995), and sudden infant death syndrome (Mitchell, 1992). This biopolitics was adopted in Indonesia yet with little significance within this context as my study will show. In contexts in which biopower prevails, the desire and willingness of women to conform to the breastfeeding guidelines make them to self-monitor and discipline themselves. Nevertheless, where there is power, resistance also exists. Resistance among mothers to breastfeed their infants exclusively for six months varies to different degrees. While some women choose to formula feed their babies, others complement breastfeeding with formula, a choice that is against the breastfeeding law in Indonesia.

Further, expert knowledge is a powerful way that governments 'govern at a distance' (Rose, 1992, p. 192). There has been a considerable emphasis in anthropology and sociology on how the reproductive bodies of women are regulated through scientific knowledge acquired by physicians. Martin (1987) used the metaphor of the body as a machine and doctor as a mechanic to show how women's bodily processes such as menstruation, childbirth, and menopause are

regulated through a biomedicalized approach. As Martin (1987) has shown, the control of bodily processes has alienated women's bodies from themselves in the United States. Davis-Floyd (1990) went further to discuss the use of obstetrical rituals within American culture which may not be beneficial to women but are created by the medical institution to monitor, regulate and control the natural birth process. Many of the routine obstetrical procedures such as electronic fetal monitoring, episiotomies, the lithotomy position and even caesarean section are dehumanizing, disempowering and harmful to women. The lithotomy position, for example, makes pushing the baby difficult, long and injurious than necessary because of the uneven weight distribution of woman's body. The scientific acceptance of obstetrical procedures has profoundly transformed birth from a natural process to a relatively predictable and controllable technological phenomenon within hospital settings. The other birth process that is monitored and controlled is dilation. The cervix is regularly checked to determine the level of dilation. If it is not progressing on schedule, an artificial time chart is executed through labor augmentation (Davis-Floyd, 1990). Sawicki (1991) who drew on Foucault's concept of power-knowledge and sexuality argued that new reproductive technologies, for example, ultrasound, fetal monitor, and amniocentesis represent the disciplinary power that is used to manage female bodies, make them mobile for multiple uses. Disciplinary power operates through the mode of subjectification by classifying and identifying subjects in efforts to further control them.

The regulation and control of women's bodies and the subjugation of their social experiences to authoritative knowledge are not only seen in the realm of birth but also in breastfeeding. Millard (1990) discussed how pediatric experts oblige women to breastfeed their babies on fixed time schedules in the U.S. The norm to breastfeed a child after every two hours is enforced in the hospital settings and mothers are requested to continue at home through self-

discipline. Millard (1990) argued that feeding babies on schedules make mothers mistrust their bodily signals including the letdown reflex in determining the timing of feedings as well as mistrusting their children's bodily signals. Further, breastfeeding schedules tend to reduce milk production and increase infant hunger. Millard (1990) maintained that breastfeeding according to the clock is the factory model of the physiological process in which emphasis is placed on time efficiency. Thus, "when the factory model was extended to breastfeeding, the process become defined as a series of steps, each of which was to be regulated by the clock, including the interval between feedings, the length of time at the breast and the frequency of feeding at each breast" (Millard, 1990, p. 218). Dykes (2005) who did her research in England extended on the work of Martin (1987) and Millard (1990) by showing how the metaphor of the capitalist production line of demand and supply governed the hospital approach to breastfeeding and was adopted by midwives and new mothers. The woman is the laborer, her breast is the machine, breast milk is the product, and the baby is the consumer. If the machines (breasts) work properly, they will produce the right quantity and quality of breast milk. If the laborer (mother) uses the machine (breast) effectively, they will be able to produce the correct amount of breast milk to the baby (consumer). Dykes (2005) argued that the mechanistic notion of breastfeeding undermines women's ability to breastfeed and also contributes to women viewing their breasts as faulty machines when they cannot produce sufficient breast milk to feed their babies.

One criticism that was lodged against Foucault's analysis of biopower is that it subjugates human agency and neglects the lived experiences of the body (Lupton, 1997, p. 101). Thus, Foucault was unable to address the being-in-the-world experience of biopower (Ferzacca, 2001, p. 110). Foucault's biopower fails to emphasize the ability of mothers and their families' to resist regulatory and disciplinary interventions from the state. Foucault himself admitted in his

later work *The Political Technology of Individuals*. that “perhaps I’ve insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself in the technology of self” (Foucault, 1988, p. 146). Foucault’s interest in the micro-powers of the individual shows that he was beginning to pay attention to the everyday practice of power relations before his death (Lupton, 1997, p. 103). The move towards a phenomenology of everyday life helps us to understand forms of authorities embodied in women's breastfeeding experiences without assuming that they are only disciplined but assuming that they also improvise and maintain agency. In the next section, I delve into the methods that I used to learn from the mothers and their families keeping with this theoretical approach.

Notes

1 When I arrived at Jogja, I observed that the streets were filled with motorbikes, and the riders wore jackets in the hot afternoon when temperatures ranged between 30 to 35 degrees Celsius. At first, I wondered why people would wear jacket when it was so warm. It took a while for me to understand why people in Jogja wore leather and thick jackets on hot days and nights when they went out.

2 *Minyak Telon* is an aromatic oil that is used to moisturise babies ‘bodies. It helps to reduce wind in babies’ stomach and prevents colic. Thus, it helps to keep infants’ stomach and feet warm.

Chapter 3

Methodology

This chapter spells out the methods that I used to conduct the research. I drew on ethnographic methodology to study with and learn from mothers on how forms of authorities are embodied in women's breastfeeding experiences. Ethnography is an “ongoing attempt to place particular encounters, events, and understanding in a fuller, more meaningful context” (Tedlock, 2003, p. 26). Tedlock (2003) stressed that ethnography was a continuous process of fieldwork rather than a recording of past experience. A mother’s way of being in the world is expressed in her everyday lived experiences. Therefore, identifying mothers through a survey questionnaire would not bring us directly into contact with the daily lived experiences of the mothers. When we use reductionist approach, we lose sight of the complexities of these women’s lived experiences of breastfeeding. So, by listening to the stories of breastfeeding mothers and observing what goes on around them, we come closer to the fullness of life as breastfeeding mothers live it. I, therefore, employed methods such as participant observation, photo novellas in addition to interviews to learn from women’s experiences of breastfeeding.

Ethnographic Fieldwork

The fieldwork spanned from June 2013 until October 2014 in Jogjakarta with ethics approval from the University of Ottawa Research Ethics Board and with institutional support from the Department of Anthropology at Gadjah Mada University in Jogjakarta, Indonesia. I did preliminary fieldwork between June and July 2013 that helped me to familiarize myself with the city, with an intense fieldwork between August and October 2014. I chose to do ethnographic field work because many of the public health studies that were done on breastfeeding practices failed to take into consideration the actual experiences of mothers and their families regarding

breastfeeding. This also gives deeper and richer understanding of women's actual (rather than recommended) breastfeeding practices.

Initially, I had planned to stay with a breastfeeding mother so that I could observe the practices but this option was not available to me as my participants in Jogjakarta do not breastfeed in front of men. The first lesson I learned from the field was thus that Jogja mothers did not breastfeed in the presence of any men, relatives or otherwise.

My first meeting with each of the participants was one that was very cordial and friendly. During my first meetings with the participants and their families in their homes, I was warmly welcomed. I was given *jamu* as we exchanged greetings. Drinking *jamu* at the participants' homes was the beginning of me occupying the world that is similar to theirs. After exchanging greetings, I would introduce myself to them and tell them of my research interest in breastfeeding. I talked about myself, giving them my name, educational status and sharing about my ethnic background with origins in Ghana. Although presenting my schooling to the participants might be an elitist move, which has the possibility to set up power relations, it helps me to find a common grounds since the lowest level of education among the women was high school.

In many cases, after my self-introductions, one further thing that the participants sought to know was whether I was married. I answered them in the affirmative which was received with broad smiles. The next question that followed was 'do you have children?' I would answer 'no.' Since I had no children at the time of my fieldwork, the comical response was often 'what are you waiting for?' My participants encouraged me a lot to have children as they said that they are a blessing from Allah.

Participants also asked me questions about my experiences of breastfeeding in Ghana. I was very honest in answering them, telling them how I had seen some women in Ghana breastfeeding on public transportation, and in churches and marketplaces. Yet, I did not pay attention to these breastfeeding practices even though they were right around me. All I knew about breastfeeding at the time of the field work came from books that I had read, and discussions I had with my supervisors, friends, and other students. I, therefore, appealed to the mothers to share their experiences with me as I humbled myself and learned from them.

In truth, I was afraid initially that not having a child at the time of the field work would prevent mothers and their husbands from sharing their experiences with me. Contrarily, it turned out that the participants were eager to help a novice with the smallest details of their experiences. The mothers were very open to talking about their schooling, age, work, husband's work, and Javanese practices. Some also talked about how they met their spouses and how many children they planned to have. Further, some of the mothers who were aspiring to do a Master's degree abroad asked me to assist them in contacting schools in North America. My first meetings in the field with the participants helped to a large extent in building strong relationships with the participants.

Over time, I came to know the mothers and their families well. At some points during my fieldwork, I felt a sense of belonging in my participants' families, but to different degrees. This gave me the opportunity to talk to their spouses about their experiences with breastfeeding practices. I was only able to talk to six husbands, mostly due to their being busy with paid work commitments. Since the men were not my core participants, I met them less frequently. Two of the husbands were virtually part of all the meetings I had with their wives. I met three of them

twice and one only once. My conversations with the men mainly concerned how they supported their wives in relation to breastfeeding practices.

Recruitment of participants

Mothers who were breastfeeding at the time of the study lived in the city of Jogjakarta and who were willing to interact with me on their experiences of breastfeeding were selected for the study. I recruited four of the mothers through personal networks and then used a snowball technique. The first participant was identified through my Indonesian research assistant who had a three-year-old child. Through the first participant, I was able to recruit three other mothers for the study. Recruiting mothers by snowballing was time-consuming in the field as I had to establish a good rapport with the mothers before asking them to recommend another mother to me. My research assistant then suggested that it would be easier to recruit mothers through a Facebook page as some mothers interacted and exchanged ideas about breastfeeding through this medium. My research assistant put an advertisement on her Facebook account. From Facebook, twenty mothers expressed interest in participating in the study. Because of the limited time, budget and resources I had in the field, I recruited seven of them based on a first come first served basis.

Research Participants

The participants of the study were eleven women who were breastfeeding at the time of the study and were part of a cluster of relations with their newborns, their spouses and different members of extended family. Three of the mothers who had more than one child also shared their previous experiences of breastfeeding their older children. The mothers were in their middle to late twenties except two who were in their early thirties. All of the participants were in heterosexual marriages, identified themselves as Javanese Muslims and resided in Jogjakarta.

Only one mother involved in the study residing and working in Jogjakarta had her family (husband and child) living outside the city. Figure 3.1. Shows a map of the different neighborhoods where I met the families in Jogja.

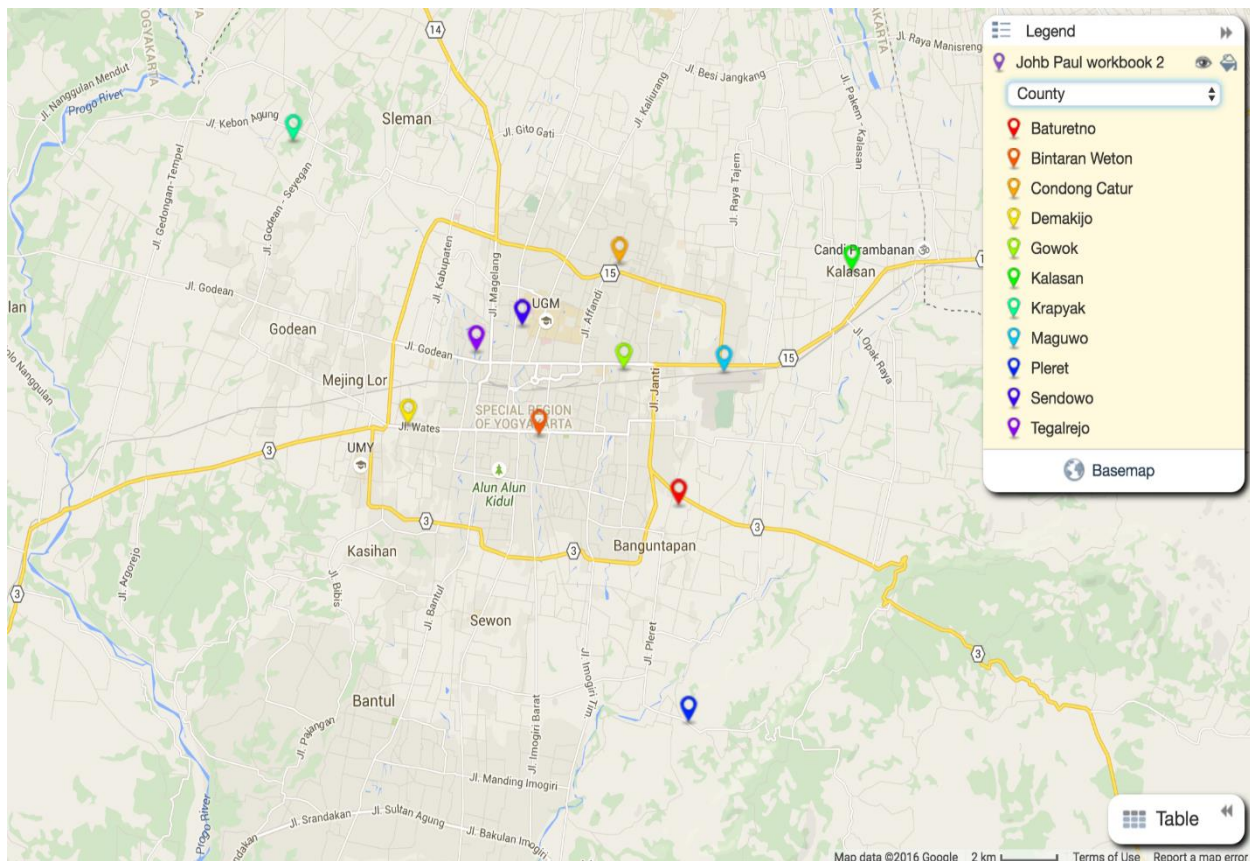


Fig 3.1. A map of different neighborhoods of the families

Description of Participants

This section describes women who took part in the study. In what follows, I give a brief description of the mothers with their spouses and children to situate their experiences in their particular context and trajectory. Pseudonyms are used to ensure confidentiality. Table 3.1 summarizes the forms of authority that the mothers' spoke more particularly to when I met them.

Rosada was in her late twenties and has a master's degree in Philosophy. After completion of her program, she was retained by the Department of Philosophy as a part-time

lecturer. Rosada is married to Timbul, and they have a baby girl named Lina. Timbul taught theology at Rosada's father's college. The couple lived in Rosada's grandparents' residence in Krapyak, a suburb of Jogjakarta. Rosada's siblings, as well as some students from the school where Timbul works also lived in the house with them. Rosada and Timbul were building their own house at the time of the study. Both Rosada and Timbul were devoted Javanese Muslims. Rosada had a caesarean section and had a lot of supports from her parents, siblings and the students. She exclusively breastfed Lina for six months, and continued to breastfeed her until she was twenty-three months old.

Wati and Danag, a Javanese Muslim couple in their mid-twenties owned a small home in the neighborhood of Sendowo in Jogjakarta. Wati was a seamstress and worked at home while her husband Danag had no permanent job. Occasionally, he worked as a motorbike repairer, or sometimes people hired him to drive them around the city or to other cities. Wati's mother and sister-in-law lived near their home, and they maintained close relations with them. Wati attended a fitness class when she was six months into her pregnancy to stimulate breastmilk production. Wati gave birth to her daughter Ella via caesarean section at a local hospital, after which she moved to her mother's home for one month for care and assistance. Her mother was supportive by cooking for Wati, bathing Ella, and also mentoring her on how to breastfeed. Ella was exclusively breastfed for six months and was weaned when she was thirty-sixth months old.

Nadja was in her late twenties and is married to Haryo. They first met in Egypt while pursuing their undergraduate degrees. They lived in a big rented house in Maguwo, a neighborhood in Jogjakarta. The couple visited the mosque regularly for prayers, and Nadja always wore her hijab. Nadja was a student pursuing her master's degree in Philosophy as well as an entrepreneur who sold breastfeeding dresses online while Haryo taught at the University.

She deferred her master's program to give birth and also to breastfeed exclusively. Nadja attended breastfeeding classes at a local hospital in Bandung, her hometown. She gave birth to her son Soni through a caesarean section. After birth, Nadja moved to her mother's place for five months for support. Her mother was very helpful by carrying Soni, cooking for Nadja, and also mentoring her on childcare. During the five-month period, Haryo visited his wife once every month. When Soni was born, an Islamic ritual was performed on him where *Kurma* (date fruits) were put on Soni's palate and two goats were slaughtered for him. Nadja breastfed Soni for seventeen months. Soni never slept in a crib, he slept in a bed with Nadja.

Indah was in her early thirties and had three children with her husband, Toyib. Their first child, a girl, was named Dikah, followed by a boy (Adam), then Ida, also a girl. The couple lived in Pleret, a neighborhood in Jogjakarta. When Indah completed her undergraduate degree she did not find a job in the government sector, so she partnered with Toyib in a newspaper distributor business in Jogjakarta. Toyib focused on distribution while Indah did the accounting. When Indah gave birth to Dikah at a local hospital, she was fed with infant formula by the midwife. The remainder of the formula was given to Indah to continue feeding her at home. Toyib was furious when he learned that Dikah was fed formula. He threw the remaining formula into the garbage bin and insisted Indah breastfeed Dikah, which she did. Adam was also born at the same hospital but this time, Indah and Toyib signed an official document at the hospital that Adam should not be fed formula. Because of the previous experience that Indah and Toyib had with the local hospital, they decided to move to a different hospital that was more supportive of breastfeeding for the delivery of Ida. Ida was breastfeeding for a year and a half at the time of the study.

Juleha was in her mid-twenties when I met her. Juleha and Rizki have a baby boy named Aryo. Aryo was a year old. They lived in a big house at Condong Catur in Jogjakarta. Also living with them in the house was a housemaid that Juleha employed to assist her with domestic chores and child care duties. Juleha worked as a free-lance local news reporter and also wrote articles for magazines in Jakarta while Rizki owned and operated a tourism business. Despite a planned vaginal delivery, Juleha ended up with a C-section after four days of labor. After delivery, Juleha moved with her son to stay with her mother for three months. She moved to her mother's place because Aryo was her first child, she had C-section and had no practical experiences of childcare and breastfeeding practices. Prior to delivery, Juleha was not enthusiastic about exclusive breastfeeding because her mother did not exclusively breastfeed her siblings, yet they were all healthy. Juleha had terrible breastfeeding experiences ranging from insufficient milk supply, depression, sore nipples, mastitis, and difficulty expressing breast milk. In the first month, Aryo slept in a crib because Juleha and Rizki were afraid that they would roll over him at night, but in subsequent months, he shared a bed with them. Aryo was breastfed for two years.

Drami is married to Agus, and they have a baby girl named Frida. Drami was in her late twenties and lived together with Agus in his family house at Baturetno in Jogja. Agus' mother and brothers also lived in the same house with them. Before Drami got pregnant with Frida, she was living separately from Agus because of her work. She was working at a hospital in the city of Solo, a town 60 km away from Jogja. They visited each other every weekend. More often, it was Agus who paid a visit to Drami at Solo. When Drami was in her eight month of pregnancy, she officially resigned from work and moved to Jogjakarta to stay with Agus. She became a stay-at-home wife in order to take care of her child and also breastfeed Frida exclusively for six months. She remained a stay-at-home wife for six months before finding a new job as a

nutritionist in a hospital in Jogjakarta. A few weeks after Drami gave birth to Frida, she could pump about 500 mL of breast milk per pumping. Her left breast was painfully engorged, which later developed into mastitis, which required surgery. Despite the challenging experiences that Drami went through, she managed to breastfeed her daughter, Frida exclusively, for six months, and continued to breastfeed her for two years. During the day, Frida slept in a crib but shared a bed with her parents at night. Drami was afraid to leave Frida alone in the crib at night in the baby's room.

Ambar was in her late twenties at the time of the study and is married to Priyadi. Ambar worked in the private sector and held a middle-level management position. Priyadi worked as a teacher. Ambar lived and worked in Jogjakarta while Priyadi and their son Joko lived in their hometown Purwokerto. In Jogjakarta, she rented a room at Gowok. At the time of conception, Ambar was working and at the same time pursuing her master's degree in media technology and communication. She worked on weekdays and attended classes on weekends. Ambar attended all her prenatal appointments in Jogjakarta but gave birth to Joko in a hospital in Purwokerto. She took a six-week maternity leave prior to her expected date of delivery and had only six weeks leave after childbirth. Ambar and Priyadi planned to breastfeed Joko exclusively, so, when Ambar returned to work after her maternity leave, she pumped and stored enough breast milk in the freezer. Care for Joko is now left in the hands of Priyadi and Ambar's older sister, Nur. Nur took care of Joko during the day while Priyadi took over the responsibilities at night.

Siti and her husband Putra have two daughters, Fitri, and Dewi. They reside at Kalasan, a suburb of Jogjakarta. At the time of the study, Siti was in her late twenties and worked at a government institution. The couple lived nearer to Putra's family house, and Siti maintained a close relationship with her mother-in-law. Her mother-in-law often assisted her by cooking for

the family. When Siti returned to work after her maternity leave, her mother-in-law helped her with babysitting. When Siti conceived her first daughter Fitri, she started searching the internet for the best brand of formula milk. She did not plan to breastfeed Fitri because she thought she would not be able to combine child care responsibilities and the demands of work when her maternity leave ended. In the seventh month of her pregnancy, she attended a breastfeeding class at a local hospital, which changed her mindset about breastfeeding. Siti exclusively breastfed Fitri for six months and continued breastfeeding her until she was 26 months old. She stopped breastfeeding Fitri when she was pregnant with her second child, Dewi. Siti gave birth to Dewi at the hospital and exclusively breastfed her for six months. Siti shares a bed with Dewi while her husband Putra and older child Fitri sleep in another room. Dewi is a year old and is still breastfeeding.

Putri was in her mid-twenties with a high school certificate. She was a migrant worker in Malaysia for eight months before returning to Jogjakarta to marry Slamet. The couple lived in the neighborhood of Bintaran Weton in Jogjakarta. Putri and Slamet have a baby girl named Rukia. Slamet did not want Putri to work outside the home. He wanted Putri only to take care of their daughter, Rukia, and also do the household chores as he worked to earn income for the family. Slamet worked at an automobile company, and he felt he was making enough income for the family. Both Putri and Slamet had lost their fathers, and they were not living close to any of their relatives. They lived in a one bedroom house. Putri maintained a close relationship with her sister-in-law over the phone, who was a midwife and often sought medical advice from her when she needed it. When Putri was in the seventh month of her pregnancy, she regularly cleaned her breasts with warm water and massaged them so that she could stimulate the production of enough breast milk for Rukia. Putri continued the cleaning practice even after delivery. Putri

exclusively breastfed Rukia for eight months. Rukia was a year old at the time of the study and was still breastfeeding. In the first month, Rukia slept in a crib during the day but at night, she shared the bed with her parents. Because Putri and Slamet have limited space in their bedroom, they have decided to discard the crib to create some space.

Fadila was in her late twenties and married to Jojo. She worked as a community service officer but changed to a secretarial job because of the workload. Fadila has much flexibility with her work as a secretary, and she could go home during her lunch break to breastfeed her daughter Lily before returning to work. Jojo, on the other hand, worked at a restaurant in Jogja. Fadila and Jojo lived in Demakijo, a suburb of Jogjakarta. Also living with them was Fadila's mother Sifa who took care of Lily during the day. Fadila was unable to breastfeed Lily exclusively for six months because she had to travel for a work conference for three days. During those three days, Lily was formula fed. When Fadila returned from the conference, she decided to continue formula feeding Lily until the box of formula was finished. She breastfed Lily for twenty months.

My final participant is Mewar. She was in her early thirties and was previously married to Satriyo, a union from which they had three children: a daughter, Sofia, followed a year later by twin brothers John and Jones. Mewar had Sofia when she was 22 years old. Sofia, John, and Jones were all born prematurely. Mewar and her family previously lived in West Java before they migrated to the city of Jogjakarta after the death of her husband in 2007. After three years, Mewar married Kevin and later divorced him. In 2013, she married Selasi with whom she had a boy, Sujatno who was a month old at the time of the study. Mewar worked as a principal of a high school in the city of Jogja while Selasi worked as a researcher. The couple lived in a big house at Tegalrejo. Selasi's mother was a dentist and lived near to the couple. Sofia, John, and

Jones were formula fed because Mewar had no information on the importance of breast milk and she faced difficulties establishing and maintaining breastfeeding. Sujatno was exclusively breastfed for six months and was weaned of breastfeeding when he was eight months old.

So it is the experiences of these eleven women and their families that I would discuss in the analytical sections of this dissertation. In what follows, I describe how I chose my research assistant, and the methods that I used in the field.

The choice of and training of research assistant

I met my research assistant in 2013 when I was in Jogja with a team of researchers to examine interlinkages between informal gender entrepreneurship economy, local knowledge systems in traditional medicine and urban development. She was one of the Indonesian students who assisted us in the field. She conducted ethnographic research in Islamic instructions in public school in Germany for her master's degree in anthropology. I choose her as my research assistant because she is a mother, she has an in-depth understanding of how things work in Jogja, she has good skills of interviewing and engaging participants in the field, and I am comfortable working with her.

I provided two days of intensive training to her. The training was divided into two parts. On the first day of the training, I explained the research problem to her. We also discussed each of the methods to use in the field. We went through each of the questions in the semi-structured interview guide, (See appendix for the interview guide). When it came to the participant observation, I explained to her that I intentionally did not design structured participant observation guide because doing so would limit our observations. It is also to be respectful of my participants and also respect their privacy. Instead of the participant observation guide, I told her

to use her senses to pay attention to what the mothers were doing and what was going around us. On the second day, we discussed ethics, and how we would communicate in the field as a team.

My research assistant was very helpful in the field because she was able to engage the women by sharing her own experience of breastfeeding with the participants. Her presence and sharing of her own stories with the women enabled the women to open up and share their own experiences of breastfeeding. As an outsider who had never breastfed and most likely never will, I often asked questions about experiences that were taken for granted by my research assistant and the women. For example, I asked questions about the kinds of assistance that mothers received from their spouses and mothers that shaped their experiences of breastfeeding.

Participant observation

To observe is to watch what is going on around and about as well as to listen and feel (Ingold, 2014, p. 387). To participate means “to do so from within the current of activity in which you carry on life alongside and together with the persons and things that capture your attention” (Ingold, 2014, p.387). Participant observation, therefore, means that we are observing and knowing from the inside (Ingold, 2013). During the study, I undertook some amount of participant observation.

Participant observation was done mainly in the homes of the mothers although some of our meetings took place at workplaces and restaurants. I spent time with their children and their families. I fed babies solid foods, played with them, and carried them. It was totally fun and enjoyable. The smiles that the babies gave me when I held them in my arms made me feel emotionally attached to them. Playing with the babies brought me closer to both the babies and the families. I also shared food with some of the families as I was invited for lunch and dinner. I was not able to fully participate as I wanted because the mothers would not breastfeed in front of

me. Although in one vein this limited my participation, in another it helped me to understand how mothers negotiate and interpret space. This, I elaborate in chapter seven of this dissertation.

To compensate for my limited participation, my research assistant made some observations on my behalf when and where it was inappropriate for me to do so because I am male. For example, she observed mothers during breastfeeding, carefully paying attention to how the babies were positioned among other things. She also observed for me the babies' sleeping places in the homes. My research assistant who is also a mother of a three-year-old girl explained these observations to me with the agreement of the mothers. I also made observations of what the fathers were doing when they were interacting with their wives.



Figure 3.2. Researcher playing with a baby in the field.

Interviews

Sherman-Heyl (2001), described ethnographic interviewing as “those projects in which researchers have established respectful, on-going relationships with their interviewees, including enough rapport for there to be a genuine exchange of views and enough time and openness in the interviews for interviewees to explore purposefully with the researcher the meanings they place on events in their world” (p. 367). Both the frequency of contacts and quality of the relationship that the researcher develops over time with the participants are essential in distinguishing ethnographic interviews from other types of interviews. As Pink (2010) indicates, the interview “creates a place in which to reflect, define and communicate about experiences” (p. 87). I used semi-directed open-ended interviews which is closer to conversations.

During the fieldwork, I met some of the mothers much more frequently than others. This was because firstly, some of the mothers were more interested in sharing their breastfeeding practices with me and secondly, because some of the mothers were recruited later in the field work. For example, I met two of the mothers five times each as they were interested in telling me more about their experiences of breastfeeding while I met the other mothers thrice, except for Mewar, whom I met only once. In all, I had thirty-four interviews with the mothers and six interviews with the fathers.

Our meetings took place in their homes, in workplaces and in restaurants. The participants selected the time and place for our meetings. I was willing to meet them at any place and time of their convenience. When at home, many of our meetings lasted four to six hours, as we had to pause our conversations several times to enable mothers to prepare food for their babies and husbands, take babies to bed, change diapers, bathe babies and soothe them when they cried. When at workplaces, our conversations were much shorter as they lasted for only an

hour or two. Most of our conversations were audio recorded with the permission of the mothers. The only interactions that were not recorded were the ones that we had when we were having lunch together or walking together. Salient items from these interactions were recorded in my field notes on my way home.

Over the course of my first meetings with the mothers, I engaged them in conversation about where they gave birth, whether they had planned to breastfeed, what motivated them to breastfeed and what their expectations of breastfeeding were before they became mothers. Further, I asked mothers to share with me their stories on breastfeeding practices as well as how they combined breastfeeding with family life and work. They were also asked to share stories about their personal experiences on some practices including breastfeeding in the hospital after delivery, nighttime breastfeeding, breastfeeding in public places, milk expressing, weaning practices, and the introduction of solid foods to babies. I heard some difficult experiences during the field interaction, which made me reflect about the troubles that women go through to breastfeed their babies. Before my fieldwork, I used to assume that my wife should automatically and easily be able to breastfeed when she one day gives birth. I did not know that breastfeeding was a skill that mothers learned over time, neither did I know the difficulties women go through when breastfeeding. One lesson I learned from the field was to be supportive of my wife when she gave birth. I elaborate on family support for breastfeeding mothers in chapter five.

I also took note of non-verbal communications the mothers used in explaining their breastfeeding practices to me. Some mothers also did some demonstrations to communicate their experiences such as how they used the manual breast pump. I was also shown some breastfeeding clothes and some books used for information on supplementary feeding. I took photographs of these materials to supplement the experiences that mothers shared with me.

A limitation of the interviews is that there was a translator between the participants and myself, namely my research assistant, as I do not speak Indonesian. During the translation, some of the meaning that participants attached to their lives and experiences of breastfeeding will indisputably get lost. However, this way of working gave me more time to observe bodily gestures and expressions.

Photo Novellas

The final method that I used to learn with these women was the Photo Novella. Photo Novella is the use of photographs in research which provide “participants voice and language through which to voice salient concerns” (Hergenrather, Rhodes, Cowan, Bardhoshi & Pula, 2009, p. 695). As Hurworth, Clark, Martin and Thomsen (2005) highlighted, the photographs taken by the participants promote critical dialogue about the meanings and significance of everyday life.

Prior to the fieldwork, I had planned to provide disposable cameras to mothers to take photographs of the places where they breastfed or expressed breast milk at work and in public spaces. But upon reaching the field, I realized that all the participants had smartphones with cameras. So, I appealed to the mothers to use their phones to take photographs of the places where they breastfed their babies. The mothers took several interesting pictures including the breastfeeding dresses that they wore when going to public places, as well as expressing machines. Pictures were also taken of places where they breastfed including bathrooms, lactation rooms, and conference rooms in workplaces. One mother, for instance, sent me a photograph of her breastfeeding her baby while riding a motorbike, a common practice in Jogjakarta. After the photographs had been given to me, I engaged the mothers in conversations about the photos. I asked them to explain what the pictures mean to them in relation to their breastfeeding

experiences. Using the photographs taken by the mothers themselves gave a richer understanding of their experiences of breastfeeding since it allowed them to reflect on and discern their own perspectives. The pictures also helped me to have an idea of where the mothers breastfed in public places. The commentary the women gave of the pictures conveyed significant socio-cultural perspectives, and workplace regulations among other such important factors interconnected with breastfeeding practices.

Analysis

All the stories that emerged from the interviews were tape recorded, translated and transcribed verbatim from Bahasa Indonesian into English. My research assistant translated the interviews to me, and I transcribed. Doing the transcription on my own helped me to gain great direct familiarity with the recorded conversations in relation to the situations and places in which these occurred. I read thoroughly through the interview transcripts, field notes, and looked at the pictures several times. This was helpful in writing down notes on individual interviews, participant observations and photos as memos. My readings of the interview transcripts were directed by the listening guide that was used by Doucet (2007). The listening guide was first developed by Lyn Mikel Brown, Carol Gilligan and their colleagues at the Harvard Project on Women Psychology and Girls' Development (see Doucet, 2007). Doucet used it for her doctoral thesis and later modified it for another research project "Do men mother?" She advocated for flexibility in the number and types of readings depending on the nature of the topic under investigation (Doucet, 2007). My first reading was to familiarize myself with narratives of the eleven mothers and six fathers. The idea behind the reading was to know what was happening in the text. I highlighted the themes, the keywords that were recurring in the text, the places that mothers breastfed, and other social actors that were mentioned in the text. In the second reading,

I made a distinction between the “I” statement (the mother) and the “we” statement (the mother with her spouse or someone else). In the third reading of the interview transcript, I followed the narratives of each of the eleven mothers. For example, what forms of authority did the mothers evoke as part of their decision to breastfeed? Who takes part in shaping women’s preparation towards breastfeeding? How did the women manage to breastfeed when they returned home? How long were infants breastfed, and what methods were used to wean them off breastfeeding? These readings were pulled together to form chapter four of the dissertation. Finally, the fourth reading, I explored broader structural issues when looking at family supports that women received during breastfeeding and how women combined work and breastfeeding. Further, I looked at Islamic faith as a form of authority influencing women’s experiences of breastfeeding. These themes were discussed in the context of the current breastfeeding law in Indonesia. Prior to the fieldwork, some of the codes I had in mind were motivation of breastfeeding, employment and breastfeeding, public breastfeeding, weaning, law, men supports of breastfeeding, and sexuality. Some of the codes that emerged from the analysis were employment and breastfeeding, weaning, men’s contribution to breastfeeding and public breastfeeding.

Another analytical strategy that I used was to engage my research assistant, friends who were breastfeeding mothers, my wife, and my two supervisors to help me make sense of some of the experiences of mothers that I was less familiar with. For example, my research assistant was a mother, Muslim, and Javanese. Throughout the interview processes and analysis of narratives, she helped me understand Islamic practices and concepts like milk kinship that I was not familiar with. I involved some of my friends who were breastfeeding mothers in conversation to gain a better understanding of some of the narratives. Working with my research assistant, friends and supervisors showed that “people have more than one way to tell a story and see a situation

through different lenses and in different lights” (Gilligan, Brown, & Rogers, 1990, p. 95). Some areas of experience of the mothers were not clear to me until my wife delivered our first child and I became a father. Initially, when I read through the narratives, I thought some of my participants were exaggerating the work that was involved in breastfeeding and childcare tasks. When I became a stay-at-home father because my wife was in school, I understood what it meant to combine writing a thesis (which was my work) with taking care of an infant. I was either playing with her, feeding her or sleeping by her side. I hardly had time to write my dissertation. My wife and I were also frustrated when our daughter was unable to latch on the nipple for three months after birth. With these personal experiences, I went back to reread the mothers’ narratives. My personal experiences helped me to better understand some of the central story line of my participants.

The interview transcripts, audio interviews, and photos as well as my notebook memos were then imported into NVivo. I used NVivo as an organizational tool in managing data in a systematic and efficient manner. NVivo was also useful in coding the transcripts and carrying out text searches. Using NVivo makes it easier and quicker for me to organize and manage my data than using manual techniques.

I could not use NVivo alone in the analysis. I had to take advantage of some manual techniques to make sense of the coded transcripts and memos, as well as how the different themes knitted together. Again, when I used NVivo’s text search function, it helped by quickly searching for words. Multiple synonyms used by the participants made it difficult to retrieve all responses on a similar theme. For example, mothers used “pumping of milk” and “expressing of milk” or “first milk” and “colostrum” to articulate the same idea. So, I had to read continuously through the coded text to fully understand similar themes.

The photographs were analyzed based on the meaning attached to them by the mothers, and selected examples are included in the dissertation to help illustrate the experiences of women. The photos were linked to the associated transcript to ensure continuity in the analysis. I also used direct quotes from the interviews throughout my dissertation to reflect the reality and experiences of the breastfeeding mothers in their own terms. Finally, my participant observation helped to ground my analysis in practices and to make sense of the mothers' narratives in context.

Conclusion

In this chapter, I have described how the research was carried out in the field. I used participant observation, interviews, and photo novellas to provide a systematic understanding of the experiences of eleven breastfeeding mothers in Jogja. In the chapters that follow, I provide humble retellings of the stories that the mothers have given me, making them speak to each other as well as trying to find broader meanings from them in terms of ways biopolitics and corresponding legalities are part of embodied breastfeeding experiences for these women living in Jogja.

Chapter 4

Breastfeeding: Women's voices on the ground

This chapter describes breastfeeding experiences of the women who took part in the study in Jogja. Mothers were exposed to breastfeeding in different ways in their homes and family as well as the type of information they were exposed to in the media. First, I describe forms of authorities that mothers evoked as encouraging them to breastfeed. Second, I look at power/knowledge, something that forms and transforms women's preparation towards breastfeeding. Third, I delve into women's experiences of breastfeeding after their returned home from the hospital. All the women in the study gave birth in the hospital, showing how biomedical practices play an important role in birth process. However, what health practitioners recommend and how this is taken home by the mothers and their families is where I provide some insights. Finally, I will attend to the ways weaning is lived, perceived and practiced.

Forms of authorities evoked as part of the decision to breastfeed

The decision to breastfeed or not by my participants was shaped by different forms of authorities including biopolitical ones (law, public health), religious Javanese ones and forms of authorities stemming from the household, and from the media. Rosada, a devoted Muslim mother and a part-time lecturer at the University told me that one of the reasons she breastfed her daughter, Lina, was because the Holy Quran required women to nurse their babies for two years. Nadja, a mother of one child who was pursuing her Master's degree in religious studies, explained that "In Islam, it is the right of a child to be breastfed. It is understandable if a woman cannot breastfeed because of medical reasons. Women who have milk but failed to breastfeed because of paid work have denied their children of the right to breast and violate Islamic law on breastfeeding." Breast milk is regarded as the right of infants and women are under a moral

obligation to breastfeed their children. While all my participants were aware of the Islamic law on breastfeeding, only Wati, a high school graduate, and a seamstress said she heard of the State law that required women to breastfeed exclusively for six months. When I asked her to tell me what the State law was about and whether she breastfed her daughter because of the law, she responded that she did not know the details of the law as she only heard about the law on a television program. She told me that she breastfed because the Holy Quran required her to do so and because of the health benefits her child would derive from breastfeeding. None of my participants evoked the State law as part of shaping their breastfeeding experience. Islamic teachings on breastfeeding practices and duration are meaningful to these mothers. Islam and public health promotions become a form of biopolitics embodied by the mothers in the management and self-regulation of their bodies.

In conversation with Rosada, she told me that breast milk provided immunity against childhood illnesses such as respiratory disease and diarrhea. She explained that feeding babies with formula might not have any immediate health risk to the child, but in the future, it may result in diabetes and adult obesity. Rosada said she acquired her knowledge about the health benefits of breastfeeding from breastfeeding blogs, AIMI and health caregivers. Nadja used her sister's frequent sickness experiences to demonstrate the danger of formula. She said, "My sister often got sick of fever and flu. My mother told me that she breastfed her for only three months." Nadja narrated to me that her sister's regular illnesses motivated her to breastfeed her son exclusively. Nadja's narration reinforced Rosada's comment that infants who were formula fed may be sick later in life, but contrasted with Juleha's previous experiences, who came from a home where her siblings were formula fed but were healthy.

Siti, an IT specialist and a mother of two girls said she wanted to formula feed when she had her first pregnancy. Two months into her first pregnancy, she was on the internet searching for the best brand of formula. She did not think of breastfeeding her daughter until she attended a breastfeeding class at the hospital in the seventh month of pregnancy. In a conversation with Siti, she told me that the most expensive formula could not replace the benefits of breast milk. She explained that the “Societal perception about formula milk was entirely wrong. People think that the most expensive formula has the best nutritional content for infants. But breastmilk is the best food.” Siti’s comments reflected public health campaign slogans that breast is best, reinforcing the superiority of breast milk to formula.

Rosada mentioned that she learned from her mother that breast milk is a medicine for infants. She said her mother advised her to breastfeed her daughter more often than usual when she was sick. She told me that breast milk helped the child to heal quickly from illness. Indah, a mother of three children and a University graduate, agreed with Rosada. But she added that breastmilk alone was not sufficient to prevent disease in older children who were feeding on breast milk and solid foods. She explained that diet played a significant role in influencing the health of children who were six months or older. She mentioned that the type of diet, timing of meals and the amount of food given to the child influenced his or her health. She recalled the experience she had with her first child, Dikah, “After the sixth month, I did not know what type of food to feed her, so I fed her a diet high in carbohydrates. She was sick most of the time. I have learned from those experiences; I feed my third child a balanced diet.” Indah’s experiences highlighted the challenges that mothers had identifying the types of solid food that provide various nutrients for the growth of the child. I elaborate on the kind of solid food that mothers feed their infants after six months of life in the latter part of this chapter.

Putra, a stay-at-home mother of one child said the natural role of a woman is to get pregnant, give birth and nurse him/her to grow healthy and strong. Juleha, a journalist, agreed with Putra when she posed a rhetorical question “I am a woman; I have breasts; shouldn’t I use them?” Like Putra and Juleha, Wati said that she felt like a mother when she breastfed her daughter, Ella. She explained “As a mother, you bear children and breastfeed them. It is only then that the love of a mother for her baby is complete.” Echoing similar views, Drami, who resigned from her job to breastfeed her daughter Frida, mentioned that she breastfed her because she wanted Frida to know her and be firmly attached to her. Drami said while breastfeeding, she sang and talked to Frida and the beautiful smiles on the faces of Frida made her know that Frida loved her and recognized her as her mother.

In an interview with Indah and Toyib, they mentioned that breast milk was cheap, convenient and readily available. Toyib explained that when their child was hungry, Indah just removed her breast from her bra and fed her. She did not need to worry herself about whether formula was mixed properly at the right temperature. Indah contributed to the conversation by saying, ‘if we were to feed our daughter with SGM¹, we would spend a lot of money on formula. Can you imagine that some mothers feed their babies three to four package of formula per month and the amount of money involve?’ When I checked the price of SGM at the Mall in September 2014, it was 84,700 Rupias per package, which translates into about \$8.47 CAD and lasts about two to three weeks depending on how often the baby was fed with formula. The financial cost involved in formula feeding transcends through almost all the narratives of the mothers.

What was interesting from the mothers’ narratives was how the risks and benefits of breastfeeding were framed in biomedical terms, but the decision to breastfeed came from Islam, public health, finance, personal experience, not the breastfeeding law from the state. The mothers

reproduced both public health slogans and Islamic moralities concerning breastfeeding perhaps because they corresponded with each other.

Who took part in shaping women's preparation towards breastfeeding?

Breastfeeding was a skill that some of my participants, especially first-time mothers, felt they lacked and that they needed to prepare for before childbirth. Siti, for instance, enrolled in a breastfeeding class at the hospital to learn some breastfeeding skills before she gave birth to her first child. The breastfeeding course, which was an initiative of public health department, was not designed to equip mothers with the practical skills of breastfeeding. Rather, it was intended to provide mothers with information about the health benefits of breastfeeding to both mother and child and also to encourage them to breastfeed. Siti told me that she learned from the class that breastmilk was superior to formula, and the gut of a child could easily digest breast milk as opposed to formula. She also mentioned that the course instructor encouraged them to persevere and endure when they felt discomfort and pain during breastfeeding. Further, she was encouraged to seek guidance from midwives or lactation consultants, should breastfeeding problems arise. Siti knew the importance of breastfeeding, but she had to acquire the skills through practice. With the second child, Siti told me it was easier to breastfeed because she had already learned the skills with the first child.

Rosada said she watched her elder sister breastfeed her two children, but she did not know that breastfeeding was a difficult skill until she started practicing it. She told me that her mother and sister were helpful in teaching her the skills she needed. Similarly, Juleha shared with me how she learned how to positioning a baby on the breast from her elder sister who was also breastfeeding at that time. She recalled how she observed her elder sister when she breastfed her child. Juleha said as she practiced what she observed from her sister, and with time, she knew

how to position her son Aryo correctly on the breast. Juleha's experience clearly showed that one way to learn is to observe and practice the activity one has observed. The mothers' narratives demonstrated the notion of knowing as actively engaging with breastfeeding practices which are different from the accumulation of information about breastfeeding in one's mind. As Bourdieu has shown through his habitus, learning skills is not straightforward. It involves repetition of action through time, trial and error and self-reflection. Mothers cannot learn breastfeeding skills by following a set of rules, but disposition guides their practices through regulated improvisation.

Breastfeeding instructors did not seem to discuss the difficulties of breastfeeding, perhaps due to a fear that they may end up discouraging expectant mothers from initiating breastfeeding. Instead of breastfeeding education addressing the real life breastfeeding difficulties of women (pain, discomfort, and cracked nipples), women were rather urged to calm down, be positive minded, and endure through breastfeeding problems. Although the strategy of teaching about the positive health outcomes of breastfeeding may encourage women to initiate breastfeeding, when breastfeeding problems arise, women may shift to mixed-feedings² as in the case of Juleha, or totally wean the child off breast milk. As some studies have shown, problems in the early days of breastfeeding can come as a shock to mothers (Hoddinott & Pill, 1999; Locke, 2012) when women are not entirely informed about the difficulties of breastfeeding.

Nadja learned from YouTube videos about how to clean and massage the breasts before she gave birth. Wati learned about cleaning and massaging of the breasts with warm water and olive oil from an exercise class she attended in her community when she was pregnant. Ambar who was in her late twenties and holds a managerial position, and Fadila who worked in the government spoke about the importance of cleaning and massaging the breasts. Ambar, for

instance, said cleaning and massaging the breasts triggered the let-down reflex that enabled breast milk to flow well for the baby. Fadila claimed that cleaning helped prevent clogged ducts from occurring while massaging facilitated the stimulation of milk production. The mothers were improvising through practice and delving into multiple sources of information. The media became a form of authority which partake in shaping the breastfeeding experience of the mothers.

At the hospital, many of my participants expected their midwives to put their naked child on their bare chests immediately after giving birth. The practice is called *iniasi menyusu dini* (IMD) in Indonesian, which translates into skin-to-skin contact between mother and child³. Siti was one of the mothers who valued the practice of skin to skin contact. She explained that skin-to-skin contact teaches a child where the nipple is to latch on when he or she is hungry, and it also enhances breastfeeding success. Unfortunately for Siti, she did not have skin-to-skin contact for either of her two children immediately after birth. For her first child, Fitri, she gave birth at midnight and her delivery bed was directly under an air conditioner in the labor room. The midwife who attended the delivery thought the room temperature was too low to put Fitri naked on her. The midwife immediately wrapped Fitri in a blanket and separated her from the mother. Siti told me that she felt robbed of part of the birth experience because she could not immediately see, smell and feel the body of her child – life that had come out of her. The feeling of her child's body is a *rasa* to Siti. Siti also did not have skin to skin contact with Dewi, her second child immediately after birth because of medical reasons. She explained that after giving birth to Dewi, part of her placenta remained in her uterus. Because of that, Dewi was quickly separated from her so that the doctor could remove the remaining placenta from her uterus. Siti

was not upset about her second experience of failed skin to skin contact as she understood that her health was at risk.

Indah, who had a vaginal delivery, complained of being denied skin-to-skin contact with her son Adam, her second child. Unlike Siti, Indah's experience was quite different. After she had given birth to Adam, the midwife immediately wrapped Adam in a blanket and placed her on her chest. Indah felt that skin-to-skin contact with Adam was disrupted and that the midwife stripped her of that part of her birth experience because she lacked knowledge. She explained that the midwife did not know that the naked baby should be placed on the mother's skin without a blanket. Because of that experience, she shopped for a different hospital where she gave birth to her third child Ida and had skin-to-skin contact with her. When I asked Indah how she felt after skin-to-skin contact with Ida, she paused awhile, thinking of the appropriate word with which to describe her emotion. After a long silence, she said "There are no words to express the inner feeling of that moment. I don't know how to describe it for you to understand. You can only feel it as a person." Indah expressed the skin-to-skin contact as *rasa* - an emotional feeling within the heart. The body is understood as open to the outside and in continuous emergence, making the skin to skin important to mothers in Jogja.

Juleha gave birth via caesarean section. The midwife put her naked baby on her chest on the operating table. Juleha told me that the moment the midwife placed her son on her, she became very emotional. She described her skin-to-skin contact experiences with a "mixed feeling." On one hand, she said, "I felt happy touching and rubbing my fingers over him. I was excited seeing him after waiting for nine months. It was a pleasant experience seeing my son latch on my breast." But on the other hand, Juleha was worried that her naked son might get cold in the low-temperature operating room. Similar to Juleha's experience, Ambar told me that at the

hospital where she delivered, her son, Joko via caesarean section, he was placed on her chest in the operating room. She explained that Joko was sucking her breast while the doctor was stitching her incision. For Ambar, this unique birth experience gave her an emotional feeling which assuaged her pain during the stitching of her incision. Ambar's experience demonstrates the Javanese notion of hot and cold which is part of what is referred to as the humoral medicine. That is the body is seen in the balance between the hot and cold. Phillips (2013) found that skin-to-skin contact immediately following caesarean birth diminished mothers' perceptions of pain and levels of anxiety by focusing their attention on their newborns.

Unlike Juleha and Ambar, who had skin-to-skin contact immediately following caesarean delivery, Rosada, Nadja, and Wati did not experience this much-to-be- desired birth experience in the operating room. The infants were separated from these mothers after the caesarean birth for neonatology specialists to monitor the newborn to prevent any possible infections. These mothers were able to have skin-to-skin contact approximately four hours later, when they reunited with their infants in the recovery room. Wati, for instance, felt disappointed not having the skin-to-skin contact with her daughter, Ella immediately after the caesarean section. Yet, she concealed her disappointment from the medical staff because she felt the doctor and the midwife knew better than her. Wati's attitude shows power and knowledge relationships between herself and the medical staff, what Foucault (1973) called a clinical gaze.

Drami did not have a caesarean section, yet her daughter Frida was separated from her for close to six hours, after being put in a crib under a heat lamp. Although the midwife was following medical standards by putting little Frida under the heat lamp, Drami felt deep sadness, disappointment, and regret for not experiencing skin-to-skin contact with her newborn daughter. She explained to me that skin-to-skin contact is that beautiful one minute moment of the birth

process in which the baby tried to find the nipple, learn to smell the mother and the breast milk, taste the breast milk and have eye contact with the mother for the first time.

Some of the mothers also spoke about their experience with the midwives regarding their first milk, which is called colostrum. Colostrum is the first thick yellowish milk that comes from the breast. In 1990, Hull, Thapa, and Pratomo found that many of Indonesian women discarded the yellowish milk because they felt it upset baby's stomach. Contrarily to this past experience where mothers threw their first milk away, my participants breastfed their children from birth so that they could get the benefits of colostrum. For instance, Putri said she fed Rukia colostrum because the midwife advised her that colostrum served as immunity against a host of infections for the baby. She further explained that although she fed Rukia the yellowish milk, she did not understand what the midwife meant when she said colostrum served as "immunity against illnesses." According to Putri, she fed Rukia colostrum because she wanted her daughter to be healthy. A similar remark was made by Indah who said she fed her daughter colostrum because the midwife said it was good for her daughter's health. In an interaction with Wati, she mentioned that she fed Ella colostrum because she wanted the best for her daughter. The midwives who had authoritative knowledge in medicine had moral authority over the mothers to explain healthy practices that were beneficial for the growth of infants. The mothers were willing to act upon the actions of the midwives. The narratives illustrated the desire of the mothers to be considered good mothers who have the best interests of their infants at heart.

Mothers made reference to midwives, doctors, friends, television programs, AIMI, and breastfeeding blogs as sources of learning about the importance of colostrum. Although some of the mothers read about the importance of colostrum from the above sources, they were still hesitant to feed their newborns the thick yellowish milk. Fadila, for instance, mentioned that she

heard about the importance of colostrum from a doctor and in a television program, yet it was her biological mother who strongly advised her to feed her daughter colostrum. Fadila's narrative demonstrated that sometimes close relatives who mothers trust could influence mothers to feed their newborns with colostrum.

Waking up to an alarm clock to breastfeed

Mothers were taught at the hospital to breastfeed their children once every two hours when they returned home. One of the mothers who followed this medical protocol from her pediatrician was Drami. Her husband, Agus set the alarm clock to every two hours so that Drami could wake up to breastfeed Frida. Drami complained of how difficult it was for her to wake up every two hours to feed her daughter. She told me that on many occasions, she switched off the alarm when it rang, but her husband would wake her up to breastfeed their daughter. Agus, who interrupted our conversation, said waking up every two hours to breastfeed Frida was a sacrifice his wife had to make to keep their daughter healthy. Like Drami, Rosada also followed the medical protocol of nursing her daughter, Lina, once every two hours for three months. She recalled that when Lina was asleep, she would wake her up to breastfeed her. She, however, stopped following this strict schedule because she was losing sleep at night. After the third month of birth, she breastfed her daughter on demand. Breastfeeding by schedule regulated feeding intervals. The clock became an instrument that was used to govern the body, making women lose confidence in their body, a finding similar to Millard (1990).

Mothers' experiences after they returned from hospital

When mothers returned home from the hospital, they were received with joy by their spouses and family members. The mothers were excited to be home after long hours of staying in a hospital environment. During the day, the mothers got assistance from family members who

carried the baby for them, giving them time to rest and regain their strength. At night, they faced a new challenge. Siti, for example, said for the first week when they returned home, she could not sleep at night because her baby took short naps at night and slept well during the day. For her, the baby thought the day was the night and the night was the day. She recalled that when she was pregnant, her child kicked her often at night and during the day she was silent. She told me that after a week, her daughter improved her nighttime sleep. At most, she woke up five times to feed, which was exhausting to Siti, but said it was better than the first week at home. Fadila shared a similar ordeal with Siti. She recalled that for the first four nights after they returned home, her daughter woke up every forty-five minutes at night. She had to change her sleeping patterns to match that of her child. That meant that she slept during the day as her child was asleep and at night she was awake with her daughter. She, told me that as weeks progressed, her daughter slept well at night.

As I probed to learn more, the mothers shared with me their stories of sleeping arrangements. Rosada and Timbul bought a crib for their daughter, Lina that was placed in their bedroom. Rosada told me that they bought the crib because they were afraid that they might roll onto Lina if she shared their bed. Medical recommendations reinforced the fears that Rosada and Timbul had about sharing their bed, linking the practice to serious health risks. But after one month of using the crib, Rosada abandoned it and moved Lina to their bed. When I asked her why would she spend money to buy a crib and then not use it, her response was that it was easier for her to breastfeed Lina in bed and also cuddle and soothe Lina when she cried at night. The abandoned crib became storage for dirty clothes. Similarly, Putri and Slamet bought a crib for their daughter, Rukia, but abandoned it after seven weeks. The crib was used as storage for baby items. Putri told me that they brought a crib because they had learned from a television program

that allowing newborns to sleep in a crib helped them to become independent and prevented sleep deprivation for parents. Putri said she abandoned because it was not convenient for her. She explained that when Rukia cried at night, she had to wake up, carry her from her crib and breastfeed her. But when she moved Rukia to their bed, she only put her nipple into Rukia's mouth when she cried. Rukia slept in the middle of the bed, between the parents. Slamet slept at the edge of the bed while Putri slept close to the wall. When Putri felt that she did not have enough milk in the right breast, she switched places with Rukia to the wall side so that she could feed on the left breast. So, there was fluidity regarding the position that baby and mother occupied on the bed.

Juleha told me that her husband bought the crib, but she never used it. She explained that when they returned home from the hospital, she felt uncomfortable letting her son sleep in the crib. She said she wanted her son to be close to her all the time. Indah and her husband Toyib were of the view that baby sleeping in a crib was not expedient since they had to wake up multiple times in the middle of the night to nurse their baby when she cried or to check on their safety. Indah described how Ida latched on to her breast at night without any assistance. She said, "Ida knows the exact position of the nipple, and once she was hungry at night she'll just latch," giving some agency to her baby.

One of the challenges that came up in some of the interviews was sharing a parental bed with infants was an obstacle to the parents' sexual relationship. For example, Danag said that having their daughter, Ella sleep between him and his wife made it difficult to have sex at night. Danag complained that even when they had sex, Wati was often in a hurry to end it because she was afraid that Ella would wake up. Danag felt disappointed with Wati for the lack of sex but added that he is not worried anymore about sex because his libido has decreased. Wati, disagreed

with Danag that bed sharing with Ella was the primary cause of the limited sex activity. She argued that it was because she received less support from Danag regarding household and childcare tasks. “I do the majority of the work at home; I cook, wash dishes, clean the house, feed Ella, wash clothes and at night I sew dresses for my customers to earn income. By the time I am done with these works, my body is physically exhausted.” Wati’s comment showed fatigue as the reason for less sex as opposed to parental bed sharing with their daughter.

Juleha told me that her husband found it difficult to understand why it became so hard to have sex. So, I posed the same question back to her: Why was it hard to have sex with your partner? Her explanation was that breastfeeding was physically draining, and she felt too tired to have sex. She also added that sometimes her breasts were heavy and painful, and she felt uncomfortable having sex with Rizki. Juleha’s experience was echoed by some of the other mothers including Ambar, Fadila, Nadja, and Rosada. An innovative way Rosada and Timbul used to navigate through this problem was to go to bed early with Lina and when they observed that Lina was deeply asleep, they moved to another room to spend time together, but if Lina woke up earlier than anticipated, the couple postponed sex to another day. Nadja and Haryo also used this method. Another way that was articulated by Juleha was to allow Aryo to spend the night with his grandmother, so that she could have quality time with Rizki.

Bed sharing, therefore, reduced mothers’ work of waking up multiple times at night to check on the safety of the baby, reduced nighttime crying, promoted uninterrupted sleep for both mother and infant and encouraged frequent breastfeeding. Also, the baby could get some warmth from the mother and father which mothers said strengthened the bond between child and parents. Breastfeeding at night was a challenge to new parents. However, they developed a sleeping plan

that helped them to adjust to breastfeeding, namely one away from strict protocols that did not seem to be useful in practice.

Navigating breastfeeding difficulties after the mothers returned home

Women who took part in the study mentioned crack and sore nipple, breast pains, engorgement and mastitis as some of the problems that arise from breastfeeding. Drami, Rosada and Siti, all had small, yet flat nipples which made it difficult for their newborns to latch. In what follows, I present case studies of two mothers who had experienced several breastfeeding problems during the course of the fieldwork.

Drami's story

When Drami gave birth to Frida, she had a small flat nipple, and it was difficult for little Frida to latch on. To address the problem, Drami wore nipple shield, a silicon nipple, over her nipple to enable her daughter to grasp the nipple. Her daughter felt uncomfortable using the silicon nipple, which made Drami to stop using it. Drami began pulling her nipples to enable Frida to latch on. While trying to make Frida latch on the breast, Drami fed her expressed breast milk so that she could get appropriate nutrients. Drami could produce 500 mL of breast milk per pumping. She produced much more breast milk than Frida needed, and she often fed Frida on the left breast because she felt more comfortable with the left arm. Because of her overabundant supply of breast milk, and Frida having difficulties to latch on, she frequently pumped (usually four -five times a day) to avoid breast engorgement.

While Drami was pumping milk from both breasts, she was still directly nursing Frida from the left breast. Unknowingly, she was stimulating the production of more milk in the left breast, so the left breast produced more milk than the right. Consequently, the left breast became engorged, a problem Drami was initially thinking to avoid. Her breast was painful and was

always full even when she had finished feeding Frida. She had blocked ducts in her left breast, nipple soreness and was later diagnosed with mastitis. She was treated at the hospital. However, she developed a breast abscess and had to undergo breast surgery.

Despite the challenging experiences that Drami went through, she did not give up on breastfeeding Frida. She continued to pump both breasts even when she was in pain. She fed Frida with breast milk through feeding bottles. Expressing milk through pain was the sacrifice that Drami had to make to fulfill her moral obligation from the Quran and establish herself as a good mother. Drami, in a very emotional tone, told me that when she finally healed after the breast surgery, she re-started nursing Frida from both breasts. However, Frida did not want to nurse directly from the breast because she became used to bottle feeding and confused the artificial teat with the nipple. During the re-lactation period, she tried to make Frida feel comfortable by singing and talking to her, yet Frida cried a lot. She felt sad about this and wanted to stop trying to nurse Frida, but her husband encouraged her to continue, and she was eventually successful. In her ordeal, Drami not only disciplined her body but her child's body was also disciplined during the re-lactation period. Drami could not hide her joy of nursing Frida. She posted on her Facebook page how important it was for other mothers to alternate between breasts during feeding. Drami's post on Facebook was a form of grassroots activism to encourage women to breastfeed.

Juleha's Story

When Juleha gave birth to Aryo, she had problems positioning Aryo properly on the breast so as to latch on. Even though she was taught by a midwife on how to position Aryo on the breast, Juleha claimed she did not understand the midwife's instruction. According to her, the midwife only said to her, "just do it like this," using her hands to demonstrate to her. Juleha

became frustrated with the midwife as she was a new mother who had no practical experience of how to position the baby during breastfeeding. She was upset that she had no support from the midwife and the hospital. Juleha also had a painful nipple sore. She was worried that Aryo might not be getting enough breast milk, and she was not confident that she was producing enough milk to satisfy him. So, she decided to feed Aryo with formula while trying to latch him on. Juleha, could not finish the box of formula bought for Aryo because she had a feeling of guilt for being a bad mother who could not breastfeed her child.

A few weeks later, she developed mastitis from the sore nipple infection leading to flu like symptoms of fever and chills and her breast became red, tender, big, and painful. She went to the gynecologist but was advised to continue breastfeeding the baby on both breasts. The gynecologist also prescribed antibiotics for her. Juleha found it difficult to follow the medical advice from the gynecologist. Subsequently, she decided to pump from the affected breast to control the pain and breastfed her son on the unaffected one. In her own words, “If I directly put the nipple into his mouth, I cannot control how he sucks the breast. But if I pump milk from the breast, I could decide when to start and stop the pumping.” Juleha initially thought that expressing milk might be a better option for controlling the pain and also getting breast milk for Aryo. On the contrary, she had difficulty pumping from the breast. She could only express 5-10 ml of breast milk per hour using the manual breast pump. She spoke to her physician about the difficulties she was experiencing with expressing her milk. She was medically advised to calm down, relax, cleanse the breast with warm water and then massage the breast. This advice did not work for her. She became distressed and decided to feed Aryo with formula again.

Two days later, she stopped feeding Aryo formula because she was afraid that her breast milk could dry up. She gave the remaining formula to the housemaid. She called a lactation

consultant from *Asosias Ibu Menyui* Indonesia to help her express sufficient milk even though she claimed she did not like AIMI's approach to breastfeeding. Juleha mentioned that AIMI was too radical in their approach to breastfeeding promotion. For her, the Association often assumes that mothers who cannot nurse their babies are lazy. She said, "I don't like AIMI's radical way of thinking; not all mothers have the same problem of breastfeeding. Not all babies have the same taste for breast milk."

Juleha spent two hours with the consultant at her home. The AIMI consultant advised her to calm down, be relaxed, and she could express more milk, the same advice she got from the gynecologist. The consultant also advised her against using a feeding bottle. She suggested to her to use a spoon and a cup in feeding the baby with breast milk so that the baby would not confuse the artificial teat with the nipple. She was disappointed that the "expert" was not helpful in assisting her find a solution to her problem.

She resorted to searching the internet for the experiences of other women who had the same problem. Interestingly, she found on a breastfeeding blog a woman who had a related problem and who resolved the problem by listening to music. Juleha adopted the woman's strategy by listening to music while pumping. Sometimes her husband pumped for her while she watched entertainment programs on television. These techniques helped Juleha to express 100-150 mL of milk per pumping compared to the 5-10mL previously. Juleha was able to navigate through the difficult moments and was able to feed Aryo breast milk.

Expression of milk was used by the mothers to navigate through breastfeeding difficulties. Drami and Juleha used the pump and the bottle when they had mastitis problems. Drami's experience taught us that when women directly feed their babies from the breasts and alternate the breasts during feeding, they would be able to avoid engorgement and mastitis

problems. Breastfeeding is a skill that is acquired through the act of doing, an active engagement between mother and child. Skills, from his perspective, are not transmitted intergenerationally; instead, they are always being done, integrated into the *modus operandi* of the human organism through training and experience in the performance of particular activities.

Baby is old enough to start eating

Seven out of the eleven mothers who took part in the study introduced solid foods to their infants after the six month. These mothers included Siti, Drami, Rosada, Wati, Indah, and Nadja. In a conversation with each of these mothers, I was told that they supplemented breast milk with solid and liquid food because that is what was recommended by physicians. Putri went beyond the recommended six months of only breastmilk to exclusively breastfed Rukia for eight months. In the ninth month, Putri and her husband Slamet decided to introduce formula to Rukia as a supplement to the breast milk. The couple made the decision based on the observation that Rukia was not gaining as much weight as compared to other babies in the community who were in the same age group as her. Putri was worried about Rukia's weight because she felt that maybe her breast milk was bad, and that was the reason Rukia was not gaining weight. She was very concerned that people might think that Rukia was not healthy. Part of her concern was derived from the Javanese perception that fat babies are healthy, whereas thin babies lacked proper nutrition from their parents. Other community members often praised mothers whose infants were fat for producing healthy breast milk and mothers felt proud of their big babies. She was also concerned about what other community members might say about her family. When I probed further by asking what she thought people might say about her and her husband, she replied that people might think that they don't have money to take care of their daughter. Like Putri, Wati and her husband Danag introduced formula to Ella so that she could gain some

weight. But to their disappointment, Ella did not like formula, so they discontinued it. Part of their disappointment may be tied to Javanese perception that parents with small babies were poor while children who were formula fed were from affluent families.

So, a fat baby was a sign of abundance. One day I was at the mall with my research assistant eating pizza. A woman who was sitting next to us had a baby boy who was big. By my estimation, he weighed more than ten pounds and people who passed by congratulated her. Initially, I was confused about why people were praising her, and my research assistant explained to me that big babies were pleasing to the eye. It is also a sign that either his mother's breast milk is nutritious, or his parents were wealthy enough to afford formula. Some of my participants often complained about how thin my research assistant and I were. We were regarded as people who were not eating properly and on time. At one point, the mother of one of my participants had her hands all over my research assistant. She was rubbing her arms, holding her shoulders and told her she needed to eat more food to gain some weight.

Unlike Putri, Ambar and Fadila introduced supplementary foods to their infants because they needed to work. Ambar lived and worked in Jogja while her husband and son lived in Purwokerto, 167 kilometers away. She returned to work six weeks after giving birth. While at Jogja, she expressed her milk, stored it in a workplace refrigerator and transported it home every Friday. Ambar did everything possible to ensure that her son Joko was breastfed. However, she gave up feeding Joko only breast milk and introduced formula when Joko was four months old. She explained to me the circumstance that made her, and the husband Priyadi introduce formula milk to Joko:

I stored pumped breast milk in the fridge and returned to work for the week. He finished all the expressed breast milk in three days. He is a boy, so he drinks a lot of breast milk. I

was at Jogja working, so I could not send the expressed milk. Consequently, my husband and I decided that he feeds Joko formula until I returned home on Friday with the expressed milk. Since then, we mixed the breast milk and the formula milk for him. During the day, he drinks formula milk and at night he drinks the breast milk. Initially, he found it difficult to drink the formula milk. He knows the taste difference between formula milk and breast milk. He seems not to like the formula milk, yet he has to adapt to my situation.

Fadila's experiences reinforced the notion of work as a reason some mothers introduced solid food to infants earlier. She introduced formula to Lily as a supplementary food when she was two and a half months old. She explained to me that her maternity leave was cut short because she had to attend training outside of Jogja for three days. Fadila recalled that as the only one in the office who qualified to participate in the training; she could not reject her supervisor's request to attend the training. Consequently, she left her daughter, Lily, with her mother. Before leaving for the workshop, she provided her mother with one box of formula that she could use to feed Lily. Upon her return to Jogja, she decided to continue feeding Lily with the formula so that the remaining formula would not go to waste. Juleha, on the other hand, faced many breastfeeding challenges and had to introduce formula as a supplementary food as early as two weeks after birth. In a sorrowful conversation with her, she explained that she could only express between 10- 20 mL of breast milk at a time. After every breastfeeding, Aryo cried which she interpreted as a sign of insufficient milk. Breastfeeding advocates would suggest that the signs that Juleha read as a sign of low milk supply did not actually indicate low milk supply. Often women pump far less than they actually produce for their babies. Besides the perceived inadequate milk supply, she also had cracked nipples, and clogged milk ducts which

subsequently became mastitis. These problems forced Juleha to introduce formula as supplementary food to Aryo.

Indah, a mother of three children, did not feed her children formula. For her first two children, she fed them with a porridge made from red rice and carrots. She also prepared plain rice with palm kernels and chicken after the sixth month. Indah told me that for her older children, it was difficult for her to identify the types of food that would provide them with reasonably balanced diets. Due to the difficulties she had in planning daily menus for older children, Indah searched on the internet for information on solid foods for her third child. She found a book called, *Makanan Bayi Sehat Alami* that translates as “Infant Food: Natural and Healthy,” by Wied Harry Apriadji, an Indonesian. In my conversations with the mothers, I discovered that most of my participants used this book to prepare food for their babies who were over six months old. Nadja, for instance, had this to say, “I saw a book from a breastfeeding blog on Facebook where many mothers recommended it. So, I thought, it is an excellent book. The book is good because it makes easy to prepare different meal for the child.” The book outlined the baby’s menu, food choices to give to the child at particular age-months, eating skills, tips on how to prepare baby food, and the logic behind the food choices for different ages. The book made it easy for many mothers to feel at ease not having to worry about variation in their baby’s diet. They were also confident that their babies would get the right nutrients.

Fig. 4.1 Infant Food: Natural and Healthy

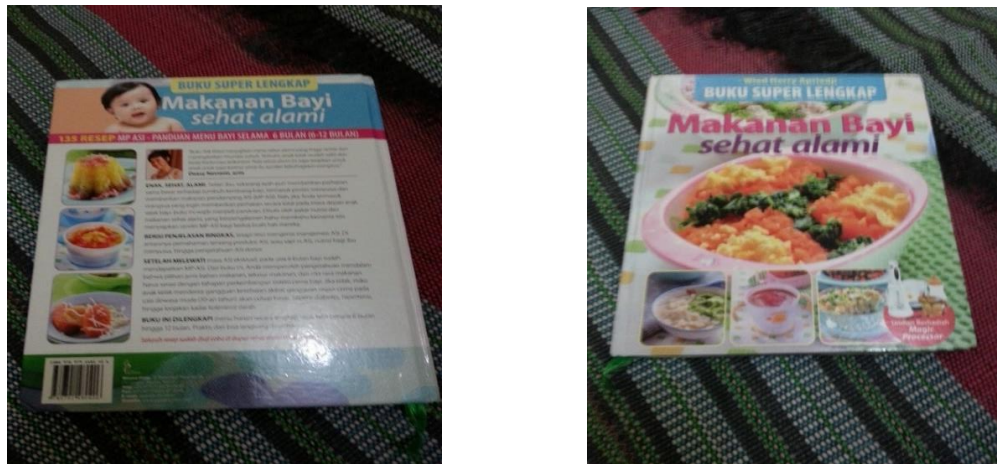


Figure 4.1. Nadja's copy of Makanan Bayi Sehat Alami

The first time I met Nadja, her son Soni was six and a half months old. During the interview, she asked me to pause the tape recorder so that she could prepare food for her son. She invited me to the kitchen to watch her cook. She blended bananas for him into a puree. I asked her why only one type of fruit? She told me that she wanted to introduce Soni to the authentic tastes of different fruits and vegetables. When I met Nadja two months later, she prepared blended cooked rice with carrot and meat for Soni. She said to me “Soni is getting old; he needs to eat meat and vegetables to grow healthy.” Fadila said when she first prepared puree for her daughter; she made it thin and watery to resemble the texture of breastmilk. As her daughter grew, she made it thicker. Some of the fruits used for the puree included mango, apple, orange, banana and papaya. Some of the vegetables mothers used for the puree included green beans and carrots.

Wati was the only mother who did not have the book *Makanan Bayi Sehat Alami*. In the sixth month, she fed her daughter with *bubursusu* which was blended rice mixed with cheese. Sometimes she added carrots and palm kernel to the bubursusu to give it a different taste. She

also fed her daughter, Ella, *tajin* which was a thick water from cooked rice. As Ella grew, she gradually introduced her to foods that they ate at home.

In sum, the introduction of solid food varied with relation to work obligations, breastfeeding problems and Javanese perceptions of what constitutes a healthy child. Wied Harry Apriadji's book gave some form of empowerment to these mothers to know what food worked for their babies at a particular age and food that should be avoided.

Infant weaning practices

Although all of the eleven mothers in Jogjakarta who took part in the study said the Quran required them to breastfeed for two years, their lived experiences revealed that some of the children were weaned as early as eight months while other children were allowed to nurse as long as thirty-six months. The table 4.1 in Appendix gives the number of months that each mother breastfed. For instance, Mewar, a mother of four children and a high-school principal, breastfed Sujatno for eight months whereas Wati, a mother of one and a seamstress, breastfed Ella up to 36 months. Mewar weaned Sujatno from breastfeeding because her breast milk had dried up. She explained that she was under lot of stress studying for the TOEFL, which she intended to use to apply for foreign University admission. Wati initially planned to stop breastfeeding Ella when she was 24 months. Wati explained that she tried all possible methods to wean Ella from nursing yet she would not stop breastfeeding. For instance, she tried putting bitter plants Javanese *turmeric* root (*Curcuma zedoaria*) on her nipples, but that did not work. She thought *turmeric* was not bitter enough for Ella. So she tried *Tinospora crispa*, what Javanese called *brotowali*, a plant that is regarded by Javanese as very bitter, but Ella continued to suckle the breast. Her friends advised her to try painting her nipple red with lipstick to show that her nipple was stained with blood. That also failed, so, Wati gave up her effort to wean Ella

of nursing and decided to allow her to nurse until she stopped on her own. What surprised her husband, Danag, was that Ella ate a substantial amount of solid foods but still demanded breastmilk. Wati felt that Ella was no longer sucking the breast for food and nutrients but rather playing with her breasts.

According to Islam, at the age of two, children are considered old enough to stop nursing. Rosada, for instance, weaned Lina at twenty-three months because she felt Lina was old enough to stop suckling at the breast according to the Quran. Wati emphasized that breast milk after two years was not nutritious enough for the growth and health of the child as the milk becomes watery in nature, yet her daughter did not stop breastfeeding for 36 months.

Siti, a mother of two, said she weaned her first child at twenty-six months instead of the initial plan of thirty months. She stopped nursing her child earlier than planned because she observed that the breast milk had become lighter than usual, and the color of the breast milk had changed to look more like its state when a baby was first born. Her second child who was twenty-one months was still breastfeeding at the time of the study. Nadja also weaned Soni at the age of seventeen months because she was pregnant with her second child. Ambar, who was thirteen weeks pregnant with her second child, was still breastfeeding her son who was one year nine months. In a conversation with Rosada, she explained to me the Javanese perception about pregnancy and breast milk. According to her, when a mother becomes pregnant, the existing breast milk becomes contaminated, which may expose the older child to unhealthy growth and possibly cause mental health problems to the unborn child. She further added that when a mother continued breastfeeding her baby during pregnancy, she divided nutrients between herself, the older child and the unborn child, and the nutrients for the unborn child would be insufficient for its proper development.

Despite the perception that pregnancy contaminated existing breast milk, some mothers did not wean their children as soon as they became pregnant again. This was because they were unaware that they were pregnant, due to their breastfeeding causing irregular menstrual cycles. So for these mothers they continued to nurse their babies for months before discovering that they were pregnant. For example, Rosada narrated to me a story of her close friend who only got to know that she was pregnant in the sixth month when she felt some movement in her uterus. Rosada explained that her friend had no regular menstrual cycle, and she was also obese. One reason some women become pregnant while breastfeeding was the assumption that they were safe from becoming pregnant when nursing. This highly popular understanding has led some mothers to become pregnant as early as three months after the birth of a child.

Another reason Siti cited for weaning her daughter, Fitri, was Fitri had developed sharp teeth and she started biting during breastfeeding. Fadila, on the other hand, weaned Lily at twenty months because she had broken her front teeth when she was playing. Fadila felt that Lily could use the broken teeth to hurt her nipples when she nursed. Indah, on the other hand, said that she weaned Ida to enable her to continue her undergraduate degree. Indah put her education on hold her education for 18 months to nurse Ida. Combining academic work with childcare and housework drained her energy and weakened her academic performance at school.

A variety of methods were used by the participants to wean their children. Wati, for instance, left her daughter with her grandmother for three days. When she came for Ella on the fourth day, she no longer wanted to nurse. Nadja tried to wean Soni by introducing him to formula. She covered her nipple with a bitter plant called *Pratawali* to prevent Soni from nursing, but it did not work. So she tried *buah mahoni*, another bitter plant, and Soni stopped

breastfeeding. Mewar, on the other hand, weaned Sujatno by feeding him formula. It was easier for Mewar to wean Sujatno through formula because she fed him breastmilk by bottle.

Indah used the services of an Islamic *dukun* (healer) recommended to her by her older sister, to wean her two older children. The Islamic *dukun* recited Arabic prayers while he put one of his hands on the baby's forehead and held an egg in the other. After the recitation of the Arabic prayers, the *dukun* gave the egg to Indah, which she later boiled and fed to the baby. The prayers and the egg that the infant ate later were meant to help the child forget about nursing. To my surprise, Indah told me that the *dukun* method worked for her. I also learned from Indah that some mothers in an effort to wean their children send them to traditional birth attendants (TBA) on the child's day of birth according to the Javanese calendar (weton, pon wage, kliwon legi and pahing). The TBA then massages certain parts of the child's body, which is supposed to help the child stop breastfeeding. The massage therapy is consistent with the Javanese philosophy of the body as winds and flows. The Javanese massage lies in the perception that the body accumulates winds which are toxic. Massage flushes out the toxic air and increases energy flows.

Conclusion

Mothers' narratives in this chapter pointed to breastfeeding as a norm despite some of the negative experiences that they went through. The mothers in the study breastfed because of their Islamic faith, health benefits, their financial situations, family encouragement and previous experiences they had seeing their mothers' breastfed. The women framed the benefits of breastfeeding in public health terms, but the actual decision to do so come from Islamic faith and the cost involved in formula feeding. The media seemed to be a prevalent form of authority which shaped women's breastfeeding experiences. The Health Law was absent from the everyday experiences of the mothers. Apart from Wati, who had heard about the breastfeeding

law through a television program, none of the parents who took part in the study was aware of the law. In a conversation with Wati, she said she went about her breastfeeding without thinking about law. The Health Law on breastfeeding was remote and distant from the mothers' daily lives.

Notes

1 SGM was the cheapest brand of formula milk in Jogja at the time I was on the field. The malls that I visited and three retail stores that I shopped in when I was in Jogja all sold SGM. One of the storekeepers told me that SGM sold fast.

2 Mixed feeding is when a mother feeds her child with breast milk and formula. In some literature, it is referred to as partial breastfeeding or combined breastfeeding.

3 Studies suggested that infants who had skin-to-skin contact with their mothers had longer exclusive breastfeeding durations (Mikiel-Kostyra, Mazur, & Boltruszko, 2002; Vaidya, Sharman, & Dhungel, 2005), and longer breastfeeding durations overall (Mikiel-Kostyra, Mazur, & Boltruszko, 2002; Moore, Anderson, Bergman, & Dowswell, 2012). Other benefits of skin-to-skin contact that were stated in the literature included the maintenance of infants thermoregulation and blood glucose levels (Hewitt, Watts, Robertson, & Haddow, 2005; Dalbye, Calais, & Berg, 2011).

Chapter 5

Family contributions to breastfeeding

My participants had nuclear families, but maintained strong ties with their extended family members. The couples lived in their own or rented houses that were near their parents' homes, so they were able to visit them frequently. I observed that because of the proximity to parents, parents and parents-in-law were also involved in the breastfeeding decision making of my participants. In this chapter, my goal is to understand how husbands and grandmothers facilitated the experience (or not) of breastfeeding mothers. Six fathers took part in the study, sharing their stories of how they shaped their partners' breastfeeding experiences. Grandmothers were not involved in the study, but the mothers shared stories of how grandmothers influenced their breastfeeding experiences and served as a source of support.

Men shaping and shaped by the breastfeeding experience of their partners and serving as sources of support

The first time I visited Indah, her husband Toyib, was at home, but he was preparing to go and pick the children up from school. So, he did not have the opportunity to listen to our conversation. On my second visit, he was in the house and became interested in the topic that we were discussing. Toyib told me that not only did he encourage Indah to breastfeed their daughter Ida, but he protected her from anyone who tried to influence her to formula feed Ida. While Toyib was talking, Indah interrupted him by narrating a story of how he threw away a box of formula given to her by a midwife at the hospital. Toyib said to me that he was upset about the attitude of the midwife and forbade Indah from formula feeding Ida. He wondered why midwives in the hospitals would give formula to mothers when many publications on the AIMI website and newspapers highlighted the benefits of breast milk and the risks that formula posed

to children¹. He reminded Indah of the right of the child to breast milk, and her responsibility as a mother to feed Ida, which he said is in the Quran. Toyib also remembered how his father-in-law advised Indah to formula feed Ida so that she could gain weight. However, Toyib stood his ground and maintained that Indah breastfeed Ida instead of using formula. Indah felt her husband was supportive in empowering her to breastfeed their daughter. Toyib played the role of a father as the protector and shielded Indah from bad advice that would discourage her from breastfeeding². Toyib's attitude demonstrated that he became an advocate of the public health messages that breast is best, and that formula is harmful to the health of infants.

Nadja's spouse Haryo, who was an Islamic teacher used the words of the Quran to encourage his wife to breastfeed. Haryo said that when Nadja gave birth, he insisted that she gives only breast milk to their son, Soni until he was two years old. Haryo explained that, "There is no verse in the Quran that supported women giving other foods apart from breast milk to infants after six months of birth." Haryo changed his mind after he learned from a public health publication that babies could start eating liquid and solid foods after six months. While public health and Islam agree on the importance and duration of breastfeeding, the place of departure is exclusivity. Unclear is whether the Quran wants women to breastfeed *exclusively* for two years. Public health recommendations suggest mothers breastfeed exclusively for six months and after that supplement breast milk with other foods.

In a joint conversation with Drami and her husband Agus, Agus told me that his wife lacked the confidence to breastfeed in public places. She did not want to breastfeed in public because she was concerned about what other people might think of her. "But I have constantly told her that I am comfortable with the whatsoever place she wants to breastfeed in public as long as the place is safe and she covered up in public." Agus also told Drami that she should not

feel shy to breastfeed in public because breastfeeding is not an illegal act; she was rather doing good for their daughter. Drami, who agreed with the Agus' comments, added that Agus encouraged her by reiterating to her the health and economic benefits of breastfeeding. My last conversation with Drami was in her house. While we were talking, her child was crying, and Agus brought the child to feed. Knowing that my participants do not breastfeed in front of men, I decided to excuse myself so that she could breastfeed Frida. To my surprise, she said, "We can continue the conversation while I breastfeed Frida." She breastfed her daughter in front of me but covered her breasts with her hijab. Drami told me that her husband gave her confidence to breastfeed in the presence of others, a skill she was missing when she gave birth.

Some of the men who took part in the study recognized how breastfeeding could be biologically and emotionally demanding and physically exhausting for mothers. So, some men assisted their wives by doing domestic duties at home. When I first met Putri, a stay-at-home wife, I observed that there were only three of them (Putri, her husband, Slamet and their child Rukia) at home. So, I asked her if her mother or mother-in-law was with them assisting with child care responsibilities. Her response was no. I was quite surprised with her response since the other first-time mothers that I visited before her, had an extended family member with them at home who provided child care assistance. In Jogja, it was very common to see grandmothers assisting mothers especially first-time mothers with their childcare tasks. Putri later told me that her mother-in-law had died before she gave birth and her mother lived in another city. She narrated to me that she was anxious as a first-time mother about how she would cope with child care responsibilities. To her surprise, her partner Slamet was very supportive in assisting her even though he worked during the day. For instance, Slamet made the bed, cleaned the rooms before going to work, and when he returned home, he assisted Putri by holding their child, Rukia

while Putri made dinner and had a shower. Putri also recalled how Slamet supported her during pregnancy by regularly buying vegetables (e.g. *daun katuk* which translates into sweet leaf or *Sauropus androgynus*) to enable her to produce enough breast milk. Often these little gestures of care provided by Slamet greatly facilitated Putri's breastfeeding experiences. When I spoke to Slamet separately, he explained that "I know that taking care of a newborn can be physically and emotionally exhausting, and sadly our parents are not here. The least I could do is to help her at home." Like Slamet, Toyib bathed the two older children and sent them to school in the morning. He picked them up in the afternoon when he finished his business. Toyib also prepared food for the older children when Indah was not at home. Indah told me "since we have our small scale business, we assist each other with the domestic tasks." In both cases, the couples indicated that household tasks are based on team work (complementing the effort of each other) between a husband and a wife instead of an equally shared division of labor, one where parents divided all household tasks equally³. What was promoted here was the ability of the couples to know how to help each other at home.

In a conversation with Siti, she mentioned how her partner, Putra was very supportive of her. Once Siti returned to full-time work after her maternity leave, Putra did all the household chores to give Siti enough time to pump her breast milk before going to work. In the morning, Putra washed all the dishes, cleaned the room, and swept before he went to work. When he returned from work, he cooked dinner for the family and on days that he was tired, he took Siti to the restaurant for dinner, or they went to Putra's parents' house for dinner, which was nearby. Siti explained that her Putra did the cooking because she did not know how to cook, but she was making every effort to learn to cook to assist him. By taking over the majority of the household

responsibilities, Putra reduced the domestic workload burden on Siti, which gave Siti extra time to relax, and also breastfeed Dewi.

When Ambar returned to full-time work, husband Priyadi, and her older sister, Nur became the primary caregivers of her son Joko. In the morning when Priyadi was teaching, Nur took care of Joko, and when Priyadi returned late in the afternoon, he took over the responsibility of care from Nur. Thus, the care for Joko shifted between Priyadi and Nur until Ambar returned home on the weekend. For the first three weeks after Ambar returned to work, Priyadi fed Joko expressed breast milk. Ambar and Priyadi were happy that Joko fed well, the expressed milk was sufficient for him, and things went as planned. Suddenly, in the fourth week, things became complicated as Joko consumed all the expressed milk before Ambar arrived home on the weekend with another batch of expressed milk. So, Ambar and Priyadi agreed that Priyadi would feed Joko formula until Ambar returned home. Priyadi had to learn how to mix formula with warm water at the correct temperature. The couple decided that Nur would feed Joko formula during the day while Priyadi fed him expressed milk at night. Priyadi woke up at night to warm the expressed milk and would feed Joko. When Joko cried at night, Priyadi carried him on his chest, and sang lullabies to him until he fell asleep again. Priyadi also changed his diapers and washed his dirty clothes.

Rosada and Timbul received a lot of support from Rosada's parents and siblings when Lina was born. The couple lived not far from Rosada's parents' home, so they virtually spent the day at Rosada's parents' house. Timbul also taught at Rosada's father's Islamic college, part of which was located in the house. During the day, Rosada's mother prepared meals for them, and if both of them were not at home, Rosada's siblings provided care for Lina and fed her with expressed milk. Looking at the overwhelming support that the couple received from Rosada's

family, I asked Timbul how he helped Rosada with breastfeeding. He told me that, “I often carried Lina on my chest and walked around the neighborhood. During our walk, I interacted with her, cracked jokes with her and sang songs to her. What is fascinating about our walk is she smiles at me.” Timbul also said the walk helped Lina to nap allowing Rosada time to relax and also do other activities like visit friends or read books. Furthermore, Timbul told me that during the week, Rosada’s siblings were at school and Rosada was teaching at the University, he fed Lina with Rosada’s expressed milk. The singing, walking, playing, soothing and corresponding smiles and laughter from Lina gave Timbul an experience of real fatherhood and a strong sense of emotional attachment. Lina also recognized her father and his voice through singing and interacting with him. Timbul developed a close bond with Lina even though he did acknowledge that Lina was closer to her mother than him.

Juleha explained how helpful her husband was when she went through a terrible breastfeeding experience. Juleha had an insufficient milk supply and had a hard time expressing it with a breast pump. Her husband, Rizki assisted her by massaging her breasts. He did it gently and added enough humor to it which made Juleha relax while pumping her breasts. Thus, Rizki provided overwhelming emotional support to Juleha during her struggles to pump sufficient milk. Rizki was much more supportive than Juleha could imagine and without his aid it was possible that Juleha would have discontinued breastfeeding. Juleha told me that when she married Rizki, she cooked and served him food. But when she gave birth to Aryo, he served himself food when Juleha was busy feeding Aryo. When I was at Drami’s home, I observed that Agus brought Frida to Drami to nurse. While Drami was breastfeeding Frida, Agus brought a drink to her. After Frida had finished nursing, he took her from Drami and burped her.

Some of the fathers bought gifts for their wives as a way of appreciating them for breastfeeding their children. For example, Timbul purchased a handbag for Rosada as a way of saying thank you.

Although some fathers positively shaped their wives' breastfeeding experiences and assisted them by performing some traditionally feminine roles, some mothers claimed that some men were unhelpful during breastfeeding. Wati, a seamstress, shared her frustration with her husband, Danag, who worked temporarily as a driver and auto body repairer. She told me in front of her husband that she had to wake up several times per night to breastfeed their child while he slept and snored.

I had less support from him. It was only in the first week of childbirth that my husband was awake with me at night when the baby was crying. After that first week, he is always sleeping and snoring at night while I woke up to breastfeed the baby three or four times per night. I want my husband to be awake with me when the baby cries at night. When the child urinates at night, and I asked him to change the diaper, he never wakes up at night. I don't know what to tell him again. So I just left him to continue his sleep.'

Juleha also said, "My husband used to help me feed our son when he was less than ten months old. He has stopped helping me because it is getting harder to feed our baby. It is taking more time to feed him. Sometimes he would just refuse to eat, and one needs to be patient to feed him." Juleha mentioned that her husband preferred to play more with Aryo as he got older. The comment by Juleha seemed to suggest that as infants grew, fathers began to pick and choose child care responsibilities that were easy, fun and enjoyable while the demanding jobs were left for mothers to do, a similar argument made by Maher (1992).

The role of the grandmothers

In Jogja, grandmothers have extensive cultural knowledge on infant nutrition and mother-child dyads. Grandmothers know which plants, vegetables, and fruits increase breast milk and also food that mothers should eat or avoid to maintain humoral balance – the state of health between the poles of cold and hot. Young mothers are reluctant to ignore the advice of their own mothers, else they would be regarded as disobedient. So, respect which is referred to *urmat* in Javanese, is an essential value of Javanese social relationships. As Geertz (1961) pointed out, respect in Java does not necessarily mean to be submissive to authority from above, but “a matter of etiquette, the rules of proper behavior in specific situations” (p. 19).

My mother was there for me during pregnancy, childbirth and the first few weeks of life

Pregnancy, childbirth and the first few weeks after birth can be challenging to women especially first-time mothers. During this critical period, grandmothers perform an essential role as caregivers of women and infants. For instance, when Nadja was in her later stages of pregnancy, she moved into her parents’ home so that her mother could carefully monitor her and provide support. Her mother prepared food for her, did her laundry and took her to the hospital when she was in labor. Nadja delivered successfully by caesarean section. After childbirth, Nadja stayed with her mother and only returned to her husband’s home after five months when she felt she had fully recovered. During the postpartum period, Nadja’s mother did not allow her to lift heavy objects and pick up her baby from the bed to avoid damage to her surgical incision and increased pain at the abdomen. Her mother carried the baby to her to breastfeed, fetched water for her to bath, and bathed the child.

Juleha also shared her story about the support she received from her mother. Two weeks after Juleha was discharged from the hospital, she experienced “baby blues,” a mild form of

postpartum depression. Every sunset and at night she cried without any apparent reason. She felt guilty, sad and was often overwhelmed by her new parental responsibilities. She had a swing in her emotions. Her hopes and dreams of becoming a good mother were fading out. Her partner was very stressed about the change in the attitude of Juleha from a happy, loving wife to an unhappy woman. Rizki felt that his wife should be celebrating the arrival of their newborn baby instead of the uncontrollable tears rolling down on her cheeks. Juleha did not explain to her husband what she was experiencing because she felt that her husband would not understand her pain and feelings (*rasa*). The pain, the sadness, and the mood swings were described as *rasa*. She kept the intense feelings of despair inside herself until she felt she could no longer bear it. So, she discussed it with her mother. Her mother shared her experiences of postpartum depression episode with her and also told her that it happens to some women. Her mother often talked to her, listened to her, prepared food for her, and above all, prayed with her. “This is a significant help and support from my mother. She boosted my confidence level to make decisions. The presence of my mom makes me feel safe. I feel like my mom is behind me, so I don’t feel afraid.”

Nevertheless, my participants who had more than one child said they did not require the assistance of their parents as they had previous knowledge of childcare responsibilities. Indah told me that she did not need the help of family members because she is a mother of three children and had enough experience. Mewar, a mother of four, echoed Indah’s comments by saying that once women grow into the skills of mothering, the caregiving role that grandmothers play decreases.

My mother advises me to drink jamu to produce sufficient and fresh breast milk

One of the problems that some of my participants anticipated before birth was their inability to produce enough breast milk for their newborns. Insufficient milk may be conceptualized as the state of which a mother has or perceives that she has inadequate breast milk supply to satisfy the hunger of her child (Hill & Humenick, 1989). For example, first-time mother Fadila mentioned she had no breast milk within the first three days after birth. On the first day of delivery, she asked her cousin who was also breastfeeding to donate breast milk to her daughter Lily, to satisfy her hunger. Fadila thought that she would have some amount of breast milk on the second day, but it turned out that she did not produce any again. She became so desperate and disappointed that she could not produce milk to feed Lily. So, on the second day, she fed Lily with water. She was determined to breastfeed Lily exclusively for six months despite not producing enough milk, hoping that things would get better. Fadila told me that she wanted to exclusively breastfeed Lily because she learned from friends, breastfeeding blogs, and AIMI that breast milk boosts the immune system and makes it less susceptible to developing allergies and infections. She resisted attempts from the midwife to give her daughter formula. She was optimistic that she was surely going to produce some milk to feed Lily. Her mother strongly advised her to drink *jamu uyup-uyup*. *Jamu uyup-uyup* is used by mothers to increase their breast milk production, yet there are other broader uses of *jamu uyup-uyup*, such as eliminating body odor. Fadila's mother brought the *jamu uyup-uyup* from the market and ensured that Fadila drank a glass of *uyup-uyup* each, morning and evening. Although Fadila was hesitant at the beginning to drink *jamu* because she felt it has not been proven scientifically, she did not want to ignore her mother's advice, which would signify disrespect to her mother.

Like Fadila, several of my participants that I spoke to said that they had little or no milk immediately after giving birth. They were stressed about having an insufficient milk supply syndrome and feared that their babies may die from hunger if they were unable to feed them for the first few days⁴.

What seemed to have been common with many of the mothers was that as soon as the women gave birth to their babies, grandmothers immediately encouraged them to start drinking *jamu uyup-uyup/ gepyokan* (*adem-adem ati*, mango leaf, tamarind leaf, papaya leaf) to enhance the production of breast milk. Wati, Rosada, and Ambar, who were all first-time mothers, narrated to me how their mothers and husbands persuaded them to drink *jamu* after birth because they had little breast milk. Wati's mother, for example, prepared *jamu* for sale from home to home in Jogjakarta. So, immediately after Wati gave birth, her mother made *jamu uyup-uyup* for her to drink. Wati admitted that *jamu* increased the breast milk. In her words, she says 'after drinking Jamu; I felt my breasts were always full of milk and my daughter Ella enjoys the taste of my breast milk.' Rosada, who had a similar experience as Fadila, mentioned that she had no breast milk immediately after Lina's birth. She tried using an electric breast pump to extract her milk, but that failed. Rosada became worried that she could not breastfeed Lina, so she resorted to drinking soy milk made for breastfeeders. She also took to massaging the breasts with the hope that she might get a little milk for Lina. Rosada began to produce milk on the third day after delivery, which was rather small. Upon her return from the hospital, her mother gave her *jamu uyup-uyup* to drink. She consumed *jamu* continuously for four months after birth to ensure a sustainable stock of milk for Lina.

Ambar also had difficulty producing enough breast milk after birth. When Ambar and I met three months after she had given birth, she recalled that she could express only 20 mL of

breast milk six weeks postpartum. Her son Jojo cried often. His frequent cries made Ambar and her older sister, Nur, believe that Jojo was not getting enough breast milk to satisfy his hunger. Nur, therefore, made *jamu* from turmeric and palm sugar that Ambar drank both at home and at work. Ambar observed that after a few weeks of drinking *jamu*, she could produce enough milk and also that the texture of milk had become thicker. Unlike the other first-time mothers who had no breast milk immediately after birth, Drami had a lot of milk when she gave birth to Frida. She could express 500 mL of breast milk at a time. Yet, her mother-in-law insisted that she drink *jamu uyup-uyup* to sustain the quantity and the quality of her milk.

My participants who had older children yet were unable to breastfeed them also consumed *jamu* to increase the amount of and the freshness of breast milk. When I met Mewar, she had three older children and formula fed all of them because of insufficient milk supply. With the fourth child, she decided to breastfeed him irrespective of insufficient milk supply. An older woman who was her friend advised her to drink *jamu uyup-uyup* to increase her milk production. When I asked Mewar whether it worked for her, she said “yes it works, it works so well. He sucks my breast all the time, and it is sufficient. I am happy that my baby gets enough milk.”

The mothers who participated in the study drank *jamu uyup-uyup* regularly from the first month of delivery until the baby was four to five months old. After the fifth month, mothers only drank *jamu* occasionally. The rationale behind the five months duration of drinking *jamu* was that in the sixth month, the infants would be introduced to solid food. Mothers would drink *jamu* again later if perhaps their babies were ill or the mothers were ill themselves, and they did not want their babies to have any side effects from Western medicine through their breast milk. For instance, Rosada recounted that her mother advised her to drink *jamu watukan* on behalf of her

daughter Lina when she had a common cold, cough, and flu. Another mother, Juleha, drank *jamu jadem* (bitter plants boiled with water) whenever her son Aryo had diarrhea. Mothers drink *jamu* on behalf of their sick infants, with the hope that it will be transported to the child's body through breast milk, fluid moving from one body to another restoring health. The taste of the *jamu* that was drunk on babies' behalf was bitter. Javanese measure the quality and efficacy of *jamu* by its bitterness. Infants were also made to suckle at the breast more than usual when they fell ill. As noted, when the mothers themselves were ill, they drank *jamu*. But, in cases where the illness persisted for long, they consumed Western medicines, but at minimal dosages.

From my interactions with some of the mothers, I observed that they were always careful in their use of Western medicine. They feared that if they consumed full dosages of such drugs, the possible side effects might spill over to their babies as they were breastfed. From the Javanese philosophy of the body as open bodies, it is understandable that these women think that breast milk as the logic of flows has the possibility to transpose side effects from their body to the babies. The mothers told me that *jamu* has no synthetic chemical compounds, and it works gradually on the body. Because the healing is gradual, *jamu* is believed to have longer efficacy as compared to Western medicine.

Not all mothers in the study followed the advice of their mothers or mothers-in-law to drink *jamu*. Three of out the eleven mothers who took part in the study were skeptical about the efficacy of *jamu*. One of those mothers was Putri. She was deterred from continuing to use *jamu* because of how the bitter leaves used in preparing *jamu* affected her baby. The issue of her *jamu* use came forward near the end of our interactions. I asked Putri if her mother advised her to drink *jamu* for breast milk enhancement. She replied that, "My mom and some old women in the community told me that *jamu* increases breast milk, so I followed their advice and drank *jamu*

for the first month after I gave birth to Rukia. I discontinued the use of *jamu* because Rukia reacted to the drink and had diarrhea.” Putri felt that Rukia was too young, and her stomach was sensitive to bitter herbs that were used to prepare *jamu*. Like following biomedical recommendations, if *jamu* worked, the women continued to use it, but if it was not, they stopped – an indication of how they maintained confidence in how things felt “right” or not. These women had complete faith in their common sense and even gave some forms of agency to herself.

Putri was also skeptical about the hygienic conditions under which *jamu* was made by the local entrepreneurs who were women. “I don’t even know if *jamu* is made under sterile conditions or if the *jamu* seller washes her hands properly before preparing the drink,” she indicated. Siti, a mother of two, cast doubt on the effectiveness of *jamu* in the production of sufficient breast milk. She compared her previous experiences of drinking *jamu* while breastfeeding her first child with her current status of breastfeeding without *jamu* use. She noted, “With my first child, I consumed *jamu uyup-uyup* to increase my breast milk flow. For my second child, I do not drink *jamu*, but I don’t see any difference in the quantity of my breast milk.” Siti continued: “From my experience, I think the more you pump your breast or the baby suckles the breast, the more breast milk you produce. It is like the theory of demand and supply. This works better than drinking *jamu* or eating a lot of vegetables to produce sufficient breast milk.” Siti’s experience was in agreement with scientific research findings that demonstrated that sufficient milk supply is triggered by adequate sucking stimulation of the nipples (Greiner, van Esterik, & Latham, 2010). They argued that insufficient milk supply is typically because of inadequate sucking stimulation to the nipple due to the replacement of breast milk with formula or with other breast milk substitutes.

Food to eat and avoid during lactation

Grandmothers also played an essential role in deciding which food that breastfeeding mothers should eat or avoid. My participants told me that when they became pregnant, they were advised by their parents, mothers-in-law and other older women in the neighborhood to eat healthy food so as to produce delicious breast milk in sufficient quantities. Mothers explained to me that they increased their fruit and vegetable intake during the prenatal and lactation period. Some of the vegetables and fruits they ate included green beans, papaya leaf, *daun katuk*⁵ (*Sauropus androgynus*), *Kurma* (dates), *kunyit root* (*Curcuma longa*, Turmeric in English), banana, guava, mango, and apple. In my conversation with her, Nadja observed that anytime she ate junk food like instant noodles, she produced only a small amount of breast milk which would also be watery. But when her mother advised her to eat the raw root of kunyit, her breast milk became thicker, flowed more freely, and tasted more delicious to the baby. Thick breast milk, to Nadja, was indicative of its richness.

Discussions around the mothers' dietary intake not only covered foods that they were advised to consume but also foods that were considered risky to the baby and were to be avoided. During pregnancy, women were told not to drink *jamu* because it would make the amniotic fluid unclean and make the unborn child unhealthy. Grandmothers also recommended that pregnant women avoid eating pineapple as it may cause miscarriage. Lactating mothers were advised against eating spicy foods and drinking beverages containing coconut milk, as they are believed to cause diarrhea in infants. They were also warned against cold foods and using ice. Ice is said to predispose mothers to a runny nose and a cough, which is later transferred to the baby through breast milk. Hot foods were viewed as having the capacity to cause significant deterioration in the quality and nutritional value of breast milk.

All foods in Java are classified into hot and cold irrespective of their actual temperature. Spicy foods and Jamu for instance, are considered as hot food. Young women are supposed to avoid hot compresses as they are not sturdy enough to handle the heat. Hot foods are for men who are strong enough to grip the heat and for postmenopausal women to rekindle lost energy (Ferzacca, 2001). Women are expected to maintain some level of heat to be attractive to men. For example in the preparation of *jamu* for a cough, *Kunir asem* (Tumeric) is added to the women's drink to enhance the beauty and also tighten the vagina while *beras Kencur* is added to the men's drink to give energy. During pregnancy, hot foods are considered dangerous as the heat may disrupt the formation process of clots, which may result in miscarriage.

Although these beliefs/knowledge are widespread, some mothers dismissed the experiential advice on food safety as old wives tales. For instance, Rosada noted, "I am advised not to take ice because my baby will get cold. From older mothers' experiences, these things do happen, but I do not find any medical evidence on the internet to support their claim." There are some conflicting forms of authorities here as Rosada, who is highly educated in Philosophy, but socialized as Javanese and Muslim trusted the traditional food safety guides but wanted them to be subjected to scientific scrutiny. Wati also contested her grandmother's advice, saying, "I don't believe in my grandmother's advice. She says I should not consume foods that contain coconut milk and that are spicy. I eat spicy foods that have coconut milk, yet nothing happens to me and my baby." Finally, Putri had this to say, "I don't believe in the traditional food safety measures because my midwife remarked there is no connection between mothers' diet and quality of breast milk."⁶ The women dismissed advice on traditional food safety because their children did not show any signs of ill-health after the mothers had consumed the "risky foods" and breastfed their babies. It may also depend on the mother and child relationship. The practices that worked for

the mothers become knowledge that we rely upon in their daily lives. Secondly, with the availability of mobile internet device, it was easy for mothers to cross-check grandmothers' knowledge with "authoritative" breastfeeding knowledge.

Conflicting advice: My mom wants me to bottle feed, but my mother-in-law advises me to breastfeed

I observed that there was often conflicting information from maternal grandmothers and paternal grandmothers on the type of food that babies should eat. For example, Indah's parents wanted her to give formula and solid food to their granddaughter so that she could gain some weight, yet her mother-in-law advised that she breastfeed because her sister-in-law was also breastfeeding. Indah told me that apart from her parents, older women in her neighborhood suggested she formula feed her daughter. According to her, "the older women in my community did not understand why I don't give formula or solid food to my baby." Additionally, Fadila's grandmother advised her to feed her daughter banana since the child often cried after every feed, an indication of hunger. So, grandmothers may have advised mothers based on their own feeding practices.

The women who took part in the study faced a tough decision on whether to follow the advice of their mothers or that of their mother-in-law. They were very cautious in order to not disrespect their parents or mother-in-law. In most of these circumstances, the mothers followed the advice of grandmothers who also breastfed. Siti, who was very concerned about the risks that formula milk posed to infants, told her mom that the practice of breastfeeding has changed over time. "Now you have to breastfeed the baby exclusively for six months." Indah mentioned that she wanted grandmothers and older women to be educated about the benefits of breastfeeding

and the hazards of formula feeding. Grandmothers may advise mothers to breastfeed or formula feed based on their previous experiences⁷.

My mother advises me to nurse while sitting down

Nursing mothers were encouraged by their mothers or mothers-in-law to breastfeed their baby while sitting down in a chair or on the sofa. For instance, Rosada, who gave birth to Lina via caesarean section, was advised by her mother to sit up and put a pillow on her lap under Lina before she breastfed her. The pillow raised Lina closer to the level of the mother's breast to avoid pulling on the breast, which Rosada said caused longer flat breasts that were unsexy. Rosada emphasized that the pillow helped her to avoid feeling pain in her lower abdomen from her incision site. Holding a newborn baby to feed required skills that first-time mothers often lacked. Rosada's mom taught her to hold the baby in the crook of her forearm with the baby's head and trunk supported by the forearm and the palm. The other hand is used to hold the breast to guide the nipple into the baby's mouth.

Similarly, Drami's mother-in-law advised her against breastfeeding Frida while lying down on the bed. She told me that her mother-in-law was afraid that she may suddenly fall asleep and roll over Frida while nursing her in a lying down position. Her mother-in-law was also scared that her breast may cover Frida's nose, which could result in breathing difficulty or suffocation. To illustrate this point, Juleha shared a story of her neighbor whose baby died because her breast suffocated the child while the mother fell asleep while was nursing the child. Echoing Juleha, Wati said, "My mom was afraid that my nipple would cover the nose of Ella while breastfeeding her at laying down position." Grandmothers were concerned about giant breasts suffocating their grandchildren to death, but research shows that infants' nostrils are flared so that they can breathe despite having a breast covering much of their nose.

Putri's mother also advised her not to breastfeed Rukia while lying down on the bed. Putri told me that her mother said that breast milk may choke the baby when nursing the child while lying down on the bed. When Putri complained that nursing while sitting up was uncomfortable, her mother taught her a breastfeeding skill that would enable her to breastfeed Rukia while lying down on the bed. She held the nipple in between the index and middle fingers when nursing Rukia while lying down on the bed. Using the index and middle fingers enabled her to control the flow of breast milk into Rukia's mouth.

Mothers initially adhered to advice from grandmothers partly because this was their first experience with nursing a baby and they wanted to do it correctly. Additionally, they considered grandmothers as wise old women who have mastered the skills of breastfeeding (Gryboski, 1996). But, as mothers became experienced in breastfeeding, they discovered that nursing a baby while sitting up was uncomfortable and exhausting. Many of the mothers who took part in the study preferred to nurse the baby while lying down in bed. They considered this position as comfortable for them and their infants. Breastfeeding on the bed also enabled children to fall asleep quickly, giving freedom to mothers to attend to other household tasks. Wati, for instance, disagreed with her mother's advice on breastfeeding while sitting down, she told me that "maybe my mom is not aware that breastfeeding while lying down is so comfortable." Fadila said, "When I return home from work I get so tired that I have no option than to lie down on the bed to breastfeed her. This is comfortable for me because I am tired."

Conclusion

In this chapter, I have explored how fathers and grandmothers facilitate the experience of breastfeeding mothers. Islam, public health, finance, personal experiences were different forms of authority that fathers and grandmothers used to shape the breastfeeding experiences of

mothers. These forms of authority are not mutually exclusive, but are intertwined and speak to each other. While fathers used the Quran to encourage mothers to breastfeed for two years, they also knew the financial gain that the family derived from breastfeeding and the health benefits that accrued to both mother and child. Grandmothers who are highly respected for their knowledge in childcare and nutrition encourage women to drink *jamu*. *Jamu* as fluid gives life to babies through increasing the flow of breast milk and enhancing the taste of breast milk. The mothers were encouraged to maintain a balance between hot and cold compresses in the context of humoral theory. Some of the mothers use their lived experience to counter grandmothers' advice on risky foods.

The mothers' narratives also spoke to the fact that midwives at the hospital often tried to get mothers to formula feed their babies and many of the couples resisted these recommendations. When babies were not gaining weight, there was pressure from grandparents to give formula to babies so that they could gain some weight. Big babies are sign of abundance while thin babies regarded as unhealthy babies.

Notes

1 Research revealed that midwives in the hospitals in Indonesia gave formula samples and bottles to mothers. Although the midwives advised mothers to exclusively breastfeed infants for six months, they also said formula was always available should breast milk not be enough. Gifts in the form of cash and free flights to Mecca were given to midwives in return for selling formula (Global Alliance for Improved Nutrition, 2013; Wade, 2013).

2 See Tomori, 2015; Hausman, 2003

3 Studies on the impact of breastfeeding on gender difference in the equality of infant care showed that women took on the majority of domestic tasks at home, as compared to men who

were more involved in paid work. Rosin (2009) argued that mothers' involvement in breastfeeding leads to an unequal split of parenting duties, thus giving men greater freedom and restricting women to the domestic sphere. In a similar vein, Rippeyoung and Noonan (2012) argued that domestic task inequality exists between men and women. They further argued that fathers in a household where children were being breastfed did fewer childcare tasks compared to fathers in a household where infants were formula-fed. Even when men were participating in domestic tasks, anthropologist Vanessa Maher (1992) argued that men were given enjoyable domestic tasks while women did menial household duties. She writes, 'It is interesting that Western industrial countries, too many women explain their decision to bottle feed in terms, among other things, of their wish to share the parental role with others, in particular with the father of the child. They describe this form of child-rearing as one step towards a more equitable division of labor... They do not often expect the father to take on other aspects of the parenting role (cleaning and so forth) or to take over the housework to enable the mother to breastfeed. Bottle feeding is often regarded as allowing a somewhat covert shift in the sexual division of labor, and as involving the father in parenting, by beginning with its most gratifying aspect' (p. 8). My participants did not argue for equality of domestic tasks, but rather, they complement the activities of each other at home.

4 Studies have shown that women produce colostrum for the first few days (3 to 4 days) after the birth of the child. After producing colostrum, the body starts to produce breast milk. See Dettwyler, 1987. Also, a newborn's stomach is about the size of marble on the first day, so they need little food.

5 Daun katuk is popular in Indonesia for increasing breast milk

6 Indonesian midwives work according to a biomedical protocol which is different from traditional birth attendants who follow traditions of their culture.

7 If a grandmother has not breastfed, she was more likely to offer advice that reflected the experience of formula feeding that undermined her daughter's or daughter-in-law's level of confidence and ability to successfully initiate and maintain breastfeeding. See Grassley & Nelms, 2008.

Chapter 6

Working and Breastfeeding Practices

In this chapter, I am concerned with how women's work as a form of authority played a role in shaping their experiences of breastfeeding. Of the eleven mothers who took part in the study, seven worked in paid employment; two worked in the informal sector; one was a stay-at-home wife and one was a student but deferred her program to take care of her son. Regarding the seven mothers working in formal organizations, five of them worked full-time, one part-time and one worked from home. In Indonesia, under the Labour Law (2003), women who are in full-time employment are entitled to receive three months maternity leave, including 1.5 months before birth and 1.5 months after birth. The law is not adhered to in the strictest of terms as some employers allow mothers to negotiate when to start their maternity leave. Because the eligibility of maternity leave depended on full-time employment status before birth in a formal organization, not all my participants were eligible for it. Rosada, for example, was not eligible for maternity leave because she worked only three hours a week. Table 6.1 in appendix A shows mothers' work status, place of work and length of maternity leave.

In what follows, I first describe how breastfeeding shape mothers' work. Second, how work, in turn, influenced mothers' breastfeeding experiences. Finally, how women used technology to manage breastfeeding at the workplace and navigate breastfeeding difficulties.

Breastfeeding shaping mothers' work decisions

Ambar, Drami, Fadila, Juleha, Mewar, and Siti all worked as full-time employees in various organizations. Apart from Mewar, who was still on maternity leave when I met her, the rest of these mothers had resumed work. When I met Fadila, she told me that she worked as a government employee, but she had changed her job position from community officer to a

secretary. Her new position came with lower pay compared to her previous position as a community officer, but it allowed her to leave work earlier and have more time with her daughter, and she had found it difficult to express her milk at her previous employer because of the workload. In her new position, she often finished work early and was able to have more time for her daughter. Changing her job position was a demotion and a loss of earnings, yet Fadila told me she was satisfied with it as she had more time at her disposal to accommodate breastfeeding. Fadila sacrificed her career to be a good mother to her child.

Drami for her part had to resign her job to breastfeed her daughter exclusively for six months. She started applying for a new job when her daughter was four months old. Luckily for Drami, she got a job in a hospital in Jogja when her child was six months old. For the six months that Drami was unemployed, she relied on her husband's income and the little savings she had accumulated. For Rosada, she declined a full-time job as a university lecturer to settle for a part-time position at the University. She worked only three hours a week. When I asked why she made such a decision, her response was, "I do not want work to interfere with my role as a mother. I wanted flexible working hours to take good care of my daughter, breastfeed her and not to leave her in the daycare for long hours." She continued, "This is not my sole decision, I took it in conjunction with my husband." Although working for three hours every week meant lower income for Rosada; she was happy with it as she spent more time with her daughter¹. Rosada valued the physical experience of being with her daughter and did not want to be separated from her daughter by work.

Some of my participants' work involved traveling from one city to the another. For instance, part of Siti's work involved traveling and working on archeological sites. Siti recalled that she sometimes moved to other cities outside of Jogja to work for few days without seeing

her daughter. She left her daughter with her husband, who was assisted by his mother. Siti told me that sometimes when she traveled to archeological sites, she brought her pumping tools, yet there was no clean water to sanitize the pumping tools after use, so she used a cloth to wipe them and only rinsed them with warm water when she would return to her hotel room at night. At other times, she did not have time to pump due to her workload. She told me that by the time she returned to her hotel room, her breasts were full, felt hard like rocks and painful. Siti acknowledged that she was fortunate that her daughter was not infected with diarrhea because of her pumping practices when traveling for work. In a similar vein, Ambar spent each week at Jogja working, while her husband and son lived at Purwokerto, which is almost a four-hour drive from Jogja. In my interaction with Ambar, she mentioned that she applied for many jobs at Purwokerto so that she could be with her child and partner, but had not heard from any of them. Fourteen months after I returned to Canada, my research assistant told me that Ambar got a new job in Purwokerto.

In the informal sector where Wati and Indah work, they realigned their work schedule to meet the demands of child care responsibilities, domestic tasks, and breastfeeding. Wati was a seamstress but worked at home. She had no apprentice to assist her in her sewing business. Wati was the primary income earner of the family as her husband, Danag, had no permanent job or source of income. When Wati gave birth, she changed her working period from the day to the night. During the day, she did domestic work like cleaning, cooking, washing, attending to the baby when she cried, and breastfeeding. She would start working at her sewing business at ten p.m., and she would finish at three a.m. In between the periods of sewing, she would change diapers for her baby, soothe her when she cried, and breastfed her while her husband slept. Wati was exhausted because she had a limited sleep at night. Unlike Wati, Indah worked outside the

home as a newspaper distributor. Most often, she carried her daughter along with her while distributing newspapers. Indah told me that there were days that she was going to distribute papers, and her daughter was hungry, so she breastfed her while riding her motorbike or she would wait until she reached a customer's home to breastfeed her.

As indicated in the narratives, Fadila, Rosada and Drami made decisions about breastfeeding that affected not only their professional careers but also enhanced their physical experiences of being with their infants. The mothers who returned to work anticipated that it would be difficult to combine full-time employment with breastfeeding. So, they began stockpiling breast milk in their freezers weeks before their return to work as a way of managing breastfeeding and working. In the next section, I discuss how work shaped the breastfeeding experiences of the eleven mothers that were involved in the study.

Work shaped by and shaping breastfeeding experiences of mothers

Five weeks before Ambar returned to work at Jogja, she started pumping her breast milk. In the beginning, she could only pump 20 mL, which she said was very discouraging, but never gave up. She stored some breast milk in the freezer before she returned to work. She expressed her milk morning and evening. Ambar told me that it was difficult for her to leave her six week old son, Joko in the care of his father at Purwokerto and resume work at Jogja. She wondered what people might say about her as a mother. Ambar, who became emotionally charged during our conversation, said the first weeks at work were challenging to her as she kept thinking about her son and wanted to be at home with him. She made videos clips of her son and while at work, she watched them as a way to emotionally connect with her son. Ambar's emotional inner feelings of missing her child while at work is *rasa* in Javanese. At her workplace, there was no lactation room. So, Ambar expressed her milk in the washroom and stored it in a shared

refrigerator where her coworkers kept their food and drink. A few weeks after storing her milk in the public fridge, Ambar said she experienced an awkward and embarrassing moment when one of her male co-workers asked a question “who has been storing these bags in the refrigerator?” Ambar told me that as soon as the question was posed, she knew the question was directed to her, as she was the only female worker among the male workers. She said it was a humiliating moment for her, and she felt uncomfortable storing her milk in the fridge again. The hostel where Ambar lived in Jogja had shared a refrigerator, but Ambar said she felt uncomfortable storing her breast milk in the hostel’s shared fridge. She explained that she did not know her co-tenants well and could not trust them. A few weeks after the disconcerting situation at work, Ambar formally asked her co-workers if she could store her breast milk in the shared fridge. So I asked what her coworkers’ reactions were. She smiled and said they allowed her to use the fridge. Ambar interpreted this gesture as a meaningful support from her male counterparts as she took a large proportion of space in the refrigerator.



Figure 6.1. Ambar expressed her milk in the washroom at work. Although the toilet looked neat and clean, expressing milk while sitting on the toilet bowl was uncomfortable.

Fadila's experience was entirely different from Ambar. She did not store her milk in the freezer before returning to work. She planned to go home during lunch breaks to breastfeed her daughter. Fadila could only accomplish this plan for two weeks after she returned to work. She explained that her lunch break was only an hour, and it took her fifteen minutes to ride home and vice versa. Although Fadila was able to spend some intimate time with her daughter during the lunch break, she was unable to take her lunch and also rest before returning to work. Because of the limited break period, she decided to express her milk at the workplace. There was no lactation room and refrigerator in the government department where she works. Fadila pumped her breasts in the conference room. She closed the door to the conference room and all windows. A female colleague of hers stayed at the door to prevent male employees from entering the room. When I asked Fadila what she did if the conference room was in use, she paused a while and remarked, "hmm, during such times, I look for an empty office no one is occupying." Fadila stored her milk in a fridge at a food store close to her office. To continue using the vendor's fridge, Fadila said she maintained a cordial relationship with the seller by buying her lunch from him. Fadila's decision to stop going home during her lunch break and express her milk in the workplace at a particular time was an act of self-discipline to be a good worker since her supervisors were monitoring her.

Drami resigned from her job to exclusively breastfeed her daughter, yet interestingly, she also expressed milk. She explained to me that she pumped milk from her breasts to avoid reoccurrence of mastitis problems that led to surgery as discussed in chapter four and to also manage pain from engorgement. Drami developed breast engorgement and subsequently mastitis problems because she had an overabundant supply of breast milk and could not let it out. Drami resorted to expressing as a way of managing her pain as well as giving her a sense of control

over her body. Even through her pain, she was committed to feeding her daughter with breast milk to avoid being labeled as a bad mother². In her new workplace (a local hospital in Jogja), there was a lactation room. Yet, she did not use the lactation room because she had an office space to herself where she expressed and stored it in a cooler bag. Sometimes her daughter was brought to her at the office to breastfeed directly.

Siti, a mother of two girls, lived with her husband Putra at Kalasan, a suburb of Jogja and worked at a government department. Siti, who knew her work involved some traveling, started expressing her milk three days after giving birth, and by the time she returned to work, her freezer was packed with breast milk. To maintain the supply of breast milk, she continued to express two to three times a day at work (the first expression was usually around 10:00 am, then during the lunch break and late afternoon if she had time) and stored it in a mini fridge that she brought from home. Siti hired a middle-aged woman to take care of her daughter under the supervision of her mother-in-law while she was at work. When I visited Siti at her workplace, I observed that she shared office space with two male colleagues. So, I asked her how she expressed her milk in a shared space with men. She told me that anytime she wanted to pump milk, she pleaded with her co-workers to leave the office. The men, understanding that she needed privacy to express her milk, would kindly oblige. Siti saw her male counterparts as very supportive as they gave her space and time to express her milk at a time when they were supposed to be working. If her male colleagues were busy with work assignments, she moved to another office where there were other breastfeeding mothers. There, she pumped her milk together with three other mothers. To her, group pumping was very exciting as well as fun, as they competed to see who expressed the largest quantity of breast milk within a given time.

Pumping at the workplace not only required women to self-discipline their bodies, but they also had to battle with the surveillance of their colleagues.

Juleha was a news reporter for a news agency in Jakarta. The news agency had an office in Jogja before being relocated to Jakarta. Juleha kept her job but reported news from Jogja. She spent most of the day in the city of Jogja and the nearby villages to collect news. Due to the type of work that Juleha did, she piled her freezer with expressed milk. She hired an experienced older woman to take care of her son while she worked. Juleha told me that with her job, it was hard for her to pump in the field. “Pumping requires some amount of time, and I have to look for a comfortable place to pump. I also have to sterilize the pumping equipment after use. So, it is complicated to pump while I am in the field collecting news.” She continued to say “what I sometimes do is let Dian³ and my son accompany me to the field. While we are in the car on the way to the news event, I breastfeed him.”



Figure 6.2. Juleha’s freezer was packed with expressed milk at home. The top compartment of the fridge was only used for her expressed milk. Frozen breast milk is put in warm water to thaw, poured into a feeding bottle and warmed in the breastfeeding warmer. The mothers used their fingers to check the temperature

Rosada's experience was quite different from the other four full-time employees that I described above. She worked as a part-time lecturer and spent only three hours at the university each week. She was not separated from her daughter for longer hours during the day, yet she also expressed milk. She pumped her milk because she wanted to allow her sisters, mother and husband to assist in feeding her daughter when she was not at home. Likewise, Putri, who was formerly a migrant worker in Malaysia and now a stay-at-home wife, said she often directly breastfed her daughter Rukia because she hardly went outside the home. But if she had to attend a friend's wedding party, then she fed her daughter with expressed milk because she did not want to expose part of her body in public⁴. When I interrogated her further to understand why exposing the breast in public was a problem for her, she said showing the breast in public can be embarrassing, and it was also against the teachings of Islam that say women's intimate parts must be covered in public. I explore this theme further in chapter seven.

Some of the mothers were concerned about the economic cost of expressing their milk. Ambar, for instance, explained that she stored her expressed milk in disposable breastfeeding plastic bags which cost four Canadian dollars for thirty pieces. Each month, she spent approximately sixteen dollars on these bags. Ambar lamented that the disposable bags were too expensive. Siti said due to the astronomical cost of these disposable bags, she used glass bottles to store her milk. She further told me that she used the manual pump because it was less expensive than an electric pump. Fadila also complained about the cost of pumping machines in Jogja. So, she started expressing her milk by hand. She discovered that it takes much more time to express milk by hand than by machine, it is exhausting, and it produces little milk. She felt that expressing by hand could not help her to pump enough to keep up with her daughter's

demand. Due to the small quantity of milk that hand expression could produce, she bought a manual pump which she felt worked amazingly well.



Figure 6.3. Siti's freezer at home. It had breast milk in bottles and other frozen food. Each of the bottles were tied in plastic to prevent the smell of frozen food entering the breast milk. The bottles were labelled with dates when the milk was expressed.

When I visited Juleha, whose family was relatively wealthy, I observed that she had both the electronic and manual pumps in her living room. So, I became curious and asked which of the two pumps she frequently used. She responded to me that she bought the electric pump first because friends told her that it was fast in expressing milk. However, after using it for few weeks, she learned from her experience that when the electric pump was set to the highest speed, it caused pain to the breast and when set to the lowest, it did not pump the milk properly. She also said fixing the electric pump on both breasts made her look like a machine. With the manual pump, she observed she could better control the pumping speed for effectiveness. The manual pump allowed Juleha to have control over her body. Juleha also mentioned that the manual pump

enabled her to massage her breasts while pumping, which dramatically increased production. Similarly, Mewar, who was economically well off, preferred the manual pump to the electric pump. She did not hide her dislike for the electric pump on the first day I spoke to her. She said, “I do not use the electric pump because I am not a cow.” She explained that the electric pump extracted every amount of liquid from the breast. Similarly, Wati told me that, “I have never tried the electric pump because I heard the electric pump will forcibly extract all the breast milk including nutrients in the breast that the baby does not need.” She continued; “A mother’s milk expressed with pumping machine has no good quality because it is forced to come out.”



Figure 6.4. Juleha washed and dried her manual pumping machine with the warmer

While it is relatively easier to combine work with breastfeeding in certain types of jobs because of flexible hours and relaxed working environment, it is harder in some fields⁵. Dami, for instance, could breastfeed her child in her office because no supervisor was monitoring her.

Siti, who worked as an IT specialist at her workplace, said, “If I have to edit the department’s website, I do it while expressing my milk. If I am expressing my milk and other employees request my technical assistance with their computers, I tell them to wait for me to finish pumping my milk first.” It was easier for Siti to integrate breastfeeding into her work while she was at the office, but as soon as she traveled to archaeological sites for work, it became tougher for her. Ambar narrated to me that, “When I arrive at the office, I do some assignments, delegate other works to my teammates and then pump my milk. If my team members have questions for me, they wait for me to finish expressing my milk.” These mothers were able to negotiate time with their colleagues or use their leisure time at work to express milk. However, it was difficult for Juleha to pump while in the field.

Because of the complexities involved in combining breastfeeding and work, a new breast milk courier service has opened up in Jogjakarta. The motorbike courier comes to the office, picks up the expressed milk that is stored in a cool bag with ice gels and transports it to the home of the mother. The caretaker feeds the baby with breast milk instead of resorting to feeding the baby with solid food. This service is helpful to working mothers as it reduces the burden of worrying about a shortage of breast milk at home. None of my participants used the breast milk courier service. It was a new business that was emerging when I was leaving Yogyakarta. But Ambar mentioned that she might consider using the breast milk courier service when she gives birth to a second child.

Expressing was not only used as a means to manage expectations of breastfeeding at the workplace, but it was also used as a way to navigate through breastfeeding difficulties that some of my participants faced.

Conclusion

In this chapter, I drew on ethnographic observations and interviews to understand how women's work as a form of authority played a role in shaping their experiences of breastfeeding. The narratives from the mothers suggested that not only did paid work shape mothers' experiences, but breastfeeding also influenced mothers' decisions on work. For instance, Drami resigned from full-time employment to exclusively breastfeed her child. Rosada rejected full-time teaching and settled for a part-time position in order to breastfeed and spend time with her daughter. Fadila had to change job to accommodate breastfeeding. These mothers sacrificed their professional goals and careers to breastfeed and to raise healthy children.

While some mothers sacrificed their paid work in order to have the physical experience of being with their babies during the breastfeeding period, other mothers used the pump and the bottle as a form of empowerment to combine work with breastfeeding. The women pumped during their break period and less busy time of the working day to ensure that their babies get the needed breast milk to grow healthy. Since there were no lactation rooms in many of the workplaces that my participants worked, they either pumped in a shared office space when their co-workers were less busy with work and could provide privacy, or they looked for unused office to express their milk. In all these situations, women self-monitored themselves to ensure that breastfeeding does not interfere with a work assignment. These women were not only under self-surveillance, but they were also monitored by their co-workers. For instance, Ambar's colleagues were curious about what she stored in the shared fridge. While the mothers self-disciplined themselves and were under the surveillance of others, they also maintained agency.

The Health Law No. 36 required mothers to breastfeed infants mandatorily for the first six months of their lives while the Labour Law (2003) only gives 1.5 months of post birth

maternity leave. The new Health Law and the Labour Law do not complement each other, placing employed mothers in a difficult situation as far as combining career and lactation. Worse is the case of mothers who worked in the informal sector who, by the law, must exclusively breastfeed for six months, without entitlement to maternity leave. Studies have shown that a longer maternity leave with pay makes it possible for mothers to breastfeed for longer durations (Baker & Milligan, 2008; Earle, Mokomane, & Heymann, 2011; van Esterik & Greiner, 1981).

Notes

1 Rippeyoung and Noonan (2012) found that mothers who breastfeed for a longer period had steeper earning declines than those who breastfed for a lesser duration or did not breastfeed at all. Earnings declines were attributed to the fact that long breastfeeding duration meant mothers worked fewer hours or entirely exited the labor force. The decision by mothers to quit a job to breastfeed affected their financial security.

2 Research has shown that many women endure physical pain from breastfeeding as a way to demonstrate their maternal selflessness and commitment to being a good mother (See Hay 1996). Additionally, Johnson, Williamson, Lyttle, and Leeming (2009) argued that pain management helped in the active creation of the ‘good maternal body,’ a body that is capable of providing sufficient nourishment for the infant while accommodating vulnerabilities incorporeality. The construction of a good maternal body required mothers to actively manage the performance of a multiplicity of physical sensation in a particular manner (Johnson et al., 2009; Stearns, 1999). There is a misconception that a good mother is one who prioritizes her child’s needs especially when it inconveniences her (See Murphy 1999). As Marshall (2007) argued, good mothering is equated with breastfeeding.

3 Dian is the name of the experienced older women that Juleha employed to take care of her son.

4 Apart from using the pump and the bottle as a way of managing work and breastfeeding, (Hausman, 2003, Gatrell, 2007) many scholars argued that pumping has the potential of empowering women by allowing them to share parenting and also the freedom to do other work outside the home (See Dykes, 2006; Morse & Bottorff, 1992). Although pumping empowers women, it also encourages them to hide their bodies.

5 Lucas and McCarter-Spaulding (2012), maintained that women whose work involves frequent travel find it difficult to integrate working and breastfeeding. Similarly, in a longitudinal study, Morse, Bottorff, & Boman (1989), found that the proximity of the infant to the workplace, the flexibility of working hours and the structure of the workplace are important characteristics to the success of the mother's ability to combine breastfeeding and work.

Chapter 7

Islamic faith as a form of authority shaped by and shaping women's experiences

Islam requires women to dress modestly and not expose their bodies in public places. Dressing modestly entails women covering themselves completely except the face and hands, which can remain visible to others. Not all my participants followed the Islamic dress code strictly. Indah, for instance, did not wear the hijab. For the four times that I visited Juleha at her residence, she did not cover her hair with the hijab. Wati only wore the hijab when she went to the city or mosque for prayers. There was variation in the ways that my participants dressed. Since Islam required women not to expose their bodies in public, the women were frequently confronted with the dilemma of negotiating which of their breastfeeding behaviors in public would be considered as feeding and which would be deemed sexual provocation. For my participants, breastfeeding was a private activity, but at times, it occurred in public places as they did not always stay at home with their babies. For example, mothers went to the mall or marketplaces to shop, attend weddings, to dine at restaurants with their families and played with their children in the park. In these public places, my participants faced the challenges of breastfeeding as their faith in Islam required them not to expose their bodies. Thus, there was religious pressure on women to nurse their babies with discretion when in public spaces.

In Islam, mothers who could not breastfeed because of maternal illness, insufficient milk supply and adoption could receive breast milk from another mother who was willing to donate. In Islamic law, a mother breastfeeding another mother's baby constitutes a type of kinship relation. My participants, who were all Javanese Muslims, argued that accepting donor breast milk established a relationship between the donor of the milk and the recipient of the milk.

This chapter contributes to understanding how Islam shaped women's breastfeeding experiences in public and private places. More specifically, I consider situations where private places became public for women during breastfeeding as well as places where women breastfed or avoid breastfeeding in public. The chapter also highlights issues of embarrassment, especially difficulties women faced in breastfeeding in the presence of men inside and outside the home. Finally, I explain how kinship ties were formed through fluids.

Women's interpretations of private and public places

My participants viewed and interpreted places differently once they became mothers. For example, the home was regarded by Juleha as a safe and private place where breastfeeding could take place. The presence of others, especially male guests, could transform a private arena like the home to a public place. Private space, like the living room, became public space for mothers when their husband's male friends, relatives, or strangers visited. Mothers would retreat to a more private place like the bedroom to breastfeed their babies when male guests were sitting in the living room. The home was not necessarily a private place in that mothers were free to breastfeed anywhere. Going to the bedroom to breastfeed because of the presence of men excluded women from public discussions in the home. As Carter (1995) highlighted, the home is a complex mixture of private and public space, even though it is often characterized as if it is a private place.

Another example was that the private car of a nursing mother would become a public space with the presence of a male driver. The mother would create a private space for herself in the car by covering herself and the baby with a blanket. The same living room and private car were defined by women as supportive of breastfeeding when male guests or relatives were absent. So, the definition of private and public place as supportive or constraining to

breastfeeding depended on the individuals around the place, the relationships between the mother and the guests, the sex of the visitors, and also partners' opinions about the place. Like Carter (1995), Stearns (1999), Dowling, Naidoo, and Pontin (2012) and Oakley (2015), I found that the demarcation between public and private space became less clear as women negotiated appropriate places to breastfeed.

All the mothers in the study did not have problems breastfeeding in the presence of females but would avoid breastfeeding in front of certain males. For example, Siti recounted how she pumped her breast milk in the presence of her male work colleagues in a car while driving to an archeological site. She asked them to look elsewhere while she expressed her milk. Siti said she could express her milk before her male colleagues because she knew them. Yet, Siti could not breastfeed in front of her stepfather-in-law. When I asked her why she could express milk in front of male colleagues but not breastfeed in the presence of her stepfather-in-law, she responded that her husband, Putra warned her not to breastfeed in front of his stepfather. So, when Siti visited her parents-in-law, she breastfed in the bedroom.

Nadja, who was a mother of a child and graduate student said, "I don't breastfeed in front of my unmarried brothers. When my brothers are at home, and I want to breastfeed my baby, I go to the bedroom to breastfeed him or my brothers leave the place so that I can breastfeed my baby." Nadja felt that breastfeeding in front of unmarried brothers was exposing her brothers to live pornography and thus encouraged them to have sex before marriage. Sex before marriage is forbidden in Islam. Unlike Nadja, Ambar was also a graduate student who was comfortable breastfeeding in front of her elder brother and father, but not in front of her brothers-in-law. Similarly, Drami, who was living with her spouse in her in-law's house, told me that she was never comfortable breastfeeding in front of her brothers-in-law. She explained that it would be

an embarrassment to her if her brothers-in-law saw her breasts. So, to avoid any embarrassment, she breastfed in the bedroom when at home. Ambar added that it was inappropriate for women to expose their breasts to their brothers-in-law. Exposing one's breasts to her brothers-in-law was regarded as a sexual enticement. Fadila, who was a secretary, said, "At home I always breastfeed my daughter in the bedroom. Even when my family members visit us, I breastfeed in the bedroom. I don't breastfeed in front of my father or brothers. When they are with me, and they realize that I want to breastfeed my baby, they leave the room for me." From these interactions with the mothers, I learned that in the home, women negotiated where to breastfeed, within whose presence to breastfeed, and if their spouse approved of it. Also, the breast was sexualized instead of being seen as a functional object for the babies.

Hiding the breast in public

In Jogja, Islam, Javanese, Hinduism and Buddhism are deeply intertwined¹. For example, the Javanese's Kraton spiritual side faces Mecca, some Jamus are consumed facing the east where Mecca is located, some Islamic inscriptions are at the entrance of the Kraton, some *jamu* inscriptions are found on Hindu temple dating from 8th-9th century and hijabs have largely replaced Javanese dressing. So, in a way, there is Islamization of Javanese culture and Javanization of Islamic practices. In Islamize Java, exposing sensitive body parts like the breasts in public or in the presence of men other than your partner or biological father is considered as indecent or improper behavior. In Javanese, the word used for indecent behavior is *saru*. Women are strongly encouraged to cover their breasts while feeding their babies in public or to find secluded places in public to breastfeed their babies.

In describing how women breastfeed outside the home, most of the mothers said that they used headscarves, aprons, and blankets to cover their breasts when feeding their babies in public

places. For example, Juleha, a journalist by profession, said, “I am comfortable breastfeeding in front of others as long as I cover myself and my son with a blanket. I had breastfed him in restaurants and in front of friends, but I covered myself with a blanket.” Juleha described how she struggled to cover her breasts while feeding her son in the presence of other people.

When he was little, I could cover him with a blanket easily but as he grew, it was difficult to cover him up. He is always grabbing and pulling down the blanket. Sometimes, I get frustrated because he is fussy and he doesn’t want to be under the blanket. People sometimes look at you, but they don’t complain about it. Sometimes I move into my car to breastfeed him.

Drami told me that she could not breastfeed in public without covering herself up, contrasting herself with other mothers she saw at the hospital where she worked. She said,

In restaurants and my place of work, I use my headscarf to cover my breasts, before nursing. In the hospital, there are nursing rooms for mothers to use, but I see some of them breastfeeding their babies in the outpatient department. These women do not cover up their breasts with a headscarf or blanket, yet they manage to breastfeed their babies without exposing their breasts. One could barely see beyond the nipple area of the breast. I don’t know how they do it: I want to believe that they wear special bras for breastfeeding mothers.

Positioning the baby correctly on the breast while hiding most of the breast is not an easy task for first-time mothers when breastfeeding in public places. Drami’s comments suggested that breastfeeding in the presence of others outside the home while simultaneously hiding the breast and correctly positioning the baby to the breast has a skill that mothers acquired as they became experienced in breastfeeding.



Figure 7.1. A mom using a hijab to cover her breasts while nursing.

Some mothers intentionally wore certain types of clothing to hide their breasts during breastfeeding. Juleha explained that,

When I became a nursing mother, I changed the way I dress. I often wear dresses with buttons in front of them. I open one or two buttons, and I can breastfeed without people seeing my breasts. I have also modified some of my old clothing. I cut my T-shirts and put buttons in front of them. When I want to buy new clothing, I look for the ones that have buttons in front of them.

When I asked Rosada, a part-time professor at the University if she breastfed in public, she said, “Yes. When I am going out, I make sure I wear dresses with buttons to make it easy for me to breastfeed her in public. I also put on special bra made for breastfeeding mothers.” She also spoke about how her breasts have become less private.

When I was young, mothers don't care about breastfeeding in public, but now women are concerned about their breasts in public. In my teenage years, I always protect my breasts but now that I became a mother, I felt my breasts are less private than when I was a teenager. Whether a mother is shy to breastfeed in public or not, she has to breastfeed the baby when he or she is hungry. We need to be polite to people around us.

Nadja also used the breastfeeding clothing. She told me that, "After using the breastfeeding clothing for some time, I realized that I could make some money out of it. So I decided to buy many breastfeeding clothing from the factory and resell it. I advertised them to my friends and also on social media like Facebook and WhatsApp." Juleha, like many of the participants, mentioned that wearing certain types of clothing in public to accommodate breastfeeding made them look unfashionable.



Figure 7.2. Breastfeeding dresses that were sold by Nadja

Breastfeeding in public spaces

Women used different means to avoid embarrassment while breastfeeding in public places. One of the ways they avoided potential embarrassment while breastfeeding outside the

home was to find discreet places with fewer people anytime they wanted to nurse their babies. Putri, a stay-at-home mom who breastfed for twenty-seven months, said that beyond the home, she felt embarrassed to breastfeed in front of people. She recalled that even with her long headscarf, she always looked for a quiet and clean place to breastfeed her daughter outside the home. According to her, “The place must be quiet, clean and there should be nobody there.” Privacy was very crucial to her and feeding in front of other people in public was unthinkable for her.

Fadila, who breastfed her daughter for twenty months, said breastfeeding should be done in a quiet, safe and comfortable place in public. Contrary to Putri, who did not want anyone to see her while feeding in public, Fadila remembered breastfeeding her daughter in public places that were less crowded with people but were comfortable for her. She bluntly said that “People especially men, should mind their own business and stop staring at nursing mothers’ breasts in public.” Fadila was unconcerned about the inappropriate sexualisation of a lactating body.

Some mothers also mentioned that they breastfed their children at home if they had to leave the city for a short period, about an hour or two. For a longer time outside the home, they prepared puree or formula for their babies. This strategy usually worked better for mothers whose children were eating solid food and water. Nadja, whose son was seven months old at the time of my fieldwork, described her experience to me, “I always try to manage my time very well. If I know that I would spend less than an hour outside in the city, I breastfed him adequately before we go out. But if we would stay in the city for longer hours, I prepared puree with which I feed him in public.” Further, Putri had this to say, “I hardly went out when my daughter was feeding only on breast milk. When I had to go to the market, I would go without

her. Now I attend my friends' wedding parties because I could feed her with formula and I don't have to expose my breasts for people to see."

In public spaces such as restaurants, mothers preferred to sit in obscure areas like in the corner instead of in the middle. They usually faced the wall so that others would not see their breasts in case they wanted to nurse their babies. Sometimes, they would have husbands sit in front of them to prevent other people from seeing their breasts. Juleha, Nadja, and Rosada all shared their experiences of sitting in the corner while breastfeeding in restaurants. This was an excerpt from Rosada's interview, "Sometimes my daughter would not want to be covered with a cloth while breastfeeding. So when I am in a restaurant, I just find a place in the corner to sit so that people do not see my breast in the course of feeding her." Juleha had similar memories of breastfeeding in restaurants, 'In a restaurant, I prefer to sit in the corner of the restaurant but not in the middle. I also avoided eating from the street vendor because it was not comfortable when I want to breastfeed my son.' Nadja said, "In the restaurant, I hide in the corner to avoid people seeing me." From my own observation of mothers at restaurants, the corners of some restaurants were dirty, but that was where mothers felt comfortable breastfeeding their babies².

Motorcycles were the most common form of private transportation for many people in Jogjakarta. Some women breastfed their babies while riding motorbikes in the city. Three of the mothers I spoke to told me that they have breastfed their babies while on the motorbike. Indah, a mother of three children who distributed newspapers in the city of Jogja, said that "In the mornings, I am in a hurry to distribute newspapers to my customers. When my daughter is hungry on my way to the distribution of papers, I lift my shirt and breastfeed her while I ride the motorbike." She wrapped her child with cloth in front of her while she rode her motorcycle. Ambar and Fadila also breastfed their babies while on a motorbike, but unlike Indah, who was

riding the motorbike and breastfeeding her daughter, both were carried on the motorbike driven by their husbands.



Figure 7.3. A mom demonstrating how she breastfed her daughter while driving her motorbike

Some malls in the city had lactation rooms. In a conversation with Juleha, she told me that when she was in the mall to shop for the household, she breastfed her son in the lactation room there. She lamented that the lactation rooms in some of the malls were not comfortable for mothers to use. She said the chairs in the room were not soft, and there were no changing places for the babies. Most of my participants admitted that the lactation room in the Ambarukmo Plaza mall was very comfortable for them.



Figure 7.4. The lactation room for mothers at Ambarukmo Plaza. This is the changing place for babies, with a sink for mothers to wash their hands, and a place to dispose of the soiled diapers. Ambarukmo Plaza is the biggest mall in the city of Jogja.



Figure 7.4.1. The lactation room at Ambarukmo Plaza Mall. The Sofa is for mothers to sit on during breastfeeding

The formula company SGM, also built a nursing room near the traditional Jogjakarta Market for women to use. A visit to that lactation room revealed that approximately ten to fifteen women use the facility in a day. The caretaker of the nursing room disclosed to me that most of the women who use the lactation room were foreigners visiting Jogjakarta. Juleha told me that she did not like to use the nursing room provided by SGM because a formula company financed it. She continued to state that “Although SGM was performing its corporate social responsibility by providing nursing rooms for mothers in public areas like market places and bus stations, SGM was also advertising and promoting formula milk to women by putting its name and logo on the buildings.” Her comment suggests that SGM did not build the lactation room for women’s convenience, but rather nursing rooms was built as a camouflage to advertise, promote and encourage women to use formula³.



Figure 7.5. The lactation room built by SGM in the market at Jogjakarta. The room is comfortable. It had comfortable seat for mothers, a changing place, a fridge to store expressed milk, toys for babies and water for mothers to drink

Indah, who breastfed all her three children for more than two years, said she never used nursing rooms when she was in public spaces like the hospital, the mall or the marketplace for any of her children. She breastfed her daughter anywhere in public as long as the place was quiet and comfortable for her. She did not understand why she should confine herself to a particular room in a public space just because she wanted to breastfeed her baby. “Why should I be isolated in a nursing room in public because I want to feed my baby?” She questioned.

Moreover, Wati, who breastfed her daughter for thirty-six months, shared her experience about how some women seemed to be embarrassed when they saw their fellow women breastfeeding in public space. She narrated an experience that she had with a woman at the hospital,

I went to the hospital one day and did not know that there was room to breastfeed my daughter, so I breastfed her at the place I was sitting but covered my breasts with the headscarf. A woman came to tell me that there was a room in the hospital where I could breastfeed my baby. I think the woman felt embarrassed that I was showing my breast in an open space in the hospital.

Wati did not understand why fellow women would be embarrassed that a mother was feeding her child in public. Meanwhile, another participant, Siti, said, “As a woman, I don’t feel comfortable to see another woman show her breasts in public especially when there are so many men in the place.” There were discrepancies in what constituted modesty and appropriate behavior for these women. While Siti saw feeding in front of men as immodest, Wati saw nothing wrong with it as long as she covered her breasts.

Public transport (e.g. buses), parks, wedding parties and other crowded areas were places that mothers regarded as difficult places to breastfeed babies. Wati, for example, took a decision

not to breastfeed her daughter at a park alone because of an unpleasant experience she had while feeding her child. She said, “One day as I was in the park with my baby, I whipped out my breast to feed her, and a man passed a derogatory comment that this is a porn action.” Wati said she felt embarrassed to the extent that she immediately stopped breastfeeding her child. When I asked her whether she would breastfeed at a park again, her response was she would breastfeed her at a park if she were in a group of other mothers or if the park was quiet with nobody around. Apart from Wati, the mothers in the study said that they did not receive any negative verbal comments when breastfeeding in public, yet they interpreted body language such as strange stares as unspoken negative comments. In another, Drami could not imagine herself breastfeeding while using public transport. She saw this as inappropriate behavior, and she would feel ashamed to do it. When I asked her how she feeds her daughter when traveling with her, she replied, “I give her expressed milk.”

The participants also mentioned that they received advice from family members, especially their husbands, about places that were appropriate to breastfeed their babies when in public. When I asked some of the fathers why they prevented their wives from nursing in public, Haryo, Nadja’s husband and a devoted Muslim responded by saying,

Breastfeeding in public means my wife is exposing part of her body that should be hidden to people. Although she might cover her breasts with a headscarf while feeding our baby, people can still see her. So my suggestion to her is to find a quiet place with fewer people any time she wants to breastfeed our son in public.

Wati’s husband, Danag, expressed similar feelings, “I don’t want my wife to expose her breasts in public. That is my request. I don’t even want her to show the breasts to family members especially men. It is private; it is my responsibility as a husband to protect her nudity. I don’t

want to sin against Allah.” Haryo and Danag wanted their wives to be modest and to maintain absolute privacy in public. On the contrary, two spouses in the study said they did not care where their wives breastfed in public, as long as they covered themselves. Indah’s husband, Toyib, for example, asserted that “breast milk is for the baby. I just allow my wife to decide where she wants to breastfeed the baby in public. She knows the places that are comfortable for her or not.” Drami’s husband, Agus, on the other hand, said:

Mothers should be proud to breastfeed her child anywhere. She is not doing anything wrong or illegal; just breastfeeding her hungry child in public. The natural task for a mother is to nurse her baby. I feel sad for babies whose mothers feed them formula because they are in public. In my opinion, it is rather people who feel ashamed to gaze at breastfeeding mothers. Personally, when I meet a mother breastfeeding her baby, I feel ashamed to look at her. My wife does not have the confidence to breastfeed in public, so I encourage her not to worry about what others would say because she is acting in the interest of our child.

Among my participants, fathers who were Muslim but not devout tended to be more liberal on breastfeeding in public, while fathers who were devout Muslims wanted their wives to maintain absolute privacy and modesty in public. The narratives of Toyib and Agus presented resistance to the dominant ideology that breastfeeding should be done in a private space. The influence of Islam on women’s experiences of breastfeeding is further considered below.

Breast milk kinship

In Islam, kinship refers to social relationships derived from blood, marriage, and breast milk. The mothers who took part in the study gave different definitions of milk kinship depending on the type of Islamic group they belonged. For Rosada, whose father was an Islamic

teacher and proprietor of an Islamic college said that milk kinship came into existence when a nursing mother suckled another woman's child directly from the breast. For Siti, who donated her milk to a child for a week, told me that, it did not matter whether the child suckled directly from the breast or was given expressed milk. So, for Siti, milk kinship existed when a mother nursed another woman's child either directly from the breast or with expressed milk. From Rosada's definition, providing breast milk by bottle does not constitute milk kinship. There should be direct contact or relationship with the milk mother and the child recipient. The difference between the two definitions of milk kinship is the mode of transmission. Also, Siti understood the milk kinship from the Sunni Islam perspective while Rosada understood it from the Shi'a Islam perspective. In Sunni Islam the baby did not necessarily need to feed directly from the breasts for milk kinship to exist. There are specific rules that govern milk kinship. For instance, milk kin cannot inherit from the milk parents; the milk parents have no legal obligation of guardianship over the milk kin (Khatib-Chahidi, 1992), and milk siblings are forbidden in marriage (EL-Khuffash & Unger, 2012; Parkes, 2005). Consider, for example, a mother who has a son who breastfeeds another woman's daughter, those two children are forbidden to marry in the future because they are connected through milk. In Java, the relationship between the recipient of the milk and the milk mother is called "ibu susu" and the relationship between the two children is referred to "saudara sepersusuan." Nadja cited a section of the Quran that prohibits milk siblings from marrying.

Prohibited to you (for marriage) are your mothers, your daughters, your paternal and maternal aunts, your mother's sisters, your brother's daughters, your sister's daughters, your (milk) mothers who nursed you, your sisters through nursing, your wives' mothers, and your step-daughters under your guardianship (born) of your wives unto whom you

have gone in. But if you have not gone in unto them, there is no sin upon you. And (also forbidden are) the wives of your sons who are from your (own) loins, and that you take (in marriage) two sisters simultaneously, except for what has already occurred (Quran verse 4:23).

Siti told me that rule of kinship does not only forbid the two children from marrying in the future. She explained in detail that none of the sons of the milk mother are allowed in future to marry the recipient child (daughter) because they are siblings. In Islam, they are regarded as “mahram”. Mahram refers to someone you cannot marry because you are close relatives. For example, father, brothers, uncles, father-in-law, brothers-in-law, etc. If any of the sons of the milk mother, falls in love with the sisters of the recipient child (daughter), they are allowed to marry because they are not related through milk. According to Islamic law, as Siti explained, the milk mother, the children of the milk mother and the recipient of the breast milk are considered families. Kinship ties are not extended to the siblings of the recipient of the breast milk. The two families (the donor and recipient family) would be expected to exchange the family certificate, which is called *kartu keluarga* to avoid incest in the future. Siti added that women were often advised not to suckle many children so as they do not forget the children they have nursed in the future.

The biological sex of the children [i.e. the child of the milk mother and the recipient child] also influenced decisions about whether to donate breast milk or not. All the mothers who took part in the study preferred to donate breast milk to either the children of their immediate family members or other women whose children were the same sex as their infants to avoid future marriage complications. Drami, for instance, said that, “I don’t mind donating my breast milk to another child, but I have to consider the sex of that baby. If the baby is a boy, I don’t

want to breastfeed him because I have a baby girl.” Drami did not want to breastfeed the boy because she considered him as a potential future partner of her daughter. All the mothers in the study shared Drami’s viewpoint and were unwilling to donate breast milk to children of the opposite sex to their children.

The narratives of the mothers have implications for milk banks. This was well articulated by Juleha, who said, “I don’t want my son to be a recipient of breast milk from milk bank because I don’t know the mother who donated it.” For Juleha, it was important to establish who received milk from whom, which the milk banks failed to do. Mixing milk from different mothers, for Juleha, leads to milk kinship confusion. To avoid milk kinship confusion that milk banks were likely to cause, Siti suggested that milk banks should establish a detailed milk registry which would provide the names of every donor, names of the children of the donor, the sex of the baby, the name of the child who receives the milk, and the mother’s name. While Siti’s idea of a milk registry seems like a good suggestion, Rosada would argue that milk banks do not need to establish records in that detail since suckling was not directly from the breast.

For breast milk donations to be considered as good, the age of the children involved was taken into consideration. The children must be at the same age. Juleha told me that the nutrients in breast milk varied based on the age of the infant. As a study has shown, Vitamin B12 in the breast milk decreased at four months (Fedders, 2013). So, a newborn who received breast milk from a mother whose child is four months old may be receiving less Vitamin B12. She recalled that the only reason she did not allow her older sister to nurse her son when she was going through a difficult breastfeeding time was that her sister’s baby was ten months old while she had a newborn. She explained that, “The nutrients in the milk of the mother of a ten months old baby is different from the nutrients that a new-born needs.” For her, it was better to find a mother

of a child who was the same age as her son or to feed him with formula, so that he received the appropriate nutrients. Siti reinforced Juleha's argument by stating that, "A good breast milk donation is that, the baby of the donor should have the same age with the child receiving the breast milk donation." The point of departure between Juleha and Siti was that Siti argued "if a mother of a child who needs the breast milk cannot find another woman whose child has the same age as her child, then breast milk from any other mother is preferred to formula."

Some mothers were also concerned about the health of the milk donor. Juleha, for example, mentioned that breast milk donors should be properly screened at hospital facilities to avoid any possible transfer of disease from donor to the child. For example, donors should be tested for HIV/AIDS before they donate to milk banks, she said. Unlike Juleha, Siti mentioned that, "There was less possibility that breast milk contains disease of donors, and that breast milk sterilizes all disease." The notion that breast milk sterilized all disease is a myth. Breast milk is a bodily fluid and diseases can be transferred through it. The Center for Disease Control and Prevention (2015) stated that "HIV and other serious infectious diseases can be transmitted through breast milk. However, the risk of infection from a single bottle of breast milk, even if the mother is HIV positive, is extremely small. For women who do not have HIV or other serious infectious diseases, there is little risk to the child who receives her breast milk." Below I illustrate stories of mothers who breastfed other women's babies or received breast milk for their babies.

Example One: Wati was a mother of a baby girl and worked at home. Her sister-in-law had a baby boy and worked outside the home. She left her son with Wati's grandmother when at work. Wati, when visiting her grandmother would frequently breastfeed her nephew when he was hungry. Wati's sister-in-law was aware that Wati had been breastfeeding her son when she

was at work, but she was comfortable with it. Indah, the mother of three children, said she breastfed her sister-in-law's son once directly from the breast. That was when her sister-in-law left her son under her care to get groceries. She breastfed him when he cried as a way to comfort him.

Example Two: A woman who was HIV positive gave birth to a baby girl with low birth weight. She was afraid that she could transfer the HIV to her child if she breastfed her. So, she looked for a wet nurse to care for her daughter. During the Christmas holiday, the wet nurse traveled with her family for vacation. Siti, who was breastfeeding her daughter at the time, offered to feed the child until the milk mother came back from her vacation. She fed her for one week but not directly from her breast, but by bottle with expressed milk. Siti received no cash payment for the milk she supplied to the child. She also exchanged her family certificate with the child's family to avoid any future marriage complications, in case, she has a son.

Example Three: Fadila's daughter was breastfed by her cousin at the hospital. Her cousin had a girl as well. When I asked Fadila why she requested that her cousin breastfeed her daughter Lily, she hesitated in answering the question immediately. But in our subsequent conversations, she told me that Lily had a rapid heartbeat, and the doctor recommended that she breastfeed her to normalize her heart rate. Fadila, at the time, could not produce enough breast milk. So she asked her cousin to breastfeed Lily.

In the first case, Wati and Indah breastfed only the children of family members to avoid concerns about future marriage complications for their children. In the second case, Siti, a mother of girls, breastfed a non-family member, but the child she breastfed was a girl. Should Siti have a boy in the future, he cannot marry the girl his mother breastfed because they are

related through breast milk. Fadila was the only mother in the study who received milk from the family member because of insufficient breast milk.

The mothers in the study were not willing to receive breast milk from women who were not their family members. For example, Wati said that, “I can breastfeed another baby, and another mother can also breastfeed my baby. But that other mother must be my sister, not any other person.” When I asked Indah whether she was willing for another mother to breastfeed her daughter, her response was, “Yes, so long as they are my family members like my sister or my sister-in-law but not any other mother.” The mothers did not want their children to be related through milk to women they did not know. So, in Islamize Java, kinship ties were formed through breast milk, indicating the notion of the body as linked through fluids.

Conclusion

Women embody Islamic faith in ways that played into their breastfeeding behaviour in public and their attitude towards milk donation. The women who took part in the study admitted that their faith in Islam did not prevent them from breastfeeding in public, but it required them to cover up in public. These women searched for quiet and comfortable private places to hide to breastfeed in public. This was to avoid being labeled as indecent women by others in society. It was also a way to remain obedient to husbands who did not want their wives to expose their breasts in public. These women, therefore, practiced discretion as a way to manage the religious, cultural, spousal, and patriarchal demands of breastfeeding in public. Given husbands’ demands that women should not expose their bodies in public, especially the breast, some women were forced to remain at home to exclusively breastfeed their babies. This excluded mothers from public life. As long as there remains a cultural expectation for women to achieve modesty through careful examination of individuals around them, women will always feel enormous

pressure to negotiate carefully places to breastfeed in public. Like Carter (1995), it became clear to me that the home, which was assumed to be a place belonging women, could at times become public, depending on the individuals around them. At home, women were expected to cover up in front of men or go to the bedroom to breastfeed. The home was not a place where women were always free to be themselves (Carter, 1995). Thus, women considered Islamic faith a form of authority that control their body through an expectation of appropriate behavior and decency in a public place. Social support, particularly from fathers, became very important in strengthening the psyche and building self-confidence in mothers around breastfeeding in public.

Islam also played a role in defining social relationships. A child who was breastfed by another woman is incorporated into the woman's family. The child is prohibited in marriage to the milk mother's children. In terms of a public and population health perspective, a mother who understood milk kinship from Shi'a Islamic perspective may use milk banks because milk kinship is not established until a child directly feeds on the woman's breast. Sunni Islam mothers are less likely to use milk banks if they do not know the woman who donated the milk. A milk registry which includes in detail information about the donor and the recipient of the milk may encourage Sunni women to use milk banks.

Notes

1 See Geertz, 1960, page 5

2 An observation that I made at the restaurant was that people smoke indiscriminately in the restaurants irrespective of whether mothers were in the restaurant or not. As studies have shown, second-hand smoke exposed children to a greater risk factor for ear infections, respiratory infections, severe asthmatic attack, and infant death syndrome studies revealed (U.S. Department of Health and Human Services, 2014).

3 According to Ecks (2008, p. 178), ‘Global corporate citizenship is not a brake on free-wheeling capitalism, but rather a strategy of extending and accelerating it by new means.’ Ecks, therefore, suggested that it would be prudent and ethical for corporations to slow down on the claim of good citizenship and state clearly in a capitalist term ‘Why they are doing what they are doing’ (Ecks, 2008, p. 178).

Conclusion

In this dissertation, I drew on various approaches to understanding how forms of authorities were embodied in women's breastfeeding experience, five years after Indonesia passed a breastfeeding law. I began by looking at various works that have been done on breastfeeding and the approaches that could be used to understand women's embodied experiences of breastfeeding within the context of Jogjakarta. In Jogjakarta, Javanese, Hinduism, Buddhism, Islam, Catholicism are practiced, attesting to a multiplicity of forms of authorities in the midst of a medico-legal law. I then turned my attention to how the ethnographic research was conducted in the field from June 2013 to October 2014. Learning from the lived experience of these eleven middle-class mothers, I shed light on several interesting themes such as women's voice on the ground, family contributions to breastfeeding, working and breastfeeding practices and how the Islamic faith shapes mothers' experiences.

I went to Jogjakarta with the intention of understanding the breastfeeding law No. 36 and how it translates into the lives of mothers and their families. Although the law was passed to create a supportive and inclusive environment for women to breastfeed, and also to ensure that they raise healthy children for the State, in my interactions with the women, it turned out that only one woman in the study had heard of the law. She knew that the State had made it mandatory for women to breastfeed through a television program. She neither knew who to report to should anyone prevent her from breastfeeding nor the possible sanctions for breach of the law. It has been observed from the study that this law as a social relation and practice was remote and distant from the everyday breastfeeding experience of these mothers. From August 2014 when I started the intense fieldwork to August 2016 when I finished writing my dissertation, there has been no report that anyone has been jailed or fined \$11,000 for hindering a

mother from breastfeeding. Likewise, I have also not heard that civil claims or charges have been brought against any formula company.

It would be hard for a mother in Jogja to bring a criminal charge against her parents or husband for advising her to feed her child with food other than breast milk within the first six months of life. Women in Jogja were socialized from childhood to respect older people and their husbands. Consequently, following the advice of a grandmother by feeding a baby with food other than breast milk within the first six months may be done merely on account of respect for the advisor. Women who may bring a criminal charge against her own family members for hindering them from breastfeeding are most likely to face social justice which may include social rejection, public humiliation, and ridicule from the community. Additionally, I would argue that women are unlikely to report family members to the Indonesian public health agency for prosecution because doing so may result in loss of income or loss of one's husband or parent to prison custody up to a period of a year. It appears that the law in Indonesia is difficult to implement, enforce and overridden by more powerful and meaningful forms of authority. Rather than showing an awareness of the law, the women evoked different forms of authorities in their breastfeeding practices. For example, though the mothers framed the risks and benefits of breastfeeding in biomedical terms which is a form of biopolitical authority, it was observed that their actual decision to breastfeed came from Islamic teachings, a form of religious Javanese authority. Islam requires mothers to breastfeed for two years. Some of the children were weaned as early as eight months while others were breastfed for thirty-six months. Islam requesting mothers to breastfeed for two years is in itself a form of politics. This form of authority plays into the ways women manage and self-regulate their bodies and how to tend to their newborns.

Islam prevails as a form of authority, and the law on breastfeeding is in accordance with the teachings of Islam.

Islam also defines social relationships. Infants who are breastfed by the same woman are related by milk as siblings. Thus, breast milk as a fluid that flows establishes kinship ties, indicating how bodies are linked through fluids. The definition of milk sibling varied among mothers depending on the Islamic group they belong. Some women had objections to receiving pooled breast milk because the donor of the milk and the gender of their children cannot be identified to avoid future marriage.

While teaching that mothers should breastfeed for two years, Islam also admonishes that women dress decently and not expose their bodies in public. The participants were, therefore, careful in their choice of public places to breastfeed in order to avoid strange and uncomfortable stares, which the mothers stated often attracted unspoken negative comments. Ultimately, public health dictates were not meaningful for women, they were more concerned about what Islam, spouses, and grandmothers say.

In some hospitals, newborns were given formula because their mothers' milk could not flow immediately after birth. The remaining formula was given to the mothers to feed the babies with at home. Some of my participants interpreted the midwives' behavior as an unethical attempt to persuade them to formula-feed their babies. Paradoxically, some hospitals and midwives seem to push formula, which goes contrary to the law that is part of their establishment. Some of the mothers resisted the midwives' effort and resorted to traditional medicines, *jamu uyup-uyup* to increase their breast milk. The mothers' narratives of their experiences highlighted the role played by family in obtaining *jamu* for them and in motivating the first-time mothers, in particular, to use it, either to increase the quantity of their breast milk or

to enhance its quality and flavor. *Jamu* was also regarded as a tonic to energize nursing mothers and protect both mother and infant from illnesses. Overall, many of my participants agreed that *jamu* works for them in increasing breast milk, transforming it into nutritious food for their babies, thus showing ayurvedic politics of the body. This has become knowledge the women rely upon in their everyday lives. From the Javanese philosophy of the body, the mothers drink *jamu* on behalf of the child with the hope that it will be transmitted to the child's body through breast milk. The mothers find hope in *jamu* in increasing their milk and also sustaining their own health and that of their children. Hope is not an abstract cultural force that is in the mind, but rather it emerges through everyday entanglement between people and things (Laplane, 2015, p. 229), which becomes a form of governance or ways to tend to bodies on the grounds.

In this study, I found that the media was also a prevalent form of authority that shaped women's breastfeeding experiences. Before mothers gave birth, they had been surfing the internet for information on breastfeeding and formula feeding. Women who had difficult breastfeeding experiences went to breastfeeding blogs, Facebook, and YouTube to read and watch how other mothers in the world resolved their breastfeeding problems. The Asosiasi Ibu Menyusui, Indonesia (AIMI) has a Facebook page, which provided a medium for mothers to share their own experiences of breastfeeding and also learn from the experiences of other mothers. AIMI used its Facebook page as a platform to advocate for breastfeeding, hoping to trigger behavioral change among mothers who preferred to formula feed their babies. Further, work related matters also plays into the mothers' experiences of breastfeeding. Some of the mothers had to resign or change jobs for lower income jobs in order to accommodate their breastfeeding plans. Mothers who took maternity leave had to stockpile their fridges with breastmilk before returning to work. Many of the working mothers in the study returned to work

within six to eight weeks. Paid maternity leaves were found to be too short and incommensurate with the duration of exclusive breastfeeding. The Health Law requires mothers to exclusively breastfeed for six months and continue for two years, but the Labour Law (2003) only gives three months maternity leaves. The Labour law allows women to take 1.5 months before birth and 1.5 months after birth. Ambar had six weeks maternity leave before birth and Fadila had four weeks before birth. So both Ambar and Fadila returned to work early after giving birth. Many of the workplaces where some of my participants worked had no lactation rooms and refrigerators for them to store their milk, showing how the law is incoherent with other infrastructures within the country, thus making its application difficult.

This research contributes to population health by demonstrating some ways in which upstream interventions, such as the Indonesian breastfeeding laws are weakened, or potentially irrelevant, if they do not contribute meaningfully to people's lives. Although the law may have been unknowingly useful for women by facilitating breastfeeding at their workplaces and in public places, the law seemed to be irrelevant in the women's retelling of their experiences. Future studies will be useful to see if there are wider impacts of the law, but this study provides a unique view into the value of understanding people's experiences to the study of population health. As population health experts and students, we must pay attention to people's experiences, learn from their experiences, so that we can advocate for laws that are socially desirable, meaningful, feasible and can contribute to the everyday life of people. Further, this study is unique by being one of the first to examine women's experiences in Indonesia, a country unique for its diversity with multiple identities. It thus appears relevant, with regards to addressing a population health problem to mandating women's practices, to take this diversity

into consideration by paying attention to the multiple layers of authority that take part in everyday life as has been proposed in this thesis.

The study has limitations. First I was unable to meet all the spouses of the women due to their busy work schedule. This limited my ability to learn from all the husbands of the women about their supports, and concerns about breastfeeding and sexuality, a topic that was actively articulated in some of the men's interview. Secondly, the women that were recruited into the study were from "middle-class families" in Jogja and thus offer an understanding of a particular group of people that should not be taken as representing all women in the city and even less in the whole country. It would be interesting to explore women's experiences of breastfeeding in the rural regions of Jogja as their experiences may be different from women in the city. Also, the study did not include mothers who do not breastfeed. It will be interesting to look at the experiences of families who formula-feed their babies. Further, the study did not look into experiences of breastfeeding mothers who are Christians, Hindu, Animist, and Buddhist. There is a need to conduct further research in different parts of Indonesia to understand the different ways breastfeeding is practiced, if the law became meaningful in some areas. Milk donation, milk sharing, milk kinship and milk banks are complicated issues in Indonesia and further study is needed to look at the complex web of social, cultural and health factors that shape the experiences of milk donors and receivers. More research on how the law came into being, how it is implemented and enforced would also provide a better understanding of this topic. Finally, research can also look at whether the law should be repealed since it is distant from the women and disproportionately punishing families.

We also know not every woman can breastfeed. Mothers with medical conditions, mothers who adopted children and gay men with children cannot breastfeed. If formula is

thought to be harmful as research has shown, then other ways of making sure babies from mothers who cannot breastfeed can be fed in beneficial ways constitutes another important area of research.

My journey to understand forms of authorities that women embody in their breastfeeding experiences has taken me to the homes of mothers and their workplaces. These women let me into their personal life and allowed me to learn from their breastfeeding experiences. At a personal level, I have learned as a husband to be supportive of my wife during breastfeeding. My hope is that sharing these women's lived experiences through this study will open a cross-cultural discussion on the multiple ways breastfeeding can be done in meaningful ways through a variety of forms of authorities and not rely solely on public health interventions or punishing laws.

Appendix A

Table 1.1. Pattern of breastfeeding infants aged 0-5 months by age group in Indonesia

Age Group	Patterns of Breastfeeding		
	Exclusively	Predominant	Partially
0 month	39.8	5.1	55.1
1 month	32.5	4.4	63.1
2 month	30.7	4.1	65.2
3 month	25.2	4.4	70.4
4 month	26.3	3.0	70.7
5 month	15.3	1.5	83.2

Source: Ministry of Health, Republic of Indonesia (2011)

Data Source: National Board of Health Research and Development, MoH RI, Riskesdas 2010

Table 1.1 showed that in 2010, a year after the breastfeeding law was passed, only 40 percent of newborns were exclusively breastfed while there was only 15.3 percent of infants aged five months were breastfed exclusively. As infant grew, exclusive breastfeeding decreased. Approximately 55 percent of newborns were fed with breast milk and processed food like formula milk and porridge. The older infant age is, the higher the percentage of partial breastfeeding.

Table 1.2. Pattern of breastfeeding in Indonesia

	2008-2012
Early initiation of breastfeeding (within an hour from birth)	29.30%
Children exclusively breastfed (0-5)	41.50%
Introduction to solid food (6-8 months)	84.60%
Breastfeeding at age 2	55.30%
Stunting (under 5 years)	35.60%

Source: Statistics Indonesia, National Population and Family Planning Board, Ministry of Health and ICF International (2013).

Table 1.2, shows that the proportion of infants aged 0-5 months exclusively breastfed in 2012 was 42% after the enactment of the law.

Table 1.3. Patterns of breastfeeding infants aged 0-5 months by characteristics in Indonesia

Characteristics	Patterns of Breastfeeding		
	<u>Exclusively</u>	<u>Predominant</u>	<u>Partially</u>
Sex			
Male	29.0	10.5	60.6
Female	25.4	11.7	62.9
Living place			
Urban	25.2	10.5	64.3
Rural	29.3	11.5	59.2
Education of Family Head			
No education	34.5	5.5	60.0
Not primary	31.4	10.5	58.6
Graduate			
Primary Graduate	26.5	12.0	61.5
Junior High	29.5	8.6	61.9
Graduate			
Senior High	24.6	13.7	61.6
Graduate			
Higher Education	22.4	9.7	67.9
Household expenditure per Capita			
Quintile1	34.7	9.9	55.4
Quintile 2	30.5	11.3	58.1
Quintile 3	26.6	10.4	63.0
Quintile 4	19.9	14.6	65.5
Quintile 5	17.5	8.7	73.8

Source: Ministry of health, Republic of Indonesia (2011)

Data Source: National Board of Health Research and Development, MoH RI, Riskesdas 2010

N.B. Exclusive = feeding infants with only breast milk

Predominant = breastfeeding and feeding baby with water or tea

Partially = Breastfeeding and feeding infant with processed food, e.g. formula milk

Table 1.3 shows the pattern of breastfeeding infants aged 0-5 months by characteristics. With respect to sex, the percentage of boys who exclusively breastfed was 29 percent which was higher than the percentage of girls who were breastfed exclusively 25.4 percent. Rural infants were also exclusively breastfed (29.3%) more than infants living in the urban areas (25.2%).

What this means is that urban infants were fed with breast milk and processed food like formula milk (64.3%) more than infants from the rural areas (59.25). By education of family head, the percentage of infants aged 0-5 months exclusively breastfed with no schooling family head was 34.5%, more than the percentage of infants exclusively breastfed with no primary school graduated family head. Only 22.4% of infants aged 0-5 months with higher education graduated head were breastfed exclusively. Meanwhile, infants with higher education graduated family head had a larger proportion of partial breastfeeding (67.9%) than infants with no primary school graduated family head (58.6%). By household expenditure per capita, infants aged 0-5 months from the Quintile 1 were exclusively breastfed (34.7%) than infants from Quintile 5 (17.5%).

The inference that can be drawn from Table 1.3 is that families who were living in the rural areas, with less education and lower household income, were more likely to breastfeed exclusively more than families who were residing in the urban settings, with higher education and higher income. Families with higher income could afford the cost of formula compared to low-income families.

Table. 1.4. Places where mothers give births

<u>Background</u>	<u>Health Facilities</u>		
	<u>Public</u>	<u>Private</u>	<u>Home</u>
Mother's age at birth			
<20	16.8	36.6	46
20-34	16.4	48	34.9
35-49	21.9	41.1	35.8
Mother's education			
No education	10.7	10.4	76.1
some education	15.4	22.6	61.3
completed primary	14.4	32.8	51.5
some secondary	15.6	45.4	38.5
completed secondary	20.8	59	19.7
More than secondary	20.9	65.5	12.8

Source: Source: Statistics Indonesia, National Population and Family Planning Board, Ministry of Health and ICF International (2013).

Table 1.4 showed places where mothers gave birth. Older mothers were more likely to give birth in hospitals than younger mother. Younger mothers under the age of 20 gave birth at home than older mothers. Mothers with higher educational level also used gave in hospitals than mothers with less educational level. Overall, mothers preferred to use private hospitals to public hospitals.

Table 3.1

Summary of the Forms of Authority that Mothers Spoke of		
Name of mothers	Forms of authority	Summary of Key stories
Rosada	Religious Javanese	I breastfed my child because the Holy Quran requires women to breastfeed for two years. Breastfeeding is the right of children and Muslim women who decided not to breastfeed their children violate Islamic law on breastfeeding.
	Media	
	Household	Breast milk provides immunity against childhood illnesses such as respiratory disease and diarrhea. I learned about the health benefits of breastfeeding from breastfeeding blogs, AIMI and health caregivers
	Work	My mother told me to breastfeed my child because breastmilk is a medicine for children. I have also seen my older sister breastfed her children. My spouse, mother, and sisters were very supportive when I gave birth. I declined a full-time job as a university lecturer to settle for a part-time position at the University to breastfeed my child. I did not want paid work to interfere with my role as a mother.
Wati	Biopolitical	I heard about the breastfeeding law that required mothers to breastfeed exclusively for six months, but I breastfed my child because Holy Quran requires women to breastfeed for two years and the health benefits my child would derive from breastfeeding.
	Religious Javanese	When I birth at the hospital, I felt disappointed that I did not have skin-to-skin contact with my child, but I could not question the midwife because I taught she knows better than I do. My mother is a Jamu producer, so when I gave birth, she made jamu uyup-uyup for me. My breasts were always full of milk when I drink jamu uyup-uyup.
	Work	I breastfed my nephew when his mother was not at home. I breastfed him because we are family and family members cannot marry each other according to the Holy Quran. I can breastfeed another baby, and another mother can also breastfeed my baby. But that other mother must be my sister, not any other person to

Summary of the Forms of Authority that Mothers Spoke of		
Name of mothers	Forms of authority	Summary of Key stories
		avoid milk sibling. I sew dresses for people, but when I gave birth, it was difficult combining my work with childcare responsibilities and domestic chores. I have to change my working time from the day to the night. During the day, I care for my child and does domestic chores and at night when she is at sleep, I sew dresses.
Nadja	Biopolitical Religious Javanese Media	I breastfed because my sister who was formula-fed often get sick of fever and flu. Her sister's regular illnesses motivated her to breastfeed exclusively. My husband often reminds me of the right of the child to breastmilk according to the Holy Quran I learned to clean and massage my breasts through YouTube videos. Cleaning the breasts help prevent clogged ducts and massaging stimulates the breasts to produce enough milk.
Indah	Household Biopolitical Work Religious Javanese	When I gave birth at the hospital, the midwife gave me a package of formula milk to send home, but my husband threw it away and encouraged me to breastfeed because of the health benefits of breastfeeding and financial cost involve in formula feeding. When I gave birth to my first child, I did not have skin-to-skin contact. For the second child, the midwife wrapped my baby in a blanket before putting her on my body. For the third child, she looked for Baby Friendly Hospital where she had skin-to-skin contact. I leave home early in the morning to distribute newspapers to my customers. When my daughter is hungry on my way to the distribution of papers, I lift my shirt and breastfeed her while I ride the motorbike. I breastfed my daughter for two years because the Holy Quran requires women to do so. I sometimes breastfeed my sister-in-law's child who is a boy. They are family, so the Quran forbids them to marry in the future. I prefer to breastfeed only children of family

Summary of the Forms of Authority that Mothers Spoke of		
Name of mothers	Forms of authority	Summary of Key stories
		members to avoid concerns about future marriage complications for their children.
Juleha	Household Media Religious Javanese Work	When I gave birth, the midwife taught me how to breastfeed by using her to demonstrate it to me, but I learned the actual skills of breastfeeding by observing my older sister who was breastfeeding at the time and practicing what I observed. When I had difficulties expressing my milk, I search on breastfeeding blogs how other women in the world overcome that problem. I don't want my son to be a recipient of breast milk from milk bank because I don't know the mother who donated it. For me, it is important to establish who receive milk from whom, which the milk banks failed to do. My work entails moving from one place to another reporting news. It 's hard for me to carry my child along with me while I am at work. Due to the type of work I do, I hired an experienced older woman who takes care of my child while I am at work. I stocked the freezer with express milk.
Drami	Work Biopolitical	I resigned from my job to breastfeed my Child. When I gave birth at the hospital, I did not experience the skin-to-skin contact with my child and I felt sad about it.
Ambar	Religious Javanese Work	I could express only 20 mL of breast milk six weeks postpartum. Her sister made jamu from turmeric and palm sugar for her, and she could produce enough milk. My husband and child live at Purwokerto, but I work at Jogja. Every Friday of the week, I go home with express milk so that my husband can store it and feed our child with it during the week. At my workplace, there is no lactation room. So, I expressed my milk in the washroom and stored it in a shared refrigerator where her coworkers kept their food and drink.

Summary of the Forms of Authority that Mothers Spoke of		
Name of mothers	Forms of authority	Summary of Key stories
Siti	Biopolitical	Siti did not intend to breastfeed when she was first pregnant, but after attending breastfeeding class organized by the hospital where she gave birth, Siti breastfed exclusively for six months
	Religious Javanese	With my first child, I consumed jamu uyup-uyup to increase my breast milk flow. For my second child, I do not drink jamu, but I don't see any difference in the quantity of my breast milk. From my experience, I think the more you pump your breast, or the baby suckles the breast, the more breast milk you produce. It is like the theory of demand and supply.
	Work	Milk kinship existed when a mother nursed another woman's child either directly from the breast or with expressed milk. I donated my milk to a child whose mother has HIV. I donated my milk because our children are of the same sex. Milk banks should establish a comprehensive milk registry which would provide the names of every donor, names of the children of the donor, the sex of the baby, the name of the child who receives the milk, and the mother's name. My work involves traveling. Sometimes when I travel to archeological sites, there was no clean water to sanitize the pumping tools after use. At other times, I don't have time to pump because of the workload.
Putri	Household	My husband was supportive when I was breastfeeding. He often buys me daun katuk to enable me to produce enough milk.
	Religious Javanese	I breastfed because the Holy Quran requires women to breastfeed for two years. As women, it is our natural role to get pregnant, give birth and nurse him/her to grow healthy and strong. When I gave birth, I drunk jamu made from bitter leave, but it gives diarrhea to my child, so I discontinued drinking jamu.

Summary of the Forms of Authority that Mothers Spoke of		
Name of mothers	Forms of authority	Summary of Key stories
Fadila	Media	I read about the benefits of breastfeeding from breastfeeding blogs (AIMI)
	Religious Javanese	When I gave birth, I had insufficient milk, but my mother ensures that I drink Jamu uyup-uyup every day. At first, I was skeptical about its efficacy, but it works. I breastfed my child because it is written in the Holy Quran that a mother must breastfeed her child for two years.
	Work	My cousin breastfeeds my child because we are family. But another mother whose child have opposite sex to my child cannot breastfeed my child because in the future they cannot marry. They are siblings connected by milk She changed her job position from community officer to a secretary to accommodate breastfeeding. There is no lactation room and refrigerator in the office where I work. I pumped my breasts in the conference room. I close the door and all windows. A female colleague of mine stays at the door to prevent male employees from entering the room. I store the milk in a fridge at a food store close to her office.
Mewar	Religious Javanese	She formula-fed her three older children because she had insufficient breast milk But with the fourth child, she drunk jamu uyup-uyup, which she said works for her

Table 4.1. Duration of breastfeeding and weaning

<u>Mothers</u>	<u>Total duration of breastfeeding</u>	<u>Reasons for weaning</u>	<u>Methods of weaning</u>
Ambar	21 months	Pregnant	Put bitter plants on the nipple
Drami	24 months	Baby is old enough	Put jamu plants on the nipple
Fadila	20 months	Broken teeth	Paint nipple red/bitter plants
Indah	18 months	Education	Traditional healer
Juleha	24 months	Baby is old enough	Put salt on the nipple
Mewar	8 months	Breast milk dried up	Introduced formula gradually
Nadja	17 months	Pregnant	Not stated
Putri	25 months	Still breastfeeding	Still breastfeeding
Rosada	23 months	Pregnant	Separation from mother temporarily
Siti	26 months	Pregnant	
First child			
Second child	21 months	still breastfeeding	Still breastfeeding
Wati	36 months	Baby is old enough	Separation from mother temporarily

Source: Fieldwork, 2014

Table 4.1 indicated the duration of breastfeeding, reasons for weaning and methods used to wean children. Three of the mothers weaned their children because they were pregnant. Another three weaned their children because they perceived them to be old. Only one mother stopped breastfeeding because her milk dried up. Another mother stopped breastfeeding because her child had broken teeth. Finally, one mother weaned her child because she wanted to continue her education.

Table 6.1. Mothers' work status, place of work and length of maternity leave

<u>Mothers</u>	<u>Work status</u>	<u>Place of work</u>	<u>Length of maternity leave</u>
Ambar	Full-time employed	Private sector	Six weeks before birth & six after birth
Drami	Resigned	Government	No maternity leave
Fadila	Full-time employed	Government	Four weeks before birth & eight weeks after birth
Indah	Self-employed	Outside Home	No maternity leave
Juleha	Full-time employed	News Agency	Twelve weeks after birth
Mewar	Full-time employed	School	Twelve weeks after birth
Nadja	Student	University	One year of leave of absence
Putri	Stayed-at-home wife		No maternity leave
Rosada	Part-time employed	University	No maternity leave
Siti	Full-time employed	Government	One week before birth & eleven weeks after birth
Wati	Self-employed	Home	No maternity leave

Source: Fieldwork, 2014

Appendix B

Interview Guide

The guide will not be followed strictly. Some of the questions will change based on the interaction with the women.

Demographic characteristics

Age
Education
Marital status
Work status
Number of children
Place of deliver

General questions

Did you plan to breastfeed your baby before delivery?
What motivate you to take that decision?
How did you prepare for breastfeeding before delivery?
After you delivered in the health facility (home, hospitals), tell us about your experience of breastfeeding while you were still in the facility?
Does your experience match your expectations?
So when you came back home, what was your experience?
For how long have you been breastfeeding?
Why did you decide to stop breastfeeding?
How did you stop her from nursing?

Family

Did you receive support from your family? Tell us about it.
How does breastfeeding affect your sexual life and your relationship with your husband?
How do you support your spouse? (Husband)

Breastfeeding and Work

So you said you work at (name). Do you mind sharing your experiences with me on working and breastfeeding?
How do you feel when you leave your baby at home and return to work?
How long is your maternity leave?
Who take care of your child when you are at work?
What support do you receive from peers and employers at work?
What challenges do you have as a working mom?

Feeding outside home

When you are not at home, how do you feed your baby?
How do you feel about breastfeeding your baby in public?
What is your husband reaction when you breastfeed outside the home?
Do you mind to share some pictures with us about places that you breastfeed your baby when you are outside the home?

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