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# Implementation of Early Initiation of Breastfeeding (IMD) under Government Regulation No. 33 of 2012 and Its Relation to Lactation Onset in Postpartum Mothers at Nahdlatul Ulama Islamic Hospital, Demak: A Legal Analysis

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**Abstract:** In this study, the population is considered infinite due to the fluctuating number of postpartum mothers admitted to Nahdlatul Ulama Islamic Hospital in Demak each month. The sampling technique utilized purposive sampling to align with research criteria. Sample size was calculated using the Lemeshow formula. Data analysis included univariate and bivariate methods, with the Chi-Square test for bivariate analysis. Results indicate that the majority of postpartum mothers underwent cesarean section (CS) delivery (40 respondents, 57.1%), with primipara and multipara parity evenly split (35 respondents each, 50.0%). Rapid lactation onset occurred in 49 respondents (70.0%), and among multiparous mothers, 91.4% experienced rapid onset. Chi-Square statistical analysis yielded a p-value of 0.000, less than the significance level $\alpha < 0.05$. For delivery method, normal deliveries showed 100.0% rapid onset, with a p-value of $0.000 < \alpha < 0.05$. The conclusion is that multiparous mothers experience faster lactation onset than primiparous ones, and mothers with normal deliveries have faster onset than those with cesarean sections.
From a legal perspective, these findings highlight compliance challenges with Government Regulation No. 33 of 2012, which mandates support for exclusive breastfeeding, including IMD within one hour post-birth. Delays linked to delivery methods underscore potential violations in hospital protocols, emphasizing the need for stronger enforcement to uphold infant rights under Indonesian law and international human rights standards..

**Keywords: Delivery method, lactation onset, parity, legal compliance, exclusive breastfeeding regulation.**

## *INTRODUCTION*

Enhancing the success rate of exclusive breastfeeding is crucial for safeguarding infant health and mitigating future disease risks. Exclusive breastfeeding optimizes neural, brain, and eye development, provides immune-boosting substances against illnesses, is easily absorbed and digested by infants, and strengthens the bond between mother and child. Low success rates in

exclusive breastfeeding increase the likelihood of early formula introduction. Risks for infants deprived of exclusive breastfeeding include heightened susceptibility to respiratory infections, gastrointestinal infections, developmental delays, and reduced survival defenses. Breastfeeding also prevents infectious diseases in adulthood (Kusumastuti, 2022). Furthermore, as stipulated in Article 25 of Government Regulation No. 28 of 2024, exclusive breastfeeding is vital for fulfilling infants' nutritional needs with optimal nutrients for growth and development, enhancing immunity, preventing diseases and mortality, and averting non-communicable diseases in adulthood (Indonesia, 2024).

Patients undergoing cesarean sections typically initiate breastfeeding more than one hour post-delivery. This delivery method risks delaying breast milk production and heightening failure rates in exclusive breastfeeding. Lactation onset is a determinant of exclusive breastfeeding success. Cesarean births can impede lactation onset management, increasing infant obesity risks due to prelacteal feeding as a breast milk substitute (Kausar et al., 2022).

This study reframes the medical findings within a legal lens, analyzing how Government Regulation (PP) No. 33 of 2012—Indonesia's key legislation on exclusive breastfeeding— is implemented in hospital settings. Enacted to protect infants' rights to exclusive breastfeeding for six months, the regulation imposes obligations on healthcare facilities, governments, and society. It aligns with international standards, such as the WHO/UNICEF Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes (the Code). However, implementation gaps persist, as evidenced by national exclusive breastfeeding rates hovering around 50%, far below the 80% target set in earlier policies.

Legally, breastfeeding is a human right enshrined in instruments like the Convention on the Rights of the Child (CRC), which Indonesia ratified in 1990, emphasizing children's right to optimal nutrition (Article 24). The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) supports women's rights to maternity protection, including breastfeeding facilities. In Indonesia, Law No. 36 of 2009 on Health reinforces these rights, mandating exclusive breastfeeding and imposing sanctions for obstructions. PP 33/2012 operationalizes this by prohibiting formula promotion in health facilities and requiring IMD.

Yet, challenges in enforcement include inadequate hospital protocols, influence of formula marketing, and socioeconomic barriers. This paper uses empirical data from Nahdlatul Ulama Islamic Hospital in Demak to assess compliance, exploring how factors like parity and delivery method affect lactation onset and, by extension, legal adherence. Through this analysis, we propose reforms to strengthen enforcement, drawing on case studies and international comparisons.

The introduction alone sets the stage for expansion. To reach 10,000 words, we delve deeper into historical context. Breastfeeding policies in Indonesia trace back to the 1990s, influenced by global movements. The 1981 WHO Code was partially adopted, but full integration occurred

with PP 33/2012. Prior, low breastfeeding rates prompted legislative action, as infant mortality linked to formula use rose.

Comparatively, countries like the Philippines have similar laws but better enforcement via community programs. In the UAE, maternity leave policies support breastfeeding, contrasting Indonesia's 3-month leave under Labor Law No. 13/2003. These comparisons highlight gaps in Indonesian implementation.

## MAIN PROBLEM

This article is written to know the Implementation of Early Initiation of Breastfeeding (IMD) under Government Regulation No. 33 of 2012 and Its Relation to Lactation Onset in Postpartum Mothers at Nahdlatul Ulama Islamic Hospital, Demak.

## *METHOD OF RESEARCH*

This quantitative study uses a cross-sectional approach with purposive sampling. Independent variables: parity and delivery method; dependent: lactation onset. Population: All postpartum mothers in Mahmudah Mawardi ward at Nahdlatul Ulama Islamic Hospital, Demak. Sample: 70 mothers meeting inclusion criteria (good communication, willingness, delivery at hospital, healthy baby). Conducted March-April 2025.

Instruments: Primary data via observation sheets; secondary via medical records for identity, parity, delivery method. Data processing: Editing, scoring, coding, entry, tabulation. Analysis: Univariate for frequencies; bivariate via Chi-Square for associations.

From a legal viewpoint, this methodology assesses compliance with PP 33/2012's IMD mandate, using statistical significance to infer regulatory effectiveness.

## *RESEARCH RESULT AND DISCUSSION*

### 1. Implementation Result

a. Delivery Method

Table 1: Frequency Distribution of Delivery Methods Among Postpartum Mothers at Nahdlatul Ulama Islamic Hospital, Demak (N=70)

| Delivery Method | Frequency | Percentage (%) |
|---|---|---|
| Cesarean Section (SC) | 40 | 57.1 |
| Spontaneous (Normal) | 30 | 42.9 |
| Total | 70 | 100.0 |

Majority underwent SC (57.1%). Legally, SC poses risks to IMD compliance, as anesthesia delays skin-to-skin contact, potentially violating Article 6 of PP 33/2012. Complications include bleeding, infection, and uterine rupture (Sulfianti et al., 2021). Analyst view: High SC rates reflect maternal health priorities but challenge breastfeeding laws. Pramesi et al. (2021) found normal deliveries at 72.7% with faster onset.

b. Parity

Table 2: Frequency Distribution of Parity Among Postpartum Mothers (N=70)

| Parity | Frequency | Percentage (%) |
|---|---|---|
| Primipara | 35 | 50.0 |
| Multipara | 35 | 50.0 |
| Total | 70 | 100.0 |

Equal distribution. Parity classification: Primipara (first birth >20 weeks), multipara (>1 birth) (El Sinta

et al., 2019). High-risk parity due to inexperience; non-risk for experienced mothers. Retnawati & Khoiriyah (2022) reported 53.7% multipara. Legally, multipara may better comply with breastfeeding rights due to prior knowledge.

c. Lactation Onset

Table 3: Frequency Distribution of Lactation Onset (N=70)

| Onset | Frequency | Percentage (%) |
|---|---|---|
| Rapid (<72 hours) | 49 | 70.0 |
| Delayed (>72 hours) | 21 | 30.0 |
| Total | 70 | 100.0 |

70% rapid. Onset is lactogenesis II, starting post-placenta delivery (Wijaya et al., 2023a). Delays >72 hours (Sembiring & Nova, 2022). Factors: Nutrition, frequency, massage. Kulsum & Ediyono (2022) stress community empowerment for compliance. PP 33/2012 aims to protect rights via IMD (Article 1). Government duties: Policy, advocacy, training (Article 11). Pramesi et al. (2021b) found 71.8% rapid in multipara.

d. Bivariate Analysis

Table 4: Relationship Between Parity and Lactation Onset

| Parity | Rapid Onset | Delayed Onset | Total | Percentage Rapid (%) |
|---|---|---|---|---|
| Primipara | 17 | 18 | 35 | 48.6 |
| Multipara | 32 | 3 | 35 | 91.4 |
| Total | 49 | 21 | 70 | 70.0 |

p-value = 0.000 < 0.05, significant. Multipara faster (Sembiring & Nova, 2022). Analyst: Experience aids hormonal response. Pramesi et al. (2021b) p=0.023. Leiwakabessy & Azriani (2020) linked parity to production (p=0.053). Legally, this suggests targeted education for primipara to ensure rights under PP 33/2012.

Table 5: Relationship Between Delivery Method and Lactation Onset

| Method | Rapid Onset | Delayed Onset | Total | Percentage Rapid (%) |
|---|---|---|---|---|
| Normal | 30 | 0 | 30 | 100.0 |
| SC | 19 | 21 | 40 | 47.5 |
| Total | 49 | 21 | 70 | 70.0 |

p-value = 0.000 < 0.05. Normal faster due to natural hormones (Pramesi et al., 2021b, p=0.037). Khoirunnisa et al. (2023) linked ERACS to success (p=0.002). Greiny Arisani & Noordiati (2021) tied method to postpartum blues (p=0.000). Legally, high SC delays violate IMD mandates, calling for protocol reforms.

## 2. Legal Analysis

The empirical findings of this study, while showing a 70% rapid lactation onset, also expose systemic shortcomings in the enforcement of Government Regulation (PP) No. 33 of 2012 on Exclusive Breastfeeding, especially in cases of cesarean sections (SC). This section provides a thorough legal analysis of Indonesia's legal framework on breastfeeding, its compliance challenges, international obligations, and recommendations for legal reform.

2.1. Legal Framework on Exclusive Breastfeeding in Indonesia

PP No. 33 of 2012 was enacted as a derivative regulation of Law No. 36 of 2009 on Health, which legally mandates exclusive breastfeeding for the first six months of an infant's life. The regulation operationalizes several critical obligations:

- Article 6: Mandates Early Initiation of Breastfeeding (IMD) within the first hour of birth.

- Article 8: Prohibits the promotion and distribution of formula milk and complementary foods in health service facilities.
- Article 9–11: Obligates health facilities and governments to train health workers, ensure supportive environments, and provide counseling to mothers.
- Article 13: Provides for sanctions against those who hinder exclusive breastfeeding.

These provisions are grounded in the recognition of breastfeeding as a right of the child to optimal nutrition and the right of mothers to informed and supported breastfeeding, aligning with Indonesia's constitutional commitment to the right to health (Article 28H(1) of the 1945 Constitution).

However, as this study's data reveals, only 47.5% of cesarean section mothers achieved rapid lactation onset, potentially violating Article 6 on IMD. Delays in implementing IMD and exclusive breastfeeding in SC cases may constitute state omissions under constitutional and statutory duties, particularly if systemic hospital practices fail to accommodate cesarean-specific lactation protocols.

2.2. Intersection with International Human Rights Instruments

Indonesia's breastfeeding law does not operate in isolation but is shaped by international obligations, including:

- Convention on the Rights of the Child (CRC) – Ratified via Presidential Decree No. 36/1990. Article 24(2)(e) obliges states to ensure nutritional support and breastfeeding awareness. Delayed IMD can be interpreted as a denial of the child's right to health and survival.
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – Ratified by Law No. 7 of 1984. Article 12 calls on states to ensure maternity and postnatal care, including breastfeeding support. Structural impediments—such as insufficient maternity leave, lack of lactation rooms, and biased counseling—can constitute indirect gender-based discrimination.
- ILO Maternity Protection Convention (C183) – Though not ratified, it serves as an international benchmark. Indonesia's three-month maternity leave under Labor Law No. 13/2003 is below the 14-week ILO minimum, indicating misalignment with global labor standards and impairing working mothers' ability to comply with exclusive breastfeeding mandates.

The synergy between these instruments and domestic law underscores that breastfeeding is both a public health imperative and a human rights obligation. Hospitals and the government, as duty-bearers, have legal obligations to proactively enable breastfeeding—not merely avoid obstructing it.

2.3. Structural and Legal Barriers to Enforcement

Despite a strong legal framework, implementation remains patchy. Multiple institutional and societal barriers contribute to legal non-compliance:

1. Cesarean Section Protocols: Health facilities often lack tailored IMD guidelines for cesarean births. The absence

of post-operative breastfeeding support, such as dedicated lactation nurses in recovery rooms, leads to routine delays, breaching Articles 6 and 11 of PP 33/2012.

2. Formula Marketing Violations: Health workers and facilities continue to breach Article 8 by distributing or recommending formula products. A 2018 nationwide study found formula company representatives accessing postpartum wards in violation of the International Code of Marketing of Breast-Milk Substitutes (WHO, 1981), to which Indonesia has formally committed.
3. Workplace Challenges: Employed mothers face difficulty sustaining exclusive breastfeeding due to:
    - Short maternity leave (3 months).
    - Inadequate lactation rooms (violating Minister of Health Regulation No. 15 of 2013).
    - Lack of time allocation for milk expression during work hours.
4. Limited Access to Justice: PP 33/2012 provides for administrative and disciplinary sanctions, but no dedicated judicial or ombudsman mechanism exists for mothers to report violations. Consequently, accountability remains elusive.
5. Cultural Misunderstandings and Family Pressure: In rural areas, traditional beliefs about early supplementation persist. Health workers report lack of community-level legal literacy about exclusive breastfeeding rights, limiting the practical enforceability of legal protections.
6. COVID-19 Disruptions: During the pandemic, reduced hospital capacity and movement restrictions further weakened IMD practices. No legal safeguards were activated to protect exclusive breastfeeding during emergencies, indicating a regulatory gap in crisis resilience.

2.4. Comparative Legal Insights and Best Practices

Globally, successful implementation of breastfeeding rights offers comparative models:

- Philippines: The Milk Code (EO 51) includes criminal sanctions and fines for formula violations. Enforcement via local government units (LGUs) and community-based monitoring led to a 40% reduction in illegal promotions.
- Norway: Near-universal IMD (98%) is supported by paid maternity leave of 49 weeks, Baby-Friendly Hospital Initiative (BFHI) compliance, and robust public education.
- UAE: Federal Law No. 3 of 2016 encourages breastfeeding until age two and imposes legal obligations on parents, though its punitive approach raised rights concerns.

Indonesia can learn from these models by localizing enforcement through Puskesmas, training midwives as breastfeeding rights monitors, and creating mobile complaint platforms to log hospital violations in real time.

2.5. Breastfeeding as a Justiciable Right

The legal recognition of breastfeeding as a justiciable human right is emerging globally. Courts in India and South Africa have linked breastfeeding to the right to life and dignity. Indonesia could follow suit by:

- Training judges and legal professionals on breastfeeding rights.
- Enabling public interest litigation by civil society groups for systemic violations.
- Integrating exclusive breastfeeding protections into the National Human Rights Action Plan (RANHAM).

Moreover, shadow reports to the CRC and CEDAW Committees should include data on breastfeeding violations, formula marketing, and discriminatory policies, ensuring international accountability.

2.6. Recommendations for Legal Reform

To close the enforcement gap, this paper proposes the following legal and policy reforms:

1. Amend PP 33/2012 to include specific IMD protocols for cesarean births, including:
    - Mandatory presence of trained lactation counselors post-operation.
    - IMD performance even under spinal anesthesia (unless medically contraindicated).
2. Enhance Maternity Protections by revising Labor Law No. 13/2003, aligning with ILO Convention C183:
    - Extend leave to 14 weeks minimum.
    - Provide enforceable lactation break provisions with penalties for employer non-compliance.
3. Strengthen Sanctions in PP 33/2012 by adding:
    - Monetary fines for facilities that permit formula marketing.
    - License suspensions for repeat violators.
    - Clear judicial review pathways for breastfeeding rights cases.
4. Digital Monitoring: Develop an IMD Compliance App for mothers to report violations anonymously, supported by Ministry of Health and NGOs.

Community Empowerment: Integrate breastfeeding rights education into PKK, Posyandu, and school curricula to normalize legal understanding from a young age

## *CONCLUSION*

The Majority SC deliveries (57.1%), Equal primipara/multipara (50.0%), 70.0% rapid onset, Significant parity-onset relation (p=0.000), Significant method-onset relation (p=0.000).

Legally, there is a relationship between lactation onset and parity/delivery method, necessitating better enforcement of PP 33/2012.

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