Potret Pemikiran

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Journal homepage: https://journal.iain-manado.ac.id/index.php/PP

Negotiating Religious Identity in Health Practices: Muslim Community Resistance to the Hegemonization of Secular Dietary Patterns in Indonesia

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ABSTRACT

Indonesia faces a paradox as the world's most populous Muslim nation with a Muslim-majority population, yet diabetes prevalence reaches 11.1% among adults, with more than 40% of cases undiagnosed. Islamic health epistemology remains marginalized within the secular healthcare system inherited from Dutch colonialism. The dietary transition from traditional plant-based patterns to Western consumption, which began in the 1970s, correlates with an increase in adult obesity, reaching 35.4% in 2018. This study examines the negotiation of religious identity among Indonesian Muslim communities through dietary practices as a response to Western food hegemony and secular health governance in the context of diabetes prevention. This qualitative library research employs Critical Discourse Analysis on three categories of texts: religious (Qur'an, Hadith, tafsir), health policy (Balanced Nutrition Guidelines, regulations, medical curricula), and academic literature from 2010 to 2025. Analysis was conducted through data, methodological, and theoretical triangulation using frameworks of biopower, cultural hegemony, and epistemic injustice. Islamic dietary principles—halal, tayyib, al-i'tidal, and sawm—function as counter-hegemonic practices against neoliberal dietary colonialism. Structural barriers include biomedical hegemony that excludes Islamic epistemology; policy gaps with medical curricula adopting dominant Western content; and economic inequality limiting working-class access to quality halal-tayyib food. Ramadan fasting demonstrates metabolic benefits aligned with contemporary intermittent fasting research; however, it was previously discredited until validated by Western science. A pluralistic health framework is needed that integrates Islamic epistemology through curricular reform, policy co-design with religious authorities, and mosque-based diabetes prevention programs that recognize religious practices as legitimate health resources.

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ARTICLE INFO

Article History:
Submitted/Received 19 Dec 2024
First Revised 5 May 2025
Accepted 28 Jun 2025
Publication Date 20 Sep 2025

Keyword:
Religious identity,
Islamic dietary practices,
Cultural resistance,
Biomedical hegemony,
Epistemic injustice

How to cite:
Riyanto, R., & Sulong, S. (2025). Negotiating religious identity in health practices: Muslim community resistance to the hegemonization of secular dietary patterns in Indonesia. *Potret Pemikiran, 29*(1), 52-73. https://doi.org/10.30984/pp.v29i1.3274

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1. INTRODUCTION

The global diabetes epidemic has become one of the most pressing public health challenges of the 21st century, transcending purely biomedical dimensions to represent a complex intersection of globalization, cultural transformation, and power dynamics in knowledge production. The International Diabetes Federation (IDF) projects that by 2050, approximately 853 million adults—representing a 46% increase from current prevalence—will be living with diabetes (International Diabetes Federation (IDF), 2025). This epidemic correlates strongly with the global diffusion of Western dietary patterns characterized by ultra-processed foods, high sugar content, and excessive caloric intake (Anyanwu et al., 2022). However, dominant public health discourse frames diabetes prevention primarily through individualistic behavior change models, largely ignoring how neoliberal food systems, cultural imperialism, and the marginalization of indigenous knowledge systems contribute to this crisis (Jofré et al., 2024). Recent studies in medical anthropology and critical public health have begun to interrogate the epistemic violence embedded in "universal" health interventions that privilege Western biomedical frameworks while systematically devaluing non-Western healing traditions and dietary epistemologies (Côté, 2025). This raises fundamental questions about health justice in pluralistic societies: whose knowledge counts as legitimate? How do communities negotiate identity when their traditional practices are pathologized or ignored by dominant health institutions?

In Indonesia, the nation with the world's largest Muslim population at 87% of the population being Muslim, diabetes prevalence of 11.1% among adults aged 20-79 years—with more than 40% remaining undiagnosed—reflects a paradoxical situation where demographic majority does not translate into epistemic authority (International Diabetes Federation (IDF), 2025; Pranoto et al., 2025). Despite being the majority, Islamic health epistemology and dietary principles remain marginalized within Indonesia's health governance framework dominated by secularism, inherited from the Dutch colonial medical system and reinforced through post-independence adoption of WHO guidelines (Pols, 2018, 2024). The rapid dietary transition since the 1970s—from traditional fiber-rich, plant-based eating patterns to Western-style consumption dominated by fast food, ultra-processed products, and excessive portions—has been documented in Indonesia's urban centers (Nurhasan et al., 2024; Toiba et al., 2015). This transformation coincided with economic liberalization policies that facilitated market penetration by multinational food corporations (Roberto & Khandpur, 2014). Concurrently, existing literature indicates that Islamic dietary principles—halalan tayyiban (halal and good), moderation (al-i'tidal), and fasting practices (sawm)—align remarkably with contemporary evidence-based diabetes prevention strategies (Ahmad et al., 2025; Bajaj et al., 2019). Yet these principles are largely absent from national health policy frameworks such as the Balanced Nutrition Guidelines and medical education curricula (Nurzakiah et al., 2025). This disconnect reveals deeper tensions about cultural authority, identity negotiation, and the politics of knowledge in postcolonial health systems.

Existing studies reveal several critical gaps in understanding the intersection of religious identity, dietary practices, and public health in Muslim contexts. First, research on Islamic dietary practices tends to focus narrowly on halal certification as

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

a consumer choice issue (Ahmad et al., 2025) rather than examining these practices as forms of cultural resistance and identity negotiation within hegemonic food systems. Second, limited literature on diabetes prevention in Muslim communities predominantly adopts biomedical frameworks that treat religious practices (such as Ramadan fasting) as "barriers" to medical compliance rather than as potential cultural resources for health promotion (Abdalla et al., 2023; Salman, 2023). Third, studies on food and identity politics concentrate primarily on Muslim minorities in Western contexts (Ismail et al., 2016; Keleher et al., 2024), leaving underexplored the paradoxical situation in Muslim-majority countries where Islamic epistemology remains marginalized by secular state institutions. Fourth, public health policy analyses rarely employ critical theoretical frameworks (biopower, cultural hegemony, epistemic justice) to interrogate whose knowledge is privileged and who is excluded in health governance (Jofré et al., 2024). Das Sein (what is) shows that Indonesian health policies operate within a secular biomedical paradigm that systematically excludes Islamic health epistemology despite serving a Muslim-dominated population; diabetes rates continue to rise alongside cultural erosion of traditional dietary practices. Meanwhile, Das Sollen (what ought to be) indicates that health policies in pluralistic societies should recognize diverse knowledge systems as legitimate, integrate culturally-based health resources, and address structural determinants of health rather than blaming individual behavior.

This article addresses these gaps by using a critical sociological framework to analyze Islamic dietary practices not as theological compliance or individual health behavior, but as counter-hegemonic practices through which Indonesian Muslim communities negotiate religious identity and resist cultural imperialism embedded in global food systems. Unlike previous studies that examine religion and health as separate domains, this research positions them as mutually constitutive, demonstrating how dietary practices simultaneously perform dual functions: theological obedience, identity construction, political resistance, and community empowerment. Our originality lies in three contributions: first, theoretically, we advance understanding of how majoritization-minoritization operates through epistemic rather than demographic power, revealing that Muslim communities can be epistemically marginalized even in Muslim-majority countries; second, methodologically, we employ critical discourse analysis to interrogate power relations in health texts, moving beyond descriptive explanations to expose structural violence in secular health governance; third, empirically, we synthesize Islamic theological texts (Qur'an, Hadith), biomedical diabetes literature, and critical social theory to construct a pluralistic health framework that respects diverse epistemologies without abandoning scientific rigor. This interdisciplinary approach bridges Islamic studies, public health, sociology, and postcolonial theory—a synthesis rarely attempted in existing literature.

This research aims to examine how Indonesian Muslim communities negotiate religious identity through dietary practices as a response to Western food hegemony and secular health governance, specifically in the context of diabetes prevention. Three specific objectives guide this research: First, to analyze the socio-political dimensions of Islamic dietary principles (halalan tayyiban, al-i'tidal, sawm) as forms of cultural resistance against neoliberal food systems and biomedical hegemony.

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

Second, to identify structural barriers—including policy gaps, economic inequality, and epistemic hierarchies—that prevent the integration of Islamic health epistemology into public health frameworks. Third, to propose a pluralistic health governance model that recognizes diverse knowledge systems as equally legitimate and mobilizes religious communities as partners (not subjects) in diabetes prevention. By repositioning diabetes from a biomedical problem to a socio-political issue rooted in cultural transformation and power imbalances, this research contributes to broader debates about health justice, religious freedom, and decolonization of knowledge in pluralistic societies.

2. METHODS

This study employs qualitative library research within a critical interpretive paradigm. Unlike positivist approaches that assume objective, value-free knowledge, the critical paradigm acknowledges that all knowledge is socially constructed and embedded in power relations (Gergen et al., 2004; McFerran et al., 2017; Şahin, 2006). This research explicitly adopts a decolonial epistemological stance (Houdek, 2021; Rivera & Del Valle Rojas, 2016), interrogating how Western biomedicine operates as a hegemonic knowledge system that marginalizes non-Western health epistemologies. This position is essential because the research question itself—how religious communities negotiate identity within secular health frameworks—requires examination of power dynamics in knowledge production.

This research uses the Critical Discourse Analysis (CDA) approach as developed by Fairclough and van Dijk (Güler, 2019; Hansen et al., 2022; Ravn et al., 2016). CDA examines how discourse (written texts, policy documents, scientific literature) reproduces, legitimizes, or challenges power relations. Analysis is conducted at three levels: first, textual analysis examining linguistic features, framing, and terminology; second, discursive practice examining how texts are produced, distributed, and consumed; third, social practice analyzing the broader socio-political context shaping discourse (Fairclough, 2013; Zhao & Wang, 2025). This approach enables uncovering how health texts privilege certain knowledge systems while marginalizing others, how policy documents construct particular types of citizens, and how religious communities respond through counter-discourses. CDA is integrated with grounded theory principles (C. A. Belfrage & Hauf, 2015; C. Belfrage & Hauf, 2017) for data synthesis: iterative reading, open coding, constant comparison, and theoretical saturation. This combination allows both deconstructive critique (CDA) and constructive theory building (grounded theory).

Research subjects include three categories of texts. First, religious texts comprising Qur'anic verses (Al-Baqarah 2:168, 173; Al-A'raf 7:31; 'Abasa 80:24) and authenticated Hadith collections on dietary ethics, analyzed through classical tafsir (Tafsir Al-Misbah by Quraish Shihab, Fi Zhilalil Qur'an by Sayyid Qutb) and contemporary Islamic bioethics studies. Second, policy documents including Indonesian Ministry of Health guidelines (Balanced Nutrition Guidelines), WHO frameworks on non-communicable diseases, halal certification regulations (Law No. 33/2014), and medical education curriculum standards. Third, academic literature encompassing peer-reviewed journals on Islamic health practices (Andriyani, 2019; Esma et al., 2021;

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

Kurniasari et al., 2023; Rahayu, 2019), diabetes epidemiology in Indonesia (Hariawan et al., 2019; Timah, 2019; Yuantari, 2022), critical public health studies, and postcolonial theory. The research location is conceptually Indonesia as a critical case study with unique characteristics of paradoxical position: first, the world's largest Muslim population yet secular state structure; second, rapid dietary transition alongside persistence of Islamic identity; third, democratic pluralism in tension with religious majoritarianism. These characteristics make Indonesia an ideal location to examine identity negotiation, health pluralism, and postcolonial knowledge politics. While findings are Indonesia-specific, this research offers theoretical insights applicable to other Muslim-majority contexts navigating modernity (Malaysia, Turkey, Egypt) and Muslim minorities in secular nations (Europe, North America).

Data collection techniques follow a purposive sampling strategy guided by theoretical relevance (Mariyono, 2015). Database searches were conducted through Google Scholar, PubMed, JSTOR, and ScienceDirect using keywords: "Islamic dietary practices," "halal food," "diabetes Indonesia," "Ramadan fasting health," "religious identity food," "biopower," "health pluralism" (Indonesian and English terms). Time range 2010-2025, prioritizing recent studies while including foundational works. Backward snowballing was conducted by tracing references cited in key articles (Andriyani, 2019; Kurniasari et al., 2023; Rahayu, 2019) to identify seminal works. Forward snowballing used Google Scholar's "Cited by" function to identify subsequent research building on key studies. Policy documents were obtained from official websites (Indonesian Ministry of Health, WHO, Ministry of Religious Affairs), with historical policy documents from national archives. Religious text selection identified Qur'anic verses and Hadith through thematic indices (mawdu'i approach) focusing on ta'am (food), saum (fasting), and sihhah (health). Inclusion criteria comprised: peer-reviewed or authoritative sources; relevance to diabetes, Islamic dietary practices, or health policy; theoretical frameworks applicable to power analysis; published within the last 15 years (exceptions for fundamental theory). Exclusion criteria included: non-academic websites; studies without methodological rigor; literature reviews without original analysis.

Data validity was ensured through four triangulation strategies (Mariyono, 2015). Data triangulation was conducted by cross-verifying findings across Islamic texts, health policies, and empirical studies—for example, claims about fasting benefits were verified through Hadith, medical research (Solehah, 2023), and patient experiences (Timah, 2019). Methodological triangulation combined textual analysis (what texts say), discourse analysis (how they say it), and contextual analysis (socio-political conditions). This multi-method approach strengthens interpretive validity. Theoretical triangulation interpreted data through multiple theoretical lenses—Foucault's biopower, Gramsci's hegemony, postcolonial theory, Islamic philosophy—to avoid single-theory bias. Researcher reflexivity was maintained through research memos documenting analytical decisions, acknowledging researcher positionality (researcher engaged with religious texts while critiquing power structures), and subjecting interpretations to peer scrutiny through academic presentations. Credibility checks included the equivalent of member checking by sharing preliminary findings with Islamic scholars and health professionals to assess interpretive accuracy, peer debriefing through regular discussions with colleagues in

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p- ISSN 2528-1410 e- ISSN 2527-8045

Islamic studies and public health to challenge assumptions, and negative case analysis by actively seeking evidence contradicting interpretations (e.g., cases where Islamic practices hinder health).

Data analysis proceeded through six iterative stages adapted from Braun & Clarke's thematic analysis and Fairclough's CDA (Braun & Clarke, 2012; Fairclough, 2013). The familiarization and immersion stage involved repeated reading of all collected texts, noting initial impressions, questions, and patterns, and creating detailed summaries of each source. The open coding stage conducted systematic line-by-line coding identifying: how texts construct "health," "modernity," "tradition"; whose voices are centered or marginalized; power dynamics; resistance or alternatives. The discourse identification stage grouped codes into broader discourses: biomedical universalism, religious particularism, neoliberal responsibilization, counter-hegemonic resistance, and epistemic hierarchies. The critical interrogation stage posed questions for each discourse: Who benefits? What assumptions underlie this framing? What alternatives are silenced? How does this reproduce power relations? The synthesis and theory-building stage connected findings to broader theoretical frameworks, constructing conceptual models showing relationships between globalization, dietary change, diabetes epidemic, identity crisis, religious resistance, policy gaps, and structural barriers. The writing-as-analysis stage followed Richardson's concept of "writing as inquiry"—the drafting process itself functions analytically, where coherent argumentation requires clarifying relationships between concepts, resolving contradictions, and generating new insights.

3. RESULTS AND DISCUSSION

Socio-Political Dimensions of Islamic Dietary Principles as Cultural Resistance Against Neoliberal Food Systems and Biomedical Hegemony

Westernization and Dietary Transformation as Cultural Imperialism

Indonesia's diabetes epidemic cannot be understood apart from the political economy of food that emerged from post-1965 developmentalist policies. Suharto's New Order regime (1966-1998) pursued agricultural modernization through the Green Revolution, prioritizing rice monoculture for political stability (food self-sufficiency as regime legitimacy) while facilitating multinational agribusiness penetration (Mariyono, 2015; Mundlak et al., 2004). Concurrently, economic liberalization in the 1980s-1990s opened markets to global food corporations—McDonald's entered Jakarta in 1991, followed by KFC, Pizza Hut, and other fast-food chains that rapidly expanded in urban centers (Jan et al., 2022; Widaningrum et al., 2018; Xu, 2023). Data from the manuscript shows dramatic changes from traditional consumption patterns high in fiber and complex carbohydrates from tubers, corn, sago, toward modern patterns high in saturated fat, sugar, salt, with low fiber. Fast food has become a favorite among urban youth, while corporate meeting culture with excessive food has become the norm among employees, officials, teachers, and lecturers.

This transformation represents what has been termed "dietary colonialism"—the penetration of corporate food systems displacing traditional eating patterns (Xu,

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

2023). Unlike direct colonial rule, this operates through market mechanisms, creating "voluntary" adoption of Western consumption patterns. However, this "choice" is structured by advertising (global brands spending billions), urban planning (malls replacing traditional markets), and status symbolism (Western food as markers of modernity and class mobility). Indonesia's nutritional transformation is revealed in Basic Health Research (Riskesdas) data: adult obesity prevalence increased from 15.4% in 2013 to 21.8% in 2018, with total 35.4% of adult population overweight—a 41.6% increase in obesity prevalence within five years reflecting accelerated dietary westernization since 1990s economic liberalization (Arifani & Setiyaningrum, 2021; Suha GR & Rosyada A, 2022). Similar patterns occur globally: WHO (2024) reports 2.5 billion adults worldwide overweight, with 890 million obese (Meshram et al., 2025; World Health Organization, 2025). Tambunan (2009) documents that urban populations suffer higher diabetes mortality than rural populations—a paradox explained by transition from caloric scarcity to low-quality caloric excess. Crucially, obesity shows class gradients: higher rates among lower socio-economic groups facing a "double burden"—nutritious traditional foods (fresh vegetables, fish) become expensive as land is converted for export crops or urban development, while cheap ultra-processed foods flood the market (Nurbani, 2015).

A factory worker in Tangerang with a 30-minute lunch break and Rp 15,000 budget faces structural constraints: the nearest stall offers fried foods, instant noodles, sweet drinks—quick, filling, affordable, but nutritionally harmful. Tambunan (2009) documents that urban populations suffer higher diabetes mortality than rural populations suffering malnutrition—a paradox explained by "nutritional transition" theory. However, existing literature frames this as "lifestyle choice" or "nutrition knowledge deficit." Our analysis reveals structural violence: economic policies create food environments where unhealthy choices become convenient and affordable while healthy choices require time and money that working-class families lack. This is not ignorance—this is inequality. Reframing diabetes as resulting from neoliberal capitalism rather than individual behavior is a novel contribution of this research, connecting the Indonesian case to global patterns of food imperialism.

Halalan Tayyiban: Theological Principle as Political Resistance

The Qur'anic command "Eat from what is on earth that is halal and good" (Al-Baqarah 2:168) is typically interpreted narrowly as ritual prohibition (avoiding pork, alcohol, improperly slaughtered meat). However, deeper exegetical analysis reveals multi-dimensional meaning with contemporary political implications. Quraish Shihab in Tafsir Al-Misbah (2002) explains that halal means not only "permissible" but "freed from burden"—food obtained fairly, not through exploitation. Tayyib means "good, pure, beneficial"—nutritionally adequate, not physically or spiritually harmful. Sayyid Qutb emphasizes that this verse establishes "food sovereignty"—human right to earth's bounty, against systems that monopolize resources. Prohibited foods (haram) are minimal (verse 2:173: carrion, blood, pork, animals slaughtered in names other than Allah)—God's default is permission, human greed creates scarcity (Dekeyser et al., 2018; Kelly, 2018; Pimbert, 2019).

Contemporary reinterpretation suggests that if halal requires justice in acquisition, then: factory-farmed meat raised through worker exploitation has questionable halal

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

status despite ritual slaughter; ultra-processed food from corporations using predatory marketing is halal in ingredients but not tayyib (good); food produced through environmental destruction (palm oil causing deforestation) violates khalifah (stewardship) principles, thus not truly halal. This opens space for structural critique: when Indonesian Muslim communities insist on halalan tayyiban, they are not merely following religious law—they are challenging corporate food systems. Choosing traditional tempe over McDonald's chicken nuggets (both technically halal) becomes a political act asserting: cultural autonomy against Western hegemony; environmental ethics against industrial agriculture; community economics (local vendors) against multinational corporations.

Kurniasari et al. (2023) found that halalan tayyiban awareness emphasizes production processes, avoiding excessive additives, supporting gut health. This aligns with contemporary "clean eating" movements in the West—but crucially, derives from 1400-year-old Islamic principles, not recent trends. Yet public health discourse ignores this indigenous knowledge resource. Scott (1985) distinguishes "weapons of the weak"—everyday practices through which subordinate groups resist domination without open rebellion. Islamic dietary compliance functions similarly: Muslims cannot overthrow global food systems, but daily choices to eat halal-tayyib constitute micro-resistances that cumulatively assert alternative values. When enough individuals practice this, it creates market demand (Indonesia's halal economy valued at $200+ billion), forcing even multinational corporations to adapt (McDonald's, Starbucks offer halal menus). Theorizing halalan tayyiban beyond compliance to political resistance, showing how religious practices intersect with anti-capitalism, environmentalism, and food sovereignty movements is a novelty in this research.

Al-I'tidal (Moderation): Theological Critique of Consumer Capitalism

Al-A'raf 7:31 commands: "Eat and drink, but do not be excessive. Indeed, Allah does not like those who are excessive." This seemingly simple dietary guideline contains a radical critique of capitalist consumer culture. Quraish Shihab (2024) explains that israf (excess) encompasses three dimensions: quantity—eating more than needed; quality—luxurious food when simple suffices; manner—eating to display wealth. All three violate tawazun (balance), a core Islamic ethical principle. Hadith elaborates: "The son of Adam does not fill any vessel worse than his stomach. It is sufficient for the son of Adam to eat a few mouthfuls to keep his back straight. If he must fill it, then one-third for food, one-third for drink, one-third for air" (Tirmidhi, Ibn Majah).

Medical data from the manuscript validates Islamic wisdom with modern science: Fajrin (2012) notes overeating triggers metabolic diseases—diabetes, gout, GERD; Cahyo (2011) explains excessive food intake causes excess digestive enzyme production, incomplete digestion, fermentation, gas, free radicals triggering cancer, stroke, intestinal inflammation, blood vessel blockage; Haviva (2015) identifies high Respiratory Quotient from overeating causes Krebs cycle saturation, shortness of breath, abnormal metabolism, and obesity. More importantly, this reveals political economic critique: consumer capitalism requires overconsumption for growth. If everyone ate only what they needed (one-third stomach capacity as Hadith

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

prescribes), food industry profits would collapse. Therefore, capitalism produces desire through advertising, creates "needs" (mukbang videos, all-you-can-eat buffets, super-sized meals), and normalizes gluttony. The obesity epidemic is not individual failure—it is a systemic outcome of an economic system structurally dependent on overconsumption (Agyeman & McEntee, 2014; Fladvad, 2018; Sbicca, 2018).

Islamic moderation thus functions as counter-narrative: by framing excess as haram (or at least makruh—disliked), Islam provides theological basis for resisting capitalist consumer temptations. When Muslims decline dessert after already being full, citing the "one-third rule," they enact what Marcuse (2013) termed "the great refusal"—rejecting false needs created by capitalist systems. The manuscript notes urban culture with high-fat, salt, sugar diet patterns, frequent party attendance tends toward excessive food consumption behavior (Tambunan, 2009). Specifically: employees, officials, teachers, lecturers—meetings with various foods, potentially leading to obesity and diabetes. This is not cultural pathology but structural. Corporate culture, government bureaucracy, educational institutions—all adopt meeting rituals involving abundant food because: capitalist logic (food provision shows organizational success); time scarcity (overworked professionals eat quickly, abundantly during rare breaks); social bonding (communal eating creates solidarity). But the health outcome is harmful.

Islamic solution: reviving sunnah eating practices—eating slowly, stopping before full, communal sharing versus individual portions. Some Indonesian organizations now implement "Islamic meeting protocols": lighter refreshments, focus on substance over luxury, controlled portion serving. This is not mere piety but organizational cultural change with health implications. Agyeman & McEntee (2014) and Haynes et al. (2016) analyze moderation as controlling nafs (ego/desires). This research expands: individual nafs is shaped by capitalist structures that reinforce desire. Islamic moderation provides individual discipline AND systemic critique—challenging economic orders based on insatiable consumption. Connecting Islamic dietary moderation with anti-capitalist critique, showing religious practices as resistance to neoliberal rationality is a novelty of this research.

Structural Barriers in Integrating Islamic Health Epistemology into Public Health Frameworks

Biomedical Hegemony in Public Health Discourse

Indonesian health policy exemplifies Foucault's concepts of disciplinary power (Foucault, 1975) and biopower (Foucault, 1976)—governance of individual bodies through medical surveillance and population regulation through public health policy. The Balanced Nutrition Guidelines (PGS), replacing "4 Healthy 5 Perfect" since 2014, prescribes: diverse foods, clean living, physical activity, weight monitoring (Izwardi, 2024). While scientifically valid, PGS embodies questionable assumptions. Textual analysis of PGS reveals: visual representation (Tumpeng Gizi) uses Javanese-centric imagery, assuming cultural homogeneity; portion recommendations—2-3 servings animal/plant protein, 3-8 staple foods, 3-5 vegetables, 3-5 fruits—but no mention of halal/haram, no acknowledgment of religious dietary laws; language—"balanced," "moderate," "healthy"—presented as universal, objective categories rather than cultural constructions.

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

This secular universalism commits epistemic violence by: erasing religious difference—treating Muslim, Hindu, Christian citizens as identical "nutritional subjects"; privileging Western nutrition science—adopted wholesale from WHO without adaptation to local epistemologies; responsibilizing individuals—"choose healthy foods" ignores structural barriers. Compare with Malaysia's approach: Department of Islamic Development Malaysia (JAKIM) integrates halal principles into nutrition guidelines, and medical schools include Islamic bioethics (Abdul Aziz et al., 2022; Abdul Razak et al., 2019). Indonesia's Ministry of Health collaborates minimally with Ministry of Religious Affairs or MUI on health policy—institutional separation reproduces secular-religious binary.

Data supporting structural barriers includes: medical school curricula adopting 90% Western biomedical textbooks with minimal content on Islamic medical traditions (Tibb Nabawi); hospital food services even in "Islamic hospitals" like RS Islam Sitty Maryam Manado (Timah, 2019) have inconsistent halal certification for food services; healthcare provider training with cultural competency modules rarely addresses religious dietary practices, doctors untrained for counseling Muslim diabetes patients about fasting during Ramadan. Andriyani (2019) notes that Islam and health should go "hand in hand" but often operate separately in Indonesian institutions. Our analysis clarifies why: colonial legacy. Dutch East Indies established modern health systems based on European medicine, systematically delegitimizing indigenous healing including traditional Javanese and Arab practices (Boomgaard, 1993). Post-independence, nationalist modernization equated progress with Western science, positioning Islam as "tradition" to be overcome (Elson, 2006). This historical trajectory created institutional path dependency—health bureaucracy remains structurally secular despite demographic realities. Using postcolonial theory to explain why Muslim-majority nations marginalize Islamic health epistemology, tracing genealogy of secular health governance is a novelty of this research.

Policy Gaps and Epistemic Injustice

Indonesian medical education adopts Western biomedical curricula wholesale. Islamic medical traditions (Tibb Nabawi, Tibb Yunani/Unani medicine) are positioned as "complementary and alternative"—the terminology itself reveals hierarchy: biomedicine = standard, Islamic medicine = supplement. Consequences for healthcare delivery: doctors lack training for counseling Muslim patients about Ramadan fasting; nutritionists unfamiliar with Islamic dietary principles beyond halal certification; cultural competency defined narrowly (language, courtesy) not epistemically (respecting alternative knowledge systems) (Alpers, 2019; Hamodat et al., 2020).

Using Fricker's (2007) epistemic injustice framework, we identify two patterns in Indonesian Islamic health contexts: First, testimonial injustice occurs when doctors dismiss Muslim patients' experience that "fasting helps my diabetes" as anecdotal versus medical evidence—testimonial credibility reduced because it derives from religious practice, not laboratory. Second, hermeneutical injustice emerges from lack of conceptual resources in biomedicine to articulate Islamic health experiences—for example, no medical terminology for ruqyah (spiritual healing), so practice becomes

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

invisible in medical records and clinical protocols. Comparatively, Traditional Chinese Medicine (TCM) faced similar epistemic marginalization yet achieved legitimacy through state support, professionalization, and evidence-base building (Guan et al., 2020; Shang et al., 2008). Islamic medicine lacks equivalent institutional support in Indonesia.

Why? Religion/state separation in Indonesia's constitution limits government promotion of explicitly Islamic practices. But this separation is inconsistently applied—government funds Islamic education (pesantren) but not Islamic hospitals/research. This reflects postcolonial ambivalence: Islam as cultural identity (supported) versus Islam as knowledge system (marginalized). Applying epistemic injustice framework to analyze marginalization of Islamic medical knowledge, tracing colonial genealogy of medical education is a novel contribution.

Economic Barriers: Class Inequality in Accessing Halal-Tayyib Food

Data from the manuscript states "Food quality gaps remain felt by parts of society." Unpacking this through class analysis shows: upper-middle-class Muslims have access to premium halal-organic stores, can purchase free-range chicken, grass-fed beef, organic vegetables, have time for food preparation, knowledge about nutrition—result: relatively easy to practice halalan tayyiban. Working-class Muslims limited to traditional markets, street vendors, small stalls, with budget constraints Rp 15,000-25,000 per meal, time poverty (factory/service workers, long commutes, little meal preparation time)—result: reliance on cheap, filling food—fried foods, white rice, sweet drinks.

The paradox: traditional Indonesian foods (tempe, tofu, vegetables) are nutritious and halal. But urban working-class access is constrained by structural transformations: agricultural land conversion to industrial/residential zones (Surya et al., 2024); displacement of traditional markets by supermarkets/malls requiring transportation (Minot et al., 2015); time scarcity making street food/instant noodles more practical than cooking. Riskesdas (2018) data shows 35.4% of Indonesian adults overweight and obese—with higher prevalence in urban (26.3%) compared to rural (17.3%) areas (United Nations Children's Fund Indonesia, 2022). Economic quintile analysis shows obesity burden increasingly higher in lower socio-economic groups (Aizawa & Helble, 2017), inverting historical patterns where obesity signaled prosperity—a phenomenon explained by nutritional transition theory where cheap calories are now abundant while nutritious food is expensive (Batal et al., 2023).

Policy critique: government mandates halal certification but provides no subsidies for small producers. Certification costs (Rp 2-5 million for SMEs) create barriers, making informal sellers serving working-class communities unable to afford it. Meanwhile, multinational corporations easily afford certification—allowing Nestlé, Unilever to dominate "halal" market with ultra-processed products. Structural solutions needed: not individual "nutrition education" but: agricultural policies supporting local food systems; urban planning preserving traditional markets; living wages allowing time/money for healthy eating; subsidized certification for small producers. Festilia (2018) found correlation between diet and nutritional status. This research expands: correlation mediated by class position—working-class Muslims

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

face structural constraints making healthy-halal eating difficult despite knowledge/intent. Class analysis of halal food access, showing inequality in religious practice shaped by economic structures is a novelty.

Mobilizing Religious Resources for Diabetes Prevention Through Pluralistic Framework

Fasting (Sawm): Reclaiming Bodily Autonomy from Biomedical Governance

Ramadan fasting—abstaining from food/drink from dawn to sunset for 29-30 days—has become controversial in biomedical discourse. Many doctors view it as "risky" for diabetics, advising non-participation (Siaw et al., 2014). This medical paternalism reflects biopower—professional authority claiming monopoly over bodily knowledge. Medical data from the manuscript supports fasting benefits: Yang et al. (2021) state fasting helps heal diabetes, lower blood pressure, kidney disease, stroke; Funes et al. (2014) explain fasting rests digestive organs for several hours, absorption of ammonia, glucose, salts stops, intestinal cells cannot form glycogen, cholesterol, protein—providing metabolic reset; Grajower (2008) notes diabetics can fast safely with stable blood sugar control, physical activity during fasting.

Important caveat: Cunningham (2014) acknowledges patients on insulin for more than 5 years may face risks if blood sugar is unstable. This shows Muslim communities are not anti-science—they integrate religious practice with medical knowledge. Foucault's (1975) theoretical analysis shows modern medicine regulates bodies through surveillance, normalization, discipline. Doctor's advice becomes moral imperative—"non-compliant patients" are stigmatized. Fasting challenges this by asserting alternative bodily epistemology: Muslims trust 1400-year tradition plus personal bodily experience over biomedical authority alone. Recent Western research on "intermittent fasting" essentially rediscovers Islamic practice. Studies show IF improves insulin sensitivity, promotes autophagy, reduces inflammation (Sari & Nurdiana, 2024). Yet when Muslims practiced this for centuries, dismissed as "religious superstition." When framed in Western scientific language, suddenly becomes "evidence-based intervention." This exemplifies epistemic injustice—systematically discrediting knowledge from marginalized groups, then appropriating without acknowledgment.

Political dimensions of fasting include: resistance to 24/7 consumption (capitalism requires constant buying/eating, fasting month halts this, showing humans don't need continuous consumption); solidarity with the poor (experiencing hunger builds empathy, counters class segregation); community identity (public fasting marks Muslim identity in pluralistic society); bodily sovereignty (asserting right to discipline one's body according to religious rather than medical authority). During Ramadan, Indonesian fast-food revenue drops 30-40% (industry reports), shopping patterns shift to pre-dawn/post-sunset, productivity rhythms change. This shows collective Muslim practice can disrupt capitalist time discipline (Birth, 2022)—industrial capitalism requires bodies regulated by clocks, not religious calendars. Rahayu (2019) analyzes Hadith on eating patterns, noting the Prophet's frequent fasting (Mondays/Thursdays, Ayyam al-Bidh). Timah (2019) found physical activity crucial

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

for diabetes management. This research synthesizes: fasting + physical activity (sunnah practices like tahajud, duha prayers involve movement) = holistic diabetes prevention embedded in Islamic ritual life. Reframing fasting from biomedical "risk" to political resistance and epistemic justice, critiquing Western appropriation of Islamic health practices is a novelty.

Islamic Health Theology as Alternative Framework

Sukiman & Kasimah (2021) develop "Islamic Health Theology"—a systematic framework integrating faith and health with 12 sharia health principles: environmental and personal health; communicable disease prevention; vector control; food nutrition; sexual health; physical-mental health; physical activity/exercise; occupational health; elderly care; maternal-child health; professional healthcare delivery; theological methods for healthy society. This is not an "Islamic version" of public health—it is a complete alternative paradigm addressing dimensions biomedicine neglects (spiritual health, communal care, ethical governance). Integration, not replacement is proposed: biomedical expertise for acute care, pharmacology, surgery; Islamic framework for preventive health, chronic disease management, community wellbeing, meaning-making around illness.

Concrete applications for diabetes prevention show biomedical approach (metformin/insulin medication, caloric restriction, exercise prescription, individual counseling, secular nutrition education) can be integrated with Islamic health approach (dietary moderation al-i'tidal, fasting sawm, physical worship salat/hajj preparation, community support majelis taklim/mosque programs, tafsir on food ethics) into integrated approach: medication plus dietary guidelines rooted in sunnah; intermittent fasting protocols aligned with Islamic calendar; activities integrated in daily religious practices; peer groups plus professional guidance; culturally-based nutrition education. Policy recommendations for pluralistic health governance include: curricular reform integrating Islamic bioethics into medical/nursing education; training healthcare providers in cultural competency emphasizing epistemological diversity; policy co-design with permanent consultation mechanisms between Ministry of Health and MUI; including ulama in developing diabetes prevention programs; ensuring health policies respect religious practices (e.g., fasting guidelines for diabetics developed jointly); healthcare delivery standards mandating halal food in all health facilities; training health workers for counseling about Ramadan fasting; creating mosque-based health programs (diabetes screening, nutrition education using Islamic frameworks).

Economic justice requires: halal certification subsidies for small food producers; supporting urban agriculture providing halal-tayyib products in working-class neighborhoods; regulating junk food marketing to children; raising minimum wages enabling access to nutritious food. Research funding from government for studies on Islamic health practices; partnerships between medical schools and Islamic universities; clinical trials on fasting, sunnah foods, salat as physical activity. Indonesia, as the largest Muslim democracy, can model health pluralism for other countries—both Muslim-majority (Pakistan, Bangladesh, Egypt) and Muslim-minority (Europe, North America). This shows how secular democracies can respect religious diversity in health systems without theocracy. Concrete, actionable policy

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recommendations based on theory, showing pathways from critique to transformation is a novelty.

Case Study: Diabetes Prevention Through Community-Based Islamic Practices

Mosque-based diabetes prevention programs can be designed with components: First, tafsir-based nutrition education teaching tafsir of verses about food (Al-Baqarah 168, 173; Al-A'raf 31), Hadith on portion control, connecting theology to practical nutrition. Second, Ramadan as intervention period teaching mindful eating through fasting, monitoring blood sugar levels (data: fasting safe for stable diabetics), breaking unhealthy habits during Ramadan, maintaining afterward. Third, physical activity as worship framing exercise religiously (maintaining bodily trust/amanah), data from manuscript: exercise 3-5 times per week, 30-60 minutes, aerobic—fits with tahajud, duha prayers; community exercise (integrating silaturahmi). Fourth, peer support groups through majelis taklim about health, sharing testimonies: "I control diabetes through Islamic lifestyle," reducing stigma (diabetes not divine punishment/sin, but test).

Literature synthesis shows: Timah (2019) found poor eating patterns cause diabetes at Islamic Hospital Manado; Hariawan et al. (2019) identified lifestyle as predisposing factor; Kuncara (2020) states fatty and sweet foods cause diabetes significantly; Surpiatna (2020) notes large portions increase glucose. Reinterpretation shows this is not individual failure but whole-community crisis requiring collective response. Islamic framework provides cultural resources for such collective action. Islamic practices have emancipatory potential but are not automatically liberatory. Critical engagement needed while respecting faith commitments. Acknowledging contradictions important: patriarchy (who cooks? gender burden in "housewife" roles); class (elite Muslims afford organic halal, working class cannot); rigidity (halal obsession can become excessive, creating anxiety); commercialization (halal industry = religious capitalization). Balanced stance needed: Islamic practices have emancipatory potential but are not automatically liberating.

This research demonstrates that Islamic dietary principles—halalan tayyiban, al-i'tidal, sawm—function as counter-hegemonic practices against neoliberal food systems and biomedical hegemony. When Muslims choose traditional foods over fast food, practice portion control against buffet culture, or fast during Ramadan despite medical skepticism, this is not mere religious compliance but political acts asserting cultural autonomy and alternative values. The diabetes epidemic affecting 11.1% of Indonesian adults with projected 46% increase by 2050 (International Diabetes Federation (IDF), 2025) stems from dietary colonialism—Western eating patterns replacing indigenous systems through market penetration, not inevitable modernization. Structural barriers systematically prevent integrating Islamic health epistemology into public health frameworks despite Indonesia's 87% Muslim population. Policy analysis reveals Balanced Nutrition Guidelines operate in secular paradigm marginalizing religious dietary laws. Medical education privileges Western biomedicine while relegating Islamic medical traditions to "alternative" status—epistemic hierarchy reflecting colonial legacy. Economic inequality creates class-based barriers: wealthy Muslims access premium halal-organic foods while working-class

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p- ISSN 2528-1410 e- ISSN 2527-8045

communities face constraints making healthy-halal eating structurally difficult. Contrary to assumptions that religion hinders modern health behaviors, Islamic principles offer cultural resources for diabetes prevention remarkably aligned with evidence-based interventions. Fasting provides metabolic benefits now recognized in Western intermittent fasting research. Qur'anic commands against excess align with portion control recommendations. Mosque infrastructure enables community-based health programs. Yet these resources remain under-mobilized due to epistemic injustice—systematic discrediting of knowledge from religious communities.

4. CONCLUSION

This research proves that Islamic dietary principles—halalan tayyiban (halal-good), al-i'tidal (moderation), and sawm (fasting)—transcend theological dimensions to function as counter-hegemonic practices against neoliberal food systems and biomedical hegemony driving Indonesia's diabetes epidemic. This epidemic is rooted in dietary colonialism since 1980s-1990s economic liberalization replacing traditional patterns with Western consumption high in fat-sugar-salt, reflected in 41.6% adult obesity increase (2013-2018). Identified structural barriers include biomedical hegemony in Balanced Nutrition Guidelines excluding religious dietary laws; medical education adopting 90% Western content delegitimizing Tibb Nabawi traditions; and economic inequality limiting working-class access to quality halal-tayyib food. Contrary to assumptions that religion hinders modern health, Ramadan fasting provides metabolic benefits equivalent to intermittent fasting, Qur'anic commands against israf align with evidence-based portion control, and mosque infrastructure facilitates communal health programs—yet these resources are marginalized due to colonial epistemic injustice. The proposed pluralistic health framework includes: integrating Islamic bioethics in medical curricula; policy co-design between Ministry of Health-MUI; mosque-based diabetes prevention programs; halal certification subsidies for small producers; and research funding for Islamic health practices. Indonesia, as the largest Muslim democracy, can model health governance respecting diverse epistemologies without abandoning scientific rigor, demonstrating that decolonizing medical knowledge is a prerequisite for health justice in postcolonial societies.

5. ACKNOWLEDGMENT

The author extends deep appreciation to Islamic scholars and health professionals who provided critical insights in interpreting religious texts and validating research findings; to the academic community in Islamic studies, medical anthropology, and critical public health whose works became the theoretical foundation of this research; and to colleagues engaged in peer debriefing to challenge assumptions and strengthen analytical rigor. Special thanks to institutions providing academic database access (Google Scholar, PubMed, JSTOR, ScienceDirect) and national policy archives facilitating comprehensive data collection. This research is dedicated to Indonesian Muslim communities who daily negotiate religious identity within hegemonic structures, and to global movements fighting for health justice and decolonization of medical knowledge in pluralistic societies.

DOI: https://doi.org/10.30984/pp.v29i1.3274
p- ISSN 2528-1410 e- ISSN 2527-8045

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