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The Mechanism of Panopticism and Society's Resistance to the Modern Healthcare System: A Study on Reactions to Power Relations in the Medical World

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ABSTRACT

Panopticism in the medical world reflects a structural dominance of power. Panopticism takes the form of medical regime authority aimed at surveillance, regulation, and discipline to frame the thoughts and actions of individuals in line with modern health standards. The issue is that panopticism doesn't always work effectively according to the desires of the medical regime. Therefore, this study aims to analyze the mechanisms of panopticism and identify the spectrum of resistance to the modern healthcare system. Using an applied method, the study found resistance in modern health practices, namely: (a) accessing modern treatment but accompanied by skepticism and criticism of modern medicine; (b) developing a pluralistic or combinative medical orientation; (c) opting out and constructing alternative discourses about the healthcare system following autonomy of will and power. Health resistance is triggered by skepticism and distrust, asymmetrical relations based on scientific authority, limited access to modern medical products, and the existence of informal networks, as well as the strong role of local social and cultural figures in directing the choices of healthcare systems for the community.

Keywords: *Health Resistance; Modern Medicine; Panopticism; Power Relations*

1. Introduction

Historically, the evolving medical orientation in society cannot be dissociated from the development of civilization in thought and culture. Contests against healthcare systems persist until today. Treatment systems rooted in belief systems and traditions, where explanations for health issues are consistently tied to the non-material world, and treatment systems of a supernatural nature still exist (Murray & Murray, 1985). On the other hand, treatment systems based on the principles of rationality and the advancement of science, relying on modern medical technology, continue to be introduced to society by medical regimes.

The Age of Enlightenment, characterized by independence/individualism, rational thinking, and advances in diagnostic technology, led to the development of modern medical systems. This development allowed the human body to be studied as an object of medical science. The progress in diagnostic technology since the Enlightenment has furthered the advancement of medical science and serves a crucial role as medical instruments in explaining everything happening within the human body (Yen, 2009).

1.1. The Development of Medical Practices in Indonesia

History records that the medical regime in Indonesia has long been constructing and internalizing modern medical values in society, starting from the pre-independence era, the era of the old order, the new order, and the reform order. Before independence, the construction and internalization of modern health values were institutionalized through practical medical activities and the establishment of medical institutions such as the founding and development of medical schools, modern medical facilities, the establishment of medical laboratory centers, and medical training and research supporting the development of the modern medical treatment system (Notoatmodjo, 2005). During the old-order government era, the medical regime established the modern treatment system by developing community health (Health Centers), which laid the foundation for the community health service system or Puskesmas (Community Health Center). In the new order era, the socialization and internalization of the modern medical treatment system were widely disseminated through various health programs to improve the Puskesmas and Integrated Service Posts or Posyandu.

Modern health values during the reform era were institutionalized through health promotion activities in the form of appeals, invitations, and directions for the public to apply and develop concepts and healthy living behaviors following modern values through health institutions and government agencies supported by Non-Governmental Organizations (NGOs). Advocacy activities, health communication, and social mobilization were actively carried out by the legislative, executive, and general public to improve the public health status and realize the vision of Healthy Indonesia. This fact indicates that in the reform era, followed by regional autonomy policies and decentralization of central authority to regions, the political process of reproducing and internalizing modern medical values and modern health services continues to be carried out and fought for (Political Health) by involving various elements, both government and community elements such as the legislative, NGOs, community leaders, social organizations, and others as a form of local community support system for health development programs carried out by the medical regime.

The latest development in the process of constructing and internalizing modern health values is marked by the issuance of Presidential Regulation Number 72 of 2012 concerning the National Health System (Sistem Kesehatan Nasional or SKN), which aims to organize health development conducted by all components of the nation, including the Government, Local Government, and/or the community, including legal entities, businesses, and private

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institutions in a synergistic manner, to be effective and efficient, thus achieving the highest possible public health and the welfare of the people as stipulated in the 1945 Constitution. Institutional strengthening strategies are also pursued by organizing and optimizing the roles of health institutions such as hospitals, community health centers (Puskesmas), sub-health centers (Polindes), health clinics, medical and paramedical personnel, as well as social and community organizations to support efforts to socialize and internalize modern medical values.

1.2. The Problems and Power of the Regime in Medical Practices in Indonesia

Although comprehensive and adequate modern healthcare facilities have been provided, the reality is that the medical regime still faces numerous health problems. Cases such as infant mortality, maternal mortality, pulmonary TB, toddler pneumonia, dengue fever, infants with low birth weight (LBW), toddlers with poor nutritional status, and other medical cases indicate that modern medical methods still encounter issues. From a regulatory perspective established by the medical regime, it seems universal. It neglects class boundaries, not considering marginalized or impoverished groups that often face complex issues when accessing the modern healthcare system and thus require different treatment.

Based on the initial data collected in the research, various problems were found that the community faces when accessing the modern healthcare system, including expensive treatment costs, limited information about modern medicine, unprofessional and discriminatory attitudes of medical personnel, complicated modern health bureaucracy, doubtful effectiveness of modern treatment, and so on. A private doctor stated that the modern healthcare system can still not accommodate the interests of service and treatment for the entire population. In reality, many people still consume traditional remedies, acupuncture, massage therapy, and various other forms of treatment.

Impoverished individuals encountered in the early stages of the research expressed disappointment when accessing medical institutions (Community Health Centers) and dealing with health bureaucracy. They reported facing discriminatory treatment, with healthcare workers stating that medicines were unavailable and responding with shouts and rough treatment during treatment. Cases of the modern medical treatment system not favoring marginalized groups were also experienced by a hospital patient who mentioned that the modern healthcare system still suffers from bureaucratic diseases, such as convoluted procedures and a lack of justice principles.

1.3. A New Path towards More Democratic Medical Practices

For the community members, the choice of a healthcare system cannot be entirely simplified through regulatory formulations, the completeness of healthcare facilities, and the ease of treatment costs conceived by the medical regime. Despite being accommodated through regulations and funding from the government, the impoverished, as a marginalized community in the city, require medical services that are non-discriminatory (fair), responsive, easily accessible in terms of both bureaucratic services and costs, and have high treatment effectiveness. In this context, the impoverished have long faced unfavorable situations such as physical and economic weaknesses, vulnerability, isolation from developmental access, and often lack strength and bargaining power, especially when interacting with higher social classes, including encounters with medical and paramedical personnel during examinations, treatments, and medical care at hospitals, health centers, and integrated health posts.

In practice, it is not uncommon for the impoverished to encounter less advantageous conditions, such as limited access to healthcare facilities, such as generic drugs and lower-class

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medical care, and the unfriendly and often unfair behavior of healthcare personnel. They are also frequently isolated from obtaining information about modern medical services. Suppose these conditions persist and increasingly harm their lives. In that case, it is not unlikely that resistance will arise from the community members, leading to the emergence of discourse or new alternatives regarding the chosen healthcare system following their autonomy.

The social reality in medical practice shows that modern medical treatment, based on the spirit of modernity, still faces problems that can generate discourse or counter-social practices as a response to the failure of the modern healthcare system experienced by the community. This study aims to criticize and formulate solutions expected to prevent the medical regime from the phenomenon of "voice and exit" carried out by the community and anticipate and respond to the weakening trust (low trust) of civil society in the performance of the medical regime. To achieve these goals, this study also evaluates the panopticism mechanism implemented by the medical regime in the modern healthcare system and the forms and impacts of resistance emerging against the access modern healthcare system by the community.

2. Literature Review

2.1. Low Accessibility of Medical Services Based on Social Status

A study conducted by Indonesia Corruption Watch (ICW), a non-governmental organization focusing on several Public Health Insurance cardholders in Jabodetabek (Jakarta Metropolitan Area or Greater Jakarta) using the Citizen Report Card (CRC) method, found that hospital services for impoverished patients face serious issues. These include hospital patient rejections for reasons such as full capacity, incomplete patient administration, inadequate patient handling equipment, a lack of specialist doctors, etc. Additionally, ICW's research indicates the presence of fees in the health administration process, perceived arrogant and unresponsive attitudes from hospital authorities, inadequate responses to patient complaints, and discriminatory treatment towards impoverished patients who express concerns about hospital services, such as being ignored or hindered (Putra, 2010).

A previous study conducted by the Surabaya City Planning Agency in 2011 still found obstacles the community faces in accessing modern medical services, including factors such as costs, the quality of health services, a strong belief in tradition, and success in the treatment process. As many as 71% of respondents stated they faced economic issues in accessing modern health services, not only related to the cost of disease treatment but also additional expenses incurred by families when a family member is ill. Moreover, 66% of respondents felt that the quality of available health services was still inadequate, hindering their access to affordable health services (Badan Perencanaan Pembangunan Kota Surabaya, 2011). The study also found that 37% of respondents still used traditional or folk medicine systems derived from folk culture (Foster & Anderson, 2009). This indicates that belief in tradition is an important consideration for the community in accessing health services. Despite receiving modern medical services at hospitals, health centers, or clinics, 44% of respondents expressed dissatisfaction with the treatment results they received from the modern medical system (Badan Perencanaan Pembangunan Kota Surabaya, 2011).

2.2. Injustice in Modern Medical Practices in Indonesia

Susanto (2010) also portrays the social reality in the medical world. He finds that modern medical services in this country are still not fully in line with the principles of justice and have not placed the social mission or social orientation in a primary position. Cases of patient rejection by a hospital due to a lack of upfront payment guarantees, the hostage-taking of

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patients and their families by the hospital due to the inability to pay for medical expenses, the detention of babies by hospitals because parents cannot afford childbirth costs, the abandonment of patients by hospitals because there is no guarantee of medical and treatment costs, the rising prices of drugs and issues of medical malpractice are some problematic health realities still quite prevalent in this country. Despite this, referring to international conventions, the constitution, and national legislation, every citizen should receive constitutional rights and guarantees to access health services and social security. Therefore, the state is responsible for providing healthcare facilities. More specifically, the rights and obligations of Indonesian citizens in the context of healthcare are also regulated in Law Number 36 of 2009 concerning Health, which regulates the rights, obligations, and responsibilities of the government related to the implementation of health efforts that are equitable and affordable for the public (Mahfud, 2010).

3. Research Methodology

This study is an applied research aimed at examining the phenomenon of community resistance to modern medical treatment and understanding and analyzing the panopticism mechanism within the medical regime. The research was conducted in three regions in East Java, namely Pamekasan Regency, representing Madurese culture; Surabaya City, representing urban characteristics; and Ponorogo Regency, characterized by agricultural villages with Mataraman culture. In these areas, the community has accessed modern medical treatment. It is familiar with facilities such as hospitals, community health centers (Puskesmas), health clinics, integrated health service posts (Posyandu), and traditional treatments provided by traditional healers.

This study conducted interviews with 150 individuals, of which 30 subjects underwent in-depth interviews using interview guidelines. Data were also collected from various sources, such as healthcare professionals (personal health) representing the medical regime, medical representatives, community leaders, and traditional healers. The method used is a Mixed Methods approach, where data were collected through direct interviews using two instruments: interview guidelines and questionnaires. Interviews were conducted directly and guided by a pre-prepared structured questionnaire. The classified data were then analyzed and interpreted theoretically. The data analysis process was carried out using both qualitative and quantitative methods. The quantitative method, in the form of statistical analysis, was also performed using the SPSS software. Meanwhile, the qualitative method was implemented through three stages: data reduction, data display, and drawing conclusions or verification.

4. Results and Discussion

4.1. Access to Modern Medical Treatment

Access to modern medical treatment is crucial to be narrated as, based on their experiences in accessing modern medical care, the history of their resistance process can be traced. Conceptually, access to modern medical treatment is defined as the ease of using modern healthcare facilities according to their needs. The ease of access to modern medical treatment is related to several conditions, including residential distance, travel time to healthcare facilities, and socio-economic and cultural status (Kementerian Kesehatan Republik Indonesia, 2018). If there is discrimination or injustice in accessing medical institutions, it will result in the growth of health disparity.

Conceptually, access to modern medical services can be grouped into three categories (Eryando, 2006): (a) physical accessibility related to the availability of healthcare services and

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the distance to service users. Physical access can be calculated from travel time, distance, transportation type, and conditions in healthcare facilities; (b) Economic accessibility, which is the financial ability of respondents to access healthcare services; and (c) Social accessibility, which is the non-physical and financial conditions that influence decision-making in visiting modern medical institutions. This concept indicates that accessing modern medical systems is not only determined by economic factors or an individual's financial ability to fund treatment but also by socio-cultural, economic, political, and other factors. Moreover, access to modern healthcare is significantly determined by how society interprets illness and disease and to what extent the illness they suffer threatens their lives.

In the framework of medical thinking, disease is presented as a fact in the context of the methodology of natural science. Essentially, disease is defined as the absence of health. This biological determinism assumes that diseases and their manifestations can be found and recognized through natural science methodologies. However, in contemporary analysis, the definition of disease or illness has expanded its meaning by involving socio-biological dimensions. Sociologically, the category of disease or illness is relatively diverse and can appear within the boundaries of "nature" and "culture" or issues revolving around the interests of individuals, society, or the state. In other words, the definition of disease and illness is a contested issue that ultimately becomes a political, social, and cultural issue, interpreted not only as a purely biological factor but also as a product of social relations (Tesh, 1988).

In this research, it was found that society interprets illness in various ways. For the community, illness is not only interpreted as a disturbance of the body due to viruses, bacteria, and the like (75%) but also as the dysfunction of an organ (72%). Meanwhile, 81% of respondents refer to illness as a condition of the body or physical discomfort that prevents them from working and illness as a condition of uncomfortable feelings that prevents them from engaging in activities (45%). Interestingly, in the community, illness is often also interpreted as a disturbance of the body due to non-medical or magical factors (75%).

Table 1. The Meaning of Sickness Experienced According to Respondents
(Expressed in percentage with n = 150)

Meaning of Illness for Respondents	Yes	No
Body Disturbance Due to Viruses, Bacteria, and the Like	75%	25 %
Malfunction of Body Organs	72%	28%
Physical Discomfort Preventing Work	81%	18%
Illness as a Non-Medical/Magical Body Disturbance	75%	25%
Condition of Discomfort Preventing Activities	45%	55%

Source: Primary Data (2023)

The difference in the meaning of illness and disease in contemporary times ultimately concludes that disease is not a simple natural occurrence but is closely linked to social relations. For example, Foucault (1975) states that the essence of social life has two sides. The first is that the population needs to be regulated or managed, and the second is that individuals must be disciplined. As Turner (1984) expressed, the body must be internally arranged and externally represented. Both aspects can be found in the category of illness, which is socially produced. Therefore, the stable reproduction of the population and the relationship of individuals with structures are central social issues (White, 2012).

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Furthermore, what are the considerations of respondents in choosing a healthcare facility? Out of the 150 respondents interviewed, the majority stated that they chose a healthcare facility because it is more suitable/leads to faster recovery (34%), and is cost-effective (31%). Meanwhile, 24% admitted that it is because of its proximity. These three factors, namely the suitability of treatment outcomes, affordable healthcare costs, and proximity, are considered by most respondents as the primary considerations in choosing a healthcare facility. In addition to being adjusted to the economic conditions of their families, respondents' choices of healthcare facilities are also related to the effectiveness of treatment outcomes and the proximity to the healthcare facility so that if there is a sudden problem, they can immediately follow up or contact the medical service provider.

Table 2. Types of Considerations in Choosing a Healthcare Facility According to Respondents
(Expressed in Frequency and Percentage with n = 150)

Consideration Type	Frequency	Percentage (%)
Proximity	36	24%
Affordable Cost	47	31%
Feels More Suitable/Quick Recovery	51	34%
Satisfactory Service	5	4%
Comprehensive Health Facilities	8	5%
Other	3	2%
Total	**150**	**100%**

Source: Primary Data (2023)

According to the respondents' admission, they have indeed often utilized modern medical treatments to seek recovery from their illnesses. Out of 150 respondents, 58% admitted to occasionally or frequently (32%) using modern medical treatments, including at Public Health Centers (35%), regional general hospitals (31%), health clinics or private hospitals (15%), village health posts (10%), and private doctors (8%). Only 10% of the respondents said they have never utilized modern medical treatments. Seeking recovery through the modern medical system is done for both mild and severe, as well as chronic, illnesses.

Table 3. Types of Modern Medical Facilities Accessed
(Expressed in percentage with n = 150)

Types of Modern Medical Treatment	Frequency	Percentage (%)
Regional General Hospitals	47	31%
Private Hospitals/Clinics	24	15%
Public Health Centers (Puskesmas)	52	35%
Village Health Posts (Polindes)	15	10%
Private Doctors	12	8%
Others		
Total	**150**	**100%**

Source: Primary Data (2023)

In the ongoing social practice, the medical regime has made efforts to facilitate the public's access to the modern healthcare system. Not only passively waiting for patients, but modern

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medical service providers or medical institutions also provide conveniences, making it an attraction for the public to access when facing health situations. Often, through its medical apparatus, the medical regime employs a "catch the ball" strategy by visiting homes or Neighborhood Associations (Rukun Tetangga, RT) and Community Associations (Rukun Warga, RW). Besides fostering community bonds, these visits aim to socialize health programs and encourage the population always to direct their health orientation towards the modern healthcare system. In response to these invitations, suggestions, sometimes with a directive tone, conveyed by medical authorities further motivate the community to access public health facilities in their residential areas. Field observations reveal that, besides utilizing Integrated Health Posts (Posyandu) and Community Health Centers (Puskesmas), people frequently access Government General Hospitals, especially when the medical facilities and personnel at Community Health Centers are insufficient, requiring patients to be referred to the Government General Hospital (RSUD).

Although health facilities for public welfare, such as Community Health Centers and Government General Hospitals or health clinics, have been available in the research area, the existing social reality indicates that there are still issues faced by the impoverished population when accessing public health facilities. In addition to cost-related factors (28%) in modern medical treatments, proximity also becomes a significant consideration (42%).

Table 4. Reasons Respondents Utilize Modern Medical Treatment
(Expressed in percentage with n = 150)

Reason Type	Frequency	Percentage (%)
Proximity	63	42%
Affordable cost	42	28%
Quick recovery	14	10%
Satisfactory services	11	7%
Comprehensive facilities/equipment and drugs	16	10%
Familiarity with existing healthcare staff	4	3%
Total	**150**	**100%**

Source: Primary Data (2023)

Meanwhile, 10% of respondents admitted utilizing modern medical treatment because it is effective or provides quick recovery. The availability of medical equipment (10%), the presence of specialized medical personnel, the professional attitude of medical staff, and so on are several considerations for respondents to utilize modern medical services (7%).

4.2. Mechanisms of Panopticism in the Modern Medical World

The concept of the panopticon or panopticism was first introduced by Jeremy Bentham in 1748–1832, proposing a new type of prison with a circular structure built around a central building that served as the residence for correctional officers. The central building allowed the guards to supervise all inmates visually. Bentham referred to such a structure as the "Panopticon." Michel Foucault further developed the concept of panopticism in his work "Discipline and Punish" (1975) to describe all forms of rational, detailed, and bureaucratic surveillance, as seen in hospital systems (Turner et al., 2010).

Panopticism mechanisms or surveillance, as conceived by Foucault, are also found in this study, although not entirely identical. Medical regimes often carry out disciplinary

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mechanisms, surveillance, or monitoring, as well as recording and productive actions, to make society "normal" or healthy (free from illness) according to the state's definition. Through the power held by medical regimes, control/surveillance and even recording of the population in neighborhoods, villages, and districts, including counties, are conducted.

In the social practice of the medical world, the concept of the panopticon and disciplinary strategies practiced by medical regimes in the research area can be divided into two realms: (a) panopticon mechanisms as a practice of dominance demonstrated by medical regimes over society through disciplinary strategies to achieve a healthy society according to the desires of the medical regimes, and (b) the practice of dominance that occurs in modern medical treatment processes, observable through the relationship between doctors and the community as patients when receiving treatment.

In macro-level social relations, panopticon mechanisms can be observed through disciplinary steps taken through monitoring or surveillance activities, social control, and subjugation of the population, including society in social practices within government health programs. Internalizing modern medicine continues intensely through policies and health development programs in line with modern medical principles. To strengthen the internalization process of modern medicine, medical regimes also equip quality healthcare human resources, including general practitioners, specialists, health nurses, midwives, medical practitioners and paramedics, pharmacists, nutritionists, sanitation workers, community health workers, and medical technicians such as medical analysts, electromedical technicians, radiographers, and physiotherapists. Various medical tools built by medical regimes through regulations and normalization in various modern medical services and other health activities demonstrate that medical regimes have implemented the panopticon mechanism for a long time.

To achieve normality and health conditions in the community, medical regimes also develop disciplinary strategies by building discursive practices through jargon, slogans, and policies related to health services. Discursive practices realized through statements and practices of medical regimes always guide the choice of the right medical system, namely the modern medical system, by utilizing the development of medical science and technology/equipment and the pharmaceutical industry conducted by pharmaceutical companies. The discursive practice of modern health values is continuously internalized through existing discursive structures, including government agencies, health departments, medical and paramedical personnel, modern health facilities, and the pharmaceutical industry, which is expected to support these efforts.

Medical regimes reinforce discursive structures by arranging and optimizing the roles of health institutions such as hospitals, community health centers, integrated health posts, health clinics, medical and paramedical personnel, and social community organizations to support the effort to internalize the modern medical system. Medical regimes hope to strengthen the boundaries of views and health treatment practices in modern medical systems through discursive structures.

In the social practice of the medical world, the dominance of power demonstrated by medical regimes through medical institutions and the personal health relationship with patients has created dependency, control, total obedience, subordination, marginalization, and other situations that are less favorable for society. In an asymmetric relationship where patients are subordinate, there is no room or opportunity to participate in decision-making, even if it concerns their lives and well-being. The subordinated position experienced by society in the medical treatment process not only causes patients to submit and comply with the advice,

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recommendations, and orders of personal health, but patients also feel alienated by medical language, prescriptions given, medical rules/regulations, as well as the attitudes and actions of personal health.

Even the social relationship that occurs in the practice of medical treatment and care has created a social distance impression with patients by personal health, which can be observed through attributes/clothing, ways of speaking, behaving, limiting oneself in providing information about health conditions, actions or treatments that doctors, benefits and types will carry out, as well as the risks of the drugs prescribed, and so on. Such social relationship patterns can occur due to exercising power (power), knowledge (knowledge), and patients' dependence, leading to submission and obedience to the medical regime.

The dominance of knowledge-based power has led to the formation of asymmetric relationships characterized by a unidirectional flow of information with personal health as the dominant party based on competence and academic background. As Foucault (2002) pointed out, power derived from knowledge has made power more subtle and difficult to resist. Nevertheless, in every power structure, resistance always emerges within the power relationship (Muzahwi, 2014). At least from the research results, there is evidence of resistance from the community as patients to modern medicine when accessing modern medicine and establishing relationships with personal health in the ongoing process of internalizing modern medicine in the community.

On a larger scale, social relations in the medical world can be observed through the process of internalizing the modern medical system through various health programs, such as the formulation of regulations and policies in the medical field and other health development activities to follow and practice modern medical values by the community effectively. In addition to using repressive power, with the power possessed by medical regimes, hegemonic power is subtly exercised through socialization, education, promotion, and other activities so that modern medical values are internalized and realized in social health practices according to the standards and provisions of modern medical regimes.

Strengthening the discursive structure is carried out to ensure that the hegemonic process runs effectively and is accepted/approved by involving medical apparatus and government officials at the local level, as well as civil society, such as cultural institutions and social community groups, including village associations, savings groups, neighborhood associations, study groups, Family Welfare Empowerment groups, Youth Organizations, and so on. Support from the local community (community support system) that emerges and develops based on local traditions is a strategic entry point that allows the modern medical system to be accepted and voluntarily approved by the community.

Furthermore, in this study, mechanisms of discipline, supervision, monitoring, as well as recording and productive actions are carried out by the medical regime to make the society "normal" or healthy (not experiencing illness) according to the state's definition through various activities, including:

1) Officials conduct door-to-door visits to residents' homes to examine the health and environmental conditions.
2) Issuance of advisories by the RT/RW officials and health personnel through circulars to maintain health and cleanliness in the environment.
3) Distributing brochures/circulars to encourage visits for treatment at health centers.
4) Encouragement to participate in educational or awareness activities about health at the neighborhood or village community center.

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5) Community participation in health check-ups for toddlers at integrated health service posts (Posyandu).
6) Encouraging community members to undergo pregnancy check-ups at integrated health service posts (Posyandu/health centers).
7) Health personnel or Family Welfare Empowerment (PKK) members visit to record or gather data on individuals' conditions.
8) Occasional visits by health personnel when individuals are suffering from illnesses.

For certain activities, respondents acknowledge that they are frequently conducted, including:
1) Issuance of advisories by the RT/RW officials and health personnel through circulars to maintain environmental health and cleanliness (21%).
2) Encouragement to participate in educational or awareness activities about health at the neighborhood or village community center (21%).
3) Community participation in health check-ups for toddlers at integrated health service posts (33%).
4) Encouraging community members to undergo pregnancy check-ups at integrated health service posts (30%).

Meanwhile, some activities experienced by a relatively significant number of respondents with an occasional intensity include:
1) Officials conducted door-to-door visits to residents' homes to examine health and environmental conditions (20%).
2) Issuance of advisories by the RT/RW officials and health personnel through circulars to maintain health and cleanliness in the environment (26%).
3) Encouragement to participate in educational or awareness activities about health at the neighborhood or village community center (26%).
4) Community participation in health check-ups for toddlers at integrated health service posts (17%).

Table 5. Types of Health Monitoring/Control Activities by Medical Personnel
(Expressed in percentage with n = 150)

No	Type of Health Monitoring/Control Activity by Medical Personnel	Intensity		
		Often	Sometimes	Never
1	Health workers go door-to-door to check the health and environmental conditions of residents	7%	20%	7%
2	Advice from RT/RW officials and health workers through circulars to maintain health and cleanliness in the environment	21%	26%	53%
3	Distribution of brochures/circulars to seek treatment at the health center	2%	10%	88%
4	Encouraged to attend educational or awareness activities about health in the RW or village hall	21%	26%	43%
5	Invited to attend health check-ups for toddlers at the integrated health service post (Posyandu)	33%	17%	50%
6	Invited for pregnancy check-ups at the integrated	30%	14%	56%

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No	Type of Health Monitoring/Control Activity by Medical Personnel	Intensity		
		Often	Sometimes	Never
	health service post (Posyandu)/health center			
7	Visited by health workers or Family Welfare Empowerment (PKK) and their conditions are noted or recorded	13%	11%	76%
8	Visited by health workers when suffering from an illness	9%	5%	86%

Source: Primary Data (2023)

The panopticon mechanism or health monitoring/control is sometimes even often carried out by various parties as an extension of the interests of the medical regime, including health officers from health centers (58%), PKK members (36%), officers from hospitals (health department) numbering 28%, community figures (RT/RW/village) as much as 56% of respondents, and health and environmental sanitation officers (27%). It is acknowledged that in the social practice of the medical world, the process of hegemony by the medical regime, whether coercive or subtle, can be accepted as a form of reasonableness so that society voluntarily follows, complies, and submits to the advice, recommendations, and invitations of medical and government officials at the local level. Compliance with the medical regime's advice, recommendations, and even instructions to access modern treatment is inseparable from the role of trusted community figures who serve as role models and religious social institutions in the research area. In Javanese and Madurese society, which has a hierarchical and paternalistic socio-cultural character, as observed in this study, the role of community figures and religious social institutions is very strong.

Monitoring or control carried out by the medical regime through its hegemonic apparatus has been done intensively over time. From the research, several activities are noted to be done sometimes, or even never, but they are carried out intensively for some activities. Activities that are sometimes and often carried out include Posyandu activities with immunization, examination of pregnant women and toddlers (82%), health education/socialization activities (67%), monitoring of sanitation and environmental activities at the RT/RW level (41%), and monitoring of sanitation and environmental activities (38%).

Table 6. Intensity of Monitoring/Control Activities Related to Health Issues Conducted
(Expressed in percentage with n = 150)

No	Health Activity Type	Intensity		
		Often	Sometimes	Never
1	Posyandu Activities (immunization, antenatal and toddler check-ups)	54%	28%	18%
2	Health education/socialization activities	19%	48%	32%
3	Health check-ups directly to residents	8%	33%	59%
4	Monitoring of sanitation and environmental activities at RT/RW	12%	26%	62%

Source: Primary Data (2023)

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From several types of activities conducted, it turns out that the panopticon mechanism is more frequently implemented through Posyandu activities and health education or socialization. Nevertheless, many respondents in this study also acknowledge other activities, such as residents' direct health examinations and monitoring sanitation and the environment.

4.3. Resistance Forms of the Community against Modern Medical Treatment Systems

Modern public health's current incarnation or manifestation can be interpreted as a form of medical regime power operating through regulation and medical surveillance or surveillance of individuals and society (Petersen & Lupton, 2012). The role of medical institutions and health personnel in public health is highly dominant, simultaneously holding authority in explaining health conditions and diseases and how to prevent diseases. The medical regime can shape the individual's identity related to their condition through power derived from medical knowledge. Even though the power possessed, the medical regime can provide knowledge and influence, directing individuals to choose the modern medical system when facing health situations.

Although the medical regime intensely internalizes modern medicine and directs the medical actions of society towards modern treatment, the social reality indicates resistance to modern treatment itself. As explained by Foucault (2002), power is a domination system that always tends to control everything and leaves no room for freedom. On the other hand, it is undeniable that within each individual, there is the ability to resist the dominant discourse that always seeks to discipline and control, including in the medical field. According to Foucault, because of the fundamental nature of power that tends to be dominant, it will have implications for the possibility of resistance, as without this possibility, power relations will not be formed (Dumm, 2002).

In power relations, resistance is very likely to occur when individuals become aware of themselves as subjects through the process of understanding themselves or technologies of the self. Resistance to modern medicine as a dominant discourse developed by the medical regime has the potential to emerge in the lives of individuals due to the existence of free/empty spaces and differences in values or ideologies inherent in individuals. In reality, it cannot be denied that socio-cultural and economic factors make society diverse, and therefore, the potential for resistance is highly likely to emerge. Value systems, social relations, ways of thinking, experiences, and perceptions of accessing modern medical services will provide a diverse spectrum of reactions to the medical regime.

The weakening of trust and skeptical attitudes towards internalized and practiced modern medicine by society can trigger and open space for resistance. In addition, dissatisfaction with modern medicine also has the potential to foster alternative discourses and give rise to voice and exit actions, causing the community to shift to other medical systems. The weakening of trust in the medical regime can be observed through the community's perceptions and impressions of the medical regime's performance in providing health services to the community over time. If access to modern medicine causes bodily harm and modern medical care is considered futile, it is still shrouded in doubt and dissatisfaction. The phenomenon of community distrust in the modern medical treatment system will strengthen. This means that resistance and the desire to exit from the modern medical treatment system are highly likely to occur because each individual inherently has the personal power to act according to their own will and autonomy.

Furthermore, in this study, several respondents admitted having experienced uncomfortable situations when accessing modern medical treatment. Various things meant include Unaffordable medical and treatment costs (59%), Complicated/bureaucratic procedures

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(64%), Arrogant/unfriendly administrative staff (62%), Arrogant and unfriendly doctors (61%), Arrogant and unfriendly paramedics (52%), Limited availability of medications (43%), Doctors always impose orders and medications (49%), Inadequate information about health services (54%), Ineffective/incompatible treatment outcomes (46%), and having to queue with very long service times (50%). This data indicates respondents' uncomfortable situations when accessing modern medical treatment, leading to disappointment and concern about the provided services.

Table 7. The Experience of Discomfort in Accessing Medical Treatment by Respondents
(Expressed in percentage with n = 150)

No	Type of Situations Faced	Intensity		
		Often	Sometimes	Never
1	Unaffordable medical and treatment costs	15%	44%	41%
2	Complicated/bureaucratic procedures	24%	40%	36%
3	Arrogant/unfriendly administrative staff	18%	44%	38%
4	Arrogant and unfriendly doctors	17%	44%	39%
5	Arrogant and unfriendly paramedics	10%	42%	48%
6	Limited availability of medications	11%	33%	57%
7	Doctors always impose orders and medications	17%	39%	54%
8	Inadequate information about health services	11%	43%	46%
9	Difficulty in transportation facilities	13%	26%	61%
10	Ineffective/incompatible treatment outcomes	12%	34%	54%
11	Having to queue with very long service times	20%	30%	50%

Source: Primary Data (2023)

Based on this research, various forms of actions by doctors and paramedics were found to make patients uncomfortable. These actions include unfriendly behavior from health administrative staff (61%), doctors who are unfriendly and tend to be authoritative (54%), nurses who are unfriendly in service (60%), doctors who prescribe medication according to their preferences (56%), doctors and nurses who are undisciplined in terms of time (52%), communication that is more dominant from doctors and nurses (60%), and the requirement for patients to follow the instructions of doctors and nurses (65%).

Furthermore, in this study, various forms of resistance were detected among respondents, including (a) respondents remaining silent and not reacting or complaining about healthcare service providers (73%); (b) remaining silent but complaining and cursing without expressing it to healthcare service providers (58%); (c) being expressive (emotional) by complaining, getting angry, and cursing healthcare providers directly (32%); (d) protesting against healthcare providers directly by calling, sending SMS, writing letters to the media to protest the received healthcare services (9%); (e) expressing complaints to local community leaders or authorities (10%); (f) conveying complaints to relatives, neighbors, friends, or others (24%); (g) switching to alternative/traditional medical systems (11%); and (h) developing a combinative medical system (modern and traditional) (36%).

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Table 8. Responses or Actions Taken by Respondents When Facing Uncomfortable or Dissatisfying Situations with Modern Medical Treatment
(Expressed in percentage with n = 150)

No	Form of Response/Action Taken	Ever	Never
1	Silent (took no action) and did not complain	73%	23%
2	Silent but complained and cursed without expressing it to healthcare providers	58%	42%
3	Expressive (emotional) by complaining, getting angry, and cursing healthcare providers directly	32%	68%
4	Protested against healthcare providers directly by calling, sending SMS, and writing letters to the media to protest the received healthcare services	9%	91%
5	Conveyed complaints to local community leaders or authorities	10%	90%
6	Conveyed complaints to relatives, neighbors, friends, or others	24%	76%
7	Switched to alternative/traditional medical systems	11%	89%
8	Developed a combinative medical system (modern and traditional)	36%	64%
9	Others	36%	64%

Source: Primary Data (2023)

Despite the various forms of resistance shown by respondents, from the available data, it can be seen that the attitudes and actions taken are more often in the form of remaining silent and not reacting at all, without complaining to healthcare service providers, remaining silent but complaining and cursing without expressing it to healthcare service providers, being expressive (emotional) by complaining, getting angry, and cursing healthcare providers directly, and developing a combinative medical system (modern and traditional).

4.4. Resistance of Health Foundations Against Modern Medical Systems

The social practice of the modern medical system still faces various problems, especially the neglect of the rights of people with low incomes to access the modern medical system to the fullest. Therefore, in this study, the issue of dissatisfaction and disappointment with the modern medical service system results in the birth of resistance. The singular truth about modern medical services, always constructed by the medical regime and strengthened through the establishment of beliefs by forming rational knowledge, often faces resistance from a society inherently possessing its power. This means that it is highly possible for the efforts of the state or the medical regime to internalize modern medical services to struggle against the autonomy of individual wills.

Suppose the performance of the evolving modern medical services is still shrouded in doubt. In that case, the phenomenon known as "voice and exit" by Hirschman will occur, and civil society's weakening trust in the medical regime's performance in providing healthcare will strengthen. In other words, resistance, neglect, and a tendency to exit healthcare (ignored and exit) are highly likely to occur because each individual inherently has the power and personal knowledge to shape discourse or social practices.

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Michel Foucault's idea of focusing on the interrelation between power and knowledge is an interesting issue, especially concerning the social healthcare practices produced by the medical regime or society. The choice of a medical system is highly likely to occur as a reflection of the dominant power working in the ongoing relations between society and dominant powers outside itself, such as relatives, neighbors, friends, traditional healers, or traditional healers (shamans, wise people, herbalists, and the like).

In other words, the health orientation that develops in the community will subtly proceed seemingly unnoticed through the apparatus of power, ostensibly to create a healthy and quality community protected from disease. Although the medical regime always strives to "conquer and subdue" the community into choosing modern medical services, this study found resistance based on various reasons, including (a) uneven distribution of provided services, such as counseling, training, health and environmental inspections, and others; (b) in providing health administration services, administrative personnel still appear arrogant and unfriendly, differentiating between patients; (c) diagnostic errors resulting in patients being forced to switch to other medical services; (d) bureaucratic processes are considered unprofessional due to long waits and queues, and (e) the ineffectiveness of generic treatments and medications.

Even though resistance is evident in this study, results also show community members who are "subdued" by the medical regime through compliance to access modern medical services because the healthcare provided by the medical regime is considered adequate. Medical facilities are perceived as complete and easily accessible in terms of distance, and the cost of treatment is relatively low, even free, due to BPJS and KIS or the Healthy Indonesia Card. This reality indicates that the panopticon mechanism practiced by the medical regime has been working quite well. Moreover, the roles of key figures in social activities in the village, such as PKK and health cadres, RT, and RW officials, have worked maximally to direct the community's choices toward a healthcare system that adheres to modern values. The involvement of figures known to be very close, with strong personal relationships with the village residents and having strong trust, effectively contributes to the practice of the panopticon in the medical world. This reality strengthens the statement that the panopticon practice carried out by the medical regime has effectively entered the minds in the form of knowledge about good healthcare. Thus, people choose modern healthcare as a way to achieve healing.

The dominant power working through medical practitioners with their medical knowledge background and the ongoing panopticism has convinced them that modern healthcare is the most suitable service for them to obtain healing. However, the existing facts show that society has adhered to traditional healing systems in the past, and even now, the social reality found in this study shows that people have thoughts and actions that attempt to combine with modern healthcare. The shift in healthcare orientation that has occurred over time indicates a serious struggle between the dominance of the medical regime to establish the panopticon mechanism by internalizing the knowledge of modern health values and norms through various media and efforts versus the orientation of traditional healthcare that has socio-culturally rooted deeply over generations, even from their original regions.

In fact, until now, there are still communities that consume traditional herbal products or practice traditional healing methods such as acupuncture, massage therapy, herbal therapy, and so on. The fact that some people still develop a popular or traditional health orientation simultaneously cannot be separated from the history of subjects who have migrant status and still carry the cultural patterns of their original regions, including when they face situations of illness or seek healing.

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Theoretically, **Figure 1** explains the implementation of Foucault's theory regarding the relationship between power and knowledge, manifested in the doctor's efforts to convince patients to accept a medical procedure and monitor the progress of treatment and care. In medical practice, a doctor will perform a medical procedure based on medical procedures and informed consent. In addition, doctors sometimes choose more subtle ways to persuade patients, such as explaining the benefits of a medical procedure or therapy, the type of procedure and medication, and the risks of treatment. Doctors' persuasions can be interpreted as efforts to create patient obedience and submission. Providing information about the worst consequences if patients do not undergo treatment and care also creates fear in patients, ensuring that they always follow the advice and orders of medical personnel.

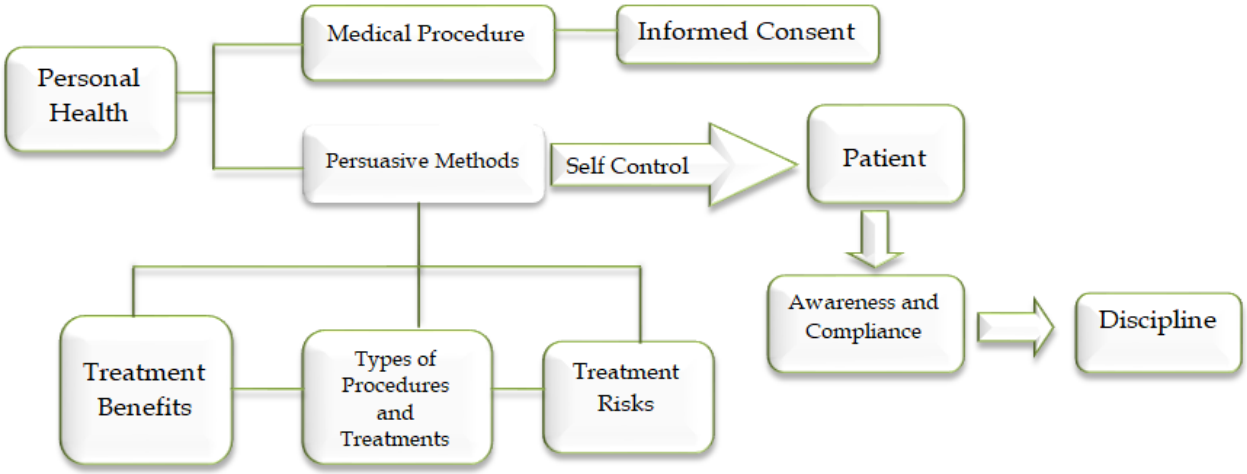

Figure 1. Scheme of the Panopticon Model Control Mechanism in the Personal Health and Patient Relationship

Source: Summary of Data Interpretation from Research Results (2023)

Figure 1 illustrates the workflow of how the panopticon mechanism operates in the medical treatment process to instill discipline in patients. In the evolving discourse on power derived from knowledge in the field of medicine, according to Foucault (1997), the endeavor to discipline individuals originates not from external forces but internally, namely, in the thoughts and mental state of the individual. Patients who have undergone examinations and treatments from doctors are often advised to return for follow-up appointments to monitor the progress of their health, especially for serious illnesses. For patients, the doctor's treatment through advice and instructions manifests the doctor's care or the medical institution's concern.

However, in the context of Foucault's power dynamics, the doctor's recommendations, orders, and treatment can also be interpreted as forms of control and dependence that arise in medical treatment. The doctor's advice and recommendations are no longer seen merely as instructions; patients consider them obligations that must be fulfilled. Patients sometimes voluntarily follow the doctor's instructions. Consequently, doctors, without needing constant supervision or full monitoring of patients, automatically receive compliance with the given instructions.

This reality indicates that in the treatment process, the power strategies practiced by doctors create obedience, submission, and dependence and cultivate awareness within patients, thereby fostering normalization and discipline within the patients themselves.

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5. Conclusion

The system of modern medical institutions still suffers from weaknesses (pathology of modernity) both in managerial aspects and service performance. In addition to the presence of unprofessional and arrogant medical administration services and medical personnel, the complexity of modern medical bureaucracy, unfair (discriminatory) services, excessively long waiting times and queuing, and the questionable effectiveness of recovery. The modern medical treatment system has not been able to guarantee the healing of patients fully. The ineffective, unsuitable, and irrational modern medical system has raised critical awareness that using advanced medical equipment with expensive medications does not guarantee the effectiveness of treatment. Accessing modern medical treatment seems to expand new disease burdens (clinical iatrogenesis).

In the social practice of the medical world, the panopticon mechanism is practiced by the medical regime in two realms: first, the panopticon mechanism is a practice of power domination demonstrated by the medical regime on the wider society (macro level), and second, the practice of power domination that occurs in modern medical treatment processes, observable through the relationship between doctors and community members as patients. Meanwhile, on the macro level, the panopticon mechanism is implemented through regulations or rules, including laws, regional regulations, policies, and health programs produced by the medical regime/government. This includes developing disciplining strategies by building discursive practices through jargon, slogans, health brochures/pamphlets, films, advertisements, posters, health education or socialization, banners, field visits, and so on, strengthened through the internalization process by the discursive structure of the medical regime, such as medical institutions and apparatus, government officials at the neighborhood, sub-district, village, district, and county levels, pharmaceutical companies, as well as social institutions based on local socio-cultural conditions.

This study found that the modern medical governmentality process through hegemony and panopticism is not always obeyed and followed by the community according to the will and authority of the medical regime. Instead, it has given rise to resistance as a product of critical consciousness. Resistance occurs due to various conditions, including (a) skepticism and weakening trust (distrust) in the modern medical treatment system, including the authority of the state (medical bureaucracy) and modern medical ideologies and health professionals; (b) the strong domination of the medical regime's power seen in asymmetric relations formed in the treatment process based on scientific or professional authority and knowledge; (c) limited community access to modern treatment due to the entry of the medical industry; and (d) the existence of informal networks and the strong role of local social and cultural figures in directing the choice of treatment systems for the community.

Community resistance takes on a distinctive character: developing low-profile techniques by avoiding, withdrawing, fatalism, and passivity in line with the characteristics of the lower class structure. Another form of resistance the community develops is personal, spontaneous, and expressive and tends to manifest, reflecting a growing critical consciousness among the people. In the context of resistance, the community manifests in three forms: (a) persisting in accessing modern treatment but accompanied by a skeptical and critical attitude toward the accessed modern treatment; (b) developing a pluralistic or combinative medical orientation; (c) some communities decide to exit and build alternative discourses or otherness about the treatment system according to their autonomy and power.

Furthermore, recommendations include the need for counter-hegemony regarding health and illness, ensuring that constructed meanings are unifocal and not solely based on the

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medical regime's definitions. This involves focusing more on disturbances in physical or biological conditions but also considering other situations, such as psychological and social-environmental conditions, which are also potentially significant contributors to community health issues. Various formal, non-formal, and informal education methods can be employed to deconstruct the meanings of health and illness, along with activities such as socialization or education and information dissemination through print or electronic media and other social media.

To create an equal or balanced relationship (balancing power) and balanced dependency between the community as patients and doctors as representatives of the medical regime, the growth of critical awareness (critical consciousness) in modern medical services is necessary through several strategies or methods. First, optimize communication and dialogue between medical professionals as representatives of the medical regime and patients and the general public as representatives of civil society through various forums. Second, increasing access to health education enhances critical awareness or self-empowerment for the general public and medical workers so that they can distinctly differentiate between the meaning of illness in biological terminology and illness resulting from environmental conditions, including those caused by the medical-industrial complex. The mobilization of local institutions, such as study forums, educational institutions, social organizations, NGOs, etc., plays a crucial role in building critical awareness. Local community support is essential and strategic as a forum to enhance critical awareness related to medical practices that do not align with the desires and needs of the poor urban community. Third, engage in health promotion involving widespread community participation to raise awareness and vigilance regarding environmental conditions, as environmental conditions can be sources of biological and social diseases. Promotional activities are also strategic as forums to reproduce positive meanings of health in biological, psychological, and environmental or social terms. Fourth, actively correct any health development policies to avoid harming the community. Fifth, to prevent an imbalanced and asymmetrical relationship with strong domination by medical personnel, defense measures should be taken if there are victims of abuse by the medical regime. Cases that harm the community, such as unfair treatment (discrimination), abuse of power, and the like, can be investigated by law enforcement agencies or NGOs to provide defense so that the relationship between patients and medical personnel or doctors is not dominant.

This study also found that despite having accessed modern medical treatment, the community resists in various ways, both covertly and semi-openly, protesting directly and vehemently against medical personnel, citing unfair and unfriendly services. Although not yet in an openly organized and systematic form, the resistance expressed by respondents reflects an attitude and critical consciousness due to dissatisfaction with the medical services they received. The cases indicate the importance of medical institutions in improving the medical personnel serving in medical institutions, including Posyandu (integrated health service post), community health centers (Puskesmas), and hospitals, to be more professional and able to provide quality services.

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References

Badan Perencanaan Pembangunan Kota Surabaya. (2011). *Kajian Feasibility Study Pendirian Rumah Sakit*.

Dumm, T. L. (2002). *Michel Foucault and the politics of freedom* (Vol. 9). Rowman & Littlefield.

Eryando, T. (2006). Alasan Pemeriksaan Kehamilan dan Pemilihan Penolong Persalinan. *Jurnal Administrasi Kebijakan Kesehatan*, *1*(6), 47–51. http://journal.unair.ac.id/download-fullpapers-8.Tris Eryando.pdf

Foster, G. M., & Anderson, B. G. (2009). *Antropologi Kesehatan*. UI Press.

Foucault, M. (1975). *Discipline and Punish: The Birth of the Prison*. Gallimard.

Foucault, M. (1997). *Disiplin Tubuh: Bengkel Individu Modern* (P. S. Hardiyanta (ed.)). LKiS.

Foucault, M. (2002). *Power/Knowledge: Wacana Kuasa/Pengetahuan*. Bentang Budaya.

Kementerian Kesehatan Republik Indonesia. (2018). *Laporan Hasil Riset Kesehatan Dasar*.

Mahfud, M. (2010). *Konstitusi dan Hukum dalam Kontroversi Isu*. Rajawali Pers. http://library.stik-ptik.ac.id/detail?id=10179&lokasi=lokal

Murray, P., & Murray, L. (1985). The Art of the Renaissance. In *World of Art Series Art of the Renaissance*. Thames & Hudson.

Muzahwi. (2014). *Di Balik Pelarangan Negara terhadap Prostitusi*. FISIP Universitas Airlangga.

Notoatmodjo, S. (2005). *Promosi Kesehatan: Teori dan Aplikasi*. Rineka Cipta.

Petersen, A., & Lupton, D. (2012). The New Public Health: Health and Self in the Age of Risk. In *The New Public Health: Health and Self in the Age of Risk*. Sage. https://doi.org/10.4135/9781446217429

Putra, L. H. (2010). Pelayanan Publik Bidang Kesehatan: Advokasi ICW untuk Pasien Miskin di Jabodetabek. *Jurnal Politik Indonesia*, *1*(2), 83–90.

Susanto, D. (2010). Strategi peningkatan kapasitas modal sosial dan kualitas sumberdaya manusia pendamping pengembangan masyarakat. *Jurnal Komunikasi Pembangunan*, *8*(1).

Tesh, S. N. (1988). *Hidden Arguments: Political Ideology and Disease Prevention Policy*. Rutgers University Press.

Turner, B. S., Abercrombie, N., & Stephen, H. (2010). *Kamus Sosiologi*. Pustaka Pelajar.

White, K. (2012). The body, social inequality and health. In *Routledge Handbook of Body Studies* (pp. 264–274). Routledge. https://doi.org/10.4324/9780203842096.ch19

Yen, T. S. (2009). *Dari Mekanisasi Sampai Medikalisasi: Tinjauan kritis Atas Pereduksian Tubuh Manusia Dalam Praktek Medis*. Dian Rakyat.

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