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UMI
WOMEN AND
THE DYNAMIC INTERACTION OF
TRADITIONAL AND CLINICAL MEDICINE
ON THE BLACK SEA COAST OF TURKEY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of the Ohio State University

By

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*****

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1998

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1998
ABSTRACT

This study examines the health care system used by people in a cluster of villages on the Black Sea Coast of Turkey. Although there have been national efforts to replace traditional healing practices with clinical medicine, in actual daily life patients and their families seek out and creatively combine both kinds of medicine. With the fieldwork technique of participant-observation, I collected data on local ideas about sickness and health, the causes of illness, and the roles of religious belief and social networks in health care. I observed the workings of the local health clinic and of several area hospitals and doctors’ offices. I gathered indigenous cultural information from many people of different ages. Married women bear the major responsibility for the care of family members, and are very active in health care decision-making. Interviews with elderly women, some of whom were local experts in such traditional skills as bone-setting, “stomach-pulling,” and midwifery, provided insight about cultural change in the area. The term “traditional” refers to a way placing value on methods learned from the elders while re-interpreting them to accommodate changing circumstances.

Health care is an empirical realm. In both traditional and clinical medicine, effective techniques and concoctions are retained and passed on, while those which fail are altered or dropped altogether. A health care system is complex and allows for many
possible adaptations, varying among people, and changing to meet new economic and social opportunities or constraints.

The expertise of one traditional bone-setter is examined in detail, including her range of techniques and her use of clinical medication. One chapter examines the local cultural ideas of the supernatural, including the belief in the "evil eye" as an agent of illness. Another chapter examines the health issues relating to birth and reproduction, as viewed by traditional village midwives, local women, and by clinic staff members. The physical and ideological furnishings of the local health clinic are also described. Observing daily life, with its life-cycle events such as birth and death, and its major and minor accidents and ailments, I learned the local cultural responses to suffering.
Dedicated to the memory of

Charlotte Farquhar Wing

and

Sylvia McCowen Hubbard
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CHAPTER I

APPROACHES

As I sit at my computer, at home in the U.S., I follow the twisting coast road in my mind, coming closer to the Black Sea town of Medreseönü, where I have done my dissertation research. The night bus from Istanbul takes about 12 hours in real time, but I can skip to the early morning hours going through a gray and sleeping Samsun. From there, the bus stops frequently to discharge bleary-eyed passengers at small bus depots along the coast. By the time we pass Fatsa, the sun is up to illuminate the tortured turns of the road as the bus roars up and around the peninsula which divides Fatsa from Ordu. Encroaching upon the road from above and falling away to the sea below, the verdant tangle of plant life is what Turks from elsewhere think of when they imagine the Black Sea — it is yemyesi, very green. After several visits, I came to realize that, despite their wild and mixed greenery, the steep hills are intensely cultivated, producing a mixed crop of beans, corn, hazelnuts and walnuts, collard greens, many kinds of fruit, cucumbers, tomatoes, eggplant, mushrooms, and many types of herbs and edible greens. As I continue my imaginary approach to Medreseönü, I see women and children walking their family cows to hazelnut groves to graze. I see men sweeping the cement sidewalks in
front of their businesses — coffeehouses, bus depots, grocery stores, appliance repair
shops, restaurants, bakeries, dry goods stores, and the like. If it is market day, vendors
are arranging their colorful wares on push carts — hanging up ready-made shirts and
dresses, building pyramids of tomatoes or melons, spreading out bright plastic tubs and
buckets, or constructing towers of olive oil cans and detergent boxes.

In my mind I am now rounding the corner past a meat restaurant perched on a
cliff overlooking the rocky shoreline. I catch first sight of the large mosque which, with
the government building, the school, two grocery stores, the pharmacy, a wedding salon,
four bus company offices, and four coffeehouses, constitutes the center of Medrese önü.
The town is nestled in a small bay which shelters a few fishing boats. Behind the
buildings along the coastal road the hills rise up so steeply that some cars, especially
those driven by inexperienced drivers, cannot make the initial run up the cobbled section
of the road leading to the villages, and must coast down backward and try again. As
large construction trucks and intra-city buses charge around the sharp turns, the local
drivers who take passengers up to their village homes deftly dodge traffic, swerving into
the oncoming lane to get enough speed and grip to make the ascent. When I arrive with
large suitcases and pack into a car with my welcoming committee, I join in the whispered
prayer of Bismillahirahmanirahim as we charge the hill and then in the relieved joking as
we reach the rutted dirt road which, although steep, is out of the reach of the speeding
traffic.
The Auditory Landscape

Typical summer sounds include the light-hearted conversations of women working in the same or adjacent gardens. This region has a special style of calling which carries information over distances, especially up and down hills or across valleys. It is most often used to carry information from the house to the fields and back. This form of calling can convey basic information such as the need to send someone right away to fetch something, it can be a location check, a call to return for a meal, a question about who is watching the cow, or a request for water or food. This form of calling is best understood within families, but neighbors and other relatives may be used to a person’s calling voice. Further east on the Black Sea Coast is a region where a special whistling language (called “bird speech”) has been developed for similar geographical reasons. Despite distortion from wind and distance, people are very accurate in their assessment of who is calling, from where, and for what reason. A woman’s lament, heard from a distance, may be the first way that a family learns about a death. The lament will include familial terms (“Oh, my father,” “Oh, my girl,” etc.) which convey who has died, as locals recognize the specific lamenting voices of most individuals. One morning in the village of Gebeşli, I watched as Aunty Emine and Uncle Ferit listened intently to the sound of a woman’s lament. They soon determined that the woman’s cow had died, and, relieved that no human life had been lost, they returned to the breakfast table.

Cows can be heard bellowing in the distance, and the sound of their bells is recognized by their owners. When cows are being driven out to pasture or home again, they are moving along quite quickly, and their bells jingle noticeably more than they do.
when the cows are grazing. Cows are also directed with switches and sometimes by the
loud curses of their owners. Many people can tell who is passing their house with their
cows without looking outside. If visual contact is made, people on good terms must greet
each other, and enemies pointedly avoid looking at or speaking with each other. People
are especially attuned to the sounds of cows in distress, and can often tell where the cow
is and what the matter is even when the cow belongs to someone else.

People also listen carefully to the sounds of cars and other vehicles and can tell a
lot about who is on the way home, or leaving, or going to a wedding (minibuses are
rented for crowded weddings), or coming back from the market in a hired car.

When there are no loud sounds, one can detect the buzzing of flies, the rustling of
leaves in the wind, the distant sound of radios or televisions, the sounds of chopping
wood or hammering nails, the scratching and fussing of chickens, and the occasional bark
of a dog or cry of a baby. The sudden intrusion of a fighter plane’s roar makes one
realize that no commercial planes ever pass over this area. The birds have different calls
for different times of day. The warning call of a familiar bird makes people look up to
see who is passing or to chase a cat away from the chicks.

When I listen to my research tape recordings and watch my videos, I am reminded
of the sensory texture of life in Medreseönü. This texture is one of the many sensory
factors which shapes local culture and colors the experience of living in this place.

*****
Regional Economy

The best-known feature of the Black Sea Coast is its lush greenness. Because of the micro-climate around the Black Sea, certain crops, notably tea and hazelnuts, can be grown only in this region of Turkey. The province where I conducted my research is called Ordu, and its major source of income is from hazelnuts, with other types of agriculture, animal husbandry, fishing, and forestry contributing also. Most of the villagers have plots of land reserved for hazelnuts, one or two milk cows per family, vegetable and fruit gardens providing most of their needs, and supplemental income from family men who travel for fishing or factory work to the big cities of Turkey or in Europe. One local man worked for a two-year period in Saudi Arabia and returned to marry and live in the village. The local type of subsistence requires constant labor from those who tend the gardens and animals, and periods of intense labor for the men involved in fishing or migrant labor. The stereotype known throughout Turkey about the Black Sea Coast is that the women do all the work while the men sit in coffeehouses and tell stories or gamble. The nature of the local division of labor brings this tendency about: women are responsible for daily agricultural work, which includes a lot of carrying, while men pitch in for the intense seasonal work of hazelnut gathering, planting, and cutting. Men also do almost all of the building of houses, transportation of goods to regional centers, forestry, and upkeep of fishing boats and nets. Due to what is clearly a developing environmental disaster, including severe water pollution, over-fishing, and catastrophic events such as the explosion of Chernobyl, fishing has dropped to very low levels. Many families are suffering from both the lack of fishing jobs and a
world decline in hazelnut prices. While many young people from the region have
migrated to large Turkish cities or to Europe, land is usually kept within the family, and
many family members return to the area in August (conveniently coinciding with the
European workers’ holiday period and children’s school vacation) for the hazelnut
harvest. The salaried city jobs bring cash to the families of the area, which has changed
daily life in a number of ways.

Population Figures

The population of the province of Ordu, according to the 1985 census, was
766,348, with 268,034 living in the cities and 498,314 living in villages. The district of
Perşembe is the region within Ordu which contains the villages in my study. It has 38
villages under its jurisdiction, and a 1985 population of 8,322. According to the statistics
of the health clinic of Medreseönü, the town center to the villages I worked in, the
population of this smaller unit is 3,832. This breaks down into the town center, six
“neighborhoods,” which I call villages because they each have their own religious
building as a centering point, and one “village,” which was independent until recently.

For the purposes of this study, I will use the name of the administrative center of
this area, the town of Medreseönü, to refer to the local scene including the villages up the
hills from it. When I need to be specific about which village I refer to, I will use its
individual name (I have done fieldwork in the villages of Gebeşli, Afırlı, Çandır, and
Okçulu).
History

The history of the area includes early mention of the Hittites, Thracians, Phrygians, and the colony of Miletus. Coveted by the Seljuk and Ottoman Turks in turn, the region was the last stronghold of the Byzantine Empire, under the Pontic Greeks, after the fall of Constantinople. It was under brief Mongol and Timurid rule until finally coming under Ottoman rule in 1461. The city of Ordu grew from a small castle with a surrounding village to a city only in the 19th century. After a big fire in 1883, the city was rebuilt with a new plan which, more or less, leaves its mark until this day.

In the First World War, Pontic Greeks in the area agitated for a restoration of an independent Greek state, aided in turn by the Russians and British who both had interests in the area. An army sent from Ankara in 1921 put an end to these efforts. Greek presence in the area survives only as a local joke that Greek blood (as well as Circassian, Georgian, Armenian, Caucasian, and Laz) runs in the veins of many. Neal Ascherson (1995) describes, in the friendly style of a scholar-journalist, the history of the peoples all around the Black Sea, and outlines the effects of twentieth-century nationalism on the Pontic Greeks, the Lazi, and other Black Sea peoples.

It was very difficult for me to solicit historical information about the area, in part because I did not have the occasion to spend time with the types of older men who tell historical stories. By focusing on contemporary village life, I may have also given the impression that I was not interested in history. With the complex local history of national, political, and ethnic battles in this century, most people seem to prefer to skirt historical re-tellings and debates unless they are sure of the audience. As a foreigner, I
may have been assumed to belong to the vast crowd of outsiders whose vehement critiques of Turkish government policies directly contradict the average Turkish citizen’s hard-won sense of national pride.

**Local Conditions**

The town center has an elementary school, a middle school, and a new high school. It also has the mosque which draws most of the men from the outlying neighborhoods on Fridays at noon. The bigger grocery stores, the main seaside road, a couple of restaurants, a wedding salon, the health clinic, the pharmacy, the government offices, the barber, the post office, and the bus depot are all in the town center.

The villages are all quite high up from the sea-level town center, so, whereas people gladly walk to town, they appreciate a ride back home up the hill, especially if they are carrying groceries. One of the recent innovations is the introduction of personal cars and minibuses to take people up and down and to weddings for a negotiable fee. This is one way for a young man to pay for his own car and to keep up with all of the area’s comings and goings. Because cars and passable roads are fairly new in the area, older people do not usually know how to drive. Local women usually do not learn to drive, but they are tickled about the women who have learned to drive, usually while living in foreign countries.
Health Facilities

As of 1990, the health facilities in the province of Ordu include the main, 400-bed hospital in the city of Ordu, the 75-bed hospitals in the smaller cities of Fatsa and Ünye, and health clinics in some 62 of the region's towns. In 1980, the 200-bed Bronchial Illness Hospital of Ordu was turned over for the use of the armed forces. A new hospital is under construction. The region also has a Mother and Child Health Center, a Tuberculosis Clinic, a Syphilis Consultancy, and an Administrative Office, with two branches outside of Ordu city, for "The Fight Against Malaria." I have visited both the Ordu and the Fatsa main hospitals. In Medreseonü itself, a new building is under construction to house the health clinic, which currently shares a building with the post office and the mayor's office. Money for the new building comes from a combination of government funding and charitable donations from local businessmen and locals who work in Europe. The town fire truck and ambulance were also purchased through a collection of donations from local families who work in Germany.

Local Identity on the Black Sea Coast

The phrase "local identity" suggests that location is the most important factor in identity. The phrase traditionally assumes a type of society in which people are born, live out their lives, work, and raise families all in the same location. The concept of "local identity" comes to the foreground because of contact with outsiders. This can happen when outsiders move in, or can happen when locals move out to other settings. When
locals move, they may continue to identify “home” as the place they came from. In this case, they must make a conscious effort to keep the connection alive.

One generation ago on the Black Sea Coast, identity was primarily based on family, which coincided for men with the location of birth, the place where one grows up, marries, has a family, works, and is eventually buried. Women traditionally had one place where they were born and grew up and a second place where they lived with their husband and his family, had children and eventually were buried. For their whole lives, they are called gelin (the one who comes, the bride) by their contemporaries in the husband’s village.

Ethnic identification has been a tricky issue on the Black Sea Coast (as well as in the rest of Turkey) since the end of the heterogeneous Ottoman Empire and the start of the Turkish nation state, which was conceived as a nation of Turks. Many top-down efforts to homogenize the population were implemented, from the severity of shipping off whole minority groups, such as Greeks and Armenians, to attempts to re-write the history of Kurds so that they would be seen as “mountain Turks” rather than as a separate ethnic group. On the Black Sea Coast, a historically a mixed area where many ethnic groups have lived side-by-side for centuries, most people today automatically call themselves Turks, although they accept the joking (and incorrect) reference to all Black Sea dwellers as “Laz” and joke about their own mixed blood. In other words, ethnic identity is only foregrounded when it is rhetorically important to emphasize difference from Europeans, Arabs, Greeks, or others, usually in a political discussion. Recently, the distinction between Kurds and Turks has been very much in discussion, both in the
Turkish media and in local places of political talk, such as the coffeehouses. In terms of local identity, however, ethnicity is usually taken for granted.

As we have seen, diversity in ethnic or religious identity was "smoothed out" at the beginning of the century, as Greeks, Armenians, Georgians, Russians, and others were sent away, left, or made conscious efforts to blend in. In everyday talk, then, everyone thus became simply Turkish and Muslim (although some Alevi retained a religious distinction in their identity). Place names were also Turkified. For example, Vona, a Greek name, became Persembe, meaning "Thursday," merely because the market was held there on Thursdays.

Within the village context, family relation identifiers (like "my uncle’s son’s wife’s mother") are most common in identifying people. Secondarily, place names can be used if the person is from another village or physical location of the house can be used to describe a person in the village (the one who lives over there, above the such-and-such field, next to so-and-so).

In a separate study (1997), I have described in detail the characteristics of the new identity-marker "Almanca," the term created to describe a local person who has moved to Germany for work but tries to maintain local ties through various strategies such as arranging marriages to maximize the benefits of both local land-owning and foreign income-earning.

Family loyalty, once assumed to be a "natural" part of selfhood often becomes strained because of the economic inequalities resulting from cash income. Those who work in Germany complain to each other that their families don’t understand how hard
and expensive it is to live in Germany, and the local family members often complain that
their relatives in Germany are holding back money which they should share, or are
showing off too much. Health care is an expense which "Almancis" are expected to
assist family members in affording.

Research

I first went to Turkey as a student/tourist in 1984, the summer after I had begun to
study Turkish as an undergraduate at the University of Pennsylvania. The following year,
I spent the summer in Istanbul in an intensive Turkish language program. My third and
fourth visits were both in the summer of 1990, when I traveled as a tourist and then went
to visit the Black Sea Coast to meet the family of my future husband. We had a wedding
in his home town of Medreseonü the following year. On my sixth visit to Turkey, I spent
a month in the villages around Medreseonü, which I had by then chosen as my fieldwork
area. At this time, I started to make video and cassette tapes and got to know a local
traditional midwife who had retired, an active elderly woman bone-setter, and some of
the staff at the Health Clinic. In the summer of 1994, we spent two-and-a-half months in
Turkey, most of it on the Black Sea Coast. My major research visits were the four
months I spent with my infant son, Timur (starting when he was three months old), in
1996, and the two-and-a-half months I spent there in the summer of 1997.
Positionality

When I married a man from the region, I acquired the kinship status of gelin, which translates as "bride" but is a word formed from the verb "to come" (gelmek) because the gelin leaves her childhood home to live with the groom's family. It is not unusual in this region for gelins to come from outside the community, but I was the first (and, to date, only) American gelin. Much of a new gelin's time is spent with her mother-in-law, and I met various older women who practice traditional medicine during social visits with my mother-in-law.

Two Austrian researchers, Sabine Strasser and Ruth Kronsteiner, (1993) visited a village near Trabzon on the Black Sea Coast to study women in Turkish culture. Both were feminists who worked with Turkish women in Austria and were interested in issues of patriarchal violence and female consent. They had to make choices about how to introduce themselves in the villages where they were to stay for fieldwork. They had learned enough about Turkish culture to know that it could be problematic to be completely honest about the fact that the unmarried woman was not a virgin and that the other woman, although previously married and mother of a son, was divorced. They decided to foster the idea that the unmarried woman was a virgin and that the divorced woman was separated from her husband because of work rather than divorce. This purposeful manipulation of identity caused some awkward moments, but these researchers concluded that cultural differences make some less palatable personal facts worth concealing. Because I was coming as a bride, with my own financial means and the status of a foreigner with higher education, direct questions about my pre-marital
virginity were never put to me (see Chapter 7 for an instance when the topic was raised). Any mistakes in conduct I may have made thus far in the village setting seem to be written off as the bumblings of a well-intentioned foreigner, especially as return visits serve as proof of my commitment to the family and the area.

When I went “to the field,” (if a cluster of villages perched on steep hills can be called a “field”) I was nervous about what my in-law’s extended family would think of my research and how I would explain my intentions to them. I was also unsure about how I could talk to the authorities at the health clinic and at the governor’s office about getting the statistics I wanted. I had expected a big social and communication gap between the traditional experts in folk medicine and the professionals at the clinic. Fortunately for me, my family connections smoothed over these problems, and, because it is a fairly small community, I found that the traditional healers and the professionals had contact with each other and were able to negotiate about their respective roles. As a family member, I needed no governmental clearance for my research. I made sure, however, that word got around about my areas of interest and what I planned to do with the material I collected. Because the Black Sea Coast is a “peripheral” region in the sense of ties with the central government and benefits from government policies, it has been understudied. This idea of being slightly left out of things is commonly shared in the region, so people expressed interest and pride that I was planning to write a book about their area and traditions.

Folklore collection has been an intense industry in modern republican Turkey, so no one is surprised to learn that an outsider/intellectual wants to ask questions about local
folklore. Traditional folklore collection has focused on men's genres of music and poetry, folk dances, agricultural practices, proverbs, stories, and songs. My interest in the women's areas of folk healing was accepted as appropriate for me, although a common misunderstanding was that I planned to practice folk healing myself rather than just studying it. The retired village midwife, for example, examined my hands to see if they were the right type for midwifery. People were generally curious about what this "American bride" was up to, patiently allowing for my slow absorption of the local dialect and customs. Those younger than me, exposed daily to standard Turkish in school and on TV, often pointed out dialectical differences or "translated" for me when their elders were speaking.

Establishing Rapport

One problem that I had anticipated was getting to know the people at the health clinic. I had thought that they would be either too busy or too suspicious of my research to talk openly with me. In this case, I soon learned that the head nurse, Nurse Rahime, was the wife of the Governor, who himself is a childhood friend of my husband. Since the wedding season was at its peak during the time I was there, and since the Governor generally makes an appearance or even officiates at weddings, I saw Nurse Rahime in social settings which were not pre-arranged. She also invited me to her house, showed me pictures of her family, and was amused when I tape-recorded her mother-in-law's lullabies to a nephew. In other words, she was very friendly and open, glad that someone was interested in the health of village women - a subject about which she cared deeply.
My initial nervousness about making contact with the local officials caused me to make the inappropriate request to my husband that he introduce me to the Governor himself. Of course, the Governor knew me from our wedding two year's previously, and a formal introduction between a married female (me) and the high male official at this point (especially when I seemed to need no official clearance at all) would have been strained, artificial, and unnecessary. When it turned out that I could meet his wife just by walking into the health clinic, the problem was solved.

This was once instance of many in which my social and research-related expectations were challenged in the Turkish cultural setting, and my access to informants and data was guided by local norms. Over time, I was better able to follow cues about appropriate behavior and develop research methods which did not significantly disrupt the normal flow of life. I quickly discovered that my video recorder, while blending in at a wedding, caused most informants to become embarrassed or to start clowning. The exception was Aunty Zeynep, the bone-setter, who had a professional manner with me at all times, jumping right into detailed descriptions of her techniques, demonstrating various procedures on her granddaughter for the video camera with seemingly practiced ease. I learned that, if making a sound recording of a social visit, I would have to expect the start of the tape to be drowned out by the excited questions of children about the machine and its fascinating sound-activated red light.

The way that I got to know the women around in the villages, aside from seeing them at weddings, was to be taken around by my mother-in-law, who personally loves visiting, in a common practice called gelin gezdirmek which can be translated as “taking
the daughter-in-law (bride) around.” This is one part of a relationship known by everyone concerned with Turkish culture to be a crucial one: that of mother and daughter-in-law. Since the traditional practice is for the new bride to go to live with her in-laws, especially until the young groom can establish his own house and security, the bride tends to spend more time with her mother-in-law than with her husband. An important social ritual after a wedding is “going to see the bride” (gelin görmek) by the neighbors of the mother-in-law. In this situation, the bride’s housekeeping skills, new furniture, cooking, and manners are commented upon by her new social circle. Her husband’s family and neighbors will always call the newcomer gelin, which literally translates as “the one who comes [into the group, family].” In gelin gezdirmek, the mother-in-law takes her bride around to see friends, family, and important neighbors such as the school teacher’s wife and the hoca’s wife (a hoca is a religious teacher who takes care of the local religious building). In such circumstances, I tried to follow as best I could the rules of “good bride behavior” and was welcomed into a wide network of homes. Fortunately for me, showing family pictures is an important ritual, so I could get clues about who we were visiting and who they were related to by looking at the pictures. Figuring out who was married to whom continues to be a problem for me, because I am used to the American-style simultaneous introduction, a technique seldom used on the Black Sea Coast. Although people would explain who was who in crowds, the photographs were easier for me to understand. Details about cultural arrangements for women in the local society are given in Chapter 3.
The Identification of Informants

I have changed the names of all informants to protect their privacy as individuals and as members of families. I have chosen to use translations of Turkish familial terms, such as “Aunty” “Uncle” and “Granny” to reflect local usage and generational distinctions. I have retained the Turkish term Yenge because its literal translation “sister-in-law” does not reflect the cultural importance placed on the distinction between those women who marry into the family and those who are from the family.

I have provided some terms and phrases in Turkish, for those readers who can benefit from knowing the originals. In a few instances, in particular when transcribing my interviews with “Granny,” I have tried to reproduce the local Black Sea pronunciation when writing out the original Turkish.

Goals of the Project

In this project, I aim to construct an ethnography of healing practices in one specific geographical area. I have chosen to study culturally specific ideas of illness, health, birth, and death because these ideas can form the warp and weft upon which the fabric of culture is woven. By studying traditional healing practices in dynamic interaction with clinical practices introduced in this century from the West by way of the Turkish national government, I can learn about the cultural construction of beliefs about health, illness, the supernatural, the place of humans in the world, gender roles, tradition, and change. By focusing specifically upon what Turkish village women and their counterparts in the health clinic know, and how they demonstrate and explain their
knowledge to others, I will not only be studying an area of culture which has been little studied, but I will be learning about how women participate in the construction, maintenance, and redesigning of culture.

The objective of this research is not only to document actual practices, but also to describe the health care system in action, showing how people choose and negotiate care for themselves and family members. This approach should add to existing studies and help develop theory which will enhance cross-cultural study in general, and, more specifically, the study of the ways women determine and are determined by their own cultures.

Introduction to the Project

In my preliminary dissertation research in five villages on the Black Sea coast of Turkey, I began with the question: Is Western-style clinical medicine destroying traditional types of health care? What I found was a complex and dynamic relationship between clinical and traditional medicine, in which individuals negotiate with experts to choose from a range of possible remedies to relieve their health problems. I also found that women are extremely active in this type of negotiation, as patients, as family members of patients, as clinical workers, and as traditional healers. Despite their training in clinical medicine, local doctors, nurses, and midwives are also intimately involved with traditional healing techniques and healers in a variety of ways — from trying to stop a practice they consider harmful to trying to incorporate methods and cultural attitudes which they respect and find efficacious. In this way, my initial essentializing of the clear
division between a “pure” local culture and a hegemonic larger-than-local culture was, to use Amy Shuman’s (1993) term, “dismantled.” As she puts it, “What needs to be displaced is any possibility of studying ‘the folk’ as an unmarked, natural, authentic category. ... The only choice now is to study the processes of marking, claiming authenticity, and negotiating boundaries between groups or genres.” (349-350)

Health and illness are personal and social issues of great importance. An illness is an incontestably real experience for a patient, one which is dealt with in culturally-specific ways. The processes of naming an illness, describing it to others, determining its cause, and acting to remedy it are determined by cultural norms and expectations. By studying how members of a culture deal with these issues, one can learn about the cultural ways in which an individual is incorporated into the social fabric.

Arthur Kleinman (1980) provides a model of a “health care system” which is “a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions.” (24) When an individual is facing an illness, as a patient, healer, or concerned bystander, culture influences what is thought to be the cause, what remedies will be sought, in what order, through what institutions, with what expectations, and with what participation by others. This does not mean, however, that all members of a local culture respond in the same way to an illness. A health care system is complex and allows for many possible choices, changing explanations, new healing methods, social criticisms of individuals’ choices and actions, and ways to reject failed methods.
Before coining “health care system,” Kleinman (1975) had defined the “medical system” as that which:

... represents a total cultural organization of medically-relevant experiences, an integrated system of social (and personal) perception, use, and evaluation. That is, medical systems are much more than particular kinds of medical facilities, practitioners, and practices. They are cognitive, affective, and behavioral environments in which illness and health care are culturally organized. Moreover, they are to be appreciated as such only on the local level, where they actually function. (596)

Kleinman (1975) has been a leader in the development of interdisciplinary theory in medical anthropology. He called for studies which both reveal the cultural complexity of health-related ideas and behavior and demonstrate how disparate healing practices are integrated into a coherent cultural system. He noted a lack of attention to the individual in previous studies of health-care decision-making, as well as an ethnocentric and Western biomedical-centrist bias. In this study, I aim to describe an adaptive local cultural system which has evolved to respond to human suffering. Through translated interviews, I hope to show that individual variations are part of any health care system.

Folklore

Folklorists often study verbal expressions of cultural concepts. Stories about real ailments and the attempts to remedy them are an important part of social interaction in Turkish culture. As women visit each other in the course of regular daily life, they tell stories about their own health, about the health of family members and neighbors, and even about the health of strangers whose extraordinary conditions or pitiful situations have been reported in the media. Along with these types of stories of sickness and
attempts at cure, there are stories by or about healers which tell how they learned their
crafts, how successful they have been with various types of ailment, and what they expect
in return for a successful outcome. Doctors, nurses, bone-setters, religious healers,
midwives, and those who have remedies for the evil eye can all equally become the
topics of lively discussion. The traditional healers tell stories of their own interactions
with clinical practitioners. Doctors and nurses in the clinics have stories about village
ignorance, health concerns, and their own interactions with local culture. During the
course of my research, I have collected many such stories and have examined them to see
how health-care is managed and represented in the community. It is my aim to present
these stories and to analyze them, in order to present a picture of the complex and
constantly changing health care system of this particular cultural area.

Recent theoretical developments in the field of folklore have integrated important
insights from other disciplines. My work has been interdisciplinary by necessity. The
trend towards interdisciplinary theoretical work has been a boon to scholars placed in the
intersections of folklore and area studies, like myself, and like those who study folklore
in South East Asia. Editors Appadurai, Korom, and Mills (1991) explain:

...folklore has become the locus and critical nexus of important interdisciplinary debates
and contests pertaining to the expressive dimension of social life ... [we are in] an era
when terms such as 'genre,' 'performance,' 'tradition,' and 'text' are no longer markers
of terminological common-sense but point, rather, to large areas of intense debate. The
field of folklore is host to these debates and, moreover, has participated in opening them
up to even larger debates in the fields of critical theory, media studies, and cultural
studies. (5)

The insights of post-colonial critics and ethnographers (Anderson 1991, Bhabha 1990,
and Ranger 1983, Jusdanis 1991, Minh-ha 1989, Said 1978, Spivak 1988, 1990, Webber 1991) have problematized the act of doing fieldwork across national and economic borders. It has become impossible to ignore the impact of social, economic, historical, and political struggles and inequalities on the collection of cultural data. A scholar aware of her or his own implication in the messy realities of cross-cultural contact can admire the resilience of folkloric forms. Sabra Webber (1991) finds that:

Folklore, like other aesthetic forms, is rhetorical, dynamic, and adaptive. It is potentially a force for both stability and change, repression and liberation. It is a phenomenon that is manipulated by its performer and subject to negotiation by its audience within communally determined bounds. But even those bounds may be knocked askew, especially when participants have frequent and intense contact with other cultural models. Folklore enables a performer in collaboration with his or her audience to appropriate selectively ideas or practices from other groups in a manner aesthetically and practically agreeable to his or her own community. (xx)

When a folklorist tries to take the “larger-than-local” (Shuman 1993) into account, the local can seem small and threatened. In another passage, Webber finds that:

As we try to place communities in global and historical settings, they begin to seem very much at the mercy of those larger forces — helpless and, finally, culturally nonviable. Folklore is a tool with which communities can reinforce and revitalize community identity when it seems the community should be falling apart under the onslaught of, say, western hegemony or the ups and downs of the global economy. (8)

While realizing that “folklore is a tool” for a community, we should also admit that it is a resource for Western academics, in the same way that the labor power or natural resources of poorer countries are resources for our economic machine. We may be panning for nuggets of folkloric gold, hoping to show that human creativity is inexhaustible. The paradigm of inexhaustibility has been used in a long series of
exploitative ventures, such as mining and fishing, which have caused extensive damage.

We cannot "extract" folklore without changing its environment. There is no such thing as "neutral observation."

David Hufford has extensively studied folk belief systems, including medical belief systems, as well as the scholarly and medical professional debates about these systems. His work is interdisciplinary, including a familiarity with scientific and medical debates, anthropological studies from around the world, comparative religious studies, philosophy, folklore, and popular cultural debates. His theoretical contributions include the description of scholarly and medical "traditions of disbelief" (1982b), the call for the accurate and non-judgmental collection of "core experience" (1982a) — which he also calls the "phenomenological approach" or "experiential theory," the need for scholarly reflexivity in belief studies (1995), and a recommendation of an "inclusionist approach" (1988) in the examination of belief. He states (1988):

In contrast to both psychological and materialist reductionism, the inclusionist position assumes that the explanations of some human phenomena will be primarily material (including biology) and others primarily psycho-social, and that some (most? all?) explanations may not be reducible to a location in a single domain... Thus the inclusionist position is by necessity interdisciplinary. Exclusionist positions [which are located on the poles of psycho-social and biological approaches] tend, conversely, to reflect disciplinary ideologies." (5)

He finds the "inclusionist" position preferable to both the "cultural relativist" and the "biological universalist" positions because:

both exaggerate the 'naturalness' of their own categories and overstate the 'constructedness' of folk categories. Therefore, both serve to defend conventional academic knowledge from the grave risk of discovering any authentic knowledge in someone else’s belief system. (12)
This work, then, is interdisciplinary and is inspired by the efforts of scholars from a range of academic backgrounds. Rather than as a methodology or type of data, the term “folklore” has become, for me, a sign which marks a place in the web made up of shifting cultural and academic strands.

Tradition-Bearers

The fact that folklorists often collect stories from elderly informants can lead to the mistaken assumption that these types of stories will disappear with the older generation. Patrick Mullen (1992) explores the relationship between tradition and the elderly:

Not all old people are active tradition-bearers, though; some passively carry on traditions, but the active ones value the past, maintain a connection with it, and often identify themselves as traditional performers and craftspeople. This does not mean that they live in the past; they keep traditions alive by using them as resources for coping with the present. Folklore as an academic discipline is not the study of the past but rather the study of present situations informed by the past. The people who actively bring the past and the present together in creative ways are the ones folklorists seek out in the community, and finding them is not hard because most people in the community know who they are. ... and they are often the oldest people in the community. This might suggest that folklore is dying out, but it is not. Younger people are often aware of tradition but do not yet actively carry it on. (2)

In Medreseönü, young women know about remedies and practices, but the older women have more actual experience, more stories to tell, are respected for their experience (thus get an audience). They may also be in a safer position to talk about health, being more responsible for the general health of the community and less responsible for the specific health of individuals (such as babies — for whose health the
young mothers are held most responsible). In the next chapter, I will discuss the fact that no one wants to be blamed for a treatment that goes wrong or fails to work. The older women, with their higher social standing, are safer from blame unless their methods are thought to be dangerously backward. Many of them have reduced their performances of actual treatments because of the possibility of blame, but they freely give advice. As they grow older and amass experience, women take on a more active and vocal role in the maintenance of tradition, even as they adapt new ways to their local needs. Traditional healing practices are performed and passed on particularly by older women, although there are a few older men who are known for specific healing abilities.

**The Term “Traditional”**

To explain my research interests to inhabitants of the villages around Medreseonü, I used the local term “kocakar ilaçlar” (which means “old woman medicines”). With the health clinic staff and with city dwellers, I was more likely to use the term *geleneksel tedavileri* (meaning “traditional remedies” or “traditional medicines”), which is the scholarly term used in Turkish. When I use the term “traditional,” in English, I mean to focus on the means of transmission of knowledge — in that it is passed down within a fairly bounded social group from one generation to another, from one individual to another, in a local setting, through well-established local pedagogical techniques.

I do not mean the word “traditional” to suggest a fixed or moribund set of old-fashioned ways. Rather, I mean it in the sense of “tradition” used by Handler and
Linnekin (1984), as a negotiation between what people know and what they learn as circumstances change:

we must understand tradition as a symbolic process that both presupposes past symbolisms and creatively reinterprets them. In other words, tradition is not a bounded entity made up of bounded constituent parts, but a process of interpretation, attributing meaning in the present through making reference to the past. (287)

When a bone-setter gives prescription pain-killers to her clients, she is using a technique which has a shorter history than the technique of binding a limb with beeswax-soaked rags. The role of a healer, however, is to bring relief from suffering through a combination of medicinal and symbolic elements. By incorporating a clinical product into her healing resources, she is appropriating both the medical and symbolic power of clinical medicine. Entirely new techniques, then, can be “traditional” and time-honored procedures can easily be abandoned if their usefulness is over. Once again, from Handler and Linnekin:

we argue that tradition is a symbolic process: that “traditional” is not an objective property of phenomena but an assigned meaning .. that the relation of prior to unfolding representations can be equally well termed discontinuous as continuous. (286)

In his book on the Kung people of the Kalahari Desert, Katz (1982) clarifies his use of the term:

The word traditional, used to describe the healing approach I studied in the relatively unacculturated areas of Dobe in the late 1960s, is merely a relative term, meant to distinguish the healing approach found in a primarily hunting-gathering setting from the approach of more sedentary Kung. It is hard to imagine one ‘original’ setting for the healing, just as it is very difficult to specify any one individual or even as the beginning of a healing dance. The context for healing among the Kung seems to have continually changed and is still changing. (254-255)
The term traditional should never be understood to describe a static cluster of know-how which cannot adapt to changing circumstances and which is a result of ignorance. Traditional medicine must necessarily adapt to changing circumstances because it is itself an empirical system, tested through time and changing circumstances, in which the effective elements are retained and the ineffective elements are rejected or re-configured.

The Term “Local”

Aware of the potential simplification and essentialization of a culture which comes with the use of terms such as “local” or “folk,” I none-the-less need a term to describe the practices and culture which occur in the region of my fieldwork. When I call a practice “local,” I do not mean that it occurs nowhere else, or that it sprung up, fully-formed, in the place where it is used. I do not claim that there is no contact between the people and culture found in the area I arbitrarily marked off as “my field” – and, in fact, I try to show that a trip to Germany or to Istanbul for an operation is part of the local health care system. The people who provided me with the information I have used in this study have a sense of local identity and local culture. Neither of these concepts are fixed in stone – they can change over time, according to different situations, in response to different challenges.
The Term "Lived"

Likewise, I prefer the term "lived" to describe practices situated in culture. Instead of trying to describe local culture, local belief, or local health care practices as if they existed as an ideal type, like a “Fortress of Forms” (Holbrook from Galip, XX), I wish to make clear that these systems are constantly in flux, being renegotiated by those who use and are used by them. I do not find the term “vernacular” (Primiano, 1995) to be preferable to “lived,” for reasons delineated in Chapter 5.

The Empirical Basis of Traditional Health Care

Hufford (1995), takes pains to emphasize the empirical basis for many practices which have been labeled and denigrated as “folklore,” “superstition,” or “folk belief.” The fact that the empirical method is the corner stone of the biomedical theory of health care does not mean that non-biomedical theories are not based on accurate and systematic observation. Hufford writes:

Folklife scholars have long been aware that folk traditions concerning architecture, food preparation, agricultural practice, botany, the making of textiles and pottery, and so forth, constitute impressive bodies of valid knowledge rooted in experience. (31)

I am confident that Hufford and other folklore scholars would unhesitatingly expand this list of folk traditions rooted in experience to include traditional healing practices. In describing the Kung health care system, Katz (1982) shows the intelligent and adaptive uses of all available medicines:

A practical and pragmatic people, the Kung use things that they believe work. They have been exposed to other systems of treatment, both African and Western, yet they continue
to rely on their healing dance. Antibiotics may be used in conjunction with a dance, to provide extra protection or to deal with diseases particularly amenable to Western medicine, such as gonorrhea. Antibiotics are also used sometimes in conjunction with or instead of indigenous medicinal salves. Although contact with Western medicine is still limited, the pattern of that contact is clear: the Kung integrate elements from other treatment systems into the tradition of their dance. The prevailing mode of healing remains _num_, though the Kung attitude remains realistic. As Gau says: "Maybe our _num_ and European medicine are similar, because sometimes people who get European medicine die, and sometimes they live. That is the same with ours." (56)

The Terms "Orthodox/Unorthodox"

Much of the scholarship which has looked at differences between the biomedical theory of health care and other theories has used the pair of terms "orthodox" and "unorthodox." For example, Norman Gevitz (1988), introduced his edited volume with the following definitions:

"Unorthodox medicine" may be defined as practices that are not accepted as correct, proper, or appropriate or are not in conformity with the beliefs and standards of the dominant group of medical practitioners in a society. Individual healers who persist in engaging in these activities in spite of the disapproval and opposition of the dominant group may be classified as "unorthodox practitioners."

And:

...orthodox physicians as a collectivity share certain ways of apprehending phenomena, certain ways of diagnosing problems and handling them once identified, and certain standards of conduct. They may be regarded as being part of a professional community in that they speak the same language, rely on the same general pool of knowledge, share certain beliefs, subscribe to similar values, and strive for common goals. (1)

While I understand the usefulness of these terms in the study of the history of medicine in the United States, I find that the term "orthodox medicine" does not work in the Turkish cultural setting because it conjures up strange and historically inaccurate associations with Christian Orthodoxy.
The Term "Clinical Medicine"

In this study, my use of the term "clinical" follows that of Foucault (The Birth of the Clinic: An Archaeology of Medical Perception, 1963/1994 English ed.), in that it describes what is practiced by institutionally-trained doctors, nurses, and midwives in the health clinic, private doctor's offices, and hospitals which serve the five villages around Medreseönü. The term encompasses the location of the healing practices (even though the clinic staff sometimes make tours of the villages to provide clinical services), the training of the staff, the costumes worn (the doctor's white coat or the uniform nurses' dress, as governed by national laws), and the technologies in use (pharmaceuticals, plaster casts, thermometers, stethoscopes, scales, test tubes, needles and syringes, etc). Foucault (1963/1994 ed.) analyses the emphasis of clinical medicine on the gaze of the practitioner, showing that biomedical medicine is a way of speaking and thinking, as well as a set of techniques. He states:

The figures of pain are not conjured away by means of a body of neutralized knowledge; they have been redistributed in the space in which bodies and eyes meet. What has changed is the silent relation of situation and attitude to what is speaking and what is spoken about. (xi)

In the history of self-described modern medicine, Foucault (1963/1994 ed.) finds a significant moment:

At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and the expressible, but this did not mean that, after over-indulging in speculation, they had begun to perceive once again, or that they listened to reason rather than to imagination; it meant that the relation between the
visible and invisible — which is necessary to all concrete knowledge — changed its structure, revealing through gaze and language what had previously been below and beyond their domain. (xii)

When I use the term “clinical medicine,” then, I mean to draw attention to the fact that it is a culturally, historically, politically, and economically situated phenomenon, as constructed in discourse and practice as “traditional medicine.” It should not be assumed to be any more or less neutral or empirically-based than any other system. As Foucault (1963/1994 ed.) shows, the strength of the clinic is a strength in discourse:

The clinic — constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse — owes its real importance to the fact that it is a reorganization in depth, not only of medical discourse, but of the very possibility of discourse about disease. (xix)

The “Health Care System” Approach

Scholarly studies which take an anthropological or folkloristic approach to examining traditional healing practices look for the context which binds the individual practices to each other and to the culture as a whole system. Arthur Kleinman’s Patients and Healers in the Context of Culture (1980), is a leading example of an ethnography of a “health care system” (Kleinman’s term) which displays the contemporaneous, cooperative, and competing natures of the many healing practices which exist in any society. Kleinman’s fieldwork examines the Taiwanese health care system, but his theoretical approach has been useful in this study of the health care system on the Black Sea Coast of Turkey. “In every culture,” he says, “illness, the responses to it, individuals
experiencing it and treating it, and the social institutions relating to it are all systematically interconnected.\(^{(24)}\) Healing, as well, can be described in a broad, systemic manner. Richard Katz's study of community healing among the Kalahari Kung (1982) is another example of the health care system approach. He writes:

I view healing as a process of transition toward meaning, balance, wholeness, and connectedness, both within individuals and between individuals and their environments. \(^{(3)}\)

Theoretical advances in the "health belief system" approach have been made by Hufford (1983, 1988), O'Connor (1995), and Snow (1993). O'Connor (1995) summarizes this approach as follows:

The systems approach includes healers, patients, theories of disease causation and cure, materia medica, and therapeutic techniques within its purview. It takes into account cultural influences, personal interpretation, intra-group variation in belief and practice, and the dynamic aspect of belief (its variability through time, across changing circumstances, and from person to person). \(^{(59)}\)

Kleinman, with his medical background, is concerned with the perceivable outcomes of healing, which he divides thus:

cross-cultural studies reveal that healing refers to two related but distinguishable clinical tasks: the establishment of effective control of disordered biological and psychological processes, which I shall refer to as the "curing of disease," and the provision of personal and social meaning for the life problems created by sickness, which I shall refer to as the "healing of illness." These activities constitute the chief goal of health care systems. \(^{(82)}\)

I am less concerned than many medical anthropologists with documenting the actual results and success rates of various techniques and remedies, so I find less need to separate the biological and social into discrete domains. In this, my approach resembles that of O'Connor (1995), who says, "I cannot speak to efficacy, except to report how users of various healing systems understand and evaluate it." \(^{(xvii)}\)
Unlike Kleinman (p. 83), I do not use the term "clinical" to refer to traditional health care practices which take place outside of the actual institution of the clinic. He makes the important observation that traditional health-care practitioners have concerns and practices which are similar to (and as important as) those of a western-style clinical practitioner. In trying to make a case for cross-cultural and ethnographic study of health care systems, Kleinman needs to sway an audience of readers (including Western medical practitioners) which has a biomedical model of health and illness. In my work, I am assuming an audience willing to suspend their disbelief in foreign practices, and trying to preserve the distinction between traditional medicine and medicine associated with the institution of the health clinic. It is a distinction made by the inhabitants of Medreseönü, and, I would argue, by most people, everywhere. There are points of overlap, like the bone-setter who gives out prescription pain-killers, but I want to reserve the term "clinic" for a kind of technology and explanatory model which was introduced to the area within the living memory of the older inhabitants.

Local Distinctions Made Between Traditional and Clinical

The people I lived with and interviewed had a clear idea about what types of practices were officially sanctioned and in use in clinics and hospitals (hastane, doktor işi) and which types were "village stuff" (köy işleri), "old woman's medicine" (kocakar ilaçlar), and "herbal, local medicines" (otdan, yandan ilaçlar). In the arenas of traditional and clinical, education in health care is one of the distinguishing factors — traditional medicine is learned by people in their own local setting, from family and
neighbors, usually as a part of general “know-how” learning by watching, helping to do, and doing; clinical medicine requires a formal training in institutions away from home, involving the use of specific items of technology not in use in the traditional setting.

**Belief, Religion and Health Care**

The study of folk belief systems is essential to the study of folk medical systems. According to Kleinman (1980):

the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness, norms governing choice and evaluation of treatment, socially-legitimated statuses, roles, power relationships, interaction settings, and institutions. (24)

Religion is an important part of the health care system of Medreseonü. In fact, all of the traditional practices could be called “Muslim healing practices” because they are performed by Muslims. Despite its secular veneer, clinical medicine is also practiced by and for Muslims in Turkey.

At the local level, individuals distinguish in various ways between general wisdom handed down through generations and practices which are considered to be specifically religious. Sometimes the distinction comes from the need to be ritually clean for a procedure — such as reading a *nazâr* prayer, or performing a ritual such as *mum dökmek* (described in Chapter 5). For Muslims who practice the required five daily prayers, ritual cleanliness is continuously renewed throughout the day.

Readers familiar with practices in other Islamic cultural situations will find some similarities between what they know as Muslim practice and what is described here. I
have chosen not to call the healing practices in Medreseönü “Islamic” or “Muslim” because these terms are too general. While the inhabitants of the area mostly consider themselves to be Muslims, and while the textual source for Muslim belief and practice is the same, lived religion is specific to individuals and communities. There are similar problems in using the general term “Turkish” to describe health care practices in a small region on the Black Sea Coast. In Chapter 5, I will discuss in greater depth issues concerning belief, including religious faith, perceptions of the supernatural, and ritual activity.

The Terms “Western” and “Modem”

The clinical medicine under examination in this work cannot simply be called “Western medicine” because, although originally imported from the West, it has taken root and become integrated into the local scene. It cannot rightfully be called “modern medicine” either, because that would suggest that traditional practices were somehow left in the past, over and done with, obsolete — when in fact they continue to be practiced, modified (“modernized”), and used in the present. Foucault (1963/1994 ed.) has shown that the term “clinical” itself conveys the historical, global, political significance of the world-view, discourse system, and technologies of biomedicine.

The Focus on the Moment of Patient/Healer Interaction

A focus on the particular moment when a patient and a health practitioner come together in the effort to solve a health problem is a convenient starting-point for studying
a health care system. The risk of this focus is that it privileges technologies, recipes, and specific techniques, and can get bogged down in the details of specific practices. It is possible that some readers might like to be able to reproduce a particular practice for their own health care purposes, as people are able and likely to take health care practices from any source that appeals to them, in which case they would require fullest detail. I tend to assume that my audience's interest is "academic" rather than practical. This assumption is the opposite of that of my informants — they consistently assumed that I wished to practice the techniques they were describing. Studies which provide a rich description of the culture which surrounds healing practices often do not describe specific techniques in great detail. Studies which stress recipes and techniques often ignore the general cultural context which makes them viable and sensible. In this work, I hope to find a balance between specific details and general cultural description.

In contrast to an approach which only looks at the practices of specialists, be they doctors or traditional healers, a patient-centered examination of the healing practices of a particular culture reveals the world-view and priorities of non-specialists. Instead of only collecting the theoretical and abstract views of experts, who are often frustrated when the behavior of a real patient does not conform to their ideal vision, I have gathered information about how patients choose, combine, and change treatments until they are satisfied with the results. In Chapter 6, I describe the various treatments sought by a woman who could not conceive a child. This patient-centered, long-term view shows how complex an individual's use of available health care can become. If I had only
interviewed the specialists who treated her, I would not have learned how she adjusted her views about traditional and clinical techniques as she progressed through a series of treatments.

My approach aims to look at the specifics of healing as windows on the general local culture, taking examples from a small number of informants linked by family ties and neighborly proximity. My intent is to describe how a health care system is an integral part of a culture, and to show how an individual in a specific cultural setting seeks relief from suffering within a web of cultural meaning and possibilities.

The Focus on Women

I use "women" in the title because I want to be indexed under that term so that a certain type of reader can find my work. I am not claiming that "women" are a homogeneous group, even within local culture, because I do not want to disguise the fact that women have a multitude of positions and possibilities which they can negotiate and inhabit at different times in their individual lives, constrained in various ways by culture in general and by particular circumstances, including economic and political factors. My choice of focus on women was, in part, a result of trends in scholarship in the United States. My access to women's discourse was also determined by my family connections to the area. My participation in the roles of gelin, wife, and mother, as determined by my own life history, gave me a particular place in local society. From this place, I was able to participate with and observe women as they interacted with the local health care system.
Anthropological Debates on Definitions of Terms "Illness" and "Disease"

Robert A. Hahn (1984), within the forum of an edited volume on South Asian Systems of Healing, extensively critiques literature on the cross-cultural study of health care systems (including Kleinman), in an attempt to reach a firm, objective, and useful definition of the terms involved for such a study. He shows the slippery nature of even careful definitions of "illness" and "disease," in which the authors' own beliefs about the reality of either are obscured in the attempt to be non-universalizing. To avoid this problem, he suggests that the common human experience of suffering be taken as a universal starting point, after which the culturally constructed natures of what he calls Illness-ideologies (the perspectives of the sufferers), Disease-ideologies (the specific perspectives of biomedical practitioners), and Disorder-ideologies (the varied perspectives of traditional, non-Western healers)." (Hahn, 1984:15-16) I find this approach useful, and similar to Hufford's "core experience" approach (1982) to study comparatively what people in various cultures report about their experiences. Hahn is still making problematic dichotomies between patient and specialist, biomedical models and "traditional, non-Western" models. Biomedical practitioners, after all, are also sufferers, a disease is a disorder in the biomedical ideal system, and the terms "traditional" and "non-Western" need to be as carefully examined as other terms in the argument. I would rather call all the perspectives Disorder-ideologies, which could then be subdivided into equally valid and interesting types such as individual experience-based descriptions and coping mechanisms, particular lived examples of biomedical
models and procedures, and any other specific models and procedures, whether they be tied to a certain group or geographic area. In this way, the complex mix of health care strategies available to any particular inhabitant of a village on the Black Sea Coast could be shown to include elements of biomedical ideology as well as traditional ideology, all in an effort to alleviate the concrete suffering of that individual and to control its effects on the community.

The biomedical model is so taken for granted that it is discussed as a universal system which can be introduced, transported, taught, and used as if it is unchanged despite changes in time, space, and human participants. Of course there is a specific history to this universalizing discourse, which is why the biomedical ideology often gets called “Western medicine.” In actual practice, however, biomedical training, technology, and the practices of specialists and patients are not as consistent and unquestioned as we, as participants in the cultural ideology of biomedicine, are conditioned to believe. There is a great deal of debate, disagreement, and change over time within any particular Western country’s health care system, despite the hegemonic front presented by the community of specialist to the general public. The physical accoutrements of a clinic (white uniforms, stethoscopes, x-ray machines, etc.) may be similar across national boundaries, but the actual beliefs and practices of clinic staff may vary widely.
Conclusion

In light of Shuman’s recommended project (1993) for folklorists, namely to “develop and contribute to discourses on local cultures as contested categories,” (362) I hope to move from the definition of the terms and theoretical approaches I have found helpful to a description of a living health care system in one interconnected group of villages on the Black Sea Coast of Turkey.

My descriptions are by necessity simplifications of the existing range of possibilities in the health care system of Medreseönü. As Bonnie O’Connor (1995) warns:

Any description of a belief system is to some extent a composite and an idealization ... It represents only a “freeze-frame” moment in a dynamic and always-changing phenomenon ... There is as much diversity within a system as there is among systems. ... Attempts to be too precise would distort the tremendous complexity and infinite variability of the actual picture of vernacular health belief and practice. (xxi)

I have not, for example, chosen to trace the history of Ottoman medicine, with its roots in Classical Greek philosophy, Islamic scholarship, and interactions with a global scientific community. Tracing the origins of clinical medicine to Europe in the early 19th century is a convenient and Euro-centric simplification. At any rate, the clinic in Medreseönü is not merely an earthly manifestation of an ideal type of “clinical medicine.” It is local and distinct in various ways which have come about in the everyday grappling on the cultural wrestling mat. Likewise, the “traditional culture” is not a pure, authentic form untouched until recently by outside forces -- it is just one of the older, experienced wrestlers taking on all newcomers and constantly adjusting to changing rules and the differing styles of the opponents. As with all systems, a health
care system is always being re-created as it is being used. In this document, frozen in time, I hope to show mobility, adaptability, and perpetual creation involved in the human response to suffering.

_Beyond estimate and analogy_

_New poetry is uttered constantly_

(Galib Beauty and Love, 881, trans. Holbrook 1994, p. 91)

_In sum, is not perpetual creation_

_The cause of original expression?_

(Galib Beauty and Love, 783, trans. Holbrook 1994, p. 91)
CHAPTER 2

LOCAL HEALTH CARE

It is mid-morning and I am tidying up after breakfast with Aunty Emine, one of the elderly traditional healers who has accepted me as family. I have spent the night with her, and try to help out with various chores around the house, in the manner of a gelin. We are shaking the carpets over the balcony, when a woman turns up at the door with two of her grown sons. I bustle about putting the carpets back in place on the wooden living room floor and the tiled kitchen floor, while Aunty Emine has them sit down. One son leaves almost immediately. I haven’t figured out why they have come at this mid-morning hour, which is not the usual casual visiting time, so I ask Aunty Emine if I should put water on for tea. She tells me to boil water and bring it to the living room. As I wait for the water, I come to understand that the woman’s son has injured his wrist and his mother brought him so that Aunty Emine could look at it. When I bring a bowl of hot water, Aunty Emine pulls a new bar of soap out from the storage area under the couch and begins to massage the young man’s wrist, asking where it hurts most, how he injured it, and in which direction it was pushed when it was injured. While the young man knows he hurt his wrist the previous evening, he is not sure just when and how (or is
perhaps intentionally vague, as if he had been drinking or fighting when it happened).

Aside from these direct questions, Aunty Emine mainly converses with the young man’s mother, who is about the same age, exchanging little bits of local news. This draws attention away from the massage, and the patient begins to add bits of news to the conversation between the women. When she hits a sore spot, the patient expresses a lot of pain, but he is cheerful and joking when she moves on to another area. After the hot water and soap massage, Aunty Emine has me bring olive oil, and she continues working on the injured wrist. The patient had come in with his wrist wrapped in a cloth saturated in beeswax. She has me warm up the cloth by passing it over the gas stove burner, so that it will soften and can then be re-wrapped after the massage. She tells the woman to wrap the wrist in a white cloth, emphasizing that it should be white and clean. She says it would be best to have the wrist looked at (by implication by a doctor who would x-ray it). She had found a spot where a nerve was pinched and had softened the spot with massage. She says that there is no break, but that she can’t be sure about a fracture. The patient seems more comfortable, and his mother expresses thanks as they are leaving. They did not drink tea, as it was not a social visit. I later saw the young man at a distance at the local marketplace, and his wrist was no longer wrapped, suggesting that it had recovered.

On another morning, I wake up with an upset stomach. I tell Aunty Emine, who has already been up to do chores and start breakfast. She tells me that her own daughter, Şengül, had asked for a plastic bag to take with her when she went to Fatsa. “I asked her ‘Why?’” she says, and laughs, “Because she might throw up!” Yesterday she had had the
same problem as I have now. I try a spoon of ground coffee and salty ayran (yogurt with water), a remedy I had learned during another illness the previous year. This makes me throw up immediately. Aunty Emine rummages through a shelf of pills, looking for the pills she had given to her daughter yesterday. I tell her that I don’t want pills because the medicine would pass to baby Timur through my milk. She says it wouldn’t hurt the baby, but I still decline. Instead, I go lie down on my bed. Concerned, her husband, Uncle Ferit, comes and sits on the side of the bed, trying to diagnose my problem, saying “You didn’t eat anything bad (Yaramaz bir şey yemedin).” He decides that I have caught a cold (Üşümüşün) I remind him that he had been scolding me the previous day for not wearing slippers. He nods, “See, you have to wear them!” They ask me to come and eat breakfast. I don’t, preferring to lie in bed feeling sorry for myself. Fortunately, Timur is enough of an infant that he doesn’t mind just lying on the bed next to me.

After breakfast, Şengül brings me a big cup of tea with lemon juice. I decline the offered sugar and drink the tea. A bit later, she comes in with her head covered in the style for prayer (suggesting that she had prayed over the remedy she was offering), with a tea glass filled with coffee grounds in lemon juice in one hand and a tea glass filled with water in the other. When I make faces and noises while drinking them, she laughs and says “Afiyet olsun (‘Good Appetite’).” A while later, Aunty Emine comes in and sits on the bed. She checks the temperature of my forehead, and feels my wrist. She pats my hand and asks if the remedy has made my stomach settle. She says that she had noticed yesterday that my color wasn’t good. She then goes on to talk about her own health, telling me that she is not supposed to eat pickles because of her tansiyon, they don’t do
her any good. She frets about the chores, how they make her head spin, her heart thump, and her back hurt. She sighs, “Well, what can I do? I have to carry on.” By noon, I am fine, ready to get up.

*****

Local Meanings

In the everyday talk about illness and its causes, people seem to attribute most problems to fluctuations in temperature. “You got cold (üşütmüşün).” “You must have been sitting in a draft.” “Don’t walk on cold tiles without slippers, you’ll get gas.” (Shoes are never worn inside the house, and slippers, although always recommended, are not often worn in the summer). “Cold drinks will make your stomach sick (miden üstür).” “She was in the sun too long, she got sun-struck (güneş çarptı).” “Oh, it’s too hot, my clothes are sticking and I feel like I’m suffocating (bunalıyorum).” “Don’t sleep with your throat and upper chest (gerdan) exposed, you’ll get a chill.”

According to local wisdom, a sick person should not be left alone. People should visit bed-ridden people, bring them things, sit by them and sympathize, spend time, give advice. Common illnesses, however, should be treated lightly — it is considered amusing to hear how someone was throwing up, racing to the bathroom, or tossing and turning all night, as long as it is over. People, as they get older, are expected to recite their various aches and pains when asked, young people should be more stoic — after all, what do they know of suffering? After a visit to a doctor, when asked about her health, one elderly women practically crowed with pride: “I’ve got high blood pressure, cholesterol, no
diabetes. Thank God, I’ve got heart problems – I’ve got everything!” (“Tansiyonum var, Yağ var, Şekerim yok, Allah’ha Şükür, Kalp var -- Her Şeyim var!”)

In local social visiting, the first topic of conversation revolves around health, in answer to the question “How are you?” Unlike in American culture, where this question is understood to be a formality requiring a short, positive answer such as “Fine, and you?” this question is answered with either formulaic modesty, as in “İdare ediyoruz.” (“We’re scraping by.”) or “Uğrasyorum.” (“We’re struggling along.”), or with real information about health problems: “Hastayım, biliyorsunuz, doktor’a gittim ...” (“I’m sick, as you know, I went to the doctor ...”). Women express sympathy for each other, they solicit advice, they show off their economic means by discussing visits to expensive specialists, they discuss the illnesses of family members and acquaintances, and they compare symptoms and remedies. Of course, there are limits to the acceptable discourse about one’s own health, and some women are known to talk too much about their problems.

Local Ideas about Contagion

The traditional model of health and illness has no room for a general idea of the contagion of everyday illnesses. Aside from certain serious conditions which are known to spread through close contact (like venereal diseases, which are also associated with immorality), people reject the idea that a healthy person might get sick just by being close to a sick person, especially a sick person in one’s own family. In fact, the culturally appropriate response to an illness is for people to visit the patient, sit close by, touch and
massage the person, spend time in the room, and make sure the person is never alone.

This contrasts strongly with the typical American cultural response of the avoidance of contact with sick people. This point was vividly driven home to me when I saw the absolute panic caused to a visiting American friend when everyone he encountered after falling and cutting his hand wanted to hold it and closely examine the wound.

Along with temperature imbalances, "filth" (pislik) is also blamed for many illness. In this agricultural setting, sewage, both human and animal, must be dealt with by each household, independently of the types of civic facilities available in towns and cities. The Health Clinic is responsible for enforcing the rules and regulations about waste which are passed down from the national and local governments. The Clinic staff may fine any household found to be fouling the creeks and rivers below their home or gardens. The disposal of filth is an issue which can cause feuds between neighbors, especially when one family lives on a slope below another. Flies, attracted to filth, are considered pis, and illnesses can be caused when flies land on food. Parasites are a known problem, to be dealt with quickly, before their effects become serious. Local children are taught where sewage is washed into the Black Sea, so that they will not swim in dirty water. Body fluids are considered pis, and must be cleaned with clear running water, as in the Islamically- mandated ablutions. Hospitals are also considered pis, and children, more susceptible to filth than healthy adults, are usually kept from spending much time there.

The criticism that a person, family, or house is filthy is a very strong insult, and people often advise each other, in a friendly way, on how to best maintain cleanliness.
An immoral, gossiping, or unfriendly person can also be called filthy. Illnesses, including those caused by nazr, are associated with filth. After recovery from an illness, a person should have a full body bath in order to wash away any remaining traces of it. As part of the process to remove the effects of nazr (the "evil eye," see Chapter 5) the person being treated enters and exits a stable, where there is animal filth, because filth is said to draw filth (pislık pisliği çeker). Women are held most responsible for the cleanliness of their homes, stables, and family members, and this is one of the factors which gives women greatest responsibility for the health of their families (See Chapter 3). A child's illness or slow development can be blamed on the mother's uncleanliness.

The term mikrop ("microbe") has recently entered the local vocabulary, transmitted through the agencies of TV, traveling relatives, local health clinicians trained elsewhere, and national education campaigns in schools. Aside from any scientific use of the term, it has become an affectionate insult, usually to a child, in everyday speech. I only once heard an elderly lady use the term in its scientific sense, in a case in which a child was about to suck on another child's pacifier -- she warned the mother in time for her to grab the pacifier away: "Don't let her have that, it'll be microbed (mikroplasıyor)". In this particular case, I think the fact that the children were from different villages increased the sense of danger of contamination. People more readily accept the idea of contamination if an outsider is involved, rather than if only known people and relatives are present. Once, upon return home after a social visit in which
illness was a major topic. Aunty Emine told me, “There are illnesses which can pass from one person to another, but, God prevent it (Allah göstermesin), we don’t have them here.”

A woman from this village, who lives in a city because of marriage, trusts her own knowledge based on the traditional model more than the mikrop model held by certain city neighbors, who she views as comically meticulous and coddling. After I suggested that her child’s runny nose might cause my child to become ill, she told me a story about a woman in her city who paid excessive attention to such things. The woman constantly fussed about mikroplar (microbes) and kept her child away from other children. The result of this concern over trifles, my informant reported with satisfaction, is that the woman’s child is always sick. To further drive home the point that mikroplar were not involved, she explained that her daughter’s nose ran only to relieve pressure in her ears (See the story of this girl’s ear problems in Chapter 3). In this case, my assigning of danger to mikrop was probably a defense against what I thought to be excessive contact between the girl and my baby, an attempt to get the mother to rein in her daughter. Her response was to tell a story ridiculing the mikrop model, which served to deflect my criticism and obviate any need to interfere with her daughter’s behavior. Ironically, in the context of spending time with Turkish mothers in big city apartments, it is I who find their attention to mikroplar excessive — Turkish housewives are very meticulous about hygiene and cleanliness, in general, so those who have internalized the mikrop model of illness seem to be constantly washing toys, bleaching clothes, wiping surfaces and little hands, and worrying about contact with other children.
The Concept of *İlgi*

One crucial concept in the local rhetoric about health care is that of *ilgi*, which can be translated as “interest” or “attention.” The most commonly heard complaint about the State-run hospitals is “*ilgilenmiyorlar*” or “*ilgi göstermiyorlar*” — meaning, “they don’t pay (enough) attention,” or “they don’t show interest.” At home, a patient should be shown plenty of *ilgi*, and a family member’s willingness to display *ilgi* is carefully watched by all. Daughters-in-law often have a heavy burden of health care responsibilities for their husbands’ aging parents, and they can be harshly judged if they do not show enough *ilgi*. People express approval of a doctor if he shows *ilgi*, and compare doctors on this basis. People who have moved to Germany for work often compare the German system favorably in contrast with the Turkish health care system. One woman, Lale (more on her below), told me about her relatives in Germany:

Sylvia: What do they say, about the hospitals, about the doctors?

Lale: They like it a lot. They really like the doctors and nurses. The really pay attention (*çok ilgi gösteriyorlar*) . They talk about how clean the hospitals are. I don’t know...

They like it a lot. They don’t like Turkey.

Religious Belief and Health

Aside from the physical hot and cold imbalances and filth which can cause illness, the local explanatory model for illness includes the overarching religious belief that everything comes from God for a reason, even if not understood by humans. The life of a human is a short span, filled with both suffering and pleasure, as decreed by God.
Illness, in this broad view, is inevitable, its onset and its cure are beyond human control. Some go so far as to say that a person's entire life, including illnesses and time and cause of death are preordained, "written on one's forehead." Others claim that God has made available in nature the remedies for all illnesses, the succor for all pain, if only humans can learn how to use them and have faith in their efficacy (see, for example, the interview with Granny in this chapter). In the more concrete level of individual illnesses and injuries, the traditional belief often points to nazår ("evil eye") as the cause of illness. (For a detailed description of the symbolic complex of meaning around nazår and the religious issues in local health care, see Chapter 5) Because nazår is mentioned in the Koran, it is a phenomenon which bridges textually-based religious belief and magical beliefs which are scorned by religious scholars. When I went on a visit with my mother-in-law to see a man who had fallen off a roof and badly broken his right arm, everyone agreed that his reputation as a hard-working and capable fellow had brought the ill-effects of nazår upon him, causing his fall from the roof of the wonderful barn he had built himself, specifically targeting his hard-working and strong right arm.

Liability

Aunty Emine is now reluctant to get involved in serious problems or with childbirth, because she has learned that people will blame the practitioner more than fate if something goes wrong. If a person is accused of giving bad treatments, it can cause a major rent in social relations. It is much safer to give some advice and send a person off to the clinic or hospital. Even if the person doesn't actually go to the clinic, they can't
later say that it wasn’t suggested. Because relationships between villagers are often life-
long, and because feuds are common and serious (see Chapter 5 for more on this
subject), women like Aunty Emine try to avoid situations which might be used as
ammunition in village strife.

Torpil and Social Networks

_Torpil_ comes from the French word for explosive mine or torpedo, but has come
to mean "pull" or "influence" in everyday talk. To get anything done which involves an
official institution and the connected bureaucracy, connections are crucial. No one in
their right mind goes into an office without first having ascertained whether or not there
is any existing familial bond or acquaintanceship involved or at least asking around for
insider information. If a person, in casual conversation, mentions trying to get a
telephone hooked up, for example, others in the room will immediately put forward
people they know who know people in the telephone company, or at least who have
successfully gotten telephones. A man’s mandatory military service is a place where
_torpil_ can ease the rigors of training (if a person from the same area is found, he takes the
new person’s side in any jostling for power or in the inevitable fights among the
soldiers). Military service is also the basis for a life-long network of _torpil_ which
transcends regional affiliation — a man’s military service buddies can be friends for life
and their assistance can be sought when their network overlaps an issue involving their
friend’s needs. In daily life on the Black Sea Coast, any contact with government
officials, be they police, schoolteachers, tax collectors, or doctors, _torpil_ is crucial. Lack
of connections means harsher penalties, longer waits, bigger fines, more homework or
physical punishment in school, and worse health care.

In her book about women's labor in the informal sector of home-based piecework
in Istanbul (1994), Jenny White describes this social networking as "a web of mutual
support." (9)

From White:

Labor and services are not given in expectation of return, but rather in expectation of
indebtedness. The labor and service which characterize a mother's relationship to her
son, for example, are not only gifts of love; they also create an unrepayable debt of the
son to his mother (the "milk debt"). This indebtedness is the foundation of the mother's
long-term social and economic security as her son grows older and is expected to support
her. While this indebtedness is consciously acknowledged and pursued, it is not
perceived to be a closed transaction (i.e., a gift which must be reciprocated by a
countergift), but rather a natural manifestation of the roles of mother and son.
Indebtedness is the currency — the common denominator — of all these exchanges. It can
be saved, stored, lose value or gain it, depending on the circumstances. I emphasize
indebtedness rather than gift giving because it is precisely the practice of putting off the
countergift (by which I also mean labor and other services) which joins people and
groups in long-term, open-ended, elastic but durable relations... Evidence of this web of
reciprocal, delayed obligations can be found in other areas of Turkish economic, social,
and political life. Relations of obligation in society beyond the family are often
represented metaphorically as family relations, as for example between the citizen and
what the Turks call "Father State" (*Devlet Baba*). (14-15)

Social relations are thus modeled on family relations, and a Turkish person from a
small community will discuss family ties when meeting a local person for the first time,
usually being able to find some blood or marriage link to bind them. White describes
how this strategy has been adapted for the large-scale environment produced in cities and
because of increased mobility:

When two strangers in Turkey meet, often the first thing they do is verbally sift through a
list of people they might know in common. They are looking for a reciprocal link on
which to base a personal relationship. Reciprocity, then, gives access to more than a particular group or grouping, but rather to a varied web of relations which are linked through reciprocal indebtedness, involving people whom the individual may not know directly. (98)

When talking about a person, the elderly women of Medreseönü always identify the person by familial relationships. Because I am accustomed to identifying people first by personal name, and because Turkish culture allows for the use of family terms for people who are not actually related, I often felt confused about whom we were discussing. In a village, everyone can call everyone else by a term which indicates a family relationship — young people call older ones “Big Brother,” “Big Sister,” “Aunty,” “Uncle,” or “Granny,” and “Grandpa,” according to relative age. A woman who has married into the village is called Yenge (the term for a woman who has married one’s own male relative), if she is older, and usually by personal name or Gelin, if younger. When in a new situation, such as coming to a big city to look for work, villagers often try to make meaningful contact with strangers by using familial terms. A person might call an unfamiliar minibus driver Söfǫ̈r Ağąbey (meaning “Big Brother Driver”), address an older woman in the street as Teyze (“Aunty”), or enter a grocery story and greet an older shopkeeper as Amca (“Uncle”). This usage with strangers is frowned upon by upper-class city dwellers, although they use the terms within their extended family or in particular relationships which last over time.

As an example of the active use of family and social networks, I offer an account of Nurcan Yenge’s visit to an eye doctor in Fatsa, the closest town to Medreseönü. She went to spend the night at a friend’s house in Fatsa so that she could visit the eye doctor
recommended by that friend the next day. Her eyes had been bothering her and she wondered if her headaches were related to eye strain. She got a ride with her neighbor’s grandson, who was visiting from Germany and has a car. When she went the next morning, she learned that the doctor doesn’t come in to his office until four o’clock in the afternoon. She had to return to the village without seeing him because she had to look after the cow. In order to return to Fatsa a few days later, she walked down to the coastal road and examined each passing minibus to find one driven by a local. Not only can a local be swayed to charge a lower fare, but may feel obliged to help an elderly woman from his own village (also quite likely a relative) to find her destination, agree to pick her up for the return trip, and read any signs that she cannot. During her visit to the doctor, Nurcan Yenge learned that she needs glasses. Her son then stopped off in Fatsa on his way to a construction site in his municipal dump truck, in order to pick up the glasses, which he then took home to his mother that evening.

In another example, during a visit to a bank in Fatsa, the banker who is a tândîk (acquaintance), asks Aunty Emine how she is. She tells him about her diagnosis of tânsiyon (high blood pressure) and yâğ (high cholesterol). The banker pulls some garlic pills out of his drawer to show her. He says they are good for tânsiyon, don’t make your breath smell, and aren’t too expensive. Aunty Emine’s grandson who is visiting from Germany writes down the name of the pills, for his own information. When we get back to the village, we ask around, and everyone agrees that garlic is good for tânsiyon and kalp (heart). This kind of informal advice occurs often, even in a formal setting such as a bank, as long as there is some kind of network relationship involved.
Diagnosis

Traditional, informal diagnosis of illness is based on patient's skin color, forehead and neck temperature, pulse felt with the fingers on the patient's wrist, and the patient's own description of sensations. Everyone knows to look for the basic signs of illness. A specialist will diagnose with more precision, for example, asking about specific feelings when a certain body part is pressed or massaged. An expert has more terms available to ask about sensations and has a larger experience of observing the symptoms and course of various ailments. When visiting a clinic, hospital, or doctor's office, a patient expects various technological means to be used for the purposes of diagnosis -- the stethoscope, the x-ray machine, the blood pressure cuff, the thermometer, and other devices associated with clinical medicine.

The Hospital

A basic provincial hospital in Turkey is not set up to provide the patients with the comforts of home. A hospital stay, unless it is in an expensive, private room, means that family members feel obliged to bring food, sheets and towels, changes of clothing, and visit with the patient to pass the time. A patient who has no family in evidence in a hospital room is greatly pitied and often brought into the circle of a more fortunate patient with gifts of food and conversation. The most frequently heard criticisms of the local hospitals are that they are dirty and smelly, that the nurses are overworked and either neglect patients or treat them roughly, that they are depressing, and that they are a
source of illness because sick people are all thrown in together. In contrast, home care is considered much more sanitary, comfortable, gentle, and healthy.

The doctors and nurses in the hospitals realize the benefits that family visits can bring to the patient. They do not deny the lack of resources such as food and bedding for patients, although they consider their conditions to be much more sanitary than home conditions, especially in villages. A compromise is continuously being worked out as the hospital staff tries to restrict the numbers and noise-levels of visitors, while each patient's family and friends try to maximize the benefits of the stay for the patient. As in all Turkish institutions, most official rules are flexible, according to the social connections of the patient and his or her family.

If an illiterate, elderly villager arrives in a hospital to seek help, the first order of business is to find someone in the noisy, chaotic hustle and bustle to ask directions. With any luck, some advance connection has been established and the villager has a name of a doctor or a nurse in the hospital. If this person can be found, then the villager can feel assured that he or she will be taken care of. If there is no such advance connection, the villager will try to establish one, either by asking a likely person (such as the guard at the door) about his village of origin, with the hope of discovering some actual family relationship or at least an acquaintance in common, or by using terms such as oğlum or kızım ("My son," "My girl") to set up a fictitious kinship in the hope of getting respect and assistance.
Nurses

Nurses who work in government hospitals (Devlet Hastanesi or Sigorta Hastanesi) are underpaid and overworked. Many of the nurses who have been working the longest are graduates of a nursing middle school program. In this type of program, girls from villages would be sent to boarding schools to be trained as nurses. This was often done when families had several daughters and little chance of marrying them all well. It was a way to have a daughter enter the cash economy, save her from village labor, and widen her social circle so that she may marry well (perhaps even a doctor!). In other words, it was a strategy for upward mobility, for one girl, and thus for her family as a whole. Now, after years of overwork and a subsistence salary, the long-term nurses are now seeing new nurses with better education (either high school or college training) coming in with better salaries and fewer responsibilities. The only way to make life at the job bearable is to make friends with the other nurses, become immune to the suffering of patients, and find ways to maximize leisure (tea and cigarettes are the nearly universal pleasures of all government workers) and minimize work. With increased privatization, nurses can supplement their work in government hospitals and clinics with work in private ones. While the government jobs are very secure and poorly paid, the higher wages of a private clinic come with the possibility of being fired for poor performance. A nurse who is very comfortable and can get away with showing little ilgi to the patients in a government hospital will change her attitude as she enters her private workplace, becoming serious, careful, respectful to patients, and hard-working.
The state-run health care facilities are the last resort destinations for patients. Even people who first try state clinics and doctors in order to save money will proceed to private practices if illness persists and money can be called in from some family member or acquaintance. Private clinics are located in nice neighborhoods, and are distinguishable from the state clinics and hospitals by their state-of-the-art equipment, new paint, new and stylish staff uniforms, and the pleasant demeanor of those who greet and serve new patients.

Interview with Lale

Lale is a woman whose husband is from the village of Gebeşli. She has one daughter, about ten years old. They are visiting the village from their home in Samsun to see the husband's relatives. (Tape 1, 1997)

Sylvia: Where are you from?
Lale: Here, but we're in Samsun.

S: Are the doctors good?
L: Yes, the Fakülte [University Hospital] is pretty good. But you go to a private doctor -- They look after you. If you go to the State Hospital, then they just look at you from across the room. They do check ups, they give you medicine, but it's up to chance. In the private one, they pay attention (ilgi gösteriyorlar).

S: There are private rooms, too.
L: Yes.

S: Now was your birth...
L: Normal, in a private hospital.

S: Do they have a special room for birth?

L: Yes, like an operating room, for births.

S: Any midwives?

L: There are midwives, but the doctor did it.

S: Normal...

L: Normal.

S: Did they have machines for monitoring?

L: Yes.

S: Do you know any traditional medicine, have you heard about it?

L: Yes, it happens around here. I hear they do it in the villages, but I don’t know...

S: Some go to doctors in the hospital and they’re not happy and they say village stuff is better — especially bone-setting.

L: Yes, there are a lot who get it [bone-setting] done, but because we never had it happen to us... [she can’t say much about it]

S: May God prevent it.

L: Yes, May God prevent it.

S: There are teas...

L: There are many different teas, Linden, we use Linden when we have flu. There’s Quince leaf, I put in carnation, I squeeze lemon.

S: Mixed?

L: Yes mixed, we drink it.
S: Is village food healthy?

L: According to me it is.

S: Do you bring it from the village [to the city]?

L: Yes, it's healthier, fresh.

S: Natural.

L: Yes, everything in the village is natural. We like it. We eat what we like. All those vegetables, greens, the leaves, everything.

Interview with Esra

In choosing how to treat a health problem, families take into account what they have heard from others or had recommended by others, but acknowledge that sometimes people choose a treatment based mostly on what they are used to (from al-şnak), what is traditional or personally preferred. Some use this phrase to make a kind of apology for what could be called “less than modern” behavior on their own part, or especially to explain older family members' old-fashioned ways. When I asked Emine whether her mother-in-law likes to go to the doctor, she replied:

Esra: No, she doesn’t like it much. You would have to force her to go to the hospital. Unless she wants it, she won’t go, she’ll stand the pain.

Sylvia: She likes the old ways, then?

E: Yes, She’s used to that. Before, they didn’t have doctors, they did everything in the village. That’s what they’re used to. It’s not that they’re scared of doctors, they just don’t like going. They like the village stuff.
S: Also, stuff is expensive...

E: Yes, it’s really expensive here [as opposed to Germany], the medicine is expensive. They take money from you.

S: No insurance?

E: No, nothing like that. It’s really expensive, but for your health, you go.

Interview with Nurcan Yenge’s Mother, “Granny”

For the purposes of this study, I’ll call this woman “Granny” (from Nine (Nee-neh), which is a diminutive word for a grandmother). She was 87 years old at the time of the interview. She comes from a Black Sea village above Fatsa, but visits her daughter and grandchildren in Medreseönü regularly. Aunty Emine’s daughter Fatma, whose three-year-old daughter was very interested in the tape recorder, was also listening to Granny while going about her own business, and asked an occasional question. Granny’s daughter, Nurcan, also interjects when her chores bring her within earshot. In my transcription of Granny’s Turkish, I have tried to indicate some local pronunciation, such as the pronunciation of the letter “k” as “g” and the shortening of verb endings. Timur, 17 months old at the time of this interview, who has been slightly feverish and whining, is on my lap, and provokes some comments by Granny.

Granny: They used to make a pill from the plant tops, we’d swallow it. On the road, in the fields, there is a flower that grows, in the grazing pastures...

Fatma: What for? For what illness? What was it for?
G: It stopped malarial fever (səltma səltma), for catching a draft (hava çalması), they would let in the air. When a child like this (indicates 17-month-old baby Timur) got a fever, so...

Sylvia: What did they use for a fever?

G: For fever, they’d put the yellow flowers’ water out in the clear night air (ayaz). When that flower’s water was boiling...

S: Is it Chamomile?

G: No, like red-ish, they smell sweet, those flowers. We would boil them with water. We’d leave them out in the clear night air, on top of the house. Then later, we drank it, so, we did it that way.

S: Doesn’t anyone do it, now?

G: Now noooo one does it, oh! They go straight to the doctor! Someone’s got a headache — (goes right to) the doctor. Now, no. I’m surprised at this, so... Then there weren’t so many illnesses. Those things (like the flower water) went in the place of medicine, they were effective, it was good. Well, they would get together to work in the fields (imege yapardu), of course, in the villages. Someone has a headache, right? Right away they would shave a tiny place right in the middle of the head, right at the base of the hair, with a strop razor. Now they have jilet (safety razor). Just like this, they would shave a little place. You know how there’s a blackberry, that you’d eat when it’s black, they would crush it with garlic, we’d crush it with garlic. In the little shaved place on your head, they would make a little scratch, so it would sting a little, in order to give a little air to the inside, give a little sweetness (or relief). They would cover it with that
(the blackberry and garlic paste), and that mübarrek (the blessed soul/brain, created by God), would get air (relief).

S: Right on the top of the head? In the middle?

Granny: Yeah, here, right here, (she indicates on Timur's head) Just a little in the middle.

S: Right where a child has a soft spot?

G: Yeah, right in this soft place. Before, that's how people passed the time. When you were sick, that was the doctor, see? For us...

S: Is it good for anything else, other than headache?

G: That wasn't for headache! It was for a fire, a fever, a flame. They did it for feeling hot. For a headache... This is old-time business (beski işler), so, now they'd take a headscarf or a handkerchief the right size for the throat, it could be a man, it could be a woman, they'd squeeze it like this. From there (indicates forehead), a blood (vessel) would come up, and if it was cut, the pain would go. In the old days it was like that, giiliüm (she is calling me her "rose"). Now I am bewildered, neither suffering ends, nor illness lessens. God forgive me! And they say old-time people... (eski toprak insanlar: literally "old earth/soil people"). With the food (gida — nourishment), people passed the time, with the old ways (eski işerde). What do I know... Illness was like that. Now a big illness happens, I can't get up, right? They would say, she got a draft (hava çaliyor), a situation would arise in a person... You'd go to the outlet of a pool, a little pond (at the base of a spring), they'd dig there, like this, you'd dig... And they'd lay you down there (she giggles), in the water, in the mud, completely naked, and you'd feel pleasure, like
going in the sea. So, we’d lie down in the clay, in the mud. That’s how you’d feel contentment. You’d lie there until you got cold, just like that remedy where you go in the sea and stay until you are done. But that clay, that mud is cold of course. And you are burning, “I’m sick!” I lay myself down in the mud. I lay down, just like this in the mud and buried myself like that. That’s how I got contentment. Indeed, I lay there until I got cold and started to shiver. Now, if you say, “I’m cold, get me out,” I’d get up from there, I get up from the mud, and I’d go to the mouth of the clear spring, of the pool, and there I’d rinse the mud off really nicely and wash off like this. Then put on clean clothes. Really clean. It is said, now... I don’t know how it’s done nowadays, (but) from that (procedure) a person wouldn’t have even a bit of illness remaining (Hastal ზგჟmastal ზგჟ kalmi). You would rise up like a saint (Pir gibê gabar ზრჟn). Like you were never sick, never had an ache. Oh Majestic Lord of the World! Still I sometimes long for it. If something like this happens to me, I’m in flames, I go right away and lie down there. Now I have a fever, I’m burning this much, “Ah!” I say. I’m looking for a breeze over there, Now what am I going to do with a breeze? I’d better go to a hidden place and lie down right in the mud! I’d feel content like that. It would get rid of my draft.

Actually, it’s a habit, this. I long for those things.

S: Don’t you do it now?

G: I don’t, there’s no one who does: “Oh my gosh – Don’t go in! You’ll catch cold! Merciful God, You’ll get sick!” Now, give it up. I don’t know, güüm... What do I know. Actually, you should do what people are used to to get their air (relief)... What do I know. Now they don’t let you do anything. “Oh gosh! You’ll catch cold! You’ll get
sick! You’ll get worse!” Well, Thanks to God, a Thousand Thanks to God, Oh Prophet of God!... Now I miss that air (relief), I miss those states. Now, what do I know...

You’ve seen those wild plants? Some of those bitter plants’ tops, the flowers, the seeds - - If I swallowed some of them, I wonder if it wouldn’t be good, I say, for example. No way now! “You’ll be poisoned, you’ll die!” they say — what if... Then a person can’t do anything, can’t be comfortable. Thank God, a thousand thanks for these our days! That’s how I’d get my air (relief)... What do I know. Now it’s like this. Be it a baby or kid, be it yourself, say you’ve got a cold, you’re burning. Then you take vinegar, you dip a rag in vinegar and you put it around on yourself like this (indicates rubbing it on her forehead, under armpits, across her chest), you lie down — all over yourself. That, blessed thing, will take away your fever. That’s how I get air (relief), nourishment. I’ll spread it on me, when it is evening, when I’m going to bed — on wherever hurts. That’s just what I do, I get comfort, it gives me air (relief).

S: Where do you spread it?

G: Just where it hurts.

S: What do you spread? Vinegar?

G: Yeah, vinegar, what do I know, whatever works, I’ll spread it a little with a rag. What do I know, when it burns, I’m feverish, I’ll sit down and spread it this way and that. If I get cold, I wrap myself. The flame inside, I don’t know... that’s how we are, dear (yavrum, lit.: “My cub”), May God do what’s good.

S: There is everything in nature, but we don’t know.
G: Yeah! There is everything. Actually you should be your own doctor, after a certain point.

(Here, her daughter interjects that she had heard about women who collected three kinds of nettle and an herb and made a tea which was healthy, we all agree that nettles are good, especially for cancer. I remind them that the previous year I had taken a whole bag of nettle tops for my mother, which seemed to help.)

S: I heard that in Erzurum they roll babies in the snow, so that they get resistant to cold, they don’t get sick after that.

G: “They wrap (swaddle) the baby in snow, that’s what they do, so the baby gets resistant. We say “He’ll catch cold!” But it’s good for the kid, that is actually good... I don’t know.

S: Do you ever go to a doctor?

G: I go, I don’t have much to go to a doctor for, maybe once in a year.

S: What did you go for?

Nurcan: Do you do any of those village cures?

Granny: Oh, you mean village medicines, no, I don’t do anything like that. No, Thank God, wherever I hurt, like I said before, I rub myself (with vinegar). If the fire gets worse, I’ll take myself to a warm water (spring) and go in. I help myself out as much as I can stand, that’s just how I do it.

S: In the old times, was there someone who made those medicines?

G: Well, just like I told you before, from the fields, from here, from there...

S: Everyone did it?
G: That was the medicine. Just that. That’s what people would do. That’s what everyone did. The old folks, the older ones.

S: Because a bone-setter was a particular person.

G: That’s a particular thing, of course, a strong person.

S: But everyone made medicine from plants...

G: They didn’t do that (bone-setting). For a pain like that here or there, aches and pains, they would boil nettles and kill it. They would put some in water and wrap it loosely around (the ache)—you know how it stings? So that it wouldn’t sting you, they would kill it (by boiling). They would hope for a remedy. Thank God, they would make it pass.

I don’t know. Thank God, a thousand thanks!

S: Why did you go to the doctor?

G: Me? Inside me, there was a flame... What do I know? I was uncomfortable right here (indicates chest). I was ill. In my stomach, like this. To find out “What’s inside? Look—Am I alright?” I did that last year at hazelnut time, you know. I was ill. The guy said, there is nothing like that inside, he said. So he put this thing like a machine, you know like this (imitates a stethoscope), he goes around like this, and he hears inside with it, he says. He said “I see a swelled liver.” What else did he say to me... “You have a weak heart.” he said. Then saying “Take this, take that,” he gave me medicine. I went again and he said it was a little bit erased. Now... I said “There’s a flame inside me, I’m burning. What is this fire?” If you ask me, they couldn’t understand it. That fire is still here just the same, this flame stays the same. I took the medicine he gave me. I took some, I didn’t take others. Nothing. Now, I say to myself, if I just boiled those old herbs,
I say to myself, if I just put their water in the clear night air, *anam* ("oh mother!") and drank it, I say inside myself. If these flowers of mine would just open, if they had already been open, I would have tried it. I'm going to drink those flowers, God willing. If I see them, I'll do it. You put them where no one will disturb them, in the clear night air. Let them sit. I'll bring you some, God willing. It's a summer flower, I haven't seen it. It used to grow in pastures. It smells sweet. That flower isn't around.

S: How did they do childbirth in the old days?

G: I didn't have any trouble in childbirth. Those who couldn't birth the baby, they'd pick them up as they were and take them straight to the doctor. *Ya upala!* (Sound indicting fast departure) If her fate was to die because of this, if her luck had run out, she'd go (die) because of it. (The baby had) one hand in, one hand out, they couldn't take the baby out. I didn't have that kind of birth. Well, it was difficult, excuse me for saying it, but I never suffered. I never saw any doctor business (*doktor ışı görmedim*).

S: Normal, at home...

G: Normal, at home. No one was home, at my house, dear. I had no one next to me. Struggle and struggle, I came back from the quarry, got in birth position, screaming and crying, it happens! (She giggles)

S: Wasn't there a midwife?

G: A village midwife, old woman's stuff, old, old wives... Now *they* would really take care of you. "Medicine from plants, from whatever's around." (*Ottan yandan ilaç*) They'd say "Medicine from plants, from whatever's around." From plant leaves...

S: Do you know cherry laurel (*taflan*)?
G: Wouldn’t I know that? Cherry laurel...

S: What’s it good for?

G: Your throat gets sore, it swells. In that case we’d wrap it. That day, you were there, you saw the cherry laurel. Thank God, Thanks a lot!

S: Does that cherry laurel fruit have any value? Against illness?

G: Cherry laurel fruit is very good. You should eat it. It is very healthy. Some get fussy, they say, it makes our mouths black (the fruit stains). Actually, you shouldn’t do anything...

(Then another woman interjects from another room that she saw a program on TV about how cherry laurel is good against cancer.)

G: From the water (of the plant), the laurel plant (defne) water, cherry laurel plant water, everything is medicine. What do you think the doctors make medicine from anyway, dear, they make it from plants, from whatever’s around! Now, they say (complain) that everything is bitter. For example, laurel leaves are bitter, cherry laurel leaves are bitter, too. Everything comes from them, Thank God! Wherever there is nourishment, of course, there is medicine. Thanks to the Lord. Everything is medicine. Whatever comes to us gives us relief. I especially love lying in that mud! Whatever draft I had, that would take care of it. (She gives a prayer of thanks and recites the articles of faith) They’d call it “the reason” Whatever we heard, we’d do. Thanks to God. Now what I have, most likely, is a shortness of breath, when you feel faint, I’ve got something like that. Thanks be to God, it’s not a strong pain here or there. Just my back hurts, of
course, lasting from the old days when I carried this and that, right? It’s old age, what can you do? An eighty-seven-year-old person!

S:  *Maşallah.* (“What wonders God has willed” — said when something is remarkably good)

G: Thank God for this my day. Eighty-seven is no joke! God forgive me!

S: Eighty-seven!

G: I am eighty-seven. Thank God I can walk this much. May God never prevent me from praying five times a day. May God give you a thousand strengths, dear. What’s one to do? I’m depending on God. Be grateful (she prays).

Now, this baby... (indicates baby Timur) This vinegar is really good. I’d take this baby (and treat him with it), and he’d be fine, don’t worry at all. Do it when he’s about to go to sleep at night, nice and light, like this. He’ll be like a saint (*Pir gibi*). Don’t get him cold, don’t sleep up (on the roof), don’t give the baby a cold.

S: Wouldn’t the air be good for him?

G: Air is good, supposedly, he may get a cold. He’s a baby, right? Not like us. Not like you. He’s a baby, little. My God, may God do the best. May his fever pass. Don’t worry. Fever makes a person uncomfortable.

S: He whines a lot.

G: I can’t wear anything (when I have a fever). I have so many various things, so many clothes, but I can’t wear them, they stick to my back. What can I do, dear. (She prays).

S: This “fallen stomach”... (For more on this, see Chapter 6)
G: Some used to do it, like this, with wild bee honey, they'd pull it like this, those who knew, those who were used to it. Like this, like this, with honey, with syrup, they'd pull it well, they'd put it back in place. An expert would get it back. In the old days, those with a fallen stomach, those with a fallen heart, whatever they had, like this, with pulling, they'd put it back in place. They'd pull, like this. They'd wrap your waist lightly with a scarf, that would hold it, and it would pass. Thank God, it is God's will... Still, the old ways were good. Thanks to God. If your head hurt a little bit, they'd squeeze your throat until a vein popped up on your forehead. They'd cut it with a razor. What can I do? May God give your sweet mother the best of health, may he pardon her. My God, don't make such suffering, don't make people suffer it My Lord, (she prays).

S: Now, a vein pops up, and then...

G: Yes, you just make a little cut and blood shoots out of that vein - whoosh!

S: Does it really come out or is it a feeling?

G: It comes out! Blood comes out. Now Emine (Aunty Emine, who has come into the room) knows about this stuff.

Aunty Emine: What stuff?

Granny: You know, how in the old days, when our heads would ache, we'd cut it with a razor, like this...

Aunty Emine: It burns...

G: It would come out, it would squirt out like this. You get relief. The sick blood comes out. (She thanks someone for bringing her tea) What can I do? We got along that way. Now, with the slightest little thing, the run right to the doctor (Yallah doktor'a!) I
call it “Ask and give money.” (She recites the articles of faith) That’s what I say. Look at my old days, I say... “Ask and give money.” Now if you say, “Let’s do this...” “Oy! That won’t do!” they say, “Are you trying to kill my kid? Are you trying to kill yourself?” A whole lot of fussing (bir sürtü tantana). When in fact, it was good. Now can you be trusted? They have ninety types of suffering -- some have cancer, some have tuberculosis, a lot of things to worry people... What do I know? (She prays).

(a person calls her from another room, and she gets up) I’m coming!

*****

Granny is greatly admired by all in the village, not only because she is sweet-natured and modest (an attribute which is conveyed in her frequent use of the phrase “What do I know?”), but also because she has the Koran memorized and is known to read the nazar prayer and other prayers with great efficacy, both for people and animals. She never used written amulets (muska) herself, and tells me that she cannot effectively read the nazar prayer over herself. When the call to prayer is heard, five times throughout the day, she removes an antique silver pocket watch and checks the time. She almost never misses a prayer, and peppers her speech with pious phrases and whole prayers.

The Dynamic Interaction Between Traditional and Clinical Healing Practices

When a woman came to the bone-setter in the Turkish village where I was conducting research, she set in motion a chain of responses which exemplifies some of the complexities of the local health care system. The woman had fallen and hurt her ankle, then had waited a week to see if it would get better. When she came to the
bone-setter, she was hoping that she would not have to go to the doctor because of the expense and inconvenience involved. The bone-setter diagnosed a broken ankle and reprimanded the woman for not having come right away for treatment. The ankle was tremendously swollen and discolored, and the woman could no longer carry on with her daily work. The bone-setter agreed to attempt treatment, but guessed that the woman might have to go to the doctor for a more complicated operation because of elapsed time, in which, in her terms, "the flesh boils in the bone." The bone-setter, through the use of hot beeswax compresses and manipulation of the ankle, got the swelling down and the bone in place. (For a more detailed description, see Chapter 4) The bone-setter, a woman from the same village who knew the rigorous requirements of daily agricultural life, worried that the woman would not rest properly and would re-injure her ankle. She agreed to give the patient pain-killers, which the local pharmacist regularly supplied to this traditional healer, only if the patient would promise to stay in bed for a prescribed period. The threat of having to be transported to the doctor for what would perhaps become a costly operation was used to gain compliance. When the woman left, the bone-setter grumbled with authority (much in the manner of clinical practitioners) about patients who do not immediately seek appropriate treatment and do not comply with "doctor’s orders."

From this example, we can see that the patient had a range of options: to do nothing until the problem became unbearable, to seek traditional help from an expert in the same village, and to go to the doctor in town. O’Connor (1995) prefers the term “order of resort,” to the older term “heirarchies of resort” (Romanucci-Ross 1969) to
describe "the sequential patterns of selection and use of health care resources." (26) She finds that:

This usage [of "order of resort"] denotes a simple chronology in the selection of therapeutic modalities, and removes the implications both of serial replacements and of "upward mobility" through the therapeutic ranks. (27)

Among the villagers I questioned, expense and convenience were strongly determining factors for ordering health care choices. People tended to try the locally available and non-cash treatments first, going farther afield and tapping more deeply into their financial and social resources if dissatisfied with the initial treatments. In local terms, an "emergency" meant that a car was needed to transport the afflicted person, with very little time to discuss options or to minimize expenses.

The bone-setter in the above case also had the choice to refuse or attempt treatment, and she felt comfortable using the pharmacist and the town doctor as back-up resources. The bone-setter has both traditional techniques and clinical medication at her disposal. She had a certain kind of authority over the patient because of the severity of the problem, yet she also had sympathy for the financial worries of the patient and understood the patient's need to balance the requirements of farming with the requirements of healing. If the outcome is success, then the healer's reputation will be enhanced. If the outcome is failure, then the healer has made it clear that the patient waited inappropriately before seeking treatment and perhaps did not comply with the rest requirements imposed by the healer. The story of the interaction between this patient and healer is then told around the area in many versions, to prove different points, and influences future health-care decisions in the community.
CHAPTER 3

WOMEN AS PRIMARY CARE-GIVERS

One village woman, Fatma, has married a Kurdish man from a central Anatolian city and comes back to visit her parents almost every summer, usually around the time of the hazelnut harvest when extra hands are most needed. Her husband has become quite wealthy, so they drive to the village in a private car and spend plenty of money on the woman’s family while they are visiting. For example, going to a restaurant is a big luxury (and a waste of money, according to the older women -- not to mention possibly unhealthy because the kitchen would not be as clean as a home kitchen), so the son-in-law tries to take his in-laws to a restaurant at least once during his visit. If he cannot convince them to eat out, he’ll buy groceries, including staples to last for months, and meat to be prepared during his visit. The couple also tries to buy things to fix up the parents’ house and to pay off any accumulated debts. Aside from this type of spending, they also bring gifts of new store-bought clothes and sweets. In the past, both parents have gone to Fatma’s house to be treated by medical specialists at the expense of the son-in-law. This situation is considered to be the sign of an especially dutiful daughter and an exceptionally generous son-in-law. Under typical conditions, such spending is
expected from sons, and the daughters’ husbands are not obligated to spend money on their parents-in-law.

The visit at hazelnut time is special because it is the time when the largest number of people is back in their home village from jobs or families in big cities or from Germany. The weather is usually dry and warm, although cool at night. Most village weddings take place in the weeks leading up to the harvest, and people joke that new brides are needed for the labor-intensive work of hazelnut picking. For those who live in cities or in other countries, the summer visit to the village is a refreshing change and a chance to catch up with the village news while reaffirming local bonds.

Married women who return from their husband’s home to their parents’ village for the hazelnut harvest come to help their family but also to see childhood friends. In the reunion of old friends, there are plenty of opportunities to demonstrate how well one has done after leaving the village. Every possible indicator of wealth is examined by those in the villages, starting with the means of transportation used by those returning: Is it an inter-city bus? Which bus company? Is it a private car? What brand? Is it Turkish or foreign? Will they give us a ride up the hill or have they gotten too proud? What are they carrying — lots of bundles and gift-wrapped packages? Did they bring a TV? How are they dressed — are their children dressed modestly or have they been spoiled by city life? Will they come visit us or have they forgotten their old friends? Will they bring us anything? Will they come to our daughter’s wedding? Will they pin gold on her? Will she have her hair done at the hairdresser’s for the wedding? Will she wear a city
Headscarf with her fancy clothes or go bare-headed like we all used to do? Will she work in the hazelnut groves like she used to do, or has she become soft and proud?

Although there is so much interest in visible signs of wealth, outright prying and unambiguous boasting are socially unacceptable. When Fatma visits her home village, her old friends can see that she has done very well for herself. To find out details of her life, however, they listen for clues in the stories Fatma tells during social visits. One of the most important signs of a woman’s maturity and economic stability is her ability to care for the health and well-being of her family. When Fatma tells stories about her father-in-law’s many trips to specialists for his health problems after an accident, she is not directly boasting, although the implications of family wealth are clear. It is normal to speak about the health of family members, and Fatma’s Kurdish father-in-law’s story is particularly interesting because he has been to Mecca (and is thus a haji), is over eighty years old, and survived being run over by a tractor while he was doing work young men would find difficult. When the doctors in the Anatolian town of his birth could not sufficiently remedy the complications stemming from the accident, his sons flew him by private plane to Ankara to be seen by the nation’s top specialists. The care and expense lavished on this revered father demonstrates the fealty and success of his five sons, and, by extension, the sons’ wives. Listeners in Fatma’s home village do not personally know this man, but they have heard about him over the years. While the ostensible point of the story is to express concern over the old man’s health and to share a story about family health and loyalty, the underlying appeal of the story is in its details of fantastic expenditure. As is common in stories told in the village, actual monetary figures are
given for various procedures or related expenses. Because of the high rate of inflation, each figure is often translated into the current lira amount so that its impact is not lost on the listeners.

At another time, we were at work in the kitchen when a woman stopped by to ask for a recommendation for a woman with bronchitis. Anne and Fatma were both present and agreed that the best remedy is mint tea with one slice of apple in it. Red current tea was also mentioned, but it is a store-bought remedy in this area rather than a home remedy. As the woman thanked them and left, Fatma began to tell about her toddler daughter’s diagnosis of bronchitis and her initial motherly attempts to remedy it. As the girl’s pain resisted the basic home remedies, Fatma began to take her to doctors. Each doctor diagnosed the girl’s illness as bronchitis. At one point, the girl was kept in a breathing tent in the hospital for three days. When this still did not solve the problem, Fatma took the girl to the doctor at the Medical School (Tıp Fakültesi), who is of higher status that the doctors she had previously seen. When that doctor also diagnosed bronchitis, Fatma protested, “Excuse me, Mr. Doctor (Doktor Bey), but this girl’s ears are hurting!” The doctor checked her ears and had to admit that Fatma was right. The story ends with Fatma’s chuckle, “I am my own doctor – all the women come to ask me about their illnesses.”

From this account, we can see a mixture of pride in being able to afford the finest specialists and pride in self-reliance. The father-in-law was publicly cared for by the males of his family, who took him to male specialists. His health and daily comfort were the private concern and topic of conversation of his wife and daughters-in-law. Fatma
told his story as an example of how her husband's family could afford to care for their esteemed elderly father. When it came to the story of her own daughter, however, Fatma was the most active character in the story. Even in the mainly gender-segregated town in Anatolia, she was able to take her daughter to a series of male specialists. She was able to provide the support which is required for a family member to stay for three days in a hospital, which, in most Turkish hospitals, entails bringing food, bedding, and clothes from home. As the final triumphant note, she was able to prove her own private knowledge and training through experience to be superior to even the expert in the Medical School. Although the ear infection was successfully treated with antibiotics procured with that doctor's prescription, it is Fatma's correct diagnosis which is foregrounded in her story as the deciding factor in her daughter's return to health.

Women in the Turkish Family

To the casual Western observer of Turkish urban life, the Turkish family structure may seem to resemble the "nuclear family" in the West, with husband, wife, and children living in the same household (usually an apartment). Although this Western model is becoming the standard living arrangement, even in many rural areas, the traditional family living arrangement is that one household will support a mother and father, their unmarried daughters and young sons, one of their married sons, and his wife and children. Even if a young couple lives in their own apartment or home, the pull of the traditional family structure remains strong — for example, a son will expect his wife to help his mother if help is needed. The gelin, or daughter-in-law, is still judged for her
respect and attentiveness to the needs of her mother and father-in-law. Jenny B. White (1994) provides insightful descriptions of Turkish family structure. Because of her interest in economic relations, she is able to portray family relations as a web of mutual indebtedness. She describes the general cultural basis for the relationship between a mother and a son:

... the close relation in Turkey between mother and son, for example, is based on a mother's labor and moral contribution to her son's welfare and on the son's inability to repay his debt to her. The son attempts to repay his debt, but as he is not able to do so, the debt he carries is converted to homage, respect, loyalty, and so on, the intangibles which make up the symbolic capital on which a mother bases her future well-being and which give her considerable power and authority over her son. (100)

This relationship determines the relationship between a mother-in-law and a daughter-in-law:

The gelin ... gives a great deal of time, labor, service, and often material benefit to her mother-in-law. Nevertheless, this does not give the gelin power over the mother-in-law: quite the contrary. On the one hand, the gelin is in an inferior position to the mother-in-law in terms of social hierarchy. A gift of labor from an inferior to a superior would not incur debt but rather would be an expression of a patronage relationship. On the other hand, ... the gelin must be seen as embedded within a set of interrelated relationships rather than as an individual in a hierarchy. Her relationship with her mother-in-law can only be understood within the context of her husband’s relationship with his mother. The gelin is part of a triadic relationship including her husband and his mother, and her labor and services are an expression of the son’s debt to his mother. (100-101)

Although married daughters are mainly responsible to their husband’s parents and to the welfare of their own children, they can still feel drawn to help their own parents, especially in a time of illness. Whereas many parents-in-law complain if their gelin spends too much time with her own family to the detriment of her husband’s, serious illness is usually considered to be a valid reason for a woman to go to her parents’ home
to help them. White looks at these relationships in the context of economic labor-sharing, but her insights are equally valid in the case of the non-paid labor associated with family health care arrangements:

A mother has a moral and emotional claim to her married daughter’s labor, especially if she has no grown sons, but this claim may not be accepted or acknowledged by the daughter’s husband and his mother. ... [Their] bond of affection and caring leads to the expectation of assistance from daughter and a sense of obligation of daughters to their mothers. (49)

It can be said, then, that the position of an individual woman in a family is determined by cultural as well as individual factors. Women’s labor is particularly important in family health care, and any one woman’s health-related labor can be claimed by family members in various ways. Again from White:

[Previous examples] illustrate the contradictions that emerge from the redistribution of a woman’s labor at marriage and the strategies families use to retain a woman’s proximity and access to her labor. The inherent conflict between her mother’s moral claim and her mother-in-law’s customary claim to her labor is negotiated by adjustments and strategies of time and space. These strategies also reflect the relative advantages of class, wealth, status, and strength of the families involved. (48)

The Family as Primary Care Unit

The family is the primary care unit. An individual with a problem will first tell her family about it, and if it continues, the family will discuss options as a group and participate in getting the patient to the appropriate health care provider. As an example of this family group discussion of health problems, I offer the following account. As we were sitting drinking tea one afternoon, visiting the mother-in-law of Aunty Emine’s daughter, a woman came to the door with a problem she wanted advice about. She was a
daughter-in-law of our hostess, and her daughter, nine years old, had a high fever and a scratchy throat. The woman explained that her child had fallen ill after eating ice cream, which had caused her throat and stomach to catch a chill. The first suggestion from the group of women was aspirin. The woman didn’t have any herself, and no one volunteered to get some from their own homes. Then, someone suggested a bath in cold water to bring down the fever. Another woman protested that this would only make things worse, and that the only good way to bring down a fever is to press vinegar-saturated cloths under the child’s arms and on her chest. One woman tentatively suggested a trip to the doctor (which would have entailed calling for a car, taking the sick child down the dirt road to the clinic, and waiting for the doctor), but another woman squelched that idea immediately, “Don’t take her -- What use would it be?” ("Götürme, ne gereği var?") The child’s health is a concern for all of the women in the family, as well as for the visiting women. Everyone gives advice, but a child’s fever is considered a fairly common, short-term illness, which does not require emergency measures such as calling for a car or even breaking up a tea-party to get aspirin.

Many elderly villagers travel to stay with their grown children in order to get access to the superior health care in bigger cities (or even to free care in Germany). During a severe and prolonged illness, or at the end of a person’s life, a female family member usually takes charge of caring for a patient, including washing, feeding, and providing company. In the traditional family structure, it is the gelin, daughter-in-law, who cares for the ailing parents, and this is one of the most difficult tasks a gelin is bound by duty to perform. Daughters who happen to live nearby may also help with the
care of their ailing parents. This is considered to be an enormous effort on the part of the woman who is nursing the patient, and she receives the public accolades of her family and neighbors and is said to be preparing a place in heaven for herself. More cynical observers note that those elders with significant wealth get better care from their family members than those who have nothing.

Care for the Elderly and Dying

A serious illness in the family causes all of the traditional family dynamics to come into sharp focus. Traditionally, an older parents would be cared for by their daughters-in-law (Turkish plural: gelinler, here gelins), who would be living in the same house or close by. Their sons would make sure the financial means are available to get care — to pay for specialists, medicines, and transportation. Married daughters would come when they could, but would be excused if their own family obligations were too pressing or the distance to their homes was great. The situation on the Black Sea Coast now has changed so that few sons live with or close to their parents because they have moved to work in Turkish or European cities. In some families, the daughter-in-law lives with the husband’s family while he is away. This situation is considered unfavorable by most gelins, who will try to join the husband and escape the village rigors and the control of their parents-in-law. Once the husband has saved up enough to support a family in the new place, and once the gelin has had a baby or two, she usually goes to join him. When a young woman is considering marriage, she considers closely the possible burden of care for the parents of a prospective groom.
The parents, then, are left without the traditional source of health care for their old age. If there are several married sons, they will try to get at least one to settle in the village. If they have managed to marry a daughter within the village or nearby, they can usually expect some care from her. Cash money for clinic and hospital treatment become easier to obtain as the children move away for salaried jobs, but the traditional, at home attention and care (ilgi), is increasingly hard to secure.

Women's Roles at a Time of Death in the Family

Women, especially the gelins, are held most responsible for the care of the dying. This customary insistence that the gelin performs the difficult tasks associated with serious illness is not unquestioned by the women themselves. While most gelins will help in the care of their elderly in-laws, they also are known to resist through various means such as public complaints, private negotiations with their husbands, stalling or ignoring requests, attempts to separate households by moving away, and the extremely serious option of withholding forgiveness as a tyrannical parent-in-law is dying.

Forgiveness is not considered a paramount virtue in the local belief system, and a gelin who has been abused by her in-laws can display her resistance in this locally acceptable way. She may say: “Bana yapılıkların altı af etmem.” (“I will not forgive what you have done to me.”), “Hakım helal etmem.” (“I will never forgive what you owe to me.”), or “Öbür dünyada yakana yapacağım.” (“I will grab onto your collar in the next world.”). This means that the dying person will face punishment for her or his sins after death.
Functions to be performed by women at a time of death include the sitting up with the body for one night, washing and performing the ritual ablutions for the body in preparation for burial, the lamenting at the home of the deceased, the preparation of food for those visiting to pay respects to the family, and the informal discussion of the life of the deceased, including attempts to gain forgiveness for any debts or slights.

The integration of the area into the national and international cash economy means that people are increasingly turning to paid professionals to do the most difficult tasks, including care for the bed-ridden, the preparation of the corpse, and sometimes even the ritual lamenting.

The Hospital as Family

In Turkish culture, the hospital is judged in direct relation to family care at home. The strongest critiques of hospital care are those which find it lacking the emotional support, wholesome food, cleanliness, and *ilgi* which can be found at home. When hospitals are praised, it is generally for their technologies and for the skills of specialists, not for their atmosphere or sympathetic care. If the family is the primary care unit, then all other health care is judged by the standards of the family. White (1994) has noticed parallels between the Turkish family and larger societal relations:

Just as in the family the father assures the normative reproduction of traditional family relations, so the Turkish state manages the economy along lines laid down by the liberal economists, raising prices, adjusting interest rates, providing incentives and punishments. Meanwhile, just as the mother in the family reproduces relations moment by moment in practice, the Turkish people renegotiate their material reproduction day by day by acting out norms such as those of reciprocity, steering small amounts of money over and around the systematic channels imposed from above. (67)
In terms of the State-run hospitals, it is no wonder that the institutions of the 
devlet (State) are seen to lack the ilgi required to get well — the patriarch is meant to be 
aloofer from day-to-day care — that is the business of women. The State builds physical 
structures, like hospitals and clinics, which are concrete examples of the patriarchal 
ability of the state to provide care for the “family” of citizens. What goes on in the daily 
routine inside the hospital is of less concern to the State, which is meant to maintain an 
dignified and elevated status.

The women within the State hospital, mostly the nurses who are meant to provide 
the daily care, are criticized by patients for their lack of ilgi, as if they were members of 
the family structure, bad gelims or ungrateful daughters. The irony is that they have no 
family obligation, and their rewards are small enough for the work they do. Like all State 
employees, they can consider themselves secure in their jobs but have no motivation to 
provide anything but the absolute minimum of service. If the nurses within the devlet 
hospital do not show enough ilgi, then the families must step in to take up the slack — 
bringing foods (even if they have been forbidden in the restricted diet —perhiz— 
prescribed by the doctors), clothing, sheets and towels, and by spending time with the 
patients.

Outside of the relations between State and citizen, private hospitals and clinics 
offer better services in return for cash. They put much stronger controls on the visitors to 
patients — keeping strict hours, limiting the number of visitors allowed, and regulating or 
prohibiting the items brought from home. The understanding is that the patient will be 
well taken care of in exchange for the high price of care. The extra-familial coldness of
this kind of cash-based transaction is mitigated by webs of social networks which make certain specialists familiar (because they treated a family member or acquaintance), or by the fact that the money needed for private care must be procured by traditionally-shaped negotiations within families.

Turks express surprise that the German State cares so well for Turkish workers, even illegal ones — it is so unlike the idea of State in Turkey. Many take this as proof that the German State is either stupid or so rich as not to care, and therefore should be taken advantage of as much as possible.

**Women as the “Front Line” of Defense Against Illness**

In Turkish culture in general, women are the “front line” of defense against illness for their families. Women are meant to monitor the health of family members, especially the very young and the very old. Health is a major topic of women’s daily conversation, and unsolicited advice is extremely common — “That boy is sick, you’d better wrap him up better and give him some mint tea.” “Don’t sit by the open window, you’ll catch cold.” “Isn’t she too skinny? You should give her a glass of milk every day.” If there is illness in the family, blame can easily attach to the mother or wife of the patient — “Did you see how she lets her kid run around without slippers?” “He probably ate something bad (presumably ill-chosen, ill-cooked, or left out to spoil by his wife).” “She’s always visiting and chatting, she doesn’t keep her house clean, her kids are always sick.” This possibility of blame ensures that health is a common topic of conversation and that women take care to show their ability in managing illnesses as well as in
preventing them. When illnesses occur, factors such as the weather or nazur can be brought up as probable causes to deflect potential blame away from the woman considered responsible for the family's health. Men in the family seem to offer advice or tell related stories about health if they happen to hear a complaint or a question about treatment, but they only become actively involved in the treatment of a complaint if they are known for particular expertise (such as prayer reading and blowing) or if transportation is needed (such as a car to ride to the hospital). Women decide among themselves what should be done in a particular case, while men are most often passive recipients of their mother's or wife's ministrations or mostly silent facilitators in the transportation of a patient to a specialist.

Gendered Rhetoric: Women and Men Talk About Illness

When women in Medreseonu talk about health care issues, they always use concrete examples taken from their own personal experience. Even when asked a general question like, "What should a person with a sore throat do?" women will give advice using personal pronouns: "You heat taflan leaves and press them on your throat," or "You should get him/her to drink hot water with honey and lemon juice." They often continue with examples taken from their own sphere of knowledge, "I gave so-and-so from up the hill some taflan leaves from our tree because her kid was sick, but she didn't use them right away and they turned brown — then they're no good." Or, "So-and-so from over in Afril makes a really good pekmez (a concentrated mulberry syrup). You can put that in hot water and give it to your baby. Before you go back we'll ask her for a
bottle. Last year she didn’t give me any, but she’ll give you some.” It is very difficult to solicit general opinions about doctors or various healing practices — every question is answered with personal examples: “I don’t know much about doctors, but my mother-in-law went to one in Ordu for her diabetes. He gave her medicine. She used it all and now she needs more. My husband is supposed to bring some when he comes back from Istanbul.” or “Dr. Gündüz (the local clinic doctor) is nice. He is not from here (*buralı değil*), but he likes it here. Maybe he’ll get married and stay.” Or “She (a local woman) gives shots to anyone who needs one. She is good at it. It doesn’t hurt when she does it — she’s got good hands. My husband had to get shots, so he went to her. When he’s down by the shore road, he’ll get one of the nurses to give him the injection, but he usually gets her to do it up here.”

Women tell about problems with health in a framework of relationships. When they give an example, they never just say a person’s name (in fact, it is often hard to learn someone’s name without directly asking), rather they say how the person fits into the web of relationships which connect the person to the speaker: “So-and-so’s girl, you know, who married our uncle’s son.” Without specific stories of the treatment of a family member or neighbor, women are unwilling to make a judgement about a particular remedy. I had been told about a spring where people used to go to get water for various ailments. When I asked about it, women had heard of it, but since they didn’t know anyone who had gone recently, they wouldn’t say what they thought about its efficacy. Women also tend to use family members and neighbors as examples rather than themselves, unless they are the only relevant case of a particular ailment. Women talk
about health in a conversational way, adding information to that of others, contributing supporting or detracting examples, and easily shifting away from health to other topics.

For women, the topic of illness and injury is an everyday one. Women share information about themselves and others, making casual recommendations or conjecturing about why a remedy didn’t work or why a person got sick. Although they pay close attention to the morality and behavior of others, they do not often claim that an immoral person deserved to become ill -- illness is usually thought of as an unfortunate state that everyone, saint or sinner, must experience at some time. One exception to this general view is the case of a local woman with a severely handicapped son. If pressed to explain this boy’s state, most women blame the father, who is a known robber, as the reason for this misfortune. For the most part, illness is seen as the will of God, a trial to be endured, which will pass only when God wills, although God has made available every kind of comfort for those who know how to find and use the bounties of creation and their God-given intelligence. Women can pass along specific detailed remedies or describe exact procedures, but they assume these are being learned in order to help specific people with specific problems. They see no point in general theorizing about the serious and everyday issues of health and illness, especially when there is always so much work to be done.

Men, on the other hand, are much more likely to make general pronouncements about efficacy, often supporting their claims with ideas heard from others, from TV, or from newspapers. They create a stage for themselves, filling the available space with their tales. They tell stories about health problems and resolutions, which are rhetorically
formed in chronological order, with beginnings, plots, character descriptions, building up of narrative tension, and a resolution, perhaps with a moral. Men give detailed information about means of transportation, the exact costs of things (including a figuring of old amounts to current value based on inflation), place names, and numbers. Men are often the main protagonist of their own stories.

When I was tape recording in a group which included men, a man would often start a story, recognized as such by everyone in the room, and would tell the entire story with few interruptions from others, until the end was reached and a point had been made. During such story-telling, women would shoot glances at each other and at me to provide silent commentary on the story and to check if I was actually interested.

The husband of Aunty Zeynep, the kirikçı (the bone-setter discussed in detail in Chapter 4), told a long, complex story about his own long-term illness, although everyone knew I had come to interview his wife. His story can be summarized as follows:

When he was about 30 years old, he decided to go down from Çandır to the Sahil mosque in Medreseönü. When he got in there, in the middle of the prayer, a green light surrounded him -- he doesn't know how he got out of the mosque and how he got his shoes, but he fainted outside. Some people picked him up and took him down to the sea, where they dunked him in the water. He revived and they took him to a restaurant to eat some yoghurt. Then he went to the doctor, who laughed and said “Didn’t I warn you?” and gave him a shot in the arm and in the leg. But he didn’t get better, so he was told to go to Istanbul. He had to take a paytun (horse carriage) to Samsun and then a train to Haydarpaşa. He was looking out of the window on the train when a bearded guy, a hoca (religious teacher), asked him if he was sick (hasta). He said no, the hoca asked twice more, and twice more he denied being sick. The hoca insisted that he was sick. The hoca was from an important mosque in Istanbul and offered to heal him for a certain price, but he declined. In Istanbul, he went to a hospital. He had a hard time finding the hospital because he didn’t know anyone in Istanbul. A young man reading a newspaper at the hospital had him wait with him and then got him in to the doctor before the other
patients. He had five treatments and stayed in the hospital a long time. He was visited by a professor doctor.

He began to believe the *hoca* he had met on the train after a dream in which two men and a woman were swinging him in a blanket like a baby.

He wanted to leave the hospital, but they didn’t want him to leave. They had his clothes and he didn’t have any money. Anyway he got some clothes and got away from the hospital and went home. At home, he tried to find a *hoca*. He finally found one who told him that he had come very late, but wrote him a *muska* (amulet with a written prayer). After seven years of emptiness (*Yedi sene boştum*), he was finally cured, thanks to the *muska*. He ends the story with a comment on how the times and morals have changed for the worse.

We can see various traditional storytelling devices, including a problem which motivates a journey, a green light (a common device in Muslim stories of spiritual pleasure or affliction), a mysterious bearded *hoca* who asks a question thrice and is thrice given a negative answer (incorrectly), a meaningful dream, a futile, expensive, and confining procedure leading to an escape, and a supernatural cure. This was clearly a story, and was listened to by the audience until the end. During his telling, the only contribution made by Aunty Zeynep was a sigh and the phrase “I suffered a lot (Çok Çektim).” Aunty Emine once interjected “I was the same,” as if to tie the story into relationship with her own experience. Later Aunty Emine explains to me that his illness had been a *ruh hastası*, or “soul (spiritual) illness,” the everyday term for mental illness.

In the following chapter, we will hear a story from Uncle Ferit, husband of Aunty Emine, about a *kırıkçı* (bone-setter) who stole patients from the doctor and walked out on his own heart operation. The storyteller makes no special claims to actually know the people involved. The point of the story seems to be to show that a traditional healer was superior to the doctor, and the story itself has typical story elements like surprise, plot-driven tension, and its relief.
The fact that it is mainly men who tell this kind of story does not mean that women never tell complete stories which involve health and illness. As an example, we will hear a story from Granny in Chapter 5, which resembles Aunty Zeynep’s husband’s story in that it is about a supernatural affliction which happened to her in her own youth. I have also been told that women tell more stories in the winter, when they have more time. It can be said, then, that the issue of health and illness is generally an everyday topic among women, who are most concerned about people they actually know and how suffering can be alleviated. When they are asked specific questions by a female researcher (and one who is integrated into the community through family ties as I was), they continue with this general conversational tone, giving examples mostly from their own families. According to several Turkish men I asked, men do not talk about health as much among themselves as women do (as women are held more responsible for managing health care within their families). When a female researcher asks a man about health and illness, the situation is more particularly framed as distinct from everyday talk (being an unusual one), and the man is likely to come up with a fully formed story, perhaps one which concerns an extraordinary event in the teller’s life, or one which illustrates a moral point or a value judgement about health care options.

In local women’s discourse, men are assumed to be outsiders to women’s conversation. The appropriate family relationships must be foregrounded in order to include men in a mixed discussion. When I am visiting a house and baby Timur wants to
nurse, the women tell me I can go ahead because "No one is at home." ("Evde kimse yok."), meaning no men are home. In terms of privacy for women, men are the marked category.

Women as Bearers of Health Care Traditions

The local traditional belief system will be discussed in detail in Chapter 5, but here it should be noted that women are the active tradition-bearers for health care. Although men may have wide-ranging knowledge of traditional remedies, it is the women who are asked for help from suffering. They keep their own knowledge alive through everyday use and discussions with others. They regularly collect and use herbs and plant material. They give advice freely to family and friends on all health-related topics. They also initiate procedures in which a male expert is required.

For example, women initiate the request for a baby's father or grandfather to perform the ritual of tying the baby's legs together with a red cord and then cutting the cord, which is to make the baby walk quickly and well. The man has to do the tying, cutting, and throwing the cut pieces of string to three places (a running stream, a busy crossroads, and the mosque yard on Friday — all places of much motion — if the Friday mosque yard is considered the same as a busy crossroads, then one piece can be buried at the foot of a tree, in which case the wind in the tree is the agent of movement), but the mother holds the baby during the procedure, which involves carrying the baby three times around the yard of the house.
A confrontation between the local traditional practices and a young outsider educated in the newly strong textually-based Islamic revival movement will be discussed in Chapter 5. The practice under attack by the young man is one which is done by pious elderly women who consider all they do to be within the bounds of a good Muslim life. The everyday practices of illiterate Muslims, especially of women, are considered by the forces of Islamic revival to represent the old and mistaken ways of ignorance. This example confirms that older women are seen to carry on traditions for the local group, whether for good or bad.

Young women with education and exposure to other ways have confided to me that they think little of most old-fashioned health care techniques, although they value herbal remedies and special foods from their home village. Young men seem to challenge old ways at every turn, especially when talking to outsiders. When it comes to their actual practices, however, most trust their health to whatever their mothers or other female relatives deem fit for them.
CHAPTER 4

A TRADITIONAL HEALER

A happy, noisy group of women and children from the village below are visiting a family in the village up the hill. I have asked to visit with Aunty Zeynep and to see her at work, and the expedition has turned into a boisterous get-together for women who can’t always find the time to sit and chat with each other. My tape-recorder (with its sound-activated red power light) is an object of great interest to the children. The women make a joke of my recording their conversation – “She’s going to write it all down in a book! We’ll be famous in America!” Back in the U.S., I will listen to the tape, remembering the festive atmosphere of a women’s mid-day social visit, trying hard to decipher the voices and sounds which pile up on top of each other (including the South American soap-opera on TV), the overlapping and the interrupting, the laughing short-hand conversation about familiar people and events, the comfortable use of local phrases and pronunciation.

Aunty Emine and Aunty Zeynep have known each other for almost all of their lives, and are both accomplished healers who can compare notes about bone-setting experiences. As the initial chit-chat flows into talk about health, Aunty Emine and Aunty
Zeynep try to accommodate my interests by discussing people they have known and treated. Aunty Zeynep is asked to take a look at the new infant in the household, since he has been fussing and not sleeping well. Aunty Zeynep holds the baby and begins to recite the nazar prayer (see Chapter 5 for more on the evil eye prayer). Conversation flows on around them, and the prayer is over in a few minutes. After tea and cookies, our visit draws to a close. Most of our group heads home to work in the gardens, but Aunty Emine and I go with Aunty Zeynep as she goes on what resembles a doctor’s rounds.

The next woman we see has a severely sprained ankle, which has swollen up to the knee until she can hardly walk. The woman is from the same generation as Aunty Zeynep and Aunty Emine, and has limped over to her daughter’s house with great difficulty, using a walking stick. Making sympathetic sounds, Aunty Zeynep begins by softening the woman’s ankle by wrapping it in hot towels. She gets the woman to sit on the carpet with her feet in front of her. Aunty Zeynep asks for olive oil and begins to massage the oil into the swollen limb with her thumbs. As she works, she tells the woman that she will have to massage her own leg for it to heal properly. The woman protests that she can’t touch it herself, because of the pain. As Aunty Zeynep’s hands move down the leg to the ankle, the woman lets out a scream of pain. Aunty Zeynep soothes her, asking her to not be afraid. She recommends that the woman wrap her leg every night in hot towels and stay off her leg for as long as possible. After the leg is softened and the swelling is slightly loosened, Aunty Zeynep holds the woman’s foot in both of her hands and slowly turns it to check if the joint and bones are dislocated. She listens for sounds coming from the joint, which would indicate dislocation. She scolds
the woman for waiting before asking for help, telling her that there is only so much she can help when the swelling is so severe and the problem has been left without treatment for so long (about a week has gone by since the woman fell and twisted her ankle). Her tone of authority, her diagnosis and instructions for care, and her frustration with the "non-compliance" of her patients reminds me of a clinical doctor.

When the massaging is finished, Aunty Zeynep has our hostess, the patient’s daughter, bring cloths soaked in softened beeswax to wrap up the leg. The women agree that pine sap works as well as beeswax for this purpose. The wax hardens as it cools, creating a protective casing around the injured limb and keeping it from moving out of place. Aunty Zeynep admonishes the woman to stay off her leg, threatening permanent disability if she continues to use it.

The treatment over, we sit around and chat over tea. Aunty Zeynep demonstrates various techniques of bone-setting, joint adjustments, and replacing dislocated veins, tendons, and muscles. She gets a young girl, about eight years old, to submit to her various demonstrations, which she does with alternating giggles and yelps. Aunty Zeynep has a specialist’s vocabulary, with particular words for body parts and conditions. She stresses the importance of the particular sound “Kart!” which indicates a joint returning successfully to its place. After a while, the conversation becomes more general, with talk about good gelins and bad ones, a sensational shooting incident of the night before, and the current state of a local woman with mental health problems.

The elderly ladies turn to one of their daily concerns, and favorite topics of conversation, the health of their milk cows. Aside from treating human patients, Aunty
Zeynep is an expert in the care of cows. She knows causes of infertility, she can diagnose illnesses in the animals, and she is often asked to help out when a cow seems to be afflicted with *nazar* (the evil eye). During this visit, in fact, she is asked to read a prayer over a piece of bread, which will then be fed to the troubled family cow. As a traditional specialist, this is just one part of Aunty Zeynep’s daily routine. She begins the prayer and blowing, but can’t resist participating in the conversation, which continues. She apologizes for interrupting the prayer, says what she wants to, and then starts again at the beginning. As she recites, she is overcome by yawns, a sure sign of the presence of *nazar*.

Other topics of conversation include wedding invitations, traditionally given in the form of new colorful head scarves but now increasingly in printed card form, wedding gifts, and the care of babies. Aunty Zeynep warns the young mother in the room not to kiss the baby excessively on its face, as it can develop a rash. Later I learn that kissing a baby too much is thought to hinder its development or cause illness. Our tea glasses are continually refilled on the small tables pulled out for our visit. We snack on cakes and biscuits until the conversation reaches a natural lull. Then our upturned palms are splashed with lemon cologne, and we gather our things and stand.

Before leaving this house, we stop in another room to visit a woman on her deathbed. Our hostess has been taking care of her invalid mother-in-law for four-and-a-half months. The room smells sharply of ammonia and antiseptic. The woman is painfully thin with a gray skin-tone. When we come in, she turns her head slowly away from the wall to face us. She recognizes Aunty Emine and is introduced to me. Holding
the woman's bony hand, Aunty Emine says some consoling words about the power of
God, wishes the woman relief from pain, and we leave.

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Meeting Aunty Zeynep

Aunty Zeynep is a woman in her sixties, who lives in Çandır, the village far up
the road from Gebeşli, where Aunty Emine lives, and more than twice as far from the
shore road and town center. Aunty Emine was born in Çandır, and visits her relatives
and friends there with some frequency. Çandır was only recently incorporated into
Medreseönü and retains a feeling of more independence from the goings on in the town
center. Unlike the other villages associated with Medreseönü, Çandır is known for
having horses as well as cows. Many families use horses in their daily trips to fields and
for bringing the cows to and from grazing. Elderly people relate that, in the past, horses
were common in all of the villages, and people get to nearby towns by going across the
hills on horse trails rather than along the coast as they do now in vehicles. When Aunty
Emine was asked about traditional healers for me to interview, she immediately thought
of Aunty Zeynep, who is known by all in the region to be a bone-setter (kırıkçıkçı),
the one who deals with breaks and dislocations).

In 1993, I was taken up to Çandır by Aunty Emine for the express purpose of
meeting Aunty Zeynep. I first met her during the social visiting described in the
previous section, which can be called “going on rounds.” The two Aunties then decided
that we should come at another time to videotape some of her demonstrations. Because
her techniques are based on the physical touching and manipulation of injured body parts, video is an excellent medium for recording them. I cannot do justice in print to the level of detail in her demonstrations, for which she would often grab her own arm or leg, or that of a nearby child or of one of us. A lengthy translation of the verbal portion of her explanations would be futile: "This comes out, see, so I take this, and rub like this, then "kart" I push it back in."

So, on another afternoon, Aunty Emine, my husband, and I went up to Aunty Zeynep’s house in Çandır. After walking up the winding dirt road through hazelnut groves, we came to the flat section of road above which sits the Çandır graveyard. Aunty Emine recited some prayers for the souls of her parents as we passed. A couple of times a year she will come up to this graveyard, cut back the grass and weeds from their graves, and recite prayers, but today she is just praying in passing, as a sign of respect and piety. As we came into Çandır, Aunty Emine began to greet people in their yards alongside the road. We came up to a group of houses arranged up a steep slope along a cement set of stairs. This was a family compound, which had grown up the hill as sons built additional rooms onto their parents’ house on the road. Aunty Zeynep’s house seems to me to be desperately poor. There is a broken pane of glass in the single window of the kitchen, which also serves as a room to receive guests. We sit on a lumpy mattress atop a rusty bedspring. The pans and bowls arranged on shelves above the sink are the old tinned copper ones, and their surfaces looks ready for re-tinning. Aunty Zeynep is wearing a homemade skirt over a homemade house dress. Her grandchildren run about without shoes, their clothes patched and dirty. We are yet to hear about the husband’s
mental/spiritual illness (described in his story of the previous chapter), and the
devastating boat accident that will handicap both her grown son and her son-in-law has
yet to occur. The house’s condition is enough to make us aware that this is a family of
little economic security.

Despite her poverty, in defiance of it, Aunty Zeynep has a confident air. Her arms
are thick and her hands obviously capable. She is a busy woman with housework, garden
work, cows and grandchildren to watch after, and a busy circuit of patients who value her
expertise and depend on her to alleviate their suffering.

Her techniques include the adjustment of joints which have been wrenched out of
place, the diagnosis of breaks, fractures, and dislocated tendons, the alignment of broken
parts of a bone, the wrapping and setting of broken or sprained limbs, the reduction of
swelling through the use of heat and massage, the diagnosis of gangrene and infection,
the manipulation of the skin near the spine for the relief of aches, the prescription of
herbal remedies, the reading of nazār prayers, the application of heated leaves on the
throat or chest for coughs and sore throats, the application of various poultices for the
reduction pain and swelling, the procurement of pain-killers from the local pharmacist
for her patients, and the application of heated drinking glasses to create vacuum pressure
on special points on the back for the treatment of various inner ailments. The setting of
bones, joints, and tendons, as well as the treatment for nazār are techniques she performs
on animals as well as humans. Locals, in general, know many techniques for cracking
various aching joints and the spine, which usually involve another person who lifts or pulls. Aunty Zeynep's knowledge goes beyond these everyday techniques. She is an expert.

On this visit to her home, Aunty Zeynep told us a story, which she repeated on another visit two years later, and is clearly very important to her. The story can be translated as follows:

Aunty Zeynep: ...Once I went to Doctor Gündüz. The wife of Hace's Yılmaz fell out of a tree. I healed that leg. The leg was fine. She went to the doctor. When she got there, my girl [to another lady her age in the room] Doctor Gündüz said to her "My girl, who fixed (pulled) this leg?" "So-and-so fixed it." I thought I was going to be jailed. First I went. The doctor said, "How did you fix this?" First, I said, "I left it in boiled water, I softened it really well in the boiled water. [demonstrating on her own leg] After that, I searched with my hand to see where there was broken bone. After that, this leg, this heel." I said "I gathered it together from this side and that," I said. "I pulled the leg down, I pulled it upwards. These pieces right here, I sought them with my hand." I said. "Before it swelled." I said. "With only beeswax." I said. "And so I wrapped it this way." I said. [to us, as explanation] With heavy wax paper, thick paper. I wrapped the paper around here like a bracelet. "I wrapped it." I said. He asked me, "How many days [did it take] Exactly how many days did you leave it?" He asked me. "I left it exactly five days," I said, "On the fifth day I opened it." "Then what did you do again after that?" he asked me. "Then again I massaged it well with olive oil. I made a dressing. Once every three or four nights," I said. "Then I wrapped it up again," I said. "I didn't let her step
down on it,” I said. At that time, he said to me “I’m going to bring you here,” he said to me, “I’ll make a place [for her in his practice], I’ll bring you here.” “No,” I said, “I’ve got small children.” “Well then, you’re going to give up this practice,” he said to me. “My grandmother taught me this,” I said. He brought me a basket of bones. [to us] Do you know what kind of bones? [M. asks, “This is Doctor Gündüz?”] Yeaa. He brought me those bones, cows’ bones. He said, “Let me see you straighten out these bones and muscles.” They were separated from each other. Look, there were some muscles in place and some were out. “How are these muscles? How are you going to bind these? he said. How was it? They were all muscle, muscle [separated] like this. “This,” I said, “I would do this way.” There is only one muscle here, one is missing [showing us on her own finger], isn’t it so? “This muscle has cooked [merged] into the flesh,” I said, “it is knitted in the flesh. There is flesh inside it [the bone]. With just one muscle, it won’t come out right. So,” I said, “if this same thing comes here to a doctor, could he attach the muscle? He can’t attach it. It would be knitted with only one muscle. Just the same way it would knit in the flesh. There are some wrenched bobbins [local word for wrist bones],” I said. He said, “What are those wrenched bobbins?” [he doesn’t understand her terminology] “Eeh, those wrenched ones,” [she demonstrates] I said, “they put a platinum bone in, they put in iron,” I said. “When I don’t do it, I send them [to a doctor],” I said. I’m telling them this [to the injured people],” I said. “When the bone won’t take here, right? Then they put in a bone or stitch them together. Then it gets straightened,” I said. “But with that kind of other dangerous stuff, I send them [to the doctor],” I said...”
I find this story particularly fascinating because it shows the interaction between a traditional healer and her modern medical counterpart. This story disproved my original hypothesis that traditional and modern experts had no contact and no respect for each other. In this story, Aunty Zeynep shows that she had been afraid of the legal consequences of practicing bone-setting, a form of traditional medicine. She discovers that the doctor was impressed with her work, but that he wants her either to practice in a formal clinic situation or to give up her art. She also tells the doctor that she is aware of her own limitations and that she does not hesitate to send a patient to a hospital or doctor if she cannot perform the necessary operations. The story shows two types of experts negotiating their roles in relationship to each other.

The traditional healer cites having small children as the reason she cannot join the doctor in his domain. This suggests to me that the traditional healing practices, performed by a woman with special skills and training, are considered to be inseparable from her normal life, and not an isolated profession which takes the place of other duties. The mention of her small children could also be seen as a strategy to dissuade the doctor from any punishment he might have been contemplating. Although the Doctor has the power of the law and of the medical profession behind him, Aunty Zeynep has the power of her knowledge and of her respected status of mother in her favor. When the Doctor tells her she must give up her practice, she challenges his right to make this demand, saying that her grandmother had taught her. Her art, she seems to imply, should be respected because of its lineage. The doctor then proceeds to test this knowledge with the cows' bones, and Aunty Zeynep never mentions if he said anything more about giving
up the practice. The outcome of the exchange being that the two experts know each other's skills and power a bit better, and both continue to practice in their accustomed manner.

Throughout our initial interview, Aunty Zeynep checked in various ways to see if we were earnest in our interest in her art. Her story about the doctor impressed with her work could be seen as a rhetorical strategy to provide evidence from a biomedical expert of her skill. She needed to know that we were not dangerous for her, perhaps outsiders who would report her illegal practice. She wanted to show us her abilities and impress us with the extent of her experience and her commitment to her practice. I imagine that she had these things in mind as she demonstrated a technique on Muammer's wrist for the video camera. When I asked her to demonstrate on my wrist as well, she deftly dislocated my wrist and then popped it back into place. In an excruciatingly real way, I learned the power of her grasp and the confidence of her technique. My scream and then my laughing relief after the demonstration were proof of my temporary powerlessness in her hands. I was impressed, convinced in a visceral way of the woman's abilities.

One thing that stood out very clearly on the cassette recording of with Aunty Zeynep was how quickly she understood what I was interested in and how easily she stepped into the role of an expert providing information. She needed no coaxing to start, and expected some kind of financial reward at the end of the video taping session. As far as I know, she has never been interviewed by a professional researcher, but she fields questions from her family and neighbors all the time. She may have considered me to be a kind of student who would pay for my lessons. Confused about her hints at the scene,
my husband and I were set straight by Aunty Emine, who recommended that we send her some money as we were leaving the area. As a known traditional expert, Aunty Zeynep is used to being asked about healing techniques. She did make a perhaps-pointed reference to the lack of respect city people show to villagers. Many elements in the interview suggest ambivalence about sharing information with an outsider. The story about the Doctor, after all, was a story of a powerful and potentially dangerous outsider. Aunty Zeynep was careful to check our intentions and respect for traditional medicine. Points in our favor included our local family connections, our fame in the area as the first American bride and the first local boy to go to America, and the fact that we had come from another village just for the sake of meeting and interviewing her about her healing practices.

A Specialist’s Language

Aunty Zeynep uses a specialist’s language when she talks about her art. She has words for each part of the body, including words which are not part of everyday speech in the area. I had to clarify many terms when translating interviews and video tape, and even local helpers had to be shown the body parts in question to venture a guess as to the correct translation of Aunty Zeynep’s terms. Institutionally trained doctors have Latin terms for body parts, as well as common terms (not the terms Aunty Zeynep uses) to explain things to their patients. Like a doctor, Aunty Zeynep has phrases to describe particular conditions, such as “kemiğin araside et girmiş” (tissue has gotten in the break in the bone) to describe a situation which she considers to be beyond her abilities to heal,
a situation in which a person has waited too long to come to her, when there is a high risk of infection, and in which case she sends the patient to a doctor. This special language is a part of Aunty Zeynep's training and sets her apart from the general population — it makes her an expert.

Returning to Aunty Zeynep

In July of 1996, I have my second formal interview with Aunty Zeynep, accompanied by Aunty Emine, Muammer, and our four-month-old son, Timur. We take her a gift of cloth for making a skirt, to show appreciation for her previous information. Aunty Emine had sent her some money the previous year to show gratitude for our first interview. The two women have known each other for a long time, since Aunty Emine comes from the village where Aunty Zeynep has lived all of her married life. As we sit down, the two women start to chat about a very important part of the life of village women, taking care of cows. Aunty Zeynep's husband is sitting in the room, but does not participate in this initial conversation. The women complain about the heat and the fact that no one is buying meat because of the mad cow disease scare from England. Because of this they can't even sell their cows and be saved from the work of keeping them. They agree that husbands are no help when it comes to cows. Aunty Zeynep tells how her cow's hip became dislocated when it turned a corner. She immediately put it right, but now she worries that if she tries to sell the cow, people will wonder why she has picked this particular time to sell it, and might guess that it had been injured.
We turn to the topic of feeding babies and it comes out that both women agree that yogurt and pekmez (condensed mulberry syrup) is better for babies than formula. Aunty Zeynep says that a doctor had come to the village and recommended that babies eat yogurt and pekmez instead of store-bought baby formula. Aunty Emine responds to Aunty Zeynep’s inquiry about her health by telling her about her high blood pressure (tansiyon). The doctor told her that yogurt water is good for lowering high blood pressure. When Aunty Emine asks her how she is, Aunty Zeynep tells us about her attempts to heal her son and son-in-law after their very serious fishing-boat accident. For the son’s multiple fracture in his arm, she put egg-sized wads of cotton under his arm to hold it in position. A doctor in Istanbul recommended various exercises to strengthen their injured limbs. The husband explains that all this misfortune came from nazur, which caused their accident.

I ask Aunty Zeynep to check baby Timur’s limbs, telling her that his shoulder joints make noises sometimes when he moves. She said that his bones were thin (zaf), which is normal for a baby, and that they will fill out as he gets older. She said the noises are normal for babies.

Turning to general talk about health, we discuss the impact of diet on health. Everyone agrees that everyone should drink a lot of water to be healthy. Aunty Zeynep’s husband says that fat, oil, and butter are good for people. Aunty Emine tells him that her doctor told her not to eat them because of her tansiyon (high blood pressure). He doesn’t reply, but he obviously doesn’t agree with the doctor. He proceeds to tell a story (summarized in Chapter 3) in which even a professor doctor in Istanbul was unable to
help him, whereas a local religious healer (hoca) was able to cure him after seven years of illness. As well as a way to tell us about an important illness in his own life, and realizing that we are recording the session, Aunty Zeynep’s husband chose to tell this story. He might have been spurred to tell this story, in part, as a response to Aunty Emine’s doctor’s opinion about fat, oil, and butter.

Then Aunty Emine asks Aunty Zeynep for more specific information for me about bone-setting, and she begins to tell about a woman who fell out of a tree and broke her leg. While she describes a break or a technique, Aunty Zeynep demonstrates using my leg. In this case, she wrapped the leg and waited three days with it well wrapped, then checked it for any signs of blackness, which indicates gangrene. If she ever sees blackness, she immediately sends the person to a doctor. In this case, there wasn’t any blackness, so she had the patient wait two more days and then sent them to get an x-ray. The patient was afraid to tell the doctor that she had been to ḵirixi̱, but the doctor and his associates were amazed at how well the job had been done. This was Dr. Gündüz, who had wanted to put her to work at his clinic (this is an important story for Aunty Zeynep, who told a full version of the interaction with Dr. Gündüz, translated above, when I first interviewed her). Ironically and sadly, the same woman who had been successfully healed of a broken leg died of breast cancer from a lump that was “no bigger than a hazelnut.” Aunty Zeynep had sent her to a doctor in Ordu because of the lump, then she went to Ankara, but she still died. And she had been pregnant, too. The women sigh and shake their heads.
Conversation turns to a recent car accident and how badly injured a man was. Then the women discuss young people, scheming to arrange the best possible matches for them. As the visit ends, the women agree that people should teach their daughters by giving them examples of the bad things that happen to others, rather than by beating them.

A Story about Bone-Setting

Uncle Ferit told me the story about a bone-setter summarized below: (July 5, 1996)

Kirikçikleri don't use plaster for breaks — plaster can break the bone into pieces. Once a guy went to a doctor for an operation on his heart. He paid his money to the doctor and the nurse. A woman came in behind him with a broken shoulder. The guy turns out to be a kirikçik. He fixed the woman's shoulder right there in the waiting room. Then he tells the nurse to give him back his money because he has given up on having the operation. He says, "This isn't a hospital, it's a house of torture!"

Later, the guy is sitting on his balcony with a friend and sees two women coming towards them. He says to his friend, "That's the nurse I got my money back from!" His friend says, "You made her sorry/wretched (perihan), she won't come to you." The guy says, "Yes she will, she needs me." The woman approaching with the nurse had fallen down the stairs and broken her tailbone. Our guy fixes it. They offer him a lot of money — he says, "No, all I deserve is this," and he takes a small amount of money.
This story shows that the traditional healer doesn't really need the doctor because he can do without the operation and save the money. The nurse comes around to respect the traditional healer more than the medicine she was trained in. The story is amusing to listeners because it shows the traditional healer, on his own, besting the powerful and expensive clinical medical system and still not taking advantage of people by taking too much of their money. The traditional healer is shown to be more expert in fixing breaks and more righteous than the doctor is. The sexual innuendoes of a man being petitioned to fix a woman's broken tailbone probably could be played up to amuse an audience of men.

In many accounts of healing by bone-setters, the traditional healer is set up in opposition to a doctor. Both are specialists who have acquired local regard because of successful treatments (in the general Turkish media, there has long been an interest in presenting stories of people who have remained crippled for life because they went to a traditional bone-setter). They meet each other's patients and check each other's work. A bone-setter can refer a person to a doctor if there is a chance of being blamed for faulty treatment later -- a doctor, however, is not meant to refer anyone to a traditional healer, although they can admire a good traditional treatment. People argue the merits of the two styles of treatment, with no clear majority supporting one side or the other. Some families take children to bone-setter (because children's breaks and sprains are common and can heal faster), whereas they recommend a doctor and x-rays for an adult. Some people, especially those who live in big cities where they mainly know about bone-setters from alarmist newspaper accounts, fear bone-setters and only resort to using their
services if the clinical medical approach has been fully utilized but has been unable to solve their problem.

What Makes a Person an Expert?

In Medreseönû, when the topic of bone-setting comes up, the name of Aunty Zeynep almost invariably comes up. She has practiced for years, with great success. Most people know someone who has been treated personally by her at some time in their lives. She lives in extremely poor conditions, her husband and sons having had consistent bad luck. Her bone-setting is a profession for her — it gives her an important identity in the area, it gives her a reason to be socially active without incurring a reputation as someone who takes advantage of other's hospitality without being able to return it, and it gives her a source necessities and even of cash income. Although she does not state a fee for her services, she knows that people value her expertise and will give her either goods such as dry foods or cloth for clothing, or money.

Although Aunty Emine knows many bone-setting techniques, she has never considered bone-setting as her vocation in the way that Aunty Zeynep does. Once, another well-known bone-setter in the area, who had passed away before I came to the area, came to Aunty Emine with broken ribs. She described the proper procedure to Aunty Emine, who then fixed her. In these kinds of circumstances, which mainly occurred before it was easy to transport an injured person to a medical doctor, Aunty Emine would gladly help a needy person. These days, she would rather send someone to a doctor than worry about being blamed later for a faulty diagnosis or treatment. She
does not look for patients and does not consider bone-setting to be a livelihood. She was well-known for midwifery in her younger days, and she is still asked to perform the ritual preparation of a corpse by the families who do not have anyone among them who can perform this special ritual. She is often asked health-related questions by family and neighbors, among whom she is known to have a knack for such things. She could certainly be called an expert, especially because of her ability to safely deliver breech births, but she is not as much of a professional as Aunty Zeynep.

The Education of a Traditional Healer

Aunty Zeynep was taught by her grandmother, when she was a teenager, before she was married. She had fallen and injured her ribs. When her grandmother fixed the problem, she asked to be taught the art of bone-setting. One of the ways that her grandmother trained her granddaughter’s sensitivity to the invisible problems under the skin was to break a pottery jar inside a bag and ask her to put the pieces back together through the bag, without opening it or looking inside. She would also have her granddaughter feel the limbs of people who had come for help, so that she would get used to what was normal and what was broken, fractured, or out of place. There was also plenty of opportunity to practice by ministering to animals, mostly cows. With the agricultural life on the steep hills of the region and with the difficult life on the sea, people seem to be constantly wrenching their limbs, falling out of trees or off roofs and breaking bones, spraining their ankles, and having their shoulders dislocated.
Both the traditional bone-setter and the clinic staff agree that the best thing a person can do to speed recovery is to get help immediately, before the problem sets and swelling makes relocation difficult. Both types of practitioners scolded their patients for delaying treatment, warning them about the risks of slow and imperfect recovery and the danger of infection.

**Aunty Emine on Bone-Setting**

I asked Aunty Emine about bone-setting in an interview (tape 1, 1993):

Aunty Emine: I don't fix broken bones now, I'm afraid. When they scream, I can't stand it. Now, say your wrist comes out. I hold it here, and I squeeze hard here, I press here. It clicks right into place. I don't get involved with surgery. If there is a fracture, if you just touch here, the person faints. If there is a fracture in the bone. Then I leave it; I send them to a doctor. They do an x-ray, they look, and there's a fracture. They say, "Are you a doctor?" I don't move it. If I mess with it could open up the fractured bone. Then tissue can get in and it is harmful. When I squeeze like this, I see the person's screaming, about to faint, then I say, "There's a fracture."

Sylvia: If there isn't one?

A. E.: If there isn't, then it pops back into place. If this shoulder gets dislocated, this shoulder. I pull slowly, and I press with my other hand here, I press here. I put my hand behind the shoulder, push, and then it goes back in place. However, I've never treated here, I've never adjusted a hip. [indicates her own shoulder] For this there was a woman, I learned from her, she's from Orta Köy. My shoulder got dislocated...
S: How did you learn?
A. E.: When I fell, my shoulder... My foot slipped, I fell, and this came out of place. Oh God! This got all swollen. It was right before my daughter’s wedding. It [the shoulder] had gone backwards. It was like this, I mean, I took hold of it right away, with this hand, I let out an “Aiii!” I pulled it, “Pop!” it went right into place. My arm was useless, when my girl was going to her husband. But it got back [to normal] fast.
S: How old were you then?
A. E.: I was 39 years old then.

Describing the Difference between a Doctor and a Bone-Setter

When discussing bone-setting, Uncle Ferit made the following analogy (tape 1, 1993):

A doctor is educated, he is like an architect, but a kirikkılık is like a construction worker, experienced in putting one brick on top of another. “In our Turkey, not like Europe, our people go to the doctor with a broken bone. The doctor takes an x-ray and puts a plaster cast on them. Then they come home, take off the cast, and go to a kirikkılık to get it fixed.”

Payment for Services:

In a discussion about bone-setting (tape 1, 1993), Aunty Emine explains that she used to fix babies and children when they were brought to her with broken or dislocated bones. She never asked for money, although, if the parents felt like giving her
something, that was fine with her. In contrast, some women charge for helping others. She gives an example of a woman who charges up front, even to read the evil eye protection prayer, which is very shameful. Traditionally, a prayer that is in exchange for money would be considered bad-intentioned. If the person is asking for money instead of for God’s help in alleviating someone’s problem, then the prayers are useless — a person may be able to fool other people, but no one can fool God.

The efficacy of a prayer depends on its correct recital, which is not difficult for the majority of people who have memorized the basic prayers. The person reciting the prayer must also be well-intentioned (iyyi niyetli) and clean hearted (temiz kalpli). The work of a bone-setter, in contrast, is recognized as a personal gift which is strengthened by experience.

The Traditional Healer

In Medreseônû, there are a few recognized healing specialists and many individuals who are thought of as practical or helpful in the treatment of everyday problems. In the course of her lifetime, a woman learns various healing techniques, which she will use to benefit her own family members. When she starts to acquire social status, because of age and family connections, she may be asked for advice by those outside her immediate family. Like Aunty Emine, she might have a period of very active service as a midwife and healer in the community, followed by a gradual lessening of interest or willingness to treat. In contrast, she may become more like Aunty Zeynep, who continues to develop her role as an expert as she ages, in part because she and her
family need the social security that her practice brings. The formation of an expert, in
traditional village culture, occurs not through an institutional training along formal lines,
but through a negotiation between the changing needs of the community and the skills
and interests of certain individuals.
CHAPTER 5

THE LOCAL BELIEF SYSTEM

The night is lit by a full summer moon, so we can easily make our way up the dirt road without flashlights. Aunty Emine, Timur, my five-month-old son, and I are going to visit close neighbors who are also related in that the hostess is the sister-in-law of Aunty Emine’s daughter Nazmiye. The road is steep, so we arrive laughing and panting, looking forward to a night of relaxation after a normal hard day’s work in the gardens. Aunty Emine has changed her blouse and headscarf for visiting, and I have my baby wrapped up and tied with a home-woven strap to my back, where he struggles and pounds my shoulders with his fists. “He’ll get used to it,” Aunty Emine tells me, “Soon he’ll be going to sleep while you walk.” Indeed, most of the village babies happily travel to the fields this way, unless there is someone at home to watch them. The young mothers often have a heavy workload and need to have their hands free and their babies secure as they do house chores and fieldwork.

I have put on a cotton headscarf with embroidery edging, a gift from a sister-in-law. I long ago gave up trying to coax my hair into its usual style in the house’s one tiny mirror, and felt I might look tidier with a headscarf that shows off my earrings. Before I
lived in the village, I had thought the Islamic head covering for women was intended to conceal the beauty of the wearer by covering her hair. To my surprise, whenever I put on a headscarf, women told me how well it suited me and showed my face. With no makeup and no hair over the forehead or cheeks, facial features are shown for what they are. Local wisdom has it that a person’s moral character can be seen from the face, and a good person’s forehead is open (איך, meaning both uncovered and clear) and shines with spiritual light. A headscarf, then, is not just an indicator of religious piety, but also a beautifying accessory and a convenience.

The village style of wearing a headscarf is very different from the newly popular urban “fundamentalist” style, which involves a large (and usually expensive) polyester or silk scarf that completely covers the hair, neck, and shoulders, and is fastened with a straight pin under the chin. These scarves do not have added embroidery edging, which is what makes the village scarves a personalized sign of the wearer’s taste, skill in handicrafts, and even mood. The urban scarf can show a wearer’s taste and economic status, but the only individually added touch is the style of draping and pinning the scarf. Urban women who wear this type of headscarf often have the traditional cotton one on underneath to secure the slippery fabric and to keep on when they take off their large scarf upon entering indoor women’s space.

We are greeted at the door by the whole family, in this case, the wife, husband, two children, and the wife’s mother who is visiting. We are led into the living room, which is brightly lit and filled with the sound from an impressively large TV set. Television is a constant presence in village houses in the evening, and this home has the
advantage of a hilltop location and a large antenna which brings in more of the new channels. Until the 1980’s, Turkey had one, then two, and at last three state-controlled TV stations. Since the privatization of the mid-80’s, an explosion of stations has led to the availability of foreign programs, religious shows, pornographic films, and sports events, including NBA basketball. Now every village home has a TV and everyone is saving up for a better antenna.

When we have settled down onto couches arranged along the walls facing the TV, our hostess asks us each how we are. In this ritualized exchange, the appropriate response is self-deprecating, using phrases which can be translated as “Well, scraping by,” or “We’re making do.” In village visits, everyone participates in one inclusive conversation around the room. If there are any private discussions to be had, women can follow the hostess to the kitchen or men can go outside together. Timur is let loose to crawl on the floor and quickly becomes a topic of conversation. The hostess asks Aunty Emine how he is doing, and she relates that he is not eating well, has been fussy, and doesn’t sleep for very long. As an American mother, I want to protest that he is doing just fine, but as a Turkish gelin, I know not to say anything. I have been previously warned not to tell anyone that I am nursing my baby, or to let anyone see leaking milk, for fear of nazar (the “evil eye,” see Chapter 5). Old women sometimes lovingly call a baby “ugly” so as not to attract nazar upon a beautiful baby. In this neighborly visit, saying how well a baby is doing could be dangerous, attracting the jealousy of others and tempting nazar. Babies who have been thriving have been known to suddenly take a turn for the worse and become very ill – symptoms pointing to nazar. In the general flow of
conversation, someone suggests that the "nazar Prayer" be read over the baby as a precautionary measure. For this, I hold the baby in my lap and the old woman who is the mother of the hostess sits beside us. With the TV blasting, the gossip and joking continuing full swing, this woman murmurs under her breath and occasionally blows on the baby. As she is doing this, she often yawns, a sign that nazār is present in the baby and is being treated by the prayer. The verb to describe the recital of the prayer means, "to read" although people recite it from memory and are often illiterate. When I ask about the prayer, which comes from the Koran, the hostess recommends that I not have it read over the baby too frequently because he might get used to it and then suffer in America where only a few people would be able to perform the prayer. She has relatives in Germany, and knows that they don’t want their babies to become dependent on the nazār treatment when they are in the village.

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Belief

I have structured this chapter around "belief," a simple term which tries to cover complex subjects such as religion, ideas about the supernatural and theories of a person’s place in the universe. These subjects are at once the most crucial to understand when studying a culture and the most difficult to describe accurately. Putting "belief" in its own chapter is a choice of convenience, but it may give the false impression that belief is not a part of all healing practices. To be perfectly clear on this subject, I will state that all health care systems are based on belief — all are based on theories of how suffering is
caused and how it can best be alleviated, theories derived from and shaping observations, taught in various ways, and shared in varying degrees throughout societies. The adherence to a microbiological theory of health and illness is as much a belief as adherence to a religious doctrine. For people with a religiously anchored world-view, the microbiological model may be fully compatible with their faith — it is quite common for the existence of microbes and the availability of the means to cure damage wrought by them to be an integrated part of an overarching faith in a Supreme Being. The use of a conventionally secular service such as clinical medicine does not prove that a patient has a secular world-view. To repeat Snow’s succinct summary (1998): “for many people all healing is faith healing.

In this chapter, then, I will briefly review some of the recent scholarship on belief which is significantly different from older forms of scholarship which were dismissive of the beliefs of foreign cultures or of poor or otherwise marginal groups. Then I will give a brief overview of various types of religious behavior observable in Medreseônlû and suggest some of the ways that the local belief system helps to integrate both the good and the bad in human behavior into a meaningful system. Then, I will outline the types of supernatural beings and occurrences which are a part of the traditional world-view of the people I interviewed. Next, I will show that there is a general feeling that the supernatural is drawing away from regular daily life, becoming rarer, and outline the local explanations of such a reduction of supernatural influence. I will also mention the interaction between the local traditional ideas about Muslim practices and the newly strong Islamist interpretation of correct behavior. Finally, I will use the belief in nazar,
the “evil eye,” as a concrete example of how belief in the supernatural works in daily life, describing its place in Muslim belief its effects, diagnosis, treatment, prevention, and impact on social relations.

Suffering is a part of life which often challenges peoples’ belief systems, leading them to look for answers for life’s most difficult questions. Because of human creativity and the tendency to search in ever widening circles for relief until it is found, suffering can cause people to expand or change their beliefs. Conversion to a new faith, returning to a family tradition which one had discarded, coming to believe in something one had disbelieved, reaffirming a belief or set of practices one had allowed to lapse, and combining elements of different cultures’ beliefs to create a personally coherent belief system (as in the integration of “Eastern” and “Western” wisdom in many “New Age” beliefs), are all types of changes in peoples’ belief systems that can be given impetus by a bout of personal suffering.

Timothy C. Lloyd (1995) divides the work of one folk expert into “life-cycle work, which balances supernatural knowledge with practical action, and emergency healing work, which draws more upon practical experience alone.” (69) This distinction may be especially important in the transmission of knowledge, in that certain techniques can be taught even to a person who does not share a similar belief system In terms of the world-view of the practitioner; however, I would argue that the emergency work in Medreseñû is integrated into the system of supernatural knowledge just as much as life-cycle work. For the pious, religious faith is always a part of explaining and treating illness. Awareness of the supernatural can become heightened in emergency situations,
and death or serious illness often cause an increase in religious activity and the use
supernatural explanatory models.

Leonard Primiano (1995) suggests the term “vernacular” to describe religion in its
lived form, “as human beings encounter, understand, interpret, and practice it.” (44) He
hopes this term will be more satisfactory for the study of human belief than the previous
scholarly terms “folk,” “popular,” and “unofficial” which all gave the impression that
there exists a pure form of religion, on a high, official plane, which is then adulterated
when it is touched by ignorant believers. Because of the history of the European
Christian debate over the use of Latin or the various vernaculars in church services, I find
the term “vernacular” to be as tainted with bipolar implications as any of the traditional
high/low, official/unofficial classic/folk, or textual/popular terms. I find “lived religion,”
or “belief system” or “religion in everyday life,” to be adequately neutral and applicable
cross-culturally.

Because a scholar’s personal beliefs may, even unbeknownst to the scholar, affect
her or his interpretations of the religious beliefs of others, the terms “folk” and “popular”
have been applied to religions merely because they are different from the religion of the
observer. For example, if Protestant Christianity is the mainstream religion of scholars in
the United States, it is not surprising that various Catholic beliefs and practices have been
studied as “folk religion.” Vernon Schubel (1993) has shown that both Western and
Sunni Muslim scholars have treated the beliefs and practices of Shi’i Muslim believers as
“folk” or “popular,” even though the Shi’is base their religion on equally serious
attention to the Muslim holy texts and traditions as paid by the Sunnis. According to Schubel:

It is tempting to organize the study of Muharram rituals around the bipolar opposition of folk tradition versus classical Islam Many “rationalist” Muslims themselves deal with the material in this way, poking fun at their coreligionists’ “superstitions” while arguing for the rationality of Islamic law. ... To my surprise, as I asked deeper and deeper questions of the people I was writing about, I discovered that much of what I thought would be indigenous folk religion has its root in the classical tradition. (160)

and:

The study of Islam needs to take the context of Islamic practice seriously, because Islam is both a transcendent reality and an articulated series of responses to it. (162)

The dynamic and interpretive nature of a belief system is described by Primiano (1995):

The process of religious belief refers to the complex linkage of acquisition and formation of beliefs which is always accomplished by the conscious and unconscious negotiations of and between believers. This process acknowledges the presence of bidirectional influences of environments on individuals and of individuals on environments in the process of believing. Within the human context, manifold factors influence the individual believer, such as physical and psychological predispositions, the natural environment, family, community affiliations, education and literacy, communication media, as well as political and economic conditions. (44)

Primiano’s concept of “the continuity of creative self-understanding, self-interpretation, and negotiation by the believing individual” resembles Schubel’s claim that:

Like all religious people [the Shi‘i Muslim] are engaged in a complex balancing act by which they exist in a multiplicity of roles simultaneously, all the while striving to remain true to what they see as essential to their religion. As they do this they are in effect continuously creating a new tradition. (162)

Schubel’s approach to studying a set of Shi‘i religious practices in Pakistan resembles that of Bowen (1993), Hufford (1992a), Primiano (1995), and Snow (1993), in that he
tries to work from a position of respect for the knowledge and practices of actual believers as they negotiate their lives based on their faith.

**Muslims and Islamists**

Since the late 1980's, a revivalist type of Islamic interpretation has had a strong impact on Turkish politics and society, after decades of Kemalist secularism. It is promoted by Islamic pedagogues, who use a network of *Imam-Hatip* religious schools to propagate their brand of strict adherence to the rationality of Islamic law and the absolute letter of the holy texts. Although this type of revivalism has occurred with regularity throughout Islamic history, the “Islamist” style of political engagement is thoroughly modern in its uses of media and rationalist ideology. I call this group “Islamists” because of their conscious self-identification with an international Islamic front, which has political and economic as well as religious concerns. This term is in contrast to “Muslim,” (although one can certainly be both Muslim and “Islamist”) which connotes a self-identification as a believer in the Koran and prophecy of Mohammed, with whatever daily rituals and beliefs an individual associates with that identification.

Bowen, in *Muslims Through Discourse* (1993), delineates a split in the Indonesian Muslim community between “modernists” and “traditionalists.” (see especially pp.21-25) The modernist approach to Islam emphasizes the “self-sufficiency of scripture and the moral responsibility of the individual” while the traditionalist approach values the history of religious interpretation of scripture and doubts the ability of each individual to correctly interpret scripture without referring to traditional scholarship. (22-24)
this split becomes most interesting for our purposes is in regard to healing practices. Traditionalists tolerate much more variety in ritual and in the daily practices of Muslims, as long as their intent (niet) is pure. Modernists, on the other hand, suspect many daily practices to be mistaken, or even sinful and encourage religious education to correct them. As Bowen puts it, "Traditionalists' idea that scripture offers alternatives is in direct contrast to modernists' conviction that scripture offers only one correct set of ritual forms." (24) Bowen gives an example of an elderly healer who has become "puzzled and a bit worried. Once sure and proud of his vast command of spells (one for nearly every purpose), he had recently begun to doubt whether such spells were a proper part of a good Muslim's life." (76) Because of increasing international travel and communication, Muslims from all countries have been able to meet, study scripture together, and compare regional customs. This has led to an increasing standardization of Islamic pedagogy and a perception held by young, active, internationally-connected Muslims that the local traditional knowledge and practices of their elders are, at best, old-fashioned and peculiar, or, at worst, fundamentally wrong and inherently sinful. Elders are no longer considered to be righteous storehouses of religious knowledge. In fact, because their traditional knowledge is, for the most part, founded on oral tradition, they are often likely to be silenced in an argument over religious detail when an educated young person refers in a convincing way to the texts and written interpretations of Islam, or to opinions in the international community of Islamic scholars.
In Medreseônû, the impact of the new style of religious education can be seen in the interaction between the elderly women of the villages and a recent graduate of an Imam-Hatip religious school. It was this young man’s opinion that, when reading the nazar duası [the prayer against the evil eye] over bread in order to treat a stricken cow, the use of bakery bread (fıırın ekmegi) was mandatory, and that the traditional use of home-baked corn bread (mısır ekmegi) was a sin (gunah). This attention to the minutiae of Muslim daily life is typical of the new Islamist “fundamentalist” movement. The elderly women were torn between conflicting feelings: they felt respect, because this young man had successfully completed his religious education; they were amused, because he was concerned with a practice which had been largely ignored but sometimes scoffed at by young men before him; and they were worried, because, although he was not condemning them for doing this practice in ignorance, they would be guilty of bad intention, and therefore of sin, if they continued to use corn bread after being told it was wrong. In this case, a young man was using a text-based education taking its strength from a national and international community, to directly challenge an orally-transmitted, local women’s practice. This is just one example of the attempt by non-locals to inscribe the local individual with Islamic modernist values after decades of non-local attempts to inscribe the individual with secular modernist values.

Islam has always been a religion encompassing a variety of peoples and cultures. The pilgrimage to Mecca (hac), Islamic education, and the transnational movement of Muslim scholars have historically been factors encouraging the integration and homogenization of Muslim practices in contrast to the adherence to the local
transmission of cultural knowledge which can have pre-Islamic roots. Debates between Muslim modernists and traditionalists are not new in Islamic history, but modern technology and communication, once the weapons of modernizing secularists, have been fully integrated into the arsenal of the Muslim modernists. The "enemies" of both types of modernizers are local knowledge and traditional world-view: the "old wives' beliefs," *(kacakar inançlar) which are "backward-minded," *(geri kafalı, "ludicrous," *(sacma sapan), "empty," *(bos), "superstitious beliefs," *(batıl inançlar), and "made-up," *(uyduruk).

Julie Marcus (1992) describes an attack on a women's religious visit to a shrine near Izmir *(Susuz Dede) by young students from an Imam-Hatip school. "[They] came on a zealous journey to inform the women of the errors of their ways. The boys asserted that there was no-one in the grave and that the rites were pagan. When the boys tore the cotton from the tomb and kicked the candles into the fire, they were ignored. Despite their brashness, the women dealt patiently with them ..." (138) The most common verbal defense used by women in such cases is the assertion that God is everywhere and only God can decide if a person's faith is pure and intentions good. In the case of these brash young men, the women may be able to excuse their rudeness on the grounds that they are young, hot-blooded *(delikanlı : literally "crazy-blooded"), and under the influence of heady doctrines.

In the current competition between a traditional Muslim world-view, which is internal and inseparable from everyday activity, and a rationalized Muslim world-view coming from institutions of Islamic education, the minute details of a person's daily life
have become a symbolic battleground. When a young hoca tells elderly ladies that they are sinning by reading a nazar prayer over corn bread, he is attacking a formerly unquestioned local practice and destabilizing the basis for the traditional world-view. When a person is taught to consciously choose the right foot to step out from a toilet room, in the name of Islamic rules of conduct, the actual individual physical body is being molded by rationalized religion. The impulse in the new Islamisist movement seems to be to “tidy up” (but not discard) their ritual details of the traditional lived Islamic practices.

It is crucial to stress that traditional healing practitioners are Muslims who consider their practices to be based in Islam and who attribute any success in healing to the power and will of God, as well as to their own God-given abilities.

Types of Supernatural Phenomena in Medreseönü

The traditional belief system in this region of the Black Sea shares with other Muslim belief systems a belief in God, the Prophet, melekler (angels), evliyalar (saints), cin (which is pronounced “jin,” and which is translated as “genie” in English), ecinni (the Arabic plural pronounced “ejunnu” in the local dialect, has a purely negative connotation), periler (fairies), and ruhlar (souls or spirits of known people who have passed on). Along with these types, all of which are mentioned in the Koran, there are also hortlaklar (the risen dead, which are the roaming corpses of evil people), karabasma (literally “black pressing,” the evil spirit who causes night paralysis), a mysterious green light which indicates the presence of a supernatural being, strange sounds and
apparitions, and special supernatural abilities in humans, such as fortune-telling or the ability to cast *nazar* or other harmful spells. Although the word “hortlak” does not appear in the Koran (not being Arabic), there is plenty of Koranic support for the idea of the spirit of a sinner leading a troubled existence after death. Likewise, the other supernatural occurrences are integrated into Muslim religious belief and Islamic practices and prayers are used to counteract bad supernatural effects.

The image of a genie in the West is of a large, turbaned creature who pops out of a lamp to help a hero. This image is based on translated folk stories from the Middle East and is, although simplified, a fairly accurate image of the type of *cin* which can become a helpful familiar for a particular person. They are said to be large and powerful and able to transform themselves into other forms, such as that of animals. A helpful *cin* can be passed down to another person, usually within a family. People who are assisted by *cin* should never tell about it, as they would loose the aid of the *cin*. In Medreseönu, one woman was known to have the help of *cin*. She would have fits, sometimes as long as two hours, in which she would speak about things of which she could have no knowledge. People would come to put questions to her, and she would answer. She may have stepped on a frog which was actually a *cin*, or disturbed a party of *cin* in some way, so that she became possessed. A person with spells of abnormal behavior, such as fits of craziness or fortune-telling abilities, is said to have *cin*. In common parlance, “*Cinlerimi attırma.*” and “*Beni cinendirme.*” are phrases, literally meaning “Don’t make my genies jump out.” and “Don’t cause me to be genied,” which are used to mean “Don’t make me mad.”
Unlike the helpful *cin, ecunnu* are bad and can change shape to fool people and harm them. If one is attacked by *ejunnu* -- for example scratched by an unfamiliar cat at night near a graveyard -- one might suffer paralysis, blurred vision, or a general reduction in abilities leading to lethargy and low spirits. Only a specialist can read the necessary prayers to lift the effects of this kind of attack. People are admonished to keep their hearts clean and to resist fear, for these types of evil beings cannot harm a confident, good person.

The *hortlak* is a particularly unpleasant being -- the dead body of a person who was so bad that the ground spits it out in disgust. It can be armless or legless, makes a screaming noise, can have long, vicious fingernails, and is likely to chase a victim all the way home and then howl outside the door for the rest of the night. People report seeing the long scratches from a *hortlak* on the outside walls of their homes. Dogs can attack and stop a *hortlak*, so it is good to have one along if walking at night. Guns, however, are useless against any kind of supernatural being. People have seen large shadows, strange sounds like birds singing at night, strange lights or voices, and apparitions such as coffins which they associate with the presence of a *hortlak*. A *hortlak* has the power to paralyze a person and cause illness. The corpse of a bad person turns into a *hortlak* within forty days after burial so it is fairly easy to determine whose *hortlak* has made an appearance.
Granny’s Supernatural Experience

Granny, whose extensive interview about local healing practices is transcribed in Chapter 2, was prompted by her daughter to tell me the following story. I was not able to record similar stories from other informants, but I am sure that there are many such stories told in the slower-paced winter days and nights. TV has taken the place of storytelling in many social gatherings, but, in the right setting, one story of supernatural experience will lead to others.

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When she was 20 years old, she was in the garden (field). When she was coming back from the field, she saw three lizards in a row on a blackberry branch. They were bouncing up and down. She wondered why they were doing that and she threw a clod of earth at there. It didn’t hit them, it hit the twig. All of a sudden, she felt someone wringing her insides (points to chest region) as if they were laundry -- her eyes went blind, and she fainted. She found out later that she had been unconscious for three days, giving no response to anything. She couldn’t see or hear. For three days, the hoca (religious teacher and ritual expert) said prayers over her body -- only at the end when he tapped her and gave her agates (ritual ablution), with some water on her face, and said, “If you let her go, I will never interfere with you (the periler) again.” When the water was splashed on her face three times, she woke right up as if from sleep. When she woke up, she couldn’t remember anything about the situation of her body during those three days. She had been in a dream world for the whole time, going from wedding feast to
wedding feast with the *periler*. The table was full of beautiful fruits, the *periler* were in fabulous costumes. They were all dancing. Everything was beautiful. She didn’t want to wake up. People saw a smile on her face while she was unconscious. When she woke up, she wasn’t hungry, because she had been feasting the entire time. The *hoca* was crying. The lizards had been *periler*, and they had been doing a wedding dance when she disturbed there. If she had hit the lizards, she would have been killed.

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The Reduction in Supernatural Occurrences

In the old days, meaning in the childhood memories of people my age as well as in previous generations, there were many terribly frightening occurrences which took place usually at night, near graveyards, often involving a green light. This is said to have been the work of *peri and cin* (fairies and genies), or of *hortlak* (the risen dead). When I asked if such things still happen, most people say that they don’t go on as much as they used to - with two differing explanations for this change. One woman, whose husband was one of the earliest workers to go to Germany from this village, has been with her husband on the pilgrimage to Mecca. They were able to afford the trip because of the job in Germany, and they have earned the status and respect accorded those who are *Haci* (those who have made the pilgrimage). This woman explained that they brought holy water from Mecca back to the village, some of which they distributed as gifts, and some of which they sprinkled around in special places to bring spiritual benefit to their surroundings and their family. This water is especially potent against malicious beings. She related that, as more people are going on the *Hac* and bringing back holy water, the
areas where the peri and cin can do their mischief are shrinking, thus reducing the numbers of encounters with supernatural beings. This theory stands in opposition to the theory of another woman of the same age, who told me that people are becoming so bad and are harming each other so much that the peri and cin are left with nothing to do. Neither theory fits with the standard Western secularist idea that changing times bring changing world-views, and that as people assimilate scientific notions, they will see their old "superstitions" to have been false. Many of the younger generation indicated to me that they thought of some of these ideas as the silly imaginings of an uneducated village society. Most, however, were unwilling to say so in front of their elders, and most, when pressed, have stories of supernatural events they themselves witnessed or experienced.

The "Islamist" revival movement has worked to downplay the influence on everyday life of "minor" supernatural beings such as ghosts and fairies, while encouraging the sense of the immanence of God in every detail of life. Although peri, cin, nazar (the "evil eye," ) angels, and various magical rites are all mentioned in the Koran, considered to be an infallible and unaltered text by all Muslims, when religious experts are asked about these issues, they often opine that villagers are exaggerating something which is real but not common.

The perception of a reduced supernatural influence on daily activity has taken its toll on the respect given to someone who is familiar with the spirit world and who can tell a good story about it. One elderly man in the village, Uncle Idris, has a reputation as a teller of tall tales (or as a big liar, depending on whom you ask). He can come up with a story for any occasion, and specializes in spooky stories and snake stories. His authority
on the subject of snakes is unchallenged, as he is known to be immune to snakes and has caught many dangerous, poisonous snakes in the village within the remembered collective history. His authority in matters of the spirit world is increasingly challenged by his family and neighbors, however, even to the point that listeners will cut him off and show open disrespect for his "lies."

One morning, I was with his family as they were gathered around the kitchen breakfast table. We were drinking our tea when the gelin from the next house appeared at the window. She had been sick with a continuous cold since I had arrived several weeks before, and had already been to the clinic because of swollen tonsils. This morning she had a severely inflamed eye which was swollen, red, and infected. Her mother-in-law had sent her over to ask Uncle Idris to read a prayer over her as a remedy. He pushed back from the table, spread his hands out expressively, and began in a storytelling tone of voice, "Well I wasn’t going to tell you this, but as I was coming home from the mosque the other night, I saw a green light near the spring by your house ..."

His next sentence included the word periler (fairies) but was drowned out by unanimous shouts of derision. One of his daughters told him to "shut up and stop being stupid." His wife exclaimed that he was "just making it up on the spot." The man’s son-in-law, who has a reputation for being something of an Islamic expert with a rigid, text-based knowledge of religion, speaks more quietly but expresses the opinion that even his father-in-law’s prayer reading might not be effective. Well, someone who asks for a prayer can’t be turned away, and so Uncle Idris is sent out into the hall to read over her as she sits on a chair. He recites under his breath and blows over her during the pauses. When
they are finished, the old man and the *gelin* come back into the kitchen. Uncle Idris's wife tells him that he should also read a *nazar* prayer over her, which he proceeds to do without leaving the room.

It seems to me that Uncle Idris still commands some respect for his ability to read prayers over sick people, but that what he enjoys most has been for the most part taken from him — the respect granted a teller of tales of the supernatural in a society with day-to-day contact with the strange and sometimes wonderful goings on in the spirit world. Because of the more modern world-view of the younger generation (with its culture of science and skepticism of old ways), he can get an audience only for his real-life stories, and mostly for his actual personally experienced snake stories. His reputation for embellishment and exaggeration continues, but the stories of the supernatural have been pushed completely off the scale of belief and are stopped before they can even begin. I am sure that he still has some listeners in some circles and in some circumstances (perhaps in the coffeehouse or on long winter nights), and I know that he tries valiantly to keep alive his reputation as a storyteller.

*Nazar: the “Evil Eye”*

*Nazar* (the "evil eye") is a belief constellation that is found in many parts of the world. The basic underlying belief common to all evil eye beliefs is that a human glance can, in some circumstances, cause harm to people, animals, or things that are the object of the glance. The belief in the evil eye is found throughout the Mediterranean area, in widely differing cultures, expressed in different languages, material artifacts, and
practices. There are studies of the evil eye which refer to pre-Christian Greek and Roman evil eye beliefs (see Dundes, ed. 1991). Because the belief can be shown to pre-date Christianity and Islam, and because it appears in a variety of contemporary cultures with various religious beliefs, the scholarship on the evil eye has generally located the belief outside of the mainstream monotheistic religions, as a “superstition,” a pagan remnant, or “folk” belief. When scholars take the time to ask believers themselves about the evil eye, they find that most believers are familiar with evidence from their own major religious texts about the reality of the evil eye phenomenon. For Muslims, the reality of nazār is irrefutable, as it is mentioned in the Koran. There is much more religious compulsion for a Muslim to accept the evil eye as a possibility, for example, than there is for a Christian to put up a Christmas tree in December. Most mainstream Christians would not accept that a Christmas tree was unchristian or that it was an evil or heretical practice, even if they acknowledge that the practice of bringing a pine tree inside the house in the middle of winter is a pre-Christian, Northern European tradition which is nowhere called for in the Bible. Likewise, faithful Muslims place most of their own practices and beliefs within their religious tradition and are quick to point out that belief in nazār cannot be classed with other “superstitions” doomed to die out as human knowledge progresses. From the outside, what may seem to be a “folk belief” is an irrefutable part of “real belief” for Muslims.

In our interview, Lale, (the same as in the transcribed interviews in Chapter 2) displayed an awareness that I, as a researcher, might be conflating religious belief with baseless superstition. Her description of nazār showed that she thought that I might be
mistakenly classifying it as a “backwards idea.” She told me that she believed in nazăr because it is in the Koran (notice, not because she had never questioned it or because she has personally experienced it or seen its effects, but because she knows it has Koranic affirmation). In my interview with her, she explained:

Lale: I don’t believe in stomach-pulling and all that stuff. I believe in nazăr because it is in the Koran. It’s read for people and animals.

Sylvia: Do you have it done?

L: Yes, because we believe in God, we do it. It is in the Koran.

S: What do you use it for?

L: For example, if you have a really nice outfit, if you don’t say “Maşallah” you can get nazăr. You believe. I mean it’s not backward superstition (batıl inançlar). It’s in the Koran. We read it [the prayer] and it passes.

S: How do you know you have nazăr?

L: Like this, for example, you feel weak, you don’t feel well you’re depressed (literally, “your soul is squeezed” – canın sızkıllıyor].

S: It happens to babies a lot.

L: Yes. For example, the baby has been nursed, fed, it’s diaper is changed, and still it is uncomfortable. We believe it has nazăr, we have it [the prayer] read, the baby gets better.

S: Who do you have read it?

L: Everyone does it.
Although I had not asked particularly about nazar, rather only in a general way about village healing practices, Lale wants to make sure that I know the difference between nazar and superstitions. She lives in Samsun and has sisters-in-law living in Germany. She uses herbal teas in the traditional ways, but rejects most village healing practices as mistaken. She considers village food to be healthier than that available in the city. She is also an experienced consumer of private clinical medicine, having had three operations because of cysts in her ovaries, traveling to Istanbul and changing doctors after the first operation in order to get a second opinion. A person like this has been in many discussions about different beliefs concerning health care, perhaps across generations, or spurred by a show on television, or due to contact with another culture, within Turkey or outside. She knows that I might have classified nazar as “village stuff” and works to set me straight (although she is just supposing about me, this was the first time we had met and I did not mention nazar before she did).

Nazar and the Health Care System

Nazar is a concept which is used in a flexible manner to explain and deal with problems of illness and strife in human society. Nazar is a convincing explanatory tool in the local culture, much as psychological metaphors are used in American discourse. For example, attaching importance to childhood experiences or birth order as formative of personality is a commonplace in our culture but seems strange to people from many other cultures. In the biomedical metaphor of the “body as machine,” organ transplants are seen as mere replacements of broken machinery, rather than as drastic or insane
measures likely to change one’s personality or karma. O’Connor (1995) offers the example of a hotly contested recommendation of a liver transplant as example of difference in ideas about the body and the self to be a point of conflict between the medical establishment in Philadelphia and the Hmong immigrant community. Emily Martin (1992) has shown that culture in the United States is bound up with “key metaphors” which structure our thoughts about our selves and others. She shows, for example, that the metaphor of the “body as a machine” leads to the wide-spread cultural belief that menopause is a time when a woman’s body begins to malfunction and decay. If a woman’s body is compared to a machine for the reproduction of the species, then birth can be thought of as a time when a woman might break down and need the services of an expert mechanic (the doctor), and then, as well, menopause is a clear sign of the end of a woman’s usefulness. The metaphor of medicine being a weapon in the war against illness has permeated our society to the extent that even treatments which try to offer alternatives to the mainstream health care culture (such as herbalism) present their goods as ways to “build up the body’s defenses.” It shapes the discourse of this work as well, for example, when I call women the “front line” of defense against illness (Chapter 3).

Martin (1992) discusses the difficulty of researching one’s own culture. She says: As an anthropologist, my problem was how to find a vantage point from which to see the water I had lived in all my life.” (11) The explanatory models used in a culture other than one’s own are much easier to notice and to describe as rhetorical devices, metaphors, or culturally-specific theories. Examining the explanatory models and “key
metaphors" of another culture is a necessary project when one wants to present an idea of how that culture works. The common pitfall of examining another culture is to assume that one’s own culture is “natural” and free of similar metaphors which shape thoughts and behavior. In discussing how a metaphor works (or “functions”) in a culture different from one’s own, it is important to realize that all humans use metaphors and beliefs as they live their lives and explain their experiences.

In the local society of Medreseönü, then, one can attempt to describe ways that the belief in nazər is used to manage social relations and to shape health care. Jealousy and covetousness are serious problems in a small-scale agricultural society with a subsistence economy. Nazar beliefs deal directly with issues of jealousy, providing a means to bring covetous feelings into the open arena of social discourse. Jealousy can be treated as intentional or inadvertent, depending on the particular issues involved in a particular diagnosis of nazər. The problems caused by nazər are serious — illness, depression, accident, the reduction of food, and the destruction of property. Because nazər can be cast both intentionally by enemies and inadvertently by well-meaning people, everyone is taught to be aware of its potential and quick to act if it strikes.

Part of the reduction in the impact of the supernatural in everyday life, described above, is the current de-personalized idea of nazər. It seems that, in the past, specific people were more likely to be singled out as the knowing or unknowing casters of nazər. Now, although the effects of nazər are recognized and treated in traditional ways, people put much less emphasis on identifying the source of nazər.
In terms of social relations, it seems that nazar beliefs are an integral part of local traditional ideas about appropriate behavior for men and women at different stages of life. Young men are less culturally restricted in their ability to look around and to make eye contact with others as compared to young women. Married men are expected to control their glances at women as a part of moral behavior, although women are often thought to be consciously attracting the attentions of men, who are thus excused for not being in control of their eyes. Older women look at people (including strangers) more directly than younger women do - they have less of a fear of being labeled improper or brazen. This might be a reason that older women are more often feared to have the power to give nazar. In a patriarchal society, young men and women of any age are often expected to keep their eyes lowered in the presence of a powerful man. Older women, however, are often in a position of questionable relation to powerful men — for instance, a man's mother often insists that he show her deference. Barren women, who must be well into childbearing years before being conclusively labeled barren, are also problematic in a patriarchal system — and they are most often thought to be jealous of the babies of others, and so likely to cause nazar.

*Nazar Interpreted by a Disbeliever*

A man from the village agreed to share his ideas about nazar only with the understanding that no one from the village would be told about his disbelief. He told me that hungry children learn to milk the family cow without the knowledge of their mother. The resulting reduction in milk at regular milking time can be blamed by the worried
mother on the harmful presence of *nazar* in the cow. If the actual situation were to be brought to light, the family would face the terrible shame of having hungry children who are led to steal because of their hunger. In this dire situation, where poverty is obvious, the blaming of *nazar* for additional troubles can shift and diffuse blame which would otherwise fall on family members. This same man told me that cows are often frightened when they see snakes while out grazing and their fear (rather than *nazar*) causes a loss of milk production. This would be an explanation fitting better with a scientific model of the world, but it should be noted that snakes have a special place in the folklore of the region and often replace the supernatural in frightening stories.

**Women’s Work**

The management of *nazar* is generally women’s work — if men sometimes read the *nazar* prayer or write amulets for protection, it is usually at the request of a woman who has diagnosed the problem. If men are troubled by something they think might be *nazar*, they often consult their mothers or wives for confirmation and treatment. Certain women are known for skill in treating *nazar*, but every woman has some means of taking basic precautions and providing the first fine of treatment for herself and her family.

**The Diagnosis of Nazar**

People know when *nazar* is present because it manifests itself in recognizable ways. In general, *nazar* often causes depression and listlessness or a sudden onset of serious illness. During treatments, there are ways to confirm that *nazar* is actually
present. If the person reciting the nazar prayer yawns or has watery eyes, the presence of nazar is confirmed. The treatments described below also have diagnostic functions.

The Prevention of Nazar

Nazar can be prevented through the use of amulets containing religious inscriptions (muska), eye-shaped blue beads, blue or red ribbon, spitting or the mimicking of spitting, the placement of an iron utensil over a milk pot, and by the simple method of hiding things from the sight of those likely to cast nazar. Women are largely responsible for taking preventative measures to protect themselves and their family members.

The Treatment of Nazar

The following description is of a procedure called mum dökmek ("pouring wax"), which is common along the Eastern Turkish Black Sea Coast and has been reported in other areas around the Black Sea and in the southern lands of the former Soviet Union. Elsewhere in Turkey, a similar procedure is done using molten lead rather than wax. The woman who performed this procedure for my benefit cites the convenience and economy of wax as reasons to prefer it to lead.

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The best day to do this treatment is the first day of the lunar month. Villagers track the phases of the moon from observation as well as from their wall calendars with a page for each day and many Islamic sayings, bits of advice, puzzles, and quotations. The
calendar shows the Gregorian date in large numbers and shows the Islamic month and
date in small numbers. The Gregorian calendar has been in use in Turkey since it was
mandated by the reform laws of 1928, but many rural people continue to rely on the
traditional Islamic calendar. If the calendar is kept current, by ripping off a page each
day, those who are illiterate can follow the symbols that show the phases of the moon.
The Islamic calendar is lunar-based, and most traditional remedies take the lunar date
into account. The best days of the week to do the treatment are Wednesday and
Saturday. I have only ever heard of women performing this procedure, at least in
contemporary times, while the patient can be male or female. The treatment is usually
done in the toilet, because nazār is dirty and can be pulled out by the dirtiness of a toilet
or stable. The patient squats or sits on a low stool nearly completely undressed, or
wearing old clothes that will be soiled by the dirty, waxy water pour over the patient at
the end of the treatment. As with every traditional remedy, the practitioner starts by
saying “Bismillahirahmanirahim” the Islamic prayer for beginnings. The main
ingredient for this treatment is a block of beeswax, which is melted in a small frying pan
used just for this procedure. The block of wax is first passed around the patient’s head in
a counterclockwise direction while a prayer is being recited by the practitioner under her
breath (about three times). The block of wax is then melted and poured into a bowl of
water resting on the patient’s head. This process creates a crackling, hissing, spitting
sound, and the louder the sound is, the stronger the nazār is said to be. The practitioner
then removes the wax from the surface of the water, where it has formed a pancake-like
shape. The underside of the wax is studied for bubbles, which indicate nazār, and for the
shapes of bird heads, which indicate enemies. The bubbly parts are ripped off of the
pancake of wax and set aside. The remaining wax is squeezed into a solid ball then
passed three times around the neck with another prayer. It is re-melted and the hot wax
is poured into the bowl of water, which is now held over the patient’s bent neck. Again
the wax pancake is examined and the nazar indicating parts are removed and separated
into two distinct balls of wax. The next step is to pass the squeezed wax around the right
arm and then the left arm, melt the wax, and pour it into the bowl held over the patient’s
arms, which are held straight out together in front of the body. The procedure is repeated
for the waist and for the legs, for a total of five successive meltings and pourings. It is
possible for the practitioner to differentiate between areas of the body strongly affected
by nazar and those not affected. A patient’s physical or mental complaints can be traced
to the effects of nazar in different parts of the body. After the final examination of the
wax and removal of the nazar-affected parts, the remaining wax becomes the third ball of
wax. The disposal of these three balls of wax is a crucial part of the procedure. The first
ball is to be buried under a tree, the second is to be thrown into flowing water, and the
third is to be tossed onto a busy intersection to be trampled and run over by passing
traffic. Some of the water in the bowl is poured over the head of the patient as the
patient straightens up into a standing position. This is repeated three times and the water
must dry on the patient. The patient is now considered dirty, and should not touch a baby
or perform any ritual requiring cleanliness (such as prayer) before getting rid of the
dirtiness by entering a stable (which is dirty and draws dirt to itself) three times. A
patient can also enter someone else’s house three times, but the implication is that the
dirt will then stay there, and so this would only be used against an enemy. If the patient needs to pick up a baby, the baby can be first passed over the head of the patient to neutralize the power of the dirt. The person doing the passing over must then go three times in and out of a stable to get rid of the dirt thus acquired.

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Aside from this complex and time-consuming procedure, and aside from the most common treatment of *nazar* through prayer and blowing, there are a few quick methods for averting the evil eye. One is to mimic a spitting sound three times in the direction of a person or object considered especially beautiful. This can even be done in a conversation, usually in a light-hearted manner, after a person or thing is highly praised. A person who is thought to be afflicted by *nazar* can have someone take a small pinch of salt in their fingers, circle the person’s head three times, and then throw the salt into a flame. The sparkling of the salt is taken as a sign that *nazar* had been present. Dundes’ (1992) book gives examples of the widespread uses of salt, spitting, and diagnosis through the use of a bowl of water and a hot substance (molten lead or live coals used in many regions).

**Breastfeeding and *Nazar***

Mother’s milk, like cow’s milk, is susceptible to the bad effects of *nazar*. Mothers are admonished by older women not to talk about nursing and not to nurse in front of others. An abundance of milk is a good thing which might easily attract *nazar*. This worry about *nazar* made it difficult for me to collect information about breast-
feeding in the village. When I spoke to mothers of young children about my own breast-feeding (which I learned to do only in select company), they seemed more willing to talk about it. The nurses at the clinic strongly encourage breast-feeding, but realize that it is a difficult subject to discuss because of the possibility of nazar. I saw many women “putting their babies to sleep” in a position which I later realized from my own experience was probably nursing — reclined on a bed next to the baby, supported on one elbow, usually with the mother’s back to the door. Even though people often glance in the room where a mother is with her baby, to make sure everything is fine, there would be no chance of inadvertent nazar because of the mother’s position. My first idea about how I should breast-feed in the village setting was that I only needed to be sure not to indecently expose myself (this being the major concern expressed in American debates about public breast-feeding). Even in all-women gatherings, however, I became aware that I should be very discreet about nursing so as not to attract attention and possible nazar. My mother-in-law would often tell other women that the baby was sleeping in my lap, when he was actually nursing, covered with a blanket. Turning one’s back to the room is another way to shield the baby and the nursing mother from unwanted glances.

**Life Transitions and Nazar**

Nazar seems especially likely to occur during transitional times in an individual’s life. Weddings are a time when nazar may be present and preventative actions are taken. It is possible that the red color of the henna used to stain the bride’s hands is an “eye-catching” preventative technique. The sacrifice of a rooster on the doorstep of the
groom's house as the couple enters is meant to purify the couple of any negative influences. In some regions of Turkey a drinking glass is broken on the doorstep for the same reason. The period of forty days after a woman gives birth (*lohusa zamanı*) is also considered to be especially dangerous for both mother and baby. They are both prevented from going outside the house. The woman's hair is tied with a red ribbon, and the baby is pinned with amulets or beads against nazar. All visitors exclaim "Mağallah" on first sight of the new baby to deflect the possible ill-effects of their admiration. In important times during an individual woman's life, especially in times of transition, nazar is a force with which to reckon.

**Clinical Practitioners and Belief**

Clinical practitioners have an ambivalent relationship to the beliefs held by their patients. On the one hand, they are from the same general culture, although they may differ in terms of regional affiliation and class. On the other hand, they have been trained in a belief system based on the microbiological model, which is often radically distinct from the explanatory models which make sense to their patients. Patients quickly realize in discussions with health professionals in a clinic or hospital that this difference exists.

According to Snow (1977):

Magic and religion do entwine in the attempt to solve the problems of everyday living and such attempts are too often seen as ignorance, as superstition, as evidence of subnormal mentality when they come to the attention of the health professional. ... [The informants among whom I work] know that many of their most valued and deeply held beliefs are different from those of the mainstream middle-class citizen, and these same beliefs are seen as laughable and ridiculous. They are quite aware that their medical
beliefs and practices are not shared by mainstream medicine and they largely know which beliefs these are: this does not result in their being dropped, it results in their being hidden. Too many poor patients are also quite aware that many physicians and ancillary health workers see them as shiftless, dirty, ignorant, lazy and inferior and would prefer not to have to deal with them. (44-45)

She makes clear that class differences play a big part in the perceptions of one group toward the other. In Turkish culture, villagers are at once praised as the “salt of the earth” and damned for being poor and uneducated.

It seems to be a human tendency to scoff at the health care beliefs held by those other than themselves. The current trend in academia, however, is for scholars of health care systems to see the mainstream biomedical model to be itself a culturally constructed and constructing metaphor and to attempt an even-handed examination of the salient health-related metaphors in other cultures. According to Gevitz (1988):

As in the case of sectarian medicine, folk and religious healing have also been the subjects of scholarly studies recently which have been less concerned with normative issues than with placing these phenomena within social cultural and historical context. Rather than dismissing the adherents of folk and religious healers as a weird fringe element or approaching them from the standpoint of psychopathology, such works examine the intellectual origins and logical coherence of these systems and what functions they serve to participants. While many scholars continue to focus on folk and religious healing among marginal groups, greater attention is being given to unorthodox beliefs and practices accepted by people generally considered to be in the mainstream of social life. (27)

Turkish clinical professionals are committed to the truth of the biological method to varying degrees. They may make a distinction between personal beliefs and professional discourse. They may wear evil-eye protection beads around their necks at the same time as they express skepticism about the validity of the nazar belief system. If they are practicing Muslims or respectful of Muslim beliefs, they must acknowledge
nazar as a real phenomenon, although they may find nazar illness to be an overused category of ailment. Pierce (1964) concerned himself with describing the culture of a Turkish village, but he could not resist giving the following example of the nazar theory of a doctor in the capital:

In addition to the formal religion, all Turkish villages have many folk-beliefs. I do not have detailed data for Demirciler on this subject, but belief in the evil-eye is common, and the villagers in Demirciler displayed the ever-present blue beads that are thought to be a protection against this menace. A well-known physician (an eye specialist, incidentally) in Ankara told me quite seriously one day that the evil-eye was not a supernatural phenomenon at all. He theorized that certain wave lengths in light were harmful to human beings and that certain people had the ability to store up these harmful wave lengths and release them at will. These frequencies when directed toward an individual (children were supposed to be most susceptible to these), cause poor health and can result in a general deterioration ending in death. He did not explain how the blue beads served to protect one from this. (89)

In ethnography, the ideal informant (whose very existence has been rightly called into question) has been untouched by the outside and has thus never learned to hide his or her beliefs in the company of those who may not share them. What is striking about the Pierce example is not so much that the doctor in Ankara wants to have a scientific explanation of nazar, but that he didn’t realize that Pierce would think his idea ridiculous.

Another example of the complexity of the clinical professional’s relationship to his cultural environment is the combination of secular and Islamic symbols displayed in the private office of Dr. Deniz in Ordu. The objects on display can be read as a text meant to inspire confidence in the doctor. In his waiting room, there are bookshelves filled with a several encyclopedia-like series on the lives of saints. A plaque which
reads: “Hastanen ilaç kullanması bir sebep olur. Şifayı verecek olan ise Allah üteleadır.” Hadis-i-Şerif (“A patient’s use of medicine is a means. If anyone gives a cure, it is Exalted God.” Sacred Hadith). The waiting room, then, is set up to be “read” and understood as a proper display of piety. This is mainly a post-1990’s type of display. The encyclopedias are made available through newspaper subscriptions, and often remain unopened on the shelves, used as a sign more than as an informational resource.

In contrast to the religious markers in the waiting room, the doctor’s inner office displays a large picture of Atatürk above the desk and a wall-sized mural of one of Atatürk’s sayings about doctors: “Beni Türk Hekimlerine Emanet Ediniz.” (“Entrust me to Turkish doctors.”). This is both a nationalistic request (“I don’t want foreign doctors - either in the Ottoman sense of using Armenian, Jewish or Greek specialist, or in the more recent fad of preferring European specialists — Turkish doctors are the best, or should be trained to be the best”) and a secular request (not “Entrust me to God.”), a pithy formula which combines two of Atatürk’s most famous political projects. The setup of the doctor’s inner office is more like the officially-sanctioned, secular displays of a public clinic. The waiting room, however, is more like a private living room, with religious books seeming to make a statement about the doctor’s personal tastes. Once again, the boundaries between traditional and clinical, religious and secular, personal and private are seen to be blurry and shifting, in constant interaction and negotiation.

“Belief” is a tricky subject, whether the beliefs under examination are one’s own or those of others. In academic circles, there has long been the idea, recently challenged
from all sides, that scholarly neutrality is possible and ideal, that one’s own beliefs can be separated from one’s analysis of a subject matter. When one’s subject is human behavior and culture, careful attention to what people actually say can lead both to an awareness of the often insurmountable difference between the specific details of people’s beliefs and to a new understanding of how all humans use their beliefs to structure and make sense of their lives.
On a sweltering summer afternoon, I head up to the house of Aunty Emine’s daughter, Nazmiye. I am trying to find a breeze and hoping to get some tea. From Nazmiye’s front yard, you can see all the way down to the sea, which today is shimmering and hazy with heat. There is a breeze here, and the curtains are blowing out of each window. Nazmiye’s middle daughter sees me coming from the kitchen window.

“Greetings, yenget!” (What younger family members call a woman married into the family) I love visiting this house, because the girls always greet me with a smile. Even Nazmiye’s husband, who is extremely shy, is amused by the very fact of an American gelin and sometimes recites his one memorized English lesson to me. I always find a good welcome here.

Today, something unusual is going on when I arrive. An older woman and her daughter-in-law are here, but they are not merely visiting. A white-haired traditional expert, Aunty Pakize, is also here, and it turns out that she is going to treat the daughter-in-law, Hatice, for a “fallen stomach” (mide düşmesi). This is the first time I am really meeting Hatice, who is eighteen and has been married less than a year, and she is very shy. Nazmiye’s daughters know my research interests, and arrange for me to be in the
bedroom while the treatment is being performed. Aunty Pakize lives with her husband in Germany, but her grown children remain in the village house and keep up the farm. Every time she comes back from Germany, women come to ask her to pull their stomachs (mide çekmek), because she is known for being good at it. The treatment is to reposition the stomach (karın or mide) and intestines (barsak) so that they do not press on the womb (rahime) and prevent conception. The procedure is also used when a person, man or woman, feels extreme abdominal pressure and cramping, as if someone is squeezing one’s gut very hard.

Hatice is worried that her fallen stomach is preventing conception, so she is hoping that this procedure will help her have a baby. In the small, brightly-lit bedroom, two of Nazmiye’s unmarried daughters and I watch the procedure and chat with Hatice and Aunty Pakize. She pulls up Hatice’s undershirt, lowers the waistband on her skirt, and begins to massage her stomach. She kneads and probes, finding that, indeed, the stomach is too low and presses on the womb. After a few minutes of massage, she grasps Hatice’s stomach with both hands and gently pulls it up toward her chest. She holds the stomach in that way for about fifteen minutes, as we chat and giggle about methods for increasing the chances of conception, including paying attention to the best time in their cycle to try, the most efficacious positions in intercourse, and the need to delay the post-coital ritual ablutions until enough time has been allowed for conception to take place. I noted during this particular procedure that unmarried women close to the patient were not only present but also took part in the conversation about sex, storing away information for future use. We all tell Hatice that she is worrying too early, that there is
plenty of time to conceive, that she is young and working too hard. Aunty Pakize tells me that the signs of a fallen stomach, besides failure to conceive, are bad menstrual cramps and abdominal pain. Hatice warms up to me after a while and is able to talk more openly about her fears.

After she has pulled the stomach for long enough, Aunty Pakize presses a roll of white cloth into the space below Hatice's navel and binds it into place with a waist scarf (pestemel) around her waist. She tells her to lie down for as long as possible in the same prone position, until night, if possible. This is not possible, because Hatice's mother-in-law, who has been visiting with Nazmiye in the living room, comes to get her after about an hour.

Later that summer, when it becomes clear that Hatice has not conceived, she asks Aunty Pakize to repeat the procedure. Everyone agrees that she didn't rest long enough the first time to let the treatment take effect. Hatice also admitted to having lifted heavy things and having jumped down from a cherry tree, both considered ruinous to the beneficial effects of stomach-pulling. The procedure was again done at Nazmiye's house. Aunty Pakize doesn't take any money for doing the procedure, but if the woman successfully has a baby after being treated by her, the woman usually gives her a gift such as a scarf. Aunty Pakize also treats women with this technique after birth to solve problems coming from childbirth. At this time, I asked Hatice if she had been to a doctor about her infertility, and she shot me an alarmed look and said "No!" as if the very idea was crazy and terrifying.
In conversation with Hatice and an unmarried friend of hers, I was told that some women who do procedures to aid conception actually look or feel inside the woman’s uterus, but these young women agreed that that was going too far.

The following year, on another summer evening, this one quite chilly, as my husband and I walk up the dirt road to the crest of the hill and then down the other side to the newly built house of Mehmet and Hatice. Mehmet, who works as a fisherman, is a school friend of my husband’s brother. The new house is across a small yard from his parents’ house which I visited a few years previously. The young couple seems well established in their new home and integrated into the family and community. They have one growing concern, however, which has consumed their thoughts and resources since early in their marriage — they have not been able to conceive a child.

Despite the ministrations of Aunty Pakize the previous summer, Hatice has still not conceived. The couple had both been tested by a doctor in Fatsa, the nearest town with a hospital, and Hatice had been confirmed as the infertile one. The doctor in Fatsa told them that their only chance to conceive was a test-tube conception. At the time, this procedure would cost them 500 million Turkish Lira (about $4,200), which was much too high for them to consider. Their next step was to consult a doctor in Ordu, a bigger city nearby. She told them that Hatice’s fallopian tubes were closed and that she would therefore never conceive. She expressed contempt for the Fatsa doctor’s idea of a test-tube conception: “What does he know?”

At this point, the couple was driven to further measures, going as far as Istanbul, where Hatice’s sister had been aided by a doctor there when she had had problems in
pregnancy due to her very young age. The Istanbul doctor offered two choices, an operation on the fallopian tubes for TL 60 million (about $430), or a test-tube conception for TL 400 million (about $2,860). They chose the operation. The doctor guaranteed that Hatice would conceive within a few months of the operation. He recommended that she stay as long as she could in the hospital, since the charge would be the same for any time under three days. The couple left the hospital eight hours after the operation to catch their bus back home to the Black Sea. By the middle of the trip back, Hatice was doubled over in pain, Mehmet was frightened for her, and they were both mortified by the idea that they were making a spectacle of themselves. They reached home, where Hatice recovered before too long. As of this writing, they have still not been able to conceive.

As we sat in the kitchen, having finished the business of collecting the tea glasses, washing, drying, and putting them away, Hatice and I talked about their traumatic trip to Istanbul and her hopes and fears since the operation. Muammer and Mehmet talked about the same things outside over their cigarettes. Later Muammer told me that Mehmet was staying home from fishing in order to be available when Hatice’s cycle reached its optimum time for conception. This means that the couple is willing to sacrifice his income as well as all of the savings they had put into the trip and the operation in order to maximize their chance to become parents.
Reproduction and Reproductive Health

Issues of reproduction and reproductive health are of central concern to women in Medreseönü. As we have seen, women are the primary care-takers in their families and villages. Women are held responsible for the health of family members, and particularly for the health of their infants and children. Reproduction is considered to be a woman's area of concern and knowledge. In general, people have a practical knowledge about the factors involved in reproduction. Children grow up hearing conversations about sex, pregnancies, and birth. They witness the reproductive cycles of animals and know that both male and female pass characteristics on to their offspring. Birth, growth, and death are all integrated into the life of the community. When a problem occurs, such as Hatice and Mehmet being unable to conceive, it is discussed in groups of women and children of varying ages. The unmarried women I spoke to knew about various kinds of birth control and techniques to facilitate conception.

The traditional view of reproduction is expressed by the analogy of the man's contribution to reproduction as the seed, and the woman’s as the field. This cosmology was found by Carol Delaney (1991) to be the major determinant of gender relations in an Anatolian village setting. On the Black Sea Coast, the inhabitants consider Anatolian villagers to be extreme in gender segregation, veiling, and patriarchal family relations. The young women I interviewed about reproductive issues have learned the clinical/biomedical model of reproduction, and speak about their ova (yumurtalarım) and about the causes of both female and male infertility (such as blocked fallopian tubes or the effects of a bout of childhood mumps). One traditional idea in current circulation,
which does not conform to the biomedical model, is that some women are said to only bear sons, or only bear daughters. Evidence for this idea is found in the animal world, in which some cows are known to bear only one sex offspring.

Among the previous generation, infertility was considered to be the woman's fault and was sometimes a cause for divorce. Barren women were often associated with the power to cast *nazær* (even now, one of the most common sources of *nazær* is the longing glance a woman with no children may cast on a baby), or with various kinds of magic or fortune-telling powers. People now believe that either partner could be the cause for infertility, but the women concern themselves more with remedies for infertility. For example, Hatice took it upon herself to try the traditional measures to increase fertility, such as having her stomach pulled by the local experts, and only required the increasing involvement of her husband as the local measures failed and more expensive, distant remedies were sought. This is the traditional division of labor — women are to see to the daily needs of their families, tend the gardens and fields, and to provide care for their families and neighbors, while men are to supply money and labor for the physical structures and necessities of the home, do the heaviest seasonal agricultural work, and provide links between their own families and the world beyond the village.

As clinical medicine becomes more readily available and gains a following, doctors, who are unrelated male experts trained in distant institutions, become more involved in the realm of health care. Currently, most women in the villages deliver their babies at home, attended by a trained midwife associated with the Health Clinic. An
increasing number, however, are making use of new technologies such as ultrasound
devices, which require visits to doctors in Fatsa or Ordu. Women combine techniques as
they see fit and as their family income allows — for example, some women want to have
regular ultrasound scans but then have their birth at home with a clinic midwife in
attendance. As cash income increases, more women are choosing to have their babies
delivered by a private doctor in one of the nearby hospitals. Most of the pre-natal care
and the assistance to the mother and baby in the weeks after birth is still provided
through the traditional channels of female relatives and friends.

I collected most of the following information about pregnancy, birth, and the care
of babies during the two visits I made after the birth of my own child. The topic was of
interest to me, and came up regularly in conversation with women of all ages. This
chapter will present information I collected when asking about birth control and family
planning, traditional births, then stories about particular experiences with hospital births.
I will examine some of the factors that shape women’s choices about where to deliver
their babies. Then I will look at two cases of problems with reproductive health which
serve as examples of the ways in which women move through levels of health care
options, from most familiar and inexpensive to farthest away and most expensive, until a
satisfactory outcome is reached.

Birth Control and Family Planning

According to Nurse Rahime, the Health Clinic provides birth control pills and
condoms for free, but sends women to the city hospital if they want to have a spiral

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(I.U.D.) inserted. She relates that women usually don't get a spiral until after their first child, because they fear that harm can come to their uterus which would be irreversible. Nurse Rahime told me that it is hard to get women to stop working for the required 15 days after a spiral is put in, so there are cases of spirals slipping soon after insertion.

Notice that the failure of a birth control device is blamed on the over activity and heavy work of village women, just like the failure of stomach pulling to result in conception, or the failure of Hatice's Istanbul operation to work.

The side effects of birth control pills that concern the local women are diabetes and heart irregularities. There is no common perception of a link to cancer, according to Nurse Rahime. When I asked an unmarried woman about the free birth control provided by the Clinic, she let out a laugh, "That's only the first pack of pills! If it were all free, they'd have a long line outside the Clinic door!" The women who are so anxious for birth control are married women who want to space their children and limit their family size, in recognition of the economic and health benefits of smaller families. The subject of female sexual activity before marriage never came up within my hearing, so the interest in birth control of a woman who has never been married is meant to be purely theoretical.

Family size is often cited as a problem in Black Sea communities. Although large families are the norm in the previous generation, most families with small children use birth control to limit their family size to two or three children. In the previous generation, there was little birth control available, there was a higher risk of infant and childhood mortality, and agricultural labor was needed. The family lands in the area
have been subdivided among siblings to an extent that everyone agrees has gone too far and is hard to sustain. Part of the push to jobs in big cities and Europe was the sudden ill-fit between traditional family size and local economic potential.

Older women speak about various traditional practices used in the attempt to induce an abortion. Some substances, such as soap or caustic agents, were inserted into the uterus, but often had dire side-effects. A miscarriage is called a düşük, which is associated with the baby falling (the same term is used when a stomach presses down out of place and causes cramping and infertility), and the most commonly cited reason for a miscarriage is a pregnant woman’s fall to the ground. I was told that, before medical abortions, women would jump from high places to try to start a miscarriage. Now, medical abortion is legal and free, although many women don’t have an abortion before their first child for fear it will ruin their chances of having children in the future. In other words, it is a technology used by married couples for spacing children. The pregnancy of an unmarried woman is something that was never discussed in my presence, and I thought it an appropriate subject for an interview.

While the limiting of family size is of great importance for women who have had children, the conception of the first child is perhaps the most consuming concern for a newly married woman. On one of my visits to the Health Clinic, I witnessed the following scene. A red-faced young man of twenty-seven came in, asked a hurried question to one of the nurses, and hurried out. When he returned, he had been to the pharmacy next door, and was carrying a pregnancy test kit (which costs about $3.50). His new bride, in her early twenties, came with him the second time. The nurses told me
to come along as they were taken into one of the observation rooms. The young woman was ten days late for her menstrual period, and wanted to find out if she was pregnant. The groom was leaving the next day for his compulsory military service, which would last almost two years, so they were really hoping that she was pregnant. The nurses sent the woman into the bathroom with a glass. She complained that the glass was filthy, but came back with the requisite sample. One of the midwives (several nurses had also come to see the results) opened the package from the pharmacy and did the test. After a minute or so, the nurse congratulated the woman and showed her the positive marker. Everyone embraced, and the woman kissed the midwife. The appropriate phrase “Gözüңüüz Aydam!” (May your eyes light up!) was called from all of the staff as the beaming couple left the clinic. The happy news, the perfect example of how life should be, was fast on its way to all ears.

The Village Midwife

The word for midwife is ebe. This term now denotes the institutionally-trained midwives who are associated with the government Health Clinic. To speak of the traditional midwife, women use the term köy ebesti (village midwife). Traditional midwifery is now completely outlawed, and the Turkish media frequently relates formulaic horror-stories about the mistakes of village midwives in the effort to eradicate their practice. It seems to me, although I can have no solid proof to support this conjecture, that young women who might have been drawn to traditional healing practices or midwifery are the same ones who are now sent to nursing and midwifery
schools. The Islamically-dressed young midwife, for example, was the daughter of an institutionally-trained nurse and the granddaughter of a village midwife. Village women who used to be practicing midwives, such as Aunty Emine, are still asked for information on pregnancy and birth-related issues, and may still be called upon in an emergency.

**Aunty Emine on Breech Births**

I ask Aunty Emine about delivering a breech baby. During all of her explanations, she shows me what she means with hand gestures, pointing to parts of her body or moving her hands as if she were performing the procedure. (Tape 1, 1993)

Aunty Emine: İrfan, and the blond one who's coming, Temel, those I delivered, they're mine.

Sylvia: Was it easy?

A: It was easy. Now you know the woman who came with her son, who brought iron? Well, that woman's baby always came out backwards, came bottom first. I delivered her three children. The kid is coming like this, I feel around, moving my hands around and around, when the contraction comes, I move my finger around, I put olive oil on my fingers, and massage like this [shows circular motion with her right hand], before that I put kolonya [on her hands, kolonya is a sterilizing alcohol cologne used in every Turkish household for its fresh smell and sterilizing properties]. I take hold of the feet, with my fingers. This hand [her left] stays on top, holding the baby’s head [which she feels through the mother’s belly], so I can feel the head. The legs pop out with the fluid. I put my [right hand] fingers in and pull the baby’s legs out. I hold the head and press down
My brother's wife is a trained midwife. She was amazed. She asked, 'How do you deliver them [breech babies]?' She was scared. [I said] "I can't do it alone. It's God's doing. The Good Lord pushes and I catch."

A midwife said "The woman's breech!" She let out a scream and said "Straight to the hospital!" I said, "Wait, forget the hospital." I said. That was a village woman [the midwife] "You hold the woman, I'll deliver her." I delivered her. My hands are small, her hands were big. Look, your hands are small, you could do any delivery. Your hands are narrow, they'd be soft, it'd work. And my hands are small, I just pop them out.

She said, you know that Pakize Yenge [the neighbor who does stomach-pulling], she came here? "Yenge, save me! I'll withstand it, just save me!" That's why she really loves me. I delivered her three girls. One was breech. Now, here's how I do it. The woman gets soft, right? [the cervix] Well, you don't force it, you go with the contractions, you help the baby. I rub and rub like this, and I put pressure [on the belly]. Like this, like this [she shows a circular motion as if feeling the woman's belly]. Wherever the baby has settled, I put my hand there, and the baby comes with the contractions. He/she makes a place in the lower groin. If you press him/her there, birth is easy. Let Nurcan Yenge tell you and you'll see. Nurcan Yenge says, "Where were you before?" [meaning she wishes Aunty Emine could have helped with her first birth] You know her daughter Rabiye? "Where were you for her?" she says.

[There is a pause and then we start to discuss bone-setting, excerpts in Chapter 4]

S: Do cows' births resemble humans' births?
A: I do cow deliveries too. Now with a cow, when the calf's coming, the leg comes first, if you pull one leg, then the delivery is hard. You don't pull it, you get both legs together and then pull. You've got to get both legs. Then you push down. In a woman's delivery, you pull towards the back, not over here, but to the back. Same with a cow, in the delivery, you don't pull forward, you push down. With a woman, you pull like this, pull toward the back. With a cow, the cord can come to the calf's throat. For that, I oil my hand and I take out the calf's head by turning it. Either the head or a leg [can get caught in the cord].

My mother's cow was dying. I went, to my mother, may she rest in peace, I had gone just by chance from here. They were lamenting "OOOhh, the cow is dying!" "You stop," I said, "Don't come." I went over there, my girl Fatma was small then. I went beside the cow. Its legs were in the air, like this, they were ready to kill it, they had a knife in their hands. "Stop!" I said. They stopped. I turned the cow over. She let out a big sigh. "Take hold of the cow right away." I said. They held her. I put one hand in, saying "Once more, once more." I put my other hand here on the cow. The cow had a big contraction, I pushed down, I pulled the calf. My gosh, my arms were about to drop off! It was so hard, but I delivered it. Then my father came over, and he kissed me. "You're unbelievable!" he said. "You didn't let me go to school." I said. "I would have made you an engineer!" he said. [she laughs].

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Aunty Emine has always been known for her sharp intelligence, and has always resented her father for keeping her out of school so that she would help with chores and
the younger children at home. Her brothers were educated and have been fairly successful. Aunty Emine travels widely, keeps a bank account, and deals swiftly with bureaucratic tangles, all without being able to read. Her accounts of successful deliveries in adverse circumstances highlight her skills and perseverance, showing that a village midwife is neither ignorant nor helpless.

Home Birth

I asked Yıldız’s mother about her births. She is a woman from the older generation who had home births with a village midwife. She lives in Afırlı and is 68 years old. She had nine babies born at home, all normal, no breech births, and one baby who died “because the water broke.” She said, “In those days, there were no hospitals!” (“O zaman, hastane, mastane yok, ya!”) More recently, her gelin had to go to the hospital for serum (given with an I.V.) while pregnant, but then had a normal delivery at home. (Tape 1, B side, 1996)

Nurse Rahime Talks about the Old Ways

While on a visit to the home of Nurse Rahime, she, along with her mother-in-law and her sister-in-law, gave me a lot of information about birthing, birth-control, local traditions, and traditions from other parts of Turkey that they had heard about. Because of the mother-in-law’s presence, I could get a sense of how things had changed over time. For example, she had given birth five times at home before there was even a local doctor, and proudly reported that four of her children (including the current governor) are
teachers and one a policeman. I take this to be a counter-claim against those who might say that the old ways had no value and were foolish or dangerous.

Nurse Rahime told me about some traditional practices which horrified her and serve as proof that progress has been made because of clinical medicine. She told me, for example, that, in the old days, they used to put a sack of cow dung under the woman after she gave birth, so that she would stay warm. She called this practice "very dirty," and said that many women died of tetanus because of this practice. Her knowledge could be based on local stories which she heard as she grew up in this area, or, quite likely, could be from her training. Whereas cow dung is considered "filth" in Black Sea villages, it is used as fuel and building material in the dry and de-forested central Anatolian plateau. In official Turkish discourse about folk practices, Anatolian practices are taken as standard. It is possible that Nurse Rahime heard about an Anatolian practice of using cow dung in a manner unfamiliar to the Black Sea, and considered it to be a perfect example of the "bad old days."

In a similar vein, a young girl in the room at the time of my interview with Nurse Rahime, asserted that a woman had died because of the old practice of having a woman crouch over a pan of boiling water to cause the afterbirth to come out quickly. This story reminded Nurse Rahime that, in some other regions of Turkey, they have a woman crouch over a kind of herb, set alight, to cause fertility. Because of the dangers of these traditional practices, she said, and because people are fully aware of the dangers of childbirth in general, and the potential for mistakes, no one now wants a traditional midwife.
Home Birth with a Clinic Midwife

Our discussion about the traditional midwives led to talk about the current situation in Medreseönü. According to Nurse Rahime, the Health Clinic midwife goes to attend birth in the woman’s home because it is more comfortable to give birth at home than at the clinic. The ambulance stands by in case an emergency requires a trip to one of the area hospitals.

In response to an inquiry of mine, she claimed that it does not matter if the midwife is male. I have never heard of a male midwife, and even the males in the Health Clinic who are not doctors are not nurses, they are “health officers.” There are a growing number of female doctors, especially in the big cities, but most doctors who deliver babies in hospitals are male.

For Nurse Rahime and for most local women, the important difference between home birth and hospital birth is that you know the home bed is clean. In the case of the expensive private rooms being used for birth, women comment on the cleanliness, the comfort, and the ilgi of a trained specialist as reasons to prefer them to home births.

Home birth is done on a floor mattress with pillows to prop up the woman, who leans back sideways across the bed. The midwife brings a bag that contains what she needs to assist the birth, such as sanitizing fluid and a tool to cut the cord. I was invited to attend a home birth, but I was never actually contacted when one was occurring.

In related conversation, I learned from Nurse Rahime and her mother-in-law that some women go to a local hot spring for infertility problems (I did not hear this elsewhere). As a new mother myself, and possibly ignorant about proper Muslim
practice, I was instructed by the elderly woman about the dangers of touching a baby when ritually unclean. She explained that after being sexually active, and before performing the complete ritual ablutions, it is very dangerous to touch or even look at a baby. Even if the baby is crying at night, one should wash up before touching it or looking at it. The women were curious about differences between Turkish culture and American culture, and brought up the importance of virginity in Turkish culture. They may have been hoping for a scandalous revelation or at least an amusing discomfort on my part, as they joked about sending a bride back if she is found to be not a virgin. I responded with bland academic neutrality and a flat generalization about American morality being different from Turkish morality.

We also discussed the limitations placed on the new mother during the first forty days after giving birth, called lohusa zamami, a period considered crucial for the health of the mother and baby. Although visitors can come to bring good wishes and small gold coins for the baby, the mother is not supposed to leave her house during this time. There are special foods for mother and guests, and other ritual practices done by women close to the new mother.

Hospital Birth

In the nearest hospital, in Fatsa, there is a very high cesarean rate (80%), in part because women who are at risk for some reason are likely to give birth in the hospital, and in part because women who like the status and security of having a private doctor often ask for a cesarean to avoid labor pains. Talking about giving birth in an özel odas
is a way to show that no expense was spared for the birth and to make sure that no one gets the impression that the birth took place in a regular hospital setting. Getting to a hospital for check-ups and when labor has started is much easier now than it had been even ten or twenty years ago. Technologies such as ultrasound are available in the hospitals, and give mothers who value the most modern techniques a sense of security. As more women have babies in hospitals, more doctors become known through personal channels, making it easier for women to trust them.

Belgin’s Hospital Birth

For a clear picture of why women dread the thought of having a baby in a regular, State-run, free hospital, I offer the following story told to me by Belgin, a woman in Istanbul. Although this example is from Istanbul, the critique of the lack of ilgi shown to patients in the State-run hospitals is similar to stories told on the Black Sea Coast.

Belgin went to a sigorta hospital (a free State-run hospital), to have her son, who is now five and has no siblings yet. She was advised by friends and relatives to withstand as much of her contractions at home as she could before going in to the hospital. Her contractions started in the afternoon, and by 2 a.m. she was unable to stand them any more. Her husband took her to the hospital, where her labor continued through the night. At 10 a.m. some doctors came in with a big group of medical students and they gave every woman a shot. [presumably of something to induce or speed up labor] All of the women were in a row of beds and they all delivered exactly ten minutes after the shot, right at ten after ten. Belgin laughed as she explained that the women who had come in
at 6 or 8 a.m. had been quite pleased, whereas she had suffered much longer while
waiting for the shot. She complained that the nurses at the sigorta hospitals pay no
attention to the laboring women, spending their time drinking tea and talking on the
telephone instead.

Birth at the Fatsa Hospital

No one in the villages would go all the way to Istanbul for a State-run hospital.
They would only feel the trip worth the time and expense if a private doctor is involved.
A young mother told me that she had good care from a private doctor in the Fatsa
Hospital, but that there was a woman in labor in the room with her who was terribly
ignored. She was screaming for help from the nurses, who were sitting close by, drinking
their inevitable glasses of tea. Only when the baby fell out onto the bed did the nurses
rouse themselves to action. The woman telling me the story had suffered a previous
miscarriage and had been under strict supervision with this pregnancy since a threatened
miscarriage at one-and-a-half months. She was very pleased with her private doctor, who
sent her home under strict orders to have complete bed rest until past three months (His
exact words were, “Don’t even stir soup!”). Her baby had been in breech position, which
worried her mother-in-law, the same woman whose breech births had been assisted by
Aunty Emine, but the baby turned to normal presentation just before birth. Her doctor
had been prepared to do a cesarean, but expressed the hope that she, being young and
likely to want more children in the future, could have a normal delivery, which is how it
happened.
Yıldız’s Cesareans

A neighbor of Aunty Emine, Yıldız, who is in her late twenties and has two children, told me about her hospital births during an interview in 1996 (Cassette 1, B side). On the tape, she relates that her first pregnancy was twin girls, but she didn’t know she had twins. Ten days before the birth, she fell flat on her back outside her house. She did not realize it, but the fall had harmed one of the fetuses. When she finally had contractions and went to the hospital in Ordu, the doctor discovered that it was a double pregnancy and that one fetus was dead. She had a cesarean by the Head Doctor at the Ordu Hospital, who performed as a private doctor with a fee. Her second child was also born by cesarean in the same hospital. She prefers the hospital, because it is safer. She tells me that the biggest danger of having a baby at home is bleeding, because some women bleed to death. She stayed in the hospital for eight days, and then had to get back to work at home when she arrived. After the second child, she stayed nine days in the hospital and then was able to stay in bed for twenty-four days at home. She says she thinks cesareans are better. The place where she gave birth was a section of the hospital reserved for birthing.

Yıldız’s daughter who survived was about seven years old when this interview took place, and she contributes details as her mother speaks. She says that the doctor had told her mother that, if she had come to him immediately after the fall, the other twin would have been saved. This child would have heard the story of the pregnancy and fall as she grew, absorbing the details from hearing the story told by her mother and others in the family (she would not have heard directly from the doctor). In this case, we can see
that the mother is held responsible for the health of her unborn child, and blamed, if not for falling, then for delaying seeking help after the fall.

**Esra’s Private Room Birth**

In 1997, I interviewed Esra, a woman younger than me by a few years. She was brought up in Perşembe, a town not far away, and now lives with her husband in the village of Gebeşli (tape 1, 1997). She was visiting her friend Nazmiye, daughter of Aunty Emine, her sisters-in-law and her two children, one four years old, the other four months old. I asked her about her birthing experiences.

Esra: I had normal deliveries in the Fatsa Government Hospital, in a private room. I was in the hospital for a week. The second pregnancy, I was sick all the time, throwing up, dizzy. I deliver in just half an hour! I go in for a check up when the time is near, and they tell me to come in the next day to deliver. I’m afraid of the contractions, so I go to the hospital. Because I deliver without contractions, I don’t trust myself, I’m scared, so that why I go to the hospital. They say it’s better at home, but I’m used to the hospital. I stay there a day and then rest at home for fifteen days.

Sylvia: What do they do for *lohusa zamani* (the lying in period after birth)?

E: You lie down, you know, they come to see the baby. They don’t let you go out in the cold. You’re not supposed to get cold at all, you sweat a lot!

S: Are there special foods?

E: They make *komposto* [a fruit syrup drink] and soup for the mother.

S: And for the visitors?
E: If the baby’s a boy, you give the visitors pilav [a rice dish], if it’s a girl, you give helva [a sweet]. They put a red ribbon in your hair [the mother’s].

S: Are you nursing your baby?

E: My first, I [nursed and] gave formula once a day for the first five months, this one, I’m just nursing, no formula. The doctor says, “the best thing is mother’s milk.”

[She doesn’t seem to worry that I will cause nazar to her milk supply, either because she knows I am nursing myself, or perhaps because she thinks of this interview in terms of a medical interview. We turn to other subjects, and later circle back to nursing]

E: Here the doctors say “Don’t nurse your baby after one year, it’s bad for the baby.” Is it bad?

S: Oh no, not at all.

E: It’s bad for the mother, if anything, not for the baby.

S: {Referring to Timur} Sometimes he bothers me, but it’s good for his health.

E: Of course it’s good for health. They grow up without getting sick all the time! This one [indicates four-year-old], was sick a lot. Babies get fever, bronchitis, we were always going to the doctor. At home, we made tea, gave honey and milk, we would rub Vicks on his chest, but it doesn’t go away without the doctor.

S: To be sure...

E: Yes, still it is better to go to the doctor.

S: I look at my friends, and the healthiest babies are nursing.

E: Yes, it’s the best.

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The Contemporary Mix of Options for Birth

I have tried to show the range of choices in birthing practices available for the women of Medreseönü. The traditional birthing was at home with the assistance of a village midwife. The current hospital birthing options include the technologies to monitor fetal development and heart rate during birth, I.V. medicines, a full range of pain reducing medications, the anesthetics and surgical equipment necessary for performing a cesarean, and the standard equipment such as forceps, umbilical cord-cutting tools, and incubators for care of babies. Hospitals also provide various surgical procedures and fertility medicines in case of problems in reproductive health. Each individual woman, in consultation with family members (usually including seriously considered input from her mother-in-law), negotiates a strategy for obtaining her preferred care during pregnancy and birth. Of course, the circumstances sometime dictate a change in plans, such as when an emergency occurs. All women state their appreciation for the expanded options available since the introduction and expansion of local clinics and hospitals, although they often complain about the cost of getting good care. The Turkish government has always expressed an obligation to provide free care to Turkish villagers and workers, but ordinary citizens are aware of a large gap between the political promises they hear and the reality they experience.

Problems with Reproductive Health

One of my unmarried informants told me about another woman who had had trouble conceiving. She had been taken up to her mother’s village (Afırlı), where a
woman had performed the stomach pulling technique. The effectiveness of the treatment had been immediately destroyed because of the bumpy ride down the road back to her home. A second try had failed for the same reason. Finally, the family asked the woman to visit them at home for the treatment. Subsequently, the patient became pregnant.

Although this woman was the next-door neighbor of Aunty Emine, although we had babies of similar ages and various family ties in common, and although I saw her frequently, we had never been alone together. One night, the two of us were alone in her room, swinging Timur in a blanket held like a hammock, trying to get him to sleep. When I asked her about how she had overcome her problems in conceiving, and asked her about the effectiveness of the stomach pulling technique, she pulled me close and whispered, "Those things are empty/futile (boş). I got pregnant after going to a doctor."

Because her mother and mother-in-law both value the traditional practices and believe in their effectiveness, she dared not express such views in front of them. She is absolutely certain (if secretive) in her attribution of success to the doctor's medicine (she had been given a fertility drug), and has a fine son to prove it. Her situation is now much less ambiguous than that of Hatice, who has had no success with any method thus far.

Lale, who has a daughter about ten years old, told me about the biggest health problem in her life:

Sylvia: I'm collecting information about health, so I'd appreciate it if you could give me examples from your lives. Have you had any illnesses?

Lale: I was sick, I had an operation. I had kis.
S: What’s that? (I look it up and find it is fibroids or an ovarian cyst)

L: It happens in your ovaries.

S: What remedy did you use?

L: I had an operation in Istanbul. I got pains, I went to the hospital, had an operation. Then we had this girl [indicates her daughter]. When she was 7 months old, I got it again, I had another operation. One of my ovaries was removed. When she was a year-and-a-half, it happened again, so they removed the other ovary.

S: Was it a private hospital?

L: Yes, a private one, we don’t use insurance. We’d rather pay and get good care. I had two operations in one place, and then switched doctors. In case he had diagnosed wrong... But the second doctor said the same thing, so I got the operation. Now, Thank God, I’m fine, but I get headaches, nervousness, I get depressed.

The Order of Resort

In the case of Hatice and Mehmet, the traditional practice of “stomach-pulling” was the first remedy tried for infertility. When it brought no results, they then turned to a series of doctors in ever more distant locations. The price of procedures in the hospitals became a deciding factor in their choice of action, although the success of the Istanbul doctor in helping Hatice’s sister through her pregnancy increased their hopes in him. In the case of the “stomach-pulling” technique’s failure to work, older women explained that Hatice must have spoiled the effects of the treatment by moving around too much or lifting something heavy. It seems that the couple now blames the fact that they left the
hospital too soon for the failure of the operation, a concept that is parallel to the model of
ruining a "stomach-pulling" through over exertion.

"Stomach-pulling" as a treatment for infertility is used in other parts of Turkey. An
acquaintance from Adana told me that her own mother had been unable to conceive for
six years after the birth of her first child. After being diagnosed and treated for a "fallen
stomach" by a traditional expert in the local woman's bath house, she became pregnant.
The woman relating this story is thus living proof of the efficacy of this traditional
practice.

Reproduction, family planning, and birth are health issues of great importance to
women in this area. They are held responsible for success and failure. Young women
are taught necessary information about these issues, which they are expected to apply to
their own lives after marriage. Women past child-bearing age have been respected for
their knowledge in this realm. Now the new availability of clinical techniques to assist
with reproduction and the cultural authority of doctors have led some young women to
doubt the wisdom of their elders.
CHAPTER 7

THE CLINIC

The Health Clinic occupies one floor of the municipal building on the shore road, in the small cluster of buildings which make up the center of Medreseönü. I am hurrying there because I am late for vaccination day, and I had expressly asked to be able to observe the workings of the clinic on this day. The staff is quite familiar with me by now, as I have come often and sat with them drinking tea and asking about the clinic's operations. I immediately cross through the waiting room, where several families with small children wait with the characteristically glum attitude that seems to come over Turkish people in line for government services. I pass through the doctor's examining room, where a baby is expressing dismay about the whole frightening procedure of vaccination. The doctor gives me a nod, I open the next door, and am met by the instant attention of the entire staff. All the nurses are having their cigarettes, in direct violation of all the advice of the anti-smoking posters up in the waiting room, and they are thus quite alert when someone enters their office, in case they need to quickly dispose of the evidence of their unhealthy habit. They ask me why I am so late, and I tell them that I have spent the night in Ordu and had to wait for a ride back. It is around noon, and twenty-one of the infants to be vaccinated have been, leaving thirty-seven yet to be done.
The nurses joke that it is the pride of those who live near the shore road which has made them dally, in contrast to the villagers from farther away who have to get the vaccination over with in the morning and get on with the rest of their daily tasks.

True to the requirements of government regulations, the walls of the nurses’ office display various enlarged tables of data they have collected, including data on population growth, mother and child health, immunizations, family planning, sanitation efforts, and other health-related statistics. Each room has, bolted to the wall, a signed, stamped, and framed list of all the contents of the room. Above everything, in each room, is a portrait of Atatürk, the modernizing leader and personification of the patriarchal Turkish State which has provided and regulates such Health Clinics.

The walls of the waiting room display posters meant for the patients and their families. Anti-smoking posters show children’s drawings picked from a national search. One shows a boy crying huge spurting tears at the grave of his father, with a pack of cigarettes over-laid with the red circular symbol of negation. An old poster carries the title “You’re Expecting a Baby.” In three out of the six sections, pregnant women, who seem to have come out of an early 1970’s fashion spread -- complete with mini skirts and flipped hair -- are shown brushing their teeth, taking a shower, lounging on a lawn chair, dancing with a partner, riding a horse, and taking a stroll on the arm of a suitably fashionable man. One section shows a variety of appropriate foods, and the remaining two sections show pregnant village women, wearing village-style head scarves, carrying a load of sticks, lifting a cauldron, washing laundry in a tub, and washing the floor. Each section has a written text which explains what should be done or not done (“Keep clean.”
“Don’t do difficult sports.” “Eat a variety of healthy foods.” “Stroll in fresh air and relax.” “Don’t lift heavy loads.” and “Don’t do difficult and tiring work.”) For an illiterate person, however, it is impossible to tell that some pictures show recommendations and others are admonishments. One could easily extrapolate a message that rich pregnant women dance, flirt with men, enjoy running hot water, and ride horses while pregnant village women carry on with their same round of chores — and although this was probably not the intended message of the poster, it is not far from the realities known well by those waiting in this room. An anti-cholera poster shows in graphic detail the types of filth encountered in village life which can harbor the disease: animal dung, swarming flies, exposed outdoor toilets, sewage running into drinking water supplies, and a thin old person in bed with a puddle forming underneath. As pictures of the desired healthy state, advertising from European drug companies are hung about — usually showing a fat, blue-eyed, blond baby with a dimpled smile. Local contributions fill a glass-fronted cabinet — embroideries made by young local women in stitching classes, and crocheted baby mittens and hats. In the corner, a poster of a blond, blue-eyed nurse in standard nursing uniform with her finger to her lips and a stern look disciplines the waiting room.

The nurses are here in full force today, and two midwives who live in their own villages rather than in Medreseönü have come in as well. This is the first time I am meeting the youngest midwife, and I am surprised by her attire. She is wearing the new style of Islamic dress, which includes an overcoat, a large polyester headscarf, a long-sleeved blouse, and a skirt which almost touches the ground over her fashionable
platform shoes. Inside the clinic, she removes her overcoat, but the rest stays unchanged.

When I get a chance to talk to her alone, I ask her about what she is wearing. I know that it is against the law for government employees to wear the clothes that mark them as Islamic traditionalists. This midwife's photograph on the clinic wall shows her in standard nursing uniform. In response to my query, she laughs, saying "And this is supposed to be a Muslim country!" She tells me that many of her patients are more comfortable with her because of her modest dress.

The staff spends the afternoon of the vaccination day calling around to try to bring in the children who had not shown up in the morning. The staff's knowledge of the familial and social relationships of the villagers is crucial to the success of contacting the parents. In many cases, a neighbor or relative is called in order to try to get a message to the parents who were not found by a direct telephone call. Since each staff member knows a particular network of people, everyone works together to try to close the net on the parents on the list. There is a lot of joking and light-hearted gossiping as the calls are placed (from the "back-stage" area of the nurse's office).

One family is reached and the man answering tells the midwife not to worry about calling another family of his relatives because he was going to see them anyway. The staff is working from a list provided by the downstairs post office (which is also the telephone center) and photocopied in the government office copier located one floor up from the clinic. The midwife from Büyükağz has only two families left, and wonders
aloud if she should take the two shots and go home. A few more families come in, and I have to go because I see the car that can give me a ride up the hill in the lot in front of the clinic.

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The Clinic as Representative of the Turkish State

Many recent theorists have worked to expose the complex relationships between the individual and the state. Their theories, which are based mainly on print media, have tended to assume literacy, and a kind of “trickle-down” nationalism, focusing on intellectuals, politicians, and generals. They also tend to assume a “blank-slate” kind of citizen ready to be inscribed with national identity. This kind of study does not examine the role of “regular” individual citizens, who are often minimally exposed to literature, in the negotiation of national identity. Foucault (passim) has shown that the state can have a visceral impact on the individual’s body and identity, through imprisonment, medication, and other forms of control. I think it has been generally accepted that states have a great deal of power over their citizens, who thus occupy a subaltern position. This power, however, is applied neither consistently nor constantly over time. Individuals both respond to and initiate relations with state power, in a complex process that includes both contestation and negotiation. Foucault (1963) has shown that a clinic is a particular kind of institution, with a vested interest in a certain world view and a specific set of
technological tools. By looking at the interaction between the state and the individual, in the context of a health clinic, we can get an idea about how this kind of negotiation takes place.

With the creation of a modern nation-state, various state institutions are established which have an impact on the daily life of citizens. One of the institutions, which can have a very personal effect on individuals, is the institution of national health care. The modern Turkish state introduced a national program of medicine based on a western clinical model, which was spread throughout the countryside to promote a specific type of integration and modernization of the Turkish citizens. The implications of the fact that a western model was adopted are vast, but, as stated in Chapter 1, my concern in this research is with the difference between the clinical model and the local, traditional model, more than the historical origins and political impact of the origins of the clinical/biomedical model.

First, I will describe the ways in which the clinic’s physical set up, its medical philosophy, its personnel, and its rules and regulations represent the state in a local setting. Then I will examine the ways members of the health clinic staff shift their behaviors and loyalties in different situations because they both represent the state and have local identities. I will specify how individuals enter into power relations with the clinic, using various strategies of body language and rhetoric, in order to achieve their desired health-care goals. To illustrate interactions between the state and the individual, I will use the example of vaccinations provided by the state to village children. As I hope to have shown in preceding chapters, the focus on the “individual,” simplifies the actual
Turkish cultural situation in which at least one family member will accompany a patient to the clinic and participate in health-care decisions. I will also describe a trip to a private doctor in Ordu, which differs in various ways from a trip to the clinic.

The clinic is a representative of the state because it is founded, funded, and furnished by the state. The most important and recognizable symbols of state affiliation are the flag outside and the portrait of Atatürk above the doctor's desk. In every room is a small framed list of the furnishings of the room, a reminder of the bureaucratic attention to detail typical of state institutions. In the waiting room, posters that seem to be mostly from the 1970's, show which health issues particularly concern the state — the improvement of prenatal care, the prevention of cholera, and the reduction of smoking-related deaths. A poster of a nurse with her finger to her lips conveys a need for patients to respect and obey the rules of the clinic, and, by extension, the state.

Along with the physical furnishings of the clinic comes a crucial yet invisible component of the clinic's operations: the western medical model of sickness and health. In a philosophical universe in which illnesses are caused by drafts, by eating cold foods, by the evil eye, by walking barefoot on a tile floor, and so on, the microbiological model is not used to explain illnesses, and in fact can seem a bit silly. The state's promotion of the biological model has made some inroads into local awareness, however, through the institutions of the health clinic, schools, television, and newspapers, and through the exposure of locals to other cultures through travel and work.
The Staff

The state also determines the staff of the clinic, as all health clinic doctors, nurses, health officers, and midwives are trained in state institutions and assigned to their locations by the state. Turkish doctors are mostly trained in urban centers at the state’s expense, and then sent to peripheral and rural areas to perform a four-to-six-year assignment that is seen as a national duty and a repayment for education. In the Medreseönü clinic, the doctor is not from the Black Sea area and may move on to another assignment when this one is completed. He has extended his stay once, and people report with pride that he likes the place. They also conspire to marry him to a local so that he will stay. The other staff members were trained in the small cities near their home villages, also at the state’s expense, but with the expectation that they would return to their home town and serve the adjoining villages. Their uniforms are meant to mark them as state employees, and they are supposed to follow procedures according to state regulations.

The Work of the Clinic

The everyday work of the clinic includes examining patients, prescribing medications, administering vaccinations, discussing and dispensing birth-control, identifying and tracking pregnancies, and performing tasks such as giving injections, stitching wounds, or treating burns. The health clinic staff also goes on rounds of the villages, checking sanitation, visiting confined patients, and gathering census information. The clinic is sometimes the agency that refers a patient to a doctor or
hospital for more extensive testing or treatment than available at the clinic. The rules and regulations for these tasks are spelled out in a handbook provided by the state to each clinic. Much of the staff's time is spent filling out reports and entering census data into charts provided by the state. In this direct way, the state meets and tracks its citizens through the health clinic.

As representatives of the state, the health clinic staff can charge fines for unsanitary toilets or stables. In this case, the health clinic staff represents the state right at the homes of its citizens, with the power to judge their cleanliness. Besides the fact that a lack of sanitation is linked to diseases such as cholera, the state's concern with the disposal of wastes is a part of the national goals of modernization and westernization and shows the extent of the state's wish for control over the populace. In practice, however, conditions deemed unsanitary by official standards are often overlooked if personal relations are good between the clinic staff and the homeowner, or, conversely, turned into a hotly contended issue if the relations are bad. The task of enforcing cleanliness is seen by both the government and the populace as a health-related one, as it fits both the germ model of illness and the local ideas about filth (*pislik*) as an agent of illness.

**The Handbook of Clinic Regulations**

A handbook is provided by the state to regulate and standardize the workings of all health clinics in the country. In this text (*Sağlık Ocağı Yönetimi*, 6th edition, 1993), we can find evidence of the state's official position and attitude about villagers and their
health care system. In the discussion of special problems relating to women’s reproductive health, the handbook states:

For example, it is necessary to get to know and visit more often, even if it disrupts the routine, those mothers who are candidates for the danger of pregnancy toxemia, those children who are undernourished, and those families whose care and education is hampered by the grandmother’s age and ignorance (yardım ve bilgisizlik). (106)

This shows that the government considers “old wives’ knowledge” to be a hindrance to the proper care of its citizens. The handbook also makes clear that the staff of the clinic is hierarchically ranked, with the doctor at the top and the midwives at the bottom. The midwives are asked to attend local social functions, such as weddings and female gatherings, in order to achieve comfortable social relations within their villages. Doctors are likewise instructed to attend male social functions. The doctors and midwives are not equals, however; the doctors are meant to supervise and correct the work of the nurses and midwives. The handbook tells the doctors:

A point which should not be forgotten when participating in this kind of house visit with a midwife is that, if the midwife has a deficiency or if her procedure is not correct, it is important that you give the proper instruction after the visit, when you are alone with the midwife, in order not to harm the respect the midwife has in the eyes of the family. (111)

Midwives, then, should be integrated into village social life and earn the respect of villagers, but must still be under the direct supervision of the doctor.

Although, in theory, the state exerts almost total control over the furnishings, funding, staff, and procedures of the health clinic, in practice, there is still some room for local autonomy. One significant example of this autonomy is the fact that the clinic’s ambulance was purchased by a local group of families who work in Germany and thus
constitute a kind of local moneyed class. It stands outside the clinic as a sign that local charitable donations can provide something that the state was unable or unwilling to provide. The competition between the central government and local pious or charitable foundations to provide resources to the common people is a feature of Turkish culture that has been widely noted in Ottoman history.

Power Dynamics

To get an idea about the state-local power dynamics in the arena of health care, we can examine the complex social behavior of the health clinic staff: The doctor, for example, is the most powerful representative of the state. At the same time, however, he is an outsider who needs to act with care in order to be accepted and respected in the local setting. The others can move more fluidly between representing the state and claiming insider status as long standing members of the local community. Two of the four midwives spend more of their working hours in their home villages than they do in the clinic. The doctor, the health manager, the two nurses, the secretary, and the remaining two midwives live close to the clinic and report to work there. There is no person who comes into the clinic who is not somehow connected to the social networks of the villages and the town. Even if a complete stranger should happen to need emergency care at the clinic, he or she will be asked questions about origins and family so that some familiarity can be established. For example, if an American tourist ever turns up in the area, he or she could be quickly integrated into the networks of familiarity by virtue of the fact that one local family now has contacts in America. Patients can be
friends, relatives, classmates, enemies, neighbors, or guests, and their reception in the
clinic in part depends on these relationships. There is no place for anonymous or
impersonal treatment.

Because staff members have all lived elsewhere, at least for their medical
education, they have formed ideas about the differences between local life and life
elsewhere. Health clinic staff members become something like “big fish in a small
pond,” acquiring status because of their education and their experience in the wider
world. When talking with people with as much or more experience in the outside world,
however, they are quick to show that they realize the limitations of their situation. This
strategy comes from the awareness that outsiders or locals who have “made it” in the big
cities or abroad can be derisive toward those who have returned to work in their
hometown.

Discussions of traditional healing practices, when conducted within the clinic, are
fraught with insider/outsider tension. When I asked what the health clinic policy was
about religious amulets worn for healing or protection, the staff members were quick to
explain that amulets are tolerated because people like them and because they do no harm.
The assumption seemed to be that an outsider (especially a westerner) would consider
them useless or even a cause of backwardness, and thus expect the clinics to work to stop
their use. It also seems that the official rule book ignores traditional healing practices
altogether, thus implying that they are not worthy of attention. Outside the clinic, staff
members kept up an attitude of skepticism about many local practices and beliefs,
although they also told me about instances in which the local practices met with success.
It is possible for a staff member to be skeptical or even derisive about certain traditional healing practices and yet hold others to be efficacious. The practices that are regarded as valuable are taken as examples of the practical knowledge of the elders, while the ones regarded as harmful are spoken of as the fruit of ignorance. One nurse, who would probably attribute most illnesses to microbes rather than to the evil eye, still wears a protective blue bead on her necklace. The clinic staff, especially the midwives, consistently practices the traditional uttering of “Maşallah” when looking at a new baby in order to avert the evil eye. The midwives also play along with the tradition that food should be given to the midwife who delivers a baby so that the baby will never go hungry.

“On-Stage” and “Back-Stage” Behavior

Staff members at the health clinic have what could be called “on-stage” and “back-stage” ways of behaving in the clinic. When they greet patients in the waiting room, they tend to be stern and business-like, speaking in short sentences and using the imperative case. They hold their bodies straight and faces serious. In contrast, in their own office, where they invited me to sit down, have some tea, and chat, they tell stories, laugh, and slump in their chairs. All of the female staff members smoked cigarettes “back-stage,” but when I tried to take a picture of a midwife with a cigarette, she strongly protested. Everyone laughed and joked about what Americans would think about Turkey’s smoking nurses. Turkish women who smoke do not do so in all situations and often prefer that their habit not be known by everyone — thus it is usually a
“back-stage” activity, in the clinic or elsewhere. In public, the nurses support the state’s anti-smoking campaign, but behind the scenes at the clinic they personally subvert it.

Another interesting subversion of official rules is the Islamically-marked clothing and behavior of the youngest midwife. This woman even uses the nurses’ office to do her prayers. This situation would have been unthinkable before the 1990’s, but now the Islamically-minded Refah party has gained considerable political influence — with the social consequence that more people have begun to mark themselves as active Muslims.

Patient Tactics

The clinic employees alter their behavior according to whether they feel most like state representatives or like locals, whether they are “on-stage” or “back-stage.” When I observed the behavior of people coming into the clinic because of various health problems, I could see that they also actively manipulate their social identities to obtain the maximum benefit from their visit. A patient is literally putting his or her body on the line when asking for state help in the intimate arena of physical health. The most common type of approach to health clinic staff is that of the humble petitioner, accompanied by a body language conveying apprehension, respect, embarrassment, and hope. This is a perfect complement to the stern and stiff behavior of the staff — and usually leads to a smooth transaction. The tendency of the staff to loiter “back-stage” a bit before seeing patients heightens the patient’s awareness of the power the clinic holds and increases the humility of the patient’s self-presentation. Of course, this is a delicate negotiation with certain boundaries — if a staff member loiters too long or shows actual
disrespect while "on stage," patients would have every right to grumble, complain, or spread stories later, depending on the situation.

Another patient tactic is one most often used by elderly women, in which the patient tries to place herself in a familial relationship with someone on the staff. Because this is a small town, there is usually some close familial tie, but I have seen this tactic used even in big city settings. An elderly woman patient might greet a nurse by saying “Hello, my girl,” (kızım, which is also “my daughter”) or, if she feels she has a better chance of getting the best treatment from another nurse, she might ask, “Is my aunt’s daughter’s girl here?” This would prompt the nurse she is addressing to ask about the family connections being referred to, leading to a shift of power to the elderly woman, who is the expert in knowing who is who. Even if it is quite a stretch, a patient could ask “Aren’t you so-and-so’s kid?” and still draw a staff member into a discussion of family relationships.

Another example of the use of familial patterns of relationship is the strategy used by a person bringing in a dependent to be seen by the staff. Because taking responsibility for a dependent is such an important act in Turkish culture, the responsible person can act in an assertive way toward state employees. While the dependent remains absolutely passive (often looking very ill), the responsible person stays on foot, actively pressing for quick service by staying near the door to the doctor’s office or speaking with any nurse who passes through the waiting area. This is typically a male strategy, but women can use it if it seems a better strategy than the petitioner style of address or the appeal to the respect due elders.
Some patients fully expect to be welcomed "back-stage," because of their previous relationships with staff members. In this case, they carry themselves in upright and moving quickly, stick their heads in the back office, smile, and wait to be welcomed in. This behavior elicits a welcome even if the staff does not immediately recognize the person—"if they act this way, then we must know them." These strategies of self-presentation are put to use, not only in state-run health clinics, but also in virtually any state-run office or in settings like banks where the power relationships are seen to favor the institution, not the individual.

Vaccination

State-subaltern power relationships manifest themselves in the behavior of state employees and of those who need to obtain services from the state. For a concrete example of the ways in which the state can make itself felt in the physical bodies and social lives of individuals, I have described the health clinic's vaccination campaign. It is important to point out that there is nothing "natural" about vaccinations. In the United States, we have been conditioned by decades of promotion and education to consider vaccinations an essential and beneficial practice (although there are some who oppose the practice on religious grounds). The theory behind vaccinations fits in with our understanding of viruses, microbes, the immune system, and illness in general. As a result, we subject our children to the temporary pain of shots and the discomfort of the reaction to vaccinations, firm in our convictions that it is best in the long-run. In contrast, many Turkish villagers seem to be highly ambivalent or downright mistrustful.
of vaccinations — taking their children for shots only because the state says they must rather than because they believe in the benefits of vaccinations. This often frustrates the staff members, who have been trained to take the benefits of vaccination for granted.

For the sake of a counter-example, in Turkey, parents have their sons circumcised with a firm belief in the long-term benefits of the practice. In this country, we used to consider male circumcision to be so beneficial to health and hygiene that it was a near-universal practice. Now that the tide of national consensus seems to be shifting to the opinion that circumcision is not necessary for health, many experts are speaking against its universal application and some have taken up a campaign against it on the grounds that it causes unnecessary pain to infants and may cause long-term psychological damage. When discussing this issue with a Turkish man, I was told that he found vaccination to be a much greater source of anxiety and pain than circumcision had been. In other words, while pain may be a cross-cultural universal, there are significant cultural differences in the perception of pain based on cultural explanatory models of health and illness.

I came across three examples of the ambivalence most villagers feel about vaccinations. The first is that parents often try to scare their children into good behavior by telling them that, if they are bad, one of the people in the group will stick them with a needle — give them a shot ("Yenge sana ışne yapar!"). A second example was the widespread alarm caused by a newspaper article that reported that two babies who had been given bad vaccinations had required amputations because of gangrene. The Health Minister was reported as saying that the government vaccinations were inferior and
The health clinic I observed received queries from concerned parents after this article was published. The third example I found of mistrust of vaccinations was a widespread rumor that powerful foreign countries, concerned about Turkey's rapid population growth, were sending a new type of vaccination that would render Turkish children sterile in later life. The woman who told me about it said it had been in the newspapers and that Turkish doctors had proved it. The rumor seems to have been connected with the introduction of the oral polio vaccine -- administered by drops rather than by injection. This unfamiliar method of administration and the state's insistence that all children receive them, even if they had already been vaccinated, seems to have led to the scare. The scene was set for such a rumor because of general mistrust of vaccinations and because it is common knowledge in Turkey that Europeans and Americans are alarmed by the Turkish population rate.

In short, the Turkish Health Bureau allocates significant resources for a national campaign of vaccination for all children, and the health clinic is responsible for carrying it out in the villages and neighborhoods across the nation. In the clinic I observed, the midwives are responsible for keeping track of all babies through the period of completing their vaccinations. Instead of having parents bring their babies in for shots individually according to their own specific age, the clinic has special vaccination days on which it administers shots to babies from the same age group. When the ambulance was first presented to the clinic, it was used to drive to all the villages to administer vaccinations door-to-door. That practice has been discontinued, to the displeasure of many villagers who find it difficult, because of the nature of their agricultural work, to bring their
children into the clinic on any one set day. One nurse complained to me that the villagers are too demanding, especially when the vaccinations are a free service. In this case, we see a clear state directive to vaccinate all the children, taken up by the health clinic staff, who have to cajole a recalcitrant population into dropping everything and bringing in children for a shot which is known to be painful and not necessarily considered beneficial.

The local health clinic, then, is a setting in which power relationships between the state and its citizens are played out. These power relationships are shaped by the fact that the state intends to impose a western medical model on a population that has had a different working model of health and illness. The staff members of the clinic have to find a balance between their duties to the state and their local social obligations. People who choose to enter the health clinic know they are entering a government office and use strategies to obtain the care they are seeking and still retain a measure of autonomy. The state provides free or low-cost health care for everyone who is willing to use the clinic. In return it asks for its citizens to accept the western model of medicine and to comply with rules regarding such issues as sanitation and vaccination. In the interaction between the health clinic and its patients we can get an idea about the complex and critical contestations and negotiations between the state and the subaltern.
Aunty Emine goes to a private doctor in Ordu. She has been feeling faint, tired and overworked. She has pains in her left side and in her leg. She worries about her age and the constant worry of tending a milk cow. Because her son has agreed to pay for her trip to a doctor, she makes the full-day expedition and arranges to stay with her daughter for the night in Ordu. Dr. Deniz finds high blood pressure, high cholesterol, and congestive heart failure. He prescribes dietary and lifestyle restrictions, three kinds of pills to be taken morning, noon, and night, and three injections. She buys the expensive medications in the pharmacy below the doctor’s office. Aunty Emine gets a woman in her daughter’s apartment building to give her the first shot before leaving Ordu. The second shot is given at the Medreseönü health clinic by a clinic nurse the following day, when Aunty Emine returns from Ordu. She has the third shot given by a woman in her home village of Gebeşli. The woman has to be persuaded because the previous shot she had given to someone else had caused a severe reaction necessitating a rushed trip to the Fatsa hospital. Aunty Emine has one of her granddaughters read the print on the pill bottles and memorizes the pills by their shape and color. As for the dietary restrictions
and the admonishment by the doctor to sell her cow, they are slowly adapted into her life.

She is canny about the value of her cow as a meat animal, and refuses to sell it for almost a year, waiting for the price to go up. From the U.S., all we can do is ask her to take care and send money for medications.

* * * * *

Conclusions

It is my hope that this research will contribute to the recently expanding academic literature on health care systems. It can add to the ethnographic literature on Turkish culture, especially in that Black Sea culture has been studied far less than Anatolian Turkish culture. As a case study on Turkish women, I wanted to help to increase the number of specific and in-depth studies of women in modern Muslim culture, studies which are needed to counter popular stereotypes about Muslim women which have caused misunderstanding and hostility between Western countries and the Middle East.

On another level, I believe that if the dynamics of the interactions between traditional and clinical medicine in one local setting can be understood, then the communication between patients and healers in a variety of settings may be improved for the benefit of all concerned. Folklorists in the United States have recently become involved in helping hospitals negotiate the treatment of patients from widely differing cultural backgrounds and individual life stories. Hufford (1995b) advocates cultural training for medical students with the assumption that “the social, cultural and psychological aspects of human diversity can be as important to accurate diagnosis and effective care as are the biological facts of health and disease.” As patients ourselves, it is important to realize
that clinical medicine has its own culture, which varies in different local contexts and
times, and this culture is always forced to interact with the medical cultures and
expectations of patients. This dissertation project aims to contribute to a growing
awareness of the complex relationships between traditional and clinical medicine by
examining health-care in one agricultural region of Turkey. It is hoped that this project
and others like it can show that both traditional and clinical medicine provide
culturally-mediated explanations and treatments for illness, and that the cultures of all
individuals and groups involved are important in providing the best care for patients. As
in any cross-cultural encounter, the potential for misunderstanding exists alongside the
potential for new understanding. I hope that this project has described the interactions
between traditional and clinical healing practices in such a way as to facilitate
understanding on personal, inter-personal, and academic levels.

Often, as I went around the villages, I would be looked over by an elderly woman
trying to see whom I resembled. I would feel included and accepted if she exclaimed
that I looked just like so-and-so, because I knew that she was finding a way to make me
part of the family, part of the "web of mutual support" described by White (1994).
Likewise, I hope that this work will be examined by those older and wiser than I and be
found to have a family resemblance to the work of the scholars and the thoughts of the
people I like to consider as my relations. As Hufford (1995a) puts it:

Life experience must coexist and share authority with technical expertise in order for a
society to develop and maintain a rich and human view of itself and the world in which it
lives. Folk belief traditions are an enormous and invaluable resource for this process.
With the wisdom that they offer, we have the capacity to enrich our lives without
rejecting the benefits that have come with scientific and technical progress. ... the
problem of the modern world is not too much intellectual activity and reasoning, and science and rational analysis do not contradict basic spiritual beliefs. The problem is a too-narrow view of what intellectual activity is and who has the capacity to reason soundly. Folklore as a field has the capacity to help our society find more democratic ways of sharing cultural authority. (40)

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Having made my imaginary approach to Medreseönü by bus at dawn, I'd like to conclude my description of the place by sitting under the pine trees, overlooking the sea at sunset. The little hill-crest with pine trees, called Çamlık (pine-treed), is one of the few places around which is not actually cultivated. There are corn stalks, beans climbing up their poles, and fruit trees coming right up to the grassy crest, of course, but this place has its value without being cultivated. The girls have boisterous picnics here, the boys run away from their chores to flop down on their bellies and wonder what lies over the sea. Even the grownups sometimes take a stroll up here, maybe to check the sky for signs of tomorrow's weather, to remember their childhood, or to send unspoken messages to family far away. The grass is full of wildflowers because the cows are not brought here to graze. The pine trees have a special pungent smell, and give off a strange whistling moan, even in a slight breeze.

As the sun drops lower, the lights of Fatsa come on across the bay. Some small twinkling fishing boats head for harbor, while others head out for night fishing. The corn stalks rustle and mothers call to their children in the distance. The sun turns orange and swells, staining the sea.
I am here in the dusk with two of Nazmiye’s daughters. They have been asking me about America and my family. I have been soliciting their help to match name and stories with faces and families. They are patient with me and amused because my mind gets twisted up in the threads of extended family relationships and the local dialectical terms for these most important ties. They learn standard Turkish grammar and pronunciation in the local school, and can “translate” local terms for me. They are well-versed in national culture, especially the music and lives of pop stars, because their hilltop house gets good reception and they have at least five channels of TV. Their father also brings home a daily newspaper with national circulation, and they have cut out various articles about health care for me.

One of the girls asks me why I am writing a book about this place, when it will be finished, and what job I will get when I’m done. I tell her that, in America, people are curious about other cultures. That, although we have doctors and clinics and fine hospitals and all sorts of medicines, we wonder about the old ways, when people used to take care of themselves and each other. That I am looking for a kind of meaning, a closeness I find in the way an elderly village woman wants to sit up with a sick person, touching her hand, bringing her special tea, discussing what went wrong and how to remedy the problem. I want to describe the difference between the old faith that all health and all illness had a reason, that they were part of God’s plan for all people who must live and die, that they fit into a system of shared meaning — and the more recent feeling that doctors don’t really know their patients, don’t really listen to them or explain
carefully to them, that they are experts in taking money, using machines, and giving medicine, but can't explain the flame inside an old woman's chest.

The girls agree that doctors can be expensive, but they know many people who have been helped by them. They worry that I am being too conservative, not giving enough credit to modern advances. The younger sister points out that I like visiting the village, but that I wouldn't want to be stuck here. She reminds me that all the young people talk about is how they are going to get away from the mind-numbing routine of constant chores, lifting, carrying, taking the cows to graze, washing, scrubbing, harvesting, mending, with almost no cash income to show for all that work. They can't even study for school properly, with all the work there is to do -- and school or marriage are the only tickets out for the girls -- the boys can run away to work in the cities, find a job on a fishing boat, or buy a minibus and start a route along the coast road.

They're glad to help their American yenge with her project, they'd love to see a book about their little spot on the Black Sea Coast, but even more, they'd like to know if their yenge might find a way to bring them away from the village, even to America. To them, young and optimistic, the promise of modernization is a golden one. The local clinic may have some faults, but that is just because it lacks resources. If one doctor's recommendations are not helpful, there must be a better doctor, in a bigger city, whose treatments would be. The old ways are nice, comforting, more spiritual, and sometimes better, but they are fading, becoming objects of nostalgia, dying as the older generation passes away, as it must be in this age of progress.
Sitting under the pine trees on a grassy hill scattered with wildflowers, it is easy to romanticize the village. I love the fresh milk, the fruits, the vegetables, the clean air. I want my son to know his family, his language, his culture, and his place here. I haven’t seen winter in the village, I haven’t been poor, I haven’t worked hard to produce my own crops, I haven’t lost family members to childbirth, accidents at sea, infection, war, or hunger. I come for the weddings, make a show of helping out, spend some dollars, and leave before the first frost. My family and friends in Medreseönü are praying for the success of my work, they send me home with mulberry syrup, hand-knit sweaters, and advice on how to cool a feverish baby. We speak by telephone on the holidays, and they know they can call on us if some emergency arises. If I can show, through this writing, that they are actively creating, molding, changing, and improving their own health care system, so that it will continue to work for their community as it changes and grows; if I can record a well-rounded picture of village life on the Black Sea Coast of Turkey in the early 1990’s, a picture which shows real people with real concerns; if I can show that I have learned what I never would have known without becoming a part of this family, of this world; and if I can show my respect for those who taught me, then I will have really done something to make them proud.
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