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THE PROFESSIONALIZATION OF MALE CIRCUMCISION IN TURKEY

A Dissertation Presented

by

OYMAN BASARAN

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfilment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 2016

Sociology

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THE PROFESSIONALIZATION OF MALE CIRCUMCISION IN TURKEY

A Dissertation Presented

By

OYMAN BASARAN

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ABSTRACT

THE PROFESSIONALIZATION OF MALE CIRCUMCISION

SEPTEMBER 2016

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Male circumcision is seen as a cultural and religious event and a rite of passage for boys in Turkey. It is surrounded by public rituals and as there is no equivalent rite of passage for girl children, circumcision signifies a crucial marker of not only religious but also gender differentiation between boys and girls.

Circumcision is a men's affair and performing circumcision bestows economic privilege and social status on circumcisers (sünnetçi). In this dissertation, I trace the practical and discursive changes in the experience of male circumcision from the perspectives of practitioners. I argue that while circumcision was always a men's affair, the professionalization and medicalization of circumcision recast the traditional occupation as a site of public masculinity by positing credentials as a barrier to access. This class-based form of modern masculinity, in different historical periods, emphasize the ideals of rationality and science embedded within modern circumcision techniques.

My work unravels the ties between masculinity and work by examining the power relations among different groups of male practitioners of circumcision (traditional circumcisers, health officers, and specialists) mediated by their interactions with families. The medicalization of circumcision (i.e. the introduction of new definitions, values, and

knowledge into the practice) was an opportunity for each professional group (first health officers and then specialists) to claim their superiority over other groups and expand their jurisdictions. My dissertation contributes to the feminist studies focusing on the relationship between gender and (professional) work from (neo-) Weberian perspective.

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PROLOGUE

On that afternoon when I was eight years old, our Istanbul apartment was unusually crowded with our neighbors and relatives. Since my father told me that I was going be circumcised the next day, I did not quite understand why we had people over to our place a day earlier. Earlier, I was dressed in a circumcision outfit, which involved regalia that made me look like a sultan. I had also worn the costume a few days prior, when we went to visit relatives to celebrate my impending circumcision, so wearing the outfit again on that day of preparation did not strike me as unusual. My father explained that a sünnetçi (circumciser) would come over in the afternoon for a checkup to see if everything was okay in anticipation of the procedure the next day. Meanwhile, the women neighbors and relatives were cooking and preparing food in the kitchen. Adult men sat and talked in the living room.

The circumciser arrived and had me sit on the couch in the living room, while my male relatives observed. He asked me to pull down my shorts and underwear. He then applied injections on my groin and told me that he just wanted to check my penis. Within a few minutes, my penis felt numbed. They then had me lie down on the dining table, which had been covered with a sheet. I was surrounded by my father, my uncles, and my grandfather who were all holding my arms down. Women including my mother were still in the kitchen. The circumciser (a health officer) approached to the table and took out some instruments out of his black bag. The next thing I remember is the smiling face of the circumciser. My foreskin hung from the scissors he held. I was surprised and a little bit scared. People were clapping and congratulating me on my bravery while some of the older women appeared in the living room, praying Quranic verses.

My younger cousin was circumcised on the same day as me and afterward, we were placed on a decorated bed to convalesce, while still wearing our circumcision costumes. We used our fez-like blue hats (part of the costume) to cover our newly circumcised and sutured penises to protect them from being bumped or jostled. People photographed us and wanted to have their pictures taken with us too. In the evening, an imam (a prayer leader) came to our apartment to recite religious poems (Mevlid) with our relatives and neighbors present. Men and women prayed with the imam in the same room.

The ritual continued the next day. My parents and my cousin's family organized a larger and more crowded celebration in Düğün Salonu (a wedding hall).[1] My cousin and I were handed gifts of money and toys while resting on our decorated bed, which was placed at the center of the celebration. People again wanted to be photographed with us. My family and the guests danced and celebrated the important step we took toward becoming men. We were told that girls can be scared of us now, because "we were now men." Some adult men, mischievously, wanted to take a peek at our circumcised penises. We were expected to be proud of our penises and attendees asked us to show them off.

Male circumcision is a crucial rite of passage for boys in Turkey. My circumciser (sünnetçi) was a health officer, a licensed practitioner who used surgical instruments and anesthesia to perform the procedure. However, only three decades earlier, traditional circumcisers trained by apprenticeship were nearly the only practitioners who performed circumcisions and were, generally speaking, unlicensed. Traditional circumcisers did not use medical techniques or instruments. In the years since my circumcision, it is mostly

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[1] Düğün, in Turkish, literally translates as "wedding." However, it also refers to celebrations (sünnet düğünü) organized for circumcision and "düğün salonu" is an indoor venue wherein some families organize these celebrations.

medical specialists (doctors) who have come to perform the procedure. Circumcision now takes place in hospitals instead of on the dining table.

Over the course several decades, much has changed about male circumcision in Turkey even as the practice has nonetheless retained much of its religious and cultural significance, especially its role in the production of masculinity. Practitioners of the procedure and ritual are at the center of these changes. This dissertation explores the connections between the changes in the ritual and the experiences and identities of circumcisers. It traces the shifts, ruptures, and continuities in the history of male circumcision from the perspective of practitioners since the 1960s.

CHAPTER 1

INTRODUCTION

My dissertation analyzes the professionalization of male circumcision in Turkey. In a country where the majority of the population is Muslim, male circumcision is seen as a cultural and religious event and a rite of passage for boys. It is surrounded by public rituals and as there is no equivalent rite of passage for girl children, circumcision signifies a crucial marker of not only religious but also gender differentiation between boys and girls.

Circumcision is a men's affair and performing circumcision bestows economic privilege and social status on circumcisers (sünnetçi). Throughout the Ottoman era, circumcision was performed by circumcisers who were trained by apprenticeship. The activities of traditional circumcisers were embedded within patriarchal relations that appropriated boys' labor into patrilineage that promised these boys authority and prestige in the future. Traditional circumcisers who were itinerant enjoyed social recognition and economic power within the communities for whom they performed circumcisions.

With the establishment of the Turkish Republic in 1923, performing circumcision came under state surveillance. The new modern state changed the conditions under which circumcision could be performed. Only formally educated professionals became the legal practitioners introducing surgical techniques into circumcision. Traditional circumcisers were both criminalized and stigmatized for damaging the health of children. In the 1960s, under the state-led project of the socialization of health care services, health officers who were exclusive men waged struggles against traditional circumcisers and within the next two decades, these professionals gained control over male circumcision in Turkey.

The state-led professionalization and medicalization of circumcision was followed by the market-oriented professionalization and medicalization of circumcision in the 1990s. Under the neo-liberal transformation of health care services, which led to the proliferation of private hospitals, male specialists challenged health officers' monopoly over male circumcision and aimed to transfer the demands toward these hospitals. The strategy of stigmatization that health officers used against traditional circumcisers were now turned against health officers themselves: Specialists discredited health officers for damaging the health of children. And with the criminalization of health officers in 2014, specialists/hospitals gained monopoly over male circumcision.

In this dissertation, I trace the practical and discursive changes in the experience of male circumcision from the perspectives of practitioners. The professionalization of male circumcision, I suggest, was an *outcome* of institutional arrangements, adaptive symbolic means, and every day struggles through which professionals gained control over male circumcision. I argue that while circumcision was always a men's affair, the professionalization and medicalization of circumcision recast the traditional activity of performing circumcision as a site of modern public masculinity by positing credentials as a barrier to access. This class-based form of masculinity, in different historical periods, emphasize the ideals of rationality and science embedded within modern circumcision techniques. These ideals have enabled the modern practitioners belonging to professional middle-class to claim superiority over others, mark their opponents as "irrational" and "unscientific," and channel the demands toward the services they provided. The professionalization of circumcision under both state-led and market-oriented

modernization of healthcare services, in other words, restructured the practice as an exclusive site of privilege and power for modernized male practitioners.

My work unravels the ties between masculinity and work by examining the institutional, discursive, and practical changes whereby performing circumcision became a source of new types of masculinities. The medicalization of circumcision (i.e. the introduction of new definitions, values, and knowledge into the practice) was an opportunity for each professional group (first health officers and then specialists) to claim their superiority over other groups and expand their jurisdictions. My dissertation focuses on these professional groups' attempts to convert their credentials, special skills, and knowledge into social and economic rewards (Larson 1977; Witz 1992; Mac Donald 1995; Savage et al. 1995). It contributes to the feminist studies focusing on the relationship between gender and work from (neo-) Weberian perspective. The following section examines the theoretical underpinnings of the dissertation.

1.1. Theoretical Framework: Masculinity and Work

Weber's notion of social closure occupies a privileged place in both sociological theories of stratification (Collins 1979; Parkin 1979; Murphy 1988; Savage et al. 1995; Weeden 2002; Tomaskovic-Devey 1993) and professions (Larson 1977; Freidson 1970; Witz 1992; Larkin 1983; Abbott 2010; MacDonald 1995). For Weber, social closure refers to the process in which social groups seek to maximize their advantages and rewards by reducing and/or closing off the resources and opportunities to outsiders. The basis of exclusion of social closure could be any social or physical attribute such as religion, race, gender, language or credentials. Social groups aim to monopolize economic

opportunities, the endeavor coupled with the pursuit of social status, by eliminating their rivals and/or rendering them subordinate to their own control.

In the particular case of professionals, neo-Weberian sociologist, Frank Parkin (1979) who further sophisticated the theory of social closure, argues that professionals use credentials and licensure to control and monitor the entry into occupations. By doing so, these groups aimed to limit the supplies of their special services to "a limited circle of eligibles" (p. 44), increasing the market value of these services. However, as sociologists of professions argue, the supply-side restrictions are not enough for professionals to achieve monopoly in the market, as they need to create demands for these services, too. The closure activities, thus, include mobilizing *symbolic* means by which professionals shape, enhance, channel, and defend the demands for the kinds of services they are offering (Larson 1977; Abbott 2010; Weeden 2002). Closure on the sides of both supply and demand, in other words, aims to create *scarcity* of individuals who have the legal, technical, and socially recognized ability to perform certain tasks.

Professionalization is a unique form of control exercised over occupations. It shapes both the content (the demographic composition) and the form (styles and meanings) of the occupations. Professionalization introduces rational and scientific principles into the occupations and, not less frequently, empowers some men over other men and women. In the field of medicine, for instance, feminists have meticulously engaged in the question of male appropriation of women's healing skills and knowledge (e.g. midwifery and childbirth) transmitted across generations as a process intrinsic to patriarchal, capitalist, and professional domination in the eighteenth and nineteenth

centuries in the West.[2] These scholars suggest that male professional groups used medical knowledge and techniques to privilege their position within society and reaped the economic benefits of the control over medical services. This process was, in other words, based on, and did reinforce, the nexus linking masculinity and rational science (Morgan 1992; Witz 1992).

Professionalization, along with rationalization and bureaucratization, changed the nature of the traditional female activities (e.g. childbirth) by removing them out of the domestic sphere and rendering them part of the public domains of organizations (e.g. medicine). These organizations became the new sites of male dominance and privilege, producing public masculinities (Walby 1990; Hearn 1992). The notion of public masculinities suggest that men largely derive their power from their roles in the public world of capitalist and state organizations rather than in the domestic sphere as fathers and husbands (Collinson and Hearn 1994). With the rise of capitalism and modern bureaucratic state, what we witness is, in other words, the proliferation of the new sources of public masculinity.

My work contributes to this corpus of studies by tracing the changing relationship between performing circumcision and masculinity. Unlike the case of childbirth, circumcision was exclusively performed by men before it underwent medicalization, as male circumcision was seen as a men's affair. However, the form of the link between masculinity and the activity of performing circumcision did not remain the same but changed over time. On the one hand, within the era prior to medicalization, performing circumcision was a source of masculinity that derived its legitimacy from classic

[2] For instance, for witch-hunts see Federici (2004) and Ehrenreich & English (1973) and for the devaluation or even disappearance of midwifery, see Ehrenreich & English (1973), Oakley (1980), Wertz & Wertz (1989), Borst (1995), Witz 1992).

patriarchal relations based on father-son bond in the domestic sphere. Apprenticeship was the sole mode of the transmission of skills and knowledge through generations, which was built on the recognition of, and the deference to, the senior male authority. On the other hand, with modernization and professionalization, the access to medical education became the new basis of the reproduction of circumcisers belonging now to professional middle class. The activity of performing circumcision was now a site of constructing public masculinity associated with rational science as the new source of legitimacy and authority.

However, the continuities between two periods should also be emphasized. The emergence of a new form of masculinity is always founded on the subordination of women and all forms of masculinities, despite their differences from each other, contribute to the maintenance and reproduction of patriarchal relations (Morgan 1992; Connell 1995). The activity of performing circumcision remained as the basis of male privilege partly because the traditional, masculinized character of the occupation to which young women had no access in the pre-modern period was protected by the modern, gendered division of labor in medicine. The persistence of patriarchal relations in the modern employment arrangements, as we shall see, continued to exclude women from performing circumcision (Chapter 2). The Turkish state, in other words, did not dismantle but reconfigured the traditional patriarchal relations and limited the access to performing circumcision to only male professionals. My dissertation, thus, shows how the control over male circumcision became, consistently, concentrated in the male hands.

Masculinity is rather a set of practices and discourses through which (mostly) men claim to power than a series of traits which individuals, in greater or lesser amounts,

possess (e.g. physical toughness). Hence, as gender scholars argue, the traits that are not conventionally seen as masculine, such as care, tenderness, mutual concern, and sensitivity, could also be mobilized by men to claim superiority, mastery, and control (Acker 1990; Morgan 1992). Sociologist Eva Illouz (2007), for instance, argues that starting in the 1920s in the U.S., managers revised the traditional definition of masculinity and adopted what was conventionally seen as feminine attributes such as paying attention to emotions, controlling anger, and listening sympathetically to others—the process that she calls "emotional androgenization of men and women" (p. 37).

Under both state-led and market-oriented transformations of the occupation of male circumcision, the discourses and techniques of *care* (first physical and then emotional) were used by male practitioners to differentiate themselves from each other and assert the control over male circumcision. Framed within scientific discourses (first biomedical and then psychological), professionals claimed to protect the boys from the potential harmful effects of male circumcision and promote their wellbeing. Pain management, post-operative care, and the elimination of fear from male circumcision, thus, became the manifestations of care as part of the repertoire of masculine practices and a ground for constructing public masculinity.

In this dissertation, I explore how both the content and the form of performing circumcision changed since the 1960s, as the control over male circumcision moved from one group of practitioners to another. I examine both supply and demand-related strategies of social closure that the professional groups used to gain their control over male circumcision. Each wave of professionalization of circumcision, I show, emerged as an outcome of jurisdictional struggles among different groups of male practitioners and

changed the structure of the activity of performing circumcision. Following sociologist Andrew Abbott (1988), I examine these struggles on three interrelated arenas of legal system, public opinion, and everyday life.[3] I show that each professional group used or demanded legal leverage against other practitioners, spread new medicalized definitions and standards about circumcision in mass media, elicited families' cooperation for the new forms of modern circumcision and broke down the ties between families and their rivals/other circumcisers. I trace how the strategies of social closure changed the form of the work that professionals perform, as these strategies introduced new ways of performing circumcisions. I also analyze the influence of the external changes (e.g. the socialization of healthcare services, state licensure, Turkey's EU candidacy and neoliberal health reforms) in shaping the jurisdictional struggles among circumcisers/practitioners by empowering, intentionally or not, one group of practitioners over another.

Finally, my work critically addresses the question of the moral and social outcomes of the professionalization of male circumcision. I use the notion of (technical and emotional) care, as both a *strategy* and a *service*. In the former sense, the medical discourses and techniques of care are located within the competition between practitioners who aimed monopolize the field of circumcision. Professionals use medicalization as a tool to create their differences from their rivals and expand their control over male circumcision. They aim to shape the demands for circumcision and channel these demands to their own services (see Chapter 3 and 5).

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[3] In Abbott's framework, the jurisdictional struggles between professionals take place on the following three arenas: Public opinion, legal system and workplace. However, I replace workplace with everyday life for a reason that is crucial for the analysis of the first wave of professionalization of circumcision: Health officers, as we shall see, could gain the control over male circumcision only because they could move out of the temporal and spatial bounds of their work places and competed with itinerant circumcisers.

In the latter sense, I focus on the distribution of care and show how class inequalities shape the access to both technical and emotional care (see Chapter 3 and 6). Scholars pointed out the tension, if not the contradiction, between professionals' exclusionary activities for gaining monopoly over certain services and the fulfillment of the normative ideals embedded in these services (Ehrenreich & English 1973; Parry & Parry 1976; Eyal 2013). What is often seen is the correspondence between the class position of professionals and that of people whom these professionals serve and hence lack of proper service for the disadvantaged classes. Similarly, my work shows that while professional groups used medicalization as a tool for expanding their jurisdictions, the professionalization of circumcision was largely incompatible with the fulfillment of the basic promise that these groups made: The (physical and emotional) well being of children. This work shows how and why the economically and symbolically disadvantaged segments of the society in both urban and rural areas often remained deprived of proper care in circumcisions.

As Gorman and Sandefur (2011) argue, after experiencing its "golden age" in the mid-20th century, the sociological interest in professional work and its main questions about power, ethics and knowledge did not disappear yet resurfaced under different names (e.g. expert, expertise, and knowledge-based work) and emerged in other sociological subfields (e.g. work, law, medicine and organizational studies). Agreeing with Gorman and Sandefur, my work acknowledges the importance of the issues that the sociologists of professions discussed and suggests that these issues are still relevant today. We can group these issues as follows: The role of expert knowledge within society, the moral and political implications of the normative orientation toward the

service of others while pursuing economic and symbolic rewards, the complex relationships among state, professions, and market, and the power relations between different professionals. My dissertation will address all these issues in the particular case of the history of professionalization of circumcision in Turkey. More specifically, my dissertation answers the following three interrelated questions:

1- How did masculinity figure in the professionalization of circumcision?
2- Through what kinds of institutional and non-institutional means did professional groups gain the control over male circumcision?
3- To what extent did the professionalization of circumcision fulfill its normative ideals (protecting boys from the potential harmful effects of circumcision)?

Before examining my methodology in detail, in the following section, I portray the cultural, religious and political significance of male circumcision in Turkey. We will see not only how male circumcision as a rite of passage shapes men's lives but also how it plays a crucial role in both the construction and dissemination of political ideologies (nationalism and xenophobia) and the state violence against dissident and minority groups (Kurds and Armenians) in Turkey. We will also discuss the effects of medicalization on the values and meanings associated with male circumcision as a religious practice.

1.2. Male Circumcision, Masculinity, and Medicine

Male circumcision is an enormously important event for boys ranging in age from three to ten in Turkey though infant circumcisions have also been performed in large cities over the last two decades. Along with the mandatory military service and marriage, circumcision represents a rite of passage constitutive of manhood. And this manhood is associated with endurance, courage, and strength. Considering the absence of socially regulated and culturally coded rite of passage for girls in Turkey, the celebratory nature

of the event produces gender differences through elevating the boys' status symbolically from boyhood to manhood. In other words, it produces gender differences by valuing this transition for boys but not for girls.

The circumcised male body is also part of the dominant religious imagination in Turkey. Neither male nor female circumcision, according to fiqh (Islamic jurisprudence), is compulsory. The Quran says nothing about them. Instead, these practices fall under the category of "sunna acts," ones that are recommended (Bouhdiba 2006). The word used in Turkish for circumcision, "sünnet," is of Arabic origin and it means complying with the practices and teachings of the Prophet, Muhammad. Despite its non-mandatory character, however, male circumcision is widely seen as a prerequisite for being a true Muslim in Turkey. It is not, for instance, unusual to see uncircumcised old men[4] who want to get circumcised before they die since they do not want to appear uncircumcised in the presence of Allah on the Day of Judgment. Also until very recently, in the case of cross-cultural marriages where grooms were not circumcised, Turkish-Muslim families often put pressure on the grooms to get circumcised. Additionally, circumcision is also often celebrated as a religious ritual for men who want to convert to Islam. Circumcision is, in other words, (still) seen as a boundary-making practice that secures gendered construction of Muslim identities.

Before the operation, boys usually wear special outfits that are designed to elevate their status in the eyes of others as male subjects. The components of the outfit are shoes, cape, a scepter and a special hat with "Masallah", meaning "God preserves him", written

[4] It was not uncommon for Kurdish boys who grew up in the rural areas in the Eastern and Southeastern regions not to be circumcised until they became adults. One of the reasons is that since traditional circumcisers who performed circumcisions in those regions were itinerant, they did not always stay in a village long enough to circumcise all the boys. Thus, at least until the last two decades, Kurdish men were routinely circumcised in military services.

on it. Families usually take their sons to visit their relatives with their outfits on. In some parts of Turkey, boys are placed on horses and paraded around. After the operation it is customary to have gatherings where prayer leaders (imam) recite religious poems (Mevlid) with their relatives and neighbors being present. Boys may also receive gifts as rewards, or in some clinics and private hospitals even a "Certificate of Bravery" (Cesaret Belgesi) for going through the operation. Also, it is very often the case that boys are encouraged to show their circumcised penises in public as a proof of manhood. Conversely, for adult men, uncircumcised penis could be a source of embarrassment. Circumcisers mentioned to me that they occasionally circumcised adult men who were planning to get married soon.

In addition to the stories about military service, circumcision stories are widely shared among adult men in Turkey. These stories are often about the pain, fear, pride and celebration that they experienced before, during and after their circumcisions. In addition to stories about military service, exchanging circumcision stories is another example for male homosocial bonding practices that regulate man-to-man interactions in Turkey—the exchanges that exclude women/femininity (Basaran 2014).

Male circumcision is also inscribed into the histories of ethnic and religious discrimination, state and everyday violence in Turkey. The circumcised body as a sign of loyalty and obedience is part of the ordinary public and political discourses in Turkey. The phrase "uncircumcised pimp" (sünnetsiz pezevenk) is widely used on a daily basis in Turkey in order to point out the so-called "traitors" within the Turkish nation—traitors who are believed to have secret connections with Christian/Western powers. More recently, Cemil Cicek, the former Minister of Justice, implied a conspiracy between PKK

(Kurdistan Workers' Party) and Armenians by pointing out the uncircumcised bodies of dead guerillas (citation). Invoking uncircumcised bodies of "terrorists" for discrediting the Kurdish movement was the Turkish state's oft-used strategy in the 1990s—the period in which the clashes between PKK and the Turkish Army peaked. Informed by the deep-rooted xenophobia, both Kurdish movement and non-Muslims are regarded as enemies that conspire to conquer Turkey, a Muslim country. Being part of the religious imagination of the nation, the (un) circumcised body is here mobilized to create another set of political divisions, "loyal citizens" versus "terrorists" within society.

However, the above accounts portraying the cultural, political and religious significance of male circumcision in Turkey should not mislead us to overlook the changes that have taken place in the custom on the levels of both practice and discourse. Indeed, this work aims to capture the medicine-related set of transformations that the custom has undergone in Turkey. These changes manifest themselves in two interrelated ways: One is that the medicalization of circumcision incorporated the moral principle of wellbeing of children into the web of meanings, concerns and values surrounding the custom. Medical professionals, as we shall see in this work in detail, justified their intervention in the practice on the grounds of protecting children from the potential harmful effects of the operation.

Second, medicine provided the public with a new answer for the question of why male circumcision is necessary. In the post 1990s, some doctors and psychologists[5] who were against circumcision pointed out that circumcision is not compulsory for Quran. They also added that if boys take the necessary minimum hygienic measures, they do not

[5] See for instance Nil Gun (2005)

need to be circumcised. Other doctors, however, advocated for the practice on the grounds that circumcision has health benefits (e.g. the role of male circumcision in the prevention of STD transmission). This debate, as we shall see in this chapter, echoes the debate over male circumcision in the beginning of the 20th cc.

Considering the cultural importance of male circumcision for not only boys but also for families in Turkey, with a few exceptions (Cansever 1965, Öztürk 1973) the lack of academic attention to this practice is noteworthy. One of the reasons that would account for the lack of academic studies on male circumcision is the taken-for-granted status of hegemonic masculinity, which remained unquestioned for a long period of time in Turkey. However, the post-1990s witnessed the destabilization of hegemonic masculinity that had been constructed and reproduced in various institutional and non-institutional contexts. It is no surprise that it is in the same period that masculinity has emerged as a distinct focus for academia in Turkey. For instance, military service, which has been one of the most powerful institutions where hegemonic masculinity has been produced, began to draw considerable, yet still not sufficient, academic attention (Altınay 2004; Açıksöz 2012; Basaran 2014). Focusing on another crucial but understudied practice of masculinity, my dissertation contributes to the growing literature on masculinity in Turkey.

1.3. Methods

This work is an ethnographically based history of the medicalization of male circumcision and is based on the fieldwork that I conducted between 2011 and 2014 in Turkey. The aim of the research was to understand the professionalization of circumcision starting in the 1960s from the multiple perspectives of practitioners

(medical specialists, health officers, traditional circumcisers). For the fieldwork, I travelled to twenty-five cities and some of their outlying towns and villages, and conducted ninety interviews with practitioners. The selection of these cities was based on two main concerns: One was to identify the possible differences in the practices of practitioners across various regions. The second concern was to reach traditional circumcisers most of whom were populated in the villages or cities in the Eastern and Southeastern parts of Turkey. The spatial distribution of traditional circumcisers throughout the country was mainly correlated with the state-organized distribution of healthcare services since the latter determined the areas in which health officers, the rivals of traditional circumcisers, were strongly or weakly present, or not present at all.

I interviewed twenty traditional circumcisers (or also colloquially known as alaylı[6]) in various parts of Turkey, and almost all of them were over the age of 60. In the Eastern and Southeastern parts of Turkey, I talked to three groups of traditional circumcisers: *Abdals*, *Tillolular* and *Barbers*. While they all were trained by apprenticeship and were using more or less same instruments, there were also important differences among them, which are, as we shall see in Chapter 3, partly derived from their different relationships with the Turkish nationalization and modernization project. Moreover, during my fieldwork in the west part of Turkey, in which state-led health service has been prominent, I talked to traditional circumcisers who would not fall under any of these categories. In other words, in contrast to the claims of the official progressivist narrative of Turkish modernization that depicts traditional circumcisers as a homogenous (stigmatized) group, I encountered a wide variety of traditional

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[6] In Turkish, while alaylı refers to a person who has not been formally educated but learned a craft from his or her master, okullu, the term that is ocassionally used for health officers, refers to a person who has been formally educated.

circumcisers. Most of these practitioners were unlicensed and most of the licensed and unlicensed traditional circumcisers were no longer performing circumcisions. Upon their requests, I did not record my interviews with the unlicensed traditional circumcisers in order to protect their identities.

Also, I conducted sixty recorded face-to-face in-depth interviews with health officers in different regions of Turkey. Almost of all of these health officers I interviewed were Turkish, over the age of fifty and were married. They grew up in households where fathers were farmers in rural areas or working at low paying jobs in small cities, and their mothers were mostly housewives. They received their medical education in one of the following institutions: Medical schools (Sağlık Koleji), Village Institutes (Köy Enstitüsü), or in the course of compulsory military service. As we shall see in detail in Chapter 3, these institutions played an important role in the Turkish state's attempt to modernize the countryside. I also observed the circumcisions that these practitioners performed in both clinics and families' homes.

The third group I interviewed was medical specialists (urologists and surgeons, N: 12). These specialists are male and were ranging in age from 30 to 60 years. I focused on this group not only because they aimed to replace health officers but also I wanted to understand how class matters in the experience of modern circumcision (see Chapter 6). Accordingly, in addition to interviewing the specialists who perform circumcisions in high-ranked hospitals, and those who perform collective circumcisions at low-ranked hospitals, I attended many collective circumcisions that municipalities organized for the boys of "poor" families in Istanbul, the largest city of Turkey. Moving across medical

institutions that were serving both upper and upper-middle classes and lower classes helped me to understand how class figures in the organization of male circumcision.

Moreover, I interviewed fathers of the sons who were circumcised at homes, clinics and hospitals for two reasons: First, I wanted to collect information about how circumcisers used to perform circumcisions in the 1960s from their perspectives. Second, and more importantly, I aimed to understand how they perceived the changes in the organization of circumcision since their childhood. Most of these fathers were circumcised by traditional circumcisers and the meanings that they attached to the modern techniques enriched my understanding of the implications of medicalization of circumcision for the laity (See Chapter 6).

My other data collection method was archival research. I collected news and articles from mainstream newspapers from 1920s until the present, scientific publications, documentaries and official documents about circumcision. By doing so, I could grasp how the cultural significance of circumcision has changed historically and identify the discursive shifts in public discourse on male circumcision. More specifically, the central theme of *childhood* in this discourse helped me a) to link the use of new circumcision techniques to the Turkish state's general concern regarding the well being of the population and b) to frame the encounters among professional groups, traditional circumcisers and families as moral conflicts over parental authority.

1.4. The Organization of the Work

The chapters of the dissertation are organized based on two concerns: The first is to provide the accounts of the three arenas, legal, public, and everyday life, in which the two waves of professionalization of male circumcision played themselves out. The second

concern is to explore the tensions between professionalization and the normative ideals that each professional group promoted.

In Chapter 2, I examine the institutional and cultural mechanisms that established men's access to performing circumcision in both pre-modern and modern periods. I argue that by placing the task of performing circumcision within gender-segregated medical education, the Turkish state restructured the access to the occupation as a site of modern male privilege. The state replaced the family and gender based social closure of traditional apprenticeship with the credential and gender based social closure of medical education. By doing so, it provided the ground for health officers who were exclusively men to gain control over circumcision.

In Chapter 3, I examine the state-led professionalization of circumcision (1960s-1990s) from the perspective of health officers. I argue that health officers medicalized the circumcision instruments and gained control over male circumcision by rendering themselves semi-legible to the state. They aimed to break down the tie between traditional circumcisers and families while performing circumcisions outside normal working hours (mostly on the weekends) and the medical institutions (mostly at homes). By doing so, health officers converted their credentials, circumcision skills, and knowledge into monetary gains. In continuation with traditional circumcision, within the state-led professionalization of circumcision, modern circumcision thus remained within communal networks of kinship and neighborliness into which health officers integrated themselves.

In Chapter 4, I examine the practices of traditional circumcisers and how they responded to the health officers' attack on their control over male circumcision. I explore

the contradictions within the process of professionalization, and argue that the exclusive class-based professionalization of circumcision became an obstacle to the fulfilment of the promises of modern circumcision. This chapter shows how traditional circumcisers (partially) introduced modern techniques to the practice without experiencing any serious challenge from families (unlike some health officers who faced resistance) due to the trust that these practitioners accumulated over time. This proves, I suggest, that the systematic integration of traditional circumcisers via formal training into healthcare system would provide better results for achieving the wellbeing of children.

In Chapter 5, I examine the second phase of professionalization of male circumcision from the perspective of specialists. I argue that specialists (urologists, general and plastic surgeons) gained the control over male circumcision by hospitalizing the practice. Specialists discredited health officers' credentials, skills, and knowledge, associated them with forms of circumcisions that were, specialists claimed, harmful to children and aimed to channel the demands toward hospitals where they perform circumcisions. This chapter discusses the symbolic means through which specialists challenged health officers and the institutional changes that strengthened specialists' position in their jurisdictional attack on their rivals.

In Chapter 6, I examine the senior health officers' response to specialists' jurisdictional attack and argue that depending on the economic capital they accumulated over time, health officers aimed to gain the upper hand by reritualizing the custom. These health officers not only submitted themselves to the specialists' new definition of male circumcision (both practically and symbolically), but also claimed to combine "the modern" and "the tradition" and revitalized the celebratory component of the ritual—the

component that is isolated from the operation itself in the case of circumcisions at hospitals. They invoke the fundamental civilization/culture dichotomy of the Turkish nationalist ideology attuned to the consumer-centered transformation of healthcare services by engaging in a unique kind of emotional labor. This labor aims to obliterate and/or hide pain from the performance of male circumcision and bring "home" ("tradition") back to the supposedly "cold" (civilized) hospital settings for their customers.

In Chapter 7, I analyze the experiences of the poor in low-ranked hospitals where specialists perform collective circumcisions. By doing so, I aim to answer the questions of whether and how class differences shape the access to emotional care within society. I argue that while the process of the modernization of collective circumcisions organized for the poor in the post 2000s significantly improved the access of the disadvantaged families to technical care in circumcisions, which was welcomed by these families, it also produced a new form of class inequality under the conditions of neoliberal transformation of healthcare services—a form that is based on the unequal access to the emotional care in circumcisions. I claim that the concentration of the supplies of the services of male circumcision at hospitals and the changing working conditions of specialists prevented specialists from allocating enough time for maintaining the emotional care of children in collective circumcisions. The hospitalization of male circumcision, in other words, did not abolish the class inequality in access to proper circumcision services but shifted the basis of this equality from technical to emotional care.

Throughout the work we will see that throughout the history of the medicalization of male circumcision, professional groups introduced new types of medical care,

techniques, norms, and goals into male circumcision, which could be summarized as follows:

Table 1: **The History of the Medicalization of Male Circumcision**

The Five Components of Medicalization	**The State-led Professionalization** (1960s-1990s)	**The Market-Oriented Professionalization** (1990s-present)
Type of Care	Technical care (i.e. pain management and post-operative care)	Both physical and emotional care.
Type of Actors	Health officers and family as an medical auxiliary	Specialists as proxy psychologists and family as a psychological auxiliary
Stigmatized Practitioner	Traditional Circumcisers	Health Officers
Techniques	Physical techniques (i.e. local anesthesia and sutures)	Both physical and psychological techniques (e.g. communication).
Goals	Physical well being	Both physical and psychological well being

CHAPTER 2

PERFORMING MALE CIRCUMCISION, GENDER, AND THE STATE

In this chapter, I examine the institutional and cultural mechanisms that established men's access to performing circumcision in both pre-modern and modern periods. I suggest that the transition from the pre-modern to the modern practice of circumcision was part of the history of the structuring of gender divisions in healthcare. I argue that by placing the task of performing circumcision within gender-segregated medical education and gendered division of labor, the Turkish state restructured the access to the occupation as a site of modern male privilege. By doing so, it provided the ground for health officers who were exclusively men to gain control over circumcision.

In the first section, I discuss the specific configuration of patriarchal relations in which traditional circumcision was located. By doing so, we will have a better grasp of the larger social and cultural context in which circumcision skills and knowledge were transmitted. We will see why apprentices were exclusively male and how they learned circumcision techniques while serving their masters.

I will then answer the question of why the Turkish state intervened in male circumcision in the beginning of the 20th cc. I will consider the state's specific policy targeting circumcision as part of its broader agenda regarding modernizing the society. I will discuss the ideological assumptions and moral claims and concerns behind the state regulation in the field of male circumcision. This section will enable us to understand why credentials became an important basis for the access to performing circumcision.

In the third section, I will explore why and how the access to the occupation was limited to only (educated) men. We will see that the new gender order maintained

patriarchal relations in the modern medical education in a new form and excluded educated women from the field of male circumcision. This section will complete our analysis of how the modern Turkish state restructured the access to the occupation as a site of male privilege.

2.1. Classic Patriarchy and Circumcisers

Feminist scholar, Deniz Kandiyoti, calls the structure of male dominance in Turkey (and other parts of the Muslim Middle East and South and East Asia) in the pre-1950 period as "classic patriarchy" (1988). In this form of patriarchy, three generations lived together and individuals gain status with age and gender. The structural features of classic patriarchy are the patterns of deference based on age, distinct male and female hierarchies and a relative separation of their spheres of activity. The classic patriarchy appropriates women's labor and reproductive capacities by patrilineage into which they marry. In this gender order, women acquire identity only through family and the status of married woman within families is very much dependent on producing sons who would continue the male lineage. Young married women's subordination to men was the price that they had to pay in order to achieve control over younger women/brides who would take over the domestic duties in the future. Women gained access to such control in their old age through their married sons who brought their wives to the family. Having a son was, thus, critical for women to gain status and power in families.[7]

[7] It is important to note that the notion of classic patriarchy based on the systematic subordination of women should not blind us to fact that women engaged in various forms of negotiation within these patriarchal relations as well (Sirman 1991).

The code of honor played a crucial role in the reproduction of the male dominance under classic patriarchy.[8] Male honor was dependent on the purity of women within men's family including sisters, daughters, and wives (Delaney 1991). Veil, for instance, served, in men's eyes, the function of the protection of women's chastity. This patriarchal code, considerably, limited women's behavior and shaped what we could call "the gendered classification of movement." Wandering, in rural areas, was a privilege accorded to only boys/men including apprentices and women's unorganized and aimless expeditions in public were frowned upon. The activities and presence of women and their interactions with other men were, hence, under strict surveillance.[9]

The transmission of knowledge and skills for circumcision was embedded within the relations of dependence and hierarchy peculiar to classic patriarchy. The itinerant circumcisers travelled from one village to another for circumcision and during these travels, masters trained their apprentices. These apprentices held different responsibilities during circumcisions: One of the responsibilities was that the apprentices held the boys down during circumcisions. For instance, when he was old enough, Mustafa helped his father by holding the boys tight. If the boy is little, he was swaddling him. If not, he used to hold the boy in a position that has been very common in circumcision for a long time in Turkey. In this position, the apprentice has the boy in his lap, puts his arms around the boy's legs, and keeps the legs as wide and tight as possible so that the boy could not move, and Mustafa's father could circumcise him without trouble (As we shall see in the

[8] For the analysis of the persistence of classic patriarchal relations in urban areas in contemporary Turkey, see White (1994) and Sarıoğlu (2013).

[9] The gendered classification did not only exist in the rural areas where the majority of the population lived in the pre-1950s. In urban areas, up until 1980s, urban middle class married women's presence in public was very limited as well. These women who lived in modern apartment buildings were ideally expected to be at home and male doorman (kapıcı) used to do many small errands including grocery shopping (Ozyegin 2001).

next chapter, the body position of the children has changed from being vertical to horizontal, as health officers began to apply local anesthesia and use stitches. They preferred placing the boys on the floor or tables).

The other responsibility for apprentices was to carry their masters' instrument boxes, and hand the circumcision instruments to them one by one during circumcision. If there was someone else who was holding the child down, the apprentice stood near his master, followed his moves and gave him the proper tool. By doing this, he became familiar with the stages of circumcision. Traditional circumcisers used to use straight razors to cut off the foreskin. Some of them applied traditional medicine on the incision after the cutting. Traditional medicines were usually prepared in advance, and apprentices often contributed to the preparation of these medicines. Hacı Bülbül (50), a health professional told me about one of those medicines: "My father was a very popular circumciser in the South East," said Hacı Bülbül and added that his father learned this craft from his own father. However, since performing circumcision, he said, was a very stressful job, he himself never wanted to learn the craft. But he helped his father with circumcisions since he was a young child. The trade was his father's sole source of income, which, he mentioned, enabled his father to provide his children including Hacı Bülbül with education. In the summertime when the school was over, Haci Bulbul and his father Burhan Bülbül, who was also called as "Revan" for being a fast walker ("Revan" in Kurdish means "flowing smoothly"), used to travel around for months:

> There was no car and we used to go from one village to another on the top of donkeys, camels or horses. I used to get tips from the locals, which I used as school pocket money. We used to stay in village over night and then go to the other one the next day.

Hacı Bülbül and his father used to circumcise at least fifty boys at a time. Hacı Bülbül carried his father's instrument bag containing forceps that were used to remove the foreskin, a spindle for keeping the foreskin straight, a pair of scissors and a straight razor that his father used to cut the foreskin off. To stop the bleeding, his father used to prepare a special medicine combining a bitter herb (meyrankort)[10] and a small piece of bark that he and his son cut off from pine tree. Burhan Bülbül used to first crush the bark into powder and then add the herb in order to make it ready for circumcisions.

The traditional training helped apprentices to gain familiarity with the instruments and the different stages of circumcision, accumulating mostly observational experience over time. They were sometimes trained to develop manual skills by working on dummy objects substituting the foreskin. A traditional circumciser, Sobacı[11] Mehmet's father, for instance, asked him to practice on small intestines of sheep with a straight razor so that he would gain and improve his skill of cutting. After having worked on the small intestines for practice, he began to accompany his father every day, helped him, and observed the circumcisions that his father performed though he said that he never wanted to start performing circumcisions because it was too stressful.

Barbers were more advantaged than other alaylıs in improving their manual skills since straight razor was their main instrument not only for circumcision but also for shaving men. Before starting circumcising boys, barbers/apprentices usually became skillful in using the straight razor for shaving. When I asked him how he learned to use straight razor, barber Hasan mentioned another dummy object "balloon":

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[10] Meyrankort grew in the region and was also believed to be beneficial for diabetes.
[11] In Turkish, "sobacı" would translate as " a person who makes and/or sells stoves." I talked to "Sobacı Mehmet." at his stove shop that was located in one of the large cities in the West.

> I watched my master and then he asked me to invite my acquaintances or people who could not afford to pay for shaving to the shop and shave them. Also, I practiced shaving on balloons. After applying shaving foam on a balloon, I shaved the foam off of it with a blunt razor. I am 77 years old and I learned how to use straight razor when I was 15.

Once believed to have accumulated enough observational experiences, apprentices moved to the next step: Performing circumcisions on their own. The decision whether or not apprentice was ready to start performing circumcision often fell on the master. The apprentices performed his first circumcision and sometimes a couple of subsequent circumcisions with their masters being present. The masters observe these circumcisions, and give them feedback on their performance upon the completion of the circumcisions. Then they inform their apprentices that they were ready to perform circumcisions on their own. In my conversation with a traditional circumciser from a western town:

> Oyman: Did your father learn the trade from his own father?
>
> Salih: Yes, from my grandfather.
>
> Oyman: Was your father performing the circumcisions on his own?
>
> Salih: I was helping and watching him and then he said that I was ready to perform circumcisions on my own. He was with me when I performed my first circumcision. I was fifteen years old.
>
> Oyman: Was it difficult?
>
> Salih: Yes, it was hard (smiling). I even once cut my hand with the straight razor.

The transition from apprenticeship to circumciser was not, however, always a top-down decision-making process. Sometimes apprentices decided to start performing circumcisions, arbitrarily. A seventy-seven-year-old unlicensed circumciser and barber Hasan performed his first circumcision in 1963 when he was twenty-seven years old. He

was born and grew up in Malatya, one of the Eastern cities in which the encounters between health officers and alaylıs were rare. After having finished the primary school, due to financial difficulties, he said, his father sent him to a barbershop as an apprentice with the aim of having him learn what Hasan called an "art." His master used to perform circumcision, as well and he brought Hasan along to the circumcisions where Hasan carefully watched and helped his master. One day, Hasan decided to circumcise a child on his own:

> Oyman: What was your first circumcision like?
>
> Barber Hasan: One day, I was at this village and the locals asked for my master but they could not reach him. I said, "I could also do it." They asked "Hasan Usta [Master] do you know how to circumcise?" I said "yes." I lied, of course. Then I went to the house where the children were waiting for circumcision. In those times, we used to place the child on the kirve's lap and pull the curtain so that no body would see us. Anyways, I asked them to pull the curtain completely. If I started shaking, I did not want people to see it. Then they pulled the curtain. I cut them [the foreskins] off. I stayed in the village four or five days. I could not go back home. I was so scared that I dressed the wounds everyday. I was removing the bandages only to place the new ones. I fixed the children, came back home, and now I was a circumciser.

Similarly, after traveling from one village to another for years with his father, Murat decided to perform circumcision on his own without his father knowing it:

> There were Göçerler [nomads] living in tents. I circumcised one of their children without my father knowing. That was my first circumcision. I was fifteen and the boy I circumcised was older than me.

Apprenticeship as the form of acquiring embodied knowledge is not only limited to circumcision in the lives of some circumcisers. Barbers, as we said, learned their skills through apprenticeship as well. Also, if their masters extract tooth, apprentices sometimes learn that craft, too. Barber Hasan, for instance, learned how to extract tooth by watching

his master. He used pliers, and extracted the teeth without anesthesia. He did not charge people for that service although others did. He said:

> Dentists would charge the locals 80 or 100 lira. You would need at least 200 liras in order to go to a dentist from the village. People did not have that much money. I did it for free.

Moreover, within the Abdals' communities, elders showed their children how to play musical instruments, and the children practiced it over and over, again. They learned to play certain songs that would fit the moods of such events as weddings and circumcisions. One of the Abdals said: "Upon people's request, we sometimes brought musicians who played drum and shrill pipe along to the circumcisions, and the musicians got extra money."

In all these forms of training, circumcisers acquire "feel for the game" (Bourdieu 1990 p.66) for the trades by engaging in repetitive and stylized acts. The knowledge and skills are learned within an embodied process that requires commitment to the craft and obedience to the master. There is no preexisting set of abstract rules or uniform examination that consecrated the novice as circumciser in this form of learning. Clear-cut separation between *seeing* and *doing* and *theory* and *practice* did not exist either. The master serves as a "visual model" (Wacquant 2004) for the apprentice, and various physical positions that the apprentice occupies as a helper enables him to gain observational knowledge.

At the heart of apprenticeship lies *reciprocal generosity* in the form of asymmetrical relationship between master and apprentice, as it involves exchanges of time, knowledge, labor, and skills. However, the reciprocal generosity is often

crisscrossed by the masters' concern regarding controlling the flow of knowledge and skills. In diverse social settings, anthropologists have shown how the fear of training future competitors shapes artisans' unwillingness to teach their crafts. In his analysis of Cretan male artisans, Herzfeld (2004), for instance, even goes so far to claim that apprentices learn what they learn despite their masters' attitudes. In the case of these artisans, the acquisition of knowledge is often coupled with massive discouragement that is both "the instrument and object of the apprentices' socialization" (p.63).

In the case of traditional circumcisers, the master-apprentice relationship was also always fused with anxiety regarding maintaining the control over the supplies of male circumcisions because performing circumcision was a source of economic and symbolic power, and a male privilege for traditional circumcisers. The exchanges between master and apprentice thus required a careful management. Unlike in the case Cretan male artisans who employ apprentices outside their kinship members, with the exception of some barbers, master-apprentice relationship generally remained within the bounds of father-son relationship, which managed the transference of the privilege over generations. In this regard, *secrecy* sometimes played a crucial role as another control mechanism in shaping the terms of the master-apprentice bond and determining the limits of the knowledge that could be disclosed. During my research, I came across stories about how circumcisers did not tell anyone, except for their children, the recipe for the medicine they used for circumcisions. "He took his secret to the grave," a common remark I heard about these circumcisers. Also, my questions regarding circumcision techniques sometimes sparked suspicion in my informants for the same reason. Before talking to me about their techniques, some traditional circumcisers wanted to make sure that I was not

trying to learn, clandestinely, the craft from them. Or, as we shall see in the next chapters, health officers sometimes forged alliances with traditional circumcisers with the purpose of learning the trade. However, traditional circumcisers did not always respond to health officers, positively. As a traditional circumciser said:

> One day a health officer watched me performing circumcision. 'You are a master. Teach me!' said he. Allah is the Witness; I did not help him [he smiles]. I was making a living out of performing circumcision. That's why I did not teach him.

Traditional circumcisers enjoyed the economic and symbolic privilege that accompanied the activity of performing circumcision. The patriarchal father-son relationship was the main mechanism that controlled the transmission of this privilege, as young women had no access to the occupation. The cultural code of honor, considerably, restricted the movements of girls while boys had a chance for an itinerant life. Girls were seen as the future brides/mothers who would join another household/lineage in the future while boys were seen as the heirs of their fathers' both economical and symbolic assets (e.g. circumcision skills).

In traditional circumcision, two forms of social closure overlapped: Family and gender based closure. The combination of these two forms of closure limited the access to performing circumcision to men, which, in turn, reinforced the masculinized character of the occupation.[12] However, by banning unlicensed and uneducated circumcisers, the Turkish state aimed to dismantle masters' authority over the category of eligible circumciser and posited modern education, rather than apprenticeship, as the principle of

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[12] Sociologist Donald Tomaskovic-Devey (1993) separates these two moments of the genderization of occupation by making an analytical distinction between "status closure" and "status composition." While status closure refers to the processes by which gender determines who has access to jobs, status composition denotes the process by which the typical gender of a class of jobs becomes a fundamental aspect of the jobs.

the reproduction of circumcisers/practitioners. In the next section, I discuss how and why the Turkish state intervened in circumcision.

2.2. Nationalism, Modernity, and Male Circumcision

With the establishment of the Turkish Republic in 1923, the new ruling elites (e.g. military officers, politicians, bureaucrats and doctors who were internationally trained) redefined the relationships between state, society, and politics with the purpose of restructuring the very fabric of the society. These elites aimed to cultivate new identities based on: A) new institutions (e.g. conjugal family), b) new loyalties (e.g. nation-state), and c) a new philosophical ground (e.g. science and positivism). The state's top-down modernization project engendered such reforms as the abolition of the office of the caliphate and religious courts and the dissolution of the dervish orders in order to centralize and secularize the state and modernize/westernize the society.

A paradox based on the civilization/culture dichotomy was central to the construction of the new Turkish identity in the 1920s. The main ideologue of the official Turkish nationalism (Kemalism), Ziya Gökalp, made a distinction between civilization (technology, science and knowledge) and culture (a set of values and habits) and warned against the risk of over-westernization. He argues that "too much" westernization would lead to moral corruption and cultural decay. He instead proposed adopting the material aspects of the civilization of the West while protecting and developing "authentic" and "pure" Turkish national culture. The fine balance between civilization and culture became foundational to the efforts of the new Turkish state's attempts to re-organize the society in the ensuing years. It was based on this dichotomy that the new ruling elites evaluated the existing practices and ideas within society and filtered, changed and/or

eliminated them in terms of their (in)compatibility with the (imagined) Westernized civilization and/or with the (imagined) Turkish cultural identity (Kadıoglu 1996).

For the new modern secular state, the public manifestations of religion were the central concern and source of anxiety. While the ruling elites saw Islam, in principle, as part of the Turkish culture, the question of whether any religious practice would be considered as acceptable was dependent on whether they saw the practice itself as a threat to the state authority and as incompatible with the official Islam. As in the case of France, the new Turkish elites aimed to regulate Islam and brought it under state control (Kadioglu 1996; Kuru 2009). Accordingly, they banned such practices as religious healing (Dole 2004, 2012) and fortune–telling (Korkman 2014), which were, they thought, signs of backwardness and inferiority. The new national elites involving senior doctors who also enjoyed privileged position in the late Ottoman period (Salgırlı 2011; Dole 2012), in other words, aimed to demolish the unscientific and religio-political authorities by implementing social, cultural, and political reforms confining Islam to the realm of individual faith.

As part of the making Muslim identity in Turkey, male circumcision also received the attention of the new ruling elites. The Turkish state made its first regulatory attempt to bring male circumcision under control in 1928. *The Law on the Application of Medicine and its Branches* (Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun) decreed that only those graduates from Turkish faculties medicine or those with equivalent degrees approved by the Ministry of Health and Social Aid could practice medicine including circumcision. The new law redrew the juridical frontiers of male circumcision (and medicine, in general) by redefining male circumcision as a risky

medical operation and banning practitioners without medical degree and a license from performing circumcision. It established physicians and health officers as the new legal practitioners of circumcision. According to the law, unlicensed practitioners would be sentenced to between six months and two years of prison time. The state-controlled medical education, in other words, became the new basis of legitimacy for performing circumcision that was now seen as part of the health care system.[13]

The legal regulation regarding performing male circumcision was not, however, devoid of controversy, as doctors had conflicting views on the subject. Kadri Raşit Anday, Turkish pediatrician, was one of the doctors who were against male circumcision. While studying medicine in military medical school in Istanbul in 1894, Kadri Raşit Anday went to France and continued his studies in Paris with French physiologist Charles Richet. During the first years of Republic, he become involved in the debates over male circumcision and opposed it, vehemently:

> Inflammation is not a good reason for circumcision. There was no water in Arabia and our prophet was born circumcised. Europeans shower everyday. Turks are now part of the Western civilization and when you shower, you do not need circumcision (Ataseven 2005).

Another doctor, Nazım Şakir (psychiatrist) agreeing with Anday, argued for banning the practice because:

[13] Another important aspect of the law was that being "Turkish" became prerequisite for medical practitioners, which was consistent with other Turkification policies in the early Republican period. In that period, the state laws rendered formal and informal occupations (e.g. the civil servant position) inaccessible to non-Turkish subjects and since religion was the unstated yet defining core of the Turkish official nationalism, these laws had implications for non-Muslim population, as well. In the field of medicine, the gradual elimination of non-Muslims from the field, which went as far back as the late Ottoman period, gained significant momentum in the early Republic period. The ruling elites redrew the juridical frontiers of medical professional occupations in a way that favored Turkish-Muslim practitioners equipped with modern techniques and knowledge over practitioners from other religious groups.

> Circumcision is not medically necessary. Considering that there is no circumcision in the civilized nations, it would not be appropriate for us to take a step further and perform circumcisions. Both circumcised and uncircumcised men could be filthy. There are many uncircumcised Europeans who are clean. Foreskin is a gift from nature and circumcision means cutting this gift off (Ataseven 2005).

These doctors believed that if the new state wanted to make a claim for Westernization, then male circumcision as a custom had no room in the new organization of the society. Other doctors had opposite views and defended male circumcision by claiming that circumcision had health benefits. Orthopedist Orhan Abdi who studied medicine in Germany in 1900, for instance, argued that circumcision would prevent syphilis. (Ataseven 2005; Topuzlu 1934). Instead of banning the practice, these doctors proposed that the state should exercise strict surveillance against the unlicensed practitioners. Some of them also emphasized the religious significance of the practice. For the pro-circumcision doctors, the modernized form of male circumcision was compatible with the new state's goal for civilization.

The debate between doctors took a critical turn when Cemil Topuzlu, internationally recognized surgeon, brought the issue to the Turkish Medical Research Council (Türkiye Tıp Encümeni) in 1934 and delivered a presentation titled "Is circumcision necessary?" (Sünnet Luzumlu mudur?). Topuzlu studied medicine in Paris, as well and served as a Minister of Development in the late Ottoman Empire in 1919. In his presentation, he took issue with pro-circumcision arguments and argued that there is no mention of circumcision in Quran and boys could be easily taught about hygienic practices (i.e. how to clean their foreskins). He said:

> Let us focus on the hygienic aspect of circumcision. It is argued that a circumcised man does not need to worry about hygiene [temizlik]. Is this not a strange argument for avoiding personal hygiene? Do not people normally wash

> every part of their bodies one by one? Why should they not bother doing the same thing for their reproductive organs [tenasül aletleri]? Are we lower than animal in this respect? There is no reason to cut off an important part of the reproductive organ for not performing self-care once a day that would take a couple of seconds. Should we also cut off our toes so that we would not need to cut off or clean our toenails?

Although Topuzlu did not advocate for banning the practice, he recommended that the council prepare a bill prohibiting circumcision before the age of 18 and send it to the Ministry of Health and Social Aid. However, the said bill was never prepared and the debate over the necessity of circumcision gave way to problematizing the circumcision methods and instruments as a response to the reported cases of circumcision injuries and accidents. (Ataseven 2005).

The debate over male circumcision was not limited to the circle of the medical community. It also made the headlines in newspapers and ordinary commentators expressed their opinions about male circumcision in columns. What was distinctive about these comments was that pro-circumcision comments criticized the other camp for vulgarly imitating the (imagined or real) West and moving away from Islamic traditions. In both medical community and public, the debate over male circumcision was, in other words, implicated in a broader question of how to draw the boundaries between civilization and culture, the dichotomy that was constitutive of new official Turkish modern identity. As cultural anthropologist James A. Boon (1999) says “foreskins are facts-cultural facts whether removed or retained” (p.556) and the foreskins of young boys became entangled in such issues as modernization, secularism and nationalism in the early years of the Republic in Turkey.

The Turkish state neither banned male circumcision as in the case of other public manifestations of Islam (e.g. religious healing and fortune-telling) nor provided children with legal autonomy vis-à-vis parental authority. By limiting the scope of the prohibition only to practitioners but not the practice itself, the Republican elites divorced the practitioners from the practice (unlike in the cases of fortune-telling or religious healing) and redefined the practice according to the dichotomy of civilization/technique versus culture/value. In doing so, the elites not only medicalized but also *culturalized* the practice as a sign of national difference. Male circumcision was ultimately decreed as compatible with official Islam and the medicalized form of the custom was now attuned to the new nation state's modernization aspirations. Male circumcision as Islamic ritual and rite of passage for boys continued to exist in modern forms in which full parental authority over children was challenged though only in medical terms.[14]

The prohibition of traditional circumcisers was part of the Turkish state's general concern regarding the health of the population, which was damaged due to wars and infectious diseases such as malaria, tuberculosis, syphilis, and leprosy (Günal 2007). Accordingly, in this period, the new Turkish state took on the role of improving public health and of protecting the health of the nation/the population. The Turkish ruling elite was aware of the fact that low population was an obstacle to succeeding the political and economic transformation that they planned. The strong nation-state, they thought, was

[14] While circumcision became part of the national reservoir of traditions and culturalized, traditional circumcisers trained by apprenticeship found no room in the new imagination of the Turkish culture. The national discourse and the state did not recognize them either as legitimate practitioner or as folkloric figures who are part of cultural heritage. They were, rather, ahistoricized. As we shall see in Chapter 4, the dehistoricization of traditional circumcisers shaped these practitioners' self-representations, as well. These circumcisers generally adopted the modern circumcision techniques, skills and knowledge and transformed their understandings of male circumcision according to modern medical principles.

based on a healthy and fit population. The Turkish state thus re-drew the judicial boundaries of medicine and empowered formally trained practitioners over others in the early decades of the Republic. Politicians saw doctors as the agents responsible for not only improving the health of the population in Anatolia[15] but also teaching people how to live according to modern hygienic rules (Salgırlı 2015). The senior doctors welcomed the civilizing mission and considered themselves as social teachers. These doctors compared themselves to the colonial agents who were "ready to go on duty in foreign lands." (Salgırlı 2015) They would bring medicine and civilization to Anatolia and rescue people from the harmful practitioners including traditional circumcisers.

However, Anatolia, in this period, was also a territory that both senior and young doctors avoided. This was so mainly because the doctors tended to want to practice in Istanbul, the largest and most developed city of Turkey, where they could convert their skills, knowledge and credentials into economic rewards, more easily. These doctors pressured the government for licensure partly because they were in competition with herbalists in Istanbul (Salgırlı 2015). In order to solve the shortage of health personnel, the Ministry of Health and Social Aid issued a compulsory service for the graduates of the Faculty of Medicine in 1923. However, while the law enforced three years of compulsory service in a village in Anatolia, the majority of the doctors did not abide by the law. The civilizing mission that doctors adopted on the surface, in other words, contradicted their professional desires for economic power.[16]

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[15] Anatolia is the westernmost protrusion of Asia, which constitutes the majority of modern-day Turkey.
[16] As we shall see in the rest of the work, at least certain regions of Anatolia and the rural areas in general remained, more or less, as a territory to be avoided for medical professionals. However, civil servant position promising upward mobility was still a very appealing option for the lower segments of medical hierarchy (e.g. nurses and health officers) composed of the sons and daughters of peasants in the 1960s. The expansion of the medico-bureaucratic apparatus could be seen as solution, though partial, to the

In the particular case of male circumcision, the wellbeing of children was the central aspect of the biopolitical rationality that emerged in the late Ottoman period and was re-framed within modern, secular ideology in the early Republican period. The new nation state designated itself as the guardian of children (Dole 2012) and childhood came to symbolize not only purity, innocencem and spontaneity characterizing the beginning of the new young state but also immaturity, ignorance, and unproductivity. Within the rhetorical universe of the official Turkish nationalism, the child epitomized the "backwardness" of the countryside (and vice versa) and hence the new elites suggested that the health of children was too important to be left in the hands of incompetent practitioners. Thus, unlicensed circumcisers, along with other religious and unlicensed practitioners, were stigmatized, and their techniques were deemed as detrimental to the wellbeing of children. A contributor to the journal Ülkü[17], for instance, wrote:

> Altogether ignorant and foul would-be midwives have been giving birth to our mother's children and of course killing most of them… Under the name of surgery, inexperienced operators are treating wounded, sprained, and broken people, and they are leaving most handicapped…The calamities that ignorant midwives, would-be surgeons, dentist barbers, and circumcisers found in the coffee-house-corner offices have been producing for years have passed before us (1933:255).

The crucial role that the well being of children played in the dominant modern nationalist imagination led the new elites to criticize and condemn not only unlicensed practitioners but also families who were seen as potential accomplices of these practitioners in

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problem of recruitment of medical professionals—the apparatus that, as we shall see in the next chapter, led to the drastic changes in the experience of male circumcision in Turkey.

[17] Ülkü was a journal that was published by People's Houses between 1933 and 1950. These houses were opened with the purpose of educating citizens according to modern-nation principles in the early years of the Republic (Öztürkmen 1994). The main contributors were politicians, historians, linguistics and novelists.

damaging the health of children. As in the late Ottoman period,[18] the elites' cultural universe in early Republican era was marked by the idea that parents (especially mothers) were in need of education regarding hygienic health practices and *parent blaming* became an important tool for disciplining families. Within scientific and non-scientific publications (journals, novels, and magazines), the creation of new generations was conceived as dependent on the creation of new parenthood/motherhood embedded within modern, secular, and rational principles. In the case of male circumcision, the cooperation of parents with state-authorized practitioners using scientific methods was seen as necessary for protecting children from the harmful effects of the custom. Parents were, in other words, considered as both a support for implementing the state's biopolitical aim and the cause for the failure of reaching this aim.

With the technique of licensure, the Turkish state aimed to gain the control over male circumcision and define who could perform circumcisions and who could not. Male circumcision was now incorporated into medical discourse that nudged aside (though not displaced) the religious values by creating room for medical norms, knowledge, and morality centered on the wellbeing of children. Male circumcision became associated

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[18] As the modern education expanded under the reign of Sultan Abdulhamid II, new elites, "the elites of modernization age" (Karpat 2002) relying on cultural capital (i.e. modern education) emerged in the nineteenth century: "Young Ottomans" (The forerunner of the group who would be responsible for the Young Turk's revolution[18]). This group of intellectuals, novelists, progressive medical university students, playwrights and bureaucrats, not only, paradoxically, opposed the political rule of Sultan Abdulhamid II but also culturally questioned existing social practices such as traditional family forms, child-rearing practices and marriage patterns and spread ideas about rights to health and happiness (Karpat 2002; Mardin 2000; Mossensohn 2007). They brought traditional marriage patterns (arranged marriage) under critical scrutiny and proposed an alternative marriage form based on equal partnership and love as the only legitimate binding force. They saw mothers as in need of modern education because the future of the children was in their hands. There was also a growing interest in the techniques of raising and educating children (Arat 2000). Publication of children magazines increased and translations of the European children's classics became widespread. The children were now seen as the symbol of innocence, purity and naivety and must be educated in state institutions and protected from the ill effects of traditions (Göral 2003).

with the notion of risk (for children and the nation/population), entailing asking a new overarching question: How to protect the boys from the potential harmful effects of circumcision? As we shall see in the rest of the dissertation, the answers that different professional groups (health officers and specialists) gave to this question required the revision of the main components of the understandings of what constitute the optimum health of children, competent practitioner, and responsive parenting.

By licensing circumcisers, the Turkish state aimed to guarantee that the access to performing circumcision would fall under the jurisdiction of educated health professionals. However, this does not explain how and why this access was concentrated into *male* professional hands. In traditional circumcision, the father-son dependence located in class patriarchy, which excluded young women, was the mechanism that masculinized the occupation. But, one of the promises of the modern state was to drive women out of the domestic sphere and provide them with (medical) education so that they could be equal partners in marriage. How did, then, performing circumcision remain a male occupation? In the next section, I discuss how the modern gender order masculinized the terms under which professionals accessed the occupation.

2.3. From Classic to Neo-Patriarchy

The young Turkish Republic promised to abolish traditional family patterns based on the subjugation of women and improve the status of women within society. Accordingly, women were granted with equal rights with men regarding divorce, inheritance, and child custody in 1926. Women were also given the right to vote in local elections in 1934 and national elections in 1935. In 1923, free elementary education became mandatory for both sexes. As a result, compared to other countries in the Muslim world, (at least upper-

and middle class) women in Turkey began to enjoy significant civil and political rights and more visibility in public in the beginning of the 20th cc (Arat 2000).

Women's rights and reforms towards gender equality were a way of constructing a new national identity that was in opposition to the Ottoman Empire and its Islamic identity. The unveiled and educated woman was a ground on which the new state claimed to be modern. Women were encouraged to move outside the domestic sphere and gain a new non-traditional public presence. The Republican elites saw the education as a key to women liberation and equated backwardness with ignorance.

However, the presence of woman in public in the new modern gender order was still limited and strictly regulated. The civil law did not change the sexual division of labor and institutionalized women's social and economic dependence on their husbands (Arat 2000). While women were encouraged to participate in public, marriage became the main mechanism through which women became visible outside the domestic domain— the domain that basically defined women's primary responsibilities. In the field of education, for instance, vocational schools for girls, in the early years of the Republic, were designed to train the mothers of the future. These schools were specialized in home economics, child care, cooking and sewing. According to the nationalist discourse, the modern Turkish women should be not only enlightened and educated so that they, as mothers, could educate their children. But they should also be honorable, chaste, and modest so that they could be good company for their husbands. The modern appearance prescribed for women in public went hand in hand with the suppression of their sexuality as the "new veil" (Kandiyoti 1988).[19] Women, exalted as mothers, were, in other words,

[19] See also Göle (1996) and Dağtaş (2016).

citizens “only to the extent that they fulfill their role as helpers and advisors” (Sirman: 2005:164) and were seen as devoid of sexuality.

While women’s presence in public was always controversial and a major social and political concern up until the present time, men’s presence in public, more or less, remained unquestioned until the 1990s. With the formation of the Republic, a new contract was established between men and the state. While in classic patriarchy based on age-related hierarchy, eldest man/father was the most powerful man and sons were dependent on their fathers for both bride price and their future livelihood, the Republican regime offered a promise for young men. In exchange for the unconditional loyalty to the state (e.g. completing the compulsory military service) and establishing a nuclear household, men, as educated husbands, gained full sovereignty within the family and were recognized as equal participants (not dependents) in the public sphere. In the modern gender order, married men became the necessary mediator between domestic and public realms and they had control over women’s (wives’ and daughters’) interactions and activities outside the domestic realm.

Under the modern political regime, new job opportunities opened up for women especially in the post-World War II period though the patriarchal opposition to women’s paid work, which is based on the code of honor, persisted, to varying degrees, up until the present time (Ozyegin 2001). Following Michael Mann (1986), the new employment arrangements could be called “neo-patriarchy.” Mann uses this term to capture both the transformation, and the persistence of, patriarchy in capitalism. He argues that while patriarchy in Europe was peculiar to agrarian societies, it did not disappear in capitalism but underwent transformation. Under the new form of patriarchy in which women

worked in public, women's occupations became "extensions of their private domestic roles—preparing and serving food, fashioning textiles and clothes, and caring for the young, the elderly, the indigent and the infirm, in educational, health and charitable occupations" (p. 44-45). Similarly, in Turkey, women were oriented towards such jobs as teaching and nursing[20] that were seen as the continuation and derivation of their roles in the domestic spheres. The labor that women put into these jobs were, as in the case of domestic labor, rendered invisible and devalued. Although both nursing and teaching were paid activities, women's labor at these jobs was often seen as sacrifices that women made (Şimşek-Rathke 2011). The notion of sacrifice that shaped the ideological construct of modern motherhood, in other words, justified the low prestige and material rewards attached to these jobs for women.

While the job opportunities enabled women to move outside the domestic sphere and achieve upward mobility, as these women came from low-income families, the traditional male anxiety regarding these women's presence in public did not disappear. Patriarchal code of honor continued to shape the behaviors, appearances, and self-perceptions of these women. For instance, being a nurse was/is a meticulously managed female performance in the sense that nurses can neither look too "cold" and "distant," nor too "warm." This is so because, while the former would contradict the image of nurturer, the latter could make them look less honorable and modest (Şimşek-Rathke 2011). The same code shaped the division of labor at the medical institutions where health officers and nurses worked in the 1960s. Health officers who were exclusively men performed both (masculinized) administrative (e.g. budget management) and non-feminized medical

[20] Men were not allowed to attend nursing schools until 2007.

responsibilities in medical institutions, while the female agents of the auxiliary staff, nurses and midwives, were not part of the administrative apparatus. While women practitioners carried out such devalued caring duties as wound care and vaccination (health officers also carried out some of these duties in the absence of these agents), health officers often performed the official duties that required face-to-face interactions with locals (for instance, public health inspections) and (male) administrative and non-administrative authorities (e.g. muhtar[21]). Health officers were, in other words, the public face of these institutions.

In the modern period, women including female professionals continued to gain identity through family and their interactions with men were under strict surveillance. During my fieldwork, I came across only one female practitioner, a nurse (Kezban) who was attending male circumcisions. However, her attendance was based on the condition that her husband who is a health officer would perform the circumcisions. Even so, Kezban said, parents often complained about her presence as an assistant during these circumcisions. Being a man was/is the informal criterion for the access to the occupation, as the ritual of circumcision was seen as an intimate relationship between men. Health officers were the only practitioners who thus could compete with the itinerant traditional circumcisers partly because moving outside the bounds of medical institutions and interacting with other men were a male privilege and performing circumcision was culturally seen as a male occupation.

The masculinized nature of the access to performing circumcision under the neo-patriarchy became, partly, rooted in the gendered education process. Health officers, at

[21] Muhtar are elected heads of neighborhoods and villages.

least in theory, could acquire the skills for circumcision at schools while nurses had no access to these skills, as performing circumcision was not part of their job descriptions. The Turkish state aimed to dismantle masters' authority over the category of eligible circumciser and posited modern education, rather than apprenticeship, as the principle of the reproduction of circumcisers/practitioners. While within the traditional, gendered division of labor, boys had sole access to such valued occupations as being a barber or a circumciser, the job segregation by sex, which was fueled by the code of honor, prevented women from acquiring the skills and knowledge for circumcision.

In the modern period, the traditional double strategy of social closure, family and gender based, was replaced with another double strategy for accessing performing circumcision: Credential and gender based social closure. By linking the occupation with education, which was backed by the technique of licensure, the Turkish state provided the ground for professionals to gain control over male circumcision. And the persistence of patriarchal relations in educational process, which limited the life-chances of female professionals, protected the masculinized character of the access to the occupation.

However, the analysis of the gender and credential based social closure mechanisms only partially explains how health officers gained the control over male circumcision in the post 1960s. In order to fully understand the first phase of the professionalization of male circumcision, we should examine how health officers aimed to shape the demands according to modern medical principles and channel these demands toward themselves. In the next chapter, I discuss health officers struggles for the recognition of the laity.

CHAPTER 3

THE EMERGENCE OF MODERN CIRCUMCISERS (FENNI SÜNNETÇI) IN TURKEY

The coup of 27 May 1960 was an important turning point in the political history of Turkey, which gave birth to the 1961 Constitution. The new constitution introduced democratic reforms and redefined the role of the state as providing social welfare to its citizens. The new constitution saw health as a fundamental right to which every citizen should have access and the military issued *The Law on the Socialization of Health Services* in 1961, which was a turning point in the history of the medicalization of male circumcision. As part of this project, in addition to other health professionals (physicians, midwives, and nurses) state-licensed health officers, who were exclusively men, were officially appointed to various parts of the country. In their new places, most of these professionals began to perform minor medical tasks[22] including circumcision by using surgical instruments (local anesthesia and suture).

In this chapter, I examine the first phase of the professionalization of circumcision (1960s-1990s) from the perspective of health officers. I argue that health officers medicalized the circumcision instruments and gained control over male circumcision by rendering themselves semi-legible to the state. They aimed to break down the tie between traditional circumcisers and families while performing circumcisions outside normal working hours (mostly on the weekends) and the medical institutions (mostly at homes). By doing so, health officers converted their credentials, circumcision skills, and knowledge into personal monetary gains. In continuation with traditional circumcision,

[22] The other tasks that health officers performed were: measuring blood pressure, keeping medical records, carrying out administrative procedures, providing first aid, administering vaccinations, and even piercing ears.

within the first phase of professionalization, modern circumcision thus remained within communal networks of kinship and neighborliness into which health officers integrated themselves.

My analysis of fenni sünnetçi, in this chapter, claims to complicate the sociological accounts of the relationship between the state and professions. On the one hand, one of the dominant views on the state/profession relationship in the sociological literature emphasizes professional autonomy vis-à-vis the state, seeing the state as intervening and professions as seeking autonomy (Freidson 1970, Larson 1977, MacDonald 1995). This view posits autonomy as the necessary component of professional identity and assumes the existence of conflict between the state and professions. On the other hand, the sociological literature on professions pictures the relationship between the state and the profession as more cooperative, as well. Sociologists including, interestingly, the scholars who tend to see the state and professions as antithetical phenomena, also argue that professions are often dependent on the state for recognition and licensure in order to be able to compete against their rivals. According to this account, the states and professions are, in other words, still external yet not antithetical to each other, as it is the state intervention that secures professional autonomy.

These conflicting accounts of the relationship between the state and professions, I suggest, show that the literature on professions in sociology generally see the state as a monolithic, preconstituted and coherent entity.[23] It overlooks the fact that the state exercises various forms of control, including symbolic, military, political, and economic,

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[23] See Johnson (1995) for an overview of the relationship between the state and professions in sociology of professions.

without necessarily these forms being attuned to each other. Thus, this literature does not take into account the fact that states, their local and national representatives, can engage in complex, multiple, and contradictory relationships with professions and these relationships could be constructive, prohibitive or regulative depending on the local power dynamics. This chapter shows that, paradoxically, the Turkish state's top-down modernization strategy for circumcision could not have succeeded if the health officers did not make themselves semi-legible to the state and escaped its economic control. The victory of health officers against traditional circumcisers, in other words, became possible thanks to not only state-authorized licensing but also the state's loose economic surveillance over its agents.

In order to examine the first phase of professionalization of male circumcision, I first provide a brief history of health officers starting in the late Ottoman Empire. We will see that health officers occupied an important place in the states' public health policies in both the Ottoman and the early Republican period and they were at the frontier of the war against epidemics. Under the project of the socialization of healthcare service, these practitioners became also part of medical team for both preventive and curative medical services throughout the country.

The Republican regime saw education as key to the transformation of the society according to modern and secular principles and the Turkish state linked the task of performing circumcision to acquiring credentials. In the second section of the chapter, I focus on the medical education and training that health officers received at state institutions. By discussing the contradictions that health officers experienced regarding performing circumcision upon graduation, this part will show the transformative effect of

the education on the identities of health officers. We will see that the economic and cultural desirability of performing circumcision for health officers did not necessarily overlap with each other.

In the rest of the chapter, I examine how health officers aimed to both shape and capture the demands for male circumcision. I first discuss how health officers, in the 1960s, spread their claims about male circumcision in public. Health officers, as we shall see, discredited traditional circumcisers and emphasized the importance of new circumcision techniques. The medicalization of circumcision was a tool for health officers to claim their superiority over traditional circumcisers and gain the control over male circumcision. To this end, as we shall see, they used print media to spread their new definitions and craft public opinion on medicalized male circumcision.

In the last section, I move from the arena of public opinion to that of everyday life where health officers directly challenged itinerant traditional circumcisers. While the Turkish state decreed education as the legitimate basis for accessing the occupation of performing circumcision, health officers' state-authorized credentials did not automatically translate into local recognition. Some of these practitioners faced resistance and challenge from families due to the use of new surgical techniques. In this section, I examine how health officers gained locals' recognition and became part of communal networks by breaking the tie between traditional circumcisers and families.

3.1. The Brief History of Health Officers

In the late Ottoman Period, particularly under the rule of Sultan Abdulhamid II (the Hamidian period [1876-1909]), the themes of science, progress, and welfare became the new sources for the legitimacy of royal power. The security and wellbeing of the

population emerged as a governing problem by which the state gradually infiltrated into the social fields that were once out of its concern and interest. The fields of public health, child welfare and poor relief were now the sites for state control and intervention (Ozbek 2008a). Sanitation and hygiene became parts of social ties between state and subjects, as the state assumed responsibility in creating conditions that promoted the health of the Ottoman citizens. Moreover, state-controlled philanthropic activities flourished in the Hamidian period. Three important institutions were salient in this period: a poor house, Darülaceze, a hospital for children, Hamidiye Etfal Hastane-i Alisi, and an orphanage and primary school. Such welfare policies enabled Sultan Abdulhamid II to claim political legitimacy by constructing himself as a figure that promotes the happiness of the public and brought comfort to children. (Özbek 2008).

The nineteenth century Ottoman state's concern regarding the health of the population manifested itself in the regulation of practitioners, as well. During the Tanzimat period (1839-1876), known as the period of reformation, two medical schools were established: The military medical school in 1839, and the civilian medical school in 1867. While the motivation behind establishing the military medical school was to train doctors for the army, the opening of the civilian hospital was a crucial step towards the Ottoman state's involvement in the re-organization of health services. In line with the emergence of public health as a modern state apparatus, the civilian school aimed to train medical practitioners who, upon graduation, would be assigned to various regions of the Empire. From 1871 onwards, the Ottoman state began to send doctors as civil servants to the rural areas and the duty of these doctors was to treat patients and more importantly

prevent diseases (Aydin 2004). They were also expected to send reports on the medical conditions within their assigned places to the center.

By the turn of the century, the Ottoman state's efforts for regulating public health gained a new momentum. The state opened a medical school (Zabıta-i Sıhhiye Mektebi) in 1910 in order to educate students as health officers. These students received lessons about smallpox vaccine and epidemics for a year and became at the forefront of the battle against epidemics in the Ottoman Empire in this period.

The key role that health officers played in public health policies also continued in the early Republican era where these policies took national and secular form. In the post-World War I period, the ruling elites' anxiety regarding the population was at its highest due to the losses during wartime. Men either died on the war front or returned home being infected with such diseases as tuberculosis, typhus, and syphilis. The state thus sought to achieve a significant increase in the number of people who would make up the human power necessary for building powerful military and economy.

While the ruling elites aimed to increase the population with the help of pro-natalist projects, they were also concerned about the quality of the population since the strong nation-state, they thought, was based on creating a healthy and fit population.[24] Accordingly, the concern regarding the quality of the population informed the changes in the field of health care services and shaped public health policies. The Turkish state changed the name of the medical school for health officers (İstanbul Küçük Sıhhat Memurları Mektebi) in 1927 and extended the length of the education to two years (Eren & Uyer 1991). Due to the difficulties in recruiting women in the early years of the

[24] It was for instance the same period wherein eugenic concerns of procreating better Turkish future generations became vocal among these ruling elites involving doctors (Salgırlı 2011).

Republic, men who underwent largely the same training process as nurses were called "health officers" as a bulwark against the effects of feminization. These health officers were again tasked to battle against epidemics.

Health officers as civil servants were an important component of the medico-bureaucratic apparatus in Turkey.[25] The new Turkish state aimed to transform and modernize healthcare services in Anatolia and the appointment of health officers as part of auxiliary personnel was an important tool for the state to achieve its mission of "civilization." Yet, health officers were not simply the carrier of this mission. More significantly, as we shall see, if they remained loyal to the conditions and terms of their appointment, male circumcision could not be medicalized/modernized/civilized in Turkey.

The Turkish state made the task of performing circumcision as part of health officers' job descriptions. During their education, health officers were, at least in theory, expected to acquire the modern circumcision skills and knowledge, and learn how to sterilize and use surgical instruments. In the next section, I focus on the education that health officers receive in order to (partly) understand the difficulties and contradictions they experienced when they first began to perform circumcisions in their new places.

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[25] As medical sociologists and historians emphasized, there is a connection between modern states' public health policies and the ascendancy of medical professional power.[25] In the UK, for instance, in the nineteenth century, the government introduced a centralized administration in which medical professionals were incorporated into modern bureaucracy. The government's desire to improve the health of the population required a healthcare delivery system that would go beyond voluntary hospitals and the activities of individual practitioners (Larkin 1983). Similarly, in nineteenth century France, physicians insisted that they should oversee medical practice and public health. Cantonal physicians who were civil servants played a crucial role in extending the network of new medical bureaucracy and fighting against illegal healers throughout the rural France (Ramsey 1977).

3.2. Doing "Dirty" Work

Almost all the health officers I interviewed (n=60) were over the age of fifty and married. They received medical education in one of the following three institutions: Medical Schools (Sağlık Koleji), Village Institutes (Köy Enstitüleri) and Military Service. These institutions aimed to transform the countryside according to modern and national ideology, bridge the urban/rural economic, social and cultural divide and craft new modern, educated and loyal citizens (Karaömerlioğlu 1998; Altinay 2004; Basaran 2014). The practitioners who received training and licensure in these institutions were tasked not only to extend health care services throughout the country but also to inculcate in ordinary people modern dispositions and "free" them from the shackles of unlicensed/unscientific practitioners. Their services were, in other words, supplemented with their "civilizing" missions.

Almost all of the health officers I interviewed went to medical schools (Sağlık Koleji) in the 1950s and 60s. While these medical schools were first affiliated with the Ministry of Health until 1976, the Ministry of National Education, later, brought them under its own control. My informants finished their education before the transition took place. After completing middle schools, the health officers took an exam and went to boarding schools where they received theoretical education and training for either three or four years. The state met the school expenses including tuition and stipends in exchange for compulsory service upon graduation. Following the graduation, the Turkish state appointed them to various provinces and districts of Turkey where they worked at such state institutions as hospitals, health posts, tuberculosis dispensaries, provincial health directorates, and sometimes municipalities in the post-60s. Some of the health

officers were reassigned to other places within the first five years of residing in their original localities. However, at the time when I conducted the interviews, all of the interviewees had been living in the current localities for more than two decades.

Three of the health officers I interviewed graduated from “Village Institutes” (Köy Enstitüleri). Twenty-one village institutes were opened in rural areas with the purpose of bridging the urban/rural economic, social and cultural divide in the 1940s and 50s. The main motivation behind these institutions was to “educate peasants by the peasants” (Karaömerlioğlu 1988). They recruited and educated young people who were required, upon graduation, to return to towns and villages as teachers in primary schools. These teachers would give peasants basic education (e.g. reading and writing) and teach them modern farming techniques. Similar to the medical schools, a contract was made between families and the state. If students dropped out of the school, families, or their sponsors, had to pay the amount of money that the Turkish state spent for them back to the state. Although the main purpose of these institutes was to educate future teachers, the position of health officer also became an option for the students in the 1940s. After having finished the first three years of village institutes successfully, the three interviewees took an exam in order to study medicine. Like other graduates, they were on the frontier of the war against epidemics in the towns to which they were assigned.

In addition to medical schools (Sağlık Koleji) and village institutes, five health officers I interviewed received basic training in military service, and were granted permission for minor medical operations including performing circumcision. Completing military service was/is a condition for men to show loyalty to the state in Turkey. Military service produces gendered citizenship by excluding women from compulsory

military service, and offered opportunities for men to empower themselves (Altinay 2004; Basaran 2014). Having no prior medical education, my interviewees acquired their licenses in the military, and then found jobs in healthcare institutions, mostly hospitals.

During their education in the state institutions, my informants received both theoretical and practical training. They took such courses as mathematics, geometry, literature, physics, anatomy, music, biology, military and public health. During their practical training, they observed their superiors and learned how to give an injection, suture and dress wounds. Senior nurses or health officers also taught them how to administer transfusion and sometimes to perform circumcision. "Practical training started in the second year of our education. We were taking the train to go to the hospital for the training in the mornings. We used to give injection and helped the nurses. Since the nurses taught us how to do it, when I got sick, I gave myself shots" said for instance a health officer who was trained in a village institute. All health officers took theoretical courses[26] and observed their superiors and learned how to perform minor tasks.

The state institutions aimed to break with young men's pre-existing habitus and transform them into modern citizens/practitioners equipped with modern dispositions, knowledge, skills, and techniques. Health officers grew up in households where fathers were farmers in rural areas or working at low paying jobs in small cities, and their mothers were mostly housewives. Their parents either did not receive formal education at all or their education was limited to primary school. Considering the socio-economic background of their families, the civil servant position was a great opportunity for them to achieve upward social mobility.

[26] The only exception was health officers who received their licenses from military service. These health officers did not take theoretical courses though they became familiar with anatomical knowledge during practical training.

When assigned to their new places as civil servants, health officers became part of the centralized Turkish public administration. This position provided them with stable income and enabled them to enjoy the protection of generous public insurance scheme. Cut off from home and mostly educated at government expense, civil servants were expected to be loyal to the state. Their activities were/are, thus, subject to strict legal rules, regulations, and prohibitions. One of the prohibited act for civil servants is to be involved in commercial or trade activities to gain profits (Kapucu & Palabıyık 2008). The purpose of this prohibition is to ensure civil servants would use their energies and times for only public services. However, it is very common for low-level civil servants to be involved in a secondary work for additional income and local state authorities often turn a blind eye to these activities in Turkey. Thus, considering that male circumcision is very prevalent in Turkey, performing circumcision was, at least potentially, financially promising for health officers. These practitioners had a chance to use their skills and knowledge outside the legally restricted contexts and enjoyed full control over the remuneration of their services.

Accordingly, some health officers emphasized that with the help of circumcision as a source of income, they could send their children to colleges. A few of them who performed circumcision in urban areas in more developed regions of Turkey increased their economic capital (i.e. property) at considerable rate through gaining locals' acceptance. For instance, Dursun Akkoyuncu, health officer who has been performing circumcision in Bandirma, a seaside town in the West part of Turkey since 1968 said:

> My father was a shepherd. We were very poor. When I became a health officer, I could support my father. I earned a lot from this occupation. Now I have a house and I have other properties. This occupation elevated my status in society. I am very popular in Bandırma. Let me tell you what a doctor who is like a brother to

> me told me once: 'The longer you stay in a place, the more popular you could become there.' Or let me paraphrase him: you could become a brand there. May Allah not let me make a mistake. I have worked for the state for 25 years and then retired.

Despite its promising character, however, not all health officers wanted to perform circumcision and even some of those who began to circumcise children upon graduation were hesitant about it in the beginning. In the sociological literature on professions and medicalization, the professionals' desire for extending their power and converting their credentials into economic rewards is often taken for granted. Professionals are seen as groups who automatically seek to maximize their advantages within the market for their services. In the case of medical professionals, they thus can medicalize practices embedded within moral ideas and local idioms and practices and render these practices compatible with their own ideologies.

However, in our case, the profitable nature of performing circumcision did not appeal to all of these practitioners and the main reason behind their reluctance and hesitation was the commonly perceived figure of sünnetçi (circumciser) who was stigmatized for being itinerant and uneducated, and doing "dirty" work in modern-medical symbolic order (not in the eyes of locals, though). According to sociologist Hughes (1958), work can be defined as dirty in so far as the task is physically disgusting and/or a symbol of moral degradation. Health officers often described performing circumcision as "dirty work," (pis iş) referring to not only physical but also symbolic and moral aspects of the task. Since performing circumcision could potentially devalue health

officers' state-authorized professional prestige, this "dirty" work could be discouraging for some health officers.[27]

Health officers' ambivalence towards performing circumcision shows, I argue, the extent to which the medical education and the institutional prestige changed health officers' identities. Traditional circumcisers were the ones who circumcised these health officers in rural areas in which they grew up and some of these circumcisers were held in high regard in communities. Since traditional circumcisers were itinerant, families in villages sometimes provided traditional circumcisers with dinner and have them stay at their houses overnight. Only within modern medical symbolic order, these circumcisers became stigmatized—the universe into which health officers were socialized during their education. This shows, I suggest, the success of the modern medical education institutions, the "rites of institution" (Bourdieu 1991), in consecrating health officers by transforming the representation that they had of themselves.

Not all of the health officers were discouraged from performing circumcisions though. Defining their techniques as fenni (scientific), these health officers wanted to take the control over male circumcision from traditional circumcisers and win families' acceptance as sünnetçi. While the terms "fenni sünnet" (scientific circumcision) and "fenni sünnetçi" (scientific circumciser) appeared sporadically in the 1920s, they did not gain foothold until these health officers collectively represented themselves as fenni sünnetçi starting in the 1960s albeit families often referred to health officers as only

[27] A similar dynamic could be observed in the case of midwives in Great Britain in the eighteenth century as well. Historians Dorothy C. Wertz and Richard W. Wertz argue that one of the reasons that doctors in Colonial America displaced midwives after 1800 more rapidly and completely was because doctors, in Britain, did not want to be known as magicians, as midwives were performing magic as well. However, in Colonial America doctors were more willing to replace midwives since Protestantism had already settled the issue of magic effectively and promoted a cultural acceptance of new science (Wertz & Wertz 1989).

"circumciser" (sünnetçi) or occasionally "doctor." By making use of the loopholes around the regulations regarding civil servants, health officers aimed to fulfill their economic motivations for performing circumcisions.

However, it was not an easy and smooth process for health officers to create demands for their services when they first started performing circumcision in the 1960s. They often faced two problems: First, health officers' circumcision training did not provide them with a sufficient sense of confidence in practice since they had to compete against much more experienced practitioners: traditional circumcisers.[28] This placed health officers at disadvantaged position vis-à-vis traditional circumcisers who refined their skills over time.

Second, and more importantly, health officers' medical training required the use of surgical instruments (local anesthesia and sutures). The introduction of these techniques into traditional circumcision, as we shall see, changed the spatial and temporal organization of circumcision and often rendered circumcision resemble surgery in the eyes of locals. Families, frequently, expressed their discontent about these techniques. Since health officers found themselves as outsiders with no established ties with locals, they thus had difficulty translating their credentials into locals' recognition.

Health officers aimed to shape families' opinions and preferences regarding circumcision in the arenas of both public opinion and everyday life. In the next sections, I first discuss how health officers spread their claims in public and aimed to shape the demands for modern circumcision by discrediting traditional circumcisers. We will see

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[28] As sociologists argued, credentials serve more symbolic purposes than practical ones (Collins 1979; Bourdieu 1991), as they create consecrated circles of eligibles for special tasks and positions, and skills are largely learned on the job rather than during education (Collins 1979).

that health officers defined traditional circumcision as detrimental to the health of children and defended the use of surgical techniques through mainly using print media.

3.3. The Medicalization of Instruments in the 1960s

A major increase in the number of health officers occurred under the project of socialization of health care services starting in the 1960s. The Ministry of Health's plan was to centralize the health care system and establish a network of surveillance system in which health institutions and professionals would be connected to each other. Health stations and health posts were established and were linked to the health centers in the counties and hospitals in the provinces with the purpose of extending the health care services throughout the country in this period. As part of the plan, the number of health posts and health stations increased from 19 to 1, 467 and from 37 to 5,776 between 1963 and 1980 (see Table 2). While there was only one medical school for health officers in 1927, the number went up to 9 in 1960 and 37 in 1972 (Table 2). The number of health officers also increased from 3,550 to almost 10,000 between 1960 and 1970—the period in which almost all of the health officers I interviewed graduated.

In this period, health officers wanted to take the control over male circumcision by medicalizing the practice. They claimed that traditional circumcisers' methods were harmful to the health of boys and these circumcisers did not have the necessary expertise for performing circumcisions, properly. In health officers' opinion, traditional circumcisers were uneducated and hence lacked the scientific knowledge about health and the body. These unlicensed circumcisers, health officers said, caused pain in boys and did not provide them with proper post-operative care. In contrast, health officers claimed, circumcision, if done properly, was no longer a source of anxiety and fear on the

part of children as well as families if families chose health officers who used such modern instrument as local anesthesia and sutures.

Such advertising slogans as “Painless circumcision” (Acısız sünnet), “Circumcision today, trip-to-the sea tomorrow” (Bugün sünnet, yarın deniz) and “bloodless circumcision” (kansız sünnet) that health officers used became mainly popular in the 1960s and 1970s though rare presence of them could be seen in the earlier periods as well. As reported in one of the mainstream newspapers in 1977:

> “Circumcision” is no more a nightmare for children. Children who go to circumciser for circumcision cheerfully leave the place running around happily after being circumcised in the blink of an eye. Elderly men who recall the sweet yet frightening memories of their own circumcisions watch these circumcisions in awe and feel sorry that they were born too early. Owing to the new medical techniques, children noticed that they were circumcised only hours later. It is now impossible to see a child crying in front of circumcisers and children who can put their pants back on right after the operation can mingle with their friends immediately and act like nothing happened. Circumcisions from 10, 20 years ago are now history (Hürriyet July 1 1977).

The congratulatory yet exaggerating tone of the article indicates that new techniques were represented as objects imbued with “aura of benevolence” (Taussig 1993), and as means of scientific progress rescuing children from traditional circumcisions. The rhetorical universe of modern circumcision praised the new techniques for bringing comfort to children and helping them to experience circumcision as if it never happened. Circumcisions traditionally took place (and still mostly are) in the summer time in Turkey and the long recovery period often prevented boys from swimming after the operation. One of the benefits of the new techniques was to shorten the recovery period, significantly and hence to allow children not to postpone the joy of swimming. As an

article on a well-known circumciser/health officer Kemal Özkan in the same newspaper, Hürriyet stated in 1976:

> Summertime means the beginning of the time for circumcision…In the meantime, modern techniques made this religiously required practice very easy. Thanks to these techniques children get circumcised without pain. Moreover, they can play soccer or even go swimming a day after the circumcision. Kemal Özkan, the renowned circumciser in Turkey and Middle East says: "Circumcision is now a science. I can actually perform it anytime of the year" (1976 June 2).

In addition to the news about non-Muslim men who were circumcised as part of religious conversion, the collective circumcisions for the poor and the celebrations organized for the circumcisions of sons of celebrities and politicians, injuries gained visibility in media in the post-1960s. The unlicensed and/or incompetent circumcisers were blamed for these injuries and after 1970s and 1980s, government officials, health officers, and sometimes urologists began to warn families about the unlicensed circumcisers. These articles emphasized that circumcision was a medical operation that could, if not done properly, result in injuries, or even, deaths. The following are, for instance, remarks that a health officer made on unlicensed circumcisers in 1971:

> For my job, I travelled many places in Anatolia and I was horrified at seeing barbers who were performing circumcision with the same straight razors that they were using to shave beards in very bad conditions. This is a murder and must be stopped (Hürriyet).

The primary medicalized concern in the 1960s was the physical needs and the technical care of children. Health officers singled out the physical well being of children as the moral aim that both practitioners using new surgical techniques (local anesthesia and sutures) and parents agreeing to the use of these techniques could accomplish in a collaborative fashion. Not only thus practitioners but also families had to be medicalized

and turned themselves into “a dense, saturated, permanent, continuous physical environment, which envelops, maintains and develops the child’s body” (Foucault 1980 p. 172). Health officers, in other words, justified their new definition of male circumcision by referring to two negative stereotypes: Incompetent practitioner[29] who uses traditional methods that do damage to the bodies of children and “ignorant” families who choose these practitioners for their sons’ circumcisions.

As part of health officers’ closure activities, print media both produced and popularized the new discourse on male circumcision. In this discourse emphasizing the principle of the protection of the heath of children from the potential harmful effects of circumcision, health officers incorporated male circumcision into a new moral economy disguised under scientific objectivism and neutrality—an economy that aims to minimize pain and maximize happiness and comfort. In this economy, pain was no longer seen as the inevitable part of the experience of circumcision but an “isolable object” (Asad 1993) that is visible and eradicable. The use of new techniques enabled health officers to assert the role of the guards of children and claim legitimacy and superiority over traditional circumcisers.[30]

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[29] It is important to note that within the lexicon of modern circumcision, the category of “unlicensed/incompetent practitioners” did not necessarily overlap with that of “traditional circumcisers” – the practitioners who were trained by apprenticeship. There were unlicensed practitioners who first observed operations at hospitals where they worked as staff (mostly as janitors) and then began to perform circumcisions on their own outside the hospitals. However, in most of the cases, traditional circumcisers were the ones who faced criticism, hostility and stigmatization due to their “harmful” techniques.

[30] It should be noted that there were also other practitioners including religious healers whom some health officers had to challenge. Giving injections was one of the medical activities that health officers were authorized to perform, and, for instance, some health officers competed with “iğneci kadın,” women healers who used to give injections in the neighborhoods wherein they lived. However traditional circumcisers most of whom performed circumcisions illegally were health officers’ main rivals when they made appearance in their new places. Among all the medical tasks that health officers were authorized to perform, performing circumcision was, potentially, the most lucrative one.

However, health officers' efforts for recognition within communal networks were more crucial than their public presence considering the ties between traditional circumcisers and families. How did health officers gain the acceptance of locals who were familiar with traditional circumcision methods? Did all locals welcome the new circumcision techniques? Did health officers face resistance or hostility when they introduced the new techniques into the practice? In the following section, I examine the interactions between health officers and families, and discuss the changes that the new circumcision techniques brought about in the experience of male circumcision and how families perceived these changes. These changes were the following: a) the duration of the operation became longer, b) blood became invisible and c) the position of children in circumcision shifted from vertical to horizontal. The new circumcision techniques, as we shall see, blurred the line between male circumcision and surgical operation and destabilized families' understanding of male circumcision.

3.3.1. "Painless Circumcision"

> People were ignorant. A man who was bitten by a snake would go to a local healer rather than a doctor. They did not believe in doctors. A snake bit once a man's wife and I prevented him from taking her to a local healer. I told him to take her wife to a hospital, otherwise I would report him to the police.

These are the words of an 85 year-old health officer, Hüseyin Hacı who was assigned to one of the towns in the western Turkey in 1958. He received his medical education in a village institute, and was on the frontier against epidemics in the 1950s. He complained how some families preferred religious healers to him when he first arrived in his new place. Like most of the other health officers, he framed his encounters with locals, local

healers, and traditional circumcisers as struggles against ignorance. He also emphasized that families were in need of education about the principle of health and hygiene.

The trope of "ignorant people" (Cahil Halk) that Hüseyin Hacı invoked was central to the Turkish nationalist discourse. The Turkish ruling elites used this trope as a rhetorical device in their attempts to modernize the society and "rescue" people, particularly peasants from the constraints of irrational traditions.[31] It was the same trope that informed the introduction of *local anesthesia* in male circumcision. While the use of anesthesia in male circumcision goes as far back as the late Ottoman period, it took an unprecedented turn in the 1960s with the expansion of the involvement of the Turkish state in the countryside by providing healthcare services. Most of traditional circumcisers, as we shall see in the next chapter, did not use any kind of anesthesia before circumcision. Thus, traditional circumcisers were often blamed for inflicting pain on children and the use of local anesthesia was regarded as a technique that would save children from (literally) pain and (metaphorically) the shackles of tradition. Local anesthesia became a sign of scientific progress, a source of comfort, and happiness for children and the essential part of the humane circumcision. Moreover, the use of local anesthesia enabled the practitioners to have control over the children during the operation because children under anesthesia, it was assumed, would not feel pain and thus stay calm.

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[31] Anthropologist Carol Delaney (1991) who conducted fieldwork in a small Anatolian village in the 1980s made a similar observation about government officials: "The government policy of appointing outsiders in informed by a particular view of peasants, namely that they are conservative, uninterested in change and unintelligent. They must be led rather than being included as partners, and the trained outsider is sent in as the leader, the agent of chance…They [government officials] scorned the village way of life and considered villagers stupid and ignorant. The villagers were of course aware of their sentiments and resented their interference." (p.220) Of course, we need to be cautious against making sweeping generalizations about such officials.

The use of local anesthesia occasionally, however, triggered conflicts among health officers, traditional circumcisers, and families. Threatened by health officers' challenge to their control over the jurisdiction, traditional circumcisers sometimes spread what health officers called "rumors" about the new instrument: "Anesthesia was first regarded as strange. Some families refused it. Circumcisers were telling them that it would cause infertility. We tried to convince them that it was not the case though" said a health officer, Sünnetçi Kamil who began to perform circumcision in 1972 in a small town in the west part of Turkey. Other health officers also mentioned the efforts that they made to dispel such "misconceptions" about injections. Some families rejected the use of anesthesia and insisted that health officers circumcised their children without it.

Another reason that the use of local anesthesia caused discontent on the part of families was that it inevitably changed the duration of the circumcision. Compared to traditional circumcisers, the use of local anesthesia prolonged the circumcision since health officers needed much longer preparation time than did traditional circumcisers. Health officers had to wait for a few minutes before the anesthesia kicked in, and some families who were accustomed to traditional circumcisions sometimes did not welcome the wait time. What was at stake for these families was not the elimination of pain but how fast the circumcision could be performed. They invoked a different notion of care for their children, a non-medicalized one, which rendered the prolonged waiting time tedious and unnecessary. In their views, the competence of circumcisers resided rather in manual dexterity and quickness than in the use of these modern instruments. "Old circumcisers would have finished it by now!" was one of the common scornful remarks

that these families made while health officers were circumcising their sons. Again in my conversation with Hüseyin Hacı:

> Oyman: Did they [locals] let you apply local anesthesia?
>
> Hüseyin Hacı: No. I did not even try. They would beat me up if I did. We used to say 'Look your kid would not feel pain if we used it' They would not listen to you. They would not give up on their customs. They used to say 'you are too slow! What kind of circumciser are you?' They were comparing us with barbers.

Another surgical instrument that health officers introduced to male circumcision was sutures. In the next section, I discuss how families reacted to the use of this new technique in circumcisions.

3.3.2. "Circumcision Without Blood"

After cutting the foreskin off with a straight razor, most traditional circumcisers used to let the incision bleed and move on to circumcising the next child. The recovery period was long and painful. Some used ashes or special medicine that they prepared from herbs, animal dung or a piece of peeled bark from a tree in order to stop the bleeding. Within the rhetorical universe of modern circumcision, the blood released in traditional circumcision was condemned as "barbaric." Health officers opposing the traditional techniques widely began to use catgut sutures in circumcisions for two interrelated purposes: 1) to stop the bleeding after the removal of the foreskin and 2) to shorten the recovery time, and minimize the risk of complications in the 1960s. Health officers saw the catgut sutures as a proper technique for protecting boys from physical damage that traditional circumcisions could cause.

The widespread use of the catgut sutures would not be possible without the increasing availability of pharmacies throughout the country. The number of the

pharmacies increased from 556 to 1,282 between 1949 and 1961 in Turkey.[32] But the Turkish state banned the use of these sutures in 2008 in compliance with the EU rules on public health. The reason behind the prohibition was that these sutures utilized animal tissues or derivative, which could transmit bovine spongiform encephalopathy commonly known as mad cow disease. Despite what its name implies, these sutures were mostly manufactured from the intestines of goat or sheep. After the ban, the catgut sutures were mostly replaced with absorbable synthetic sutures. However, some health officers continued using catgut sutures and obtained them by using informal networks.

As in the case of local anesthesia, the technique of sutures also became a site of conflicts among health officers, traditional circumcisers, and locals. For some families, the symbolic release of blood during circumcision was, as in the ritual of sacrificing animals on Eid al-Adha, necessary. The reactions of these families towards the use of sutures could sometimes be harsh. Some health officers said that it took a few years for families to get used to stitches. "They insisted that I would not use stitches. I told them that I could make it bleed this way too but they did not let me use stitches" said a health officer who was performing circumcision in a small town in the west part of Turkey in 1964.

Moreover, traditional circumcisers, once again, used the strategy of spreading "rumors" in order to prevent families from choosing health officers. They strove to instill fears in families by subverting the biomedically informed meaning of sutures and associated it not with progress but *impotence*. Traditional circumcisers told families that by stitching the veins, health officers "stitch" their children's masculinity implying that the new technique would damage the children's penises and hence their manhood.

[32] http-//www.e-kutuphane.teb.org.tr/pdf/tebakademi/insan_gucu/7

Additionally, the use of sutures troubled some families because, like local anesthesia, it prolonged the circumcision. Once health officers cut the foreskin off with scalpel or, sometimes, thermal cautery, they identify the cut blood vessels, and stitch them up so that the vessels would not bleed. Suturing the incision was an important step of medicalized circumcision because it minimized the possible complications (i.e. inflammation and infection) that an open wound would suffer. Some health officers faced an opposition due to the extra step:

> Oyman: When you first came here, did you use sutures?
>
> Health officer: No! I am telling you, they won't even let me use local anesthesia. I was almost beaten up when I attempted to use stitches on the child. His family said "what are you doing? Be quick. Are you performing an open heart surgery?"

Or in my conversation with another health officer:

> Oyman: I am wondering how people reacted to you when you first began to perform circumcision?
>
> Health officers: Let me tell you… I was going to their houses to circumcise their children and I was telling them that I was going to use local anesthesia and sutures. Some of them objected to me. "What are you doing? Are you performing a surgery? why are you numbing it? Why are you suturing it?" I was saying "take it or leave it" [işinize gelirse]. Then they got used to them.
>
> Oyman: Why did these families not want you to use local anesthesia and sutures in the beginning?
>
> Health officer: Well you know, in the past, barbers used to just cut off the foreskin with straight razor and then leave. Maybe they were putting powder on it. That would take two minutes or even one minute. In our method, you apply local anesthesia and wait for it to kick in and then you suture the veins. It was taking eight or ten minutes. That bothered people.
>
> Oyman: Were they telling you that you were slow?
>
> Health officer: Yes, of course. I heard the question "are you performing surgery?" many times. In some villages, you know conservative [tutucu] villages, they said "circumcision is not a circumcision without blood." I was saying "what does this have to do with blood? It is good that there is no blood."

Moreover, in traditional circumcisions, the child was usually placed on the lap of someone who puts his arms around the child's legs and kept the legs as wide and tight as possible so that the child could not move and the circumciser could circumcise him without trouble. In health officers' discourse, the vertical position of children was often scornfully likened to the restraint position of animals being sacrificed for religious purposes on Eid al-Adha where butchers pinned the animals down to slaughter them. "They are children, not sheep" was one of the oft-made remarks that health officers made about traditional circumcisions.

The introduction of new techniques required a shift in the body position of children. As we shall see in detail in the next chapter, children who were circumcised used to sit on someone's lap during traditional circumcision. However, health officers had to have children lie down on a flat surface (e.g. floor, a dinner table or a portable operating table) so that they could perform circumcision, smoothly. The horizontal body position was seen as necessary because otherwise it would be very difficult for health officers to suture the incision.[33] Not surprisingly, the shift in the position of children occasionally also caused discontent for families who were accustomed to having children in vertical position in circumcisions, as it further likened male circumcision to medical operation.

[33] However, it is important to note that almost none of the circumcisions that health officers performed during my fieldwork went as smoothly as they were intended to. Children needed to be pinned down in these circumcisions as well, and sometimes I was asked to be part of it. In rare cases I took the place of family members who were not willing, or do not have the capacity (e.g. some felt too dizzy), to pin their boys down. In rare cases, I pushed the crying boys' knees down so that they would not be able to free themselves.

Both local anesthesia and sutures often became sites where different aspirations, moral values, priorities, and interests surrounding the practice of circumcision contested each other and turned into impasse for establishing a secure and stable network of the medicalization of the custom. The temporal and spatial changes that these instruments brought about in the organization of male circumcision resembled the practice to medical operation and disrupted families' *sense* of male circumcision as a ritual. Drawing on Bourdieu's theory of habitus and body, the religious studies scholar Catherine Bell coined the term "sense of ritual" through which, she says, "members of a society know how to improvise a birthday celebration, stage an elaborate wedding, or rush through a minimally adequate funeral" (Bell 1992, p.80). Ritual activities generate distinctions between what is or is not acceptable ritual and differentiate themselves from other activities by triggering the perception that they are distinct and special. Rituals derive their meaning and value from their differences from other activities, mostly mundane ones. The question of whether or not a particular activity counts as a ritual, thus, depends on the cultural context in which the activity takes places.

Similarly, in the case of male circumcision, families cultivated a sense of male circumcision vis-a-vis other rituals (e.g. animal sacrifice) that were all distinct from non-ritualistic activities. The introduction of new circumcision techniques often destabilized families' pre-reflexive grip of what circumcision is or is not by blurring the boundaries between circumcision and medical operation (hence the question "are you performing a heart surgery?") While the moral principle of the physical well being of children undergirding new techniques required the existence of certain sensibilities towards pain and blood, families often had other stakes and concerns regarding circumcision and

circumciser (e.g. manual dexterity and quickness). Considering that the ritual of circumcision, like other rituals provided families with a sense of place within moral order, it is hardly surprising that the de-ritualization of male circumcision sparked resistance, frustration, and sometimes hostility in families.

However, not all health officers faced opposition or resistance from families when they tried to perform circumcisions by using modern techniques. Health officers who were working in cities described their relationships with locals much smoother than those who were assigned to towns and villages. The former group did not mention harsh encounters with the locals. But breaking families' resistance toward the use of new technique was otherwise essential for them to take control over the practice. The medicalization of the custom required the family to adopt the role of *medical auxiliary* where parents (particularly mothers) assume moral responsibility for the post-operative care of their sons. This role was defined in opposition to "ignorant people," who were assumed to resist the progressive modern medical circumcision techniques and did not pay due attention to the physical wellbeing of their children. The Turkish state's strict strategy of licensure required the pact between parents and traditional circumcisers to be broken down and be replaced with the tie between health officers using modern techniques and the parents who were now endowed with modern sensibilities regarding circumcision.

How did the health officers who encountered resistance and hence lacked legitimacy in the eyes of families respond to the impasse they faced? What kinds of tactics did they use in order to gain the upper hand against traditional circumcisers? As sociologists of professions and social historians of medicine argue, the success of

healthcare practitioners' endeavors to build trust with the laity is largely dependent on their social characteristics rather than credentials (MacDonald 1995; Starr 1982; Witz 1992; Borst 1995; Wertz 1989). Especially in cases where medical practitioners encroached upon jurisdiction of local healers who have close ties with communities (e.g. professionalization of childbirth), making inroads into the tasks (e.g. giving birth) requires crafting respectability in the eyes of these communities.

Similarly, health officers had to negotiate the conflicting demands and requirements that they faced on the ground. While they met the traditional, gendered criterion for accessing the occupation, aka being a male practitioner, they initially lacked locals' trust. In the following section, I focus on health officers' endeavors for the recognition of the laity and discuss four distinct tactics: The rhetorical tactic of persuasion, repressive tactic (resorting to military power), compromises, and temporary alliances (I will further discuss the repressive tactic and temporary alliances from the perspective of traditional circumcisers in the next chapter). Depending on the local power relations among health officers, traditional circumcisers, and families, health officers chose one of these tactics or a combination of two or three of them.

3.4. Tactics for Recognition

One of the tactics that health officers deployed was *the rhetorical tactic of persuasion.* Some health officers put a great deal of effort into convincing families of the benefits of local anesthesia and sutures. To dispel what they call "rumors" about the new techniques, they emphasized that they work only on the foreskin, not the glans or urethra. "I was saying 'look when your arm gets scratched, does it do any damage to the function of your arm? No. So it is the same'" said, for instance, a health officer who spent a year

convincing families of why the new techniques would not cause impotence. These health officers aimed to instill modern sensibilities regarding pain in families by telling them why these techniques served the best interests of their children.

Another way of persuading families was that health officers referred to its use in tooth extracting. They told families that the purpose of the application of local anesthesia in both cases is the same: the elimination of pain. However, the analogy between these two uses had its own limits since it was not uncommon to have your teeth extracted without anesthesia in villages at that period of time. When some traditional circumcisers (especially barbers) went to a village for circumcision, they also used to serve the demands for dental work mostly for free. The lack or high cost of transportation to cities where modern dentists were located made this option convenient for peasants.

Another tactic that health officers used in their efforts to take control over the jurisdiction of circumcision was to have recourse to the military force, gendarmerie. With this force, the Turkish state aimed to control the countryside and extend their authority over provinces. It charged gendarmerie with the tasks of maintaining order and security in provinces, and of legitimizing reforms by asserting that they were acting in the best interest of local inhabitants. As we shall see in the next chapter in detail, since most traditional circumcisers performed circumcisions illegally, some health officers used their legal leverage against these circumcisers and reported them to the gendarmerie in order to drive them out of practice.

Moreover, depending on the intensity of resistance they faced, health officers sometimes avoided the rigid insistence on using the new techniques by making *compromises*. Some of them did not use local anesthesia or sutures and others cut the

foreskin off with straight razors instead of surgical instruments. This was especially true for health officers who graduated from village institutes and began to perform circumcision in the early 1950s. Such compromises were also more common at health officers' first arrival:

> Faruk (health officer): Some families first insistently demanded that I used old techniques and I sometimes complied with them so that I would not lose customers. But once these demands grew too much, I said "no."
>
> Oyman: What kind of old techniques did you use? Straight razor and herbs?
>
> Faruk: No, I did not use straight razor but I used herbs a couple of times instead of sutures. Once I switched to sutures, some families got upset. There was one family who insisted on seeing blood and when I rejected them, they just left."
>
> Or, as another health officer, Selim (62) said:
>
> We first performed circumcision with straight razor. Using straight razor was part of the craft at that time. There were circumcisers who received permission for performing circumcision. I don't know how though. They had improved their skills by performing circumcision over and over again. They were using straight razors. We struggled against them. Now those circumcisers are not performing circumcision anymore.

In addition to making compromises in the face of families' resistance, health officers also sometimes *cooperated* with traditional circumcisers when they first began to perform circumcision in some places. There were two reasons for health officers to make investment in this cooperation: One is that they wanted to benefit from the trust that families have of traditional circumcisers. Health officers and traditional circumcisers went to villages together where health officers performed circumcisions using surgical instruments and they then split the fees. Traditional circumcisers agreed to partially sharing their control over the demands with health officers because they wanted to learn

from health officers how to use modern circumcision techniques. This form of cooperation between health officers and traditional circumcisers partly accounts for how traditional circumcisers adopted modern circumcision techniques (in addition to the fact that some of them received short medical training in order to get permission for performing circumcision).

The other reason that health officers cooperated with their rivals was their insufficient experience in performing circumcision. As mentioned before, health officers often complained that the practical training in performing circumcision they received at schools was limited and they did not feel confident enough to start performing circumcision, immediately. In order to reverse this situation, some health officers accompanied and observed more experienced practitioners. A few of them worked with older and more experienced health officers. In my conversation with a health officer:

> Health officer: I did not begin to perform circumcision for a long time. Then I came here in the 1990s and went to circumcisions with another health officers as an assistant for two years. I learned how to circumcise from him. It was a master-apprentice relationship.
>
> Oyman: What did you do to help him?
>
> Health officer: He let me give injections, and I was also preparing the bandage that he was using to dress the incision. I observed him. That's how I learned.

However most of these licensed circumcisers observed traditional circumcisers. Dursun, for instance, graduated from medical school (sağlık koleji) in 1968, and he was 18 years old when he was assigned to a town in the West part of Turkey, Balıkesir, a western city where he began to work at Turkish State Railways. When I asked him how he learned how to perform circumcision, he said:

> D.A.: How did I learn? We received theoretical and practical education from our superiors, urologists at school. Also, we learned how to perform circumcision in the field.
>
> Oyman: You mean, from the circumcisers you mentioned before?
>
> D.A.: Yes. They were barbers. They had licenses and were well known here. They had many clients. You received education on circumcision, you had diploma but people preferred those circumcisers to you. I watched them performing circumcision. We thus were also doing it old style: Cut the foreskin off and then wrap it sloppily. Blood was coming out, boys were scared, we were scared, and parents were scared too. Now we are doing it new style.

Traditional circumcisers were willing to teach health officers the trade only if they did not have permission for performing circumcision. These traditional circumcisers could benefit from health officers' legal status in case they got in trouble with the gendarmerie. Otherwise they refused to help health officers since they did not want to lose the upper hand in the competition against health officers over the control of services in the field.

The range of tactics that health officers used could be grouped into two poles: At one end lie the tactics that affirm health officers' distinction from traditional circumcisers and polarize their relationship with each other, which included the rhetorical tactic of persuasion and resorting to military power. Especially in the areas where the number of health officers was high, these health officers usually chose these tactics. However, in other areas where the presence of health officers was rare, health officers mostly chose the tactics of alliances, which had an unsettling effect on health officers' claim to superiority over traditional circumcisers as well as the triumphalist and progressivist narrative of the medicalization of male circumcision. Except in a few cases, there was thus silence woven around these tactics in the narratives of health officers I interviewed. In these areas, health officers failed in dismantling the pact between traditional

circumcisers who also learned how to use modern techniques and families, and had to share the control over male circumcision with their competitors.

No matter what tactics, if any, health officers used, all of them had to imitate, to varying degrees, the itinerant character of traditional circumcisers. Although health officers as civil servants were assigned to particular workplaces (mostly hospitals) with regular work schedule (9 am-5 pm), they followed traditional circumcisers' path and visit towns and sometimes villages mostly on the weekends but without staying overnight. When health officers began to perform circumcision, the locals' recognition was, as we shall see in the next chapter in detail, territorially distributed among traditional circumcisers who accumulated it by travelling from one village to another over years. If health officers wanted to win the competition against traditional circumcisers, they had to abide by the rules of the game, which required them to submit themselves to traditional circumcisers' temporal-spatial rhythms to some extent. It was this requirement that, as we mentioned before, partly, discouraged some health officers from performing circumcisions in their new places. When I asked, for instance, Osman, a health officer why he did not want to perform circumcision in the beginning, he said: "Well, Abdals, gypsies were performing circumcision. I did not want to be called 'sünnetçi.'' And when he decided to perform circumcisions, he partly imitated traditional circumcisers and travelled to remote places for circumcisions.

Itinerancy was a male privilege that traditional circumcisers enjoyed, and the gendered reconstruction of public space combined with the state's loose economic control enabled health officers to compete with these traditional circumcisers outside the bounds of medical institutions. The crucial point is that the spatio-temporal character of

the practices of health officers/fenni sünnetçi was far from a temporary phase in their efforts towards the consolidation of their control over the practice. To the contrary, itinerancy remained a crucial part of the identity of modern circumcisers/ *fenni sünnetçi*, as it enabled health officers to have control over their additional income—the income that was unrecorded and untaxed. Although mandatory appointment system is an important technique of control and legibility that modern states use for their agents and itinerancy often poses a threat to the modern state surveillance, this chapter shows that the full application of this technique and hence the full legibility of health officers would be an obstacle to the professionalization of circumcision.

Health officers who had a legal leverage against traditional circumcisers attacked their rivals in the arenas of public and everyday life starting in the 1960s. By using print media, they strove to craft public opinion about their skills, knowledge, and credentials, and publicized a medicalized discourse on male circumcision based on new techniques (local anesthesia and sutures) and norms (the physical wellbeing of children). However, considering that almost half of the population was illiterate in the 1960s (citation), the scope of influence of printed media was limited. More important than the weapons of licensure and printed media in the jurisdiction struggles between health officers and traditional circumcisers was thus the encounters between health officers and locals. By interacting with families face-to-face, health officers replaced traditional circumcisers and broke the pact between their rivals and families. Health officers' closure activities on the sides of both supply and demand, in other words, created themselves as the sole practitioners who have the legal, technical and socially recognized ability to perform male circumcision.

Male circumcision was/is a performance conducted by men (fathers, sons and male practitioners) and health officers, as male practitioners, met the informal criterion for accessing the occupation. However, health officers did not simply rely on the cultural expectations and norms regarding the gender of circumcisers but instead re-defined them by associating the occupation with a new form of legitimacy for performing circumcision: modern education. The first wave of professionalization of male circumcision, in other words, recast the occupation as a privilege for modern male practitioners by stigmatizing, marginalizing, and criminalizing the experiential knowledge and skills peculiar to traditional circumcisers. This process led to the incorporation of performing circumcision into the gendered division of labor in medicine and strengthening the link between the occupation and modern masculinity associated with rationality and science. Moreover, the first phase of professionalization enabled, as we shall see in Chapter 4, another group of male professionals, specialists, to make jurisdictional claim over the occupation by associating it with a new set of credentials, knowledge, and skills.

How did traditional circumcisers respond to the intrusive presence of health officers? Although most of the traditional circumcisers were unlicensed prior to the 1960s, they were still performing circumcisions and they continued to perform circumcisions even after the arrival of health officers. The next chapter discusses the professionalization of circumcision from the perspective of traditional circumcisers. We will see that traditional circumcisers were not simply "victims" of this process but they tried to maintain their control over male circumcision by adopting new circumcision techniques. We will also see that the professionalization of circumcision itself was an

obstacle to the fulfillment of the promise of medicalized circumcision for the disadvantaged segments of the society. Combined with Chapter 4 and 6, the next chapter will provide us with insights about the policy implications of my work.

CHAPTER 4

THE MARGINS OF THE PROFESSIONALIZATION OF CIRCUMCISION

On a hot summer day in 2012, I accompanied a health officer licensed to perform circumcisions that was to take place at a home in one of the poorer neighborhoods in a large city. While surrounded by the immediate family members of the 7-year-old boy who was to be circumcised, the health officer first had the boy lie down on a white portable stretcher on the floor in the living room, and then habitually opened his kit containing needles, sutures, scissor, scalpel blades, and forceps. While we all were waiting for the local anesthesia he applied to the boy's groin to set in, he started chatting with the boy's grandfather, who used to illegally perform circumcisions. Although the health officer who made disparaging remarks on unlicensed/unscientific circumcisers in our earlier conversation was about to make similar remarks about him performing circumcisions illegally, we found out that the grandfather adopted the use of local anesthesia at some point and was also using non-surgical stitches. The health officers/fenni sünnetçi, Mehmet who has been performing circumcisions for over 30 years in the same location, caught by surprise, did not yet give up on making these remarks though now in milder forms.

Mehmet was also surprised by the fact that he came across a traditional circumciser since, as he said in our earlier conversation again, he never met any traditional circumciser before. When I asked him how I could contact these circumcisers, he recommended that I should try going to remote villages where traditional circumcisers might still be performing circumcisions. But it would be hard for me, he said, to find any traditional circumciser within the city that is located in central Anatolian region. He

emphasized that only health officers were, now, performing circumcisions in the city and towns.

Sünnetçi Mehmet was right in his recommendation. In most cities where health officers made strong presence, traditional circumcisers were no longer performing circumcisions. I had to travel to the outlying towns and villages in order to reach these circumcisers. The success of health officers in gaining the control over male circumcision in these areas manifested itself in spatial terms by confining traditional circumcisers who were once visible within cities to these peripheries of the cities. For professional middle classes, social mobility usually goes hand in hand with spatial mobility and these classes tend to have distinct spatial bases (Savage et al. 1995). Similarly, the activities of health officers were mostly concentrated in cities or towns, in which performing circumcision were financially promising.

The spatial bases of health officers had regional aspects as well. When I travelled to the Kurdish cities in the Eastern and Southeastern regions of Turkey where the number of health officers was very low, I found myself in different circumstances in which both licensed and unlicensed traditional circumcisers were much more accessible within cities. In these regions, I had almost no problem talking to traditional circumcisers about their practices. Some of the health officers I interviewed were first assigned to one of these cities but applied for reassignment within the first five years of their assignment for several reasons. The oft-stated reasons were that they felt like outsiders since they could not speak Kurdish or Arabic, the native languages of these regions and/or that they did not want to work under what they called "undeveloped" conditions devoid of infrastructure and basic level of comfort. The spatial concentration of health officers, in

other words, contradicted the aims of the socialization of health care services, which was intended to transform the healthcare services in the countryside.[34]

In this chapter, I examine the practices of traditional circumcisers and how they responded to the health officers' attack on their control over male circumcision. While in the previous chapter, I analyzed technical care as a strategy on the levels of both discourse and techniques, in this chapter, I ask the question of why technical care was not equally distributed within society. I argue that the exclusive class-based professionalization of circumcision became an obstacle to the fulfilment of the promises of modern circumcision. This chapter shows that traditional circumcisers (partially) in the margins[35] of the state control introduced modern techniques to the practice without experiencing any serious challenge from families (unlike some health officers who faced resistance) due to the trust that these practitioners accumulated over time. This proves, I argue, that the systematic integration of traditional circumcisers via formal training into healthcare system would provide better results for achieving the wellbeing of children.

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[34] It is crucial to note that the Turkish military wanted the project of the socialization of health care services to begin in these regions in order to solve the Kurdish question. The military framed this question as a problem of regional backwardness rather than as an ethno-political question (Yeğen 1999) and posited the socialization project as a project of struggling against the "backwardness" of Kurds and a means to incorporate/depoliticize them. The doctors were assumed to be the models of modern life and educators who would not only cure but also equip the Kurds with basic principles of hygiene and "civilize" them (Günal 2007). However, this plan, as far as these regions are concerned, was fraught with (at least) two problems: First, health professionals were generally not eager to work in these regions due to harsh living conditions. And second, health professionals in these regions often reported the problem of not being able to communicate with locals (Günal 2007). While there was an attempt to provide a language course for health professionals, it was never implemented. The state's unwillingness to provide health professionals with this course was attuned to the Turkish state's general Turkification policies that aimed to eradicate the public visibility and audibility of non-Turkish languages including Kurdish (Aslan 2009).

[35] I define the "margins" as the spaces where health officers did or could not break down the ties between unlicensed traditional circumcisers and families, and where these ties were not only protected but also redefined in a medicalized form. The margins of the state-medical authority do not necessarily overlap with the territorial peripheries of cities although unlike in Kurdish cities, health officers' struggles against traditional circumcisers largely resulted in the spatial displacements of the latter toward outlying towns and villages in other regions. In these spaces, mutually beneficial alliances and sporadic interactions, not competition, between modern medicine and unlicensed traditional circumcisers took place.

In the following sections, I first provide an account of different groups of traditional circumcisers who are, in contrast to the assumption of modern circumcision discourse, far from being homogenous. Then I examine how traditional circumcisers responded to the intrusive presence of health officers in territories where they worked. By using various tactics, as we shall see, traditional circumcisers aimed to maintain their control over circumcision and increasingly incorporated modern techniques into their repertoire.

4.1. Traditional Circumcisers

One of the groups of traditional practitioners I interviewed was the ethno-religious group called *Abdals*. Being formerly nomadic, Abdals most of whom are Alevi Turkmen are now settled in different parts of the country. However, playing music at weddings, which has been their main way of making a living, at least until very recent times, led them to live an itinerant life. Usually in summers, male musicians go from one wedding to another, and play their instruments and sing for the locals. As in the case of circumcisions, the musical skills have also been transmitted through apprenticeship, usually from fathers to sons. Clarinet, shrill pipe, cümbüş (a Turkish, twelve-string, fretless, banjo-like music instrument) and darbuka (goblet-shaped hand drum) are their most common instruments. With the growing demand for wedding halls, which usually provide bands as part of the wedding programs, Abdals have fallen from grace and have faced the risk of losing their main source of income over the last three decades.

The economic challenges that Abdals faced are coupled with, and reinforced by, their class-based cultural forms of exclusion. Abdals are subject to stigmatization due to partly their religious identity and partly their itinerant life. In public discourse, they are

likened to other stigmatized groups such as "gypsies" and "beggars," who are regarded as morally degraded. Most of Abdals are Alevis, a religious minority who has faced discrimination in both the Ottoman Empire and the Turkish Republic.[36] For a long time, Abdals were also excluded from compulsory military service (Yörükan 1998, p.108). The Abdals whom I interviewed also often mentioned that they encountered difficulties finding jobs in public or private sectors due to their stigmatized identity.

Until recent times, in addition to musical performance, performing circumcision has been another source of income for Abdals. Most of my interviewees learned the craft from their elders, usually their fathers. The circumcisers I interviewed did not receive formal education partly because until the last few decades, Abdals used to see formal education as a waste of time, and instead encouraged their children to learn a trade (e.g. playing a musical instrument). Performing circumcision was seen as an important skill that men/boys could acquire, and make a living out of it. However, similar to the process of the recent devaluation of their musical skills, with the increasing presence of medical professionals, circumcision as a source of income is no longer an option for the younger generations. Wedding halls (Düğün Salonu) were again one of the common venues where health officers used to perform circumcisions.

Another group of circumcisers I talked to was *Tillolular* (circumcisers from Tillo). Tillo is a district of Siirt located in southeastern Turkey. As part of the Turkification policies that required the names of cities, towns and villages to be derived from Turkish words, the name of Tillo was changed to Aydınlar in 1964 and remained so

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[36] Despite the secular reconstruction of the polity and of state-society relationship in the post-Ottoman period, religion remained as one of the important symbolic sources for the national imaginary in Turkey. The Turkish state aimed to control religion by positing Sunnism, the largest branch of Islam, as the true Islam, and hence Alevis have experienced physical and symbolic forms of both state and mass violence, ranging from discriminatory policies to massacres throughout the history of Turkish Republic.

until 2013. Known as "the center of the holy ones" the name of Tillo is derived from Arabic *Tall*, "hill, elevation" (Lahdo). Until very recently, the population was composed of Arabic-speaking people while the majority of the inhabitants are now Kurdish. A flow of immigration from Siirt to larger cities such as Istanbul, Ankara and Van has occurred over the last three decades due to the decreasing number of available jobs and the war between PKK (Kurdistan Workers' Party) and the Turkish army, which peaked in the 1990s.

Until the 1980s, circumcision was the main source of income for the majority of men in Tillo. To perform circumcision, Tillolular, trained by apprenticeship were travelling not only to various parts of the eastern and southeastern Turkey but also Iraq and Syria for months, mostly, on foot. And they were called "wanderers." However, the wars (the war between PKK and the Turkish army, and the Iraq War) limited the geographical scope of their activities, considerably. As a result, the number of circumcisers from Tillo has decreased over the last decades. Unlike Abdals and, as we shall see, barbers, circumcision is the only activity that Tillolular engaged in for a living.

The third group of alaylıs I interviewed is *barbers*. Barbers were also trained by apprenticeship. As an apprentice, they first helped their masters during circumcisions and then began to perform circumcision on their own—the same masters from whom they learned the craft of being a barber. In addition to circumcising children and working as a barber, some of them also used to extract teeth without using anesthesia. Barbers were seen as doctors in some parts of Turkey (e.g. Adıyaman) until the early 20th century.

Except *Tillolular,* all the traditional circumcisers engage in other trades and businesses: Some are barbers, musicians, carpenters or farmers and others own small

shops (e.g. stove shops). While health officers differentiate themselves from the stigmatized type of traditional circumcisers who are often called as "Abdals" in a derogatory way, there are also axes of demarcation within traditional circumcisers, themselves. Both barbers and Tillolular, the followers of Sunni Islam, carefully differentiate themselves from Abdals. When I asked barbers, for instance, whether or not they travelled around to perform circumcision, some were troubled with the possibility of being mistaken for Abdals and emphasized that they work only by appointment. Similarly, when I asked Tillolular whether or not they played music in circumcisions, they often said, "No, we are not Abdals! We only perform circumcisions." Tillolular put a special emphasis on their understanding of performing circumcision as a pious and exclusive activity and most of them proudly told me that they were descendants of saints who once lived in Tillo.

There were, however, traditional circumcisers who would not fall under any of the categories outlined above. During my fieldwork in the west part of Turkey, in which state-led healthcare services were prevalent, I could contact a few traditional circumcisers most of whom were no longer performing circumcisions. All the traditional circumcisers across different regions, more or less, used similar instruments even before they contacted modern medicine starting in the 1960s. They performed circumcisions in distinct territories that were partitioned according to locals' demands. These practitioners used to travel from one village to another often on foot, sometimes on mules or rarely by train. Depending on the distance between two villages, they sometimes stayed in a village over night before moving to the next one. Some used to spend the night at one of the families' houses or mosques. "Those were times of hardship," said one of the

circumcisers after mentioning that he and his father were very poor and they used to walk from one village to another to perform circumcisions. The emphasis on the hardship that they went through was one of the main themes in these circumcisers' accounts about their past.

Due to the territorial partitioning among circumcisers, some circumcisers moved between cities. As a traditional circumciser became known in a certain area over time, he usually preferred settling in that area in order to diminish the travel cost and eliminate the burden of travelling long distance. The territorial partitioning was especially significant among circumcisers from Tillo. Most of these circumcisers I interviewed were not located in Tillo because they were settled in cities where they used to go for circumcisions (e.g. Mardin and Batman). These circumcisers are usually careful in not encroaching on each other's territory though a case of conflict between two circumcisers from Tillo arose in one of the interviews.

Engaging in other trades helped some of the circumcisers to expand their circles as well. "No one would trust me if I was not a barber. It is important to be a tradesman [esnaf] " said one of the barbers, Hasan. Since families knew him as a barber, they, he said, trusted his skills. Usually families contacted barbers for circumcision through barbers' customers who used to come to their shops, regularly. Similarly, locals knew Abdals for their primary trade of being musicians since Abdals used to go to weddings in villages.

Families compensated traditional circumcisers for their services in non-standardized monetary form or pay them in kind. The typical procedure of exchange was the following: once circumcision was over, the circumciser himself or the apprentice

walked around holding a tray and collected money from the child's families and relatives. If the family cannot afford paying the circumciser in cash, the circumciser might receive such small gifts as a chicken or a shirt. There was no pre-established standard for the compensation. The standardized monetary form of compensation became more common in the case of circumcisions that health officers performed starting in the 1960s.

As we saw in Chapter 2, the new nation state culturalized (and tamed) male circumcision by modernizing the practice and excluding traditional circumcisers from the modern national order in the beginning of the twentieth century. Traditional circumcisers were largely banished from the practice and were deemed unworthy of being part of the new state's invented tradition. The power of this modern and national rhetoric was obvious when I was trying to reach Abdals in Kırşehir. The city is located in the central Anatolian region in which Abdals were well known for their musical activities, both nationally and internationally. Neşet Ertaş, the most prominent Abdal musician/folk music singer, for instance, was born in Kırşehir. He started his career as a musician attending weddings and after acquiring fame, he performed folk songs (türkü) for the national public broadcaster (TRT). TRT also periodically broadcasts concerts of groups of Abdal musicians. Abdals are, in other words, folklorized for their musical activities and are part of the cultural stage of the nation.

However, this was not true for their circumcision activities. In Kırşehir, I was advised to contact the head of a culture center where he (Mustafa) managed a cultural heritage project of documenting the history of city. Mustafa was surprised to heat that I was interested in interviewing traditional circumcisers. After providing me with a brief description of the cultural heritage project, which included Abdals for their musical

talents, he added “we actually never thought about talking to Abdals about their circumcision practices [pause] maybe we should.” I received a similar reaction from Kamil, licensed traditional circumciser, to whom Mustafa introduced me. Kamil decided to quit performing circumcisions after he started working for the Ministry of Culture and Tourism as a musician. When I asked him if he would agree to talk to me about circumcision, he sounded surprised as well:

> Look, they did all the researches about culture, Abdal traditions, and music. Even foreign researchers came and talked to me. They all asked me about the musical instruments that I was playing. But circumcision [pause] it is the first time that someone wants to talk to me about circumcision.

This shows, I suggest, the success of the symbolic violence that the national discourse exerted upon traditional circumcisers. While Abdals as musicians were part of the cultural representation of the national difference, they, as circumcisers, were rendered invisible and incompatible with the meticulously managed official modern national identity. Although, as we saw, traditional circumcisers are far from being homogenous but differentiated along ethnic and religious lines, the modern national discourse placed these circumcisers under the category of ineligible/cruel practitioners.[37] Their skills and knowledge as circumcisers were/are not even seen as worthy of being folklorized/culturalized while modernized circumcision was/is seen as part of the reservoir of representations of Turkish culture.

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[37] The most crucial component of the representation of traditional circumcisers in modern national discourse was that traditional circumcisers were not concerned about the health of children and more specifically about pain and post-operative care in circumcisions. As we saw in Chapter 2, this was not entirely true. Traditional circumcisers often used herbal medicine for post-operative care and sometimes sterilized their instruments. However, it would not be wrong to say that they did not address pain or post-operative care as systematic as did health officers.

How did traditional circumcisers respond to the intrusive presence of health officers within their territories? As we saw in the previous chapter, few traditional circumcisers spread “rumors” associating the use of new instruments with impotence and infertility. These traditional circumcisers wanted to maintain their control over male circumcision without changing their practices. However, traditional circumcisers increasingly adopted, rather than rejecting, the modern techniques, norms, and knowledge over time. In addition to the non-systematic incorporation of traditional circumcisers into the health care system, an option that was hardly available after 1960s, and both alliances and sporadic encounters between unlicensed traditional circumcisers and healthcare professionals account for how traditional circumcisers, to varying degrees, adopted the modern techniques.

However, before examining why unlicensed traditional circumcisers adopted the new techniques and how modern circumcision changed traditional circumcisers in both practical and discursive levels, in the following section, I discuss health officers’ another tactic: Having recourse to military power. Licensure is the most effective strategy of social closure in limiting the supplies of services, and starting in the 1960s, combined with the state’s loose economic control over the activities of civil servants, licensure helped health officers to convert their credentials into economic rewards. This technique gave health officers legal leverage and more specifically, enabled them to have recourse to military power against traditional circumcisers. Using this weapon, health officers aimed to break down the tie between traditional circumcisers and families. How did the technique of licensure play itself out in the encounters among traditional circumcisers, health officers and families? How did traditional circumcisers respond to their

criminalized status? How did they negotiate with the military authority? In the next section, I answer these questions by taking a closer look at the interactions among unlicensed traditional circumcisers, surveillance authorities, health officers, and families.

4.2. State Surveillance and Traditional Circumcisers

Like in Europe (Ernsley 1999), the gendarmerie (jandarma) has been essential to modern state formation in both late Ottoman Empire and Turkish Republic since the 19th cc. The Ottoman bureaucrats aimed to extend their authority over provinces (Özbek 2008b) by charging gendarmerie with the tasks of maintaining order and security in provinces. They sought to "legitimize reforms by asserting that they were acting in the best interest of local inhabitants, although they did not pay particular attention to indigenous suffering" (Özbek 2008b, p. 49). Gendarmerie, in other words, was an important tool for the state to gain, in Weber's sense, the monopoly over the legitimate use of violence in rural areas.

Gendarmerie was also a crucial figure in exercising surveillance over alaylıs in the post-1960s in Turkey. In some parts of Turkey, especially after the 1980 coup d'eta gendarmes tightened the control mechanisms, and, significantly, limited traditional circumcisers' activities. Some health officers used their leverage stemming from their legal status against these circumcisers and reported them to the gendarmerie. Traditional circumcisers were occasionally brought to the court and while a few of them were arrested, others paid fines. A traditional circumciser, Bayram (64) for instance, mentioned conflicts with state authority in this period. It was his father who taught Bayram how to circumcise children and his father got a license after having performed a couple of circumcisions under the surveillance of the medical experts at a hospital in 1960s. But he himself was unlicensed, which got him into trouble with authorities in the

past. Upon health officers' complaints, he said, he was first taken to the police station, and then brought to the court a few times in the 1960s. He was once sentenced to fifteen days of jail time but since he had no previous convictions, he served none of it and continued performing circumcision, secretly.

Another traditional circumciser (Abdal), Ahmet (65) who performed circumcisions for 45 years had also trouble with gendarmerie in the past. I talked to him in a small village located eighty kilometers (50 miles) away from a small city in central Anatolian region. He began to circumcise children after he got married in 1967. He circumcised his sons and grandsons as well. He learned how to perform circumcision from his uncle with whom he used to go to circumcisions. He said that he also sometimes played musical instruments during the circumcisions without having any kind of written notation. "We learned the repertoire through oral transmission [kulaktan dolma]" said he. Interestingly, the phrase "kulaktan dolma" is commonly used in Turkish in a pejorative sense in order to doubt certain information/knowledge that is claimed to contradict scientific truths. By using this phrase, Ahmet discredited his experiential musical knowledge and skills.

However, when we talked about performing circumcision, he still honored his embodied knowledge and skills, and invoked the legitimacy of the traditional authority. Although he did not have any problem performing circumcisions without license until the 1980s, he had a harsh encounter with the gendarmerie after that period. He said:

> The gendarmerie came to the village. They wanted me to bring the instruments to the police station. They said, "You do not have a license." What license? [angry voice] I inherited this craft from ancestors. What are you talking about? Then a well-respected elder in our village confronted them so that I would not go to the police station.

While having recourse to gendarmerie was a crucial tactic for health officers in their battles against alaylıs, this tactic worked only to the degree that the military force had legitimacy in the eyes of families. As the sociologists focusing on the cultural aspects of state formation argue (Bourdieu 2014; Loveman 2005; Corrigan & Sayer 1985), in order for the state to acquire and hold the monopoly over the use of physical violence, it has, first, to secure locals' recognition for the use of such violence. This explains why health officers' tactic of having recourse to military power often failed in the Kurdish areas where such legitimacy lacked—the region that has a long history of riots, state violence, and armed struggles. A traditional circumciser who has been performing circumcision illegally in one of the cities in that region, for instance, provided the following anecdote about his encounter with gendarmerie: "I was about to circumcise a boy and a gendarme stopped me and told me that I could not do it." And then the circumciser added "But the family had known me for years, and they said to the gendarme 'it is none of your business! This is our son!' and then I completed the circumcision."

Traditional circumcisers used various tactics to deal with the threatening presence of gendarmerie. Some of them, for instance, began to bring health officers along to the circumcisions so that if the traditional circumcisers got into trouble for not having permission for circumcision, the health officers could step up to protect traditional circumcisers from potential conflicts with the state surveillance authorities. These forms of alliance were also chances, as we saw in the previous chapter, for health officers to learn how to perform circumcision from well-experienced traditional circumcisers and, more importantly, to benefit from the trust between traditional circumcisers and families. In return, traditional circumcisers did not only gain a legal shield but also an opportunity

to learn how to use the new instruments, if they wanted. Both parties, in other words, had something to gain from such alliances.

Another tactic that traditional circumcisers used was to gain a license for circumcision. As we saw in Chapter 2, with the *The Law on the Application of Medicine and its Branches* (Tababet ve Şuabatı San'atlarının Tarzı İcrasına Dair Kanun), the Turkish state banned practitioners without formal medical education from performing circumcisions. There was, however, an exception to the rule: Based on the 58th and 59th clauses of the law, if a circumciser could prove officially that he had at least ten-year long experience in circumcision, then the Ministry of Health and Social Aid would grant him permission (*sünnetçi ruhsatnamesi*) for performing his job (the permission was granted only for circumcision). Moreover, circumcisers who had less than ten-year long experience could receive permission for circumcision on the condition that they observed operations performed by a specialist in a hospital from two up to six months, and passed the qualification exams.

Two of the traditional circumcisers I interviewed acquired their certificates from nearby hospitals after having proved, under the surveillance of physicians, that they were qualified for performing circumcision. They either received basic training, which could take up to six months, or only performed a few circumcisions in the presence of physicians, and proved their competence. The training involved applying local anesthesia, and dressing and suturing the wounds. One of the traditional circumcisers, Ayvaz (Abdal) said:

> Health officers were giving me hard time for not having a license. So I applied to the health board to get one and they sent me to the nearby hospital. On that day there were boys who were going to be circumcised at the hospital, and three doctors asked me to circumcise the boys. I told you, I did my military service as a

> sergeant in the public health department [Sıhhiye]. I already knew how to dress a wound and to give an injection. They gave me a certificate that allowed me to dress wounds, give an injection and perform circumcision. I always kept it in my tool bag so that no one could interfere with my business.

In some parts of the country, even till 1970s, after having received practical training, hospitals granted some of them permission for circumcision due to the shortage of health personnel. Nevertheless, the recruitment of traditional circumcisers into the health care system was far from systematic and traditional circumcisers were not generally interested in applying for the permit, as they did not generally encounter a problem performing circumcisions until the 1960s. After this period, some unlicensed traditional circumcisers said that when they applied for permissions, their applications often got rejected due to the arrival of their replacements; health officers.

From the perspective of traditional circumcisers, the professionalization of circumcision was a violent process in both economic and symbolic senses. By criminalizing non-licensed and non-educated practitioners, the Turkish state aimed to strip traditional circumcisers of the means of both livelihood and symbolic authority. Although some health officers faced resistance, the new techniques acquired legitimacy in the eyes of locals over time. In the face of this change, unlicensed traditional circumcisers, to varying degrees, adopted the modern circumcision techniques. In the following section, I discuss how modern circumcision changed the practices and discourses of traditional circumcisers.

4.3. Adopting Modern Circumcision

One of the fundamental novelties that modern circumcision introduced to the practice was sterilization. According to the modern circumcision norms, practitioners had to

sterilize instruments before using them again in order to prevent infections. Health officers often blamed traditional circumcisers for performing circumcision without sterilizing their instruments and causing damage to the health of boys. The lack of sterilization, according to the professionals, was one of traits of traditional circumcision, which made it "barbaric" and "outdated."

However, while sterilization was not the standard part of traditional circumcisions, contrary to the professionals' claims, it was not completely foreign to traditional circumcisers. Hacı Bülbül, for instance, used to let the instrument soak in a bowl of boiling water with the plastic parts of the tools being outside the bowl: "This method used to kill the germs." His father used to pick up the tools one by one, scrape the ragged edge of the scissors off using the end of a pin to and then dry them off a night at home before the circumcision. Or some traditional circumcisers used to ask the families to bring boiling water before the circumcision. Also, others used open flame to sterilize their instruments at home in advance.

In addition to the use of traditional sterilization methods, some traditional circumcisers, however, incorporated modern sterilization techniques into circumcision. The former Barber Hasan used to perform circumcision in Malatya, one of the cities in which the encounters among practitioners were not as dramatic as in the other parts of Turkey. Nevertheless, a brief interaction between Barber Hasan and what he calls "friends" who worked as medical assistants at a hospital changed his style and repertoire of tools to a considerable extent. He said:

> I had friends who were working at a public hospital. They helped me a lot. I did not use to sterilize bandages but only let them sit within a cup of boiling water. So there was no sterilization. Then I started taking the bandages to the hospital, and my friends were putting them in a sterilizer for me.

The retroactive symbolic effects of the introduction of modern sterilization techniques on circumcision could be observed in Barber Hasan's changing evaluative categories and perceptions. In his account, his own old techniques are rendered not only obsolete but also unworthy of being called "sterilization," a prescriptive term that is reserved exclusively for modern hygienic techniques. This should be seen, I suggest, as an another example for the extent to which modern circumcision values and norms influenced representations that traditional circumcisers had of themselves.

Another technique that traditional circumcisers adopted was local anesthesia. Prior to the 1960s, some traditional circumcisers used their own methods for managing pain. They, for instance, put ice on the children's groin. Nevertheless, most traditional circumcisers used to simply cut the foreskin off without employing any kind of method to eliminate the pain, preemptively. But their encounters with modern medicine techniques changed the traditional circumcisers' pain management methods. For instance, barber Mehmet learned how to perform circumcision from his master, who was a barber, as well. He also watched other senior traditional circumcisers. However, he then began to go to circumcisions with health officers at the age of seventeen:

> Oyman: Why did health officers want to take you to the circumcisions?
>
> Barber Mehmet: I am a tradesman and I knew many people. I told them that I could find them customers only if they let me come with them. I worked with two health officers. Obviously, not all health officers were good practitioners. Before I met health officers, I used to perform circumcision without local anesthesia. Then I watched how they worked. I observed old circumcisers as well but they did not know how to stop the bleeding.

Almost all the traditional circumcisers including those without license I interviewed eventually added local anesthesia into their set of instruments after the 1960s. The main reason for their adoption of the local anesthesia was that they wanted to benefit from anesthesia, which was, they thought, a better pain management method than they used. A few of licensed traditional circumcisers learned how to administer local anesthesia in mandatory military service and others from medical professionals when they went through training at hospitals. Most of the unlicensed traditional circumcisers learned the technique from health professionals with whom they had short-lived and random contacts.

Another technique that traditional circumcisers adopted was suturing though less common than local anesthesia. Prior to the 1960s, post-operative care was not completely absent in traditional circumcisions. While most traditional circumcisers used to cut the foreskin off with straight razor, and let it bleed until it stopped, others used ashes or special medicine that they prepared out of herbs, animal dung or a piece of bark from trees to stop the bleeding. Additionally, a traditional circumciser, Celil Abdal used to use a string he made out of animal intestines. He said that his father taught him how to make it and he used it to stitch up the incision to prevent it from bleeding.

One of the consequences of the contacts between traditional circumcisers and modern medicine is that some traditional circumcisers adopted modern technique of suturing. Health officers introduced absorbable catgut sutures made out of animal tissues into circumcision in the 1960s, a material that was similar to what Celil Abdal was using. These sutures were important for health officers since they were useful for preventing the risk of the operation. Barber Murat, for instance, began to use these sutures once he

started working with health officers. Health officers, he said, not only taught him how to apply local anesthesia (before he used to either numb the penis at all or apply ice on the penis) but also other medical procedures in the 1970s—a couple of years after he began to perform circumcision. He said:

> The biggest favor they [health officers] did for me was to teach how to stitch up and dress a wound. Most of them are not alive, anymore. May Allah be pleased with them [Allah rahmet eylesin]. I used to apply powder on penises after cutting off the foreskins and then wrap it with bandage, which did not work well. It never stopped bleeding. Then, I learned how to do it properly. It was very simple: After cutting off the foreskin, you hold the vein with forceps, use absorbable catgut sutures, and then stitch it up. It heals very quickly.

The post-operative complications were the main reason for traditional circumcisers to get into trouble with the legal and surveillance authorities, and hence adopting modern sutures could be a tactic for traditional circumcisers to avoid such a trouble. Some health officers reported the traditional circumcisers to local authorities when children were brought to hospitals due to excessive bleeding or having too much of their foreskins cut off. Sobacı Mehmet, for instance, began to use stitches to prevent complications after the circumcision. He said:

> The locals did not want me to use stitches. I was explaining to them: If I did not stitch it up, then it would be like I left the tap running. I mean, it would then bleed; I had to cover the wound. What if it bled the next day? I did not have a license. I would be in trouble.

The change in the traditional circumcisers' self-representation was also explicit in their discourses. Some traditional circumcisers adopted anatomical and medical knowledge, and such terms as "artery", "penile adhesion" and "hemophilia," which enable these traditional circumcisers to claim expertise and differentiate themselves from others. "Old

circumcisers could not notice penile adhesion. That's why they made mistakes. If the foreskin is attached to the glans, it bleeds a lot" said for instance Murat who had a chance to observe doctors at a hospital, and performed circumcision unlicensed. Similarly, the capacity for diagnosing hemophilia was also a sign of demarcation between traditional circumcisers. Hemophilia was one of the major causes for excessive bleeding in the recovery period and if a circumciser is not competent enough to realize that a boy has hemophilia and still circumcise him, the boy is likely to hospitalized after the operation. Some unlicensed and licensed traditional circumcisers told me that unlike others, they could tell if a boy has hemophilia and if he had it, they would send him to a hospital without performing the circumcision.

Starting in the 1960s, both licensed and unlicensed traditional circumcisers gradually incorporated the modern circumcision techniques into their repertoire. While such concerns as hygienic instruments, pain and recovery were not completely absent in traditional circumcisions, traditional circumcisers did not address these concerns in a systematized, generalized, and calculated manner as did health officers in modernized/medicalized circumcisions. The modern circumcision norms and values changed the representations that traditional circumcisers had of themselves and their practices. Traditional circumcisers recognized the importance of the modern circumcision techniques for such reasons as not getting into trouble with authorities and/or believing that the new instruments and techniques served the health of children. As a result, these circumcisers significantly contributed to the normalization of the use of these techniques in society.

The technique of licensure was crucial for the professionalization of circumciser, as it gave health officers legal leverage over traditional circumcisers in the jurisdiction struggles. This leverage was also supplemented by health officers' access to print media where they discredited and stigmatized traditional circumcisers. However, the victory of health officers against traditional circumcisers was also spatially limited since the activities of health officers tended to be concentrated in areas where these practitioners could convert their credentials into economic rewards. Thus, in the margins of the exclusive class-based professional control, the forms of exchange of knowledge, time, and skills between health professionals and unlicensed traditional circumcisers took place. While the state aimed to link credentials and performing circumcision via licensure and place the medicalization of circumcision under the control of professionals, the medicalization of male circumcision, to varying degrees, took place in the margins of the state control. What emerged was, in other words, a form of undesired generosity—"undesired" from the perspective of the state.

While health officers' control over male circumcision was spatially limited, the Turkish state was very successful in dismantling the apprenticeship/patriarchal father-son bond as the principle of the reproduction of circumcisers. Both licensed or unlicensed traditional circumcisers, who were still performing circumcisions, were themselves trained by apprenticeship but the conditions for the transmission of their knowledge and skills to the next generations no longer existed. Most of their sons acquired modern education to varying levels, and joined the working-class labor force, or were engaged in small businesses. Modern education, in other words, became the only legitimate means for accessing the position of circumciser over time.

No matter how much contribution the unlicensed traditional circumciser made toward the medicalization of circumcision, it would be far-fetched to claim that they fully embraced the new techniques. Almost all of them began to use local anesthesia but not always sutures and they did not take all the required hygienic measures. Some of them were self-trained. Particularly the boys in rural areas and also in many towns were deprived of the proper care in circumcisions.[38] Due to the prevalent ideological rigidities in the early years of the Republic, the ruling elites excluded traditional circumcisers from the practice. What would the outcomes be if the Turkish state chose a more cooperative strategy in regulating the circumcisers in the 1960s? I claim that the systematic incorporation, rather than the exclusion, of these practitioners would make these practitioners a more solid part of the network and serve better the goal of the protecting of the well being of children. This is so because, most families did not encounter the new instruments before the traditional practitioners including unlicensed ones used them and, unlike some health officers, except for one unlicensed traditional circumciser, none of the others mentioned any problem with eliciting families' cooperation for the use of these instruments. And this was so mainly because of the trust built between these two parties over time. The incorporation traditional circumcisers into the network of modern circumcision, in other words, would better serve the goals of the project of the socialization of health care services.

Health officers' tactics of closure in the arenas of public opinion and everyday life was, overall, a success. During the first phase of professionalization, although specialists (e.g. urologists and surgeons) were licensed to perform circumcisions, their activities

[38] As we shall see in Chapter 4, the sons of the poor in cities were also deprived of proper care.

were confined to either teaching health officers how to perform circumcisions or serving only upper class families and circumcising their sons. While health officers' efforts elevated the status of performing circumcision in modern and medical symbolic order and incorporated it into the gendered division of medical labor, specialists tended to see this task as a too lowly medical task and avoided performing routine circumcisions. However, specialists' general reluctance regarding performing circumcisions began to change in the post 2000s when private hospitals made strong appearance in health care services in Turkey. In the next chapter, I explore the second phase of professionalization of circumcision by discussing, in detail, specialists' jurisdictional challenge against health officers.

CHAPTER 5

THE MARKET-ORIENTED PROFESSIONALIZATION OF MALE CIRCUMCISION

In this chapter, I examine the market-oriented professionalization of male circumcision from the perspective of specialists. I argue that specialists (mainly urologists, but also general and plastic surgeons) gained the control over male circumcision by hospitalizing the practice. Specialists discredited health officers' credentials, skills, and knowledge by associating them with forms of circumcisions that were, specialists claimed, harmful to children. By doing so, specialists aimed to channel the demands toward hospitals where they perform circumcisions. This chapter discusses the symbolic means through which specialists challenged health officers and the institutional changes that strengthened specialists' position in their jurisdictional attack on their rivals.

First, I examine how specialists spread their new definitions of male circumcision in public and discredited health officers. In the post 2000s, specialists accentuated the emphasis on the hygienic conditions in which circumcision took place. While only the instruments used in circumcisions were medicalized prior to this period, specialists rendered the settings of circumcisions as part of the concern regarding the well being of children after the 1990s. They also raised the skill-related standards for proper circumcision, which, they claimed, health officers could not meet, and imposed their credentials as the necessary legitimate basis of performing circumcisions.

Collective circumcisions were the backbone of specialists' attack on rivals since health officers used to perform these circumcisions, routinely. After examining the hospitalization of male circumcision, I focus on the question of how specialists

condemned collective circumcisions and associated health officers with these circumcisions. I trace the history of collective circumcisions since the 1960s and examine how it became modernized/hospitalized in the 1990s, strengthening the position of specialists in their competition against health officers.

In the rest of the article, I focus on the institutional changes that significantly shaped the jurisdictional struggles between health officers and specialists. As Abbott says, interprofessional struggles are often affected by external changes (e.g. new laws) and parties usually gain the upper hand against each other with the help of these changes. Without the top-down criminalization of unlicensed practitioners, for instance, it would be much harder for health officers to drive traditional circumcisers out of practice. In the post 1990s, new set of institutional arrangements began to affect the jurisdictional struggles between specialists and health officers. These changes are: The health and social security reforms, the new public health regulations targeting collective circumcisions and, lastly, the new bill that prohibited health officers in 2013 from performing circumcisions, independently. With the help of these changes combined with symbolic means through which specialists discredited health officers, specialists, I argue, consolidated their monopoly over male circumcision.

5.1. The Hospitalization of Male Circumcision

5.1.1. From Home to Hospitals

Up to the 1990s, home was the main setting for male circumcisions in Turkey. It was/is customary for families to have celebratory gatherings as part of the ritual at their houses. Circumcisers performed circumcisions on tables or on the floor with men being present in the room (sometimes female family members, too). While hygiene was part of the

lexicon of modern circumcision in the past too, the setting for circumcision did not become an object of discursive elaboration, moral judgments, and regulatory interventions until the mid- 90s. Health officers medicalized only the *instruments* that are used in circumcisions without changing the setting where the circumcisions took place. The new phase, however, accentuated the emphasis on the importance of hygiene, condemned homes and outdoor venues (in the case of collective circumcisions) for their unhygienic conditions, and proposed medical institutions, mainly hospitals, as the proper settings for circumcision.

Specialists justified the movement from homes to hospitals on the grounds of these institutions being not only hygienic but well-equipped, as well. They reassessed the riskiness of male circumcision in physical terms (and, as we shall see in the following section, in emotional terms) and required medical attention and care that, they claimed, only medical institutions could provide. This was so because;

(a) Hospitals are segregated and sterilized places conforming to the principles of asepsis and antisepsis.

(b) Pre-operative screening (e.g. blood work, checking pulse and blood pressure) could be managed at medical institutions in order to assess children's general medical condition.

(c) Hospitals can provide better post-operative care, as children can stay overnight for further observation at hospitals, if necessary.

Specialists claimed that all these aspects of hospitals made these settings the most suitable for performing circumcisions. They claimed that performing circumcision required a larger medical team than the combination of health officer and his assistant and should involve not only specialists but also anesthesiologists and nurses. This medical team, they argued, can provide boys with proper pre- and post- operative care in

hygienic conditions at hospitals. Accordingly, performing circumcision at home was marked as unhealthy and too risky for the wellbeing of the boys. The medicalization of the setting in the post 1990s was also, as we shall see in this chapter, attuned to the neo-liberal transformation of health care services, which has channeled the health care services to hospitals.

5.1.2 New Skills and Knowledge

As we saw in Chapter 2, some health officers did not want to perform circumcisions due to its stigmatized status ("dirty work") in modern medical universe. Others who began to perform circumcision had to negotiate this stigmatized status and their institutional prestige. By gaining victory against traditional circumcisers, health officers incorporated the task into the modern medical universe and defined it as professional work.

One of the advantages of the growth of division of medical labor is that the high ranked health care practitioners can delegate to others the tasks that are unpleasant or lack esteem (Larkin 1983). While specialists sometimes trained health officers for performing circumcision, they avoided performing circumcision, routinely until 2000s since they tended to see it a too lowly medical task. However, after the 1990s, specialists designated themselves as the new legitimate practitioners (This was so mainly because their employers, private hospitals, as we shall discuss later in detail, began to target the demands for circumcisions). Specialists claimed that they were more knowledgeable about the anatomy of penis (e.g. penile disorders) and circumcision operations than health officers were. They also emphasized that they could better assess if, and when, children should be circumcised. Specialists, in this period, widely, incorporated into the lexicon of modern circumcision such terms as (pathological) phimosis, paraphimosis, and

hypospadias.[39] Health officers, in other words, increasingly found themselves in a similar position as their former rivals, traditional circumcisers, as their educational credentials, knowledge, and experiential skills became devalued and stigmatized.

In the state-led professionalization of male circumcision (1960s-1990s), health officers' definition of male circumcision was based on two stigmatized groups: One is the group of traditional circumcisers who, health officers claimed, did damage to the health of children. The second group was families who chose these traditional circumcisers. Health officers challenged parents' authority over their children and often triggered moral conflicts with them. Health officers claimed to know what is the best for the children, discredited the existing forms of performing circumcision, and aimed to implant medical norms regarding circumcision in families. They sought to elicit parents' cooperation and their active participation as medical auxiliary in enhancing children's wellbeing.

Specialists' new definition of male circumcision was also erected on the hills of its own moral opposites: One is the group of health officers who circumcised children in unhygienic conditions. The second group is composed of "bad" parents who have their sons circumcised outside hospitals. Specialists constructed a more layered and complicated medical object—the body of children— which is assumed to fall outside the competence of health officers. They introduced higher standards for the proper physical care of boys and claimed that health officers could not meet these standards.

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[39] Phimosis refers to the inability to retract the foreskins covering the glans of the uncircumcised penis and it occurs due to scarring, infection or inflammation, which causes difficulty with urination. And paraphimosis is a medical condition in which the retracted foreskin of uncircumcised penis cannot be returned to its normal position and it is often stated that it is important for doctors to recognize this condition promptly as it can result in gangrene. In both cases circumcision is recommended. Another urological problem, hypospadias refers to a condition in which the opening of the urethra is on the underside of the penis, instead of at the tip. This birth defect can be detected only in medical examinations and babies with this problem should not be circumcised since the extra tissue of the foreskin may be needed to repair hypospadias in the future.

Accordingly, this new group of professionals encouraged families to bring their sons to hospitals whey they perform circumcisions in order to better protect the health of their sons from the potential harmful effects of circumcision.

Collective circumcisions that health officers routinely performed up until the 1990s were the backbone of specialists' moral and jurisdictional attack on health officers. In the following two sections, I discuss the modernization of collective circumcisions and its significance in the jurisdictional struggles between health officers and specialists. We will see that the state's regulation of these circumcisions in the 1990s strengthened the position of specialists who aimed to break down the ties between families and health officers, and channel the demands for circumcision toward hospitals.

5.2. Collective Circumcisions in the Ottoman Empire

Throughout the Ottoman history, the circumcision festivities where the sons of sultans and those of poor families were circumcised were great opportunities for sultans to show generosity as a technique of legitimacy in the eyes of the Ottoman subjects (Özbek 2008a). Imperial grandeur, justice, and royal dedication to the "tradition of Prophet" (Terzioglu 1995) were the general themes in these circumcisions. After the 15th cc almost all the festivals were held in palaces in Istanbul and usually lasted from 10 to 15 days with the exception of the longest and the most expensive festival that Sultan Murad III (r. 1574-95) organized for his son Prince Mehmed. Ordinary people also attended this festival, which took fifty days. During the festival, between 3,000 and 10,000 boys of poor families were circumcised. Surgeons, first, circumcised a number of those boys every day and then the chief surgeon circumcised the princes at the end of the festivities

in a special room. Small gifts were also given to the boys after the circumcisions (Nil Sarı et al. 1996).[40]

The palace-organized collective circumcisions began to be medicalized in the late Ottoman Empire. As in the previous festivals, Sultan Abdulhamid II turned the circumcisions of the princes into an opportunity for showing royal power and generosity as well and strengthened its legitimacy in the eyes of the Ottoman subjects. The Hamidian circumcisions, however, were different from previous collective circumcisions, as hundreds of children were circumcised in the Imperial Hospital for Children and other medical centers. Prominent Ottoman surgeons were appointed for the operations and the state inspected these operations to ensure the surgeons performed the circumcisions in scientific manners. At the medical centers, the state served parents and children lunch and dinner, and the circumcised children were kept in the hospital for a night for the follow-up evaluation. During these circumcisions, the state organized various activities to entertain children and their parents. The children were also provided with "new shoes, clothes, and most importantly Abdulhamid II gave them imperial gifts (atiyye-i seniyye)" (Özbek 2008a).

The medicalized form of collective circumcisions enabled the Hamidian regime to legitimize its claim about being part of the "civilized" world and helped Sultan Abdulhamid II to construct paternalistic image as the protector of the poor in a new

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[40] While our knowledge, in general, about the techniques that surgeons used to use are limited, the Ottoman Surgeon Şerafeddin Sabuncuoğlu's work *Cerrahiyye-i Ilhaniye* (Royal Surgery) written in 1465 explains his techniques in detail. Sabuncuoğlu describes special scissors with slightly curved blade tips. During the operation, he applied wads and dressings and then used ashes of dried gourds or fine white flour for the incisions as post-operative care. As wound treatment, "egg yolk cooked in rose water and ground with the oil of roses was applied and kept on until the following day. The wound was then dressed with other medicaments until it healed" (Nil Sarı et al., p. 923). Sabuncuoğlu, in his book, also recommends double ligations for healthy and safe circumcisions.

scientific form. With medicalized circumcision, the sultan could portray himself as "concerned monarchical father" who attended to the well being of the poor male Muslim children by addressing their families' concerns and saving the children from pain (Özbek 2008a, p.56). Male circumcision, in other words, became a site for political legitimacy in the late Ottoman period in a unique way linking the newly flourishing ideas about childhood to modern medical techniques.

5.3. Collective Circumcisions in the 1960s

The cultural and political importance of collective circumcisions as a technology of generosity and charity has continued in the Turkish Republic period. In the villages of Turkey, it was customary that rich families, along with their own sons, have the sons of poor families circumcised, as well. In cities, charitable organizations, private companies, associations, children protection agencies, municipalities, and wealthy families organized collective circumcisions that received local and national media coverage particularly starting in the 1960s. In these entertaining events where famous singers occasionally gave concerts, children were provided with circumcision outfits, food, and toys and were sometimes driven around by cars or are placed on horses and paraded around.

Health officers and sometimes traditional circumcisers performed these collective circumcisions in such settings as parks, schoolyards, and sporting facilities in cities and towns. Performing these collective circumcisions was an important sources of income for some of these practitioners due to the number of children involved, which ranged from 50 to 500 within a day. But more importantly, these circumcisions served as an informal training opportunity for the newly graduates to gain experience. As we discussed in Chapter 2, the health officers I interviewed often complained about the insufficient

practical training at medical schools. These inexperienced practitioners developed their skills with remarkable dexterity and precision during collective circumcisions. A formally educated circumciser whose father was also a circumciser said:

> My father was performing circumcisions and I was watching him. It was a good job. People were showing him respect and he was making good money. He was in high demand. He was working very hard. I studied for health technician for two years in a university and then I started performing circumcisions too. I especially learned how to perform circumcision in collective circumcisions. I improved my skills thanks to these circumcisions that I performed for five years.

Since it was a crucial opportunity for circumcisers to improve their skills, some of the health officers accepted to perform these circumcisions for free. Sometimes two or three health officers performed collective circumcisions together. At other times, health officers performed collective circumcisions only with their assistants. As a health officer said:

> Now, I am a circumciser and I will circumcise a child. And you want to learn how to perform circumcisions. How are you going to learn? I cannot let you circumcise these children because his parents trust me. It would be inappropriate for me to let you circumcise him. But in collective circumcisions, hundreds of children were circumcised and there was usually more than one circumciser present. No one can tell who is the circumciser and who is the assistant. He [the assistant] could take advantage of the situation by circumcising children and gaining experience. I, thus, now oppose collective circumcisions, particularly the way there were being performed in the past.

While talking about collective circumcisions in the 1960s, another health officer said:

> Imagine that you are rich and want to organize a collective circumcision for 500 children. Who would you hire for this job? You would ask who would do it for free, right? And who would perform those circumcisions for free? Of course, someone who wants to improve his skills. There were many people who accepted to perform these circumcisions for this reason in the past. Many mistakes were made and many children suffered. Maybe those children still suffer.

In these collective circumcisions, the bodies of the sons of poor families became objects of informal training for inexperienced and young health officers and were exposed to poor medical care.[41] During these circumcisions, health officers used to move from one child to another very quickly within a very limited period of time. Fenni sünnetçi Ahmet, for instance, has been performing circumcisions since 1966. He first worked with another senior health officer, Metin who studied medicine at a Village Institute and began to perform circumcisions in one of the western towns in 1951. Ahmet himself did not receive medical education but got a license from a state hospital after assisting Metin for seventeen years. Metin was known as "jet circumciser" because, he said, he once circumcised 126 children in three hours in 1970. Ahmet and Metin often performed collective circumcisions together. Ahmet said:

> Ahmet: You do not even have time to eat. We were just putting some powder on the penis and then letting the boys go. We did not have enough time to dress the wounds. It was like a bus terminal. Children were lined up and were being held by the elderly people. We were cutting one penis off and moving to another one. Once Metin and I circumcised 120 children inside a park.
>
> Oyman: Was it an event that the municipality organized?
>
> Ahmet: Yes. Children of poor families (fakir fukara). 120 children. It was one child per one minute. We are doing our best to be careful but it was nothing like the circumcisions today.

While health officers, as we saw in the previous chapters, blamed traditional circumcisers for not sterilizing their instruments and not being concerned about pain, some health officers said that they occasionally performed collective circumcisions even without local anesthesia due to time constraints. Others emphasized that these circumcisions were

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[41] Scholars discussed how their vulnerable and disadvantaged positions in society often turned women, the poor, and racial groups into objects of ethically problematic medical researches and training (see, for instance, Humphrey 1973; Cahill 2001; Gamble 1993).

mostly performed under unhygienic conditions with no sterilization. Traditional circumcisers also sometimes performed collective circumcisions. For instance, Barber Hasan who, as we saw in Chapter 4, learned how to use the surgical techniques (local aesthesia and sutures) from health professionals in the 1960s, were performing collective circumcisions without using these techniques:

> Barber Hasan: I learned how to suture the incisions and apply local anesthesia from friends at the hospital. Then everything became much easier. I was for instance applying two or three stitches and the incision was healing much faster. I was also performing collective circumcisions. I remember, once I circumcised 156 children in two hours on my own. I smoked only one cigarette during that time.
>
> Oyman: Did you use local anesthesia and sutures for these circumcisions?
>
> Barber Hasan: No, I just used a coolant. For local anesthesia, I would need another three or five minutes. I was circumcising each boy in a minute or so.

Specialists began to criticize collective circumcisions in the 1990s and claimed that these circumcisions should be moved to hospitals where children could, they claimed, gain proper care. In the next section, I discuss how the state's regulation of collective circumcisions played into the hands of specialists and hospitals.

5.4. The Modernization of Collective Circumcisions

In the post 1990s, there was a growing attention to collective circumcisions in public in Turkey. The derogatory remark "çirkin görüntü" [distasteful image] was often made to capture the unhygienic conditions in which these circumcisions were performed. Interestingly, it was the remark that was also used for the religious practice of slaughtering animals on Eid al-Adha in outdoor settings. Such practices were seen, at least by the highly educated segments of the urban middle and upper-middle classes, as at odds with the desired modern image of cities. What we saw was the revitalization of the

old class-based nationalist and modernist sentiments condemning collective circumcisions as signs of cruelty and backwardness in a historical period in which the hope for attaining the West was very much crystallized in the prospects for EU membership.[42]

Echoing the public discontentment over collective circumcisions, the Turkish Ministry of Health issued a circular on collective circumcisions in 1997. Besides (re-) emphasizing that circumcision is a risky medical operation, the circular stated that collective circumcisions should take place in hygienic settings conforming to the principles of asepsis and antisepsis in order to prevent post-operative complications that had been observed in the past. According to the new regulation, the organizers of the collective circumcisions were now mandated to get permission from local authorities (Il Sağlik Müdürlük) and circumcisers were prohibited from performing more than eight operations, and not more than fifty children per day in total. Practitioners were also required to work with an assistant and they could no longer use the same set of equipment for everyone unless the tools were sterilized. The number of the sets of surgical instrument was stated to be at least half of the number of children being circumcised. The code also required the attendance of a medical expert during the operation, preferably a urologist. In case there was no available urologist, then surgeons would be the second choice.

Considering that the new regulation increased the costs for health officers and limited the demands by introducing new constraints (i.e. fees for an assistant and a specialist, and higher standards for the equipment), collective circumcisions became less

[42] For the first time in 1999, Turkey was recognized as a candidate country for full membership (Öniş 2008)

reasonable option for health officers. The new regulation also encouraged further involvement of specialists in male circumcision and rendered hospitals the most convenient settings for these types of circumcisions, as hospitals could better meet the new requirements than health officers. This regulation was, in other words, another crucial factor in strengthening the position of specialists in their competition against health officers.

Instead of having all children lie on the ground and circumcise them within the same day, which some health officers resembled to a "factory," hospitals introduced an appointment system to the organization of collective circumcisions over the last decades and began to schedule time slots for a certain number of families each day. The fragmentation of collective circumcisions in the form of appointment system, which addresses children *individually* rather than *en masse*, requires that a certain amount of time should be allocated for each child in order to provide them with proper care. Otherwise, rushing circumcisions could cause mistakes and would prevent practitioners from preparing children physically and emotionally. With the appointment system, practitioners would have enough time to comfort boys before the operation (In Chapter 6 we will see how and why this system failed in achieving its goals).

The collective circumcisions began to take place in hospitals and particularly in private hospitals in the post-2000s. But why did private hospitals become part of the organization of collective circumcisions? What was at stake for them to have their specialists circumcise the sons of lower-class families? And considering that even by 2003, only 24 % of the poorest had health insurance in Turkey (Agartan 2012), how did these families gain access to these private hospitals? In the next section, I answer these

questions by taking a closer look at the reforms in healthcare and social security system. The analysis of these broader external changes (in addition to the state's regulation of collective circumcisions) will enable us to have full understanding of the engines behind the hospitalization of male circumcision—the engines that were supplemented with specialists' symbolic attacks on health officers.

5.5. Reforms in Healthcare and Social Security Systems

As in the case of the project of socialization of health care services, the radical changes in the field of healthcare services occurred in the aftermath of another coup d'état in 1980. Following the economic crisis between 1977 and 1980, the coup d'état, which suppressed the effective opposition brutally throughout the country, laid the groundwork for restructuring the economy according to neoliberal precepts (Cosar & Yegenoglu 2009). While the 1961 constitution assigned the state the role of main provider in healthcare services, the (current) 1982 constitution, which was ratified by popular referendum under the military rule (1980-1983), emphasized both the regulatory role of the state and the importance of private sector in the organization of healthcare services. In the ensuing years, the structural adjustment policies that the IMF and the World Bank (WB) formulated replaced the principles of planned economy and national developmentalism with structural adjustment policies. These international institutions claimed that these policies could reduce the massive public debts that were seen as responsible for the crisis. Accordingly, in exchange for the loans they provided, both IMF and the WB required the Turkish governments to decrease public expending in social services (e.g. health and education) and favor market-oriented policies in these services.

One of the problems that the project of the socialization of health care services in the 1960s aimed to solve was the lack of primary care network, which caused a huge burden on hospitals. While the project was successful in improving the access to basic health care in some rural areas, it failed in overcoming the regional and urban/rural divides throughout the country. Key health indicators (infant mortality, under-five mortality, maternal mortality) varied significantly across regions and the low level of these indicators was significant in the Eastern and Southeastern parts of Turkey (Günal 2007). Moreover, in the post-1980s, the workload of hospitals, significantly, increased in major cities (e.g. Istanbul, Izmir and Ankara) where population grew as a result of internal immigration. In this period, the focus of health reforms thus shifted from bringing basic healthcare to peasants to providing hospital services to the increasing urban population.

Although neoliberal health reforms were part of all the governments' agendas in the aftermath of 1980 coup d'état, it was the Justice and Development Part (JDP), the Islamist ruling party since 2002, that implemented these reforms, more or less, successfully. The JDP aimed to strengthen the primary care network by introducing family medicine as well as to improve citizens' access to health care services. The main axis of the JDP's neoliberal reforms in the organization of the healthcare services was the principle of competition for customers' demands as a solution to such problems as high public debts, the inefficient delivery of health care services, and the high costs of these services in general. The JDP aimed to attract private investments in healthcare services with the help of generous government subsidies. Concurrently, private sector increased their lobbying activities and pushed for further commodification of healthcare services

(Yılmaz 2013). As a result of these reforms, between 2002 and 2014, the number of private hospitals increased from 271 to 556 and the number of beds in private institutions increased from 12,387 to 40,509 in Turkey. [43]

The JDP also restructured the social security system. In the previous social security system, the society was divided into three public insurance schemes corresponding to three occupationally defined groups: civil servants, workers, and self-employed. These schemes collected their revenues from employees and employers with no additional financial support from governments. Among these groups of beneficiaries, the most advantaged group was civil servants who benefited from better benefit packages and higher quality of healthcare services than did the other groups.

Within the previous system, in addition to the inequalities among beneficiaries of the three public insurance schemes, the inequality between publicly insured and uninsured sections of society was also salient. Due to the high level of informal employment rate, the overall access to healthcare services was very low. To address this issues, in the 1992, Green Card Scheme was introduced. It was a means-tested programme for the poor funded through the government budget. However, one third of citizens were still not covered by any health insurance, including the green card (Günal 2007; Yılmaz 2013; Agartan 2012).

The JDP abolished the occupational status-based inequalities in access to healthcare service, unified all public health insurance schemes and introduced General Health Insurance (premium based financing system) in 2008. The government criticized civil servants' advantageous position and promised to improve the conditions for the

[43] The Ministry of Health of Turkey Health Statistics Yearbook 2014 http://saglik.gov.tr/TR/dosya/1-101702/h/yilliktr.pdf

poor. Accordingly, with the new social security system, the percentage of the poor who had coverage went up to 82 %, as the state funded the health care services that they used (Agartan 2012). The integration of private hospitals into the public health insurance, significantly, increased citizens' access to private hospitals (Yılmaz 2013). This was especially true for middle class families who could benefit from these hospitals by paying additional payments. Private hospitals became an option for basic services including male circumcision and public hospitals became more accessible in general for the poor.

Since 2000, collective circumcisions were increasingly channeled toward private hospitals under municipal contracts. Before the introduction of the new social security system, Islamist municipalities funded these circumcisions. Using means-testing procedures, these municipalities assessed whether low-income families were in need of circumcision services. They also organized entertaining events for families and provided their sons with gifts and circumcisions outfits. After the implementation of the new social security system, private hospitals were allowed to sign contracts with insurance funds, including the public one, as part of private public partnership model that the reforms implemented. Municipalities continued funding the rest of the ritual (e.g. outfit, toys, and entertaining events) while private hospitals charge the public fund (SGK) for the operations. These state-sponsored circumcisions were important for private hospitals not only for financial reasons but also for symbolic reasons since these hospitals, which were/are in competition with each other, used these circumcisions as an opportunity for advertising their generosity. With the new regulation of collective circumcisions, the poor could now have their sons circumcised at well-equipped private hospitals instead of parks or schoolyards.

Regardless of the type of circumcision, in the neoliberal period, private hospitals aimed to expand their share in the market for male circumcision. Accordingly, health officers' control over the demands for male circumcision became a new target for these hospitals. The economic struggle was, once again, accompanied by symbolic struggles over definitions, classifications, and values. Unlike in the case of the struggle that health officers waged against traditional circumcisers, specialists/hospitals' closure activities took place first in the arenas of public and everyday life, and then finally of legal in 2013. Both associations' and private sectors' lobbying efforts resulted in a bill that prohibited health officers from performing circumcision, independently. According to this bill, health officers were allowed to perform circumcisions until the summer 2015 and then only specialists could perform circumcisions at hospitals. While, as we saw in Chapter 2, the Turkish state turned a blind eye to the activities of health officers starting in the 1960s, the new law, as a technique of social closure on the supply side, took health officers' informal autonomy away and consolidated specialists' (hence hospitals') monopoly over male circumcision.

One of the associations that engaged in lobbying activities regarding the legal status of circumciser was "Professional Circumciser Association" (Profesyonel Sünnet Yapanlar Derneği). The head of the association is a urologist and he has been performing circumcision since 2003. He said that he established this association for three reasons: One was to gather information about techniques of circumcision. He was in touch with some senior health officers who were willing to share their experiences with him. The other reason was to educate families about circumcision. Before establishing the association, he said, he realized that families did not know much about circumcision. The

association, thus, provides families with free counseling on circumcision. But more importantly, he said, he wanted to encourage specialists to perform circumcisions and replace health officers:

> Up until present, people who perform circumcisers are either health officers or alaylıs. Specialists were not much interested in circumcision in the past. But there is now an increase in the number of specialists in Turkey. You can see doctors in every corner of the country. We want more and more specialists to perform circumcisions. Health officers say that doctors do not know much about circumcision. This is, of course, a serious accusation. Yes, doctors are not as experienced as health officers but they can better handle the complications than health officers.

With the implementation of the new bill in 2015, we can suggest that performing circumcision will lead to the concentration of the control over male circumcision in the hands of a new group of male practitioners and private hospitals. Specialists' claim over male circumcision relied on health officers' success in incorporating performing circumcision into the gendered division of medical labor and reinforcing the gendered aspect of the occupation (in a modern form). These specialists, however, not only met the culturally informed gendered criterion for performing circumcision but also raised the educational barrier for practitioners to access the occupation. In addition to being a male practitioner, new credentials that accompanied new skills and knowledge became the basis of the access to the occupation.

In the state-led phase of the professionalization of circumcision, one of the mechanisms that protected the link between masculinity and the occupation was the gendered-segregated medical education. In this period, the traditional double strategy of social closure, family and gender based, was replaced with another double strategy for

accessing performing circumcision: Credential and gender-based social closure. Girls could not be health officers who were eligible to perform circumcision.

Within the second phase of the professionalization of circumcision, the basis of social closure became only credential. The institutional barriers for women to access the occupation of performing circumcision no longer exist, as the urology specialty is not a vocational training like the health officer. However, this does not mean that patriarchal relations and value do no longer shape the employment structures in medicine. In Turkey, specialization is generally organized as a male-dominated area and women are discouraged from pursuing careers in certain specialties including urologists and surgeons. For instance, in 1986, 5.5 percent of urologists and 4 percent of surgeons were women. In 2002, these numbers went up to only 10 percent and 9.8 percent, respectively (Gelegen 2007). Neo-patriarchy is, again at work here: Women tend to choose professional careers (e.g. pediatrics) that were seen as compatible with their primary roles as caregiver in the private realm.

The market-oriented phase of the professionalization of circumcision was an outcome of the jurisdictional struggles between health officers and specialists and rested upon the stigmatization and devaluation of both the credentials and experiential knowledge of the former. However, until very recently, health officers continued performing circumcision despite their loosening grip over the demands for circumcision. How did health officers most of whom were now in their 50s and having been performing circumcisions for over 30 years respond to specialists' jurisdictional attack? Some health officers resisted the trend toward the hospitalization of male circumcision and defended the home-based circumcisions. These health officers claimed that the hospital-based

circumcisions destroyed the traditions since families who are used to have circumcisions at home do not want to go to hospitals. Parents, they claimed, rather have their sons circumcised at home where they could have both the operation and the celebration. However, with the appointment system, they added, parents do not know when their sons' circumcisions will be scheduled and hence they cannot plan the celebration ahead. Hospital-based circumcisions, in other words, are not "traditional" enough for these health officers.

Another change in health officers' self-representation was related to the modernization and hospitalization of collective circumcision. When I was conducting my research, most of the health officers/fenni sünnetçi were no longer performing collective circumcisions. Some of these circumcisers, boastfully, mentioned the number of children they used to circumcise at once during these circumcisions. Health officers who were still in business often, scornfully and retrospectively, used the term "collective massacre" in order to express anger for the collective circumcisions that they used to perform in the past. Collective massacre was a trope that marks these circumcisions as scandalous and signs of backwardness. For instance, in my conversation with a fenni sünnetçi Selim:

> Oyman: Are you performing collective circumcisions?
>
> Selim: Not anymore. I was performing circumcisions in both cities to which I was assigned. But I am a health professional and the likelihood of the spread of such infections as Hepatitis B or syphilis is very high in those conditions. There is no sterilization. Then I decided that I would not go to collective circumcisions.

In my conversation with another health officer, Fatih:

> Oyman: Did you used to go to collective circumcisions?
>
> Fatih: A couple of times but then I stopped. Why did I stop? Because we were not paying attention to sterilization. As a health team, we were normally careful about

> sterilization and were concerned about infections. But in collective circumcisions, we were not as careful. You had one instrument or maybe two and these instruments were being contaminated and you had to clean them on site.

However, some health officers continued performing circumcisions and changed their styles according to the new norms of the hospitalization of circumcision. Those health officers adopted hospitals' appointment system and instead of having all the children gather in one place, as they did in the past, they began to schedule visits to families at their homes. In my conversation with a health officer, Süleyman:

> Oyman: Are you still performing collective circumcisions?
>
> Fatih: Yes, I am. But the collective circumcisions I am performing are nothing like the ones you see on TV. Over the last six or seven years, we make a list of boys who would be circumcised. In the past, it was not like this. [Wealthy] People used to want us to perform these circumcisions in parks or backyards. It is understandable because then they would not have to pay for the venue. But we are now asking them to give us a list with the names, phone numbers and home addresses so that we could perform the boys' circumcisions at homes.

Comparing with the circumcisions that they used to perform, these health officers mentioned that thanks to the appointment system, they no longer have to rush the circumcisions and they can now devote more time to each child. Hence, they said, they could pay more attention to their wellbeing and the hygienic conditions of the venues and the instruments.

Some of the senior health officers with economical capital had a unique response to the specialists' attack on their control over male circumcision. The channeling of circumcisions towards hospitals changed the experience of circumcision, drastically. The hospitalization of male circumcision a phase at which circumcision became more reduced to a medical operation and the venue became isolated from the other main components of

the ritual (e.g. celebration or religious ceremony). Male circumcision was, in other words, no longer located in the communal networks of kinship and neighborliness into which practitioners are integrated. Some health officers running clinics promised their customers that, they claimed, hospital-based circumcisions could not provide: Experiencing "authentic" circumcision in modernized settings. I will analyze the new kind of circumcision that these health officers created in the next chapter.

CHAPTER 6

THE RERITUALIZATION OF MALE CIRCUMCISION

In this chapter, I examine the senior health officers' response to specialists' jurisdictional attack and argue that depending on the economic capital they accumulated over time, health officers aimed to gain the upper hand by reritualizing the custom. These health officers not only submitted themselves to the specialists' new definition of male circumcision (both practically and symbolically), but also claimed to combine "the modern" and "the tradition" and revitalized the celebratory component of the ritual—the component that is isolated from the operation itself in the case of circumcisions at hospitals. They invoke the fundamental civilization/culture dichotomy of the Turkish nationalist ideology in the context of the consumer-centered transformation of healthcare services by engaging in a unique kind of emotional labor. This labor aims to obliterate and/or hide pain from the performance of male circumcision and bring "home" ("tradition") back to the supposedly "cold" (civilized) hospital settings for their customers.

To understand health officers' strategy against specialists, we need to take a closer look at the process of the *sentimentalization* of male circumcision. In the post 2000s, emotions emerged as the new morally problematic object of reflection and action for both practitioners of circumcision (specialists and health officers) and families. Scholars argue that, under neoliberalism, which aimed to shape the society in the image of the market, the commodification of emotional and affective labor and intimacy gained unprecedented role in labor markets not only in Turkey (Korkman 2015) but also the rest of the world (Hochschild 2012; Illouz 2007; Hardt 1999). With the neoliberalization of

health care services which built the principle of competition for demands into the heart of the health care system in Turkey, practitioners of circumcision began to perform emotional labor[44] on both boys and their middle and upper class families as consumers. These practitioners incorporated new feminine themes into their practices, as they started paying attention to emotions and developing strategies for promoting the emotional health of children. By doing so, they also aimed for the satisfaction of the parents/the customers who were interested in turning circumcisions into memorable and entertaining events for their boys.

In the sociological literature on emotional labor, it is often stated that the commodification of emotional labor leads to the recruitment of women as devalued laborers. This is so because, the scholars suggest, women are seen as inherently capable of performing emotional labor and hence emotional labor is, ideologically, coded as unskilled. In the field of healthcare, for instance, the emotional labor that nurses who were largely female until recent times perform is also neither monetarily nor symbolically recognized (Smith 1991, 1992; Bone 2002). Our case of the sentimentalization of performing circumcision, however, shows that we should be wary of taking such dichotomies as reason/emotion, masculine/feminine, and male/female as straightforward and inevitable. The correlation among such polarities should, rather, be seen as contingent and changeable. Drawing on the psychological discourses on childhood development and trauma, the practitioners of circumcision presented and marketed

[44] According to Hochschild (1979; 2003), emotional labor is a kind of labor that tries to change in degree or quality an emotion, which is *fear* in the case of male circumcision. Bolstered by the growing authority of psychology, more specifically by the psychological notion of trauma, the practitioners of circumcision developed new circumcision techniques to remove fear out of male circumcision and achieve circumcision without trauma.

themselves as emotionally sensitive toward children. These male practitioners' emotional labor was no longer invisible, devalued or unrecognized. The emotional labor framed within scientific principles, in other words, became part of the repertoire of masculine practices through which male practitioners claimed superiority and control in the field of circumcision.

In the first section of the chapter, I examine the discursive underpinnings and the techniques of the sentimentalization of male circumcision. I will then analyze senior health officers' contradictory discursive strategies for differentiating themselves from specialists. We will see not only how the sentimentalization and hospitalization of male circumcision shaped health officers' practices and discourses but also how senior health officers reclaim their superiority over specialists. Some health officers criticized hospital-based circumcisions for being not traditional enough, others highlighted the importance of experience in performing circumcision, which specialists, they said, lacked.

In the last section, I focus on the clinics that health officers run and examine how they re-ritualize circumcision in order to create market diversity among urban middle-class families. Ritualization, as Bell (1992) says, is a cultural strategy of differentiation and these health officers, I argue, used this strategy to re-draw the boundaries between traditional and modern and to differentiate their circumcisions from hospital-based ones. The emotion labor that health officers perform on children, in these settings, became intertwined with the emotional labor that they perform on/for their customers.

6.1. The Sentimentalization of Male Circumcision

As we saw in the previous chapter, the post 2000s witnessed new standards and requirements for the proper technical care for children, the process we called "the hospitalization of male circumcision." Within the same period, not only physical but also emotional wellbeing of children has gradually gained importance in the practices of circumcisers and families alike. In the earlier periods, health officers' concern regarding the emotional state of children was mostly subordinate to the purpose of rendering the operation smoothly, and they saw emotional comfort as non-deliberate and secondary benefit of the use of surgical instruments in circumcisions. With the insertion of the discourse on trauma into male circumcision, the emotional wellbeing acquired a positive independent existence in modern circumcision. This process called for separate concerted and systemic strategies addressing the potential psychological and emotional damages of the operation.

It was no coincidence that psychology and more specifically trauma began to gain a foothold in male circumcision over the last three decades in Turkey. The psychological discourse, knowledge, concepts, and themes have gradually become available to various segments of society through mass media (e.g. television programs, self-help books, magazines and newspapers) though the reception of psychology varied by age, class, and gender in society. Moreover, as private universities began to flourish, the number of psychological departments has increased significantly, which correlated with the increasing availability of psychological consultation services for well-educated urban middle classes in large cities (Kayaoğlu & Batur 2013). Counseling services also became a crucial component of school system with the purpose of providing educational guidance

for students and support for their personal issues. An increasing number of people, in other words, became familiar with vocabularies of psychology about various intimate issues regarding intimate relationships (e.g. child-rearing practices, marriage, love, and sexuality) and mental disorders (e.g. depression and anxiety).

In the case of male circumcision, in the same period, psychologists began to express their opinions about the potential psychological effects of male circumcision and the practitioners of circumcision adopted the emergent language of psychology, specifically, the key term “trauma.” While psychiatric traumatology emerged in Turkey during World War I (Aciksoz 2015), the notion of “trauma” largely made its way into the political and medical discourses in Turkey in the aftermath of the 1999 Marmara earthquake (Dole 2015; Aker et al., 2007). In this devastating earthquake, more than 17,000 people died, hundreds of thousands were severely injured and more than a million of people were displaced from their homes. In the following days and months, many governmental and non-governmental organizations and professionals including psychologists and psychiatrists flooded the area for assistance. The earthquake marked a crucial moment for the expansion of the authority of psychiatry, as it “facilitated psychiatry’s movement beyond the clinic, as a form of expertise granted new value to speak about the affective, behavioral and political vicissitudes of the everyday” (Dole 2015, p.283). Also, the post-earthquake period witnessed not only dramatic increase in the scholar interest in the notion of psychological trauma (Aker et al., 2007) but also in the mobilization of the concept “trauma” into political discourses concerned with silence, violence, and suffering in the history of Turkish nationalism (Gül Kaya 2015). Trauma, in

other words, emerged as a discursive tool for political and scientific interventions in the post earthquake period in Turkey.

As sociologist Nikolas Rose (1998) says, psychology is a generous discipline in the sense that the main reason behind the dissemination of psychology in various social areas is "its capacity to lend itself 'freely' to others who will 'borrow' it because of what it offers to them in the way of a justification and guide to action" (p.87). The practitioners of circumcision borrowed the notion of trauma to re-define the vulnerability of children and concomitantly, to re-assess the riskiness of circumcision. While the generalized and routine use of anesthesia and sutures in male circumcision indicated that the ideas of "painless circumcision" and "circumcision without blood" were now widely recognized and well-received in society, the re-definition of performing male circumcision connected the question of proper circumcision to a new objective: circumcision without trauma.

The concern regarding trauma as the potential consequence of circumcision in the future triggered new questions about the possible links between age and the susceptibility for trauma. Age figured as a risk factor in circumcisions, which was not a major concern prior to the 1990s. As a health officer who has been performing circumcision since the 1970s said "Everyone talks about the proper age for circumcision these days. This was not the case in the past." Although a few health officers expressed their opinions on the proper age for circumcision in media in this period as well, the elaboration on age did not become systematic and explicit until the last two decades.

The trauma-centered discourse encapsulated childhood in the domain of psychological knowledge mainly centered on the considerations about the sexual, emotional, and cognitive development of children. With the emerging question regarding

proper age for circumcision, childhood became divided into psychosexual development stages and the question of what age the child should be circumcised became an object of scientific elaboration. The vulnerability of children no longer resides only in their physical bodies but also in their psychological states of being. According to this discourse, circumcision is generally not recommended during the most vulnerable period, commonly called, "Oedipal period." A child psychologist says:

> Circumcision should not be performed in the Oedipal period, which is between the ages of 2 and 6. In this period, the boy is more likely to see circumcision as punishment because it is in this period that boys already become scared of their fathers and considering that they also hear phrases like "your penis will be cut off," it would be hard to convince the boy that circumcision is not a punishment.

A key assumption underlying the discourse on trauma is that what is unknown and unexpected can cause trauma in children. If a child who will be circumcised is at a certain level of awareness of his surrounding, and not be fully informed of circumcision, then, circumcision, psychologists claimed, can turn into a traumatic experience. As the same child psychologist said:

> There is an unanticipated event involved in trauma. I mean, something that a person was not expecting. For instance, a mother is pregnant with her second child and the first kid is not being informed of it. Normally it is good news. The kid is going to have a sibling. But if you do not say anything to the kid and do not prepare him/her for it, it could be traumatic for him/her. In the case of circumcision, we are telling boys 'You will be a man. There will be a celebration. You will wear nice clothes and receive gifts.' That's it. We do not talk to them about pain. We do not inform them about the steps of the procedure. You know, this is actually the traumatic part of the circumcision.

We can observe the growing importance of the question of age in infant circumcisions operated by specialists. This form of circumcision recently emerged as an alternative to ordinary circumcisions and particularly appealed to some fractions of the middle and

upper-middle class families. Traditionally, circumcision interrupts the ordinary lives of boys and inscribes itself into their memories. By organizing celebrations, families turned circumcisions into memorable events for boys to tell other men in the future. Most families, therefore, tend to have their sons circumcised when they would be old enough to remember the event.[45] Over the last two decades, infant circumcision has however become a choice on its own in the market of circumcisions in large cities. Increasingly families with high educational capital (i.e. college degrees) who are not invested in the ritualistic aspect of male circumcision choose this form of circumcision.[46]

The distinctive significance of infant circumcision should be understood in relation to regular circumcisions. Compared to regular circumcisions, specialists claimed, the recovery process is shorter and the risks of post-operative complications are lower in infant circumcision. Specialists also emphasize that infants would suffer less pain or feel only discomfort since babies' pain threshold is higher than older children. The question of the proper age for circumcision is also regarded as related to the cognitive development of children that revolves around the question of the level of children's awareness of their surroundings. Thus, infant circumcision as a category of circumcision could be seen as the best way of preventing the potential traumatic consequences of circumcision. As a urologist, one of my interviewees, said:

[45] Families used to make exceptions regarding the age if their sons had medical problems at birth, which would require immediate medical care. For instance, newly born boys could, and still can, be circumcised in severe cases of phimosis, known also as "tight foreskin."

[46] Most of these families do not organize celebrations following the operation that usually takes place at private hospitals. Despite their indifference, or sometimes even hostility toward the custom, these families still have their sons circumcised for mainly two reasons: One is *pragmatic* in the sense that they do not want their sons to experience peer-pressure in the future and feel inadequate. The other reason is medical since they believe that circumcision brings health benefits to their sons, which include a decreased risk of urinary tract infections, a reduced risk of sexually transmitted diseases and protection against penile cancer.

> Since urologists began to perform circumcision, mistakes in operations have been considerably minimized. But families are now concerned about the psychological effects of circumcision on their children. Children's fear of circumcision that arises as they develop cognitively makes parents worry. The question of how to prepare children for circumcision and to protect them from psychological effects of circumcision begin to puzzle parents. Parents either make up excuses to postpone the circumcision or take the risk of having their sons circumcised under general anesthesia in order to comfort them. The only solution to eliminate or at least minimize traumatic experience is infant circumcision.

In the case of non-infant circumcisions, with the increasing importance of the concern regarding age in circumcisions, both specialists and health officers began to pay more attention to the age of children whom they circumcise. In both print and screen media, especially specialists have increasingly been incited to reflect on the proper age for male circumcision and the practitioners of circumcision, more and more, adopted such technical terms as Oedipal period into their discourses. While their opinions about the proper age for circumcision might vary, they all justify their opinions on the grounds of potential psychological consequences of the operation and the age of children.

By adopting psychological discourse, the practitioners of circumcision reworked the idea of childhood that was central to Turkish national discourse and required special attention to the emotional state of children. As we shall see, the incorporation of trauma into male circumcision led to the proliferation of new techniques (e.g. communication techniques) managing the emotional worlds of children. Emphasizing the importance of transparency in their interactions with children, both senior health officers and specialists began to use emotional techniques more widely.

The sentimentalization of male circumcision went hand in hand with the emergence of a new form of parent-blaming, as well. The sentimentalization of male circumcision re-codified parent-child relationship and brought new moral obligations,

those of emotional kind, for families. The insertion of the discourse on trauma into male circumcision turned the family into not only *physical* as in the 1960s but also *emotional* environment that was seen as crucial for the healthy development of children. Parents were regarded as in need of education about the potential traumatic effects of circumcision on children and be expected to be attentive to not only pain and post-operative complications but also their children's vulnerable emotional world. The practitioners of circumcision called upon families to address their children's fears and prepare them for the operation, psychologically. Parents, in other words, were defined as *emotional auxiliary* in assisting specialists who adopt the role of psychologists.

In the post-2000s, the stigma that was attached to peasants in the welfare period was re-projected onto a new group: Poor citizens who migrated to cities from rural areas in the post-1990s—the groups about which neoliberal health reforms, as we shall see in the next section, were concerned. Parents became target of denigration and harsh criticism for causing trauma in their sons. A few examples are worth mentioning: Lying to children about circumcision, using circumcision as a discipline technique (i.e. threatening to have their children circumcised twice if they misbehave or calling a circumciser to have them circumcised if they do not obey the rules) and making jokes that would instill fear in children (e.g. "your penis will be cut off by an ax"). In addition to psychologists, specialists and health officers, in mass media, criticized such interactions as manifestation of ignorance and bad parenthood in the reconfigured moral universe surrounding circumcision. The new definition of male circumcision, in other words, went hand in hand with the emergence of psychology-based form of parent-blaming.

The sentimentalization of male circumcision shaped senior health officers' discourses and practices. The health officers adopted the psychological discourse on trauma and began to emphasize the importance of achieving not only physical but also psychological well being of children. A health officer who has been performing circumcision for 40 years said:

> %80 of circumcision is about psychology. Then comes asepsis and antisepsis. Unconscious is very important. His trauma stemming from his childhood and his relationship with his mother and father can come to the surface. I talk to children, give them candies or Turkish delight and tell inform them of the steps of circumcision. I show them the instruments and if I am using chloraethyl spray for local anesthesia, I first spray it on their hands. I prepare them for circumcision by talking to them and telling them that there is nothing to be afraid of. That is the most important part.

Or as another health officer said:

> Cutting the foreskin off properly is not the most important part of circumcision. That is what the law requires anyways. That's the physical part. More importantly you should not cause trauma in the boy.

Although some health officers mentioned that no one used to talk about proper age for circumcision when they first began to perform circumcisions, they became more observant of the age of children over time. While health officers do not tend to take the scientific considerations about proper age into account in their practices in the strict sense that they refuse to circumcise children going through the Oedipal period—although two practitioners I interviewed sometimes turn down families whose children are the ages of 3 or 4 and suggest that the families should wait until the children turn 8 years old—some health officers mentioned that they are now more attentive to these stages in their

communications with children than in the past and pay extra attention to children who are categorized as being in the Oedipal period.

The sentimentalization of circumcision also changed the criteria for success in performing circumcisions. While having a good track record in performing circumcision without a mistake (e.g. overcutting the foreskin or causing too much bleeding and post-operative complications) has always been a proof of success and a reason for boast for health officers, not causing trauma in children was also now added to the repertoire of self-representations of practitioners. Performing circumcision without causing trauma turns into a marker of achievement even though the objective ground of measure for that kind achievement is feeble. They mentioned that knowing about child psychology is important in circumcision and their ultimate concern is children's wellbeing and not making money. As a health officer who has been performing circumcision since the 1960s said:

> For instance, I circumcised men in your age group and then circumcised their sons too. I ask them the following question: "How do you remember your circumcision?" They answer "I remember it well'" It means that no damaged has been done to his unconscious and no disorder has been caused to his psychology.

The effect of the sentimentalization of circumcision on health officers was not however limited to the level of discourse. Some of them also organize the circumcisions in a way that would compete with hospital-based circumcisions and create market differentiation in the urban middle classes. In the next section, I show how some health officers who had enough economic capital to operate clinics created a new form of circumcision in their struggles against specialists/hospitals. Since health officers were not allowed to seek additional income sources, these health officers opened these clinics upon retirement or

they partnered with physicians who were allowed to have private officers at that time. These clinics are located in cities and mostly serve middle class families. In some of these clinics, health officers perform other medical tasks as well (e.g. measuring blood pressure, providing first aid, administering injections and piercing ears). In the following section, however, I examine the clinics where health officers exclusively perform circumcisions.

6.2. "A Clinic but not like an ordinary clinic:" The Reritualization of Male Circumcision

> Our clinic where only circumcisions are performed is different from ordinary clinics. It is designed so that boys are circumcised without being aware of the operation in an entertaining way. Indeed, our staff is composed of people who are trained to provide such comfort for children and families…our clinic makes a difference and differentiates itself from others by turning circumcisions into entertainments in which boys have no fear of circumcision. Our clinic is taken as a model by our competitors and became a brand itself…we are pleased to host our valued guests and friends and provide them with this privilege.

These words are taken from the framed ad hanging on the wall of the clinic that fenni sünnetçi Mustafa has been running in Istanbul since 1989. Mustafa began to perform circumcisions in 1979 when he was 29 years old and learned how to circumcise children when he completed his military service in a military hospital. During the military service, he was taught by senior nurses how to dress a wound and administer injections. He also assisted surgeons in an operation room where soldiers were circumcised and he himself performed a few circumcisions. Upon completing his military service, he was granted a license allowing him to perform minor medical tasks including circumcisions in civilian life.

While waiting in the well-decorated and well-lit waiting room of the clinic for my interview with Mustafa who was circumcising a boy inside the operating room, other

boys were playing with their toys on the corner of the waiting room and the elderly members of their families were sitting on leather chairs and chatting. Then one of the staff members began to play a very loud music, which, as I later found out, was a routine preemptive measure in case the boy who was being circumcised screamed during the operation. Then the music would drown out his voice and families in the waiting room would not hear him.

Being puzzled by the striking euphonic organization of the clinic, I walked into the operating room that contains not only surgical equipment but also a PlayStation and started talking to Mustafa once he completed the circumcision. As expected, my interview with him was interrupted by one of his staff members who walked into the room in order to inform him that the next boy in the line for circumcision was now ready. Mustafa stepped outside the operation room, greeted the boy and put his arm around him, as the same staff member handed him a microphone. Then the following dialogue between Mustafa and the boy who was seven years old took place:

> Mustafa: What is your name?
>
> The boy: Murat Yaman.
>
> Mustafa: When are you going to be circumcised?
>
> Murat: Today.
>
> Mustafa: No. Not today. Tomorrow. Today we will only put two different kinds of cream; one is banana flavored and the other one is lemon flavored. You will play PlayStation inside the room and collect points. Okay?
>
> Murat: Okay.
>
> Mustafa: Now I am going to ask you a few questions. Who is the most beautiful girl in your class?
>
> Murat: Nisa (he smiles).

Mustafa: What (soccer) team are you supporting?

Murat: Fener[47]

Mustafa: Fener? Everyone is supporting Fener! Anyways, now repeat after me,

Murat: I pledge on my honor to be a man.

Murat: I pledge on my honor to be a man.

Mustafa: to never break my word

Murat: to never break my word.

Mustafa: to always support Fener.

Murat: to always support Fener.

Mustafa: Good job!

Murat was incited to perform the script of dominant masculinity in Turkey, a country where breaking your word is seen as a sign of weakness for men and being a soccer team fan is a common heterosexual male bonding practice. In this performance, circumcision became intertwined with the traits and practices of masculinity promising men/boys power and prestige. The performance was an instantiation of the construction of boyhood based on passing a phase filled with uncertainty and potential fear.

Afterwards, Murat was taken to the operation room where he lied down on the bed for circumcision. Facing the TV screen, he began to play his game while sünnetçi Mustafa was circumcising him. In the meantime, Mustafa was talking to Murat in order to ensure he was feeling comfortable. Then the loud music coming from the waiting room started and lasted briefly in the background. During the operation, the staff members

[47] Fenerbahçe Sports Club, also known as Fenerbahçe or Fener, is a major Istanbul based multi-sports club.

were taking a video of the entire event at the end of which they prepared a CD for purchase for Murat's family, which, I later found out, was another routine practice in the clinic. Murat was not aware of the fact that he was being circumcised and once Mustafa completed the operation, we all stepped outside. Fenni sünnetçi Mustafa was handed the microphone once more:

> Mustafa: Murat you are now a man. You were very brave. I congratulate you on your courage. So Murat, tell us, did it hurt?
>
> Murat: No.
>
> Mustafa: Bravo, bravo! I hope you would be as brave and successful in the rest of your life as you were here. Here is your "Certificate of Bravery" (Cesaret Belgesi).
>
> Murat: Thank you [then the preparation for the next circumcision began].

In front of Murat's family and other families, sünnetçi Mustafa wanted to highlight that he completed the circumcision without causing pain on Murat. He put efforts into comforting the boy through communication and other methods (e.g. videogames). In our interview, fenni sünnetçi Mustafa emphasized the importance of preparing boys psychologically in advance. Invoking the psychological form of parent-blaming and the notion of psychosexual development of children based on the question of age, he incorporated psychological reasoning into his discourse, justifying the use of new techniques for managing children as follows:

> The biggest problem for us begins in cases where boys are seven years old. Since those boys are very aware of their surroundings, they fear from than the young boys. And you know, in Turkey people make jokes about circumcision like cutting penis off with an ax. Since the child at that age cannot tell whether it is real or a joke, he buries all these jokes in his unconscious. And when the time comes for circumcision, everything in his unconsciousness comes out. So who is going to step in at that moment? The circumciser [sünnetçi] and his team will step

> in. They will operate with the knowledge of the psychological state of the boy and approach the boy, accordingly.

Sünnetçi Mustafa carefully distinguishes his practice from specialists who perform circumcisions at hospitals. In his well-equipped and hygienic clinic, he does not only use emotional techniques of circumcision but he also reritualizes the practice. The hospitalization of circumcision in the 1990s de-ritualized the custom by medicalizing the setting where circumcisions are performed. It was a phase at which circumcision became more reduced to a medical operation and male circumcision was no longer located in the communal networks of kinship and neighborliness into which practitioners are integrated. However, instead of moving the venue from medical setting back to community/home, Mustafa strives to construct home-like comfort in a medical setting in order to re-highlight the distinctiveness of male circumcision from ordinary medical operation and create market differentiation within (upper) middle class families—the kind of comfort that that would go against the principle of the organization of hospitals based on their distinctions from homes.

The reritualization of the custom as a strategy of distinction was also salient in another clinic I frequented in Istanbul. The clinic is called "Circumcision Palace" (Sünnet Sarayı) that was opened by Kemal Özkan in 1976. Kemal Özkan was the most popular circumciser/fenni sünnetçi in Turkey until he died in 2014. He was also known as "the circumciser of the elite" (sosyete sünnetçisi) since he used to circumcise celebrities' boys, receiving mainstream media coverage for decades. During the period of time in which I conducted my research, he was not performing circumcision due to health problems and his two sons, who have been assisting him since they were young children,

were instead running the clinic. One of the sons was a health officer (Hakan) and the other one was a urologist (Tarkan).

The clinic/palace also represents itself as distinct from hospitals by claiming to merge the "modern" with the "tradition," highlighting that they are not imposing their own methods on families. Parents are asked to bring their children to the clinic a week prior to the scheduled circumcision date so that the children could undergo medical examination, if necessary, and families and the circumcisers could decide on how to proceed with the circumcision. During this visit, families including their boys are also encouraged to watch the circumcisions that are taking placing during the day in the clinic. In our interview, Hakan emphasized the importance of this practice, which, he said, enables the children to gain familiarity with the procedure and prepare themselves emotionally. According to the psychological discourse on trauma, what is unknown and unexpected can cause trauma and by offering the option of pre-operation visits, we can suggest, the Circumcision Palace addressed this potential risk of the operation for the emotional well being of children.

The first part of the circumcision takes places in a big and spacious room wherein tables and chairs are placed in front of a stage. On the stage there are five red large throne-like chairs and a piano. The performance starts with the cheerful entrance of a clown holding a microphone upon the stage. Accompanied by a loud jingle, the clown then brings in the children who line up on the stage. The boys wear the common circumcision outfit composed of shoes, cape, a scepter, and a special hat with "Maşallah", meaning "God preserves him", written on it. Facing the audience that involves their families on the stage, each talks into the microphone and answers two

questions posed by the clown: What is your name? What soccer team are you a fan of? Soccer, a hyper-masculine sport in Turkey, is one of the gender-related elements that the performance incorporates here too. Then the clown and a singer invite mothers and the boys to the stage where they have a slow dance together.

After the dance, the boys are seated and the circumciser (Hakan) comes on the stage. He talks to the children before injecting local anesthetic into their penises—a procedure that is accompanied by the theme song of their favorite soccer teams. Unlike fenni sünnetçi Mustafa, Hakan does not hide from children the fact that they are about to be circumcised. He advocates for full disclosure and tells the children all the instruments he will be using one by one and all the stages of the circumcision. He then applies the local anesthesia.

While the local anesthesia becomes effective, the singer invites the elderly family members (e.g. parents, grandparents, aunts etc.,) to the stage where they dance together. Upon the second round of injections is carried out, the music stops and the singer solemnly announces the praying that is to come. An imam (religious figure) wearing a floor length vest and a cap walks in slowly. Demanding silence and reverence, his steps drastically fill the once uplifting joyous atmosphere with sobriety and calmness. The body comportment of the families is now adjusted to the imperative of next part of the performance. Women put on kerchiefs distributed by the staff and once the imam takes a seat and starts praying, everyone raises their both hands up to the chest level with the palms facing inside and prays along. After the completion of the praying, the circumciser calls each boy one by one and performs the operation along with the chanting of the imam saying "Allahu Akbar" (God is the greatest) in the background. Following the

operation, a certificate of manhood acknowledging their endurance and bravery as men is handed to the boys. Then the boys give soldier salute. The clown paraphrases the well-known expression uttered after circumcisions "Oldu da bitti maşallah, damat olur inşallah" (it has happened at once, May God preserve him; he will be a groom, by God's will) by replacing the word "groom" with such words as "scientist," "prime minister," and "professor." Families and the boys then reunite on the stage and dance together once again.

When I first watched this performance, the boys being taken to another room in the backstage upon the completion of the circumcision on the stage struck me as puzzling. I then found out that what was happening on the stage was not the entire process. The other circumciser (Tarkan) completed the operation in another small yet well-equipped room that they built recently. I was also told that there were times when the boys were directly taken to this room that they opened a couple of years ago if they were difficult to manage (e.g. if they constantly cry). Once I was chatting with Hakan right before he stepped onto the stage in order to circumcise boys. While the boys were lined up standing and facing the audience, one of them who looked upset and scared caught Hakan's eye. Hakan then turned to me and said: "I will take that one to the backstage. He looks like he will cry."

In the clinic, the circumcisers and the staff were all concerned about children's expressions of pain, fear and frustration. The efforts for eliminating pain and fear from children's experience of circumcision were indistinguishably tied with the efforts for rendering pain and fear invisible and inaudible, especially, to families who were potential customers and watching the circumcisions. In cases where boys cried after the

circumcisions, the circumcisers sometimes warned them half-jokingly and told them not to cry since, they added, there was nothing to cry for. They were worried that children's expressions of pain, fear, and frustration could be seen by the observers/audience/customers as failures on their parts though in my conversations with both Hakan and Tarkan, they often blamed parents for not preparing their children psychologically in advance.

Parent-blaming was very common in health officers' dialogues with me and the parents. Hamit, a 60-year-old health officer, has been performing circumcisions routinely since 1983. In the waiting room in his clinic, there was a TV screen hanging on the wall for the visitors who would want to watch circumcisions that he performed in another room. Before interviewing him, I attended a circumcision that he performed in the clinic. Hamit and I entered the operating room together and then he put his gloves on, and got ready for the circumcision. He first applied local anesthesia and before cutting the foreskin off, Hamit wanted to inform me of the merits of circumcision:

Hamit: Do you see this white stuff [smegma] here?

Oyman: Yes.

Hamit: This is why Americans also circumcise their boys. Because it is healthy.

In the meantime, in the other room, the boy's relatives were watching the circumcision. When Hamit began to work on the foreskin, the boy started crying "It hurts! It hurts!" Hamit was frustrated over the boy's reaction and responded dismissively, saying: "No it does not. You are making it up!" Then, Hamit first looked at me and said "it is just fear" and then turned to the parents and said "This is your fault, you know, right? I am sure you

have familial problems and your boy is affected by them. Or did you scare him of circumcision before you came here?" Although not every health officer was as straightforward as was Hamit, almost all of them complained about the manner in which parents interacted with their boys about circumcisions.

Health officers were well aware of the fact that fear and panic could be contagious and hence often wanted to keep boys apart from each other (This was another reason why Hakan took the boy who was, he thought, about to cry, to the backstage). Fenni sünnetçi Basri, a health officer who had a clinic in Bursa, has been performing circumcisions since 1980. When I went to his clinic, he was getting ready for a circumcision. His clinic was smaller than other clinics I visited. There were two small adjacent rooms, operating and waiting rooms separated only by a thin wall. In the operating room, there was a boy waiting to be circumcised and in the waiting room, there was another boy waiting with this parents for his turn. Basri kindly asked the boy and his parents in the waiting room to step outside the clinic. After the operation, I found out that the reason for his request was that in case the boy who was about to be circumcised cried during the operation, the other boy would not hear him and not get scared.

Before the operation, Basri talked to the boy and tried to clam him down. He patted the boy's cheek and said "Don't worry. It won't hurt." Basri then asked me to take a picture of the child before the operation. After receiving his parents' permission, I took a picture of him. Once local anesthesia kicked in, Basri began to circumcise the boy. The boy looked nervous and scared and then he started crying. Basri quickly turned to me and said "please don't take a picture of him, now." I did not. The fact that the boy was crying was a potential sign of failure for Basri and, unsurprisingly, Basri also blamed the parents

after they left the clinic. He said that he was sure that the parents did not prepare their boy in advance, emotionally.

The management of the visibility and audibility of pain and fear were, to varying degree, common in all these clinics. Almost all these clinics for instance offer the option of playing PlayStation during circumcision. These clinics often engage in a teamwork that meticulously creates a front (Goffman 1978) in which circumcision turns into a pleasant experience for the eyes and ears of family members. In these settings, the emotion labor on boys is incorporated into another ethos: Seamless and undisturbed experience of male circumcision as an entertaining event—an event in which pain must remain in the backstage of the performance. Any possibility of disruption is precluded and the event is structured as a series of comforting moments to be remembered in the future (and hence to be recorded/photographed).

By managing pain and fear in circumcisions, these clinics meticulously reorganize the two components of the ritual: Witness and memory. This type of circumcision is clearly different from infant circumcisions and the circumcisions that are performed using general anesthesia at some high-ranked hospitals. In infant circumcisions, the question of whether or not the baby would remember the operation is irrelevant. More importantly, some specialists advocate for this type of circumcision since babies are, supposedly, too young to remember the operation, which ruled out the possibility of experiencing trauma for the babies. Similarly, some specialists prefer performing circumcisions under general anesthesia regardless of the age of the boys. In these types of circumcisions, the role of the witness in the ritual of circumcision becomes superfluous, as the event is not meant to be remembered.

Another striking aspect of these clinics is that they all use personalized advertisement strategy. For instance, in the "Circumcision Palace, " there was a display of photos of Kemal Özkan with politicians or celebrities, along with his license, on the walls. These photos were taken at the occasions where Kemal Özkan circumcised these well-known families' boys. Combined with the carefully managed performances, the display of such photos establishes "overt showmanship," (Langford 2002), which is typically excluded from the dominant professional codes of medicine. Comparing professional's office with airlines, Hochschild (2003) argues that the professional's own office should be arranged in a pleasant but impersonal décor while airlines seem to model "'stage sets' on the living rooms seen on daytime television serials: the Muzak tunes, the TV and movie screens, and the smiling flight attendants serving drinks are all calculated to 'make you feel at home'" (p.51). Similarly, the kind of aesthetics in hospitals reflects professional codes that aim to inspire confidence and convey the impression of objectivity while health officers, in their struggles against hospitals/specialists, put a critical distance from these codes yet without violating them, as they also work under hygienic conditions and well-equipped settings.

In these clinics, health officers, I argue, invoke the fundamental civilization/culture dichotomy of the Turkish nationalist ideology in the times of the neoliberal transformation of the society. They accomplish this by engaging in a kind of emotional labor that aims to bring "home/warmth" ("tradition") back to the supposedly "cold" (civilized) settings. Based on the dichotomy of civilization/culture, as we saw in Chapter 2, the Turkish state, in the beginning of the 20th cc, incorporated modernized male circumcision into the reservoir of the representations of culture. This dichotomy

requires a careful balance between two extremes; "over-civilized" and "too traditional," and the question of whether or not a certain practice is "over-civilized" is open to interpretation and contestation. While in the 1960s, young health officers had an interest in de-ritualizing/modernizing the custom in order to differentiate themselves from traditional circumcisers, in the post-2000s, these health officers in their senior years had interest in re-ritualizing the custom in the period of time where patients are increasingly turned into customers. On the one hand, health officers saw hospital-like hygienic conditions as a sign of progress and provided these conditions in their clinics. On the other hand, they aimed to differentiate their circumcisions from hospital-based circumcisions. To this end, they claimed to keep up the proper balance between tradition and civilization and represented hospital-based circumcisions "too civilized" and estranged from "traditions." They, in other words, reritualized the practice by highlighting the distinction of their circumcisions from mundane operations that are, they claim, performed at hospitals.

The professionalization of male circumcision restructured the occupation as a site of constructing modern masculinity associated with science and rationality. By incorporating what is conventionally seen as a feminine theme, "emotional labor" into their practices, the practitioners of circumcision, over the last two decades, represented themselves as emotionally sensitive toward children. By having recourse to the scientific elaborations on emotions, vulnerability, and well being, the practitioners use the care for the emotional state of boys as a strategy within the competition for the demands for circumcision. Unlike in the case of women and female practitioners, their emotional labor

is neither devalued nor unrecognized. On the contrary, it became a crucial part of the self-representations of the practitioners.

The state-led the professionalization, at least in principle, aimed to enhance the physical well being of children by introducing medical knowledge, skills, norms, and techniques into the practice. However, as we saw in the previous chapters, the technical care in this period was not equally distributed within society mainly due to the class-based character of the professionalization. Citizens in certain regions of Turkey and in villages throughout the country where traditional circumcisers were prevalent did not receive proper medical care since these circumcisers were not incorporated into health care system, systematically. Similarly, our analysis of the collective circumcisions in this period showed how class inequalities shaped the access to proper circumcision care in the urban areas. For all these segments of the population, in other words, the promise of the professionalization remained unfulfilled.

The combination of the sentimentalization and hospitalization of male circumcision led to a new regime in which emotional care became a crucial part of the wellbeing of children. Under this regime, in addition to technical care, emotional care requires the practitioners of circumcision to perform a new kind of labor to achieve proper male circumcision. We can now ask the same question that we asked for the regime of technical care: Is emotional care in circumcision equally distributed within society? Although it is too soon to fully assess the hospitalization of male circumcision under neoliberal policies, the next chapter will provide us with some insights into how the disadvantaged urban classes experience the sentimentalization and hospitalization of male circumcision. As we shall see, while the neoliberal reforms in health care system,

rightly, received criticism for transforming the system according to market-oriented and consumer-centered principles, in the case of circumcision services, these reforms also significantly improved the access of the sons of the poor to technical care. However, it also simultaneously reproduced the class differences in new terms.

CHAPTER 7

CLASS, TIME, AND CIRCUMCISION

As we saw in the previous chapter, for the practitioners of circumcisers, especially for senior health officers, performing emotional labor has been a crucial market strategy for consumer demands for modern circumcision in the post 2000s. As in the case of the use of local anesthesia and sutures, the techniques of emotional labor extended the necessary time for the proper care of children in circumcisions, as practitioners now allocate extra time for managing children's feelings. The concern regarding trauma became tied to the concern regarding providing comfort to (middle class) families, which requires the elimination of fear and expressions of pain from circumcisions.

Time is an important element of the care work in healthcare industry and scholars showed the link between the poor quality of health care services and the time constraints under which health professionals (especially nurses) work (see, for instance, Bowers et.al.). In the case of collective circumcisions in the 1960s, health officers used to rush through these circumcisions and did not give proper care to the boys of the poor. Specialists claimed that the problem with these circumcisions was not only that they took place in unhygienic settings but also that health officers did not devote enough time for each child for sterilization and using sutures. In these kinds of circumcisions, they added, practitioners could not prepare children psychologically, either. They claimed that if collective circumcisions were performed at hospitals working with appointment system, children would receive better care than they did in the past. This was so not only because hospitals are more hygienic than the settings where collective circumcisions used to occur

but also the appointment system would enable specialists to devote enough time for each child and provide them with both technical and emotional care.

While in the previous chapter, I analyzed emotional care as a strategy on the levels of both discourse and techniques, in this chapter, I focus on emotional care as a service and analyze the experiences of the poor in low-ranked hospitals where specialists perform collective circumcisions. By doing so, I aim to answer the questions of whether and how class differences shape the access to emotional care within society. I argue that while the process of the modernization of collective circumcisions organized for the poor in the post 2000s significantly improved the access of the disadvantaged families to technical care in circumcisions, which was welcomed by these families, it also produced a new form of class inequality under the conditions of neoliberal transformation of healthcare services—a form that is based on the unequal access to the emotional care in circumcisions. I claim that the concentration of the supplies of the services of male circumcision at hospitals and the changing working conditions of specialists prevented specialists from allocating enough time for maintaining the emotional care of children in collective circumcisions. The hospitalization of male circumcision, in other words, did not abolish the class inequality in access to proper circumcision services but shifted the basis of this equality from technical to emotional care.

First, I discuss the changing working conditions of health professionals in the last three decades. The neoliberal reforms introduced new disciplinary mechanisms and market-oriented incentives for health professionals in order to increase the efficiency in the deliveries of healthcare services. These reforms rendered health professionals vulnerable to the marketing strategies of their profit-seeking employers (private

hospitals). This part will enable us to understand why specialists in the low-ranked private hospitals made investment in performing circumcisions though they saw this medical task as incompatible with their credentials and why they performed these circumcisions under time-pressure.

Second, I take a closer look at how circumcisions take place in private hospitals. Contrary to the expectations, we shall see, in the case of collective circumcisions, the appointment system did not allow specialists to devote enough time for children mainly due to the competitive conditions under which they work. Compared to the emotional care that the sons of middle and upper-middle class families obtain, this chapter shows, the sons of the poor received inadequate emotional care although the hospitalization of collective circumcisions improved the physical care that they received. Unlike in the case of middle class settings, the lower-class families mobilize their own coping mechanisms and use contextual and transient tactics (e.g. turning to others for help) in order to manage their sons' emotions.

In the last section, I address the critiques of the neoliberal reforms in healthcare system, which were voiced by associations, unions and academics (see, for instance, Sonmez 2012; Aksakoglu 2008; Soyer 2007). Based on our discussion in this chapter, I complicate, if not disagree with, these critiques by claiming that these critiques are often "physician-centered" and do not pay enough attention to how disadvantaged classes experience and evaluate the changes that the reforms brought about in their lives. In the case of circumcision, the lower class parents welcome their access to private hospitals although their sons are circumcised by professionals who work under time-constraints at these hospitals.

7.1. Competition, New Disciplinary Mechanisms, and Specialists

As mentioned in Chapter 4, although specialists were eligible to perform circumcisions since 1928, they were not willing to perform circumcisions up until 1990s. As in the case of the health officers who did not want to begin to perform circumcisions due to the stigma attached to sünnetçi (circumciser) in the 1960s, medical specialists avoided performing circumcisions mainly because they were viewing it as a too lowly task. The mismatch between the prestige accorded to their position within the symbolic hierarchy of medical professions and the low status attached to performing circumcision shaped my dialogues with specialists as well. When I asked them about their training for performing circumcisions, they were often offended by my questions. On the one hand, they said that compared to other tasks they performed, circumcision is too simple and does not require complex skills. Some of them added that performing circumcision is only a matter of practicing suturing and there is no need for receiving a special training. On the other hand, they claimed that circumcision is a very risky operation and should not be left to the hands of health officers. Some of them emphasized that penis is a crucial part of men's bodies and should be given due care.

Despite the low status of performing circumcision in the gendered division of medical labor, what were reasons for specialists begin to perform circumcisions in the post-1990s? As we saw in the previous chapters, according to almost all of the health officers I interviewed, medical specialists simply wanted to "get a piece of the pie" (pastadan pay almak)—the same idiom that traditional circumcisers used for health officers who began to perform circumcisions in the 1960s. I suggest that while economic

incentives certainly played an important role in the specialists' claim to the demands for modern circumcisions, these incentives solely cannot explain why medical specialists began to perform circumcisions over the last two decades—especially those specialists who work at low-ranked private hospitals in cities. In order to understand the complexity of the specialists' investment in circumcisions, we should take a closer look at their changing working conditions and the new disciplinary mechanisms that the neo-liberal re-ordering of healthcare services brought about.

As we saw in Chapter 4, the JDP's health reforms aimed to build the principle of competition into healthcare services accompanying the significant increase of the number of private inpatient institutions including hospitals and clinics over the last two decades. These institutions are mostly located in large cities that have larger markets for healthcare services than small cities. Public hospitals that the ruling party (JDP) criticized for wasting public resources also became autonomous and subject to the pressure of competition with the private institutions. The ruling party claimed that the competition could promote efficiency in delivering healthcare services (i.e. maximum service with minimum cost), as the service providers would be incited to better their services in order to increase their market share.

In this period, the competition among medical institutions was paralleled by the emergence of a new disciplinary mechanism of competition for health professionals: performance-based revolving fund. According to this system, each medical task including circumcision was assigned a point-value. Health professionals receive their commissions from revolving funds according to the number of points that they collect. This system

made health professionals dependent upon the competition among their employers by linking the number of demands that health professionals can meet with revenue.

The newly graduated health professionals including specialists often found themselves in precarious employment and working conditions. Health professionals have been more and more employed on contract-basis especially in private sector, which has brought instability and uncertainty to their lives. The precarious working conditions rendered them vulnerable to the pressures stemming from the competition among hospitals for consumer demands. Health professionals tended to adopt market-driven calculative thinking under the pressure of competition fueled by the technique of revolving funds. Health professionals' calculative thinking combined with a new form of adherence to employees (mostly low-ranked private hospitals) that is obtained by eliminating the temporal guarantees of employment.

Under the new point-based reward system, healthcare professionals including specialists were now motivated to increase the number of physical examination that they performed and hence limit the time they allocate for each patient as much as possible. More hospital visits mean more profits for hospitals, and more points and hence more financial gains from the revolving fund for healthcare professionals. The professionals were also encouraged to lean towards performing more surgeries than they were in the past. As a result, the average number of physical examination within a year per person went up from 2 to 7 and the number of surgical operations per 1,000 population went up to 116 in 2010.[48]

The upsurge in the number of hospital visits was also related to the radical change in the social security system. As we saw in Chapter 4, the premium-based General Health

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[48] http://www.saglik.gov.tr/TR/dosya/1-72577/h/saglikistatistikleriyilligi2010.pdf

Insurance increased the overall access to healthcare services in Turkey. Private hospitals increasingly became a reasonable option for not only middle and upper-middle classes but also for lower classes. Although, according to the point system assigning a certain value to each medical task, performing circumcision is located at the bottom of the hierarchy of the medical tasks that specialists perform (a urologist, for instance, would gain more points from performing prostate surgery than performing circumcision), since private hospitals used collective circumcisions as a technique of generosity, specialists working in low-ranked hospitals performed these circumcisions.

In their clinics, senior health officers spend a great deal of time and energy in eliminating pain and fear from circumcisions. How do the circumcisions take place in private hospitals? What are the differences between the circumcisions at lower-ranked hospitals and the (collective) circumcisions at higher-ranked hospitals? Does the hospitalization of collective circumcision, and more specifically the appointment system, achieve its goal of providing both technical and emotional care for boys? In the next section, I answer these questions by focusing on private hospitals where circumcisions take place in Istanbul.

7.2. Class Inequality, Time, and Emotional Care

I was waiting to conduct an interview with a urologist at the waiting room in one of the high-ranked hospitals in Istanbul. As usual, I arrived at the hospital earlier than the appointment time in order to have a chance to observe/talk to families at the waiting room, one of my fieldwork sites wherein I could interact with families as an ordinary person. A family—a father, a mother and their son— was waiting to be called into the urologist' office. The urologist first invited all the family members to his office and

talked to them for ten minutes. Then the child came out of the office alone and sat across from me. Once we started chatting, he asked me whether or not he would feel pain during circumcision. I said "no." I later found out that the meeting that the urologist and the family members had was a consultation meeting and the child was going to be circumcised a day later. When I asked the urologist about the purpose of the meeting afterwards, he said that he wanted to talk to the child in order to inform him of the details of the operation and comfort him. After telling me that he had a friendly conversation with the boy and asked him about his personal life (e.g. how he is doing at school, his favorite class and soccer team), he added:

> The communication with children is essential if you want to win their trust. They should not see circumcision as a punishment. A practitioner should know about child psychology. Of course we are not psychologists and we cannot do their jobs but we should act like one and prepare the boys psychologically.

As we saw in the previous chapter, in the post-2000s the practitioners of circumcision began to address and manage children's fear of circumcision and possible sense of punishment in order to prevent the occurrence of trauma in children. To this end, they used transparency as a technique shaping interactions between practitioners and children and claimed that this technique would help practitioners to win children's trust, alleviate their fears of circumcision and thus minimize, if not eliminate, the traumatic effect of the operation on them. Within the new formulation of the well being of children, the practitioners regarded children as rational beings capable of processing the messages that adults convey to them. Full disclosure regarding the stages of the operation is strongly advised. Not telling the child that he is going to get circumcised, which is a common

practice in Turkey, is often frowned upon because it erodes, they argued, the boys' sense of control over his surrounding.

Pre-operation consultation was common for circumcisions that specialists perform at high ranked hospitals. They did not lie to children about the procedure and, depending on their age, informed them of the details of the operation. They were well aware of the fact that the children they would circumcise could be exposed to the fear-provoking stories about circumcision, which are in circulation in public. As in the case of clinics run by senior health officers, they wanted the children to feel safe and in control over their surroundings.

After visiting the high-ranked private hospital, on the same day, I went to a low-ranked private hospital in Istanbul where collective circumcisions took place. I began to wait for the specialist who was going to perform the circumcisions with other families in the second floor of one of the hospital. The municipality of the district wherein these families were registered scheduled for each family circumcisions in the hospital. The district was one of the neighborhoods populated by families coming from impoverished regions of Turkey. Most of them were either working at low-paying jobs or running small-scale businesses. The boys were wearing the special circumcision outfits that the municipality distributed. Following the operation, the families were scheduled to participate in the festival that the municipality organized, too. During these festivals, families sometimes attend concerts and children are handed gifts and candies. As part of the management of poverty, these festivals become an important tool for the Islamists municipalities to represent themselves as the protector of the poor.

As time passed, the floor of the hospital became overcrowded with families waiting for the urologist who was going to perform the circumcision. The urologist was late because he was at a surgery and one of the fathers who found out about it complained to the nurse, saying "Why did the doctor accept another patient knowing that there are circumcisions today?" The nurse told him that it was emergency and the doctors had to attend the surgery. Due to the prolonged wait time, parents and their sons were gradually getting tense and restless.

With the arrival of the urologist who rushed into the operating room, a nurse took one of the children to another room where she applied local anesthesia to him. A few minutes after the door was closed behind them, the scream of the boy passing through the walls of room flooded the floor and was echoed by the other boys' screams in a contagious manner. Unlike in the case of clinics serving middle class families, there was no spatial arrangement for precluding the spread of fear and pain among children in this setting. While parents were making great efforts to calm their children down by shushing, reprimanding, offering candy or promising gifts, the nurse was going through the list of the boys scheduled for circumcision one by one. Once the drug kicked in, each was taken to another room for the operation. The presence of the families in this room was necessary because they were needed to calm the children down so that the operation could be carried out smoothly. During one of these operations, a father who was about to faint walked out of the room with the help of one of his relatives. Being concerned about his pale face, the nurse put him to a bed in another room. Only a few minutes later, his wife hastily walked out of the room, turned to me and asked: "Could you please come in

to help us?" She sounded very worried and panicked. Having the father's pale face stuck in my head did not keep me from taking this invaluable opportunity for my research.

Following the mother, I also walked hastily into the room where the boy was lying in a bed surrounded by a urologist, a male nurse, and a male relative. The nurse and the relative were trying to hold the boy down while the urologist was operating on him. The child who did not look older than six years old was very scared, as he was screaming and struggling to free himself from their hands. The mother asked me whether I could help them to keep the child stable. Despite my little hesitation, I accepted and grabbed one of the boys' legs. I was now inundated with conflicting feelings: On the one hand I was feeling like I was making the very disturbing procedure easier for the boy's family, the urologist and ultimately the boy himself. On the other hand, I was feeling guilty for being accomplice with the team inflicting pain and fear on him. Everyone faced away while the doctor was cutting the foreskin off. Once the operation was over, the nurse handed a certificate of manhood[49] to the boy and informed his mother regarding recovering procedures. Having tears in his face and without looking at the certificate even once, he handed it to his father. The boy was still crying and his father asked him "why are you crying like a little girl?" The boy was in silence. The father asked him another question: "Did you like the certificate?" The boy first shrugged off and then said that he did not like it.

On another day, I was visiting another private hospital where collective circumcisions were taking place. On the fifth floor of the hospital, I was again waiting with families for the urologist to come. The door of the room where boys were going to

[49] On the certificate was written: "[name] earned this certificate due to the courage he showed today. We congratulate him and wish him the best for the rest of his life."

be circumcised was decorated with flowers, streamers, and a doll. There was also a pile of soccer balls for the boys who have undergone the operation as a gift. Once the nurse announced that she would start administering local anesthesia, a boy wearing circumcision outfit, his father, his mother, and an extended family member started arguing over the circumcision:

The boy: I do not want to be circumcised.

The father: They would not let you do your military service, then.

The boy: I do not care.

The male extended family member: What kind of a man are you?

The boy: Mom, I do not want to go in.

While his mother was trying to convince the boy, another mother was dragging her son on the floor and telling him that they would only measure his penis and he would not feel any pain. In the meantime, upon seeing the pen that the janitor was holding in his hand, another boy began to cry since he thought that the pen was a circumcision instrument. His mother corrected him and told him that it was his turn to go into the circumcision room. The boy had two younger brothers who were also going to be circumcised. The mother was worried that his brothers would hear him cry in the circumcision room and get scared. Families were very aware of how contagious the feelings of fear and pain could be.

In the meantime, the boys who were circumcised were walking out of the circumcision room one by one. One of the mothers asked his son to give soldier salute and the boy complied with the request with tears in her eyes. He was still crying. His father told him that they got him a toy truck and would take him for ice cream. Another

boy who was looking calm when he walked out of the circumcision room sat next to another boy who was waiting to be circumcised. He turned to the other boy and told him in a mischievous way: "They will cut off your penis."

Unlike in the case of high-ranked private hospitals, the appointment system that was meant to enable specialists to devote enough time for each boy did not work mainly due to the overall demands that the specialists had to meet at these low-ranked private hospitals. Specialists were often late for these circumcisions and it was not uncommon to see long lines of families waiting for their turns. One of the reasons that made my visits to these hospitals very striking to me was that, in the meantime, I was also attending circumcisions not only at high-ranked private hospitals but in clinics that I examined in Chapter 5. In these settings, as we saw, with the help of various tactics (e.g. videogames, music and clown) practitioners pay special attention to children's emotional well being and aim to give comfort to both children and their families. Obliterating any signs of discomfort and pain, circumcisions are meticulously turned into entertaining and memorable events for families. Boys were giving soldier salutes with smiles on their faces and (some) mothers got only happy tears in their eyes. While families at the low-ranked private hospitals barely, if any, had opportunities for taking photos or videos of the operations, in the clinics, the necessary visual distance for recording the events was guaranteed. In the former setting, families are mostly left to their own devices in handling the process of circumcision. Panic, screams, and restless body gestures prevail. Families mobilize their own coping mechanisms and use contextual and transient tactics (e.g. turning to others for help) in order to complete the operation and manage their sons' emotions.

Circumcision is, traditionally, an event that is meant to be remembered. On the one hand, families who have the procedure done in clinics anticipate that their future memories would be imbued with a sense of comfort. On the other hand, in the collective circumcisions, the present was arrested with the recurring presence of expressions of pain. Being marked by hastiness and urgency, the present was inhabitable not with comfort but with hypervigilance and sense of emergency.

The sense of emergency shaped health professionals' rhythms, too. As in the case of health officers performing collective circumcisions in the 1960s, specialists had to move from one child to another very quickly. There was an important difference between the collective circumcisions in two periods, though. In the post 2000, the new techniques prolonged the time necessary for proper care for children by introducing the concern regarding the emotional wellbeing of children in circumcisions and set new evaluative and moral standards for practitioners. They produced new knowledge and assumptions about medical care. While, unlike the collective circumcisions taking place up until the 2000, the technical care (e.g. hygiene and sterilization) was more or less provided for children at hospitals, it was not easy for specialists were working under time pressure at low-ranked private hospitals to reconcile the imperatives peculiar to proper emotional care and the increasing demands that they had to meet. In my conversation with a surgeon about the difference between ordinary and collective circumcisions:

> Oyman: How is your communication with children?
>
> Hakan: We are doing our best. If children are too young, it becomes difficult for us to communicate with them, of course. We are telling them how we will apply local anesthesia and then explain all the stages. In other words, we are telling them everything.
>
> Oyman: What about collective circumcisions?

> Hakan: Those are difficult in terms of both communication and techniques. We are using the same system but we sometimes have to use fewer sutures because we have to be faster in those circumcisions. And of course there is no opportunity for talk to children in collective circumcisions.

The difficulty for specialists to perform emotional labor is sometimes experienced as uneasiness that they project onto parents (parent-blaming), as in the case of health officers. In my conversation with a urologist who performs collective circumcisions:

> Oyman: How many circumcisions do you perform per day in this period of time? [Summer time]
>
> Mustafa: Let me make something clear first. This is a special occasion [collective circumcisions]. Normally I perform two or three circumcisions per week. Now we perform 30 or 40 circumcisions per day. Municipalities organize these circumcisions. This is partly about benevolence but also partly about marketing. If you asked my opinion as a doctor, I do not approve it. But you know, we have to perform these circumcisions because the hospitals are requiring us to do. Circumcision is a medical operation and it should be taken seriously. Of course, we sterilize our instruments one by one and do our best to prevent contamination. But in these situations, I cannot understand children's psychology. Or even if I understand them, I cannot pay attention to them. But under normal circumstances, I first talk to children and if I feel like they are not ready for circumcision, psychologically, I recommend general anesthesia. Educated families ask me about the operation. They read about circumcision on internet. And they actually talk to their sons and inform them about the operation. if they are old enough, children understand what their families say to them.
>
> Oyman: But this is not the case in collective circumcisions?
>
> Mustafa: No. Since they do not pay anything for these circumcisions, they do not care about whether or not anything would happen to their sons like psychological trauma.

While proper care requires attention and time on the part of healthcare professionals, the shortage of time has always been part of the lower-class families' experience of male circumcision. On the one hand, the lack of proper hygienic measures in collective circumcisions that health officers hastily performed marked the classed character of

circumcision services in the 1960s. On the other hand, in the neo-liberal period in which collective circumcisions underwent modernization and the new techniques of emotion labor lengthened the necessary time for proper male circumcision, time figures in the reproduction of class inequality on a new basis: Now, it is emotional care, or lack thereof, of which the sons of the lower-class families were deprived. The neoliberal reforms, in other words, did not abolish the class inequality in access to proper circumcision services but shifted the basis of this equality from physical to emotional care.

The market-oriented professionalization of circumcision leading to the concentration of the supplies of male circumcision in the hand of specialists/hospitals, I suggest, became an obstacle to the fulfilment of the promise of modern circumcision (the emotional wellbeing of children) for disadvantaged groups. The spatial basis of the group of specialists is much more limited than than that of health officers, as specialists are concentrated at hospitals in urban areas and the accumulation of lower class families in low ranked hospitals made it difficult for these specialists to use the techniques of emotion labor.

Scholars, unions, and medical associations (Turkish Medical Association) voice their dissent against these reforms in public and claimed that instead of seeing healthcare services as a matter of citizenship right, the JDP government implemented market-oriented reforms and turned patients into customers. They criticize the government for placing health professionals under precarious working conditions via the performance system. Health professionals, they said, now have to work for longer hours for profit-seeking hospital and are rather interested in maximizing their points than paying due attention to their patients. The JDP's health reforms, the critiques say, thus could not

attain the goal of increasing the wellbeing of the society but produced catastrophic results for citizens who cannot afford purchasing services from high ranked hospitals.

The Leftist critiques of the reforms in health care system are right in pointing out the insufficient time allotted for health care services. However, these critiques often assume that JDP's neoliberal policies in healthcare system (and other areas as well) destroyed a system that was once fair and just. Thus, they often fail in understanding that such policies could, after all, empower lower classes, which could explain these classes' consent for these policies and the political authorities that implement these policies. In a similar vein, Turkish political economist Ayşe Buğra (2011) points out the consecutive electoral successes of the JDP and asks the following question: Although Turkey has been ranked low in both human and economic development indexes and did not show a good performance in its struggle against poverty, why do people still vote for the JDP that has been in power since 2002? Social policy is, she says, one of the fields in which we could find an answer to this question. The changes in social security and healthcare system, for instance, broadened the scope of options for lower class families. Thus, she suggests, we should focus more on how people experience the effects of these policies rather than reaching ready-made and hasty conclusions about them.

Similarly, a sense of empowerment was salient in my interviews with lower class families. While waiting for their sons' circumcision, the fathers in their thirties often mentioned to me that they could now take their sons to whichever private hospital they wanted. They provided me with examples from their own circumcisions in which they experienced pain and massive bleeding. These fathers were circumcised by either traditional circumcisers or by health officers during collective circumcisions. They

pointed out the progress in circumcision techniques and the hygienic conditions where circumcisions took place. Even though, as this chapter shows, the neoliberal reforms regarding circumcision did not dismantle yet reproduce class inequality on a new basis, the improvement in the delivery of the physical care in circumcisions between generations was welcome by the disadvantaged families.

CHAPTER 8

CONCLUSION

Why and how are the prestigious occupational positions within society usually held by men? How do men construct their identities based on work? How does masculinity shape their work and vice versa? What are the strategies that men use to gain and maintain control over the work? This study set out to answer these questions by exploring the professionalization and medicalization of male circumcision in Turkey. Performing circumcision is culturally defined as a male occupation and bestows economic privilege and social status on circumcisers. The dissertation framed the professionalization of male circumcision as an outcome of power relations between different groups of male practitioners (traditional circumcisers, health officers and medical specialists) and analyzed how medical professionals (first health officers and then specialists) achieved the control over male circumcision by medicalizing the practice. I argued that professionalization of circumcision recast the occupation as a site of constructing public masculinity by positing credentials and license as a barrier for access. The professionalization of circumcision first excluded uneducated and subsequently, less educated male practitioners. The dissertation also further explored the moral and social consequences of the gendered professionalization of circumcision that transferred the control over circumcision from one group of practitioners to another for the different segments of the society (i.e. lower and (upper)middle classes).

This dissertation answered three interrelated questions:

1- How did masculinity figure in the professionalization of circumcision?

2- Through what kinds of institutional and non-institutional means did professional groups gain the control over male circumcision?
3- To what extent did the professionalization of circumcision fulfill its normative ideals (protecting boys from the potential harmful effects of circumcision)?

The professionalization of male circumcision is divided into two historical periods: State-led (1960s-1990s) and market-oriented (1990s-present) professionalization. In the first phase of the professionalization, the professional group, health officers, introduced modern techniques, skills, and knowledge into the practice and challenged traditional circumcisers' control over male circumcision. Under the welfare project of the socialization of health care services, the Turkish state assigned licensed health officers who underwent formal training to various parts of the country in order to both improve and modernize the healthcare services. Starting in the 1960s, these health officers gained locals' acceptance and drove traditional circumcisers out of practice to a great extent.

Health officers' victory was located within gender-segregated medical education. The The itinerant traditional circumcisers were trained by apprenticeship and girl children had no access to the position of apprentice. In traditional circumcisions, the skills, knowledge, and techniques were transmitted between (male) masters to (male) apprentices. In the modern period, the Turkish state replaced the family and gender based social closure of traditional apprenticeship with the credential and gender based social closure of medical education. The Turkish state placed performing circumcision as part of the job descriptions for health officers while closing off the position of health officers to girls. The legally protected gender-segregated education, in other words, was the main structural mechanism that gendered the access to performing circumcision in the modern period.

The victory of health officers against traditional circumcisers incorporated the task of performing circumcision into the gendered division of medical labor and reinforced the link between occupation and masculinity in a new modern form. Starting in the 1990s, male specialists (primarily urologists but also surgeons) began to challenge health officers' control over male circumcision by stigmatizing and devaluing their credentials, skills, and knowledge. In mass media, they spread new definitions of proper circumcision (e.g. circumcision without trauma), aimed to shape the public opinion on circumcision and channel the demands toward hospitals. Specialists and private hospitals engaged in lobbying activities and prevented health officers from performing circumcisions, independently. Again, in addition to the culturally informed link between the occupation of circumcising and masculinity, women's low access to the male dominated specialties (e.g. urology) strengthened the position of male specialists in the market for circumcision.

This study engaged with the sociological literature on professions and used the Weberian and neo-Weberian notion of social closure. This notion suggests that social closure refers to the process in which social groups seek to maximize their advantages and rewards by reducing and/or closing off the resources and opportunities to outsiders. The basis of exclusion of social closure could be any social or physical attribute such as religion, race, gender, language or credentials. Social groups aim to monopolize economic opportunities, the endeavor coupled with the pursuit of social status, by eliminating their rivals and/or rendering them subordinate to their own control. To this end, these groups use strategies (e.g. licensure) whereby they could control and shape the supplies of, and demands for, their services. Closure on the sides of both supply and

demand aims to create scarcity of individuals who have the legal, technical and socially recognized ability to perform these services.

My dissertation contributes to this literature by examining the complex relationship between gender and social closure. While feminist scholars analyzed the ascendancy of male professional power from the perspective of female healers, they often accepted male practitioners as a homogenous group. By drawing on the basic premises of masculinity studies, this study focused on power relations between male practitioners without overlooking the role of subordination of female practitioners in the construction of male dominance. It showed how the exclusion of female practitioners from the occupation in both traditional and modern periods rendered the transference of the control over male circumcision from one group of male practitioners to another possible.

The Turkish state played a crucial role in professionalization of circumcision via the techniques of credentials and licensure. The national discourse emphasized the importance of the wellbeing of the population and defined healthcare professionals as agents who would both modernize and improve the healthcare services within society. Accordingly, the state saw traditional healers and practitioners including circumcisers as inimical to the health of the nation. The state's top-down act of licensing rendered these healers and practitioners, who had ties with locals, illegal and provided an opportunity for licensed and formally educated professionals to convert their credentials, skills and knowledge into economic and social rewards by representing themselves as the only legal practitioners.

However, my study showed that the strict application of licensure in the case of circumcisers not only limited the scope of the medicalization of male circumcision but

also often created conflicts between professionals and locals. One the one hand, in the 1960s, it was not uncommon for families to reject the use of the new techniques by a practitioner with whom they were not familiar. Health officers had to engage in various tactics including cooperating with their rivals in order to gain locals' acceptance. On the other hand, traditional circumcisers generally did not have a problem introducing the same techniques to male circumcision partly thanks to the trust that they built over time. However, most of these traditional circumcisers working in rural areas did not fully incorporate the new techniques into their practices and the sons of the disadvantaged groups were still deprived of proper care. My study, in other words, showed that the Turkish state's strict licensing policy hindered the systematic incorporation of traditional circumcisers into the healthcare system and hence failed in fully meeting the goal of achieving the wellbeing of children.

By banning health officers from performing circumcisions, independently in 2013, which became effective in the summer 2015, the ruling party, JDP decided to follow the lead of the Early Republican period. While it is too soon for us to assess the consequences of the JDP's new policy, my study provided insights into how this policy would shape the quality of the care that the sons of both lower and (upper) middle class families will receive. The combination of the increasing overall access to hospitals that are mostly located in large cities and the shortage of specialists poses a question of how these specialists will meet the demands for circumcision. Considering that almost all Muslim boys become circumcised and parents still tend to have their sons circumcised in the summer time, it would not be too far fetched to claim that taking their informal autonomy away from health officers or not allowing them to run private practice would

lead to supply-demand imbalance in circumcision. And the sons of the disadvantaged parents who had access to only low-ranked medical institutions where health professionals feel the time-pressure the most will likely be the ones who suffer from this balance.

Further research, however, is needed to reach empirically grounded full understanding of the recent trends in the organization and experience of circumcision. Based on our discussion in this study, the following questions for further research could be asked: How will healthcare professionals at medical institutions handle the demands for circumcisions? Will specialists delegate the circumcisions to other male healthcare professionals including male nurses/health officers? Also, due to the shortage of specialists, will we witness the feminization of the occupation? Unlike in the developmentalist period, professionals now do not have to move outside the bounds of medical institutions and go to families' homes to perform circumcisions, which might loosen the strict gendered criterion for accessing the occupation. Will female healthcare professionals perform circumcisions at hospitals, too? If yes, how families will negotiate the changing gendered character of the occupation?

Table 2: Number of Health Posts and Health Stations (per year)

Year	Socialized Regions	Health Posts	Health Stations
1963	1	19	37
1965	12	416	970
1970	25	851	2,231
1980	45	1,467	5,776
1990	73	3,454	11,075

Source: Ministry of Health Official Website,
http://www.tkhk.gov.tr/Dosyalar/e061aaf913224050b3690668e458809e.pdf

Table 3: Number of Health officers and Number of Persons per Health Officer (per year)

Year	Number of Health Officers	Number of Persons per Health Officer
1960	3,550	7,701
1965	4, 676	6,661
1970	9,954	3,548
1975	11,021	3,362
1980	11, 664	3,810
1985	10, 525	4,780
1990	21, 547	2,604

Source: TURKSTAT (Turkish Statistical Institute), Statistical Indicators, 1923-2004 (Ankara: TURKSTAT, 2006), table 3.2, p.45.

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