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SIN IN THE CITY

An Urban History of Medicine and Modern Morality in Turkey

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Introduction

Therefore also will I make thee sick in smiting thee, in making thee desolate because of thy sins.

Micah 6:13 (KJV)

Recognized in Judaism, Christianity, and Islamic scholarship, the eighth century BCE prophet Micah unambiguously linked causal connections between sin and sickness; iniquity incurred illness. Looking beyond his own modest and relatively moral village Moresheth, he castigated the people of Jerusalem and foretold the corrupt city’s destruction. For the immoral city, disease and ruination were inevitable. Within and beyond the three monotheisms, many of humanity’s systems of faith and social traditions routinely connected immorality with disease, often with starkly opposed spatial designations. In classic literary works such as Dante Alighieri’s fourteenth century epic The Divine Comedy, transgressions could be categorized and situated accordingly. In his poem’s depiction, Inferno was a distinct place with nine concentric circles that corresponded with the severity of sinners’ offenses. Beyond beliefs in heaven and hell, customs of geographically siting notions and attributes of good and evil are likewise profuse. Cities thus figure prominently in such cosmographic constructs—along with other contexts (e.g., the rural, the wilds, or the frontier). However, the moral characters of areas rarely are ever constant across cultures or through time. In the contrasting views of the Puritans and the transcendentalists, for example, histories of religion and environment in America reveal different manifestations of Christianity that corresponded with utterly discordant interpretations of wilderness. In the earlier tradition, the forest evoked suspicion and trepidation; in the latter, it inspired wonderment and reverence for the divine (cf. Schama 1995). Histories of ideas about urban environments likewise demonstrate inconsistent associations regarding their presumed virtues, or lack thereof. These preconceptions of cities also extend to their inhabitants, oftentimes ascribing determinist stereotypes that would presume moral character and physical constitution. Depicted as the peak of civilization, its virtues, and its source of security, the urban also may loom as a locus of desperation, depravity, and disease. In this chapter, we examine examples from early republican Turkey. In doing so, we reveal how reframed associations between sin and city connected with conceptualizations of disease, public health, and civic responsibility. The state’s vernacular for diseases and other health risks unambiguously equated good health with good citizenship. It thus conveyed that afflictions like syphilis, alcoholism, tuberculosis, and even malaria and varieties of injuries were
the consequences of civic/moral transgressions. These shifts transpired amid broader developments towards enhanced governance and state interventions in the biopolitics of subordinate populations (Foucault 2007, 2008). Though these advances by the state were evident in the late Ottoman context (e.g., in education; cf. Fortna 2002; Evered, E.Ö. 2012), they accelerated appreciably with the ascendency of modernist leanings and the emergence of the Turkish nation-state, contributing to rapid change in not only the practice of public health but also the associated rhetoric.

Considering the city of the early twentieth century amid nation-building and modernization, it was a site in which reformers actively redefined notions of transgression. As a consequence, we consider the concept of sin itself as especially fluid, with officials’ efforts shifting it from the uniquely religious and eternal to the secular, scientific, and civic. Traditions of historical analysis supporting this approach—at least insofar as state authorities were concerned—are apparent in accounts of both the modern state and modern medicine. Viewed as the religion (or ideology) of the modern era, nationalism and its anticipated institutional manifestation (i.e., the nation-state) typically functioned conspicuously to recast religious sin against one’s god or a divine ideal as, instead, an act against the state and one’s fellow citizens. Encompassing obligations to the public health of the nation and one’s community in this perspective, early twentieth century states propagated routinely notions of hygienic citizenship wherein the individual dutifully adhered to dictated precautions and submitted to prescribed therapies (cf. Bashford 2004). Relying on systems of education and enforcement, the modern state authored and enacted lessons and laws covering all manner of personal conduct that might have a bearing on a nation’s wellbeing, ranging from cleanliness and diet to attire and sexuality. In this inquiry, therefore, we scrutinize historical examples from the emergent republic of Turkey in which urban officials sought to contend with both modern sins and sickness in this fashion.

Our windows into the early Turkish republic include state-authored documents and publications, the minutes of and papers presented at medical congresses, ministerial and parliamentary reports and minutes, in addition to the laws that resulted, public health education materials, and accounts from the press and others. Based on these records, a growing number of secondary sources, and our prior research on various dimensions of disease and the state, we synthesize and present our findings with special attention to the country’s urban context. Within these many accounts, we also discern and engage with how the state confronted transgressions (i.e., sins) thought to undermine the nation’s wellness and productivity, identifying the typically urban basis of such initiatives. Whether demonstrating how city dwellers were the direct targets of public health schemes or how they served as the populations of pilot projects, this aspect is significant owing to the demonstrated state (and thus urban) bias towards the nation’s rural majority. In the following section, we ground our study by presenting the historical geographic contexts of our research and the processes that culminated with the production of those primary sources that we analyze. In subsequent sections, we consider a broad range of the sins encountered and confronted by the state and its physicians. Though many of these acts existed as or became actual criminal offences, considering them as sins is useful because of the way that religious norms began to give way to secular sensibilities amid modernization. Of greater significance, however, we argue through the course of this chapter that the state and its officials strove to convince and compel the nation to follow state laws as devoutly as religious ones, conditioning people to self-surveil and self-regulate their own conduct along with that of their neighbors in ways that would yield the hygienic citizenship (or governmentality; Foucault 2007, 2008) of the modern medicalized nation-state.

Situating Sin and Sickness in the Cities of Early Republican Turkey

When Turkey’s public health community gathered at the republic’s inaugural medical congress in Ankara in September 1925, politicians and physicians alike concurred regarding what they feared to
be a potential catastrophe facing the country. Just as Micah admonished the people of Jerusalem for their sins and thus predicted disaster, Turkish officials spoke prophetically about their circumstances and the perils of misdeeds and inaction. Their imagined upheaval, however, was not of the sort associated with biblical cataclysm. Rather, they figured the specter looming over the nation-state was a demographic collapse, and their principal adversaries were epidemiological. Among the most respected professionals in society, the physicians contextualized their fears historically and sociologically (Anonymous 1926). The Ottoman Empire (1299–1923) experienced constant conflict and internal unrest throughout its final century, including genocidal losses, widespread out-migration, World War I (1914–1918), the Turkish War of Independence (1919–1923), and linked population shifts (e.g., between the Ottoman and Tsarist empires, the Middle East, and the Balkans) in its final years. Instability, impoverishment, and dislocation also gave rise to widespread conditions of hunger, disease, deaths, and declining fertility (e.g., Yalman 1930, p. 253). In the 1920s republic, therefore, population anxieties and an associated demographic discourse were pervasive (Evered, K.T. and Evered 2011). Moreover, in broad terms, the republic bore striking similarity to other nation-states of the era that also prioritized public health and promoted pronatalism (e.g., Italy; cf. Ipsen 1996; Caprotti 2006).

To avert disaster and enhance the population’s prosperity, nationalist leaders developed a public health infrastructure well before the republic’s 1923 official establishment. Created on May 20, 1920 and led initially by Dr. Adnan Adıvar (1882–1955), the **Sıhhat ve İçtimaî Muavenet Vekaleti** (**ŞİMV**, or Ministry of Health and Social Welfare) prioritized a number of diseases and conditions thought to most jeopardize fertility, longevity, and economic productivity. Among the most worrisome, leaders listed malaria, syphilis, tuberculosis (TB), and trachoma. Institutionally, the ministry’s agenda entailed standardization of services and therapeutic practices in prevention, diagnosis, and treatment of diseases, expanding the numbers of and training further the country’s physicians, initiating state schooling and staffing of midwives and first aid personnel sufficient for clinics and birthing centers in all cities, towns, and villages, and establishing a greater number of effective sanatoria. Supporting these efforts, ŞİMV’s general directorate included two branches devoted respectively to information and to instruction. Focused on quantification of the population and its circumstances, health, and geographic situation, the medical statistics branch collected and assembled empirical data on diseases, births and deaths, marriages, migration patterns, and medicines and other therapies prescribed (**Sağlık Dergisi** 1948, p. 65). These efforts were to be enhanced through the eventual completion of volumes for the **Türkiye’nin Sıhhi-İ İçtimal Coğrafyası** (or the Socio-Medical Geography of Turkey; e.g., Besim Zühtü 1922; Hıfzı Nuri 1922; Kemal 1922; Nazmi 1922; Esad 1923; Ahmet Hamdi 1925; Fahri Cemal 1925; İbrahim Ismail 1925; Muslihiddin Saıvet 1925; Hasan Tahsin 1932; Mehmet Ali [1925] 1991; Mehmet Hayri [1922] 1994). The republic charged provincial medical directors with researching and writing these tomes. Though officials conducted surveys and research, compiled figures, and then wrote up their findings—oftentimes noting their own practices and recommendations—at the scale of the province, these directors themselves were based in provincial capitals. In other words, their collection of data, consideration and analysis of it, and formulation of policy options undeniably privileged city populations and modernist sensibilities (Evered, K.T. and Evered 2011, 2012a). Additionally, while politicians and public health officials extolled the virtues of those physicians who devoted themselves to working in villages and the countryside (Güvenç-Salgırli 2015), their idealistic rhetoric did not eliminate preconceptions and intolerance. In most provincial surveys, urban–rural prejudices were apparent and abundant (Evered, E.Ö. and Evered 2013a; Evered, K.T. and Evered 2012b).

The administrative dilemmas of compiling and then handling this information at the scale of the emerging nation-state and then translating findings in ways that could be applied and taught to the wider population presented additional challenges for ŞİMV’s general directorate branch devoted to
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public health propaganda. Tasked with “enlightening” the nation, the branch developed, printed, and disseminated various media to the wider public. Though the statistics branch reported that almost 6 million free brochures were published and distributed between 1923 and 1948, along with roughly 725,000 black-and-white and color posters (BCA 490-01-1211-22-1-38, p. 51), there are no figures that indicate where and to whom the ministry ultimately presented these materials. Beyond logistical and administrative bias favoring urban distribution, it is likely that the far lower rates of literacy in rural areas also impacted on who actually received or read the state’s pamphlets, posters, and other print media. While public health lessons were developed for plays, radio, and film, geographic distance and accessibility again must have created obstacles. For example, scheduling around the agricultural calendar was a major concern in the development of a reliable mobile rotation of educational films for agrarian towns and villages (Evered, K.T. and Evered 2012a, p. 314). To circulate their lessons in hygiene and health, officials also established medical museums, just as Ottoman era public health administrators began to do in the empire’s final decades. These museums, however, were at fixed locations in just the largest cities, and, though travelling exhibitions were developed and deployed, they typically only reached the other larger urban centers of the republic (Evered, K.T. and Evered 2016a). To overcome the obstacles of both accessibility and literacy, ministry officials endeavored to distill the main points from their intended instruction and the museum displays into a so-called Sihhi Müze Atlası (or Medical Museum Atlas; T.C. Sıhhiye ve Muavenet-i İctimaîye Vekaleti 1926). With 1,000 copies printed (T.C. Sıhhat ve İctimaî Muavenet Vekâleti 1933, pp. 111–112; Özpekcan 2002), this atlas contained color pictures that derived from the original large-scale paintings featured in the museums and their travelling exhibits. Presented during a period of intense change, the public health lessons that the atlas imparted also complemented ongoing dynamics of modernization and nation-building. These efforts also aligned with the ideology of the new Turkish nation and state as defined and guided by Mustafa Kemal Atatürk (1881–1938), an agenda known as Kemalism (cf. Zürcher 2004; Yılmaz, H. 2013). Within the pages and vibrant imagery of the atlas, it championed the virtues of medical science and set norms (i.e., standards of hygiene and conduct) that helped to facilitate the republic’s biopolitical governance over its citizens (cf. Foucault 2007, 2008). Utilizing pictures to connect with the rural and generally illiterate majority, SMV’s graphically legible messages also favored unquestionably metropolitan and comparatively affluent lifestyles (Figure 3.1). The ministry thus presented clearly the message that the rural should look to and emulate the urban in matters of modern health and morality (Evered, K.T. and Evered 2016a). In doing so, it employed a vernacular that entailed referencing many of the nation’s most dreaded afflictions as köylü hastalığı (or village diseases; cf. Evered, K.T. 2014).

To disseminate and apply its new hygiene-driven moral order, the republic did not only resort to public health propaganda; it also instituted a far stricter regime of legislative controls over its population’s health and their associated lifestyles and conduct than experienced previously in the Ottoman era. To this end, the public health ministry, its physicians, and parliamentarians worked together to draft, enact, and enforce a broad range of new laws. Focused in principle on the entire population, administration and implementation commenced typically from the republic’s new capital city Ankara and then from the provinces’ capitals. For the politically elevated and invigorated Ankara (cf. Evered, K.T. 2008), many of the epidemiological challenges were actually close at hand and awaiting confrontation. These included those identified as the country’s greatest threats: syphilis and malaria (cf. Evered, K.T. 2014). In the coming sections—and moving beyond simple characterizations of the rural (and its “village diseases”) as less healthy and least responsible—we address a range of the moral failings and transgressive acts (i.e., sins) that were seen in and from the vantage of urban medical officials and the regulatory steps that they endorsed and applied.
In the nascent Turkish republic, secular public health administrators effectively recast many religious mandates in terms of civic responsibility. As noted, urban populations typically were among the first to experience these shifts. Integral to their cultivation of hygienic citizenship, officials even reframed norms of gender, family, and sexuality as matters of liability and legality (Evered, K.T. and Evered 2016a), and there were traditions of variously doing so in the overlapping Ottoman context as well (e.g., Yilmaz, S. 2016, 2017). Sexual transgressions that once violated religious mores and the traditional and cultural values found in homes and communities thus became offenses against state and society—at least in the eyes of medical and social reformers (Evered, E.O. and Evered 2017). From their vantage, officials like Dr. Muslihiddin Safvet viewed a particular urgency in effecting
this transition owing to their impressions of the ravages of STIs (especially syphilis) on the living and unborn. As the SIMV director for Ankara—both the new capital city and the wider province of the same name—the ambitious physician compiled information for and authored one of the most detailed of the new socio-medical geographies. In his 1925 account—as in those of other provincial SIMV directors—he equated unequivocally the problem of STIs with prostitution, particularly when it involved unregulated sex workers. For the doctor, there were also distinct socio-political scales and circumstances associated with syphilis: sites where the disease flourished, on the one hand, but also where it could be brought under effective control and even eradicated, on the other hand. In his view, wider conditions of conflict exacerbated problems of ignorance, transmission, and disease impacts, and cities were the geographic key both to understanding syphilis’s devastations and to overcoming it as a national foe. Towns and villages, alternatively, presented different levels of threat and opportunity. As he surmised, Anatolia’s traditional towns seemingly demonstrated the lowest levels of infection, permitting delayed attention, and he attributed this conclusion to residents’ presumed proximity, density, and familiarity with one another. In short, customs and close quarters accounted for effective mutual surveillance and policing, with suspected offenders risking social exclusion, physical or sexual violence, and banishment from home and community. In contrast, he deemed village and rural circumstances to be ones that promoted the disease but that also inhibited immediate effective intervention. In his reckoning, villagers and farmers were too diffuse to enable constant and mutual scrutiny among neighbors. Widely dispersed throughout the country, Turkey’s agrarian communities also lacked accessibility and legibility for the state. This lack of roads and knowledge complicated further any immediate public health engagements.

For Dr. Muslihiddin Safvet, cities were prime locations for action. Urban populations, in his view, both presented frequent cases (along with heightened risks for and rates of contraction) and were numerous and proximate enough to facilitate effective governmental surveillance, sustained testing and treatment, and regular policing. Apparently unable to envisage abstinence—much less accountability—among the republic’s men and male youth (though their roles in the propagation of STIs were well acknowledged in the late Ottoman context; e.g., Yılmaz, S. 2017), the doctor and many (though not all) of his contemporaries promoted plans to regulate female sex workers. This focus on women and girls was not unique; many of the Western states of the late nineteenth and early twentieth centuries were also afflicted by similar biases and prejudices in policy and enforcement. In his account, the doctor depicted the budding capital as a site in dire need. Owing to wartime depredations, poverty, and a growing population, syphilis in Ankara continued to “sink its teeth into the youth” (Muslihiddin Safvet 1925, p. 91, cited and critiqued in Evered, E.Ö. and Evered 2013a, pp. 280–281). He presented his design for a regulated genelev (or “public house”, the common Turkish euphemism for a brothel) as both effective and an ideal model for wider emulation throughout the emergent nation-state.

Of particular importance, the authorized genelev restricted sex workers to a specific location in the city. Whereas past efforts in the Ottoman era focused more on policing prostitution in order to achieve moral geographies (e.g., Wyers 2008; Özbek 2010) rather than public health objectives, such efforts tended to simply push the activity from quarters of affluence and political influence to those of lesser means and scrutiny. Many medical reformers of the day viewed the genelev as a means to fix the activity in particular sites well away from most citizens while also compelling regular inspections and treatment. Situated near the city’s Kengri Gate (along the road to the city of Kengri, later renamed Çankırı), Ankara’s genelev was in an area so marginal that municipal administrators also approved a nearby cemetery. The cemetery’s siting was also based largely on public health concerns. The establishment and its 60 to 70 registered workers were thus out of sight from general public view but also close enough to enable surveillance and twice-weekly physical examinations. Conducting examinations and treatment for the wider populace out of a recently renovated and modernized hospital, the doctor promoted wider distribution of services through the state’s steadily expanding network.
of clinics and dispensaries. These should include, in his view, initiatives that went beyond caring for syphilitics to also include his recommended prenuptial examinations of both prospective brides and grooms prior to state-certified marriages. By 1925, he had characterized his efforts in Ankara as a resounding success worthy of replication elsewhere (Muslihiddin Safvet 1925, cited in Evered, E.Ö. and Evered 2013a, pp. 281–285).

With a succession of laws that legislators—a number of whom were physicians—enacted at the time when Dr. Muslihiddin Safvet established policies for Ankara (as early as 1921) and in the years thereafter, the public health and safety of Turkey’s cities—and eventually the nation—seemed attainable. The emerging republic-wide legal regime covered the siting of genelev (e.g., away from state buildings, schools, places of drinking, places of worship, and thoroughfares with abundant traffic), their operation (e.g., prohibiting alcohol and music and establishing provisions for funding and taxation), associated working conditions, inspections, and sanctions, and it standardized care and treatment. Related legislation also mandated that all syphilitics comply with state-approved monitoring and therapeutic requirements. Stipulations included weekly visits to state or approved private physicians, maintenance of treatment report cards, and immediate notification of local health authorities when establishing new places of residence. Within this statutory infrastructure, the April 1930 Public Health Law (or Umumî Hıfzısıhha Kanunu; Resmî Gazete 1930) was the most comprehensive act to govern issues associated with syphilis. It was extremely broad in its coverage (involving 15 sections

Figure 3.2  This 1930s anti-syphilis poster warned citizens to “Frengiye Yakalanmaktan Kork” (or “Be Afraid of Catching Syphilis”), with a blue central image that advised “Boyle eğlencelerde bulunmaktan sakin” (or “Avoid these types of entertainment”). In the peripheral images, however, the state revealed its scientific authority with the novel image of the microscopic slide, conveyed that salvation came from testing, registration, and therapies for those afflicted, and depicted the consequences of ignorance and irresponsibility through images of advanced affliction, still births, insanity, incarceration, and death.

with over 300 articles) and merited parliamentary debate on many of its provisions, with those concerning prostitution not being matters of open debate (Wyers 2008, p. 26; cf. Wyers 2012, 2017). Lack of public discussion in parliament, however, does not imply an absence of discord; contestation over prostitution was contentious between SIMV and the Ministry of Interior, which oversaw internal security and preferred a prohibitionist approach to sex work. The question of state registration of both sex workers and _genelev_, in particular, was very divisive, with the Ministry of Interior associating prostitution—illicit and licit—with public disorder, drunkenness, and violence (Evered, E.Ö. and Evered 2013a, 2013b; Evered, K.T. and Evered 2012b). For its part, SIMV’s public health education materials sought to mark out the places and practices that were acceptable—and those that were not. It did so while also encouraging immediate registration and treatment, and its posters illustrated graphically the horrific consequences of not complying with preventive warnings and therapeutic requirements (Figure 3.2). In practice, regulating sex work invariably meant regulating all women and girls, their conduct, and their bodies. Throughout the republic, therefore, the state mandated compulsory medical examinations and enacted a broad legal categorization of unmarried sex as suspect (cf. Evered, E.Ö. and Evered 2013a). In doing so, the state instituted a regime that endures—and arguably continues to marginalize not only the nation’s sex workers but women and girls as well—up to the present day.

**Urban Intemperance**

The dilemmas posed by adopting either regulatory or prohibitionist laws constitute a major theme of research in recent historical geographies of the state, the city, and public health (e.g., Howell 2000, 2009; Philips 2002; Legg 2010). In addition to the regulationist–prohibitionist divide over sex work in the early Turkish republic, dealing with sins of intemperance also posed distinct legislative challenges. Despite the religious proscription for many of the Ottoman Empire’s Muslim citizens, ethno-religious minorities were exempt from _sharia_-based bans on alcohol and its consumption through most of the empire’s history, so long as they refrained from selling beverages to Muslims. As a result, alcohol was often a readily obtainable commodity, particularly in those quarters of port cities inhabited by minority citizens and frequented by foreign residents and visitors (cf. Georgeon 2002), and images of its abuse were predominantly urban as well (Figure 3.3). Even in the final decades of the empire, however, modern medical reformers had begun to voice their objections to alcohol—like their progressive temperance counterparts in the United States and elsewhere in the West. Though limited to specific cities and short episodes (ibid.) in the absence of greater organization and momentum, this activism gave way to one of the greatest legislative debates of the nascent republic’s inaugural parliament. On April 28, 1920, just days after their body first convened, MPs began to consider a proposal put forward by their peer, MP Ali Şükrü Bey (1884–1923), a representative for Trabzon. Despite the fact that the remnants of the Ottoman state were controlled by the Allied powers that occupied Istanbul (cf. Mills 2017) and that the Turkish War of Independence was underway, the problem of drinking was deemed urgent enough to address. For his part, Ali Şükrü Bey’s motives were admittedly religious, but through the course of 1920, as the matter was debated and formative ministries generated reports, a consensus began to re-emerge between those claiming to speak for traditional Muslim values, on the one hand, and those who advocated scientific reasoning and modern medicine, on the other hand. Viewed globally, it is interesting to note that this debate ensued within months after America’s January 1920 initiation of enforcement of the 1917 Eighteenth Amendment via the 1919 Volstead Act, the key articles facilitating prohibition and its enforcement in the United States. 

Bearing some similarities to America’s seemingly incongruous union of progressive and regressive interests that backed temperance (e.g., physicians and early feminists, on the one hand, and nativists and racist groups like the Ku Klux Klan, on the other hand), anti-alcoholism in Turkey
Enduring still in Turkish folklore and humor, for example, is the image of excessive drinking embodied by Bekri Mustafa (or "Drunk Mustafa")—a janissary soldier who routinely required the hire of the porters who regularly queued outside port city taverns to carry home drunken revelers.

*Source:* Authors’ collection.
relied on this tenuous union of physicians and conservative proponents of early twentieth century Islamism, though contemporary parliamentary discourse, state works, and popular accounts sometimes included representations of the rural poor drinking to the point of excess and even addiction. Such images often appeared alongside references to prostitution and with depictions of drunken peasants’ presumably miserable hovels (e.g., as in the afore-noted medical museum atlas; Evered, E.Ö. and Evered 2016a). Far more commonly, however, the drinking contexts of most narratives were decidedly urban. In the magazine produced by Yeşilay (the Green Crescent, the emerging anti-addiction society championed by some of the country’s leading physicians), depictions of drunkenness in the country’s cities featured not only in cautionary tales but also in summaries of news items reporting related crimes (as generated in and reported for the country’s cities). Many of the anti-alcohol groups and efforts were also urban-based, including the organizations formed, the medical museums and their travelling exhibits, and the press coverage. Adding to the “scientific” arguments, some physicians, such as Yeşilay leader Dr. Mazhar Osman Uzman (1884–1951)—and later in the 1940s Dr. Fahrettin Kerim Gökay (1900–1987)—even employed arguments that straddled awkwardly the boundaries between obstetrics and eugenics when they argued against alcohol owing to its presumed impacts on not only unborn children but also their genetics, hinting routinely of a connection between drinking and insanity. This discursive jumping of scales—and associated appeals for governance—went from that of the city to the body and genetics, and it continued to the scales of the republic and its national territories.

Buoyed not only by a religious and scientific rationale but also by nationalist fervor, anti-alcoholism also targeted foreign populations. This rhetoric identified especially the occupying Allied forces in Ottoman Istanbul and ethno-religious minorities. The latter were readily scapegoated, in particular, given Greece’s initiation of the invasions resulting in the War of Independence. Depicted as flooding through Anatolia’s port cities as imports and draining the nation’s finances, alcohol also appeared to sap the nation’s strength and monetary resources in corresponding vilifications of allegedly disloyal minorities. In mid-September 1920, the proposed prohibition bill that banned production, importation, sales, and consumption passed by the slimmest of margins (i.e., a tied vote, with the parliament’s presiding chair’s vote determining the outcome) and was ratified months later upon its publication in February 1921 (Resmi Gazete 1921; cf. Üçüncü 2012; Evered, E.Ö. and Evered 2016a). Almost immediately, as in America, evasion of its enforcement became a preoccupation for many, including many who did not drink (e.g., a recurrent legend purports that the most successful figure to profit by defying the law in Ankara was the new capital’s head of police). With Istanbul occupied well into September 1923, the true test of prohibition enforcement for the early republic never came to pass.

Ali Şükrü Bey’s proposal and his depictions of Anatolian cities awash in drunkenness and alcoholism prompted the prohibition debate in the nascent parliament. Recalling the time of his youth and the innocence of his native Trabzon, a city situated on the Black Sea coast in the wider hearth of hazelnut cultivation, he exclaimed that, by 1920, “at the bottom of each hazelnut tree there is a tavern” (Evered, E.Ö. and Evered 2016a, p. 56). However, even with the cooperation of the country’s leading physicians and the slim passage of a prohibition bill within two years, the law ultimately proved unsustainable—far earlier than America’s 1933 repeal through its Twenty-First Amendment. On fiscal grounds, economic ministry officials feared not meeting payments for war reparations. Additionally, the MPs of grape-growing provinces reported in 1922 on extreme hardships experienced among their constituents and failures in their efforts either to market or to process the fruit for other purposes or to identify viable substitute crops. The political terrain also shifted rapidly in these years. Under uncertain circumstances, a soldier killed Ali Şükrü Bey in March 1923, and the parliament’s first session ended shortly thereafter in April. When the second parliament convened, it did so under the consolidated authority of Kemalists; Islamists, traditionalists, and ultranationalists were thereafter excluded.
In September 1923, another MP and his colleagues intended to revive the alcohol economy and submitted a proposal for the state to recognize that the Koran prohibited neither production or sales of alcohol. In response, the state then declared particular provisions regarding alcohol; it assumed control over marketing, increased fines for associated tax violations, and banned public consumption. Each of these measures prefigured an eventual step taken by the increasingly secular republic, making it an exclusively state-controlled concern, along with other commodities (e.g., tobacco). In April 1924, MPs approved a state-sponsored nine-article bill that effectively ended prohibition and put alcohol production and sales solely in the hands of the state monopoly TEKEL (Evered, E.Ö and Evered 2016a). As Ankara itself continued to expand geographically and develop as the national capital, a prominent feature included a massive pastoral concern that occupied adjacent farmlands. On the grounds of Atatürk Orman Çiftliği (AOÇ, the Atatürk Forest Farm)—a site devoted to modern agricultural research, education, and development—two of the most prominent features included a brewery and a beer garden. Proponents justified the former on the basis of Turkey’s abundant annual grain harvest and the needs to process and preserve it, on the one hand, while increasing its value, on the other hand. Regarding the latter, the beer garden featured alongside areas for hiking and picnics, music and dance, swimming, a zoo and amusement park rides, and relaxing outdoors in AOÇ’s wide, green spaces. In short, alcohol featured prominently, while the state promoted a new aesthetic for its modern, educated, and healthy society—one that was decidedly urban and affluent (e.g., Figure 3.4; noting comparable examples of place-making and nation-building, see Bozdoğan 2001; Kezer 2015).

In this reframed and domesticated context, beer had its officially designated place. Linked by name with the city and the nation’s founder, AOÇ produced and sold beer, along with other alcoholic (e.g., wine) and farm (e.g., non-alcoholic drinks and food) products, and—for conservatives—this trade likely carried the social and religious stigma ascribed by many traditionalists and religionists. However, for many other Turks—especially for secular nationalists living in Turkey’s cities—the only official admonishments that they heard were limited to ones of moderation (Evered, K.T. and Evered 2018; Evered, E.Ö. and Evered forthcoming). Predating and equivalent to America’s post-prohibition mantra (often ascribed to Canadian Samuel Bronfman and his concern Seagram’s), the authorities encouraged Turks to “drink responsibly” rather than abstain. Beer was distributed throughout the country and sold in most of its bakkal, small shops analogous to traditional America’s corner stores, and the modern republic guaranteed its place in cities and towns, shifting—at least for some—the transgressive aspects of drinking in a Muslim society to just public spectacles of drunkenness and the medical dilemma of alcoholism.

Combating the Sins of Uncleanliness, Greed, and Vanity

With responsibility for a healthy nation placed on its citizens, many other aspects of individual conduct came under public health officials’ scrutiny if they seemed to connect with either the spread of disease or the infliction of disability. From this medicalized vantage, traditional sins that might include sloth, avarice, and pride became quite relevant in teaching about modern threats to public health and promoting notions of hygienic citizenship. Emphasized particularly for people in urban contexts, risks to their health had widespread impacts beyond just individuals and their family; entire communities and the nation were in jeopardy. In this section, we engage with how these notions of uncleanliness, greed, and vanity were written into a wider national narrative of disease and public health, preventive medicine, and individual responsibility. As noted through our prior examples, though the republic’s population was predominantly rural and agrarian, these articulations of sin and sickness targeted principally the urban site and citizen.

In examining early republican socio-medical geographies and other documents’ coverage of TB, one of the immediate facts to emerge was that the physicians themselves were quite inconsistent
in their accounts of the disease. In several instances, observations ranged from a complete absence to low levels limited to just common pulmonary manifestations or accounts mitigated by climate, ecology, or lifestyle (e.g., Hıfzı Nuri 1922; Nazmi 1922; Ahmet Hamdi 1925; İbrahim Edhem 1925; İbrahim İsmail 1925). Sometimes, doctors attributed an absence of TB to outdoor ecologies,
whereas others pointed specifically to pastoral nomads as suffering from it. In other instances, however, the disease was equated with both urban living and an absence of cleanliness—always in people’s homes and sometimes including city air (e.g., Esad 1923). As the director for Urfa observed of the province’s larger towns, TB was common “due to their lack of clean and pure air, sufficient sustenance, [and] hygienic residences,” and he noted how people’s traditional views and beliefs imperiled health and wellness (Sefik Arif 1925, p. 39). References to people’s “dingy homes” and conditions of filth were also frequent (e.g., Hasan Tahsin 1932, p. 333). Indeed, even in the homes of the cultivated and comfortable, consumption appeared in state depictions as stemming from the poor (e.g., recalling Figure 3.2, in a preceding panel to this image, the source of the disease was a disheveled and homeless consumptive who spat on the street). Extolling the virtues of healthier lifestyles—marked by cleaner homes and cities—only a few of the directors seemed to realize that much of what they wrote about was conditions of pervasive poverty rather than many isolated instances of individual irresponsibility.

State officials’ limitations in perceiving and attributing cause to profound differences in socio-economic class and poverty also played a role in their treatment of the urban rich in most broader narratives of disease. Though discussions about and legislation aimed at eliminating malaria acknowledged the role of increasing levels of rice cultivation throughout many parts of the country, and the associated problem of increased breeding grounds for mosquitoes and greater exposure for those living and working nearby (cf. Evered, K.T. and Evered 2011), those land owners responsible for this initially unrestrained expansion of rice fields typically evaded accountability. Indeed, the stigma of malaria as a “village disease” endured and factored into even the graphic depictions of it that featured in public health propaganda (Evered, K.T. and Evered 2012a). A unique exception to this pro-urban/-elite bias included the accounts published by Dr. Serif Korkut (ca. 1895–1957), later also an MP. In his works, he focused unambiguously on the wealthy living in cities in assessing culpability for the many people in the country who acquired and were lost to malaria (Evered, K.T. and Evered 2016b). Attributing a significant measure of the calamity that was malaria to the greed of urban elites, however, markedly distinguished his account from those of the state, wherein the peasant and village were depicted as those at fault.

In state accusations of those of higher socio-economic standing, however, women were not so immune. Featuring prominently in the later pages of the afore-noted medical museum atlas, the vanity of modern women came under scrutiny by physicians and the ministry. While the modernist state did not hesitate to objectify the women of the country in ways that brought it more in alignment with other nations of the West (e.g., through beauty contests; cf. Shissler 2004), the women themselves were not immune to criticism. Complementing its presentation of microscopic slides that revealed the bacteriological enemies that Turkey faced, the atlas also made conspicuous use of X-ray imagery. In one of these instances of presenting this new scientific gaze—also notable in late Ottoman publications—the health risks targeted included the perils posed to the nation by high-heel shoes. Detailing the epidemic-like spread of the latest style in footwear, the country is warned about the dangers of pride and the potential toll of the newest trend. Charging the nation’s women and girls to avoid being “fooled by fashion,” prints of X-ray images demonstrate the purported risks and impacts of heels (Figure 3.5). Pointing clearly to a problem of the urban and affluent, this section of the atlas nonetheless illustrates how even the modern republic’s rich women needed to resist their pride and police their conduct.

**Summary and Conclusion**

Framing cities as the seats of both sin and sickness is not a novel occurrence, and the two often complement each other in unique and revealing ways. In the context of the modernist Turkish republic
Figure 3.5 X-ray views of the “unnatural” and ultimately dangerous positioning of women’s feet, ankles, and legs because their vanity allowed them to be “fooled by fashion.”

Source: T.C. Sıhhiye ve Muavenet-i İçtimaîye Vekaleti (1926, p. 66); also included in Tokaç and Topçu (2011).
of the 1920s, there was an imperative to re-invent sin, public health, and the city in ways that were meaningful to society: a new civic morality, a modern approach to public health, and a new urban ideal. The first of these was manifest in the new ideas of citizenship promulgated by the nation-state, the second was carried out by one of the primary arms of its state apparatus—the Ministry of Health and Social Welfare—and the latter was embodied especially by the country’s forward capital. In each of these instances, the declaration of the new norm, institutions, and associated values entailed challenging and displacing traditional and apparently general knowledge and accepted social norms. Secular nationalism and the state supplanted religion and sharia, physicians succeeded ocak (families and individuals who cured particular ailments) and other traditional healers, and Ankara replaced Istanbul. The sensibilities of the newly envisioned society brought about new standards—and new notions of sin.

In the new republic’s promotions of hygienic citizenship, however, not all groups were held to the same standards, and biases and prejudice rooted in class, education, gender, urban–rural relations, and ethno-nationalism substituted commonly for science and actual knowledge. In the early republic, as in other societies, we therefore can look to the city to see how societal divides intersected and were mirrored in the country’s ideas of and opportunities for public health. In this manner, the city is not only a target for those seeking to implement and achieve public health, but also a vantage from which we can ascertain how effective such programs are and what segments of society are being included or excluded.

The contentious dimensions of these associations are far from resolved. Invoking public health arguments and justifications based on urban social order and concerns over the nation’s youth, tensions over alcohol between regulationist and prohibitionist interests returned in 2013 to the forefront of Turkish politics. Linked powerfully with WHO encouragement to Turkey’s ruling Islamist party to achieve measures of alcohol suppression comparable to those realized in a preceding anti-tobacco campaign, the debate’s alignment with religionist–secularist tensions and the subsequent protests in Istanbul’s Gezi Park demonstrated clearly the connections between state pronouncements and regulation over both modern and medical concerns in an already divided society. Arguing that their motivation derived solely from considerations rooted in public health, officials claimed that those paying the toll for alcohol abuse were the youth. Viewing instead with great suspicion the very proposition that these claims were health-based, secularist protestors routinely yelled a phrase that even appeared on signs and T-shirts: “Şerefine Tayyip!” (an invented toast to then prime minister and now president Recep Tayyip Erdoğan; cf. Evered, E.Ö. and Evered 2016b). Demonstrating the politicized nature of invoking one set of ethics or another, secularists expressed clearly that the truly unhealthy and immoral sin was prohibition and the imposition of one group’s religious beliefs on an entire society.

Note
1 A forward capital is a symbolically relocated—and sometimes newly built—capital city (e.g., from Istanbul to Ankara, or from Philadelphia to Washington, DC).

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