HEALTH AND ILLNESS EXPERIENCES AMONG THE URBAN POOR: THE CASE OF ALTINDAĞ

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Approval of the Graduate School of Social Sciences Institute

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I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

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This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

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ABSTRACT

HEALTH AND ILLNESS EXPERIENCES AMONG THE URBAN POOR: THE CASE OF ALTINDAĞ

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In this study similarities and differences in health experiences among urban poor in relation to the forms of capital they possess: *economic*, *social*, *cultural*, and *health* capital and the different positions they hold in the urban field, are analyzed. The research was conducted in two poor *gecekondu* neighborhoods in *Altındağ, Baraj* and *Gültepe*, via face to face interviews with 40 individuals.

A main finding has been that the different forms of capital, in volume as well as in composition, had an influence on the urban poor's health perceptions, health care access, health seeking strategies and experiences in health institutions.

The rural-urban migrants refer to a *habitus* in relation to health which still strongly relies on their rural practices. Major differences among men and women have been observed, where men seem to be more open to integrate into the urban dispositions.

Economic capital plays a crucial role. Regular income earners do tend to emphasize that they have a certain autonomy and control over their health. On the other hand, benefit dependent poor mention that they have less control over their health. *Economic capital* can be seen as very much the same among the group studied, but the differences in health experiences rely strongly on *Cultural capital* is understood as their different identities: villager/non-villager; illiterate/ non-illiterate; women/men; healthy/non-healthy. Social capital (formal and informal solidarity networks) is studied as the role in health experiences, access to health care and strategies to use the existing health system; as well as how individuals support each other materially and immaterially. Social capital is important because it converts into economic capital, not as exchange but as use value.

An analysis of the different forms of capital allows us to address at the interrelationship of structural conditions in the field and the practices actors

experience through their internalized *habitus*. Health experiences therefore differ even among a socio-economic homogenous group.

In addition to the above mentioned forms of capital, it is also argued that health itself should be considered as a form of capital. Health capital (self perceived health/illness and medically diagnosed disease) influences and is influenced by the other forms of capital.

Keywords: Health Experiences, Urban Poor, Forms of Capital, Health Capital, Ankara/Turkey

ÖZ

KENT YOKSULLARININ SAĞLIK VE HASTALIK DENEYİMLERİ: ALTINDAĞ ÖRNEĞİ

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Bu çalışmada kent yoksullarının çeşitli sermaye biçimleri (*ekonomik*, *sosyal*, *kültürel*, ve *sağlık*) ile olan ilişkileri ve toplumdaki farklı konumlarına göre sağlık deneyimleri analiz edilmiştir. *Altındağ*'da yer alan iki yoksul gecekondu mahallesinde -*Baraj* ve *Gültepe*- 40 kişi ile yüz yüze mülakat yolu ile görüşülerek, araştırma yapılmıştır.

Çalışmanın ana bulgusu, kent yoksullarının sağlık algıları, sağlık hizmetlerine erişim, sağlık-arama stratejileri ve sağlık kuruluşlarındaki deneyimleri üzerinde farklı sermaye biçimlerinin etkisinin olduğudur.

Kent yoksulları kırdan kente göç eden gruplardan oluşmakta ve bu gruplar kırsal pratiklerinde güçlü şekilde varolan sağlıkla ilgili habituslarını sürdürme eğiliminde olmaktadırlar. Diğer yandan erkekler kadınlara nazaran kentsel *yatkınlıklarla* daha çok bütünleşmeye açık gözükmektedirler.

Ekonomik sermaye sağlık deneyimlerinde önemli rol oynamaktadır. *Düzenli gelir elde edenler* sağlıkları üzerinde belirli bir özerklik ve/veya kontrole sahip olduklarını vurgulamaya eğilimlidirler. Diğer yandan, *yardıma bağımlı yoksullar* sağlıkları üzerinde daha az kontrole sahip olabilmektedirler. *Ekonomik sermaye,* kent yoksullarının sağlık deneyimlerini birbirine benzeştirirken, çeşitli kimlikler ile kendisini gösteren farklılıklarla (köylü-kentli; okur-yazar/okur-yazar olmayan; kadın/erkek; sağlıklı/sağlıksız) belirginleşen kültürel sermaye güçlü şekilde bu deneyimleri farklılaştırmaktır. Sağlık deneyiminde *sosyal sermayenin* (formal sosyal sermaye ve enformel dayanışma ağı) sağlık hizmetlerine erişim, varolan sağlık sistemini kullanmaya yönelik stratejiler ve bireylerin birbirlerine yaptıkları maddi ve manevi destek üzerinde etkisi vardır. Sosyal sermaye, değişim değerinden ziyade kullanım değeri ile ilişkili olarak ekonomik sermayeye dönüşmekte ve sağlık deneyimini etkilemektedir.

Çalışmaya konu olan sermaye biçimleri analizi, alandaki yapısal koşullar ve eyleyicinin içselleştirilmiş habitusları yolu ile gerçekleştirdiği pratikler arasındaki

karşılıklı ilişkiyi gösterir niteliktedir. Bu nedenle, sağlık deneyimleri sosyo-ekonomik olarak homojen bir grupta bile farklılaşabilmektedir.

Adı geçen sermaye biçimlerine ek olarak, sağlığın bir sermaye biçimi olarak ele alınabileceği görülmüştür. Sağlık sermayesi (bireysel olarak ifade edilen rahatsızlıklar ve tıbbi olarak teşhis edilmiş hastalıklar) diğer sermaye biçimlerini etkilerken aynı zamanda onları da etkilemektedir.

Anahtar Kelimeler: Sağlık Deneyimleri, Kent Yoksulları, Sermaye Biçimleri, Sağlık Sermayesi, Ankara/Türkiye

To Mehmet Toprak Özen

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LIST OF ABBREVIATIONS

ABBREVIATIONS

DIE: State Institute of Statistics (the institution name was changed as TUIK)

DPT: State Planinng Organization

DWL: Desocialized Wage Labor Regime (defined by Wacquant)

ETF: House Assessment Document gathered systematically by Ministry of Health

HICES: The Household Income and Consumption Expenditure Survey

HNP: Health, Nutrition, and Population

HIV/AIDS: Acquired immune deficiency syndrome or acquired immunodeficiency syndrome

OEDC: The Organization for Economic Co-operation and Development

RF: The Government Employees Retirement Fund (ES in Turkish)

SSF: Social Security Foundation

SSI: Social Security Institution (SSK in Turkish)

SE: The Social Security Agency for Artisans and the Self-Employed (*Bağ-Kur* in Turkish)

TUIK: Turkish Institute of Statistics

UN: United Nations

UNDP: The United Nations Development Programme

UNICEF: The United Nations Children's Fund

WB: World Bank

WHO: World Health Organization

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CHAPTER 1

INTRODUCTION

Throughout the history of humans, there have been many shifts and changes in the economic, political, and cultural domains which have played a crucial role in determining individual and community health. One of the main characteristics of our modern society is the existence of social inequalities and inequities among different social groups sharing common features in terms of access to and control of material resources or the distribution of life chances, social status, and political power. From primitive to modern times, many different types of inequalities have existed. While some people have a disadvantaged, subordinated position as regards access to resources necessary for survival and reproduction as well as possessing and controlling the ownership of wealth, certain groups are in an advantaged and privileged position in society. This position, or individuals' social background, has an indisputable impact on their chances of living a long and healthy life. In all societies and in all historical periods, people defined as paupers are disadvantaged in terms of health.

Today, one of the greatest social inequities is that people who are marginalized experience more illnesses, disability and live shorter lives than those who are more affluent (Benzeval, et al. 1995:1). Health inequalities among different social groups in terms of occupational status, social class, gender, race, ethnicity, and age indicate the significance of the social determinants of health in modern society. These inequalities are a crucial indication of the unequal structure in modern society. The concentration and polarization of the poorest and the richest, which is referred to as the concept of "new poverty", has led to increasing academic interest on health inequality. In recent

times, "new poverty", particularly in the urban context, as a result of the globalization processes and structural changes, is reflected in scholarly work with growing awareness. More and more connections are drawn between poverty and the structure of social inequalities.

The first shift is the re-structuring of work under economic globalization with its dominant neoliberal ideology. With new technological developments, the production process has become dehumanized and led to the deskilling of the labor force. There is a decline in manual jobs and expansion in services and professional managerial jobs. In terms of the forms of capitalism, a shift has taken place from "organized capitalism" dependent on a welfare state and a national economy to "disorganized capitalism" (Lash and Urry, 1987), where multinational companies, transnational corporations, and international organizations have begun to dominate the economic field (Sassen, 1998). Workers have much less job security, are more vulnerable to unemployment, earn less money, and as a labor force they are disorganized and less unionized. The shift in work structure has created the concentration of poverty and wealth at opposite poles.

As a second shift, the contemporary rise of neoliberalism with the decline of the welfare states, as Wacquant (1998) calls "Desocialized Wage Labor" (DWL) regime as the new norm of employment and requirement of full citizenship has become prevailing. In addition to the mutation of wage labor, one of the reasons for new marginality and poverty is the retrenchment of the welfare states and the reduction of state expenditures on welfare for the sake of economic globalization. With this transition, "individual responsibility" has become a popular catch phrase in many domains like health. The idea of individual responsibility in health is often emphasized and supported by many nations. Wacquant refers to this negative shift in the welfare regime as the *erosion of state social capital* and *negative social capital* by (1998, 2001a).

Today, people everywhere in the world are experiencing poverty in both absolute and relative terms. Along with poverty, people are experiencing ill-health. This focus is crucial because health seems to be important both as a cause of poverty and as a consequence of it (Wagstaff, 2002). According to Navarro et al. (2006) health inequality is associated with social inequality. In fact, not only can it be said that health inequality is almost a direct result of social inequality, but a positive association

between economic inequality and health inequality, as well, has been observed for most countries and throughout a long time period (Townsend and Davidson, 1982; Wilkinson, 1996). It remains true that the epidemiological and demographic transition has resulted in the decrease in infant mortality rates and infectious disease and increasing chronic disease. However, while the absolute health of the population has improved, the gap between the rich and the poor in terms of various health status indicators has expanded.

Poverty reflects directly on people's way of living, their health status and well-being, nutrition and capacity to survive. Recently, vulnerability to poverty and the precarious nature of working life, both of which also lead to health risks, have become a real part of modern life. The en result is a picture with polarization in terms of both welfare and health. Recently, international organizations such as the WHO, UNDP, UNICEF, World Bank, and governments have reported that there is a close link between poverty and health. Underdeveloped, low income countries are also closely associated with low health indicators. Poor people, whether in developed or developing countries, suffer from various health problems identified as preventable, requiring relatively cheaper treatment like communicable diseases. Recently, this association has been coming up much more often than it ever has. Although considered extensively by these organizations via indicators, the link between health experiences and poverty within unique populations has not been as thoroughly studied.

This study, does not focus directly on health outcomes according to different socio-economic indicators as done by epidemiological studies; instead, it concentrates on health experiences, which are assumed to be conducive to a better an understanding of the real life influences of poverty. According to Cockerham (1998), a medical sociologist, in the US -although it is important- even if health care access was equalized, the gap between the rich and the poor in mortality would remain unchanged because living conditions and lifestyle can not be equalized. Conditions which produce illnesses, such as those of poverty or poor nutrition need to change. Also, the quality and the coverage of health care among different classes differ a great deal as stated by Cockerham (Ibid.).

A look at Turkey reveals that fundamental changes took place after the 1980s. With the adoption of neoliberal policies under the name of structural adjustment

policies, unequal distribution of income has increased, real wages have decreased, the proportion of social services within the public spending budget has been cut, the unemployment rate has increased, and the quantity of labor force demanded has decreased. Moreover, the proportion of employment in the informal sector has increased accompanied by the decrease in registration to one of the social security institutions. As a result of these changes, poverty has been discussed a great deal recently. The traditional welfare regime based on kinship and common origin ties has lost its power since the 1990s. Macro economic changes have resulted, among other things, in rural-to urban migration. One of the consequences of these developments has been the fact that the traditional solidarity networks and support systems have changed form. Where family and kin-networks used to function as the pillars of the traditional welfare regime, the existing welfare programs and assistance remain limited. Those individuals and families, who cannot benefit from the state support system as well as those who cannot rely anymore on informal solidarity networks, often end up in greater poverty. In addition to these economic and social changes, Turkey has witnessed a demographic and epidemiological transition. Life expectancy has increased, infant mortality has decreased, and infectious diseases as a pattern of mortality and morbidity have decreased. Meanwhile, inequality and social-economic polarization have increased Health indicators reveal some improvement; however, the gap between rural and urban areas and between the western and the eastern regions of Turkey has been consistently widening.

Now, the poor are disadvantaged twofold because they are not equal in terms of access to material basic resources and services such as health, food, shelter and security, and also because they have the worst health status. Not only are they the most underprivileged they also have the most urgent need for health care and other resources. The problem becomes what Tudor Hart (1971) once called an "inverse care law"; that those people in the worst health receive the least services. In addition to the adverse effects of poverty on people's health, negative health experiences can lead to further impoverishment. That is, ill people begin to lose their capacity to work and can not afford health services if they do not have social security of any kind.

It can be said that health inequality is essentially systematic. The differences in health outcomes between social groups are such that poorer and/or disadvantaged

people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.

In this regard, the main objective of this thesis is to try to explain how the urban poor experience this health inequality. I will not try to prove that poverty is a predominant social precursor to poor health; or that the disadvantaged health status among the poor is associated with reduced life expectancy and a high risk of death from preventable and treatable illnesses. Neither is measuring health status a sociological matter; it is a "public health" or epidemiological matter. I will endeavor to examine the social positions of the individuals concerned and the social processes playing a role in the health experiences of the poor population from a sociological point of view.

Within this context, I attempt to identify some clues about the economic, cultural, and social factors on the health experiences of the poor. These clues will more easily be obtained via an analysis of their experiences including their health problems, difficulties in health care access, health and illness perceptions, health seeking strategies, and institutional experiences in health care settings.

In the academic and public discussions frequently one often comes across the argument that poverty is interlinked with health. In such a sense, the poor are lumped into a sort of homogenized mass in which all in question are prone to health problems. This study, on the contrary attempts to address the variety and differences in the health experiences of the urban poor. To this end, I basically integrate into the analysis the individuals' use and transfer of different *forms of capital*, operationalized by looking at their demographic characteristics, occupational and educational skills, migration histories, employment status, access to social security and health provisions, etc.

This thesis is concerned with how the urban poor experience, perceive and cope with health while living in poverty. With the adoption of Bourdieu's concepts, this thesis not only examines economic factors, but cultural and social factors, as well. Structural dimensions are thought to play an important role but the agents themselves cannot be seen simply as passive actors. In fact, according to Bourdieu and Wacquant, "those dominated are always in the position to use a certain amount of power no matter which social universe they are in: the concept of belonging to a field, by definition, entails the ability to have influence in it - even if it means doing this while

being excluded by those in power[1]" (Bourdieu & Wacquant, 2003: 65). This study, therefore, emphasizes the experiences of the individuals within a given structure; however, the experiences of the individuals allow a certain degree of agency which is set by the different *forms of capital* they possess.

The agency's capability is revealed in its relationship with the *forms of capital* in terms of their *volume*, *composition*, and *trajectory*. It should be stated that the *forms of capital* are not constant, but in a permanently changeable state. For Bourdieu (2003), each has an exchange rate; that is, they may be converted into each other in a given *field*. The maintenance and improvement of the position of agent requires pursuing strategies of reconversion. That enables the reproduction of the value of the capital in the *field* (Bourdieu, 1986). The logic behind the functioning of the capital, that is, the conversions of one type into another carried out by the agent, indicates his/her power and capability to have control in the *field*. No doubt, the conversion calls for a certain amount of labor and time to be transformed from one type into another, as in labor time accumulated in the form of capital (Ibid: 253). In this regard, the thesis also examines the role of the agency specifically by looking its capacity to convert one form into another with the potential to influence health experience.

In terms of health inequalities, prior studies have examined the relationship between health status and socio-economic factors such as employment status, income, housing, occupation, and having a car. Studies of health inequalities, which are composed of *artifact explanations*, *health selection explanations*, *cultural/behavioral explanations* and *materialist explanations* have been summarized in the *Black Report* (See Chapter Two for details), a key study documenting inequalities in health in the UK. This study is criticized by authors such as Popay et al.(1998), according to whom, while a strong materialist-structural research tradition developed in the health inequalities field through the 1980s and into the 1990s, in the wake of the *Black Report*, this tended to be "empiricist in nature, simply adding more social variables to an increasingly long list of risk factors" (Ibid: 626). Researches either tend to analyze in a structuralist way, focusing on socio-economic factors, or in an individualistic way, focusing on lifestyle and behavioral factors.

Navarro (1978) defines "ideological function" as one of the "negative state interventions". According to him, the state plays a major role in regulating the

[1] Translated from Turkish into English by author.

ideological debate over the cause and character of illness in capitalist society; for example, there is a clear tendency to see illness in individualistic terms rather than in terms of the environmental and the social causes of health inequality (Ibid:118). The other feature of the ideological mechanism is the tendency to treat rather than prevent a disease. A more recent paradigm is "blaming the victim", which also remains questionable. Identifying the link between structure and agency remains a problem in health research. Recently, there are attempts at solving the structure-agency contradiction with the application of Bourdieu's theoretical framework to the field of health.

The lay perspective is used in the sociology of the health discipline to define people's everyday life experiences in relation to health. In the health field, the criticism of the medical dominance over people's health and "medicalization" discussions (Conrad, 1992; Zola, 1972, Friedson, 1970a) have compelled sociologists to focus on the lay perspective. Friedson's study on professional dominance carries important influences in medical sociology. During the late 20th century, in addition to medical sociologists, sociologists like Habermas (1976) and Beck (1992) have criticized expertise. Habermas is critical of expertise and uses the notion of "expert culture". Recently, lay knowledge has been evaluated to be at least as valuable as professional medical knowledge (Prior, 2003: 43). There has been a gradual shift away from explaining health-related behavior simply in terms of "health beliefs" towards attempting to understand the lay person's actions in terms of their own logic, knowledge, and beliefs, which are grounded in the contexts of people's daily lives (Williams, 1995: 580). The lay perspective continues to receive more attention in the discipline of sociology of health and illness than ever before. Especially articles published in "Sociology of Health and Illness" have lent significance to the topic. There is a need to understand health and illness in terms of people's own interpretation of its onset, the course of its progress and the potential of the treatment for the condition. People's own perceptions and their conceptualization of the health and illness worlds, which consciously or unconsciously urge them to act for practice, should be considered. People's health discourses are influenced much more by their social context. Living in poverty as a social context surrounding them not only has impacts on health care access, but also shapes their definition of health and the discourse of health, when they become ill, their recovery methods and strategies,

illness prevention and the maintenance of health. Although the lay perspective is crucial for an understanding of people's health practices, in fact, the understanding of a "knowledgeable patient" or "lay expert" may conflict with the "logic of practice". In medical sociology, there are two tendencies in this respect: structural and phenomenological.

On the other hand, according to Bourdieu (1990), practice is not consciously, or at least wholly consciously, organized (p: 61). Focusing on only the lay perspective may cause an overestimation of subjectivity if it is examined without the consideration of the given social context or structure. Also, Bourdieu (1977) states that "each agent wittingly or unwittingly, wily nilly, is a producer and reproducer of objective meaning… it is because subjects do not, strictly speaking, know what they are doing, that what they do has more meaning than they know" (p: 79). Here, the concept of *habitus* as a "durable disposition" becomes important.

There is awareness in the subdiscipline of medical sociology that more theoretically satisfactory accounts of the inter-relationships of social structure, context and agency in their impact on health and well-being should be developed (Williams, 2003, Popay et al., 1999). For many scholars in different disciplines such as medical anthropology, medical sociology, public health, epidemiology, and nursing, Bourdieu's theory of practice has been seen as a solution to understanding the relationship. This has led to a dramatic increase in the number of studies adopting his theory. There has been an increasing number of studies done on the health issue by adopting Bourdieu recently; however, they mostly focus on a specific aspect of health such as health behaviors and lifestyles, health and illness perceptions, *social capital* as a health determinant- especially the neighborhood effect, poor people's experience in hospitals, the effects of the *forms of capital* on health status, home care, use of medication by older people and so on (See Chapter Two for details).

Within the Bourdieuan framework, if people's experiences and ideas are assumed to change systematically according to the position they occupy in the *field*, it may be possible to say, for the purposes of this study, that the urban poor living in *gecekondu*s may have different health experiences than other people in urban space. Also, unlike Bourdieu, I examine the differences in health experiences for the same group and I explore the social and cultural factors underlying the differences, if there are indeed any to be found.

The answer to why the health and illness experiences of the urban poor living in *gecekondu* areas are sociologically meaningful lies in these mentioned changes and inadequate theoretical explanations which embrace these people's health experiences. Firstly**,** the aforementioned changes illuminate the recent period, enabling us to focus on the health experiences of the urban poor, firstly because *gecekondu* people are closely associated with poverty. Here, I assume that those changes render them more vulnerable. The weakening power of their functioning informal network, their close attachment to the informal labor market in urban areas, their cultural position in the urban *field* as rural to urban migrants, and their close association with various illnesses have directed me to examine their health experiences, which are assumed to be different. Secondly, theoretical explanations about health employ the duality between the structure and agency. In general, health studies are either based on the structure or on the will of the agency. The focus on the agency without a look at the big picture may lead to the false justification of the "blaming the victim paradigm" supported by the neoliberal view. Also, focusing only on structure makes the agency a passive object that tolerates everything imposed on it by the existing structure. However, it is assumed that the health experiences of people can not be restricted like this. This thesis is an effort to transcend this dualism following the theory of Bourdieu to reach a true understanding of the health experiences of the urban poor.

Theoretically, this thesis is based on Bourdieu. Also, in addition to Bourdieu some of Wacquant's concepts are employed, deemed useful especially for examining new poverty in Turkey. In terms of health experiences, the thesis follows Bourdieu's theory based on the concepts of *habitus*, *field*, and the *forms of capital*. The *forms of capital*, namely *economic*, *cultural*, *social* capital, all of which are claimed to be influential in the health experiences of poor people, will be examined.

I also add *health capital* to this list in order to identify differences in health experiences according to the state of people's health (See 5.1. for details).

Unlike other studies, this study deals with the various aspects of health practices, including the understanding of health and illness, health seeking strategies, and institutional experiences. In general, studies have been done either on middle class or on different occupational classes comparatively. The focus has been on poor people only in terms of how they cope with illness; how they perceive health and

illness, and what they do for health maintenance and recovery. In this framework, the following questions will try to be answered:

> (*1) What are the differences and similarities in the experiences and perceptions of health among the urban poor?*
> *(2) How do different forms of capital (economic, social, cultural) influence the health experiences of the urban poor?*
> *(3) Can health be considered as a different form of capital?*
> *(4) What is the role of the agency in health experiences?*

In this framework, this study was conducted in two poor neighborhoods in *Altındağ* via face to face interviews with 40 individuals. As a disadvantaged area, *Altındağ*, which is recognized as one of the oldest *gecekondu* settlements was selected with its low poverty and health indicators (discussed in Chapter Four).

Based on the methodological view of Bourdieu, I agree that the agency's views and interpretations are an indispensable component of the precise reality of the social world. In order to see the relationship between *habitus* and *field*, and the *forms of capital* we should see the agency as a carrier of *habitus*. I think that the health and illness experiences of the poor can be understood using a qualitative method which would help reveal meanings behind everyday life experiences for the specific social context.

In order to select the study participants, first I selected the neighborhoods by looking at socio-economic indicators and health indicators and enlisted the help of experts. The selection of the interviewees was done by snow-ball sampling with several key informants used as starting points. In every household, one household member aged 18 or older was interviewed.

The following chapter is devoted to a theoretical review of the academic discussions on growing social inequalities, which have emerged as a result of global economic and social re-structuring.

The second part deals with the poverty-health interaction in different historical periods by focusing on how the meaning of health and inequality has changed from ancient times until today, and which underlying philosophies and paradigms have been influential.

The third part touches upon the meaning of health. First the biomedical understanding of health and the official WHO's definitions will be examined. Then, different sociological approaches on health will be dealt with, and the lay perspective as to what health is, the sick role, and health seeking strategies will be examined.

The next part is allotted to Bourdieu's theory of practice and concepts constituting the basis for this thesis. In the last part a specific focus will be put on empirical studies on health, specifically those who followed a Bourdieuan theoretical perspective.

The third chapter is allocated to the Turkish case. Firstly, social inequalities that emerged after the 1980s based on the transformations in different domains of society, objectified as "new poverty" are discussed. In this part, the focus will particularly be on the transformations in the labor market and the welfare regime in Turkey under the influence of the neo-liberal economic model after the 1980s. In particular, the change in the Turkish work structure and its reflection on city employment as well as its role in bringing about and sustaining chronic poverty will be discussed. Then poverty studies that accelerated after the 1990s will be mentioned. The second part of the chapter is allotted to health inequalities in Turkey. After giving brief information on the Turkish health care system, I will focus on health inequalities in Turkey based on health indicators. Then, how different disciplines deal with the subject of health and health inequalities will be discussed. This chapter is crucial for an understanding of the connection among social security, access to health care and the health experiences of the urban poor.

The fourth chapter deals with the methodology of the thesis. It starts with the conceptual framework of the thesis by defining the concepts to be utilized. The concepts, most of which are taken from Bourdieu, will be presented in their operationalized form. The stages of the selection of the two neighborhoods and the selection of the sample will be explained. Also, the difficulties faced during different stages of the research are mentioned here. Lastly, some descriptive information about the two neighborhoods is presented. This description is largely based on interviews with the two neighborhood headmen.

The fifth chapter is devoted to the results of the research. It starts with the socio-demographic characteristics of the participants. It continues with a description of the urban poor's *economic capital* and its influences on their health experiences.

Firstly, the findings on the rural health experiences of poor will be presented. Then, their migration patterns, and problems in terms of health and their health experiences in their first years upon arrival in the city will be examined. This part will continue with the discussion of the urban working conditions, child and women's labor, and nutrition and the influences of all of these on their health experiences. In the following part of the chapter, both formal and informal *social capital* will be dealt with. In this part, the influence of formal social security/assistance as well as informal social solidarity networks on health care access will be discussed. The next part of the chapter deals with *cultural capital* and its influences on health experiences. In this part, being poor, being educated, being a villager, and being sick are all examined as different identities determining the institutional experiences of the urban poor in health care settings. In the last part, *health capital*, subjectively perceived (illness) or medically diagnosed (disease) will be analyzed. Furthermore, the perception of health and illness are examined. The last part is devoted to the *health seeking strategies* of the urban poor.

In the conclusion chapter of the thesis, following a brief summary of the research findings, the thesis's research questions will be discussed in accordance with the theoretical framework.

CHAPTER 2

THEORETICAL FRAME

The reconstructing of capitalism with globalization, whether it is defined as "disorganized capitalism" (Lash and Urry, 1987), "post-industrial society" (Bell, 1973) or "risk society" (Beck, 1992), has generated patterns which have fueled a new type of social inequality objectified as "new poverty" or "new marginality" (Wacquant, 1999) especially after the 1980s. Recently, social inequalities as seen in the polarization of the poor and the rich are also reflected on the disparities in health status and experiences of people in different levels in society. Understanding this new type of poverty requires a look at the changes in economic and social policy, and health domains. The most important ones are the more flexible structure of work, structural unemployment, the expansion of the informal sector and the changes in social policies supported by the neo-liberal view. In this regard, sociologists have been trying to understand the new forms of poverty and their reflections on different fields and there is a growing interest in the international and national academia.

This chapter is divided into five parts. The first includes a theoretical review of the social inequalities which emerged as new poverty after the 1980s. The changing structure of work and social policy is underlined here.

In the second part, the focus is on health inequalities. This has been discussed by many scholars in different disciplines since it gained momentum with the publication of the *Black Report* (Townsend, Davidson, 1982). Health is accepted as one of the crucial indicators of social inequalities. Health inequalities will be touched upon in this section, with an emphasis on the relationship between poverty and health. To understand the recent forms of the poverty and health interaction, firstly a historical

overview will be provided. Information will be given about the history of the poverty-health interaction in order to ensure a grasp of the distinctive features of the recent form. After, a brief history of this interaction, the changes which took place in health and health policy after the 1980s will be discussed and studies of health inequalities peculiar to the contemporary situation will be mentioned.

Then, following the main focus of this thesis, the changing definitions of health, illness, and disease will be examined and reviewed from different perspectives: biomedical understanding, official definitions, sociological points of view, and lay perceptions of health. The main question in this part is "What is health?" After reviewing the different definitions and views about health, health and illness experiences will be touched upon in terms of health seeking or coping strategies in order to recover and be protected from illness; the sick role including experiences of the chronically ill; and experiences in health care units, which function as conceptual tools for the analysis of the health experiences of the urban poor.

The next part is devoted to Bourdieu's theory of the reproduction of social inequalities based on the concepts of *habitus*, *field*, and *forms of capital*. As the theoretical premise of this thesis, Bourdieu's concepts will be utilized in order to achieve an understanding of the health experiences of the urban poor.

Bourdieu's theory has been adapted in a wide range of domains, one of which is health. These studies focus especially on the health related behaviors and health perceptions of lay people. A general review on health researches which are based and refer to Bourdieu's concepts will follow.

2.1. Recent Social Inequalities

Social inequalities which comprise patterns of advantaged and disadvantaged life chances are frequently cited by sociologists. Life chances are resources or opportunities which individuals possess; they include income, education, housing, health and other valued resources. Social inequality creates stress in the system and is assumed to have a corrosive impact on social order. In this case, the system permanently seeks different ways of overcoming crises. In pre-modern society, inequalities were legitimized by attribution to divine authority. However, in modern times, the legitimization of inequalities has become difficult to explain. Inequalities

contradict with the main principles of modernity. These main principles are the individual, rationality, science and freedom of choice that originated from the Enlightenment. At any time, softening contradictions and the sustainability of a socially cohesive society has been an issue. It is also argued that social inequalities are much more related with the redistributive mechanisms of the structure. Recently, the new distribution of economic resources with economic globalization and changing social policies has created a new form of social inequality in which there will usually be extremes of poverty and wealth. This new distribution view is supported by New Right, which sees social inequalities natural and inevitable.

Some segments of society are more prone to poverty, exclusion and ill-health than ever before. The new period is a picture of the fragmentation of the poor and the rich and the economic gap increased dramatically. To understand the present, one must look at the economic and social restructuring processes of society peculiar to the period after the 1980s.

After the 1970s, a new era began with the economic, social, political and cultural transformations of modern capitalism. A look at the changes in social, economic, and political reformation will enable us to accommodate the relationship between social inequalities and health inequalities at a more comprehensive level. Recent decades have witnessed two fundamental macro-social shifts, each of which has had profound impacts on socioeconomic and health conditions. The first one is the recent restructuring of capitalism with the changing structure of work. The second one is the new structuring of the social policy in terms of social protection after the decline of welfare states.

The new structuring of capitalism is called globalization, which indicates shifts in the economic and social structure of society. Globalization is mostly associated with the flexible movement of capital transnational in order to cope with crises and maximize profit. The shift into the globalization project involves major technological changes which have dramatically altered production processes and increased the speed and scope with which information and ideas, as well as capital, move around the globe (Berger, 2001: 889-890). There is a shift from Fordist industrialization based on the centralized mass production of standardized products to the post-Fordist industrialization model based on flexibility in terms of working conditions, production, and specialization. While Fordism is characterized by mass production

with the image of "assembly line" from the beginning of 1900s, post-Fordism is characterized by new information technology, the rise of the service and white collar worker and globalization. It is the flexible production of diversified goods on a new, global scale in contrast to Fordist economy (Gartman, 1998: 121). "More flexible production processes require more decentralized forms of labor process and work organization" (Nettleton, 1995: 216-217). With new technological developments, the production process has become digitalized, computerized and automated. This, of course, has led to the deskilling of the labor force and the dehumanization of the production process. Sassen (1998) discusses the urban impacts of economic globalization. She compares different periods in terms of the role of the cities in economic activities. In the 1800s, when the world economy consisted largely of trade, the crucial sites were harbors, plantations, factories, and mines; cities developed alongside harbors and trading companies were servicing centers at that time (Ibid: 9). However, in the 1980s, she states that:

> Finance and specialized services have emerged as the major components of international transactions. The crucial sites for these transactions are financial markets, advanced corporate service firms, banks, and the headquarters of transnational corporations. These sites lie at the heart of the process for the creation of wealth. And they are located in the cities (Ibid: 9).

According to her, economic activities and production moved from large cities to the zones in low-wage countries (Ibid: 19). The central rationale for these zones is access to cheap labor for the labor-intensive stages of a firm's production processes and tax breaks and lenient workplace standards in the zones are additional incentives (Ibid: 19). On the one hand, companies maximize their profit by making directly investing in the underdeveloped world, on the other; people living in low economic conditions in their countries have to be subjected to work conditions with low wage and a precarious and risky work atmosphere. This outcome is one sign of recent social inequalities which have emerged due to economic globalization

The main characteristics of the new organization of work have altered the social class structure of societies and caused the emergence of new form of poverty debates, both industrial and non-industrial. According to Berger (2001), the globalization project supported by the neoliberal perspective has not only altered the existing structure of work, it has also led to an increase in the global level of inequality. "During the 1980s and into the 1990s, real wages stagnated and even

declined for large segments of the population, and large numbers of workers were unemployed or were dependent on part-time or temporary work or employment in low-paying, entry level jobs that convey few benefits and little job security" (Waters, 2001: 87). As companies have begun to seek cheaper and less organized non-unionized labor, structural unemployment has emerged. Technological change has led to a decrease in the job opportunities for unskilled workers.

DiPrete et al. (2002) express that post-Fordist economy is asserted to have caused "devolution" of internal labor market. This devolution has generated (1) a loss of job security and consequently higher rates of worker displacement; (2) a greater use of "contingent" workers, who have low job security; (3) higher levels of job mobility as a consequence of the presumably greater rates of job creation and job destruction in the post-Fordist economy (DiPrete et al., 2002: 177). Nettleton (1995) expresses that there needs to be a skill-flexible core of employees and time-flexible periphery of low-paid and therefore insecurely employed workers (p: 217). Also, there is a decline in manual jobs and expansion in service and professional or managerial jobs.

As a result, economic globalization creates its disadvantaged populations such as immigrants, disadvantaged women, elderly, people of color and masses of shanty dwellers. Women are the preferred labor force because they have submitted to working in disadvantaged work conditions with long hours, low pay, temporary and part time jobs; therefore, the debate over the feminization of poverty has emerged. As a result, the emergence of the working poor, feminization of poverty, emergence of chronic unemployment and underemployment, the new urban poor in most cases as people in the underclass, especially migrants, is what a picture of the recent times is made up of.

Regarding economic globalization, it can be said that there is a shift from "organized capitalism" dependent on a welfare state and national economy to "disorganized capitalism", where multinational companies, transnational corporations, and international organizations have begun to dominate the economic field instead of national sovereignty in economic and social field (Lash & Urry, 1987).

The contemporary rise of neoliberalism and of inequality following the 1970s is historically tied to the decline of the welfare state, forming a second shift. Advocates of the welfare state indicate that it has both material and psycho-social effects by preventing dramatic falls in living standards and by a wider effect on the

degree to which citizens experience a sense of control of their lives (Coburn, 2000: 139). The idea of the welfare state is a moral system as emphasized by Marshall's writings (1950). According to him, "social rights" were, together with legal and political rights, one of the basic elements of modern citizenship. In Marshall's view, the capitalist market system fragments society by emphasizing individual self-interest, but the welfare state unifies it by granting equal rights of entitlement to everybody. "The welfare state functions as a form of social cement tempering the individualism of the market with a good strong dose of social altruism" (Saunders, 1999: 6).

After the 1980s, when welfare state policies began to be questioned, the New Right policies in different sectors advocated by Reagan and Thatcher became dominant in the world. The "New Right" critique of welfare in the 1980s rested on two arguments (Ibid: 56). The first was that the cost of modern welfare state systems was spiraling and that radical cuts would be needed to prevent social security, health and other welfare budgets from absorbing an ever-increasing proportion of total national income. The second was that the modern welfare state was not a "moral system", but had rather evolved into a system which was in some respects ethically questionable. The critique of welfare basically argues that the system has expanded to a point where it seems to be supporting substantial numbers of people who could support themselves and that it is actually encouraging people to rely on the state rather than work for a living. Neoliberals assert that the modern welfare system created social fragmentation. According to neoliberals, nor was the system particularly effective at helping the poor, indeed, rather than solving social problems, the welfare state had created new ones, for it had fostered the emergence of a new "underclass". However, people have been subjected to low wages without legal restriction and protection in the state of perennial risks such as unemployment, disability, and sickness and they have been less organized to pursue their rights.

According to Schram (2006), new welfare policy reframes poverty and welfare in terms of the concept of "welfare dependency", in Europe "labor activation". These two imply that low wage work is being enforced on the poor. This labor activation policy is often justified in terms of helping the unemployed overcome their "social exclusion" (Ibid). As, what Handler (2004) calls, a "paradox of inclusion", these policies on the one hand provide "rapid attachment" to the paid labor force; on the other they risk helping the poor overcome their exclusion in ways that reinscribe their

subordination. According to Wacquant (2001a), the Keynesian welfare state has been replaced by a "liberal-paternalistic regime". This new regime offers less monetary aid to low income families, and more discipline upon the adults in families. For him,

> It is liberal at the top, towards business and privileged classes, at the level of the causes of rising social inequality and marginality; and it is paternalistic and punitive at the bottom, towards those destabilized by the conjoint restructuring of employment and withering away of welfare state protection or their reconversion into instruments of surveillance of the poor" (emphasis in original) (Ibid: 402).

Neoliberal policies are associated with what he calls the "penalization of poverty" designed to manage the effects of neoliberal policies at the lower end of the social structure of advanced societies (Ibid: 401). Wacquant (1998a) defines the new type of social policy supported by neoliberalism as *negative social capital*, visible in black American ghettos, explaining *the erosion of the state social capital*. He states that "public institutions operate as negative social capital that maintains ghetto residents in marginal and dependent positions" (Ibid: 29). He asserts that the state lost its *Left Hand* characterized by education, public health care, social security, social assistance and social housing (Wacquant, 2001a: 402).

In terms of social inequality experienced in urban areas, Wacquant (1999) focuses on the concept of *new marginality* in order to characterize the regime prevailing after the 1970s since the close of the Fordist era in advanced societies. According to him, emerging regime of marginality is fuelled by four structural logics "that jointly reshape the features urban poverty in rich societies": a macro-societal drift towards inequality, the mutation of wage labor, (entailing both deproletarianization and casualization), the retrenchment of welfare states, and the spatial concentration and stigmatization of poverty (Ibid: 1641). In order to display the resurgence of social inequality in cities, he states that both wealth and poverty are visible in developed cities. He explains that "the two phenomena, though apparently contradictory, are in the point of fact linked" (Ibid: 1641). To cope with emergent forms of urban marginality, societies face a three-pronged alternative: they can patch up existing programs of the welfare state, criminalize poverty via the punitive containment of the poor, or institute new social rights that sever subsistence from performance in the labor market (Ibid: 1645-1646).

Also, Wacquant (2001b) uses the concept of Desocialized Wage Labor (DWL) to define the new norm of employment and requirement of full citizenship. With the expression DWL, he refers to a wage labor relationship that is permanently –rather than cyclically- insecure, structurally –rather than conjuncturally- unstable, systematically –rather than incidentally- under remunerated as well as increasingly incapable of sheltering those who enter it from the perennial risks of employment, namely, deprivation, disease, joblessness, and the inactivity brought on by old age (Ibid: 56). According to Wacquant (1999), "the mutation of wage labor" is one of the fundamental changes preparing the ground for new poverty or urban marginality. According to Wacquant (2001b), the imposition of DWL continues both institutionally and ideologically. On the ideological front, he asserts "there is a worldwide campaign supported by international organizations, think tanks, government and mercenary intellectuals, journalists etc., aimed at inculcating new categories of thought that naturalize the neoliberal vision of the world" (Ibid: 57-58). This kind of regime normalizes the requirement of the reduction of state expenditure, especially in the areas of welfare for the sake of economic globalization. According to him, the reliance of the new found popularity of the idiom of "responsibility", a prevailing concept in almost all fields such as health, supports this campaign (Ibid:58). He defines this process as the "cultural normalization of insecurity". On the institutional front, he asserts that:

> Imposing desocialized wage labor entails establishing a new framework of rules and regulations that materialize and enforce the new "social contract". In the United States and I would argue also in the United Kingdom, this is done by two major, concomitant and complementary transformations: "downsizing" the welfare states in order to force people into peripheral segments of low-wage work; upsizing the penal state so as to control and contain the dereliction and disorders generated by this policy of social dumping. (Wacquant, 2001b: 59)

Now, people are less protected as a labor force and people face the aforementioned risks in life. They are mostly left to their own devices by the state and the new paradigm of employment and citizenship, the DWL regime, supported by neoliberalism is more or less imposed.

According to Walby (2000), social inequality will enter the twenty first century in new forms. In the period "social inequality will be globally structured, but the nature of the connections will be different, more intense, the linkages more speedy,

the significance of physical distance less important" (p: 814). Like Wacquant, she emphasizes the new flexibility and new forms of work, both precarious and poorly paid. The new types of working arrangements are increasingly temporary, part-time, subcontracted, and self-employed. Also, she emphasizes that "global competition among nation-states and the erosion of the power of the traditional working class will continue to curtail welfare state expenditures" (Ibid: 815). By putting a special emphasis on gender, race and ethnicity, she explains the new form of social inequality like so:

> The core concepts of social inequality will not cease to be relevant in the twenty-first century. There will still be inequalities based on class, on race/ethnicity, and on gender. But the forms will be new, and there will be new intersections. There are two main sources of transformation: The transition of gender relations from a domestic to a public gender regime will continue to reshape family inequalities as well as those in the workplace; globalization and the information age will reshape space and time and the terrain on which social inequality operates. (Ibid: 817).

The DWL system as Wacquant asserts or the new forms of social inequality as Walby states produce new poverty whose distinctive characteristics can be identified using various theoretical explanations. As a result of neoliberal policies, the proliferation of new poor identities has come about in different conditions like the working poor, unemployed, urban poor, poor women, elder poor and so forth. Moreover, poverty represents a specific social environment, created by society or by its negligence, which affects most aspects of life, including health, illness, health care access, and other experiences.

In order to comprehend the interconnectedness of "new poverty" and health experiences, the meaning of newly emerged poverty must first be discussed. It bears saying that there is no universal concept of poverty which can be applied to all cultures, societies, or times. Although each country should, of course, be evaluated in its own economic, social, political, and cultural dynamics, this does not mean that one should ignore macro-structural changes that came about under the name of globalization as mentioned before. Moreover, when we try to understand poverty experienced recently, we should consider the tendency of restructuring of society with a different fields.

One of the main theories which led to a controversy is the "culture of poverty" thesis, which has its basis in Oscar Lewis's ethnographic study conducted on

five Mexican families, namely, *Five Families: Mexican Case Studies in the Culture of Poverty* (1959). Lewis suggested that behaviors and beliefs are learned in early childhood and can contribute to multigenerational poverty. Lewis observed that by the time children were six or seven the culture of poverty was so ingrained in them that they were more likely to live the same impoverished lives as their parents.

The results of Lewis's thesis produced many discussions among scholars on the distinction between the culture of poverty and socio-economic poverty. Although Lewis's culture of poverty thesis is understood and seen as a tool for legitimizing the individualistic aspects of poverty, especially by neoliberals, the fact of the matter is that Lewis did not only focus on individual behavior in this study; instead Lewis tried to examine the structure in which poverty is experienced. Many scholars criticize Lewis's culture of poverty thesis and they ignore this focus on the structure. The theory is criticized as being negative, static and tending to "blame the victim". Lewis characterized the poor as isolated, inward looking, and weighed down by strong feelings of marginality, dependency, alienation, inferiority and powerlessness against existing institutions. The concept "culture of poverty" may be evaluated as a response to an existing dominant institution as indicated by Islam (2005), according to whom Lewis saw it as an extreme form of adaptation that the poor are forced to make under certain circumstances and in certain places. Also, he states that, in Lewis theory, as a response, the poor reject the dominant culture, and its institutions, because it does not serve them (p: 2-3).

The concept of social exclusion is also used to explain poverty. Lenoir (1974) is considered a pioneer in the use of the term "social exclusion" (cited in Bhalla and Lapeyre, 1999: 1). He developed a stigmatizing view of the excluded; those who have no access to the fruits of economic growth. These socially disadvantaged groups are those who are mentally and physically handicapped, suicidal people, the aged and invalid, drug abusers, delinquents, asocial persons and so on (Ibid).

Townsend (1979) defines poverty and deprivation in both economic and social terms. He differentiates between two types of deprivation: material (food, clothing, and housing) and social (associated with family, recreation and education). He defines poverty in terms of relative deprivation which is a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs. The definition of absolute

poverty depends on the subsistence needs level such as shelter, food, clothing and so on and basic needs such as basic services. Relative poverty is understood in terms of its relation to the standards of society (Ibid: 31). Now, most researchers are interested in relative poverty. In this regard, it can be said that the perspective of relative poverty makes it possible to consider the actor view on the perception of his/her socioeconomic status via comparison with the standards of society.

Sen (1992) developed a different approach to poverty. Sen (1999), states "poverty must be seen as the deprivation of basic capabilities rather than merely as lowness of incomes" (1999:87). The notions of individuals' capabilities and functionings lie at the heart of Sen's approach (1992). Capabilities mean opportunities to achieve valuable functionings or states of being. Functionings include both physical elements such as being adequately fed and sheltered and more complex social achievements, such as taking part in the life of the community, being able to appear in public without shame, and so on.

Another work on poverty done by Dasgupta (1993) examines the influences of equal and unequal asset distributions and the functioning of the labor market and on those seeking employment (Ibid). This concept of "economic disenfranchisement" is similar to Sen's concepts of entitlement and capabilities.

Desai (1995) focuses on the dimension of resource requirements for guaranteeing capabilities, which will vary from society to society depending on social norms and practices (cited in Bhalla & Lapeyre, 1999: 12).

According to De Haan (1999), poverty is not conceived only as income poverty but also as the experience of social exclusion in terms of deprivation in the economic, social and political domains. De Haan focuses on the multidimensionality of deprivation.

According to Bhalla and Lapeyre (1999) the capitalist system in the 1970s and 1980s has been followed by a deep restructuring of the entire social relationship (Ibid: 2). The globalization of capital and restructuring of labor markets has caused new types of social and economic regulations such as privatization, deregulation, reduction of public services, a shift towards targeted assistance and the deregulation of the labor market. They indicate that the new poverty problem does not pertain to marginals (the disabled or those excluded from social norms) but to such multidimensional problems as precarious jobs and unemployment, the weakening of family and extra-

family networks and a loss of social status (Ibid). They emphasize that social exclusion is a multidimensional structural process embracing the precariousness of labor and unemployment on the one hand, and the breakdown of social bonds through the crises of the welfare state, the rise of individualism and weakening of primary solidarity on the other (Ibid: 5). Those who conform to the market-driven ideals of individualism are included in society and can participate, while those who fall outside of the criteria for inclusion and participation, because they are single mothers, sick, disabled, or poor -because they are dependent- are excluded. Exclusion involves disintegration from common cultural processes, lack of participation in societal activities, alienation from decision-making and civic participation, and barriers to employment and material resources (Raphael, 2001).

Silver (1995) outlines three main paradigms about exclusion (cited in Bhalla & Lapeyre, 1999: 9). The first one is the solidarity paradigm, which explains exclusion in terms of a lack of social ties between individuals and society. The second one is the specialization paradigm, which explains exclusion in terms of various distortions, discrimination, market failures and unenforced rights. The third one is the monopoly paradigm, which explains exclusion in terms of some groups controlling or monopolizing resources to their advantage.

Therefore, social exclusion is either mentioned with unemployment or the precariousness of jobs, or lack of social ties, non-realization of social rights; certain social scientists, who explain new poverty as the terms of exclusion, have agreed that people are excluded systematically because of recent economic and social restructuring. According to Bhalla and Lapeyre (1999), the concept of social exclusion may be superior to that of poverty in two main respects. Firstly, it focuses on the multidimensional character of deprivation, and can thus provide an insight into the cumulative factors that keep people deprived. Secondly, it enables an analysis of deprivation as a result of dynamic causal factors (Ibid: 13-16).

Classifying who are the poor as a sociological category is difficult and a complex question to answer because it is different as social classes, and interest groups. Poverty is neither a fixed condition nor a personal or group characteristic, but rather it is an experience or a stage in the course of life. The poor are a group of people who do not voluntarily participate or enter into this so-called group. These

people sharing some common features are attributed the label of "the poor". And, at the same time, they have different features which lead to differentiation among them. The poor are defined according to different time periods. According to Kosa (1969),

> The slaves of the Roman Empire, the serfs of the Middle Ages, the peons of Latin America, the inmates of English poorhouses or the marginal farmers in Appalachia and the racial minorities in the urban ghettos were all called poor, even though they represented varying degrees of deprivation and different stages of forlornness' (Kosa, 1969: 1).

In Simmel's terms, the poor as a social type emerge only when society recognizes poverty as a special status and assigns specific persons requiring assistance to that category. According to him,

> The fact that someone is poor does not mean that he belongs to the specific social category of the "poor". . . . It is only from the moment that (the poor) are assisted ... that they become part of a group characterized by poverty. This group does not remain united by interaction among its members, but by the collective attitude which society as a whole adopts toward it. ... Poverty cannot be defined in itself as a quantitative state, but only in terms of the social reaction resulting from a specific situation. ... Poverty is a unique sociological phenomenon: a number of individuals who, out of a purely individual fate, occupy a specific organic position within the whole; but their position are not determined by this fate and condition, but rather by the fact that others... attempt to correct this condition (cited in Coser, 1977: 183, Simmel, 1965).

The restructuring of capitalism with a global division of labor with the adoption of new types of flexible work, and the domination of neoliberal policies with the decline of welfare states have changed the focus of social inequality: from class-based social inequalities to position-based social inequalities such as gender, race, ethnicity and so on. This change also is dealt with by Noll and Lemel (2001). They state that:

> As a result of the development of modern welfare state institutions, the individual's standard of living is less dependent on their occupational position and employment income. Class position and socio-economic status thus have lost their former dominance as a structuring principle of social inequality. Instead, other dimensions of inequality - like gender inequality, inequality between generations, ethnic inequalities and regional disparities - have gained attention and are considered to be more important than the "old" inequalities between classes and social strata (Ibid: 3-4).

We witness a growing powerless working class, less organized and becoming more vulnerable, poor and deprived of social rights.

The global division of labor has caused a concentration of the poor and the rich at opposite poles. Although class based and socio-economic inequalities have not been mentioned as recent form of social inequality by many scholars, socio-economic inequalities can be observed also in space in the form of certain areas in urban/metropolitan areas as Wacquant (1999) called "no go areas", or they get visible as homeless people

2.2. Health Inequalities

In order to understand the peculiarity of recent times in terms of health inequalities, we should take a journey into the history of poverty and health interaction. The close poverty-health interaction is not new; it has existed throughout human history. Also, this interaction is closely related with the history of the welfare regime in societies. The intersecting point in the poverty-health interaction is social inequality and the welfare regime.

Various changes in the history of human life such as the transition into sedentary life, increasing population density, technological innovations, civilization, and mass migration to the cities, industrialization and then globalization have raised the question of social determinants of health (Baer, et al., 1997: 39-59). In pre-industrial times, "relatively egalitarian societies including nomadic foragers, village horticulturalists, and tribal pastoralists enjoyed good health and long lives while they fulfilled their material desires" (Ibid: 40). For the pre-industrial period, shortage of food, natural disasters, warfare, and infectious diseases influencing the whole community were the main causes of death. Epidemiological studies indicate that "disease became a more rampant and devastating problem for human populations with the advent of agrarian state societies or civilization" (Ibid: 41). When the transition into sedentary life was realized and agrarian state societies emerged, not only did inequalities increase, but the social determinants of health became more apparent. "Increasing social stratification, resulting from the emergence of a small managerial class in archaic state societies, created the conditions that resulted in a more than adequate food supply for elites and serious and often chronic food shortages for poor urbanites, peasants, and slaves" (Ibid: 49). Therefore, in state societies, unequal access to food led to the emergence of malnutrition and greater

susceptibility to disease among the economically disadvantaged masses, particularly in urban areas. According to Cohen (1989), "the power of the elite not only affects the quality of food for the poor but undermines their access to food, their very right to eat" (p: 69). In pre-the industrial period, diseases were generally attributed to supernatural forces such as gods, magic, witchcraft, and evil spirits, and there were traditional healers such as "shamans who treat patients using herbs accompanied by various rites and ceremonies" (Perrin, 1995: 76).

During the Middle Ages, "death rates were very high and life expectancy was low compared to contemporary times, although life expectancy was lower for women than for men, for city dwellers compared with country dwellers, and for the poor compared to the rich" (Lupton, 1994: 80). Periodic famine and malnutrition were common and disease spread easily, especially in the cities (Ibid). At that time, religious and secular healing systems co-existed.

In spite of the fact that religion and the power of the Roman Catholic Church's hierarchy dominated all thinking and practice in the Middle Ages, treatment of the poor and needy was done for charitable reasons. In those times, there was no modern welfare regime; instead community health was important for the laborer's needs. The rise of mercantilism in the seventeenth century produced "a need for able-bodied, healthy laborers for business and industry and by the eighteenth century, maintaining levels of health in the population adequate for the needs of industry became public policy" (Kurtz & Chalfant, 1991: 159). The first hospitals were built during the Middle Ages. As an institution, "the hospital emerged in medieval society and was closely interconnected with the whole idea of Christian charity, especially towards the poor" (cited in Turner, 1995: 151, Horden, 1988,). In pre-industrial times, the poor and the sick were thought as one. Institutionalization, bureaucratization, specialization and expansion of the hospital occurred with the Enlightenment and the Industrial Revolution due to rapid urbanization, considerable population increase, medical innovations and enlightenment philosophies (Turner, 1995; Kurtz & Chalfant, 1991; Porter, 1999). When the church ceased to play a major role in the organization of public domain at the end of the Middle Ages, the management of the individual body was reallocated to a more scientific medicine (Turner, 1989: 219). Zola (1972) and Turner (1995) suggest that medicine replaced religion as the dominant moral ideology in modern societies. A biomedical understanding of health

and disease, which sees patients as objects of medicine rather than individuals with social backgrounds, emerged and became widespread. According to Turner (1995), "since the sick were typically the poor, they also became useful in the fulfillment of science" (p: 161).

During the 19th century, with the transformation of agrarian societies into industrial, poverty was much associated with epidemic diseases like cholera and typhus in Europe (Porter, 1999: 79, 92). The Industrial Revolution and accompanying population shifts to urban areas "precipitated new and threatening health problems because of the squalid conditions of the growing urban areas, the crowding urban areas, the crowding of individuals within such places and the lack of adequate sanitation" (Kurtz & Chalfant, 1991: 159). As a result of the transition period, huge masses died from the Black Death, cholera and others. It is striking that, for example "cholera killed the economically vulnerable and dispossessed first and the economically secure only as an afterthought" (Porter, 1999: 91). During this period, the idea was adopted by ruling elites, notably the aristocratic government, that "cholera would kill two birds with one stone, eliminating poverty and political unrest by eliminating the poor and their demands for reform" (cited in Porter 1999: 92, Durey, 1979; Morris, 1976). On the other hand, the poor believed that the medical profession manufactured cholera to obtain the corpses of paupers for anatomical dissection (Porter, 1999: 92). Cholera rioters, especially the British working class, insisted on social justice. Essentially, the history of cholera sheds some light on the relationship between power, poverty and health. Throughout time, we see that the poor with their body are defined, deprived, managed, and controlled by those who have power. So it can be said that the poor had little or no control of over their physical/body capital in history.

In modern times, the legitimization of inequalities has become more difficult because "individualism, reason, and freedom became main principals of modernity with the Enlightenment period" (Hamilton, 1992: 21-22). In every period, alleviating conflict and the sustainability of social order became an issue. The philosophy of modernity gives significance to the individual as a starting point for all knowledge and action (Ibid). The legitimization of the existence of poverty since the Middle Ages was realized with the distinction of "the deserving poor" (to help whom was a task of the church, local or central government and private charity) and "the undeserving poor"

(undeserving of any assistance): deserving poor are able-bodied poor for whom work would be provided and impotent poor such as sick, children, very old, lunatics, and/or handicapped people; undeserving poor are those who are unwilling to work such as vagrants and beggars (Fischer, 2001; Porter, 1999). The Poor Law Act in 1601 was based on this distinction.

Health as a right of citizenship had been declared an ideal of modern democracy by the French Revolution (Porter, 1999: 97). Now, health was a public issue. "The Enlightenment concept of health as a social value and a political right provided a rationalization for reforms dictated by the economic costs of premature mortality from epidemic disease, created by rapid urbanization as the pace of industrialization increased" (Ibid: 109). Scientific innovations such as the germ theory provided an understanding of microorganisms as the cause of disease such as Pasteur, and Koch. While previous theories ascribed disease to supernatural or divine agents, during the 19th century the idea that disease was caused by microorganisms expanded. Still, there was no awareness or acceptance of the socio-economic causes of disease. With this perspective, the implementation of disease prevention and management and sanitary facilities as a public policy emerged. In the history of human beings, when patterns of diseases change, new approaches emerge. In terms of the history of medical knowledge, Foucault's words make much sense. According to him, "modern medicine has fixed its own date of birth as being in the last years of the eighteenth century" and he defines biological causes of disease as the pathological basis of disease (Foucault, 1973: xii).

During the nineteenth century, Rudolf Virchow as a pioneer of social medicine, which is rejected by biomedical understanding, argues that "material conditions of people's daily life at work, at home, and in the larger society constituted significant factors contributing to their diseases and ailments" (cited in Baer, Singer, Susser, 1997: 36). Virchow stated that "the improvement of medicine would eventually prolong life, but the improvement of social conditions could achieve this result even more rapidly and successfully" (Ibid).

The Industrial Revolution and urbanization changed the concept of the poor "from dissipated agricultural laborers and country vagabonds into agglomerated masses crowded into sprawling urban slums" (Porter, 1999: 115). The urban proletariat was created by industrialization. With the development of capitalism, the

character of poverty changed because the urban poor multiplied and the hazards of industrialization affected workers. During this period, workers were affected by new insecurities as compared to the pre-industrial poor. "The risks of grave accidents, of unprovided old age, or of job losses all increased and were slowly recognized as new causes of poverty" (Ferge, 2001: 11925). From the fifteenth century onwards, politics of poverty combined from the start the function of policing (control and punishment) and of helping (poverty alleviation) (Ibid). Before the late nineteenth century, the state primarily intervened in society in order to maintain law and order rather than to provide social security for all. Modern welfare states arisen with massive industrialization, urbanization, and the emerging working class as their consequences. Working class poverty speeded up state intervention to social policy. Both concepts of poverty and health changed. The structural factors for both health and poverty gained recognition. According to Porter (1999), at the end of nineteenth century,

> when industrialization moved families from the land to the city, networks of mutual aid became redundant as wage earning employment required a nuclear, more isolated and anonymous family to be socially and geographically mobile. The social dislocations experienced by families as the result of industrialization left them unable to cope with the effects of disabling accidents at work, major episodes of illness, periods of unemployment, or dependent elderly or physically and mentally compromised relatives who were unable to work. Nation-state responded by creating policies to provide social security to meet these needs without forcing respectable citizens to accept aid under the demeaning and disenfranchising rules of traditional poor laws. (p: 196)

The Fordist regime is the economic and social system prevailing in the industrial world from the 1920s to the 1970s. It enhanced the efficiency of the labor force by providing welfare services such as housing, health care and social protection. In that period, the working class began to earn a social wage, not an individual wage. Social wage, "the term used to describe state resources that accrue to people other than through salaries, for example through free health services or free education" is defined as a working class victory by Marxists (Senior & Viveash, 1998: 315). The welfare state became a major component of Fordism. As the actor of redistribution, the state had a major role in the provision of social services to workers, such as health care, education, housing and pension schemes. According to Saunders (1994), "from the outset, the welfare state comprised a framework of institutions and policies designed to enhance the welfare of citizens and reduce the various dimensions of inequality" (p: 1).

The source of inequalities, health inequalities in particular, have changed with changes such as the post-Fordist production, globalization, and the decline of the welfare state mentioned in the previous part of this chapter.

As a result of social inequalities having been experienced for three decades, new welfare policies and changes in the structure of work have been observed. It can be stated that this has also had negative impacts on people's health both in terms of insecure working conditions due to no or little regulations and reduced health care access with the changing health policy. It is inevitable that changes in the work structure will affect workers' health and safety. According to Fustukian, et al. (2002), the change in work structure affects workers in three ways (p: 210-213). First while workers worldwide are at risk of exposure to a range of physical, chemical, biological, psychosocial and ergonomic hazards in their work environments, occupational diseases and injuries are more common in poor countries, where most workers do not benefit from equivalent occupational health and safety standards, because the new organization of the work structure is not concerned with social protection or the social security of workers. Second, inequalities are evident in the global movement of workers. Migrants tend to be concentrated in sectors of economic activity with no health or safety protection, and little or no legal protection. Third, the changes of technology from highly regulated to less-regulated or even entirely unregulated settings have occurred. According to Fustukian et.al. (2002), "the transfer of technology to low and middle income countries may pose additional risks to workers in these settings" (p: 211). Production processes across the world may be considered hazardous and risky to human health. With the changing work structure in terms of production processes, technology, space, and deregulation, new vulnerabilities have come into existence. Fustukian et al. express that women and children are particularly vulnerable members of the global workforce, in part because they are less likely to be formally organized and more likely to be employed in the informal sector (p: 213). So these vulnerable groups have been subjected to more hazardous working conditions in unregulated settings. It should be said that the changing structure of work and other structural changes are influential in determining people's health in contrast to the claims of neoliberal paradigm.

When we look at health policy, we see the domination of neoliberal policies on health issues. This seems to accelerate health inequalities with reduced state

protection. The New Right perspective, against the welfare state, mainly asserts that firstly, "the market system can most efficiently supply the goods and services in demand"; and secondly, "that individual responsibility should be encouraged as promoting community care and encouraging people to use private health insurance" (Senior & Viveash: 1998: 332). According to the proponents of the New Right, "state provision creates a nation of dependents who are unable to exercise individual responsibility for their own welfare" (Ibid). In addition to individual responsibility, family units should take care of their own relatives as promoted by the 1990 NHS Community Care Act. Informal care is promoted, and families, rather than the state institutions, are viewed as the source of care for the elderly and mentally ill. In accordance with neoliberal policies, *individualism* in health is emphasized in health policies, focusing on life styles such as cigarette smoking, eating behavior, alcohol abuse, exercising to keep the body healthy, fit, well-functioning, and strong enough to perform to daily activities and work duties in markets.

Bunton (1998) conceptualizes the neoliberal policies on health as anti- or *post-social policy*, "which would appear to replace social concerns with those of global economic freedom, a sectoral rather than national focus, and individualized risk and insurance approaches that stress privatized service provision and promote an enterprising self" (p: 26). According to Bunton, contemporary health care systems have been subjected to considerable restructuring and transformation, "not simply in the ways that services themselves are organized but also in the ways in which health is conceived, achieved and delivered" (Ibid). The new neoliberal strategy produces *active citizenship* through participation in health promoting activities such as self-care.

According to Navarro (1976), state intervention in contemporary capitalist society is both negative and positive. Under the notion of negative functions, there are the *structural selective mechanism*, *ideological function*, *decision-making* and *repressive coercive mechanisms* (Ibid:208-212). In the structural selective mechanism, the alternative medical system, for example, is excluded because it threatens the profitability of capital. Secondly, he believes that the state plays a major role in regulating the ideological debate over the cause and character of illness in capitalist society. For example, there is a clear tendency to see illness in individualistic terms rather than in terms of environmental and social causes. The other feature of the ideological mechanism involves the tendency for the treatment of disease rather preemptive

prevention. Next, Navarro suggests that the state has the decision making power to legitimize the dominance of certain classes and interest groups. Finally, there is a repressive-coercive mechanism of the state serving the interests of the dominant class, such as the cutting and undermining of health programs which may conflict with dominant sources of power.

In addition to the changes in the structure of work and the new welfare regime, demographic change is also crucial for an understanding of the health inequalities as it is today. Demographic transition, which explains changes in the demographic structure of societies, has led to increasingly growing numbers of older people due to increased life expectancy. This transition is one from a demographic regime in which high fertility and mortality rate were observed, to a regime of low fertility and mortality rate. Demographic aging, defined as an increase in the percentage of a population aged sixty-five years and over, is a global trend with the exception of Africa (Lloyd-Sherlock, 2002). "Population ageing is usually a consequence of a country passing into the final stage of demographic transition, when sustained drops in fertility occur" (Ibid: 196). As the number of children born falls, the size of the elderly population increases. There is a negative global paradigm of old age which characterizes elderly populations as economically unproductive and as a growing financial burden on the social sectors (Ibid: 206). On the one hand, the elderly suffer from many diseases, especially the chronic types and those that require expensive health care; on the other hand, the state has reduced the budget for health in many countries. This can be considered as a factor accelerating social inequality in health in terms of age.

Much more related with demographic transition, the third change is the emergence of new patterns of morbidity and mortality which have come out in every society to different degrees, called the epidemiological or health transition. The central feature of this transition is "the complex mix between the old time set of health problems such as communicable diseases, reproductive diseases, malnutrition and environmental sanitation, and the emerging set of health problems such as cardiovascular disease and malignant neoplasms" (Waters, 2001: 80). The notion of epidemiological transition suggests that "improved social, economic and health conditions cause a transition from short life expectancy, with high rates of infant mortality from infectious diseases, to increased survival with a greater proportion of

deaths from degenerative diseases" (Nettleton, 1995: 192). To answer why improvements in the health status of society have emerged, some assert that medical advances and interventions from the perspective of biomedicine are the underlying cause for these changes, while some advocate that they are due to improvements in nutrition, changing reproductive practices and hygiene. This debate called the "efficacy debate" in the mid-1970s was criticized by McKeown, advocating the latter thesis (Ibid: 163-164). However, both theses have been criticized by various authors because these changes in health are explained by socio-structural factors such as standards of living, real income, working conditions, and so forth. As a result, these changes in health have led to the paradigm shift in the conception of health and illness, which now contributes to a comprehension of health with social, economic, environmental, cultural and behavioral dimensions.

Although there is a general tendency in mortality and morbidity patterns from acute infectious disease to chronic illnesses in the world, it is important to see that there are also differences between developed and underdeveloped societies. Lloyd-Sherlock (2002) differentiates between the experiences of the developed and developing world like so:

> The developed world has gone through an 'epidemiological transition' similar to, and associated with, the demographic one. This has seen the main causes of death and illness shift from infectious diseases, under-nutrition and inadequate hygiene to a post-transition phase, where 'diseases of wealth' (including chronic disease, road accidents and stress) are now prominent. In developing countries the situation is often more complex, and is sometimes referred to as 'incomplete epidemiological transition'. On the one hand, easily preventable diseases and poverty-related problems still continue to account for a high share of mortality and morbidity. On the other, emerging 'diseases of wealth' have seen rapid increases. Often distinct epidemiological scenarios can be identified between different geographical zones (rural/urban, rich/poor region) and between different socio-economic groups. As such, many developing countries face a double health challenge (p: 201).

We should see that the general increase in the absolute health of the population disguises increasing inequalities in mortality rates between people with different socio-economic conditions and different positions such as gender, race, ethnicity, and age. Due to the emergence of the changes in the definition and nature of work and working conditions, new patterns of health risks have come about, especially related to stress and mental health. Netletton (1995) focuses on social inequalities in health as follows:

> Social inequalities in health have long been recognized. Reports on the 'laboring classes' produced in the mid-nineteenth century revealed how those who were poor experienced more disease and illness than those who were rich. The 1990s are no different: poor people die younger than people who were rich; they are more likely to suffer from most of the major 'killer' diseases; and they are more likely to suffer from chronic long-standing illnesses. During this century the overall life expectancy of the population has increased for both men and women, from 45.5 years for men and 49 years for women in 1901, to 74 for males and 79 for females in 1993. However, this general increase possibly disguises increasing inequalities in mortality rates between rich and poor. It is argued that taken as a whole, the absolute health of the population increased. However the gap between the mortality and morbidity rates of those who are poor relative to those who are rich has also increased an increase which has become especially marked since the early 1980s (p: 160)

In recent times, health is much more connected with poverty. The European Health Report (2002) indicates that poverty and ill-health form a vicious circle, poverty being both a major determinant of poor health and a potential consequence of it. Whether defined by income, socio-economic status, living conditions or educational level, poverty is assumed as the most important determinant of ill-health (Ibid: 70). According to the report, living in poverty is associated with lower life expectancy, high infant mortality, poor reproductive health, a higher risk of exposing infectious diseases, higher rates of tobacco, alcohol and drug use, a higher prevalence of non-communicable diseases, depression, suicide, anti-social behavior and violence, and increased "exposure to environmental risks" (Ibid).

Society today can be defined using different terms such as risk society, post-industrial society, post-fordist society, post-modern society, a global village and so forth. Flexibility at work, post-social policy, globalization of chronic infection like HIV/AIDS, economic crises in the world and risk of being poor and so on are evidence of what Beck (1992) called "living in a risky society". According to Beck (1992), modern society is characterized by uncertainty or risk. He defines risk as non-calculable or non quantitative uncertainties in modern society. According to Taylor-Gooby et al. (1999), the risk was seen primarily as the outcome of the operation of natural forces or of external human interventions such as the plague, drought and barbarians in traditional society. However, modern conception of risk is much different. It includes awareness that human interventions into nature (through technology) and into society (through government policies or economic activities) designed to mitigate risks may also generate damage that is unpredicted and difficult to control (Ibid: 179). In modern society, we can say that there are *manufactured risks* in Luhman's (1993) terms. A look at the history of poverty reveals a similar picture. The

main causes of poverty were drought, warfare, natural conditions and disasters in pre-industrial societies; today, however, there are structural reasons behind poverty or "manufactured poverty". Nowadays, there are growing arguments that droughts, warfare and natural disasters are again gaining importance. However, a more unequal distribution of resources globally results in differences in coping.

An understanding of the mechanisms and processes to reproduce the relationship between social inequality and health inequality requires an overview of conventional approaches describing inequalities in health explanations which link socio-economic status or other statuses and health behavior or health outcomes and new approaches which give significance certain concepts as *social capital*, *social cohesion*, *place* and *lay knowledge*. There are several conceptual frameworks within sociological debates about health inequalities with regard to poverty. A more adequate theoretical framework explaining the recent health problems of society is necessary for future research.

Health inequality is sometimes conceptualized with the connection of structural factors and sometimes with individual behavior. The concept of poverty brings to mind certain related concepts such as the culture of poverty, social deprivation, absolute poverty, relative poverty, underclass, social isolation, marginalization or exclusion. The concept of health invokes concepts like life expectancy, infant mortality, access to health care, health status, modern versus traditional medicine, health seeking behavior, risks, lay perspective to health, conception and representation of health and illness. While the epidemiological perspective as the study of the distributions and states of health in human populations at the individual level focuses much on the causes of diseases for the purpose of surveillance, control and prevention of health disorders, sociological perspective deals with the social processes of the production of sickness and health (Blume, 1986).

There are four basic classical approaches to explain the link between socio-economic status and health outcomes in society derived from the *Black Report* by Townsend and Davidson (1982): artifact explanations, health selection explanation, cultural/behavioral explanations and materialist explanations.

The artifact explanation of health inequalities rests on the idea that the relationship between class and health is artificial rather than real (West, 1998: 9). This

explanation draws our attention to the social processes that are involved in the production of statistics (Nettleton, 1995: 171).

According to the health selection explanation, the health status of people can influence the social class position of individuals. It has been argued that those who are healthy are more likely to drift into upper classes. This implies that health assigns people into different social strata and that ill health leads to an assignation to a lower position in the social hierarchy. Poor health "selects" people who have a job with fewer opportunities for control, who are at risk of unemployment, who live in deprived neighborhoods, who have fewer social networks, and who eat worse food and indulge in addictive and sedentary behavior (Marmot, 2000).

"Cultural behavioral theories explain differences between various social classes in terms of health behavior and beliefs" (Senior & Viveash, 1998: 91-96). In contrast to health selection, this explanation presents a view of class as the antecedent to health with cultural/behavioral factors as the mechanism by which health inequalities are produced (West, 1998: 9). The determination of cultural behavior presupposes considering social class at behavioral level and localizing lower class as ill-health class. This explanation is sometimes called "blaming the victim" because it suggests that the solution to ill-health depends largely on the willingness of the working class to adopt the more enlightened and responsible lifestyles associated with middle class (Senior & Viveash: 91). The cultural explanation of illness directs health policy makers to apply health education programs; however, in addition to the significance of cultural values, it should not be forgotten that one of the main reasons behind differences in health, disguised, is rooted in the maldistribution of resources. Consequently, only focusing on health behavior patterns for social classes reduces health problems and inequalities to an individual approach towards health. For this reason, policy solutions are seen more in terms of health education rather than more equal economic redistribution favored by advocates of materialist theories (Taylor, 1997: 258). As a result, it can be said that health inequality is less an automatic product of material deprivation and more a consequence of lifestyle and behavioral choices.

In contrast, the materialist explanation emphasizes the impacts of social structure on health. In general, this approach focuses on the impacts of factors such as poverty, the distribution of income, unemployment, housing conditions, pollution and working conditions in both the public and domestic spheres (Nettleton, 1995:

173). Townsend and Davidson in (1982) *The Black Report*, demonstrate social class influences on certain health indicators. While upper class people have the lowest mortality rate, lower class people have the highest. This study was done by looking at the mortality rate and some types of diseases. They concluded that inequality exists between social classes in terms of health status. Whitehead and Dahlgren (1991) argue that "working conditions play an important role in inequalities in health--the lower the occupational class, the more likely people are to experience poor working conditions, including physical strain, serious injury, greater noise and air pollution, shift-work, a monotonous job, and a forced pace of work with fewer voluntary pauses" (p: 1060).

According to Benzevial et al. (1995) in the materialist tradition, there is a close link between poverty and low income. He especially emphasizes the costs of poor housing as particularly significant. Accommodation that is cold, damp, vermin-ridden, or overcrowded is associated with well-known health hazards (Ibid: 53-68). The materialist approach in general emphasizes material conditions such as wages, housing, working conditions, access to health services, employment status etc.

In addition to the socio-economic emphasis of health inequality researches, gender, race, ethnicity, age, and dependency are emphasized by other approaches. While the cultural behavioral explanation attributes gender differences to gender roles and internalized behavior, the materialist approach makes an explanation based on poor employment conditions peculiar to women. Women visit doctors more frequently than men. This leads women to define themselves as ill more often, to report more illnesses, and adopt the sick role more often than men (Senior & Viveash, 1998: 140). Culturally defined gender roles influence the willingness of men and women to accept being sick. Jewson (1997), states that "macho lifestyles" such as too much alcohol and cigarettes, dangerous activities and sports, fast driving or physical violence as masculine attitudes, and feminine roles such as low prestige and domestic responsibilities, in brief, gender-based attitudes and values, account for differences in health and illness behavior. Also, the material conditions of women distinct from men cause ill-health. According to Senior and Viveash (1998), "a large percentage of women in paid employment do part-time work, which tends to be poorly paid and have fewer perks, and this may force women into poorer living conditions" (p: 144). Lahelma, et al. (2001) questions the orthodoxy that women are sicker, but men die quicker. According to them, differences in health by gender are fewer than hitherto

thought, but vary between countries and by age, partly because of the different employment roles of women.

In terms of ethnic differences in health, there are also dual approaches explaning why certain ethnic groups suffer from certain illnesses, why their mortality and morbidity rates differ. According to Senior and Viveash (1999), there are explanations based on genetic-biological factors, individual behavior-cultural values, material-structural factors, migration and racism, and unequal treatment by the health service. Smaje (1995) states that some diseases are prevalent in certain communities, such as immigrants from the Caribbean who have high death rates for tuberculosis, hypertension, cardiovascular disease, diabetes, accidents and liver cancer. There is much evidence for the ethnic patterning of disease. Blackburn (1991) explains this based on a structural explanation and states that "black people, are more likely to be unemployed, or be in low paid jobs, living in poor housing and live in areas that they lack adequate social and educational resources than white people" (pp: 36-37).

According to Nettleton (1995), studies in the racial patterning of health, which have increased in epidemiological literature, have five tendencies that lead to imbalance (p: 184). First, studies which adopt a biomedical approach tend to make explanations by focusing on the biological and individual characteristics of different ethnic or racial groups. Second, some studies tend to focus on certain conditions, more common among some ethnic groups. Third, "race has in some instances come to be treated as an independent variable which in itself is taken to be a cause of health and illness" (Ibid). Fourth, "the concepts of race and ethnicity are treated as 'discrete and unproblematic concepts and the fact that they are socially created categories often goes unacknowledged" (Ibid). Finally, "the extent to which race is an indicator of social relations which are shaped by nationalism, colonialism, imperialism and racism" tends to be left unexplored. Like socio-economic and gender inequality in health and disease, there are many explanations for the racial and ethnic patterning of health. Only adopting one can lead to other aspects of ethnicity being ignored. Smaje (1996) tries to transcend the dualities created in studies of ethnic patterning of health by following Bourdieu. He mentions that the analysis of ethnic patterning of health has failed to examine the social meaning of ethnicity, while too often becoming enmeshed in unhelpful dualities which counterpose material to cultural explanations, multiculturalism to anti-racism, and epidemiology to sociology" (p:139). He discusses

different explanations for the ethnic patterning of health within an interactive framework by following Bourdieu. He tends to see ethnicity as both an identity and a structure. Nazroo (1998) criticizes the general tendency of of studies on ethnic inequality in health focusing only on genetic and cultural differences and states that they "ignore issues relating to class disadvantage" (p: 710). Nazroo by agreement with Smaje, asserts that it should allow a dynamic exploration of culture, the relationship between culture, disadvantaged position of ethnic minority in capitalist society, context, class, gender, geographical location, lifestyle, and a life course together.

Age is also an important variable in the health inequality debate. Age is, in most cases, treated as a purely biological phenomenon. Aging is not only a matter of passing years, but it is also influenced by social and cultural processes. With the demographic changes, life expectancy has increased. The patterns of health and illness according to age group have changed. As a variable, age in health inequality studies is not dealt with separately; it is considered together with other variables such as gender, ethnicity, location, and social class. In different cultures and times, the elderly can be treated differently, and the attitudes towards elderly women and men can change in terms of the values attributed. In the elderly population, chronic diseases are more frequently seen. This is much associated with passing years. However, entering to the phase of being old may cause some health problems, such as depression, that change according to different cultures. Jewson (1997) states that:

> In modern Western societies, the onset of old age is marked by retirement from the workforce, often resulting in a significant decline in income and a change in perceived social status and importance. Social inequalities are often heightened in this phase of life. Although not all the elderly are poor, the older people become, the more likely they are to experience poverty. This effect is independent of class, ethnicity, and sex. (p: 87).

Old age is overtly stressed in health inequality studies, but Mayal (1998) criticizes this tendency and states that child health is ignored in medical sociology. She sees children as a minority group. Roberts (2000) states the disadvantaged position of children in terms of mortality and morbidity patterns, as well as accidents by constituting the relationship between poverty, class and health.

For all types of inequalities, there is a dichotomy between individual volition and societal determinism. Divorcing cultural and behavioral values from materialist conditions leads to monistic sociological approaches. In terms of gender inequality, it

can be said that traditional gender roles place women in to the domestic domain. This restriction may make them vulnerable to certain illnesses due to substandard housing for poor women. According to Labonte (1993), "we risk losing sight of the simultaneous reality of both" if we focus only on one (p: 57). In other words, "if we focus only on the individual, we risk privatizing—rendering personal—the social and economic underpinnings to poverty and powerlessness" (Ibid). If we focus only on the structural issues, we risk ignoring "the immediate pains and personal wounds of the powerless and people in crisis" (Ibid).

There are three critiques toward the conventional theories of health inequalities put forth by Popay and et al. (1998). First, existing theoretical frameworks fail to capture the complexity of causal explanation in the health inequalities field. In particular, these explanations are inadequate to explain the role of social organizations, processes and relationships at a macro level in the generation of inequalities. Second, there has been a lack of attention to the development of concepts which will help explain why individuals and groups behave in the way they do in the context of wider social structures. Third, the importance of developing work on the re-conceptualization of the notion of "place" within explanatory models of inequalities in health is highlighted alongside the neglect of a robust historical perspective. The combined effect of social structures and individual human agency, considered by Bourdieu, should be comprehended. Popay et al. is concerned with the concept of "place" and lay knowledge in theorizing health inequalities. Places are the site in which macro social structures impact upon individual lives (Ibid: 626-627).

Recently, health inequalities research has been focused on various factors such as social cohesion, *social capital*, life course, place, lay knowledge and so on. Wilkinson (1996) displays the significance of the concept of social cohesion in health inequalities research. According to him, in advanced capitalist societies, higher income inequality creates lowered social cohesion which in turn produces poorer health status. Coburn expresses the impacts of social cohesion on people's health; however, Coburn (2000) focuses much on impacts of neoliberalism as deteriorating *social capital* and health. He argues that:

> There is a particular affinity between neoliberal (market-oriented) political doctrines, income inequality and lowered social cohesion. Neoliberalism, it is argued, produces both higher income inequality and lowered social cohesion. Part of the negative effect of neoliberalism on

> health status is due to its undermining of the welfare state. The welfare state may have direct effects on health as well as being one of the underlying structural causes of social cohesion. The rise of neoliberalism and the decline of the welfare state are themselves tied to globalization and the changing class structures of the advanced capitalist societies. More attention should be paid to understanding the causes of income inequalities and not just to its effects because income inequalities are neither necessary nor inevitable. Moreover, understanding the contextual causes of inequality may also influence our notion of the causal pathways involved in inequality-health status relationships. (Coburn, 2000: 135)

With those words, Coburn makes a structural explanation about rising neoliberalism and its structural impacts on the market model and welfare regime. He advocates the idea that "the more market-oriented or neoliberal the regime, the greater the income inequality" (Ibid: 140), and therefore, "the more market-oriented the society, the higher the social fragmentation and the lower the social cohesion and trust" (Ibid: 142).

The other important concept in health inequality research is life course or life-histories. Although a life course approach to inequality research is presented as a recent methodological innovation, it actually has a long history (Popay et al., 1998: 622). A life course approach enables one to reach longitudinal datasets. This approach reveals biological and social "critical periods" during which social policies that will defend individuals against an accumulation of risk are particularly important (Bartley et al., 1997: 1194).

Popay and et al., while criticizing the conventional theories of health inequality, attach importance to "place" and "lay knowledge" in inequality research in order to produce a richer and more dynamic framework for understanding the relationship between human agency, social structures and health inequalities. According to them, the study of places people inhabit may allow us to explore the way in which structures work themselves through into the dynamics of everyday life (Popay et al. 1998: 635). They assume that places can be conceptualized as the locations for structuration; the interrelationship of the conscious intentions and actions of individuals or groups and the environment of cultural, social and economic forces in which people exist. Popay and et al. give significance of the link between place and lay perspective. They indicate that:

> Attention to the meanings people attach to their experience of places and how this shapes social action could provide missing link in our understanding of the causes of inequalities in health. In particular, the articulation of these meanings—which we refer to as lay knowledge—in narrative form could provide invaluable insights into the dynamic

> relationships between human agency and wider social structures that underpin inequalities in health. (Popay et al. , 1998: 636)

2.3. What is health?

We all have an idea more or less about the meaning of health but we have difficulty pinning a definition on the concept. First of all, it can be said that it has many aspects; it is culturally and socially structured; its definition changes from one period of the other; and it is influenced by personal experiences. When someone may emphasize positive aspects of health, such as well-being, some other give a negative focus such as absence of illness. The other way of focusing on the concept is the state of its functioning or having the capability in everyday life to do things such as work and performing everyday routines. In keeping with Bury's (2005) statement that "health is something of an enigma", I prefer to glance at different definitions before giving a more comprehensive definition (p: 1). In this part, after some older definitions of health are mentioned, professional and official definitions like the view of biomedicine and WHO as an international health institution will be cited. Then, I will focus on how health is sociologically defined with examples from studies of lay definitions and perceptions. Finally, health as an attribute or identity and its relations will be examined with a focus on the sick role within society.

Awofeso (2005) states that "the word health was derived from the old English word *hoelth* that meant a state of being sound, and was generally used to infer a soundness of the body"(p: 802). What health is is tied to the dominant approaches of body, health, and illness in a given historical context. In this regard, in ancient times, Hippocrates emphasized the balance of these four humors: black bile, yellow bile, blood, and phlegm. One of the oldest definitions of health given by Hippocrates is that "health is primarily that state in which these constituent substances are in correct proportion to each other, both in strength and quantity, and are well mixed" (cited in Morgan, et al., 1988: 12). Illness and pain emerge due to an imbalance of the four humors. In that period, scientific medicine was not developed but is this the early period upon which today's scientific medicine is based on. According to White (2006), the earliest definition is attributed to Pericles in the fifth century B.C.: "Health is that state of moral, mental, physical well-being which enables a person to face any crisis in life with the utmost grace and facility" (p: 95).

Domination of medical understanding on health field started, as Foucault (1979) indicates, that the birth of modern medicine covered the period during the final years of the eighteenth century with the rise of science and the philosophy of Enlightenment. As Porter (2002) indicates, "during the nineteenth century, the development of bacteriology and pathological anatomy marked a major change in both thought and practice" (cited in Bury, 2005: 3). The boundaries between medical and traditional/folk medicine were not as rigid. Also, there was no such thing as specialization in a field. Today, there are different specialization fields for almost each organ of the body. The scientific medicine became dominated with the institutionalization, emergence of hospitals. One of the main developments bringing about medical dominance, professional authority and medicalization is related with legislation ensuring that all official doctors had university medical training by the nineteenth century (Senior & Viveash, 1998).

In terms of professional definition, biomedical model of disease internalized by scientific medicine are clearly seen in its disease perception. Turner (1995) summarizes the view that: (1) disease is regarded as the consequence of certain malfunctions of the human body (body as biochemical machine); (2) the medical model assumes that all human dysfunctions might eventually be traced to such specific causal mechanisms within the organism; (3) this model excludes alternative models; (4) the medical model presupposes a clear mind-body distinction where ultimately the causal agent of illness would be located in the human body (p: 9-10).

This model of explanation of disease is inadequate in understanding modern illness and psychological problems such as stress and chronic diseases. The explanation of disease is based on the "germ theory" existing in the nineteenth century. This theory advocates that every disease is caused "by a specific, identifiable agent, namely a 'disease entity' such as parasite, virus or bacterium" (Nettleton, 1995: 3). It reduces all disease and illness behavior causally to a number of specific biochemical mechanisms. According to the model, the patient is regarded only as a living organism in which the ill parts have to be treated without any consideration for his/her social life or life standards. Atkinson (1988) criticizes this model of explanation prevailing in Western-scientific medicine as below:

> It is the reductionist in form, seeking explanations of dysfunction in invariant biological structures and processes; it privileges such explanations at the expense of social, cultural and

> biographical explanations. In its clinical mode, this dominant model of medical reasoning implies: that diseases exist as distinct entities; that those entities are revealed through the inspection of 'signs' and symptoms'; that the individual patient is a more or less passive site of disease manifestation; that diseases are to be understood as categorical departures or deviations from 'normality'. (cited in Nettleton, 1995: 3, Atkinson, 1988: 180).

The biomedical view of health is the absence of disease as many authors state (Blaxter, 1990; Aggleton, 2002; Nettleton, 1995; Turner, 1995, Bury, 2005). This approach on health defines health from its negative aspect by focusing not on health but on disease. According to the biomedical view, health is "normal" biological functioning and can be understood with regard to biological indicators. It is understood that health is the absence of biological abnormality or of "objective" signs of diseases such as bacteria, germ, or medical test figures exceeding the interval of the "normal" and that psychological and social processes are independent to be ill. And a healthy body "is restored to health through treatments" (Turner, 1995: 9).

In terms of official definition, the WHO's definition of health has been the most frequently used one since 1948. According to this definition, "health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity"[2]. This definition is criticized by many authors because of the word "complete" which leads to idealism to a lack of attention to the patterns of inequality. According to Bury (2005) "the phrase "complete well-being" remains as elusive as it is positive, and health, illness and medicine are related in complex ways" (p:2). It can be said that the awareness of the influence of environment, and awareness of multiple risk factors in that period led to this bio-psycho-social explanation unlike the germ theory.

In the last two decades, biomedical view has been increasingly called into question (Taylor, 1999: 254, Nettleton, 1995: 5). First, despite certain medical advances in certain areas, the major diseases of modern societies as most frequent causes of deaths such as cancer remain. These health problems are seen to be resistant to effective medical treatment and cure. So the attentions of health professionals and policy makers have tended to shift towards the environmental causes of disease. Second, modern (Western) medicine has been criticized for its

[2] This definition was first made in WHO's preamble as adopted by the International Health Conference in New York, 19-22 June 1946 and entered into force on 7 April 1948 (Awofeso, 2005: 802, internet source: http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/, accessed 8 april 2005).

detached and mechanistic approach to illness, where patients are seen as collections of symptoms rather than people.

There is a paradigm shift in the conception of health and illness, which now contributes to a conception of health with its social, economic, environmental and cultural dimensions. In this regard, the social origins of health and disease have drawn much more attention than before, which has also been reflected in the official definitions. "Increasing interest in the social aspects of health and sickness in the last quarter of the twentieth century has been accompanied by a growing skepticism of modern medicine" (Taylor, 1999: 270). Certainly, the growing influence of sociological perspective on medicine and health care is crucial, but the social aspects of health have begun to be noticed also by medical sciences like epidemiology and public health. Epidemiology takes into account certain variables such as ethnicity, age, culture, class and regions. Recently, on the one hand the social aspects of health and illness have been taken into account; on the other, a healthy lifestyle and health behavior have been considered.

We frequently encounter headings in newspapers or magazines such as "healthy lifestyle", "healthy foods", "taking care of your body". As Nettletton (1995) expresses, "twenty years ago, the mention of health and illness would probably have invoked images of hospitals, doctors, nurses, drugs or a first aid kit" (p: 1). However, today, "we witness a broader range of images including healthy foods, vitamin pills, aromatherapy, alternative medicine, stationary bikes, health clubs, aerobics, walking boots, running shoes, therapy, sensible drinking, check-ups and more" (Ibid: 1). This is "a new health consciousness" and "danger-awareness" as defined by Crawford (1980, 2006). This notion takes into account life styles in relation to health. In particular, health behavior utilized among public health specialists and epidemiologists have been deemed important to becoming healthy. Sociologists like Zola (1972) and Crawford (1980, 2006) describe this as a trend of "healthism".

The changing nature of disease within modern society and the skepticism of modern medicine underline the perspective that social and behavioral aspects of health and disease should be considered. Under these changes, the official definition added a focus on basic needs, human rights, and individual behavior as lifestyles in Ottowa Charter for Health Promotion in 1986. According to WHO:

> In keeping with the concept of health as a fundamental human right, the Ottawa Charter emphasizes certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to a holistic understanding of health which is central to the definition of health promotion. (WHO, 1998: 1)

The one definition of health promotion as a behavior-oriented strategy is "a scientific conception to help people change their lifestyles towards a state of optimal health" (Schlicht, 2001: 11416). Health promotion is a public health activity to promote the health of society. McKinlay and Marceau (2000) criticize conventional public health in terms of its philosophical obstacles to change. According to them, public health is identified with two major types of social philosophy producing a dichotomous philosophy (pp: 26-27). While one of them is individualism, expressing individualistically oriented social philosophy, the other is collectivism emphasizing collectivistically oriented social philosophy. In collectivism the focus is on categories such as age, sex, social class, race and ethnicity or places and social positions in society, whereas in individualism the focus is on the individual choices of people. According to the public health philosophy, conception of health has dual meanings that mechanistic view and the holistic view of health are existent in the same discipline. The former has been explained as a biomedical understanding of health and disease or medical model, the latter is more suitable for the sociological model explained by Turner (1995). However, the pervasive belief in public health stated by Mechanic, (1973) "all public health problems are dysfunctions which can and must be remedied rather than part of a complex pattern of adaptation to changing life conditions and social patterns" (p: 9). This indicates that the biomedical understanding of disease is still the dominant view over social aspects of disease.

On the other, the sociological model of health and illness taking a critical and opposed position on the biochemical model and placing health and illness in a social context, is indicated by Turner (1995) as: (1) the sociological model treats the concepts of medical science as products of cultural changes; (2) it denies the mind/body distinction through the development of embodiment; (3) it does not assume that disease, like crime, can not have a single causal framework; (4) according to this model, the sickness of the patient cannot be understood outside the historical, social and cultural context of the person (p: 10).

According to the sociological model the causes of disease are differentiated in terms of life experiences, life standards, people's social relationships, nutrition, etc. Sociology emphasizes the social origins of disease, the processes that shape both people's experiences of illness, and the medical knowledge with its practices around which health care is organized.

There are different sociological approaches. According to the functionalist view, health is the ability to participate in normal social roles. Parsons (1952) sees health and illness as:

> Certainly by almost any definition health is included in the functional needs of the individual member of the society so that from the point of view functioning of the social system, too low a general level of health, too high an incidence of illness, is dysfunctional. This is in the first instance because illness incapacitates fort he effective performance of social roles…We may say that illness is a state of disturbance in the 'normal' functioning of the total human individual, including both the state of the organism as biological system and of his personal and social adjustments. It is thus partly biologically and partly socially defined. (Ibid: 430, 431).

In the functionalist view, illness as the opposite of a healthy state has an important detrimental effect on the harmony and balance of the social system by preventing individuals from performing their social roles.

In contrast, Marxists see health in association with the capitalist system and view good health in political terms. Under this perspective, health is not only a state of physical or emotional well-being but "access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction" (Baer, et al., 1986: 95, Baer et al., 1997: 5). The definition of Bear et al. is based on the perspective of critical medical anthropology. Taking a neomarxist perspective, Kelman (1975) who sees health within the context of a system of production, makes a distinction between *functional health* and *experiential health* (cited in Baer et al, 1997: 4). With the first, he defines a state of optimum capacity to perform roles in society to carry out work. That means healthy individuals are functional for profit making in a capitalist society. On the other hand, "experiential health entails freedom from illness and alienation and the capacity for human development, including self-discovery, self-actualization, and transcendence from alienating circumstances" (Ibid: 4).

The definition of health is essentially multi-dimensional and relative in character. The "lay perspective" adopted especially by the social constructionist

perspective differs from the medico-centric view of health. According to them, like other cultures Western scientific medicine is a kind of cultural system. Contrary to the Western medical point of view, the social science has been showing more interest in ordinary people, the patient's point of view or the lay perspective (Pierret, 1995: 9). While the biomedical view sees health as the absence of disease, sociological approaches focus on social factors that provide good or ill health. However, lay perceptions of health and disease indicate that health has various aspects and is influenced by a variety of social factors. Certain sociological researches are crucial for understanding the individual perception of health. The studies of Herzlich (1973), d'Houtard and Field (1984), Blaxter (1990), and Pierret (1995) can be cited as the most important ones.

The study done by Herzlich (1973) is accepted as the first study to examine the health definitions of lay people. There were respondents in this study from Paris and Normandy, most belonging to the middle class (cited in Blaxter, 1990: 14). The respondents distinguished clearly between illness, the negative concept, which was produced by ways of life and especially urban life and the positive concept of health, which came from within. In addition, it was established in Herzlich's study that health has three dimensions: the absence of disease, a "reserve of health, associated with the person's "constitution" and "resistance", and a positive state of well-being or "equilibrium". The tension between "not being sick" and "being well" is defined by the concept "health in a vacuum" by Herzlich (cited in Pierret, 1995: 56-60).

Similarly, d'Houtard and Field (1984) examined health perception for different social classes (cited in Lawton, 2003: 31). They found that "predominantly manual lower classes tended to evaluate health in terms of its physical attributes, as a means to an end, in which the body was seen as the instrument for achieving that end" (Ibid: 31).

Blaxter (1990) highlights the variety of definitions which people use to describe whether they and others are healthy. The survey was carried out with a sample of 9,000 respondents across the UK between 1984 and 1985 (Ibid: 9-10). In her study, the respondents tended to define health negatively, as the absence of illness, functionally as the ability to cope with everyday activities, or positively as fitness and well-being (Ibid: 14). There are some other important additions to previous studies: the first is that health has a moral dimension, reflecting not only the adoption or

maintenance of a healthy lifestyle, but also how people respond to illness and deal with its consequences. The second important addition is that there are some respondents who feel healthy despite having a serious chronic illness (Ibid: 22). As a result, health as discussed in her study is essentially multi-dimensional and relative. It includes both objective and subjective components and attempts to consider the positive as well as the negative range.

A further important point in her study is the concept of "health as reserve" that resembles with Herzlich's (1973) concept of "reserve of health". Blaxter argues that health. seems to be perceived as "reserve stock" which one gets through birth. In time, people invest in this stock by practicing healthy behavior and avoiding self-neglect and unhealthy practices (Blaxter, 1990: 16). In her findings, she finds that elderly who feel that their stock is diminishing give a negative explanation of health unlike youths. Health as functioning becomes important for old age, too. In addition to age, she also includes the gender dimension. While the men younger than 40 years old tend to define health as fitness, for young women, social relationship and coping with family problems are stressed more frequently (Ibid: 27). Various definitions were made by respondents in the study. These are: health as not being ill, health as a reserve, health as being fit for function, health as physical fitness, health as a behavior, health as a good social relationship, health as a positive vitality, health as a feeling of psychosocial wellbeing, and health despite disease

Pierret (1995) analyzes the individual's type of concern about health matters and his/her general ideas about health. There are four constructs of health: health as illness (not being sick), health as a tool (when you have health you have everything), health as a product (as an objective to be reached), and health as an institution (matter of public policy and institution). In Pierret's study, for those with manual occupations whose bodies were "tools" or "implements" used on the job, health was seen in relation to work, as both the ability to cope and the absence of illness (Ibid: 21). In contrast, for middle class people health was at the center of attention. While ideas about the health of manual workers and small-farmers corresponds to the "health-illness" and "health-tool" constructs, mid-level private sector employees tend to attach importance to pleasure and their view of health corresponds to the health product construct (Ibid: 22). Lastly, public sector wage earners' understanding of health corresponds with the health institution construct. According to Pierret, the

"health-tool construct" is one way to conceptualize health as a capital. Moreover, health is much more related with 'work' in people's minds. Pierret states that approaches which identify the relationship between health and working conditions as does Grossman (1972), see health as a "durable goods" which everyone is endowed with at birth (cited in Pierret, 1995: 18). Accordingly, although it depreciates over time, it can be renewed through an 'investment' that combines various "factors of production" medical treatments or healthy behaviors to preventing illness (Ibid: 18). Like the Grossman model, Kuh, et al. (1997) define *health capital* as the accumulation of health resources, both physical and psychosocial, inherited and acquired during the early stages of life which determine current health and future health potential (p: 173). Income potential is the accumulation of abilities, skills, and educational experiences in childhood that are important determinants of adult employability and income capacity. Income potential and *health capital* are seen as two dimensions of an individual's transition to adulthood. This conceptualization of *health capital* represents the life-course perspective of health researches, in particular studies about health inequalities. As recognized by Smith et al. (2003) health is dynamic and changeable; people are never either sick or well, but always in a process of transitioning into various states of wellbeing and disease (p: 504). Through the life course of individuals, events, resources, or *forms of capital* are crucial in becoming ill or well.

Different health definitions and perceptions by professional and official, sociological, and lay perspectives are given above. Now health as an attribute or identity will be discussed by focusing on the sick role and health seeking strategies in the case of illness in order to understand the illness experience.

How the state of being sick is conceptualized is the first issue here. Parsons (1952), representing functionalist view of society, was the first sociologist to theorize the sick role. In accordance with the view of illness as a disharmonizing influence on the social system, the sick person is mentioned as an obstacle to social order because this person cannot perform their duties or functions in society. For him, disease is unintended and can be treated only with medical assistance. Thus, medical assistance is thought as necessary and functional in order to enable the individual to return to their everyday life such as their role in the labor market or family. Medicine as an institution, working for social order and integrating individuals to society as healthy individuals, is assumed to fulfill the health needs of society. According to Parsons

(1952), there are four aspects of the institutionalized expectation system relative to the sick role: (1) the first aspect of the sick role is the exemption from normal social role responsibilities, relative to the nature and severity of the illness. This withdrawal from social obligations requires legitimization by a physician; (2) a sick person cannot get better without professional help and support; (3) a sick person has a social obligation to improve and get well; (4) The obligation of the sick person is to seek out *technically competent* help, namely, that of a physician and to cooperate with him in the process of trying to get well (Ibid: 436-437).

What is striking in his sick role conceptualization is perception of the sick role as temporary. This is one weakness of Parsons's theory, because this description seems to be specific to acute illness. He does not mention the permanent sick role of people with chronic illness and disability. Changing patterns of disease toward chronic diseases alter the doctor–patient relationship because chronic diseases are not completely cured, raising the importance of care and social support. The type of disease has a determining role in the relationship. Szasz and Hollender (1956) criticize Parsons's sick role conceptualization and include the role of the type of illness in doctor patient interaction. They suggest that patient passivity and physician assertiveness are the most common relations to acute illness; less acute illness is characterized by physician guidance and patient cooperation; and chronic illness is characterized by physicians participating in a treatment plan where the patients have the bulk of the responsibility to help themselves.

There is a shift from the old times' set of health problems such as communicable diseases to the emerging set of health problems such as chronic illnesses, called health or epidemiological[3] transition. Chronic illnesses are accepted as new patterns of mortality and morbidity. However, as mentioned above, both chronic illnesses and acute illnesses are seen among the poor. The study of illness experience as narratives, chronic illness and lay belief and knowledge, as a general feature of late modern culture have risen and gained greater attention (Bury: 2001). Also, the biomedical paradigm has been questioned because a wide range of information is available to the chronic patients. As Gerhardt (1989) points out, a result of the effects of ageing population and the related predominance of chronic physical and

[3] Epidemiology refers to "the study of disease in terms of distribution, occurrence, determinants, and control in a defined human population" (Modeste, Tamayose, 2004: 42).

psychosomatic illnesses, management and care have superseded treatment and cure and the biomedical paradigm have lost their previous power. There is difference between acute and chronic illnesses in terms of society's attribution to those illnesses because the second, by definition, is a long term, and perhaps permanent event in a person's life. In the classical functionalist works, such as Parsons' (1952), the sick role is conceptualized with its temporary character, the role legitimized and recovered only by the assistance of medical doctors, a kind of deviant role potentially detrimental to the maintenance of social order. Parsons' conceptualization is limited in that it disregards long-term illnesses and the permanent sick role as well as the possibility of other health seeking strategies or coping other than medicine. Being permanently sick or a chronic patient is a unique experience viewed as *biographical disruption* by Bury (1991, 2001). It is not only a disruption of the physical body, but the illness experiences also cause disruption in all fields of life: attachment to the labor market, social relationships, school attendance, and the performance of other everyday routines. Bury (1991) distinguishes between two meanings of chronic illness. First, there is illness in terms of its *consequences* for the individual, that is, the effects on the more practical aspects of everyday life following the occurrence of symptoms, such as disruption of work and domestic routines, the management of symptoms, and so on. Second, the meaning of chronic illness may be considered in terms of *significance,* which refers to the connotations and imagery associated with the given conditions.

The experience of chronic illness can very often mean a severe reduction in resources in terms of energy, skill, strength, time, money, friends and so on (Nettleton, 1995: 94). It should be accepted that illness is a part of identity of the sufferer especially for those who suffer from long-term illnesses. Lemert (1962) distinguishes two types of labeling experienced by the sick and the disabled. The labeling of a person as sick or disabled constitutes a form of primary deviance; the secondary deviance refers to the adaptations a person makes in response to such labeling. Sickness and disabling conditions are often stigmatized in society. According to Goffman (1968), they are discredited and commit to greater withdrawal from social participation, especially in public areas. For example, when we look at the design of the cities, we see that the design of the cities are mostly planned according to, what Goffman calls, "virtual social identity" (the way they should be if they were "normal"), but not according to "actual social identity" (the way they are).

Friedson (1970b) is interested in the societal reaction to the sick role by considering the seriousness of illness and its legitimacy (cited in Nettleton, 1995: 71). He proposes three types of legitimacy. First, there are those cases where it is feasible for a person to get well in that their disease can be treated and so the legitimacy of their access to the sick role is "conditional". Second, in the case of incurable illness, the access to the sick role must be "unconditionally legitimate" because the person cannot act to get well. Third, where the illness is stigmatized by others, the person's access to the sick role may be treated as "illegitimate" and rights and privileges of the sick role are unlikely to be granted. The type of deviance for which the individual is not held responsible by imputed legitimacy and seriousness

Table 1: Societal reaction to the sick role according to the seriousness of illness and its legitimacy.

Imputed seriousness	**Illegitimate (stigmatized)**	**Conditionally legitimate**	**Unconditionally legitimate**
Minor deprivation	Cell 1 Stammer Partial suspension of ordinary obligations; few or no new privileges; adoption of a few new obligations	Cell 2 A cold Temporary suspension of few ordinary obligations; temporary enhancement of ordinary privileges. Obligations to get well.	Cell 3 Pockmarks No special change in obligations or privileges
Serious deprivation	Cell 4 Epilepsy Suspension of some ordinary obligations; adoption of new obligations; few or no new privileges.	Cell 5 Pneumonia Temporary release from ordinary obligations; addition to ordinary privileges. Obligation to cooperate and seek help in treatment.	Cell 6 Cancer No special change in obligations or privileges

Parsons' formulation of the sick role can be found in cell 5. Many scholars agree that Parsons' theory of the sick role represents the ideal type, but not empirical reality. According to Nettleton (1995), Friedson's conceptualization is important because "it draws attention to the extent to which the experience of illness is bound up with the wider social context", and "it makes clear that the meanings imputed to

illness can impact upon the experience and the identity of the sufferer" (cited in Nettleton, 1995: 71).

Under this discussion of the sick role, what people do for their health also bears discussion. Health seeking strategies include what people do when they face health problems, and what they do to be healthy. Here it should be stressed that the word "strategy" is used in this thesis. However, in the public health literature, health seeking behavior is more commonly used. This type of wording indicates disciplinary differences. Bury (1991) distinguishes among the terms *coping*, *strategy*, and *style* in the context of chronic illness[4]. By considering of Bury's distinction, I utilize the term *strategy,* which "directs attention to the actions people take or *what people do* in the face of illness rather than the attitudes people develop" for him (emphasis in original) (Ibid: 461). What do people do when they face illness and to be health? The answer of this question is closely associated with such factors as income, access to basic resources including health care, cultural values towards illness, healing, and response to the sick by specific society, and with being sick. All of these are important.

It is not only medical assistance that is crucial for the recovery of the patient; informal social relations also play a significant role in terms of the patient entering the sick role and the process of becoming healthier**.** Parsons ignores other social processes and for him, only the institution of medicine may help the patients. However, as Friedson (1970a) expresses, the individual who feels ill applies a "lay referral system" in the social process. Friedson argues that the lay person only consults the doctor after a series of consultations with significant lay groups including the family, relatives, friends, and neighborhoods. Parsons does not consider the existence of an informal/lay culture which defines illness in a social context. Friedson (1970a) states that:

> Some illness is not considered serious enough to warrant more than a slight reduction of everyday life activity. Other illness is defined as incurable, to be adjusted to as such. Much illness never reaches the stage of formal consultation with a professional. Parsons sick role obviously applies to only a small part of the process of seeking a cure for illness. Its limited reference to only some stages of the process of seeking help may be in part a necessary deficiency, however, for the earlier stage of illness, at which professional help is not yet

[4] According to Bury (1991), while the term *coping* means the "normalization" against the chronic illness by "maintaining sense of value and meaning in life in spite of symptoms and their effects", the *style* "refers to *the way* people respond to, and present, important features of their illnesses or treatment regimens" (emphasis in original) (Ibid: 461, 462). The distinction of three terms is done in the context of chronic illness.

> prescribed and sought, are considerably less definite and thus more difficult to conceptualize with clarity (Friedson, 1970a: 12-13).

The meaning of illness may vary according to culture and time as before touched. Also, as stated by Friedson, being sick in a socially acceptable way does not necessarily depend on the medical legitimization of illness. Studies of illness behavior, the processes by which people define themselves as ill, have shown that only a minority of symptoms are brought to medical attention and a decision to consult a doctor is often the result of a long process of help seeking, influenced by a range of social and cultural factors (Taylor, 1999: 264). This is defined by Nettleton (1995) as the "symptoms iceberg" (p: 73).

In Parsons's conceptualization, the sick cannot get better without professional help and support. This conceptualization ignores traditional and personal healing methods. The meaning attributed to the specific illness in a specific culture can vary and legitimization of the sick role and healing methods may change according to the meaning. Therefore, the type of illness with attributed meaning may lead to health seeking strategies.

There are many factors which influence whether one consults a doctor other than the presence or the severity of symptoms. Zola (1973) identifies five "triggers" which cause the decision to seek help. The first is the occurrence of interpersonal crisis such as a divorce or losing a job. The second trigger is the perceived interference of illness with social or personal relations. The third one is another person sanctioning the seeking of help. The fourth one is the perceived interference with vocational or physical activity. When the person feels ill, they can no longer do the job sufficiently or perform everyday activities. The last one is the temporization of symptomatology. In this situation, people have tendency to determine specific time according to the continuity and severity of symptoms.

Attaching importance to informal remedies and the lay referral system, Suchman (1965), divides the stages of illness into five. Namely, (1) symptom experience, (2) assumption of the sick role, (3) medical care contact, (4) dependent patient role, and (5) recovery and rehabilitation. In the first stage, the awareness and evaluation of the first symptoms with their severity are experienced by the individual and popular remedies are applied by oneself. While evaluating the symptoms, some react with denial, some accept, some delay and wait for further development in

accordance with Suchman's stage one. In the second stage, the sick role is either approved or not by the "lay referral system" and this approval makes the suffering individual seek health care services. The stage of medical care contact includes the approval or non-approval of the sick role by the doctor. In the fourth stage, in which the ill person makes a decision regarding illness and treatment, the individual is sick and expected to follow the role by obeying the advice of the doctor. The last stage is identified as the end of the sick role for temporarily ill individuals or permanent sick role for chronically ill individuals. The study is important in that it encompasses chronic illness and informal network.

The emergence of modern scientific medicine is historically tied to the Enlightenment, Industrial Revolution, and urbanization period. As Foucault says "modern medicine has fixed its own date of birth as being in the last years of the eighteenth century" and after this period, and as Canguilheim (1978) states, what is normal and pathological is determined by modern scientific medicine. As Turner (1995) states, the boundary between the traditional and the scientific healing was not clear. Traditional medicine and scientific medicine dichotomy has emerged with the institutionalization and expansion of scientific medicine. According to Csordas and Kleinman (1996) the distinct features of non-medical healing are that it is non-scientific, non-Western, non-empirical, non-technological, religious, and peculiar to traditional societies. It became accepted as a pre-modern type of healing.

Kleinman's definition and distinction of three healthcare sectors is important as a conceptual tool for health seeking strategies. According to Kleinman (1988), the healthcare system is "a local cultural system composed of three overlapping parts: the popular, the professional, and folk sectors" (p: 50). The popular sector refers to "the lay, nonprofessional, non-specialist popular culture arena in which illness is first defined and health care activities initiated" (Ibid: 51). In other words, the popular sector refers to remedies conducted by sick persons themselves, their families, social networks, and communities such as diets, herbs, baths, a massage and so on. The professional sector is composed of organized healing professions as in modern scientific medicine. It encompasses the practitioners and bureaucracies of both biomedicine and professionalized heterodox medical systems. Lastly, "the folk sector is the non-professional, non-bureaucratic, specialist sector, encompassing both sacred and secular healers" (Ibid: 59). It encompasses healers of various types who function

informally and often quasi-legal or sometimes, given local laws, on an illegal basis. Deciding to apply one or some of them is closely associated with the patient's perception of illness or what Kleinman calls, explanatory models (EM). In what conditions people apply them is also closely related to the type of illness they have.

The other weakness of Parsons's theory is the expectation of cooperation between the doctor and patient relationship and the doctor role, that is, in the doctor-patient relationship there is a positive agreement. Parsons emphasized that:

> The patient has a need for technical services because he doesn't 'know' what the matter is or what to do about it, nor does he control the necessity facilities. The physician is a technical expert who by special training and experience, and by an institutionally validated status, is qualified to 'help' the patient in a situation institutionally defined as legitimate in a relative sense but as needing help (Parsons, 1952: 439).

While the role of the patient is defined as a socially vulnerable supplicant, seeking official verification from the doctor, the role of the doctor is defined as socially beneficent, and the doctor-patient interaction is seen as harmonious and consensual (Lupton, 1994: 7). Criticisms go toward this explanation, because it tends to explain the role of doctor as universally beneficent, competent and altruistic, and patient as compliant, passive and grateful, and the medical encounter as a consensual agreement. In the medical encounter, doctor and patient may have different interests, culture, socio-economic status and different interests which may be conflicting. Unlike Parsons, Freidson (1975) characterizes the doctor-patient relationship by conflict rather than consensus. He sees this relation as a "clash of perspectives" (Ibid: 286). The separate worlds of experience and of reference of the layman and the professionals are always in potential conflict with each other (Ibid: 286). In addition, a lot of studies have proven that there is a difference between the doctor's medical language and the comprehension and interpretations of the dialogue by patients (Lacroix and Assal, 2003: 34). In general, doctors prefer this language in the course of interaction; however it should not be forgotten that patients are not doctors, or have inadequate information about their illnesses.

The medical encounter is much influenced by the medicalization described as "a process by which non-medical problems become defined and are treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992: 209). When scientific medicine emerged and gained popularity during the Enlightenment period, medicalization gained influence. Lupton states that:

> With the rise of modern European states in the seventeenth and eighteenth centuries, medicine's sphere of influence began to extend from the sick bed to the community. The welfare of the population and maintenance of its growth in changing conditions caused by industrialization, urbanism and free market economy became a paramount concern, and with the greater emphasis on environmental health, epidemiology, infant and maternal welfare and the new prominence of the institutions of the clinic and the hospital, society became more medicalized (Lupton, 1994: 85).

Conrad (1992), in his article on "medicalization and social control", examines medicalization as social control at three levels.

1. at a conceptual level: medical vocabulary or model is used to "organize" or define the problem,
2. at the institutional level: organizations may adopt a medical approach to treating a particular problem, in which the organization specializes,
3. at the interactional level, physicians are most directly involved. Medicalization occurs as part of the doctor-patient interaction, when a physician defines a problem as medical or treats a social problem with a medical form of treatment (Ibid: 211).

Zola (1972) explains the medicalization of society in such a process categorized in four concrete ways. First, through the expansion of what in life is deemed relevant to the good practice of medicine. The second process is through the retention of absolute control over certain technical procedures. The third is through the retention of near absolute access to certain "taboo" areas. Finally, through the expansion of what in medicine is deemed relevant to the good practice life (pp: 492-497).

According to Illich (1995), medicine produces disease to provide profit maximization. Medicalization, defined as perceiving, comprehending and evaluating social actions and problems in accordance with medical model, enables medicine to transform institution making a profit. He develops a concept of "iatrogenesis" described as the monopolization of physicians. "Medicine determines as religion and law, what is "normal", "appropriate" and the "desired" with medical understanding of disease and health (Ibid: 41). He argues that modern medicine was both physically and socially harmful.

According to radical feminists, men, having professional authority as physicians, produce technologies over the female body in medical settings and exercise power over the body. As patients women are subject to the authority of the male-dominated medical profession in the medicalization process. "Feminist critique of medicine has frequently gone to the heart of issues concerning the body, the illness experience, the changeable nature of disease categories and their use for social control, and relations of power between patients and medical professionals" (Lupton, 1994: 131).

Conrad (1992) states that, medicalization as a social control is considered by feminists since women's natural life processes are much more likely to be medicalized than men, and gender is an important factor in understanding medicalization (p: 220). Women's bodily experiences such as contraception, menstruation, menopause, childbirth and sexuality are more and more intervened in by medical techniques and treatments.

Health policies involving women and the family such as control of childbirth and women reproduction determined by today's male dominated medicine are produced for medicalization. According to Cheal (1991) medical discourse has certain characteristics in accordance with the medical or clinical model. The first one is the objectification of the body, where the body is objectified as a "thing" to be studied scientifically and subject to professional manipulation (pp: 60-61). This is one of the features of the medical model bringing about patients as an object of study rather than as individuals living in society. An important implication of this view is the loss of a holistic perspective. The second important characteristic is the signification of body as a potential problem. These problems are classified and described by expert knowledge. Within the medical view, the body transforms into a docile and controlled body, and poses potential problems. Next is related to the justification of medical intervention. Some of the body's problems are described as an expression of physical or moral danger. The fourth point is autonomous institutional force within which the professional's work is dominates the body. The specialization on technical skills is an example causing the body to be seen in a fragmented way. Those outlined features of medical view are applied not only to the human body but also to families and society. Medicine has become a monopolized growth-industry through justifying the interests of patients and community health expressed in health policies.

2.4. Bourdieu's Theory of Practice: Habitus, Capital, and Field

Habitus

Bourdieu brings forth the solution of the prevailing structure-agency dualism via the concept of *habitus*. The solution to this is in "a total science of society which must", as Wacquant states in the preface of the book with Bourdieu[5], (from Turkish translation, 2003), namely *Réponses pour une anthropologie réflexive,* "jettison both the mechanical structuralism which puts agents on vacation and the teleological individualism which recognizes people only in the truncated form of an "oversocialized cultural dope" (Ibid: 20).

While, the roots of the concept of *habitus* are found in Aristotle's *hexis*, Bourdieu used this concept to transcend mentioned above. Wacquant (2001c) defines this concept in Bourdieu's theory as:

> Habitus is a mediating notion that helps us revoke the common sense duality between the individual and the social by capturing "the internalization of externality and the externalization of internality", that is, the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel, and act in determinate ways which then guide them in their creative responses to the constraints and solicitations of their extant milieu (Ibid: 316).

As Wacquant states (in Preface of the book) where the concepts of perceptions and evaluations of agents in their everyday life come from should be revealed and how they are in relation to external structures of society should be investigated (Bourdieu & Wacquant: 2003: 21). As Bourdieu states, everyday life experiences of people are based on *habitus*. According to Bourdieu, "talking about habitus means displaying the personal and even the subjective, which is the social and the collective" (Bourdieu & Wacquant, 2003: 116). Bourdieu defines the concept of *habitus* as:

> …systems of durable, transposable dispositions, structured structures predisposed to operate as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them (Bourdieu, 1990: 53)

[5] The preface and introduction of the book was written by Wacquant, but in other chapters, Bourdieu answers Wacquant questions on Bourdieu's various studies.

According to Bourdieu (1984), notion of *habitus*, or pattern of unconsciousness preferences, classificatory schemes and taken-for-granted choices which differ between groups and classes and distinguish them one from the other, are relevant to an understanding of the ways in which sub-cultures pass on practices and beliefs (Bourdieu, 1984). Bourdieu theorizes that if one belongs to a certain group and identifies with that group, then one will make choices in everyday consumption rituals which reflect the *habitus* of this group (Lupton: 40). When the agent as the carrier of *habitus* faces another *field* or group whose dominant *habitus* feels strange, "the sense of distinction" can emerge. According to Bourdieu (1984), as Wacquant states (1998b), "the aesthetic sense exhibited by different groups, and the lifestyles associated with them, define themselves in opposition to one another: taste is first and foremost the distaste of the tastes of others" (Wacquant, 1998b: 223). This means that the space of lifestyles and the space of social positions are occupied by the different groups such as dressing styles as bodily representation, which "is the most indisputable materialization of class taste" (Bourdieu, 1984: 190).

Wacquant (1998b) expresses that "habitus is also a principle of both social continuity and discontinuity: continuity because it stores social forces into the individual organism and transports them across time and space; discontinuity because it can be modified through the acquisition of new dispositions and because it can trigger innovation whenever it encounters a social setting discrepant with the setting from which it issues" (p: 221). Bourdieu's observation in Algeria is an example of *the sense of distinction* while practicing old *habitus*, such as the continuity principle, although the *field* changes:

> I am reminded of my observation in Algeria of the people who, having "pre-capitalism habitus", had been thrown into a "capitalist universe". Moreover, in revolutionary historical situations, the change in objective structures happens so fast that agents whose mental worlds were shaped by those structures suddenly feel outdated; their actions are incongruous with the times and meaningless, so to speak. In short, the tendency of the groups to maintain their existence, which is due to, among other reasons, the fact that agents who constitute the groups are equipped with durable dispositions by which they survive with their economic and social conditions, may be the principle underlying faith just as conformity, unconformity and rebellion6. (Bourdieu & Wacquant, 2003: 122).

[6] Translated from Turkish into English by author.

Field

Although the concepts of Bourdieu are mentioned in different subheadings, they are relational. In fact, Bourdieu theorizes how society is reproduced. Bourdieu (1984) states that, a *field* is defined by specific issues and interests, which cannot be reduced to the specific issues and interests of other fields. Bourdieu points out that "the field is a structured space of positions that imposes its specific determinations upon all those who enter it and is an arena of struggle through which agents and institutions seek to preserve or overturn the existing distribution of capital" (Bourdieu & Wacquant, 2003: 85; Wacquant, 1998b: 221-222). According to Bourdieu, in his article, Wacquant (1998b) mentions that "as the mediation between past influences and present stimuli, *habitus* is at once structured, by the patterned social forces that produced it, and structuring: it gives form and coherence to the various activities of an individual across the separate spheres of life" (Wacquant, 1998b: 221). Also, *cultural capital* internalized by an individual agent as *habitus* is not suddenly abandoned when the *field* is changed. The effect of the previous *field* continues. Via practice, it reproduces itself again and again. According to Bourdieu and Wacquant (2003) "it is one and the same thing to determine what the *field* is, where its limits lie, etc., and to determine what species of capital are active in it, within what limits, etc." (Ibid: 82-83; Bourdieu & Wacquant, 1992: 14).

For Bourdieu (1984), each class has its own *habitus* which "designates the system of durable and transposable *dispositions* through which we perceive, judge and act in the world" (cited in Wacquant, 1998b: 220). These unconscious schemata as "acquired through lasting exposure to particular social conditions and conditionings, via the internalization of external constraints and possibilities" are shared by people subjected to similar experiences (Ibid: 220). This is closely related with the concept of "the logic of practice" proposed by Bourdieu (1977). Bourdieu (1977) proposes that "practice is neither the mechanical precipitate of structural dictates nor the result of the intentional pursuit of goals by individuals but rather the product of a dialectical relationship between a situation and a habitus" (p: 261). There is tension between the *habitus* and the *field*. Sometimes the rules of the *field* dominate; sometimes internalized cultural values embedded in individual agents, specifically in the body, dominate the practice. As Wacquant says, "the theory of social space, group making, and symbolic competition is generalized in *The Logic of Practice,* in which two modes of domination,

personal and structural, are differentiated and their workings traced via the moulding of the "body as analogical operator" of the practice" (emphasis in original) (Wacquant, 2002: 553). For Bourdieu, "individual agents do not mean individuals who consciously constitute structure, and do not mean "particles" pushed and put mechanically by external forces"; instead, individual agents are the carriers of the capital in different volumes and composition in the field" (Bourdieu & Wacquant, 2003: 94). By possessing various types of capital, the position of individual agents is determined in a *field*, which in the first instance is "structured space of positions and imposes its specific determinations upon all those who enter it", and which is, in the second instance, a "*battlefield* wherein the bases of identity and hierarchy are endlessly disputed over" (Wacquant, 1998b: 221-222). Therefore, "in lieu of the naive relation between the individual and society", Bourdieu substitutes the constructed relationship between *habitus* and *field* (Ibid: 222). Neither *habitus* nor *field* has the capacity unilaterally to determine social action, but their relationship is determining (Ibid: 222).

Forms of Capital

According to Bourdieu, capital is:

> ... accumulated labor (in its materialized form or its "incorporated," embodied form) which, when appropriated on a private, i.e., exclusive, basis by agents or groups of agents, enables them to appropriate social energy in the form of reified or living labor. It is vis insita, a force inscribed in objective or subjective structures, but it is also a lex insita, the principle underlying the immanent regularities of the social world (Bourdieu, 1986: 241).

He makes an analogy between the *forms of capital* in a *field* or social space and a card game, or *illusio*, as he states below:

> The social world can be conceived as a multi-dimensional space that can be constructed empirically by discovering the main factors of differentiation which account for the differences observed in a given social universe, or in other words, by discovering the powers or forms of capital which are or can become efficient, like aces in a game of cards, in particular universe, that is, in the struggle (or competition) for the appropriation of scarce goods of which this universe is the site. (Bourdieu, 1987: 3-4)

According to Bourdieu (2003), every game[7] (*field*) has rules, and the players (agents) play the game according to these rules peculiar to the game. There should be trump

[7] Although Bourdieu likens the field to a game, he also explains the difference between them (Bourdieu & Wacquant), 2003. Unlike a game, the field is not the product of conscious creation and it complies with subtle or uncoded rules; it complies dispositions.

cards (the *forms of capital*) whose power is changeable according to the game (*field*) (Ibid: 82). According to the cards in a game or *forms of capital*, the power to struggle can change. Agents are distributed in the overall social space according to the dimensions of the *volume* of capital which agents possess, the *composition* of their capital, and their *trajectory* in social space (Wacquant, 2006: 221). The *forms of capital* they possess place them in a particular area in a social space.

According to Bourdieu, capital can present itself in three fundamental guises: as *economic* capital, which is immediately or directly convertible into money and may be institutionalized in the form of property right; as *cultural capital*, which is convertible, on certain conditions, into *economic capital* and may be institutionalized in the form of educational qualifications; and as *social capital*, made up of social obligations ("connections"), which is convertible, in certain conditions, into *economic capital* and may be institutionalized in the form of nobility (Bourdieu, 1986: 243).

In addition to these *forms of capital*, there is symbolic capital defined by Bourdieu. For him, symbolic capital is a "capital —in whatever form— insofar as it is represented, i.e., apprehended symbolically, in relation of knowledge or, more precisely, misrecognition and recognition, and presupposes the intervention of the habitus, as a socially constituted cognitive capacity" (Bourdieu, 1986: 255).

These *forms of capital* are not constant according to Bourdieu; however, each has an exchange rate; that is, they may converted into each other depending on the context. Conversion requires specific labor and time. Wacquant (1998b) states that:

> Individuals and families continually strive to maintain or improve their position in social space by pursuing strategies of reconversion whereby they transmute or exchange one species of capital into another. The conversion rate between various species of capital, set by such institutional mechanisms as the school system, the labor market, and inheritance laws turns out to be one of the central stakes of social struggles, as each class or class fraction seeks to impose hierarchy of capital most favorable to its own endowment. (Ibid: 224).

Bourdieu (1986) asserts that the conversion of the *forms of capital* is the key for the reproduction of capital. He says that the convertibility of the different types of capital is the basis of the strategies aiming at ensuring the reproduction of capital (and position occupied in social space) by means of the conversions least costly in terms of conversion work and of the losses inherent in the conversion itself (in a given state of the social power relations) (Ibid: 253).

1. Economic capital

According to Bourdieu, "different forms of capital can be derived from *economic capital*, which is at the root of all the other types of capital but only at the cost of a more or less great effort of transformation, which is needed to produce the type of power effective in the field in question" (Bourdieu, 1986: 252). However, the other types of capital are not entirely reducible to *economic capital* -they have their own specificity- but *economic capital* is at their root. This capital is one type of capital which is directly convertible into money. Bourdieu (1984) states that the space of social position is organized by two crosscutting principles of differentiation, *economic capital* and *cultural capital* (p: 190).

2. Social Capital

Recently, the concept of *social capital* has been widely addressed in both social and health sciences. Not only have researchers dealt with the concept, but international organizations as the World Bank, policy makers, and development agencies have also used it (Campbell, 2001). The coining of the term in the mid 1990's was largely stimulated by Putnam's work on civic participation and its effect on local governance (cited in Muntaner et al., 2000). The World Bank (1999)[8] uses *social capital* as tool for eradicating poverty and defines it as the institutions, relationships and norms that shape the quality and quantity of society's social interactions. In fact, the World Bank sponsors a website devoted to the topic of *social capital*, where information is exchanged and issues actively debated (Muntaner et al., 2000: 108).

Bourdieu defines *social capital* as:

> the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition—or in other words, to membership in a group—which provides each of its members with the backing of the collectivity-owned capital, a "credential" which entitles them to credit, in the various senses of the word. (Bourdieu, 1986: 248-249).

Wacquant (1989) follows Bourdieu's use of the concept of *social capital* to establish an understanding of the relationship between poverty concentration and race. He states that:

[8]http://www.worldbank.org/poverty/scapital/library/webgd1.htm, accessed 10 September 2007.

> Among the resources that individuals can draw upon to implement strategies of social mobility are those potentially provided by their lovers, kin, and friends, and by the contacts they developed within the formal association to which they belong—in sum the resources they have access to by virtue of being socially integrated into solidarity groups, networks, or organizations, what Bourdieu calls 'social capital' (Wacquant, 1989: 22).

He operationalizes the *social capital* of the African-American residents in Chicago's poverty stricken areas as having a partner or best friends. He concludes that they possess a lower volume of *social capital*. Living in the ghetto as an isolated area results in preventing people from possessing *social capital*. He states that nearly half of the residents of extreme poverty tracts have no current partner (whom they are married to or live with) and one in five admit to having no one who would qualify as a best friend (Ibid: 23).

A distinction should be made between formal and informal *social capital* as done by Wacquant (1998a). Wacquant develops Bourdieu's concept of *social capital* and distinguishes formal and informal *social capital*. He states that:

> This notion may be extended to encompass an individual or a group's attachment to, or dependence upon, environing formal organizations. One may then distinguish between informal social capital consisting of resourceful social ties based on interpersonal networks of exchange, trust, and obligations from formal social capital made up of ties (positive or negative, desired or not) anchored in formal organizations to which one participates as member, client, or ward. Both types of social capital clearly impact on a person's capacities opportunities, and strategies (Wacquant, 1998a: 28)

3. Cultural capital

Bourdieu's (1986) conceptualization of *cultural capital* is different from the functionalist approach advocated by economists. Economists, Bourdieu argues, emphasize merely *cultural capital*, education in particular, in terms of monetary investments and profits and fail to explain different resources and agents such as the domestic transition of *cultural capital*. He continues:

> Their studies of the relationship between academic ability and academic investment show that they are unaware that ability or talent is itself the product of an investment of time and cultural capital. Not surprisingly, when endeavoring to evaluate the profits of scholastic investment, they can only consider the profitability of educational expenditure for society as a whole, the "social rate of return," or the "social gain of education as measured by its effects on national productivity". This typically functionalist definition of the functions of education ignores the contribution which the educational system makes to the reproduction of the social structure by sanctioning the hereditary transmission of cultural capital. From the very beginning, a definition of human capital, despite its humanistic connotations, does not move

> beyond economism and ignores, inter alia, the fact that the scholastic yield from educational action depends on the cultural capital previously invested by the family. Moreover, the economic and social yield of educational qualification depends on the social capital, again inherited, which can be used to back it up. (Bourdieu, 1986: 244)

Thus, *cultural capital* does not depend solely on academic success in school; the role of the family in the transmission of *cultural capital* should be considered as well. Educational qualifications obtained from schools are only one part of *cultural capital* according to Bourdieu.

Bourdieu (1986) opines that *cultural capital* exists in three forms: in the embodied state, i.e., in the form of long-lasting dispositions of the mind and body; in the objectified state, in the form of cultural goods; and in the institutionalized state, which is an academic or educational qualification (Ibid: 243).

Cultural capital exists in the embodied state; that is, it is embodied in individual. It is inherited and acquired by the family through socialization. It is not easily transmitted like material goods, because it is strongly linked to people's *habitus*. He states that "this embodied capital, external wealth converted into an integral part of the person, into a *habitus*, cannot be transmitted instantaneously (unlike, money, property rights, or even titles of nobility) by gift or bequest, purchase or exchange"(Bourdieu, 1986: 244-45). This type of *cultural capital* is acquired quite unconsciously, and its acquisition and transmission are more disguised than *economic capital*. He maintains that "the transmission of cultural capital is the best hidden form of hereditary transmission of capital, and it therefore receives proportionately greater weight in the system of reproduction strategies, as the direct, visible forms of transmission tend to be more strongly censored and controlled". (Bourdieu, 1986: 247). This type of capital includes normative behaviors such as language use, manner of dress, or other proper conducts. This capital is also defined as bodily capital, because it requires the internalization of certain dispositions of the mind and the body. Bourdieu says that "it is linked to the body and presupposes embodiment" (Bourdieu, 1986: 244).

Cultural capital in the objectified state has a number of properties which are defined only in relation to *cultural capital* in the embodied state (Ibid: 244). This type of *cultural capital* refers to cultural goods or materials which can be consumed both

materially (which presupposes *economic capital*) and symbolically (which presupposes *cultural capital*) (Bourdieu, 1986: 247).

Cultural capital in the institutionalized state can be defined as the institutional recognition of the *cultural capital* held by an individual, most often understood as academic credentials or qualifications. This is mainly understood in relation to the labor market. It allows for an easier conversion of *cultural capital* into *economic capital* by guaranteeing a certain monetary value for a certain institutional level of achievements (Bourdieu, 1986: 248).

4. Symbolic Capital

Symbolic capital designates the effects of any form of capital when people do not perceive them as such (Wacquant, 1998b: 221). It is derived from the *misrecognition* of the efficacy of these three fundamental kinds of capital. Linguistic skill or capital which individuals possess, is essentially a capacity related with the status in the *field* as Bourdieu and Wacquant (2003) point out. In fact, the communication of two individuals is not seen as ordinary conversation (Ibid: 139). Various positional coordinates such as educational level, social background, gender, etc. should be considered in conservation analysis. For Bourdieu, "All of these variables intervene in every moment of the objective structure of "communicative action" and the form taken by linguistic interaction is deeply interconnected with a structure that is left unconscious and always operates "in the background " of "what is discussed." (Bourdieu & Wacquant, 2003: 139). For Bourdieu, the conversation of a Frenchman and Algerian does not involve two individuals talking with each other, but, in fact, a history of colonization and domination. Therefore, he asserts that "every linguistic interaction has the potential to become an act of domination (Bourdieu & Wacquant, 2003: 140). Also, for him, "linguistic ability is a capacity related with the position in society" (Ibid: 141). This domination produces "symbolic violence" in the *field* by demonstrating legitimate language capital in the *field*, if the agents who occupy asymmetrical positions in the composition in terms of the capital in the related *field* (Bourdieu & Wacquant, 2003, 140-141).

2.5. Bourdieu in Health Studies

Bourdieu's theory of practice has been applied to a number of different fields. Recently, his concepts, especially *habitus*, have been frequently used to understand health. Many studies are related with the perception of health, body, health *habitus*, health behavior and lifestyle, long-term care, and doctor-patient interaction.

In *The Body and Social Theory*, Shilling (1993) argued that the body may be best conceptualized as an unfinished biological and social phenomenon, which is transformed, within changing limits, as a result of its participation in society (cited in Nettleton, 1995: 109). He adopts Bourdieu's work (1984), namely *Distinction: A Social Critique of Judgment and Taste*, in which it is argued that bodies are used as markers of distinction. Focusing on sport and the body, Shilling argues that the body can contribute to the reproduction of social inequalities. Nettleton summarized the main points of Shilling's work as follows:

> Focusing on sport and the body, Shilling (1991) claims that the sport, food, etiquette, and so on varies according to social class. Working-class people, he argues, have a more 'instrumental' orientation to view of illness and thus the body is treated as a "means to an end". The middle classes, in contrast, treat the body as "an end in itself", for example they might participate in sports not so much to get fit as for intrinsic value that might be derived from such activities. The production of physical capital is of course contingent on the circumstances in which people live. Women, for example, are less likely to participate in sporting activities as they have less leisure time or are likely to prioritize the care of bodies around them before themselves (Graham, 1984). The conversion of physical capital refers to the translation of such bodily activities into other forms of capital, be they social, economic or cultural. Shilling (1991) examines this conversion process in terms of class and gender. An example of the conversion of physical capital to economic capital for working class men would be through sport; for example, they may become footballers or boxers. This process, however, is precarious due to the high risk of injury or the short-term nature of such careers, and is in any case extremely rare (Nettleton, 1995: 121-122).

Lumme-Sandt and Virtanen (2002) examine older people's medication by using the concepts of *habitus* and *field* by using data from focus group discussions with people aged 65 and over. Utilizing Bourdieu's concepts, the study aims to show how users of medical drugs act, and how they themselves see their position in a field of medication. According to them, "the role of users in the field of medication is often overlooked and ignored, and users themselves tend to be perceived as objects rather than subjects" (Ibid: 299). They state that older users accept the dominant position of doctors in the field of medication, but at the same time they have doubts about drugs. They point out this suspicion based on their cultural views that the drugs are unnatural and artificial and this is peculiar to Protestant culture (Ibid: 301).

Carpiano, in his dissertation (2004), examines the relationship between *social capital* and health outcomes by producing a Bourdieu-based *social capital* conceptualization. He analyzes the impacts of forms of neighborhood *social capital* (operationalized as social support, social leverage, informal social control, and organizational participation) and an individual resident's access to that capital (measured by neighborhood attachment) on adult health outcomes (as smoking, drinking, chronic health conditions, and perceived health). According to his finding, higher levels of *social capital* were associated with better health outcomes regardless of each resident's network access. In addition, he found that higher levels of neighborhood social support were associated with higher likelihoods of drinking and smoking. The study shows that neighborhood is crucial in terms of providing a health promoting/health damaging environment (Ibid:196)

Another important study conducted by Meinert (2004) based on long term fieldwork in rural Eastern Uganda explores the use of Bourdieu's concepts of capital and *habitus* in order to analyze the local understandings of resources and strategies of health. Meinert argues that in order to more fully analyze how people think about, and strive for, health, the concept of bodily capital may be a useful addition to Bourdieu's original form of capital (p:11). She asserts that the body is not merely the carrier of *habitus* as implied by Bourdieu (2000); instead, he suggests that the body is also a form of capital, which might be added to Bourdieu's theory of *forms of capital* (Ibid: 11). In this research, which investigates children's understanding and experiences in relation to health, and the body in Kwapa is regarded as an important resource for health which people count on and work upon in relation to health (Ibid: 22). She states that:

> In Kwapa children's bodily development is an ongoing preoccupation for families, which, to go by the high rates of malnutrition and stunting that prevail in the area, is not always successful. Acquiring enough food for everybody to be satisfied and fully developed cannot be taken for granted in all families. Parents in Kwapa struggle to feed, 'keep' and care for children as a form of investment in their bodies, which parents expect will eventually come back in the form of labor, care and other kinds of resources. Many young people in Kwapa are preoccupied by developing their bodily capital in different ways: they are keenly interested in how they can shape and decorate their bodies to become socially and sexually attractive. These different kinds of work on the body are forms of 'accumulated labor', using Bourdieu definition of capital (Meinert, 2004: 22).

She adds that health in Kwapa is described in terms of the "good life". According to him, "children learn from early on that what people strive for is to have a good life,

which is closely connected to concepts of home, family, and personhood" (Ibid: 23). A good life is possible by working for the resources of "wealth", "unity", "learnedness", "intelligence" and "bodily strength". Based on his findings, she criticizes Bourdieu in two ways. First, she holds that the idea of Bourdieu's autonomous space does not capture the richness of lay people's everyday practices in relation to health. Secondly, she points out that Bourdieu's idea of embodied *cultural capital* as purely individual does not fit with Ugandan ideas about the collective nature of children's competences from school. She indicates that Bourdieu's unit of analysis is the individual; however, the unit of analysis for health issues is the family.

Gatrell et al. (2004) examine inequalities in psychological morbidity in two cities in north-west England by applying Bourdieu's notion of social space with a quantitative method (cited in Veesntra, 2005). In each city, they select high and low income places for their survey. They investigate the overlap between social space and geographical space. Along with basic demographics (age, gender, marital status), they assess numerous aspects of material circumstances and social relationships: *economic capital* (e.g., income, car ownership, satellite television installed, home ownership), educational capital (personal educational qualifications), occupational status, and *social capital* (sense of loneliness, desire to move, meeting with neighbors, sense of community) (Ibid: 17). Psychological health indicators comprise the presence of a long-standing illness, loneliness, perceived troubles managing financially and age. According to their findings *economic* and *social capital* are closely intertwined when it comes to the social space manifesting psychological morbidity.

Crossly (2004) employs Bourdieu's theory of practice in the mental health field. From an anthropological perspective, he examines the key practices of resistance of patients, or "survivor(s)" as he called them. He sees the resistance *habitus* as a challenging effect on the symbolic power of psychiatry.

Rhynas (2005) draws our attention to the fact that Bourdieu's Theory of Practice can be used in nursing studies, in particular nurses' conceptualization of illness and the patients in their care. According to her, Bourdieu's theory of practice offers nurses a framework through which to develop nursing research and develop a theory. She states that "nursing has at times found itself caught between the worlds of biomedical objectivity and the more subjective notions of care and compassion" (Ibid: 183). She points out the significance of Bourdieu's theory of practice as:

> As a theoretical framework for nursing research, the theory of practice has much to offer. It has the potential to allow nurse researchers to develop valuable insights into the interactions of nurses with the structures and agents within the field and the symbols of specific illnesses. Through this exploration, his work could facilitate deeper understanding of how nurses view and react to patients in their care, and how their work relates to the field of care. (Ibid: 184).

In the case of nursing studies, Angus et al. (2005) examine the physical, symbolic, and experiential aspects of receiving long-term care by using Bourdieu's concepts of *habitus* and *field*. As an ethnographic study on homecare, the study was done in 16 homes in urban, rural, and remote locations in Ontario, Canada by gathering data about domestic and care giving routines through observation and interviews (Ibid: 161). They found that:

> Although all of the care recipients and their family caregivers indicated a strong preference for home care over institutional care, their experiences and practices within their homes were disrupted and reconfigured by the insertion of logics emanating from the healthcare field. These changes were manifested in three main themes: the politics of aesthetics; the maintenance of order and cleanliness; and transcending the limitations of the home. In each of these dimensions, it became apparent that care recipients engaged in improvisatory social practices that reflected their ambiguous and changing habitus or social location. The material spaces of their homes signified, or prompted, altered or changing social placement (Ibid.)

According to them, when applying Bourdieu's concepts of *habitus* and *field* to long-term care, "disjunctions may develop between the embodied habitus of care recipients and the objective conditions of what they have come to expect from their home environments" (Ibid: 166). They conceptualize the home care and hospital care as different fields. They see homecare as the change in the concordance between the body and *field*. According to them, "the logics and conflicts of the field of healthcare become active within the home which already possesses its own logics and hierarchical arrangements" (Ibid: 166).

Veenstra (2005) examines the effects of class on health in British Columbia, Canada by adopting Bourdieu's approach. Instead of looking at economic ownership and control over the means of economic production, he examines the possession of various cultural tastes and dispositions, lifestyle practices, parental educational background, educational capital, *economic capital* and occupational type. He calls the poor group, *class of solitude,* not associated with any occupational class

> This is a poor group with members who tend to rent accommodation in temporary living situations and are likely to be young and single, separated or divorced. This grouping is not obviously associated with any specific occupational categories. I refer to this group as the

> 'class of solitude,' noting the degree of loneliness and lack of belonging to the community evident among the members of this sector, but am least confident that this section of social space represents a real social grouping. (Ibid: 27).

Veenstra found that the mental and psychological interpretations of overall well-being are better explained by social (class) groupings than measurements of physical well-being. While an excellent self-rated health pattern is prevalent in professional class and middle class, fair/poor health falls within the working class. Depression falls in his mapping within the class of solitude in addition to obesity and the presence of injuries (Ibid: 28). He also found that the presence of long-term illnesses falls within the working class. His study is important in terms of the visualization of indicators of physical and mental health situated within social space by mapping the use of exploratory multiple correspondence analysis techniques.

Cocherham (2006), a medical sociologist, tries to produce a theoretical model for lifestyle in the Asian context and applies the model to HIV/AIDS by using Weber and Bourdieu's concepts. According to him, the Western type of lifestyle theoretical literature that links differences in lifestyle patterns to class distinction should be developed for the Asian case. His model illustrates the capacity of sociological theory to explain the daily health practices linked to chronic diseases and some acute diseases such as HIV/AIDS. By using Weber's concepts of life choices and chances and Bourdieu's notion of habitus, the model is developed (Ibid: 9). According to him, class circumstances, age, gender, race, ethnicity, religion and ideology, and living conditions constitute life chances and provide the social context for socialization experiences that influence life choices. There is a dialectical relationship between life choices (agent) and life chances (structure). This interaction between life chances and choices produce individual dispositions toward action. These dispositions constitute a habitus as suggested by Bourdieu. Dispositions produce practice. People either practice a healthy lifestyle or unhealthy lifestyle. According to him, habitus is the centerpiece of the health lifestyle paradigm.

Stokes et al. (2006) analyzes the tendency of general practitioners in UK to remove certain patients from their list and not treat them by utilizing both accounts from doctors and patients with the interactionist perspective on doctor-patient interaction and Bourdieu's theory of practice. In this research, they analyze the topic through Bourdieu's theory of practice, by examining "paired" accounts of the same removal event by both remover and removed. The research demonstrates the

unthinking or non-reflective nature of people's understanding of the rules governing social interactions, but also demonstrates how apparent rule violations make the rules explicit and expose patterns of power distribution. They see the number of patient removals as a strategic exercise of symbolic power by general practitioners. In addition, the removal is experienced as an overtly violent symbolic act by patients. However, patients do not passively accept the situation, instead they "resist medical power covertly and avoid direct confrontations" (Ibid: 631). Stokes et al. see the field of health care as an arena of power struggle in the context of the doctor-patient relationship. This study has made important contributions to studies of doctor-patient interaction because they consider both accounts and consider health care as a *field* or "game" which has rules.

Lo and Stacey (2007), in their examination of clinical encounters, have developed a conceptual model for understanding the role of culture in the clinical encounter, paying particular attention to the relationship between culture, contexts and social structures. They link Bourdieu's notion of *habitus* and Sewell's axioms of multiple and intersecting structures. They call patient orientations, "hybrid habitus". This reformulation of *habitus* highlights patients' broad cultural orientations towards health, but they underline the way that multiple structural forces such as ethnicity, class, and immigration intersect within the context of a clinical encounter.

In addition to these studies, there is an effort to solve classical debates on structure and agency in health inequalities and grasp the relationship between the structure agency and the context by employing Bourdieu's theory of practice by many authors such as Williams, (1995), Smaje (1996), Popay et al. (1998), Frohlich et al. (2001), Williams (2003), and Lynam (2005). The concept of habitus is especially seen as a key concept to transcend dualities. While Williams (1995) searches for social distinction in the construction of health related lifestyles by paying attention to the *logic of practice*, *habitus*, *bodily hexis*, Smaje (1996) tries to understand the ethnic patterning of health with the many factors and interrelationships between them by using Bourdieu" s theory of practice (see 2.3. for details). Popay et al. (1998) criticize the vicious debates in health inequalities researches on "causality" and they focus on the "lay perspective" and "place" (see 2.3. for details). Similarly, Frohlich et al. (2001) have tried to construct a theoretical proposal for the relationship between context and disease. They have developed a "collectivist lifestyle" as a tentative solution, inspired

by Bourdieu's theory of social action, Gidden's structuration theory and Sen's capability theory. "Collective lifestyle" "as a form of meta-lifestyle" is defined as an expression of a shared way of relating and acting in a given environment (Ibid: 691). It is proposed that context is created by relationships between people. Also, Williams (2003) is concerned with the relationship context, structure, and agency in terms of determinants of health. She proposes "a more historically-informed analysis of the relationship between social structure and health using the knowledgeable narratives of people in places as a window onto those relationships" by examining the study of "the weight of world" and "logic of practice" by Bourdieu (Ibid: 131). According to her, "Bourdieu has a very simple message that is "the social world is accumulated history" and the stories about the "weight of the world" hammer home the point that structure can be very heavy indeed undermining individual and collective capacities and capabilities" (Ibid: 145). Like many, Lynam (2005) also points out the inadequate explanations on health inequalities and tries to see health disparities by using Bourdieu's and Smith's conceptualizations. According to her, Bourdieu's concepts of *field*, capital and *habitus* are conducive to providing a theoretical framework especially for the disadvantaged, she continues that:

> A central concern was to make visible the ways broader societal practices, sanctioned in policy and tradition, structured relationships and shaped experiences of those largely outside of the formal institutional discourses, such as the poor, immigrants, women, and/or youth. As such, Bourdieu's perspective enables an analysis that can refine and extend our understandings of links between deprivation and health to considering the ways in which broader range of capital when available, or recognized, can be drawn upon as resources for health.

The above mentioned theoretical and empirical studies are only some considered as important within a wide range of health studies. The reason why Bourdieu's concepts are so frequently employed in the health domain recently is that Bourdieu is able to grasp agency, structure, and context through the conceptualization of *field*, *habitus*, and the *forms of capital*. His conceptualization is deemed as a solution for many areas such as linguistics, media studies, sociology of body, sociology of health and illness, nursing, public health and epidemiology, medical anthropology, women studies, public administration, politics and so on. For some, his popularity in many fields of discipline arises from his conceptual framework; however, some use Bourdieu's concepts selectively, such as *social capital* (mostly used in health inequality research recently) without grasping his general theoretical framework of the logic of

practice and the reproduction of inequalities. Bourdieu points out and complains about people misunderstanding his theory (See Bourdieu & Wacquant, 2003 for details).

CHAPTER 3

THE TURKISH FRAME

This chapter deals with the changes experienced especially after the 1980s in terms of social inequality and health inequality in Turkey. Recent social inequalities have created "new poverty" especially concentrated in disadvantaged areas, namely *gecekondu* areas, in the metropolitan cities in Turkey. Turkey has witnessed many transformations with the influence of neoliberal policies. In the first part, the focus will be on particular transformations in the labor market and the welfare regime in Turkey. In particular, this part deals with the change in the Turkish work structure and its impact on city employment and its role in bringing about and sustaining chronic poverty. Social inequalities will be demonstrated with the recent figures. Poverty studies, which accelerated after the 1990s, will be mentioned. The second part of the chapter is allotted to the health inequalities in Turkey. After briefly giving information on the Turkish health care system, health inequalities in Turkey based on health indicators will be discussed. Lastly, how different disciplines deal with the subject of health and health inequalities will be revealed. This chapter is crucial for an understanding of the relationship between social security, access to health care and the health experiences of the urban poor.

3.1. Recent Social Inequalities in Turkey

Social inequalities in Turkey can be examined with looking various processes and changes which Turkey experiences. As indicated by Erman (2003), "mass rural-to-urban migration has produced squatter settlements on the city peripheries that are the residential environments of the urban poor" (p: 55).

Structural changes in work in both rural and urban areas are crucial for gaining an understanding of the dynamics of change in Turkish society. The first change which triggered the mass rural to urban migration to big cities and the emergence of the *gecekondu* is the introduction of new technologies in agricultural production with the Marshall Plan. This transformed the agricultural production from labor intensive technology to capital-intensive technology. As a push factor, this transformation oriented the rural labor force to the cities because of the underemployment in rural areas (Kalaycıoğlu & Rittersberger, 2000: 525). The emergence of the *gecekondu* is historically tied to this migration. The spatial concentration of *gecekondu* regions in the cities produced by "chain migration" from rural to urban area emerged. This migration took place through migrants' social networks based on common geographic origins or kinship ties, which acted as a crucial mechanism of support among rural migrants (Erder, 1995). Governmental tolerance with amnesty laws played a crucial role in accelerating the construction of informal housing and the permanence of *gecekondu* regions in the cities. Especially during the mid-1980s, "in order to compensate for the losses of lower classes were experiencing as a result of the neoliberal policies practiced by the government, attempted to "bribe" them through permitting the construction of up to four-storey houses on the *gecekondu* land" (Erman, 2003: 46). According to Erman, Turkey, where economic restructuring has been the aim of successive governments since the 1980s which have favored liberal policies to this end, is no exception in experiencing increased poverty and income inequality (Ibid: 42).

In 1980, with the January 24th Decisions, a new phase in the Turkish economy opened up, which aimed at the liberalization of economy, and which adopted export-oriented policies instead of import-substitute industrialization (cited in Erman 2003: 44, Demir, 1993). As an extension of neo-liberal policies Structural Adjustment Programs were implemented. As the number of jobs in the formal sector both in the private and public sectors decreased due to the type of economic policies adopted, the informal sector expanded (Ibid: 44). Also, public spending on areas such as education and health decreased, the unemployment rate increased, and income inequality increased as indicated with the below figures.

While in the 1980s the total health expenditure was 3,5%; this rate went down to 2,9% in 1985. The rate was increasing between 1987 with 3 percentage and 1993,

with 4,3 percentage. But then, it decreased to 4,1% in 1994. The year, 1997, saw an decrease with 3,5 percentage. Then the rate increasingly was rising from 1998 with 4,1 percentage to 2004 with 6,3%[9].

One of the indicators of the intensification of poverty is the Gini Coefficient, which measures income inequality. In Turkey, it rose from 0,43 in 1987 to 0,49 in 1994, displaying the imbalance in individual income distribution in Turkey (DPT, 2000: 16). While this rate was 0,51 for urban areas, it was 0,41 for rural areas. Considering household distribution in terms of income groups by quintiles it is observed that the share of the income of the poorest quintile in Turkey dropped from 5,24% in 1987 to 4,86% in 1994, while the share of the richest quintile rose from 49,9% to 54,9% in the same period (Ibid: 16). These numbers indicate increasing unequal income distribution. There was no significant change in income distribution of the rural households whereas the shares of the first four groups of urban households decreased and the share of the richest group considerably increased, thereby reaching 57,2%**.** Although there was a tendency to decrease in 2002, a rural-urban difference still existed (0,44 for urban areas, 0,42 for rural areas) (Yükseler, 2003: 3). From these figures, we can say that income inequality is less than it is in urban areas. In 2003, the Gini coefficient decreased to 0,42 and 0,4 respectively in 2004 (TUİK, 2006: 42).

The unemployment rate is a crucial indicator revealing the results of neoliberal policies. While the unemployment rate was 8,4% in 1988; 8,6% in 1994; and %6 in 1998, this rate began to rise again; it was 7.3% in 1999 (DPT, 2000: 18). Recent figures indicate that this percentage is on the rise. While this rate was %8.4 (in urban areas %11.6) in 2001, it rose to 10.3 % (in urban areas, 14.2 %) in 2002. In the first quarter of 2003, this rate rose to 12.3% (in urban areas 15.4 %). The rate decreased to 10,5% at the end of 2003, and 10,3% in 2004 (13,6% in urban), 10,3% in 2005 (12,7% in urban), and 9,9% in 2006 (12,1% in urban)[10]. However, the rate once again increased in 2006. The unemployment rate did not decrease to below 10,4% (12,1% in urban areas) until March 2007. In general, the unemployment rate has increased; in particular, the number of youth unemployed has risen. The youth unemployment

[9] These statistics were obtained from the official web site of State Planning organization, http://ekutup.dpt.gov.tr/1950-04/esg.htm , accessed 4 October, 2007.

[10] Statistics related with Gini Coefficients were obtained from the official web site of State Planning Organization, http://ekutup.dpt.gov.tr/1950-06/esg.htm , accessed 4 October, 2007

fluctuating from 1988 to 2004 increased. While the youth unemployment rate was 17,5% in 1988; it decreased until 1992 and it rose once again to 17,7% in 1993. It decreased again until 1996 and then started its climb. The rate reached 20,5% in 2003[11].

The striking figure is related with the educational status and unemployment rate when compared to developed countries. Figures indicate that when the level of education increases, the unemployment rate increases as well. The unemployment rate for illiterate people in 2004 was 3,7%; this rate for an education level below secondary education is %9,1; it is 15,1% for those who went beyond secondary education; and the unemployment rate for those with bachelor's degrees is 12,4%. Although there should logically be a directly proportionate relationship between level of educational and a position in the labor market, this is not the case for Turkey.

The other indicator which can be conducive to an understanding of the increasing poverty in Turkey is the Human Development Index developed by the UNDP. This index is calculated according to three criteria: life expectancy at birth, adult literacy rate and the combined primary, secondary and tertiary gross enrollment ratio, and GDP per capita (UNDP. 2005: 341). According to the Human Development Index value, Turkey was ranked number 69 on the HDI scale in the year 1995, but regressed to number 86 in the year 1999 (DPT, 2000: 110-111). According to the Human Development Report for 2003, Turkey is in 94th place (UNDP, 2005). As an alternative index, the Human Poverty Index takes into account criteria such as probability at birth of not surviving to age 40, adult illiteracy rate and two indicators, seen as a standard of living by UNDP, the percentage of the population without sustainable access to an improved water source and the percentage of children underweight for their age (Ibid: 342). According to this index, Turkey ranked 19th in 2003.

In addition to these figures, neoliberal policies have resulted in a sharp decrease in employment opportunities in the formal sector. Employment opportunities narrowed particularly for people who migrated after the mid-1980s (Kalaycıoğlu & Rittersberger-Tılıç, 2003: 202). On the one hand, employment opportunities decreased for new migrants, on the other real wages decreased

[11] Statistics related with unemployment were obtained from the official web site of State Planning Organization, http://ekutup.dpt.gov.tr/1950-06/esg.htm , accessed 4 October, 2007.

(Pınarcıoğlu & Işık, 2001a: 35). As Harvey indicates in his recent work, *A Brief History of Neoliberalism* (2005), the neoliberalized global political economy is a system that benefits few at the expense of many, and which has resulted in the recreation of class distinction through what Harvey calls "accumulation by dispossession" (p: 117). In the Turkish case, the application of neoliberal policies, structural adjustment programs, and privatization have led to the emergence of new poverty and increased the gap between the rich and the poor. Income inequalities have increased; employment opportunities in the formal sector have decreased; unemployment increased especially in the urban areas and for the young; the informal sector has expanded, "especially new migrants after 1985 were able to find a job in the informal sector" (Kalaycıoğlu & Rittersberger Tılıç, 2003: 202); public spending has decreased; real wages have decreased and become more flexible, the traditional welfare regime has begun to lose its capacity. Also with demographic changes there is an increase in the working age population. All the results after this period have constituted grounds for new poverty in Turkey.

Structural adjustments and stabilization policies are assumed to have a role in the increase of employment through decreasing real wages according to neoclassical economy theory (Yentürk, 1997). According to this approach, if wages decrease, and employment does not increase, it is related with the inflexibility of the labor market. In Turkey, while real wages decreased through these policies, employment did not increase adequately and the unemployment rate rose contrary to this expectation. The situation in which chronic unemployment exists as a result of decreasing wages is defined as a stagnationist regime (Ibid: 8-9). The flexibility of the labor market made employment move toward the informal sector, subcontracting, and concentration in sectors other than trade contrary to the expectation of structural adjustment policies (increasing employment). According to Yentürk, seeking a close relationship between employment and wages is not right (Ibid: 10). In her study on the manufacturing industry in Turkey, she expresses that the employment increase in the manufacturing industry has remained at a low level as a result of structural adjustment and stabilization policies experienced after the 1980s (Ibid: 4).

According to Pınarcıoğlu and Işık (2001a), the state had a traditionally strong role in terms of its role as referee in the relationship between social classes and it played a part in controlling the redistributive mechanism before the 1980s (p: 33).

However, after 1980, this role of the state changed: the state became more passive in the economy, withdrew from its conciliatory role between social classes, and ended its role in redistributive mechanism. Polarization between social classes increased, especially during the mid-1990s. Income inequality increased. The aforementioned changes after the 1980s also influenced cities. Pınarcıoğlu and Işık (2001a, 2001b) define urbanization before 1980 as "soft integrating urbanization" and define urbanization after 1980s as "tight exclusionary urbanization". After the 1980s forms of new poverty came into existence. New migrants were only able to find insecure and low paying jobs. In fact, unlike the 1950s and 1960s, for the last few years, it has become harder to find jobs even in the informal sector (Şenyapılı, 2000).

According to Buğra and Keyder (2003), until the end of the 1980s, the expectation was that workers in the informal sector would gradually become formally employed. This situation began to change towards the end of the 1980s. This prediction that the labor market would evolve toward formal employment for a progressively larger part of the workers in the industrial sector has ceased to be valid (Ibid: 17)

After the 1980s, as a result of the restructuring process with the application of structural adjustment policies the informal sector in Turkey has been expanding (Lordoğlu & Özar, 1998). The rapid urbanization tendency, high agricultural labor force, inadequate employment of industrial investment, and competitive policies based on cheap labor have led to an increase in the insecurity of the expanding informal sector. As a result, the coverage of the social security system is restricted to the formal sector. Approximately one of three workers in urban areas and three in four in rural areas are not registered with the social security institutions (WB, 2006: iii). The social security system in Turkey including pensions, health insurance and unemployment insurance is based on membership to a social security institution. Social security regulations and policies in Turkey are designed by ignoring informal sector workers (Lordoğlu & Özar: 1998: 6). Also, informal workers in Turkey do not benefit from unemployment insurance, nor are they a part of other similar social security mechanisms (WB, 2003: 8). This means that the social security system of Turkey excludes people such as informal workers, who do not have any social security because social security including health benefits, unemployment wages and pension varies according to the employment status of people. For example, street vendors,

homemakers, daily causal workers, daily home cleaners, pieceworkers or unregistered working people in both formal and informal sectors are excluded from the social security scheme. These workers who provide cheap labor to the capitalist system are invisible to official institutions. Since informal workers do not have a regular income, their vulnerability to risks including diseases and job accidents is greater (Lordoğlu & Özar, 1998: 18). In particular, women and children are more susceptible to having informal jobs, difficult working conditions and low wages in addition to the nonexistence of social security (Bircan, 1998: 27).

In terms of poverty, employment in the informal sector in Turkey is both the mainstay of many of those who are poor and the proximate cause of their poverty (WB, 2003: 30). In the UN report (2006), the informal sector is expressed as having a crucial role in employment generation, and therefore, in poverty reduction. The term "paradox of inclusion" (Handler, 2004) can be mentioned here like paradox of labor activation policies in European countries. On the one hand, informal workers try to survive and cope with poverty by using informal mechanisms, in particular, informal mechanisms provide integration of *gecekondu* people to the city, and on the other hand this type of work sustains the poor position in society, that is, results in the reproduction of poverty. According to Pınarcıoğlu and Işık (2003), problems due to crisis periods and social, cultural, and political transformations were overcome relatively successfully by means of the dynamism of informal mechanisms (p: 51). They saw the informal sector as a "security valve" which prepared the ground for a relatively soft social transformation (Ibid.). Clientalist-patronage relationship playing the role in political structures facilitated the using of informal mechanisms (Ayata & Ayata, 2003). With the 2000s, there is a transformation in the term poverty defined by Pınarcıoğlu and Işık (2003), that is, a transformation from poverty which has rules, can be overcome, and handed over to a type of poverty with no rules, and difficult to overcome. The economic crisis in 2001 had a negative impact on the informal sector. They express this effect on the informal sector as follows:

> The informal sector must become even more informal in order to overcome the crisis. This means offering fewer jobs that pay less in worse working conditions. In sum, now the informal sector needs to play a role deepening poverty, not preventing it as it was before. Ultimately, the solidarity network based on the community-family fed by the informal sector will lose its power, which means the emergence of a more permanent and excluding poverty. (Ibid: 52-53).

Also Pınarcıoğlu and Işık (2003) express that new forms of poverty, such as people with chronic diseases, the disabled, elderly, etc., will emerge. (p: 52-53) In this regard, if *gecekondu* people have not secured formal jobs and manage to survive with jobs in the informal sector with lower wages, worse working conditions and lack of insurance, how can they handle an illness situation? This requires an examination of the welfare regime and health care access.

There are two mechanisms by which the state provides welfare benefits: social security system, and social assistance and social services. The social security system where eligibility depends on employment status and total contributions paid into the relevant social security type is composed of three different organizations; namely, the Government Employees Retirement Fund (RF), the Social Security Institution (SSI), and The Social Security Agency for Artisans and the Self-Employed (SE). Membership to any of these schemes enables access to medical care and pensions.

The benefits of RF are composed of a retirement pension, job disability pension, disability pension, survivor's pension, retirement bonus, death grant, marriage bonus, lump-sum payment, repayment of contribution, and medical care (DIE, 2004, 132). The SSI provides benefits including work injury and occupational disease insurance, sickness insurance, maternity insurance, disability insurance, old age insurance, and death insurance. Sickness insurance covers medical care and treatment in the case of sickness of the insured and their dependents except for work injury and occupational disease (Ibid: 133). Benefits of SE are composed of disability insurance, old age insurance, death insurance, and health insurance. Health insurance benefits include medical examination, treatment and/or hospitalization for both the active insured and their dependents (Ibid: 134).

SSI covers private and public sector workers, both active and retired, and their spouses and children. SSI covered 26,2 % of the total employed workforce in 2003 (WB, 2006: 68). RF covers active or retired government officials and their spouses and children, 10,3 %. SE covers self-employed persons, disabled persons, and their spouses and children. SE covers 11,6 %. In addition, private insurance covers 0,1 % of the total employed workforce. The percentage of employed but unregistered workforce is 51,7 % (11.5 million unregistered workers) (Ibid.). Employers have a responsibility for registering employees, but ultimately it is the employer's decision. In general, employers tend not to register employees.

Looking at the employment status of the employed labor force without social security coverage, it can be observed that in 2004, 36% of workers without social security coverage were unpaid family workers. Unpaid family workers are not traditionally covered by a formal social security plan. We should note that the majority of unpaid family workers live in rural areas. This explains the low percentage of the insured workforce in rural areas. 31% of the unregistered workforce is self-employed, 14% constitutes the causal employees, and 17% are regular employees. Not surprisingly, the non-coverage percentage is high among causal employees with 92% (1,7 million of 1,8 million total causal employees are uninsured) (Ibid.). The insured, with their dependants, currently (as of April 2007) compose about 80% of the total population, that is, 20% of the total population is uninsured12.

Table 2: State-Run Social Security System in Turkey[13]

Social Security Mechanisms	**Eligibility Criteria**	**Benefit Schemes**	**Type of Benefits**
Social Insurance	▪ Employment status ▪ Past/present contributions	▪ *SSI* (for private sector employees) ▪ *RF* (for public sector employees) ▪ *SE (*for the self employed)	▪ Medical care (health care medicine) ▪ Pension
	▪ Reasons for redundancy ▪ Previous contributions	▪ Unemployment Insurance	▪ Income support ▪ Medical care Vocational training
Social Assistance, Social Services	▪ Low level of capital resources ▪ Social security status ▪ Categorical conditions	'*General assistance*': ▪ Social assistance and Social Solidarity Fund ▪ Social Services and Child Protection	▪ Various kinds of medical, educational and financial aid
		'*Categorical assistance*': ▪ Disabled ▪ Elderly ▪ Veterans etc.	▪ Pension
		'*Tied assistance*': ▪ Green card scheme	▪ Health care

[12] Republic of Turkey, Social Security Institution, Monthly Statistical Bulletin, no: xx, 30 April, 2007. (See the web site for details, http://www.sgk.gov.tr , accessed 10 December 2007).

[13] This table is cited from Ş. Eroğlu's conference paper, namely, *Social Protection: The Way Forward,* presented at the Annual Conference of the Development Studies in November 2004. The web site is http://www.devstud.org.uk/conference/workshops/3.5/SProtection.doc , accessed 10 April 2007.

The second mechanism of social security in Turkey is social assistance and social services delivered to those who have low income and no social security coverage. These benefits are administered by the central government and local authorities. These benefits includes medical, educational or financial aids under the general assistance, pension for the disabled, elderly, and veterans, and health benefits, called as Green Card. In addition to these benefits, various benefits such as fuel and food assistance from municipalities and administrative districts within a province are given to the poor. Those who want to receive these assistances have to obtain the document indicating their "poverty status" from neighborhood headman in order to receive this assistance.

The Green Card provides health care access for those who have not capacity to pay for health services and do not belong to any social security institution. It provides people, who can obtain the document indicating "poverty status" from their neighborhood headman, with free doctor visits, and treatment including access to medicine, medical examinations, tests, and surgery. The green card system, introduced in 1992, has indeed been one of the most dramatic changes in the lives of the people who have not been covered by any insurance scheme. (Ayata & Ayata, 2003: 126). The total number of green card holders increased to eleven million by the end of the year 2001 (Ibid.). Green card holders have to renew their green card every year by giving related documents about social security status, property ownership and so on. In addition, some green card owners may fail to renew it every year as they cannot afford the expenses for travel, photo and getting a residence registration from the headmen (Ibid.). In case of major accidents and serious illnesses that require expensive treatment, the green card has provided access to hospitals for many poor families. On the other hand, Ayata and Ayata (2003) state that the green card system does not prove so efficient in providing access to hospitals in the case of more routine health problems as the patients often fail to get sufficient care from doctors and the hospital personnel.

The level of coverage and quality of care vary widely among different social security institution (Buğra & Keyder, 2006: 212). For example, health services quality given to those who have Green Card is not equal with health services given to those who have Retirement Fund in terms of coverage. Although the right to health is a constitutional right, all people in Turkey do not benefit equally. With de-ruralization

and urbanization, the prevailing reality has become that of the informal and sporadically employed urban worker, for whom employment status could not be counted upon to lead to stable social security coverage (Ibid). In addition to people living in rural areas the, people living in *gecekondu* neighborhoods in large cities by reason of low socio-economic conditions do not have social security or health insurance in comparison to those in other parts of the cities (Ergör & Öztek, 2000: 201). It can be said that social exclusion is high in Turkey because a considerable part of the population is either unemployed or employed without being registered; that is, these people do not have social security or social insurance (Adaman & Keyder, 2006[14]). Also, lack of access to health services reinforces the feeling of social exclusion for people living in *gecekondu* areas (Ibid: xi). This form of exclusion is closely interlinked with employment status; that is, exclusion from the formal labor market.

As Erman (2003) indicates, the Turkish State has never been "a welfare state" as understood in the West**.** Decreasing public spending, decreasing real wages, increasing unemployment and underemployment and decline of traditional welfare regime based on family support can be characterized by losing, "what Bourdieu calls the "Left Hand" of the state, symbolized by education, public health care, social security, social assistance and social housing" (cited in Wacquant, 2001a: 402). According to Buğra (2001), the welfare regime of Turkey is the traditional regime in which the family and wider web of social relationships are expected to shoulder significant responsibility for the provision of welfare. However, this traditional model is drastically challenged by recent social, economic and demographic changes[15] (Erman, 2003: 45). As a result, family solidarity no longer has the capacity to provide social security. According to Buğra and Keyder (2006), "the informal pillars of the developmentalist period derived from the character of rural-urban migration, namely, the continuing ties of newly urbanized immigrants with their villages of origin, possibilities of informal housing, and the importance of family and neighborhood assistance mechanisms have lost their capacity under the pressure through economic,

[14] The report by Adaman and Keyder was accessed 3 January 2007 from the web site http://ec.europa.eu/employment_social/social_inclusion/docs/2006/study_turkey_tr.pdf

[15] The population's changing demographic structure is important in the traditional welfare regime in losing power based on family solidarity. People of working age (15-64) accounted for 65,5% of the total population in 2004. While the proportion of urban population in 1970 was 28,7%, this rate in 2004 was 60,4% (source: http://ekutup.dpt.gov.tr).

social and political developments" (Ibid: 220). This is defined as the "erosion of the informal pillars of the developmentalist welfare" by Buğra and Keyder. Evaluated in Bourdiean terms, this situation is such that while *social capital* based on common origin and kinship ties was very crucial for those who migrated before the 1980s in terms of finding a job and the construction of *gecekondu*s, after this period, this *social capital* was lost to new migrants. It follows from this that increasing poverty and the weakening of *social capital* are most certainly closely associated.

The decline of the traditional welfare regime and changing work structure as a result of the post-1980 reorientation of the country's development strategy away from a protectionist regime with heavy state intervention and public sector employment, towards an outward-looking, market oriented neoliberal regime can be characterized by what Wacquant (2001b) calls the DWL regime. With the expression DWL, he refers to a wage-labor relationship that is permanently insecure, structurally unstable, systematically under remunerated as well as increasingly incapable of sheltering those who enter into it from the perennial risks of employment, namely, deprivation, disease, joblessness, and the inactivity brought on by old age (Ibid: 56). According to Wacquant (1999), "the mutation of wage labor" is seen one of the fundamental changes which prepares the ground for new poverty.

Wacquant (1999) defines new poverty as "advanced marginality" in the cities fuelled by the resurgence of social inequality as a macrosocial dynamic, the mutation of wage labor as an economic dynamic, the reconstruction of welfare states as a political dynamic, and concentration and stigmatization as a spatial dynamic. Howsoever Wacquant develops this conceptualization for cities of Western societies, especially in ghetto regions; it is possible to see these dynamics of change in Turkey. In this respect, "new poverty" emerged after the 1980s in Turkey, the process of migration, the concept of the *gecekondu*, the new structure of work, the welfare regime, and finally health policy and system are evaluated under these "four structural logics" (mentioned in Chapter Two in detail) which fuel "new poverty". The changing structure of work toward precarious employment, the adoption of neo-liberal policies after the 1980s and the structure of the welfare regime of Turkey are crucial in explaining new (urban) poverty.

After the 1980s, not only did social, economic, and political changes emerge, but also demographic change with its third phase affected the structure of society in

social and economic ways. Demographic change in Turkey can be classified into three stages (Ünalan, 2002). The first one was between 1923 and 1955. Both the first World War and the Turkish Independence War between 1919-1923 caused massive population losses. In order to overcome labor shortage, a pronatalist policy encouraging high birth rates was implemented until 1965. With decreasing death rates, the population growth rate increased rapidly. The second period of demographic transition in Turkey can be dated from 1955-1985. During the 1950's, although the fertility rate began to decline, the population continued to grow. Between 1955 and 1985, the population doubled from 24 million to 51 million. During 1980s, Turkey entered the third stage of its demographic transition. The population growth rate decreased, and the fertility rate declined. The age composition of the population also changed. Turkey now had a young population as a result of high fertility and growth rates (Ünalan, 2002: 3). According to the 1997 Census, those under the age of 15 constituted 31% of the total population. Although senior citizens over 65 were a small group, only 5.8 % of the total, it was expected that this percentage would increase rapidly in the following decades as a result of declining fertility and mortality rates.

The distribution of the population into three main age groups indicates that the demographic structure of Turkey has changed. The percentage of the 0-14 age group decreased from 32.8 % in 1995 to 30 % in 2000, in contrast to the 15-64 and 65 and over age groups, which were estimated to increase (DPT, 2000: 84). Between the years 1995-2000, the number of people in the 15-64 age group increased from 62.13% in 1995 to 64.39% in 2000. The percentage of the elderly population exhibited a similar increase; that is, the percentage of senior citizens rose from 5.02 % in 1995 to 5.57 % in 2000 (Ibid: 86).

The third phase of the demographic change had impacts on the labor market. The population in the working age constituted the majority of population, meaning more people were seeking employment in the market.

3.2. Health Inequalities in Turkey

In terms of health or epidemiological transition, Turkey has experienced changes in a different way than developed countries have. While the infant mortality rate was 163 per thousand in 1960 in Turkey, it decreased to 38 per thousand in 2000

(UNICEF, 2002). The child mortality rate for children under 5 dropped from 219 per thousand in 1960 to 45 per thousand by 2000. Life expectancy at birth rose from 56 in 1970 to 70 in 2000 (UNICEF, 2001). Also, lots of communicable diseases either dramatically decreased or were completely eradicated via vaccination. However, health care access is a major problem in Turkey as well as the unequal provision of health services according to different social security institution.

The Ministry of Health is the major provider of primary and secondary care and of preventive health services in Turkey. Primary health services including health stations, health centers, health houses, and mother and child health centers aim to provide the first service in order to prevent illness and the first intervention. The duties of health centers include woman and child health services, services for fighting against infectious disease and fatal diseases, disability and loss of labor force, immunization services, health education, environmental health services, population planning services. First and ambulatory aid services and patient care services are the most important ones (Eren, 1982: 32). While health centers increased in number with the socialization legislation in 1961, the state of inaccessibility to services due to inadequate health personnel remained a major problem, especially in the rural context. Although "The Law on Socialization of Health Services" was enacted in 1961, it was implemented in 1963. The main aim of the law was to spread health services to make them easily and equitably accessible to the whole population (T.C. Sağlık ve Sosyal Yardım Bakanlığı, 1965).

According to the statistics[16] obtained from the Ministry of Health, the percentage of rural health houses without a midwife is 66%. This rate in East Anatolian (83%), Central Anatolian (72%) and South East Anatolian (72%) regions is below the average rate in Turkey. The percentage of health centers without a medical practitioner is %22,3 for Turkey. This has exhibited a downward trend (11,6% in 2000; 12, 4% in 2001; 13,4% in 2002; 16,8% in 2003; and 22,3% in 2004), even though the number of health centers doubled between these years. This rate is under the average in East Anatolian (38%), Black Sea (27%), and Central Anatolian (%28) regions. In general, the number of health personnel per person has continued to

[16] Basic health statistics obtained from the official web site of Ministry of Health. http://www.saglik.gov.tr/istatistikler/, accessed 10 January 2008

decrease, and the percentage of health centers without a midwife and a medical practitioner has fallen by the year.

In general, basic health indicators such as the infant mortality rate paint a better picture than that of previous years; however, the gap between regions and between the urban and rural areas has increased (Hamzaoğlu & Özcan, 2006). In 1978, the infant mortality rate was 119 per thousand; in 2003, the rate was 23 per thousand. However, in rural areas, the rate was 146 in 1978 and 39 in 2003. The gap between rural and urban areas increased between these years (from 11,2 to 20,7). The gap between the eastern and western regions increased in terms of infant mortality rate between those years (from 1,36 to 1, 86). Also, the immunization rate is similar. The rate of babies not fully immunized (12-23 months babies) was 54,3 in 1998; while this rate in 2003 was 45,8%. In urban areas, the rate in 1998 was 48,2% and in 2003, it was 37,1%. However, in rural areas, the rate decreased from 63,2% to 63,5% between these years. The regional gap also widened. The tendency to change also remained valid for other health indicators like prenatal follow-up, malnutrition, and the rate of women who give birth without the presence of health personnel.

These figures indicate that health inequality has increased in Turkey. The inequalities between regions and between urban and rural areas have also been demonstrated in all Five-Year Development Plans. It is stated that there is a maldistribution of health personnel and services across the country. The socialization of health services eliminated regional differences to some degree by expanding the first level of health services. The elimination of these differences through providing sufficient health personnel and services has not succeeded in the strictest sense.

3.3. "New Poverty" and Health Studies in Turkey

Recently, in Turkey we have witnessed a rise in the number of poverty studies which focus on urbanization, migration, working life, gender and -to a lesser extent- health. In this part, I would like to review firstly how poverty studies, which have picked up speed for a decade, deal with the issue of health, and which aspects of health they are concerned with. Secondly, I would like to examine some health studies and try to indicate how these studies deal with the social, cultural and economic aspects of society, especially with poverty, and urbanization, and so on.

Morçöl and Gitmez (1995) made a typology of poverty by conducting a study on 550 people with different socio-economic statuses in 1992 in Ankara. They have determined the types of poor by using objective and subjective indicators. In terms of subjective poverty, doers are defined as those who evaluate their own living conditions as better than the five years ago and their living standards better than their close relatives' and neighbors'. They defined three types of poor groups: doers; accommodators, who are between doers and losers; and losers. According to them, the length of time that losers spend in the city is shorter than that of accommodators. Accommodators are composed of people who assess their living conditions as the same when compared to the past and their other neighbors and relatives. Losers consider themselves as worse than the past and neighbors and relatives. Doers consider themselves as better than the past and neighbors and relatives. They define the loser as new urban poor.

Erder (1996) carried out her field study in Ümraniye, a *gecekondu* neighborhood in Istanbul, by examining the role of social networks in gaining economic opportunities. According to her, migrants who can make use of chain migration opportunities can more easily adapt to the city's housing and labor market. Those who can not take advantage of the social network can not access social mobility opportunities. Benefiting from the informal housing market, which is considered one of the informal pillars of the traditional welfare regime before the 1980s by Buğra and Keyder (2006), depends on social networks especially based on kinship, common geographic origin, or ethnic origin. She expresses that the lack of a social network for finding a job or shelter reinforces the poverty of rural migrants. Erder (1995) expresses that those who migrated to the city after the 1980s are the poor of the city. As Buğra and Keyder state, the informal pillars of the traditional welfare regime based on social network and ties, such as being able to own a *gecekondu* in the informal housing market, decreased or ended after the 1980s. According to Erder (1998), new migrants are at a disadvantage in terms of poverty compared to previous migrants. She expresses that the functions of the traditional social relationships prevailing in previous periods in reducing the problems faced by rural migrants have been changing in such a way that they have become more exclusionary and rigid (Ibid: 112). In terms of migration, there is a shift from the chain migration pattern to forced migration during the 1990s. These new groups have come to the city without any support from

their homeland, and settle in existing *gecekondu* settlements as tenants because they have no way of building new *gecekondu*s.

The other study by Morçöl (1997) examines the lay explanations of poverty in Turkey and their determinants. Theoretically, there are three explanations of poverty in terms of the attributions of the causes of poverty: structural, fatalistic and individualistic. In their social psychological analysis, income, gender, age, and education are included as the main determinants of explanations for poverty. The sample consisted of 550 people who were interviewed in 14 neighborhoods in Ankara in 1992. In this study, the categories of the poor and non-poor were defined on the basis of family income. The distinction between poor and non-poor was made according to poverty line statistics for a family of four that was published by the popular Turkish daily newspaper, Hürriyet (eg. The equivalent of $571 US per month at the time). The poor participants were divided into subcategories: those with monthly family income above $250 were classified upper poor and those below, lower poor. According to the findings of this research, both poor and non-poor persons attributed the causes of poverty mainly to structural factors (p: 735). The reasons the poor participants favored structural explanations were probably that they experienced unemployment more frequently and that they lacked sufficient education. Poor persons also favored fatalistic explanations more than persons in higher income groups. A plausible explanation for the finding that the non-poor participant favored more abstract structural explanations for poverty is that they were also more educated. In terms of gender and age differences, this study concluded that women and older people favored individualistic and fatalistic explanations. Men and people with higher levels of education preferred abstract structural explanations.

There are some studies about the evaluation of poverty based on the Household Income and Consuption Expenditure Survey (HICES) such as the studies by Dağdemir (1992), Dumanlı (1996), Erdoğan (1996), and Dansuk (1997).

Dağdemir (1992) examined the income distribution of the years 1968, 1973 and 1987 (cited in Erdoğan, 2002). He used the absolute poverty criteria and the criteria of earning less than the average level of income in this study. He found that poverty had decreased from 1968 to 1987. The income share of the poorest 40 % and the poorest 60 % increased in 1973 and 1987. During the 1968-1987 period, poverty declined and the income share of the poorest 40 % and 60 % in the total level of

income increased by 5.3 % and 8.3 % respectively. According to him, poverty was prevalent in families with lives as wage earners and in the self-employed.

The study by Dumanlı (1996) examined poverty by using the data from the 1987 HICES. The study measured the poverty line by calculating the minimum amount of calories needed; that is, 2540 calories daily. He emphasizes that there are regional differences according to this calculation. Based on this calculation, the rate of poverty in the Eastern and South Eastern Anatolian regions was 33,97 % on a household base in 1987. These two regions' poverty rates both at the household level and individual level seem to be much more severe than in other regions. Also there is a difference between the rural and urban areas. In contrast to other regions, the poverty rate in the urban areas of the Central Anatolian Region (38,33%) is higher than in the rural areas (29,14%).

Erdoğan's study (1996) is based on the 1994 HICES. The poverty line is calculated according to amount of minimum necessary calories, basic needs, and half of the average income. She classifies the poor into three groups: "extremely poor", "low level poor", and "high level poor" by adapting three approaches. She defines the "extremely poor" as those living on less than the minimum amount of calories per day needed by an individual. The group called "extremely poor" is determined as people who could not earn enough money to meet the food need by calculating minimum food expenditure. Secondly, the poverty line is calculated using the basic needs approach, the minimum level of income that the households need are determined by taking into account the necessary amount of expenditure on housing, clothing, transportation and furniture besides the expenditure on food. The households with income below these levels are classified as "low level poor". Thirdly, the calculation of the poverty line is based on the food rate approach. According to the obtained poverty line, poor households are defined as "high level poor" (cited in Erdoğan, 2002). The results of the study show that the proportion of the extremely poor is 11%, the proportion of the low level poor is 20% and the proportion of the high level poor is 12% in Turkey (cited in Özcan, 2003: 34).

In terms of the measurement of poverty in the Turkish case, the other study conducted by Dansuk (1997) displays the relationship between poverty and social indicators with a new approach by examining consumption expenses derived from HICES. He measures poverty in terms of consumption spending based on the theory

of human capital. In this regard, food, clothing, household goods, services and care for the house and household members, individual care, health and personal care, transportation, communication, culture, education, rent and other expenses are indicators for calculating the poverty line. According to the study, rates of poverty are 24,36 % as absolute and 47,62 % as relative according to the consumption pattern (Ibid: 105). Also, absolute poverty as minimum food consumption is 14,24 % and relative poverty as average earnings is % 30,12. He also identifies social groups handicapped by poverty as women, illiterate people, rural people, people who are outside the social security system and people who work in the informal sector. His study is crucial in that it identifies regional differences and vulnerable social groups with a new approach to poverty measurement based on the determination of consumption patterns. Also, his including health expenses in the consumption expenses is noteworthy because the costly health expenses among other expenses means that paying for health care and medication out of the proverbial pocket rather than the receiving free health services can be a serious impoverishing factor for those excluded from the social security system. Dansuk indicates that health expenses are in third place following food and rent expenses (Ibid: 39).

The qualitative study done by Pınarcıoğlu and Işık (2001, 2001b) pertains to the ways and strategies for survival in the squatter housing among migrants from rural to urban areas in Sultanbeyli, İstanbul. In this study, the migrants' welfare and poverty status was analyzed by collecting information about home and land ownership, the ownership of household goods, employment status by places of origin and length of stay in the city. It was found that first generation migrants are much more successful in acquiring sources in the city such as land and home ownership. According to Pınarcıoğlu and Işık (2001a, 2001b), poverty has a tendency to transfer to the newcomers to the city, called as "poverty in turns". With relationships in local networks, the urban poor develop survival strategies and poverty is transferred to the new arrivals.

Kalaycıoğlu and Rittersberger-Tılıç (2003) propose a model which attracts attention to the social solidarity networks in poor households as a coping and survival strategy for poverty in Turkey. According to them, the "family pool" is a system based on inter-generational transfers and reciprocity in kinship networks. In addition to *economic capital* transfers, social and *cultural capital* is also transferred through

generations and relatives. They state that the system is a prior and imperative solidarity system for people in terms of survival.

Kardam and Alkaynak (2002) examine the gender dimension of poverty and identify how women experience and cope with poverty. They conducted a research on poor women with low income in Ankara. They examined the poverty experiences of women in terms of conditions and levels of "capability". According to them, social and psychological influences of poverty are experienced more intensely by women than by men due to traditional gender roles (Ibid: 213). While they try to continue their social roles restricted to domestic responsibilities in spite of increasingly impoverished conditions, they struggle with poverty based on their "capabilities" in definite restrictions determined by patriarchal domestic ideology. Women have developed various coping strategies about food consumption, accommodation, heating, electricity, water, health, education, and so on. In terms of coping with health problems, there are some strategies such as using another person's Green Card, trying to get free check-ups and treatment, trying to receive information about health problems from health institutions, postponing solving health problems and act only when the illness has reached its peak.

A research conducted by Ozar was summarized in the special issue *Informal Sector and Social Security: Problems and Perspectives* of Freidrich Ebert Stiftung (1998) by Lordoğlu and Özar. His research was carried out in low income neighborhoods in İstanbul in 1996. He conducted interviews with 1210 households and obtained information about family members' socio-demographic features and their relationship with the labor market. According to the results, 2525 family members out of 5634 family members in 1210 households were working (Lordoğlu & Özar, 1998: 8-9). 80% of the working family members worked in jobs related to the informal sector. He concludes that there is no unique type of definition of the informal sector and emphasizes the diversity in the sector. Among the people who work in the informal sector, there are unpaid family workers, wage earners, self-employed working alone in their workplace, and employers who employ wage workers. In addition, he emphasizes the considerable number of self-employed people in this sector and he highlights that street peddlers do not compose the majority of working people in the informal sector contrary to such expectations. The most important findings are related to one of the main arguments of the thesis: health seeking strategies of people in the

informal sector. As it is known, working in the informal sector is accompanied by exclusion from any kind of social security. There are many strategies resorted to. While the majority go to private hospitals and private doctor clinics (52%), the number of people who do not receive health care services is significantly high with 11,9 % (Lordoğlu & Özar, 1998: 13-14). Belonging to any social security scheme, whether as the active insured or a dependant provides free access to health services by paying a fixed percentage of the cost of medication. In Ozar's study, there are few family members in this situation even in the dependant position. 83% of respondents do not have any social security, not even as a dependant. This uninsured status of the respondents naturally prevents them from receiving health care free of charge, instead they tend to either not receive health care due to lack of money, or to receive health services from the private sector. Receiving health services from the private sector has a detrimental effect on their *economic capital*. When we consider their irregular and low wages and the high cost of health services in the private sector, it can be said that receiving health services from the private sector is as crucial reason for impoverization.

Ayata and Ayata (2003) investigate the various aspects and specific processes associated with poverty in Turkey on the basis of qualitative data conducted in fifteen provinces. There are two groups in the study: the first one involves the unemployed and casually employed poor depending on benefits provided by formal institutions or informal networks. They define extremely poor as the sick and the disabled, the unemployed, female-headed households and the unskilled uneducated casual laborers, that is, the "benefit dependent poor". The second group comprises families who have higher incomes than benefit dependent poor and at least one member of the family is regularly employed albeit on the minimum wage or an amount only slightly higher. Those families are defined as "regular income earning poor". Also, regular income earning poor have one of the social security schemes such as SSI, RF, or SE. They compare these two categories in terms of basic needs such as food, clothing, shelter, expenditures, health and education in order to understand the various aspects of poverty. According to Ayata and Ayata, unemployment and casual employment is the strongest economic correlate of poverty and of benefit dependence (Ibid: 105). Benefit dependent poor are the unemployed or casual workers who frequently change jobs and are constantly threatened by unemployment. Also, benefit dependent poor

have a low level of education and are unskilled and inexperienced in factory work. The other characteristic of benefit dependent poor expressed by Ayata and Ayata is their ill health situation. They expresses that ill health limits their chances of finding a job and therefore becomes a major source of low income and poverty (Ibid: 106). According to the results of the study, being ill makes them to work at relatively easy jobs such as garbage picking, street selling, and shoe shining on a part time, casual or temporary basis and therefore ill health prevents the sick person from having regular work.

Ayata and Ayata express that there is a close association between ill health and the poor being more vulnerable to illnesses. One of the absolute poverty indicators is that the children do not generally get continuous, proper and sufficient medical treatment. Illnesses such as conjunctivitis, convulsions, hyperactivity syndrome, down syndrome, speech difficulties, enuresis, rickets, mental retardation, asthma, congenital heart defects, vertigo, strabismus, bone deficiency, tonsils, rheumatism complaints, bronchitis, sinusitis, pneumonia, hearing deficiency, growth failure and psychological disorders are most frequently seen in children of poor families, a considerable number of which are directly related with malnutrition, and poor living conditions of the poor families. According to the case study, the poor have difficulty paying medical expenses and may even have to sell their existing properties (Ibid: 125). In the research, it is found that the poor people do not get adequate and sufficient medical treatment, as many have to confine themselves with temporary pain relief even in the case of major and or chronic diseases in order to avoid expenses. In addition to pain, they suffer from chronic diseases which influence everyday life of whole family members and lead to inefficiency in work. Ayata and Ayata define poverty in this sense that it creates a vicious circle, where low-income, social insecurity, vulnerability and ill health mutually reinforce each other (Ibid: 126).

In terms of health seeking strategies, Ayata and Ayata define four types of access to medicine: two are institutional, and the other two are both the private and the personal. The first institutional method is the endorsement of the prescriptions by SSI. The second method, in wide practice, is to find an acquaintance with insurance coverage to get the prescription approved by his his/her own doctor. Informal social networks of families play an important role in these methods. According to the results of interviews, even those who use the most efficient strategies cannot always have regular access to medicine, even in the case of major and chronic diseases. Medical

centers functioning in providing services health services for the poor are seen insufficient due to reasons such as the absence of doctors and nurses, the limited range of services and the inability of these institutions to provide access to tests and medicine. In terms of gender, it is noticed that men, especially casual workers, tend to not go to hospital because of the fear of losing their jobs. Waiting for treatment in the hospital leads to a reduced income. The research indicates that there is an informal solidarity network in the case of health problems faced by poor families in a manner of cash contributions mostly from close relatives or help.

Ayata and Ayata express the difference between benefit dependent poor (the unemployed and casual workers) and regular income earning poor in terms of health care access (Ibid: 128). Although regular income earning poor who have a social security scheme like SSI or RF have free access to health care, they have difficulty paying the commission charge for medicine prescribed by doctor especially for expensive medicines such as cancer medicines. However, regular income earning poor see doctors more frequently and follow medical advice regularly in comparison to the benefit dependent poor.

According to the poor in this research, there are three problems faced in health care (Ibid: 129). First, they typically face long waiting lists and have difficulty in seeing doctor at the right time. Second, they can not get proper medical care because the doctors often refuse to treat patients who have not visited them in their private clinics. The third major problem area is identified as surgery. In this particular case, the surgeons would ask for an additional charge for the surgery called as "knife fee" by patients. This illegal practice also exhausts the *economic capital* of the poor patients since they may be being forced to go to the private clinic by doctors even if they have a social security scheme.

Boratav's study (1995) in İstanbul (two districts and one village) and some central Anatolian villages (18 villages) is concerned with social classes, their socio-economic features and welfare indicators and life styles in Turkey. The study deals with welfare indicators, one type of which is health status indicators by social class. Boratav uses two indicators to examine health problems. The former is health services utility; the latter is direct health status (Ibid: 42). Health status indicators are having had an abortion without any medical assistance, not having had a check-up during the last pregnancy, having given birth to the last child outside of a hospital or health

center, having given birth a stillborn, having suffered from one miscarriage or more, infant mortality rate among children born in the last five years, female mortality during pregnancy, the postnatal period and childbirth period, and lack of insurance. Social classes are divided into two: urban and rural classes. Urban classes are unemployed, highly qualified workers, white-collar workers, unqualified service workers, blue-collar workers, artisans/marginals, low level employers, or mid to high level employers. Rural classes are capitalist farmers, rich farmers, rich peasants, mid-level peasants, lower level peasants, poor peasants, agricultural workers or rentiers. According to Boratav, (1) Being insured affects health status indicators positively; (2) The unemployed and artisans/marginals have a worse health status, and these groups are the least insured in all classes; (3) Insurance rate and health status are higher in upper middle class bourgeoisie and qualified workers; (4) People working in regular and formal employment conditions make more use of free health services provided by the social security system. This affects their health status indicators positively; (5) Urban and rural social groups are different in terms of health status. People living in rural areas are more disadvantaged than people living in urban areas in terms of health status. This study displays social inequalities between the different classes. Health status indicators are related with women's reproductive characteristics. Indicators are much more connected to women's and children's health. Boratav determines social classes in terms of "relations of production". Consequently, materialist conditions such as employment, occupational position and work conditions are recognized in this study in order to construct a relationship between health status and social class. Cultural differences and behavioral differences between individuals are not considered as the basis of this analysis.

In public health literature, health inequality between social classes or between different groups is one of the main issues questioned. Recently, the issue has been discussed and examined but few studies have actually been conducted. Dedeoğlu and Erengin (1998) studied this concept and constructed a relationship between morbidity differences as the dependent variable and independent variables such as gender, economic condition, social security, type of housing and education. The study covered 785 people in 300 households. According to them, women, squatter house dwellers, people with poor economic conditions, less-educated people and people without social security have worse health than other people (Ibid: 143). According to them,

the basic determinants of health are the socio-cultural system in which people live, their economic power, beliefs, environmental and working conditions, and education levels (Ibid: 140).

Belek's study (1999) is about the causes or determinants of health. Social class, education, income and area of residence are variables which he emphasizes. The cross-sectional study done in Antalya, covers 1092 adults aged 15 years and older. Dependent variables comprise perceived health, temporary disability and psychological health (Ibid: 53). In this study a class scheme developed by Boratav (1995) was employed. For the basic classification of social classes of the heads of household, two main classes were determined in this study: those with means of production and those without. Then, a total of six classes were identified: blue-collar workers, unqualified employees, white-collar workers, highly qualified white-collar workers, the self-employed, and bourgeoisie. Blue-collar workers, white-collar workers, unqualified employees and highly qualified white-collar workers do not have any means of production, and consequently, they sell their labor power to the bourgeoisie, who have capital. The bourgeoisie have their own means of production and employ workers. Self-employed people have means of production as well, but people in this category do not have sufficient capital to employ any other people (Belek, 1999: 55-56). According to Belek, the most important determinant for all the three health status determinants is class structure. Blue collar and unqualified employees are the most disadvantaged groups.

The other study done by Belek (2000) is about the individual effects of social class, income, education, and area of residence on psychological distress. This research is derived from the previous one. This study examines whether social class independently affects the occurrence of psychological distress when income, education, and area of residence are controlled. According to the study, "inequalities between social classes are large and similar results are obtained for income and education groups. Inequality in psychological distress is greater by social class than by the other variables" (Ibid: 97).

In Turkey, certain sociologists have been interested in the social and cultural construction of health. Türkdoğan (1991) is of important status in the development of the sociology of health and illness. He tried to examine the relationship between the health-disease system and culture. This study does not directly focus on health

inequality. Instead, it explores cultural differences in health seeking behavior and treatment methods; patient- (medical, scientific) doctor relationship of women and men; the duality of modern medicine and traditional medicine (traditional patterns, beliefs, behaviors and attitudes related with diagnosis, recovery and cure); cultural aspects of maternal and child health; and nutrition. According to Türkdoğan, a relationship exists between socio-economic factors and the health-illness system. He suggests that income, social class, and occupation are crucial in the determination of the health status of people (Ibid: 102). The study determined the number of people by different occupation and income consulting doctors. According to the findings, people with high income are more likely to see a doctor (Ibid: 103).

Tezcan's study (1992) focuses on the problem of infant and child mortality in Turkey. She argues for a re-evaluation of the theoretical paradigm that views childhood issues primarily in relation to mothers rather than within the dynamics of a broader cultural context. According to Tezcan, the present emphasis on mothers as a primary key to the problem reflects an extensive and implicit conceptualization of "motherhood" that has penetrated scientific discourse and methodology. She analyzes different experiences of women with child mortality in relation to family circumstances, proximate kin and cultural factors. She conducted her research in 1986 in Göçkent, İstanbul, where newly migrants lived. As a low income population, Göçkent's subjects lived in *gecekondu*s. A household survey and in-depth interviews were employed in this study. In her sample of 229 women, four determinants of Turkish child mortality were identified: the husband's education, household composition, the woman's attitude toward abortion, and the presence of drinking and smoking in the household. These variables were said to reflect the household and cultural conditions surrounding the mother.

Güler (2001) places importance on socio-cultural factors in determining the mental health state of women in the *gecekondu* areas, *Karanfilköy* and *Küçükarmutlu* in *İstanbul*. The aim of this study was to determine whether the mental health of women living in *gecekondu* areas is affected by economic and social constraints. The sample consisted of 492 women and girls, ages ranging between 15 and 65. While 107 of the women were illiterate, 300 of them had finished elementary school. In terms of marital status, 434 of them were married, 58 were single. A questionnaire consisting of 105 questions was applied to 492 women and the Beck Depression Scale was applied

to 40 women. According to the findings, women live in houses with non-hygienic conditions. 40 % of the women receive assistance from health services with complaints like anxiety, anger, headaches, and depression. Especially women who work as domestic workers have a sense of low self-worth. According to the findings from the Beck Depression Scale, 30 % of the women have a high level of depression and 25 % of women are moderately depressed.

Adak's study (2002) examined attitudes and behaviors of women between the ages of 15 and 49 living in rural and urban areas regarding the health-illness system as a subsystem of the social system. Dealing with women's attitudes and behaviors toward the health-illness system in cultural and social contexts with a traditional structure of society and value system, this study aimed to analyze how women perceive health and illness; how their attitudes and behaviors regarding health and illness are shaped by social and cultural factors such as education, age, income, marital status, residential area and so on; and what their norms and values are with regard to the sick role and status. For these purposes, Adak conducted a fieldwork in Antalya, one of the major migrant-receiving cities in Turkey. The sampling was selected from villages (33 women), small towns, *gecekondu* areas, middle status residential areas, and higher status residential areas. In Antalya, 181 women constituted the urban sample. The rural sample consisting of 74 women was selected from two villages in Antalya. According to the findings of the study, the most frequently used family planning method among married women is RIA. Modern contraception methods are mostly used in middle status residential areas. As the literacy level increases, the percentage using modern family planning methods also increases. While 18.4% of women perceive health as physical health, 18.4% mental health, 1.6% of them see health as capacity to perform daily duties. Diseases from the perspective of women are caused by malnutrition (25.5%), stress (21.2%), microbes (14.9%), cold (5.5%) and habits detrimental to health such as alcohol use and smoking (3.9%). The definition of a sick person and the sick role as stated by the women is explained as being associated with physical power and the sick are those who can not cope with daily duties and activities functionally. 74.1 % of women, when they are ill, say that they do not choose the traditional avenues of medicine (bone setters, hodjas, Islamic monasteries, etc.). However, 25.9 % of women state that they resort to the traditional practices. Women in rural areas use traditional medicine a great deal more than those in urban areas.

There is a positive correlation between resorting to traditional medicine and education, the status of the residential area, and distance from health centers. Income is not found as a factor which determines the preference or lack thereof regarding traditional medicinal practices. However, there exists a relationship between religious belief and preferred treatment methods. 65.5 % of women believe in the evil eye and possession by evil spirits. There is a link between religious ideas and the conception of health. In terms of health locus of control, people believe in fate. Most of women believe fate is responsible for someone being ill. This idea is more frequent in rural and gecekondu areas. Despite this idea, 88.6 % of women believe in the benefits of modern medicine.

Cirhinlioğlu (2001) conducted a research on doctor-patient relationship in two Sivas Hospitals. He claims that the doctor-patient relationship in Turkey is a doctor-centered interaction, called "paternal relationship" by Stewart and Roter (1989). In the research, interviews were done with 100 doctors from both medical faculty and Social Security Institution Hospital and 150 patients in both hospitals except for inpatients. There is a similarity between the socio-economic conditions of doctors and patients (Ibid: 76). According to the results of the research, while the characteristic in a patient that doctors prefer is being easily adaptable in the process of diagnosis and treatment and high educational status, the doctors do not feel it is not important that patients have characteristics such as having high socio-economic conditions, being urbanites, having similar a world view, and being patient who does not ask about health related issues in doctor patient interaction. According to Cirhinlioğlu, doctors define the ideal patient profile because educated patients and patients who can ask questions reflects a more modern patient type (Ibid: 67). Doctors see patients as a product of society with their families rather than simply seeing them as ill people to be treated. They state that patients do not reflect their income source and they only require treatment. According to Cirhinlioğlu, these expressions by doctors do not reflect the reality in hospitals because they contradict patients' utterances.

In addition, doctors do not want an authoritative, oppressive and dominating doctor-patient relationship during the treatment process. Especially doctors working in the SSI Hospital state that the time allotted to the each patient is very limited and they do not communicate with the patient; instead they try to finish the session for each patient quickly. Therefore, doctors transform into experts who diagnose and

quickly prescribe medicine instead of constituting the ideal relationship with patient. The relationship is closely associated with the number of patients in the unit of hospitals which the doctors are required to examine. Doctors in the two hospital expressed that problems relating to the patients experienced by doctors arise from the number of patients, patients' low educational and socio-economic level, inadequate auxiliary staff, and inadequate conditions of hospital.

In addition to the perception of doctors regarding patients, patients' view of doctors, the health system, and their problems in hospital settings have been investigated by Cirhinlioğlu. According to the results, patients do not always go to the hospital or to any health care unit when they are ill. About half of the patients do not use modern medicine to get better. I prefer to use the concept of health seeking strategies in the thesis. In terms of health seeking strategies, patients tend to not go to the hospital for simple diseases; they wait to get better. Half of the patients who do not prefer to go to hospital express that hospital bureaucracy is tiring; and therefore, they avoid going to them to receive health services. Besides, 36 percent of all respondents emphasize lack of money for not going to a hospital.

In terms of the doctor patient interaction and view on doctors, the majority of patients state that they do not have the right to select doctors. According to Cirhinlioğlu, in spite of the fact that patients' views about doctors are mostly positive, it is striking that patients' views about doctors reflect slight distrust (Ibid: 74). 60 % of respondents state that their dialogue with doctors is not good; one third of respondents express that doctors ignore the patients; more than half of the patients state that doctors are not sure about their diagnosis in the hospital where the patients are examined; majority of them express the wish that they hope no one ever needs to go to "those places" and nor should they be left without one. These findings indicate that patients are not very satisfied with doctors and hospitals. The other finding is related to the patients' definition of the ideal or desired doctor. The first three characteristics are attentive and congenial, being knowledgeable and self-confident and being informative. Cirhinlioğlu concludes by stating that there is an inconsistency between the doctors' view of the desired patient profile and patients' expectations of doctors (Ibid: 77). While doctors hope for educated patients, the patients expect attentiveness and congeniality. He states that doctors do not know or consider patents' expectations. According to Cirhinlioğlu, patients' demands and expectations

reflect the existing paternalistic relationship between the doctor and the patient and he states that patients develop resistance to the paternal relationship.

In terms of the relationship between working conditions and diseases tied to the job performed, there is a research by Ilhan et al. (2006), which aims to determine the frequency of job accidents and occupational diseases according to working conditions and socio-demographic characteristics of cleaning workers in three central districts of Ankara. According to the findings, cleaning workers (no: 162) do not benefit from occupational health services adequately. Also it is found that occupational diseases and exposure to occupational hazards (26 %) occur among one third of the workers. There is also an awareness of the risks of the job by workers. According to the study, 87,7 % of workers are aware of the health risks of their job.

In the Turkish case, the relationship between new poverty and health experiences has not been adequately examined, especially in the area of social science from a sociological standpoint. Although there has been an increase in the number of studies done on poverty; these do not deal with this relationship directly; instead they much deal with the role of the solidarity networks based on kinship and geographic origin in coping with poverty. In these studies, health is accounted as one of the basic services to which people should have access. Although, Ayata and Ayata on poverty and Özar and Lordoğlu on informal sector do not directly focus on health issues, their studies have crucial findings which would be touched upon. Especially, Ayata and Ayata study is important in terms of health evaluated as important face of poverty with sociological viewpoint. In addition to poverty studies, there are studies on health inequalities conducted from an epidemiological perspective, such a those done by Belek, and Dedeoğlu and Erengin. However, these studies are insufficient in constructing a relationship between poverty and health. Some social scientists such as Türkdoğan, Boratav, Adak, and Cirhinlioğlu have dealt with this subject from a sociological viewpoint. Adak's research is much more relevant to this thesis, but it is not directly related with poverty. Moreover, her research is limited to women. Although Türkdoğan's study is directly related with health and the cultural system, Boratav includes health as a welfare indicator in his study on social classes. Therefore, there is no considerable number of sociological study covering both the poverty experienced in Turkey after the 1980s and health experiences together, or touching upon the mechanisms which sustain the interrelation between poverty and ill-health.

CHAPTER 4

METHODOLOGY

4.1. The Conceptual Framework of the Thesis

Most health studies either tend to make a structural analysis by focusing on socio-economic factors, or they are more individualistic, focusing on lifestyle and behavioral factors. Similar to Bourdieu's work, this study is an effort to transcend the dualities such as structure and agency in the case of health experiences. Health practice can not only be explained with material conditions not with the influence of cultural or behavioral factors; health is a multi-dimensional and multi-causal concept. On the one hand, structural factors objectified as *the forms of capital* in a specific *field* for a specific group (here, the migrant urban poor living in *gecekondu* areas) are influential; on the other hand, cultural factors internalized by individual agents, objectified in and reproduced by way of practice play an important role in health experiences. Therefore, Bourdieu's concepts can be utilized as conceptual tools for understanding health experiences of urban poor.

This thesis is based on Bourdieu's conceptualization of the *forms of capital*, *habitus* and the *field*. This application of Bourdieu concepts into the health is due to the fact that Bourdieu brings forth the solution of the prevailing structure-agency dualism via the concept of habitus. As asserted by health sociologists like Shim (2002), Williams (2003), and Popay et al. (1999), more theoretically satisfactory accounts of the inter-relationships of social structure, context and agency in their impact on health and well-being should be developed. His principal focus is the question of how routine practices of individuals are influenced by the external structure of their social world, and how these practices contribute to the maintenance of that structure

(Jenkins, 1992). In a discussion of the health experiences of individuals with their perception of health and illness, the external structure such as the welfare regime of the country in which they live, changing structure of work, increasing social inequality and poverty should not be disregarded. When we consider the *gecekondu*s as the disadvantaged pole in an urban field, it is not possible to say that *gecekondu* people's health experiences are independent from structural factors. According to Bourdieu, the recurrence of social practices over time is based on an individual's routine practices as influenced by the external structure of their social world and the contribution that these practices then make to the maintenance of the same structure (cited in Frohlich et al., 2001: 789). After the 1980s, as stated by studies about new poverty, Turkey witnessed increasing income inequality, increasing unemployment, reduction in numbers of formal employment opportunities, and decline of the traditional (informal) welfare regime based on family support as a result of the adoption of neoliberal policies (See Chapter Three for details). These changes prepared the ground for the new poverty experienced after the 1990s. It would not be possible to understand the health and illness experiences of people without considering macro-societal changes in Turkey. Poverty as a social context for *gecekondu* people has a crucial role in shaping health experiences. This thesis is based on the fact that a real understanding of health is possible with revealing experiences of the individuals in their social and cultural context with macro-structural domain.

Habitus

Focusing on only the lay perspective may cause an overestimation of subjectivity if it is examined without the consideration of social context or structure. Also, Bourdieu states that "each agent wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning… it is because subjects do not, strictly speaking, know what they are doing, that what they do has more meaning than they know" (1977: 79**).** Here, the concept of "habitus" as "durable dispositions" becomes important.

In this thesis, *habitus* as "systems of durable dispositions" is used to understand the health practices of urban poor. Our sample comprises people who have three characteristics: (1) they are urban poor; (2) they live in *gecekondu* areas; and (3) they are rural migrants with several generations. How their health practices have

changed (or not) after migration, should be called into question in accordance with continuity and discontinuity principles of *habitus*. The social, economic and cultural structure and relationships of the rural field are not the same as in urban field. For example, rural people work jobs based on unpaid family labor; their access to services is much more limited; traditional healing and beliefs about health and illness may differ. It is crucial for this thesis determine when they moved to the city and possible changes in their habitus. However, to assume their health *habitus* changed suddenly and they adapted to the city immediately would be a mistake.

Changes in experience after the 1980's in Turkey in relation to the implementation of neo-liberal policies are crucial for the *habitus* of these people. Poverty experienced by *gecekondu* dwellers is an important structural constraint which shapes their *habitus* in relation to coping with ill-health situations. Thus, *habitus* can not be understood without revealing external changes, constraints, beliefs, values, understanding or orientations toward health, illness and health care in order to obtain clues about patterns of health experiences. Therefore, by considering macro-structural changes, habitus should be understood with the notion of *capital*, or resources which agents possess in the field. I make use of the notion of *habitus* to clarify the health practices of the urban poor according to their differing levels of possession of resources. The capability to access resources is inevitably linked with such strategies to strive for health. Also, as a part of these "durable and transposable dispositions", the role of people's view on health and illness will be analyzed.

Field

As defined earlier, Bourdieu's statements (1977), "the field is a structured space of positions that imposes its specific determinations upon all those who enter it and is an arena of struggle through which agents and institutions seek to preserve or overturn the existing distribution of capital" (Bourdieu & Wacquant, 2003: 85; Wacquant, 1998b: 221-222). In addition, according to Bourdieu, the field can be considered as a space (Bourdieu & Wacquant, 2003: 85). In the thesis, urban and rural area is assumed different fields in interrelationship with each other.

Forms of Capital

Within the Bourdieuan framework, if people's experiences and perceptions are assumed to change systematically according to their positions occupied in the field, it may be possible to say that, for the purposes of this study, urban poor living in *gecekondu*s may have different health experiences than other people in urban field. However, in addition to the *volume* of the *forms of capital*, the *composition* and *trajectory* of the capital are also crucial for a visualization of the similarities and also differences in the health experiences of urban the poor living in gecekondu areas. Bourdieu (1984) asserts that people in similar positions in the field have similar lifestyles and habitus; however, in the thesis, I try to explore the differences in health and illness experiences for urban poor occupying the same status in the field. It should be examined the differences in possession of the *forms of capital* in order to understand inner differences. As Meinert states (2004), states that "the game of health" is socially stratified depending on individuals' and families' relative access to and embodiment of various *forms of capital* (p: 12). Bourdieu's conceptualization of the *forms of capital* enables us to understand the influence of different types of resources on health experiences in that it helps unfold lay people's everyday practices in relation to health. In this regard, the thesis explores similarities and differences in the ways health is described, experienced, and striven for among the urban poor.

1. Economic capital

In this thesis, *economic capital* is crucial because income either comes in exchange for labor, or it comes from other sources and is closely linked with people's experiences with health. Employment status, relationship with the labor market, characteristics of the job possessed, working conditions and lack of *economic capital* are expected to play a major role in *gecekondu* dwellers' psychological and physical health as well as their health experiences. Practices in relation to accumulating *economic capital* are all included. For example, migration as one topic explored in the thesis is regarded as one of the strategies employed to accumulate *economic capital* or to cope with poverty. The *forms of capital* should be taken into consideration in relation to one another and the convertibility of different types of capital into one another should not be ignored. These conversions, according to Bourdieu (1987), are not automatically realized, but require effort and time.

In this thesis, *economic capital* is operationalized as income derived from wage work, pension, and other resources, property ownership, employment status, relationship with the labor market, characteristics of the job held, and working conditions.

2. Social capital

The concept of *social capital* is increasingly mentioned in debates about health inequalities in the public health discourse. One important study was done by Wilkinson (1996) using a Neo-Durkheimian approach. According to him, the greater the social inequalities that exist, the more social relations will suffer. Inequalities tend to produce anger, frustration, fear, insecurity, and other negative emotions. Material inequalities will often go together with the fear of or the actual distressing experience of, failure to secure a socially acceptable material standard of living. Therefore, according to this approach, smaller social inequalities are associated with better social relations. Wilkinson (1996) states that the breakdown in social cohesion emerges because individuals perceive their relative position in the social distribution of income, which creates anxiety and other psychosocial injuries, which, in turn, affect health.

As stated by Muntaner et al. (2000), *social capital* presents itself as an alternative to materialist structural inequalities such as class, gender and race in health inequality studies. According to Muntaner et al., the use of *social capital* invokes a romanticized view of communities without social conflict, and favors an idealist psychology over a psychology connected to both material resources and social structure (Ibid: 107). According to the *social capital* perspective used in health inequality researches, involvement in community life (also civic participation) generates *social capital* that is conducive to good health.

Bourdieu does not have a theory consisting of merely *social capital*; instead, his theory is based on *forms of capital* as resources which individuals possess, *habitus*, and *field*. Simply picking up Bourdieu's notion of *social capital* and adapting it to research, health research in particular, can be misleading. Many social scientists, particularly neomarxists, criticize the use of this concept. According to Campbell (2001) the concept seems like a gift for the thinkers of the neoliberal free market who argued that grassroots voluntary organizations and neighborhood networks should take over many functions such as welfare (Ibid: 2). Muntaner et al. (2000) also criticize the use

of the term in the public health discipline. There is the paradigm of "blaming the victim", which sustains the individualization of health by focusing only on the health behaviors of the individual without consideration of material conditions. After the popularization of *social capital* in public health and international organizations, Muntaner et al. have labeled a new set of public health implications associated with the idea of the loss of *social capital*: "blaming the community" (Ibid: 116).

However this thesis does not concentrate merely on *social capital* as a resource which determines health practice; it focuses on other resources, as well, which are expected to play a role in health experiences. As indicated above by Wacquant (1989), the *social capital* of poor people living in disadvantaged areas is low. Here, a close link between *social capital* and *economic capital* is apparent. Greater *economic capital* may result in greater *social capital* in some circumstances.

As indicated by Buğra (2001), a decline emerged in the traditional welfare regime based on family or kinship ties after the economic crisis in Turkey. She employs the concept of *social capital* as used by Putnam (2000). In Turkey, a Western type of subject-state relationship has not developed (Kalaycıoğlu & Rittersberger-Tılıç, 1998: 69), so the traditional welfare regime based on strong family and kin networks has become important for Turkey as a substitute for the state-based welfare regime. Kalaycıoğlu and Rittersgerber-Tılıç (2003) have proposed a model which draws attention to social solidarity networks in poor households as a coping and survival strategy for poverty in Turkey. According to them, the "family pool" is a system based on inter-generational transfers and reciprocity in kinship networks. In addition to *economic capital*, *social* and *cultural capital* is also transferred between generations and between relatives. They state that the system is a primary and imperative solidarity system for people to survive. The principle of reciprocity plays important role. In Turkey, strong family and kinship networks play an important role as an alternative model of social control and organization (Kalaycıoğlu & Rittersberger-Tılıç, 1998: 78). Therefore, *social capital* as a concept does not only mean access to resources, but also interpersonal relationships. However, this traditional welfare regime lost its power after the 1980s due to the consequences of the structural adjustment policies such as the decreasing formal employment opportunities, enlarging informal sector, decreasing state expenditure on services, increasing unemployment in urban areas, drastically increasing youth unemployment, inadequate coverage by the social security

system, and lastly inaccess to health care (See Chapter Three for details). However, as Pınarcıoğlu and Işık express (2003), the dynamism of the informal mechanism both in the informal sector in the labor market and the informal relations based on kinship and common origin are crucial both for coping with poverty and the maintenance of their poor position in society as it will be discussed earlier. Similarly with Buğra and Keyder (2006), they suppose that informal networking has lost its role after 2001 crisis. It can be said that there exists a close relationship such as the structural changes experienced after the 1980s and the *habitus* of the tendency to use informal mechanisms to survive.

Following from Bourdieu's concept of *social capital* and Wacquant, this thesis focuses on the influences of people's *social capital* on their experiences with health. In accordance with Bourdieu and Wacquant, *social capital* is operationalized as any network of relationship based on interpersonal relationship and support such as family, kinship ties, neighborhood, common geographic origin, and friendship. This refers to *informal social capital* as defined by Wacquant (1998). *Formal social capital* is operationalized as any network of relationship based on an institutional relationship derived from the state-individual relationship such as social security including health care access, social assistance and aids. *Informal* or *formal social capital* is examined here in relation to other *forms of capital* and health experiences. In particular, the social security status, closely connected with the relationship to the formal labor market, is crucial for health seeking strategies. In terms of health experiences, the social security status of individuals is tied to their formal labor market attachments or lack thereof. Many working age people who are employed informally, as well as the unemployed do not belong to any social security institution. This kind of isolation can be conceptualized as *negative social capital* as done Wacquant (1998). As seen in the Turkish case, there exist close relations between *economic capital* (job, unemployment status) and formal capital (social security status and social assistances). He exemplifies this with ghetto residents who do not have access to basic services and for him, public institutions operate as *negative social capital* that maintain the marginal and dependent position of ghetto residents (Ibid: 29). It is possible to say that people living in *gecekondu* areas in Turkey as disadvantaged places suffer from inaccess to basic resources including health care. This raises the following question. How do people cope when they are ill?

This question is addressed here in terms of *social capital*. The thesis also examines the role of informal *social capital* as a substitute for formal *social capital* as a coping strategy.

3. Cultural capital

In this thesis, I do not choose to classify *cultural capital* into three types as Bourdieu has done; instead, I use the concept as a whole. Here, the concept is used to understand differences in health experiences among the poor and I try to identify: (1) How the urban poor see themselves, such as being poor, being villagers or urbanites, being literate or not, and being sick or not; (2) what they practice in accordance with the identity they have taken over and internalized; and (3) how these identities are institutionally recognized in society, in the labor market, and, in particular, in health care settings.

Such identities and their representations in individual agents can be important when people go to the hospital or to any healthcare facility. This type of *cultural capital* is much more closely related with *habitus* and represents the normative behaviors within the culture to which one belongs. There is a direct link between *cultural capital* and the cultural aspects of health such as traditional healing methods inherited. How people's beliefs shape their health seeking ways such as orientation toward traditional or scientific treatments are addressed in this thesis. *Cultural capital* is assumed to play a part in their health seeking strategies, strategies of coping with illness, institutional experiences, and their health perceptions.

4. Health Capital

Before explaining how I use the term, I will explore it as it is in Bourdieu's theory and its different usages in other studies. According to Williams (1995), the body in Bourdieu's works is also a form of capital which is sometimes specifically referred to as "physical capital", and at other times subsumed under the more general rubric of *cultural capital* (Bourdieu, 1978: 832). According to Nettleton (1995), the dimensions of the body, therefore, can actually contribute towards the reproduction of social inequalities. In this respect bodies may differ in terms of what Bourdieu calls physical capital (p: 120-121). Nettleton states that one's position in the social structure impacts upon one's body in terms of health status such as morbidity and mortality rates which vary according to class, race, gender and so on (Ibid). According to

Bourdieu (1984), the body is the most indisputable materialization of class taste. He expresses that:

> The body is the most indisputable materialization of class taste, which it manifests in several ways. It does this first in the seemingly most natural features of the body, the different dimensions (volume, height, weight) and shapes (round or square, stiff or supple, straight or curved) of its visible forms, which express in countless ways a whole relation to the body, i.e., a way of treating it, caring for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus. It is in fact through preferences with regard to food which may be perpetuated beyond their social conditions of production (as, in other areas, an accent, a walk, etc.) and also, of course, through the uses of the body in work and leisure which are bound up with them, that the class distribution of bodily properties is determined (Bourdieu: 1984: 190).

He examines tastes in food, which is closely associated with the idea of the body for different classes. He states that whereas the working classes are more attentive to the strength of the (male) body than its shape, and tend to go for products that are both cheap and nutritious, professionals prefer products that are tasty, healthy, light and non-fattening (Ibid.). When examining Bourdieu's works, it can be said that there is no direct definition of *health capital*, or bodily capital; instead Bourdieu focuses on the use of the body in relation to sport and taste in food.

Several scholars such as Shilling (1993), Wacquant (1996), and Meinert (2004) have shown that the body itself as a capital can usually be added to Bourdieu's theory of capital. Wacquant works on bodily capital, concentrating on sport, boxing and racing, in particular. He sees the bodily capital of boxers which is relatively independent from other *forms of capital* or power that circulate in society (Wacquant, 1996: 27). According to him, what are common for people who use their body such as comedians, disk jockeys, dancers, preachers and athletes are bodily crafts based on kinetic knowledge, skills, and powers. He continues that:

> It's independent from cultural capital: you don't need to succeed in school in order to succeed on the basketball court; you might even be able to go to school if you have enough bodily capital of a kind valued by a college. It's independent from economic capital: you don't have to be rich in order to step onto the gridiron; you might even get a fellowship or money from "boosters" to do so (in the case of the happy few who reached the promised the land of professional stardom, your body can earn you millions of dollars). Lastly, bodily capital is relatively independent from social capital: it's not who you know, it's what you do on the field that determines your fate; in fact you will accumulate a great deal of social capital if you accomplish great deeds on the field. (Ibid: 27-28).

Although the focus here is not directly on bodily capital in relation to sport, Wacquant's study lends insight to the concept of bodily capital, in particular African-

Americans. It is clear that bodily capital may be independent from other *forms of capital* in different contexts like sport. However, the focus here is on health experiences and it is assumed that the human body (such as its strengths or having disease or illness) is important in relation to other *forms of capital* and health experiences. The significance assigned to bodily capital and the use of the body can vary according to people in different class. The use of the body in work and leisure may be closely linked with people's experiences in relation to health.

As stated earlier, Shilling (1993) use the concept of body as an unfinished biological and social phenomena, which is transformed, within changing limits, as a result of its participation in society (cited in Nettleton, 1995: 109). Also, Meinert (2004) conceptualizes body as a capital (See Chapter Two for details). Like Wacquant, Shilling focuses on bodily capital in relation to sport while Meinert's study concentrates on the body as a separate form of capital in relation to health.

It can be said that like other *forms of capital* the body is a capital if the definition of "capital" (accumulated labor) by Bourdieu (1986) is taken into consideration. The thesis does not directly focus on the body; instead the body is examined in relation to health. In this thesis, bodily representations are examined in terms of *cultural capital*. Also, how people view their body and health is analyzed within the context of health experiences.

When we examine the term in poverty studies, *health capital* as one dimension is also used in poverty and exclusion studies. Social exclusion is not directly addressed in this thesis, but these studies can be reviewed in terms of the usage of the term. De Haan (1998) conceptualizes health as human capital in order to display the multi-dimensionality of social exclusion. According to him, there are five dimensions of social exclusion: physical, economic, human capital including health and education, *social capital* and political (Ibid: 15). Health as one of the forms of human capital is operationalized as health and nutrition indicators.

When we look at the lay perception of health, we see that one important perception is seeing health as a type of capital. Grossman's use of "health capital", Herzlich's concept of "health as reserve", Blaxter's concept of "reserve stock", and Pierret's concept of "health as tool" can be interpreted to mean that health can be assumed as capital (Grossman, 1972; Herzlich, 1973; Blaxter, 1990; Pierret, 1995). In addition, Pierret (1995) points out that the perception of health as a tool seems to be

one way to conceptualize health as a capital. (See Chapter Two for details on the definition of health). According to Bourdieu, in addition to the fundamental *forms of capital*, there can be other *forms of capital* which are specific to the field such as academic capital, scientific capital, law capital, etc. (Bourdieu & Wacquant, 2003). In light of this additional information about the capital, and the definition of a capital, *health capital* should be added. If capital is taken to mean accumulated labor, and it requires time and energy for its acquisition (Bourdieu, 1986), we can add *health capital* to Bourdieu's *forms of capital*. Keeping in my mind the concept of capital derived from Bourdieu's theory and different definitions of health, I can give a tentative definition of "what is health" as follows:

Health relates to the state of psychological and physical well-being and satisfaction. This again is based on meeting basic needs and the endeavor for health which is constructed in a specific field. The health of an individual agent in the field, is based on his/her capability of control. Thus, the value, perception and practice of health changes according to the field, such as scientific field, rural field and urban field, and according to the groups such as social class, gender, ethnicity, age etc.

Health capital is operationalized as self-perceived health and well-being, self-perceived illnesses, and medically defined diseases. *Health capital* is not understood as "the goods" like Grossman conceptualizes, but it varies according to differences in the position or the state of possession of the *forms of capital* in society. With the concept of *health capital*, the relationship with health experiences including the perception, health seeking strategies, and institutional experiences are examined. In this thesis, health as capital is mentioned as one of the crucial factors which play a role in shaping people's health experiences. The social, cultural and economic context wherein people live is crucial in health/illness experiences.

The main purpose of this thesis is to examine the similarities and differences in the health and illness experiences of the (migrant) urban poor living in *gecekondu* areas in relation to the different aspects of their living experiences, conceptualized as the *forms of capital*.

Within this framework, this thesis analyzes health and illness experiences or practices in relation to the notion of the *forms of capital*. The definitions of the *forms of capital* and their operationalization for the study are displayed in the following table:

Table 3: The definitions of the *forms of capital* and their operationalization for the study

Forms of capital	Definition	Operationalization
Economic	that which can be "directly convertible into money"	Any economic activity which provides income
Social	The aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition or in other words to membership of a group (Bourdieu, 1986, 248). *Social capital* is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition (Bourdieu & Wacquant, 1992: 119)	• Informal social capital: social solidarity networks • Formal social capital: social security status, health care access, institutional social assistances
Cultural	Forms of knowledge; skill; education; any advantages a person has which give them a higher status in society	Representations of self and internalized identity such as being poor, being literate, being villager, being sick.
Health	*Health relates to the state of psychological and physical well-being and satisfaction. This again is based on meeting basic needs and the endeavor for health which is constructed in a specific field. The health of an individual agent in the field, is based on his/her capability of control. Thus, the value, perception and practice of health changes according to the field, such as scientific field, rural field and urban field, and according to the groups such as social class, gender, ethnicity, age etc.*	Self-perceived illnesses, medically diagnosed diseases, self-perceived health and wellbeing (physical and psychological)

4.2. Qualitative Methodology

This study strives to find an explanation for how and why the *forms of capital* which determine people's position in the field, shape *gecekondu* people's health experiences and the mechanisms and processes leading to the close interaction of poverty and health experiences. In accordance with the study's objectives, a qualitative research method was used on the basis of primary and qualitative data. The qualitative research method was preferred because qualitative method places an individual in different contexts of social structure and has the potential to illuminate people's personal experiences.

The logic underlying qualitative methodology is that it will help reveal the understanding processes, meanings and experiences in everyday life within different social contexts. In concordance with the conceptual and theroetical framework of the

study, ethnography is the best fit in terms of investigating the questions, why and how. It helps to describe the research focusing on how individuals and groups view and understand the world and construct meanings. Ethnography means simply "writing about way of life" (McNeill, 1990: 64). Ethnographic researchers constantly search for meaning in the behaviors, artifacts, events, and people's interpretations of the world to make the relationships between part and whole, and they make cultural inferences based on what people say, and the way people act (Spradley, 1979). In this context, this thesis focuses on the health experiences of gecekondu people, including ways of defining health from an insider's point of view, health seeking experiences with coping strategies, and institutional experiences varying from bureaucratic problems in health care unit to doctor-patient interaction. This study aims to shed light on health experiences by encompassing both the individual perspective and macro-structural influences with depending on Bourdieu's conceptual framework. Here, the need to to understand health and illness in terms of people's own interpretation by considering structural changes arises. Especially ethnographic research undertaken by sociologists and anthropologists investigates lay knowledge of health and illness, which have resulted in a rich body of interpretative research (Lupton, 1994: 104).

The positivist approach in the sociology of health and illness is not adequate in explaining health and illness experiences. It fails to reveal the knowledge of those outside the margins. Quantitative methods employed with a positivist approach do not provide an adequate explanation for unexplained variances in individual and personal actions outside the ordinary (Young, 2004: 22). It appears that reality is not to be objectively defined; rather it is shaped within the everyday life and experiences of people. Social life permanently changes under the influence of dynamic processes. To obtain clues about social life, processes and changes should be embraced. These clues can only be uncovered by observing people in their everyday life and examining their perspectives and meanings. Aquiring an understanding of the structural influences on health, such as the changing structure of work, is only possible by examining experiences, processes, meanings and discourses. However, to accept completely that all structural changes, power relations, dominant discourses and ideologies determines everyday life and health and illness experiences might lead one to see the actor as someone simply absorbing the ideologies of dominant discourses

passively, without any role. A completely deterministic approach, based on the claim that structure entirely determines the actor, is not acceptable for the purposes of this thesis. The impacts of structure or social context may be examined by comprehending life experiences. This is valid for both concepts of poverty and health. As poverty can not be comprehended only with certain indicators based on the expert view, even though they are certainly important, the concept of health can not be understood sociologically by merely examining health indicators such as morbidity, mortality, and life expectancy without considering health and illness accounts of people. It follows from this that it should be accepted that "the real is relational" as Bourdieu and Wacquant (2003) assert.

Bourdieu criticizes the prevailing dualisms in social sciences seen in both theoretical and methodological approaches. He tries to transcend these dualisms by identifying the relationship between social structure and mental structure (Bourdieu & Wacquant, 2003: 22). As discussed earlier, Bourdieu aims to do this by focusing on the relationship between "habitus" and "the field" While summarizing Bourdieuan theoretical and methodological view, Wacquant states that:

> Bourdieu advocates the priority of reflexivity over all types of methodological monism which posit the ontological priority of structure or agency, system or actor, the collective or the individual. According to him, these kinds of dualistic alternatives reflect the perception of reality based on common sense and sociology should rid itself of this17. (Ibid: 24).

He criticizes the positivist approach as follows:

> A social science must accept that an agency's views and interpretations are an indispensable component of precise reality of the social world in order to avoid this reductionist trap. Of course, society has an objective structure, but it is also true that it is composed of "design and willpower", as Schopenhauer's puts it. Individuals have practical world knowledge and they use this knowledge in ordinary activities18 (Ibid: 18-19).

By following the Bourdiean theoretical and methodological approach, it can be said that actors are neither rational in practice, nor are they passive bodies in society. The thesis focuses, on the one hand, on actor experiences, on the other, the structure of the society. The aim here is to understand, in general, the reproduction of society in terms of health.

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[17] Translated from Turkish to English by author.

[18] Translated from Turkish to English by author.

Unlike those conducted with a positivist approach, it is my belief that health researches carried out utilizing the qualitative methodological tradition could set the micro picture within a macro social context. In this thesis the aim is to draw a micro picture, that is, health experiences, within the macro, meaning the social context such as structure of work, welfare regime, migration, health policy and the related dynamics of change.

4.3. The Selection of the Neighborhoods and Participants

4.3.1. The Selection of the District

In order to answer the determined questions, it was planned that the research would be carried out within some neighborhoods in Ankara. For the selection of the district to be used, in addition to the statistics and expert views, certain studies revealing information on a socio-economic map and providing income levels by districts were used. Güvenç (1998) demonstrates the spatial distribution of status (determined according to typology of house ownership or tenure types). Levels of income in Ankara indicate that the İstanbul-Samsun highway is a sort of border separating two different urban areas in terms of status-income profiles. According to him, the poorest and the wealthiest people reside south of the highway, while people with low income and wage earners stay north of the highway. In southern Ankara, the poorest and the wealthiest are separated by the railway (Ibid: 5). There are striking contrasts between the south and the north in terms of status, background, income, participation in the labor market. The poorest people inhabit the area around the Ankara Castle and the zone between the railway and the highway (Ibid: 12). Although this was an important clue for the selection of districts, the main aim was not to analyze the poorest for the thesis; but rather to focus on the differences and similarities among poor people's health experiences.

The central districts of Ankara were selected by using health indicators obtained from Health Directorate of the Province of Ankara and by using socioeconomic indicators obtained from State Institute of Statistics and State Planning Organization. Central districts were selected because the study is related to the urban context. Other districts have a much more rural population. Districts with both low

health and demographic indicators and low socio-economic indicators were selected because this would lend itself to a visualization of the link between poverty and health.

The Selection of Socio-economic Indicators

Answering the question of who can be classified as "poor" is very difficult. Poverty is often measured by designating a poverty threshold via income categories. However, the determination of income is difficult and even if it is done, income alone does not explain poverty because of its multidimensional character. Also, there is no reliable study in Turkey which provides a record of people with their income. There are some measurements of poverty, done by the State Institute of Statistics but it is not district based. Also there is the study carried out by the State Planning Organization which ranks the counties of Ankara according to socio-economic development (Dinçer, et al., 2004). With a principal component analysis, counties are divided into 5 categories based on demographic indicators, employment indicators, education indicators, health indicators, industrial indicators, agriculture indicators, financial indicators and other welfare indicators. However, this study does not take into consideration central counties. Thus, these studies are not conducive to the identification of a study group for a research such as this on urban poverty.

Indicators were determined through a review of the Human Development Index, National Demographic and Health Survey and the report of the HNP Poverty Thematic Group of The World Bank (WB, 2000).

To select the district, certain indicators were selected such as the green card rate, unemployment rate, and illiteracy rate. While the unemployment rate and illiteracy rate are common in all international development indicators, the green card rate as a type of social assistance is related with the Turkish welfare regime. A green card is given to people who have no capacity to pay for health services and do not belong to a social security system. The document indicating "poverty status", which can be obtained from the neighborhood headman provides people with free doctor visits and treatment including access to medicine, medical examinations, and tests.

These indicators were used for the selection of districts but not for the selection of the participants. After the selection of neighborhoods, the field study was done with one member from each household selected via snow-ball sampling. The

district selection was made so that relatively poor neighborhoods could be accessed. Numbers related with these indicators are shown below:

Table 4: Green Card Rate by Central Districts of Ankara*

Central Districts	Mid-Year Population (2003)	The Number of People Who Have Green Card	The Rate of People Who Have Green Card (%)	Ranking
Altındağ	257301	59713	23,21	1
Çankaya	624722	33916	5,43	7
Etimesgut	147724	7312	4,95	8
Gölbaşı	58127	6540	11,25	2
Keçiören	693283	49564	7,15	5
Mamak	414339	43959	10,61	3
Sincan	347817	25597	7,36	4
Y. Mahalle	574998	36455	6,34	6

*Numbers of people who have Green Card and Mid-year Population was received from the Health Directorate of Province of Ankara.

As can be seen, Altındağ has the highest percentage of people with a green card in 2003. Altındağ, as the oldest *gecekondu* settlement, still has the majority of the *gecekondu* population. When we assume that people living in a *gecekondu* have low socio-economic status, this result is not surprising. Having a green card means not belonging to a social security institution. It should be recalled that being insured is closely linked with having a position in the labor market in Turkey; therefore, we can infer that people who have a Green Card either are unemployed or work in the informal sector.

Table 5: Illiteracy Rate by Central Districts of Ankara*

Central Districts	Population (2000) (15+)	The Number of Illiterate People	The Rate of Illiterate People (%)	Ranking
Altındağ	288698	27399	9,49	1
Çankaya	618587	23598	3,81	8
Etimesgut	129223	5516	4,27	7
Gölbaşı	25676	1464	5,70	4
Keçiören	459768	29831	6,49	3
Mamak	300436	26113	8,69	2
Sincan	186212	10537	5,66	5
Y. Mahalle	411369	19491	4,74	6

*This calculation was made with the use of the population census in the year 2000 for Ankara received from the Turkish Statistical Institution.

The second socio-economic indicator, the illiteracy rate, is also the highest in Altındağ.

Table 6: Unemployment Rate by Central District of Ankara and Age Groups*

Central Districts	Pop. (15+) %	Unemp number (15+)	Unemp rate (15+)	Ranking (15+)	Pop. (15-24)	Unemp number (15-24)	Unemp rate (15-24)	Ranking (15-24)
Altındağ	288698	20708	7,17	2	83352	8601	10,32	3
Çankaya	618587	31241	5,05		178862	12835	7,18	8
Etimesgu	129223	7588	5,87	5	45037	3343	7,42	7
Gölbaşı	25686	1445	5,63	7	8515	663	7,79	6
Keçiören	459768	26843	5,84	6	124797	12288	9,85	5
Mamak	300436	21342	7,20	1	89241	9456	10,60	2
Sincan	186212	12379	6,65	3	53695	5936	11,05	1
Y. Mahalle	411369	25266	6,14	4	110915	11059	9,97	4

*This calculation was made with the use of the population census for Ankara received from the Turkish Statistical Institution. The unemployment rate was calculated according to the unemployment for the last week of the census. Unknown age groups were not included this calculation. Also unemployment rate was calculated except for the economically inactive population such as housewives, students, the retired, etc.

The unemployment rate for those 15 and over is the highest in Mamak, while Altındağ takes second place in terms of the unemployment rate for those 15 and over; in terms of young unemployment, the district ranks third. Sincan ranks second in terms of youth unemployment.

Table 7: Unemployment Rates by Age Groups for Each Central District of Ankara*

Age Groups	Altındağ	Çankaya	Etimesgut	Gölbaşı	K.Ören	Mamak	Sincan	Y. Mahalle
15-19	42417*	77112	14673	4347	63599	42177	27628	54605
	3950 *	3366	1180	308	4916	4048	2613	3725
	9,31% *	4,36%	8,04%	7,09%	7,73%	9,60%	9,46%	6,82%
20-24	40935	101750	30364	4168	61198	47064	26067	56310
	4651	9475	2163	355	7372	5408	3323	7334
	11,36%	9,31%	7,12%	8,52%	12,05%	11,49%	12,75%	13,02%
25-29	40155	67865	17547	3370	59923	41321	27873	50439
	3277	6166	1391	236	4609	3636	1978	4505
	8,16%	9,09%	7,93%	7%	7,69%	8,80%	7,10%	8,93%
30-34	33653	60045	15244	3021	54208	35811	23926	44591
	2310	3208	834	179	2904	2490	1281	2492
	6,86%	5,34%	5,47%	5,92%	5,36%	6,95%	5,35%	5,59%
35-39	32635	61670	14977	2991	53953	33750	23387	45152
	2249	2591	720	142	2342	2043	1117	2037
	6,89%	4,20%	4,81%	4,75%	4,34%	6,05%	4,78%	4,51%
40-44	25368	55998	11145	2478	43800	25970	18210	42265
	1540	2062	432	72	1655	1352	781	1613
	6,07%	3,68%	3,88%	2,91%	3,78%	5,21%	4,29%	3,82%
45-49	19721	48084	8297	1803	34791	20140	13382	35391
	1125	1763	382	68	1305	1032	589	1508
	5,70%	3,67%	4,60%	3,77%	3,75%	5,12%	4,40%	4,26%
50-54	14552	40123	5775	1181	26326	15507	9236	27203
	685	1337	245	46	895	646	378	1053
	4,71%	3,33%	4,24%	3,89%	3,40%	4,17%	4,09%	3,87%
55-59	10755	29315	3648	721	18739	11127	5525	17777
	440	713	125	16	461	346	171	555
	4,09%	2,43%	3,43%	2,22%	2,46%	3,11%	3,10%	3,12%
60-64	9422	23356	2672	520	15279	9090	3929	13131
	224	332	62	9	221	176	93	238
	2,38%	1,42%	2,32%	1,73%	1,45%	1,94%	2,37%	1,81%
65+	19085	53269	4881	1076	27952	18479	7049	24505
	257	234	44	14	163	185	55	206
	1,35%	0,44%	0,90%	1,30%	0,58%	1%	0,79%	0,84%

*In the first line, the population of the district is given by age group, the second line illustrated the unemployed, and at the third line indicates the unemployment rate.

When examining unemployment rate by age groups, it can be said that unemployment rates according to age groups indicate a more balanced distribution in Altındağ and Mamak districts in comparison to other districts. Among all age groups, those in the 20-24 age group have the highest rate. This rate reflects the reality of youth unemployment faced these days in Turkey. Unemployment rates are concentrated in the 20-24 age group; in other age groups this rate is lower. Unemployment rates in the 35-44 age group in Mamak and Altındağ are nearly twice the rate in other districts.

Selection of Health Indicators

There are lots of indicators to measure the health status of those living in any region. For health statistics, the only source is ETF records (House Assessment Document). Collected ETFs, which include socio-demographic information of people who belong to specific health center regions, are transferred to Province Health Directorates and then sent to the Ministry of Health after the required analysis is done. Each stage -collecting, examining, analyzing- has many problems[19] but there is no source except for the statistical data based on ETF.

In addition, during the selection of indicators, I was inspired by the WHO's definition of the "diseases of poverty", Human Development Index, National Demographic and Health Survey, the report of HNP Poverty Thematic Group of The World Bank (Socio-economic Differences in Health, Nutrition and Population in Turkey, 2003) and the Health Statistics of the Ministry of Health. While approaching these institutions for statistics, it was seen that receiving all the statistics was not possible due to afore mentioned problems. In the end, it was understood that among the long list of indicators, certain indicators based on district were available. These indicators are included infant mortality rate, child mortality rate, crude death rate, crude birth rate, total fertility rate, mother death rate, birth rate without aid of health personnel, average number of antenatal care visits, premature birth rate, underweight birth rate, dead birth rate, average number of infant follow-ups, average number of children (aged 1-4) follow-ups, population per health personnel, incidence of diseases of poverty (measles, pneumonia, diarrhea), and other diseases such as mange, amoebic dysentery, streptococci, scarlet fever and Hepatitis A (collected regularly in Turkey).

Recently, some causes of death have begun to be defined as "diseases of poverty" by the WHO because they primarily affect the poor, and they worsen poverty's toll. There are six diseases of poverty: tuberculosis, malaria, HIV/AIDS, measles, pneumonia and diarrhea (www.who.int/tdr). According to WHO, all six diseases can be prevented or treated for a small amount of money. The incidence of

[19] For detailed information see http://www.izleme.saglik.gov.tr/docs/Leyla_Bayazit.ppt, accessed 10 October 2006.

HIV/AIDS, malaria and tuberculosis were excluded after statistics were obtained because incidence of HIV/AIDS is very rare in Turkey. According to the data, there was one incidence of malaria in Ankara in 2003. Also, tuberculosis statistics are not obtained on a district base but on dispensaries, each of which is responsible for a few districts. In addition, data on certain communicable diseases such as mange, amoebic dysentery, streptococci, scarlet fever and hepatitis was included this analysis.

Some important indicators were not accessed by district. Life expectancy, which is accepted as one of the main development indicators (UNDP, 2005), was not obtained because this indicator is not among those which were analyzed by district regularly. Vaccination rate is also an important variable to the determine health status of the region because vaccination is crucial for the reduction of infant and child deaths; however, also this data is not obtained by district. The percentage of children stunted and percent of children underweight are other important indicators which are seen as results of inadequate nourishment and poverty. In studies on socio-economic inequalities in child health (Wagstaff, 2001), these two indicators are used.

The 2003 health indicators were obtained from the Health Directorate of the Province of Ankara. The health indicators of the central districts of Ankara are shown below:

Table 8: Certain Health Indicators on District Base (1)

Central Districts	Infant Mortality Rate (‰)	Child Mortality Rate (‰)	Crude Death Rate (‰)	Dead Birth Rate(‰)	Mother Death Rate (per hundred thousand)
Altındağ	0,56	0,07	0,31	1,12	0,00
Çankaya	2,95	0,00	0,02	5,90	0,00
Etimesgut	6,19	0,21	1,04	5,31	0,00
Gölbaşı	7,36	0,23	1,63	7,36	122,70
Keçiören	2,77	0,05	0,24	1,38	0,00
Mamak	9,62	0,23	1,44	4,25	28,30
Sincan	8,86	0,48	1,59	7,04	22,72
Y. Mahalle	7,15	0,19	0,88	4,66	31,09

When examining this table, we can say that the districts of Mamak and Gölbaşı have the highest mortality rates.

Table 9: Certain Health Indicators on District Base (2)

Central Districts	Total Fertility Rate (‰)	Crude Birth Rate (‰)	Premature Birth Rate (‰)	Underweight birth rate
Altındağ	1,66	0,47	3,93	7,85
Çankaya	0,55	0,16	2,21	4,43
Etimesgut	2,13	0,66	5,31	13,27
Gölbaşı	3,64	1,03	1,23	8,59
Keçiören	1,24	0,37	1,38	10,79
Mamak	2,49	0,74	8,49	11,60
Sincan	3,17	0,97	2,27	8,63
Y. Mahalle	1,19	0,37	10,26	9,33

While the total fertility rate and crude birth rate is high in Gölbaşı, the premature birth rate is the highest in Yenimahalle and the underweight birth rate is the highest in Etimesgut.

Table 10: Certain Health Indicators on District Base (3)

Central Districts	Birth rate without aid of health personnel (%)	Average Number of antenatal care visits	Average Number of Infant Follow-up	Average Number of Child (1-4) Follow-up
Altındağ	0,56	3,16	3,12	0,60
Çankaya	0,07	3,25	5,07	1,14
Etimesgut	0,62	2,23	3,98	0,68
Gölbaşı	1,85	3,86	6,40	1,07
Keçiören	0,06	3,20	3,69	0,93
Mamak	0,26	3,75	5,06	1,46
Sincan	0,57	4,21	7,79	1,94
Y. Mahalle	0,56	3,33	5,68	0,60

In this table, it is seen that the birth rate without the aid of health personnel is high in Gölbaşı. Its cause may be due to the predominance of the rural population and inadequate access to health care. In terms of follow-ups, Altındağ has the lowest level.

Table 11: Certain Health Indicators on District Base (4)

Central Districts	Strepto-cocci Angini (%)	Scarlet fever (%)	Hepatitis A (%)	Pneumonia rate (%)	Diarrhea rate (%)	Measles rate (%)	Amoebic dysentery Rate (%)	Mange Rate (%)
Altındağ	0,01	0,04	0,08	0,42	1,11	0,02	0,1	0,06
Çankaya	0,16	0,01	0	0,03	0,42	0,01	0,08	0,02
Etimesgut	0,15	0,02	0,01	0,02	0,43	0,02	0,03	0,01
Gölbaşı	0	0,01	0	0,36	2,51	0,01	0	0,12
Keçiören	0,07	0,02	0	0,02	0,73	0,02	0	0,06
Mamak	0,19	0,02	0	0,05	0,86	0,02	0	0,04
Sincan	0	0	0,01	0,03	0,68	0,00	0	0,03
Y. Mahalle	0,03	0,02	0	0,05	0,66	0,02	0	0,02

Certain diseases such as scarlet fever, hepatitis A, pneumonia, and amoebic dysentery are the most frequently seen in Altındağ.

According to these results, Altındağ, Mamak and Gölbaşı as central districts have a low socio-economic level and a low health status level based on the selected indicators. Based on this ranking, interviews were done with head of the Health Group Directorate of each of these districts. As a result of the interviews discussing choice of neighborhood(s), Gölbaşı was eliminated since those living in Gölbaşı who have a low socio-economic level are concentrated in the rural area instead of the urban area. This district does not meet with the thesis's objective because the emphasis is on urban poverty instead of rural poverty. Various neighborhoods in the Altındağ and Mamak districts were recommended for the study. The head of the Health Group Directorate was interviewed about the Mamak neighborhoods. In Altındağ, the Social Aid and Solidarity Foundation and the head of the Health Group Directorate were asked for their opinion about neighborhoods for information on which areas fit our criteria. Altındağ as a central district was selected because this district indicates lower status in both socioeconomic situation and certain health indicators. As a result of an professional guide, neighborhoods were observed for the study. The Baraj and Gültepe neighborhoods in Altındağ were selected. To the contrary to the opinions of the experts, Gültepe was selected. According to the experts, one of the safe *gecekondu* areas in Altındağ was Baraj, while one of the most dangerous neighborhoods was Gültepe and Hıdırlıktepe according to their suggestions. They stated that these neighborhoods were mostly associated with crime.

However, in terms of the different experiences of the *gecekondu* dwellers, I selected the two neighborhoods. There are many differences between the two neighborhoods, but the most striking one is their location in the city. While Baraj is not very close to the city center, Gültepe is vitually in it.

4.3.2. The Selection of the Participants

For the selection of the district where the interviews were to be conducted by using socio-economic and health indicators, taking into account the experts' suggestions, a non-probability purposive sampling was used. The selection of the interviewees via snow-ball sampling with several starting points was deemed more appropriate for the study. The interviews were applied on a household basis. In every household, one household member, 18 or older, was interviewed. There were two key informants each neighborhood. They were women and conversant with their neighborhoods, having lived there for a long time. Also, the neighborhood headmen of the two neighborhoods guided us for the selection of the interviewees. These people guided me to "the poor". I talked about briefly about my research and said that I wanted to interview the poor families in their neighborhoods. In fact, the criterion is their conception of "the poor". Afterwards, key informants directed me to the households with low-income, with members having casual jobs, unemployed, chronic patients, uninsured or those with the green card, receiving food and fuel aids from the municipality or the administrative district. While objective criteria were used for the selection, the neighborhood people's conception of "the poor" was taken into consideration for the selection of interviewees. With a few starting points, each participant directed and introduced me to another. The participants or/and leading person(s) did not merely identify and suggest for me, they also made introductions, generating trust and making my work easy. When I was referred from one participant to another, I was welcomed. In fact, from time to time they tried to summarize my study and state the aims of the study as far as they understood.

4.4. Data Collection

In this research, primary and qualitative data were used because this was the best fit to the research questions. In-depth interviews and observations were used to gather data. Literature reviews for both general and Turkish case and research questions of the thesis directed me in formulating the interview questions. At the stage of formulating interview questions, other researches and studies were very helpful in accordance.

The in-depth interview, as one of the qualitative data collection methods, was used in this research. Qualitative data was collected with face to face in depth interviews with the squatter house dwellers in two neighborhoods of Altındağ district: Baraj and Gültepe. Mainly open-ended questions were used to analyze the complex and multidimensional relationship between the *forms of capital* and health experiences. Instead of full dependency to interview questions in the same order, topics related with research questions were focused on.

A pilot study was conducted because field experience would help me see if my interview questions would be conducive to obtaining the desired information, enabling my evaluation of the method used, observing neighborhoods and people in understanding the appropriateness with the study objectives and, at the end, to reconstructing and reorganizing the topics and the interview questions. Five pilot interviews were done with a tape recorder in Baraj neighborhoods in December, 2004. After the evaluation of the pilot interviews, some questions were omitted, some added, and some topics were questioned differently. It was understood in the field that questions should be easier to be understandable. Also, when we first arrived in Baraj, preliminary observations were made with neighborhood people, the neighborhood headman and health professionals in the mother-child health center in order to become acquainted with the place.

A qualitative study using in depth interviews with a total of 40 persons from different households was conducted from the winter of 2005 until the fall. The five pilot interviews were conducted in the fall of 2004. All interviews were recorded; transcribed and the transcribed texts were used for qualitative analysis. A total of 50 interviews were done, 5 of them were pilot interviews and 5 of them were cancelled because one of them had a chronic disease and was in depression, so the interview

was left incomplete as asked by the interviewee. The other two were cancelled because my observations and answers from each interview were contradictory. Also, I observed contradictory statements during the interview. These two households were not appropriate for the study's objectives. The last one was incomplete because the interviewee went to her village for a long time, and the second visit did not take place. 22 of the 40 original interviews were conducted in Baraj and 18 of them were done in the Gültepe neighborhoods.

The questionnaires in this research were filled in on a household base but the interviews were conducted with one member of each household. The questionnaire was composed of eight sections entitled: household table including socio-demographic characteristics; migration history; occupational history of the members; income, ownership and consumption; residence, neighborhood and spatial information; social relationships, network and solidarity; poverty experiences and perceptions; illness and disease history of household members, self-perceived well-being, health experiences including understanding and definition of health and illness, health care access, utilization of health care, health seeking ways including applying scientific or traditional healing methods, coping strategies in the case of illness, health promoting strategies, and institutional experiences in health care services.

Participant observations generated a rich source of highly detailed information about all aspects of the topic at hand. Observations were made during the research in the field. Field notes for this study are composed of observations during the interviews of the household members, the physical appearance of houses, household goods and furniture, conversations among household members; observations about neighborhoods and people when chatting with each other on the road, at home or anywhere; and evaluation notes for each household. This was crucial because some things can only be observed. In my opinion, observations and field notes provide both additional information and complement the in-depth interviews. During the data collection process, I took notes at the end of the day after the interview was completed for the interview base.

The respondents decided the date and time of the meetings. However, there were few respondents who did not abide by the time set for their meeting. Each interview lasted approximately two hours and thirty minutes.

Before the process of interviewing, I tried to summarize my study in general terms by using simple words, I informed the respondents about the purpose of the study, the type and length of the procedures, the confidentiality of the data gathered by recording the interviews, and their rights to withdraw from the study at any time.

I asked them whether they would be uncomfortable with the tape recorder. Although I stated that the study was done for scientific reasons, one of them was uncomfortable with the presence of the recorder. In this case, I stopped recording and took notes by hand. Few of them were able to manage the recording process. Some asked if it was recording, some asked me to turn it off and the turn it back on after they were dne talking about their private life, which they wanted to keep confidential. When I felt that she/he was tired, I stopped and continued after the break or the next day. Most of the interviews were completed in two or three sessions, especially those with chronic patients. This process involved taking notes and using a tape recorder.

4.5. Analyzing the Data

The quality of an analysis depends on understanding the data; this means reading and re-reading is required. I completed the data collection phase of the research in October, 2005. The interviews were recorded in the field by using a digital type-recorder and then these records were transformed into an electronic environment. I transcribed the interview data by listening to the interviews several times. This was a very time-consuming phase. The transcripted text was printed and each interview as was read and separated into themes and coded after a consideration of the research questions. I did not use any qualitative analysis software programs. Coding is an interpretive process of searching data for themes, regularities and patterns. I created a list of codes. After the coding on each interview, I listed interviewees' excerpts under each code. Then, I reviewed the last text once again and any unnecessary information was excluded, and sub-codes were decided. Thereafter, the interviews were ready for interpretation and reporting.

4.6. The Difficulties of the Study

There were three main stages where I experienced difficulties during the study. The first one was during the literature review on poverty and health; the second was during the sample selection, and the last one was during the research.

In the course of the literature review, I could not find studies directly on poverty with a focus on health experience for Turkey from a sociological perspective. Sociology of health as a subdiscipline of sociology is not adequately developed in Turkey. Also, studies on health are limited to the medical and health sciences domain. Sociology of health has emerged with the critics of the Western based, scientific medical paradigm, which regards disease as a consequence of a certain malfunction of the body. Sociology as a discipline tries to break the traditional medical understanding by emphasizing the social origins of disease and the processes that shape both people's experiences of illness, and the medical knowledge and practices around which health care is organized. From a sociological point of view, social processes and factors are influential in health or illness experience. The underdevelopment of the sociology of health field in Turkey, with few studies, was one of the main difficulties during the study. I could not benefit from Turkish literature on the sociology of health due to this underdevelopment.

The second difficulty was faced at the stage of the sample selection. For the selection of the districts, a list of indicators related with socio-economic status and health status were determined with reference to other resources. However, during when I contacted the related institution, district based statistics of the main indicators were hard to obtain. As for information on neighborhoods, it was seen that neighborhood headmen were not well-informed. Therefore, information such as the history of the neighborhood was obtained from interviewees, especially those who have resided at the given neighborhood for a long time.

The last group of difficulties was encountered during the research. First, while I was introducing myself as a researcher and talking about the research in general, it was difficult to convince people. People in both two neighborhoods, especially in Baraj, thought that I came from a charity organization although I mentioned purpose

of the research again and again. Therefore, there were lots of demands for interviews at first. Lots of women in Baraj gave me pieces of paper with their names, telephone numbers and addresses on them. I did not conduct any interviews with them for ethical reasons because they would be expecting aid. Then, when they understood that there was no any aid, demands for interviews ended abruptly in the neighborhood. In this stage, 2 people in different households did not accept the meeting of interview for this reason. They said "if there is no aid there will be no interview, we do not have time for this".

For the selection of the interviewees, a few people who were well-informed about the neighborhood and its dwellers helped me; at this stage it was observed that people tended to try and make themselves out to be the poorest. After observing contradictory statements from some interviewees, certain interviews were cancelled. This is probably related to the increasing charity and assistance from institutions. This tendency was quite visible and I observed that any foreign person was seen as a potentially benevolent individual or agent for job opportunities or clients. Some interviewees wanted used-clothes, household goods, educational materials for their children such as books and notebooks. Moreover, women, in particular, saw foreigners as potential employer or agent for employment opportunities. They stated that they want to work. Staying to the confines of their neighborhood, they could not find any jobs. Few of women tried to sell their hand-made lacework, hand-knitted pullovers, headscarves, shawles, and so on. Women demanded certain jobs such as housekeeping and baby-sitting. They expected me to provide a network for job opportunities like these.

In the research stage, the other difficulty was related with access to male interviewees. The majority of the working men in the two neighborhoods were daily workers, so reaching them was more difficult in comparison with accessing female interviewees, the majority of whom were housewives. Also, some male interviewees had to stop in the middle of the interview because they were informed by telephone about some job opportunities at that moment. This caused me to try and organize another visit for the interview. For interviewing men, I usually went to the neighborhoods on Sunday, which is usually a non-work day. This caused a timing problem. Before starting an interview I made an appointment with people, then I had the meeting. However, some did not abide by the time set for interview. This brought

about the necessity to organize other visits. While some of them went to the doctor for their children, some went to their village, or even forgot the time.

The next difficulty was experienced with people who hade chronic illness. They became very tired in the progress of the interview. I discontinued if their concentration decreased. So again, I set another date with them. One interview was cancelled because the respondent was in depression and did not want to continue the interview.

During the interviews with men, there were always other household members present; at least their wives. This sometimes caused the wife's intervention into the interview answers. I solved this problem by asking both of them. Therefore, any interruptions were prevented and different views from different household members were received and recorded.

The other difficulty at the research stage was the existence of the tape recorder. In order to be sure that it was not threatening, they asked about confidentiality. At first, I explained that I used this tool for scientific reasons and I said no one would find out about the answers except for us. Despite this explanation, two of them did not want me to record their answers, and I continued to take down notes by hand.

The next difficulty at this stage was the duration of interviews. One usually lasted approximately three hours. Sometimes I observed they were bored. At such times, I gave a short break and talked about some topics which would interest them such as the demolition of their *gecekondu*'s, aid, the development and education of their children and so on.

The last difficulty during the research was peculiar to the neighborhoods. Baraj neighborhood settled on high hills. Between the outskirts of two hills there is a main road; 1st street. Actually getting to the houses was very difficult for me. After lots of stairs on hilly land, I reached them. The majority of the interviewees resided in these houses which were relatively cheap in comparison with more level ground. The Interviews in Baraj neighborhood were done in the winter months under rainy and snowy weather conditions. Ascending and descending long dangerous stairs was very tiring and risky. Also there were no stairs to reach some houses at the peak. The neighborhood headman stated that there were many accidents and injuries for this

reason especially during winter periods. Even the location of some houses where I interviewed was very dangerous because there were big rocks over the houses.

The difficulty which is specific to neighborhood is related to the Gültepe neighborhood. In comparison to Baraj, Gültepe has high crime rates according to information received from Gültepe dwellers and the neighborhood headman. It was stated that stealing, murder, and assaults were very common. In one household, I made an appointment to talk with a young male member of the household; the interview had to done realized with his mother because he had been stabbed and injured. Therefore, key informants people well-known in the neighborhood orientated me for interviewing. I only had interviews with people who were suggestedby these people. In this neighborhood, interviews did not continue after a specific time, 6 pm. At the beginning of the research in Gültepe, Gültepe people were anxious and restless due to newly committed murders. Unlike Baraj, people in Gültepe were usually at home. Gültepe people acted more protectively for the same reason.

4.7. Two *Gecekondu* Neighborhoods in *Altındağ*: *Baraj* and *Gültepe*

4.7.1. The District of *Altındağ*

Rural-urban migration to Ankara began with Ankara being established as the capital city on 13th October 1923 and rapidly increased with agricultural transformation during the 1950s. The Altındağ district, as the oldest settlement, is located in the northernmost area in Ankara and was established in 1955. Altındağ was one of the most migrant receiving districts in Ankara. Altındağ was quickly surrounded by *gecekondu* settlements when this massive migration started (Şenyapılı, 2004a). When the research was started and completed, before the demolition of the *gecekondu*s within the framework of urban transformation project, 75% of the district was covered with *gecekondu*s. 31% of the district is composed of hilly lands (www.altindag-bld.gov.tr). Since 2005, the demolition of the majority of the *gecekondu* settlements in Altındağ, including Baraj and Gültepe neighborhoods has been taking place under the urban transformation project. Now, Altındağ, with its 113 neighborhoods, is one of 8 districts which belong to the Ankara metropolitan municipality.

According to the last census (TUIK, 2000), the urban population of Altındağ is 400,023. It is the fifth most populous district among the central districts of Ankara. If we look at the age distribution, it is seen that working age people (ages 15 - 64) account for 67,41 %. According to 200 population census, infants and children (ages 0-14) account for the greater part of the population with 27.81 %. In terms of age distribution, older people (65 and over) are fairly rare with 4,78 %.

As mentioned before the unemployment rate, especially among youth, is very high with 10.32 %. The green card rate is very high with 23.21%. The other important indicator is illiteracy, which is also high in Altındağ with 9.49 %[20]. As age increases, the illiteracy rate increases. Only 39,27 % of the Altındağ population has an educational degree beyond primary school. While 19,02 % of the Altındağ population has a high school degree, only 6,88 % of the locals have a university degree.

Among all age groups, it is striking that females have lower educational degree in comparison with males. In fact, the gap is huge among illiterate people in Altındağ. While illiterate males account for 1,68 % of the Altındağ population, illiterate females account for 7,81 %. This is valid for educational status above a primary school degree. While male high school graduates account for 8,24 %, this rate for females is 5,96. In terms of all educational degrees from primary school to university degree, females have a lower rate.

4.7.2. *Baraj* and *Gültepe* Neighborhoods

Both neighborhoods are defined as *gecekondu* areas. While the population of the Baraj neighborhood is 18,247, the population of Gültepe is 4,361 according to the 2000 population census. While Baraj is the third most populous neighborhood in Altındağ, Gültepe is 28th. Baraj has more hilly land in comparison with Gültepe. Baraj has 112 streets and Gültepe has 30 streets. According to the neighborhood headman of Baraj, there are about 5,000 households. More than half of the *gecekondu* settlements in Baraj were constructed on state-owned land. While very few have legal title deeds, the majority of *gecekondu* owners have title deeds without legality obtained from the municipality after amnesties. Equally, the majority of the Gültepe *gecekondu*s were

[20] Calculations were made for the urban population of Altındağ and educational status was examined among people older than 15 years. Unknown age groups were not included the calculation

constructed on state land and the number of households who own a legal title deed is very low.

Whereas the Baraj neighborhood is one of the neighborhoods located in northernmost areas in Altındağ, Gültepe is located near the center of Altındağ and near Ulus, Dışkapı, hospitals and business and shopping centers. In contrast to Gültepe, Baraj is the remotest neighborhood in Altındağ. To the north of Baraj, there is the Ankara Local Road and Karacaören Village; to the west, there are the Esenboğa Airport Road or Çankırı State Highway and the Yeşiltepe, Aktepe, and Şenyuva neighborhoods belonging to the Keçiören district; to the north east, there is the Çubuk Dam; and the Karakum, Doğu and Dereboyu neighborhoods are located to the south of Baraj. To the east, there are no settlements. Gültepe is within easy walking distance to the center of Altındağ, approximately 1 km far. Babür Street is located north and northeast of Gültepe. At the north, Çalışkanlar, Yenidoğan and Örnek neighborhoods are located; to the east of Gültepe, there is the Cebeci Asri Cemetary; to the west Altındağ Street take place; to the south, Aktaş, Demirlibahçe and Şafaktepe neighborhoods and Bentderesi Street are located.

While Baraj was established after the 1970s, Gültepe has existed since the 1950s. According to Şenyapılı's study on *gecekondu* settlements in Ankara, Gültepe was established in 1955 (2004a: 354). One of the family members interviewed in our sample had migrated from Gümüşhane in 1950. According to him, there were few settlements in Gültepe, instead the land was composed of arable fields. Unlike Gültepe, Baraj was settled later. The Baraj neighborhood headman and people living there stated that it was founded after the 1970's. the neighborhood headman of Baraj stated that there was no settlement for people except for barns and vineyard cottages owned by people living in Solfasol before the 1970s. During the years between 1986 and 1994, massive migration increased to Baraj from especially from the villages of Central Anatolia. After 1994, the construction of *gecekondu*s was not permitted in either neighborhood. Since then, renting has increased. According to the neighborhood headmen of Baraj and Gültepe, after 1994, a few attempts to construct *gecekondu*s were concluded with the immediate demolition of these *gecekondu*s. They stated that their neighborhood met the cheap sheltering need of unskilled migrant labor force.

The original inhabitants of Gültepe had migrated from Gümüşhane and Tokat. According to the neighborhood headman of Gültepe, there are two sections within the neighborhood. One section is composed of settlements between from 182nd Street to 192nd Street, and the second covers from 193rd Street to 212th Street. The latter region is composed of gypsy inhabitants who migrated from Bolu, the former is composed of inhabitants from Gümüşhane, Erzurum, Sivas, Haymana, Kars, Tokat and the districts of Ankara. In the neighborhood, there was ethnic segregation. According to the interviewees, the crime rate in the second section is very high, with crimes such as stealing, violence, murder, buying and using of illegal drugs like hashish and heroin and so on. Some people living in this section were beggars. The majority of the rest were employed in informal sector in jobs such as shoe shining, scrap collecting, collecting paper, iron or paper materials to be recycled, shammering. The inhabitants living in the first section are generally employed in semi-skilled and unskilled manual jobs and are drivers, furnuture workers, and casual workers such as porters, cleaners and street peddlers. The majority of the interviews were done in the first section of the neighborhood. There was only one interview conducted in second section. According to the interviewees and the neighborhood headman, unlike in Gültepe, any crime in Baraj is very rare.

Unlike Gültepe, Baraj inhabitants were composed of migrants from districts of Ankara (especially Kalecik, Kızılcahamam, Çubuk), Çankırı, Yozgat and Çorum. There were not a large number of migrants from the East and Southeast Anatolian regions. According to the neighborhood headman and interviewees, people preferred this place because it was near their native regions. The majority of Baraj inhabitants are daily workers or cleaners. While Gültepe is more heterogeneous, Baraj is much more homogeneous in terms of ethnicity, hometowns, and jobs. Also, Baraj seems like an Anatolian village. Women in particular did not have any contact with the city except for compulsory situations such as going to the hospital or paying bills.

The neighborhood headmen stated that both settlements are similar in terms of poverty indicators such as unemployment rate, especially among the youth, illiteracy rate, green card rate, fuel and food assistance rate and so on. Both stated "our neighborhood is a place for poor people" and only very few people whose income may be better are settled in these neighborhoods because they have their own houses and they do not want to move. The Gültepe neighborhood headman stated

that about 70% of the Gültepe inhabitants have received fuel and food aid and have the green card. Also, the Baraj neighborhood headman said that about more than half of the Baraj inhabitants had received fuel and food aid and had green cards although he could not cite an exact number.

CHAPTER 5

HEALTH EXPERIENCES OF URBAN POOR

This investigation was undertaken to identify the health experiences of *gecekondu* people living in poor economic conditions in an urban area. The experiences including health and illness perception, health seeking strategies, institutional experiences were examined in relation to the *forms of capital*, namely economic, social, cultural, and health, which poor *gecekondu* people possess as resources.

Although the results from the data presented here and derived from in-depth interviews are not representative of all *gecekondu* people's health experiences in Turkey at the macro level, the rich material from the interviews is conducive to a comprehension of the patterns of impacts of different *forms of capital* on health experiences in the context of two neighborhoods. As seen in the methodology chapter, Altındağ has low socio-economic and health indicators, which can be assumed as poverty indicators. Instead of simply examining the reciprocal relationship between poverty and health, based on the indicators representing poverty and ill health relationship, this thesis focuses on experiences in order to understand the mechanisms and processes that lead to the perpetuation of the close interaction of poverty and ill-health.

Before continuing with the main findings of the qualitative study in the two neighborhoods in Altındağ, Ankara, some general socio-demographic characteristics of the respondents should be provided in order for a visualization of the sample. Generally, in this chapter, the economic, social, cultural and health dimensions of the

experiences of *gecekondu* people will be examined. To this end, health experiences will be constructed.

First, *economic capital*, including rural health experiences, migration and health experiences, urban working conditions, child labor, women labor, and nourishment will be examined in order to depict how low income explains health experiences of the urban poor. The impacts of economic difficulties on well-being and state of health will be given in due course from the individuals' point of view.

The second part is allotted to the relationship between health experiences, social security/assistances and solidarity networks of urban poor. In terms of informal *social capital*, social network, relationship, support, and assistances based on kinship ties, neighbor ties, friendship ties, or ties based on common origin will be analyzed. Social security status, social assistance, or any institutional support or assistance in terms of formal *social capital* will be investigated. Both types are elaborated on in order to understand the health experiences such as accessibility to health care, faced problems in health care institutions according to the security types.

The third part is related with *cultural capital*. The possibility of relationships will be examined between the type of identity which the urban poor assign to themselves and health experiences. What will be discussed in particular is how *cultural capital* influences the relationship with health institutions and their staff such as doctors, nurses and other personnel.

Health capital represents the health status of urban poor such as medically diagnosed diseases, illnesses, and self-reported well-being. First, which illnesses urban poor have will be presented. Moreover, the differences in health experiences according to the sick role will be investigated. The expectation is that varying health experiences will be found between the chronically ill and healthy persons. In this part, how urban poor understand and conceptualize health and illness will be investigated. Also, health seeking strategies which they apply will be examined.

5.1. Description of the Respondents

There were a total of 40 interviewees: 22 living in Baraj, and 18 in Gültepe. There are 11 female and 11 male interviewees in Baraj and 9 males and 9 females in Gültepe. In all, I interviewed 20 male and 20 female *gecekondu* dwellers.

Interviews were done with one member from each household. 15 of the interviewees were the head of the family. The head of the household is considered the basic breadwinner of the household - previously or recently. I say previously because some heads of the households suffered from chronic illness and had no capability to work at the time of the interview and they were unemployed and there was no other person with the role of breadwinner in the family. Therefore, the head of the household should be conceived as the potential or estimated head of the household. There are five household members who previously occupied basic breadwinner position in their families, but then transferred the breadwinner position to their sons. The common characteristic of these household members, the previous breadwinners, is that they are unemployed due to a disease which prevents them from labor market attachment. Also, I interviewed the 15 spouses of the heads of the family. Only a few other household members were interviewed. Other than breadwinners and spouses of breadwinner, son, mother, father, and brother of head of the household were interviewed. If we look at the sex of the head of the household, we see that almost all of them are male. Only two are female. One of them lives alone by surviving with the elderly benefit provided by the state. The other one lives in an extended family with her sons and a daughter, grandchildren, and daughter-in-law.

Regarding the number of household members, the average number of household members in Baraj is 4.18; the number in Gültepe is 4.28. The average number of household members in total is 4.22. Families in Baraj which have 5 people in the families represent 36.4%; in Gültepe, families with 6 members explain 27.78 percent of Gültepe families. These average numbers of the household members in our sample is higher than both the average numbers in Turkey and Ankara[21] for urban areas. The average household size in Turkey is 4,5: while this average is 4,18 for urban areas and 5,19 for rural areas. Ankara has a smaller household size than the average for Turkey. In Ankara, the average household size is 3,82: the average is 3,73 for urban areas and 4,66 for rural areas of Ankara.

A look at the age distribution of the interviewees reveals that the majority of the respondents are in the working age. The average age of the interviewees is 42. I interviewed younger people in the Baraj neighborhood in comparison to Gültepe.

[21] The numbers are obtained from the official site of Turkish Statistical Institution (TUIK) according to the 2000 Population Census of Turkey. The web address for this information is http://www.tuik.gov.tr/VeriBilgi.do?tb_id=39&ust_id=11, accessed 10 January 2008.

While the average age of the interviewees in Baraj is 38.32, average age of Gültepe interviewees is 46.44. The number of the respondents in the age group between 30 and 39 (30%) is higher than those in other age groups. While 9 interviews were done with respondents in the age group between 30 and 39, in Baraj, the majority of the interviews in Gültepe (6 respondents) were done with respondents in the age groups between 40 and 49.

The majority of the respondents (33) were born in villages. Only 2 respondents were born in districts and 5 respondents, as second generation migrants, were born in Ankara. There are 13 respondents who were born in the villages of Ankara (11 in Baraj; 2 in Gültepe). The rest of the respondents in Baraj neighborhood were born in other central Anatolian villages of such as Çorum, Çankırı, Yozgat, Kırşehir and Eskişehir. In Gültepe, the place of birth of respondents were more scattered around Turkey. The respondents in Gültepe were born and migrated from central, eastern, southern, and northern regions of Turkey such as the villages of Gümüşhane, Kars, Tokat, Burdur, Sivas, Erzurum, Çorum. There is consistency between their place of birth and the place they came from. All the respondents or their family (for those who were born in Ankara) migrated from rural areas. The majority of respondents' place of origin, and therefore the areas they migrated from, is the Central Anatolian Region (28 respondents).

Both neighborhoods are *gecekondu* areas in which I interviewed rural to urban migrants from first, second, and third generations. First generation migrants are those who, as adults or younger, themselves made the move from a rural area to an urban area. Second generation migrants are the children of migrants, who were either very young at the time of migration or were born in an urban area. There were 27 first generation respondents (18 in Baraj, 9 in Gültepe); 12 second generation respondents (4 in Baraj; 8 in Gültepe); and 1 third generation respondent (in Gültepe).

The time that the respondents (if he or she was born in Ankara, his or her family's date of migration) migrated from rural area varies from 1 year to 79 years. Among migrants, new comers were very few in the sample. The number of migrants who had come from their villages 5 years before was only 3. The number of rural migrants who had migrated 10 years or before is 11. The majority of the respondents have been living in Ankara for a long time. The migration years are concentrated in

the years between 1975 and 1999. There were four respondents who had migrated the years between 1946 and 1954.

When we look at the educational status of the respondents and their family members, we see that the majority of respondents, 70 percent, have a primary school degree. In Baraj, the rate of primary school graduates is 86 percent. There is one illiterate and one literate respondent and one high school graduate. In Gültepe, primary school graduates account for half of the interviewees. There are two literate respondents and one illiterate, two interviewees dropped out of primary school, one interviewee dropped out of junior high school, furthermore there are: one high school graduate, one vocational high school graduate and one university student.

The labor market attachments of the respondents with their social security status are given in the table below.

Table 12: Respondents' Employment, Occupational and Social Security Status by Neighborhood

	Neighborhood/Social Security Status[22]			
Employment Status	**Baraj**		**Gültepe**	
Unemployed	4	Uninsured with Green Card (2) Dependant SSI (1) Dependant RF (1)	2	Uninsured (1) Uninsured with Green Card (1)
Wage worker in the informal sector *(casual worker, waiter, construction worker, Pieceworker at home)*	4	Uninsured (2) Uninsured with Green Card (2)	3	Uninsured with Green Card (2) Dependent SSI (1)
Self-Employed-Informal *(garbage collector, simit vendor, street vendor, housepainter)*	2	Uninsured (2)	2	Uninsured with Green Card (2)
Formal Sector *(gas station worker)*	1	SSI	0	-
Employed Total	7		5	
Housewife	11	Uninsured (4) Uninsured with Green Card (3) Dependent SSI (3) (2 of them is seasonal) Dependent SE (1)	8	Uninsured (2) Uninsured with Green Card (2) Dependant SSI (3) Dependant SE (1)
Retired (*furnaceman, truck driver and porter, tea servicing*)	0	-	3	SSI
Total	22		18	

According to this table, there are six unemployed, five of whom are chronic patients. One of them is considered an educated youth who is unemployed and under depression. While the majority of the respondents (no: 11) were employed in the informal sector including self-employed and employees such as casual workers with no social security, and formal sector employee was only one. Working respondents as self-employed in the informal sector are evaluated as marginal sector workers such as garbage collectors and street peddlers. Also, there are 19 housewives and three retired

[22] Respondents whose social security status has been specified as "dependant" are those who benefit from the social security scheme of another family member registered to that social security scheme. There are three social security agencies in Turkey. SSI refers to the Social Security Institution covering private and public sector workers. RF refers to the Government Employees Retirement Fund covering public sector employees. SE, or *Bağ-Kur* in Turkish, refers to the Social Security Agency for Artisans and the Self-Employed. The Green Card, as a kind of social assistance, provides health benefits to people who do not belong any social security institution (See Chapter Three for details).

among respondents. The main characteristic of working in the informal sector is being unregistered to any social security agency. As seen in table, respondents working in the informal sector are either uninsured or dependent position in terms of social security. The number of uninsured among all the respondents is 25. Among them, 14 have a green card which provides access to health care.

5.2. Economic Capital and Influences on Health Experiences

The low level of income which the urban poor possess is assumed as an important indication of their poverty experiences. One of the main dimensions of poverty is the economic dimension, as discussed before. The urban poor's poverty experiences based on working life with irregular and low income, permanently falling into the unemployed status and difficult subsistence all influence both the state of being healthy or ill and health experiences of the urban poor. In this part, I try to present rural health experiences, migration patterns, urban working conditions, women labor, child labor, nourishment and their impacts on being ill and having different health experiences. For each, I examine what kind of differences can be found among the urban poor.

5.2.1. Rural Health Experiences

Agricultural work is considered as unpaid family work. In our sample, the first generation families, to a considerable extent, and the second generation, to a lesser extent, have experience of agricultural work. The experience of rural migrants in agricultural production provides certain clues about the nature of agricultural work. One of the main features of rural work is the employment of women, children, and men; that is, all family members have a role in agricultural production and livestock. Children after graduating from primary school start to work the arable land and attend livestock. Agricultural work is also the main reason for leaving school or not continuing education for both girls and boys. The majority of the rural migrants in the first generation worked in their own or their relatives' arable lands and attended livestock as unpaid family workers. Only a few worked as waged agricultural laborers if they did not have land in their villages. Especially women were at the heart of the production process unlike in urban work experience. In urban areas, most of the

women undertook domestic duties or only a few have work experience in the urban labor market, most of them having worked for a short time period. The excerpt below indicates the characteristics of unpaid family work in rural areas.

G.B. (49 year old female living in Baraj) migrated to Ankara 31 years ago. She expresses the working conditions of agricultural work for a woman:

> *Köyde işçisin. Tarla tapan soğukta kalıyorsun kuruda yaşta kalıyorsun. Kendi kendine tarla da bitmiyor. O tarlada durmadan çalışacaksın. Köyde hiç durmuyorsun ki. Ev de var çocuk da var tarla tapan da var çok ağır çalışıyorsun köyde. Çoluk çocuk herkes çalışır köyde 6 ay çalışır 6 ay yersin.*
>
> In the village, you are a worker. Working the land, you are out in the cold, the rain and such conditions. Products do not grow spontaneously. You have to constantly work the land. You are rarely in the village. You have a home, you have kids, you have the fields; living in the village means working very hard. Everybody even children subsist in village by working 6 months and spending the earnings during the other 6 months.

In rural areas, women undertake housework, raising the children, agricultural work, and tending to livestock. They have many responsibilities and an active role in the economic domain when compared with women in urban areas. While most of the first generation migrants and their parents worked as unpaid family workers, only one family had a paid worker status in their village before migrating to Ankara because they did not own land. S.B. (29 year old female living in Baraj) migrated 6 years ago and has work experience in a rural area as a waged worker. She stated:

> *Tarlalarda işçi olarak çalışıyorduk eşimin ailesinin durumu iyi değildi tarlaları yoktu zenginlerin tarlalarında çalışıyorduk günlük parayla. Çok az paraya çalışıyorduk mecburen fakirlikten.*
>
> We worked as workers in fields. My husband's family was poor and they did not own any land. We worked in lands of the rich with daily wages. We received very low wages but we had to because we were poor.

İ.Ö. (40 year old male living in Baraj) migrated to Ankara 5 years ago for easier access to health services, as he was a chronic patient and unemployed. He had experience only in agricultural production. He said:

> *Kendimi bildim bileli çalışırım. Köyde çoluk çocuk hepimiz çalışırız okuldayken de yaz tatillerinde çalışırdık. Okul bitince de tarlada çalışırdık. Koyun güderdik.*
>
> I have been working for as long as I remember. In the village we all work, children and adults, during the summer and during the school year. When school was out we would work the field. We would tend to the sheep.

Child labor, especially rural work, was also a common phenomenon for the respondents' family members who had spent their childhood in rural areas. All family members including children, even school children undertook various tasks related to rural economic activities and domestic chores as a component of the unpaid family labor force. Although family members participated in rural types of work regardless of gender, the type of work for children of the two sexes differed. In addition to economic activities, household or domestic chores were additional duties for girls such as A.A. (35 year old male living in Baraj) states about his sister:

> *Ben erken çıktım köyden ilkokulu bitirir bitirmez. Anamgilin de bir şeyi yoktu biz de giderdik onlar gibi tarlaya bahçeye çalışmaya. Daha da küçükken ablam bize 3 erkek kardeşine bakardı. Hem bize bakar hem de bağa bahçeye giderdi. Benim köy hayatım fazla olmadı ama bizim orda 9-10 yaşındayken başlanır çalışmaya. Hatırladığım kadarıyla, ablam 10 yaşında çapa yapardı. Bahçelerden patates çıkarırdı. Annem tarlaya çalışmaya giderdi o da bize bakardı.*
>
> I left my village early when I finished primary school. My family did not have (own) anything. Like them, we worked the land and gardens. When we were young, my older sister cared for us, her three younger brothers. She would look after us and work in gardens and vineyards. I did not spend a lot of time in the village, but there, people would usually start working at about age 9-10. As far as I remember, my sister hoed when she was 10 years old. She picked potatoes. When my mother went to work the land, she would take care of us.

Similarly, Ayata and Ayata (2003) state that "in rural areas the children join their parents in agricultural work if there is a family farm, but more frequently they work with their parents as agricultural laborers" (Ibid:120). As stated by the IPEC project (ILO, 2003), in both rural and urban areas children undertake various jobs, whether as wage earners or unpaid family workers. According to the report, not only do children engage in economic activities, they also perform domestic chores, activities that take place within the households and usually involve services rendered by and for household members fee of charge (Ibid: 17). Child labor should not be seen only as a coping strategy against poverty like in the urban context; but it should be considered as *habitus* peculiar to the nature of rural work. During the research phase of thesis, I found that the respondents regard it as normal that all family members work without being paid for their work, including the very young children; they see it as a part of everyday life in the rural field without questioning it. The below excerpts represent this pattern which as expressed by the respondents:

When they migrated to urban areas, child labor was used as paid labor, an important source of *economic capital* adopted by rural migrants in order to cope with

survival difficulties, especially in the first years. Although structural changes alter *habitus*, it can not be said that this *habitus* of child labor ended completely for the second generation migrants (more obvious change is to be observed in third generation migrants). Although child labor decreased after migration, it seems to have been adapted to the new situations or structures. There was no dramatic decrease in the number of rural child laborers in both economic activities and domestic chores until the 1990s. The dramatic decrease took place between 1994 and 1999 (ILO, 2003). According to the report, in rural areas, the percentage of children who participate in the economic activity was 15.7% in 1994 and, lower, 7.67% in 1999. Also, the percentage of children who performed household chores was 22.36% in 1994, but 25.64% in 1999 (Ibid.). While the boys who participate in economic activity in rural areas decreased, the situation for girls was not the same, if we assume that girls performed more domestic duties. It would be correct to say that traditional gender roles are more resistant to the change. This decrease in the use of boys as laborers may be explained with rural-to-urban migration. However, villagers certainly did not decide abruptly to stop having their children work . The tendency of using child labor did not disappear completely although "considerable increase in the percent of not-employed children is observed" (ILO, 2003). Rather, it transferred to the cities. Child labor has begun to be used as wage labor, especially in the informal sector after migration and before migration seasonally.

The health experiences of rural people, their health seeking strategies in particular, are closely associated with economic factors, the nature of rural work, the accessibility to health care, solidarity patterns and their culturally internalized views on health and illness, and traditional gender roles. In terms of self-perceived health and health experiences, women, children, and men should be evaluated separately. When considered in terms of its influence on health, there was no statement among respondents related to the negative characteristics of rural work except for exhaustion, and this came from the female respondents in particular.

Women carry a greater burden in terms of work when compared to men in rural areas. They perform domestic duties, raise the children, care for the livestock and do agricultural work. These responsibilities have negative influences on women's bodily capital when combined with the coercion of traditional gender roles, that is, the tendency of frequently becoming pregnant. Most of them state that they immediately

returned to work after they had given birth, with only a few days' rest. The female respondents had much more to say about the burden of work in rural areas than the male respondents. They tended to compare rural and urban work. F.A. (67 year old female living in Gültepe) expresses working conditions in the village as:

> *Köydeyken iş zordu gece 3'te kalkıyoduk. Tarlaya gideceksin ekmek pişireceksin. Aş pişecek. Çocuğa bakarsın. Evin işini de yaparsın. Akşam 6'ya kadar çalışırdık. Davar inek vardı onlara bakardık. Tarlarımız uzak olduğu için erken kalkar yürüye yürüye giderdik. Yanımıza helkelerle yoğurt alırdık ekmek alırdık. Kışın da mal yimliydik davar yimliydik. Ekmek pişiriydik. Çamaşır yıkıydık makine yoktu ki o zaman. Malların altını alıydık. Tezek yapıydık kışa. İş yapmaktan yorgunluktan tabanlarımız ağrırdı ellerimiz ağrırdı. Ayakta dolana dolana çalışırdık. Doğum yapıydık 2 gün sonra erkenden ekine gidiydik. 2 gün yatardık ondan sonra işe.*
>
> When we were in the village the work was hard. We got up at 3 a.m. You go to the fields, you bake bread. Food has to be cooked. You take care of the child. You do housework. We would work until 6 in the evening. We had cows and calves. We took care of them. Because our fields were far, we would get up early and walk there. We would take bread and yoghurt with us in containers. In the winter we bred and took care of the cows. We baked bread. We did the laundry. There were no machines back then. We would muck the cows and make patties for winter. Our feet and hands would ache from working and the exhaustion. We worked on our feet all day. We would give birth and return to the harvest after two days. We would rest two days, and then it was back to work.

In the villages all the births take place with the assistance of village midwife or another woman. The birth is not medicalized like in cities. It is seen as an ordinary event in the course of life. They tend to practice traditional methods. Childbirth is seen as a private issue for women according. This perception can be explained, to a certain extent, by the preference for female doctors after migration to the city.

All respondents were asked the number of births that had taken place for the last three generations. There was a sharp decrease in the number when they migrated to the city. As the generation descends it is encountered that there were lots of pregnancies almost per year and very high rates of infant and child mortality and morbidity. F. K. (78 year old female living in Baraj) spent the majority of her life in her village and has only been in Ankara for six years. She talks about the children she lost as follows:

> *Çocuklar oluydu ölüydü sonra. Birinin senesi bitmeden öbürüne hamile kalıydım. Hemen oldu oldu öldü. Büyüdüler öldüler koca koca çocukken. Öldükçe bir daha olsa diyorduk. 10 çocuğum öldü. Hiç aşı neyi olmadılar köyde. Sağlam doğuydu ateşlenip hastalanıp ölüydüler nebim valla. Evlat acısından çöktüm erkenden. Bakamıydık ki çocuklara. Yazın doğuysa bırakıydık bebeyi evde. Çocuklar bakıydı.*
>
> The children would be born, but then die soon after. I would be pregnant with the next one before the previous child was a year old. They were born and then they died. They grew up and died when they were grown children. Each time one died, we wished for another. 10 of the children I gave birth to died. They did not get any shots or anything in the village. They

would be born healthy and then die from a fever. I don't know. I withered away from the heartache early in life. We wouldn't take care of the children. If they were born in the summer, we left them with the kids to be taken care of. The children took care of the babies.

As expressed above, the cultural values and conditions of the rural affected these people's health experiences. In addition, access to health care plays important role. In the rural area, health services are provided in health houses or centers[23] under minimum conditions. However, rural people did not always receive health services except for urgent cases. They state that they suffered from illness but received no health services. They had to go to the district centre or the city. Except for urgent cases, they tried to cope with illnesses with their own methods, depending on traditional methods. Physical distance resulted in lack of access and was important determinant factor in terms of health seeking strategies.

M.E. (51 year old female living in Baraj) is one of the newcomers to the city. She migrated with her children and husband for health reasons 6 years ago, because her husband is a chronic patient. She expresses the impacts of inaccessibility to health services and poor economic conditions on infant and under 5 child mortality.

8 hamilelik yaşadım. 1'i bebekken, 2 si de 3-4 yaşlarında kızamıktan öldü. Köyde çok bebemiz ölürdü. Para yok nasıl götürecen. Kim götürecek. Köyde benim gibi anaların hep içi yanar. Köyde doktor yok, biri götürecek de Kaleciğe gideceksin ya da Ankara'ya.

I had 8 pregnancies. One died as a baby and two died when they were 3-4 due to measles. Many of our babies died in the village. There's no money so how are you going to take them to a doctor? Who is going to take them? In the village, mothers are always mourning just like me. There are no doctors in the village, if you can manage to find someone to take them, you have to go to Kalecik or Ankara.

The state of health care access is particularly related with the health care system provided by the state. Inaccessibility and scarce health services in rural area may have negative consequences for women and child health and may result in health inequality based on the field. These inequalities are also displayed in all Five-Year

[23] According to "The Regulation of Bed and Personel Standards of the Rural Organization of Ministry of Health", published in the Official Newspaper, dated 26 October 1994, numbered 22093, there are three types of health centers: province type health centers, village type health centers and district type health centers. The village type health center is the smallest one and provides services to a smaller population. In this type, there is one medical practitioner, one health officer, two midwives, a medical secretary, driver, and janitor in terms of staff. While each district type health center provides health services to a population between 10.000 and 30.000, each province type health center provides service to 30.000 and 50.000 people. In addition to village type health centers, health houses belonging to the health centers provide health services in rural areas to a population between 2000 and 2500. The services offered at health houses include mother and child health services, injections, patient follow-ups, and dressing. In each health house, one midwife serves. (Öztek, 2001: 8-9).

Development Plans as regional differences based on health status indicators and health personnel. It is stated that there is a misdistribution of health personnel and services across the country. Despite the fact that socialization of health services eliminated regional differences in some degree by expanding primary health services, the elimination of these differences through providing sufficient health personnel and services has not succeeded in full. This is the policy aspect of the lack of access rural people have to health services provided by the state.

In addition to inaccessibility, economic conditions are also important as M.E. expresses. Both two negatively affect the health of rural people, especially children. In M. E. case, measles, accepted as one of the *diseases of poverty* by WHO, caused the deaths of one infant and two children. These diseases, although able to be prevented via vaccination cause an increase in the frequency of infant and under 5 mortality in rural areas due to inaccessibility and poor economic conditions.

M.F. (74 year old male living in Gültepe) is a retired furnaceman, who migrated to Ankara 59 years ago. He states that:

> *Köydeyken, o zaman hasta da olmuyorduk ki. Çocuktum o zaman. O zaman doktoru kim biliyordu ki. Hasta olunca o zaman çekerdin. Yoksa ölürdün.*
>
> In my village, I did not get sick. I was a child then. Nobody knew any doctors in those days. When we were ill, we suffered through it. Otherwise you would die.

This pattern is valid also for other respondents who lived in a rural area in one part of their life. In addition, there is a tendency to perform everyday activities and responsibilities when they were ill with diseases such as influenza. There is a perception of the distinction of illnesses: important and urgent illnesses required health services and unimportant illnesses were overcome in the course of daily life.

There is also a direct relationship between the type of work and social security status. In terms of health care access, social protection in rural areas is provided by the informal family network instead of being part of any social security scheme. Agricultural work has non-insurance status. In all families, family members did not have insurance when they were in their village. SE[24] for agricultural workers started to be implemented in 1970 on a voluntary basis. In fact, they have a legal right to belong to SE as social security institution; there were no families under SE in their rural life.

[24] The Social Security Agency for Artisans and the Self-Employed (See Chapter Two for details).

This tendency led to limited access to free health care. The majority of the respondents expressed that they tended to not to receive health services except for sudden, important, or vital situations while they were living in the village. They stated that they went to the district or provinces for paid health services in urgent cases, because there were no health services in the village except for primary health care such as those at the health center. Health centers in the village either did not exist or were inadequate. They exhausted their economic sources in the case of illness because they paid for health services. For rural people, receiving health services was an enormous loss of *economic capital* so they preferred to avoid health services except for urgent situations due to the expense. This uninsured status kept them from going to the doctor. While 38 families had no access to health care freely, only 2 families did due to chronic disease. While one is green card holder, the other belongs to SE. These two immediately started the procedures for free health care access after the diagnosis of their chronic diseases.

Most of the families, when they were in their villages, lived at a level of subsistence. The general pattern was that they worked in summer time and consumed their products in winter. They avoided both paying the premium for SE and paying for health services because they did not accumulate money. Low income prevented them from having social security and thus health care access. This tendency caused by low level of economic conditions first affects children and women as expressed above respondents. People also procrastinate in receiving health services even in important cases. This behavior sometimes renders health problems as insoluble as O.G. (34 year old male living in Baraj) expresses:

> *13 yaşındaki kızda doğuştan kalça çıkığı var. Tedavisi vardı yaptıramadık o zaman köydeydik para yoktu, sigortamız da yoktu. 12 yaşındaki kızda da şaşılık var. Tedavisini yaptıramadık erken yaşta tedavi edilirmiş. Bilemedik nazardan oldu zannettik. Biz çok geç kaldık.*
>
> My 13 year old daughter has a congenital dislocated hip. It had a treatment but we were in the village then, so we could not have it fixed. We had no money or insurance. My 12 year old daughter is cross-eyed. We could not have it treated. Apparently it is something that can be fixed when you are young. We did not know. We thought it was because of the evil eye. We were too late.

According to the belief of *nazar* (the evil eye), people, especially infants and children can be ill because of the envious eyes of some people. It is believed as one important source of illness. Such an understanding about the cause of illness is prevalent both in

rural and urban areas. In order to avoid the evil eye, people tend to wear a blue glass bead beat which is said to protect one from the evil eye.

Although certain patterns about rural health practices can be found in the talks of the respondents referring to their life experiences before migrating, it can not be considered as satisfactory to make generalizations on their present situations. Rural-to-urban migrants should be evaluated as those who realized the jump from one *field* to another. However, understanding rural health experiences is important to see changes in health experiences after starting to live in the city.

5.2.2. Migration and Health Experiences

When we examine the causes of migration, there are four patterns which emerge in this research: *economic-based* labor migration, *social-based* migration, *health-based* migration, and *forced* migration. I prefer to classify migration patterns in accordance with the sample. *Economic-based* migration is a migration pattern which refers to the movement from rural to urban area by reason of economic-based pull and push factors. *Social based* migration refers to the movement from rural to urban field by reason of social or familial relationship as push or pulls factors. The *health-based* migration pattern is migration experienced by rural people for being able to access health services, which are inadequate in the rural field. *Forced* migration is the migration of rural people due to political unrest, war, or any other compelling conditions in their rural field. Among the families of the sample, economic reasons hold a significant role in the decision to migrate. For of our respondents who migrated for economic reasons, the distinction between push and pull factors gets difficult, because on the one hand rural people were aware of the economic difficulties of livelihood in their village, on the other hand they searched the city for employment opportunities via informal channels. In economic-based migration, both push and pull factors play a role in migration. However, economic difficulties in the village were much stronger emphasized by the respondents. Lack of arable lands and sheep or cattle, survival difficulties due to crowdedness, and will to escape from rural poverty are certain reasons representing economic based migration in this research. Rural people intended to migrate in order to create opportunities for economic sources as the reproduction strategy which individuals or families tend to practice in order to

improve their position in the *field*. The following excerpts, taken from interviews, illustrate the economic-based labor migration from the rural to the urban field:

F.A. (67 year old female living in Gültepe) migrated to Ankara with her husband and children 30 years ago. She explains why they migrated from their village as:

> *Köyde çiftçiydik, ekiydik, biçiydik, yetiştiremiydik. Köyde malımız mülkümüz hayvanımız yoktu fakirdik çok. Tarlamız vardı ama yetmiydi. Başkalarının tarlalarında da çalışırdık. Sen bi kötü tarla satmışsın onu almış öbüründen onu almış derken tarla sahibi olmuş kayınpeder. Ama toprakları pek ürün vermiydi. Onları ekiydik idare ediydik. Küçük küçük 5 tarlamız vardı. Iki ineğimiz vardı sadece. Yetmedi bunlar geçime. Mecbur çolunan çocuğunan geldik buraya.*
>
> We were farmers in our village. We sowed and we harvested but we could not survive on what we got. We were very poor; we did not have any houses or animals. We had a field but it wasn't enough. We also worked in others' lands. Somehow by buying and selling my father in law had some land. But the soil did not yield much. We worked that land and tried to get by. We had 5 small pieces of land. We only had two cows. These did not sustain us. In the end we had to come here with the children and all.

O.G. (34 year old male living in Baraj) is unemployed and a chronic patient. He had migrated to Ankara with his wife and daughters: He explains the situation in their village which caused them to migrate:

> *Köydeyken tarla sürüyorduk dedeme ait tarlayı. Maddi geçimsizlik vardı. Kalabalıktık. Geçinemedik geldik. 2 kardeşim eşleri çocukları hepsi bir göz odada kalıyorduk. Çocuklar hep bir arada yatıyordu.*
>
> When we were in the village, we worked my grandfather's land. We were having trouble getting by. We were crowded. We couldn't make it so we came. We were all staying in a one room house with my two brothers, their spouses, and their children. Our children slept in one bed all together.

The main economic reasons are poverty and difficulty in surviving with crowded, extended families, no or insufficient land or livestock ownership, ownership of unproductive lands, unemployment as push factors and finding a job in the city, the hope for finding a job, the wish to guarantee children's life such as providing an occupation for children are to be considered as pull factors. 28 respondents' migration stories are associated with economic based migration. Economic type migration is not concentrated to specific years.

In addition to economic reasons, they migrated due to social reasons or obligations. Four housewife respondents came to Ankara due to marriage; however, their husbands had migrated for economic reasons. Two respondents migrated due to social reasons; the existence of conflict among (extended) family members. N.D. (39

year old female living in Baraj) expresses the reason of migration related with the disagreement in the family in the rural area:

> *Kayınbabam evlendi diyom ya, ben ne diyom. 2. karıyı görünce kovdu bizi evden. E ondan dolayı geldim. Köyde dursam ne yapayım. Köyde hiç durmadım ki diyom ya üvey kaynana bakar mı ona. Anası öleli, bunlar küçük küçükmüş. Ondan sonra bu evlenince en büyüğü benim herifi evden kovmuş. Daha çocukken gelirmiş Ankara'ya ameleliğe. Diğer zamanda kayınbabamın tarlasında çalışırmış. Köyde evli hiç durmadık. 3 gün durduk. 4. gün işte kaynanam yatağımı yorganımı atmaya başladı.*
>
> My father-in-law married his second wife. Then he threw us out of the house. That is why I came. What was I to do in the village? I didn't stay. A step-mother in law wouldn't take care of you. My husband's mother died when they were little. Then when the oldest brother got married, he threw my husband out. Even as a young boy he came to the city to work on construction sites. At other times, he would work my father-in law's field. We left the village soon after we got married. We had been there 3 days when my mother in law started to take my bed apart.

In the forced migration pattern, there are 3 families who were forced to move and were dislocated. The reasons for this type of migration are blood feuds, war, and political unrest. One family was obliged to migrate in order to escaping a blood feud. B.B. (20 year old male living in Gültepe) talks about his family migration story as:

> *Babamın kan davasından dolayı kaçıyorduk. Duramadık orda. O yüzden geldik buraya. Ama gelir gelmez vurdular babamı. Babam 4 yıla yakın hastanede komada kaldı. Beyin ölümü gerçekleşince fişini çektiler.*
>
> We were on the run because of my father's blood feud. We couldn't stay there. That is why we came. But they shot him as soon as we arrived. My father was comatose in the hospital for four years. They unplugged him when his brain died.

Migration stories under the pattern of forced migration did not take place after the 1990s, rather, with three families who had migrated long time ago.

Health-based migration in the study is concentrated on access to health services. There are three household members who had to migrate for adequate health services. While two of them are heads of the household, one is the son of the head of the household. While the two are chronic patients whose lives depend on dialysis, one is bedridden due to cerebral hemorrhage. İ.Ö. (40 year old male living in Baraj) has suffered from diabetes for 18 years and he has been living dependent on dialysis due to kidney failure for 5 years. He gives details of his migration story as:

> *2000'de buraya geldim. 1987 yılında şeker hastalığına yakalandım. Son 5 yıldır böbrek hastalığıynan uğraşıyorum şekerden dolayı. Diyalize bağlı yaşıyorum. Hastalıktan dolayı Ankara'ya geldik. Hasta olduğum için diyalize girmem gerektiği için buraya göç ettik. Gelmemizin başka bir nedeni yok. Ben hasta olmasaydım zaten buraya gelmezdim. Mecburduk başka çaremiz yoktu. Tabi elimde olan bir şey olsa neden geleyim Ankara'ya.*

> I came here in 2000. My diabetes was diagnosed in 1987. I have suffered from kidney disease for 5 years due to diabetes. I am dependent on dialysis. We migrated due to my disease and because I need dialysis. There is no other reason for out migration. If I was not ill, I would not have come here. There was no alternative. Of course, if I had a choice, why would I have come to Ankara?

This type of migration can be evaluated as a health-seeking strategy for those who need to be under permanent medical control. It can be said that although the general need for escaping poverty or improving economic conditions is a common aim for migration for this study, one of the triggers providing spatial mobility is people's health status, such as the existence of chronic disease in the family. In this regard, migration should not be evaluated only as a spatial movement of people due to economic, social, or forced reasons, but as one also employed as a health seeking strategy by rural people.

While the number of respondents who migrated to Ankara alone for work (not for seasonal work but to settle down) is 6, the number of respondents coming to the city for marriage is 4. Also, one respondent came to the city alone to be with her single son when her husband died. In addition to those first generation migrants, there are 16 first generation respondents who came with spouses and (or not) children. As second generation migrants, there are 8 respondents who migrated with their parents and (or not) siblings and 5 respondents whose parents came first and were born in Ankara.

Whatever the reason for rural to urban migration; there is a tendency for a seasonal labor movement from rural to urban areas before migration. In both neighborhoods, this tendency is also apparent. It is common among the respondents to migrate together as a family; also there is considerable number of migrants who first migrated alone and their other family members arrived later. In general, one of the male members of rural households migrated to the city first while leaving the women and children back in the village. This provided the rural migrants with knowledge and experiences about the city both in terms of labor market opportunities, the social environment, sheltering opportunities and other opportunities provided in the city such as health care access. They both worked in urban area and rural area seasonally in order to alleviate livelihood difficulties experienced in rural areas. While this tendency provides labor supply (especially cheap labor) to the urban labor market, it enables the transmission of *economic capital* to rural

areas. It can be regarded as efforts to be included in the urban labor market by shuttling back and forth between the city and the village. The excerpts below reflect this tendency:

S.B. (29 year old female living in Baraj) migrated 6 years ago from a village in Yozgat for economic reasons. First her husband came for seasonal work (6 years before migration). She expresses that:

> *12 yıldır evliyiz. 6 yıl köyde 6 yıldır da buradayız. Eşim önceden 3–4 aylığına Ankara'ya gelip çalışırdı. Yazları çalışırdı kışın bile geldiği olurdu. 2 kaynım da biri 17 diğeri 27 yaşında havalar iyi olunca geliyorlar amele olarak çalışıyorlar dışkapıda bekâr evlerinde kalıyorlar. Sonra geri köye gidiyorlar.*
>
> We have been married for 12 years. We spent 6 years in the village and 6 here. At first my husband came to work N Ankara for 3-4 months. My two brothers in law, one 17 and the other 27 come to Ankara when the weather is good and work on construction sites and live in a house temporarily. Then they go back to the village.

H.B. (50 year old female living in Gültepe) migrated to Ankara from a village in Erzurum 30 years ago. Her husband came 42 years before for seasonal work. They were married 31 years ago. She expresses that this is a very common tendency for eastern Turkey:

> *Eşim geldi once. O Ankara'da çalışıyordu ben köyde. Köyün erkekleri yazın davara giderlerdi reçberlik yaparlardı. Kışın evde otururlardı. O yüzden Ankara'ya gelirlerdi kışın iş yaparlardı. Evlenmeden once de bekar zamanında da gelirmiş. Doğu tarafında erkekler kışın iş olmadığı için 5'i bitirince İstanbul'a Ankara'ya gelir çalışırlar. Askerliğe kadar çalışmış eşim. Sadece biz değil orada herkes öyledir. Genelde evlenirlerse orda kalıyorlar. İnşaatlarda falan çalışırlarmış. Ara işlerde çalışıyorlarmış beyim gibi. Ankara'da, İstanbul'da. Daha çok istanbula gitmişler. Ondan sonra bunu bir tanıdık akraba makarna fabrikasına koymuş. Biz de geldik.*
>
> My husband came first. He worked in Ankara, I worked in the village. Male villagers went to herd as herdsmen in summer time, and worked as farmers. In winter, they stayed at home so they went to Ankara to work. My husband came before and after we got married. Men in Eastern Anatolia go Ankara or Istanbul in winter after when they finish primary school due to unemployment in the village. My husband worked until his military service. It is not only us, everyone there does this. In general, when they are married they stay in the city. They worked in construction sector or as casual works in Istanbul and Ankara as my husband did. They mostly go to Istanbul. Later our relatives got him a job in a pasta factory. So we came.

This tendency is apparent in 18 of the 40 families. The type of work they had was in the informal sector for all. Casual jobs such as porting, construction work in addition to working as drivers, dishwashers, waiters and public bath workers abound. 10 rural migrants among the 17 worked as daily workers in the construction sector and portage seasonally. On the one hand, rural workers provide the labor supply of the urban labor market; on the other they begin to gain knowledge about city life, the social

environment, housing opportunities, and urban labor market. For the majority of the rural poor who lived in difficult economic conditions in their villages, seasonal work seemed like a solution for gaining *economic capital* even if they earned low wages. However, when they migrated to the city and they continued these kinds of jobs and they did not have opportunities for mobility such as support from informal social network, the households were subjected to higher risk of poverty.

The age and sex of family members who migrated seasonally shows that firstly, there are no female family members who migrated alone for work; they were either adult males or young males in the families who tended to migrate for work; secondly, although child migration for work does not constitute the majority, there are 3 children who migrated alone for seasonal work in the urban labor market.

In addition to seasonal labor movements, rural people tend to come to the city for health services seasonally. Seasonal flows should not only be thought of as labor movement. The health problems of rural people are not solved in the village, making rural people mobile between the *fields*. Rural people try to receive health services by using informal social network such as their villagers or close or distant relatives. Rural migrants inhabiting the city assisted in terms of guidance and accommodation. In the relationship between rural and urban fields, there is reciprocity. More than half of the respondents express that their relatives and villagers come for this purpose and stay in their home for short time periods. A few families who had migrated from the rural areas in need of access to health care, first came to Ankara seasonally for health services related with their diseases until they finally migrated permanently. Although a few respondents explain the cause of migration or seasonal movement to the city citing access to health care, there is a flow of rural people permanently for coping with illness and inaccessibility when their illness histories are examined. Most of the respondents state that they moved to the city in certain periods before migration especially for the medical operations of mostly the elderly.

5.2.3. Urban Working Conditions and Health Experiences of Urban Poor

The seasonal urban work experience of the rural labor force is considered as the first step of integration to the urban labor market especially intensified in the informal sector jobs. In general, rural migrants only have work experience in

agricultural production and in livestock and represent an unskilled labor force except for few semi-skilled workers such as truck drivers, housepainters, etc. The majority of rural migrants are both primary school graduates and unskilled. This orientated them into manual jobs as porters, and construction workers when they first came to the city. The first work experience of first generation migrants in 40 families was commonly concentrated in the informal sector. When the work experience of the first comers from each family is evaluated, it can be said that working in the informal sector, either self-employed (marginal) or as a casual worker, has a crucial role in the integration of rural migrants to the urban labor market and survival within the city. Among respondents, there are migrants who came to the city alone for work or because of marriage, and those who came with their parents. All the respondents (no: 6) who came alone for work are male respondents who worked in the informal sector under worker status in a definite workplace, self-employed, or as casual workers. Migrated individuals due to marriage reasons are female respondents and their husbands' effort to integrate into the labor market were realized via articulating to the informal sector as well. Husbands of or father-in-law of women who migrated for marriage reasons were first employed as factory workers (formal), self-employed, or informal workers. Also, one respondent came alone to her son who first worked as a casual worker. Almost all household heads (household heads of that period) of 16 respondents who came with their spouses and/or their children have experience in the informal sector as casual workers, and street peddlers and in the formal sector such as factory workers. 2 household head respondents among them did not have work experience in the urban labor market due to chronic illness. Household heads of respondents' families who migrated with their parents and/or siblings had jobs such as factory workers, street peddlers, casual work, and stall holder at bazaars when they first came to the city. Lastly, there are 5 respondents who were born in Ankara. The heads of their families also first worked in the informal sector as casual workers when they came to the city.

Among all 40 families, 6 first comers' first jobs were in formal sector such as janitor in hospital, factory worker in manufacturing industry (no: 4), and manual worker for the municipality. The rest of them first worked in different areas of the informal sector except for the 2 unemployed chronic patients.

What kind of experiences these rural migrants had in the urban labor market after they migrated is crucial for insight into their poverty experiences and health experiences which seem to be much related with their labor market experiences. It is true to say that the economic conditions of the urban poor are very low. This is closely associated with their position in the urban labor market. Respondents' and other family members' relationship with the urban formal labor market is very limited. Only few work in or retired from the formal sector. There are many factors influencing their employment status, the economic sector in which they work, that is, their integration into the urban labor market. The weak attachment of *gecekondu* people onto the urban labor market, especially the formal labor market, seems to pose more of a risk of being exposed to urban poverty. First I want to give a job profile and try to derive the basic characteristics of the type of work which *gecekondu* people engage in.

Table 13: Household Head's Employment and Occupational Status by Neighborhood

Employment Status	**Baraj**	**Gültepe**
Unemployed	2	2
Employed Total	19	10
Wage worker in informal sector *(casual worker, construction worker, porter, domestic cleaner, waiter, furniture worker, marble cutter)*	10	3
Self-Employed-Informal *(garbage collector, simit seller, street peddler, tea seller, truck driver-carrier, housepainter)*	2	4
Formal Sector *(janitor, butcher, gas station worker automotive body repairer, stock room worker, worker in home appliance firm)*	4	3
Formal-Seasonal Worker *(gardener)*	2	0
Contracted Formal Worker *(construction worker at municipality)*	1	0
Housewife	0	1
Retired *(furnaceman, track driver-carrier, tea servicing at paper factory, municipality driver, hammam worker, servant*	1	5
Total	22	18

This table serves to present the situation of the heads of the families in terms of their relationship with the labor market. According to this table, there are four unemployed. While three of them have a chronic disease which prevents integration into the labor market, one of them was injured and is receiving medical treatment due to the attack

of a thief at the time of the field research. Household heads in employed status are intensified in the informal sector with 19 household heads among 29 employed household heads. The majority of the workers in the informal sector work as casual workers. The number of working household heads in the informal sector as self employed is 6, such as garbage collector, simit seller, street peddler, tea seller, truck driver-carrier, and housepainter. The household head who is working as tea seller at bazaar is retired but at the same time is noted in the table as self employed. He is both working in the informal sector as self-employed and retired as a previously self-employed person from SE. As seen in the table, formal sector workers are lesser than workers in the informal sector. Formal sector work is also categorized in itself as full time formal worker, contracted formal worker and seasonal formal worker. While there are seven full time formal workers, there are two seasonal workers and one contracted formal worker in the primary breadwinner position. Only one is an elderly housewife who subsists with elderly benefit as formal social assistance. There are six household heads in the retired category; while one of them is retired from the Retirement Fund; the other five retired from the formal sector and they belong to the SSI.

Sectoral shift is crucial because of two reasons. Firstly, sectoral shift is important because it lends itself to an understanding of the urban labor market relationship of urban poor and the details of their poverty experiences. Secondly, understanding job-hopping between sectors is helpful in this context to evaluate the health experiences of the urban poor because free health care access is closely associated with the sectors. The informal sector, which urban poor are mostly engaged in, does not provide health care access because of the uninsured status. This directly changed the respondents' health experiences and the problems they faced.

In this regard, we can see their work experience in their life course and in different periods. Among 40 families, family members are classified in four groups in terms of sectoral shifts in their work experience: those confined within the informal sector; informal sector workers including the self-employed and marginal sector workers who previously worked within the formal sector for a short period but returned to the informal sector; formal sector workers who succeeded in transferring from the informal sector to the formal sector; and formal sector workers who had no experience in the informal sector.

Table 14: Sectorial Shifts of Household Members

Groups by the state of sectorial shift	A*	B	C	D	Total
Working members at present	19	7	9	4	39
Unemployed seeking a job	1	1	-	-	2
Unemployed due to chronic illness	5	2	1	1	9
Housewives who left work due to marriage, pregnancy, child upbringing	3	2	1	3	9
Non-working members due to military responsibility	2	-	-	1	3
Retired	-	-	7	-	7
Student	1	-	-	-	1
Elderly	1	-	-	-	1
Total	32	12	18	9	71

*A: Those confined within the informal sector
B: Informal sector workers including the self-employed and marginal sector workers who previously worked within the formal sector for a short period but returned to the informal sector
C: Formal sector workers who succeeded in transferring from the informal sector to the formal sector
D: Formal sector workers who had no experience in the informal sector

In the first group, there are 19 household members in 16 families who have work experience only in the informal sector and were working in this sector at the time of the interviews. The majority of them occupies/occupied breadwinner position in their families. In addition, there are 13 family members in 10 families who had work experience in only the informal sector and did not work or were unemployed during the research. Family members who previously worked but do not presently or those who can not work at present consist of the unemployed seeking a job, the retired, housewives, the unemployed with an illness which prevents them from working, non-working members who are doing their military service, students, and the elderly.

In the second group, there are 7 family members who had formal sector experience, but work in the informal sector for the time being. They also have the main breadwinner position in the family. In addition to them, there are 5 family members who previously had work experience both in the formal sector and the informal sector, but were unemployed or did not have work at that time due to unemployment, having chronic diseases and domestic responsibilities. The occupational shift from the formal sector to the informal sector took place after the 1990s for all 7 household heads and 4 family members who do not work at present.

The majority of them have formal sector work experience ranging from 3 months to 2 years.

In the third group, there are 9 family members who made the sectoral shift from the informal sector to the formal sector. 8 of them have the main breadwinner position in their families and worked at that time. Among household heads, few are seasonal workers with an insured position of 8 months. The rest of the 4 months, they work as casual workers at the Dışkapı worker station. Also, there are 8 family members who transferred from the informal sector to the formal sector; however they are not working for the time being. Among them there are 6 retired under the household head position. Two of them consist of one chronic patient and one housewife. The unemployed one who has a chronic disease is also the breadwinner and there are no working members in the family. When we examine all 17 family members of the 15 families who made the sectoral shift from the informal sector to the formal sector in their work histories, it is seen that the majority of them migrated to Ankara a long time ago. When we examine the migration years of the families whose members made this shift, we see that the majority of them migrated to Ankara between 25 years and 59 years before. Approximately half of the household members who made this shift started to work in the formal sector before the 1990s.

In the fourth group, there are 4 family members who have only formal sector experiences and continue to work in the sector. While one family member has a breadwinner position which he took over from his father due to chronic disease, the three are not in the breadwinner role in the family. All are the sons of heads of the households and working in the formal sector is the first work experience for all four. In addition, there are four family members who worked before in the formal sector. They do not work now. 3 of them are housewives; one is a chronic patient; and one is currently in the army.

The above figures indicate that shifting from the informal sector to formal sector in terms of work experience of the family members in two *gecekondu* areas is not a general tendency. However, it can be said that urban poor are mostly engaged in the informal sector and have less work experience in the formal sector. They have little work experience in the formal sector, more notably so in the second group. In terms of the public/private sector, it can be said that respondents and their other family members so not have much work experience in the public sector. There are two

household heads who worked in the public sector. While one retired from the public sector as a janitor in a hospital, the other worked public sector as caretaker for fourteen years, but retired from the private sector. As expressed by Şenyapılı (2000), although some rural migrants, by using informal social network, could transfer to formal jobs, this movement from a "periphery job" to a formal job was limited (the role of the social network will be discussed in the next part of the chapter). Each respondent states that one or more family members have experience with the informal labor market including marginal jobs.

Before the 1980s, there was a general expectation that rural migrant workers in the informal sector would gradually become formally employed (Çağlar and Keyder, 2003). On the contrary, it has been seen that informal sector employment is not temporary, but that it becomes permanent. Individuals actually become confined in this sector according to the statements of the respondents. Sectoral shift experiences mentioned by respondents indicate that there is no tendency to shift from the informal sector to the formal sector. In fact, there is a tendency to work in the informal sector in the study. As Yentürk (1997) indicates, the neoliberal structural adjustment policies experienced after the 1980s including the flexibility of labor market have made employment move to the informal sector, subcontracting, and concentrating in sectors other than trade.

In terms of socio-economic status, (See Chapter Three for classification made by Ayata and Ayata, 2003), there are two groups: regular income earning poor and benefit dependent poor. The benefit dependent poor include irregular income earning poor such as casual workers, and no income earning poor who do not earn an income from wage work due to illness or disability. In this regard, there are 19 irregular income earning poor families, 16 regular income earning poor families in the research group. Also, there are 5 families, a member of whom, having carried single breadwinner position previously, can no longer earn an income from wage work due to an existing chronic disease, which they may be receiving treatment for and the elderly. Among no income earners, a family member occupying the main breadwinner position previously is unemployed with the introduction of chronic disease. Three chronically ill household heads, one having been treating the previous household head, and a female household member in single family could not transfer their

position to other family members and they entered into an extremely dependent position because there is no income received regularly or irregularly as a wage.

A look at the income of the families reveals that regular income earning families make an average of 550 YTL per month. The offically declared minimum wage was 488, 70 YTL during the interview time. Among the 16 regular income earning families, there are 7 families where more than one member earns an income either from a job and/or a retirement pension. A considerable number of families among the income earning poor receive a pension as a source of income. Also, a group of people who had migrated first to the city transferred their role as the main provider of income to their sons. Commuting expenses and personal needs, especially smoking, take a big chunk out of their earned income. In addition, 5 regular income earning families among 10 renter families pay rent. Among income earning poor families, the working members in the formal sector receive an average of 390 YTL per month. The majority of them receive a wage under the minimum wage in spite of being registered. Among them, there is one who receives 200 YTL per month.

While no income earning poor families are economically dependent on the state and/or informal network completely. The causes of poverty for all are related with health reasons. As mentioned earlier, there is no member with the potential to take over the role of main provider of income in those families. Two of them receive state benefits for disability and old-age. The other three do not receive any benefits. Their illness experience is new and they depend on their social network in terms of borrowing money, food and fuel in addition to the Municipality's fuel and food assistances. Irregular income earning poor families make an average 270 YTL per month. The majority of them have one working member. When we remember that the majority of families have at least 4 members, their meeting the basic needs for survival is very difficult as respondents have stated. Among them, casual workers receive daily wages between 10 and 20 YTL. However, indefinite working days and the decrease of jobs in winter make their family income irregular. They receive an average of 250 YTL monthly. The self-employed and marginals are not much different from casually employed persons in terms of earned income. They receive an average of 345 YTL per month. Also, it is observed that there is an imbalance between the income and expenses for both no income earners and regular income earning poor families. Income which does not meet basic needs especially for no

income earners and irregular income earners makes them permanently indebted. Food and fuel assistance, which the majority of households are receive, play a role in facilitating their subsistence according to the statements of the respondents (See next part of the chapter for details).

In general, the socio-economic conditions of the urban poor vary from time to time. Morçöl and Gitmez categorize the poor as *loser*s, *doer*s, and *accommodator*s (See Chapter Three for details). An examination of the stories of each case reveals that they can not be said to be in the same category throughout their lives. As the economic conditions change, a person may become a *doer*, an *accommodator*, or a *loser*.

It should be expressed that a significant number of families have fluctuating work histories as stated in their sectoral shifts later. However, if we examine their view about recent economic conditions, it can be said that there are three groups among the respondents as well: those who think that they live in better economic conditions (*doer*); those who think that they live in the same economic conditions (*accommodator*); and those who think that they live in worse economic conditions (*loser*).

More than half of the respondents (no: 27) state that they are living in worse economic conditions than before. The majority of them (no: 18) are the respondents in the benefit dependent poor category.

Some respondents (no: 7) state that they have been living the same poor position for some time. When we examine their work histories, it is seen that the family members of nearly all hold a benefit dependent poor position, working in informal sector with irregularly earned wages. Their economic conditions are irregular for a long while.

Respondents who think that they live in better economic conditions (no: 6) are seen only among income earning poor families. The perception of living in a better economic condition among respondents is closely associated with having a full-time, regular job with insurance. Very few respondents state that they are living in slightly better economic conditions than before.

Low and irregular income in the household influences family members' health and well-being negatively. The majority of respondents mention being depressed due to low and (or) irregular wages. M. Ko. (33 year old male living in Baraj) and his wife point out the effects of poverty experiences on their well-being as:

M.Ko: Çok oldu moral bozukluğu. İşte böyle bir zor durum oluyo, telefonun kapalı oluyo, elektriğin kapalı oluyo, insan strese giriyor.
Eşi: Bir de çocuk geliyor, kitap alacam şunu alacam bunu alacam diyor alamadığın zaman zor oluyor. Kara kara düşün ondan sonra.
M.Ko.: Köye gitmiştik neyse geldik. Bayramda bayramdan eve geldik daha kapıyı açtık, zil çaldı elektrik faturası 5 gün içinde ödenecek yoksa kesilecek. Su faturası geliyor, telefona baktım telefon kapalı. Hani ister istemez bi stres yani cebinde 100 milyonda olsa bu sefer. Hesaplıyon 100 milyon elektrik telefon şunları yatırsam diyon o zaman çocuklar ne yiyecek. Kapatılırsa kapansın diyon. Hani cezalı da olsa 15 gün sonra 1 ay sonraya kalıyo. Ama tabi ister istemez yattığın zamanda düşünüyon ya elektriğimi keşke yatırabilsem, işte suyu yatırsaydım, çocuklara şunu alsaydım, bi stres oluyo insan. Uyuyamıyoruz eşim döner ben dönerim yatağın içinde. Uyu uyuyabilirsen. Ayın yarısı böyle moral bozukluğu oluyo. Böyle düşüne düşüne daha da beter oluyon.

M.Ko.: There have been many upsetting experiences. You have a hard time, your phone is disconnected, your power is cut, and you get stressed.
Wife: Then the kid comes, I want to buy a book, I want to buy this, I want to buy that and it is hard when you can not. Then you start thinking trying to find a way out.
M.Ko.: We had gone back to the village because of the religious holiday. We came home. No sooner had we opened the door than the doorbell rang. They said either pay your electricity bill within 5 days or it will be cut. The water bill arrives. I checked the phone, its disconnected. Of course it naturally causes stress even if you have 100 million Lira (currently 100 New Turkish Lira) in your pocket. You do the math; if I pay the bills, what will the children eat? So be it if they cut it. Even if you have to pay interest later, after 15 days you pay it next month. But of course you can't help it; lying in bed you wish you could pay the electricity bill, the water bill, you wish you could buy the kids something, you get stressed. We can't sleep then. We both turn in bed. Sleep if you can. Half of the month goes by like this, all upset. The ore you think about it, the worse you feel.

There are also some respondents who mention the relationship between worsening physical health and difficult economic conditions. G.B. (a 49 year old housewife living in Baraj) is a regular income earning poor. Her son took over the breadwinner position after her husband had a heart attack. They migrated in 1976. When they migrated to Ankara, her husband's job in the rubber factory was ready. He has been working for 29 years. He has not yet retired because the insurance premium was not paid regularly in his first job. He worked as registered janitor for different municipalities between 1991 and 2004. G.B. talks about economic difficulties which she says caused her husband's heart attack and then lose his job as follows:

2-3 yıl önce elimiz çok dardaydı. Oğlum askerdeydi, beyim çalışıyordu. 8 nüfusa az bir maaşla bakmak zorundaydı. 150 milyonla geçindik. Ne bulduysak onu yedik. Yiyemedik daha doğrusu. 3 torun 2 gelin evdeydi. Sıkıla sıkıla o dönemde, 1,5 yıl önceydi, kalp krizi geçirdi beyim. Hanım beni kurtar dedi bana bir şey oluyor dedi yüzükoyun yattı. Biz bilmiyoruz ki ne olduğunu hemen götürdük hastaneye. Hastanede sedyenin üstündeyken geçirdi kalp krizini. Doktorlar hemen müdahale etti. Durmuş kalbi. Canlandırmışlar tekrar. Cana gelmiş.

We were having a very hard time 2-3 years ago. My son was doing his military service, my husband was working. He had to provide for an 8 person household on a small salary. We had to get by on 150 million Liras (currently 150 New Turkish Lira). We ate whatever we could get. Actually we couldn't. We had 3 grandchildren and 2 daughters in law living with us. Those were very hard times. One and a half years ago my husband had a heat attack. Save me, something's happening to me, he said and lay down prone. We didn't know what was

> happening. He had his heart attack on the gurney in the hospital. Doctors intervened immediately. His heart had stopped. They revived him. He came alive.

Working Conditions

The working conditions of the urban poor are crucial because of two reasons: the first one is the possibility that working conditions have a role in perpetuating the vicious circle of poverty; the second one is the possibility that it is reflected onto the body and health and these people's experiences with health. The role of the informal sector in poverty is elaborated on, inasmuch as urban poor are mostly engaged in the informal sector. In addition to the importance of the income they earn, the characteristics of work are also crucial.

When we examine family members' work history including present and previous jobs with the main characteristics such as working hours, insurance status, quality of job, duration of work, etc., it can be said that the majority of families have engaged mostly in the informal sector jobs, instead of the formal sector. This information gives us the opportunity to derive the main characteristics of informal sector jobs. Although defining the sector is very difficult as Lordoğlu and Özar (1998) express, it can be said that the main characteristic of the sector is that workers are unregistered and therefore they do not belong to any social security institution. This situation especially makes access to health services difficult and differentiated health experiences according to different insurance statuses exist for this reason. Howsoever grasping and defining the main characteristics of informal sector is difficult, it should be illuminating to gain insight related to its variety and its impacts on health status and experiences.

In our research, there are two groups who work in the informal sector. The first group consists of workers who have a definite workplace but have no insurance the way workers in private sector do; and consists of workers who have no definite workplace and have no insurance like casual workers. The second group is composed of workers who hold a job and are self-employed such as a housepainter; and workers with assumed to be a marginal job such as a tea seller, simit seller, garbage collector, and street peddler. Whether they perform small-scale trade or work as dependent to definite or various employers, it is true that they are unregistered to any social security institution. The main characteristics of the informal sector can be derived from the questions about their satisfaction / dissatisfaction with their job and awareness of

risks and threads in relation to their job. Certain characteristics are peculiar to certain groups in the informal sector. For example, irregularity of working days and indefinite workplace is much associated with casual/daily workers. The striking features for our sample are (1) constantly changing jobs, (2) requiring little or no skill and education, (3) irregularity of working days, (4) lack of constant workplace, (5) flexible working hours, (6) low and irregular wages, and employer tendency to not pay wages or not to pay wages on time, (7) lack of social security, (8) lack of job safety and subjected to more health risks, and (9) no job satisfaction.

Although, there is no question about the meaning or definition of work, respondents had tendency to explain "work" based on their perspective. The answer of "what is work" can be derived from the respondents' evaluation of their own jobs and their evaluation about other family members' jobs. In all respondents, the first characteristic of work includes jobs with more or less regular income. Instead of the amount of wages, the expression is on the regularity of wages. The regularity of income was not only expressed in the interview during chats on their income, they emphasized regularity repeatedly when they mentioned their future expectations, poverty experiences, and sufferings. Irregularity may even determine their well-being, food consumption, and sense of being healthy, which will be touched upon later. The majority of respondents with irregular family income tend not to accept irregular jobs as a job. Especially the women whose husbands have a casual job such as porter and construction worker, evaluated their husband's employment status as "virtually unemployed". When I first asked about their husband's job, they tend to give the answer "he is unemployed". During the course of the interview, it was understood that their husbands work as casual workers. This tendency is more evident in Baraj because the number of casual workers in that neighborhood is more than in Gültepe.

F.K. (78 year old female living in Baraj) lives with her son who has worked as a casual worker since his childhood. She evaluated her son's job as:

> *Bir gün çalışıyo üç gün çalışmıyo eve para girmiyor ki. Bir günün bir günün tutmuyor. Zaten işsiz gibi bir şey. Çalışıyo diye yazma istersen. Çalışmıyo de.*
>
> My son works one day and does not work three days in a week, no money comes into our home. Our days are not consistent. Anyway, he is sort of unemployed. If you want, write down that he is not working. Write that he is unemployed

Working days in a week are evaluated as one of the important indicators of the definition of work by the respondents. The number of working days directly determines the income entering the household. Like F.K., the next excerpt is related with casual work. The respondent emphasizes the going daily to the same workplace with a minimum of one day's weekend rest as the basic characteristic of work. Especially the wives of those who work as casual worker, even seasonal worker who are insured, and work in marginal sector do not see these jobs as work.

N.B. (26 year old female living in Baraj) explains the irregular characteristics of her husband's job as:

> *2002 den beri mevsimlik çalışıyor. 3 yıldır 6 ay boş kaldığında hamallık yapıyor. Ne kadar çalışacağı ne zaman iş olacağı belli olmuyor. Günlüğü de değişiyor. Saati hiç belli olmuyor. Herkes öyle gidiyor burda. Orası işyeri değil. Senin işin oluyo mesela yüklemeye çağırıyorlar. Zaten şuan işsiz sayılır. Bu iş değil ki.*
>
> He has worked seasonally since 2002. He has worked as a porter for three years when he is unemployed for six months. It is unknown how many days he works, when a job will be available. His daily wages are changeable. His working time is not fixed. Everybody is like that here. There is no workplace. For example someone needs workers, you are called for loading. Anyway, now he is pretty much unemployed. This is not a job.

The seasonal characteristic of jobs is one of the main dissatisfaction points because it causes irregularity and only seasonal income. It is striking that the majority of respondents who or whose other family members, especially the household head, work in the informal sector except for those who do not work in a definite workplace with a definite wage complain about the seasonal character of their jobs. Most of them work in the construction sector or in porting in Siteler, the center of furniture manufacturing in Ankara. Respondents who work as casual workers in Siteler state that there are decreasing working days with the coming of winter because furniture production and shopping in Siteler in winter decreases.

In addition to casual workers and seasonal workers, being self-employed in the informal sector is also not regarded as having a job. M.Ko. (33 year old male living in Baraj) is a self-employed housepainter. The dialogue below between the respondent and his wife indicate the seasonal characteristic of informal jobs, as an unintended feature of work:

> *Eşi: Hiçbir işte çalışmadı Mehmet.*
> *M.Ko.: Ben hep serbest meslek üzerine çalıştım.*
> *Eşi: Devamlı inşaatta.*

M.Ko.: Köydeyken çiftçilikle. Ankara'ya geldim inşaatta. 1994'de Ankara'ya geldim. O zamandan beri alçı, boya, işte öyle inşaat üzerine, yazın iş artıyor kışın da yat.
Eşi: Yine de günü gününü bulmuyor.
M.Ko. : Belli de olmuyor. Kışın da çıktığı oluyor bir tanıdık oluyor, siz gibi birisi geliyor ya işte boya işi var, hani ben boyacıyım dediğim zaman benim daireyi, bir boya o şekil belli olmuyor yani, kışın da olabiliyor.
Görüşmeci: Kaç saat çalışıyorsunuz?
M.Ko.: 8 saat 12 saat 15 saat belli olmuyor yani o da düzensiz. Bazen bitirene kadar devam ediyorum.

His wife: Mehmet has never had a job.
M.Ko: I always work as self-employed (have "free" work)
His wife: He is always on a construction site
M.Ko.: I engaged in agriculture in the village and I worked in the construction sector when I came to Ankara in 1994. Since then, I plaster and paint walls. In summer time, the number of jobs increases, in winter I rest.
His wife: it is erratic however
M.Ko.: It is not known, too. Sometimes I get jobs in winter time. Some acquaintance comes and they ask you to paint their house when they find out you are a painter.
Interviewer: How many hours do you work in a day?
M.Ko.: 8 hours, 12 hours, or 15 hours, it varies, that is, it is irregular too. Sometimes I continue until it is finished.

This dialogue indicates clashing perspectives in the domestic field. There is difference among the statements between "has never had a job" and "work as self-employed". Housewives whom I interviewed, housewives of the respondents such as M. Ko, or housewives I talked without recording focus on only one thing: regularity; because they suffer from irregularity deeply when their husbands go to work and they come face to face with survival difficulties and the requests of their children at home. The self-employed in the sample are not much different from casual workers in terms of both the job's seasonal character, the amount of income earned, irregular character of income, irregular working days, and lack of insurance and so on. A peculiar feature is being relatively free in terms of being able to work without the existence of the employer, and being flexible in working hours and days they determine themselves; in brief, they are in the position of decision-maker. However, when we look at the working hours, it is seen that they work long hours because their job is based on the completion of the job which they undertake in the framework of agreement with customers. On account of these features, self-employed is defined as "free work" like M. Ko. expresses and it is defined as "no job" by his wife due to irregularity in many aspects.

In addition to the regularity in different aspects, the other characteristic of work as being considered as work is the insurance status of the job. The social security status in our sample is much more underlined due to the majority of respondents suffering from ill-health and having no access to health services. P.B. (23 year old

female living in Baraj) lives with her husband and three children. Her husband works as casual worker. She says:

> *Emekliliği yok sigortası yok iş olma garantisi yok işsiz sayılır. Doktora gidemiyorsun. Ölsen para lazım. Böyle iş olur mu?*
>
> No pension, no insurance, no guarantee of work. He is pretty much unemployed. You can't go to the doctor. Even if you die, you need money. What kind of a job is that?

Regularity and social insurance are seen as the main characteristic of what is considered real "work". There are nine casual workers in the main wage earning laborer position in families without any working family members. Casual work is associated much with irregularity in terms of working days, payments, working hours, work activities, workplace, and so on. It is perceived as the nearest status to being unemployed due to frequent exposure to unemployment.

When rural migrants who have work experience only in agricultural production and/livestock came to the city, they have worked mostly within the informal sector, which does not require any skill or education. It is observed that the majority of household heads are primary school graduates (three fourths of 40 families). Most of the household heads in the families interviewed in the two neighborhoods have jobs in the informal sector. As mentioned before, jobs in the informal sector are generally manual jobs, have ambiguous working times and income, are uninsured, are temporary in character, and present health risks. In terms of income, as well, there is no guarantee for paying wages or there is a delay in payment. One of the significant characteristics of these jobs within the informal sector is the irregularity in terms of many aspects. This irregularity brings about different aspects of poverty. The irregular character of informal jobs makes people have irregularities in different ways from unbalanced food consumption to their feeling of wellbeing or their feeling of healthy. In this regard, informal work is crucial because it seems to influence all aspects of life and reinforces the poverty cycle.

In addition to the above features, in the informal sector jobs change constantly. Work histories of household members indicate that there is tendency to always be job-hopping. According to the statements of the respondents, there are lots of reasons behind this. This tendency is closely associated with other characteristics of informal sector jobs such as low wage, employer's tendency to not pay, lack of social

insurance, flexible working hours and so on. The excerpt below serves as an example which represents this pattern. N.A. (28 year old female living in Baraj) expresses her husband's job, which changes constantly:

> *Biz evlenmeden önce 2 yıl lokantalarda çalışmış köyden yazları gelip gidermiş. İlk evlendiğimizde lastikçide, lokantada, benzinlikte, kargoda ve sitelerde hamal olarak çalıştı. Sigorta yapılmadı, para zamanında verilmedi, ya da hiç verilmedi. Bu işlerde hep 1-2 ay çalıştı çıkardılar. Çok işe girip çıktı. Beyim nereye girdi nereye çıktı belirsiz. Birbuçuk ay işsiz kaldı buraya girmeden önce. 2 senedir Altınparkta mevsimlik temizlik yapıyor mevsimlik çalışıyor. Ssk sı var 6 ay yapılıyor 6 ay yok.*
>
> Before we were married, he worked in restaurants two years seasonally by coming and going to the village. He worked in tire repair shop, gas station, and as a porter in a cargo company and in Siteler during the first years of our marriage. He was not registered to social security; he was not paid on time, or was never paid at all. He worked each job one or two months, and he was fired. He kept changing jobs. It is uncertain where he worked. Before beginning his last job, he remained unemployed one and half months. Now he works as seasonal worker cleaning in Altınpark. He is insured for 6 months and then uninsured for the other 6 months in a year.

As Ayata and Ayata state (2003), casual workers change jobs frequently shifting from one employer to another even in very short periods of time. Not only do casual workers suffer from working at jobs for short periods of time but also other informal workers who work in the private sector with no insurance change their job constantly as seen in the excerpt above. Ayata and Ayata state that "during the frequent periods of unemployment between changing employers and jobs, the casual worker himself and often the whole family who depends on him lose an income" (Ibid: 105). The *economic capital* worsens when the source of income of the family is only based on casual work. So their exposure to poverty reaches high levels due to the characteristics of informal work.

The other characteristic is employer tendency to not pay or delay payment or make incomplete payments, which influences the *economic capital* of *gecekondu* families as expressed in N.A.'s case. The excerpt from H.T. (32 year old male living in Baraj) explains the main characteristics of the informal sector job. He works as a casual, daily worker. Like other informal workers, he suffers from not receiving daily wages. He states that:

> *Çalışıyoz ama paraları alamıyoruz. Adam kendi trilyonluk, ama paraları vermedi akşam yine. Onu bekledim. Arkadaşlarıma dedim siz beklen burda diye. Adam çalıştırıyo çalıştırıyo akşama kadar. Sonra parayı vermeden gönderiyo. Olumlu hiçbir yönü yok. Güvencen yok hem de güvenli değil çünkü çok tehlikesi var. Duvarlara çatılara çıkıyorsun mesela. Ağır kaldırıyorsun belin ağrıyor.*

> I work but can not get money. The man (employer) trillions, but he didn't pay me again tonight. I waited for him. I told my friends to wait. He worked us until night and sends us without paying our wages. There is no positive aspect of my job. There is no social security. Also there is no occupational safety because it is very dangerous. For example, we climb walls and get on the roof. I carry heavy things, and my back hurts.

The majority of the respondents complain about earning inadequate money because firstly, the wages are low and secondly, employers have the tendency not to pay on time or not pay at all even at the end of the work. This feature indicates the exploitative characteristic of the informal sector. These tendencies of employers make the survival of the urban poor more difficult and prevent them from escaping poverty and reinforce their poor position by due to low level of income. Due to the nature of informal work, there is no contract including employee rights, definite working hours, definite wages, nor is there any supervision by the state. As a result of the lack of registration and of state control, the determination and the payment of the wages is dependent upon the employer's conscience. Not paying the wages signifies a dual exploitation. Besides profiting by extracting from surplus value by employing workers with long hours and low wages as classical exploitation, there is tendency to continuously decrease the cost of labor. This calls for investigation because this is a commonality in the work experience of the majority of the families. In this regard, it can be said that informal sector jobs play a role in impoverization and the perpetuation of poverty. M.Ay's excerpt below (35 year old female living in Baraj) explains this as:

> *Eşim sigortalı olarak kola fabrikasında çalışıyordu 7 yıl çalıştı. 1998 de işten çıkardılar iflasın eşiğine geldi işçi çıkarttılar 50 kişi. 1998'den 2002 ye kadar da ne iş bulsa yaptı. Beyim hiçbir yerde alamadı tam olarak parasını. Sadece şimdi öyle değil hep böyleydi. Amelelik yaptı. 2 ay araba yıkadı. İnşaatlarda çalıştı. Sitede simitçilik yaptı. Samancıda çalıştı, hamallık yaptı. Köylerden arabayla saman yükleyip indiriyordu. Para vermediler. İş hergün çıkmadı. İş için her yeri dolaşıyordu. Fazla para kazanamıyordu, parasını da vermiyorlardı, sürekli başka işler aradı. 2003'de benzinlikte çalışmaya başladı. Araba yıkıyordu. Bu işi de 1 yıl yaptı. Sigortası yapıldı ama hastalanıyordu yaz kış zor oluyordu bir ara kaynakçılık yaptı birkaç ay. Oradan da çıktı sigorta yapacağız diye söz verdiler, yapmadılar. Sigortayı bırak parasını bile vermediler. En son sitelerde demircinin yanında. 2-3 ay oldu gireli. Oradan da çıkmak üzere dengesiz. Parayı zamanında vermiyorlar. 40 bir veriyor 50 bir veriyor. 380 milyon şuan maaş görüyor aylık. Oradan da çıkacak parasını alabilse... Tam alamayınca kira ödeyemiyoruz, faturalar faiziyle geliyor, faizler birikiyor. Bir de faizleri ödemeyle uğraşıp duruyoruz. Çocuklar aç kalıyor yeri geliyor ekmek parası bulamıyorsun. İyice fakirleştik biz böyle böyle. Önceden fabrikada çalışıyordu aldığımız belli harcadığımız belliydi şimdi her şeyimiz alt üst oldu.*

> My husband was working in cola factory with insured status. He worked 7 years. In 1998, he was fired. 50 workers were fired due to near bankruptcy. He worked any job he found between 1998 and 2002. He did not get all of his money anywhere. This isn't just for his jobs now. It has always been this way. He worked as a casual worker; he washed cars for two months, worked in construction sites. He sold simit in the neighborhood. He worked loading

> hay in villages; he worked as porter. He didn't make much. They did not pay. There wasn't work everyday. He looked all over for jobs. In 2003, he started to work in gas station. He was washing cars. He left the job after one year because he became ill; it was too hard to work both in winter and summer although he was insured. He worked as welder few months in Siteler. He left the job because they promised to insure him but they did not. They did not even pay his wages. His last job is steel working. He has worked there for two or third months. He is now almost out of a job due to irregularity. The employer does not pay on time. He pays 40 one day, another day he pays 50. His monthly wage is officially 380million. He will leave the job when he receives his money… When he doesn't get all of the money, we can not pay our rent, our other bills get interest and the interest is accumulated. Then we try to pay off the interest too. Our children go hungry. Sometimes we can not afford even bread. We have impoverished due to this. He used to fork in a factory. The money we received and what we spent was definite. Now everything is all mixed up.

M.Ay.'s husband was working as a steel worker. She compares formal and informal work in terms of regularity. Her husband works six days a week with a salary of 380 million Turkish Liras (380 YTL) if the employer pays. This wage is also under the minimum wage of that period[25]. This exploitative character of the informal sector, as M. Ay expresses, has an important role in poverty. When I met M. Ay for the second session of the interview, she said her husband had not received his money and he had left the job. Again he returned to daily casual work. Casual workers in our sample earn between 10-20 YTL on a daily basis; however it is not guaranteed they will work everyday as Ayata and Ayata (2003) mention. Their troubles are doubled because they receive low wages in general and they may not receive their wages on time or at all. The two main causes of constantly changing a job are not receiving wages or irregular payment and lack of insurance. Sometimes, certain jobs have a definite time frame. This also leads to people constantly changing jobs.

All respondents whose family members worked or work in the informal sector complain about this exploitation. This tendency, while seeming to be unique to the informal sector, employer tendency to not pay wages is not limited only to the informal sector, it is striking that formal sector workers in the private sector also suffer from this tendency in the study, though to a smaller extent. A.Ay. (36 year old female living in Gültepe) explains her husband's work experience. Her husband has worked as an automotive body repairer with social insurance for 14 years in different workplaces. She expresses the irregular income and its influences as follows:

[25] The offically declared minimum wage was 488, 70 YTL during the interview time. This information is obtained from the official website of Ministry of Labor and Social Security, http://www.calisma.gov.tr, acessed 21 february 2007.

Mesela parasını vermiyorlar az veriyorlar ya da sigorta yapmıyorlar. Bu yüzden hep iş değiştirdi daha önce. Genelde işsiz kaldığı zamanlar bunalıma girdik. İşe girdiği zaman bile 1 ay geçene kadar bayağı sıkıntı çektik. Parasını düzenli vermediklerinde çok sıkıntı çekiyoruz. 500 alıyor ama Allah bilir ne zaman verirler ne kadarını verirler. Görüntüde o kadar alıyor. Sabrediyoruz yapacak bişey yok. Zorla para alınmıyor. Parayı vermeyince noluyor kirayı veremiyorsun elektrik su telefon veremiyorsun. Borç birikiyor. Perişan oluyorsun. O orda stres oluyor ben burada stres oluyorum bir şekilde idare ediyoruz. Yapacak bir şey yok. Maddi durumumuz gelirimiz hiç belli değildi bir iyi bir kötü oldu. Hiç düzenimiz olmadı eşim sürekli iş değiştirdiği için.

For example they do not give his money or give him a small part of his wage or do not insure him. For this reason, he used to constantly change jobs. We were usually in depression during his unemployment periods. Even when he began to work, we had difficulty surviving until one month was passed. We suffer from irregularity of payment. He receives 500 YTL but we never know when they will pay, or even how much they will pay. That is what he receives officially. We have to be patient and wait; there is nothing else to do. You can not get money by using force. When we do not get money, we can not pay the rent, electricity, water, or the telephone bills. Debts are accumulated. We become desperate. He becomes stressed there and I become stressed here but we manage somehow. There is nothing to do. Previously, our income was not regular. Sometimes it was good sometimes it was bad. We never had order because my husband changed his job constantly.

According to the new work law enacted in 2003, in the event of payment below minimum wage, incomplete payment or no payment consciously in return for work or overwork, the employer pays the fine determined by the law[26]. Although A.Ay.'s husband has worked for 14 years in formal sector, he has permanently changed his workplace because of the problems with payments. Workers in the formal sector are aware of the risks about job security and occupational hazards, but they do not know their legal rights and do not act together with other workers who suffer from the same things in their workplaces. In our sample, the formal workers work in small scale workplaces instead of factories or large scale firms. They always try to solve problems by trying to persuade the employer. It can be said that although the work and working conditions are regulated by law, especially emphasizing the registration of workers, reality is different because employers do what they like for the sake of more profit. In Turkey, labor costs are very high when the laborer is registered. This cost orientates the employer to employ workers without registering them.

Job satisfaction and risk awareness that derived from respondents' answers both about their own jobs and other working members' jobs in their families are crucial in terms of the elaboration of the working conditions of the urban poor. The number of total working members is 40 in 31 families. There are five families having

[26] See for details http://www.calisma.gov.tr . The new work law (numbered 4857) enacted in 22.05.2003, published in Official Newspaper in 10.6.2993 numbered 25134.

no working members. Also there are four families without any working members but the household heads are retired. There are total 6 (plus one retired but working at the same time) retired people in all of the households. Retired members feel grateful for having been able to retire and receive a pension. In particular, as they observe their neighbors living in poverty, unemployment, low and irregular wages and as the uninsured, their gratefulness increases. The excerpt below reflects this:

> *Bakıyorum çevreme herkes işsiz özellikle de gençler. Ankara'nın işsizleri burada toplanmış sanki. Bizim zamanımızda öyle değildi. Çok iş değiştirirdik ne iş olsa yapardık iş vardı. Çocuk aldığı parayla yol parasını ödeyemiyor ki, çalışmasa daha iyi. Bakıyorum bu duruma halime şükrediyorum. En azından emekli olabildim. Düzenli alıyorum param, doktor desen doktora da gidebiliyoruz. Ben işimi de severek yaptım ayrıca.*
>
> When I look around, I see, everybody is unemployed, in particular young people. It is as if the unemployed of Ankara are clustered here. It was not like that in our time. We changed jobs continuously, we did whatever the job was and there were jobs too. The kids can not meet their commuting expenses, so not working at all is much better. When I look this situation, I am thankful for my situation. At least, I was able to retire. I receive regular money. I can go to a doctor when I want to. Also I had a job that I liked.

Like M.F. (74 year old male living in Gültepe) says above, the feeling of gratitude increases when they see the poorer families near them. It is observed that the majority of the retired members of all the families in our sample, it is expressed that there is no job risk both in terms of occupational safety and health and precariousness[27]. Only one retired person states that he is satisfied due to having been able to retire and at the same time he is dissatisfied with his last job due to extreme exhaustion as a truck driver and porter. The other retired person was also dissatisfied with his job as a "scrubber" at a hammam because he thinks that the job is unhealthy. These two

[27] Recently, the words as precariousity, precariousness, or precarious job have become popular. The root of the word lies in the word *pray,* which comes from the Latin word *precor* and *precarious,* which means uncertainty and contingency (Barbier, 2004). According to this use, what is precarious is what is uncertain and what can only be obtained from praying (Ibid.). Recently the use of the word is related with the quality of employment. There is no standard use for this word between different countries. Its use in France and in Italy implies any type of employment which does not conform to the guidelines mentioned in the on Labour law. In the UK and Germany, there is no significant mention of "employment precariousness" (Ibid.). Bourdieu (1963) used the word *précarité* in his research in Algeria in the 1960s. He pointed out the social divide which seperated permanent workers from the contingent or casual ones (cited in Barbier, 2004). Bourdieu's (1998) most recent use of the term *précarité* is close to my use of the term. According to him, *précarité* is everywhere and results in collective effects that are most observable in the case of the unemployed. Like unemployment, common features define it and precariousness also affects those who are apparently spared by its influence. Hence *précarité* appears as one of the aspects of a dominated condition in society, close to unemployment and exclusion. And these situations are the product of a new "mode of domination" which is underpinned by a generalized state of insecurity (Ibid.) In accordance with the Bourdieun use, I use the word to referto the employment relationship between the labor and the capital as characterized by job insecurity.

barely retired because of permanent job-hopping. Sometimes their insurance premium was paid and sometimes not.

Only four working members have job satisfaction. The common characteristics of the four are being a formal worker with definite workplace, definite working hours and days, definite wages, and social security. The reasons of job satisfaction are much more related with social security and primarily regular wage.

The majority of the working family members (29 members of 23 families) state their dissatisfaction based on various reasons. On account of the aforementioned characteristics of informal work which the urban poor are engaged in, the majority are dissatisfied with their work. While most family members work in the informal sector as dissatisfied with their job, only one respondent states gratitude. This respondent is a housewife whose husband as the only breadwinner of the family works as casual worker. Although this respondent's socio-economic level is very low, she is thankful when she compares their family with the unemployed. The feeling of gratitude comes about by comparing families of lower socio-economic level. Actually, this feeling is much associated with fatalism without questioning the structure. Among the most important reasons of job dissatisfaction is the precariousness of a job. In this regard, the main reasons behind this are expressed as lack of social security, and irregular and low wages; among other reasons, no everyday job due to irregularity, the seasonal character of the job, employer tendency to not pay wages, the risk of being fired, no future and no pension are expressed. In terms of reasons of job dissatisfaction, problems related to occupational health and safety were brought up less than the precariousness features of the job. Exhaustion, back aches, sleeplessness, working under difficult conditions, and chronic illness preventing work are stated.

The number of working members who feel both satisfied and dissatisfied about their job is 8. They express their views about the job based on reasons similar to those mentioned above.

The respondents' risk awareness about the job performed by family members involves the precariousness of the job and occupational health and safety. All the jobs performed by urban poor are manual jobs. Especially, informal workers with or without a definite workplace are subjected to health risks such as extreme exhaustion, sleeplessness, and back aches due to long hours working heavy jobs when employed as porters, construction workers and so on. The difference in risk awareness is much

more related with flexibility of the work and how the body is used according to the job. Also, there is a close relationship between the precariousness of the job and the state of health and well-being of the urban poor, for example, long working hours cause exhaustion or working night shifts lead to sleeplessness.

The first issue to mention here are the impacts of the type of job on the health state of the working poor. The first group exhibiting similar impacts on health is casual workers. Mus.B. (51 year old male living in Baraj) has been a casual worker for four years as the only working member of his family. He complains about his job as:

> *Ağır iş amelelik, vücudu yıpratıyor. Aslında yaşım da genç değil. Aşırı yorucu, sırt ağrısı bel ağrısı. İş bitince her yerim sızım sızım sızlıyor. Ama çarem yok. Yeri geliyor çok ağır kaldırıyorsun saatlerce sürüyor. İnşaatlarda çalışıyoruz. Tehlikeli sonuçta.*
>
> Casual work is heavy work, it wears out the body. In fact, I am not a young man. The job causes extreme exhaustion and back aches. After the end of the job, my whole body aches. But there is no alternative. Sometimes, I lift heavy things for hours on end. I work in construction sites. Of course it is dangerous.

The second issue to mention here are the occupational hazards peculiar to the workplace in terms of workers' safety regardless of working in the formal or informal sector. In the sample of the research, there were no working members in large-scale companies or factories. Large scale workplaces employing more than 50 workers are subject to certain regulations according to the new work law enacted in 2003 (Demircioğlu, 2004). These regulations related to workers' health and safety are the employer's obligation to form an occupational health and safety board and responsibility to employ a doctor in industrial workplaces where more than 50 workers are employed. However, one noteworthy issue in labor law is that it does not include people working in the informal sector. In fact, the law lays the ground for flexibility and informality in many aspects. When it is taken into account that working people make up half of the labor force in Turkey, it can be said that we are faced with a group of people whose safety and occupational health are either left to themselves, or to their employers' conscience. Below, there is an excerpt from N.D. (39 year old female living in Baraj) related with the unsafe workplace:

> *O da dün tahta kesiyorlarmış o da vurunca gözüne değmiş. Gözü sarılı. Götürdük ilaçlarını alamadım inanır mısın bacım? Sigortası yok, kaldı ilaçlar. Ya iş kazası geçirdi yani dün. İşi tehlikeli. Orda birkaç kişi öldü. Makinada çalışıyor makinada… O gün parmağını kestirmiş bi oğlan. Parmak gitmiş. Bi başkası da parmaklarını koparttırdı 2 ay önce. Memet dediğim bu kardeşimin parmakları şöyle şurdan koparttırdı söylemesi ayıp kısa kısa duruyor. Ne yapalım eşimin de işi bu. Valla 4 ay deneme süreli. Yani eğer 4 ay sonra adam memnun olursa devam edecek sigortası da yapılacak, memnun olmazsa hadi git diyecek.*

> When my husband was cutting wood with the machine yesterday, he got some wood in his eye. Now his eye is bandaged. Can you believe that we went there but I could not buy his medicine? He is uninsured. He had an accident on the job yesterday. His job is very dangerous. Some workers died in this workplace. He works with machines. One day, a boy's finger was cut in the machine. Someone else recently got his fingers cut off two months ago. The fingers of this man, Mehmet, are stubby now. There's nothing to do. This is my husband's job. This job has a 4 month trial period. That is, if the employer is satisfied, he will keep my husband and insure him; but if he isn't, he will lay him off.

N.D.'s husband is a carpenter. He works but he is not registered and whether he will be permanently hired or not will certain after the 4 month trial period. In N.D.'s husband's workplace, the number of employed workers is about 10. Thus, the employer does not have to employ an occupational doctor or nurse or even have health and safety board. In Siteler, while daily workers are employed mostly for transporting and carrying furniture, seasonal workers one part of whom constitutes seasonally migrated workers from rural areas, are employed for production according to the information obtained from many respondents'. Employers prefer to employ workers with a minimum labor cost by not registering them to the relevant social insurance institution. The gaps in the law make this easier. Therefore, workers have no access to health services, they are not protected from health risks and threats brought about the job itself, and they can be retire in spite of long years' work experience. As in N.D.'s case, worker safety and health is ignored by the state. This makes working people in the informal sector more vulnerable to occupational hazards and health risks because there are no rules in this sector, and no state protection. They are out of coverage. The next excerpt is related with marginal work**.** L.A. (40 year old male garbage collector living in Gültepe) is a garbage collector and he touches upon the risks of his job:

> *Topladığım şeyi eve getiriyorum bahçeye. Atık madde topluyorum özellikle teneke ve plastik. Nakliyeye para veriyorum. Pislik içindesin sürekli. Bu işte dikkat etmezsen hayatına malolabilir. Mikrobun içindesin. İstesen de sağlıklı olamıyorsun. İnsan sağlıklı olmak için ne yapar elini yıkar hijyene dikkat eder. Ama benim işimde atılan şeylerin içine bile bile giriyorum. Elimi sokuyorum vücudumu sokuyorum ne kadar eldiven taksamda dikkat etsem de olmuyor. İster istemez bulaşıyor. Kokuyor. Hastane işine gitmem mesela. Hastanede kaptın mı kurtuluşu yok. Bir de doğanın verdiği zorluklar var. Kışın soğukta çalışıyorsun. Kendimi korumaya çalışıyorum. Kışın daha az çalışıyorum. Hasta olursam bu sefer aileme zararı olur. Önce kendimi düşünürüm. Ben sağlıklı olabilmeliyim ki aileme yardımcı olabileyim.*
>
> I bring whatever I collect home to the backyard. I collect waste materials especially tin and plastic. I pay for shipping. I am constantly in grime and dirt. This job could cost you your life if you aren't careful. You work in germs. You can't be healthy even if you wanted to. You wash your hands to be healthy, you pay attention to hygiene. But in my job I have to consciously wade into waste. I put my hands in it, my whole body in it. No matter how much I wear gloves or take care it doesn't matter. I still get the germs. It smells. I don't go to

> hospitals for this work though. If you contract something there, you have no chance. Then there are difficulties related to nature. You work in the cold in winter. I try to protect myself. I work less in winter. If I get sick my family will suffer. I think of myself first. I have to be healthy do that I can help my family.

Garbage collectors decide on their own working conditions. The determining factor is related with the income they earn will sustain their family. Most of the time, L.A. goes to work after 6 p.m. when the waste is put outside buildings. In winter, he works less because of the cold weather conditions. Although he determines his own working conditions, the job is very risky in terms of health as he indicates. He is aware of the health risks and tries to adopt health promoting behaviors.

The next group of workers is the shift and night workers. In addition to exhaustion, sleeplessness is common in shift work and night work. N.T. (45 year old male living in Baraj) has a chronic illness. He states that he is able to work only as a simit seller. According to how he feels on a given day, he works an average of 13-14 hours a day.

> *Şimdiki işte gece saat 3'de kalkacan herkesin uykusunun en tatlı yerinde. Taksicilere daha çok sattığım için gece çalışıyorum. Rahatsız olmasam neyse. Geceler soğuk oluyor adam üşüyor. Yağmur yağıyor kar fırtına oluyor. Elim yüzüm şişiyor kulağım duymuyor kulaktan iltihap akıyor. Karaciğer iltihabı oldu 3 sene önce. Üşütmekten soğuktan sürekli inşaatlarda çalışmaktan eskiden de çoban olarak çalışmaktan sefillikten oldu. Uykusuz kalıyorum. Bünyem ne kadar dayanırsa dayanabildiğim yere kadar. Kimseye muhtaç olmayayım diye poğaça simit alıp satıyorum kahvelerde, gaz istasyonlarında, taksi duraklarında.*
>
> In my present job, I wake up at 3 a.m. when everybody is fast asleep. I work at night because I sell more to taxi drivers. It wouldn't matter if I were not ill. Nights are cold and I feel cold. It is raining, snowing, stormy. My hands and face swell, my ears don't hear well and discharge comes out of my ears. I was diagnosed with hepatitis 3 years ago. It happened because of working in cold weather, always working in construction, working as shepherd, and destitution. I am sleep deprived. I work as much as I can bear. I sell simit and pastry in coffeehouses, gas stations, and taxi stations so I do not have to depend on anyone.

Health is not only explained with the present job, but also with the cumulative impacts of previous jobs. Working in jobs with difficult conditions for long years harms *health capital*. I concede that health and disease can not be explained merely with one cause, they are multicausal; however it is evident that some of these jobs emphasized here directly influence the *health capital* of the urban poor negatively. When we examine the years of work experience, working long years especially under heavy and unsafe working conditions wears out the body increasingly with time as expressed also by the respondents. S. K.(70 year old male living in Gültepe), who was

able to retire but now constantly changes jobs and works under difficult conditions, expresses that:

> *Hep ağır işlerde çalıştığım için çok hastalık çıktı. Günde 700 ton indirip kaldırırdım tek başıma. Altınovada ofise buğday taşıdım, demir çelikte çalıştım, trafoda çalıştım, çiftliklerde çalıştım, fındıklarda çalıştım, kömür deposunda çalıştım, amelelik yaptım, inşaatlarda çalıştım, nakliyecilik yaptım. Her yere gittim bir sürü değişik şehre. O zaman eşim evde kalırdı. Giderdim iş bitene kadar ayda bir kere gelirdik yani. 70 yaşındayım ama 1997 yılında çalışmayı bıraktım. Bütün hayatım böyle geçti. Şimdi de ne ararsan var her türlü hastalık. Yine iyi dayandım bu kadar çalışmaya. Romatizmam var orda burda çalışmaktan oldu. Ağır kaldırmaktan fıtık oldum.*
>
> I have lots of illnesses eases because I have always worked in jobs with difficult working conditions. I unloaded and carried loads weighing a total of 700 tons a day all by myself. I carried wheat to an agricultural office in Altınova, I worked for an iron and steal factory, in an electric plant, in farms, in hazelnut fields, in a coal warehouse, as a casual worker, and truck driver and porter. I went everywhere, to lots of different cities. Those days my wife stayed at home. I would be away until the job was done and come home once a month. I am 70 years old now but I stopped working in 1997. My life went like this. Now, I have all kinds of diseases. But I lasted well considering how long and how much I worked. I have rheumatics arising from working in different places. I also ruptured due to loading heavy burdens. I have rheumatism due to working here and there. I have a hernia from lifting heavy things.

S.K.'s work history involves many jobs under insecure and unsafe working conditions. In spite of the long years he worked from 1954 to 1997 both in the formal and informal sector, he was able to retire in 2003, having paid his SSI premiums. Now he suffers from many illnesses as a result of working under difficult conditions for so long.

In terms of working hours per day, it can be said these people work at least 10 hours a day. Casual workers in the sample work an average of 12 hours, the self-employed and marginal workers have irregular working hours depending on their own decisions and the completion of a given job. Informal workers with a definite workplace but without insurance work at least 12 hours a day. They are daily workers. If the job is a daily job, they might work everyday. Formal sector workers work an average of 12 hours a day, 6 days a week. The labor law states that working hours should be 45 hours a week and a maximum of 11 hours a day. Reality is different as seen in the formal workers in the respondents' families (see appendix for details). According to the law, workers are paid overtime. However, formal workers may not even receive all of their promised wages and this was the case during the timeframe of the study.

When we look at the severity of the harsh working conditions leading to health problems which in turn prevent the urban poor from working, we identify two

types of removal: temporary and permanent. The working conditions of urban poor as mentioned above are very flexible and are pose a threat for the health and well-being of workers. The worker is not the only one concerned with his health and safety; the whole family is. Working conditions sometimes have temporary effects on the *health capital* of workers; sometimes they have permanent effects. A.Ay. (36 year old female living in Gültepe) explains the temporary effect of occupational hazards on health as follows:

> *Kaporta dükkanı açtık evlendikten 2 sene sonra 1989 yılında. O zaman durumumuz iyiydi. Araba da aldık. 1 sene sonra dükkan yandı mal da gitti beyim de yandı. Daha da düzeltemedik durumu iyice düştük. Nerden baksan 1,5 sene çalışamadı eşim. Bakımını kaynanamgil üstlendi o süre onlara taşındık. İşe neye gidemedi belden aşağısı yandı bacaklarının üstüne basamıyordu. Sen sakatsın iş yapamazsın diyorlar o da gittiği yerden geri dönüyordu. O yüzden de çok sıkıntı çektik. 1,5 sene doktor kontrolündeydi. Ancak 1992 yılında tekrar işe girebildi. Değişik işyerlerinde çalıştı ama doğrulamadık. Parayı düzgün vermediler hiç. Ya da sigortasını yatırmadılar. Buraya yeni girdi 1 ay oldu. Kaportacı deyince herkes çok para alıyor sanıyorlar aslında öyle değil. Bunun aylığı 500 milyon. Kaç yıldır çalışıyor. Kaportacılığa 11 yaşında başlamış şimdi olmuş 40 yaşında.*
>
> We opened an auto body shop in 1989, 2 years after we got married. Then we were doing fine. We bought a car, too. A year later the shop burned down. We lost what we had and my husband got burned. We still haven't gotten back in shape; we became desperate. My husband didn't work for a year and a half. MY mother in law took care of him, we moved in with them. He couldn't go to work or anything. He was burned from the waist down. He couldn't stand. They told him he was an invalid and couldn't work; they turned him away and wouldn't give him a job. That's also why it was so hard. He was under medical observation for a year and a half. It wasn't until 1992 that he managed to get a job. He worked in different places but we couldn't straighten things out. They never paid him regularly. Or they didn't insure him. He just started working in this place a month ago. When you say auto body repairman people think he makes a lot but he doesn't. He gets 500 million lira (now 500 New Turkish Lira). He has been working for a long time at this job. He started when he was 11 and now he is 40.

A moment's carelessness had important consequences for his later life. Although the working conditions were determined by her husband as he was self-employed, occupational accidents in specific jobs like his job are seen frequently. His accident resulted in, 5 years of unemployment. The accident resulted in both loss of *health capital* temporarily and exhausted his *economic capital* because he lost his workplace as the main income source. While he was unemployed, his family cared for him and supported the family financially. He changed jobs frequently because he was never paid on time.

On some occasions, the negative effects of harsh working conditions on health cause people to work less or work part time. In B.B. (20 year old male living in Gültepe)'s family, his mother carries the main breadwinner position in his family. His

mother has been working as daily domestic worker for a long time. B.B. expresses that:

> *Annem gözden ameliyat oldu 3-4 defa. Gözünde kanlanma oluyordu ayak parmaklarında da kaşınma oluyordu deterjan alerjisi var. 3 senedir. Ev işlerinden oldu hep. 4-5 aydır da bel fıtığı var, sürekli ev işlerinde çalışmaktan oldu yine. Ameliyat olması gerekiyor. Bel fıtığı olalı daha az çalışmaya başladı. Eskisi gibi hergün çalışamıyor. Kazandığı para az diye nereye olsa yürüyerek gidiyor. Mesela taa Tandoğan'a yürür. Hem hastalık hem yorgunluk perişan oluyor kadın.*
>
> My mother had her eyes operated on 3-4 times. Her eyes would get bloodshot, her toes itched she is allergic to detergent. It all happened because of housework. For 4-5 months she has had a herniated disk. This happened because of doing housework for people. She needs surgery. Since she got hernia she hasn't been working as much. She can't work everyday like she used to. Because she doesn't make a lot of money, she walks everywhere. For example she walks all the way to Tandoğan. Illness and fatigue are wiping the poor woman out.

When I met this family after one month, his mother had had a back operation waist. His family had migrated 19 years ago for blood feud reasons. After the murder of his father, his mother had to take over the breadwinner position in order to maintain the subsistence of her little children.

Some health risks peculiar to the job itself caused long term unemployment or prevented her from working. E.A. (26 year old male living in Gültepe) lives in an irregular income earning poor family and his family states that their socio-economic conditions have been declining since they migrated. Recently, they see themselves poorer. He has a family with lots of illness experiences including himself. E.A.'s father's experience represents this pattern. He expresses that:

> *Babam 8 sene hamallık yaptı kömür taşıdı yük taşıdı pazarlarda bel fıtığı oldu. Şimdi 20 yıldır çalışamıyor bel fıtığından.*
>
> My father was a porter for 8 years. He carried coal and other things in the bazaar. He got a herniated disk. It's been 20 years since he last worked because of his hernia.

Hernia is prevalent especially among family members who work in casual jobs and house keeping in our sample. This illness experience arising from the job results in their exclusion from the labor market or work less. Although E.A.'s family migrated 28 years ago, they have become poorer by the day as E.A. expresses. When his father became ill and had to leave his job, there was no family member he could transfer his breadwinner position to because his children were very young.

The case of H.K. (70 year old female living in Gültepe) as a no income earning poor person from wage work is an example of work-related illness and being elderly at the same time, which causes exclusion from labor market completely.

> *6 yıldır romatizma var. Bel ağrısı da var. Ev işinde çalıştığım için soğukta git gel halı yıka. Temizlik yaptığımdan hep hastalandım. Gençliğimde çok hasta olmadım. 50-60 yaşımdan sonra hep hastalık. Şimdi tansiyon var kemik erimesi var bunlar yaşlılıktan herhalde yavrum bilmiyorum ki niye oldu gelince hepsi birden geldi.*
>
> I have had arthritis for 6 years. My back hurts, too because I cleaned homes, going and coming in cold weather and from washing carpets. I got ill because I cleaned. In my youth I rarely got sick. After age 50-60 I kept getting sick. Now I have hypertension, osteoporosis. These are probably from old age, my child. I don't know why but they all happened at the same time.

She began to work when she was 38 years old, following her separation and then divorce from her husband. She left her job 8 years ago. Old age and her increasing number of illnesses pushed her into a dependent position. In spite of 24 years work experience in homemaking services such as cleaning, ironing, and cooking, she lives only on an old-age pension[28].

Working conditions are discussed in the materialist/structuralist perspective in terms of the potential to damaging health of workers. According to Jewson (1997), "work processes and working environments can pose very serious threats to health as a result of both occupational injuries and occupationally related diseases" (p: 73). According to him, workers in manual occupations have a greater risk than others because of being involved with machinery, chemicals, and industrial wastes. When we think of the working people in our sample, very few do these kinds of jobs involving machinery and so on. Instead, the majority of working people in our sample and people who have previous work experience and have not worked, work/worked as daily casual workers, and self-employed in the informal/marginal sector. In the informal sector, there are no regulations in terms of job security or job safety. As mentioned earlier, they face many occupational risks. In addition, the irregularity and low level of income make them stressful and low level of psychological well-being is

[28] Her old-age pension, 63 YTL a month in 2005, is given in the framework of the act numbered 2022. According to Act No: 2022, dated 10/06/1976, Concerning Granting of Pensions to Turkish Citizens over 65, needy, unprotected and destitute persons who prove their poverty by presenting certificates issued by relevant provincial authorities will be granted pension for a lifetime. The Grant will be stopped if the beneficiary is no longer in poverty.
(See web site for details, http://www.emekli.gov.tr/2022.html, accessed 12 December 2007)

more common among respondents who (or whose working family members) are dissatisfied with their job. Similar findings are presented by Belek (1999) for the case of Antalya. According to Belek[29], blue-collar and unqualified workers have high level of distress and high level of stress is more common amongst workers dissatisfied with their job.

Experiences with Unemployment

While low wages are a major cause of poverty for regular income earning poor families, low and irregular wages and frequent falls into the unemployed position become a problem in terms of providing for irregular income earning families. The concept of poverty is much associated with unemployment, irregularity, barely getting managing, or living on the edge by many respondents. The impact of poverty experiences, due to low and irregular income, on the state of health and well-being is much more related with depression and stress. In our sample, it is clear that there is a close association between low and irregular income and psychological health[30], well-being and physical health[31] derived from self-assessed health of respondents such as depression, helplessness, and stress. The negative impacts of poverty on feeling depressed are frequently seen among the unemployed; the chronically ill and unemployed; unemployed housewives whose husbands are casual workers and those self-employed in the informal sector and marginal sectors; casual workers and self-employed in the informal sector and marginal sectors.

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[29] He uses social class to measure distress by adopting Boratav's classification (See Chapter Two for details). He excludes unemployed in his analysis.

[30] Turner (1995) criticizes the division of mental and physical illness made by medicine. According to him, this division, philosophically and sociologically problematic, corresponds to a cultural division between mind and body (p: 3). I use the concept of mental health and physical health by not internalizing the philosophy reproducing the Cartesian dualism of the mind and the body and not assuming mind and the body as separate entities. On the contrary, I try to display existing relationship between the mind and the body in case of illness in accordance the Bourdieuan framework where Bourdieu opposes all the dualisms developed by modernity (Bourdieu & Wacquant, 2003). I do not look from the view of point of medicine as the professional and the esoteric one; Instead, I try to understand perspective of urban poor who tend to also distinguish illnesses as physical and psychological one (See subheading of Health Capital for details). This distinction is not peculiar to the modern medical paradigm. I also prefer psychological well-being instead of using mental health.

[31] There are many depression scale and measures. I did not use any scale which measures the existing and the level of depression. "Global self-rated health was measured using the following question: 'How would you rate your own health? As: good, poor, or something in between?" (Ahs & Westerling, 2005: 294). Instead, I prefer to use self-assessed health obtained by asking the respondents about their well-being and dispiritedness. Self-assessed health is accepted as subjective health indicators.

There are many family members who experienced medically diagnosed mental health problems after the fall into the unemployed position. M.A. (30 year old male living in Gültepe) lives in a regular income earning poor family because of the pension salary of his retired father. The close association between unemployment and psychological health is expressed as:

> *İşsiz olduğum için bunalımdayım. İntiharı düşünüyorum, hem de her saat. Benim için bu kurtuluş olarak görüyorum. İntihara kalkıştım daha önce. Çok düşündüm her saat düşünüyorum. Babamın aldığı 400 milyon emekli maaşı. Belki başkaları için sorun değil ama ben bunu kaldıramıyorum. Yaşım olmuş 30 kendime yakıştıramıyorum. Birtek ben okudum aileden birtek de ben işsiz kaldım. İşsiz kalınca karım beni terketti. Boşandık. 4 sene önce 2001 yılında evlendim. 50 gün evli kaldık. Ben de işsizlikten dolayı depresyon var. Bunalımdayım sürekli intihar düşünüyorum. Hergün gidiyorum iş görüşmesine ama yok. Ölümü kurtuluş olarak görüyorum. Iş bulsam bunalım falan kalmaz. Psikoloğa götürdüler, ama hala devam ediyor. Doktor aynaya bakarak konuş dedi biraz faydası oldu. Aynaya geç aynada konuş dedi doktor bana psikoloğa gittim. Faydasını gördüm. Siz geldiniz içimi dökmüş oldum bana terapi gibi geldi. Sohbet ettik. Çok teşekkür ederim. İçimi boşalttım rahatladım sayenizde. Bugün boş boş oturacaktık iyi oldu bizim için.*

> I am depressed because I am unemployed. I consider suicide; every living minute. I see it as the only way out. I have attempted suicide before. I always think about it. My dad gets a pension of 400 million lira (currently 400 New Turkish Lira) a month. Maybe it isn't much a big problem for others; but it is for me. I can't bear it. I am 30 years old and I am ashamed. Only I went to school in the whole family. And only I am unemployed. When I lost my job, my wife left me. We got a divorce 4 years ago. We got married 4 years ago in 2001. We stayed married for 50 days. I am in depression due to unemployment. I constantly think about suicide. I go to interviews everyday but to no avail. I see death as salvation. If I found a job I would be rid of depression. They took me to a psychologist and I still go. The doctor told me to talk to myself in the mirror. It helped a bit. Go in front of the mirror and talk said the doctor I went to a psychologist. I benefited. You came to visit I got some things off my chest it felt like therapy. We talked. Thank you very much. I let it all out and fell better thanks to you. I was just going to sit around doing nothing. This was good.

Being chronically ill and living in harsh economic conditions is a specific experience. There is a feeling of helplessness because they are ill Helplessness arising from being ill and being poor is seen among respondents who are in the same position. N.T. (45 year old male living in Baraj) has hepatitis and had to work to provide for his family. In our sample, chronically ill people are either unemployed or employed in the type of job they can do such as marginal jobs. This case indicates the pattern that living in low and irregular income as chronically ill influences well-being and psychology as follows:

> *Yeğenim insan ne kadar olsa üzülüyor. Neden dersen işsizlik yüzünden. Eve geliyon, eve şöyle bir bakıyon, evde yiyecek içecek yok. Çoluğun çocuğun rahatsız oluyor. Onun için şey yapamıyom yani, elin kolun bağlanıyor yani. Bakıyom şöyle, ne de olsa atayım ben, üzülmesen şey olur yani mecbur üzülecen tabi. Dörtyola gidiyom acaba bir şey yaparmıyım yani simit, poğaçaydı filan, insan şöyle bir düşündüğü zaman, dayı ne düşünüyon diyorlar. Oğlum siz bilmezsiniz benim içimi diyom. Dayı diyorlar seni bir doktora götürelim nasıl götüreceniz oğlum diyom. İnsanı bayağı adamı etkiliyor. Sürekli kendimi kötü hissediyorum hem hastalık hem de yokluktan dolayı.*

> It's upsetting of course. It's because of unemployment. You come home, you have a look and there is no food or drink. Your children aren't comfortable. You can't do anything. You are helpless. I think; I am a father so of course I get upset. I go to Dörtyol thinking I can do something like sell simit or pastries. But people ask me what I am thinking. I tell them they can't know what goes on inside me. They tell me they will take me to a doctor, I ask them how they will be able to do that. It gets to you. I always feel bad both the illness and destitution.

There are three benefit dependent respondents with a chronic illness and working at the same time. Living in poverty as a sick person is specifically mentioned by Ayata and Ayata (2003) by discussing the relationship between benefit dependency and an ill-health situation. Similar to our findings, they express that ill health limits their possibility of finding a job and therefore becomes a major source of low income and poverty. In addition, they state that being ill makes them work relatively easy jobs such as garbage picking, street selling, and shoe shining on a part time, casual or temporary basis and therefore ill health prevents the sick person from doing regular work. In our sample, the permanently sick who work at the same time regulate their working days and hours according to the severity of their illnesses at a given time. Loss of health determines their relationship with and position in the labor market. Being sick causes them to feel that they are not fulfilling the requirements of the role as the main provider in the family and they see themselves as inadequate. This feeling is much more related with the traditional gender roles in our culture. There are social rules about the working of male members of families.

In terms of unemployment, we can conclude that ill-health or being sick is an important precursor to unemployment on the one hand, experiencing difficulties related to unemployment (including temporary employment as a casual/daily worker) damage to well-being and psychological health in the case of respondents' families. Also, there is a case in which individuals experienced loss of work on account of work related illnesses and this experience caused the individual to mental problems. These findings are proved by many authors in different cases. They state that the unemployed are at a lower level of psychological well-being as the effect of unemployment on health (Bartley, 1994; Janlert, 1997; Dooley, et al, 1996; Artazcoz, 2004). In the Turkish case, Yüksel (2003) proves that the unemployed are much more subjected to psychological distress then the employed. In the research conducted in Ankara, the majority of the unemployed in the study were suffering from depression; however, unemployed men were more deeply under depression as compared with

women. In our research, feeling depressed and low level of well-being is more prevalent among the housewives especially among those whose husbands are the main provider of income or if there are no income earners. Casual workers are assumed to be between the employed and unemployed because they frequently fall into unemployed positions, especially in winter. The precariousness of jobs in terms of job insecurity or the permanently existing risk of being unemployed is negatively influential on psychological health and the well being of family members.

5.2.4. Using Child Labor and Consequences for Health

Low and irregular income entrance to the household made rural migrants, especially in their first years in the city, send their children out to work. Using child labor, they tried to cope with economic difficulties in the urban area and they felt they were helping their children learn a trade for their future. Children became wage earners, especially in the first years, instead of going to school. This tendency makes them immediately enter the urban labor market and earn income early for their families. Among the respondents, 18 of the families used child labor in the city. Some of them worked seasonally and continued to work when the migrated when they were young; and some of them worked seasonally but when they came to the city they were young adults; the majority of them started to work immediately after migration. In fact, some of them migrated alone for work, and some of them migrated with their families. The excerpts below are some examples of child labor during their first years in the city:

L. A. (40 year old male living in Gültepe) was born in Ankara. His father and mother moved to Ankara 41 years ago. When he was an infant, his parents got divorced and he started to live with his father. On account of his father's alcohol addiction, he had to work and went to school at the same time to survive. He now works as a garbage collector after having worked at other jobs and now lives with his wife and 2 daughters in Gültepe. He talks about work experience during his childhood as:

> *Yaşam tarzımız ilkokul bitene kadar babaya muhtaçtık. Ortayı bitirene kadar da her türlü konuda kendi kendime kendi çabamla emeğimle bir şeyler yapmaya çalıştım. Terzide, lokantada çalıştım komi olarak. 12-13 yaşında. 6 ay çalıştım terzide. Lokantada toplam 3,5 sene çalıştım ama ayrı lokantalarda. Bulaşıkçılık*

da yaptım. O zaman meslek düşünmüyordum ki ben, aç kalmamak için kendi harçlığımı çıkarmak için çalışıyordum. Ben lokantayı meslek olarak benimsemiştim. Para vermedi ayrıldık. En son çalıştığım lokantada devir oldu, kendi elemanı olunca ayrıldık. Ondan sonra girmedim. Şevkim kırıldı.

I depended on my father until graduation from primary school in terms of lifestyle. Until graduation from junior high school, I tried to something with my own efforts. When I was 12-13 years old, I worked in tailor's shop and restaurant as bellboy. I worked in dressmaker for 6 months. I worked in restaurants 3, 5 years but in different restaurants. I did dishwashing too. I was not thinking of learning a trade. I was just trying to earn enough money for food and earn pocket money. In fact, I had decided on restaurant work as an occupation but the owner of the restaurant did not pay my wage and so I left. The latest restaurant which I worked at was transferred to another person. I left when he got his own employees in place. After that I did not try to find a job in a restaurant. I was discouraged.

L.A. worked as a wage earner when he was not in school, and at the same time he performed domestic chores such as dishwashing, cleaning, and preparing meals. He says that he had no parent or any other person to take care of a child and he felt lonely. The excerpt below from E.A. (26 year old male living in Gültepe) indicates the continuity of the type of economic activity starting in childhood.

O zaman çalışıyorduk teneke sırtımızda odun taşıyorduk Pazarda yük taşıyorduk. Hamalcılık yapıyorduk kardeşlerimle birlikte. Hem okula gidiyorduk bir yandan da pazara. 6-7 yıl böyle sürdü. 7 yaşımdan beri çalışıyorum. Okula başlamadan önce çalışmaya başladım. Sitelerden teneke odun toplardık. Şimdi hamalcılık yapıyorum haftada bir pazara gidiyorum hastalıktan dolayı.

Those days we were working. We were carrying firewood on our back. We were carrying loads in the bazaar. We were loading with my brothers. We went to school, at the same time we were going to the bazaar. It lasted 6-7 years. I have worked since I was 7 years old. I started to work before I went to school. We collected firewood and tin from Siteler. Now I am a porter, I go to the bazaar one day a week due to my illness.

The majority of the family members who worked in their childhood were not able to have a profession because they had to continue to work in irregular jobs as E.A did. In addition, the chronic illness he contracted in his youth destroyed any possibility of getting into the urban labor market but he survived by hanging onto a marginal part of the informal sector. This case could be considered separately because of chronic illness experience but it can be said that family members who worked as children in different jobs in the informal sector as casual workers maintained this status in the labor market. Only a few of them have a distinct occupation. When H.G. (61 year old male living in Baraj) migrated to Ankara 35 years ago, he sent his sons out to work due to survival difficulties and wanted his sons to learn a trade. He expresses that:

İlk geldiğimizde para yetmiyordu. Küçük oğlum 19 yaşındaki 13 yaşından beri berberde çalışıyor. Meslek sahibi olsun diye berberlik işine soktuk. Evdeki diğer 27 yaşındaki diğer oğlum da 12 yaşından beri kasaplarda çalışıyor. Şimdi 7 yıldır Tansaş kasap reyonunda çalışıyor. Bizden ayrı oğlum da çocukluktan kaportacıda çalışmaya başlamıştı. Okutmadık çalışsınlar diye. İyi kötü şimdi işleri var şimdi.

When we first came, we suffered from lack of money. My 19 year old younger son has worked in a hairdresser since he was 13 years old. I made him do the job to learn a trade. My other 27 year old son in the household has worked in butcher's shops since he was 12 years old. Now he has worked in butcher department in Tansaş for 7 years. My other son who lives away from us started to work in auto body shop when he was a child. We could not have them go to school so they could work. Now they have jobs, more or less well.

A look at the girls reveals that girls worked only in periods when they were extremely hard up economically and they did not continue to work as in N.B.'s case. N.B. (26 year old female living in Baraj) expresses that:

1990 yılında geldik geçinemiyorduk. 1992 yılında 13 yaşında başladım çalışmaya. Sitelerde özel şirkette mobilyacıda telefona bakıyordum, çay yapıyordum. 1 yıl yaptım. Diğer işi bulunca çıktım. Sitelerde özel şirkette elektrik bobinaj yapıyorduk. Bu işi 5 yıl yaptım. Evlenince de bıraktım.

When we came in 1990, we could not survive. I began to work in 1992 when I was 13 years old. I was answering the phone and serving the tea in a private company in Siteler. I worked one year. I left when I found another job. We were making electrical coils. I worked in this job 5 years. I left when I got married.

Rural migrant families' using child labor as a strategy to adapt to and survive in the city and cope with economic difficulties had two consequences for later the life of those children in our case: the first is continuity of a similar socio-economic level with their own family; the second is the erosion of their state of health. Children whose educational levels remain low like their parents' and who do not have specific occupational experience continue to earn their life by holding onto some part of the informal sector. When they come of age after years of experience in precarious jobs, they may leave work due to the erosion of their health. The excerpt below from E.A. (26 year old male living in Gültepe) explains this:

Bende de abimde de bel fıtığı var. Daha okula gitmeden başladık hamallığa ne olacak. Askerden önce başladı 1995'de. Ee çocukluktan beri hamallık yaparsan onun bunun eşyasını sebzesini meyvesini taşırsan böyle olur tabi. O kadar ağır taşıyoruz ki. Görseniz can dayanmaz. Küçücüktük boyumuzdan büyük eşyaları taşırdık. Odunumuzu yakacağımızı kendimiz toplardık, yiyeceğimizi pazardan toplardık. Şimdi de öyle ya. Belimizin ağrısından mecbur haftada bir gidiyoruz, başka ne iş yapabiliriz ki. Bildiğimiz bi hamallık.

My brother and I have hernia. It was certain to happen because we began to carry heavy loads before even starting school. I was diagnosed in 1995 before doing military service. Of course, it is bound to happen if you work as a porter, and carry someone's goods, vegetables' and fruits boxes. How a heavy burden we carry. Your heart would break if you saw it. We were little boys at the time and we were carrying loads bigger than ourselves. We gathered our own

> firewood and find our food at the bazaar. We still do the same things. We go to work one day a week due to back pain. There is no alternative. We know only portage.

Like in E.A.'s case, they can only work in the informal sector in their later years or work for a limited amount time, because of the negative characteristics of informal sector which they are subjected to (low irregular pay, manual work, lack of skills, lack of insurance, and working under difficult conditions with long hours detrimental to both psychological and physical health). They tend to hold more precarious jobs because the years which they should have invested in their human capital via education or learning were spent struggling to survive as in the case of L.A. or contributing to the families' income to cope with economic difficulties as in the case of E.A.. State of health should be considered by taking into account the work histories of people during the course of their lives. Childhood in our case is observed as a lost period coerced by economic conditions both in terms of health development and having a profession. It is a lost period in terms of work because they were not able not invest for their future labor market attachments by getting an education or learning useful skills. And it is the lost period in terms of health because they were subjected to the negative characteristics of informal sector which ended up being detrimental to their body and health in their early ages.

5.2.5. Women Poverty and Consequences for Health Experiences

A look at the work history of each respondent family reveals that, in terms of the gender dimension, women have a weaker attachment to the labor market and have work experience mostly in the informal sector, notably for shorter time periods compared to the men in the families. There are four working women, all of whom work as informal workers. One of them is the head of the household in her family and works as a domestic cleaner. She undertook the breadwinner position after the death of the income earning member of the family. The other two are spouses of the head of the household. One of them works as a superintendent and domestic cleaner and the other one does piece work at home. The last one is the daughter of the family and works as textile worker with no insurance and work for less than the minimum wage, for approximately one third of the minimum wage. There are 11 women in 10 families

who used to work and left their jobs. Among them, 5 women have work experience in the formal sector for short time periods ranging from four months to 5 years.

It is seen that women work under difficult and exhausting conditions for long hours without insurance. They also earn a lower wage than men. T.D. (45 year old female living in Gültepe) worked as a domestic cleaner for six years. She expresses the exploitative character of her job as:

> *Çocuk bakıcılığı yaptım, hastabakıcılık yaptım, ev temizliğine gittim. Ama tüketti bu işler beni. Şimdi bel fıtığı oldum milletin pisliğini temizleyeceğim diye. En son bel fıtığı yeni olduğumda bir arkadaşım iş buldu bana. Çocuk bakıcılığı gittim, baktım kadın doktor. Çocuğa bakacakmışım, evin işini görecekmişim, bir de annesinin evine gidecekmişim onun işini de görecekmişim. Çok teşekkür ederim dedim sen kendine bu işleri becerebilecek güzel bir işçi bul dedim. Ben makine değilim dedim. Tamam, ben senin evini temizleyeceğim çocuğuna bakacağım ama annenin işinden bana ne dedim. İnsaf insan bu kadar da sömürülmez ki. Sen bir doktor olarak bunu düşünüyorsan helal olsun sana dedim. Zaten daha sonra da çalışamadım ağrılarım artınca.*
>
> I work as baby-sitter, patient care taker, and maid. But these jobs destroyed me. Now I suffer from a herniated disk because I had to clean other people's filth. The last time when my disease was newly diagnosed, my friend found a job for me. The job was baby-sitting and the mother of the baby was female medical doctor. She demanded baby sitting, housework, and also her mother's housework. I said thanks, but you need to find a good worker to handle all of those. I said that I was not a machine. I said its okay, I would clean your house, I take care of your baby, but your mother's housework is not my business. Nobody should be exploited like this. I could not work afterwards anyway when my pain worsened.

T.D started to work after her husband squandered his income instead of providing for the household. She was compelled to work due to the breadwinner being irresponsible. Therefore she had to find a job in the informal sector. Especially manual jobs with difficult working conditions have negative influences on the health status of individuals as T.D. expresses. Most jobs available in the informal sector have difficult working conditions and are unregulated, so they have detrimental effects on workers' body and *health capital*. Even though working in the informal sector is seen as a solution by rural migrants for survival in the city, the end result is greater poverty since the long-lasting physical effects ultimately cause unemployment. The work itself proves to be a reason for unemployment as seen in T.D.'s case.

H.Ay. (27 year old female living in Gültepe) mentions the exploitative and time consuming characteristics of her work. She knits berets at home and is paid for each beret. Then she gives them to a shop to be sold. She makes very little money. She expresses that:

İki çocuk yokluk, çocukların istediğini alamıyorsun hep eksik oluyor her şey. Bunlara hep katlanıyorsun. Sürekli yok diyorsun çocuklara. Katkıda bulunmak için ben de örgü örüyorum. Ne kadar örersen o kadar kazanıyorsun şapka başına 2 milyon. Günde on şapka örsen 20 milyon. Günde 5 tane örmeye çalışıyorum gece gündüz bazen sipariş alıyorum o güne yetiştirmem lazım geceleri uyumuyorum. Çok yoruluyorum. Bayağı uğraştırıyor. Eşim de dışarıda çalışmama izin vermiyor.

Two children and deprivation, you can not buy the things the children want, every time something is missing. I always have to endure these sufferings. Again and again I have to say "no" to my children. I knit in order to contribute to the household income. The more I knit the more money I earn. I receive 2 million Turkish Liras per beret. If I knit 10 berets per day, the wage is 20 million. I try to knit 5 berets per day working day and night. Sometimes I receive an order and I try to make the deadline and I work through countless nights for this reason. I get very tired. It is hard work. My husband does not let me work out of the home.

Piece work describes types of employment in the informal sector in which the worker is paid for each unit they produce. In order to earn more money, they work longer hours. This is a kind of coping strategy with poverty in which women are capable. In our sample, the majority of housewives are willing to work outside as the income earner. They do not want to sit at home and do nothing in the face of poverty. They try to struggle, even though they exist in a field full of with cultural values with set rules, strict roles, and obligations no matter how limited they are restricted. Their husbands do not let them to work outside the home as in H.Ay.'s situation. Therefore, the only contribution they can make is through working at home. In this case, women's capability to struggle with poverty is determined by the inner family power relations supported by domestic-patriarchal ideology.

This presents a paradoxical situation. On the one hand, the informal sector with its irregular characteristics results in the impoverization of *gecekondu* families, especially after the 1990s accompanied by the decreasing formal job opportunities (full time, regular, insured jobs) and the expansion of the informal sector; on the other hand, the sector provides a channel for the elimination of poverty by the internalization of employment of other family members in the sector as seen in H.Ay.'s case.

The reasons why women work are the deterioration of economic conditions due when the breadwinner does not fulfill his duties as seen T.D.'s case; the death of the breadwinner, the breadwinner being ill; separation from the breadwinner; the breadwinner's having irregular and/or seasonal jobs; and too low a level of income causing difficulty surviving as seen in H.Ay.'s case. That is, women's attachment to the urban labor market happens mostly under compelling circumstances. Income obtained from the work activities of women both at home and outside the home

remains only as a "contribution to the family income" because they earn less than men. They can only hold informal sector jobs and face difficult conditions as H.A. expresses, in that the work takes a long time and ravages the body while being accompanied by low wages.

It is observed that the utilization of women's labor under compelling conditions is regarded as a strategy for coping with poverty under restricted conditions of capability. As Kardam (2003) expresses, while women try to continue their social roles restricted with domestic responsibilities in spite of increasingly impoverished conditions, they struggle with poverty based on their capabilities in definite restrictions determined by patriarchal domestic ideology. The decision for having the woman work is made in this restricted field as seen in H.Ay.'s case. In spite of the fact that H.Ay. found a job outside the home, her husband did not allow it. It is observed that women are not allowed to work as it is not deemed necessary and should they get permission, they are only able to work in limited conditions.

When we evaluate the reasons why people leave their jobs and the reasons why women have a tendency to not work among the 40 families, there are 11 women (in 10 families) who worked before and left their jobs. Six of the women left their jobs due to domestic responsibilities such as upbringing children followed by pregnancy and marriage. It appears that women's domestic responsibilities have priority over work. When they were married and immediately got pregnant, they left their jobs because of husbands' attitude towards women working and traditional gender roles towards a woman's place and responsibilities. Their predetermined traditional roles compel women to carry the burden of domestic responsibilities such as upbringing children, caring for elderly or ill family members, and do housework instead of making money. Among women who have previous work experience, three of them were fired. Informal sector jobs are precarious in character because there are no regulations, rules, workers' rights and so on. Two women among those fired could not work again because of their responsibility of raising children followed by another pregnancy.

Although women are normally prevented from working outside the home by the domestic ideology prevalent in *gecekondu* families, it is observed that, even to a lesser extent, the women started to work as a kind of coping strategy with poverty or the strategy for overcoming crises when they became impoverished. As in the excerpt

below, it is observed that they worked for a short time period and did not continue their jobs after a crisis was overcome. Women are the labor equivalent of *reserve army of labor*.

A.A. (35 year old male living in Baraj) is a waiter in a night club. He used to be self-employed together with a business partner but he and he was swindled. As a result of excessive debts, executions, police investigations, he experienced cerebral hemorrhage, then chronic depression lasting two years. His wife undertook the duty of breadwinner in the family due to necessity.

> *Ben bunalıma girdiğim zaman eşim Nabay tekstilde işçi olarak çalışmaya başladı, küpür dokuyorlardı. Vardiyalıydı 1 sene çalıştı, 1 sene sigortası yattı. Kızımız 2 yaşındaydı çocuklara bakan olmayınca mecbur kaldı ayrıldı. 2000 yılında yine eşim çalışmaya başladı. Yemek fabrikasında yemek dağıtımı işinde çalıştı. Mutfağın temizliğini yapıyordu. Kışın çalışıp yazın çıkıyordu mevsimlik işti. Yine çocuklardan dolayı 2002 de tamamen iş hayatını bıraktı. Çocuklara kimse bakmadı anneme gönderdim bakamadı. Ablama paraynan bakıttım. Komşunun birine paraynan bakıttım bakamadı bıraktı. Kardeşimin karısı baktı biraz. Çocuk annem gelecek annem gelecek diye pencerenin kenarında sürekli bekleyip duruyormuş. Dayanamadık. Zaten o zaman da ben çalışmaya başladım. Allah razı olsun eşimden çok anlayışlı bir eşim var.*
>
> When I was under depression, my wife started to work in Nabay Tekstil as worker. She weaved. Her job was shift work and insured. She worked 1 year. Nobody cared for my children, so when my daughter was two years old and my wife had to leave her job. In 2000, my wife began to work again. She worked in a food delivery factory. She cleaned the kitchen. The job was seasonal; she worked in winter and left in summer. She left her working life completely again in 2002 due to our children. Nobody took care of our children. I sent them to my mother, but she could not do it. I hired my sister for money. I paid my neighbor but she could not do it and left. My brother's wife did it for a short time. My daughter would wait for her mother in front of the window. We could not bear it. I started to work afterwards. Thank God for my wife, she is very understanding.

Like A.A.'s wife, there are some women who express their readiness to work due to the chronic disease of their husbands. Although there are few cases like A.A's., it would be true to say that the dominant view towards women working is domestic ideology, which attaches importance primarily to domestic duties and confines women to the home, even in necessary conditions. On the one hand, housewives are willing to work; on the other their husbands are unwilling. The dialogue below by M.D. (39 year old male living in Baraj) and his wife are a clear example of this:

> *M.D. : İstemiyorum*
> *Eşi: Ben isterim eğer sıkışırsak ev parası ödemek zorunda kalırsak mecbur çalışmak zorundayım. O zaman annem de gelir, çocuklara bakar.*
> *M.D. : Yok hayır ben asla istemiyorum. Bunlar köylü kadın bilmezler. Durumum iyiyse istemem. Bunlar cahil insanlar kandırırlar. Bir de bunlara ağır iş veriyorlar emeklerinin karşılığını alamazlar. Kadınlar o kadar ağır işe nasıl dayanır. Işi bilmiyorlar işi öğrenene kadar çok zorlanır. Akşam gece 11 de gelecek. Nasıl olacak. Vardiyalı iş var. Durumu iyi olan insan çalışır mı niye çalışsın.*

M.D.: No. I do not want it
His wife: I want to. If we have difficulty paying for the house I will have to work. Then my mother will come and take care of the children.
M.D.: No, I definitely don't want (her to work). These are villager women, they do not know. If my economic condition is adequate, I do not want it. They are ignorant people who can be deceived. Also they have to do hard work and not get their labor's worth. Women can't take such hard work. They are inexperienced so they have trouble until they learn the job. She will come home at 11 p.m. every evening. How could this be? There is shift work. Someone who is well off doesn't work, why should she?

His wife tries to legitimize working outside by mentioning the necessary condition which might emerge later. In two neighborhoods, the demolition of *gecekondu* houses became an issue and the owners of *gecekondu*s would be able to have apartments by paying installments, during the time of the research. She tries to bargain with her husband about working. At that time, the situation did not necessitate the wife to work because M.D. had a formal job with insurance and he did not think that it was necessary. The general tendency in the study group is that there are housewife women willing to work to cope with poverty by using their capabilities but they were not permitted to work by their husbands, who made the excuses that they had domestic responsibilities. There are 13 families whose heads as the main wage earners do not permit their wives to work; 6 women could not work because had to raise the children and their husbands did not allow them to work; and 12 women could not work due to responsibilities involving raising children in spite of the positive view of their husbands toward their wives working. The rest of them are composed of working women and nonworking women who could not work due to old age, illness, and inability to find a job in spite of non-interference from their husbands.

Although İ.Ö. (40 year old male living in Baraj) has no income derived from wage work, he does not regard his wife's working outside the home as a solution to their dependency to the state and his parents in terms of assistance. He can not work as he has diabetes. He insists on not letting his wife work:

Eşimin çalışmasını istemiyorum. Biz köyden geldiğimiz için biraz hanıma düşkün oluruz. Biraz ortam bozuk. Şehir hayatına köyden gelen kadın ayak uyduramaz. Onun için çalışmasını istemiyorum. Ben nereye gidersem onlarda oraya gelir. Ben karıma sonuna kadar güveniyorum ama şehir hayatına güvenemiyorum. Biz şehir hayatına ayak uyduramayız. İnsanlar bizim gibi değil bizim gibi düşünmüyor.

I do not want my wife to work. We are fond of our wives because we are from the village. Also people are corrupt. Women from the village can not keep up with city life. For this reason I do not want her to work. Wherever I go they come with me. I trust my wife completely but I do not trust city life. We can not keep up with city life. Urban people are not as like us and do not think like us.

N.B. (26 year old female living in Baraj) points to her husband's work. He is the only wage earner in a five-member family. He works as a gardener seasonally. In winter, he works as a casual worker. He does not make enough money. She wants to work but having three young children prevents her from working outside the home. She states that:

> *Eşim karışmaz da çocuklar küçük. Onları nasıl bırakayım bakan da olmaz*
>
> My husband would not interfere but my children are very little. How can I leave them? Also I would not be able to find a baby sitter.

İ.Ö.'s family is an example of no income earner poor. His family is needy and dependent. He takes money regularly from his mother and receives a disability salary from the state. He meets his health care needs via green card. Although they are dependent, he does not give up the tendency. There are few cases in which husbands let the women work but the responsibility of bringing up children presents an obstacle as in N.B.'s case. Although husbands seem like they might give the women permission to work, essentially they have a traditional view of gender roles. They see child care as the first responsibility of their wives. When they are in the village, women play important role in economic activity as unpaid family workers; however, once they come to the city, the husbands begin to prohibit their wives from participating in economic activity. They would permit their children to work as a coping strategy with poor economic conditions, but not their wives.

Entering a new and strange field may lead to the production of new *habitus* to adapt to city life. Essentially, husbands not letting their wives work could be regarded as an extension of the attitudes existing in rural life. Women in rural areas work in fields as unpaid family laborer in a controlled and secure area according to the respondents, but city life is different and strange for them. There is a distinction between the work place and the home unlike in rural areas. In addition, the internalization of the priority of domestic duties has made women strangers to outside work. Rural migrants, who are accustomed to the traditional family work in rural areas, do not easily adapt to the new environment. They try to continue their existence in the city by confining women to the home by maintaining domestic ideology.

Among the respondents, there is an awareness of the poverty experienced especially by women. They emphasize that they have unique experiences of poverty

because they can not use their capabilities to participate in economic activities and therefore coping with poverty. This has consequences for the health experiences for women. The excerpts below indicate experiences of women who want to cope with poverty but can not use their capabilities to earn wages due to their domestic responsibilities and the unpermissive attitude of their husbands:

M.E. (51 year old female living in Baraj) has a family surviving on a disability pension from her husband and her son's low wages obtained from a formal job. She has a peculiar experience because she has to care for her bedridden husband. Therefore, she has to be at home permanently. She is living in poverty. She wants to work but can not due to her responsibility to her husband. When I was interviewing her, I observed that she had difficulty talking with me and she could not concentrate entirely. She seemed to be worn out and exhausted. She talks in a desperate way as:

> *İsterim de çalışamam. Eşime bakıyorum. Beni çok yıprattı. Bazen çok bunaldığımda çeker giderim hastayı rahatlaştırdıktan sonra. 2 saat sonra da gelirim. Psikolojik sorunlarım var benim. Para yok. Çok dardayım bunaldım iyice.*
>
> I couldn't work even if I wanted to. I care take of my husband. It has exhausted me. Sometimes when I am very depressed, I sometimes go away after making the patient comfortable. I come two hours later. I have psychological problems. We have no money. I am extremely depressed.

N.D. (39 year old female living in Baraj) is a housewife and her family is trying to get by on her husband's wages. For most of his life he worked as a casual worker except for a few years' formal work experience. He has just found a job and works as carpenter in Siteler. He has no insurance for the time being. Although they are barely getting by, he does not let his wife work. She complains about her poverty experiences peculiar to women as follows:

> *Eee her yoksulluğu kadın görüyo. Erkek ne görüyo... akşam geliyo şuraya oturuyo. Sabah diyom ya çocuk bana holta alttı gitti. Bebeye vallahi söylemesi ayıp sabanan 17 yaşındaki kocaman bebe telefon almıyoz diye ağlayarak gitti. Alamadım vallahi alamadım. Bacım inanır mısın alamadım. Babası diyor ki dur oğlum dur dur dur... bayramdan sonra alayım didi. 15 tatil gitsin alayım didi. Sabahtan öyle diyo anne bi cep telefonu alamadınız diyo. Korkuyorum inan kendine bir şey yapacak diye. Sabahtan beri yanıyom ona kendi kendime. Cahil çocuk gelmeyiverir. Takar kafaya. Yanlarındaki bebelerin hep varmış. Hep varlıklı. El senin varını yoğunu bilir mi? Benlen eğleniyonuz diyo. Kocam neylen alayım diyo karnımı doyuramıyom diyo. İnan ev telefonu kapalı, elektrik yatacaktı su gelmiş yatıramadık hiçbirini. Ben de kendi kendime kafama takıyom her şeyi. Erkek ne yapıyo....erkek geliyo akşamları şurda yiyo içiyo, yatıyo, çekiyo gidiyo sabahleyin. Hoca hastalığına32 yakalandım böyle böyle. Psikolojik. 4 sene önce başladı. Sinirden geçim sıkıntısından. Hocaya*

[32] Among most of the respondents, there is a tendency to refer to illnesses related to psychological problems such as depression as *hoca hastalığı*. This concept is used to emphasize that psychological

gittim. Biraz faydasını gördüm. Sonra da hastaneye gittim. Ama geçmedi eve para girmeyince alamamaktan bunaltı geliyo. Çalışayım da kurtulalım desem eşim engel önümde. Okula gitmeyen kızla da böyle oturuyok çaresiz çaresiz. Anne kız ee napcan. Oğlumu gönderebildim kızımı gönderemedim okula parasızlıktan. Bu kız hergün ağlıyor beni göndermediniz diye. Bu gidemeyince ben iyice kötü oldum. İlaçlar da fayda etmiyor artık. Görüyon değil mi gördükçe bakıyon. Vallahi yoksulluk hepsinden zor.

The wife experiences every aspect of poverty. What does the man see? He comes in the evening, he sits down here. My son walked out on me this morning. He's a grown up 17-year old and he left crying this morning because we could not buy him a mobile phone. I swear it's true. I could not buy him one. Can you believe it? I could not. His father said "you wait, wait, wait". He promised to buy him one after the religious holiday. He promised to buy him one after spring break. He said this morning "Mother, you could not buy me a measly mobile phone". I get scared that he might hurt himself. I have been upset about this since this morning. The foolish child may not come home. He might let it get to him. Apparently all the students in his class have one. They are all wealthy. How can other people know what you have and don't? He says you are teasing me. My husband says "how I can buy it? I live hand to mouth". Believe me, our telephone is disconnected, we could not pay the electric and water bills. I think about all of this constantly. What does the man do? He comes home in the evening, eats and drink, goes to bed, and leaves in the morning. For this reason, the Hodja illness (hoca hastalığı)33 has befallen me. It is psychological. It began four years ago. It is because of survival difficulties and stress. I went to a hodja. It helped me a bit. Later, I went to a hospital. But I have not recovered because there's no money coming in and I get depressed. I want to work so we can get by but my husband keeps me from working. I sit home with my daughter who does not go to the school like this, helplessly. What is there to do? I was able to send my son but not my daughter due to destitution. The girl cries everyday because we didn't let her go to school. For this reason, I feel very bad. Now, the medicine does not help. Do you see our situation? I swear poverty is the most difficult thing.

This specific poverty experience of women is also expressed by some male respondents like S.A. (68 year old male living in Gültepe):

Kadına ben para verirsem o da bana yemek hazırlayacak yoksa ne hazırlayacak....Bu kadın ne yapabilir. Evkadını yoksuldur. Her geçen gün bunalıma girer ne yapacak eli kolu bağlı.

If I give my wife money, she can make a meal; if not what can she cook?... What she can do? A housewife is poor. With each passing day she gets even more depressed. What can she do? She is helpless.

M.Ay (35 year old female living in Baraj) had formal job before marriage. Her husband does not let her work. She is permanently stressful and depressed. She has

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illnesses are the business of religious healers instead of medicine. They do not believe that the treatment of psychological problems can be done by the field of medicine. Therefore, they prefer to use the term *hoca hastalığı* most of the time. (it will be discussed in detail under the subheading "Cultural Capital").

[33] Among most of the respondents, there is a tendency to refer to illnesses related to psychological problems such as depression as *hoca hastalığı*. This concept is used to emphasize that psychological illnesses are the business of religious healers instead of medicine. They do not believe that the treatment of psychological problems can be done by the field of medicine. Therefore, they prefer to use the term *hoca hastalığı* most of the time. (it will be discussed in detail under the subheading "Cultural Capital").

two children and has to take care of her children. She compares her life before and after marriage. She comments on living with poverty as a housewife:

> *Evhanımı olmaktan başka çarem yok. 2 tane çocuğum var napabilirim ki. Aslında çocuk olmasa ekmeğimi taştan çıkarırım. Ben çalışan bir kadındım durumum iyiydi. Küçük çocuk okula gitmeye başlasın çalışırım. Eşim de izin vermiyor ama ben o zaman geldiğinde eşimi takmam. Evhanımlığı fakirsen zor. Evde çocukla sen kalıyorsun. Muz görüyorlar televizyonda alamıyorsun. Herşeyi istiyorlar. İdare etmeye çalışıyorsun. Zor. Bir şey yapamamak zoruma gidiyor. Bende sinir yapıyor.*
>
> I have no choice but to be a housewife. I have two children. What can I do? Actually, if I didn't have children, I would wrest a living from the soil. I was a working woman, I was doing alright. When my little son begins school, I will go back to working. My husband does not let me work but then I will pay him no mind. If you are poor, being a housewife is difficult. You stay home with the children. They see a banana on TV, you can not buy one. They want everything. You try to manage. It is difficult. I am ashamed of not being able to do anything. It makes me upset.

It is possible to say that women have a different experience of poverty from men and they experience poverty more deeply because they live at home in the *gecekondu* in the environment where they are always directly up against poverty. Most of the female respondents state that they are always with the children and they deal with the unmet needs of children continuously as N.D. and M. Ay. express. In addition to the female respondents, a few male respondents also express the aspect of poverty which women live with. In N.D.'s case, a relative dimension of poverty is emphasized. Her son may feel poor when he compares himself to other students in his class. When people compare themselves with those who are wealthier, they are even more aware of their poor position. In three cases, it can be said that *economic capital* is directly associated with *health capital*, that is, women's experience of poverty (such as unmet needs of children (N.D. and M. Ay. cases), responsibility to raise children or care for a patient, confinement at home, capabilities not made use of, feelings of helplessness, etc.) cause them to be more susceptible to experience psychological problems like depression. Güler (2001) proves the negative effect of poverty on the psychological well-being among the poor women living in *gecekondu*s. According to the findings of the research, a considerable number of poor women (30%) have high levels of depression. The negative influence of poverty on psychological well-being is frequently seen especially among women who can make comparisons in our sample. Women who compare their present living circumstances with those in their past experiences as M. Ay. is doing, are aware of the feeling of poverty and are more susceptible to psychological problems.

The majority of the female respondents express that in their villages they suffered from physical fatigue because of the burden of work; in the urban area they are comfortable physically but they are constantly falling into depression due to poverty. In rural areas, they performed agricultural work and tended to livestock as economic activities in addition to housework. According to them, the rural type of work for women affects their physical health negatively, but being a housewife living in an urban area affects their psychological well-being negatively. As stated above, women feel helpless against poverty and they seem to be vulnerable to depression. According to Freund (1982) who touches upon the effects of social control on health, says that powerlessness springing from different types of social control makes people sick. His view is adaptable to the case of poor women. Poverty experiences peculiar to women can be characterized as evidence that disease and illness are produced and reproduced in the urban context.

5.2.6. Nutrition and *Diseases of Poverty*

It is observed that living conditions of poverty first affect the children in this research. In terms of the food consumption of the urban poor, all of them state that they are not adequately nourished. Undernourishment as a result of low and irregular income has negative impacts on health. In both neighborhoods, there are babies born underweight, infant and child mortality, and *diseases of poverty*.

Malnutrition is evident evident in all 40 families. Only few have, however, experienced starvation, and those who did, experienced it in the first years of living in the city. Most of them state that they consume "dried food" like pasta, soup, boiled and pounded wheat (bulgur), and often have leguminosae etc. They consume meat, milk and milk products, vegetables and fruits very rarely. Also, they consume vegetables and fruits more in comparison to meat. Meat is consumed especially on the Holiday of Sacrifices. Most of them can not buy meat even once a month. They state that food assistance from the Municipality prevents them from starving. I did not calculate their calorie intake in order to understand the level of their poverty as Erdoğan (1996) did, but it can easily be said that they are not able to consume adequate and a variety of food as they stated. Below is an excerpt by M.H. (33 year old male living in Baraj) representative of the general tendency about nutrition:

Her istediğini alamıyorsun düzenli beslenemiyorsun. Çocuğun ağzına bir şey ayda yılda değiyor. Paran olduğu zaman alıyorsun paran olmazsa alamıyorsun. Son zamanlarda et almadık. Sebze arada bir alıyoruz. Süt almadık. Tahıl makarna belediyenin verdikleri ile idare ediyoruz. Aç kaldığımız da oluyor. Geçen sene kışın oldu. Tabi ki sıkıntı çektiğimiz bakkallardan veresiye aldığımız oldu birkaç ay işbaşı yapana kadar. İsteyip de alamadığın çok oluyor. Çocuklar her şeyi istiyor. Şehirde her istediğini alamadım parasızlığın yüzünden her istediğimi yiyemedim. Yetersiz beslenemedik kısacası şehirde.

You can't get everything you want, you can't eat right. The child only eats (some types of food) very rarely. You buy things when you have money and you don't when you don't have money. We haven't been able to buy meat lately. We buy vegetables from time to time. We haven't bought milk. Grains and pasta-we get by on what the municipality gives out. Sometimes we go hungry. It happened last winter. Sometimes we would get things from the small grocery store to pay later when we started work. Often you want something but you can't buy it. Children want everything. I wasn't able to get them everything they wanted. I was so broke that I couldn't eat the things I wanted to. In short, we haven't been eating decently in the city.

M.H. works self-employed in the informal-construction sector. His job prospects decrease in winter time and then they suffer from undernourishment. In this story, seasonal unemployment means seasonal undernourishment. His wife is under depression due to living in poverty and irregularity according to her statements. She mentions depression and undernourishment arising from poverty. This directly influenced both the birth weight of their daughter (2,200 gr) and the growth of their children. Poverty for families like M.H.'s family is not a temporary situation. M.H. states that there has been a decrease in jobs since the economic crises in the 1990s; therefore, they have become more vulnerable to poverty. This permanent situation not only influences birth weight, but also results in growth deficiency. There is a close relationship between birth weight, irregular income in the household, poverty experiences of women, and growth deficiency. This close relationship is emphasized below. M.H.'s wife expresses that:

…. Küçük doğan kızım ilk kızımda gelişim geriliği var. Boyu normalden çok kısa. Diğer kızım da çok zayıf. Bol bol meyvesini yemezse ne olur. Maddi durum her şeyden önemli.

My first daughter, born underweight has a development deficiency. She is shorter than normal. My other daughter is very skinny. It is like this because they can not eat enough fruit. Economic condition is more important than anything.

Urban poor tend to compare their current level of nutrition with the food they got when they were living in the rural area. According to the majority of respondents, the main difference between the village and the city in terms of poverty experience is the "point" of hunger. They state that hunger can be experienced in the city, but this

is not the case in the village due to powerful social solidarity. Hunger and inadequate nutrition is often experienced especially during the first years in the city. The below excerpt from M.Ay. (35 year old female living in Baraj) fits this pattern:

> *Köy burdan iyi. Burada yokluk çok. Bir ekmeğin olmadı mı konu komşu yardım ediyor köyde. Burda yalnızsın. Herkes zor durumda olduğu için de kimse birbirine destek olamıyor. Tarladan herşeyi kalkıyor yiyecek bulunuyor. Burada herşey poşete kalıyor. Köy burdan çok çok iyi ben oradakilerin hiç aç kaldığını görmedim fakir ama aç kalmaz oradakiler. Burada paran yoksa çatır çatır aç kalır ölürsün. Tarladan kurusu yaşı unu ekmeği bulunuyor. Buranın iyi yönü işte belediyenin yardımı başka da bir şey yok. Köyde çoluk çocuk herkes 6 ay çalışıyor 6 ay yiyor. Ama burası da köy gibi. Herşey var kentte ama parası olan için iyi.*
>
> The village is better than it is here. Here there is poverty. When you don't have bread in the village, the neighbors help. Here you are alone. Because everyone is hard up, no one can support each other. The fields yield all kinds of food. Here everything is in plastic bags. The village is much better. I have never seen anyone go hungry. There, everyone is poor but no one is hungry. Here, if you don't have money you can starve to death. You can get anything from the fields. The only good thing about being here is the municipality's assistance. Everyone, kids and adults alike work 6 months and eat 6 months. In that way, it is similar here. The city has everything but it's only good for people with money.

When they first came, they suffered from problems in terms of fulfilling basic needs like food, heating, and affording rent and paying the bills on account of inadequate and irregular income dependent on their jobs. A few respondents express that they suffered from hunger when they first came, especially in winter due to the type of job held. All the respondents who suffered from hunger in their first years had irregular family income because of the informal quality of the job which the head of the household held.

S.A. (68 year old male living in Gültepe) retired from the formal sector after 10 years working between 1954 and 1964 in the informal sector. He worked as a casual worker, waiting in worker stations for jobs. He says that:

> *Açlık oldu. Destek de olmadı. Biz dışarı yansıtmayız. İçimize atarız biz. Ben yağlı yedim derim. Akrabam desen yoktu. Komşularımız iyiydi. Ama içimde kalır hep. Bir laf vardır ben yağlı[34] yedim derim dışarı çıkar dişimi karıştırırım yemesem de. Özellikle kışları oldu, işten ayrıldığım zaman oldu. Çok fazla yokluk sefalet çektik.*
>
> We suffered from hunger. There was no support either. We are not ones to show our suffering. We endure in silence. I said that I ate yağlı. No relatives. My neighbors were nice but I did not reveal anything. Although I did not eat, there is a saying that goes I say that I eat yağlı and I go out picking my teeth with a toothpick. Especially during winter I went hungry and when I left work. We suffered extreme poverty.

[34] "The yağlı" is commonly used among the respondents. It is colloqualism, meaning something the bread is dipped into. This word is sometimes used to denote meaty foods consumed very rarely by the poor.

Casual jobs especially construction work decrease in winter, sometimes making poor families face hunger as one indicator of absolute poverty. In S.A.'s case, poverty and hunger experience was seen as shameful. Irregular income and frequent unemployment experiences in the first years reflect affect child health in particular.

When we examine the birth weight of babies, underweight births are common in families who suffered from malnutrition. A considerable number of families (22 underweight births took place in the city among 14 families) have experienced this. While some families had babies weighing less than 2 kg, the majority of them were born with weight between 2 kg and 2,5 kg.

When we look at the period when they were born, it is seen that more than half of them were born after 1990. This period is coincides with year that respondents' families were impoverished when studying the work histories of the family members, especially the ones of the heads of the household. Most of the respondents indicate their awareness of decreasing job opportunities in the urban labor market. It is striking that there is a consistency between the employment status, the type of job they performed at the time being and underweight births. It is not a coincidence that urban poor experiencing poverty with low and irregular income and unemployment and the birth of underweight infants overlaps. The economic activities of the majority of families who had underweight babies were mostly in the informal sector. This type of work and surviving difficulties due to low and irregular income caused pregnant women to be malnourished.. There are certain cases below:

N.A. (28 year old female living in Baraj) was married 5 years ago. She has a three year old son. Her husband as the provider of income worked in different areas of the informal economy such as an automobile tire station, petrol station, restaurant, and as casual worker during the pregnancy period of his wife. He was frequently unemployed and constantly changed jobs. She expresses that:

> *2 kilo doğdu oğlum. Gıdasız kaldım. Fazla beslenemiyordum parasızlıktan, çocuk da zayıf doğdu.*
>
> My son weighed 2 kg when he was born. I was undernourished. I couldn't eat well due to lack of money; therefore my son was born thin.

M.D. (39 year old male living in Baraj) has a 12 year old son and a 9 year old daughter. As in N.A.'s case, his wife was malnourished due to financial constraints.

When his wife was pregnant, he worked in a night club and he frequently changed his jobs due to irregular and low wages.

> *Gıda alamamışsın demiş doktor eşime. Oğlan 7 gün küvezde kaldı. 2100dü kız da 2,500 dü. O zaman perişandık. Paramı vermiyorlardı anlaşamıyorduk sonra başka gazinoya gidiyordum. Bazen ceptekini bile harcayıp geliyordum.*
>
> The doctor told my wife she was undernourished. My son stayed in an incubator for 7 days. He was 2100gr and my daughter was 2500gr when they were born. We were desperate then. They wouldn't pay me, therefore we were in a disagreement. Then I started to work at another night club. Sometimes I came home having spent the money that I had in my pocket (let alone earning any).

A. M. (35 year old male living in Gültepe) and his wife were married 13 years ago. They are second generation migrants who were born in Ankara. They have four children. Unlike other children, their last child was born under weight.

> *En son olan oğlum 2400 gr doğdu. Çok kötü dönemimize denk geldi maddi açıdan. Eşim hamile hamile ev işlerine gitti. Yeterli gıda alamadı. Özellikle kışın çok çektik. Eşim hamileydi ben hasta. Her zaman çalışamadı eşim. Aç kaldık çok aç kaldık. Ekmeği bu getirdi bu getirdi başkaları komşular yardımcı oldu. Ben hastalıktan dolayı çalışamadım.*
>
> My last child, my son, was born 2,400 gr this year. It coincided with the most difficult period for us in terms of economic conditions. My wife went to work in spite of being pregnant. She could not eat enough food. We were starved most of the time. Our neighbors helped us by giving bread. I could not work due to my illness.

As mentioned before, diseases of poverty are those which can be prevented or treated with a relatively small amount of money. The emphasis on diseases of poverty is important because certain diseases affect the poor first. Among the 40 families, there are 17 cases in 10 families. While 10 cases of illness in 4 families were realized in the rural area before they migrated to the city, 7 cases among 6 families happened in the urban area. It is evident that children are more vulnerable, because all of these cases are related with infant and child health. For this reason, in this research context, there is a close association between child health and poor living conditions. Inaccessibility to health services resulted in most of the infant and child deaths (8 deaths in 2 families), which happened when they were living in their villages. Only 2 cases resulted in death in the city. In terms of child health, we face three diseases: measles, diarrhea, and pneumonia. The main causes of child and infant mortality are measles and diarrhea among the respondent families. There are some statements made on this matter by the respondents. H.G. (61 year old male living in Baraj) migrated

from his village with his family 35 years ago. When they first came to the city they had difficulty in the urban labor market. He expresses that these difficulties influenced their children health negatively. He states that:

> *İlk geldiğimizde çok sıkıntı çektik. Seyyar satıcılık yapıyordum perişandık. Her türlü sıkıntıyı çektik. Çocuğumuz öldü. Biri zatürreeden öldü. İkizler epey büyüdü 4 aylıktı. Biri öldü bakımsızlıktan gıdasızlıktan. İshal oldu. O zamanlar aç kalıyorduk resmen.*
>
> When we first came, we suffered a lot. I was a street peddler and we lived in destitution. We suffered from every kind of difficulty. We lost our children. One of them died from pneumonia. Our twins grew up and got to 4 months. One died due to lack of care and undernourishment. He had diarrhea. We literally went hungry during those years.

M.D. (39 year old male living in Baraj) has been working in the informal sector for a long time but now he has a regular formal job in the private sector. He was often unemployment because he was constantly changing jobs until his present job. Unemployment prevented him from meeting the basic needs of his family like heating and food. This directly influenced his child's health. He expresses that:

> *Kızım zatürree oldu 21 gün hastanede yattı. Zaten küçük de doğmuştu kızım. Odun kömür alamamıştım üşütmüş.1997 yılıydı, 1,5 yaşındaydı. O zaman Erzincan'a gitmiştim 6 ay inşatta çalışmış gelmiştim. İşsizdim para yoktu. Destek olan da yoktu çünkü çevrem de hep benim gibiydi. Yakacaksız kalınca gıdasız hastalandı çocuk.*
>
> My daughter caught pneumonia. She stayed in the hospital for 21 days. She was born underweight too. She caught cold because I could not buy wood or coal for heating. It was 1997; she was 1,5 years old. At that time, I was unemployed after working in a construction in Erzincan for 6 months. There was no job and no money. Also there was nobody supporting me because people in my network were also like me. She got ill due to lack of burning fuel and food.

The other statement by A.M. (35 year old male living in Gültepe) is related to the association of permanent poor conditions with frequently faced health problems. He has been unemployment many times, having worked in the informal sector as a casual worker, and in the marginal sector before his illness started. After he was diagnosed, A.M.'s life has been much more difficult as A.M. expresses below:

> *Şu an 3 kız bir oğlum var. Bir kız bir oğlan öldü. 6 aylık kızım zehirli ishalden öldü, 3,5 yaşındaki oğlum da kapının önünde öldü araba ile vurdular. Bunlar ilk çocuklarımızdı. Oğlum doğuştan kalp hastasıydı. Doktor dedi ki ölüsünü bekleyin sabaha çıkmaz dedi. Ameliyat oldu iyileşti ama trafik kazasından öldü. Yeni doğan oğlum da hasta, tedavi görüyor. İdrar yollarında genişleme var. Böbreklerde çürüme olabilirmiş. Doğuştan. Bir de bronşit var.*

> Right now I have three daughters and a son. Previously, I lost a daughter and a son. My 6-month old baby daughter died from diarrhea, and my 3,5 year old son got run over by a car right outside our door. They were our first children. My son had congenital heart disease. Doctor assumed that he would die by morning. He was operated on and recovered but he died in the accident. My newborn son is also ill, he is being treated. He has urinary tract enlargement. There is a possibility that he has kidney decay. Also he has bronchitis.

When I came to this family for a visit one week later, I saw that his son had been treated in hospital from pneumonia. He had recently been picked up from the hospital. For this family, being ill is a part of life.

It is evident that poor families' children are vulnerable to illnesses which have the potential to influence their future life when we consider health as capital accumulated during a life course. As a consequence of irregular, low, or no income in the households, children are more vulnerable. However, many of the diseases they face could be actually prevented with medical interventions at reasonable costs.

5.3. Social Capital and Consequences for Health Experiences

This part describes the impacts of social security and assistance and social solidarity networks on the health experiences of the urban poor. Having a social security scheme enables people to access health services. The difference between health care access types can differentiate the experience of the urban poor in the health care settings or their health seeking strategies. The problems and suffering resulting from the gaps in the social security provided by the state in terms of health care can cause the existence and reproduction of informal remedies, which will be discussed later. These informal remedies have the potential to reinforce the health *habitus* of the urban poor by reproducing it again and again. Firstly, the possession of formal *social capital* including social security and social assistance and their impacts on health experiences will be examined; secondly, how the informal networks of the urban poor are converted into different *forms of capital* and have impacts on health experiences will be focused on.

5.3.1. Possession of Social Security and Receiving Assistance and their Consequences for Health Experiences

Economic difficulties and limited or no access to health care plays a determining role in health care access. There is a combined effect of low income and

uninsured status. People are uninsured because they work in the informal sector or are unemployed.

The informal-formal distinction is made on the basis of registration in the social security system in Turkey. The sector of the job is crucial in terms of access to health care for both the holders of the job and their dependent family members such as spouses and children. As mentioned in the previous part of the chapter, in the context of our research, formal jobs were usually held in the period before the 1990s, the sectorial shift from formal to informal sector abounded during the period after the 1990s. This tendency shows that registration to any social security organization has decreased. As Alagöz and Yapar (2003) state; although the working age population has increased, a decrease in the unemployment rate, and economic indicators were better in 2000 when compared to 1998, when the number of insured workers decreased. The percentage of unregistered workers increased by 3% in 2000 (cited in Alagöz and Yapar, 2003: 446-447, Türk-İş, 2003: 1). The structural adjustment policies determined by the IMF are to be considered as main causes for this tendency. This increased the premium for cost of labor, encouraging employers to employ unregistered workers and resulted in a decrease real wages. As mentioned before, there are some cases among the respondents and other family members where they receive less than the minimum wage in spite of being registered to social security institutions (See previous part of the chapter for details on sectoral shift, employer tendencies). The tendencies towards the urban poor prove the general changes as mentioned by Alagöz and Yapar (2003). As the number of jobs in the formal sector, both in the private and public sectors, decreased due to the type of economic policies adopted, the informal sector expanded (Demir, 1993, cited in Erman, 2003: 44). Thus, the labor market as a source of social security has a limited role due to the social security system based on the state of registered or formal jobs and the inadequacy of legal regulations.

In our sample, there are 24 families who are under the category of benefit dependent poor and 16 regular income earning families as per the application of Ayata and Ayata's (2003) conceptualization. The income earning poor position comprises those families who have at least one working member in the formal sector with insurance. As seen in the previous chapter, when we evaluate all family members, among 39 individuals who work at present, 13 are registered in social security

institutions. Among them, two are seasonally insured and taken as benefit dependent poor due to the irregularity of income. In addition, there are 7 retired individuals among the families who receive a pension from a social security organization. In two families, there are both workers with insurance and retirees. Among the 40 household heads, there are 7 full time formal sector workers with insurance, 2 seasonal formal workers and one contractual formal worker (See previous part for details). Other working household heads are employed in the informal sector as self-employed or informally employed.

The formal informal distinction is important for health care access. Holding a formal job is associated with being insured. For this reason, the urban poor's employment status and their jobs are crucial for access to health care. Job and employment status is not only of importance for the worker's access to health care alone, but also for the dependent family members. There are 169 individuals in the 40 families. While 48 family members have no insurance and have no free access to health care, 55 family members have no insurance but have a Green Card for free health care access. While there are 17 active SSI holders including the retired, 41 individuals have SSI for health care access as a dependent. In addition, there are two active SE holders, who are retired, and there are 3 individuals who have SE for health care access under dependent position. Lastly, there is 1 retired RF holder; 2 individuals use RF as a social security scheme as dependents. In many families, there are different access types in the same family. There are differences between the types of social security schemes, Green Card being a type of assistance providing health care access. The uninsured with considerable numbers have no free access; instead they must pay to receive health services.

As stated earlier, social security is seen as *formal social capital*. In addition, another relationship between the state and the individual is social assistance. Types of social assistance in our sample are composed of the Green Card as "tied assistance"providing free health care access; disability pension, widow's pension, old-age pension as "categorical assistance", food and fuel assistance from the municipality, and student scholarships from local Social Solidarity Foundation as "general assistance".

Table 15: Social Security Status and the Social Assistance Received by the Urban Poor according to Employment Status and Types of Job

Employment Status and Occupation of Household Head	**Social Security Status of Household Head**	**Types of Social Assistance which all family members have**
Employed (29)	SSI (8)	Food and fuel assistance from municipality (4)
	Seasonal SSI (2)	Food and fuel assistance from municipality (2) Fuel assistance from SSF (2)
	SE (1)[35]	-
	No insurance (18)	-Green Card (10) -Food and fuel assistance from municipality (14) -Food and fuel assistance from SSF (3) -Fuel assistance from SSF (1) -Student Scholarship from SSF (2) -Disability salary (1)
Unemployed (4)	No insurance (4)	-Green Card (3) -Disability Salary (1) -Food and fuel assistance from municipality (2) -Widowed salary from SSK (1) -Health care access from SSK (1) -Bread Assistance from municipality (1) -Fuel assistance from SSF (1)
Retired (6)	ES (1)	-Food and fuel assistance from municipality -Bread Assistance from municipality -Disability salary -Inner-city bus card given to the disabled
	SSI (5)	Food and fuel assistance from municipality (2)
Housewife (1)	Not belong to any social security organization	-Green Card -Old-age pension -Food and fuel assistance from municipality -Inner-city bus card given to the elderly -Cloth assistance from *Deniz Fener*[36]*i*

This table illustrates the complexity; some assistance is given on an individual basis some on a family basis. In addition, the same family can receive various types of assistance. However, the table may help one see the general picture. It is obvious that household heads' having social security determines whether they will receive any assistance. While the Green Card is given to those who have no social security, other

[35] There is one household head retired from SE and he also works as tea vendor informally. He is included in the table as employed with SE.

[36] *Deniz feneri* is a charity foundation based on voluntary donation. It started its activities with a television program in 1999. It was institutionalized in 2002. It provides assistance to poor families such as food, clothing, health, and accomodation. (See website for details, http://www.denizfeneri.org.tr/icerik.aspx?kod=BIZKIMIZ, accessed 12 February 2008).

assistance such as fuel and food assistance is distributed not only to those household heads who have no insurance. It is related with the application requirements for each. The assistance of Ankara Metropolitan Municipality covers a wider part of the society because this type of assistance covers the families who have income below the poverty line determined by Türk-İş as distinct from SSF assistance. It is striking that some families under the benefit dependent position could not receive assistance, sometimes temporarily, sometimes permanently. This is valid for Green Card and food and fuel assistance, too. For other assistance such as disability salary, widow pension, old-age benefit in the scope of "categorical assistance", this is not valid because the related position is documented with as a medically approved document which shows the degree of disability in order to get categorical assistance. However, the level of income and the social security status of the family members can change because of job-hopping and sectorial shifts. However, it would not be true to say that there is a systematic surveillance of income and social security status by the related institutions as reported by the respondents. As an important finding, there is an "internal control mechanism" for receiving assistance among the urban poor. This can be conceptualized as the "culture of complaint". A Considerable number of individuals believe that their fuel and food assistance was revoked because the neighbors complained about it. Excerpts below touch upon this internal mechanism. The interruption of assistance is also prevalent among benefit dependent poor families.

M.H. (33 years old, male, living in Baraj) has worked as a casual worker during his whole working life. Although he has never registered to one of the social security schemes, the fuel and food assistance from the municipality was temporarily interrupted. He expresses that:

> *Mahallede insanlar birbirlerini şikayet ediyorlar şunu var bunu var diye belediyeden yardım almamaları için. Herkes birbirinin kuyusunu kazıyor. Bizim arabamız var diye şikayet ettiler. Sonra kanıtladık arabamız olmadığını geliyor şimdi. Bir akrabam köye gidecekti arabaya bişey olmasın diye bana bıraktıydı, onu benim sandılar.*
>
> People in the neighborhood tell on each other to the municipality so that they won't get assistance from the municipality. Everyone is working behind each other's back to get others into trouble. They complained about us saying we have a car. Then we proved that we don't have one. A relative of mine was going to the village and had left the car with me for safekeeping; they thought that was mine.

The opposite is also true for F.A. (67 years old, female, living in Gültepe). Although she proved the family's status, they have not received assistance again.

F.A.: Belediyeden yardım alıyorduk da bu sene vermediler. Bizi şikayet etmişler oğlu çalışıyo kızı çalışıyo diye. Onlar da kestiler. Bir sürü maaş alıyorlar demişler. Elimde belge götürüyom gösteriyorum 3 kere gittik yok inandıramadık.
Kızı: Gidiyorum belgeleri gösteriyorum diyor ki sen yalan söylüyorsun diyorum ki bu belgeleri devlet verdi bana devlet yalan mı söylüyor diyorum. İnanmıyorlar bize. Kavga bile ettim yine de alamadık. Ben ve annem ssk, kardeşim gelin yeşilkart. Yeşilkart belgelerini götürdüm babamın belgesini de götürdüm olmadı. Türk insanı adi millet. Bak burada arabası var evi var dört dörtlük işi var ama her türlü yardımı alıyor. Yardım almak için bile Türkiye'de tanıdığın olacak böyle şey olur mu hiç. Sırf gıda ve kömür geliyor diye evi kendininse çalışmayanlar var burada. Napacak çalışıp da her şey önüne geliyor. İmkanı var ama çalışmıyor. Yani bu da iyi bişi değil ki. Yardımın bir anlamı yok. Ya hak eden verecekler iş bulana kadar. Belirli bir süre verecekler. İş bulunca da kesecekler ama tespit ederek. İnsanların şikayeti üzerine nasıl kesilir. Toplam gıda kömür yardımı 1 sene aldık.

F.A.: We were getting assistance from the municipality but we didn't get it this year. They complained about us saying the son and daughter work. So they stopped the assistance. I take them a document and show them but they won't believe me.
Daughter: I go and show them the papers but they accuse me of lying. I tell them w got the papers from the government. I even fought with them but we still couldn't fix things. MY mother and I have SSI and my brother and his wife have a greencard. I took the greencard paper in but it didn't help. Turks are a bad people. See, he has a car, a house and a great job and he still gets all kinds of assistance. Even to get assistance you need to have connections. It's unbelievable. Just because they get food and coal they don't work if they own their house. Why should they? So assistance is meaningless. They should give it to people who deserve it until they find a job. For a limited time. Then they need to check people to give them assistance. How can they just cut it off upon someone's complaint? We got food and coal assistance for a year total.

Not only have those who do not receive assistance, but also those who receive assistance, expressed the injustice in the determination of people to be assisted. Especially respondents who belong to a social security organization point out this injustice as S.B. (29 years old, female, living in Baraj) states:

SSK lı olmak demek yardıma ihtiyaç yok demek mi. Önceden yardım alıyorduk. Artık yok 2 senedir kesildi SSK lı olduğumuz için. Okulda burs veriyorlar öğrencilere biz SSK lı olduğumuz için alamıyoruz. Kömürü kendimiz alıyoruz kesildi. SSK lı olanlara muhtar fakirlik ilmuhabere vermedi.

It doesn't mean that you don't need assistance if you have SSI. We used to get it. But we haven't for 2 years because we have SSI. They give scholarships to students but we don't get it because we have SSI. We have to buy our coal now. The neighborhood chief wouldn't certify people with SSI as poor.

While some respondents tend to express their gratitude for receiving food and fuel assistance because they have not suffered from hunger since than, the prevalent view among the respondents is that food and fuel assistance are not the solution for them and most of the respondents express the injustice and the role of informal networks in the selection process.

A.M. (35 years old, male, living in Gültepe) is a chronically ill street vendor. All members of his family benefit from health services with the Green Card. He also receives food and fuel assistance from the municipality and SSF, and a student scholarship from SSF. However he states that:

> *İşin gerçeğini söylemek gerekirse belediyeden Allah razı olsun derim. Geldi geleli insanları yiyecekten boğdu. Demek istemiyorum ki belediye, kendi cebinden verdi. Hakkımızı veriyor. Sonuçta dünya bankasından alıyorlar. Daha önce bunlar yapılmadı. Ama Melih Gökçek geldi geleli en azından gıdamız var. Bugün evimde kuru fasulye nohut mercimek varsa gıda yardımından geliyor. Açlık çekmiyorsun en azından. Şimdi bakın yardım yine de çözüm değil. Bence bugün bana belediye yardımı vereceğine bana iş versin daha iyi. Ben kendim de alırım. Adamın emekliliği geçmiş 10 yıl adam halen çalışıyor. Onun yerine 2-3 genç çalıştırsın devlet. Emeklilere de yeterince para versin onlar da çalışmasınlar.*
>
> To tell you the truth, I say thank God for the municipality. Ever since they came, they have drowned people in food. The municipality pays out of their own pocket. We get what we deserve. They get it from the World Bank anyway. These weren't done before. But ever since Melih Gokcek became the head of the municipality at least we have food. Today, if I have beans, chickpeas and lentil it comes from the. At least you don't starve. But assistance still isn't the solution. I think that if they gave me a job instead of municipality assistance, it would be better. Then I would buy it myself. For example, this man still works even though he could have retired 10 years ago. Instead of him, the government should hire 2-3 young people. And they should pay retired people more so they don't have to work.

Although the majority of the recipients of fuel and food assistance hold that assistance is not the solution, they add how important it is for meeting their urgent needs. However, the urban poor in the benefit dependent poor position who do not receive any assistance say that they suffer from hunger and having no coal or wood in winter time. There are five benefit dependent poor families who do not receive assistance.

The social security status and types and health assistance have a role in the health experiences of the poor in terms of health care access. The social security type has a determining role. Also, health benefit from SSF, that is the Green Card, provides the urban poor with access to health services and being able to receive medicines and other materials.

Social insurance is tied to formal work; that is, holding a formal job plays a crucial role in being registered to one of the social security schemes. They suffer from economic difficulties resulting from the insecure features of the sector; Moreover, they have no free access to health care. Below, there are different cases according to social security status and type in terms of health seeking strategies.

In the case of the uninsured, there is a tendency to not seek health services. Among the respondents, there are 11 uninsured without health benefits. They receive health services by paying the cost of the services themselves; otherwise they can not

receive any. The second is a more prevalent tendency among the uninsured. The uninsured respondents comprise the unemployed, casual workers, self-employed, and informal workers with definite workplace. The general tendency for other respondents who have the Green Card is to go in the case of suddenly illnesses and accidents requiring medical care. A look at the causes of not being registered to a social security scheme and not having Green Card reveals several reasons. Three respondents own a vehicle, so their Green Card application was refused. Their socio-economic status is not high when we look at their income. Two of them have a vehicle because they need it for their job. M. K. (40 years old, female, living in Gültepe) is an uninsured housewife. They could not receive any assistance due to their truck. Her husband is a truck driver and porter. He makes long distance travel constantly. She talks about why they could not receive any assistance:

> *Şoför kamyonla nakliyecilik kendi kamyonumuz şirketler istiyor mesela mobilyacı evden eve nakliyat. 2 haftada bir kere ancak iş oluyor araba eski olduğu için onlara fazla iş verilmiyor ve masrafı da çok oluyor. Yeşilkartımız vardı daha önceden ama arabayı alınca iptal oldu. Ama sonuçta bu bizim işimiz. Ben anlayamıyorum evleri var çok güzel arabaları var nasıl oluyorsa onların var bizim yok yeşilartımız. Başkasının üzerine geçiriyorlar herhalde mal mülkü. Benim maddi durumum iyi olsa ben açıkçası istemezdim. Mağdur olanın hakkını yemezdim. Yazık değil mi benden kötü olanın hakkını yemezdim.*
>
> My husband has a truck. He's a driver. Companies, for example, call him to deliver furniture. He only gets called once every other week. Because the truck is old, he doesn't get called often. And he doesn't make much money and there are expenses. We used to have a greencard but it was cancelled when we bought the truck. But this is our business. I don't understand. People have houses and nice cars but they have a green card and we don't. I guess they register their property under someone else's name. Frankly, I wouldn't want that if I was well off. I wouldn't steal that right from someone. I wouldn't deprive someone worse off than me.

In the website of the Altındağ District head official[37] (Altındağ Kaymakamlığı), the application requirements for applying for the Green Card, based on the Social Assistance and Solidarity Encouragement Law numbered3294, are (1) being inhabitants within the district, (2) not being registered to a social security institution, (3) the document displaying the poverty status obtained from the head of the neighborhood and (4) not having any property in your name. When we look at Green Card holders among the respondents, not all are tenants, some Green Card holders own a *gecekondu.* The tendency of transferring the ownership of property to others among the urban poor, as mentioned by M.K., is mentioned many times by two

[37] http://www.altindag.gov.tr/saglik.htm, accessed 10 January 2008.

neighborhood people, both respondents and other neighbors with whom I was talking during the fieldwork. However, among the respondents, none of them admitted to employing this strategy themselves.

In addition to the above case, the common reasons for not being able to apply for the Green Card is that the application procedures require time, which influences their income negatively, especially for casual workers, and the lack of money for commuting required to apply. The uninsured respondents do not seek health care services for health problems; this is general tendency. They state that they "manage" or "get by". They only receive health services under "necessary conditions" determined by the state of emergency and the severity. H.T. expresses that:

> *Ben günlük çalışıyorum. Başvursam yeşilkarta bir sürü günüm gidecek eve para girmeyecek. Eşim de mahalle dışında bir yeri bilmiyor, baş edemez başvuramadık o yüzden. Gitmiyoruz, gidersek de para veriyoruz. Sigortamız olmadığı için doktora gitmiyor ağrımızı çekiyoruz. Köydeyken de yoktu sigorta. Borç bulup ankaraya geliyorduk ya da kazaya giderdik. Hastane var ama bize bakmıyor ki. Ben şu çocuğu Dışkapı'ya götürdüm kaç sefer. Adam parasıylan bakmıyor. Bura SSK hastanesi diyo parayla bakılmaz. Lan hemşerim dedim çocuk ölüyo diyom yok diyo olmaz diyo. Ha köyde yaşamışım ha burda. Hastaneye gidemedikten sonra varmış yokmuş napim. Ayrım yapılıyor. Şimdiye kadar hiç doktora gitmedim kendim için. Hasta olduğum zaman evde yatıyorum. Çok ciddi olduğunda yataktan kalkamazsam o zaman hastayım derim. Moralim bozuksa düzelmek için evden çıkar giderim. Ağrım varsa ağrı kesici içerim yoksa ağrıyı çekerim. Hep parasızlıktan gidemiyoruz. Hanımı götürmek istiyorum götüremiyorum kulaklardan. Kendim mideden gidecektim gitmedim. Kalbim için gidecektim gitmedim. Hizmete ulaşamama en büyük sorunumuz. Ulaşılsa da doktorların iyi tedavi edememesi.*
>
> I am a daily worker. If I applied I would lose many days and we wouldn't make money on those days. My wife doesn't know any place outside the neighborhood; she couldn't manage so we haven't been able to apply. We don't go to the doctor. And if we do, we pay. We just bear the pain instead of seeing a doctor. We didn't have insurance back in the village either. We would borrow money and come to the city or to a nearby town. There are hospitals but they won't give us service. I took my child to Dişkapı many times. They won't accept your money. They say it is an SSI hospital you can't use money. I tell him my kid is dying and he still refuses. What difference does it make whether I am here or in the village when I can't go to a hospital anyway? There is discrimination. I have never gone to a doctor for myself. When I am sick I stay home. When it's serious and I can't get out of bed, then I say that I am sick. If I am in a bad mood, I just leave the house. If I have pain I take a painkiller or I bear it. We can't go because we can't afford it. I want to take my wife in for her ears but I can't. I was going to go to have my stomach checked. I was going to go to have y heart checked but I didn't. We don't have access to services, that's the biggest problem. And even if you do have access, the doctors don't do it well.

H.T. reflects on the tendency of the uninsured in terms of health seeking strategies. They do not know what illness they have. They suffer from health problems but they are not diagnosed by a doctor. So they consult "popular sector" as a health seeking strategy as Kleinman (1988) mentions, such remedies as taking medicine, the rest, bearing the pain without doing anything, and taking herbal teas (see 2.3. for details).

SSI hospitals before the implementations of Health Transformation Program[38] only took individuals who had SSI as a social security scheme; those insured and their dependents. During the interview, people had not gone to a health care unit they chose because of this restriction. Green Card holders could go only to state hospitals; they could not to go to university hospitals or SSI hospitals. However, now, they can go any hospital, even private hospitals, with the recent regulation under the Health Transformation Program. But we must evaluate the health experiences of the respondents according to the regulations and laws of that period when the interviews took place.

The institutional experience is not faced often by the uninsured because of the tendency to not seek health services and the behavior of "managing by oneself" internalized with remedies in the popular sector. They seek professional help in sudden and urgent cases. When they can go to a hospital or a health care unit, the treatment costs become a problem. So the cost also prevents them. In most cases, they could not afford the costs. The problems experienced in health care units are valid for almost all. In hospitals, they suffer from time-consuming bureaucratic procedures, long waiting lists, as well as lines disinterest and scolding from health personnel. N.T. (45 years old, male, living in Baraj) as an uninsured respondent states that:

> *Hastanede çocuğa bakmadılar. Yüzüne de bakmıyorlar adamın. Ne bileyim şöyle azıcık yakın olsunlar. Pek azarlıyorlar adam. Hangi birine bakim diyor o da. Bilmiyorum düzelmesi imkansız. Adamlar bakmıyor, hepsi kendi havasında, kimi sigara içiyo, keyif yapıyo. Doktorlar hiç iyi davranmıyorlar. Ne bileyim valla hemen adamı azarlayı azarlayıveriyorlar. Yeğenim burda hastaneye SSK'ya vardığın zaman aha çocuğu götürdüm hastaneye kafada ağrı var çocukta, 15 milyon para aldılar. Dedim bu ne ya. Dayı dedi oraya git bir fiş al, oraya git muayene olucan dedi. Oraya götürdüm hemşireye, hemşire dedi ki git dedi özel hastaneye gidcen. Yeğenim ben buraya para verdim. Banane dedi dayı verdiysen dedi. Ben orda aslında numarayı alıp da orda sağlık bakanlığına telefon çekmeyi şey yapmadım işte, akıl etmedim. E kafa zaten kötü zaten hastayım bende. Çocuğu halsiz halsiz oraya götürdüm. Dışkapı SSK da öyle paramızı yedikten sonra, yine para verdik özel polikliniğe gittik.*
>
> They wouldn't take care of my child at the hospital. They don't treat you like a human being. I wish they would show a bit of interest. They really tell you off. And their problem is they have too many people to take care of. I don't know; it doesn't seem like it can be solved. They

[38] The Health Transformation Program aims to unify all different access types under the same frame and implement general health insurance. The project has not yet been implemented completely, but some improvements have been made such that all individuals can begin to benefit from all types of health institutions as of 2003. In 2005, the coverage of the service was expanded for Green Card holders. They can receive services like outpatient treatment and medicine (by paying the 20% of the cost of the medicine) in addition to inpatient treatment previously given from this time. Finally, Green Card holders have the right to receive health services from all hospitals (Ministry of Health, 2004, Gümüşel, 2006).

> don't serve you. They are all in their own world, smoking and enjoying themselves. The doctors don't treat us nicely. I took my child to the SSI hospital because he had pain, they charged me 15 million Liras (currently 15 YTL) I was confused. They said to get a ticket here and go get checked up there. I took the ticket to the nurse; she said to go to a private hospital. I told her I paid money and she said it was none of her business. I should have gotten the phone number to the Ministry of Health and called them but it didn't occur to me then. My head isn't well anyway. I took the child there, all tired. After Dışkapı SSI ripped me off, we still paid at a private clinic.

In the stage of "medical care contact", many respondents complain about the disinterest. Only a few express satisfaction. Most of them are chronic patients and insured in spite of considering the problems of time-consuming bureaucratic procedures. M.H., as a Green Card holder, talks about the problems he faces in hospitals but his concerns are also mirrored by other respondents with different access types. He mentions that:

> *Hastanede 1 günde teşhis konmuyor. Defalarca hastane yollarında yoruluyorsun. Ondan sonra da bıkıyorsun. Bakıyorsun, lanet olsun diyorsun gitmiyorsun. Oradan oraya gönderiyorlar oradan oraya gönderiyorlar. Ben hergün yol parası veremem ki. Ayrıca ayrım da yapıyorlar bu herkes için böyle değil. Tanıdığın varsa işlemlerin daha hızlı yürüyor, daha çabuk sonuç alıyorsun. Ama adamın yoksa kuyruklarda doktorun hemşirenin hasta bakıcının azarlamasına maruz kalıyorsun. Dinle dur. Eğer karşılık verirsen kavga çıkıyor, bunlar kavga ediyor atın şunları dışarı diyorlar. Sonra da çıkıp geliyorsun. Nereye gidersen git bir adamın olacak. Hakkını aratmıyorlar onlar devamlı haklı pozisyonunda. Seni sıradan bir vatandaş gözüyle görüyor. Başhekime şikayet etsen seni mi sıradan bir vatandaşı haklı görecek kendi personelini mi. Kendi personelini tutacak beni tutacak değil ya. Oradaki vatandaşımız gidiyor, evrak veriyorlar git şurda yaptır gel diye kafası karışıyor belgelerle evraklarla çok uğraşılıyor git gel. Çoğu bilemiyo şaşırıyor. Biz artık o evrakları istemiyoruz bunun başka yolu yok mu? Hastanede elli tane yere gönderiyorlar. Daha fazla doktor gerekiyorsa daha fazla doktor çalıştırmaları lazım. Daha fazla hemşire koymaları lazım. Devlet dairelerinde ayakçı dediğimiz evrak taşıyan insanlar var böyle insanlar olsa 10 kişinin evrakı ile ilgilense. İnsanlar hasta haliyle dolanıp duruyor hastane içinde. Hastanede rezil oluyor insanlar. Hastalar da hasta yakınları da. Sırf bu yüzden hiç gitmek istemiyorum doktora gitmiyorum da. Televizyonlarda görüyoruz kavga. Bu insanlar boş yere dövüşmüyor. Karşındaki insan sana nasıl davranıyorsa insanlar da o şekilde davranıyor. Bazılarının da işi acele oluyor bir an önce işini bitirmek istiyor gözü açıklık yapıyorlar. O onun önüne giriyor o onun önüne. Öyle tartışma çıkıyor. Hastanelerde neden sıra var. Neden olsun? Böyle olunca insan nefret ediyor hastanelerden.*
>
> They don't diagnose you in one day at a hospital. You get tired from it all and then you swear off going. They send you all over the place to different people. I can't afford to commute everyday. And besides they discriminate. It's not the same for everyone. If you know someone they process you more quickly. But if you don't have someone in there, you wait in line and the doctors, hospitals and caretakers tell you off and scold you. If you answer back, you get into a fight and then they kick you out because you are fighting. Wherever you go you have to know someone. They won't let you look out for yourself. They are always in the right of things. They see you as an ordinary person. If you complain to the director of the hospital who would they believe? You, an ordinary person, or their own staff? Not me of course. Our people go there; they are told to go here and then to go there with their papers to have this or that done and people get confused. We don't want to deal with that paperwork anymore. Isn't there another way? They send you to fifty different places in the hospital. If they need more doctors, they should hire more. And more nurses. There are people we call paper pushers in government offices who have the paperwork done. Maybe if there were these people in hospitals and they did this for 10 people at a time it would work. You get exhausted in hospitals. Both patients and their relatives. This is why I don't go to hospitals or to a doctor. We see the fights on TV. These people aren't fighting over nothing. They behave the way they

are treated. Some are in a hurry and want to be finished as soon as possible so they try to be cunning. They cut in front of people in line. Then a fight breaks out. There are lines in hospitals. Why should there be? When it is like this you hate hospitals.

Similar problems are valid for SSI holders. A.Ay. states that:

İdare ediyoruz. Sıkıntı da çekiyoruz çekmez miyiz? Seni bilmediğin yerlere gönderiyo. Şurda film çektir şurda tahlil yaptır diyo sonra da bana getir diyor. Bir gün de olacak iş değil. Eşimin zamanı yok işten izin alıyor hergün de alamaz ki. Uğraşmak birkaç gün harcamak lazım. Hem işyerinden sıkıntıya gidiyor hem sağlığı kötüye gidiyor halledemezse. Gidiyorsun doktoru bulamıyorsun. Zar zor muayeneni oluyorsun. İlaç misal. Oraya iki ilaç yazmış ilacın biri var biri yok. O kadar eczaneyi geziyoruz dolaşıyoruz yok. Geri gidiyorsun o zaman doktora daha değişik bir ilaç yazacak onu alacaksın yoksa yok. Öyle yani sıkıntısı çok. Zaten gitmek istemiyorum doktora. Bana bir sürü dert çıkarır diye gitmem. Sevmiyorum o ortamı. Bir sürü uğraştırıyorlar.

We manage. Of course we have problems. They send you to places you don't know. Have an X-ray taken here, have the tests done there and then bring them to me; that is what you are told. It can't be done in one day. My husband doesn't have the time. He takes a day off of work but he can't do this everyday. You have to take a few days. He gets into trouble at work and his health worsens if he can't take care of things. You go, you can't find the doctor. You get your check up with difficulty. Medicine.. The doctor prescribes two, but they don't have one of them. We got to all kinds of pharmacies but they don't have it. Then you have to go back to the doctor so he can prescribe another one. I don't want to go to the doctor anyway. I don't go because it is so much trouble. I don't like the atmosphere. They give you a hard time.

In addition, respondents express their awareness of the differences according to access type in receiving health services. Ö.A. (25 years old, male, living in Baraj) states that:

Emekli Sandığı olduğu için her yere gidebiliyoruz. İstediğim yerden hizmet alabiliyorum. Rahatız işimizi halledebiliyoruz. Sıkıntım yok. İlaç konusunda da sorun yok. Sigorta gibi değil rahatız.

We can go everywhere because we are in RF. I can get services anywhere I want. We are comfortable. We can have our business taken care of. I have no problems getting medicine either. It's not like SSI. We are fine.

As stated earlier, both poverty and uninsured status influence health care access negatively. M.A. (30 years old, male, living in Gültepe) is unemployed and in depression. Although he was diagnosed and had started treatment, he now could not go to the doctor because he was uninsured and has no money to pay for the medical examination and treatment. He expressed that:

Doktora gidemiyorsun hastalıktan ölsen para lazım. Sigortam da yok yeşilkartım da. Hiçbirşey yapmıyorum, gidemiyorum. Sigortam olmadığı için param olmadığı için gidemiyorum.

You can't go to the doctor. Even if you die you need money. I don't have insurance or a greencard. I don't do anything. I can't go because I have no money or insurance.

Poverty is not only important for receiving health services, but also commuting expenses make respondents avoid seeking services. A considerable number of respondents emphasize the commuting expenses as an obstacle for health care access as M.H. (33 years old, male, living in Baraj) mentions:

> *Çok oldu doktora gidemediğimiz parasızlıktan. Gidecek olsak bile yol parası bile sorun.*
>
> It has been a long time since we last saw a doctor because we have no money. Even if we wanted to go, even the commuting fare is a problem.

The commuting expense is not only important for the benefit dependent poor; some regular income earning poor respondents also emphasize this problem as H.Ay. (27 years old, female, living in Gültepe) expresses:

> *SSK lı olsak bile yoktu para yoktu ki götürem. Kızım uykuda bayılmıştı. Param yoktu götüremedim. Yol param yoktu.*
>
> Even though we have SSI there was no money to go. My daughter fainted while she was sleeping. I had no money so I couldn't take her. I didn't have commuting money.

Being insured or having the Green Card for free health care access and also having money during the time of feeling ill play a crucial role in the transition to the next stage, what Suchman called, "medical care contact". Medical care contact is very rare among the respondents. There are many factors in addition to being uninsured and lack of money. The most common one is bureaucratic difficulties within the hospital such as long waiting lists and lines for medical examinations, tests, and treatment.

Institutional experiences in health care settings differentiate according to social security status. The uninsured respondents suffer from access difficulty and even if they can access by paying, they have difficulty to paying the treatment costs because they must pay not a certain amount of the price like the insured but all of it. This economic incapability keeps them from receiving health services. For all respondents, insured or not, the hospital atmosphere was an important problem. The aforementioned problems in this setting, in general, make them avoid receiving services. In addition to the problems experienced in hospitals, actually finding and buying the medicine is the main problem for Green Card holders. The access type prevents Green Card holders to go on to the recovery stage. While this difficulty is

expressed as a situation which can be coped with for insignificant illnesses, the situation for chronic illnesses makes the illness severe and makes the respondents suffer. Living with a chronic illness is possible by taking medicine regularly and being monitored. E.A. (26 years old, male, living in Gültepe) mentions the difficulty of finding medicine as a Green Card holder as:

> *Bende epilepsi var. Ankara Hastanesi'ne gidiyorum, ama yine aynı ilacı veriyorlar. Film çekilmesi lazım 2 ay sonraya gün veriyorlar. Çok erteledikleri için de tetkiki yaptıramıyoruz. Muayene de boşuna gidiyor. Yeşil kartım çıkalı 2 ay oldu daha yeni ondan önce hep para ile alıyorduk ilaçları. Yeşilkartlı olmak zor ilacı bulamıyoruz ki. Eczanelerde çok sıra oluyor, insanların tansiyonu çıkıyor eczanede hastanede sıradayken. Çok zor alabiliyoruz ilacı. İlaç bulunmuyor. Geliyor ilaç bir anda bitiyor. Resmi işler çok uzun. Yeşilkartlı olduğum için perişan oluyorum.*
>
> I have epilepsy. I got to Ankara Hospital but they still give me the same medicine. I need have X-rays taken but they give me an appointment for two months later. Because they put it off so long we can have the tests done. The check up is wasted. It has only been 2 months since I got my greencard. Before that we paid for the medicine. It's hard to have a greencard because we can't find the medicine. There are long lines (in the pharmacies green cardholders can go to) when we go to get the medicine and then it's already finished. Bureaucracy takes long. The greencard makes things so hard for me.

Similarly, G.B. (49 years old, female, housewife, living in Baraj) expresses the difficulty by comparing it with her previous access type as:

> *İlaç almak tam bir işkence. Kaymakamlığa gidiyoruz diyor ki ilaç gelmedi. 2 ay oldu yeşilkart alalı. Daha birgün ilaç alamadık. Bu kadar sıra olmamalı. İlaç bulunmalı. Biz yeşil kartlıyız ama daha faydasını göremedik… Tedavi olmak için sırada bekliyorsun. Beyim şeker tedavisi olması için gönderdiler. Çok sıra var. Ne bir kan alıp ölçecekler şekeri şu kadar diyecekler. Şunu yesin bunu yemesin diyecekler. 3-4 gün gittik geldik. 6:30 da gidiyoruz. Her yere gidiyoruz ama her yerde de sıra var. SSK lı iken de aynı sorunları yaşıyorduk. Ama SSK da ilacı daha rahat alıyorsun buluyorsun. Şeker tedavisi için 4 gün gittim. Adamı bir kenara oturtuyorum ben sırada bekliyorum. Her istediğimiz doktora gidemiyoruz. Gidemiyoruz belli yerlere gidebiliyoruz sadece.*
>
> Getting medicine is torture. We go the district governorship they say the medicine hasn't come. It's been 2 months since I got the greencard. I have never been able to get medicine. There shouldn't be such long lines. The medicine should be available. We have greencards but we have never benefited from it. You wait in line to be treated. My husband needed treatment for his diabetes. All they have to do is to draw blood, measure his sugar level and say eat this; don't eat this. We came and returned everyday for 3-4 days. We go there at 6.30 in the morning but there are lines everywhere. I had him sit down and I waited. We had the same problems when we had SSI. But you can find and get medicine when you have SSI. We can't go to any doctor we want. We can only go to particular ones.

Here, we try to look at the issue through the eyes of urban poor. Within this context, the doctors' feelings and problems are irrelevant. For Turkey, the health care structure is important in addition to respondents' expressions. Cirhinlioğlu's study (2001) on doctor-patient interaction done in two hospitals in Sivas, sheds light on the

issue of doctors and interaction with them. According to the findings, doctors do not want an authoritative, oppressive, and dominating doctor-patient relationship during the treatment process. Especially doctors working in SSI Hospital state that the time allotted to each patient is very limited and they ca not communicate with patient; instead they try to finish each session rapidly. Therefore, doctors turn into these experts who only diagnose problems and quickly prescribe medicine instead of forging the ideal relationship that the patient would like. This structural problem peculiar to the health care system in Turkey may be a determinant in the doctor-patient interaction.

5.3.2. Possession of Informal *Social Capital* among the Urban Poor and Consequences for Health Experiences

The possession of informal *social capital* by the urban poor is mostly based on the family, kin groups, common geographic origin, and especially neighbors. Each network functions differently for the respondents. The informal network functions as a *security valve* for different periods from the decision to migrate to coping with the new, recent form of poverty. First, I follow a chronological order regarding the functions of the informal network. In the decision to migrate, the clustering of rural migrants in certain *gecekondu* areas, and illegal *gecekondu* building in the city, the informal network especially based on kinship ties and the same village origin had important roles among our respondents. Rural people's social ties with their relatives or fellow villagers in the city function help the decision for migrate and integration to the city for most of respondents. While very few respondents state that they did not benefit from the informal network when they first came to the city, the majority state the main functions of their informal network in finding a *gecekondu*, finding a job, temporarily staying in a relative's or a fellow villager's place of residence, and building a *gecekondu*. Below, there are some excerpts:

H. G. (61 years old, male, living in Baraj) migrated 35 years ago. He states the benefits of informal network in that period as:

> *Hem iş konusunda hem ev konusunda gecekonduyu yaparken her konuda destek oldular. Bizim Balalılar hep et işiyle uğraşır Ankara'da. Birbirimizi tanırız. Baraj mahallesine geldiğimizde, bizim köylü oturuyordu buralar hep boştu. O zaman elektrik su yoktu. Bir kuyu vardı o kadar. Akrabaların boş evinde kaldık. Sonra hepimiz çevirdik evleri yaptık. Akrabalarım kardeşlerim destek oldu her konuda.*

> They helped us with everything; jobs, building the gecekondu. People from Bala are usually in the meat business in Ankara. We know each other. When we came to Baraj, people from our village lived here. Otherwise it was empty. There was not electricity or water back then. There was only a well. We stayed in the empty house of one of our relatives. Then we all built houses. My relatives and siblings helped with everything.

Social assistance from the network based on kinship ties and common geographic origin, or being from the same village or town plays a supportive role in the integration of new comers. According to the respondents and my observations in the two neighborhoods, there is a close relationship between common origin and occupation.

For some respondents, the social network only functioned as guidance in terms of settling down in the neighborhood like E.A. (26 years old, male, living in Gültepe). He was born in Ankara and his family migrated 28 years ago. He expresses that:

> *Bizim köylüler burada çok akrabalar çok. Annemin amcası varmış. Burada çok kişi vardı. Yönlendirmişler. Ama hiçbiri yardımcı olmadı bizi yalnız bıraktılar geldik çile çekmeye başladık halen de çekiyoruz. Çok akraba vardı ama hiç yardım etmediler. Kendi yağımızla kavrulduk.*
>
> There are lots of people here from our village. My mother had an uncle. They guided my family. But no one really helped us; they left us to our on devices. We came and started having problems. We still do. We had to make it on our own.

In addiditon to the migrants who migrated many years ago, newly migrated individuals in families also gave various assistance as S.B. (29 years old, female, living in Baraj) case. S.B. migrated 6 years ago. First her husband came seasonally for work to the city, then she came. Then her sister migrated two years ago and her husband's brother came few months ago for seasonal work. This is a kind of *chain migration*. She mentions the assistance received from the relative as:

> *Eşimin ablası vasıtasıyla geldik. Önce eşim geldi onlarda kaldı ameleydi o zaman. Sonra biz geldik. Topraklıkta oturuyordu ablasıgil. Aynı evde oturduk 2 sene. Geldiğimizden beri ablası çok yardım etti. Yakacak verirlerdi, çocuklara giysi verdiler. İlaçlarımızı aldılar. Makinem yoktu kendi makinesinde çamaşırlarımı yıkardık.*
>
> We came with the help of my husband's older sister. My husband came first and stayed with them. He was a worker then. Then we came. They were staying in Topraklık. We lived in the same house for two years. His sister helped us a lot. They gave us wood, clothes for the kids, bought us our medicine. I didn't have a washer so I would do the laundry with her washing machine.

Similarly, H.Ay. expresses the support. She migrated 8 years ago from village of Gümüşhane. She mentions that:

> *Ev bulmada iş bulmada hep yardım ettiler. Benim dayım burada oturuyordu. Kardeşlerim de buradaydı. Onlar burada birlikte ev tuttular. Sonra evlenip gittiler. Kardeşlerim akrabalarım o onu getirmiş o onu getirmiş. Burası ucuz olduğu için gelmişler.*
>
> They helped us find jobs and a house. My uncle lived here. My brothers were here, to. They rented a house here together. Then they got married and left. My brothers and relatives brought someone here, and then those people brought others. They came because it was cheap here.

Most of the first migrants who migrated alone to work received assistance, especially those staying in a relative's home like M.B. (36 years old, female, living in Baraj). Clustering migrants in the same physical space facilitates integration, at least in the *gecekondu* area. She says:

> *8 sene oldu geleli. Evlendik geldik. Eşim geleli 10 sene olmuş. 2 yıl halasının yanında kalmış. İnsanlarla hiçbir sorun yaşamadık hep bildiğimiz adamlardı akrabalar köylülerimiz o yüzden sıkıntı çekmedik. Kolay uyum sağladık yani.*
>
> We have been here for 8 years. We got married and came. It has been 10 years since my husband came. He stayed with his aunt for 2 years. We never had any problems with people. We knew everyone; relatives and fellow villagers. We adapted easily.

Similarly, M.D. (39 years old, male, living in Baraj) states that:

> *Teyzemin oğlunun yanında kaldım. Annem teyzeme bakmış teyzemin oğlu da bana baktı. Karşılıklı. Teyzeme annem 13 yıl bakmış. Teyzem duldu. Bu mahallede de akrabalar vardı. Köyden gelene de biz yardımcı oluruz. Hastane olsun iş olsun.*
>
> I stayed with my cousin. My mother took care of my aunt for 13 years, so he took care of me. My aunt was a widow. We had relatives in this area. And now we help when someone comes from the village; whether its hospital business or other.

The principle of reciprocity is central in the traditional welfare regime. The reciprocal relationship also continue to this day as M.D. case. Many respondents whose relationship with the village continue try to assist their kin such as by temporarily offering their home, guiding them when receiving health services, and support them during the search for informal jobs. In a study which develops the model of strategies for coping with poverty by Kalaycıoğlu and Rittersberger-Tılıç (2003), the "family pool", based on the principle of reciprocity, plays crucial role as a social solidarity pattern among the urban poor. This system not only functions as a coping strategy, as

seen among the respondents, but it starts with their decision to migrate. In accordance with the model, the respondents especially mention reciprocity in various forms of solidarity and support.

However, it is striking that staying at a relative's home temporarily, in most cases, can be reciprocal and exploitative in character, when they first come to the city. The majority of first generation migrants who migrated alone for work were subjected to exploitation by their relatives like A.A. (35 years old, male, living in Baraj):

> *23 yıl once geldim. 2 yıl akrabamda kaldım. Para getirmediğim işsiz olduğum zamanlar önüme ekmek koymadıkları oluyordu. Bir parça ekmek koyuyorlardı başka koymuyorlardı. Zaten kazandığımı da onlara veriyordum. Hayatta her şey karşılıklı. Bir de o zaman çocuktum ben.*
>
> I arrived 23 years ago. I stayed with a relative for 2 years. Sometimes when I wasn't bringing in money they would make me go hungry, not give me any bread. Or maybe only one slice. I gave them what I was earning anyway. Everything in life is tit for tat. And I was a child then, too.

Similarly, M.F. (74 years old, male, living in Gültepe) migrated 59 years ago. He expresses the appropriation of a newcomer's economic sources as:

> *Tamam, ev bulmama yardımcı oldular, zaman zaman kaldım akrabalarda. İlk geldiğimde kaldım. Daha sonra ev yaptım. Yol gösterdiler. İş bulmama da yardımcı oldular. Bilmiyoruz tabi burayı. Ama akrabada kalmak zordu. Ben kalıyordum akrabada ama parayı aynen veriyordum onlara. Para getirirsem iyi, getiremezsem koymazlardı evlerine. Çok aç kaldım. Ya ekmek alacan ya et alacan ki pişirip yenecek. Yoksa yok.*
>
> Okay, they helped me find a house, sometimes I stayed with relatives when I first came. Then I built a house. They guided me. They helped me find a job, too. I didn't know this place back then. But it was hard to stay with relatives. I stayed but I gave them all the money I earned. If I didn't earn money, they wouldn't let me stay. I went hungry lots of times. Either you buy bread or meat so it can be cooked and eaten, or else.

According to Pınarcıoğlu and Işık (2001) poverty has a tendency to transfer to the newcomers to the city, a phenomenon called "poverty in turns". This transference of poverty is provided by the approriation of new comers those economically like the cases above. On the one hand first generation migrants try to cope with poverty by exploiting newcomers, on the other, new comers benefit from first generation migrants in terms of help with finding a job and accomodation until settling down in the city completely. For our case, this tendency is evident in male migrants who migrated alone for work, especially when they were children.

When we look at the work experiences of all family members we see that working in formal jobs is closely associated with the functions of the social network especially the close or remote relatives for all. All of them did not find a formal job without support. When the sectorial shift is examined, working in a formal job is more frequent it was before the 1990s. This is not only valid for formal jobs; the social network is also crucial for finding employment opportunities. The close or remote relatives are important at this point. While finding a job with the mediating role of the relatives seems to be more visible in the period when the rural-to-urban migrants came to the city; kin as a source of support still retains its mediating role although the support has decreased recently, which is mentioned by many respondents. M.D. (39 years old, male, living in Baraj) states that:

> *Istanbul'daki işi amcam bulmuştu. Ankaraya ilk geldiğimde sitelerde çalışmaya başladım onu da dayım ayarladı. Gazinoda kaynım sayesinde çalışmaya başladım o orda çalışıyordu. Erzincana gittim akraba sayesinde. Ostimdeki işim de akrabaların yardımı ile oldu. Çalıştığım işlerin hepsinde akrabalar aracı oldu, ya da tavsiye ettiler. En son 1999 yılında benzinlikte iş bulunca ayrıldım. Yine akrabanın tavsiyesiyle.*
>
> My uncle found me the job in Istanbul. When I first came to Ankara I worked at Siteler, and my other uncle found me that job. I started working in a nightclub thanks to my brother in law. I went to Erzincan with my relatives' help. All the places I worked a relative helped me get a job or they referred me. Finally when I found a job at a gas station I left. Again with a relative's reference.

A considerable number of respondents especially living in those families whose household heads are causally employed complain about the lack of social environment which have a potential of playing a mediating role in finding a job. H.T. (32 years old, male, living in Baraj) expresses the lack of informal social network which may be beneficial for finding a formal job as:

> *İyi bir iş sigortalı güvenceli bir iş arıyoz ama denk getiremedik. Şirketlere gidiyoruz. Başvuruyoruz. Tanıdık olmadığı sürece almıyor yani. Askerden geldikten sonra işsiz kaldım. Zaten tanıdık olmadığı sürece işe almıyorlar. Adam seni temizlik şirketine almıyor. Ya müdür olacak ya şef olacak tanıdık. Ondan sonra seni işe alacak.*
>
> I am looking for a good job with insurance but I haven't found one yet. I go to companies, I apply. They won't hire you unless you now someone. I was unemployed for some time after I got back from the military. They won't hire you in a cleaning company. Either the director or head has to be someone you know. Only then ill they hire you.

As seen in H.T.'s case, when the social network is inadequate finding a formal job is difficult for the urban poor. In addition, occupational segregation within the urban

labor market according to kinship ties, common origin or ethnic identity may exclude some who have low possession as M.A. (30 years old, male, living in Gültepe). M.A. as someone unemployed points out this strict segregation in the urban labor market:

> *Akrabalık ilişkileri her şeyi belirliyor. En büyük sorun kürtlükten çıkıyor. Onlar kötü durumda yaşıyor deniyor ama her yerde de iş bulabiliyorlar ama benim böyle bir bağım yok…Bu belediye başkanı kim gelirse kendi mezhebini tutuyor. Herkes kendi adamını topladı. İşe soktu düzen böyle olursa ne olacak. Ben Sivas'lıyım dedim. Dediler sivaslıları işe alıyorlar adam dedi deden var mı ben de iki tane dedim. Öyle değil dedi cemevi falan dedi. Meğerse alevileri alıyorlarmış. Bana cemevinden kağıt getir dedi o zaman işe alırım seni dedi. Böyle olunca insan işsiz kalıyor tabi. Özelleştirme girdi işsizlik çoğaldı. Şirket kuruyorlar azıcık maaş veriyorlar. Özelleştirmede hakların yok. 300 lira maaş veriyorlar onu da akşama kadar canını çıkardılar. Herkes görüyor ne olduğunu. İşsizlik ortada. Tedaşa işçi alınacakmış. Sınava girdim 80 milyon para verdim. 78 puan aldım. Adamım yok diye işe giremedim. Dediler torpil yok peki neden bu torpil giriyo. İşe giremedim. Adamı olan işe giriyo olmayan giremiyor. Bizde Kürtlük yok iş bulamıyorum hep işleri onlar kapıyor. Bense bu işin uzmanıyım ama beni işe almıyorlar nesin diyorlar ne yapabilirsin yerine. Çevrem yok dayım torpilim yok. Bizim azınlık bir etnik grubumuz olmadığı için acı çekiyoruz. Onlar kendilerine bir çevre oluşturup her işlerini kolaylaştırıyorlar. Esas ezilenler bizleriz aslında. Sağlığımı kaybediyorum çevren yok, işsiz kalıyorsun bu sefer de iyice bunalıma giriyorsun. Yurtdışına iş için gidenlere doğum yeri olarak ankara izmir vb. yazınca adam yerine koymuyorlar. Urfa antep diyarbakır yazınca hemen işler yoluna giriyor. Eskiden sağ sol davası vardı. Şimdi ekmek davası var. Onu da biz alamıyoruz.*
>
> Kinship ties are the determinants for everything. The biggest problem I because of Kurdishness it is said that they are in difficulty but they can find a job anywhere. I don't have that kind of a connection. Whoever I the head of the municipality will help and hire his people. I said I was from Sivas. They said they hired people from Sivas. Then they asked me if I had grandfathers. I said I have two. He said, not like that; an Alawite house (cemevi) he said. He said he would hire m if I got a paper from the house I belonged to. With privatization, unemployment increased. They have companies and hire people but they pay 300 million Liras and they work you to the bone. They were hiring worker at the National Electric Company. I paid 80 million Lira to take their test. I got a 78. I wasn't hired because I didn't know anyone there. They said you have to have contacts on the inside. I didn't get the job. I am not a Kurd so I can't find a job. They get all the jobs. I am god at what I do but they won't take me. They ask me what I am instead of what I can do. I have no network. We suffer because we are not members of an ethnic minority. They make their work easy by establishing ties. We are the real underdogs. I'm losing my health. When you have no network, you can't find a job and then you get depressed. When you go abroad to work, if it says on your ID card that you are from Ankara or Izmir etc, they don't think much of you. But if it says Urfa or Diyarbakir, everything is great. In the old days, there was the right wing left wing fight. Now there's only the bread fight. And that I can't win.

Similarly, F.A. (67 years old, female, living in Gültepe) states that:

> *Çevremiz yok bizim. Elinizden bir tutan olacak ki. Dayın olacak burada dayın yok ki. Akrabalar destek olmadı ki. Yoktu zaten. Öylece kaldık eridik gittik. Çocuklarım da eridi gitti işte. Her şeyde adamın olacak. Elimizden bi tutan olacak ki iş bulacak çocuklara. Başka türlü iş sahibi olunmaz. Fakirlerin çocuklarını işe almıyorlar. Kızım ben hastayken hastanede sormuş temizlik şirketine. "işçi lazım mı demiş çalışmak istiyorum demiş. O da nerelisin demiş Sivaslıyım demiş kızım da. O zaman size iş yok demiş. Haymanalıysan gel bize dedi. Devlet işi değil bişey değil bi temizlik işi sonuçta. Biz memurluk istemedik ki yani bu kadar zor olsun. İnsanlar birbirlerini tutuyor. İş olsa işsizlik ortamı da olmaz. Sıkıntı da olmaz hırsızlık da. Başvurmadığımız yer kalmadı. Hiçbir yerden bi cevap gelmedi. Tokatlılar hamam işletiyor hamamcılar, balalılar kasapçılık yapıyor, haymanalılar temizlik şirketinde çalışıyor. Gümüşhaneliler şoförlük yapıyor. Biz Sivaslıyız diye bize bir şey yok. Memleketli olmadığın için almıyorlar.*

> We have no network; no one to help us. You have to have an uncle, but you don't have one here. My relatives didn't help. We just withered away. My children withered away. You have to have contacts everywhere so that you can find your kids a job. Otherwise you can't find work. They don't hire the children of poor people. While I was sick in the hospital my daughter asked the cleaning company if they were hiring because she wanted to work. They asked her where she was from. She said Sivas and they told her 'then no'. They said come work if you are from Haymana. Its not important government work or anything; it's just cleaning. Why is it so hard? People help their own. If there were jobs, there wouldn't be any unemployment, no hardship, and no crime. We tried everywhere. None answered. People from Tokat run hammams, those from Bala run butcheries, those from Haymana run cleaning companies. Those from Gumushane are drivers. We are from Sivas so we can't do anything. They won't take you if you are not from the same place.

While this occupational segregation according to common origin provides people in the same network with job prospects, this kind of structure excludes others from different backgrounds like M.A. and F.A..

When we compare the first years of rural-to-urban migrants in the city with their more recent informal ties, it is seen that there is a considerable decrease in the number of contacts. As Işık and Pınarcıoğlu (2003) maintain, they could not get rid of poverty and they could not transfer the poverty to newcomers. Also, their potential of converting informal *social capital* to *economic capital* such as owning a *gecekondu*, finding a job, and mutual or non-mutual economic solidarity has begun to lose its function. However, most of them still rely on relatives, especially close relatives, and neighbors in case of crises such as unemployment and sudden illnesses. More than half of the respondents express the shrinking in their network as a result of poverty especially.

S.A. (68 years old, male, living in Gültepe) states the decrease in social relationship based on economic conditions as.

> *İşte eski hörmetleri bulaman. Zaman insanlar değişti. Güçlüysen araban her yerde gidiyor yoksulsan yürümeyiyorsun önüne her engel çıkıyor.*
>
> You can't find the respect of the olden days. People have changed. If you are strong, your car goes everywhere. If you are poor, you can't even walk; there are obstacles everywhere.

Similarly, N.B. (26 years old, female, living in Baraj) states that:

> *Paran olsa daha çok kapısını açıyor. Evini açıyor. evine giren çıkan da çok oluyor ağırlıyorsun. Öteki türlü yüzüne bakmıyo aman bu işe yaramaz diyo. Selam bile vermiyo arkasını dönüp de gidiyor. Yüzüne bile bakmaz.*
>
> Money opens doors if you have it. It gets you a house where you can host people. Otherwise people are horrible to you. They think you aren't good for anything. They won't even greet you in the street.

M.Ay. (35 years old, female, living in Baraj) states that:

Paran olmayınca ilişkiler de azaldı. İşsiz kaldığımızda özellikle. El adamı maddi duruma göre değişiyor. İnsan kendini mahçup hissediyor katılamıyorsun. Ama insanların bizden uzaklaşması değil paramız olmadığından biz ilişkiye giremiyoruz.

When you don't have money you have fewer contacts. Especially when you are unemployed. People change with money. You feel ashamed and can't take it. But its not that people are distancing themselves; it's that we don't have money and so we can't maintain relationships.

Among the benefit dependent poor and respondents who feel themselves as recent loser, the decrease in social relationship is commonly seen. As similar with our findings, Ayata and Ayata (2003) state that "the benefit dependent poor tend to minimize and often they would try to avoid their social relations with friends, neighbors and relatives, as they feel ashamed o f their deprived situation and their dependence on other people" (Ibid: 134).

Of the respondents those who express no change in relationship are the regular income earning families and those whose economic conditions have been relatively the same over long periods of time. Respondents who see themselves as recent losers also express the decrease in social network.

The recently decreasing economic solidarity is emphasized by many respondents. One reason is being in similar socio-economic conditions, the other is exclusion due to becoming poorer. However, the social network especially based on close relatives and neighbors functions in crises periods mostly in the form of borrowing money mutually.

M.H. (33 years old, male, living in Baraj) states that he does not receive any support from people around him:

Yok ne borç alırız ne de yardım. Acı durumu atlatmaya çalışıyoruz. Kimseden borç almıyoruz. Yok öyle bir desteğimiz yok. Bunun memleketimizle ilgisi yok yani Yozgatlılara özgü değil. O insanların da çoğu mağdur durumda herkes bir yol çizmiş. Herkesin çoluğu çocuğu geçindirecek ailesi var senin de herkes alıyo asgari düzeyde para kim kime yardım edebilir ki. Öyle olunca kimseden öyle maddi destek alamıyorsun. Bir sefer yardım etse 2. sefer edemez. Kimsenin gücü yok ki.

We don't borrow money or accept charity. We try to get over painful situations. We don take money from anyone. We don't have that kind of support. This has nothing to do with were in the country we come from. Most of those people are suffering as well. Everyone is trying to get by on their own. Everyone has a family and kids to look after. Everyone gets minimum wage; who can help another? When that's the case, you can't ask anyone for help. If someone helps you out once, they can't do it again. No one has the power.

This tendency is common among those who have similar socio-economic conditions to their relatives, neighbors, or friends.

There is also a decrease in relationships with the village in addition to the social network in the city. This decrease is somewhat related with lack of money for commuting, the distance between the village and the city, and is somewhat tied to the non-existence of relatives in the village. These reasons make most of them visit their village only on certain days such as religious holidays or funerals. In terms of social solidarity, the principle of reciprocity is also valid in the relationship with the city. But the number of respondents involved in reciprocal support is very limited. Few respondents express that they go to their village to work seasonally and getting a wage or food in return for labor at a recent time after becoming poorer. This is evaluated as a strategy for coping with poverty. M.Ko. (33 years old, male, living in Baraj) and his wife express that:

> *M.Ko.: Geliyor biz de karşılığında her yaz gider çalışırız. Yazın babamın tarlasına çalışmaya gidiyoruz. Biz de onlarda birbirimize yardım ederiz her türlü erzak gelir. Babamgil destek oluyor. Bak yarın birgün yoğurt süt gönderecekler. Mecbur gideceksin yardıma destek vermeye. Ee şekerin kilosu kaç para ben bilmiyom. Şekere para vermiyoruz hep köyden geliyor. Eşim yazları tarlada çalşır babamgilin tarlasında. 11 yıldır her yaz gider çalışır. 3 ay kalır en az. Kışlığımızı çıkarırız. Ya mesela köye telefon ediyon, baba diyon benim yoğurda ihtiyacım var, şuna ihtiyacım var diyon o da gönderiyor. Geçimimiz kolaylaşıyor. Çok çok kolaylaştırıyor hem de. Ha ekmeksiz kaldığın zaman en azından şurda bir hamur yoğurup da fırına iki tepsi sürüp de karnını doyurabiliyon yani un köyden geldiği için. Para yönünden de yardımlaşırız. Hani 100 milyon da verse, 200 milyon da, 500 milyon da verse borç yok aramızda.*
>
> *Eşi: Yazın da biz ona veriyoz eğer bizim de elimizde çok olursa biz de yazın destek oluyoruz. Karşılıklı yani ayırdım yok. Yazın da biz onlara gönderiyoruz elimizden geldiği kadar. Mesela kaynatamın cebinde 5 milyon varsa o bizim, bizim varsa onun bizde ayırdım yok. Biz sadece evleri ayırdık bak Fransa da birlik. Fransadaki bile köyle birlik.*
>
> *M.Ko.: Bütçe aynı yani. Daraldığı zaman hemen takviye oluyo. Babam ve erkek kardeşim yardım ediyor. Kız kardeşimin durumu yok zaten. Kendisini ancak geçiriyor. Eşimin ailesi de erzak verir. Bazen odun kömür verir.*
>
> *Eşi: Bize zaten millet inanmıyor, nasıl ayrılık olmaz diye. Sen buradasın, o orda, o orda. Diyom ayrım yok diyom inanamıyorlar çoğu. Kayınbabam kesinlikle diyo ben ölmeden size ayrılmak filan yok. Hepiniz destek olacaksınız birbirinize diyor. Yazları iş oluyor kışları işsizlik çekiyoruz o zaman da babam devreye giriyor Babam sıkıştığımız zaman daraldığımız zaman yardım ediyor her zaman değil. Kışın mesela birkaç ay 100-200 civarında gönderir.*
>
> *M.Ko.: Şuanda el borcumuz var bi de telefon kapalı. Paran olmadığı zaman gidip arkadaştan alıyon. Son bir yıl içinde çok borç aldık. Şimdi yani bizim iş diyom ya 3 gün çalışıyon iş olmadığı zaman bi sıkıntın oldu mu 4. günü mesela 15 günde bir ayda bir kere yani.*
>
> *Eşi: Ya telefon parası mesela aylık geliyo. Onu aylık yatıramadın mı 2 ayda bir toplanıyo, 2 aylık toplandığı zaman zaten senin bütçeni aşıyo, tabi komşudan alıyon, eline geçince de veriyon.*
>
> *M.Ko.: Bayramdan önce kapalıydı. İkinci taksidi herhalde, ikinci mi üçüncü mü. Üçüncü fatura gelecek yani daha kapalı telefon. Akşam işte komşudan aldım. Dün maaş almış, hani harçlığın var mı dedi o orada çıkarttı şunu al dedi, hani ondan aldım. Çok rahatlattı, Allah razı olsun. Ufak tefek borçları komşudan alıyoruz. Büyük paraya ihtiyaç varsa o zaman babamdan alıyoruz karşılıksız.*

> M.Ko.: We go to work every summer in my father's field. We help each other and all kinds of supplies come. My father helps us. Soon they will send us milk and yoghurt. Of course you have to go to help. Now I don't know how much a kilo of sugar costs. We never pay for it.

> They send it to us from the village. My husband works in the fields in summer. He's gone there every summer for 11 years. He stays at lest 3 months. We get by on that for the winter. Or if you call the village and say you need yoghurt or this or that he sends it. This helps us survive. A lot. We get flour from the village so we just bake bread when we have no bread. We also help each other with money. No matter if he gives us 100 million, 200 million or 500, it is not a loan.
> Husband: In the summer we give him money if we have more than we need. It's reciprocal. We send them as much as we can in the summer. For example, if my father in law has 5 million in his pocket, it's ours and vice versa. We share everything. We only have separate houses.
> M.Ko.: Our money is joint. When we have little, it is supplemented. My father and my brother help. My sister is hard up. She can barely take care of herself. My husband's family gives us staples too. Sometimes wood and coal.
> Husband: people don't believe how everything belongs to all of us. They say, you are here, they are there. My father in law says no separating things while I am alive. You will all support each other. In the summer we work but in the winter I am unemployed then my father helps. He helps when we have difficulties; not all the time. In the winter he sends us 100-200 sometimes.
> M.Ko.: right now we owe some people money and our phone is disconnected. When you don't have money you borrow from a friend. We borrowed a lot this past year. In our kind of work you work 3 days, you may not have work the 4th day. Maybe once or twice a month.
> Husband: like the phone bill, it comes once a month. When you can't pay it that month, it increases ad you definitely can't pay it off. So you borrow from people and pay them back. Last night I got it from the neighbor. They got paid yesterday, he asked if I needed money and gave it to me. God bless him. We get small loans from our neighbor. When we need more then we get it from my father and we don't have to pay him back.

This is the only case among the respondents that exemplifies a common budget. In fact, this case best explains "the family pool model" conceptualized by Kalaycıoğlu and Rittersberger-Tılıç (2003). In the model, "a family is defined as an extended family/kin group which does not live under one roof, but has three sub-groups" (Ibid: 212). "One sub-group of households lives in the village of origin, another consists of migrant households in the metropolitan cities, and the third sub-group lives in the developed countries abroad, as workers" (Ibid: 212-213). The central position is the group in the village who provide the permanency of the system by giving support especially in the form of food as seen in M.Ko.'s case. According to the study, the second group, those in the metropolitan cities, are the managers, accountants of the kin group; however, the bussiness of management in our case is undertaken by the first group. The third group is composed of the immigrant workers abroad in many European countries. They provide the permanency of the system by investing money in the pool as in the case of M.Ko. This kind of system is closed to others. It is striking that M.Ko. expresses the borrowing money from neighbors or friends as "stranger debt" (*el borcu*). This kind of common budget as in M.Ko.'s family leads to the differentiation of "us" and "others".

The other respondents who are in a reciprocal relationship with their village in terms of economic solidarity seem to be poorer in relation to their relatives in the village. They try to cope with poverty by working seasonally in the village and getting food or money in return for labor. In addition, there are income earning poor families who support their relatives living in poverty. H.Ay. (27 years old, female, living in Gültepe) states the reciprocal support as:

> *Ben de erzak gönderiyorum ordan da geliyor. Bana belediyeden yardım geliyor. İhtiyacım olmayanı gönderiyorum. Çünkü onların da durumları kötü gelirleri hiç yok. onlardan da peynir, kuşburnu falan geliyor. Gidip gelen oldukça gönderiyorum. 6 ayda senede bir göndeririz. Gittiğimde de köyde çalışıyorum. Yardım amaçlı anneme babama yardım ediyorum. Her şeye. Ama çökeliğini patatesini alıp geliyorsun. Gittiğimizde1 ay-2 ay kalırız. Geliyor ben de gönderiyorum onlar da gönderir. 6 ayda 3 ayda bir. Çok fazla değil.*
>
> I send them staples, and we get help from them. I get assistance from the municipality. I send them what I don't need. For they send us cheese, rosehip and such. When someone comes to visit, I give them stuff. We send things to them every 6 months. And when I go, I work in the village. I help my parents. With everything. But you get cheese and potatoes coming back. We stay 1-2 months when we go. We all help each other.

Very few respondents share the food assistance from the municipality and administrative district with their poor neighbors, relatives in the city, or relatives in the village. All forms of social solidarity in our case are reciprocal.

The other type of assistance or form of coping strategy with poverty is living rent-free in a *gecekondu* owned by relatives (no: 9). While the number of tenants among our respondent**s** is 12, the number of *gecekondu* owners is 19. While some gecekondu owners built their *gecekondu* illegally, some bought one. Except for three, they do not have a legal title deed. Not paying rent is important for both those who have a *gecekondu* or who are assisted.

The other type of support is seen in the assistance regarding household goods among the urban poor. People who buy new household goods transfer the old ones to the poorer neighbors or relatives. This tendency is common among our respondents and it can be regarded as the manifestation of the sharing culture of the poor taking place in especially relative and (or) neighbor based network. M.F. emphasizes this culture as:

> *İlk başta onun bunun eskisiynen idare ettik. Akraba komşu verdiydi hep. Kanepeler, televizyon, buzdolabı, elimiz yettikçe aldık çalışmaya başladığımda. Sonradan yeniledik eskidikçe. Çamaşır makinesini emekliyken aldık. Biz de bizim eskileri dağıttık ihtiyacı olana genelde yeni gelenlerin ihtiyacı oluyor.*

> At first we made do with others' hand-me-downs. Relatives and neighbors gave us things. Sofas, TV, fridge, we bought things as we earned more. Then we got new ones as they got old. We bought the washing machine after retirement. And we gave away the old things to those who needed them. Newcomers usually need things.

In general, starting to earn regular money enables them to buy new household goods. In fact, starting to buy new ones seems to be an indication of being a doer. Gaining the ability to buy household goods can be evaluated as the practice representing the "transference of poverty". According to Işık and Pınarcıoğlu, poverty is transferred to the newcomers. Renewing household goods symbolizes the transference of poverty. However, in our case, the respondents who transferred their old household goods to those poorer are very few in number; instead they are in the position to receive the goods. Only some respondents, all of whom are in the position of regular income earning poor, are able to offer this kind of assistance.

The case of unemployment and sudden illnesses are the main reasons behind receiving assistance from social environments. However, this assistance is not regular and is not given on a permanent basis. The majority of respondents state they are in a social and economic solidarity environment in the case of illness. The social network, especially neighbors and close relatives, has functions such as supplying a car, lending money, non-reciprocal economic assistance in a short time, and social solidarity among the women in the case of illness. The supply of a car by neighbors is common assistance for Gültepe because taxis do not come to the neighborhood because of the stigmatized character of the neighborhood with a high crime rate. So the social and economic solidarity among Gültepe residents is much more common in an urgent case. Also, the number of chronically ill respondents is more in Gültepe than in Baraj. This may also explain the existence of social solidarity in the case of illness in Gültepe, seen more than in Baraj. The two cases below explain the support of the social network in the beginning of the crisis, in this case a sudden illness. However, the Baraj neighborhood has different characteristics that result in social solidarity. In terms of distance, Gültepe is very near the central hospitals, but Baraj is not. Also lots of houses are settled at the peak of a hill in Baraj. These two differentiate Baraj from Gültepe in terms of access. There is a difference between the inhabitants settled in the peak and settled in flatter places in terms of socio-economic status. The rent is low on the peak and the poorest reside there. The social solidarity in Baraj is, in general, providing a car for the poorest resident at the top of the peak. According to my

observations, while chatting with neighbors, I saw that many accidents such as broken legs and miscarriages happened in winter time because of the location. For Gültepe, the social solidarity in the case of illness is existent because they may be subjected to injuries by the other part of the neighborhood (the crime rate is higher) and the taxis can not come to the neighborhood although the neighborhood is near hospitals. As mentioned in the methodology chapter, the neighborhood is segregated according to the illegality. I did not interview the residents in the other segment of the neighborhood, so I could not collect any data. For Baraj, social solidarity in the case of illness is much related to both the long distance to the hospital and its peaky characteristic. Also, the neighborhood is segregated but not in a stigmatized way. As stated earlier, Gültepe, also known as Çinçin, in public has stigmatized because of the frequent crimes. In addition to providing a car, there are other types of assistance.

N.T. (45 years old, male, living in Baraj) mentions the neighbors' support in the case of illness as:

> *İşsiz kaldığımızda akrabadan destek almadık. Sadece komşulardan aldık. Hastaydım o zaman. Açık söylüyom 6 aydır yataktan kalkmadım mahalle bilir en kötü dönemim işte o zamandı, çocuklar 3'ü de okuyordu. Yani yol parası yoktu. Mahalle yardım etti. Kimisi tüpümü doldurdu, kimisi ekmeğimi aldı. Geçen sene oldu bu mahalle bütün yardım etti. Allah razı olsun yani. Konu komşu sağolsun. Daha doğrulamadım yeğenim vallahi bak. Komşuların dışında kimseden destek almıyoruz.*
>
> When we were unemployed we didn't get any support from relatives. Only from neighbors. I was ill then. Really. I was bedridden for 6 months the neighbors know how difficult it was. All 3 of the kid were in school. They didn't have money to commute to school the neighborhood helped. Some got us gas for the stove, some got us bread. Last year everyone helped. God bless them. You see, I still haven't gotten back on my feet. We don't get support from anyone else.

Similarly, Ö.Ö. (45 years old, female, living in Gültepe) expresses the assistance from relatives (at the same time, her relatives were her neighbors) in the case of illness as:

> *Adam hastalandı kalpten, anjiyo oldu. İşten çıkardılar. Kömürü başkaları alıyor o bu yardım ediyor akraba komşu. Bazen gıda getiriyorlar. İlaç parası veriyorlar ilaçları alamayınca zoruma gidiyor. Elden gelen olmuyor. Ben geldim geleli kendimi anca idare edebiliyorum karnımızı anca doyurabiliyoruz.*
>
> He fell sick because of his heart and had an angio. The laid him odd. Others buy us coal; people help; relatives and neighbors. Sometimes they bring us food. They give us money for medicine. It shames me when I can't buy the medicine. Nothing to do. Ever since I came, I have barely been able to feed the family.

The neighbors' support comes into prominence in the case of emergent cases of illness or accidents. However, there is not a permanency of assistance. Although this assistance seems to be non-reciprocal for the short time, in fact, the assistance is reciprocal when evaluated over a long time period.

A.M. (35 years old, male, living in Gültepe) states that:

> *Hasta olduğumuzda borç alıyoruz konudan komşudan akrabadan. Mesela gece rahatsızlık olduğu zaman tabi komşunun arabası varsa yardım ediyo, acil durumda doktora gidiyorsun. Sen komşuna nasıl iyilik yapıyorsan karşılığını görürsün. Cebinde beş kuruş paran yok. Taksi gelmiyor mahalleye. Kimden isteyeceksin tabi ki en yakınındakinden komşundan istiyorsun. O yönden mahallemiz çok iyi. Zorda kalana yardım edilir burada böyle acil durumlarda. Bir ölü olsun, bir yaralanma olsun, bir hastalık olsun yardımlaşma muhakkak olur burada. Herkes birbirine destek olur. O da olmazsa bura hiç çekilmez.*
>
> When we get sick we borrow money from neighbors and relatives. For example if something happens in the middle of the night, the neighbors help if they have a car, you can get to a doctor. When you help your neighbors they help you back. There's no money, taxi cabs won't come here. Of course you ask those close to you, your neighbors. Our neighborhood is great that way. They help those in need here in emergencies. When there's a death, an injury, people always help and support each other. If not for that this wouldn't be a tolerable place.

The economic support in the case of illness is provided much more to those who are benefit dependent poor and have no free access to health care. They are not prepared for a sudden illness situation, so neighbors and relatives offer them cash assistance as E.A. (26 years old, male, living in Gültepe) states:

> *Annem 6 sene once felç oldu. Trafik kazası geçirdi. Felç geçirince komşular aralarında para topladı, annemi hastaneye götürmüşler ben askerdeydim o zaman.*
>
> My mother was paralyzed 6 years ago in a car accident. Then the neighbors collected money and took her to the hospital. I was in the military then.

In addition to economic assistance, social support and solidarity among the women is striking. Women support each other themselves such as helping with housework and cooking. H.Ay. (27 years old, female, living in Gültepe) expresses that:

> *Manevi destek alırız en çok. Yapar komşum işlerimi gelirler, yemeğimi yaparlar.*
>
> We mostly get immaterial support. My neighbors take care of my affairs, cook for me.

The social solidarity among the urban poor in the case of illness is a disposition which they internalize and practice against poverty, because being sick requires money and other types of support. The support in the case of illness is seen

much more commonly among the urban poor than in other circumstances. Assistance is less in the case of unemployment. In the case of unemployment, in general, the commonly seen assistance is the lending money to unfortunate neighbors and (or) relatives in a time of crisis.

Social solidarity among the poor is still crucial in order to help people cope with poverty in various forms, although the power to convert it to *economic capital* diminishes. A sudden illness situation is a specific circumstance in which the most assistance is visible. The informal network plays a role especially if the illness happens suddenly such as heart disease, cerebral hemorrhage, and home or traffic accidents. The assistance during the sick role is less than at the onset of the illness. Difficulties in health experiences related with the gap of the *state social capital* are filled by informal networking as much as possible. Their network functioning for coping with difficulties regarding health care access and access to free medicine is less, because they have no adequate network to overcome these difficulties. Many respondents are aware that a social network is influential in health care setting but they lack of them like G.B. (49 years old, female, housewife, living in Baraj). The Socio-economic conditions of their social network are similar with theirs. She is a Green Card holder and states the difficulty she experienced and emphasizes the importance of the social network:

> *Devletin herkesi bir tutması lazım. İstese yapar. İlacımı alabilsem muayene olabilsem rahatlıkla. Ayrı muamele yapıyor. Diyelim ki senin okumuşluğun var orada tanıdıkların var sen işini hemen hallediyorsun ben günlerce sürünüyorum. Benim tanıdığım yok diye ben bir iş göremiyorum. Devlet ayırdım yapıyor.*
>
> The government needs to treat everyone the same. They could if they wanted to. I wish I could buy my medicine and get a check up easily. They discriminate. If you are learned and know people there, you do your business easily. It takes me endless days. I don't have any contacts there. The government discriminates.

A considerable number of respondents state that they benefit from the social network in the case of access to health care or receiving medicine.

5.4. Cultural Capital and Consequences for Health Experiences

Cultural capital, in other words, informational capital,[39] is regarded as a conceptual tool for understanding the health experiences of the urban poor. The identity which urban poor feel belongs to them and internalize is crucial. They take over these identities from the previous generation; they behave and present themselves accordingly and their identities are institutionalized. In this framework, internalized identities of the urban poor such as being poor, being a villager or an urbanite, being literate and being sick are included, because, as I mentioned before, I think that it is influential in their health experiences, especially in their institutional encounters in health care settings. While some findings were obtained by posing questions to the respondents, some were obtained by observation and from field notes such as bodily representation.

Identifying with Being Poor and Its Consequences for Health Experiences

In our study, the majority of the respondents define their own socio-economic status as poor. When I first went to the neighborhoods and during my research there, there was a tendency to define themselves as the most poor in hopes of getting social assistance. They stated their position as poor without hesitation. It was observed that the increasing number of charities towards the poor play a significant role in this. This may be given as a strategy to gain economic source by seeking social assistance. The statement "we are the poorest family in this neighborhood" was frequently made by respondents and other neighborhood people I encountered during the fieldwork. Except for a few cases, each defines their family as poor especially by mentioning their lack of adequate income. Those who define themselves as poor mention trying to get by on low and irregular income, living with debt, lack of property ownership, and economic dependency. For the most, being poor is defined as "managing" or "getting by", especially by female respondents. It is conceptualized as "the art of managing" by Erdoğan (2001). They try to survive on low income. Economic difficulties are at the heart of their life and they do not leave the domestic field and workplace very often. Leisure time is not an issue for them while struggling with the consequences with poverty. They spend time with their neighbors and relatives in

[39] Cultural capital, which has three forms, is also named as "informational capital" by Bourdieu (Bourdieu & Wacquant, 2003: 108) in order to point out its variety.

their spare time. However, the chats that I observed were related with economic difficulties, strategies, and job opportunities. The institutions like the municipality, neighborhood chief, administrative district within a province, and the schools which their children attend, their poor identity is sustained and institutionalized. Only a few respondents see themselves as somewhere in the middle of the continuum by comparing themselves with other neighbors who are not income earners. They tend to "Thank God" for their socio-economic conditions because they earn a regular income. Below are few examples:

A.M. (35 year old male living in Gültepe) is in an irregular income earning poor family. He can only work as a street peddler because of his illness and his wife also earns an irregular wage. He states that:

> *Ben kendimi fakir görüyorum. Ben eskiden kendimi 2. sınıf insan zannederdim şimdi o da yok. Eskiden cebimizde bi on milyon lira olurdu şimdiki gibi cep boş olmazdı. Gider ekmek alırdım. Şu ekmek param, şu çocukların parası şu alışveriş parası derdim kazancım belliydi. Şimdi yok ne olduğu belli değil. Para bulunca koştura koştura ekmek alıyoruz ne alabilirsin ki o parayla. Fakiriz. Yokuz biz insanlar nazarında. Sınıf bile değiliz. 3. sınıfı devlet öldürdü. Zenginlerle birlikte işbirliği ile devlet bizi öldürdü.*
>
> I see myself as poor. I used to see myself as a second class person, but now it is not so. Before, ten million Turkish Liras were in my pocket, the pocket was not empty as it is now. I went and bought bread. My income was known; I divided up my income into bread money, children's money, shopping money. Now it is not definite. What can I buy with this money? I go to buy bread immediately when I have money. We are poor. We do not exist for people. We are not even a social class. The government killed the third-class people. The state killed us in collaboration with the wealthy.

A.Ay. (36 year old female living in Gültepe) has a regular income earning poor family. She evaluates her socio-economic status as:

> *Orta görüyorum. Genelde sağıma soluma bakınca buradakilerle karşılaştırınca orta. Mahalleye göre orta. Ama başka yerlerde oturanlara göre düşünürsek fakiriz.*
>
> I see us in the middle when I compare myself to the people to me, my neighbors. However, when I consider other people in other neighborhoods, we are poor.

Townsend (1979) defines poverty in terms of relative deprivation, which is a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs. Like A.Ay., most of the respondents tend to express their position in society by comparing themselves to their local community; their neighbors, close and remote relatives and wider society as urbanites. In our sample, feeling as poor is much associated with the

standards of local and wider society. Therefore, they tend to distinguish the field of *gecekondu* as their living field and the field of urban field as wider society when they express their poor position.

M.Ko. (33 year old male living in Baraj) is a self-employed housepainter. It's a seasonal job which is reflected in his definition of his own socio-economic status as:

> *Ne açız ne tokuz. Durumumuz bile belirsiz Kışın yoksul hissediyom, yazın orta. Vallaha öyle oluyor. Bura hep biz gibi düzensiz mahallede herkes benzer parasal yönden.*
>
> We are neither hungry nor full. Our state is not definite. I feel poor in winter, in the middle in summer time. I swear. It is true. The neighbors are like us. They earn irregular income. Everybody is similar financially.

.

M.Ko. also evaluates his socio-economic position according to the neighborhood as A.Ay. Irregular jobs, like in M.Ko.'s case, cause irregular income entrance into the household and this tend them to define themselves different.

According to the findings in this study, all 40 respondents feel poor when compared to urban people; however, there are different expressions in terms of socio-economic status when comparing themselves with neighbors, relatives, and other generations. Baraj, as expressed before, is more homogenous in terms of the jobs people hold. As a result of my observations, chatting with neighbors, and interviewing with the neighborhood chief, I found that most of the neighbors work in daily jobs. People who have regular and insured jobs are very rare and accepted to have a higher position in the neighborhood. Most of the respondents living in Baraj define people in their neighborhood as poor families with low-income, unemployed, people working in temporary daily jobs, or casual workers, unskilled workers. Most of the respondents in Baraj express the similarity of their socio-economic status with neighbors. The "higher" people seem to be regular income earning poor families and the "lower" seem like needy people or no income earning benefit dependent poor according to their statements. However, Gültepe has a more cosmopolitan structure according to the respondents. They primarily classify the neighborhood the people into two groups: those who earn a living honestly and those who do so illegally. All the respondents there preferred to compare themselves with honestly earning families when asked to talk about their economic conditions. The interview with the neighborhood chief revealed that youth unemployment is high in the neighborhood.

According to the respondents in Gültepe, there are the unemployed, the regular and irregular income earning families, some workers working in state institutions, marginally working people such as garbage collectors, the self-employed, etc. in the first part, and people who earn their life by begging, stealing, dealing heroin and hashish in the second part. There are different perceptions of socio-economic status in comparison with their neighbors: respondents who see themselves as the same with their neighbors; respondents who see themselves as being in better socio-economic conditions; respondents who see themselves in the middle; and respondents who see themselves worse than their neighbors.

Respondents who see themselves as the being in the same socio-economic conditions define their neighborhood as homogenous; that is, there are only poor people living in the neighborhood. Half of the respondents express that their neighbors live similarly poor economic conditions. The majority of them are in Baraj. It is true when one remembers that Baraj is truly more homogenous in terms of labor market attachments. People living in Baraj define their socio-economic status with reference to the field. In general, the spatial perception of the Baraj respondents is limited to their neighborhood, especially for the women, in contrast to those in Gültepe. They have little contact with the city center because Baraj as a location is remote place from city center. They expressed that they have no money for commuting except under necessary conditions like going to the hospital and dealing with official affairs. However, the respondents in Gültepe tend to compare themselves with people in the city center (according to them Ulus, Dışkapı) in general. Gültepe is at the center according to them. For example, they can get to a hospital easily on foot.

All respondents who see themselves as being in better socio-economic conditions and the majority of respondents who see themselves in the middle when compared with neighbors are regular income earning poor families. At least one member of each household works in a job for at least the minimum wage with social security or is retired from a formal job. Like other groups, they see themselves as poor compared to those in other parts of the urban areas. All the respondents who see themselves as worse or at the bottom in terms of economic conditions are the benefit dependent poor, whether they are no income earners or irregular income earners.

M.B. (36 years old female living in Baraj) lives with her husband, who provides for his household by earning a daily wage from casual work. She defines her economic position in society with reference to her neighbors. She expresses that:

> *Ben kendimi orta halli görüyom ne zengin ne fakir. Kendi halime şükrediyom. Başkalarına bakınca bizden çok daha düşkünleri var burda. Zenginlere de bakınca kendimi fakir görüyom. Düşkünlere bakınca da iyi görüyom... Pek de düzgün değil ama düşkün de değiliz.*
>
> I see myself as in the middle, that is, neither rich nor poor. I am thankful for my condition. When I look at others here, I see that there are those poorer than us. When I look at the rich, I see myself as poor. I see myself in good position when I look at the dependent… Although our economic condition is not great, we are not dependent.

In addition to these subjective perceptions and experiences, information on people's jobs, education, social security status, and other demographic information for three generations were received from the respondents. When we compare the generations, we do not see an enormous change in socio-economic conditions between generations. The majority of the respondents' parents live in rural areas. People who have the best economic condition among the three generations are families who have regular income earners in worker status or in public servant status. The economic conditions of three generations of most of the respondents according to household heads' jobs vary from benefit dependent poor to regular income earning poor. Either they have succeeded in changing their position from benefit dependent poor to regular income earning poor when compared to previous generations or they retain their benefit dependent or regular income earning poor position. A considerable number of respondents changed their position from regular income earning to benefit dependent poor position when compared to previous generations. It is striking that there is not an enormous change between the generations and there are no respondents that realized upward mobility. When we examine the household tables and relative tables, there is a consistency between information on the tables and individuals' evaluations of their own economic positions according to their relatives.

When we look at their own expressions, some respondents express that they have the worse economic conditions among their close and remote relatives (no: 14). About half of the respondents (no: 21), more commonly among benefit dependent poor families, state that they continue to hold a poor position similar to other generations. Among them, some define their own economic conditions by comparing the economic conditions of the remote and close relatives differently. They see their

economic conditions as the same as those of their close relatives but worse than those of remote relatives, or vice versa.

The number of respondents who think that they live in better conditions than do their parents and other close relatives is very few. The majority of them are income earning poor. Thus, it can be concluded that there are no enormous differences between generations, between relatives, and between neighbors.

Being poor sometimes brings about exclusion, and sometimes discrimination that sustains their position. O.G. (34 years old, male, living in Baraj) states that:

> *İnsanlar öyle değişti ki. Anlamıyorum. Önceden iyiydi. Düşenin dostu olmuyor hiçbir yerde. Eğer elimizde olsa herkes gelir bizden iyisi de yoktur o zaman biz fakirleştikçe herkes kaçtı gitti uzaklaştı bizden. Adam bize ne diye gelsin. Mesafeli herkes. Akrabalarında azalıyor görüşmek istemiyorlar pek, para isteyeceğiz diye.*
>
> People have changed so much. I don't understand it. It used to be okay. Now no one has anybody to help them in their time of need. If we could help it, everyone would come. Then we would be the best. But as we got poorer people fled. Why would they come to us? Everyone is cautious; they distance themselves. Your relatives drift away too. They don't want to see us because we might ask them for money.

In some cases, being poor is a stigma. Some respondents constitute the relationship between being a charity case and being a poor by focusing the stigmatization. The important finding from the respondents' expression is that their feeling of being poor is sustained by the assistance they receive. E.A. (26 years old, male, living in Gültepe) expresses that:

> *Aslında biz kimseden destek istemiyoruz. Yardım da istemiyoruz. Yardım olunca insan utanıyor. Kendini daha bir fakir hissettiriyorlar. İnsan kendini daha bir farklı hissediyor. Devlet yardım yapmasın iş bulsun ki biz de utanmayalım kimseye rezil olmayalım. Destek istemiyoz da çalışma imkanımız olsa bizim için gerisi önemli değil. Normal işimiz olsa hiçbirşey istemiyoruz kimseden. İlk zamanlar yemek yardımı aldık. Kızılaydan yemek getirdik. O zaman her sabah yemek dağıtılırdı. O zaman 10-12 yaşlarındaydım ben gider yemeği alırdım. Akrabaların durumu iyi olduğu için utanıyordum. Korkuyordum biri görecek diye. Babam bel fıtığı olduğunda kızılaydan yemek yardımı aldık. Annemle sabahları gidip alıp geliyorduk. Ben o zaman çok küçüktüm. Annem de ben de utanıyorduk zorumuza gidiyordu yardım almak akrabalarımızın durumu iyiydi.*
>
> We actually don't want anyone's help. We don't want any support. When people help you get embarrassed. They make you feel even poorer. It feels different. I wish the government would find us jobs instead of giving out assistance. Then we wouldn't be embarrassed or ashamed. We don't want support. It would be okay with us if we could work. At first we got food assistance. They would deliver in the morning. Then I was 10-12 years old. I was ashamed of our relatives, whose state was better than ours. I was afraid someone would see. When my dad got hernia we got help from the Turkish Red Crescent. We would go with my mother to get it in the morning. I was young then. We were both embarrassed.

This excerpt can be interpreted with the concept of "the sense of distinction" and "symbolic violence" by Bourdieu (1984). Social assistance is given to those who prove his/her poverty status. This is the first step through which their lower position in social space is documented. Receiving assistance, especially in public, is the second step for sustaining the feeling of distinction. In general, the urban poor have a lower educational status; they earn less, their power to convert one type of resource into another is inadequate; they suffer from various illnesses; and they have less access to services. This low level of possession especially *economic capital* plays a determining role in receiving assistance. While they receive assistance, their sense of being poor is sustained. For this reason, assistance given to the poor operates as "symbolic violence". According to Bourdieu (1998), it is "the subtle imposition of systems of meaning that legitimize and thus solidify structures of inequality" (cited in Wacquant, 1998b: 217). Assistance seems to be seen as a symbol of the structure of the inequality.

When we look at health experiences, being poor is influential in this setting. The poor position is also sustained in health care settings according to access type. SSI and Green Card holders are often subjected to discrimination in health care settings. The source of discrimination for them is being poor symbolized by a Green Card or SSI. Here are some statements by respondents who think that they are discriminated against. As a SSI, F.A. (67 years old, female, living in Gültepe) expresses that:

> *Memnun değilim sigortadan, böyle bakarlarsa memnun değilim. Ama hiç olmamasından da iyi. Memurlar her iyi hastaneye gidiyorlar ama sigortalılar gidemiyor. SSK'lıları ayırt ediyorlar, dışlıyorlar. Filme sokmadan muayene etmeden ilaç yazıyorlar önce bakıyorlar sigortalı mı değil mi emekli sandığı mı vb. diye.*
>
> I am not happy with the insurance. If this is how they take care of you, I don't like it. But it's better than not having it at all. Civil servants can go to any hospital but SSIs can't. They discriminate against those with SSI. They prescribe a medicine without even looking at the x-ray or giving you a check up. The first thing they do is look at your papers to see which insurance you have.

Different access types cause the reproduction of inequality which they face in health institutions by being labeled as poor. B.B. (20 years old, male, living in Gültepe) shares his view and experiences in a health care setting as:

> *Hastaneye gidiyoruz acil hastamız var. İki saat bekliyoruz. Onaylanacak da doktor görecek de. Ne de olsa fakirsin diye bakıyorlar. Yeşilkartlıyız diye, sen fakirsin der gibi bakıp o da insanın zoruna gidiyor. Gereken*

ilgi gösterilmiyor zengin olsak öyle olmaz. Acil olsa bile insan yerine koymuyorlar. Zengin olsa hemen özel hastane. Fakirin canı da önemli değil. İlaç alırken sıkıntı çekiyoruz. Bulamıyoruz. Bazı yerler anlaşmalı. Ana baba günü. Ya da ilaç olmuyor. Mecbur acilen almak zorunda olduğun zaman parayla alıyoruz. Hastanelerin insanlara daha iyi bakması lazım. Biz de insanız. Hayvanca muamele görmek istemiyoruz. İnsanca muamale görmek istiyoruz. Doktor bağırıyor hemşire bağırıyor bazen güvenlik görevlisi bile bağırıyor. Diyor ki aşağılayarak sen kimsin? Bu çok düşündürücü bir durum. Ben kimim? O diyor ki ben buranın paşasıyım diyor. O zaman biz de zor kullanıyoruz o zaman işini hemen yapıyorlar hepsi. Kargaşadan korktukları için işini yapıyorlar. Annemi hastaneye kaldırdım kadın baygınlık geçiriyor. Git sıra bekle diyor. Bekle ki sıra gelsin. Ben de bağırdım çağırdım. Polisler geldi. Seni orda insan olarak görmüyor nesne olarak görüyorlar. Alsınlar bizi çöpe atsınlar onlara göre ama ben zengin olsam öyle olmaz. Para konuşuyor insan değil.

We go to the hospital with an urgent case. We wait for two hours. First we need to get validated so we can see a doctor. They see you are poor. They look at you with eyes saying you are poor, you have a greencard and that offends you. You don't get the attention you need. Even if it's an emergency you get treated horribly. If you were rich you'd just go to a private hospital. A poor man's life is worth nothing. We have a very hard time getting medicine. We can't find it. Some places have agreements. They're very crowded. Or sometimes they don't have the medicine. When it's an emergency we have to get it so we pay for it. Hospitals should take better care of people. We're people too. We don't want to be treated like animals. The doctor yells, the nurse screams sometimes even security yells at us. They yell at you in a degrading way asking who you are. It gets you thinking. Who am I? He says he's the king of the place. Then we try to use force and then they do everything they are supposed to quickly. They do their job because they are afraid of making a scene. I took my mother to the hospital she was unconscious. They tell me to wait in line. You have to wait. I started yelling. The police came. They really don't see you as a human there; but a thing. If you ask them, we should just be thrown away in the dump. Bu I wouldn't be that way if I were rich. Money talks; not people.

Here, being a Green Card holder is perceived as the same thing as being poor. The Green Card becomes a kind of symbol representing lower economic position in social space or a *field*. Being poor in the hospital setting causes them to feel discriminated against, stigmatized, and medicalized as B.B. states. He directly emphasizes medicalization, which the urban poor is often subjected to. For Bourdieu (1984), the body is main indication of class. Low level of "symbolic capital" due to being poor, "recognized as legitimate competence, as authority exerting an effect of (mis)recognition" (Bourdieu, 1986: 245) is an important indicator of the domination-subordination relationship in a health care setting.

Feeling like a Villager and Illiterate and Its Consequences for Health Experiences

In this part I deal with being a villager and being illiterate together because peasantry is closely associated with illiteracy for the context of the migrant urban poor. In institutional encounters of the urban poor in health care settings, it is not possible to differentiate between their effects. Therefore, after mentioning these identities with the statements of the respondents, I will focus on their health experiences by considering the two identities together.

I try to reveal how they identify themselves: as an urbanite or a villager or in between the rural and the urban. The feeling is assumed to be crucial in institutional experiences of the urban poor, especially in the case of the doctor-patient interaction. Feeling like an urbanite or a villager does not change according to benefit dependency. Instead, the duration of stay in the city, labor market attachment, gender, and Turkish language use is crucial in defining identity.

The duration of stay in the city is influential for feeling as an urbanite. The respondents are not newcomers, they are either first generation migrants who have lived for many years in the city or second generation migrants, some of whom were born in Ankara or have lived in Ankara for long. B.B. (20 years old, male, living in Gültepe) states that:

> *Kentli hissediyorum kendimi. Burada büyüdüm o yüzden.*
>
> I feel I belong in the city because I grew up here.

Erman's (1998) study conducted in two neighborhoods in Ankara (Çukurca and Bağcılar[40]) examines the rural-to-urban migrants' self-identification as being an urbanite or being a villager, based on the argument of "integration". According to the findings of this study, respondents who considered themselves as urbanites are not only those who had stayed in the city for long years. "Neither being new in the city nor living in gecekondus prevented them from claiming urban identities" (Ibid: 549). In contrast to Erman's study, in my study, a long duration of stay in the city plays an important role in feeling like an urbanite.

The majority of the respondents who see themselves as urbanites are male. They feel like urbanites because of urban labor market attachments in addition to their long stay in the city. Mus.B. (51 years old, male, living in Baraj) discusses the relationship between being urbanite and having a position in urban labor market as:

> *Şu durumda kendimi kentli hisediyom. Yapacak is var, düzensiz, güvencesiz az gelirli olsa da.*
>
> In this position I feel I belong in the city. I have a job, no matter how irregular, insecure and low paying it is.

 During the time of the research conducted by Erman, Çukurca was gecekondu settlement and Bağcılar was a lower middle class district (Erman, 1998: 543).

He has lived the least in the city among other respondents who see themselves as urbanites. He migrated 15 years ago and is a first generation migrant. The attachment in urban labor market even in informal sector may cause people to feel like urbanite for some like for Mus.B.

Among the respondents who feel like urbanite, there is a difference among family members. Women in general do not see themselves as urbanites, both because they have little contact with the city center and most of them, especially the women living in Baraj, are confined to the neighborhood and the family network. Also, the women in two neighborhoods have limited work experience in urban labor market in contrast to the men. This is also mentioned by Erman (1998). Male respondents in our sample state that they spend more time outside the neighborhood and are in contact with the other places unlike females. She compares male and female migrants in terms of self-definition. According to her, "while migrant women do not have anything but their housing environment and their kin and neighbors as the basis for their self-identities, migrant men have their occupations and, occasionally, interactions with the more established parts of the city as the basis for feeling themselves to be urbanites" (Ibid: 350).

They are the first generation migrants and in a category of benefit dependent poor family. They migrated 17 years ago. While N.T. emphasizes existing within the city with working and being capable of providing for his family as the determinants of being an urbanite, his wife sees herself villager by emphasizing her relationship with the space and bodily representations peculiar to the modern urbanite women.

Only two respondents who feel like urbanites are female; one was born in Ankara and has work experience in the city; the other, H.B. (50 years old, female, living in Gültepe), sees herself as an urbanite by focusing the *habitus* peculiar to the rural *field* that:

> *Kendimi kentli gibi hissediyorum. Çünkü oranınkiyle buranınki bir olmuyor. Köy farklı. Köy işi farklı. Tamamen ayak uydurdum. Artık köy işi bana yabancı geliyor artık. Yaşam tarzımız aslında köylü. Şimdi köyden gelen olsa ya da bi büyüğümüz gelince ağzımızı kapatırık. Yanında yemek yemezzik çay içmezzik. Biz büyüklerimizden öyle gördük. Adetlerimiz devam ediyor. Su içmiyok sessizce konuşuyok aramızda. Erkekler yemek yer biz de kaldırırız sonra sofrayı içeri alır orda yeriz. 5 tene çocuğum var babamın yanında kaynımın yanında sevmem, dönüp de bakmam. Bizim oranın insanı karısını da çalıştırmaz. Bilmiyorum adet öyle. Yoksullukta çekseler açlık da karılarını çalıştırmaz bizim kürtler. Varlık da yoksuluk da çeksen içinde çekersin kimsenin haberi olmaz.*
>
> I feel I belong to the city because it's not the same here. The village is different. The work there is different I have adapted. Now village work is foreign to me. Our lifestyle is like a

> villager's though. Now if someone from the village came, an elder, we would shut up, not eat or drink tea in their presence. That's what we learned from our elders. Our traditions continue. We don't drink water, we talk quietly amongst ourselves. Men eat and we clear the table and then set it up in the kitchen and eat there. I have 5 children. I don't cuddle them when my father or father in law is around. Our people don't let their wives work, either. That's just the way it is. Even if they are desperate Kurds don't let their wives work. Whether you are rich our poor you suffer on the inside. No one knows.

She migrated 30 years ago with her husband and has been in the category of regular income earning family for three years after her husband retired. Economically, she states her family as doers. In terms of being an urbanite, she bases the relationship between being an urbanite and *habitus* on life style and traditional role of the woman. She emphasizes the difference between the village and the city where she has lived in her perception of what is considered urbanite. According to Bourdieu and Wacquant (2003) "it is one and the same thing to determine what the field is, where its limits lie, etc., and to determine what species of capital are active in it, within what limits, etc." (Ibid: 82-83; Bourdieu & Wacquant, 1992: 14). However, even if she realized the spatial movement, it does not mean that the effects of the previous *field* are over. She states that when she encounters her villagers she continues to abide by the rules of the previous *field*, so the reproduction of the cultural values continues even within the urban *field*. The restriction on the bodily representations of women in the urban *field* according to the cultural values of rural *field* can be examined with the adaptation of the concept of "family pool" by Kalaycıoğlu and Rittersberger-Tılıç (2003). This model does not only function as a source of economic solidarity among relatives but social and cultural transmission is made. There are three groups in the system of family/kin group. Among them the group living in the village carries out the reproduction of cultural values especially belonging to patriarchal values. In H.B. case, relatives in the village and elderly relatives play a role in the reproduction of cultural identity. The group living in the village of the family/kin group controls migrant households in the city in terms of cultural reproduction.

There is one case, E.A. (26 years old, male, living in Gültepe) who discusses the relationship between language use as embodied *cultural capital* and being an urbanite as follows:

> *Kentli gibi hissediyorum çünkü Türkçe konuşabiliyorum. Kürtçe konuşurum anlarım aile içinde. Burda doğdum. Burda büyüdüm. Annem kendini Kürt olarak hissediyor biz Türk olarak hissediyoruz.*

I feel I belong in the city because I can speak Turkish. Among family I speak and understand Kurdish. I was born and raised here. My mother feels Kurdish and we feel Turkish.

When I first met this family, after introducing myself and the aim of the research, I started the interview with his mother. I could not communicate with her easily. For most of the questions directed to her, she misunderstood. Her son tried to translate her words with by adding his comments. When I felt that she actually suffered during this Turkish interview, I interrupted the interview and I began to interview her chronically ill son. For E.A., being able to speak Turkish is the most important determinant of being an urbanite and at the same time, of being Turkish. There are generational differences in terms of the continuity of culture. Here, it can be said that there is an assimilation of ethnic identity in the second generation; however, Kurdish language use among the family ensures cultural reproduction by individual agents.

More than half of the respondents express the feeling of being a villager and the majority of them are female respondents. In addition, all the first generation respondents who migrated between one and ten years ago feel like villagers. They consider themselves villagers in spite of the fact that they have spent many years in the city. This is valid for both first and second generation migrants. When they consider themselves as villagers, they mainly emphasize that they have not kept up with city life in terms of life standards, spatial integration, life style, and bodily representation such as dressing styles.

The focus of dressing and life styles as internalized *habitus* in individual agents and reproduced in the city is more common among female respondents. As Erman (1998) indicates that it is difficult for migrant women to feel themselves to be urbanite (p: 550). A.Ay. (36 years old, female, living in Gültepe) states her feeling of being a villager based on life style and taste and also spatial differences according to life style.

Köylü gibiyiz. Dışarı hayatına bakıyorum kendime bakıyorum. Biz köylüyüz yani. Bi Ulus'a git Kızılay'a git ordaki insanlara bakıyorsun kendine bakıyorsun köylü gibisin yani. Görüntüne bakıyorsun. Giyim tarzı farklı yaşam tarzı farklı. Yediklerin içtiklerin farklı. Sosyetik onlar az az koyuyorlar tabaklarına mesela biz ekmeği çok yeriz. Sen yerde yerken rahatsın onlar masada. Ben köyde büyümedim ama eskiden gecekondular köy gibiydi biz evimizde koyun kuzu beslerdik geldiğimizde. Mahalle olarak köy yaşantısı gibiydi zaten.

We're like villagers. I look at the life outside and our life here. We are villagers. Go to Ulus or Kızılay and look at the people there and then at yourself, you feel like a villager. The way you look, dress, live, what you eat and drink-it's all different. High society people put small amounts on their plate for example, but we eat a lot of bread. You are comfortable eating on the floor, they eat at the table. I didn't grow up in the village but gecekondus used to be like

> villages. We used to raise sheep and lambs when we came. As a neighborhood we had a village-type lifestyle.

She migrated with her parents and siblings 29 years ago. Spending many years in the city is not conducive to feeling like an urbanite unlike for males. Actually, she focuses on what Bourdieu (1984) expresses in his book *Distinction: a Social Critique of Judgment of Taste* related with distinct cultural practice by social class. According to Bourdieu (1984), as Wacquant states (1998b), "the aesthetic sense exhibited by different groups, and the lifestyles associated with them, define themselves in opposition to one another: taste is first and foremost the distaste of the tastes of others" (Wacquant, 1998b: 223). This means that the space of lifestyles and the space of social positions are occupied by the different groups such as dressing styles as bodily representation, which "is the most indisputable materialization of class taste" (Bourdieu, 1984: 190). A.Ay. defines herself as a villager by discerning the urbanite taste as the taste of others. She is aware that she is different in terms of life style such as bodily representation or image as dressing style, and eating habits and style, in brief, "the sense of distinction".

In addition, some male respondents state the dressing style which separates the urbanites and non-urbanites. M. Ko. (33 years old, male, living in Baraj), who migrated eleven years ago, points out that:

> *Yani nihayetinde köylüyüz. Kentlilikle hiçbir alakamız yok aslında. Ben şehirli olamam. ya işte yaşantımızdan mı artık hani şehrin yaşantısı ile bizim yaşantımız konuşma tarzımız farklı. Şimdi eşim bana ne kadar dese ki şu kravatı gömleği giy dese giyemem. Sanki onları giydiğim zaman bir suçluluk hissediyorum.*
>
> Essentially we are villagers. We actually don't have any similarities with city people. I can't be a city person. I don't know if it's the way we live or speak; it's all different. No matter how much my wife tells me to war a shirt and tie, I can't. I feel guilty when I do.

Some respondents point out the intergenerational difference in feeling like an urbanite or a villager by focusing on bodily representation like G.B. (49 years old, female, housewife, living in Baraj):

> *Köyden gelince alışamıyorsun hemen. Biz köyde doğma büyümeyiz. Şehire uyum sağlayana kadar bayağı zaman geçiyor. Bir şehirli gibi olamıyorsun ki. Köyün kültürü ayrı oluyor buranın kültürü ayrı oluyor. Zaman zaman artık alışıyorsun. Mesela buranın görüm olaraktan farklı. Yemekleri alışverişleri insanların giyimleri hepsi farklı. Göre göre alıştık. Ama uygulayamadık. Çok değişiyor kafam çok karışıyor. Köye gittiğinde köye uyum sağlıyorsun kente gittiğinde kente uyum sağlıyon. Alıştım çünkü. Ama esas olarak köylü hissediyorum. Mesela ben kendimi siz gibi hissedemem. Siz okumuşsunuz tahsillisiniz. Biz siz gibi olamayız ne kadar olsa köylüyüz. Siz burda doğmuşunuzdur şehirde doğma büyümeyle fark ediyor. Mesela*

benim çocuklarımla aramda fark var. Köye gittiklerinde onlar köye uyum sağlayamıyorlar. Ben de kente çocuklarımın sağladığı kadar uyum sağlayamıyorum. Mesela çocuklarım kendi çocukları ile aralarında fark olmaz çok fazla. Kızımın köyle hiç alakası yok mesela. Burayla alakası var.

You get used to things quickly when you come here. We were born and raised in the village. It takes some time to get used to the city. You can't quite be like a city person. The culture in the village and here are different. After some time you get used to it. For example, this place looks different. The food, shopping, people's clothes are different. We got used to seeing it but not doing it. Everything is very different; I get confused. You adapt whether you go to the city or the village. But I actually feel like a villager. I could never feel like you. You went to school, you are learned. We can't be like you, we are villagers. You were probably born here; it makes a difference if you were born here or there. For example, my children and I are different. They don't adapt when they go to the village. And I can't adapt to the city as much as they have. There won't be a huge difference between my children and their children. My daughter for instance has nothing to do with the village. She is tied to the city.

As other respondents focusing on bodily representation, G.B also demonstrates "the sense of distinction".

Few respondents state the neighborhood effect on bodily representation like the rule peculiar to the gecekondu area. M.Ç. (45 year old, female, living in Gültepe), who migrated 18 years ago, expresses the neighborhood effect in the mode of bodily representation.

Ben köylü olarak görüyorum. Kentte yaşayan köylü gibiyim. Köy yaşamından vazgeçemiyoruz. Burası da zaten köy gibi. Çevre saçını kapamış sen açacak değilsin ya. Çevreye uyuyorsun. Saçım açıktı önceden. Buraya gelince açmıştım. Dediler ki "saçını kapat napacan, allaha şükret kocan getirsin sen ye çocuklarına bak ilerde faydası olur faydasını görürsün" dediler. Yani saçımı kapatmamı çevre etkiledi, tuhaf karşıladılar.

I see myself as a villager. I am like a villager living in the city. We can't give up village life. This is life the village anyway. People around you cover their heads. You can't not do it. You conform to those around you. I didn't use to cover my head. I had taken it off when I came here. They said "cover your head; what is there to do? Thank God that your husband brings home food. Take care of yourself and your kids and you will benefit later. " They influenced me into covering my head. They were strange about it.

According to my observation during the fieldwork, the majority of women I interviewed and saw in the neighborhoods covered their hair as they did in the village, especially in Baraj. This had become a rule in the neighborhoods according to some female respondents. There is the continuity of the *habitus* from one *field* to another. Wacquant (1998b) expresses that "habitus is also a principle of both social continuity and discontinuity: continuity because it stores social forces into the individual organism and transports them across time and space; discontinuity because it can be modified through the acquisition of new dispositions and because it can trigger innovation whenever it encounters a social setting discrepant with the setting from which it issues" (p: 221). Thus, I encountered the continuity of the *habitus* about

women covering their hair because the social forces of the previous *field*, that is, the rural area is continuing. It can be said that the effect of the *field* (rural) does not end with the move to the other *field* (urban).

Also, some respondents emphasize the space and identity conformity. Especially women respondents point out the space of gecekondu neighborhood, distinguishing themselves from other places, especially from the apartment block areas in the city. Most of the female respondents in Baraj focus on the "living space", which determines the identity of one as an urbanite or a villager as L.S. (21 years old, female, living in Baraj) states:

> *Köylüyüz. Köyde yaşadığımız için burası da köyden farksız olduğundan yani. Birtek yapılan iş farklı. Evler köy gibi, kadınlar köylü gibi giyiniyor. Farklı değil pek. Evet, burası bize çok yabancı gelmedi uyum sağladık.*
>
> We are villagers. Because we live in this place which is so like a village. The only different thing is the work you do. The houses look like the do in the village, the women dress that way. It's not much different. Yes, I guess this place wasn't so foreign to us. We have adapted.

Similarly, H.T. (32 years old, male, living in Baraj) states that:

> *Köylü olarak görüyoz. Şehirli olarak nasıl görelim ki. Yaşantı yok hiç bi giyim kuşam yok, şehirli nasıl görek. Öbür tarafnan bu taraf bir mi yani. Ulustan bu tarafı bakın bir de diğer tarafa bakın. Diğer taraf öbür taraf şehirli. Bura köy. Benim köy burdan düzgün.*
>
> We see ourselves as villagers. How can we fell like city people? We don't live that kind of life, dress that way. Here and the other parts are different. Look this side of Ulus and the other side. The other side is where the city people live. Here it's a village. My village is better than here.

Both respondents are aware of the spatial concentration of lifestyle according to the type of city. According to Güvenç (1998), there is a spatial distribution of status and income in Ankara; one can take the İstanbul-Samsun Highway as a border (See Chapter Four for details). In addition to income, the respondents focus on the life style differences according to space.

In addition to bodily representation and space, some respondents express the low economic conditions which prevents being urbanites. F.A. (67 years old, female, living in Gültepe) expresses the lack of *economic capital* as:

> *Köylü gibi hissediyoz. Aha halimiz, neyimiz kentli. Ben hiçbir zaman modern olamadım karnım mı doydu sanki. Evimiz kötü kendi halimiz görünüşümüz neresi kentli elimiz bir para görmedi ki gidip gezeyim*

yiyeyim içeyim. Buradan başka yer bilmem ki ben. Benim nerem moderen. Bi gidip kuaföre saçımı mı yaptırabilirim, kıyafet mi alabilirim yok hiçbiri. Köylü geldik köylü gidecez. Her şey parayla. Paran olmasa sen buraya gelebilin mi yok. 300 milyon parayla ne alak ne giyek bu kadar kişi. Karnım doymadı elim para görmedi ki sosyeteye girim. Durumun iyi olursa buraya uydum dersin kötü olunca uyamıyosun.

We feel like villagers. Nothing about us is like city people. I was never able to be modern. My belly has never been full. Our houses are bad; we don't look like city people. We never had money so I was never able to go out for fun and drink. I don't know any place other than here. What's modern about me? Can I go to hairdressers and get my hair done or buy clothes? No. We will remain as villagers forever. Everything is about money. If you didn't have money could you have come here? No. what can we buy or wear with 300 million? There are so many of us. My belly isn't full; I have no money how can I be high society? If I were well off I could say I adapted but you can't when you are hard up.

In the group of respondents who see themselves in the in-between category or ambiguous category, the majority focus on the low level of economic conditions which put them in this category. One of those in the in-between category, S.A., states by focusing the dressing style of modern urban man that:

Orta halli denir ya öyleyim. Ne bilinçli ne bilinçsiz orta derecede. Senin sorduklarına cevap verebilecek kadar kentliyim. Hukuktayken hoca dedi ki kravat takacaksınız dedi. Ben takamam hocam dedim. Ben boğuluyorum zannediyorum dedim. Emirlerinize karşı çıkmak istemem ama. Ruhum daralır. Medeniyet yularıymış gibi. Ben köyden koptum. Aslında ne güzel insana yakışır bir şey.

I am what you would call stuck in between. Not aware or unaware. I am citifies enough to be able to answer your questions. When I was working at the school of law the professor said we would wear ties. I told him I can't. I would feel like I was choking. I wouldn't want to disobey you but my spirit would feel constricted. It feels like the bridle of civilization. I am from the village. It actually really suits a man.

He focuses not only on being an urbanite or a villager, he also emphasizes being literate or illiterate. For most respondents, being a villager and illiterate is perceived together as seen in their expressions.

M.H. (33 years old, male, living in Baraj) states about the in-between position:

Kendimizi ne şehirli gibi ne de köylü gibi hissediyoruz. Nedeni şehirli gibi alışveriş yapamıyorsun. İstediğini alamıyorsun. Öyleymiş gibi de yaşayamıyorsun. İkisinin de ortası yani ne şehirli oluyorsun ne köylü oluyorsun. Nerde oturuyorsun Ankara da oturuyorum. Hepsi bu başka bir şey yok. Şehirde oturuyorsun da ne bileyim dağın başında gecekonduda oturuyorsun. Ne kadar şehirliyim desen yalan konuşmuş olursun. Benim dairem yok benim bir şirketim yok.

We feel we belong neither to the city nor to the village. The reason is that you can't shop like city people. You can't buy what you want. You can't live like you are. You are stuck in between. Where do I live? In Ankara. But that's all. You live in a gecekondu on a mountain somewhere. It would be a lie to say I am a city person. I don't have an apartment or a company.

A.M. (35 years old, male, living in Gültepe), who was born in Ankara, defines himself ambiguously against the modern and the urban identity by mentioning his experience as:

> *Ne kentli olduğumuz belli ne köylü olduğumuz belli. Bizim ne olduğumuz belli değil. Köylünün bir hayatı vardır kentlinin bir hayatı vardır bizimki ikisi de değil. Biz ekmeği bulursak peyniri bulamıyoruz. Bunları köylü kendi yapar kentli de satın alır. Biz ikisini de yapamıyoruz. Görünüşte Türkiye'nin başkentinde oturuyoruz. Ama burası ayrı bir yer hem merkezde hem de merkezin dışında. Burada ilkel bir yaşam var. Zorla yaşıyoruz. Yaşadığımız yok bizim burda…Burada kira vermiyoruz diye duruyoruz. Şimdi Ankara'da apartmanda en düşük kira 300 milyon. Benim aylık en az 1 milyar gelirim olması lazım ki benim o kirayı ödemem lazım. Bugün 200 milyon kiraya vermiş olsam 100 milyon da elektrik su telefona vermiş olsam. 700 milyondan aşağı olmaması lazım. O zaman normal bir hayatım olur. Belki köşeye bile artırabilirim. Günlük 5 milyona geliyor toplam kazancımız en fazla 10 milyon. Anca ekmeğini alıyon. 15 ekmek alıyorum günde. 2 ayda bir çocuklarım et görüyor. O da tavuk. Parça tavuğunda kilosu 2.750 milyon. İnsanın bir milyar geliri olacak ki etini de alacan iyi de bir yerde oturacan. Yaşayacaksın. İnsan burada bu fakirlikte yaşadığını hissetmiyor ki. Burada yeni bir ayakkabı da giysen yeni bir tişörtte giysen yeni bir pantolon da giysen alay ediyorlar. Az bişey yani yeni bişey giydiğinde bakıyorlar sen kendini ne zannediyon diye laf atıyorlar. Yeni şeyleri layık görmüyorlar. Ben 13 senedir evliyim daha kendime bir şey almadım. Eskileri giyiyoruz. Yıkıyoruz ütülüyoruz. Giyiniyoruz. Mesela eşim gidiyor temizliğe gidiyor orda veriyorlar. Yeni bir şey almıyoruz hiç. Hiçbirimize, Çocuklara da. Ben kendimi nasıl şehirli hissedeyim ki?*
>
> We don't know if we're city people or villagers. Our lives resemble neither. If we are able to find bread, we can't find cheese. A villager would make these and a city person would buy them. We can do neither. It appears like we live in the capital city of Turkey. But this is a separate place far from the city center. There's a primitive life here. It's hard. We don't live. We can't afford rent so we stay here. Right now the cheapest rent is 300 million. I would have to make at least 1 billion a month to pay that rent. If I pay 200million rent, 100million for utilities a phone, it can't be less than 700million. Then I would have a normal life. Maybe I could even save a little. We make 5 million a day, 10 million maximum. You barely get your bread. I buy 15 loaves of bread a day. My children see meat once every two months. And that's chicken. Chicken pieces are 2.750 million a kilo. You have to make 1 billion a month to buy meat and live in a nice place. You're going to live. Here we don't feel alive in this poverty. Here they make fun of you if you buy new pants, a new t-shirt or shoes. When you wear something new they ask you who you think you are. They don't think you deserve new things. I have been marred 13 years and haven't bought myself anything. We wear the old things. We wash and iron them. My wife goes to clean houses, they give her clothes there. We never buy anything new. For any of us. Even the children. How can I feel like a city person?

He expresses the poor economic conditions which put him in this ambiguous position. Here, being an urbanite is perceived as the average living conditions and he relates this with meeting basic needs. The other point he mentions is the effect of the neighborhood. Actually, he states the impossibility of being an urbanite in this neighborhood. Also it is striking that the neighborhood, mentioned earlier for women, is influential in bodily representation. There is a constraint for how the bodily representation should be. If the individual's distinct bodily representation is visible among the poor, he or she becomes "the other".

The other identity is being literate or illiterate. Education as a form of social reproduction works to meet the needs of the workforce and ensures that the labor

force is technically competent. In addition, being literate or illiterate puts people in different positions in society.

If we look at the educational status of head of the household and spouses of the head of the household, we see that the educational status of head of the household is slightly higher than his spouse. The rate of the household heads who have a primary school degree is 67, 5 percentage; the rate for their spouses is 64, 7%. While the lowest educational level in Baraj is primary school graduation, there are three household heads below primary school graduation in Gültepe. At the same line, among the spouses in Baraj, there is no any educational status below primary school. The majority of them are primary school graduates (80%). In Gültepe, there are seven spouses below primary school graduate level and the percentage of spouses with a primary school degree is 42, 9%. If the two neighborhoods are compared, it can be said that educational status of Baraj is higher than that of Gültepe for interviewees, heads of the families and their spouses.

When we evaluate intergenerational differences in the illiteracy rate, we see that the illiteracy rate tend to reduce when generation go forward. Also, women's rate of illiteracy is higher than men's. While the illiteracy rate for household heads is 2, 5% in our sample, the same rate for spouses of head of the household is 3, 03%. If we look at the illiteracy status of the father of head of the household, we see that 45% is illiterate. Illiteracy rate of mothers of the head of the household is much higher with 65%. While the illiteracy rate of the father of spouse of the household head is 47, 06% this rate for the mother is 61, 76%. Among the father and mother of household heads and spouses of the household heads, the highest educational level is primary school graduation.

When we examine the educational level of the children of household heads, either they are continuing their education or the least educational level is primary school graduation. More than half of all the children are composed of those who continue school and those who are in an irrelevant age for school. More than half of the graduate children are composed of primary school graduates. There are few children who continue to school after primary school. They are more advantageous than previous generations but a dramatic change in educational levels for the graduates could not be mentioned. At least, there are no literate and illiterate children among them.

As regards the dropouts and three generations' (previous and the next generations of the household heads) non-attendance at school, in rural areas, school non-attendance is closely related with lack of interest in education, their traditional views on gender roles, unpaid family work such as agricultural work and household chores, and difficulties in access to schools. If we compare generations, we see that the previous generation (mothers and fathers of the heads of the families and their spouses') living in the rural area and first and second generation migrants whose childhood was in rural areas have had little opportunity for education because both economic activities, household chores and the views of rural people about education. Like the mothers and fathers of migrants, equally, migrant respondents who lived in rural areas in their childhood are less-educated or illiterate and there are similar underlying reasons.

In rural areas, the education of girls is deemed unnecessary. In general, schooling is not desired or necessary for the families; in particular, the schooling of a girl is seen inessential. Girls are seen as "guests" in the families as some respondents emphasize. The majority of women who lived in rural areas in their childhood are either illiterate or primary school drop-outs. There are some women who have a primary school degree. Usually they left school in their third year of primary school, and during their school years, they did not go to school on a regular basis. In addition, the majority of men whose childhood was spent in rural areas are primary school graduates. They did not continue with education after primary school in order to work. In agricultural production, unpaid family labor is the main reason for lack of education. The school is seen as an obstacle for work. This is valid for both girls and boys. Girls attending school of is seen as obstacle to the completion of domestic work and the care of younger siblings in addition to agricultural work.

G.B. (49 years old, female, housewife, living in Baraj) migrated from a village of Kalecik with her husband and daughter 30 years ago. Her spouse is unemployed and a chronic patient. She is literate. She says about her educational life:

> *Ankara'ya gelmeden önce Kalecik'in Kılçak köyünde oturuyorduk. Ben çocukken, okul öğretmenleri devleten ceza alırsınız dedi bizi zoraki gönderdiler Ailem okula gönderdi ama 1 hafta gönderiyorlardı 2 hafta göndermiyorlardı. Ailem göndermek istemiyordu. Bir tek kalemi silgiyi bilirdim bir de fişi. Elime kitap almadım hiç. 3 sene gittim. Yollamadılar koca kız oldu memeleri çıktı diye. Hem de okul eve uzaktı. Devlet bizim köyü başka köye taşıdı o zaman hiç göndermediler.*

> Before we came to Ankara we were living in Kılçak village in Kalecik. When I was a child, the school teachers said we would get a fine so we had to go. My family sent me to school but they sent me 1 week and not again for 2 weeks. They didn't want to. I only knew a pencil and an eraser and the word cut ups. I never touched a book. I went for 3 years. They didn't let me go. They said she grew up her breasts are showing. School was far from our house anyway. The government moved our village elsewhere, so they didn't send me to school again.

While entering adolescence is an important factor for girls leaving school according to rural people, it is not an issue for boys. If we examine the family and kin tables of respondents, it is seen that no women left or attended school with their own decision or desire. Family intervention has a key role in the decision. When talking about their education or their mother or sisters' education, almost all women and men respondents state that "girls were not sent to school in villages". They state that girls are usually taken from primary school and they fulfill domestic duties such as child care and housework and working in agricultural production until marriage. In our sample, the marriage age of women in the rural area is about 15. Marriage is another reason for not sending girls to school.

After the migration, this time, after seeing and recognizing city life with negative experiences in labor market migrants began to comprehend the significance of educational status. Even though they themselves are not well-educated, they endeavor to provide their children to de regularly schooled. Almost all interviewed families in both the pilot and main interviews express their desire to educate their children except for a few. First generation migrants who suffered from negative educational histories state that they are very willing to send their children to school; however, now urban poverty prevents their children from being educated. Like the accounts below, from time to time people had to select one of their children to be educated. Labor market experiences of household heads such as unemployment especially chronic patients, irregular causal job accounts without social security and so, irregular income in their integration to city life prevent their children from receiving an education. N.D. (39 years old, female, living in Baraj) has one daughter and two sons (successively, 15, 17, and 7 years old). She migrated from her village with her husband 18 years ago. Her husband is a furniture worker with no insurance. Both she and her husband are primary school graduates. She expresses that she had to choose one of her children for education because of poverty:

> *Kızımı okuturdum okutamaz mıydım, herkesin çocuğu okuyo. Yokluktan okutamadık. Bunun yaşları hep okuyo. Kızım çok ağladı çok sızladı bacım. Neylen okutayım. Onu okutuyon beni okutmuyon diye. İyi de*

> *deki hadi okut. Sen olsan okutabilir misin yani? İş okutmada değil. Hadi diyelim ki yazdırdın. Neylen yollayayım. Günlük bebeye beş milyon veriyom (oğluna) Ulusa gidiyo. 2 milyon yol parası. 1 milyon da yiyo. 5 milyon yetmiyo bile. Ama yoksulluktan bebe yine de idare ediyo. Sabahtan akşama kadar matbaa bölümünde. Bitirince birinin yanına bir şey olarak girer. Matbaanın işi iyi yani geleceği iyi. Küçük de 1'e gidiyo. Bu sene başladı daha. Okula gitmeyen kızla da böyle oturuyok gün boyu. Anne kız ee napcan. Okusaydı iyi olurdu. Ben cahil kaldım o kalmıyaydı. Burada lise yok. Görüyon değil mi gördükçe bakıyon. Vallahi yoksulluk hepsinden zor.*
>
> I would have of course sent my daughter to school; everyone's children go. We couldn't afford to. Her peers are all in school. My daughter cried a lot, sister. Saying you let him go but not me. If I were to send her to school… you try. It's not about sending her to school. What would I send her with? I give my son 5 million every day. He goes to Ulus. 2 million for commuting, 1 million for food. 5 million isn't even enough. But he gets by. He is learning printing morning till night. When he's finished he'll get a job. It's a good, promising trade. The younger one goes to first grade. He just started this year. We sit around all day with my daughter. It would have been good for her to go to school. I stayed uneducated, I wish she didn't. there's no high school here. See? Believe me poverty is the hardest thing.

According to the World Bank Report for Turkey, the primary coping strategy of the poor has been to reduce consumption, particularly the consumption of food and the quality of food consumed, but there are also indications that the poor may have to cut back on education expenses and withdraw children from school (World Bank, 2003: 45). Educational expense becomes an important expense which reduces the earnings of the urban poor especially for benefit dependent poor. In N.D.'s case, the family has to choose one child to send to school. Here, the patriarchal cultural values also seem to be influential in the decision of who will go to school. Ayata and Ayata (2003), by emphasizing that poverty itself becomes the most serious obstacle to the education of children, state that in some occasions "the parents have to make a choice between two or more children as to educate only one of them and let the other work; in such cases, their preferences for the schooling would first be the brighter ones and secondly the boys" (p: 121).

Families that recently migrated first tried to integrate into the labor market in the cities. Poverty experiences of the first generation reflected onto their children's educational life negatively. None are illiterate among the children of the families in the two neighborhoods; however, there are children who left school in order to earn money in their school age. Regarding intergenerational differences in terms of labor market integration, we see that they hold a similar position in the labor market; at the very least they perform manual jobs in the formal or informal sector.

The significance of education varies according to urban/rural *field*, gender, and belief in educational requirement for finding a job. Economic conditions lead to either cutting back on educational expenses or withdrawing children from school and

guiding them to integrate into labor market. The latter is more evident in our sample. First generation migrants whose childhood was in rural areas and their parents could not receive an education because of the workload or disbelief in the necessity of education. Also, there is gender dimension. It is influential in the decision of sending boys and girls to school. The gender dimension is valid for both urban and rural areas. Families who suffer from economic hardship tend to send boys to school. However, during the first years in Ankara, they use child labor as a coping strategy. Therefore, we can say that low educational level, or illiteracy, is both a cause of poverty and a consequence, especially in the urban context. In terms of health experiences, it is difficult to understand the degree to which *institutionalized cultural capital* or *embodied cultural capital* is influential. So, it is beneficial to suppose they go together. A low level of education determines a lower position in labor market if the social network is not so strong.

There is a close relationship among being poor, being a villager, and being illiterate. In the rural *field*, being educated is not perceived as a potential to be converted into *economic capital*. The value of the *forms of capital* changes according to *field*. Being educated is not deemed valuable in the rural *field*; it is not seen as a kind of "trump card" in a game in Bourdieuan terms. They perform agricultural work and domestic duties. For these tasks, education is not seen as essential. When they migrated to the city, they became aware that a higher level of education is conducive to finding a job in the formal labor market. Lacking the requirements of the formal labor market made them integrate into the informal sector. As stated earlier, the sector with its exploitative characteristics sustains their poor position in the urban *field*. In addition, being literate or illiterate is crucial in terms of cultural integration into the urban *field*. In addition, women feel more illiterate than men. Considerable number of women respondents state that they feel illiterate and foreign when they face urban institutions like hospitals.

According to Turner (1995), the hospital[41] is a crucial institution within a modern system of health care, but it is also symbolic of the social power of the medical profession, representing the institutionalization of specialized medical knowledge. This is also mentioned by Friedson (1970a), who states that the power of

[41] The word hospital comes from the Latin word *hospitalis* which refers to "hospites" or gusets (Turner, 1995: 158).

professionals is derived from their legitimized status and presumed technical expertise. "The hospital as a professional arena of medical power illustrates many of the fundamental processes of industrial society, namely urbanization, secularization, the dominance of professional power, and the development of service sector" (Turner, 1995: 153). In addition to the focus on the hospital as symbolized professional/medical dominance, there is an argument which regards hospitals as a peculiar culture equipped with modern bureaucratic regulations in accordance with modern-rational thinking (Foucault, 1973; Friedson, 1970a; Turner, 1995, Mumford, 1983). According to Mumford (1983), "not all the values that are expressed in hospitals are useful for all patients", and hospitals reflect middle class norms instead of a setting in which all the different cultures become visible and interact (p: 372). As symbolized by the modern, the urban, and the professional, the bureaucratic, the rational, hospitals can be assumed to be a strange place for the non-urbanites. In effect, the doctor-patient interaction becomes a clash of different identities as seen in the excerpts below. Only respondents who consider themselves villagers and illiterate, among them especially females, view the hospital as strange place.

M.Ko. (33 years old, male, living in Baraj) expresses his feeling of being discriminated against based on bodily representations as:

> *Anlayış, en önemlisi anlayış. Ya ne bileyim bir insana güzelce bakmak var, güzelce anlatmak var bir de köpek gibi havlamak var. Ayırdım yapmasa. Yani şimdi varıyon, senin kıyafetine bakıyo, bi de normal öbür insanın kıyafetine bakıyo, ayırdım yapıyo.*
>
> Tolerance. That's the most important. You can look at a person and explain to the nicely or you can bark at them like a dog. If only they didn't discriminate. You go all that way; they look at your clothes and then look at the other, the normal person's clothes. They discriminate.

Being educated is also important in a hospital because the hospital bureaucracy is arranged according to the literate people. Gecekondu people with a low level of education have great difficulties. In addition to bodily representation, G.B. focuses on the importance of being educated in a hospital setting. This is valid also for those who possess a low level of institutional type of *cultural capital*. She states that:

> *Mesela okumuşlar gibi ben konuşamıyorum konuşmayı beceremiyorum işte napim. Ondan çok ayırdım var. O zaman adam yerine koymuyorlar ayrım yapıyorlar. Giyimine bakıyo beğenmiyo, o zaman adam yerine koymuyo. Kendini yabancılıyosun sona. Sana bir soru soruyo mesela okumuşluğun yok aklın sarmıyo ya ters yanlış anlıyorsun. Anlayamıyorum diyelim o da beni azarlıyor bağırıyor dalga geçiyor. Bir de yaşlıyım ya. Git*

yav hanım senle mi uğraşacam diyor. Okumuşluğum yok perişan oluyorum hastanede. Doktorun dediklerini de anlamıyom çoğu kez. Bir sürü yere gönderiyorlar.

They went to school. I can't speak, what can I do? I am very different. Then they don't treat you right. Hey discriminate. They don't like your clothes, don't treat you nicely. You feel bad. For example they ask you a question. You aren't educated so you don't quite understand or you misunderstand. The make fun of you or yell at you because you can't understand. And I'm old. Go away; I can't deal with you they say. I am not learned, it's horrible for me at hospitals. I usually don't understand what the doctor is saying. They send you too many different places.

According to Parsons (1952), the rights and duties of the physician are supported by three social norms: universalism, collective orientation, and affective neutrality (p: 455-465). This means that physicians should treat patients equally irrespective of age, gender, race, class, ethnicity or physical appearance. With this idealization, Parsons ignores the inner conflict between the physician and patient. In contrast, according to Lupton (1994), "in doctors' and other professionals' interaction with patients, it is not only the biomedical model and the imperatives of time which shape medical judgments, but value judgments about the patient based on gender, social class, ethnicity, age, physical attractiveness and the type of illness (for example, whether it is "deserved" or not)" (p: 123-124). Discrimination in a hospital setting is frequently stated by respondents; they state that they are stigmatized due to either being poor, symbolized with specific access types, being illiterate or due to different bodily representations unlike the urbanite, well educated people, and the rich and middle class people.

S.B. (29 years old, female, living in Baraj) who sees herself as a villager does not have much contact with the outside other than her home environment and kin. She migrated 6 years ago and has not gone out alone except to a hospital and health center. In fact, she does not go to her neighbors' home due to restrictions from her husband. She is confined to the domestic field, which causes her to feel depressed according to her expression. She expresses that:

Depresyondayım geldiğimden beri. Köydeyken böyle değildim, daraldım, kimse yok konuşacak. Birkaç akraba dışında kimseyle görüşmem eşim izin vermez. Burada evlere gidip gelmeyiz dışarıda görüşürüz duvara dayanır elişi yaparız…Çok zorda kalmadıkça gitmem doktora. Çocukları burada ana sağlığa götürürüm. Bazen de hastaneye. Doktorlar bazen sinirli oluyorlar azarlıyorlar. Keyiflerine göre. Herkese öyle değiller memurlara daha bi farklılar. Bizim görüntümüze bakıyor dalga geçiyor küçük görüyorlar.

I've been in depression since I came here. I wasn't like this in the village. There is no one to talk to here. My husband won't let me talk to anyone but relatives. Here we don't visit each other at home. We go out. We lean against the wall and knit things… I don't go to the doctor unless I have to. I take the kids to the mother-child health center here. Sometimes to a

> hospital. Doctors are sometimes angry and they scold you. Depends on their mood. They aren't that way with everyone, not to civil servants. They look at us and belittle us and make fun of us.

For a considerable number of the women, it is striking that being a civil servant is associated with wealth. In terms of health care access, the majority of respondents state that there is different treatment and opportunities between the civil servants and the others. "The sense of distinction" is more commonly perceived by female respondents in terms of being non-urbanite. Women go to the hospital and to other health care institutions more than men by reason of unwillingness to lose daily income as the working members of the families. This is also expressed by Ayata and Ayata (2003). They state that men, especially casual workers, tend to not go to the hospital because of the fear of losing their jobs. In the context of our research, frequently seen child illnesses push not men but primarily women into contact with health care settings. The majority of female respondents, especially those living in Baraj, have limited contact with the city center, and any other places except their home environment, kin, and neighbors. As Erman (1998) states, their spatial movement is restricted by this close relationship network. Therefore, they only go to the related official institutions to paying the invoices and go to the health care unit as a public field. The sense of distinction in a health care setting is often expressed by female respondents due to little contact with the public field.

E.A.'s (26 years old, male, living in Gültepe) experience with the doctor indicates the doctor-patient interaction in which the doctor prefers "the paternal type" of doctor-patient interaction in which doctor has an active and dominant role and perceives the patient's questions about the illness as interfering with the professional field and the patient is assigned a passive role:

> *Neyim var deyince de sen napacan seni ne ilgilendiriyor ki öğrenip de napacan şu ilacı kullan yeter diyor. Karışma diyor benim işime. Bana şöyle bir bakıp beni küçük görüyor.*
>
> When I ask them what is wrong with me, they say nevermind about that. What are you going to do if you find out? Just use this medicine; don't interfere in my business they tell me. They look me up and down and scorn me.

E.A.'s experience is an example of the paternal type of doctor-patient relationship. According to Stewart and Roter (1989), in a paternal relationship, the doctor is dominant over the patient who has a passive role in the interaction and obeys the

advice and rules determined by the doctor. In this case, however, the introduction of a reciprocal type of relationship by the patient's participation in the conversation was interrupted suddenly by the doctor's directing the patient to the paternal type. The doctor-patient model characterized by mutuality refers to the mutual interaction in which both doctor and patient have active role (Ibid: 21). This interruption comes from the doctor's wish to protect the professional field. The doctor's wish to protect the field is defined as "a form of social closure" by Friedson (1970b). Professional dominance is reproduced by maintaining "a body of esoteric knowledge". The participant relationship model is perceived as the intervention to the "esoteric" knowledge of the doctor in the case of E.A. However, in the Turkish case, the number of patients assigned to one doctor is great, which reduces the time of the doctor-patient interaction. Cirhinlioğlu's study (2001) touches upon this point; he expresses the prevalence of the paternal type of doctor-patient interaction.

Medical language full of esoteric knowledge is stated by some respondents to make rural migrants feel foreign to the hospital setting as M.K. (40 years old, female, living in Gültepe) expresses:

> *Bir kere halkı bilinçlendirmeleri lazım. Doktor diyor ki mesela sen de bilmem ne hastalığı var. Doktor açıklama yapmalı en azından ne sorun var anlatmalı herkes her hastalığın adını nerden bilsin. İnsanlar hastalıklarının ne olduğunu bilmediklerinden psikolojik olarak çok kötüye gidebiliyorlar doktor da bu hastalık konusunda bilginiz var mı deyip eğitim vermeli bence. Eğer doktor yapmıyorsa da başka bir personel yapsın. Şunu yaparsanız iyileşirsiniz şunu yaparsanız kötüleşirsiniz demesi lazım. Şuanda Türkiye'de olan doktorun karşısına çıkıyorsun neyin var diyor şunum var diyorsun. Git şu şu tahlilleri yap gel diyor. Gidiyorsun yaptırıyorsun tahlilleri yine doktorun karşısına çıkıyorsun diyor ki şu şu ilaçları kullan haftaya kontrole gel. Tamam da bana noldu ne hastalığım var ne yapmam gerekir nasıl iyileşirim hiçbirşey yok. Kendimi makine gibi hissediyorum o zaman. Ben de insanım. Bazı insanlar gidiyor doktora bakalım bu sefer ne diyecek diyor körü körüne gidiyorlar soru sormuyorlar. Çoğu cahil köylü. Köyünden yeni çıkmışlar. Bazıları da iyileşmiş miyim iyileşmemiş miyim diye merak ediyorlar. Ama öyle olmuyor ki bu sefer başka sorunlar çıkıyor. İlaç yan etki yapıyor o zaman ne olacak. İlaç değişiyor haydi bir daha kontrole gel. İnsan kendini deneme tahtası gibi hissediyor haliyle. Doktorlardan istediğimiz bizi bilgilendirmeleri biraz da ilgi.*

> They need to increase the public's awareness. The doctor says you have bla bla illness. The doctor should at least explain the problem. How can everyone know all the names of the illnesses? People can have psychological problems if they don't know what they have. If not the doctor then someone else should explain. They should say you will get better if you do this but you will get worse if you do this. Right now, you see a doctor in Turkey; you say I have this and that and he says use this medicine and come back in a week. Okay but what is wrong with me? What should I do? How will I recover? Nothing. I feel like a machine. I am human too. Some go to the doctor lets see what he will say this time. They don't ask questions they just go ignorantly. Many are ignorant villagers. They just came. Some are curious if they are better yet or not. But this time other problems come up. The drugs have side effects. Then what happens? The doctor changes the medication and tells you to come back. You feel like a guinea pig. What we want from doctors is for them to inform us and a bit of attention.

Turner (1995) points out that the biomedical model of disease or view of medical model presupposes a clear mind-body distinction where ultimately the causal agent of illness would be located in the human body (p: 9-10) (See Chapter Two for details). This distinction views the individual as only a flesh or machine, instead of human being as M.K. mentions. Also Atkinson (1988) criticizes Western-scientific medicine in that the individual patient becomes a more or less passive site of disease manifestation. Internalizing the medical model of disease by the medical doctor reflects onto the professional's treatment of the individual patient and the doctor-patient interaction. M.K.'s case is an example of the expression of feeling like a machine against the medical view. How this model is influential in other classes like middle class or upper class is not the case for the thesis. I only focus on poor *gecekondu* people, so I can evaluate only their views.

Similarly, L.A. (40 years old, male, living in Gültepe) says that:

> *Ben askeri hastanede yaptım askerliği, nöroşuriji ne demek. Bunu böyle yazacağına Türkçesini yazsana bu ney nöro kafa beyin. Cahil bizim halkımız ne bilsin. Diyor ki doktor sen bu kağıtları bilmem nereye götüreceksin adam önünden geçiyor görmüyor. Bir sürü zaman kaybı oluyor zaten zamanı yok adamın. Adam bir an önce neyse belli olsun diyor atacaksa atsın kesecekse kessin. Bir hastaneye gittiğinde üçüncü, beşinci günü artık kabak tadı vermeye başlıyor. Zaten zamanın yok. Bir de bu ne demek şu ne demek diye düşün dur.*
>
> I did my military service in a military hospital. What is "nöroşirurji"? Instead of writing it this way, why don't they write it in Turkish? "Nöro" means head, brain. Our people are ignorant. How are they supposed to know? The doctor says take these papers to this place and the walks off. So much time is wasted. The doctor doesn't have any time anyway. You want to now what you have a soon as possible, if they are going to cut anything or what. Once you go to a hospital on the 3rd or 5th day you don't want to go again. You don't have time anyway. And on top of all that, you have to think about what this is or what that is.

Similarly, O.G. (34 years old, male, living in Baraj) expresses that:

> *Köyden gelmişiz bilmiyoruz bu ortamları yabancılık çekiyoruz. Doktorun dediğini tam anlamıyoruz.*
>
> We came from the village. This place is foreign to us. We don't quite understand what the doctor is saying.

All three cases touch upon the medical terminology used at the interactional level that renders the rural migrant individual patient a stranger in the setting, interaction, and her/his illness. A considerable number of respondents express what L.A. says that people in most of the time leave the doctor office with many questions. Gecekondu people who identify themselves as a villager and poor and a stranger to the urban *field*

have troubles with this vocabulary. According to many medical anthropologists and medical sociologists especially in the social constructionist tradition, biomedicine as a dominant form of explanation and treatment for illness is assumed as a cultural system. (See Chapter Two for details). It is in the realm of "facts" and reproduces the epistemology from Cartesian legacy as mind-body and culture nature dualities, and has own a unique vocabulary based on esoteric knowledge in the doctor patient interaction. The two different cultures (the realm of disease and the realm of illness) emerge, clash, and lead to a lack of communication with the practice of biomedicine as cultural system.

The professional language used by the doctor, essentially, sustains the "sense of distinction" of urban poor. The individual's linguistic is essentially a capacity related with the status in the *field* as Bourdieu and Wacquant (2003) point out (See Chapter Two for details). He asserts that "every linguistic communication has the potential to include the domination of the action of the power" (Bourdieu & Wacquant, 2003: 140). Conversation between two individuals should not be seen as an ordinary talk, especially if they occupy different position in society. In this respect, the doctor-patient interaction is not only an ordinary conversation through the use of specific medical language; moreover, the use of medical language by the doctor should not be seen only as a technical ability. It is a kind of "professional dominance" like Friedson also states (1970a). This domination produces "symbolic violence" in the *field* by demonstrating legitimate *language capital* in the *field*, if the agents occupy asymmetrical positions in the composition of capital in the related *field* (Bourdieu and Wacquant, 2003, 140-141). The use of medical language, for this reason, on the one hand sustains the "sense of distinction", on the other, reproduces the inequality between the subordinated and dominated.

It can be said that when *gecekondu* people with different *cultural capital*, essentially, peculiar to the rural *field* with the dressing style, different accent as language capital, and low level of institutional form of *economic capital* encounter professionals with abundant educational capital and acquired skills, higher level of *economic capital*, symbolizing the urban and modern one, with dominant position in the *field*, they a clash of identities. In terms of the *gecekondu* people who try to integrate into the city; on the one hand, they continues their cultural values; on the other, the doctor-patient encounter is actually kind of a picture of "distinction" and

"reproduction of inequality". Actually, the rural and urban cultural values inherited in individual agents and reproduced by practice in accordance with these values clashes. This clash takes place between the modern/urban and non-modern/rural with the internalization of the sense of distinction by both. Distinct cultural values, visible in dressing style or ways of pronunciation, or misunderstandings arising form the doctor's use medical language due to the difference between the scientific language and lay language are perceived by the doctor. When the doctor behaves differently towards different patients by not fulfilling the role obligations of affective neutrality, universalism, and collective orientation (also these don't seem possible), and organizes the interaction according to this sense of distinction, the interaction between doctor and patient reproduces the unequal relationship between them. Therefore, the powerful and dominant position of the professional against the poor *gecekondu* person determines the type of the relationship: paternal interaction.

Feeling of being sick and its consequences for health experiences

Being permanently sick is another identity which is assigned different levels of importance in different domains of life. The health experiences of *gecekondu* dwellers should be examined because they depend on and are in contact with medical institutions permanently. In accordance with Bury's distinction of the meanings of chronic illness, I examine two aspects or "meanings" of illness: first, the impacts of illness experiences on everyday life experiences; and second, the meaning of the sick role with its connotations, attributions and imagery in the urban *field*. When we assume that long-term illnesses and being in a specific societal group has different cultural meanings and attributions, we can say that the urban poor who suffer from economic difficulties have a unique experience.

In the thesis, I do not classify the illnesses according to the existent chronic disease lists[42]; instead I prefer to use the concept of chronic illness to denote long-

[42] Chronic illnesses are classified in the Chronic Disease List (CDL), including the Category A (basic list) and Category B (extended form). Category A includes diseases such as addison's disease, asthma, bipolar disease, brochiectasis, cardiac failure, cardiomyopathy, chronic obstructive pulmonary disease, chronic kidney disease, coronary artery disease, crohn's disease, diabetes insipidus, diabetes mellitus (type 1 and type 2), dysrhythmia (irregular heartbeat), epilepsy, glaucoma, haemophilia, hyperlipidaemia (high cholesterol), hypertension (high blood pressure), hypothyroidism (inactive thyroid gland), multiple sclerosis, parkinson's disease, rheumatoid arthritis, schizophrenia, systemic lupus erythematosus, ulcerative colitis. Category B varies according to the coverage of insurance firms. In

term illnesses which cause disruption in the individual's life. For example, a herniated disk is not included in wither category of the chronic disease list, but I take it as an illness which obstructs everyday life because it may cause one to leave work or obstruct the fulfillment of domestic duties among the family members in our sample. Also, certain illnesses which can be curable but the urban poor may continue to suffer from these because of little or no access to health services. Therefore, the illness becomes a long-term illness. As a result, I prefer to use the name of the illness instead of which category it belongs in.

More than half of the respondents suffer from long-term illnesses. While two of the sick respondents were previously the main income provider of the family and transferred the duty to their son, three sick respondents are unemployed and there is no one earning a living from wage work in the family due to illness. While two sick respondents are retired, two sick respondents work are the main and sole income provider. In terms of biographical disruption, one rupture took place in the attachment to the urban labor market. The sick individuals lose their ties with the market according to the severity of illness. This takes place either as a complete disconnection from the market or a weakening in the ties according to the severity of illness. This rupture or weakening makes the individual change his/her position both in the family and labor market. The excerpt below is an example of the shift from breadwinner position in the family and the employed position in the labor market to dependent position in the family and the unemployed position. H.A. (48 years old, male, living in Gültepe) transferred his breadwinner position to his 24-year-old son three months ago. He shares his ideas about being sick and being unemployed as:

> *Yaptığımız işlerden mi bilmiyorum tabi sağlığımız kötü stres çok var. Bende şimdi 8 yıldır kalp 5 yıldır midede ülser var. 2 kere de kalp krizi geçirdim. Üzülünce kötüleşiyorum. Uzun yola artık dayanamıyorum gece gündüz uykusuz kalıyorsun. Gidersen adamlar arabanın içinde yatacaksın diyor kışın soğukta ona da dayanamıyorsun. Onun için artık gitmiyorum. İş sorunum olmazsa ben böyle çökmezdim ben 2 senede çöktüm. Sitelerde iş çıkarsa gidiyordum geçen haftaya kadar. Ev eşyası taşınacaksa yardım ediyordum. Ama yapamadım kalbim kötüleşiyor yoruluyorum. Önceden çok iyiydim. Rahatlıkla uzun yola gider gelirdim. Şimdi oğlan çalışıyor 3 aydır. Sıkıntı stres şu kredi kartını bir ödeseydik. Oğlanı nişanladık 3 milyar kredi kartı borcumuz var. Midem de stresten oluyor. Kendimden pek yok artık ama bakalım çocuklar büyüyor. Fazla iş yapamıyorum yaparsam sıkışıp kalıyorum. Çünkü stres bir yandan iş yok bir yandan evin sıkıntısı bir yandan evin darlığı var. Stresim hiç bitmez benim. Çok önemli sağlıklı olmadığım için onun da sıkıntısını çekiyorum rahat hareket edemiyorum istediğimi yapamıyorum eskisi gibi. Valla 2 seneye kadar düşüş var daha kötü olduk. Önce daha rahattık. En kötü dönemimiz son yıllar. İşsizlik bir yandan hastalık bir yandan iyice çökertti beni.*

Turkey, there is no chronic illness form for the surveillance of chronic diseases in contrast to communicable disases (Minisry of Health, 2007: 54).

> I don't know if it's from the work I do but my health is bad. I have stress. I have had a heart disease for 8 years and an ulcer for 5 years. I have had 2 heart attacks. I feel bad when I am upset. I can't take long rides anymore. You are sleep deprived if you go. If you go, they tell you to lie down in the car and it's cold. So I dont go anymore. I wouldn't have gotten this way if it wasn't for my problems at work. I used to go to Siteler to work until last week. I helped if there was furniture to be carried. But now my heart is failing so I tire easily. I used t be fine. Now my son has been working for 3 months. If only we could just pay off the credit card. My son got engaged, so we owe 3 billion in credit card debt. My ulcer is because of stress too. At least the kids are growing up. I can't work much. My stress is never over. I can't do the things I like because I am sick. Within two years I worsened. I was comfortable before. These last years have been bad. Unemployment and sickness have destroyed me.

He states that he tried to work daily as a porter in Siteler until one week ago, but he understood that he was not capable of work due to the increase in the severity of the symptoms when he was working. Unlike some respondents' concerns about the dependent position, he does not complain about this, instead he sees his sons as the security of the family's future. Also he only recently lost his breadwinner position so he is not fully dependent. The other respondents who transferred breadwinner position are uncomfortable because of losing this position. Becoming a sick, in general, is equated with becoming dependent, which forces the ill individual into a different position in society.

Some respondents with chronic illness want to work to gain self-confidence. The long-term sick role is a difficult process to cope with because the role confines the sick to the home and they perceive themselves as uselessness in the family or in society while living indoors. Ö.A. (25 years old, male, living in Baraj), who suffers from congenital kidney failure, emphasizes his desire to work for community participation as:

> *Haftada 3 gün diyalize giriyorum. 11 de kalkarım normal zamanda kitap gazete okurum. Diyalize gideceksem erken kalkar hastanenin arabası alır burdan beni giderim. Diyalizden gelince dinlenirim. İşi paradan ziyade evde durmamak için istiyorum. Bunalıyorum hem hastayım hem de sürekli evdeyim. Dışarı çıkmak insan arasına girmek istiyorum. Hasta olunca evden dışarı çıkmayayım mı? Kendimi hapiste gibi hissediyorum. Haftada 4 gün çalışabileceğim iş arıyorum. Kendimi yalnız, hasta ve işe yaramaz hissediyorum, iş bulabilsem daha iyi olacağım. Tamamen aileme bağımlıyım maddi olarak bu beni rahatsız ediyor. Babam sorumsuzca para harcayıp borç yapıyor. Söz sahibi olmadığım için izliyorum sadece.*

> I go into dialysis 3 days a week. Normally I get up at 11 and read the paper. If I am going to dialysis that day I get up early. The hospital car picks me up and takes me. When I come back I rest. I want a job more to be out of the house than to make money. I feel suffocated; I am sick and I stay home. I want to go out and mix with people. I feel I m in a prison. I am looking for a job I can work 4 days a week. I feel lonely, ill and useless. I would be better if I could find a job. I am completely dependent on my family financially and this bothers me. My father squanders his money and owes people. I can only watch because I have no say.

In addition, Ö. A. had to leave to school due to the severity of his illness. This is another disruption among the sick. Being sick makes the individual powerless against poverty. Especially, young and adult respondents who have a long-term illness feel incapable against poverty like Ö.A.; however, the elderly and the retired respondents who have chronic illnesses focus on lack of ability for bodily movement in daily activities, instead of focusing on poverty. M.F. (74 years old, male, living in Gültepe) expresses this incapability:

> *Yürüyebildiğim rahat hareket ettiğim zamanlar kendimi sağlıklı hissederim. Şimdi hastayım. Yeni ameliyat oldum prostattan. Bir de damar tıkanıklığı var 3 senedir. 2 aydır yerimden kalkamıyorum Kendi işimi bile yapamıyorum. Hanım yardım ediyor. Moral bozukluğu da olur ister istemez ama çok da kötü olmam alıştım artık hastalıklarıma.*
>
> I feel healthy when I can walk and move. I am ill now. I just had prostate surgery. I have also had atherosclerosis for 3 years. I haven't been able to get up for 2 months. I can't go about my affairs. My wife helps. I am also depressed but I am used to being ill by now.

Family support plays as a mediating role in coping with the consequences of the illness as in M.F.'s case. However, living alone makes the chronic patient makes it more difficult to cope with illness. H.K (70 years old, female, living in Gültepe) states that:

> *6 yıldır romatizma var, 3 yıldır kemik erimesi, 3 yıldır göz ağrısı 2 kere ameliyat oldum kataraktan. Romatizma gözüme vuruyormuş tansiyon gözüme vuruyormuş. 5 yıldır yüksek tansiyon var bel fıtığı var. Bunlardan dolayı işlerimi dinlene dinlene yaparım. Yapamadığım zaman da çok olur bir başlar ağrı. O zaman istirahat ediyorum. Hemen hemen hergün öyleyim bu ara. Titreme oldu başım döndü, tansiyon hapım yoktu yanımda. Ben kimseye muhtaç olmayayım derim hep, başka çarem yok yalnızım. Beni yoklarlar gelirler hergün üvey torunlarım, kardeşim var onunla da birbirimizi yoklarız ama ne de olsa yalnızım. Mesela burda hırsızlık çok olur. Hırsız girdi geçen gün. Cama tıkır tıkır etti. Kimo dedim kaçtı. Gözüm de görmüyo. Beni üstümden dışarıdan kitlemiş. Bişey çalamadılar. Ben de bayılmışım korktum. Bi zaman sonra ayıldım kimse yok ki beni kaldıracak hep kendi kendime idare yapıyorum.*
>
> I have had arthritis for 6 years, osteoporosis for 3years, and eye pain for 3 years. I had 2 cataract surgeries. My arthritis and hypertension hurt my eyes. I have had hypertension for 5 years and hernia. These are why I work a little and then rest. Sometimes I can't work at all from the pain. Then I just rest. It's that way these days. I got the shivers, I got dizzy but I didn't have my blood pressure pills with me. I try not to be dependent on anyone. I have no other choice; I am alone. My step grandchildren check on me everyday. I have a sibling too but I am alone. There are many robberies here. A robber came the other day. There were sounds coming from the window. I said who is it so they ran away. My eyesight isn't good either. The door was locked so they didn't take anything. I fainted with fear. I came to but there is no one to help me up. I try to get by on my own.

In addition to lack of or weakening mobility as a consequence of illness, social relations also weaken. N.T. (45 years old, male, living in Baraj) has suffered from liver

inflammation (hepatitis) for three years, and has headaches and ear pain. He was also operated on due to hernia caused by carrying heavy objects in harsh working conditions. He expresses the weakening social ties due to chronic pain as follows:

> *6 aydır çok kötüyüm ama yine de zorlana zorlana çalışıyom. Daha doğrulamadım yeğenim vallahi bak. Kulaklarım doğru dürüst duymuyor. Gece saat 3'de kalkıp poğaça simit satıyom. Rahatsız olmasam neyse, zorlanıyorum. Geceler soğuk oluyor adam üşüyor. Asker harçlığı gönderiyoz. Elim yüzüm şişiyor kulağım duymuyor kulaktan iltihap akıyor. İşe zor gidiyom yani. Valla yeğenim mesela şu anda kimseye gitmeyiz yani gidemiyoz yalan yok başımın ağrısından, hastalığımdan. Duramıyom ağrıdan dinleyemiyom kimseyi ağrım çok. Sanki gelenler konuşunca kulağım daha bi ağrıyo zaten az duyuyom. Ben evvelden iyi kazanıyordum ama şu anda çökerttim. Neden dersen evvelden ben iyi kötü şey yapardım, yani elim ayağım tutuyordu. Rahatsızlığımdan bu yana kendimi iyi hissetmiyorum. Mesela inşaata gidiyorum çalışmaya diye çalışamıyorum. Karaciğer iltihabından dolayı bilhassa benim göğsüm ağrıyor. Bi de kafam ağrıyor. Yani seninle konuşurken bak nefesim kesiliyor yani. Adamı bayağı etkiliyor. İnsan ağrıdan sızdan bişey yapamıyor. Ben şu anda bak 60 doğumluyum mesela şu suratımıza bak mesela aynı yaşlı adam gibi gösteriyom kendimi öyle de hissediyorum. Yaşlı görünüyom herkes bana dayı diyor. Ben 42 yaşındayım beni gören 60-70 yaşında zannediyor torunun gelinin var mı diyorlar. Hastalık beni bu hale soktu işte. İşe başvuruyorum şaşırıyorlar beni görünce almıyorlar yaşlı diye.*
>
> I have been very bad these last 6 months but I still struggle to work. I still do not feel well. I am hard of hearing. I get up at 3 in the morning to sell pastries and simit. It would be okay if I weren't ill. It is cold at night and he's cold. We have a son in the military; we send him pocket money. I swell up, my ears don't work, and discharge comes out of my ears. I can barely work. We can't visit anyone because I am so sick. It's too painful. It feels like my ears hurt ore when people are talking. I used to make a decent living but now I can't. I haven't felt well since my illness. I go to construction sites to work but I can't. My chest hurts due to my inflamed liver. My head hurts. See, even talking to you I am short of breath. You can't do anything with the pain. I was born in 1960. Look at this face! I look and feel old. People call me uncle. I am 42 but people think I am 60-70. they ask me if I have grandchildren or a daughter in law. This is what the illness did to me. I apply for jobs but they won't hire me because they think I am old.

He also shares his view about the stigmatizing effect of the representation of body as the aged due to suffering from illness. The responses of social environment like seeing him as aged cause additional effect on his well-being negatively. This also indicates the identity of being elderly is not intended in society.

The sick role may force the sick individual into a different position in the *field* such as a dependent position. Being sick and being healthy are not assigned the same value and attribution in societies. Being sick, especially those who are kept from integrating into different fields of society such as work and social relations may have different health and living experiences. In addition, sick individuals who have lost their healthy state permanently—for whatever reason—are stigmatized in different areas of life. The position of individuals who suffer from long-term illnesses is not only determined by their ill-health state but significance, meanings, connotations, imagery, and stereotypes about the illness and "the sense of distinction" as being sick also determines the position of the sick individual in a social space. These

connotations of others sometimes lead to stigmatization and exclusion. As Bury (1991) states, the second meaning of chronic illness lies in its significance according to different connotations and imagery (p: 453). Below, there are some excerpts mentioning labeling, stigmatization and exclusion of the sick in different fields of society.

For the urban poor, being sick is an additional problem influencing their poor identity. There are some respondents who express that they have not received any assistance regarding illness and they emphasize exclusion from social environment. This is valid especially for those who have a relatively higher socio-economic position in the social network. İ.Ö. (40 years old, male, living in Baraj) states that:

> *Bir insan hastalandı mıydı çevre adamı dışlıyor. Kendi imkanlarımla her şeyimi satıp buraya geldim. Hasta olduğum için durumumuz kötü diye kimse yardımcı olmak istemiyor. Başkalarını bırak kendi kardeşin tarafından bile dışlanıyorsun. Ben senden para isteyeceğim zannediyor. Benden kaçıyorlar. Ben dışlansam nolacak dışlanmasam nolacak. Elhamdülillah şimdilik kendimize yetiyor. Onu gösteriyor durum. Benim 4 erkek kardeşim var burada hiçbirinden yardım görmedim. Benle beraber yedi tane oğlanız biz. Durumları iyi hepsinin. Sadece annem ayda 100 milyon karşılıksız para gönderiyor.*
>
> When you are sick people exclude you. I sold all I had to come here. Because I am sick and we are poor no one wants to help us. Even my own brother shuns me. He thinks I will ask him for money. They avoid from me. But it doesn't matter. Thank God we get by. I have 4 brothers, none ever helped. We are 7 male siblings. They all do well. Only my mother sends me 100million a month outright.

In addition to exclusion from the labor market, chronically ill individuals are also excluded from the social network in certain circumstances. Some chronically ill respondents or those in families where one of the members is chronically ill express this exclusion. The emergence of the illness causes unemployment and economic difficulties for many. Unlike many respondents, İ.Ö.'s close relatives' economic conditions are better. His brothers in Ankara work in the formal sector or as employee in public institutions. His exclusion, as he expresses, seems to be based on the poverty he lives in.

M.E. (51 years old, female, living in Baraj) has a husband who is paralyzed. She is always at home and looks after her husband. She states that after the onset of his bedridden state, their social environment began to exclude them. She states that:

> *Komşular iyi ama hiç gitmem onlar da gelmez. Evde erkek var diye kimse gelmez. Halbuki bu çocuk gibi yani kimseye bi zararı dokunmaz, felçli yatalak, ne konuşur ne hareket eder. Keşke birileri gelse diye gözlüyo insan. Anası babası bile arayıp sorduğu yardım ettiği yok. Unuttular iyice bizi. Herkes onları ayıplıyor ama yine de gelmek istemiyorlar. Eşim hastalandıktan sonra gelen giden yok. Bayramda bile gelmezler. Önceden*

bayramlarda gelirlerdi şimdi onda da gelmezler. Hepsinin durumu iyi. Bunun kardeşlerim buraya gelmemizi istemediler onlara yük oluruz diye para isteriz diye. Şimdi de ne arar ne sorarlar. O yüzden istemiyorlar, düşkünsün ya o yüzden.

The neighbors are nice but I don't go to see them and they don't come. No one comes because there's a man in the house but he's like a child. He is apoplectic and bedridden. He doesn't even speak or move. I wish people would come. Even his parents don't call or help. They have forgotten about us. Everyone thinks badly of them and still they don't want to come. No one does since my husband fell ill. Even during the religious holidays. The used to but now they don't. They are all doing well. His brothers didn't want us to come here. The thought we would ask for money and be a burden to them. Now they don't even call. They don't want you because you are destitute.

A.M. (35 years old, male, living in Gültepe) suffers from skin cancer. His bodily representation, his color, due to his treatment leads to stigmatization when he is applying for a job, when he is in a hospital, or on a bus. Not only does he suffer from the consequences of his illness, he also has t deal with society's reaction to his illness. The visibility of symptoms put more of a stigma on the sick individual. Also, he points out the negative reactions of his neighbors people when he obeys medical advice. He expresses that:

Şu anda benim ilerde düzelme ihtimalim yok. Benim ilerde kör olma ihtimalim %90. doktor öyle diyor. Gözlerim puslu görmeye başladı. Renkler birbirine karışmaya başladı rahatsızlığımdan dolayı aldığım haplardan dolayı. Benim 24 saat o gözlüğü çıkartmama lazım. Onu taktığımda insanla alay ediyorlar. Ayıplık onların. Mahallenin insanları yapıyor. Şöyle bir bakıyor, sen kendini ne zannediyon diye laf atıyorlar… Cilt kanseri olduğum için çalışamıyorum. Şimdi benim güneşe çıkmam yasak. Haftada üç gün makineye (ışın tedavisi) giriyom. Ama bana işe başvurduğumda haftada üç gün makineye giriyom diyom. Diyorlar ki kardeşim sen bize lazım değilsin. Aslında sana ihtiyacım var ama diyo bu durumundan dolayı seni işe alamam diyor. 2001'de başladı hastalığım 4 yıl oldu. Fototerapi de gördüm, kemoterapi de. Yaşım büyük değil. 35 yaşındayım ama, kendi yaştlarıma bakıyorum herkes çalışıyor en azından tatil günü var, hastalık günü var. Hem şu rengime bak kim işe alır beni. Makine yakıyor bir, bi de esmerim. Ben şuan çalışmayı öyle bir istiyorum ki ama karşı taraf iş vermeyince umutların da söniüyor. Noluyor bir darbe de ordan geliyor hastalığınla baş başa kalıyorsun iyice çökertme oluyor yani. İyice batağa giriyon yani. Zaten yarıya kadar girmişik ama böyle giderse iyice çökeceğiz çıkamayacağız bataktan... Ben nereye gitsem kendimi yabancı hissediyorum. Hastanede, sokakta, iş ararken, otobüste. Neden ileri geliyor biliyor musunuz? Renk. Şimdi rengin insanlar arasında çok ayrı bir şeyi var. Şimdi mesela hastaneye girdiğin zaman bütün millet şöyle bir döniiyo sana bakıyor. İnsanlarımız esmerliği çok ayırt ediyor. Garipsiyor. Mesela bir otobüse biniyosun sanki bişey var herkes gözünü sana dikiyor. Kendini suçlu gibi hissediyorsun sana bunu hissettiriyorlar. Neden yani bu ben ne yapmışım. Bir hata mı yaptık. Sağına soluna bakıyosun. İş için Çankaya'ya gittim bir büroya iş için. Şöyle bir baktı bana. Gözünü dikti bana. Kusura bakma kardeşim dedi alamam dedi. Niye dedim "renk" dedi bana. Düşün yani durumu. Yani ben bunları yaşadım. Bana karşı heryerde ayrımcılık yapıyorlar.

I don't have a chance of getting better. I have a 90 percent chance of going blind. My vision is cloudy. Colors blend because of my illness and the medication. I need to wear those glasses 24 hours. But then people make fun of me. It's their shame. The neighbors do this. I can't work because I have skin cancer. Now I can't go out in the sun. I have radiation therapy 3 days a week. I tell them this when I apply for work and they say they don't need me. Well, I need you but I can't hire you, they say. My illness started in 2001, 4 years ago. I have had phototherapy and chemotherapy. I am not old. I am 35 but my peers are all working at least they have holidays and sick days. Look at my color; who would hire me? The machine does it and I am dark anyway. I really want to work but no one will give me a job so I lose all hope. Another

> blow from there and I am left with my illness. Wherever I go I feel like a stranger. In the hospital, on the street, on the bus, looking for a job. Do you know why? My color. It is very different. I walk into a hospital and everyone stares. People find it strange t be so dark. You feel guilty. They make you feel that way. But what is this so* what did I do? I went to an office in Cankaya to apply for a job. He looked at me and said he couldn't hire me. He said it was because of my color. I am discriminated against everywhere.

E.A. (26 years old, male, living in Gültepe) suffers from epilepsy. Epilepsy, among other chronic illness, is distinct in terms of the visibility of the symptoms. He expresses that:

> *Geleceğimden korkuyorum. Ben rahatsızım o yüzden iş vermiyorlar. Epilepsi hastasıyım. Askerliğimi hastanede geçirdim. Askerliği yarıda bıraktırdılar rapor verdiler. Ben epilepsi hastası olduğum için çalışamıyorum, her yerde kriz gelebiliyor. Başka hastalık olsa neyse. Sara hastasıyım deyince değişik bakıyorlar. Bakmadığımız yer çalmadığımız kapı yok. Temizlik şirketleri, güvenlik, tekstil heryere baktık. Dışlıyorlar insanı hastasın diye. İş olsa da gitsem sürekli risk var her yerde bayılabiliyorum. Tehlikeli benim hastalığım. Ortalama ayda 2 hafta epilepsiden dolayı bir şey yapamam. Her hafta bayılırım çok utanıyorum, farklı bir yerde olursa diye korkuyorum küçük görüyorlar beni. Haftada bir hamallık yapıyorum pazarda artık pazardakiler alıştı şaşırmıyorlar ilk zamanki gibi.*
>
> I fear my future. I am ill so they won't give me a job. I have epilepsy. I spent my military service in the hospital. They gave me a report and discharged me early. I can't work because I may have a seizure anywhere. If it were another illness.. They look at me funny when I tell them my illness. I have looked everywhere for a job. Cleaning companies, security, and textile, everywhere. They shun you because you are ill. Even if I found a job there's the risk I could faint anywhere. My disease is dangerous. I can't do anything at least two weeks out of a month. I faint every week. It's very embarrassing. I am afraid it will happen somewhere else. They look down on me. I am a porter once a week at the bazaar. People there are used to my seizures. They don't get surprised like at first.

According to Goffman (1968), sickness and disability are discredited and lead to greater withdrawal from social participation, especially in public areas. Also Friedson (1970b) states that where the illness is stigmatized by others, the person's access to the sick role may be treated as "illegitimate" and the rights and privileges of the sick role are unlikely to be granted. Epilepsy is seen in this category. Epileptic seizures can happen anywhere. The Visibility of the symptoms in the epilepsy case makes it illegitimate. The meaning attributed to illness can impact upon the experience and the identity of the sufferer as E.A. mentions. Sociological studies on illness experience have increased recently, but epilepsy gets a great deal more attention as a stigmatized illness than other chronic illnesses (Kelly& Field, 1996: 243; Pierret, 2003: 8). According to Scambler and Hopkins (1986) "enacted stigma refers to instances of discrimination against people with epilepsy on the grounds of their perceived unacceptability or inferiority… Felt stigma refers principally to the fear of enacted stigma, but also encompasses a feeling of shame associated with "being epileptic"' (p:

33). These statements of Scamber and Hopkins are the best fit with what I felt while I was interviewing E.A. He expresses his fear of and warns me against the possibility of a seizure happening during the interview. Unlike other interviewees, it is striking that the words "shame" and "fear" are frequently used by E.A., especially when talking about his illness and poverty experiences.

5.5. Health Capital and Consequences for Health Experiences

As mentioned before, working conditions; low and irregular income; no or limited access to health care, makes urban poor vulnerable concerning their health, physical and/or psychological health and well-being. In this part, firstly, I mention the types of illnesses which the urban poor have and their well-being; then I will examine their health experiences: how they perceive and interpret health and illness, and lastly, which strategies they develop for seeking good health. In this part of the chapter, the main focus is on the differences in health experiences among the urban poor according to gender, type of access, identities, chronic illnesses or not, benefit dependency, and neighborhood settings.

5.5.1. The State of Health and Illness and Well-being

Health status is measured based on various indicators in the international and national contex. In this part, I do not use such indicators; instead I focus especially on subjective well-being and self-perceived illnesses. There is also information on medically diagnosed diseases of the urban poor. Among the respondents, not only "diseases of poverty" are prevalent, also chronic illnesses are commonly seen especially among the adults and elderly but also among the youths. There are many kinds of diseases, chronic[43] or acute. Although acute diseases are curable or prevented

[43] The classification of diseases as acute and chronic diseases is made by scientific medicine in order to distinguish their duration and development instead of severity. An acute disease lasts for just a short time, but begins rapidly and has intense symptoms. In contrast, a chronic disease produces symptoms for quite sometime lasting for three months or more. An acute disease can be mild, severe, or as even fatal as the chronic one. A chronic disease is persistent and lasts for a long time period and may recur. Chronic diseases with long duration and generally slow progression includes diseases such as diabetes mellitus, heart disease, stroke, coronary artery disease, ulcerative colitis, rheumatoid arthritis, asthma, hypertension, epilepsy etc. Acute diseases with short duration and rapidly developed symptoms include influenza, strep throat, measles, pneumonia, etc. (This information has been compiled from the official web site of World Health Organization, http://www.who.int and Modesto & Tamayose, 2004: 17).

via vaccination, among the family members of the respondents, children especially died from various infectious—curable—diseases. The majority of these deaths happened before migration when they were still in the rural areas. Infant and child mortality is closely related with lack of health services and health personnel, low income, and cultural perceptions about the significance of illnesses. As mentioned earlier, during their first years in the city, they had negative experiences like inadequate nutrition, which directly reflected on child health (See 5.2. details).

The number of illnesses among the respondents and other family members increase as age increases. While children frequently become ill from infectious diseases such as influenza, strep throat, pneumonia, bronchitis, excluding diseases from birt. The elderly and adults have chronic illnesses such as asthma, hypertension, heart disease, diabetes mellitus, rheumatoid arthritis, cancer, kidney failure, glaucoma, coronary artery disease, ulcerative colitis, stroke, osteoporosis, hepatitis, and chronic bronchitis. Among the children, there are cases of hip dislocation and aplopia, which require diagnosis and treatment in early ages. Also, there are cases of growth deficiency and hormonal imbalance. It is striking that various child illnesses are frequently seen among benefit dependent poor families. They suffer both from unmet basic needs and lack of access to health services. Although majority of benefit dependent poor have a green card, which provides free access to health care, the majority state the inefficiency of the green card especially when they try to get prescribed medicine. Also, the job-hopping and sectorial shift of the heads of household to informal sector prevent the continuity of treatment and cause a delay due to the change in insurance status. They try to cope without receiving health services by themselves so their children's health problems recur.

Another frequently found illness among the urban poor is hernia. There are 10 herniated disk cases. All women who work or used to work as daily domestic cleaners suffer from this illness. It might be assumed that working conditions do have an influence on the types of illnesses experienced. Another group frequently bothered by the same illness are those who performed work by carrying, loading, and lifting heavy loads. Also, there are some housewives with the illness. These 10 individuals were medically diagnosed with herniated discs but a considerable number of individuals in all 40 families have waste pain complaints (no: 10) and they have not yet gone to the doctor. In addition to occupation, benefit dependency is another factor. The majority

of them suffering from the illness are benefit dependent poor. All of them define themselves either as accommodators or losers after migration and for some time. Their illness experiences influence their lives negatively; some of them have had to leave their jobs or work in short time due to the illness or work. There is a close interaction between ill health and low income. While the working conditions can influence health negatively, the illness experiences can cause unemployment or may direct to part time work. So, it can be concluded that the sick individual's family, even if he/she is not the main income provider, becomes poorer.

Another most frequently cited illness is depression. More than a quarter of the families have ill individuals suffering from depression. All of them have been medically diagnosed, some have been treated; however, the illness for the majority continues, because their economic situation is either the same or worsened. Also many individuals state their feeling of dispiritedness, being stressed or depression but actually without having seen a medical doctor. The majority, whether medically diagnosed and the ones whoa are not, state that they are ill due to survival or economic difficulties. Besides, there is a difference according to gender. Depression is much more common among women (See 5.2. for details). And for most, the illness or complaints are mentioned as *hoca hastalığı* and the women usually apply to traditional healers for treatment (to be discussed below). The majority of individuals who have medically diagnosed with depression or complain about having depression are in the category of benefit dependent poor and strongly feel themselves as losers.

In addition, illnesses like ulcerative colitis (no: 8), heart diseases (no: 6), and hypertension (no: 12) are mentioned. Individuals with illnesses or complaints emphasize the economic conditions in which they live in. The majority of the individuals who have heart disease (no: 4) and complaints of heart palpitation and pain (no: 7) are male. While the majority of them are household heads, some transferred their main income provider position to their sons due to the illness. Majority of them are not elderly but they are adults (age between 29-51). The majorities of individuals who have these illnesses see themselves as recent losers and they actually are benefit dependent poor. While hypertension is frequently seen among the elderly, a considerable number of adult and young individuals also have the illness (no: 7). There were no families whose member(s) did not have a disease or any health complaints during the interview.

When we examine the period when their illnesses started, we encounter with a period of worsening economic conditions and consequent reduction in income. Reasons are listed follows: unemployment, bankruptcy, sectorial shift from the formal to the informal sector, and specific events such as the death of child in the family. For example, the majority of individuals who have medically diagnosed depression have not been treated yet due to financial problems. When we evaluate the etiology[44] from the expressions of the respondents, we observe that only few point out genetic reasons, behavioral reasons, and specific events, but the majority does stress economic reasons. However, we can not calculate to what degree the cause is behavioral or structural. The analysis here addresses at the perceptions of respondents. For example, I observed that almost all the male members of the 40 families, even including some chronic patients, smoke. They see themselves as loser in bad economic conditions. Some typical statements and perceptions of respondents about causes of their illnesses can be presented as follows:

A.A. (35 years old, male, living in Baraj) works as a waiter in a night club. He earns an income only from tips. His 8-year-old daughter died in a traffic accident a year before the interview date. His wife suffers from depression and headaches and all her teeth have rotted due to her daughter's death. This is an example of a specific event caused by a death. A.A.' wife states that:

> *Cebeci tarafında akrabalarımıza gitmiştik oğlanların elini tutuyordum ablalarıydı kızım. Yavrum aniden atladı arabaya bir anda oldu. Kızım kağıt gibi ordan oraya havada döndü. Orda vefat etti. İçim yanıyor. Gözümün önünden gitmiyor yavrum... Depresyondayım tedaviler de pek fayda etmiyor uyuşturuyor ilaçlar o kadar. Kızım vefat edince saçlarım beyazladı 1-2 haftanın içinde. Dişlerimin hepsi çürüdü. 29 yaşındayım ama gören 50 yaşında sanar. Evlat acısı kadar zor bişey yokmuş. Kendimi de suçluyorum.*
>
> We had been to some relatives in Cebeci. I was holding the boys by the hand, she was the older sister. She suddenly jumped in front of the car; it all happened in an instant. She was tossed into the air like a sheet of paper. She died there. I am extremely sad. I can't get her sight out of my head. I am in depression. The treatment is not helping; it just numbs me. My hair went white within a couple of week after my daughter died. All of my teeth rotted. I am 29 but people might think I am 50. Nothing is as painful as losing a child. I blame myself, too.

There are 5 traffic accident cases in our sample. Two resulted in deaths of children; the rest resulted in various illnesses. According to Ayata and Ayata (2003), among the poor, health problems stem from a number of factors: the high incidence of work

[44] Etiology is "the study of the causes or origins of disease or health problems, taking into account all predisposing factors of the disease" (Modeste&Tamayose, 2004: 43).

and traffic accidents; malnutrition; greater exposure to germs and disease in the house and neighborhood environment due to unsanitary conditions; delayed or insufficient medical treatment; in the case of women, giving birth to many children; higher incidence of violence in the neighborhoods; higher frequency of accidents hurting children in the absence of adult care and surveillance.

The other cause of illness is genetic. İ.Ö. (40 years old, male, living in Baraj) suffers from diabetes mellitus. This disease has damaged his his eyes and kidneys. He has lost eyesight in one eye and he suffers from kidney failure and hypertension. He lives being dependent on the dialysis machine. He states that his illness is genetic. Many deaths in his family resulted from this illness. His father, his uncles, his grandfather and his two brothers have diabetes like him. He states that:

> *1987-1988 arası şeker hastalığına yakalandım. 20 senedir şekernen uğraşıyorum. Son 5 yıldır böbrek hastalığıynan uğraşıyorum şekerden dolayı. Diyalize bağlı yaşıyorum haftada üç gün. Şeker gözlerimi de yedi. Her şeyi yiyo şeker aklına neresi gelirse. Biri görmüyor diğeri de iyi görmüyor. Kendimi çok hasta hissediyorum bazen yerimden kalkamıyorum diyazlize bağlı yaşıyorum şeker yıktı beni mahvetti. Ama yapacak bir şey yok ailede bir sürü kişi şekerden öldü çoğu da bu hastalığı çekiyor. Kardeşim de ayağını kestiler şekerden. Bizim hastalık irsi.*
>
> I got diabetes in 1987-1988. I have been dealing with it for 20 years. The last five years, I have been having kidney problems due to diabetes. I live on a dialysis machine 3 days a week. Diabetes destroyed my eyes, too. It has a bad effect on everything. One doesn't see, and the other doesn't see well. I feel very ill; sometimes I can't even get up. Diabetes destroyed me. But there's nothing to do. Many in my family suffered from it. My brother lost his foot; they cut it off. Its hereditary.

Ö.A. (25 years old, male, living in Baraj) suffers from congenital kidney failure. His illness is an example of a congenital illness; his mother suffers from chronic bronchitis due to poor living conditions, and his father is ill because of behavioral reasons according to Ö.A. He mentions that:

> *Annem bütün çocuklarını evde doğum yapmış. Bizi de ikizimle beni de evde doğum yapmış eş düşmeyince doktora gitmiş. Uzun zaman küvözde kalmışım. Kız kardeşim sağlıklı doğmuş. Doğuştan beri var hastalığım. İkizdik ben özürlü doğmuşum. Doğuştan damar tıkanıklığı damarda genişleme varmış. İdrar yollarında kist varmış alınmış. 5 yaşımda da ameliyat geçirdim. Sürekli doğduğumdan beri hastanedeyim. Hayatım hastanelerde geçiyor. 15 yaşında da kateter takıldı. Annem soğuktan kronik bronşit oldu. Bir sürü çocuk doğurmuş soğukta karda kışta çocuklarının bezlerini yıkamaktan yaşam koşullarından hasta oldu. 3 aydır hastaydı yeni yeni toparlanıyor. Penisilin vuruldu. Babamda da bacakta damar tıkanıklığı var 7 senedir. İki kere ameliyat oldu. Sürekli alkol ve sigara yüzünden oldu onunki.*
>
> My mother gave birth to all of her children at home. My twin and I were born at home too but my twin didn't come out so she went to the doctor. My sister was born healthy. I stayed in the incubator for a long time. My sister was born healthy. This illness is congenital. I have congenital atherosclerosis and enlargement. There was a cyst in the urinary tract but it was removed. I had a surgery when I was 5. I have been in and out of the hospital all my life. I had a catheter put in at age 15. My mom got chronic bronchitis from the cold. She had many

children in the cold in winter. She got sick from washing cloth diapers in the cold from the living conditions. She was sick for 3 months. Now she's a little better. She had a penicillin shot. My father has had atherosclerosis in his leg for 7 years. He had 2 operations. His is because of alcohol and smoking.

E.A. (26 years old, male, living in Gültepe) suffers from epilepsy. Traffic accidents, poverty experiences and working conditions are seen as the causes of the illnesses in the family according to E.A. As mentioned earlier and in this case, working conditions and poverty experiences are perceived as influential on the family members and at the same time illness experience leads to the loss of economic sources as E.A. expresses.

Ankara'ya geldiğimizden beri sağlığımızdan olduk. Ben epilepsi oldum. Trafik kazası geçirdim. Ondan oldu. Araba çarptı. Araba vurduğundan beri rahatsızım. Beyin travması geçirdim. Sürekli bayılıyorum neresi olursa olsun. İnsan nasıl can çekişir ben de öyle oluyorum kriz geldiğinde. 7 yıl oldu vuran kişi çarptı bana kaçtı. Çok borç altına girdik bu yüzden. Biriktirdiğimiz ev alacağımız paranın hepsi gitti. O zaman yeşilkartta yoktu. Babam bel fıtığı oldu ağır taşımaktan. Ben de de bel fıtığı başlangıcı var ben de çocukluğumdan beri pazarlarda yük taşımaktan böyle oldum. Annem 5 sene önce trafik kazası geçirdi felç oldu. Araba çarpacak diye korkmuş paniklemiş durmuş yolun ortasında çarpmış araba. Annem stresten çile çekmekten kalp hastası tansiyon hastası oldu. 30 yıldır çekiyor. Gittikçe ailece çöktük yani. Fakirlik bizi çökertti sağlığımızdan olduk diyebilirim.

We have been unhealthy since we got to Ankara. I got epilepsy. I had a traffic accident. That's how it happened. A car hit me. I had brain trauma. I faint everywhere. I have seizures. It has been 7 years. It was a hit and run. We have a lot of debt because of this. All the money we had saved up to buy a house is gone. There was no green card then. My father got hernia from carrying heavy loads. I have the beginnings of hernia. I have been porting at bazaars too. My mother has a heart disease and hypertension from the stress and agony. She has been suffering for 30 years. As a family we are destroyed. Poverty did this and we lost our health.

In addition to the illness histories of the family members in general, I examined the respondents' own evaluation of their health and well-being; physical and mental. There are three typical answers used to describe self-perceived health and well-being: bad, in-between, and good. However, respondents' perceptions of health and well-being are not the same. The majority of respondents make a distinction between physical and psychological health and well-being and they express that they feel good, bad or in-between by emphasizing physical health and psychological well-being separately. For this reason, the grouping should be made according to this distinction: respondents who feel bad both physically and psychologically; respondents who feel good both physically and psychologically; respondents who feel bad psychologically but good physically; and respondents who feel bad physically but good psychologically.

The number of respondents who feel bad both psychologically and physically at present constitutes the majority (no: 26). It is striking that some respondents feel bad both psychologically and physically but state their overall health and well-being as good or in-between. Among them, the explanations of overall health as in-between or variable are made according to illness experience such as pain and severity of illness.

G.B. (49 years old, female, housewife, living in Baraj) suffers from high ocular pressure, hypertension, and depression. The severity of her illness depends on the weather conditions as she expresses and the severity of her husband's illnesses at any given time.

> *Bende 20 yıldır depresyon, 7 yıldır göz tansiyonu ve yüksek tansiyon var. eşimde de 2-3 yıldır kalp ve tansiyon var. 1,5 yıldır da şeker var. bunlar hep yokluktan üzüntüden oldu. Beyimin işi yoktu. Kiralar faturalar. Yokluktan indir bulgur indir çorba sürekli gıda alabilir. Eşimin ailesinde şeker var ırsi ama kalp yok. Kalbi sıkıntıdan oldu. Adamın rahatsızlığı var son zamanlarda kalbi kötü o yüzden moralim çok bozuluyo. Maddi durumdan da bozuluyo. Son zamanlar havadan dolayı kendimi iyi hissetmiyorum. Bu ara devamlı kötüyüm mesela 2-3 gün iyiysem diğer zamanlar iyi değilim. Sisli havalarda kalbim sıkışıyor. Bitkin bir halde oluyorum, tansiyonum çıkıyor. Genel olarak sağlığım Hiç belli olmuyor. Mesela bir şeye canım sıkılır aniden tansiyonum çıkıyor o zaman sağlıksızım. Dışarı hiç çıkamam sisli havalarda çok sıcakta çıkamam göz tansiyonu var. Çok zor. Tuzu sıfır yerim. Yağlı yemek yemem. Hamur işi yasak. Bayat ekmek yerim. Perhizim çok. Mesela bir akrabaya gittim tuzunu normal katmış orda bir kaşık yesem kötüleşiyorum. Gözlerim görmez başım döner midem bulanır çok zor Allah vermesin. Gözümün önünde nokta nokta şeyler görüyorum.*

> I have been in depression for 20 years. I have had raised intraocular pressure and high blood pressure. My husband has had a heart illness for 2-3 years. He has ha diabetes for 1.5 years. All this happened because of poverty and sadness. He didn't have a job. The rent, the bills... My husband's family has diabetes but heart disease isn't hereditary. His heart got sick because of hardship. He's bad these days so I am very upset. Lately I don't feel well because of the weather. Foggy weather makes my heart constrict. I get exhausted, my BP goes up. My health is unpredictable. If I get upset about something my BP goes up; then I am unhealthy. I can't go out in foggy or hot weather, I have high eye pressure. Its hard. I eat no salt. I don't eat greasy food, no pastries or pasta. I eat stale bread. I have to diet. When I go to a relative's house, if I eat one spoonful of something with a normal amount of salt in it I start feeling bad. I get dizzy and nauseous and see spots.

Also, there are some respondents who feel bad both psychologically and physically presently but they state their overall health and well-being as good. When we examine their statements, they tend to thank God because they are not disabled, worse, or physically dependent on others.

While some respondents see themselves bad physically and psychologically focus on economic reasons for self-perceived health and well-being, others focus on directly on the illnesses they are experiencing. Thus, differences emerge between the statements of overall health and of psychological and physical health. In addition, it is complicated to distinguish their health and poverty experiences. From my

observations during the course of interview, it might be however concluded that factually health and poverty are more directly interrelated. When they talked about their illness experience frequently they switch the subject and started talking about poverty experiences and vice versa. This should be seen as an indirect indicator for the interlinkage of these two experiences. As mentioned earlier, there is a close interrelationship between illness and poverty. Illness may be a cause of poverty and existing working conditions, and at the same time it may be a result of poverty. The emphasis of low level of economic conditions is high among the benefit dependent poor and among those who see themselves at present as losers. Respondents who have a chronic disease emphasize their illness experience to explain their well-being:

M.H. (33 years old, male, living in Baraj) states that:

> *Bende unutkanlık baş ağrısı moral bozukluğu kalp ağrısı, eşimde 9 senedir depresyon, kızımda da gelişim geriliği var. Bunlar hep geçim sıkıntısından yetersiz beslenmeden oluyor. Ailece moralimiz hiç iyi değil. İşler kötü. Ağrım var kalbimde 10 gündür, olsa da olmasa da mecbur çalışıyoruz. Yaz aylarında çalışırken fazla düşünmediğimiz için daha iyi oluyorum. Kış ayında öfkeli sinirli oluyorum günü nasıl geçireceğim diyorum. Acaba yazın iş olacak mı olmayacak mı diye düşünüyorum. Seneyi nasıl geçireceğim diyorsun. 3-4 senedir sağlığımız ruh sağlığımız bozuk. Stres parasızlık işsizlik.*
>
> I am forgetful. I have headaches, depression and heart ache. My wife has been in depression for 9 years. My daughter has delayed development. It's all because of destitution and malnourishment. We are not well. I have had an ache in my heart for 10 days. We work no matter what. I don't think about it too much in the summer while working so its better. In the winter I am angry and don't know what to do with myself all day. I think about if I will have a job in the summer. You think about how you will get by this year. For 3-4 years we have been mentally and physically unwell. Stress, poverty, unemployment.

M.H. is a benefit dependent poor and he expresses that they are losers. Although he does not have any chronic illness or a disability he sees himself as unhealthy. Economic difficulties and the illness of other family members are closely associated as seen in the excerpt. While benefit dependent poor and especially "recent losers" tend to focus on economic difficulties when defining their health and well-being, income earning poor and especially doers tend to define their feeling healthy or unhealthy by focusing on their illness experiences. In addition, among the respondents, chronic patients and the elderly seem to make explanations about their health and well-being more frequently according to their severity of their illnesses.

The number of respondents answering with "good" good both psychologically and physically is very rare (no: 2). The common characteristics of them are that they are male household heads, have no medically diagnosed disease at the time being.

Respondents who feel good psychologically but bad physically are also both regular income earning poor and chronic patients. They are also very few (no: 4). They tend to focus on their illness and its severity when making explanations. All of them are chronically ill for a long time and they state that they have internalized being chronic patients and living with their illness.

Most of the respondents who feel bad psychologically but good physically are both benefit dependent poor and lack a chronic illness. Also, many of them suffer from depression, dispiritedness, and headaches because of irregular income and survival/subsistence problems. In addition, almost all of the benefit dependent poor respondents feel bad psychologically, especially focusing on economic difficulties. The statement below indicates how economic difficulties determine health status and the well-being of the urban poor. P.B. (23 years old, female, living in Baraj) states that:

> *Bu ara kış ya doğru dürüst iş olmuyor moralimiz iyi değil. Eşim amele haftada bir iki gün anca gidiyor bu ara. Eve para girmeyince de 15 gündür iyi değilim ne yapacağım diye başım ağrıyor. 3 çocukla çok zor oluyor. Biri okula gidiyor ihtiyaçları var. Eve para girerse çok iyi hissederim hiçbir yerim ağrımaz. Çok yokluk çekersek şimdiki gibi kendimi halsiz hissederim başım ağrır. Yatarım o zaman.*
>
> It's winter so there isn't much work. We are unhappy. My husband is a worker. He only goes once r twice a week. When there is no money, I get headaches thinking about what to do. Its hard with 3 children. One goes to school. He needs things. I would feel so much better if we had money coming in. I would have no aches. If we have no money like now I feel tired and have a headache. Then I go lay down.

In addition to the present perception of health and well-being of urban poor, the information of changing health and well-being after migration was asked. They tend to give both either negative or positive answers when describing the impacts of being and living in the city. Also, they tend to focus not only on their own health, but they refer to their whole families. Respondents who think that their health has become worse constitute the majority (no: 36). being in the city had positive consequences on their health, mainly because of better access to health care than in their villages of origin, few mention a relationship between their age and worsening health. Ö.A. (25 years old, male, living in Baraj) migrated with his family for health care access reasons. He states that while his health has been worsening, health care accessibility in the city had influenced his health positively. He states that:

> *Olumlu etkiliyor. Sağlık hizmetlerine burada ulaşabiliyorum. Ama hastalığım gün geçtikçe ilerliyor.*

It has a positive effect. I can get to health services. But my illness is progressing day by day.

F.K. (78 years old, female, living in Baraj) migrated 6 years ago. She already had some illnesses while she was living in the village. She talks by focusing on being elderly and refers to the positive influences of the city conditions in terms of access and physical conditions:

İyi yapar şehir yeri insanı. Sağlık iyi olmaz mı temiz yerde. Köylü ecik tozlu, dumanlı olur biliyon mu. Burda toz duman olmuyo. Bişey olmuyo burda. Yaşım geçti artık olur hastalık napacan. Şehir yeri naspın yavrum. Benim hastalık dolu diyom ya. Hiç tükenmez. Öliyom hemen hemen her gün. Allah vermiş hastalığı yükletmiş nöriyim. Doktora da gidiyom. Aha yine de gidecem kötüyüm gene.

The city makes you better. There is health where it is clean. The village is dusty and dirty. Here there's nothing. I am old so I have illnesses; nothing to do. What is the city going to do? I have lots of illnesses. I die almost everyday. I see the doctor but I will go anyway; I am not well.

The rest of the respondents who feel their health is worsening emphasize their poverty experiences, in particular illnesses resulting from dispiritedness (See 5.2. for details). Although they emphasize that their health has become worse, a considerable number of respondents feel that being in the city is crucial in terms of access to health care. In addition to economic difficulties, some respondents compare the village and city life in terms of food and air pollution. They think that air pollution and unnatural foods in the city have negative consequences on their health.. The below given answers express this emphasis. M.H. (33 years old, male, living in Baraj) is benefit dependent poor and he thinks that he is a loser both in his present situation and also after migration. He feels unhealthy both psychologically and physically. He focuses first on economic difficulties and then on village and city life in terms of food and malnutrition as:

Moral bozukluğu var sürekli işten dolayı. Tabi ki oldu sağlık açısından. Her istediğini alamadım parasızlığın yüzünden her istediğimi yiyemedim ama köylü olmuş olsak davarın olacak malın olacak sütün olacak yoğurdun olacak her şeyin olacak. Ama burada her şey parayla olduğu için istediğini alamıyorsun istediğini yiyemiyorsun. Tereyağı annem ben çocukken kalkardım yayık yayardı tereyağı çıkartırdı içinden mesela onu taze taze sabah kahvaltısında yerdik. O duruma bakarak öyle yaşamak başka burada normal 300 bin liralık yağla yaşamak başka. Yetersiz beslenemedik kısacası.

We are constantly unhappy because of work. It had effects on our health. I couldn't buy what I wanted and couldn't eat what I needed. If we were in the village we'd have a cow, milk and yoghurt and everything. But here everything is money, so you can't buy things. My mother used to make her own butter. We would eat that every morning. There's that, and then there's living here with butter that costs 300 thousand. We weren't able to eat well.

The other statment is from H.B (50 years old, female, living in Gültepe), who is regular income earning poor stands for a "doer". She states that she feels unhealthy physically but healthy psychologically. In addition to economic difficulties and age as sources of bad healthy, she emphasizes the food consumed in the village and in the city and air pollution as:

> *Sağlık durumuna bakarsan bizim memleket daha sağlıklı. Yeşilligi, sütü peyniri. Hiç hastalıkları olmaz. Ama burada kalkıyon yağından sütündn peynirinden her şeyinden hastalanıyorsun. Havası kirli. Köyde yaşayan akrabalarımız çok sağlıklı hem de uzun yaşıyorlar. Benim annem öyle gelinin annesi kaç yaşında kendi işini görüyo. benim annem horasan'da torpağnan ugraşırdı. Hep bişiler ekerdi kendi salatalığını soğanını domatezini fasulyesini patlıcanını biberini annem öyle sağlıklıydı ki. Birgüne birgün hastalanmadı. Doktora gitmiş İstanbul'da doktor demişt ki teyze sen nerde yaşamışsın. Köyde tarlada bahçada demiş annem de. Şaşırmış doktor her şeyi temiz çıkmış. Yani köydekiyle şehirdeki bir olmuyor. Bir sürü hastalık çıktı. Bir de çok sıkıntı sıkıntı çektik burada. Şunun şurası 3 yıldır rahat ettik herif emekli olunca. Önceden hiçbir hastalık yoktu. Yaşlanıyoruz da artık. 10 yaşındayken 20 yaşındayken başka şimdi başka. O zaman yiyebiliyorsun her şeyi şimdi yiyemiyorsun.*

> Our village is healthier. There's green, milk and cheese. No illnesses. But here the milk, butter and cheese make you sick. The air is polluted. Our relatives in the village are healthy and they live long. My mother and my sister in law's mother are old but they are able to all their work. My mother planted her own vegetables; she was so healthy. She never got sick. She went to a doctor in Istanbul and the doctor asked her where she spent her life because she was so healthy. She said out in the field and in the groves. It's not the same in the city and the village. Now there are lots of diseases. And life was hard here. We have only been comfortable for 3 years since he retires. Before that there were no illnesses. And now we're getting old. It's different than being 10-20 years old. Now we can't eat everything we used to.

The number of respondents who mention no change in their health is three: while one (L.S., 21 years old, female, living in Baraj) sees no change because is a very recent migrant, the other (M.D., 39 years old, male, living in Baraj) states not having been had an illness after migration, and the third, , M.B. (36 years old, female, living in Baraj) states that she could not have a baby but the city has positively influenced her situation due to the access to health care:

> *Sağlık için bura iyi hasta olunca hemen gidersin köyde gidemezsin. Köyde pek de hasta olmadım. Ama olunca hasta hasta çekiyon gidiyo. Mecbur kalmayınca gidemiyosun. Burda en azından sağlık ocağına gidiyon. Bana göre yok sağlığımızı olumsuz etkilemiyor. Valla ne bileyim hep aynı ne iyiye gidiyo ne kötüye. Evlenince çıkıyo tabi çocuğumuz olmuyor şimdi. Onun için gidiyoruz.*

> This place is better for health. You can go easily if you get sick, you can't in the village. I didn't get sick often in the village. But when you do get sick, you have to bear it you can't go unless you absolutely have to. Here at least you go the health center. I don't think it has a bad effect on our health. I don't know it's not getting better or worse. You have problems when you get married. Like now; we are having difficulty conceiving. That's why we go.

5.5.2. Health and Illness Perceptions

Here, the main focus is on how the urban poor perceive of and define health and illness. There are two studies considered to lay the grounds for understanding health perception of urban poor. Shilling (1993) argues that there are two perceptions for the body: body as "a means to an end" and "an end in itself". According to him, working class people's orientation towards illness and the body is conceptualized as "a means to an end" while middle class people treat the body as "an end in itself". For Bourdieu (1984), each class has its own *habitus* which "designates the system of durable and transposable *dispositions* through which we perceive, judge and act in the world" (Wacquant, 1998b: 220). These unconscious schemata as "acquired through lasting exposure to particular social conditions and conditionings, via the internalization of external constraints and possibilities" are shared by people subjected to similar experiences (Ibid: 220). Thus, the way the urban poor define health and illness is assumed to be different from how middle or upper class people would as Shilling (1993) points out in his work. Similarly, Pierret (1995) holds that an individual's type of concern about health matters and individual's general ideas about health changes according to the occupational classes. In the study, four health constructs were determined: health-illness, health-tool, health-product, and health-institution (See Chapter Two for details). Under the light of these theoretical arguments, I try to reveal the health constructs of the urban poor with both similarities and differences obtained by analyzing their definitions and explanations about health, illness, and the causes of health and illness in this part of the chapter.

Respondents' tendency to perceive the body and health as "an end" or "tool" is derived from the answers they gave to the question "Whose health is the most important among family members?". The majority of the respondents see health not as an end but as a tool. Holding manual jobs tends to lead to explanation like this. As stated earlier, all the (previously) working family members have/had manual jobs, so the health of the body is crucial. When the main provider of income becomes ill, this means living in even poorer economic conditions because becoming the breadwinner being ill prevents income. So the first focus among respondents is a healthy "male" body for survival. It is striking that the majority of women respondents give priority to their husband's health or to those who occupy breadwinner position in the family.

Except for two female-headed families, the rest of the families have male breadwinners. Female respondents tend to give priority to the breadwinner position because of the responsibility of the main income provider in the family and also children because of their dependency position in the family. The majority of female respondents do not pay attention to their own health unlike their husbands and children. They put their health in third place. The tendency to give priority to the breadwinner's health is more prevalent among the respondents whose family member in the breadwinner position works a daily/casual job. Similarly, the priority of the breadwinner's health is more prevalent among benefit dependent poor respondents. There are some different excerpts below.

P.B. (23 years old, female, living in Baraj) is a housewife and her husband as the unique provider of income is a daily/casual worker. Her husband earns an irregular wage so they are benefit dependent poor. She gives priority to her husband's health by stating:

> *Eşimin sağlığı hepimizden önemli. Çalıştığı için eve para getirdiği için.*
>
> My husband's health is more important than all of ours. Because he works and brings in the money

M. Ko. (33 years old, male, living in Baraj) is a self employed housepainter, as the unique income provider in his family. The priority given to the breadwinner's health is also stated by the breadwinner himself:

> *Ya şimdi tabi çocukların önemli ama bi yerde de aile reisinin. Benim sağlığım önemli hasta olmayayım ki çalışabileyim. Ha şimdi ben hasta olduğum zaman çalışamadığım zaman bu sefer çocuklar ailem aç kalacak.*
>
> Now of course the children's is important. But I am the head of the family. My health is important. I need to stay healthy and work. If I can't wok, then the family will go hungry.

A.Ay. (36 years old, female, living in Gültepe) is a housewife and her husband works in an auto body repair shop with insurance. They have been regular income earning poor for a long time. Her husband has one and half years of unemployment experience due to a workplace accident. She says that:

> *Beyimin, çocukların sağlığı. Beyim çalıştığı için çocuklar da muhtaç olduğu için. Dayanamam onlara bişey olsa.*

> My husband and my children's health. Because my husband works and the kids are helpless. I couldn't take it if anything happened to them.

In addition to the breadwinner's role as income earner and children as dependent position, some respondents give priority to their own health because of their role in the family as M.E. (51 years old, female, living in Baraj):

> *Hepimiz de sağlıklı olsak iyi de yok işte. Geri dönüş yok eşim için. Oğlana diyorum ben ona söylüyorum o bana söylüyor. Belim ağrısa bile bakmam lazım adama. Hizmet yapıyorum, iyi olmam lazım.*
>
> If only we were all healthy but no. There is no going back for my husband. I tell the boy but he tells me back. Even if my back hurts I have to take care of him. I am serving; I have to be healthy.

Some chronically ill respondents give priority to their own health because their illness requires special attention and management according to them. The common characteristics of the respondents who pay attention to all members' health among their family are the retired, unemployed, or economically inactive male members of the families.

Giving priority to those who occupy the breadwinner position in the family means the body and health is seen as a tool for earning income. Unlike the middle class perception of the body and health as an end, as Shilling (1993) emphasizes, the urban poor tend to see their health as a tool, because their main concern is, in general, poverty, lack of adequate and regular income, subsistence difficulties, etc.

Respondents' answers to "What does health mean to you?" can be categorized according to Pierret's study. Here, first I focus on how they perceive health. Defining health as the absence of illness is prevalent. Among the respondents, this explanation is organized around the tension between the absence of illness and the state of physical and psychological well-being. Unlike Pierret's study, a considerable number of respondents who see health as the absence of illness, physical or (and) psychological, emphasize contentment or peace of mind. With peace, respondents actually mean regularity and order. This way of defining health is prevalent among the benefit dependent respondents who earn irregular money. In addition to peace, some individuals define health as happiness and joy. The number of respondents who see health as the absence of illness focus both on physical and psychological well-being, only on psychological health which physical health is dependent on, and only on physical health is approximately equal. Respondents who define health as the absence

of illness by focusing only on physical health explain the concept health by relying on their own health experiences, such as physical pain as the consequence of being sick. More than half of the respondents define health as absence of illness as the first focus. In general, it is difficult to see the differences between them, because respondents' statements fit two or three constructs. It may be accepted as the way to define health with multiple or triple focuses which do not essentially conflict with each other.

M.D. (39 years old, male, living in Baraj) is a gas station worker and regular income earning poor. The excerpt below is an example of the health-illness construct with a focus on mental health and psychological well-being.

> *Sağlik akıl sağlığının yerinde olması insanın kendini iyi hissetmesi. Stres hastalıkların nedeni. Dinç olur kendini iyi hisseder.*
>
> Health is having good mental health and feeling good. Stress causes illnesses. (A healthy person) feels energetic and good.

On the other, the statement by İ.Ö. (40 years old, male, living in Baraj) is an example of the "health-illness construct" with the focus on physical health. He suffers from diabetes mellitus. He is benefit dependent poor and does not earn money. His family survives with social assistance. He makes an explanation based on his illness experience.

> *Vücut sıhatli olduktan sonra sağlıklı olursun. Moral de huzur da ona bağlı. Huzurlu vücudu işleyen insan sağlıklı olur.*
>
> If the body is healthy you will be healthy. Your mood and peace of mind depend on it. Someone whose body works peacefully is healthy.

B.B. (20 years old, male, living in Gültepe) explains the meaning of health as:

> *Hem bedenen hem ruh olarak insanın kendisini iyi hissetmesi demektir. Sabah mutlu kalkmaktır. İşte bugün şunu yapacağım bunu yapacağım der sağlıklı insan. Sağlıklı insan plan yapar yaşama bağlıdır…Düzenli spor, sağlıklı beslenme, düzenli uyku. İş sıkıntısı yaşamıyorsa düzenli geliri varsa zaten bunlar olur. Sağlıklı insan dinç ve huzurludur. Beden ve ruh sağlığı ikisi de iyidir. Ruhsal açıdan kendini kötü hissedenin zaten bedeni de kötüleşir. İş yaşamı düzensiz olan ağır iş yapan zaten hasta olur annemde olduğu gibi. Sağlıksız bir insan sabah kalkamaz. Okula gidemez işe gidemez. Dersini çalışamaz.*
>
> It means to feel physically and mentally well. It is getting up happy in the morning. A healthy person says I will do this and that today. He makes plans and likes to live. Regular exercise, a good diet, sleeping well. These will happen if there are no work problems and have a regular income. A healthy person is energetic and has peace of mind. If you feel bad mentally, your body will worsen. If you have harsh working conditions you get ill, like my mother. An

> unhealthy person can't get out of bed in the morning. H can't go to work or school. Cant study.

The first statement of B.B. reflects the *health-illness construct* in a way that unifies physical and psychological health. Among the respondents who see health as absence of illness, the tension between the physical and psychological health is felt. Some only focus on physical health like İ.Ö., some base their explanation on psychological health like M.D., and some think there are one like B.B. In addition to the way of seeing health as the absence of illness, he sees the cause of good health as a result of economic factors. Lastly, he sees being healthy as having the capability to continue everyday life. Pierret explains the health-tool construct, with the interviewees' statement as "when you get health, you get everything" (Ibid: 17). However, the statement which means the respondent sees health as tool is, "when you become ill, you cannot do anything", as expressed by B.B. The statement is such because the main focus is not health for the urban poor but the illness.

The second construct is "health as tool", which means that the body and good health is a tool enabling movement, work, going to school, performing domestic tasks; in brief, being capable of everything according to the respondents. In this type of explanation, health is seen as a capital. There is a close association with the view of health as tool and the performance of manual work, especially daily/casual work. In general, respondents do not see health as "an end" as found out earlier from the priority given to the health of different family members, but their focus is sometimes on the capability of movement, sometimes on the absence of illness, and sometimes on poor living conditions. For most of the respondents who view health as tool, health is seen as a function either for capability to move or for work. There is a close association between health, illness, and work. In addition to work, their illness experiences influence their definition. Respondents who have difficulty with physically movement due to illness tend to explain health in this way. When we look at the evaluations of chronically ill respondents, especially those who have difficulty moving and meeting personal needs, this way of explanation as a first focus is observed. It is striking that seeing health as tool is sometimes the first focus and sometimes additional. There is only one respondent who defines health as only a tool, who is chronically ill and has difficulty moving and meeting personal needs. The excerpts below reflect this focus:

M.E. (51 years old, female, living in Baraj) is housewife and his husband has been bedridden for long years. Her son is breadwinner and earn below the minimum wage with insurance. However, she focuses her husband's state when she makes explanation. First she defines health as absence of psychological illness. Existence of her illness, depression for long years, may be influential to focus on psychological illness. Then she gives importance to capability of the body and work. She states that the absence of illness is everything as:

> *Rahat olacan. Kafan rahat olacak. Huzurlu olacan. Stress sıkıntı moral bozukluğu hastalık yapar. Her işini tutar. Sağlık olmayınca dirlik olmuyor. Sağlık olmayınca çalışamıyon. Her şeyin başı sağlık.*
>
> You should be comfortable and have peace of mind. Stress and unhappiness makes you ill. You can't be comfortable without health. You can't work without health. It all starts with good health.

P.B. (23 years old, female, living in Baraj) is a housewife and her husband as the sole income provider works as a daily/casual worker. She views health both as a tool and an end.

> *Her işi yapabilmek demektir. Doktora gideceksin düzenli o zaman sağlıklı olur. Hasta olmaz. Kendine iyi bakar iyi beslenir her işi yapar. Vücudun hasta olmazsa herşeyi yapabilirsin.*
>
> It means being able to do all your work. If you go to a doctor regularly, you will be healthy. You take care of yourself, eat healthy and do everything. You can do anything if your body is healthy.

She defines health having the capability to do everything. Secondly, she defines health as a result. One of the factors resulting in good health is accessibility to health services. This explanation is common among those who have difficulty accessing health services, especially those such as green card holders and the uninsured. (See related subheading of *social capital* for details of the problems of green card holders and uninsured respondents).

S.A. (68 years old, male, living in Gültepe) defines health in terms of illness, end and tool as follows:

> *İnsanın bedeni her yönüyle bozulabiliyor, ruhu sıkıntıdaysa. Sağlık yiyeceğin giyeceğin olmasa açıkta kalsan ısınamazsan barınamazsan o zaman sağlıksız olursun. Bunların hepsi önemli. Bunlar olmazsa beyin yoruluyor. Yoksullukla hastalık aynı şey. Varlıkla olur temizlik. Ben de isterim hergün yıkanmayı. Sağlık kendine bakmak doğru düzenli sıhatli insanca kendinin doktoru olabilecek şekilde yaşamaktır. Bunun için de maddiyat olacak. İnsanın temel ihtiyacıdır sağlık. Bu da bu koşullarda olmuyor mümkün mü? O yüzden de insan sağlıklı olamıyor Çok önemli sağlık olmasa çalışabilir misin? Yürüyebilir misin?*

> Your body can worsen in every way if your soul is in distress. You will be unhealthy if you don't have food, clothes, heating and shelter. All of these are important. If you don't have these your brain gets tired. Poverty and illness are one and the same. Cleanliness happens with wealth. I would like to take a bath everyday. Health is taking care of yourself and living in a healthy was so that you can be your own doctor. For that you need money. It is a human's basic need to be healthy. But is it possible under these conditions? That's why you can't be healthy. It s very important could you work or walk without it?

He starts with the focus on psychological well-being, determined by poor economic conditions, or directly poverty itself, and continues to define healthy individual with focusing capability of work and movement. Now, we can pass the details of the construct of health as product, as the most touched upon

The sick especially the chronically ill who have difficulty to move easily or (and) the elderly make explanation in accordance with the construct health as tool or (and) health as absence of illness in most cases as a consequence of their illness experiences. The other difference is that those who make fatalistic explanations in terms of the cause of illness are the sick, and the majority of them are elderly as well. They emphasize that illness comes from God in addition to other factors. The below excerpt by M.F. expresses that:

> *Sağlık hem vücut hem ruh sağlığının iyi olması. Dinç olmak her işini yapabilmek demektir, çalışmaya gücü yetmek demek. Allahın takdiri bilemezsin nerden geldiğini hastalığın. Allah belirler onu da.*
>
> Health is having good physical and mental health. It means having the energy to do all your work yourself, to be able to work. It is God's will; you can't know where illness comes from. God determines that, as well.

M.F. defines health as being capable of work and being able to meeting personal needs. M.F. is retired and previously worked as a porter and furnaceman. He performed manual jobs like other currently/ previously working family members. His statements imply that he thinks the body is a tool. In addition, there is a fatalist explanation about cause of health and illness in addition to health constructs. This kind of explanation implies that health and illness come from God. Fatalist explanations of health are more prevalent among the elderly and the sick like M.F. Also, the "health locus of control" perceptions of respondents correspond with their perception about the cause of poverty. Fatalist explanations can be assumed to mean that health is seen as an outcome or an end. Some factors can be structural factors, some can be behavioral factors or some, like M.F. states, related with fate.

The last way of explaining health is seeing health as a result. This is the most complicated construct because respondents base their explanations on various factors which result in health or illness. This way of explanation is much more common among the respondents than other any other way of defining health. Poverty experiences and experiences of illness especially tend to cause explanations like this. In terms of "health locus of control"[45], almost all respondents who define health as product focus on structural factors such as unemployment, irregular and/or low income, directly poverty, inadequate nutrition and care, lack of access to health care due to lack of income. Only a few respondents mention behavioral factors such as harmful habits in addition to poverty experiences. There is no unique focus on behavioral factors which influence health or not; it is supplementary. The explanation that "health is a product" is a little bit different in terms of content. According to the findings of Pierret, interviewees whose explanation fit health-product "took health to be an objective to be reached, but they thought that reaching it depended on several factors" (Ibid: 15). This construct is prevalent among middle class people and was found to be associated with the view of health as an end and not a tool. In contrast, our respondents see a healthy body as a tool and not as an objective. There is no statement which connotes "health as an objective to be reached". Instead, on the one hand they see health as tool; on the other hand, they draw a close association specifically between poverty and health (actually illness). Unlike other constructs, a considerable number of respondents who define health as a product explain only by focusing on health as a result of such factors. It is not always a supplementary explanation. In addition, the most commonly seen statement defining health is the construct in which respondents see health and illness as the result of such factors, especially the structural one.

Some respondents who point out access to health care as a cause of being healthy are all either uninsured or Green Card holders. They point out that being able to access health care and have regular check-ups is one of the determinants of being healthy as M.H. (33 years old, male, living in Baraj) states:

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[45] Health locus of control means people's attribution of responsibility for their own health, reflecting whether they believe that their health is controlled by factors relating to their own behaviors or by external factors over which they have no control such as chance, fate, or structural factors (Modeste, Tamayose, 2004: 65, 83).

Sağlık kontrolünü sürekli yaptırırsan sağlıklı olursun. Ama şu an bilmiyorum doktora gitmediğim için. Doktora gitmediğin için de acaba neyim var diyorsun düşünüyorsun o da sende bir stres yaratıyor. Gitsen de doktora muayeneni olsan tertemiz. Hastalık işsizlikten düzensizlikten oluyor. Ruh sağlığını da etkiliyor insanın işsizliği psikolojisini bozuyor. Paran olursa kontrolünü sürekli yaptırırsan sağlıklı olursun.

If you have regular checkups you will be healthy. But I don't know now because I haven't been to a doctor. That causes stress because you don't know what you have. It's great to have a check up. Illness happens due to unemployment and disorder. It affects your mental health. If you have money and get regular checkups, you will be healthy.

He has not gone to any health care unit for himself because of inaccessibility. He is a casual worker and he has had a Green Card for one week. Other respondents who touch upon access to health care to explain being healthy have no free access to health care or have newly acquired a Green Card.

N.T. (45 years old, male, living in Baraj) suffers from several illnesses and poverty. He is in the category of benefit dependent poor and works as a *simit* seller. He defines health as a product by focusing on deprivation as follows:

Varlığa bağlıdır sağlık. Şu soba odun kömür olmasa şurda hastalandı mıydı, üşüdün mü hastasın. Yiyeceğin olmadı mı hastalık. Sağlık odur. Odununun kömürünün olması yiiyeceğinin olması sağlık odur. Varlık mesela kendi varlıklı olursa karşıdaki varlıksız olursa o senden varlıklıdır yani sağlıklıdır. Sen sağlıksız oluyon o zaman. ya yeğenim paran varsa sağlıklısın yoksa sağlıksızsın. Yokluktan geliyor sağlıksızlık bence. Yeğenim sağlıklı olmak ilk evveli şu anda kendime iyi bakmak. İnsanın kendinin sağlıklı olması için kendini çevreden korundurmak buna da para lazım.

Health depends on wealth. If you don't have a heater and wood and coal and you got sick you would catch cold and get sick. You get sick if you don't have food. That's health. Wealth; if someone is wealthier than you, they are healthier than you. Ill health comes from destitution. Being healthy is being able to take care of yourself. To be healthy, you need to protect yourself from the environment and for that you need money.

Similarly, E.A. (26 years old, male, living in Gültepe) explains health as a product by focusing on health care access as a factor like some other respondents mention.

Sağlıklı olmak çok iyi. İnsanın durumu iyi olursa sağlık da iyi olur. Maddi duruma bağlı sağlık. Hasta olsan hastaneye gidersin. Durumumuz iyi olmadığı için hastaneye de gidemiyoruz. Eğer hastaneye gidip de parayı ödeyemezsen seni hastanede alıkoyuyorlar. Sonra da cezaevine.

Being healthy is great. If you are well off, you will be healthy. Health depends on financial status. If you are ill you go to the hospital. We can't go because we don't have money. If you go and you can't pay they detain you there. Then it's off to prison.

He is epileptic and permanently in contact with a hospital. He stated that he was nervous and suffered from irregular heartbeat when he was in the hospital. During the

interview, he did not mention the experience of detainment in the hospital. After the interview, he talked about this experience. When the traffic accident happened 7 years before from the interview date, he had no insurance, nor a green card for health care access. He was detained in the hospital until the hospital expenses was paid. His family had to use the money which they had saved to buy a *gecekondu*. He was later released. Each respondent's explanation is thought in their own life experiences' context. Their explanation is generally based on these experiences.

M.Ay. (35 years old, female, living in Baraj) is benefit dependent poor and her husband is a daily/casual worker. She defines health as:

> *Hastalık şikayetinin olmaması, huzurlu yaşam demek sağlık.*
>
> Health is not having complaints, leaving in peace.

This is the reply to the question of "What is health for you?". Her answer fits the *health-illness construct*. When she talks about the causes of being healthy and the characteristics of a healthy individual, her health construct increased into two as follows:

> *Sağlıklı olmak huzura ve gelire bağlı. Hasta olmaz sağlıklı insan. Morali düzgün olur sıkıntılı olmaz. Evinin huzuru olur hepsi gelirine bağlı. Düzenli bi geliri olur. İşi olur. Parasız olursan tedavi de yaptıramıyorsun tedavin yarım kalıyor. Sağlıklı olmak için doktora gitmeli kontrole gitmeli insan.*
>
> Being healthy depends on peace of mind and income. A healthy person doesn't fall sick. They will be in a good state of mind and won't have problems. Your home will be peaceful; it all depends on income. A healthy person has a regular income; a job. You can't get treated if you don't have money; your treatment is left unfinished. You have to go get checkups to be healthy.

In general, having a job means having a formal job among the respondents. As stated earlier, individual who works in informal sector is counted as unemployed among the respondents, especially among the female respondents. Here, actually M.Ay. focuses formal job as a cause of being healthy. Health is seen a product or a result of formal job, and regular money. M.Ay.'s focus on the peace is much related with the regular income. She suffers from irregular money entrance into her household because of her husband's job. Lots of respondents make explanations dependent on both quality (regular/irregular) and quantity of their earned income. For this reason, the last excerpt is a kind of health as product construct.

N.D. (39 years old, female, living in Baraj) touches upon directly poverty as many respondents did. Lots of respondents see illness as the same as poverty like N.D. But unlike other respondents, she gives an example of inter-family relationships as a result of poverty:

> *Huzur elinde olması maddi yani sağlık. Hastalık yoksulluk demek. Elinde olursa huzurun olur, huzur olduktan sonra sağlık olur. Huzursuzluk yoksulluktan olur. Niye dövüşürsün sen evde herifnen, yoksulluktan dövüşürsün. Ya öyle değil mi? Ya elinde olsa huzurun olmaz mı?*
>
> Peace and having money means being healthy. Illness means being poor. If you have money you will have peace of mind and then health. Discontent comes from poverty. Why do you fight with the husband? Because of poverty. Wouldn't you have peace if you had money?

We can conclude that (1) the urban poor, in general, define health with more than one focus; (2) health-tool, health-illness, and health-product constructs are prevalent among them, but for the majority, they explain the relationship with their poverty experiences; (3) they tend to explain illness although the question is directly "what is health?"; (4) they tend to see the body and health as a tool, not as an end or objective to be reached; (5) in general, their experiences such as illness experiences lead them to their definition of health (6) the most common explanation is the health-product construct, which the respondents explain by focusing on social factors, especially meeting basic needs, economic difficulties, and health care access, (7) there are not so many differences in health construct according to gender, but priority given varies according to gender; women give priority to the breadwinner and/or the family and also women tend to focus on psychological health by using the word, *peace*; (8) the body and health as a tool or instrument for reaching the objective, i.e. earning income, is much associated with the male body due to males' breadwinner positions in the family, in general. Most of the female respondents especially express the distinction between rural work and urban work with their position. They generally say that they work in the rural *field* but only men work in the urban *field* (see 5.2. for details). So the focus for female respondents is on the male body. In the rural *field*, the entire family, regardless of gender and age, work as unpaid family workers. Giving priority to men's health as breadwinner in the urban *field* seems to be the "new disposition".

Health is the instrument for earning an income in general for our context. The findings seem to correspond, to a large extent, with previous studies' findings such as Shilling's distinction of "means to an end" and "an end in itself" for different classes,

the study of d'Houtaud and Field (1984), and Pierret's (1995) health construct (See Chapter Two for details). As mentioned before, Bourdieu expresses that people who are subjected to similar experiences -for our context it is the poverty experiences in the rural area of rural to urban migrants- share the *habitus* (See Chapter Two for details). The definition of health and illness reflects the dispositions of health *habitus* peculiar to urban poor. However, as seen in the findings, there are differences according to gender, access type, income level, the state of being chronically ill. We can say that the health perceptions of the poor are similar but not identical. The mentioned differences among the poor result in inner differences.

5.5.3. Health Seeking Strategies

In our context, health seeking strategies[46] describe what the urban poor do when they become ill or for promoting their health and how to cope with illness and the difficulties related with lack of access to health care. When we evaluate health seeking strategies in terms of methods utilized, we observe that the urban poor try to recover by themselves by using popular remedies. Except for chronically ill individuals, under medical monitoring, the action taken by respondents when they face health problems varies according to the illness or the severity of illness, or to what they called "necessary conditions". With necessary conditions they mean the type of the health complaint. In general, they prefer to not receive health services or can not; that is, they tend to seek remedies in the *popular sector*. There are many factors behind this tendency. The factors are related with economic factors, health care access, meaning attributed to a given illness, gender, and being permanently sick. These factors are interconnected. Low income and lack of social security seem to be the most powerful factors in the beginning. Also, the meaning attributed to pain and the type of illness is crucial in the decision of whether to consult a doctor (*professional*

[46] Especially the word "strategy" is used in the sis. However in the public health literature, health seeking behavior is commonly used. This type of wording indicates where the discipline focuses. Bury (1991) distinguishes the terms of *coping*, *strategy*, and *style* in the context of chronic illness. According to Bury, while the term *coping* means the "normalization" against the chronic illness by "maintaining sense of value and meaning in life in spite of symptoms and their effects", the *style* "refers to *the way* people respond to, and present, important features of their illnesses or treatment regimens" (emphasis in original) (Ibid: 461, 462). The distinction of three terms is done in the context of chronic illness. By considering of Bury's distinction, I use the *strategy* which "directs attention to the actions people take or *what people do* in the face of illness rather than the attitudes people develop" for him (emphasis in original) (Ibid: 461).

sector), traditional methods, or popular remedies. In terms of the gender dimension; women go to the doctor more than men in most cases; however, they go for their children. In general, they tend to ignore their need for medical assistance because of the combined effects of low income and inaccessibility. Although male health is given significance in families, they also tend to not seek health services like women because of a concern of loss of income when they spend too much time in hospitals. These factors determine "necessary conditions". They tend to distinguish between illnesses in terms of whether the remedy needs to be sought in scientific medicine and illnesses which may be coped with and managed by oneself. When they don't have the necessary status, they tend to "manage by themselves" or use "self-treatment". Most of the chronically ill respondents are out of this context, because they state that they have to receive regular medical assistance in order to live. For most respondents low and/or irregular income prevents them from allotting money for health. Remedies in the popular health seeking strategies identified as "managing" or "getting by" by the respondents include rest, herbal teas, eating vegetables and fruits, taking medicine without consulting a doctor. For many respondents, the severity of pain is the determinant for seeking health services. This is valid for many cultures; however, the pain does not point to a significant disease all the time. When they first experience a symptom, they tend to wait and watch to understand and evaluate the seriousness of the situation.

Suchman's (1965) sick role stages have been adapted to provide a conceptual tool in order to facilitate comprehension from the beginning of illness to recovery (or managing with illness for chronically ill individuals) namely, *symptom experience*, *assumption of the sick role*, *medical care contact*, *dependent patient role*, and *recovery and rehabilitation* (See Chapter Two for details). Also, Kleinman's (1988) distinction of the three healthcare sectors is important as a conceptual tool for health seeking strategies, namely: *the popular, the professional, and folk sectors* (See Chapter Two for details).

The first stage includes an experience, that is, what the respondents do and react when they begin to experience any change in their health. Except for most of the chronic patients (later presented), the first action taken by the respondents is the same for all. They tend to evaluate symptoms such as its change related to the severity of symptoms. While evaluating the symptoms, some respond with denial, some accept, some delay and wait for further development.

The first action generally is the evaluation of symptoms; taking action for practice varies according to the severity of symptoms as for L.S. (21 years old, female, living in Baraj):

> *Yatarsın dinlenirsin iyi olana kadar… iyice kötüleşirsem giderim doktora.*
>
> You lie down and rest until you are better. if I get worse, I go to the doctor.

In this stage, respondents use the *popular sector* or self-treatment methods such as rest, herbal teas, taking vegetables and fruits, and taking medicine. Taking medicine is more prevalent among them. Especially female respondents tend to take medicine for any pain like N.A. (28 years old, female, living in Baraj):

> *Ağrı kesici alırım. Nane limon kaynatırım üşütmüşsem. Geçmezse doktora giderim.*
>
> I take painkillers. I boil lemon zest and dried mint if I have a cold. If it doesn't go away, I see a doctor.

As a reaction to the symptoms, waiting for change in the symptoms is also common among respondents.

In the second stage, the individual who experiences symptoms shares his/her assessment with the "lay referral system" or informal social network for consulting and getting an opinion about health complaints. The informal social network is crucial for validation that she/he is sick or not. The opinion of people around the individual lead to what action she/he takes. Now the illness, aware by the individual, becomes a social phenomenon with this validation. S.B. (29 years old, female, living in Baraj) says that:

> *Beyime telefon ederim kardeşime danışırım o işlere yardım eder dinlenmeye çalışırım. Çok zor durumda kalırsam doktora giderim.*
>
> I call my husband. I ask my sister. She helps with the work. I try to rest. If I feel very bad, I go to the doctor.

In this stage, the meaning of illness, which changes from culture to culture, becomes crucial. The meaning attributed to illness is understood in this stage. Some illnesses are seen as important, some are not. The necessary conditions compelling them to get health care are defined by respondents. Crucial illnesses and symptoms are generally defined as the sudden and unexpected such as accidents, burning, bleeding, injury, broken and dislocated bones, persistently high fever, increasing pain, fainting, giving

birth, and heart attacks. When thesetake place, informal social solidarity has a crucial role among our respondents (See 5.3. for details). The case of illness is specific circumstances in which the most assistance is visible. The informal network plays a role especially if an illness happens suddenly, such as heart disease, cerebral hemorrhage, and domestic or traffic accidents. The assistance offered during a persisting illness is less than at the onset of an illness.

Symptoms which could be managed by self-treatment are defined as unimportant within the *lay referral system* such as influenza, headache, known pain, back pain, fever, and psychological illnesses. M.Ay. (35 years old, female, living in Baraj) states in which conditions she would consult a physician as:

> *Başvuramıyorum işte parasızlıktan. Çocuklar aşırı ateşli olur da ateşini düşüremezsem götürürüm borç bulur yine götürürüm.*
>
> I can't go because I don't have money. If the kids have a fever and I can't get it down, I take them. I find someone I can borrow money from and I take them.

Similarly, Mus. B. (51 years old, male, living in Baraj) states that:

> *Çok ciddi durumlarda. Ağrılaşırsak yerimizden kalkamazsak. Yaralanma kırık olursa.*
>
> In very serious situations. If we can't get up. If there is an injury or a broken bone.

The role of economic conditions and inaccessibility are important in going onto the next stage. Howsoever *lay referral system* accepts the sick role, lack of money and access prevent them from going to the next stage or cause a delay. The general tendency among the urban poor is the experience of the first and second stages. Respondents tend to not consult the *professional sector* in spite of awareness of the severity of the illness and legitimization by the social environment such as other family members, relatives, or neighbors. Here, poverty experiences play an important role with the combined effect of *economic* and *formal social capital*. Also, *informal social capital* plays a mediating role in consulting scientific medicine. High significance attributed to illness tends to make them seek a remedy from medical units; low significance tends to make them to see if the illness will be rendered tolerable with self-treatment. On the one hand, social constraints keep them from seeking medical assistance all the time, on the other, they get used to the situation and the self-treatment as the remedy internalized by individuals.

M.A. (30 years old, male, living in Gültepe) is unemployed and in depression. Although he entered the sick role previously, he could not go to the doctor this time because he is uninsured and has no money allotted to the necessary medical examination and treatment. He expressed that:

> *Doktora gidemiyorsun hastalıktan ölsen para lazım. Sigortam da yok yeşilkartım da. Hiçbirşey yapmıyorum, gidemiyorum. Sigortam olmadığı için param olmadığı için gidemiyorum.*
>
> You can't go see a doctor. Even if you die of illness you need money. I don't have insurance or a green card. I can't do anything because I don't have insurance.

Poverty is not only an important obstacle for receiving health services, but also for commuting to the city center in the first place, which leads the respondents to forego the services. This is not rare; a considerable number of respondents emphasize commuting expenses as a hindrance for getting medical assistance as M.H. (33 years old, male, living in Baraj) mentions:

> *Çok oldu doktora gidemediğimiz parasızlıktan. Gidecek olsak bile yol parası bile sorun.*
>
> Many times we have been unable to go from destitution. Even if we could go even the commuting fare is a problem.

The commuting expense is not only important for benefit dependent poor; some regular income earning poor respondents also emphasize this problem as H.Ay. (27 years old, female, living in Gültepe) expresses:

> *SSK lı olsak bile yoktu para yoktu ki götürem. Kızım uykuda bayılmıştı. Param yoktu götüremedim. Yol param yoktu.*
>
> Even though we have SSI we didn't have money to take her. My daughter fainted in her sleep. I couldn't take her because I couldn't afford it. I didn't have the commuting fare.

Being insured or having a Green Card for free health care access and also having money while feeling ill play a crucial part in whether or not one can go on to the next stage, what Suchman (1965) called, "medical care contact". *Medical care contact* very rarely happens among the respondents here. There are many factors in addition to being uninsured and lack of money. The most common one is bureaucratic difficulties within the hospital or at any health care unit such as long waiting lists and actual lines for medical examinations, tests, and treatment. The duration of the time spent in the hospital is important for the urban poor, especially for those who are the breadwinner

of the family. L.A. (40 years old, male, living in Gültepe) touches upon the problems faced in hospital settings, which keep him from seeking health services as:

> *Pek doktora gitmem. Çok fazla zaman alıyor ağrımı çekerim. İdare ederim. Bi gidersem 1 ay hastaneden çıkamam. Kendimi korumaya çalışırım. Maddi gücüm yeterse de doktora giderim. Çok acil olursa giderim doktora. Bir insan kötüleşeceğini hisseder. Bazı hissedemeyeceği şeyler de olabilir. Moral bozukluüğu etkiliyor insanın sağlığını. 600 kilo kömürümü çaldılar ona canım sıkıldı. Kalbim sıkıştı doktora gitmedim önemsemedim. Gidip bir de doktorda mı sıkıntıya düşecen diyom psikolojin bozluyor gitmiyorsun. Hastanede daha kötü oluyorsun. Oralarda oyalanmayayım diyorsun. Gitmeyince de küt diye yatalak olabiliyorsun. Bu ara kalbimde sıkışma oluyor. Geçen gün yürürken rahatsızlık meydana geldi. Göstermedik gitmedik. Bir anda ağrı girdi. İmkanlar elvermiyor gidemiyorum. Yeşilkart var. Ama yeşilkarta sıkıntı var. O ortamda çok zaman geçiyor. Kendi sağlığınızla ilgilenecek boşluğu bulamıyorsunuz ki. Gelir düzeyini yakalayamamışsın 3-5 gün hastanede geçireceksin çalışamayacaksın. En az o kadar. Bunun tedaviye başladığı zaman 1 ayı geçer. E benim para kazanmam lazım. Öyle saçma işler yaptırıyorlar ki*
>
> I don't go to the doctor often. It takes too much tie so I just bear the pain. I get by. If I go I won't be able to leave the hospital for a month. I try to protect myself. I go if I can afford it. I go only if its an emergency. You feel it if you are about to worsen. There could be things you can't feel are coming. Being unhappy affects health too. They stole 600 kilos of coal from me. That upset me. My heart felt constricted but I didn't go to a doctor. I didn't make a big deal of it. You think why go to the trouble of seeing a doctor? Your state of mind is disrupted. You get worse in a hospital. You think I shouldn't waste time there. When you don't go you might be bedridden suddenly. These days I have a problem in my heart. It happened while I was walking the other day. I didn't go. A pain came suddenly. I can't because I can't afford to go. I have a green card but it's problematic. You waste a lot of time. Its hard to find time to deal with your illness. You don't have money and you're supposed to spend 3-5 days in the hospital and not work. At least that long. When you start treatment it will take at least a month. But I have to make money. They make you do such ridiculous things.

Spending long periods of time in a hospital setting leads to work days missed and so it reduces income obtained from work. As mentioned earlier, the breadwinner's health is seen as more significant among other family members for many respondents. However, if we look at the action taken by the breadwinner, we see that they tend not to seek medical care when they feel ill. L.A. expresses that his health comes first because he earns the family income. In this case, there is an inconsistency between what he thinks and what he does. This is much related with the concept of "the logic of practice" proposed by Bourdieu (1977). Bourdieu (1977) proposes that "practice is neither the mechanical precipitate of structural dictates nor the result of the intentional pursuit of goals by individuals but rather the product of a dialectical relationship between a situation and a habitus" (p: 261). There is tension between the *habitus* and the *field*. Sometimes the rules of the *field* dominate; sometimes the internalized cultural values embedded in an individual agent, specifically in the body, dominates the practice. As Wacquant says, "the theory of social space, group making, and symbolic competition is generalized in *The Logic of Practice,* in which two modes of domination, personal and structural, are differentiated and their workings traced via

the molding of the "body as analogical operator" of the practice" (emphasis in original) (Wacquant, 2002: 553). In L.A.'s case, not seeing a doctor for his health complaint as a practice can be viewed as the product of this dialectical confrontation. Here, social structure overturns mental structure via the internalization of the rules, or the structure of the working mechanism of the urban *field*. The domination of the personal and structural works differently for different groups of people who share similar experiences. I think that the lower position that the urban poor occupy within social space due to their lack of the capital forms deemed valuable or functional in the *field*, results in widening the gap between what they think and what they do.

The fourth stage is the *dependent-patient role stage*, in which the ill person makes a decision regarding the illness and treatment after the validation or legitimization of the illness by the doctor. Their decision is influenced by low income and accessibility to health care. These factors keep them from meeting the requirements of the treatment. After the diagnosis of the illness by a medical doctor, the accessibility of and the money required for treatment and health maintenance becomes problem. In some cases, it leads to delays in seeking treatment and therefore the advancement of the illness as in O.G. (34 years old, male, living in Baraj)'s case:

> *2 sene önce kalp krizi geçirdim. Daha yeni ameliyat oldum. 5 damar tıkalı 3'ü başarısız geçmiş. Daha kötü olduk. Geç kaldık 2 senedir var hastalık. Yeşilkartı alamadık o yüzden geç kaldık. Yeşilkart çıkar çıkmaz ameliyat oldum. Allah razı olsun devletten. Dükkan üstümde görüniyordu o yüzden çıkartamadık yeşilkartı. Parasızlıktan gidemedik.*
>
> I had a heart attack two years ago. I just had a surgery. 5 blood vessels were clogged; 3 weren't successful. It became worse. I have had this for 2 years so this was done late. We couldn't get the green card; that's why we were late. I had the operation as soon as I got the green card. Thank God for the government. We couldn't get the green card because the shop was registered under my name. we could afford to go.

Being insured or holding a Green Card for free access to health care is deemed important among respondents for access to health care; however, the insured could not buy medicine prescribed for treatment because they could not afford to pay the percentage of the medicine. The husband of Ö.Ö. (45 years old, female, living in Gültepe) is uninsured because he was recently fired. However, he had access to health care for another 6 months after being laid off. She states that:

> *Şimdi ilaç alamıyorsun. İlaçların yüzdesini bile veremiyoruz. Doktora para olmayınca gidemiyoruz. Sürekli öksürüyorum. 1 senedir var gidemedim doktora. Ilaç içiyom kendi kendime. Parasızlık yüzünden gidemediğimiz çok oldu. Sayısız. Yol parası bile bir sürü. Gidemediğim zaman parasızlık yüzünden gidemiyorum.*

> I can't buy medicine. We can't even pay for the necessary percentage of the cost. We can't go to the doctor without money. I cough all the time. It has been a year and I haven't been able to go. Just getting there costs a lot of money. When I can't go its because I can't afford to.

The type of doctor-patient interaction is evaluated in this stage as institutional experience. Obeying medical advice is seen as a patient's responsibility which should be performed if she or he wants to recover from the given illness according to Parsons (1952) (See Chapter Two for details). However, economic factors and inaccess to free health care prevent them from going along with medical advice such as taking medicine, as mentioned above, practicing diet, getting a check-up, etc. Although the individual decision is based on these factors in most cases, some respondents state that they do not change their eating habits. This is not only seen among temporarily ill urban poor, but also very few chronically ill urban poor individuals state this. There is a gap between what people want for recovery and what people can do. M.Ç. (45 year old, female, living in Gültepe) states that:

> *Doktor diyor ki acı yeme tuzlu yeme şunu yeme bunu yeme. Acı olmazsa olur mu yemeğin tadı olur mu? Vageçemiyoruz bunlardan. Mide ağrısından da duramıyoz tabi.*
>
> The doctor says not to eat spicy, salty food and this and that. What taste does food have if its not spicy? We can't give these up. But then its hard to bear the stomach ache.

Smoking is another important tendency although the doctors advise not smoking.

For the mentioned reasons, some respondents employ some informal/illegal ways to cope with treatment expenses. These ways include using the prescription record books (*sağlık karnesi*) of people close to them in order to get prescriptions or medical examinations, and the use of illicit medication. These kinds of informal remedies help them cope with illness situations. These kinds of strategies are quite common among especially chronic patients because they can not afford even 20% of the medicine's cost, which people with the official book pay, as they state. As a cancer patient and benefit dependent poor with a Green Card, A. M. (35 years old, male, living in Gültepe) talks about his strategy of obtaining medicine illegally:

> *Ben doktora dedim ki "hocam dedim ben şuanda işsizim yani benim durumum bu. Bana diyorsunuz ki işte haftada 3 gün makineye gireceksin. Şu şu ilaçları kullanacaksın. İlacın %20'sini ödüyorsun. Zaten garibanız ben nerden bulayım ben parayı. Bana yeşilkartı vermiş devlet, ilacın %20'sini ödemek zorundasın. Benim ilacım 1 milyar İtalya'dan geliyor. Aylık kullanmam lazım. Alamıyoruz, %20'sini ödeyemiyoruz. Daha ödemeye başlamadık ayda yapar 200 milyon ben bunu çalışmazsam nasıl ödeyeyim zaten hasta olduğum için doğru dürüst çalışamıyorum. Parasızlıktan dolayı sıkıntımız çok oluyor. Yeri geliyo bana ilaç yazıyo. Eczanenin vermediği ilacı bile bana yazıyo. Sonra sana bul diyor. Ben bunu bulamadığım zaman nolacak.*

Kaçak ilaç almaya sevk ediyorlar insanı. Kaçak satılıyor. İzmir caddesinde amerikan pasajında satılıyor. Kaçak satılan ilacın bir kutusu 55 milyon bana yazıyor 10 kutu ben bulamıyorum ki 550 milyon nasıl alacağım. Kaçak ilacı bile tam alamıyoruz parasızlıktan.

I told the doctor, "Sir, I am unemployed. You tell me go in the machine 3 times a week. Use these pills. You pay 20% of the cost of the medication. I am already poor. Where can I get this money?" The government gave me a green card but I have to pay 20%. My pill costs 1 billion and it comes from Italy. We haven't started paying. I have to buy it every month. This costs 200 million a month. How can I pay this if I can't work because I am sick? Sometimes the doctor prescribes even medicine that the (green card compatible) pharmacy doesn't have. Then what? They push into buying illicit medicine. They are sold in Izmir caddesi in the American mall. The doctor prescribes 10 boxes of the pill. The illicit drugs are 55million a box. How can I find 550million? We can't even get these.

Similarly, Kardam and Alkaynak (2003) identify certain strategies utilized by poor women in their research such as using another person's Green Card. Among our respondents, they do not only use someone else's Green Card, but also their social security schemes such as SSI, RF, and Bağ-Kur. The general tendency is that those who have SSI, RF, or Bağ-Kur as social security scheme or Green Card as social assistance use their prescription record book for meeting the need of medicine of the urban poor. They use their *informal social capital* for investment into their *health capital*. M.Ay. (35 years old, female, living in Baraj) indicates that:

Kızımın öğretmenlerinden çok destek gördüm kendi karnelerine ilaç yazdırdılar hep.

My daughter's teachers helped me a lot. They got prescriptions in their book for me.

Efforts are made to resolve difficulties in health experiences related with access problems by using the informal solidarity network. In general, the urban poor solidarity network for coping with difficulties of health care access and access to free medicine is less, because they have no adequate network to overcome these difficulties. However, a considerable number of respondents state that they benefit from the social network in the case of access to health care or the purchase of medication. They frequently use the word "managing" or "getting by" for health seeking strategies. It also includes these kinds of remedies. These kinds of strategies are only used by the uninsured and Green Card holders. G.B. (49 years old, female, housewife, living in Baraj) expresses that:

Beyimin kardeşi çok yardımcı oldu onun karnesine yazdırıyoruz. Bir buçuk yıldır idare ediyoruz, kaynımız karnesinden. Her işlemi yaptık muayene de olduk ilaç da aldık. Yeşilkartla ilaç alamıyoruz ki. Çok zor.

> My husband's brother helped a lot. We used his book for the prescriptions. We have been getting by for a year thanks to his book. We got every procedure; had checkups and got medication. We can't get medication on the green card. Its very hard.

The fifth stage, Suchman (1965) identifies, is recovery and rehabilitation. In this stage, the patients either leave the sick role or continue to live with the role: it depends on the type of illness. In terms of the effects of lack of *economic capital*, the main point is related with incomplete treatment or delaying the treatment due to economic difficulties. This tendency is seen among many respondents. They continue to be sick because they could not complete the treatment and their illnesses recur as M. Ko. points out:

> *Kızda hormon bozukluğu var, 6 yaşında göğüsleri çıktı. Bir sene biz ona kan almalar, tahliller her şey yapıldı. Şey yine de bilmiyoz. elki ilerde 15-16 yaşında belki bir zararı olabilir. Onu da bilmiyoz hani. O zaman maddi durum olmadığından yeşil kartı da iptal edince biz kaldık. Özele götürdük 200 milyon diyo hani bir muayenesi. Birisi tanıdık amaçlı gittik hani o da para almadı bi sefer götürdük. Nasıl götürelim parayla. Bir film istiyor bir kan tahlili istiyo özelde. Ha o da dünyanın parası…Çocuğu bir daha götüremedik. Bir de şu anda kızımın cücelik raporu var. Cüce kalır diye rapor verdiler, çocuğun boyu hani uzamaya başlayınca, hani uzamaz dedilerdi, bir daha götürmedik.*
>
> The girl has hormone problems. She got breasts when she was 6. One year we had everything done. Blood tests, other tests. We still don't know. Maybe it will be bad when she's older, 15-16. We don't know that either. We had no money then and our green card was revoked. We had to take her to a private hospital and would have 200million for just one check up. But we knew someone. Otherwise it would have been impossible they want X-rays and tests in the private hospitals. It costs a fortune. We have never been able to take her again. And now my daughter has a dwarfism report. Then she started getting taller. They had said she wouldn't so we didn't take her again.

There are many cases where people could not afford the treatment and so could not complete this stage. There are also some cases of detainment at the hospital and foreclosure due to hospital expenses. The families subjected to these events were uninsured when they were in the hospital. They had to stay in the hospital against their will because of emergencies such as a traffic accident, cerebral hemorrhage, and going into labor. M.Ay (35 years old, female, living in Baraj) talks about the foreclosure:

> *2 milyarı geçik devlete borcumuz var. Hastanelerde ameliyat oldum icra. Elektriği kaçak kullandık tam 1 milyar ceza kestiler. Sezeryan oldum borçlu kaldık. İcra geldi. 1 hafta oldu aldık yeşilkartı. İcra memuru geldi baktı vaziyete. Buzdolabına baktı senin mi dedi, kaynımın dedim. Bacım halında kiliminde ne var dedi, evde alacak bişey yok dedi. 6 ay oldu. Bu eşyalar para etmez dedi. Daha da sonuç çıkmadı. Borç 380 milyon faizi ile 780 milyon. 3,5 yıl oldu. O zaman yeşilkartımız yoktu. Ben hep kara gün gördüm. Allah çileyi benim için yaratmış şimdi de ben dış gebelik oldum. Kanama oldu gece götürdüler ameliyata aldılar beni. Oradan da 800 milyon borcumuz yine geldi icra. Mahkemelik olduk. Dikişlerimi alınması lazımdı ona bile gidemedim.*

> We owe the government over 2 billion. I had an operation; then came foreclosure. We used electricity illegally. The fined us 1 billion. I had a caesarean, we couldn't pay. Foreclosure. After a week we got the green card. The foreclosure officer came. He asked if the fridge was mine I told him it was my brother in law's. He said we had nothing he could take. These things weren't worth any money. We haven't heard back yet. The debt is 380 million but it is 780 million with interest. It had been 3.5 years. We didn't have a green card then. I have always been very unfortunate. God created problems for me. Now I just had an ectopic pregnancy. I was bleeding so they took me at night and operated. We owed them 800 million for that. Foreclosure again. We are in court. I had to get my stitches removed and I haven't been bale to go even for that.

B.B. (20 years old, male, living in Gültepe) talks about the detainment which happened to his brother's wife:

> *Yengem doğum yaptı 2 sene önce. O zaman yeşilkartları yoktu. Hastanede tutttular göndermediler parayı bulana kadar. Komşulardan borç aldık bulduk buluşturduk neyse çıktı 10 gün sonra hastaneden.*
>
> My brother's wife had a baby two years ago. They didn't have a green card then. they kept them at the hospital. Wouldn't let them go until they paid. We asked people and borrowed and got them out 10 days later.

Suchman's illness stages take place similarly among the urban poor; however, the transition from one stage to the next and the completion of the sick role is influenced to a large extent by mentioned factors. What about health maintenance? How do the urban poor protect their health? Is there any awareness about health? Recently, individualism in health, lifestyle, and health behavior has become popular topics especially after disease patterns and causes of mortality changes with the health transition. By the raising awareness of "new health consciousness", "healthism" (Zola, 1972) or "self-care" (Bunton, 1998) supported by neoliberal policy, the behavioral aspects of health have become important (See Chapter Two for discussions). There is tension between the structure and the individual. However, here I do not focus on the individual behavior from the perspective of individualism or structuralism. I try to understand the relationship between the *forms of capital* possessed by the urban poor, *field*, and *habitus* in the case of their health experiences.

Health promoting behavior**,** closely related with their relationship with their body and health, seems to be practiced more by middle class people than the poor. According to Shilling (1993), while the body is "an end itself" for the middle class, it is "a means to an end" for the working class. He states that middle class people are engaged in such activities as exercise, diet, consumption of healthy food, etc. As discussed before, the urban poor have an instrumental orientation toward health and the body. In this respect, their preventive behavior seems not to be in the center of their life. When we look at what the urban poor do to protect their health, we see

various and similar activities: dressing warmly to prevent colds, consuming fruits and vegetables, compulsive exercise, and walking. The most declared activities are bundling up and paying attention to food consumption, because they mostly suffer from the common cold and influenza. Some respondents state that they do not anything for their health.

Ö.Ö. (45 years old, female, living in Gültepe) touches upon good nutrition which is required for health, economic conditions permitting:

> *Yediklerine dikkat edecen iyi beslenecen hareketli olacan. Olursa elde iyi beslenirim. Yeme içmeyle ilgili. Maddi durumla ilgili sağlıklı olmak.*
>
> You have to watch what you eat and be active. If I can help it I eat well. Being healthy has to do with eating and drinking and money.

Similarly, N.B. (26 years old, female, living in Baraj) attaches importance to economic conditions as:

> *İyi giyiniyoz. Ne bulursak onu yiyoz. Şunu yiyim bunu yiyim demiyosun. Bulamıyon ki.*
>
> We try to dress warm. We eat what we can find. You can't pick and choose. You can't find any.

M.A. (30 years old, male, living in Gültepe) is in depression and he does not attach importance to his own health and explains:

> *Hiçbirşey. Günde 2 paket sigara içiyorum. Pek umurumda değil sağlığım.*
>
> Nothing. I smoke two packs a day. I don't really care about my health.

Similarly, S.A. (68 years old, male, living in Gültepe) states that:

> *Yapamıyorum. Nedenleri ömrüm bitiyor. Ekonomiye dayalı bilinçsizliğe dayanıyor. Allah akıl verirse düşüneceksin. Tabi ki önem vermiyoruz. Ammaaan deyip geçiyoruz. İnsanın sağlığını koruması için ekonomik durumu iyi olacak. Hem ruh hm beden sağlığı için.*
>
> I can't. I am old. Its because of finances and ignorance. If God gives you intelligence you think. Of course we don't take care. We just brush it aside. You have to be well of to protect you health. Both mental and physical health.

A.A. (35 years old, male, living in Baraj) emphasizes behaviors seen as detrimental to good health as:

Biz en sağlıksız yaşayanlardanız alkol var sigara var. Vücut sağlığına zarar verebilecek her şey var bizde. Kendimize pek dikkat etmiyoruz.

I am one of the unhealthiest. There is alcohol, smoking. Everything to harm health. I don't look after myself.

The numbers of smokers is very high among the families. Smokers are rare among chronically ill respondents and female respondents. The majority of the male members are smokers. Also, some drink alcohol. They are aware of the negative effects of these behaviors, but they continue.

L.A. (40 years old, male, living in Gültepe) is a garbage collector. He mentions compulsive exercise just like other respondents who use their body for work:

Vücudumuzu da bilinçli kullanmamız lazım. Burdan bir çıkıyorum yürüyorum. Telsizler aydınlık komple geziyorum sokak sokak. İster istemez bünyeyi yoruyor. Zorunlu spor yapıyorum. Koşmuyorum ama sürekli yürüyorum. Günlük yapıyorum sürekli. İşim gereği yürüyorum. Şimdi bir şey söyleyeyim mi? Bir şeyi bilinçli yapmanın önemi var. İnsanının kendinde de var. Birşeyi fazla yeyince de yeterli yemeyince de rahatsız oluyorsun. Şartlar da var insanın kendinde de. Şimdi ben kullanılacak çağdayım benden verim alınabilir. Şimdi ben 50 yaşına kadar böyle giderim. Fazla zorlamadan benden ülke verim alabilir aile. Burdan 2 gibi çıkıyorum. Saat 9'a kadar geziyorum. Hesap edince 6 saat yürüyorsun. Durduğun zaman 5 dakka duruyorsun fazla değil.

We need to use our body carefully. I go out, take walks. Telsizler is always well lit so I go walking there, go street by street. I don't run but I always walk. It is forced. I walk for my job. You feel bad hen you eat too much or not enough of something. It depends on the circumstances but also on you. I am at a productive stage. I will be until 50. The country state could easily use me. I leave here at 2. I walk around until 9. That means 6 hours walking around. When I rest it's for 5 minutes maximum.

In general, from the statements of the respondents, health promotion or health maintenance is not an issue for them. However, they try to perform the practices related with the prevention of illness, especially the common cold and influenza, the most frequently seen illnesses. As mentioned earlier, health does not matter for them, but illness does. They take action not for "being healthy" but for "not catching illness".

Being permanently sick or a chronic patient is a unique experience conceptualized as *biographical disruption* by Bury (1991, 2001) (See Chapter Two for details). It is not only a disruption of the physical body, but the illness experience also causes disruption in all fields of life: the labor market attachment, social relationships, attending school, and performing other everyday routines. Bury (1991) distinguishes two meanings of chronic illness. First, there is meaning of illness as *consequences* for the

individual, that is, the effects on the practical aspects of everyday life following the occurrence of symptoms, such as disruption of work and domestic routines, the management of symptoms etc. Second, the meaning of chronic illness may be seen in terms of *significance,* which refers to the connotations and imagery associated with the given conditions (See 5.4. for details).

As a consequence of the illness for the individual, the management of symptoms by permanently seeking medical advice, regularly taking medicine, and conforming to the regimens given by the doctor become the primary concern in their life after the onset of long-term illnesses. Instead using traditional or popular methods, the majority rely on only medical assistance although some of them also believe in the traditional healing methods. Chronic illnesses or long-term illnesses except for depression for most are seen to be in the field of scientific medicine. In general, permanently sick respondents do not apply alternative methods and they believe that they should be under medical control constantly as a health seeking strategy. When they feel their state worsening, they usually immediately consult the doctor or use prescribed medicine or apply regimens peculiar to their illnesses permanently. Therefore, they enter a new period in their life by internalizing, practicing, and continuing the new lifestyle. Below, there are few excerpts for the sick tendency of health seeking strategies when they feel bad. İ.Ö. (40 years old, male, living in Baraj) suffers from diabetes mellitus, kidney failure, hypertension, and glaucoma. He mentions the requirements of his illness as:

> *Ben beş senedir bulgur yemiyorum zaten yaramıyor bana gelmiyor. Pirinç, nohut, fasulye yemiyorum. Bunlar yasak bana. Belediye veriyor ama ocağa koyup kaynatmıyor bunlar, ben yemediğim için. Bana yasak olduğundan dolayı bunlar da yemiyor. Bizim işimiz pirinç pilavıynan makarna yemek onlar serbest bana. Ben beş senedir bunları yiyorum. Bulguru yedimiydi doğru makineye gönderiyor beni. Sebze meyve yiyemiyorum. Salatalık yiyemiyorum. 3 aydır ağzıma yeşillik almıyorum. Her şeyden belli miktarda yemem lazım. Balık senede 2 sefer yedim. Salatalık yasak havuç turp yasak. Belirli aylarda belirli yiyecekleri yiyebiliyorum. Yoğurt bile 1 çay bardağından fazlası yasak. Ben fazla beslenemiyorum diyetim olduğu için. Eşim de çocuklarım da bana uyuyor. İlaçları mecburen kullanmak zorundayım. Başka çarem yok. Sürekli doktora gitmek ve dediklerini harfiyen yapmak zorundayım.*
>
> I haven't eaten cracked wheat for 5 years. Its not good for me. I can't eat rice, chickpeas or beans. The municipality gives these out but these guys won't cook them in the house because I can't eat them so they don't either. I can eat rive and macaroni. I've been eating that for 5 years. Cracked wheat sends me to the machine. I ant eat fruit and vegetables. I can eat cucumbers, carrots or radishes. I have to eat everything in moderate amounts. I can eat some things during certain months. I had fish 2 times a year. I haven't touched any greens for 3 months. I can't eat much because I have a special diet. I have no other choice. My wife and children eat what I eat. I have to take my medication. I have no choice. I have to go to the doctor and do exactly as he says.

E.A. (26 years old, male, living in Gültepe) suffers from epilepsy, irregular heartbeat, problems with sight, and a herniated disk. He talks about health seeking strategies with emphasis on epilepsy as:

> *Kendimi kötü hissedersem ilacımı alırım. Hafta içi doktora giderim. Bayılma durumunda havale geçirirsem beni götürürler. Artık alıştım bayağıdır böyle. İnşallah yanınızda geçirmem, heyecanlanma oluyor geçiririm diye. Annemlere haber bile vermem çoğu kez. Giderim sürekli doktora. Gitmem gerekiyor benim.*
>
> I take my pill if I feel bad. I go to the doctor during the week. They take me if I have a seizure. Its been this way a long time. I am used to it. I hope I don't have one while you are here. I don't even tell my parents most of the time. I always go to the doctor. I have to.

H.A. (48 years old, male, living in Gültepe) suffers from heart disease and ulcerative colitis. He explains what he does when he feels worse as:

> *Beni hemen alır götürürler taksiyle. Hastalığımı bildikleri için. Komşular götürür. Normalde ilaçlarımı alırım. Doktorun dediklerini aynen yaparım. Ağır kaldırmam kendimi yormam. Yediğime dikkat etmeye çalışırım.*
>
> They take me immediately by taxi. They know my illness. The neighbors take me. Normally I take my pills. I do exactly as the doctor says. I don't exhaust my self and don't lift heavy objects. I try to watch what I eat.

Methods employed change from illness to illness. This is related with the significance of the given illness according to the respondents. Some illnesses are paid more attention and regarded to require permanent medical control, medicine intake or regimens, such as kidney failure, diabetes mellitus, hypertension, asthma, heart diseases, epilepsy, skin cancer, and coronary artery disease. However, some illnesses are seen as painful but not deadly and as manageable without permanent medical control, such as a herniated disk, sinusitis, ulcerative colitis, depression, osteoporosis, rheumatoid arthritis, hyperlipidaemia (high cholesterol), migraines, and hypothyroidism. The latter group of diseases is most commonly seen among female respondents**.** However, some sick respondents expresses that they should do what the doctor advises such as taking medicine and regimens, but they could not obey the rules about the management of illness because of economic difficulties and their uninsured status. Non-obedience of medical advice is prevalent among the female respondents, even among the chronically ill.

Some respondents like H.B. (50 years old, female, living in Gültepe) believe that such illnesses as rheumatoid arthritis are manageable with their own remedies. She suffers from rheumatoid arthritis, high cholesterol, migraine, ulcerative colitis. She says that:

> *Doktora giderim. Bazen hiç gözüm kesmez doktora gitmeye. Romatizma bastırınca sıcak su içerim. İçine de iki aspirin atarım iyi gelir. Biraz terlerim rahatlarım. Biraz da kendi kendinin doktoru olacaksın. Kolesterol için diyet yapıyorum. Yürürüm yürümeyi çok severim. 3 ayda bir kolesterol için kontrole giderim.*
>
> I go to the doctor. Sometimes I don't bother. When I have arthritis pains, I drink hot water. I put it two aspirin and it helps. I sweat a bit and relax. You have to be your own doctor sometimes. I am on a diet due to high cholesterol. I walk. I like to walk. I have my cholesterol checked every 3 months.

E.A. (26 years old, male, living in Gültepe) talks about his mother's health seeking strategies. His 55-year-old mother suffers from hypertension, coronary artery disease, and heart disease. Economic difficulties caused restrictions in conforming to the medical advice they received and they tend to relieve existing symptoms of the illness with their own methods. He expresses that:

> *Kendi kendimizi iyileştirmeye çalışıyoruz. Sarımsak yiyoruz doğal yollardan iyileşiyoruz işte. Sağlık için harcama yapamıyoruz. Eczanelerde ilacımızı bulamıyoruz günlük ilacımız var alamıyoruz. Annemin ilaç alması lazım 40-50 milyon nasıl alalım. Annemde yüksek tansiyon var 30 yıldır. İlaç da alamıyoruz. Sarımsak limonla idare ediyoruz. Tuzsuz yemek şekersiz çay yağsız yemek yiyor. 30 yıldır da damar tıkanıklığı var. Kendi kendine idare ediyor. İyi beslenemiyoruz. Annem mecburen sarımsak yiyor ilacını alamıyoruz.*
>
> We try to heal ourselves. We eat garlic; we try to get better naturally. We don't spend money on health. We can find our pills in the pharmacy. We have daily pills but we can't buy them. My mother needs medicine but its 40-50 million. How can I get it? She has had high blood pressure for 30 years. We can't buy the medicine. We use garlic and lemons. She has food without salt, tea without sugar and non-greasy food. She has had atherosclerosis for 30 years, too. She gets by on her own. We don't eat well.

N.T. (45 years old, male, living in Baraj) suffers from hepatitis, earaches, and headaches. Economic difficulties and uninsured status caused them to prolong the duration of the illness and led to the progression of the illness. He talks about being sick and both helpless against the pain he suffers:

> *Valla bir şey yapacak durumum halim yok yeğenim. Şimdi ağrı sızı iyi kötü kendimi şey yapıyom. Karnım acıyo. Derim hanım kiremit koy, yahut bir şey koy der. Ona göre kendimizi şey yapıyoz yani tedavi ediyoz. Arada bir de ağrı kesici alıyoz. Hastayım ama sosyal güvencem olmadığı için doktora hiç gidemiyorum. Eşim de hasta o da gidemiyor. Hiçbir hastalığa gidemiyoruz. Eşimin fıtıktan ameliyat olması lazım gidemiyoruz. Benim hastalık ilerledi zamanında gidip ameliyat olmam gerekiyordu gidemiyorum. Yani hiçbirine gidemiyoruz parasızlıktan sigortasızlıktan.*

> I have no way of doing anything. I try to take care of my on pain. My stomach hurts, I tell my wife to put a tile on it. We try to fix it ourselves. Sometimes I take a pain killer. I am ill but I can't go to the doctor because I have no social security. My wife is ill too and she can't go. We can't go for any illness. She needs a hernia operation. I should have gone for an operation a long time but I couldn't. No money, no insurance, so went go.

A.M. (35 years old, male, living in Gültepe) suffers from skin cancer, depression, hypertension, and hepatitis B.

> *Bana kırmızı et yasak kuru fasulye, nohut, pilav, mercimek ağır yemekler baharatlı yiyecekler yasak. Benim yiyeceklerim salata türü, yeşillik, beyaz et serbest bana ama bunları alamıyon. Balığı kışın yiyoruz bazen. Neylen alacaz. Sürekli makineye giriyorum. Doktorun söylediklerini yaparım zaten benim her şeyim kontrol altında. Yememe içmeme dikkat etmeye çalışırım. Sigara içiyorum. Sigara içiyorum. Hastanedeyken bile sigara içiyordum. Bende sinir çok bu benim kurtuluşum.*
>
> I can't eat red meat, beans, chickpeas, rice, lentil, rich foods or spicy foods. I have to eat salad vegetables and white meat. But I can't buy these. Sometimes we have fish in the winter. I always go into the machine. I do what the doctor says. I am always monitored. I try to watch my intake. But I smoke. I did even when I was in the hospital. It is my only escape.

According to Bourdieu (1984) different classes have different lifestyles. Among most of the sick respondents, there has been a sudden change in lifestyle of the ill with the onset of disease, although a few resist this new lifestyle like A.M. and H.B. and a few could not practice the requirements of the new lifestyle due to economic difficulties such as E.A.' mother and N.T.. This tendency is prevalent among women. In general, the sick individual's management of the illness is most important. Changing *habitus* and the lifestyle of individuals who occupy the same position in the *field* is difficult according to Bourdieu; however, I think that it is contextual. In addition to low income, being sick puts people in a different position. While the majority of the sick respondents have changed their lifestyle such as eating habits, taking the time to take medicine and for other treatment methods as phototherapy, chemotherapy, and dialysis, even though it is difficult for them. Based on the "logic of practice", adopting and practicing new (sick) lifestyle changes depends on the tension between the severity and the significance of illnesses, material circumstances, and cultural values as seen in the cases above.

When we look at the utilization of traditional medicine or scientific medicine by the respondents, we see that seeking traditional methods for healing is not related with accessibility to modern medical services, educational qualification, benefit dependency position, age, or neighborhood among the respondents. Instead, it is related with gender, feeling like a villager, and the illness type. Traditional healing

methods for the treatment of illness are not preferred by more than half of the respondents. Among them, there are respondents who tried traditional methods previously but they have not since then. These respondents either did not benefit from these methods or have negative experiences which caused damage to their *health capital.*

H.A. (48 years old, male, living in Gültepe) was born in Ankara and define himself as urbanite. He is third generation migrant. He expresses the bruising effect of traditional healer on *health capital* as:

> *Kırık varsa hastaneye git film çektir. Ben cezasını çekiyorum. Daha önce kırık çıkıkçıya gittim kemik ters kaynamış. Kolum eğik duruyor şimdi. Aşağıda bir tane var orada yaptırdık. Bu elimle fazla yük taşıyamıyorum. Bağladılar tuttu dedi çıktık.*
>
> You have to go to the hospital if you have a broken bone. I am suffering from this. I went before to a bone setter and the bone healed wrong. Now I have a crooked arm. There's someone down there. I can't carry much with hi hand. They tied it up and said it set so left.

H.K. (70 years old, female, living in Gültepe) was also born in Ankara and she sees herself as an urbanite. She is a second generation migrant. She states that she does not use traditional methods because:

> *Benim işim doktorluk. Ben niye gideyim. Doktorun işi ayrı hocanın ki ayrı*
>
> What I have is for a doctor to fix. Why should I go (to a hodja)? They have different jobs.

She suffers from a few chronic diseases and she distinguishes between the jobs of the medical doctor and religious healer as many respondents express. Among the respondents, who both use and do not use traditional methods, there is a tendency to distinguish three kinds of illness. The first one refers to illnesses which belong in the field of scientific medicine such as chronic illnesses; the second one refers to the illness type which is the business of religious man, mentioned as "*hoca hastalığı*" such as headaches and depression; and the third one is the type of illness cured by healers in family chambers (*ocak*) such rashes, scarlet fever, measles, warts, jaundice, etc.

Identifying a cause for the illness also determines which methods they might use. The source of illness in depression, stated as *hoca hastalığı,* is accepted fundamentally as a spirit sort of genie or fairy-like supernatural forces.

M.E. (51 years old, female, living in Baraj) migrated 6 years ago from a village of Kalecik with her son and husband. Her husband was paralyzed and she has cared

for him. She feels like a villager and she continues health seeking ways used back in her village in the rural *field*. She expressed both mediated (genie, fairy) and unmediated (economic difficulties and confinement into the domestic field) causes for her illness as:

> *Hoca hastalığım vardı. Bunalıma girdim cin peri hastalığı. Geçim derdinden buna bakmaktan sürekli evde dura dura bunala bunala cinlendim. Psikolojik olaraktan iyi geldi.*
>
> I had hodja's disease. I was in depression because of spirits. It was because of survival problems and taking care of him. I just broke down and got possessed. It felt good.

Female respondents and those who feel like a villager have the tendency to use these methods. These traditional methods or strategies are generally used when they believe that the treatment methods of scientific medicine are not useful and they use traditional methods according to their perception of the illness distinction. While some illnesses are seen as the business of the medical doctor, some illnesses are seen as the business of religious healers. In addition to the respondents who feel like villagers, there is one case. She sees herself as an urbanite and uses traditional medicine. However, her feeling of being an urbanite seems to be complicated. On the one hand, she defines herself as an urbanite by distinguishing the rural and urban area in terms of cultural values; on the other hand, she reproduces rural cultural values when she encounters her fellow villagers or relatives. She uses various sources of traditional medicine as expressed below:

> *Hacıbayram camisine giderim. Dua ederim fatiha okursun. Kırık çıkıkçıya giderim. 2 kere kolum çıktı. Kırık çıkıkçıya gittik. Doktor bişi yapamazsa hocaya gidiliyor. Hocalar diyor ki cin çarpmış. Dua okuyorlar muska yapıyorlar. Sen ne vermişsen onu alıyorlar. Oluyor tabi ben de bel kayması oldu ben ağır kaldırdım doktor dedi ki romatizmadan. Aslında doktor bilemedi. Sonra belimi çektirdim iyileşti. Evde çektirdik. Tanıdık bir adam geldi. 8-9 ay oldu şikayetim yok.*
>
> I go to Haci Bayram Mosque. I pray. I go to bonesetters. I broke my arm twice. We went there. If the doctor doesn't do anything you got to a hodja. They pray for you and make you a prayer pouch charm (muska). They take whatever you give them. I also had back problems. The doctor said it was due to arthritis but I was lifting heavy objects. The doctor was actually wrong. Then I had the bonesetter pull on me and it was fine. We did it at home. A man we know came. Its been 8-9months and I am fine.

As an illness-specific type of traditional health seeking, a family chamber, *ocak*, is commonly used by the respondents. Family chambers are divided according to illnesses such as a wart chamber, a measles chamber, a jaundice chamber, etc. According to Duvarcı (1990), the family chamber refers to the family believed to heal

with a gift for curing that specific illness handed down from the ancestors. This traditional skill is transmitted to next generation by "giving them a hand" (*el vermek*). Here, the hand has a symbolic meaning; that is, it is a symbol of remedy. The remedial hand is transmitted to the next generation by teaching the healing practice. Akman (2007) states that giving-taking "hand" is done with a ceremony involving praying, and the existing healer transmits his/her remedial hand by spitting into the mouth of the hand-taker. There are two family chambers among the respondents' families. In order to understand family chambers as a traditional method of healing in detail, the two excerpts below explaining the family chamber (*ocaklı)* are crucial.

İ.Ö. (40 years old, male, living in Baraj) migrated to Ankara 5 years ago so as to access health services easily. While he is a traditional healer, he applies scientific medicine for his illness. The distinction of illness according to the experts as medical doctors and traditional healers is also made by traditional healer himself. He explains as:

> *Benim hastalığım ocaklık hastalık değil doktorluk hastalık. Hastalığa göre değişir. Bizim hastalık ırsi. Babadan kalma. Herkes şeker hastalığından ölüyor bizde. Bende sarılık eli vardır mesela. Hastanede yatarsın sarılığın geçmez. Bana da babadan kalan bir şey bu. 1 hafta sürmez ben keserim iyileştiririm. Öyle ocaklar var. Ben böyle şeylere inanırım. Baş ağrısı ocağı var mesela bunlara inancımız var. Hocalık değil el yani bu. Hoca ayrıdır el ayrıdır biz muska falan yazmayız. Bana 15 tane çocuk getirdiler hep sarılıklarını kestim. Hastane sarılığı geçiremiyor mesela. Cenabı allahın verdiği bişey bana babamdan kaldı. Babam el verdi bana. Şurubunu hazırlıyorum nohut yumurtadan şurubunu yapıyorum. Onu içiyo bir hafta sonra geçiyor. Çil eli var. Közlü eli var. Bulgur püskürtmesi eli var. Bunun hocalıkla ilgisi yok. Köslü elinde dokuz toprak alırlar. Getirir onu çalar şişen yere. İyileşir. Köslü kolay kolay ölmez kim öldürürse onda el kalır. O toprağı çalar sana. Adam 13 sene olmuş sarılığı geçmemiş doktor demiş biz iyileştiremiyoruz gidin bunun ocağını bulun demiş. Bizim köye geldi. Kestim. 1 hafta içinde geçti. Ben de şimdi kıza öğretiyorum el vereceğim benim bi ayağım çukurda.*

> My illness isn't one to be treated traditionally. I need a doctor. It depends on the illness. Mine is hereditary; from my father. Everyone in our family dies of diabetes. I have a healing hand for jaundice for example. You go to the hospital it doesn't go away. This I got from my father, too. I heal in 1 week maximum. There are people like that like a head ache healer. I believe in these. This is not a hodja thing. It is a healing hand. Hodjas are different we don't write prayers for pouch charms. They brought me 15 children, I healed them all of jaundice. The hospitals can't do this. This is a God given gift I got from my father. I make syrup from chickpeas and eggs. They drink it and they are fine in a week. There's a freckle healer, etc. there are different methods like putting soil on a swelling part. There was a man who couldn't get rid of his jaundice for 13 years. The doctor said to find a healer, we can't cure this. He came to my village. I healed him in one week. Now I am teaching my daughter. I am dying so I want her to have the healing hand.

The other traditional healer, G.B. (49 years old, female, housewife, living in Baraj) states that:

Bulgur püskürtmesi oldu kızım. Doktora gittik geçmedi. Ama bir komşumun eli vardı götürdüm kesti. Gittik geldik geçti. Alerji gibi bir şey. Kıpkırmızı olur. Ocak babadan anadan geçer herkeste yoktur. Sarılık eli siğil eli vb.adam istemez de gönlünden ne koparsa verirsin. Vermesen de olur. Mesela gözde arpacık çıkar. Benim de annemden bana geçmiştir ben de arpacığı iyileştiririm. Anneden el verdiği zaman geçer. Benim beyimlere de kızılyürük derler. Bunlar da el. Doktorlar bunu bilmez. Doktor tedavi ediyor geçmiyor ne olacak. Beyimde yılancık eli var anasından geçmiş. Kıpkırmızı şişer.

My daughter had a rash. We went to the doctor but it didn't get better. A neighbor had a healing hand. He fixed it. Its like an allergy. Its red. You get the gift from you parents. Not everyone has it. People have different diseases they cure. Warts, jaundice… you can pay what you like or not pay. Like if you have a stye, I can cure those. I got it from my mother. My husband's family is called kızılyürük. They are halers too. Doctors don't know this. Doctors can't fix anything. My husband has a yılancık hand. He got I from his mother. It swells up and reddens.

İ.Ö. emphasizes especially that the family chamber is different than the religious man, the hodja; instead he sees himself and other traditional healers of a certain family chamber as traditional experts who specialize in a particular illness. Being a traditional healer belonging to the specific family chamber is a kind of *cultural capital* in embodied form. *Cultural capital* as "scarce symbolic goods, skills, and titles" is one of the types of capital which determines the social position of an individual agent in social space (Wacquant, 1998b). However, their skill is not converted into *economic capital* and higher status in the urban *field*. They both state that they earn money from this practice as a donation if the patient wants to give some. The dominant healing practice is scientific medicine in the urban *field*, so the practice of traditional healing does not provide an important title in the urban *field*. As mentioned earlier, the value of every form of capital varies according to the *field*.

As seen in G.B.'s case, the traditional healer of family chamber has the role of both healer and patient due to the distinction of illness according to family chambers. Among the respondents, a general tendency to use the methods other than scientific medicine is not that they see them as alternative; instead they distinguish them according to their expertise and use both going to the medical doctor and a traditional healer or religious man or tomb etc. However, they usually consult the medical doctor first and employ traditional methods second.

In the other excerpt related with family chamber by L.A. (40 years old, male, garbage collector, living in Gültepe), the details of practice are explained as:

Cezaevinde elimde sivilce çıban gibi bir şey çıkmıştı önemsemedik. Aman geçer dedik. Kimseye de demedik meğerse egzamaymış. 5 sene bu hastalığı çektim. Askerliğimi hastanede yaptım doktorlara gösterdim. Uyguladıkları tedaviyle iyileşiyordu ama zamanla gene çıkıyordu. Bu zengin hastalığı. Şu şu yemekleri yemiyecen. E ne yiyecem kardeşim. Ye dediği yemekleri imkanı yok yiyemem. Yeme dediklerini de her zaman

yediklerimiz. Bulgur yeme diyor, ekşi yemeyecen. Yoğurt yemeyecen. Acı yemeyecen. Halkımızın özünde var acı acısız yemeğimiz yok. Toplum olarak seviyoruz. Ben yemedim. Sonradan baktım geçiyo gene çıkıyor. Artık tersini yapmaya başladım. Yarayı bir türlü iyileştirememediler. Tersini yapınca düzelmeler olmaya başladı. Ben bazı şeylere doğaüstü güçlere inanırım. Dediler yakın dostlarımız bunun ocağı olur dediler. Bu yara ancak böyle geçer dediler araştırdık gittik. Yaranın dişisi erkeği olur dediler. Dişiyse komple sarıyor elini erkeği ise belirli yerde kalıyormuş ilerlemiyormuş. Bendeki dağılmayan erkeğiymiş. Bunu erkek ocağından olan erkek birine gösterecen dediler. Burayı boya kalemi ile çizdi. Tükürüyormuş gibi şeyler yaptı okudu üfledi. Ayın belirli günlerinde aç karna geleceksin dedi şunu şunu yemeyeceksin dedi doktorların dediği gibi. Bir de öyle deneyelim dedik ve geçti bir daha da çıkmadı.

I got a wart-like thing my hand in prison. I didn't care. I thought it would get better. It turned out to be eczema. I suffered for 5 years. I did my military service in the hospital. I showed it to the doctors. It got better with their advice but then it came back. It's a rich man's illness. You only eat special food. I can't afford those. No spicy food, yoghurt, no sour food, no cracked wheat. Spice is in the essence of our people. But I stopped. It started again. They couldn't get rid of it. I believe in some supernatural things. They told me to see a healer. That's the only way they said. I went. They said this lesion has a male and a female one. If it's a female, it covers the hand. If it's a male it stays put. Mine was the male kind. They said I have to go to someone who specializes in the male kind. He marked it with a colored pen. He made like he as spitting and said prayers. He said to come certain days of the month and not eat this and that like the doctors. I tried it worked. It never came back.

In addition to family chambers and religious healers, there are also some other traditional remedies such as tombs (*türbe*) to be visited, bone setters (*kırık çıkıkçı*), traditional dentists, and traditional midwifes. The last two were used and practiced only in the village among the respondents; the others are practiced both in the village and in the city. F.K. (78 years old, female, living in Baraj) migrated 6 years ago from a village in Çorum. She expresses her feeling of being villager. She states that she applies many ways of traditional healing methods as:

Ee hasta olunca gidiliyo. Şöyle bir yanın tutmuyo elin ayağın çekiliyo o zaman gidiliyo ocaklara. Hocaya da bi ağrı geliyo başıma biliyon mu. Şey derler biliyon mu cin. Bir hocaya da o vakit hocada muska olur muska alıyok. Ondan sonra onu boğazına tak diyo yahut başına tak diyo hoca muskayı verince. Sonra iyi oluyon. Türbeye de çok gittim çocuklarım öldü. Vay anam vay 9 çocuğum küçük küçükken öldü 1 I de icik büyüdü öyle öldü. Türbelere gittim yavrum tekrar çocuğum olsun diye. Sonra allah üç çocuk daha verdi.

Well, you go when you are ill. When you have numbness or a limb doesn't work you go. I go the hodja if I et a head ache. They say its from being possessed. They give you a prayer pouch charm to wear around your neck or on you head. Then you are fine. I went to visit tombs too. I lost many children. 9 died very young. 1 grew up a bit and then died. I went to tombs to pray I would have children. Then God gave me 3 more.

While tomb visits are done for illnesses which could not treated by scientific medicine such as chronic illnesses and infertility as seen among the respondents, bone-setters is preferred for back pain, neck aches, backaches, dislocated bones, and broken bones. However, the bone-setter is not sought more than other traditional healing strategies; they state that they used this method for dislocated and broken bones when they first came to the city. Praying for good health or recovery from existing illnesses can be

regarded as a kind of traditional health protective activity. Activities for protection from "evil eye" (*nazar*) can also be evaluated like it. However, I do not directly ask about evil eye, I observe some objects protecting from it in many households. I want to mention one particular observation in the Baraj neighborhood. When I went to a respondent's home for the interview, she and her sister were very welcoming. At the house, there was one newborn and a one-year old. While the one-year old baby had the evil eye (*nazar boncuğu*), the newborn did not. I observed that the female respondent whispered something to her sister silently when I turned to the newborn to cuddle him. I did not understand what she whispered. Then, the respondent, the mother of the newborn, went to the next room to get a blue evil eye and pinned it onto the clothing of the newborn. Now, we could start the interview, for the newborn was adequately protected. The symbol of this belief drew my attention in many families I met.

CHAPTER 6

CONCLUSION

This study is an attempt to examine the similarities and differences in terms of the health experiences of the urban poor living in *gecekondu* areas in Ankara. Within the scope of this endeavor, their relationship with their social positions have been revealed and conceptualized as the *forms of capital*; namely, *economic*, *cultural*, *social*, and *health capital*. Based on the findings, one can unequivocally say that the poor are especially vulnerable to ill-health experiences. Moreover, poverty is seen as a precursor to illnesses and that the poor suffer even from illnesses that could easily be prevented. The social inequality in health related matters experienced by the poor is mostly treated as a policy issue, leaving aside a deeper sociological analysis. Solutions are often conceived only in form of policies addressing at changes in income distribution or financial support. Yet individuals' perceptions, experiences, and coping strategies related to health/illness remain virtually overlooked.

There is a tendency to explain health inequalities based either on simply individual behavior or on structural factors. In such a sense the poor turn into a kind of homogenized mass, in which everybody is open to health problems. In this study, I make a concerted effort to address the variety and differences of health experiences among the urban poor by examining the *forms of capital* they possess. Academic and public discussions frequently state that poverty is interlinked with ill health. In addition to the struggle to change lifestyle and detrimental health related behavior, there are demands of a more equal distribution of income. With a mind to get rid off this reductionism, this thesis intends to transcend the dichotomy. Bourdieu's

concepts, *habitus*, *field*, and *forms of capita*l are utilized as conceptual tools. In this framework, the research questions aimed to be answered have been:

> (*1) What are the differences and similarities in the experiences and perceptions of health among the urban poor?*
>
> *(2) How do the different forms of capital (economic, social, cultural) influence the health experiences of the urban poor?*
>
> *(3) Can health be regarded as a different form of capital?*
>
> *(4) What is the role of the agency in health experiences?*

Based on Bourdieu's methodological view, the agency's views and interpretations are an indispensable component of the precise reality of the social world (Bourdieu & Wacquant, 2003). The purpose of capturing this reality and revealing the essence of the everyday life experiences for the specific social contexts necessitates the use of a qualitative method, so as to facilitate a better understanding of the health and illness experiences of the poor.

For the inquiry of the different *forms of capital* influencing the health experiences of urban poor, the research was conducted in two poor neighborhoods in *Altındağ* via face to face interviews with 40 individuals. *Altındağ* was chosen as disadvantaged area with the *gecekondu* settlements, *Baraj* and *Gültepe*. The poverty and health indicators for the mentioned neighborhoods are low.

In order to understand how the urban poor experience health, it is important to gain insight into the types of illnesses they suffer from, their access to health care, their perceptions of health and illness**,** the health seeking strategies they employ, and their institutional experiences in health care settings. These issues are discussed firstly. During this discussion, some socio-demographic characteristics such as gender, age, and neighborhood setting as well as the different *forms of capital* held by the urban poor in these areas are incorporated into the analysis. It was assumed that the socio-demographic characteristics and the *composition* and *volume* of the *forms of capital* would reveal the differences and similarities in their health experiences. *Economic capital* was operationalized by looking at income, employment status and type of job held. *Social capital* was differentiated into *formal social capital* (social security and assistance) and *informal social capital* (social solidarity). The possession of *cultural capital* was determined

by looking at such identities like being an urbanite/a villager, being literate/illiterate, being sick/non-sick, and being poor. Additionally, *health capital* was added to the *forms of capital*. *Health capital* includes self-perceived illnesses and well-being as well as medically diagnosed illnesses. It was added to provide an understanding of the distinct experience of sick people. Underlying this argument has been the assumption that the group studied has peculiar experiences. The main findings as regards their possession of different *forms of capital* taking part in their health experiences, will be presented.

The first finding of the study is that the possession of *economic capital* by urban poor is low and has decreased in the recent decades. The attachment of the urban poor to the formal labor market is very limited; more often than not, these people find employment in the informal sector. Their engagement in the formal labor market has decreased especially since the 1990s, following the economic crises in Turkey. The informal labor market, with its low/irregular income and its unsafe and insecure working conditions, is exploitative in character. The informal sector, which the urban poor try to integrate into, provides a way for them to make a living in the urban *field*; but, on the other, the informal market sustains their poor position in the urban *field*.

The second finding is that the urban poor are not a homogenous mass in terms of socio-economic status. Among the urban poor, we can differentiate at least two groups in terms of income: *benefit dependent poor* (families whose members are unemployed or casually employed without being insured) and *regular income earning poor* (families who have higher income than *benefit dependent poor* where at least one member of the family is regularly employed) They differ in terms of meeting basic needs in their everyday practices. Actually, many of the respondents describe and perceive their income situation as declining. Still three "types of poor" can be classified among the respondents: "doers", "accommodators", and "losers". A typical statement for a loser could be "with our arrival to the city, we even got worse. In the village we at least could find food"; "accommodators" may state "coming to the city did not bring any change at all", and finally, the "doers" would state "in the village we could not survive, but in the city, we at least could find a job" or "in the village we could not go to see a doctor but now we have a chance to do this".

The third finding is that state support offered to the urban poor is very limited. The urban poor strongly rely on informal solidarity networks in order to handle difficult situations. These networks are not necessarily limited to the direct

family or kin but also extend to neighbors. Nevertheless, a general trend was described saying that these networks actually have lost a lot of their strength recently. This was expressed as "people got poorer, nobody visits each other, there is nothing to offer to the guests".

The fourth finding is that the varying identities (ascribed or attributed) of the urban poor differentiate them in social space. In addition to being poor in the *field*, traditional gender roles, being a villager or not, being sick, and being illiterate make them different. The way the respondents perceive their treatment by medical staff can be seen as explanatory. They feel that they are downgraded "as villagers" and "illiterate". Being a "green card holder" even reinforces these labelings.

The fifth finding is that the urban poor are more vulnerable to both infectious and chronic illnesses. In general, they have less *health capital*. In addition, work-related factors, malnutrition, living in economic difficulties are all crucial factors that explain their illness experiences. Living in poverty and not being able to meet even their basic needs firstly affects children. In general, while children suffer from acute and communicable diseases, adults and elderly are more prone to chronic illnesses. Illnesses are frequently interlinked with a low level of possession of *economic capital*. Illness may result in the loss of a job, or changing jobs, but it almost always means working for less money. Typical examples are: a herniated disk as a consequence of hard physical labor; or pneumonia (a *disease of poverty)* as a result of unhealthy living standards; or depression, which is actually among the most frequently cited illnesses. However, only a few of these illnesses are medically diagnosed. But the fact that they for example perceive themselves as being in depression should nevertheless be seriously considered in any sociological analysis. A true understanding of health experiences requires that we address more than just factual or medical diagnoses.

The sixth finding is that the physical and psychological well-being of urban poor changes according to income, type of illness, age and gender. When they describe their state of psychological well-being as bad, most of them focus on living in poor economic conditions. Chronically ill respondents say that they feel themselves bad by focusing on their physical health. In general, almost all of the elderly have a chronic illness (es) and provide fatalistic explanations about their well-being. Respondents stating their psychological well-being as bad commonly belong to the *benefit dependent poor* and the *recent loser* categories. They actually perceive themselves to

have been better off when they first arrived in the city years ago and/or up until 10 years ago.

The seventh finding is that the urban poors' perception of health and illness is influenced by the economic difficulties experienced, illness experiences, gender, and access to health care. In general, the urban poor see their body and health as *a means to an end*, not as *an end in itself*. In particular, the health of male and working members' is a strong priority because they are the ones who are considered as the main breadwinners. They mostly hold manual jobs. Their body must remain strong and healthy to ensure that the family is provided for. This priority of the male breadwinner is supported by the family in general, and most specifically by the female respondents. This kind of perception puts women at the bottom of the list, ranking after husbands, sons and daughters.

The ninth finding is that the urban poor perceive health as the *absence of illness*, *as a tool* especially for work and *as the result of various factors*. There is a close relationship between their living experiences and health perceptions. They do not explain health or illness based on one single explanation; they touch upon different factors. Health is perceived *as a product*. Poverty experiences are central. Among the *benefit dependent poor* respondents, the explanation based on *health as the result* of economic factors is more common. This finds its expression in statements like "If you are poor you are ill" or "you need money to buy good food like vegetables, fruits and meat to be healthy" For those who are uninsured, access to health care is important in their definition of themselves as healthy. In addition, the explanations provided vary according to gender, age, and being sick. The sick, in particular the chronically ill and/or the elderly, tend to explain in accordance with the construct *health as a tool* by saying "health is having the strength and the ability to do everything; working and performing daily activities" and/or with the construct *health as the absence of illness*. Those respondents simply referred to the fact that "health is the opposite of illness". The latter have a tendency to perceive illness as something which must be observable.

The tenth finding is that the urban poor tend to distinguish illnesses according to whether they are serious and only if they are, they will they seek professional help in medical institutions. If they perceive the illness as non-threatening, they frequently try to treat it themselves. They further distinguish illnesses into those which necessitate traditional medicine or scientific medicine and they categorize illnesses to

be treated accordingly. Still it can be stated that their trust in scientific medicine is strong. The use of traditional methods such as "family chambers", tomb visits, and religious healings are common among females or (and) respondents who define themselves as villagers. Here, we may stress that some of the women have hardly ever left their neighborhoods even if they have been living in the city for a relatively long period of time.

The eleventh finding is that the urban poor do not seek health services in the case of illness. Only under certain conditions and most importantly in cases of rare emergency do they go to health institutions. In this context, the respondents frequently referred to problems such as "not having the money to commute to the hospital" and of course "not having social security to cover the expenses". Furthermore, they stressed "loss of time due to extended and complicated bureaucratic procedure, which results in a loss in income" for daily workers.

The last finding is that the urban poor feel discriminated against in health care settings. They feel they are stigmatized because they are poor, especially if they are Green Card holders. Their access type is seen by themselves as a symbol representing their socio-economic condition. Also, some respondents state that they are discriminated against by health personnel due to their bodily representations. In institutional experiences, they have a "sense of distinction". Especially women who mostly spend their life in domestic *field* and go to hospital mainly for their children strongly express this. Respondents, especially females and those who define themselves as *villagers* or (and) illiterates, feel foreign to the environment at health care units. They have difficulty communicating with doctors and other personnel. They try to follow the instructions of the medical staff without even the vaguest idea what they mean. This can partially be explained by the fact that the language used is comprehensible to some social groups and not to others. They feel distinct from the modern/urban, and at the same time different from the rich by saying that "they see and treat us differently by looking at our clothes, accents, etc". The final finding is not only another reason why they prefer not to go to hospitals but also an issue in and of its own.

The first research question is "What are the differences and similarities in the experiences and perceptions of health among the urban poor?" First, the similarities of urban poor in their relationship with the *forms of capital* are summarized: urban

poor's economic conditions have become worse; their *formal social capital* is inadequate for social security and has decreased recently; their *informal social capital* has lost its function mainly in terms of economic solidarity; their *cultural capital* in embodied form is based especially on feeling like a villager; their educational level, important in determining their position in the urban *field*, is lacking and; they have a low level of *health capital*.

The low possession of the *forms of capital* both sustains their poor position in the *field* and has consequences for their health experiences. The most observable similarities are that they have tendencies to not apply to health care institutions and they apply to popular remedies or "managing by oneself", such as using medicine without a doctor's advice.

However, the different positions of the urban poor differentiate their experiences. Their similar positions in the economic field make them live similar consequences for health experiences. However, they, more or less, differ among each other based on characteristics in terms of income and access type such as *benefit dependent/regular income earning poor*, formal sector worker/informal sector worker, unemployed/employed. Besides, they have different experiences according to their positions in society and the family such as being breadwinner, being housewife, being child, and having a strong solidarity network. The other difference is observable according to the role in which they see themselves in society, such as being villager/illiterate, being elderly, being sick etc.

For example, the urban poor with strong informal networks are much more easily able to cope with health care access problems, the consequences of illness, and meeting the requirements of the treatment. On the other, sick individuals, unlike others, are dependent on doctors' advice in order to survive with and manage chronic illness instead of using traditional and popular remedies. Living with a chronic disease requires the acceptance of the existence of illness and obeying the rules for being alive. The other example is that women go to health care settings more often than men, but not for themselves. They go primarily for their children. In contrast to men, women ascribe to popular remedies and apply traditional methods. Men trust in scientific medicine more than women; however they do not apply for another reason, the concern of loss of income.

In terms of similarities and differences, it can be concluded that their place in the economic field resembles them; however their different roles and positions such as being sick and being women differentiates their experiences.

The second research question is "how do the different *forms of capital* (*economic*, *social*, *cultural*, and *health*) influence the health experiences of the urban poor?" On the one hand, *economic capital* influences self-perceived health and well-being, vulnerability to certain illnesses, health and illness perception and health care access. On the other, *social capital* influences health care access and coping with illnesses. *Cultural capital* influences institutional experiences in health care settings. *Health capital* influences all health experiences and perceptions.

The third research question is "can health be regarded as a different form of capital?" According to Aggleton (2002), there are many words that we think we understand until we begin to question them: health is one of them (p: 1). According to Bourdieu (1886), capital as accumulated labor "takes time to accumulate and which, as a potential capacity to produce profits and to reproduce itself in identical or expanded form, contains a tendency to persist in its being, is a force inscribed in the objectivity of things…" (p: 241). In accordance with this definition by Bourdieu, health can be regarded as capital when the findings are taken into account. Being healthy and having a strong body is an important tool for performing manual work according to many respondents. This *habitus* tends urban poor to give priority to the male body and health. For Bourdieu a capital is a resource providing individual profit, and individuals invest in it for pursuing conversion. Their health and strong body is a resource for the main income provision. However men do not apply to health care institutions. This is related to the relationship with other *forms of capital*, that is, their social security type and the concern of loss of income. In addition to giving priority to health, the breadwinner has also privileges in relation to other members of the family, e.g. The more nutritious food is served to them. Female respondents frequently stressed these aspects. In order to be able to struggle in the economic field, good health is crucial. The sick role, according to the findings, leads to exclusion from the labor market, sometimes from the social network. Like other types of capital, people can invest in this capital by gaining power in the *field*. Their economic difficulties may preclude them investing in *health capital*; however, in given conditions, they try to practice according to their *habitus* in a way that they protect themselves by applying to health

promoting practices such as dressing tightly. Meinert (2004) makes a similar discussion and adds *bodily capital* to the forms of capital. She sees the body as a resource by examining the Kwapa community in Uganda. However, in the context of urban poor, not all the body is crucial but a "male" and "healthy" body is crucial for providing income. Their practices are not related with investing into body, but for remaining healthy. So, different from Meinert, in this study health is considered as a capital.

The fourth research question is "what is the role of the agency in health experiences?" The positions they occupy in the *field*, their power relations and struggles they engage in, are closely associated with the *volume* and *composition* of the different *forms of capital* the urban poor possess. The findings show that, in general, *habitus* internalized by the urban poor, which are peculiar to the rural *field*, do not have a function in the urban *field* such as not allowing to educate, especially for girls. They are not educated, so they have no chance to convert an *institutionalized form of cultural capital* to *economic capital* by finding a formal job. While their type of skills in the rural *field* may qualify them in agricultural production, these form of skills are not of value in the urban *field*. As a rural migrant, the urban poor continue their *habitus*. As agent, they supply cheap labor to the urban labor market; however, their position in the informal labor market precludes investing in the *forms of capital*. In urban *field*, the urban poor have adopted new dispositions through the imposition of the structure of the new *field*; that is, to "discontinue habitus" in order to cope with both poverty and difficulties in preventing or coping with health problems. Social solidarity between neighbors (but not necessarily relatives) in the case of illness can be cited as an example for new dispositions.

. The struggle of individual agents in the *field* requires their conversion and reconversion capacities. In general, the *forms of capital* they rely on do detain them to convert. In spite of this, the most observable strategy among the poor is the usage of *informal social capital* to convert into *economic capital* or *formal social capital*. In terms of the conversion to *informal social capital* to *formal social capital*, using another person's prescription record book for themselves illegally, can be given as typical example. Another typical example of conversion as internalized new dispositions in the urban *field* are monetary aid especially from neighbors and relatives, even though remaining on a very limited level.. As a result, it can be said that urban poor internalize and

practice the strategy to transfer a relatively high possession of one form of capital to a relatively low form of capital. They try to "fill in the gap" abusing the system. So they can survive in the urban *field* by pursuing the reconversion strategy.

In terms of health, it can be said that the urban poor try to meet their basic needs. In their point of view, health is valued as a strong body to put to work; health promotion is not practiced but they have certain practices to keep them away from illnesses. The low level of *forms of capital* which are valuable in the urban *field* leaves them in a position where they have no control over the *field*, over their life, and over their health. While living in poverty, their control over health is almost negligent. This results in similarities among the poor. The Turkish word for health (*sağlık*) comes from *sağ*, which means "(being) alive". There is a direct correspondence between the literal meaning of the word and how the urban poor perceive health. "Being alive" to them means to have the ability to reach one's basic needs.

When we turn to the tentative definition of health after examining the findings, it can be added health as a capital. Health relates to the state of psychological and physical well-being and satisfaction. This again is based on meeting basic needs and the endeavor for health which is constructed in a specific *field*. The health of an individual agent in the *field* is based on his/her capability of control. Thus, the value, perception and practice of health changes according to the *field*, such as scientific *field*, rural *field* and urban *field*, and according to the groups such as social class, gender, ethnicity, age etc.

The main contribution of the study to the discipline of sociology is that it considers the issue of health as not only composed of health indicators but also refers to the peculiarity and variety of experiences of different groups in society. In this case the urban poor. Urban poor are a highly complex group of individuals and more heterogeneous than assumed. Their different *forms of capital* and different roles and positions make their health experiences different, too. By following Bourdieu's theory of practice, this thesis indicates that the issue of health is multi-dimensional and relational. In addition, it is suggested that health can be considered as a form of capital.

The study may be important also as a contribution to the development of sociology of health and illness as a subdiscipline in Turkey. Although this subdiscipline of sociology has been developing for about three decades and many

researches have been conducted in many parts of the world, especially in the developed ones, it has not yet developed in Turkey.

I want to state that although the understanding of new poverty in Turkey is not the main focus in the thesis, the thesis gives clues that it can be understood in relation to the *forms of capital*, *field* and *habitus* and the study suggests that poverty has also health dimensions that deserve to be examined elaborately.

In conclusion, an analysis of the different forms of capital allows us to address at the interrelationship of structural conditions in the *field* and the practices actors experience through their internalized *habituses*. Health experiences therefore differ even among a socio-economic homogenous group. In addition to the mentioned forms of capital, it is also argued that health itself should be considered as a form of capital. Health capital (self perceived health/illness and medically diagnosed disease) influences and is influenced by the other forms of capital.

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APPENDICES

APPENDIX A

KENT YOKSULLUĞU VE SAĞLIK ARAŞTIRMASI
GÖRÜŞME FORMU

GÖRÜŞÜLEN KİŞİ NO: _____
HANE NO: _____
İSİM _____
ADRES: _____

GÖRÜŞMELERİN KAYDI

Görüşmeler	Tarih	Görüşmeci	Başlangıç Saati	Bitiş Saati
1. Ziyaret				
2. Ziyaret				
3. Ziyaret				

HANEHALKI TABLOSU (……..kişi)

Kişi	Cinsiyet	Doğum Yeri	Doğum Tarihi	Eğitim Durumu	Medeni Durumu	İşi	Sosyal Güvence Durumu
Kendisi							
Eşi							
Annesi							
Babası							
1. Kızı							
2. Kızı							
1. Oğlu							
2. Oğlu							
……							
……							
……							
……							

AİLE/AKRABA TABLOSU

Kişi	Cinsiyet	Doğ. Yeri	Doğ. Tarihi	Eğitim Durumu	Medeni Durumu	İşi	Yaşadığı yer/Konut	Sosyal Güvence Durumu
Annesi								
Babası								
Eşinin Annesi								
Eşinin Babası								
……								
……								
……								
……								
……								
……								
……								
……								

GÖÇ

1. Ankara'ya ailenizden ya da akrabalarınızdan ilk olarak kim (ler), hangi amaçla, ne zaman, Ankara'nın hangi mahallesine göç etti?
2. Ankara'nın hangi mahallelerinde oturdunuz? Ayrılma nedenleriniz nelerdi?
3. İlk göç ettiğiniz yıllarda ne tür sorunlarla karşılaştınız (ya da aileniz karşılaşmış) (ekonomik, sosyal, kültürel vb.)? Hala aynı sorunları yaşıyor musunuz?
4. Göç edilen yerde daha önceden göç etmiş akraba ya da hemşeriler var mıydı? Bu ilişkileriniz (sizin ya da ailenizin) göç kararınızda ve karşılaştığınız sorunlarla baş etmenizde ne derece etkili oldu?
5. Göç etmeden önce (siz ya da aileniz ya da ilk göç edenler) yaşamınızı nasıl sürdürüyordunuz?
6. Siz ya da ailenizin göç etmesi yaşam koşullarınızda herhangi bir değişme yarattı mı? Bu anlamda köyle kent arasında ne farklar var? Göç edilen yer ile şuan yaşadığınız kenti karşılaştırdığınızda her iki yerin de olumlu ve olumsuz yönlerini değerlendirir misiniz?
7. Göç edilen yerle (ya da memleketinizle) olan ilişkileriniz devam ediyor mu? Gidiyorsanız ne sıklıkla ve ne amaçla gidiyorsunuz?
8. Göç ettiğiniz ilk yıllardan bu yana kadar geçen zaman içinde yaşam tarzınızda, aylık kazancınızda ya da genel olarak maddi durumunuzda hangi dönemlerde, ne tür değişmeler oldu? Şuan düşüş mü var yoksa daha iyi şartlarda olduğunuzu söyleyebilir misiniz?
9. Geriye dönmüş olsaydınız, yine göç etmeyi düşünür müydünüz? Ya da göç ettiğiniz yere dönmeyi düşünüyor musunuz? Neden?
10. Size kimler derler (Türk, Kürt, Sünni, Laz, Çerkez, Yörük, Alevi, Abdal... vb.)?
11. Kendinizi kentli mi yoksa köylü olarak mı tanımlarsınız? Neden?
12. Kendinizi bu kente ait hissediyor musunuz? Neden?
13. Kendinizi bu mahalleye ait hissediyor musunuz? Neden?

İSTİHDAM DURUMU/İŞ

14. Hayatınız boyunca ne tür işlerde çalıştınız. Diğer aile bireyleri ne tür işlerde çalıştılar, anlatır mısınız? (tam zamanlı-yarı zamanlı-geçici, evde parça başı iş yapıp yapmadığı; sosyal güvence durumu; günlük çalışma süresi; haftada kaç gün çalıştığı; her bir işte kaç yıl/ay çalıştığı; kaç yaşında nerede kim(lerin) aracılığı ile çalışmaya

başladığı; ne kadar süreyle işsiz kaldığı; ayrılma nedenleri; ek iş yapıp yapmadığı, vb.)

15. Şuan çalışıyorsanız (evde gelir getiren kişi) çalıştığınız işten memnun musunuz? Neden?
16. Şuan çalışıyorsanız (evde gelir getiren kişinin) çalıştığınız işin olumlu, olumsuz riskli ve güvenli yönlerini değerlendirir misiniz?
17. Çalışmadığınız (evde gelir getiren kişinin çalışmadığı) dönemlerde çevrenizden destek alabildiniz mi? Varsa kimlerden, ne tür destek aldınız? Bu destek düzenli miydi?
18. Eğer şuan işsizseniz iş arıyor musunuz? (evde normal koşullarda gelir getiren kişi işsizse iş arıyor mu?) Önümüzdeki günlerde iş bulabileceğinizi düşünüyor musunuz? İş bulmak için neler yapıyorsunuz?
19. Sizce (evde normal koşullarda gelir getiren kişinin) işsiz kalmanızın en önemli nedenleri nelerdir?
20. İşsiz kaldığınız (evde normal koşullarda gelir getiren kişi) zamandan bu yana hayatınızda (ekonomik, sosyal, kültürel) neler değişti? Anlatır mısınız?
21. Çalışmıyorsanız (evde gelir getiren kişiler) yaşamınızı nasıl sürdürüyorsunuz? Çevrenizden ya da herhangi bir kuruluştan destek alıyor musunuz?
22. Ev hanımı iseniz ev hanımı olmanın getirdiği zorluklar var mı? Riskli ve güvenli yönleri nelerdir? Anlatır mısınız?
23. Ev hanımı iseniz çalışmayı düşünüyor musunuz? Dışarıda gelir getiren bir işte çalışmamanızın nedenleri nelerdir? Ev içinde gelir getiren herhangi bir faaliyetiniz/işiniz var mı (örgü, dantel, dikiş, parça başı iş, bebek bakıcılığı vb.)?
24. (siz, eşiniz, ya da ailedeki diğer üyeler) İş bulmak için herhangi bir meslek edindirme kursu aldınız mı?

GELİR/MAL MÜLK EDİNME/TÜKETİM

25. Aylık geliriniz nelerden oluşuyor? Haneye ayda ne kadar para giriyor?
26. Geçiminizi sağlamanıza yardımcı olan diğer kişi ya da kuruluşlar kimlerdir? Size ne şekilde düzenli olarak destek oluyorlar? (arkadaş, akraba, hemşehri, komşu, devlet yardımları, gönüllü kuruluşlar, belediye yardımları, öğrenci bursu, yaşlılar için ulaşım kartı, vb, .)

27. Memleketinizden yiyecek erzak geliyor mu? Ne kadar zamanda bir ve ne kadar miktarda geliyor? Gelen erzaklar sizin geçiminizi ne ölçüde kolaylaştırıyor?
28. Ankara'ya gelmeden önce kendinize ait ne tür mal, mülk ya da ev eşyanız vardı (tarla, ev, arsa, araba, traktör, televizyon, buzdolabı, çamaşır makinesi, vb.)?Bunları ne zaman ve ne şekilde elde etmiştiniz?
29. Ankara'ya geldiğinizden bu yana ne tür mal, mülk ya da ev eşyası edindiniz (tarla, ev, arsa, araba, televizyon, buzdolabı, çamaşır makinesi, vb.)? Bunları ne zaman ve ne şekilde elde ettiniz?
30. Kendi anne babanızın, eşinizin anne babasının ve çocuklarınızın gelirleri, mal mülk sahibi olup olmama durumları (neler) ve genel olarak ekonomik durumlarını kendinizle karşılaştırdığınızda nasıl değerlendiriyorsunuz?
31. Bankada ya da başka bir yerde birikiminiz var mı?
32. Borcunuz varsa nereden ya da kimlerden ne zaman ve ne amaçla almıştınız? Son bir yıl içinde kaç kez, ne amaçla borç aldınız?
33. Kredi kartı kullanıyor musunuz? Borcunuz var mı?
34. Kira geliriniz var mı?
35. Vefat etmiş yakınlarınızdan size herhangi bir miras kaldı mı? Kaldı ise neler?
36. Aylık giderlerinizi neler oluşturuyor? Her biri için ayda ortalama ne kadar harcıyorsunuz? (kira, elektrik, su, ısınma gideri, telefon, gıda, yol masrafı, temizlik maddeleri, sosyal etkinlik, sağlık giderleri, eğitim giderleri, giyecek ve diğerleri)
37. Bu giderlerde sizin için öncelik sırası nedir?
38. Geçiminizi kolaylaştırmak için siz ya da eşiniz (salça, sebze kurutma, bahçede sebze meyve yetiştirme, tavuk yetiştirme, reçel, turşu, bulgur, yapma, ekmek vb.) neler yaparsınız?
39. Sizin ya da ailenizin en acil ihtiyaçları neler?

BESLENME

40. Siz ve aile üyeleri yeteri kadar beslenebiliyor mu?
41. Son bir hafta içinde gıda tüketiminize baktığınızda neler tükettiğinizi söyleyebilir misiniz? (et, süt ve süt ürünleri, tahıllar, yağlar, meyve ve sebze vb.)
42. Hiç aç kaldığınız bir dönem oldu mu? Anlatır mısınız?
43. Gıda tüketiminde ailede öncelikli olan kimdir? Neden?

KONUT-MAHALLE-MEKAN

44. Oturduğunuz ev kaç odalı? Tuvalet-banyo var mı? Nasıl ısınıyorsunuz? İçme suyu sorun oluyor mu? (Evin fiziksel görünümü, olanaklar vb.) ?
45. Oturduğunuz ev kira mı yoksa kendinize mi ait? Kira ise ne kadar kira ödüyorsunuz?
46. Ankara'nın diğer mahalleleri ile karşılaştırdığınızda bu mahalleyi nasıl buluyorsunuz? Hangi mahallelerle hangi açılardan farklı, değerlendirir misiniz?
47. Bu mahallede oturan insanları maddi durumları ya da yaptıkları işler açısından nasıl tanımlarsınız? Bu mahalle hakkında dışarıdaki insanlar neler söylüyorlar?
48. Bu kentte oturmaktan memnun musunuz? Neden?
49. Bu mahallede oturmaktan memnun musunuz? Neden?
50. Bu evde oturmaktan memnun musunuz? Neden?

SOSYAL İLİŞKİ AĞLARI/DAYANIŞMA

51. Gününüzü genel olarak nasıl geçiriyorsunuz? Bize bir gününüzü anlatır mısınız? Köyde de böyle miydi (göç etmişse)? Karşılaştırır mısınız?
52. Boş zamanlarınızda neler yapıyorsunuz?
53. Mahalle dışında herhangi bir faaliyete katılıyor musunuz? Mahallede herhangi bir etkinliğe katılıyor musunuz? İnsanlar mahallede en çok ne için bir araya gelirler?
54. Mahallede ya da mahalle dışında en sık kimlerle ve ne amaçla bir araya gelirsiniz? Görüştüğünüz kişiler hangi mahallelerde oturuyorlar?
55. Görüştüğünüz kişilerle aranızda maddi yardımlaşmalar var mıdır? Varsa ne şekilde?
56. Başınız sıkışsa, maddi sıkıntılar yaşasanız ilk olarak kimlere danışır ve yardım istersiniz? Bu kişilerden ne tür bir destek görürsünüz?
57. Son yıllarda çevrenizde görüştüğünüz insanlarla olan ilişkilerinizde olumlu ya da olumsuz herhangi bir değişme var mı? Varsa sizce bunun nedeni sizce nedir?

YOKSULLUK

58. Siz toplumda kime fakir kime zengin dersiniz? Zengin ve fakir kişilerin özellikleri nelerdir?
59. Siz kendinizi toplum içinde nerede görüyorsunuz? Kendinizi hangi gelir ya da ekonomik gruba ait hissediyorsunuz?

60. Kendinizi fakir hissediyorsanız, sizce bu ne zaman, neden gerçekleşti?
61. Hayatınızda genelde (en çok) ne tür olumsuz durumlarla (ekonomik, sosyal, kültürel) karşılaşıyorsunuz? Maddi nedenlerden dolayı en son ne tür sıkıntılar yaşadınız? İnsanlarla olan ilişkilerinizde en çok ne tür sıkıntılar yaşadınız? Bunlarla nasıl baş ediyorsunuz?
62. Gelecekle ilgili kendiniz ve ailenizdeki diğer üyelerine yönelik beklentileriniz var mı? Varsa bunlar nelerdir (eğitim, iş, maddi vb.)
63. Sizce fakirliğin en önemli nedenleri nelerdir? Nelerden dolayı fakirlik ortaya çıkmıştır? Fakirlikten kimler sorumlu?
64. Sizce fakirlik ne demektir?
65. İnsan fakirlikten kurtulmak için ne yapmalıdır? Fakirlikten kurtulmak insanın elinde midir? Değilse kimlerin, hangi kuruluşların ya da kurumların elindedir?

HİZMETLER/DEVLET

66. Sizce devletin en önemli sorumlulukları nelerdir?
67. Sizce belediyenin en önemli sorumlulukları nelerdir?
68. Eğitim, sağlık, ulaşım, çöp toplama, elektrik, su ve diğer hizmetlerden yeteri düzeyde yararlanabiliyor musunuz? Mahallenize yeterince hizmet veriliyor mu? Verilmiyorsa nedenlerini açıklar mısınız?
69. Mahalle olarak yaşadığınız sorunlar nelerdir? Bu sorunları çözmek için bir araya geliyor musunuz? Çözüm için kimlerle ilişkiye giriyor, neler yapıyorsunuz?

SAĞLIK

Hastalıklar, Sağlık-Hastalığı Algılama, Tanımlama

70. Çocukluğunuzdan beri ne zaman ve ne tür ciddi rahatsızlıklar geçirdiniz, nedenleri nelerdi, iyileşmek için neler yaptınız? Kimlere başvurdunuz? (AİLEDEKİ HER ÜYE İÇİN)
71. Fiziksel sağlığınızı düşündüğünüzde, son zamanlarda fiziksel sağlığınızın iyi olmadığını düşündüğünüz oldu mu? Hangi nedenlerden dolayı iyi değildiniz?
72. Ruh sağlığınızı düşündüğünüzde (stres, depresyon, moral bozukluğu, duygusal sorunlar vb.) son zamanlarda ruh sağlığınızın iyi olmadığını hissettiğiniz oldu mu? Hangi nedenlerden dolayı iyi değildiniz?

73. Son zamanlarda fiziksel ya da ruh sağlığınızın kötü olmasından dolayı (ayrı ayrı) kendi işlerinizi yapabilme, çalışma gibi günlük etkinliklerinizi yerine getiremediğiniz oldu mu, oldu ise son 1 ay içinde kaç gün bu durumu yaşadınız?
74. Kentte yaşamanın sağlığınızı olumlu ya da olumsuz etkilediğini düşünüyor musunuz? Düşünüyorsanız neden?
75. Kendinizi hangi durumlarda sağlıklı ve hangi durumlarda hasta hissedersiniz?
76. Şuan kendi sağlığınızı genel olarak nasıl değerlendiriyorsunuz?
77. Sizin için kendiniz dahil ailede en önce kimlerin sağlığı önemli? Neden?
78. Sizce sağlıklı ve hasta olmanın en önemli nedenleri nelerdir? Sağlıklı insan nasıldır?
79. Sağlık sizin için ne anlama geliyor? (Sağlık ne demektir tanımını yapabilir misiniz?)

Sosyal Güvence/Sağlık Hizmetlerine Ulaşım

80. Sosyal güvenceniz (sigortanız) var mı? Varsa nedir ve ne zamandan beri var?
81. Köyde yaşarken sosyal güvenceniz var mıydı? Eğer göç etmeden önce sigortanız yoksa bu anlamda ne tür sıkıntılar yaşıyordunuz?
82. Şuan sahip olduğunuz sosyal güvenceden memnun musunuz? Memnun değilseniz ne tür eksikliklerin olduğunu ve ne tür sorunlar yaşadığınızı anlatır mısınız?
83. Herhangi bir sosyal güvenceniz yoksa ne zamandan beri yok?
84. Herhangi bir sosyal güvenceniz yoksa nedeni nedir? (yanıtlayamazsa ipucu verilecek: evde gelir getiren birinin olmaması, boşanmış olması, eşi ya da anne-babası ölmüş, işverenin yapmaması, yarı zamanlı ya da geçici çalışmak gibi işin niteliği, maaşının daha yüksek olması için sosyal güvenceyi kendisinin tercih etmiyor olması, diğer)
85. Sosyal güvenceniz yoksa bunun getirdiği sıkıntılar nelerdir?
86. Yeşilkartlı mısınız? Yeşilkartlıysanız memnun musunuz? Neden?
87. Sizce hayatınızın güvenli ve risksiz olabilmesi için neler gerekli? Neler sizin daha güvenli bir yaşam sürmenize katkı sağlayabilir?

Sağlık Arama Stratejileri-Kurumsal Deneyimler

88. Kendinizi rahatsız hissettiğinizde öncelikle neler yaparsınız?
89. Hangi durumlarda herhangi bir sağlık kuruluşuna başvurursunuz?

90. Son bir yıl içinde sağlık hizmeti almak isteyip de, maddi sorunlar yüzünden alamadığınız oldu mu? Oldu ise kaç kez ve ne tür rahatsızlıklardı? Bu durumda ne yaptınız, anlatır mısınız?
91. Sağlık hizmeti alırken en çok sıkıntı çektiğiniz konular nelerdir?
92. Herhangi bir sağlık kuruluşuna başvurduğunuzda kendinizi nasıl hissediyorsunuz? Size nasıl davranıyorlar?
93. Doktorun söylediklerini tam olarak yerine getirir misiniz? Getirmezseniz neden?
94. Sağlık personelinden beklentileriniz nelerdir?
95. Doktora gitmiyorsanız nedenleri nelerdir?
96. Hangi durumlarda diğer iyileştiriciler, ocak, hoca, türbe, kırık-çıkıkçı, vb. başvurursunuz?
97. Doğduğunuzdan bu yana ve kente geldiğinizden bu yana sizce genel olarak sağlığınızda değişme oldu mu? Oldu ise sizce nedeni nedir? (yanıtlamazsa ipucu verilecek kent yaşamı, iş yaşamı, yaş vb.)
98. Siz ya da aile bireylerinin hastalanması durumunda maddi ya da manevi destek alır mısınız? Alırsanız kimlerden ve ne tür bir destek alırsınız?
99. Sağlığınızı korumak için neler yaparsınız? (yanıtlamazsa ipucu verilecek sıkı giyinme, ilaç alma, bitki çayı, beslenmeye dikkat etme, egzersiz-spor yapma, sigara-alkol almama, vb.)
100. Yalnızca kontrol için doktora gider misiniz? En son ne zaman düzenli sağlık kontrolüne gittiniz?

Doğurganlik/Çocuk Sağliği (erkeklere de eşleri ile ilgili sorulacak)

101. Kaç yaşında evlendiniz?
102. Sizin kaç çocuğunuz var, kaç kardeşsiniz, anneniz kaç kardeşti, babanız kaç kardeşti?
103. Sizce artış ya da düşüşün ya da herhangi bir değişme olmamasının nedenleri neler olabilir?
104. Neden bu sayıda çocuk sahibi oldunuz? Siz ve eşiniz (ayrı ayrı belirtilecek) kaç çocuk sahibi olmayı istiyordunuz?
105. Kaç kez hamile kaldınız (eşiniz)? Bunlardan kaçı şuan yaşıyor ve kaçı kürtaj, düşük, ölü doğumla ya da ölümle sonuçlandı?

106. Herhangi bir aile planlaması yöntemi kullanıyor musunuz? Nasıl korunuyorsunuz?
107. Hamile olduğunuz (eşiniz) süre içinde doktora kontrole kaç kez gittiniz?
108. Nerede ve kimlerin yardımlarıyla doğum yaptınız? (eşiniz)
109. Bebeği(leri)niz kaç kilo ve kaç cm doğdu? Eğer hatırlamıyorsanız size göre irimiydi yoksa çok mu zayıf doğdu?
110. Bebeğ(leri)iniz doğduktan sonra kaç kez sağlık kontrolüne gittiniz? (her çocuk için ayrı sorulacak)
111. Ankara'ya ilk geldiğiniz yıllardan itibaren düşündüğünüzde (Ankara doğumlu ise hayatınızı şimdiye kadar yaşadıklarınızı düşündüğünüzde) neler kazandınız neler kaybettiniz? Gelecekle ilgili umutlarınız var mı? Şuan ki durumunuzdan daha iyi koşullarda yaşayabileceğinize inanıyor musunuz? İnanıyorsanız neler nasıl değişebilir anlatır mısınız? Genel olarak hayatınızı değerlendirebilir misiniz?

APPENDIX B

INTERVIEWEES IN *BARAJ* NEIGHBORHOOD

Name *	Relationship to HH	Int. date (2005)	Duration ***	Visit	Mar St.* ***	Age	Sex	Edu **** *	Occup.of Int. / HH	No of h. m.	Soc. Sec. Type	House Own.	Where they migrated from	When, with whom, they migrated?
İ.Ö.	HH	30.01	1h 30m	1	M	40	M	PSG	Unemployed	3	Green Card	Tenant	Kalecik/ Village	-5 years (with wife and daughter) 1st generation
G.B.	MHH	02.02.	2h 40m	1	M	49	F	L	Housewife/ Construction worker	5	Green Card	Owner without legal title deed	Kalecik/ Village	-31 years (with husband and daughter) 1st generation
H.G.	FHH	11.02.	1h 20m	1	M	61	M	PSG	Unemployed/ Butcher	6	SSI from working son	Owner without legal title deed	Bala/ Village	-35years (with wife) 1st generation
L.S	SHH	18.02.	1h. 5m	1	M	21	F	PSG	Housewife/Casual worker	4	Unins.	Tenant	Yozgat/ Village	-1 years (with husband and sons) 1st generation (her husband had worked seasonally for 5 years before migration)
Ö.A.	Son	21.02.	3h	1	S	25	M	PSG	Unemployed –Retired janitor	4	RF from his retired father	Tenant	Çankırı/ Village	-7 years (with his parents, his siblings) 2nd generation

M.Ay.	SHH	22.02. 25.02.	-2h -1h 30m	2	M	35	F	HS G	Housewife / Casual worker	4	Green Card	Father in law's house without legal title deed	Kalecik/ Village	-10 years (alone when she was married) 1st generation -Her husband came 15 years ago 1st generation
S.B.	SHH	23.02. 24.02.	-2h -27m	2	M	29	F	PSG	Housewife/Janitor in student dormitory	5	SSI from her working husband	Owner without legal title deed	Yozgat/ Village	-6 years (with husband and children) 1st generation (her husband had worked seasonally for 6 years before migration)
M.H.	HH	22.02. 28.02.	-2h 40m -1h 58m	2	M	33	M	PSG	Casual construction worker (does parquet inlay for his account)	4	Green Card	Owner without legal title deed	Yozgat/ Village	-17 years (with his parents and his siblings) 2nd generation -His wife was born in Ankara, 2nd generation
O.G.	HH	05.03.	2h 20m	1	M	34	M	PSG	Unemployed	6	Green Card	His wife's sister's house without legal title deed	Çubuk/ Village	-10 years (with his wife and daughters) 1st generation
A.A.	HH	14.03. 15.03.	-2h 30m -2 h	2	M	35	M	PSG	Waiter	4	Unins.	His father's house without legal title deed	Çankırı/ Village	-23 years (alone), 1st generation -His wife came when she was married 13 years ago 1st generation

M.D.	HH	21.03.	2h 45m	1	M	39	M	PSG	Gas station worker	5	SSI	Owner without legal title deed	Çankırı/ Village	-26 years (alone) (He had worked seasonally in İstanbul for one year before migration), 1st generation -His wife came when she was married 15 years ago, 1st generation
N.A.	SHH	25.03.	2h	1	M	28	F	PSG	Housewife / Seasonal worker (gardener)	3	Seasonal SSI from her working husband	Her father's house without legal title deed	Kırşehir/ Village	-15 years (with his parents and her siblings), 2nd generation -Her husband came when he was married 5 years ago, (he had worked seasonally for two years in Ankara before marriage), 1st generation
Mus. B.	HH	30.01.	1h 25m	1	M	51	M	PSG	Casual worker	4	Green Card	Owner without legal title deed	Kalecik/ Village	-15 years (with wife and children), 1st generation (first his father came 21 years ago for work, then his mother and siblings came, he stayed in the village at that time)
M.E.	MHH	09.02.	2h	1	M	51	F	PSG	Housewife/ Gas station worker	3	SE from her disabled husband	Owner without legal title deed	Kalecik/ Village	-6 years (with husband and son) 1st generation
M. Ko.	HH	11.02. 27.04.	-1h 45m -55m	2	M	33	M	PSG	Housepainter (self-employed)	5	Unins.	Owner without legal title deed	Çankırı/ Village	-11 years (alone) 1st generation (he had worked seasonally for 5 years in Ankara before migration) -His wife was born in Ankara, 2nd generation

N.B.	SHH	17.02.	1h 35m	1	M	26	F	PSG	Housewife/Seasonal worker (gardener)	5	Seasonal SSI from her working husband	Owner without legal title deed	Kalecik/ Village	-15 years (with her parents and her siblings) 2nd generation -Her husband came when he was married 8 years ago (He had worked seasonally for 4 years in Ankara, before marriage), 1st generation
N.D.	SHH	18.02.	1h 40m	1	M	39	F	PSG	Housewife/ Carpenter	5	Unins.	Owner without legal title deed	Kalecik/ Village	-18 years (with her husband) 1st generation (Her husband had worked seasonally for 4 years in Ankara, before migration)
F.K.	MHH	22.02.	2h	1	W	78	F	IL	Housewife/ Casual worker	2	Unins.	Owner without legal title deed	Çorum/ Village	-6 years (alone), 1st generation -Her son migrated 13 years ago 1st generation (he had worked seasonally for 12 years before migration with his father)
M.B.	SHH	23.02.	1h 40m	1	M	36	F	PSG	Housewife/ Casual worker	2	Green Card	Owner without legal title deed	Kalecik/ Village	-8 years (with husband) 1st generation (Her husband had worked seasonally in Ankara for 2 years before migration)
P.B.	SHH	25.02.	1h 25m	1	M	23	F	PSG	Housewife/Casual worker	5	Unins.	Tenant	Yozgat/ Village	3 years (with husband) (her husband had worked seasonally for 4 years before migration) 1st generation
H.T.	HH	28.02.	1h 15 m	1	M	32	M	PSG	Casual worker	3	Unins.	Owner without legal title deed	Kalecik/ Village	-19 years (alone) 1st generation -His wife came when she was married 6 years ago 1st generation

N.T.	HH	27.02. 27.04.	-1h 35m -1 h	2	M	45	M	PSG	*Simit* vendor (self-employed)	5	Unins.	Owner without legal title deed	Eskişehir/ Village	-17 years (with his wife, sons and daughter) 1st generation

INTERVIEWEES IN *GÜLTEPE* NEIGHBORHOOD

Name *	**Relationship to HH****	**Int. date (2005)**	**Duration *****	**Visit**	**Mar St.* *****	**Age**	**Sex**	**Edu .***** **	**Occup. of int/ HH**	**No. of h. member**	**Soc. Sec. Type**	**House Own.**	**Where they migrated from**	**When, with whom, they migrated**
Ö.Ö.	SHH	05.05.	2h	1	M	45	F	PSG	Housewife/Unemployed	4	Unins.	Her father's house with legal title deed	K.Hamam/ Village .	-27 years (when she was married) 1st generation -First father in law came 50 years ago for seasonal work, then her husband, his siblings and his mother came 35 years ago, 2nd generation
F.A.	MHH	06.05.	2h 5m	1	W	67	F	IL	Housewife/Unemployed	6	SSI from her died husband	Owner without legal title deed	Sivas/ Village.	30 years (with her husband, sons and daughters) 1st generation (her husband had worked seasonally in Ankara for 25 years before migration)

E.A.	BHH	09.05.	3h 16m	1	S	26	M	PSG	Porter at bazaar/Porter at bazaar (casual worker)	5	Green Card	His relative's house with legal title deed	Kars/ Village	-He was born in Ankara. His parents and his siblings came 28 years ago 2nd generation
H.B.	SHH	06.05. 08.05.	-45m -1h 46m	2	M	50	F	PSD	Housewife/Tea vendor at bazaar (self-employed)	5	SE from her retired husband	Owner without legal title deed	Erzurum/ Village	-30 years (with husband), 1st generation (Her husband had worked seasonally in Ankara for 12 years before migration)
H.K.	HH	14.05.	1h 20m	1	D	70	F	PSD	Housewife	1	Green Card	Owner with legal title deed	Selanik/ Village	-She was born in Ankara. -Her parents came to Ankara 79 years ago 2nd generation
A.Ay.	SHH	17.05.	2h 20m	1	M	36	F	PSG	Housewife/Automotive body repairman	6	SSI from her working husband	Tenant	Tokat/ Village	-29 years (with her parents and siblings) 2nd generation -Her husband migrated with his parents and siblings 25 years ago, 2nd generation
M.A.	Son	18.05.	2h 30m	1	D	30	M	VSG	Unemployed/ Retired public bath worker	3	Unins.	Tenant	Tokat/ Village	-25 years (with his parents and siblings) 2nd generation (his father went to the cities in the South for seasonal work before migration to Ankara)

B.B.	Son	24.05.	2h 56m	1	S	20	M	US	Pirate CD vendor based on daily wage with brother/daily domestic cleaner	6	Green Card	Owner with legal title deed	Kars/ Village	-19 years (with his parents and siblings) 2nd generation (his father worked seasonally abroad as truck driver before migration to Ankara)
T.D.	SHH	29.05. 30.05.	-22m -2h 28m	2	M	45	F	PSG	Housewife/retired bus driver (now prisoner due to being user and seller of hashish)	5	SSI from her retired husband	Her brother's house without legal title deed	Gümüşhane/ Village	-39 years (with her parents and her siblings) 2nd generation -Her husband was born in Ankara and his family came to Ankara 55 years ago 2nd generation
S.A.	HH	07.06. 10.06. 14.06.	-2h -2h 10m 1h 20m	3	D	68	M	PSG	Retired from paper factory (serving tea and coffee to factory employees)	2	SSI	Tenant	Çorum/ Village	-41 years (alone) 1st generation (he had worked seasonally in Ankara for 8 years before migration) 1st generation
A.M.	HH	16.06.	2h 40m	1	M	35	M	PSG	Street vendor (self-employed)/doorkeeper and domestic cleaner	6	Green Card	His father's house with legal title deed	Gümüşhane/ Village	-He was born in Ankara, his parents came to Ankara 55 years ago, 2nd generation -His wife was born in Ankara, her family migrated to Ankara 42 years ago, 2nd generation
M.Ç.	SHH	05.10. 06.10.	-1h 15m -1 h	2	M	45	F	HSG	Housewife/marble cutter	4	Green Card	Tenant	Kalecik/ Village.	-18 years (when she was married). 1st generation -Her husband came to Ankara alone for work 28 years ago 1st generation

M.K.	SHH	07.10.	2h 19m	1	M	40	F	L	Housewife/ Truck driver and porter (self-employed)	4	Unins.	Tenant	Burdur/ Village	-24 years (when she was married) 1st generation -Her husband with parents and brother came 45 years ago 2nd generation (her husband's father had worked seasonally in Ankara for 15 years before migration)
L.A.	HH	12.10.	2h 20m	1	M	40	M	JHS D	Garbage collector (tin and plastic only)	4	Green Card	Tenant	Çorum/ Village	-He was born in Ankara, his parents came 41 years ago 2nd generation, -His wife was born in Ankara„her family migrated to Ankara 55 years ago, 2nd generation
H.Ay.	SHH	19.10.	1h 41m	1	M	27	F	PSG	Pieceworker at home/Worker in stock room of clothing store	4	SSI from her working husband	Tenant	Gümüşhane/ Village	-8 years (with her husband and her son) 1st generation
S.K.	HH	26.10.	53m	1	M	70	M	PSG	Retired truck driver and porter	2	SSI	Tenant	Gümüşhane/ Village	-33 years (with wife), 1st generation (he had worked seasonally in Ankara for 18 years before migration)

H.A.	FHH	21.10. 22.10.	-1h -1h 32m	2	M	48	M	PSG	Unemployed / worker in home appliance firm (installation and shipping of home appliances)	6	Green Card	His father's house with legal title deed	Gümüşhane/ Village	-He was born in Ankara, first his grandfather came 55 years ago with grandmother, his father and father's siblings, (his grandfather had worked seasonally in Ankara for 5 years before migration) 3rd generation -His wife came when she was married 26 years ago. 1st generation
M.F.	HH	22.10.	1h 40m	1	M	74	M	L	Retired furnaceman	4	SSI	Owner with legal title deed	Gümüşhane/ Village	-59 years (alone) Then his parents came 55 years ago. 1st generation -his first wife came 52 years ago when she was married; his recent wife came 35 years ago when she was married. 1st generation

* The names of the interviewee are not stated for the sake of confidentiality.

**HH: Head of the household; SHH: Spouse of head of the household; MHH: Mother of head of the household; FHH: Father of head of the household; BHH: Brother of head of the household; Son: Son of head of the household.

***h: Hour; m: Minute

**** Martital Status. M: Married; S: Single; W: Widowed; D: Divorced.

*****IL: Illiterate; L: Literate; PSG: Primary School Graduate, PSD: Primary School Dropout; JHSD: Junior High School Dropout; JHSG: Junior High School Graduate; HSG: High School Graduate; VSG: Vocational High School Graduate; US: University Student

APPENDIX C

TURKISH SUMMARY

Bu çalışmanın temel amacı kent yoksullarının çeşitli sermaye biçimleri ile olan ilişkileri ve toplumdaki çeşitli konumlarına göre sağlık deneyimlerindeki farklılık ve benzerliklerini anlamaya çalışmaktır. Sağlık deneyimleri; sağlığı nasıl algıladıkları, ne tür sağlık-arama yollarını izledikleri, karşılaştıkları sorunların nasıl üstesinden geldikleri ve sağlık alanındaki kurumsal deneyimleri ile olan ilişkilerini içermektedir.

Öncelikle kent yoksullarının sağlık deneyimlerinin araştırılmasının sosyolojik açıdan meşru zeminini anlayabilmek için öncelikle toplumda son yıllarda yaşanan değişimleri ele almak gerekmektedir. Yaklaşık son 30 yıldır hem dünyada hem de Türkiye'de çeşitli alanlarda dönüşümler gerçekleşmiş, bu dönüşümler toplumsal eşitsizliklerin biçimini değiştirerek sağlığı da kapsayan farklı alanlardaki eşitsizlikleri derinleştirmiştir. İnsanlık tarihi boyunca makro düzeyde yaşanan değişimler toplumda dezavantajlı gruplar üzerinde çeşitli etkilerle kendisini gösterdiği bilinmektedir. Son yıllarda görülen toplumda sosyal sınıf, toplumsal cinsiyet, ırk, etniklik ve bunun gibi toplumda farklı konumları işgal eden gruplar arasında farklılığın gittikçe artması, en somut hali ile zenginliğin ve yoksulluğun kutuplaşarak bu gruplar arasındaki eşitsizliğin her geçen gün artması bize günümüz toplumunun resmini vermektedir. Bu farkındalığın akademik ortama, eşzamanlı olarak "yeni yoksulluk" ve "sağlıkta eşitsizlikler" konularına olan ilginin artarak yansıdığı görülmektedir.

Esas olarak, sermayenin rahat hareket ederek, karını ve birikimini artırma yönündeki çabası ekonomik alanda küreselleşme çerçevesinde yaşanan değişimlerde görülmektedir. Küreselleşmenin fikirsel zemini olarak, neoliberal paradigmanın son 30

yıldır çok çeşitli alanlarda hakim olduğu görülmektedir. Ekonomik alanda yaşanan değişimler somut olarak çalışmanın yeniden yapılandırılmasına bakılarak anlaşılabilir. Enformasyon teknolojilerinin hakim olması ile yeni teknolojik gelişmeler, üretim sürecinin insansızlaşması yani işgücünün emek sürecinden bir anlamda tasfiyesi ile sonuçlanmıştır. Bu değişim, kol gücüne dayalı işlerin sayısını azaltırken, diğer yandan özellikle hizmet sektöründe profesyonel-yöneticiliğe özgü işlerin önemini artırmıştır. Lash ve Urry'nin (1987) kavramlaştırdığı şekli ile refah devleti ve ulusal ekonomiye dayalı "örgütlü kapitalizm" yerini, çok uluslu ya da ulus-aşırı şirketlerin hakimiyet kazandığı "örgütsüz kapitalizme" bırakmıştır. Somut duruma bakıldığında, işçilerin iş güvenliği açsından daha korunmasız olduğu, genel olarak ücretlerin düştüğü, işgücünün örgütsüzleştiği, sendikasızlaştırıldığı, emek giderlerinin düştüğü görülmektedir. Küreselleşme ile birlikte, sermayenin dünya çapında rahat dolaşıma girebiliyor olması, ucuz emek arayışı gayesi ile, sermayeyi azgelişmiş ülkelere taşımıştır. Artık fabrikalar ve büyük şirketler gelişmiş ülkelerin kentlerinden azgelişmiş dünyaya taşınırken bu şirketlerin merkezi gelişmiş ülkelerin büyük kentlerinde kalmıştır (Sassen, 1998). Böylece, ucuz ve örgütsüz işgücü "yabancı sermaye" tarafından sağlanmıştır. Özellikle azgelişmiş ülkelerdeki kadınlar ve çocuklar bu süreçte düşük ücrete boyun eğmeleri nedeni ile tercih edilmektedir, bu da akademik ortamda "yoksulluğun kadınsılaştırılması" tartışmalarını gündeme getirmiştir. Genel olarak gelişmiş dünyada Post-Fordist üretim-birikim rejimi, Fordist rejimin yerini almıştır.

1973 yılındaki petrol krizi sonrası refah devletinin gücünü yitirmesi, neo-liberal politikaların hakimiyet kazanmaya başlaması, kısacası sosyal devletin zedelenmesi yaşanan ikinci dönüşümdür. Wacquant (1998) devletin rolündeki değişim ve iş yaşamının yeniden yapılandırılmasını birlikte ele alarak Toplumsuzlaştırılmış Ücretli Emek Rejimi (*Desocialized Wage Labor Regime*) kavramını ortaya atmıştır. Amerika ve İngiltere gibi gelişmiş ülkelerdeki değişimlere bakarak, bu rejim ile artık yaygınlık kazanmış "yeni istihdam ve tam vatandaşlık normunu" kastetmektedir. Ücretli son yıllarda yaşanan marjinallik ve yoksulluğun kökeninde temel olarak "emeğin mutasyona uğraması" ve devletin refah için ayırdığı payın azalmasını göstermektedir (Wacquant, 2001a). Ayrıca çok çeşitli alanlarda "bireysel sorumluluk deyiminin" sıklıkla kullanılır olduğunu ifade ederek topluma dayattığını söylemektedir. Kısacası Wacquant'ın deyimi ile "sosyal sermaye erozyona uğrayarak" devlet, eğitim, sağlık

hizmetleri, sosyal güvenlik, sosyal yardım gibi hizmetlerde büyük kısıntılara giderek "Sol Kolunu" kaybetmeye başlamıştır (Wacquant, 2001a: 402).

Bu değişimlerin topluma yansıması yoksulluk ve refahın yoğunlaşarak eşitsizliklerin ciddi boyutlara ulaştığı görülmektedir. Toplumsal dönüşümlerin toplum ve insan sağlığını doğrudan etkilediği düşünülürse, sağlıksızlığın da yoğunlaştığı aşikardır. Navarro ve diğerlerinin (2006) ifade ettiği gibi sağlıkta eşitsizliğin kökeni esas olarak toplumsal eşitsizliklerdedir. Genel anlamda sağlık göstergeleri incelendiğinde birçok hastalığın eradike edildiği ya da azaldığı, bir kısmının aşılama ile önlenebildiği, yaşam süresinin uzadığı, bebek ve çocuk ölümlerinin azaldığı, ölüm nedenleri olarak bulaşıcı hastalıkların yerini kronik hastalıklara bıraktığı görülmektedir (Nettleton, 1995). Bu literatürde epidemiyolojik ya da sağlık dönüşümü olarak ifade edilmektedir. Ayrıca yaşam sürelerinin uzaması ile doğurganlığın azalması ile demografik değişim de gerçekleşmiştir (Lloyd-Sherlock, 2002). Ancak, rakamlara ayrıntılı bakıldığında dikkat çeken en önemli nokta "yeni yoksulluk biçimleri" ile eşzamanlı olarak, farklı gruplar arasındaki aralığın artarak devam ettiğidir.

Türkiye'ye baktığımızda dünyadakine benzer şekilde dönüşümler yaşadığı görülmekte ancak bunlar irdelenirken Türkiye'nin değişim dönüşüm dinamiklerini kendi özgüllüğü içinde ele almak gerekmektedir. Türkiye'de de ekonomik alanın hakimiyetinin küresel boyuta taşınması ile birlikte 1980 yılları sonrasına tekabül eden bir dizi değişim ve bu değişimlerin sonuçlarını yaşamıştır. Yeni-liberal paradigmanın somut olarak politika düzeyinde yansıması yapısal uyum politikaları çerçevesinde görülmektedir. Sonuçta 1980'li yıllardan sonra gelir dağılımı eşitsizliklerinde artış, ücretlerde düşüş, devletten sosyal hizmetlere yönelik ayırdığı bütçede düşüş, işsizliğin artması, talep edilen işgücünde azalma, kayıt dışı istihdamın artarak enformal sektörün genişlemesi, ve bunun gibi bir birçok toplumsal bir aradalığı (*cohesion*) zedeleyecek etkilerden bahsetmek mümkün[1] (Alagöz ve Yapar, 2003; Kalaycıoğlu ve Rittersberger-Tılıç, 2003, 198; Lordoğlu ve Özar, 1998; Bircan, 1998). Bunlar yaşanan toplumsal eşitsizlikleri derinleştirerek yoksulluğun yeni biçimlerinin yaşanmasına neden olmuştur.

Türkiye'de günümüzde yaşanan yoksulluğu anlayabilmek kırdan kente 1950'lerde yoğunlaşan kitlesel göç ve sonrasını irdelemeyi gerektirir. Şenyapılı'nın (2004) Ankara incelemesinden yola çıkarak süreci irdelersek, 1920'lerde barakalaşma ile başlayan, daha sonraki süreçte barakaların mahallelere dönüşmesi, ancak günümüz

[1] Rakamlar için bkz. Bölüm 3.

gecekonduların 1950'lerde oluştuğunu söyleyebiliriz. Tarımsal yapılardaki önemli değişimlerin sonucu olarak kırsal-becerisiz işgücünün kentlere akın etmesi ile önceleri barınma ihtiyacını karşıladığı düşünülen ancak daha sonra kentsel mekanda varlığını sürdüren gecekondular yalnızca bir yapı olmanın ötesinde anlamlar içermektedir. Aslında bir bakıma Türkiye'nin yaşadığı süreci anlatmaktadır. Bu birinci kuşak göçmenler kent mekanının yapılanmasına ilişkin yasal boşluklardan da yararlanarak önceleri barınma ihtiyacını karşılayan sonraları ise kar sağlamaya başlamışlardır. Ancak 1980'lerin sonları 1990'ların başlarında gecekondu yapımına izin verilmemiştir. Bu süreçten sonra yeni göç edenler açısından gecekondu mahalleleri kiraların ucuz olduğu barınabilecekleri bir yer olarak görülmüştür. Aslında bir bakıma Türkiye'nin yaşadığı süreci anlatmaktadır. Bu birinci kuşak göçmenler enformal ağlar yardımı ve dayanışma ile büyük oranda bu süreci kendi lehine çevirmeyi başarmış ancak yeni yoksulluk biçiminde bu ağların işlevselliği yitirilmiştir.

Türkiye'de refah rejimi birçok yazarın ifade ettiği gibi hiçbir zaman Batı'daki gibi bir rejim değildir (Kalaycıoğlu ve Rittersberger-Tılıç, 2003). Buğra ve Keyder (2006), 1980 öncesi dönemde Türkiye'nin enformel dayanakları olan yani akrabalık, hemşerilik, komşuluk ilişkileri temelinde varolan geleneksel refah rejimine sahip olduğunu belirtirler. Ancak 1980'ler hatta 1990'lı yıllar sonrasında bu rejimin enformel dayanaklarının zedelenmesi ile eski gücünün azaldığını eski işlevini yitirdiğini dile getirirler. Ayrıca gittikçe artan yoksulluk karşısında tutunarak strateji ürettikleri ağların zayıflaması onları daha da yoksul hale getirmiştir. Benzer bir şekilde, Pınarcıoğlu ve Işık (2001a, 2001b) bu dönem için devletin rolünün ekonomik alanda pasifleştiği, sosyal sınıflar arasında kutuplaşmanın arttığını, özellikle de 1990'lı yılların ortalarında gelir adaletsizliğinin ciddi olarak yükseldiğini belirtirler. Ayrıca 1980 öncesini kentler açısından "yumuşak bütünleştirici kentleşme", 1980 sonrasını ise "gergin dışlayıcı kentleşme" olarak nitelendirmektedir.

Artık gecekondular göçmenlerin mekan gereksinimini gidermek için yapımında kendilerinin de bulunduğu ya da rant sağlamak amacı ile yapılan yapılar değil, artık gecekondular daha iyi koşulları sağlayamayarak bir üst sınıfa hareketliliği gerçekleştirememiş eski göçmenler, düşük gelirli aileler, ve yeni göçmenlerden oluşmaktadır. Yani Pınarcıoğlu ve Işık'ın (2001a) deyimi ile "yoksulluklarını devredemeyenlerdir". Pınarcıoğlu ve Işık (2003a) 2000'li yıllar sonrası yoksulluk biçiminin ekonomik krizlerle desteklenerek değiştiğini "kurallı yoksulluk" biçiminin

yerini "kuralsız yoksulluğa" terk ettiğini belirtmişlerdir. Birincisinde politik alanda klientalist-patronaj ilişkilerin ve toplumsal alanda da enformel mekanizmaların etkin olduğu ve bu yollarla baş edilebilen bir yoksulluk biçiminden bahsetmektedirler. İkincisinde ise artık enformel mekanizmaların eski işlerliğini yitirtmesi ile kuralları belirgin olmayan dolayısı ile de nasıl baş edilebileceği belirsiz bir yoksulluk biçimi hakim olmaya başlamıştır. Ayrıca enformel sektör "güvenlik subabı" işlevini yitirerek göçmenlerin kent emek pazarı ile bütünleşerek kentte varolabilme koşullarını artık yeniden üretmemeye başlamış, enformelin yıkıcı etkisi" gündeme gelmiştir (Pınarcıoğlu ve Işık, 2003b). Onlara göre, enformel sektör düşük ve düzensiz geliri, daha kötü çalışma koşulları ve güvencesiz yapısı ile yoksulluğun daha da derinleşmesinde önemli rol oynamaya başlamıştır. Bu kavramsal şemalar son yılların rakamlarına bakıldığında da fark edilebilir düzeyde görülmektedir (Bkz. Bölüm 3).

Toplumsal eşitsizliklerin topluma doğrudan etkisi aslında sağlık açından da çeşitli sonuçlar doğurmuştur. Her ne kadar dünyada olduğu gibi Türkiye'de "epidemiyolojik dönüşüm" gerçekleştirmiş olsa da son yıllarda gözle görülebilir şekilde sağlık göstergelerinde farklar artmıştır. Bebek ve çocuk ölüm oranları, gebe izle yüzdesi, sağlık ocaklarında doktor ve ebe doluluk oranları ve bunun gibi birçok değişkene bakıldığında; doğu-batı ve kır-kent arasındaki fark büyük oranda artmıştır (Hamzaoğlu ve Özcan, 2006). Bunlar gelir adaletsizliğinin artışının sağlıkta eşitsizlikle görülebilir olduğunun kanıtıdır.

Bu çerçevede sağlık ile yoksulluk arasında karşılıklı bir ilişki söz konusudur. Bir yandan yoksulluk temel kaynaklara erişim ve kontrol edebilmelerini engelleyerek sağlıksızlaşmaya, öte yandan sağlıksızlık da yoksullaşmaya yol açmaktadır. Bu anlamda sağlık hizmetlerine en çok ihtiyacı olan toplumsal kesimin yoksullar olduğu bilinmekte, ancak hizmete en az ulaşabilenlerin de onlar olduğu görülmektedir. Bu durum Tudor-Hart (1971) tarafından "ters bakım yasası" (*inverse care law*) olarak nitelendirilmektedir.

Birçok açıdan dezavantajlı konumda olan yoksulların daha çok "önlenilebilir" hastalığa maruz kaldığı, daha kısa yaşam beklentisi olduğu bilinmekte ve çok çeşitli araştırmalarla kanıtlanmaktadır.

Ancak bu eşitsizliği nasıl deneyimlediği, nasıl algıladığı ve baş edebilmek için neler yaptığı ve bu eşitsizlikte hangi faktörlerin etkili olduğu literatürde çok da fazla irdelenmemektedir. Ayrıca yoksullar bir grup olarak algılanmakta ve kendi içsel farklılıkları göz ardı edilmektedir. Sağlıkta eşitsizliklere yönelik çalışmalara bakıldığında

ise yapı-eylem ikiliğinin yeniden üretildiği görülmekte çalışmalar ya yapının sağlığa etkisi üzerinde yoğunlaşarak makro düzeyde çözüm önermekte, ya da sağlığın davranışsal boyutu irdelenerek davranış değiştirmeye yönelik uygulamalar yapılmaktadır. Ancak hem sağlık hem de yoksulluk kavramlarının tek boyutlu ve tek nedenli olmadığı da açıktır. Dolayısı ile bu kavramlar sosyal, kültürel, ekonomik boyutları ile birlikte ele alınmalıdır.

Son yıllarda sağlıkta eşitsizlikler konusunda yapılan araştırmalarda bu yapı-eylem-kontekts-eyleyen arasındaki ilişki birçok sağlık sosyoloğu tarafından irdelenmiş ve ikiliklerin nasıl aşılacağına yönelik tartışmalar üretmişlerdir (Williams, 1995; Popay ve diğ, 1998; Frohlich, 2001). Ve bu ikiliğin aşılması yönünde Bourdieu sosyolojisinin temel alındığı ve kavramlarının sağlık alanına artarak uyarlandığı görülmektedir.

Bourdieu'nun belirttiği gibi "toplumun bütünlüklü bir bilimi, hem eyleyicileri "tatile" çıkaran mekanik yapısalcılıktan, hem de bireylere ancak "aşırı toplumsallaşmış kültürel sersem" (*oversocialized cultural dope*) biçiminde ya da *homo economicus'*un az çok sofistike yeniden doğumu görünümü altında yer veren erekselci (*teleological*) bireycilikten kurtulmalıdır" (Bourdieu ve Wacquant, 2003: 20). Bourdieu bu ikilikleri alan, habitus ve sermaye biçimleri kavramlarını ortaya atarak bir tür eylem (*practice*) kuramı ortaya atmaktadır. Ve birey ile yapı arasındaki ilişki yerine *habitus* ile *alan* ilişkisine bakmakta, *alan* içindeki eyleyicileri de *sermaye biçimlerine* ne kadar (*volume*), hangilerine (*composition*) ve hangi yönde (*trajectory*) sahip olduklarına bakarak alan içindeki konumlarının oluştuğunu belirtir. Bourdieu gündelik hayat pratiklerine ve eyleyicinin bu pratiklerde kullandığı algı ve değerlendirmelerine önem vererek "pratiğin mantığını" anlamaya çalışmıştır. Ona göre evreni oluşturan yapılar iki düzeyde varolurlar: birinci düzeyde nesnellik "maddi kaynakların ve toplumsal olarak kıt değer ve mal edinme araçlarının, yani sermaye biçimlerinin, dağılımı" ile oluşur. İkinci düzeyde nesnellik ise "toplumsal eyleyicilerin pratik etkinliklerinin, davranışlarının, düşüncelerinin, duygularının, yargılarının simgesel matrisi olarak işlev gören zihinsel ve bedensel şemalar biçimindedir". (Bourdieu ve Wacquant, 2003: 17).Bu ikinci tür nesnellik yapısına *habitus* adını vermektedir. Wacquant bu kavramı şu şekilde açıklar: "Tanımlanmış ve toplumsal koşullara tekrar tekrar maruz kalmak, yapılanmış ataleti ve dış gerçekliğin zorlamalarını organizmanın içine kaydeder, böylece bireylerde toplumsal çevre gereğinin içselleştirilmesi anlamına gelen dayanıklı ve bağlam değiştirebilir yatkınlıklar bütününü yerleştirir" (a.g.e., s: 22).

Bourdieu'nun kuramında alan, habitus ve sermaye biçimlerini kendi aralarındaki ilişki çerçevesinde açıklamak gerekir, bu şekilde onun önerdiği gibi *bağıntısal* düşünme sağlanabilir. Ona göre toplumda esas olarak varolan şey bağıntılardır, eyleyiciler arasındaki ilişkiler değil (a.g.e., s: 81). *Alan* nosyonu diğer kavramlarla birlikte anlamlı hale gelmektedir. O *alanı* "konumların yapılandırılmış mekanı" (a structured space of positions) olarak adlandırır. Her alan kendisine ait kuralları içinde barındırır. Bu alanda sermaye biçimlerinin farklı dağılımı ile eyleyiciler farklı konumlara sahiptir ve alan bir tür iktidar ilişkisi ortamıdır. (Wacquant, 1998b). Bourdieu alan şöyle tanımlar:

> Bir alan alanın etkisinin görüldüğü mekan olarak düşünülebilir, öyle ki, bu mekana giren bir nesnenin başına gelenler, nesnenin içkin özellikleri ile değil, ancak alanın asli özellikleri ile açıklanabilir. Alanın sınırları, alanın etkilerinin bittiği noktada bulunur. (Bourdieu ve Wacquant, 2003: 85; Wacquant, 1998b: 221-222)

Sermaye biçimleri ise eyleyicilerin alanda rekabet etmelerini mümkün kılar. Bu temel sermaye biçimleri *ekonomik*, *sosyal* ve *kültürel* sermaye türleridir. Her sermaye türünün değeri ya da önemi alana göre değişiklik göstermektedir. Ve bu sermaye biçimlerine eyleyiciler yatırım yaparak ve birbirlerine dönüştürerek (conversion) alandaki rekabet güçlerini artırırlar.

Bu çalışma sağlık alanında yapı-eylem ikiliğini aşma ve sağlığı çok boyutlu düşünebilme gereği ile Bourdieu'nun kavramsal şeması ile şekillendirilmiştir. Çalışmada yoksulların sağlıksız olduğunu yeniden tekrarlamak yerine bu eşitsizlik durumunu nasıl yaşadığına bakarak, kırsal *alandan* kentsel *alana* göçü gerçekleştirmiş gecekonduda yaşayan kent yoksullarının sağlık deneyimleri farklı sermaye türlerine göre ve toplumdaki konumlarına göre analiz edilmiştir. Çalışma hem *habitusların* taşıyıcısı olan eyleyiciyi hem de yapıyı bir arada kavramanın gereğini kabul ederek, kentsel *alanda* her ne kadar ekonomik olarak benzer konumda olsalar da kendi içsel farklılıklarının olabileceğini varsayar. Çalışmada *ekonomik sermaye* gelir ve emek pazarı ile olan ilişkisi olarak kullanılırken, *sosyal sermaye, formal* biçimi ile sosyal güvenlik statüsü ve sosyal yardımlar şeklinde, *enformel* biçimi ile de toplumsal ağlar ve dayanışma olarak somutlaştırılmıştır. Öte yandan üç farklı biçimle varolan *kültürel sermaye* kavramı "köylü", "hasta", "yoksul" vb. çeşitli kimlikler çerçevesinde anlaşılmıştır. Bu kavramlara ek olarak alandaki konumu belirlemede etkili olabileceği düşünülen *sağlık sermayesi* kavramı irdelenerek sermaye biçimlerine eklenmiş ve bireysel sağlık ve iyilik

hali, bireylerce ifade edilen rahatsızlıklar ve tıbben teşhis edilmiş hastalıklar olarak somutlaştırılmıştır.

Bu çerçevede çalışma aşağıdaki araştırma sorularını yanıtlamayı hedeflemektedir:

1. Kent yoksullarının sağlığı algıları ve deneyimleri arasında benzerlik ve farklılıklar nelerdir.
2. Ekonomik, sosyal, kültürel sermaye biçimleri kent yoksullarının sağlık deneyimlerine nasıl etki etmektedir.
3. Sağlık farklı bir sermaye biçimi olarak ele alınabilr mi?
4. Sağlık deneyimlerinde eyleyicinin rolü nadir?

Kent yoksullarının sağlığı deneyimleme biçimlerini anlamaya çalışma çerçevesinde, 2005 yılında Ankara'nın Altındağ merkez ilçesinde *Baraj* ve *Gültepe* mahallelerinde derinlemesine-yüz yüze mülakat tekniği ile 40 kişi ile görüşme yapılarak araştırma gerçekleştirilmiştir. Öncelikle ilçe bazında sosyo-ekonomik ve sağlık verileri incelenerek sağlıksız ve yoksul olan merkez ilçeler belirlenmiştir. Daha sonra her ilçenin sağlık grup başkanları ile görüşülmüş ilçelerin genel yapısı, mahalleler ve yaşayanların sağlık durumları hakkında bilgiler elde edilmiştir. Bu çerçevede Altındağ ilçesi gecekondu yerleşiminin yoğun olduğu ilçe olarak seçilmiş ve Altındağ ilçesi Sağlık ve Sosyal Yardım Vakfı yetkilileri ile mahalleler konusunda ayrıntılı olarak görüşülmüş ve farklı özelliği olan iki mahalle seçilmiştir: Baraj ve Gültepe. Baraj mahallesi Altındağın en kuzeyinde bulunan en uzak mahallesi iken Gültepe Altındağın merkezinde bulunmaktadır. Bourdieu'nun metodolojik yaklaşımına uygun olarak eyleyicinin düşünceleri, gündelik hayat pratikleri sosyal dünyanın gerçeklerinin ayrılmaz parçası olarak kabul edilmiş ve niteliksel yöntem kullanılmıştır.

Sağlık deneyimlerine bakılırken hastalıkların yanı sıra sağlık ve hastalık algıları, sağlık hizmetlerine erişim, sağlık arama yolları ve baş etme stratejileri, sağlıkla ilgili kurumlarda yaşanılan deneyimlere bakılmıştır.

Araştırma yoksulların sağlık deneyimlerini anlamak ve benzerliklerinin yanı sıra içsel farklılıklarının kavranması açısından önemli sonuçlar elde etmiştir. En önemli görülen bulgular sermaye biçimlerine sahip olma durumlarından sağlık deneyimlerine kadar aşağıda verilmiştir.

Birinci bulgu kent yoksullarının ekonomik sermayeye düşük düzeyde sahip oldukları ve son zamanlarda da bunun gittikçe azaldığıdır. Kent yoksullarının kentsel emek pazarında formel işlere sahip olmaları oldukça sınırlı olduğu görülmüş, daha çok enformel sektöre tutunarak kentte varolabilmenin arayışı içine girdikleri görülmüştür. Ailelerde çalışan/daha önce çalışmış olan tüm bireylerin çalışma deneyimleri incelendiğinde, 1990'lı yıllar öncesinde formel sektörde iş bulabilme olanakları daha fazla iken 1990'lı yıllar sonrasında azaldığı görülmüştür. Bu ekonomik krizlerin ardından daha da belirgin hale gelmiştir. Ancak enformel sektörde çalışıyor olmak düşük/düzensiz gelir, güvensiz/sağlıksız çalışma koşulları, sigortasızlık ve iş güvencesinin olmayışı gibi sektöre özgü özellikler kentsel alanda yoksul konumu işgal eden bu kişilerin daha da yoksullaşmasına neden olmaktadır. Ayrıca alanda mücadele kapasitelerini azaltmaktadır. Ancak varolabilme koşulları, içine dahil olduklarında korunmasız oldukları bu sektöre tutunarak mümkün olmaktadır.

İkinci önemli bulgu kent yoksulları ekonomik olarak her ne kadar benzeşseler de aralarında farklar olduğudur[2]. Yoksullar *yardıma bağımlı yoksullar* ve *düzenli gelir elde eden yoksullar* olarak ayrılmıştır. Yardıma bağlı yoksullar (24 aile) gelir düzeyi düşük, üyelerinin hiçbirinin kayıtlı çalışmadığı aileler iken; düzenli gelir elde eden yoksullar (16 aile) üyelerinden en az bir kişinin kayıtlı çalıştığı, birinci gruptan daha yüksek gelire sahip yoksul aileler anlaşılmaktadır. Bu aileleri yaşam deneyimlerine bakıldığında birbirinden ayıran temel nokta temel ihtiyaçların karşılanıp karşılanamadığıdır. Ayrıca, Türkiye'de yaşanan değişime uygun olarak, kent yoksulları son zamanlarda ekonomik anlamda düşüş yaşadıklarını belirtmişlerdir. Buna göre çoğunluğu *kaybedenler* (*losers*) olmakla birlikte, yoksullar arasında *kazananlar* (*doers*) ve *aynı kalanlar* da (*accomodator*) vardır. Birinci gruptakiler son yıllarda ciddi düşüş yaşadıklarını ve bunun hayatlarına olumsuz etkide bulunduğunu ifade ederken, aynı kalanlar olanlar göç ettiklerinden beri ekonomik anlamda pek birşeyin değişmediğini söylemişlerdir. Aynı kalanların uzun yıllardır benzer işler yapması nedeni ile gelirlerinde çok büyük değişim olmadığını ifade etmişlerdir. Kazananlar ise çoğunlukla kent emek pazarına formel iş bularak entegre olabilmiş, kayıtlı olmaları nedeni ile en azından sağlık hizmetlerine erişebiliyor olmanın önemli olduğuna vurgu yapmışlardır.

[2] Yoksulların kendi içinde farklılıkları Ayata ve Ayata'nın (2003) çalışmaları baz alınarak, sosyo-ekonomik durumlarındaki değişme açısından farklılaşmaları ise Morçöl ve Gitmez'in (1995) çalışmaları baz alınarak anlaşılmıştır.

Üçüncü bulgu yoksullara yönelik devlet desteğinin oldukça sınırlı olduğudur. Devlet korumasının (*state protection*) düşük olması, yoksulların riskli durumlarda başetme anlamındaki bu boşluğu enformel ağ ile kapatmaya çalışmalarına yönlendirmiş ancak, literatürde de belirtildiği gibi, bu ağlar eski işlerliğini yitirmiştir. Ancak yine de eskisi kadar olmasa da önemini korumaktadır. Araştırmada kan bağına ve hemşeriliğe dayalı ilişkilerin yani sıra, komşuluk da işlevi olan önemli bir ağ olarak görünmektedir. Yoksulların ekonomik olarak birbirlerine benziyor olması, aralarındaki dayanışma ilişkisini de zedelemektedir. Çoğu, ilişkilerinin azaldığını belirtirlerken neden olarak "hepimiz fakiriz, birbirimize gidemiyoruz, yardım edemiyoruz" şeklinde tipik ifadeler kullanmaktadırlar.

Dördüncü bulgu kent yoksullarının içselleştirdikleri çeşitli kimliklerin sosyal alanda onları farklılaştırmasıdır. Alanda yoksul olmanın yanı sıra, geleneksel cinsiyet rolleri, köylü ya da kentli olma, hasta olma, eğitimsiz olma gibi özellikler onları birbirlerinden ayırmaktadır. Bu kendilerini tanımlama ya da algılama biçimleri günlük hayat pratiklerini de etkilemiş ve bu yöndeki habitusları bedenlerinde, davranışlarında ve pratiklerinde görünür olması kentsel alanda onların "farklılık hissini" güçlendirmektedir. Bu da hastane gibi kente özgü kurumlarda belirgin olmaktadır. Hastane ortamında "yeşil kartlı olma", "köylü olma", ya da "eğitimsiz-cahil olma" gibi kimliklerin bedenlerinde somutlaşması ile hastane çalışanlarının onları ayrımcılık yaptığı ve farklı davrandıkları vurgulanmıştır.

Beşinci bulgu kent yoksullarının hem bulaşıcı hem de kronik hastalıklara karşı korunmasız olduğudur. Genel anlamda çok sık hastalandıkları ve çeşitli kronik hastalıklara sahip oldukları için sağlık sermayeleri düşüktür. Ayrıca gittikçe düştüğünü birçoğu tarafından ifade etmişlerdir. Hastalığı tetikleyen faktörler arasında en çok işe yönelik nedenler, yetersiz beslenme ve zor ekonomik koşullarda yaşama en önemli faktörler olarak belirtilmiştir. Yoksullukla yaşamak temel ihtiyaçların karşılanamaması nedeni ile öncelikle çocukları etkilemekte bu, hastalık durumlarına bakıldığında anlaşılmaktadır. Genellikle, çocuklar geçici bulaşıcı hastalıklardan dolayı sıkıntı çekerken, yetişkin ve yaşlılar kronik hastalıklara daha yatkınlık göstermektedirler. Aile üyelerinde görülen hastalıklar ekonomik sermaye ile oldukça ilişkilidir. Çalışma koşullarından dolayı gündelik çalışan işçilerde özellikle bel fıtığı yaygındır. Dünya Sağlık Örgütü'nün "yoksulluk hastalıkları" olarak nitelendirdikleri hastalıkların çocuklarda özellikle yaygın olduğu görülmektedir (zatürree gibi). Ancak her zaman

doktora gidemedikleri için rahatsızlıkların hepsi de tıbbi olarak teşhis edilmemiştir. Buna örnek olarak depresyon verilebilir. Depresyon özellikle kadınlar arasında yaygın olarak ifade edilmektedir.

Altıncı bulgu kent yoksullarının fiziksel ve psikolojik iyilik hallerinin gelir, hastalık türü, yaş ve cinsiyete göre değişiyor olmasıdır. Kendilerini psikolojik olarak kötü hissedenler genellikle ekonomik zorluklara vurgu yapıyorlar. Öte yandan kronik hastalar fiziksel sağlıklarına vurgu yaparak kendilerini kötü hissettiklerini ifade ediyorlar. Hemen hemen yaşlı olup kronik hastalığa sahip görüşülen tüm kişiler kendi iyilik halleri konusunda kaderci bir anlayış sergilemektedirler. Kendini psikolojik olarak kötü hissedenlerin çoğunluğu yardıma bağımlı yoksullarda ve kendilerini "kaybedenler" olarak ifade edenlerde daha çok görülmektedir.

Yedinci bulgu kent yoksullarının sağlık ve hastalık algılarının ekonomik zorluklar, hastalık deneyimleri, cinsiyet ve sağlık hizmetlerine erişimleri ile ilişkili olmasıdır. Kent yoksulları kendi beden ve sağlıklarını "amaç" değil "araç" olarak görmektedirler. Özellikle ailede gelir getiren kişi rolünü üstlenenlerin sağlığına öncelik verilmektedir. Hemen hemen hepsi erkek olan bu kişiler kol gücüne bağlı işlerde çalışmaktalar ve bedenlerinin güçlü ve sağlıklı olması gelir getirici işlevi nedeni ile istenmektedir. Bu öncelik kadınların çoğu tarafından özellikle belirtilmiştir. Bu tarz bir algılama ile kadın kendi sağlığını çocuklardan sonra yani 3. plana itmiştir.

Dokuzuncu bulgu kent yoksullarının sağlığı "hastalık yokluğu", çalışmak ve günlük etkinlikleri rollerine uygun görevleri yerine getirebilmek anlamında "araç" ve çok çeşitli faktörlerin "sonucu" olarak algılamakta ve tanımlamalarıdır. Genel eğilim onların tek bir açıklama biçimini benimsemek yerine, bu üç açıklama biçimini ikisine ya da üçüne birden vurgu yaptıklarıdır. Sağlığın bir ürün, çıktı, ya da sonuç olduğu yönünde açıklama yapanlar genellikle yoksulluk deneyimlerine vurgu yapmaktadırlar. Ve *yardıma bağımlı yoksullar* arasında genel açıklama biçimidir. Güvencesi olmayanlar arasında ise sağlık hizmetine ulaşıp ulaşamama ile ilişkilendirilmektedir. Kronik hasta açısından bakıldığında, onların daha çok hareket yeteneğine vurgu yaparak aslında sağlığın bir araç olduğu yönünde açıklamaları yaygındır.

Onuncu bulgu yoksulların hastalıkları önem derecesine göre ayırt ettikleri ve bu ayrım çerçevesinde sağlık hizmeti alınıp alınamayacağına karar verildiğidir. Hastalığı tehlikeli görmedikleri durumlarda kendi kendilerine iyileşmeye çalışırlarken, yaralanma, bayılma, kalp krizi vb. durumlarda doğrudan hizmet kullanmaktadırlar. Ayrıca benzer

bir biçimde hastalıkları ayırarak geleneksel tıp ya da bilimsel tıbba başvurmaları belirlenmektedir. Bilimsel tıbbın ve geleneksel sağaltımın (örn. *ocakların*) ayrı uzmanlık alanları olduğu ifade edilmektedir. Ancak özellikle kendini kentli hisseden erkekler açısından modern tıbba güven vardır. Geleneksel yöntemlere inanan ve başvuran uygulayanların kadınlar ve aynı zamanda kendini köylü hissedenlerde fazla olduğu görülmektedir.

On birinci bulgu kent yoksullarının hastalandıklarında doktora gitmeme eğilimidir. Bu eğilimi etkileyen çeşitli nedenler olmakla birlikte çoğunda yaygın pratiktir. Acil durumlar dışında sağlık kuruluşlarına başvurmadıkları görülmüştür. Genel olarak gelir yetersizliği, sigortasız olma, günlük işten elde edilecek gelir kaybı kaygısı nedeniyle ve hastane ortamında yaşadıkları sorunlar nedeniyle sağlık kuruluşlarına pek başvurmamaktadırlar.

Son bulgu sağlık kuruluşu ortamında kent yoksullarının kendilerine ayrımcı davranıldığını hissetmeleridir. Yeşil Kart sahipleri bu erişim türünün yoksulluğu nitelemesinden dolayı kendilerine farklı davranıldığını ifade etmektedirler. Yeşil Kart yoksulluğun sembolik ifadesi olarak o kişilerin etiketlenmelerine ve farklı davranılmasına neden olduğu ifade edilmektedir. Bazı kişiler de bedensel temsillerinden dolayı sağlık personeli tarafından ayrımcılığa uğradıklarını belirtmişlerdir. Bu kişiler genellikle kadın ve kendini köylü ve eğitimsiz hisseden hastane ortamı dışında kentsel alanla fazla ilişkisi olmayan kişilerden oluşmaktadır. Ayrıca hastane ortamında kendilerini yabancı ve ayrı hissettiklerini de belirtmektedirler. Bu ortamda doktor ve diğer sağlık personeli ile iletişim kurmada onları anlamada zorluk çektiklerini belirtmektedirler.

Birinci araştırma sorusu kent yoksullarının sağlığı algıları ve deneyimleri arasında benzerlik ve farklılıkların ne olduğu idi. Öncelikle benzerlik ve farklılıkları görmek açısından sermaye biçimleri ile olan ilişkilerine bakmak gerekmektedir. Genel olarak kent yoksulları düşük ekonomik sermayeye sahip ve ekonomik koşulların daha kötüye gittiği çoğunlukla belirtilmektedir. Sahip oldukları formal sosyal sermaye açısından onların riskli durumlarla baş edebilmeleri için yetersiz olduğu görülmektedir. Ve son yıllarda enformel sektörde çalışmaları nedeni ile kayıtsız dolayısı ile de güvenceden yoksun olmaktadırlar. Enformel sosyal sermayelerine baktığımızda benzer şekilde azaldığı gözlenmektedir. Her ne kadar ekonomik dayanışma anlamında eski etkisini yitirse de kent yoksulları arasında hala önemini korumaktadır. Kültürel

sermayeleri kendilerini ifade etme ve bu yönde davranış sergilemeleri kentsel alanda onların pozisyonunu belirleyici etkiye sahiptir. Ayrıca sağlık sermayeleri çok çeşitli hastalıklara maruz kaldıkları ve artış göstermesi nedeni ile de düşüktür.

Sermaye biçimlerine düşük düzeyde sahip olmaları alanda onların yoksul konumlarını sürdürdüğü ve sağlık deneyimleri açısından önemli sonuçları olduğu söylenebilir. En çok gözlemlenen benzerlikler sağlık hizmetlerine başvurmama ve daha popular iyileşme yöntemlerini kullanarak doktor tavsiyesi olmaksızın ilaç kullanma gibi kendi kendilerine idare etmeye çalışmalarıdır.

Ancak kent yoksullarının farklı pozisyonları onların sağlık deneyimlerini de farklılaştırmaktadır. Gelir, sağlık hizmetlerine erişim durumları, yardıma bağımlı ya da düzenli gelir kazanan yoksul olmaları, formal ya da informal işçi statüsünde olmaları, işsiz ya da çalışan olmaları bir fark yaratmaktadır. Ayrıca gelir getiren kişi, evkadını, çocuk olmak, güçlü sosyal ağlara sahip olmak da onları farklılaştırmaktadır. Diğer bir farklılık da toplumdaki kültürel konumlar yani kendilerini hangi kimliklerle ifade ettikleridir. Farklı kimliklere alana özgü farklı anlamlar yüklendiğinden bu farklılık ortaya çıkmaktadır. Örneğin güçlü enformel ağlara sahip yoksullar sağlık hizmetlerine erişim, hastalıkların sonuçları ve tedavi ihtiyaçlarının giderilmesi konusunda yaşadıkları sıkıntılarla daha kolay baş edebilmektedirler. Diğer yandan, uzun süreli hastalığa sahip bireylerin sağlık arama yolları diğerlerinden farklı olarak, yaşayabilmek ve hastalıklarını yönetebilmek için, geleneksel ya da popüler tedavi yöntemleri yerine doktorun önerisine sadık kalma yönündedir. Kronik hastalıkla yaşamak hastalığın varlığının kabulünü ve kurallara uymayı gerektirmektedir. Diğer bir örnek cinsiyet farklılığı açısındandır. Kadınlar erkeklerden daha çok sağlık kuruluşlarına gitmekte ancak kendileri için değil daha çok çocukları için başvurmaktadırlar. Erkeklerin aksine, kadınlar daha çok popular ve geleneksel yöntemleri kullanmaktadırlar. Erkekler bilimsel tıbba kadınlardan daha çok güvenmekte ancak gelir kaybına uğrama kaygısı nedeni ile sağlık hizmetlerine daha az başvurmaktadırlar. Benzerlik ve farklılıklar anlamında ekonomik sermaye sahipliğinin onların sağlık deneyimlerini benzeştirdiğini kültürel olarak farklı rol ve pozisyonların da deneyimleri farklılaştırıcı rolünün olduğu söylenebilir.

İkinci araştırma sorusu ekonomik, sosyal, kültürel sermaye biçimlerinin kent yoksullarının sağlık deneyimlerine nasıl etki ettiğidir. Ekonomik sermaye kendi sağlıklarını ve iyilik halleri, bazı hastalıklara karşı korunmasız olmaları, sağlık algıları ve

sağlık hizmetlerine ulaşımlarını etkilemektedir. Diğer yandan sosyal sermaye sağlık hizmetlerine erişim ve hastalık durumu ile baş etmedeki önemi anlamında ön plana çıkmaktadır. Kültürel sermaye ise kurumsal deneyimleri farklılaştırmaktadır. *Sağlık sermayesi* incelenilen tüm algı ve deneyimleri etkileme potansiyeline sahiptir.

Üçüncü araştırma sorusu sağlığın farklı bir sermaye biçimi olarak ele alınıp alınamayacağıdır. Bourdieu'ya (1986) göre bir sermaye biçimi, birikimi için emek ve zaman gerektirir (s: 241). Sağlık da bu çerçevede sermaye biçimi olarak düşünülebilir. Sağlıklı olmak ve güçlü bir bedene sahip olmak görüşülen birçok kişiye göre kol gücüne dayalı iş açısından bir araç olarak nitelendirilmektedir. Bu habitus yoksulları genellikle gelir getiren kişilerin erkek olması nedeni ile erkek sağlığına öncelik vermeye yönlendirmektedir. Bourdieu'ya göre sermaye kişiye bireysel kazanç sağlayan ve bireylerin bu sermayeye yatırım yapması yolu ile yatırım yapabilecekleri bir kaynaktır. Yatırım yapmak sermaye biçimlerini birbirlerine dönüştürebilme ile mümkündür. Araştırma çerçevesinde düşündüğümüzde sağlık ve güçlü beden temel gelir getirici olması nedeni ile bir kaynak yani sermaye olarak düşünülebilir. Ancak erkekler sağlık kuruluşlarına başvurmadıkları görülmüştür. Bu önem verilip verilmemesinin yansıması değil, diğer sermaye biçimleri ile olan ilişki ile ilgilidir. Yani, sosyal güvence türleri ve gelir kaybına uğrama kaygısı hastaneye gitmemelerini altında yatan en önemli nedenlerdir. Sağlığına önem verilmesine ek olarak, haneye gelir getiren kişiler gıda tüketiminde de diğer aile üyelerinden ayrıcalıklı konuma sahiptir. Bu önceliklerin olması gerektiği kadınlar tarafından özellikle vurgulanmaktadır. Ekonomik alanda mücadele etmek iyi sağlıkla mümkün olmaktadır. Bulgulara göre hasta rolü emek pazarından dışlanma bazen de sosyal ağlardan dışlanma ile sonuçlanmaktadır. Diğer sermaye biçimleri gibi, insanlar bu sermayeye de verili koşullar ölçüsünde alanda güç kazanmak için yatırım yapmaktadır. Ekonomik zorluklar sağlık sermayesine yatırım yapmayı zorlaştırsa da, nesnel koşullar altında habituslarına uygun şekilde sağlığı geliştirici, daha doğrusu hastalıktan koruyucu, sıkı giyinme gibi, pratikleri uyguladıkları görülmektedir. Meinert (2004) sermaye biçimlerine beden sermayesinin eklenebileceğini tartışmış, Uganda'da yaptığı araştırmada bedenin bir kaynak olarak algılandığı sonucuna ulaşmıştır. Ancak kent yoksulları kapsamında beden tüm yönleri ile değil, "gelir getirici erkek" ve "sağlıklı" beden imgesi ön plana çıkmaktadır. Pratikleri de doğrudan beden üzerine yatırım yapma değil ancak sağlıklı kalmak

üzerinde yoğunlaşmaktadır. Böylece Mienert'den farklı olarak bu çalışma sağlığı bir sermaye biçimi şeklinde ele almaktadır.

Son soru ise sağlık deneyimlerinde eyleyicinin rolünün ne olduğuna ilişkindir. Eyleyicilerin alanda işgal ettikleri konumlar, güç ilişkileri ve mücadele kapasiteleri sahip oldukları sermaye biçimlerinin miktarı ve yapısı ile yakın bir ilişki içindedir. Bulgular gösteriyor ki, yoksulların içselleştirdikleri kırsal alana özgü, eğitime önem verilmemesi gibi habituslar kentsel alanda işlevsel değildir. Eğitimsizler, dolayısı ile formal iş bulabilmek için *kurumsallaşmış kültürel sermaye* biçimini *ekonomik sermayeye* dönüştürebilme kapasitesine (*reconversion*) sahip değiller. Kırsal alandaki tarımsal üretimde kullanılan beceri türü kentsel alanda kırsal alandaki gibi bir değere sahip değil. Kırsal göçmenler olarak kent yoksulları habituslarını devam ettirmektedirler. Eyleyici olarak, kentsel emek pazarına ucuz emek akışını sağlamaktadırlar. Ancak enformel emek pazarındaki konumları onların sermaye biçimlerine yatırım yapabilmelerini engellemektedir. Enformel sosyal sermayelerini ekonomik sermayeye dönüştürme güçleri daha önce söz konusu iken, bu güçleri yeni yoksullukla birlikte azalmıştır. Yine de az da olsa sahip oldukları enformel ağları dayanışmaya dönüştürebilmektedirler. Aynı zamanda, yoksullar az da olsa yeni alanın yapısının gerektirdiği şekilde yeni *yatkınlıkları* (*dispositions)* benimsemişlerdir. Bu, yoksullukla ve sağlık sorunları ile başetmek için, eski habituslardan kopuşu göstermektedir. Hastalık durumunda akrabalık bağı olmayan komşular arasında sosyal dayanışma yeni *yatkınlıklara* örnek olarak verilebilir.

Eyleyicinin kendi sağlığı üzerindeki rolü ve kontrolü, yani *yapabilirliği,* sahip oldukları sermaye biçimlerinin kompozisyonu ile de ilgilidir. Eyleyicilerin alandaki mücadeleleri onların sermaye biçimlerini birbirine dönüştürebilme kapasitesine bağlıdır. Kent yoksulları arasında sağlıkla ilgili olabilecek sorunlarla baş edebilmek için en yaygın kullanılan dönüştürme strateji yukarıda bahsedildiği gibi enformel sosyal sermayenin hizmete erişim ve ilaç yazdırma ya da muayene olmak için başkasının sağlık karnesini kullanmasıdır. Ayrıca sağlık deneyimleri açısından, enformel sosyal sermaye hastalık durumunda (çok azı doğrudan parasal yardım olmakla birlikte) *değişim değerine* sahip olmasa da *kullanım değeri* olan maddi ve manevi yardım şeklinde ekonomik sermayeye dönüşebiliyor.

Bulguların incelenmesi ile daha önce yapılan sağlık tanımına ek olarak sağlık bir sermaye biçimi şeklinde düşünülmüştür. Önceki tanıma bakarsak: belirli bir alanda

yapılanmış ve anlam yüklenmiş olan sağlık, birey temelinde temel ihtiyaçların karşılanması, kontrol edilebilmesi ve üzerinde çaba sarf edilmesi ile geliştirilebilen psikolojik ve fiziksel iyilik hali ve memnuniyetidir. Ayrıca belirli bir alanda bireyin sağlığı onun kontrol kapasitesine de bağlıdır. Böylece sağlığa verilen değer, algı ve pratik alana göre ve çeşitli sosyal gruplara göre değişiklik göstermektedir.

Bu çalışmanın en önemli katkısı sağlık konusunun yalnızca sağlık göstergelerinden oluşmadığı, farklı grupların deneyimleri temelinde özgüllüğü ve çeşitliliğini göz önünde bulundurmasıdır. Çalışma kent yoksullarının sanılanın aksine daha heterojen bir yapıya sahip olduğunu sağlık deneyimlerine bakarak göstermiştir. Sermaye biçimlerine sahip olma durumlarındaki farklılıklar ve farklı rol ve konumları nedeni ile sağlık deneyimleri de farklılaşmaktadır. Bourdieu'nun pratik kuramını izleyerek tez, sağlığın çok boyutlu ve ilişkili olduğunu göstermiştir. Ek olarak çalışma sağlığı bir sermaye biçimi olarak ele alınmasını önermiştir.

Bu çalışma Türkiye'de bir alt disiplin olarak sağlık sosyolojisinin gelişimine katkı sağladığı düşünülmektedir. Her ne kadar bu alt disiplin son 30 yıldır özellikle gelişmiş ülkelerde çeşitli araştırmalarla yaygınlık kazanmış olsa da Türkiye'de çok gelişmemiş ve ilgi yeteri düzeyde değildir.

Her ne kadar bu çalışma doğrudan Türkiye'de yaşanan yoksulluk üzerine odaklanmasa da, yoksulluk konusunu sermaye biçimleri, alan ve habitus kavramları ile ele alınabileceğinin ipuçlarını vermektedir. Ayrıca çalışma yoksulluk üzerine yapılan çalışmaların sağlık boyutunun daha ayrıntılı irdelenmesi gerektiğini önermektedir.

Sonuç olarak, sermaye biçimlerinin analiz edilmesi alandaki yapısal koşullar ve eyleyicinin içselleştirilmiş habitusları yolu ile gerçekleştirdiği pratikler arasındaki karşılıklı ilişkiyi bize gösterir. Bu nedenle, sağlık deneyimleri sosyo-ekonomik olarak homojen bir grupta bile farklılaşabilmektedir. Adı geçen sermaye biçimlerine ek olarak, sağlığın bir sermaye biçimi olarak ele alınabileceği düşünülmüştür. Sağlık sermayesi (bireysel olarak ifade edilen rahatsızlıklar ve tıbbi olarak teşhis edilmiş hastalıklar) diğer sermaye biçimlerini hem etkiler hem de onlardan etkilenir.

APPENDIX D

CURRICULUM VITAE

PERSONAL INFORMATION

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EDUCATION

Degree	Institution	Year of Graduation
MS	METU Sociology	2000
BA	METU Sociology	1997
High School	Edirne High School, Edirne	1989

WORK EXPERIENCE

Year	Place	Enrollment
1998 – 2006	Ankara University, Faculty of Health Education, Department of Health Education, Ankara	Research Assistant