

Health as venue of social and gender activism: Population politics and volunteer health workers in Islamic Republic of Iran¹

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The Origins of Volunteer Women:

The early years of the Islamic Republic of Iran were largely consumed by establishing and stabilising the new regime. The founders of the regime chose to do this not by boosting pluralism and the development of a civil society, which had been a major demand of the 1979 anti-Shah revolution. Rather it was done through eliminating opposition groups and consolidating and refining the regime's ideological position on political, economic and social matters. While the Pahlavi regime (1924-1979) had sought to de-politicize the nation, the Islamic regime felt it needed to mobilize the public in support of its ideological and socio-political visions. Such continuous mobilisation, however, requires the delivery of some benefits, if not political freedom. In any case, with or without mobilisation, the mechanisms of control enter into the calculus of the state (Richards 1995). The oil money, particularly during the low prices of the 1980s, was not enough to finance the elaborate state machinery and fulfil the regime's material commitment made to the poor and oppressed who were considered their primary constituencies. To deal with this limitation, the government adopted a strategy of controlled public participation in arenas that were not a political threat to their desire to monopolize state power but would cut down the cost of their development policies. One such initiative has been the introduction of a volunteer health program in low-income neighbourhoods. This program, which can safely be considered one of the largest and most successful initiatives, was introduced in 1992, and by 2006 it involved close to 100,000 women and had spread into 340 cities, towns and 2657 villages of the country.

In this paper, based on an analysis of a longitudinal study carried out in 1996-7 and 2007, I look at some of the unintended consequences of the Volunteer Health Workers Project on the lives of volunteer women and their communities, and at some possible implications for gender role ideology and the state's gender vision. There has been little attention paid by either the state, scholars or women's rights activists to these effects of the Volunteer Health Workers even though they have constituted the largest national program of this nature for women and their communities. This neglect stems from the authorities not attributing any political value to the volunteer women's seemingly innocuous delivery of basic health and family planning information to their neighbours. On the other hand, women's right activists and oppositional political leaders viewed this and other such programs as social activism at its best; given that they worked under the umbrella of the state, these volunteers were presumably incapable of challenging the state ideology.

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However, an examination of the two sets of data clearly indicates that Volunteer Health Workers participating in this large scale public mobilization have evaluated this unconventional avenue of public participation as an opportunity to redefine their own role, if not of women in general, at least within family, household and their community. Clearly, the exiting data indicates that they have delivered far above what the Ministry of Health had expected of them. But in the process of delivering information, using the legitimacy that the Islamic Republic had bestowed on them, they extended the role of women as wives and mothers from the restricted focus of domestic affairs to a vast array of public participation in the lives of their neighbourhoods. In effect they have broadened the household role of women so that it rippled out into the community to mobilize women's citizenry rights in a much broader manner than the state had envisaged.

Given the spread of this project into many rural and urban neighbourhoods, this paper focuses on two inter-related aspects: firstly the impact of the volunteer women's role on their personal lives, that is, their self perception as well their marital relationship, including their position in the family; and secondly, how their new unpaid but official position may have influenced their stand in the community. The positions have opened the possibility of a broader public role for these women. New avenues have been carved for organizing collectively for change, and not only at their neighbourhood level. They are now able to demand more services at the municipality and state levels as well. Finally, in the light of these findings, I raise the question of whether a governmentally engineered initiative such as VHW program can at least create an environment that leads to a re-definition and expansion of women's role from domestic to public participation -- eventually to women's empowerment and the promotion of a democratization process in a social if not a political sense. This has been one of the preoccupations of women's rights activists who have been frustrated by the limited space for public participation and the development of a meaningful civil society which they view as fundamental to the process of democratising society.¹

Constructing a Modern Islamic Society:

The emerging consensus concerning development in the Islamic Republic differs fundamentally from that of the Pahlavi regime's trickle-down policy (Haliday 1979; Mason 1998; Amirahmadi 1990). The Islamic Republic, concerned with building its legitimacy, gave priority to meeting the population's most basic needs in an attempt to avoid alienating their major constituency--the poor and less privileged. This ideological commitment was enshrined in the Constitution of the Islamic Republic.

An overview of policies put in place in the immediate post revolution years (1979- 1989) indicates that the government identified three major channels for reaching the less-privileged segments of society: the provision of basic foodstuffs, the availability of basic health care, and access to education. The budget allocations of the government clearly indicate these priorities (Table 1). However, the provision of basic food stuffs was introduced as a temporary measure to counteract the hardship imposed by the Iran-Iraq War (1980-1988) and it was never intended to be permanent (Amirahmadi 1990).

Education had a privileged position in the eyes of the government at this time because the regime viewed education as a vehicle for disseminating its "Islamic" ideology and counteracting the Westernized worldview promoted by the previous regime. Furthermore, access to education and

basic health care was the main channel for reaching the less-privileged. Thus, primary school text books were quickly revised, and within a few months of the Islamic Republic's take over in 1979 a substantial amount of religious material was added to the curricula. An important characteristic of the new curricula was the presentation of a very parochial and hierarchical family structure where women's place was within the domestic sphere and subordinate to the husband. The regime adopted the slogan of "jihad against illiteracy" in launching the literacy program. In the heat of revolutionary fervour, hundreds of volunteers and committed personnel were trained to teach basic literacy and new schools were established in rural areas. The Islamic regime was fairly active in encouraging parents to send daughters to school (Mehran 1991, 2002; UNICEF 1995). The Islamic appearance of education largely disarmed many parents who previously opposed female education on religious grounds, and there was increased social pressure to educate daughters. The net result has been a higher overall rate of female literacy and a higher rate of educational enrolment among children with a reduction in the gap between enrolment rates for girls and boys (UNICEF 1995). While the regime had its own agenda in promoting the Islamisation of society through education, it has made education, including higher education, more accessible to women, who by 2006 formed 64% of total university students. In fact, since the election of the conservative government of Ahmadinejad in 2005, a new quota system has been introduced that insures that at least 50% of the spaces in key disciplines are reserved for males.² Nonetheless, other unintended consequences of the expansion of women's education have yet to be examined.

The regime also adopted pro-natalist policies which included encouragement of early marriage, discouragement of family planning and re-enforcing images of women as wives and mothers. Consequently, in the 1980s there was a considerable increase in the number of school-aged children, the majority of whom now lived in urban areas. This raised an enormous challenge for the regime's ability to continue providing -- much less improving -- universal basic education, which was also made into a government monopoly.³ By the late 1980s, overcrowded classrooms, lack of textbooks, teacher shortages, and inappropriate buildings became topics of social debate, political jokes, and a legitimate vehicle of criticism of the Islamic regime -- which remained intolerant of political criticism. All these factors made many religious leaders conscious of the problems entailed in a rapidly increasing population, particularly regarding unemployment.

In contrast to the provision of education, designed primarily to benefit the regime by cultivating its ideological vision of Islamic society, improving universal access to basic health services has been the main avenue through which the regime communicates its commitment to the poor, "have not" regions of Iran. As Table 1 indicates, during the early years of the Islamic Republic, the government allocated a substantial segment of its budget to health even through the eight years of the Iran-Iraq War. The Ministry of Health had given priority to basic health care, common diseases that were responsible for many health problems, and mother-and-child health centres. It was helped by young and committed professionals, many of whom were familiar with the needs the culturally heterogeneous nation and its more than 40,000 villages. The government designed and implemented an efficient, low-cost health system which today (2008) has remained one of its most successful programs and sources of legitimacy (Shadpour 1994).⁴

Table 1: Budget allocation of regime

Ministries' budget	1976 %	1981 %	1986 %	1990 %	1995 %	2000* %	2006* %
Education	8.5	16	17.6	22	13	13.6	2.2
Health	3	6	7.5	9	7	6.6	2.7
Defence	28	10.5*	13*	10.5	5	13.6	7.5

*Note: The Iran-Iraq war continued from 1980 to 1988

Source: Planning Organization

Despite the eight-year Iran-Iraq War that placed considerable pressure on it, the Ministry of Health's achievements were commendable. The infant mortality rate, which was high despite the nation's high per-capita income, dropped substantially (see Table 2). Maternal mortality decreased significantly and life expectancy increased. Overall, Iran has had a commendable improvement in its human development index. This clearly demonstrates the importance of political choices in respect to development priorities. Like the Ministry of Education, however, the Ministry of Health was facing increasing pressure on its limited resources by the growing, young population and thus perceived the increasing rate of population growth and the pro-natal policy of government detrimental to the well being of the nation. Following the national survey of 1986, which estimated the population at around 50 million, experts and politicians started to discuss the consequences of increased population for the country and for the regime.

Table 2: Changes in the Health Profile of Iranians

	1974	1984	1986	1993	1996	2000	2006
IMR	91	51	45	34	-	29	30
MMR	*-	140*	91	-	40	37	76
life expectancy		67.5	67	-	69	69	71

Source: Shadpour 1994

*the gap between rural and urban, which was considerable under previous regime, has narrowed considerably.

The depressed economy of the 1980s and the need to reconstruct war torn regions and industries were already challenging tasks. On the other hand, the failure to deliver basic services would severely affect the credibility of the government of the *mustazafin'* (oppressed and powerless), which had pledged to build a just Islamic society in which all would enjoy basic health care, education, and equal opportunity. Having no other options, by 1988 the government introduced and carried out one of the world's most efficient family planning programs (Hoodfar 1996, 2000, 2001). This major turn-about in policy was approved by Ayatollah Khomeini, the supreme religious/political leader and at one time a serious opponent of all family planning programs, which he considered at the time an imperialist plot against Muslims.

Table 3. Annual Rate of Population Growth in Iran

1992	58 million	2.7 %
1996	59.5 million	1.46%
Year	Population	Annual rate of growth
1966	25.7 million	3.1 %
1976	33.7 million	2.7 %
1986	50 million	3.4 % *
1993	58 million	2.7 %
1996	59.5 million	1.46 %
2000	63.7 million	1.02 %
2006	70.6 million	1.03 %

Sources: 1966-1986, United Nations Demographic Yearbooks (United Nations, New York). 1992-1995; Iranian Family Planning Board.

* This figure excludes a net influx of approximately 2 million refugees from Afghanistan; the overall rate of population growth for that year was 3.8 per cent.

This laudable success can be attributed to four overlapping factors: a comprehensive design and definition of the program that, it was insisted, is a family planning and not a population control program; an effective national consensus-building campaign; efficient delivery services; and trust building. These four factors won a considerable degree of support from women. To the government's credit, the family planning program has indicated a sophisticated understanding of the complex interplay between fertility behaviour and of social, economic, religious, and political variables, including the position of women (Malek Afzali 1997; Hoodfar 1996, 2000). The program and its publicity masterfully reiterated the independence of the family, if not of women, in making choices in relation to planning the population's reproduction. The campaign emphasized that the program's central goals were to prevent unwanted pregnancies and genetic abnormalities, allow parents to space the births of their children, treat infertility, and improve women's and children's health.

Abortion, a controversial subject in Iran, was left out of the family program because, it was argued, abortion has nothing to do with family planning but rather relates to the question of women's general health. This strategy effectively prevented the opposition from mobilizing against the program on those grounds.

Credibility of the program was enhanced considerably by an honest communication of not only

basic information on contraceptive methods and benefits but also side effects and disadvantages. Both the family planning program and general health services were primarily directed at the low-income population whose lack of literacy required unconventional, especially oral and face-to-face, means of communicating the information and gaining trust.

Given the pre-existing rural health network, including village “health houses”, problems were more easily addressed in rural areas.⁵ Centres were usually staffed by a local man and woman, trained in basic health care. Their duties included providing mother and child health care and vaccinations; they also maintained records of births, deaths and other vital health information about all members of the village. Medical care by a doctor was available once or twice a week. In urgent cases, the health workers referred residents to the nearest hospital. Thus the village health workers were instructed in contraceptive use and provided with information and supplies for the local population. The strategy has worked very well and contraceptive prevalence was much higher than initially expected, especially given the rural preference for larger families.

In fact, the national consensus about smaller families was so strong that even the expressed disapproval of family planning program by the new conservative president, Ahmadinijad (2005--present) did not worry the program directors. They believed that even a major budget cut for this program would have only a minor impact on the fertility trends (Trait, 2006.)

Perhaps the greatest challenge to the program was winning over the ever increasing and overpopulated low-income urban neighbourhoods which had grown at an alarming rate during the Iran-Iraq War. Despite the regime’s firm commitment to men as the absolute head of the household, the program demonstrated some awareness that women exercise considerable autonomy in decisions affecting fertility and that the collaboration of women more than men would be central to the success of the family planning program. The cost of an urban neighbourhood outreach program, such as existed in rural areas, seemed impractical for the Ministry of Health. To solve this problem, the Ministry of Health initiated the program of Volunteer Health Worker women, which has proven to be very successful in achieving the expressed goals. Moreover, like most other governmental policies, it has entailed other unintended consequences. These have important implications for the government’s gender ideology and Iranian civil society, particularly the women’s rights movement(s).

Volunteer Women's Community Health Workers' Organization:

Although this extremely successful initiative is paradoxically presented as a non-governmental organization (Ministry of Health 1996), it was conceived by the Ministry of Health and Medical Education in 1991 with the goal of reaching low-income women in major cities without significant investment. In the early phase of the initiative, its political consequences were not discussed seriously. "Who could imagine a few barely literate women carrying contraceptive pills and appealing for the vaccination of children as political?" said one medical doctor. The success of *rural* health workers in promoting modern contraception had made salient the value of face-to-face relations, particularly in the area of mother and child health and fertility concerns. Thus, the question was how to do the same, economically, in low-income *urban* areas.

In 1991, a pilot project was launched with 200 women from low-income neighbourhoods in a district near Tehran, and by mid-1996 the program included over 20,000 volunteers throughout Tehran and all the major cities. By 2007, the official number had reached to 98,688 women (see Table 4). The organization's success attracted funding from international organizations, including the World Bank, (Bulatao and Richardson 1994; UNFPA n.d.).

Table 4. Women Community Health Volunteer Workers (CHVs)

	Population under coverage (this can be also household numbers if that is easier to find)	Number of CHVs	Number of Urban Health Centers involved
1994	1,500,000	5700	150
1995	4,218,000	13,400	417
1996	6,000,000	20,000	600
2007	15,825,043	98,688	2755

Source: Malak-Afzali and Askari-Nasab 1997, and the Ministry of Health, Office of Family and School Health (Office of Health Education-public participation sector) 2007

Community Health Centres, which are mainly set up in low- income urban districts, appoint volunteer women in each neighbourhood who act as intermediaries between local women and the Health Centre. These volunteer health workers receive basic health care training. Each volunteer covers approximately fifty to eighty households in her neighbourhood, serving as the centre's contact person and providing health information for her neighbours.

Although their most important concern, once appointed, is promoting modern contraception and family planning, volunteers are involved in other health matters. They are expected to keep records of all families with young children, new births, and pregnancies. They invite pregnant women to visit the clinic for pre and post-natal care and for vaccinations. Volunteers also monitor the health needs of their neighbourhoods and communicate them to the centre. This well-rounded approach to neighbourhood health issues has been very significant in bringing legitimacy to the role of the volunteers and it has also made the job more appealing to the volunteers themselves, as our data indicate.

Initially, female volunteers were selected during the annual door-to-door fertility surveys. The surveyors were instructed to identify middle-aged, seemingly knowledgeable and sociable mothers, who have some education. At a later date, the Organization of Volunteer Women Health Workers, housed in the local health centre, contacts and invites them to join the organization. In other cases, the organizers may contact the local mosques that normally have Koranic or other classes for women, and they in turn introduce the organization and invite women to join. In more recent years, often volunteer women themselves invite potential women to join the organization. The officially stated criteria, though not always observed, are quite significant. The volunteer women should be

married with only a few children; able to read and write, at least; in good standing in the community; enthusiastic about participating; and have the permission of their husbands. Recently, many somewhat more educated women have joined this program.

Although presented as a means of insuring the commitment of the husband to his wife's new responsibilities, requiring his permission nevertheless indicates that the Ministry of Health does not see any problem in the lack of autonomy for the women as wives. In contrast, the ideologues of the regime and religious/political leaders have never mentioned the necessity of husbands' permission when they invite women to participate in street demonstrations and elections.

Attaching such a condition for joining the program reinforces the ideology of control of husbands over their wives. There is a gender asymmetry in such a condition insofar as it is hard to imagine a similar requirement for husbands who might be invited to do similar public services. Clearly, few women would decide to participate if their husbands strongly objected. Yet, if they are to participate, should it not be the choice of the woman? Although this condition is not observed in practice, the attachment of that condition for participating in such a project -- one claimed to be part of "Iran's reproductive rights program" -- legitimizes the control of husbands' over their wives.

The volunteers meet in weekly or fortnightly sessions, during which a guide familiarizes them with the concerns, principles, and organizational structure of the Ministry of Health, particularly the delivery of health services to the locals. Contrary to the hierarchical teaching pedagogy practiced in Iran, there was considerable emphasis on making these classes participatory. Moreover, while providing health knowledge they also emphasized the frequent validity of women's traditional knowledge while also tactfully warning mothers about harmful practices. These classes were effective in improving interpersonal skills and building volunteers' confidence--a kind of empowerment and leadership training (Fatahi 1996).

The volunteers are nominally unpaid. Ideally they were to be supplied with an information kit including four books and a bag, stamped with the Ministry of Health logo, and occasional items such as a pen. They and their family members might also receive free or priority treatment in some health care services. In the past, as a way of encouraging the volunteer women, the Ministry of Health had invited successful volunteers to visit important shrines in Mashad and elsewhere. There were also several new women's sports centres which volunteers could attend free of charge. However, these services have almost all been stopped, given an increased number volunteers and a reduced budget.

Ministry of Health officials frequently refer to the organization as an example of how the Islamic Republic has made room for indigenous initiatives and public participation. The initiative, however, is not as original as they claim since the principal idea is borrowed from non-Iranian non-governmental and governmental initiatives elsewhere. For instance, the program greatly resembles China's neighbourhood grandmother system, as well as non-governmental Islamic health organizations such as Pesantren in Indonesia (Sciortino et al 1996), and efforts in Thailand and Latin American countries where housewives were mobilized for family planning and public health purposes. In fact, it has been shown (Hoodfar 2001) that the Iranian government, despite its active recruitment of male mullahs in support of family planning, has deliberately ignored women's religious preachers and gatherings that have operated independently, though individually, for

centuries. Had the government really been interested in indigenous institutions, these women preachers, who operate among mostly traditional and low-income neighbourhoods, should have been the first to be recruited to promote health, given their legitimacy in the eyes of these communities. However, the regime's earlier attempt to organize them under the regime's umbrella confirmed it would have proved difficult to exercise control over such an informal, autonomous institution.

To the government's credit, their plan has been well adapted to the cultural setting of urban Iran. On the other hand, it is quite evident that while the government welcomes the idea of public participation, it likes to remain firmly in control of these organizations, particularly in urban settings. For instance, authorities are apprehensive about making it possible for volunteers to meet in large groups and until October, 1998, the authorities had not facilitated the production and circulation of a newsletter for them in Tehran despite suggestions from many volunteers.⁶ In 1995-6, interviewees in Tehran told us they had suggested the creation of a special volunteer centre so they could come together in an independent space, share ideas and develop a sense of belonging. Apparently, the highest authorities of the Ministry of Health immediately rejected the idea, as they feared that if 20,000 strong and committed women were to gather, no one would be able to control them. Although this was presented to me (by several different high officials) as a somewhat humorous anecdote, it provides some insight into the political concerns of the government: an ambivalence in wanting citizens to participate in honouring the regime's commitment to basic services that the state cannot afford to provide, while on the other hand wanting to exercise firm political control. Had the government possessed the economic resources, it is doubtful whether it would have contemplated relying on volunteers.

The Research:

A close review of available documents on the initiatives and statements made by many officials in charge of volunteer women suggested that the voices of the volunteers were never presented. The absence of any study dealing with their perceptions and aspirations prompted a small qualitative survey of volunteer women on their self-perceived roles and their impact on their own lives as well as on the neighbourhoods, between 1996 and 1997, as part of the International Women and Law program launched by Women Living Under Muslim Laws in 1991-2001. We then found that women had welcomed this opportunity to be publicly active, even though many of the volunteers were well aware that this space was open to them only because the Ministry of Health intended to achieve its goals with the least cost. While the results of this study were very rich, it was too small to enable us to draw any serious generalizations and it was focused only on volunteers in Tehran. On the other hand, the volunteer program was still in its early years, and it was not clear how long it would continue in terms of assessing its long term impact on the women, their community and society as whole. By 2006, the project had lived for more than a decade and a half. While expanding greatly, its functions and general structure had not undergone any major change. Thus we carried out the second phase of our study in 2007, this time under the auspices of WLUML's Women's Empowerment in Muslim Contexts project.⁷ In this study, we carried out 100 in-depth interviews in Tehran, Mashhad, and Tabriz as well as some eight focus group discussions that involved a further 98 volunteer women in these three cities. The interviewees were chosen from diverse districts that

included older as well as newly established low-income neighbourhoods in the three cities.

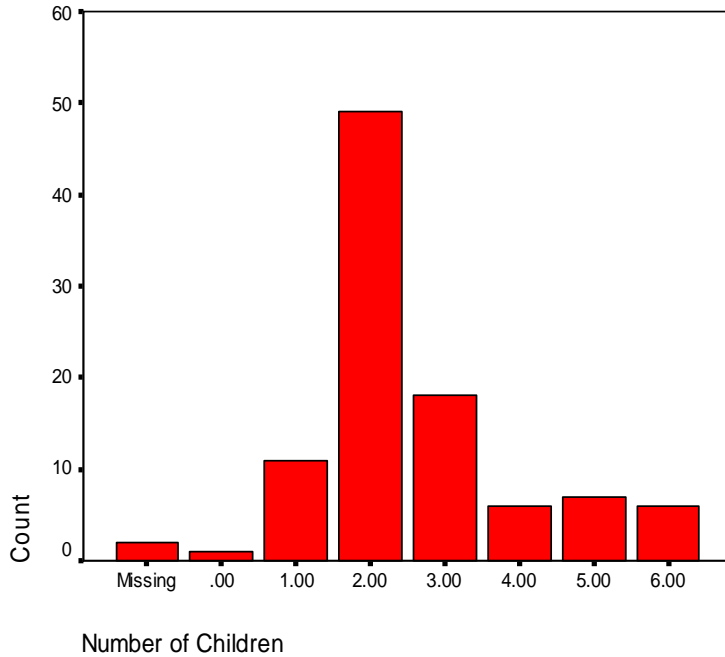
In the first phase of the study, six of the 28 interviewees were between the ages of 20 and 30; fifteen were between the ages of 31 and 40; and seven were between the ages of 41 and 47. Sixteen had a high-school level of education and eleven had achieved secondary school; only one woman had more than high school. All but two of the interviewees were married, with children numbering from one to five.

The age range of the women in the second phase was from 18 to 57 (see Table 5) and the number of children varied from zero to six with fifty percent having two children (see Graph 1 below). The majority of the interviewees had a high school diploma (58%); eight women had university or equivalent qualifications; and 34 women had primary or secondary education. Eighty-nine of the interviewees described themselves as housewives; four were hair dressers and four others women were religious instructors; there was one curtain maker and interior designer, one seamstress and one student.

Table 5: Age of interviewees in 2007

ages range of interviewees	Frequency	Cumulative Percent
Valid 18-19	2	2.0
20-24	1	3.0
25-29	6	9.0
30-34	15	24.0
35-39	18	42.0
40-44	19	61.0
45-49	24	85.0
50-54	12	97.0
55-57	3	100.0

Graph 1: Number of children by the interviewees



The number of the years that women were involved as Volunteer Health Workers varied (see Table 6) but it appeared that very few of the women who were involved in the Volunteer Health work ever left the job. As one older woman said, once you learn the system and you have the knowledge to help other women, it will be impossible for us to stop doing what we do now whether our Ministry of Health card has expired or not.

Table 6 number of years engaging in VHW

Years of engaging in VHW	Frequency	Cumulative
Valid 0.25-4.99	28	28.0
5-9.99	37	65.0
10-14.99	34	99.0
15-more	1	100.0

We found that despite the rather long interviews that we were conducting, the interviewees were delighted to participate in the study. Quite a few mentioned that they wished the Ministry of Health and other officials were more interested in what they have done and have to say. Several women knowing that we were academics asked us to write about their contribution to society despite them not being highly educated.

Volunteer Women's Assessment of Their Work:

Our opening question to all interviewees was why they had joined the volunteer program. Responses to this question varied from, "for the first time, I had a chance of doing something for my community," to "since I was not allowed to be a teacher, which I really wanted to be, I thought this might be the next best thing that I could do," or "I thought that if nothing else I will learn about many health issues for myself, and maybe others would benefit, too". Others said that they had always wanted to have a chance to get out of the house, expand their world and have a public role for example to be a teacher, a nurse, work in the bank, or something of the sort but that their family or husbands would not agree. Thus they seized this opportunity as the next best thing.

Although some had faced some opposition from their husband or families, they had found ways to soften that opposition. While many husbands had resisted the idea of them looking for a job, few had objected to volunteer work since it was unpaid labour and it did not involve leaving the neighbourhood all that often. Some women said that their husbands initially were not too happy and that had the position not been with a government organization, they would not have allowed them to join.⁸ Comparison of the data from Tehran, Mashhad and Tabriz, indicates that the women in Tabriz had experienced more pronounced opposition from their husband and families. Contrary to our expectation, women from the religious and usually conservative city of Mashhad had experienced almost no opposition, and there were no marked differences across level of education or income in the study population. Our focus group discussions with women in Mashhad indicated that while the concept of volunteer work, particularly for a government organization, is rather new in Iran, many women in Mashhad have a history of being involved in charity activities. The religious ideology of the regime and the legitimacy that the state continues to enjoy made it easier for women to join the volunteer program. On the other hand, despite the strong integration of the Turkish minority in the Iran state structure, there remains a mild tension between Turks and the central state. This may in part explain the higher level of opposition experienced by the women in Tabriz, which houses a large Turkish population. These details are important because so often the role of wider political issues in making personal decisions is ignored.

Some of the opposition from families was expressed as, "only a fool will go and work for nothing," indicating an unfamiliarity with the volunteer concept. On the other hand, opposition from the husband tended to stem from their reluctance to lose control over the time and mobility of their wives. They were told that their volunteer work might mean neglect of their family responsibilities. The most serious objection from the husbands was toward their wives having to go door to door in the neighbourhood to provide health information or update the household records. "What if you were invited into homes and there were men there who could harm you?" Or they were worried about their honour as a man and their standing in the community if they allowed their wives to move around freely in the neighbourhood.

Determined to join the program, women found ways of putting their husband's mind at rest. Those with longer years of experience as a volunteer told us that it was helpful that initially the women who were invited to become volunteers were not very young and therefore were less subject to strict control. Such volunteering is now more institutionalized and acceptable to the communities and is easier for all to join. The younger women readily point out that had it not been for their predecessors' good work and positive reputation they could not so easily join the program and be at

the service of their community while also learning something and expanding their horizons.

Women with longer years of service explained that they had developed their own strategies to reduce family opposition. For instance they would go in teams of two and not alone, even though this meant they had to spend more time visiting the households they covered. Others had adopted the strategy of saying that the Ministry of Health forbade them from going inside people's homes. Yet some women in Tabriz, knowing of their husband's likely opposition, simply did not tell them what they were doing for a long time since so much was happening during periods when their men were neither home or in the neighbourhood. They would only reveal to them their new activity gradually and in a manner that would not alarm them. In more recent times, should a husband oppose his wife joining, one of the older and more experienced volunteer women would go and talk to the husband and for a time offer to accompany the younger volunteer until she had gained enough experience. None of these strategies are reflected in any of the manuals of the program or any research or documentation of this project. These initiatives only indicate the eagerness of the women for expansion of their role beyond the restricted conventional criteria of home and family.

All interviewees were asked to list all their activities: first, those that are part of their responsibilities and then those extra activities that are results of becoming a volunteer. Beside door-to-door visits and keeping a record of the basic health information of households, volunteers referred women to the clinic, informed them about pre-natal and postnatal care and vaccinations. Many volunteers spend considerable time informing their neighbours about nutrition. The information dispensed was not always picked up during their training but rather gleaned from newspapers and women's magazines such as *Zanan* or *Zan-e-rouz* (two of the popular women's magazines) or other publications.

In response to our question about the impact of their involvement in volunteer work on their lives, without exception women expressed very positive views. They had learned a lot from the training they received and felt much more in control of their lives. A large majority stressed the importance of learning how the health system worked and how that had helped them learn to navigate their way around other government institutions. They enjoyed their ability to help their neighbours. "Our world has expanded and our knowledge has increased. I feel I can respect myself more now and, because of that, others also respect me," said a middle aged volunteer from Tabriz. Another woman said, "I have discovered that learning in itself is pleasurable and I feel that I am blessed that by sharing my knowledge with my neighbours I gain more *savab* [reward from God for good deeds]. That compensates for not being paid, as far as I am concerned." Another woman put it this way:

I am religious but I do not think much of this government because of their backward ideas on women and the terrible family law they have introduced, but I have to admit that their volunteer program has changed my life and that of many other women like me who are caught between economic hardship and the control of their husbands. Being a volunteer makes us feel we are a valuable member of our community.

A significant aspect of our findings was that regardless of how their husbands felt initially, all interviewees said that their husbands now were very happy and satisfied with them being a Volunteer Health Worker. When we asked the interviewees to explain what had made their husbands so supportive of their activities, the replies were insightful, both culturally and

ideologically. Examples:

My husband had always objected to my working, even though I had a high school diploma and could get a job as a teacher, or something like that. You know men do not want their wives to work because they feel that if they bring money home then they will not obey or respect them. They feel they can no longer play the king of the home. They assume their wives would not try to comfort them when they come home from a day of work. Other men may feel embarrassed in the community because many traditional people may think that the husband cannot, or is too lazy to, support his wife and children. This bothers men a lot. However, now that I can work as a volunteer that receives no pay, he does not feel bad. Moreover, he can see that I have learned a lot from my training. I also teach our neighbours and relatives and they respect me for it. This makes him also proud of me.

Another 39-year-old woman, who by then had been working for 3 years said:

My husband didn't want me to work, and having children and living a long way from town would make it impossible to have a job. But I must tell you that being home all the time and not having many relatives in Tehran, where I have come to live since my marriage, made me short-tempered and I was often hard on my children and my husband. But, now that I go to the clinic and meet with other women and learn something, I have changed. I am a different person. I love my neighbourhood. I continuously think about what we can do to improve it. I also have become a better housewife. My home is clean. I pay much more attention to hygiene. I cook better and more nutritious food and tell my husband and children why I cook this food and not the other. Neighbours, family, everyone respects me more. My husband calls me "*Khanom* (Madam) Doctor", and when his friends have questions on health or family planning he comes and asks me. You see we have now become more like friends, because now that I am more involved in society, I can talk to him about health matters, bus services, trying to encourage the municipality to create a sports area for our children and so on. Never before did I get into these kinds of talks with him or any one else. Now my life has changed.

Another woman interviewee said:

It is interesting that I always thought that men did not want women to learn anything because they liked to believe that women are less intelligent. But now that I am a volunteer and I have learned so much, it appears that he enjoys it almost as much as I do. We argue less, we discuss things more, whether it is about children and neighbours or relatives or the country as a whole. I do think the government should encourage this public role for women; it does not cost them anything, we do a lot for nothing, and it adds to the value of family [and she jokingly added] it can help to bring the divorce rate down.

We asked them if they knew of any volunteers whose family life had deteriorated because of their engagement in this project. None, whether in Tehran, Tabriz or Mashhad, could think of one such volunteer. Rather, the engagement of the women in volunteer work and their adoption of a more public role have brought the husband and wives closer to one another. Their worlds have become

closer and they have more to share. They have become more like friends and equal partners rather than one being in charge of the other. This has democratized their marital relationship if not their whole household. Often reform and demands for more equality between men and women have been dismissed on the ground that these are Western ideas and that Iranian traditional culture and popular sentiment are not ready to accept such values. However, the volunteer experience indicates that if the claim to equity is based on real change, the popular culture and the public, despite their religiosity, is quite ready to incorporate such values into their lives and world view without seeming contradictory to Islam, which they view as their guiding principle. They may, however, distinguish between the state's Islamic ideology and their own spiritual commitment to Islam.

Most volunteer engaged in activities far beyond their defined mandate. In fact they have redefined their mandate in such a way as to incorporate a large array of public activities, e.g., demanding that local shop keepers observe the hygiene regulations; demanding that local vendors sell only healthy food to children; going to local schools and talking about the importance of hygiene and good nutrition; or giving basic reproductive health lessons for young people to the older female students. The recounting of the volunteers' experiences indicates that initially some of the local shops had not taken their requests seriously and had ignored the volunteers warning. The volunteers had enlisted the support of the doctors and nurses at the health centres and sent officials to issue fines or even close the disobedient shops. After a few such occurrences, the news quickly spread that volunteer workers also had authority in enforcing rules of hygiene in their neighbourhood. As one of the program officials put it: "Despite our very strict definition of the volunteers' mandate, every day they find a new way of extending their sphere of influence and they draw us into supporting them. Sometime I feel that because they are unpaid, they have more moral authority than our paid staffs".

At least some of the volunteer women are well aware that they have been pushing their boundaries, but they feel that there is no point in worrying about health delivery if public health is lacking. "I think they (the Ministry of Health) should organize to ask us what we think is needed and revise their program at least every two years. But since we have been successful in doing what they really wanted us to do, which is advising women on contraception and making sure all children are vaccinated, they do not feel they have a reason to listen to us. But we do what we can regardless, because we are doing this to please God and bless our neighbours."

The other kind of activity they engage in is improving the neighbourhoods by organizing and then demanding that the municipality provide them with services not automatically available in many outlying, newly developed, low-income neighbourhoods of Tehran. These include, for instance, regular garbage collection, paving major roads, or creating green spaces or neighbourhood playgrounds for children on undeveloped land formerly used as garbage dumps. In this respect, however, there were marked differences between the activities of volunteer women working with a more organized centre and women who merely had a minimum health education at their urban health clinic. For instance, women from Hakimieh were more inclined to encourage the neighbours to petition for asphalt, clean water, better bus services, sport facilities for youth, and so on. Many had initiated these activities and had brought other women and men, including their own husbands, to work as a collective, had organized meetings in their homes or in the local mosques, and had formed pressure groups. Many of them had become skilful in employing appropriate external sources of support such as the head of the local health centre or even the vice-director of the Ministry of Health who could write a letter of support to encourage the municipality to deliver the

services.

In several cases where these tactics had not delivered the desired result, the women had organized themselves and had contacted newspaper and TV channels to come and to their neighbourhood and publicize their grievances against the municipality. At least in all known cases this strategy has worked. “You have to know how to talk to them. The government keeps saying they are the government of the *mostazafin* (the poor and oppressed.) So we remind them that we are the people they are supposed to work for. We tell them we have no desire to be leaders but we want to be respected as citizens,” Masomeh, a 40 year old, long term volunteer woman, explained to us.

The level of political savvy one can extract from their stories that have been carefully presented in the least political manner is an indication of a culture of resistance and subversion, in a context of little public space or democracy. Given the long history of repression, the emergence of women as local leaders has been unprecedented.

The active role of volunteer women in addressing the needs of the neighbourhood has brought them much prestige and status. Moreover, it has encouraged many others either to join the organization or become active in mobilizing their community to demand services and hold the state accountable. Many volunteers proudly recounted what they had achieved, how they had learned from the other volunteers' experiences, and how they guided each other in these activities including petition-writing, which was quite unusual in Iran given the long history of political repression:

We needed a playground for our children, particularly during the summer times. I had gone to the relevant office to register our request but they did not take me seriously. What made me upset was their condescending attitude towards me when I told them that I was Volunteer Health worker. They told me that even the paid worker cannot get far, so how do you expect us to take your demand seriously? I came home thinking we have to change these attitudes. I talked to the other volunteers. One woman said we could write a letter and ask all mothers in the neighbourhood to sign. Then we identified the possible areas that could be turned into a football ground for youth to play. In the end, every man and woman in the neighbourhood signed the letter and our men also became involved. We collected more than 30,000 signatures and chose five people which included me and one other woman, one young 16 year old youth and two older men from our neighbourhood to transmit the petition. We made an appointment and send a copy of our letter to two newspapers. This time nobody treated me like a fool and within a few weeks we had two football grounds, one on each side of the neighbourhood. Now whenever I go to their office they treat me with great respect.

I never knew that I could do these things, but now I am always advising other volunteers on how to go about organizing these things in their neighbourhood. Moreover now women and men come to me, and not to our local council who is supposed to attend to community needs, to organise and demand various services. For instance, our local school did not have teachers and our children were suffering, so we organized and for three days ten of us, as parents, went to the relevant office and sat in front of the directors' office and forced them to listen to us. Finally they sent teachers for our schools.

Early on, these activities brought Volunteer Health Workers to the attention of municipalities, particularly Tehran. As part of Iran's strategy for reintegrating into the international community after more than a decade of isolation, many of the higher ranking officials had participated in several international conferences on the environment, and particularly the Habitat conference in 1996. In the process, officials themselves learned much about the issues and were stimulated by the programs that other developing countries had adopted. They also learned that beside the official delegates, each country was also represented by NGOs working in the relevant field, but Iran had essentially no NGO. To save face, the authorities tried to create a facade of having active NGOs.⁹ So they identified the Volunteer Women Health Workers as one possibility. They published several pamphlets and organized a few workshops for them on public health. They were encouraged to take an active role in promoting public health, for example by advising people not to dump their garbage in the street, not to raise animals at home, and so on. However, we could not bring attention to how women had come to learn about petition writing, which had not been part of an Iranian culture and at a time when would be willing to sign any petition given the risks involved.

There were other sorts of activities that the volunteers engaged in. Given that they worked in low-income neighbourhoods, they often came to know of households that could not buy necessary medicines, or of a daughter who did not have a minimum trousseau to get married, or a husband who had lost his job, and so on. The volunteers often tried to mobilize their network to collect money or find jobs for the needy in their neighbourhood. They provided personal services, such as taking a sick child to the clinic, cooking for a family whose mother was sick or hospitalized, or helping with the lessons of a child who had missed school. These activities stimulated a respect and trust within the neighbourhood towards the volunteers. In the context of Iran, becoming acquainted with families would inevitably mean getting involved in family problems, both among in-laws and within couples. Many volunteers had learned to deal with such issues by trying to curtail disagreements.

Working as a volunteer has also meant an expansion of the women's network and the development of strong relationships and a sense of belonging and identity. One of the volunteers' major demands has been the creation of opportunities for more collective activities for them. First they were asking for a special newsletter that would connect the volunteers across the nation. This demand was denied to those volunteers in Tehran until 1998 because of the possible political implications of such newsletters, even though volunteers in other cities had won the right to have such a newsletter.

Many of the volunteers have been suggesting that the health centres organize visits to different volunteer training sites so that they might learn from each others' experiences. Although the cost of such local visits would be insignificant, that request has been ignored, no doubt as a result of political caution. Others suggested that these collective meetings could be in the context of visiting shrines, a comment that was repeated independently by a number of volunteers. This is interesting for several reasons. First, it might have been motivated by the idea that such a meeting could sound like a legitimate activity, given the stress placed on their work as a religious act. Second, such a religiously oriented activity appears very legitimate in the eyes of the Islamic government. Third, historically and culturally, women have always enjoyed much more freedom of movement if their reasons were religious; thus they could anticipate that neither their families, husbands, nor neighbourhoods would be concerned should they go for these "*zayara*" (religious visits), even when extended over as much as a few days. Yet the religious aspect would not change the fact that such

meetings would be quite unconventional and would indicate a departure from a convention according to which women are largely excluded from public life.

Some, but not all, interviewees were asked if they anticipated at some stage wanting to stop being a volunteer. Many said only if they were very sick and felt that they could no longer work. Others said no, not if they did not have to. Two women, as though the thought had not crossed their minds, became worried and asked if anyone would be asked to stop being a volunteer. Clearly, they are doing a great service for the country and are saving much money for the government by delivering good, efficient service at no cost, while the women, themselves, feel rewarded. They feel they have become agents of change by sowing the seeds of public participation in their neighbourhoods and their family.

The success of volunteer program has become both a source of prestige, particularly internationally, but also a dilemma and a nightmare for the Ministry of Health that initiated it. Since the Ministry had not planned to fund or manage such a large organization indefinitely, it wanted to pass it on to a different governing body. But they have several significant concerns. First, the authorities in the Ministry are determined to ensure that its primary function, community health work, is not diverted to other volunteer activities. Second, the expenses of the organization need to be paid without inciting the Volunteer Health Workers to begin demanding monetary rewards. However, now that the concept of volunteer work has been so widely accepted, such a concern is less significant. Nonetheless, volunteers are periodically reminded that their reward is the blessing of God and that those who work for monetary reward do not enjoy the same fulfilment and social respect.

However the most significant concern, particularly for the founding fathers, is to prevent the organization, especially in Tehran, from falling into the hands of those with larger political motivations. There is no political organization inside Iran that has an organic link to grass roots communities. Therefore, a ready made institution such as volunteer women with 100,000 active women in more than 350 cities and hundreds of villages would be a dream fulfilled for any political organization. The implications of such a take-over for the Ministry of Health, particularly its founding fathers, would be considerable. Indeed, it is the political concerns that have most pre-occupied the officials at the Ministry and they feel compelled to continue housing the organization and to keep reminding the volunteers that they should consider their work as ethical and social. But at all cost, they should stay away from politics.¹⁰

However, what they have not foreseen is that volunteer women be interested in the politics of social transformation and in the creation of a different female citizen and family structure. This is a form of politics that they seem to have successfully executed already.

It remains to be seen whether these experiences will encourage more women to join the organizations and learn to develop a sense of collective identity and solidarity concerning their common needs and demands.

Conclusions:

Established in 1979, the Islamic Republic of Iran replaced the family planning program introduced

by the previous regime with pro-natal policies along with a gender ideology that viewed women primarily as mothers and wives belonging to the private sphere. Then in 1988, the Regime made a *volte face* and introduced one of the most successful family planning policies in the developing world. In order to reach the urban, low income population who were its primary constituency, the government introduced a program aimed at mobilizing the women of these neighbourhoods to support the family planning program and promote mother and children's health.

Women eagerly accepted this new public role and performed the task beyond the expectation of Ministry of Health. This resulted in the expansion of the program to some 100,000 volunteer workers, the largest such public mobilization in the modern history of Iran. However, in the process of transmitting health messages, these volunteers continuously found new ways to redefine their mandate as Volunteer Health Workers and to further expand their position in other areas of the public sphere. They mobilized their neighbourhoods to demand goods and services and encouraged women and men to exercise their citizenry rights. In the process of these activities and their new self confidence they have transformed their family structure and redefined their role as partners to their husband rather than subservient wives. Furthermore they present as a model for others to follow.

In short, these women view their volunteer health work as an avenue of public participation and subverting the regime's gender ideology. Even more remarkable is that they were able to do accomplish this seemingly political transformation while the Ministry of Health was constantly on the watch in order to keep the program essentially apolitical.

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¹ These debates attracted more attention during President Khatami's tenure (1998-2005) when the government adopted a policy of promoting NGOs and civil society.

² The debates on introducing quotas to limit the access of women to higher education was launched in 2002 by conservative forces, but it was only after the 2005 election when hard line conservatives came to power that these policies have been implemented. See www.meydaan.org for further discussion.

³ Pre-university formal education in Iran is the monopoly of the government, although in the 1990s a tightly controlled non-profit system was introduced.

⁴ In addition to hospitals and community health centres in the towns and cities, the Ministry of Health established "health houses", in the larger villages, which provide basic health care for the population of the surrounding area.

⁵ For a comprehensive description and discussion of the Iranian rural health network, see Shadpour 1994.

⁶ Given the existence of some regional autonomy within the system and the lack of a hyper-political

atmosphere, the volunteer women's organization in several other cities were able to produce and circulate their own local newsletter long before their counter parts in Tehran were given the same opportunity in September 1998.

⁷ Women's Empowerment in Muslim Contexts (WEMC) is housed in the South East Asia Research Center, City University, and is a five year research programmer consortium that includes Iran, Pakistan, Indonesia, and Muslim China. Supported by the DIFD, WEMC incorporates Women Living Under Muslim Laws as its partner leading the Iran component of the research.

⁸ A similar view is held with regards to the question as to whether or not women should be employed by the government. Although government pay is lower than the in private sector, many families would only allow their daughter/wife to work in the government sector. The real reason behind this is the fear that in the private sector, individual male owners in charge might use their position to sexually molest women. Even when the actual threat does not exist, the assumption of such a threat prevents families from allowing their daughters to work.

⁹ During this period the Interior Ministry made it possible for at least one real environmental NGO (as oppose to "governmental NGOs" [sic]) to register.

¹⁰ The interview was published in Rabet-e-salamat (Volunteer Health Workers' Newsletter) 1998:2 (2-3).