

Health as a Context for Social and Gender Activism: Female Volunteer Health Workers in Iran

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THE EARLY YEARS of the Islamic Republic of Iran following the 1979 revolution were largely consumed by establishing and stabilizing the new regime. The founders of the regime chose to do this not by promoting pluralism and the development of a civil society, which had been a major demand of the 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 governments under the Pahlavi dynasty (1925–79) had sought to de-politicize the country, the Islamic regime sought to mobilize the public in support of its ideological and socio-political positions. Such continuous mobilization, however, requires the delivery of some benefits, if not political freedoms. The state's income from oil, particularly during the low prices of the 1980s, was not sufficient to finance the elaborate state machinery, nor to fulfill the regime's material commitments pledged to the poor, who were considered its primary constituency. To deal with this limitation, the government adopted a strategy of controlled public participation in arenas that were not seen as a political threat to its monopoly of state power, but that would lower the cost of its development policies. One such initiative was the introduction of a Volunteer Health Workers program in low-income neighborhoods. This program, through which women deliver basic health and family planning information to their neighbors, has become a large and highly successful volunteer initiative. Introduced in 1992, by 2007 it involved close to 100,000 women, having spread to 340 cities and towns and 2,657 villages.

In this article, based on analysis of two studies carried out in 1996–97 and 2007, I look at some of the unintended consequences of the Volunteer Health Workers program on the lives of volunteer women and their communities, and at possible implications for gender roles and citizens' activism.

I also raise questions about what should be considered activism and where to draw the boundaries of state and civil society under the restricted political systems of the Middle East.

Little attention has been paid by the state, scholars, or women's rights activists to the impact of the Volunteer Health Workers, even though they constitute the largest national volunteer program of its kind for women and their communities. The authorities have not attributed any political consequences to the women's delivery of health services. On the other hand, women's rights activists and opposition political leaders have viewed this and other such programs as social activism, given that the women worked under the umbrella of the state. Even during the promotion of nongovernmental organizations by the Reformist government under President Seyed Mohammad Khatami (1997–2005), reformists and political intellectuals continued to assume that effective political activism in Iran is solely the prerogative of the middle classes and of organized workers. Thus few, including the Volunteer Health Workers themselves, were aware that their initiatives were capable of challenging the state's ideology and policies.

However, my examination of the two sets of data indicates that many Volunteer Health Workers participating in this large-scale public mobilization have viewed this avenue of public participation as an opportunity to redefine their own roles, if not the roles of women in general, within the family, the household, and their communities. In the process of delivering information, using the legitimacy that the Islamic Republic bestowed on them, they have extended the role of women as wives and mothers from the restricted realm of domestic affairs to public participation in the affairs of their neighborhoods. They have mobilized women's citizenship rights in a much broader manner than the state had envisaged.

Given the spread of this program into many rural and urban neighborhoods, this article focuses on several of its interrelated aspects. First, it examines the impact of the volunteer women's roles on their personal lives—that is, their self-perception and their marital relationships, including their position in the family. Second, it looks at how their new unpaid but official positions may have influenced their standing in the community and the way in which these newly acquired positions have opened the possibility of a broader public role for women. Third, it traces the development of a new understanding of what may be considered citizens' activism and how avenues for public participation have prompted women to organize collectively for change at the neighborhood level and beyond. The volunteer activities, given their state-backed position, do not quite constitute what Asef Bayat (2010) has described as "quiet encroachment." Nonetheless the volunteer workers' frequent successful attempts to broaden their mandate are a form of renegotiating their roles as women, as volunteers, and as community organizers, one that demands a new understanding of political and social activism in the context of restricted cultural and political environments. Finally, the article

raises the question of whether a governmentally engineered initiative such as the Volunteer Health Workers program can, even if unintentionally, lead to women's empowerment and the democratization of family and household structures, as well as expand the limited space for public participation and the development of a meaningful civil society.

Constructing a modern Islamic society

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

An overview of policies put in place in the immediate post-revolution years (1979–89) indicates that the government identified three major channels for reaching the less-privileged segments of society: the provision of food, access to education, and the availability of basic health care. The provision of basic foods distributed through ration cards given to households, introduced as a temporary measure to counteract the hardships imposed by the Iran–Iraq War (1980–88), was never intended to be permanent (Amirahmadi 1990).

The regime prioritized education as a means of disseminating its Islamic ideology and counteracting the Westernized worldview promoted by the previous regime. Primary school textbooks were quickly revised, and within a few months a substantial amount of religious material was added to the curricula. An important element of the new curricula was the presentation of a hierarchical family structure where women's place was identified as within the domestic sphere and subordinate to the husband. In launching the literacy program, the regime adopted the slogan of "jihad against illiteracy." In the heat of revolutionary fervor, hundreds of volunteers and other personnel were trained to teach basic literacy, and new schools were established in rural areas. The Islamic regime actively encouraged parents to send their daughters to school (Mehran 1991, 1992, 2002; UNICEF 1995a). Its advocacy of female education largely disarmed many parents who previously opposed schooling for girls on religious grounds, and there was increased social pressure to educate daughters. The result has been higher rates of female literacy and educational enrollment among children, with a reduction in the gap between enrollment rates for girls and boys (UNICEF 1995b).

While the regime had its own agenda in promoting the Islamization of society through education, it made education, including higher education, more accessible to women, who by 2006 accounted for 64 percent of university students. The high rate of education of women in turn has expanded their expectations in terms of public participation socially, economically, and politically. Education has also facilitated their knowledge of diverse secular

and religious worldviews on gender equality, and women have increasingly questioned legal limitations that the Islamic Republic has imposed on them both within marriage and in the wider society. Women have steadily launched initiatives to expand the political space available to challenge the state and its promotion of discriminatory legal and social treatment of women. Meanwhile, the radical Islamists, *usolgara*, who came to power under the government of Mahmood Ahmadinejad (2005–present), have sought to limit women’s access to secular university education and to redirect women to religious schools.¹

Whereas the educational system was 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 seeks to demonstrate its commitment to the poor. During the early years of the Islamic Republic, the government allocated a substantial segment of its budget to health (increasing from 3 percent of the total budget in 1976 to 7.5 percent in 1986 and 9 percent in 1990) even through the eight years of the Iran–Iraq War. The Ministry of Health gave priority to basic health care, common debilitating diseases, and maternal and child health centers. Helped by young and committed professionals, many of whom were familiar with the needs of the culturally heterogeneous country and its more than 40,000 villages, the government designed and implemented an efficient, low-cost health system that today remains one of its most successful programs and sources of legitimacy (Shadpour 1994; Hoodfar 2008).²

The Islamic regime initially adopted pronatalist policies that included encouragement of early marriage and discouragement of family planning. The annual population growth rate increased from 2.7 percent in 1976 to 3.4 percent in 1986, and the total population grew from 33.7 million to 50 million over the same period. Urbanization too continued apace. Consequently, the 1980s saw a considerable increase in the number of school-aged children, the majority of whom now lived in urban areas. This increase posed a major challenge to the regime’s ability to continue providing—much less improving—universal basic education.

Despite the considerable pressure placed on the Ministry of Health by the Iran–Iraq War, its achievements were commendable. The infant mortality rate, which was high in relation to the country’s per capita income, dropped substantially from 91 deaths per 1,000 live births in 1974 to 45 per 1,000 in 1986. Maternal mortality decreased significantly and life expectancy increased. Overall, Iran in the early post-revolutionary years achieved a notable improvement in its human development index.

By the late 1980s, however, overcrowded classrooms, lack of textbooks, teacher shortages, and ill-equipped buildings became topics of social debate and a vehicle for criticizing the Islamic regime, which had little tolerance for political criticism. Many religious leaders came to recognize the problems of a rapidly increasing population, particularly in relation to unemployment. Like-

wise the Ministry of Health faced increasing pressure on its limited resources from the growing young population and thus perceived the increasing rate of population growth and the pronatalist policy as detrimental to the well-being of the nation. Following a national survey in 1986, which estimated the population at around 50 million, experts and politicians started to openly discuss the negative consequences of increased population growth for the country and for the regime (Hoodfar 1996a, 2008).

The depressed economy of the 1980s and the need to reconstruct war-torn regions and industries were challenging circumstances. At the same time, failure to deliver basic services would severely affect the government's credibility with the *mustazafin* (oppressed and powerless), as it had pledged to build a just Islamic society in which all would enjoy basic health care, education, and equal opportunity. In 1988 in a significant reversal of its position, the government introduced an ambitious—and ultimately highly successful—family planning program (Hoodfar 1995, 1996a, 2001, 2008; Aghajanian and Mehryar 1999; Ladier-Fouladi 2005). This major policy reversal was approved by Ayatollah Khomeini, Iran's supreme religious and political leader and formerly a fierce opponent of all family planning programs as an imperialist plot against Muslims.

The success of the family planning program can be attributed to four overlapping factors: a comprehensive design and definition of the program that insisted it was not a population control measure; an effective national consensus-building campaign; efficient delivery of services; and trust-building (Hoodfar 1995, 2008). These four factors won considerable support from women. To the credit of the government and its experts, the family planning program reflected a sophisticated understanding of the interplay between fertility behavior and social, economic, religious, and political factors, including the position of women (Malek-Afzali 1992; Malek-Afzali and Askari-Nasab 1997; UNICEF 1996; Hoodfar 1996a; Aghajanian 1991). The program and its publicity reiterated the independence of the family, if not of women, in making choices related to planning reproduction.³ The campaign emphasized that the program's central goals were to prevent unwanted pregnancies and genetic abnormalities, to allow parents to space the births of their children, to treat infertility, and to improve the health of women and children. Abortion, a controversial subject in Iran, was left out of the program because, the government argued, it has nothing to do with family planning but rather relates to the question of women's general health. This strategy effectively prevented opponents from mobilizing against the program on the grounds of opposition to abortion.

The program's credibility was considerably enhanced by communication of information both on contraceptive methods and their benefits, and on their side effects and disadvantages (Hoodfar 2008). Both the family planning program and general health services were primarily directed at low-income

populations whose lack of literacy required unconventional, especially oral and face-to-face means of communicating information and gaining trust.

Given the pre-existing rural health network, including village “health houses,” problems of providing information and family planning services were more easily addressed in rural areas in Iran than in most other countries.⁴ Such houses were usually staffed by a local man and woman, trained in basic health care. Their duties included providing maternal and child health care and vaccinations and maintaining records of births, deaths, and vital health information for all members of the village. Medical care by a doctor was available once or twice a week. In urgent cases, health workers referred residents to the nearest hospital. Village health workers were instructed in contraceptive use and provided with information and supplies for the local population. The strategy was successful: contraceptive prevalence increased to a higher level than initially expected, especially given the rural preference for larger families. In fact, the national consensus about the desirability of smaller families spread so widely that even the expressed disapproval of the family planning program by the conservative President Ahmadinejad did not worry the program directors. They believed that even a major budget cut for the program would have only a minor impact on fertility trends (Trait 2006).

Perhaps the greatest challenge to the family planning program was winning over the low-income urban neighborhoods that had grown rapidly during the Iran–Iraq War. Despite the regime’s firm commitment to men as the absolute head of the household, the program demonstrated 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 program. The cost of an urban neighborhood outreach program of the type that existed in rural areas seemed impractical to the Ministry of Health. Instead the ministry initiated the women’s Volunteer Health Workers program, which has proven to be highly successful in achieving the expressed goals.

Volunteer Health Workers’ community organizations

Although often misleadingly presented as a nongovernmental organization (Ministry of Health 1996), the Volunteer Health Workers program was conceived by the Ministry of Health in 1991 with the goal of reaching low-income women in major cities without significant investment. Community health centers, which are mainly established in low-income urban districts, appoint volunteer women in each neighborhood to act as intermediaries between local women and the health center. These volunteers receive basic health care training. Each volunteer covers approximately 50 to 80 households in her neighborhood, serving as the center’s contact person and providing health information

to her neighbors. Although the volunteers' primary concern was expected to be promoting modern contraception and family planning, they are also 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 postnatal care and for vaccinations. Volunteers also monitor the health needs of their neighborhoods and communicate them to the center. This well-rounded approach to neighborhood health issues has been very significant in attaching legitimacy to the role of the volunteers, and it has made the job more appealing to the volunteers themselves.

The Volunteer Health Workers program was launched in 1992 as a pilot project with 200 women from low-income neighborhoods in a district near Tehran; by mid-1996 the program included over 20,000 volunteers throughout Tehran and all major cities. In 2007 the official number of volunteers approached 100,000 women (Table 1). While this success has brought the program national and international recognition as well as some international funding, its potential political implications have preoccupied higher authorities in the Ministry of Health, which never intended to continue the program indefinitely.⁵

Although the numbers in Table 1 are cumulative and many of these volunteers may no longer formally be in the program, my research indicates that once women have acted as volunteers and have familiarized themselves with the health system, they continue to perform as though they were still formally appointed volunteers. This was confirmed by the officials managing the program in all three sites in which my colleagues and I conducted research. Some former volunteers still participate in the sessions organized by the community health centers, and others regularly join the informal health meetings that volunteers organize either in one of their homes or in a mosque.

During the early phase of the Volunteer Health Workers initiative, its political consequences were not given serious consideration. "Who could imagine a few barely literate women carrying contraceptive pills and appealing for the vaccination of children as political?," said one medical doctor in response to my question on the impact of the mobilization of large numbers

TABLE 1 Population served by Volunteer Health Workers in urban health centers, 1994–2007

Year	No. of Volunteer Health Workers	Population served (millions)	Number of urban health centers
1994	5,700	1.5	150
1995	13,400	4.2	417
1996	20,000	6.0	600
2007	98,688	15.8	2,755

SOURCE: Malek-Afzali and Askari-Nasab 1997; Ministry of Health, Office of Family and School Health (Office of Health Education, Public Participation Sector) 2007.

of women. The success of rural health workers in promoting use of modern contraception had shown the value of face-to-face communication, particularly in the area of maternal and child health and fertility. Although rural health workers were paid, the Ministry did not have a budget for the urban volunteers. The question was how to achieve similar levels of success with the least cost in low-income urban areas. Thus, the Volunteer Health Workers program was born, even though volunteerism was a relatively novel concept in Iran, with the exception of charitable and religious activities.

Initially, female volunteers were selected during annual door-to-door fertility surveys. Survey-takers were instructed to identify middle-aged, seemingly knowledgeable and sociable mothers who had some education, which was used as an indicator of leadership quality and acceptability in their neighborhoods. After the selection, the Volunteer Health Workers Organization, housed in the local health center, contacted the women to invite them to join the organization. In other cases, the organizers contacted local mosques that had Koranic or other classes for women, where they could describe the organization and invite women to join. In more recent years, volunteer women themselves have been inviting promising candidates to join the organization. The officially stated criteria, although not always observed, are that the women should be married with only a few children; able to read and write; in good standing in the community; enthusiastic about participating; and have their husband's permission to participate. Although presented as a means of ensuring the husband's commitment to his wife's new responsibilities, requiring his permission nevertheless indicates that the Ministry of Health accepts the notion of a lack of autonomy for married women. In contrast, the ideologues of the regime and religious and political leaders have never stipulated a need for husbands' permission when they invite women to participate in street demonstrations and elections.

As the program gained support and respect within communities, many better-educated women joined the program. Health is a legitimate community concern, and becoming a Volunteer Health Worker was perceived both as an extension of women's role as caregivers within their families, and as a religious act of benevolence by helping others to maintain their health.

The volunteers meet in weekly or fortnightly classes, during which a representative of the Ministry of Health familiarizes them with the concerns, principles, and organizational structure of the ministry, particularly the delivery of health services to local communities. Moreover, while providing health knowledge, the classes also frequently emphasize the validity of women's traditional knowledge while tactfully warning mothers about harmful practices. These classes are effective in improving interpersonal skills and building volunteers' confidence (Fatahi 1996).

Ministry of Health officials frequently refer to the Volunteer Health Workers program as an example of how the Islamic Republic has promoted

indigenous initiatives and public participation. The initiative, however, is not original to the Ministry; the principal idea is borrowed from nongovernmental and governmental initiatives outside Iran. For instance, the program resembles China's neighborhood grandmother system, as well as nongovernmental Islamic health organizations such as *Pesantren* in Indonesia (Sciortino et al. 1996) and efforts in Thailand and Latin American countries to mobilize housewives for family planning and public health work.

To the government's credit, its approach has been well adapted to the cultural setting of urban Iran. On the other hand, it is evident that while the government welcomes the idea of public participation, it remains firmly in control of these volunteer organizations, particularly in urban areas. For instance, authorities are apprehensive about allowing volunteers to meet in large groups and waited until October 1998 to facilitate the production and circulation of a newsletter for volunteers in Tehran, despite frequent requests for such a publication.⁶ In 1996–97, interviewees in Tehran told us they had suggested the creation of a special volunteer center where they could meet to share ideas. Apparently, Ministry of Health authorities immediately rejected the idea because they feared the consequences that would follow if 20,000 strong and committed women were to gather at centers through the country. Although this was presented to me by several high officials as a humorous anecdote, it provides some insight into the political concerns of the government: an ambivalence in wanting citizens to participate in honoring the regime's commitment to basic services that the state cannot afford to provide, while on the other hand striving to exercise firm political control. Had the government possessed the requisite economic resources, it is doubtful whether it would have contemplated relying on volunteers.

The research on women volunteers

A review of available documents on the initiatives and statements made by many officials in charge of Volunteer Health Workers suggested that the voices of the volunteers were never included. The absence of any study dealing with their perceptions and aspirations prompted me to carry out a small qualitative survey between 1996 and 1997 of volunteer women on their self-perceived roles and the impact on their own lives and their neighborhoods. The survey was conducted as part of the International Women and Law Program launched by Women Living Under Muslim Laws (Hoodfar 1998). The findings indicated that women welcomed the 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 at the lowest possible cost. While the results of this study were instructive, it was too small to support any generalizations and it was limited to volunteers in Tehran. Moreover, it could not shed light on the

long-term impact of the program on the women, their communities, and society as whole because the program was still in its early years, and it was not clear how long it would continue. By 2006, the project had been in place for a decade and a half. While expanding greatly, its functions and general structure were largely unchanged.

My colleagues and I carried out a larger study in 2007 to examine the impact of volunteerism on the volunteers, their families, and the wider community. Besides interviewing Ministry of Health officials in middle and upper management positions, and some physicians who were in charge of the volunteer programs, we carried out 100 in-depth interviews in Tehran, Mashhad, and Tabriz as well as eight focus group discussions with an additional 98 volunteer women in these three cities. The women were chosen from diverse districts that included both older and newly established low-income neighborhoods. With the 1996–97 study serving as background, in this new study we were interested in four main questions. First, how did the women assess the benefits and drawbacks of their volunteerism on their own lives, on their family and family relations, and on their community? Second, did they view their volunteerism and contribution in the national (as opposed to the neighborhood) context—and if so, to what extent? Third, to what extent were they interested in the national debates and issues related to women and gender equality? Fourth, as volunteer workers, did they develop any formal or informal networks through which to pursue their public or economic interests collectively?

In the earlier study, six of the 28 interviewees were between the ages of 20 and 30; 15 were between ages 31 and 40; and seven were between ages 41 and 47. Sixteen had a high school education and 11 had achieved secondary schooling; only one woman had more than a high school education. All but two of the women were married, with between one and five children. They had been volunteers for one to four years. In addition to these interviews, I had also observed and conducted discussions in four volunteer sessions, three in Tehran and one in Mashhad.

In 2007, we interviewed 100 volunteer women, 50 in Tehran, 25 in Mashhad, and 25 in Tabriz. Nine were aged 18–29; 33 aged 30–39; and 58 aged 40 and older. Ninety-seven of the interviewees were married, two were single, and one was widowed. Three interviewees had no children; 11 had one child; 49 had two children; 18 had three children; among the older women 6 had four children, 7 had five children, and 6 interviewees had six children. (One woman was not married and data for two interviewees were missing.) The majority of the interviewees (58) had a high school diploma; eight women had university or equivalent qualifications; and 34 had primary or secondary education. Eighty-nine described themselves as housewives; four were hair dressers and four were religious instructors; there was one curtain maker/interior designer, one seamstress, and one student.

The number of years that women were involved as Volunteer Health Workers ranged from one to over 15, with 37 having 5–10 years of experience and 35 having more than ten years. Although some women had let the validity of their Ministry-issued volunteer cards lapse, they continued to participate in the program and used the cards as identification in their dealings with government institutions. Women themselves, the health officials, and the neighbors were unconcerned about the lapsed cards. As one volunteer woman said, “Once one has learned the system and has the knowledge to help other women, it will be impossible to stop doing what one does, whether our Ministry of Health card has expired or not.”

Despite the lengthy interviews that we conducted, the women willingly participated in the study. Several mentioned that they wished the Ministry of Health and other officials were more interested in what they had done and had to say. Several women, knowing we were academics, asked us to write about the contributions they have made to society despite not being highly educated.

Women’s assessment of their volunteer position

Women in Iran experience cultural, legal, and religious limitations on their autonomy and life choices regardless of their class position or education, particularly following the establishment of the Islamic Republic. The state has also introduced laws that have exacerbated women’s lack of autonomy (Mir-Hosseini 2004). One of the most important limitations is that a woman, at least theoretically, has to have her husband’s permission to leave the marital home; another is that a woman requires her husband’s permission to hold a job, particularly if it requires her to leave her neighborhood. Many men are wary of allowing their wives to hold a job because they feel their position of authority over their wives is derived primarily from their economic power. Many women who would like to work or to participate in social activities are frustrated by these limitations, and thus seek ways to expand their social environment. The Islamic Republic, while discouraging women from entering the labor market, has promoted the possibility of social volunteerism and religious activism for women, often in the context of engaging in service delivery programs that reduce the cost to the government. Iranian women have largely responded positively to these volunteer initiatives. To date, however, research has failed to examine how women negotiate their engagement in these activities, how they evaluate their mandates and redefine them, and whether women have managed to transform these opportunities to serve their own interests. Nor has the literature categorized these forms of activism, which remain outside categories of traditional activism, including the “quiet encroachment” that normally characterizes clandestine, if not illegal activities.⁷ Clearly the Volunteer

Health Worker program, now almost two decades old, is fertile ground for examination of women's activism.

Our opening question to all interviewees asked why they had joined the volunteer program. Responses 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, 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."

Although some volunteers had faced opposition from their husbands or families, they found ways to soften that opposition. Opposition from husbands was mostly expressed as their reluctance to lose control over the time and mobility of their wives, and their concern that women's volunteer work might mean neglect of family responsibilities. The most serious objection from husbands was toward their wives having to go door to door in the neighborhood to provide health information or update household records. "What if you were invited into homes and there were men there who could harm you?" Other husbands were worried about their own "honor" and the effect that allowing their wives to move around freely in the neighborhood would have on their standing in the community.

Some of the younger and better-educated women reported that the opposition from families was expressed as, "Only a fool will go and work for nothing," indicating an unfamiliarity with the volunteer concept. Yet, other women reported that although many husbands had resisted the idea of their looking for a job, the objection to volunteer work was less pronounced, since it was unpaid. In other words, women's engagement in volunteerism was no threat to their husbands' position as breadwinners. Neither did it involve leaving the neighborhood. Some women said that their husbands initially were not happy with their volunteer work, but since the work was woman-related (health, pregnancy, and children), it made it easier for them to accept. However, there was universal consensus among interviewees that had the position not been with a government organization, they would not have been allowed to join. Generally even families who allow their daughters and wives to enter the labor market prefer the government sector despite its lower pay, for fear that in the private sector, male owners or superiors might use their position to sexually molest women. Apparently the same logic applies to volunteer work. Under the restrictive social environment for women in Iran and most other Middle Eastern countries, the state, even if it is exploitative and holds regressive views on gender equality, can potentially offer legitimate spaces where women can have some autonomy and exercise leadership.

Comparison of the data from Tehran, Mashhad, and Tabriz indicates that the women in Tabriz had experienced more pronounced opposition from their husbands and families to their participation in the Volunteer Health

Worker program. Contrary to our expectations, women from the religious and highly conservative city of Mashhad had experienced almost no opposition. Our focus group discussions with women in Mashhad indicated that while the concept of volunteer work, particularly for a government organization, is relatively new in Iran, many women in Mashhad have a history of being involved in charitable activities. The religious ideology of the Iranian regime and the legitimacy that the state continues to enjoy in this city made it easier for women to join the volunteer program. Because both Mashhad and Tabriz are considered religious, culturally conservative cities and given that there were no marked differences between the levels of education of either the husbands or the volunteers in the two cities, the historical lack of religious volunteerism in Tabriz may at least partly explain this difference in attitudes toward women's participation in the Volunteer Health Workers program. Another factor may relate to the fact that the population of Tabriz is predominantly of Turkish origin. Although the Turkish minority is well integrated in the Iranian state structure, the central government does not enjoy the same legitimacy in the eyes of the indigenous population in Tabriz, at least over the issue of language.⁸ All of our interviews and focus group discussions in Tabriz were conducted in Turkish, and we were commended in every interview for using the Turkish language as opposed to Farsi.

Determined to join the program, women found ways of putting their husbands' minds at rest. Those with more years of experience as volunteers told us that it was helpful that initially the women who were invited to become volunteers were older and therefore less subject to strict control. Such volunteering is now more institutionalized and acceptable to the communities and it is easier for all, young and old, to join. Younger women readily mentioned that had it not been for their predecessors' good work and positive reputation they could not so easily have joined the program and served their community, while also learning something and expanding their horizons.

Women who served longer explained that they had developed their own strategies to reduce family opposition. For instance, they would go in teams of two, as opposed to alone, even though this meant they had to spend more time visiting the households they covered. Others adopted the strategy of saying that the Ministry of Health forbade them from going inside people's homes and they only met people at the door. Some women in Tabriz, knowing of their husbands' likely opposition, simply did not tell them what they were doing for a long time, since much of their work was done during periods when their husbands were neither at home nor in the neighborhood. They would only reveal their new activity gradually and in a manner that would not alarm their husbands. In recent times, should a husband oppose his wife's joining, one of the older and more experienced volunteer women would talk to him and offer to accompany the younger volunteer until she had gained enough

experience. None of these strategies is offered in the manuals provided by the program. These initiatives indicate the eagerness of the women to expand their roles beyond the conventional restrictions of home and family.

Interviewees were asked to list all their volunteer activities: those that are part of their officially defined responsibilities and those extra activities that they assumed after becoming a volunteer. Besides door-to-door visits and keeping a record of the basic health information of households, volunteers refer women to clinics and inform them about prenatal and postnatal care and vaccinations. Many volunteers spend considerable time informing their neighbors about nutrition. The information dispensed is not always acquired during their training but rather gleaned from newspapers, women's magazines, or other publications.

In response to our question about the impact of volunteer work on their lives, women without exception expressed positive views. They had learned a good deal from their training and felt more fully in control of their lives. A large majority stressed the importance of learning how the health system works and how such knowledge has helped them to navigate their way around other government institutions. They enjoyed being able to help their neighbors. "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 neighbors I gain more *savab* [reward from God for good deeds]. That compensates for not being paid, as far as I am concerned." A woman from Tehran 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 volunteers makes us feel we are valuable members of our community.

A noteworthy finding was that regardless of how their husbands felt initially, all interviewees said their husbands were now pleased with their being Volunteer Health Workers. When we asked the women to explain what had made their husbands so supportive of their activities, the replies were insightful, both culturally and ideologically. According to a woman from Mashhad:

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 who 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 neighbors and relatives and they respect me for it. This also makes him proud of me.

A 39-year-old woman from Tehran, who had been volunteering for three 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 neighborhood. 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 more nutritious food and tell my husband and children why I cook this food and not the other. Neighbors, 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 anyone else. Now my life has changed.

Another woman from Tehran 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 neighbors 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.

We asked the women whether they knew of any volunteers whose family life had deteriorated because of their engagement in this program. None could think of one such volunteer. Rather, women's engagement in volunteer work and their adoption of a more public role have brought husbands and wives closer together. 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 equality between men and women have been dismissed on the grounds that these are Western ideas and that Iranian traditional culture and popu-

lar sentiment are not ready to accept such values. However, the volunteer experience indicates that if the claim to equity is based on real change, then Iranians, despite their religiosity, are ready to incorporate such values into their lives and worldview without seeming contradictory to Islam.

Most volunteers engaged in activities far beyond their defined mandate. Many redefined their mandate so as to incorporate public activities: demanding that local shopkeepers observe hygiene regulations; demanding that local vendors sell only healthy food to children; speaking at local schools about the importance of hygiene and good nutrition; and giving basic reproductive health lessons for girls in high school, to cite a few examples. The recounting of the volunteers' experiences indicates that initially some of the local shops did not take their requests seriously. The women therefore enlisted the support of doctors and nurses at the health centers and sent officials to issue fines or even to close the noncompliant shops. After a few such occurrences, the news quickly spread that volunteer women also had authority in enforcing rules of hygiene in their neighborhood. Volunteers are aware that such activities were not part of their original mandate, but they view this omission as an oversight on the part of the program designers. For instance, one older woman from Tehran with some 12 years of volunteerism explained to me how she mobilized the neighborhood and later encouraged other volunteers to follow her example:

Most of the doctors who designed these programs were from the middle classes and had never lived in these neighborhoods. They did not know about our dusty roads, dirty ditches, or shops with no refrigerators. There are many variables that they simply did not know they needed to include if they want a healthy population. So we have to bring it to their attention. They should invite a group of us more-experienced volunteers to have a focus group discussion like what you organized and let us tell them what needs to be done. But it is unfortunate that they do not think we can help them improve the program, as it will cost them nothing.

She then explained in detail how she organized the shops and vendors around the local schools to make them more hygienic. When they did not listen to her, she phoned the office of the Vice Minister of Health and the heads of the community health centers to report the shops and asked the Public Health Office to issue warnings to them. She also asked other community members to phone the appropriate offices to impress upon them that they have a mandate to promote public health. Once she succeeded, she shared her experience with other health workers and encouraged them to do the same. 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. Sometimes I feel that because they are unpaid, they have more moral authority than our paid staffs." Although this statement was presented with both admira-

tion and frustration, it indicates that those charged with implementation of the program tend to be flexible and make room for volunteers to extend the sphere of their influence.

Some of the volunteer women realize that they have been pushing their boundaries, but they feel that unless public health standards are enforced, there will be no point to their community health activities. One volunteer explained, "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 neighbors." Indeed once women have succeeded in achieving their goals, they share their experiences with other volunteers and encourage them to follow their example. Thus these activities are gradually incorporated into their mandate, if only informally.

Another activity volunteers engage in is improving neighborhoods by demanding that the municipality provide them with services not automatically available, such as in many outlying, newly developed, low-income neighborhoods of Tehran. These services include regular garbage collection, paving major roads, and creating green spaces or neighborhood playgrounds for children on undeveloped land formerly used as garbage dumps. Some volunteers encouraged their neighbors to petition for asphalt, clean water, better bus services, sport facilities for youth, and the like. Many initiated such activities and brought other women and men, including their husbands, to work as a collective, organized meetings in their homes or in local mosques, and formed pressure groups. Many volunteers had become skillful in employing appropriate external sources of support such as the head of the local health center or even various directors of the Ministry of Health who could write letters encouraging the municipality to deliver the services. In several cases where these tactics did not produce the desired result, the women contacted newspapers and television stations to come to their neighborhood and publicize their grievances against the municipality. "You have to know how to talk to them. The government keeps saying they are the government of the *mustazafin*' [the oppressed and powerless]. 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," a long-term volunteer explained to us. The level of political savvy one can extract from volunteers' stories, which are carefully presented in the least political manner, is indicative of a culture of resistance and subversion in a context of little public space or democracy. Given the long history of repression by both state and society, the emergence of women as local leaders is unprecedented.

The active role of volunteer women in addressing the needs of their neighborhoods has brought them prestige and status. Moreover, it has en-

couraged many others either to join the program or to 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 other volunteers' experiences, and how they guided each other in such novel activities as petition-writing. A typical experience is described by a woman from Tehran:

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 a 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 neighborhood 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 neighborhood signed the letter and our men also became involved. We collected more than 3,000 signatures and chose five people, which included me and one other woman, one young 16-year-old youth, and two older men from our neighborhood, to transmit the petition. We made an appointment and sent a copy of our letter to two newspapers and let them know this. This time nobody treated me like a fool and within a few weeks we had two football grounds, one on each side of the neighborhood. 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 neighborhood. Moreover now women and men come to me, and not to our local council who are supposed to attend to community needs, to organize and demand various services. For instance, our local school did not have enough 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 in Tehran under the then popular mayor Karbaschi in the 1990s. As part of Iran's strategy for reintegrating into the international community after more than a decade of isolation, many higher-ranking officials had participated in international conferences on the environment, including the 1996 UN Conference on Human Settlements (Habitat II). In the process, officials learned much about the issues and were stimulated by the programs that other developing countries had adopted. They also learned that besides the official delegates, each country was also represented by NGOs working in the relevant field, but Iran had essentially no NGOs. To save face, the authorities tried to create the impression of having active NGOs,⁹ and they identified the Volunteer Health Workers as one example. One Tehran

municipality published several pamphlets and organized a few workshops on public health, to which some of the Volunteer Health Workers were invited and through which they were encouraged to take an active role in promoting public health, for instance by advising people not to dump their garbage in the street, not to raise animals at home, and so on.

This connection with the municipality and international conferences illustrates how volunteer women came to learn about petition-writing and incorporate it into the extension of their volunteer health work. Given the country's history of dictatorial regimes under which signing a petition entailed a high risk, petition-writing was not part of Iranian political culture. Despite the successful constitutional movement in 1906, and a popular revolution in 1979, the political culture in Iran has remained severely restrictive and thus citizens, particularly those with limited means and few connections, have had to find other ways of expanding their citizenship rights.

Initially, I had assumed these municipal initiatives and volunteers' enthusiasm for public participation would evaporate, but the women involved kept these local committees active, often shifting the focus of their activities to reflect the current needs of their local community. Such active involvement was also encouraged after the 1997 election of reformist President Khatami, who promoted the idea of civil society and active participation of citizens (Arjomad 2005). However, few resources during his presidency were directed toward promoting civil society in low-income communities, as reformism remained primarily a middle-class movement (Hoodfar, forthcoming). Indeed, despite much interest in the evolution of modern civil society in Iran, studies focusing on these unassuming and citizen-led forms of activism have not yet caught the imagination of scholars.

Volunteers also engaged in other activities. Because they worked in low-income neighborhoods, they often learned of households that could not buy needed medicines, or of a daughter who did not have a minimum dowry to get married, or a husband who had lost his job, and so on. The volunteers often tried to mobilize their networks to collect money or find jobs for the needy in their neighborhood. 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 respect and trust within the neighborhood toward the volunteers. Furthermore, becoming acquainted with families inevitably meant getting involved in family problems, whether involving in-laws or parents and their children. Many volunteers learned to deal with such issues by trying to mediate disagreements.

Many of the volunteers have suggested that the health centers organize visits to different volunteer training sites so that they might learn from one another's experiences. Although the cost of such local visits would be insignificant, the request has been ignored, no doubt as a result of political caution

and lack of interest in further promoting volunteer networks. A comment repeated independently by a number of volunteers was that these collective meetings could occur in the context of visiting shrines. This is interesting for two reasons. First, it might have been motivated by the idea that such a religiously oriented activity would appear legitimate in the eyes of the Islamic government. Second, historically and culturally, women have always enjoyed much greater freedom of movement if their reasons were religious; thus they could anticipate minimal opposition from families, husbands, or neighborhoods should they go for religious visits, even when lasting a few days. Yet the religious aspect would not change the fact that such meetings would indicate a departure from a convention according to which women are largely excluded from public life.

Some interviewees were asked whether they anticipated wanting to stop being a Volunteer Health Worker at some point. Many said they would do so only if they were very sick and felt 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 whether anyone would be asked to stop being a volunteer. Clearly, the women feel they are providing a valuable service for the country and are saving money for the government by delivering efficient services at no cost. They believe—with some justification—that they have become agents of change by sowing the seeds of public participation within their families and neighborhoods.

The success of the volunteer program has become both a source of prestige, particularly internationally, and a dilemma for the Ministry of Health that initiated it. Because the ministry had not planned to fund or manage such a large organization indefinitely, it wanted to pass responsibility for it to another governing body. But the ministry has several significant concerns. First, authorities in the ministry are determined to ensure that the program's primary function, community health work, is not diverted to other volunteer activities. Second, the expenses of the organization need to be paid without prompting the Volunteer Health Workers to begin demanding monetary rewards. Now that the concept of volunteer work has become so widely accepted, such a concern is less relevant. 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 sense of fulfillment and social respect.

The dominant government concern, however, particularly for the originators of the program, has been to prevent the volunteers, especially in Tehran, from joining forces with individuals with larger political motivations. There is no non-state political organization inside Iran that has an organic link to grassroots communities. Therefore, a ready-made institution such as volunteer women with 100,000 active members in more than 350 cities and hundreds of villages would be a dream fulfilled for any political organization. Yet during President Khatami's administration the reformist government

failed to use the volunteers as a base to mobilize Iranians in support of their ideology of public participation. The implications of such a political agenda for the Ministry of Health would be considerable. Indeed, it is the political concerns that have most preoccupied officials at the ministry, and they feel compelled to continue housing the organization and to keep reminding the volunteers that, at all cost, they should stay away from politics.

What the ministry and the leadership did not foresee is that volunteer women would become engaged in the politics of social transformation and in the creation of a novel articulation of female citizenship and family structure. This is a form of politics that volunteer women seem already to have successfully entered. This “mundane” realm of politics, often overlooked in discussions of activism and national-level politics, represents an important avenue of public participation under a restrictive political and cultural system. Citizens, particularly women, may occupy state-provided spaces in order to fulfill some of the government’s mandates, yet their partnership with the state should not automatically be taken as signaling their exclusion from civil society. This is a point well understood by the conservative faction of the Islamic Republic. Our research and other studies indicate that since 2000, conservatives, worried about the advancement of reformist tendencies, have been courting volunteers. One of their strategies is to woo women from low-income neighborhoods to the conservative camp by inviting them to join *Basij* volunteer organizations, which are charged with safeguarding the moral values of the Islamic Revolution, in particular hijab and gender segregation.

Conclusions

Established in 1979, the Islamic Republic of Iran replaced the family planning program introduced by the Shah with pronatalist policies along with a gender ideology that viewed women primarily as mothers and wives confined to the private sphere. Then in 1988, the regime made a *volte face* by introducing one of the most successful family planning policies in the developing world. In order to reach the low-income urban population that was its primary constituency with the least cost, the government introduced a program aimed at mobilizing the women of these neighborhoods to support the family planning program and promote maternal and child health.

Women eagerly accepted this new public role and performed the task beyond the expectation of the Ministry of Health. This resulted in the expansion of the program to some 100,000 volunteer workers, the largest such public mobilization in modern Iran. In the process of transmitting health messages, however, these volunteers continually found new ways to redefine their mandate as Volunteer Health Workers and to expand their position in other areas of the public sphere. Rather than seeing themselves as passive agents of the Ministry of Health, they viewed themselves as partners of the ministry. To their credit, the program directors, particularly at the level of middle

management, showed great flexibility in accommodating and reinterpreting the volunteer women's mandate. Without such flexibility this program would have lost its appeal to most volunteers.

Weaving the neighborly traditions and their newly defined responsibility as Volunteer Health Workers, women quietly introduced major changes in their own lives and those of their communities. They mobilized their neighborhoods to demand goods and services and encouraged women and men to exercise their rights as citizens. In the process of these activities, drawing on their newly gained self-confidence, women have transformed their family structures and redefined their roles as partners to their husbands rather than subservient wives. Furthermore they represent a model for others to follow.

In short, these women view their volunteer health work as an avenue of public participation and reinterpretation, if not subversion, of the regime's gender ideology. Even more remarkable, they have been able to accomplish this political transformation while the Ministry of Health was constantly on guard in order to keep the program apolitical. Under a restrictive political system where citizens, particularly the poor and women, are limited in organizing independently for change and demanding a fairer share of resources, they manage to imaginatively occupy new niches presented to them and to work quietly toward improving their lot. The survival of the Iranian state and of many other authoritarian regimes in the Middle East, particularly non-rentier states, is to a considerable degree dependent on how easily they can achieve a gradual and quiet accommodation of these otherwise excluded segments of society.

Notes

This article is based on field work undertaken as part of a larger project entitled *Women's Empowerment in Muslim Contexts: Gender, Poverty and Democratization from the Inside Out* (WEMC). Coordinated by Women Living Under Muslim Laws and the Southeast Asia Research Centre, at City University of Hong Kong, WEMC research encompasses Iran, Indonesia, Pakistan, and Muslim China. I am indebted to my colleague and co-researcher Dr. Houreih Milani Shamshiri for her comments and discussions on issues of women's health and social transformation. I also thank Rochelle Terman and Rima Athar for their comments and editing skills.

1 A debate 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 radical Islamists came to power that these policies were implemented. Under the quota at least 40 percent of the spaces in key university disciplines are reserved for male students. See «www.meydaan.org» for further discussion.

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

3 Women who were aware of the government's keen interest in the success of the family planning program used the opportunity to demand publicly that the government address issues related to women's employment

and discrimination against women (Hoodfar 1996b).

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

5 The program's success has attracted funding from international organizations, including the World Bank (Bulatao and Richardson 1994).

6 Given the existence of some regional autonomy within the program, volunteer women's organizations in several other cities were able to produce and circulate their own local newsletter long before their counterparts in Tehran were given the same opportunity.

7 Bayat (2010). Also see Bayat (2002) for a thorough review of categories of activism in

the Middle East and North Africa, as well as Norton (1995) and Zubaida (2001).

8 Although Turkish is the first language of some 20 percent of Iran's population, the official language and medium of all government educational institutions in Iran is Farsi. Turkish and Kurdish populations in Iran have been highly critical of the lack of accommodation by the central government, although the Islamic regime has removed some restrictions and private organizations can teach and promote their local language.

9 During this period the Interior Ministry made it possible for at least one actual environmental NGO (as opposed to what the regime refers to as "governmental NGOs") to register.

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