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Regt, M. de

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Pioneers or Pawns? Women Health Workers in Yemen

MARINA DE REGT

From 1993 until 1998, Marina de Regt was employed as an anthropologist in what has been regarded as one of the most successful Dutch-financed projects in Yemen: the Hodeida Urban Primary Health Care Project in the port city of Hodeida. Working together with a group of young women who were trained as health educators (*murshidat sihhiyat*), she was impressed by their strength and motivation to bring about social change. Yet, gradually she also gained insight into the more ambiguous elements of their work, as their training and employment had ushered in new forms of social control. Were the *murshidat* pioneers, successfully transgressing gender boundaries in Yemen, or were they pawns, deployed to realize the agendas of the Dutch donor and the Yemeni state?

The Dutch government is one of the main Western donors in Yemen and numerous development projects have been established and supported with Dutch development aid.[1] These projects are in most cases implemented in cooperation with Yemeni ministries. The Hodeida Urban Primary Health Care Project was a bilateral project between the Dutch Ministry of Foreign Affairs and the Yemeni Ministry of Public Health. Established as a pilot project in one of the squatter areas of Hodeida in 1984, the project extended its activities to all government health centres in Hodeida in 1993. In 1999 Dutch support to the project came to an end and the project assets and activities were completely handed over to the Yemeni Ministry of Public Health.

In the fifteen years of its existence the project had come to be seen as one of the most successful attempts to improve basic health care in Yemen and the experiences in Hodeida functioned as a blueprint for other projects and for health care policies in Yemen. The project was considered a success for two reasons. First, a primary health care system had been set up with a strong focus on preventive mother- and childcare such as weighing and vaccinating children, pre- and postnatal care, health education, family planning counselling, and home visits to mothers in the areas around the health centre. Second, the project had successfully trained women as *murshidat*, while in other parts of the country it was very difficult to recruit women. This was due to the low status of certain health care professions, the low level of education of girls and women, the heavy workload of women (in particular in rural areas), cultural notions such as that of the male as breadwinner, and gender segregation – all of which worked against women's employment. In eight years' time almost one hundred young women were trained in Hodeida and employed by the Yemeni Ministry of Public Health. These women had moved out of their houses, taken up paid work in health care, and, in some cases, even became managers of clinics. Dutch development workers saw the *murshidat* therefore as pioneers, who were able to improve the health situation in Yemen by providing preventive health services and in addition shifted the boundaries of dominant gender ideologies by taking up paid work in the public sphere. Yet, aspects of the work of the *murshidat* that were seen as emancipatory, such as engaging in paid work and carrying out home visits, also had their downside. Some of the *murshidat* were, for example, forced to take up paid work, while doing home visits to unrelated families affected their respectability negatively.

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Three cohorts of *murshidat*

The ways in which the *murshidat* benefited from their work or experienced new forms of social control depended much on the historical period in which they became *murshidat* and on the social and economic status of their families. In the fifteen years of the project three cohorts were distinguished: the first cohort was trained in 1985 and 1986, the second cohort between 1988 and 1990, and the third cohort after 1990.

The women in the first cohort came from (lower-)middle class families living in the city centre. They saw their training as *murshidat* mainly as a next step in their educational trajectory; they were not looking for paid work. While both education and paid work of women were negatively valued in their families, these women were inspired by the revolutionary slogans of the 1960s in which the relationship between education and development was promoted by the Yemeni government. They saw their training as *murshidat* as a form of self-development; they highlighted, for example, their ability to overcome the obstacles put up by their (male) relatives or by the local community. The fact that the *murshida* profession was a new phenomenon in Hodeida was also helpful. It gave them ample opportunities to emphasize certain aspects of their work and to downplay other aspects in order to make their work acceptable to their relatives. They stressed, for example, that they were working with mothers and children and were not having contacts with unrelated men, but they kept silent about the home visits they carried out. The fact that they did not live in the squatter areas where the project was located at first, made it easier for them to hide the exact nature of their work from their relatives and neighbours.

The women in the second cohort, in contrast, were living in the squatter areas. Their parents were often rural migrants from villages in the Tihama, the coastal strip on the Red Sea, or returnees from Africa. While during the Imamate many Yemenis had migrated to East Africa, they returned in the 1970s when nationalist governments came to power there and migrants lost their favourable position. Also, Yemen's president al-Hamdi encouraged Yemeni migrants to return home and promised them employment and free housing. Yet, al-Hamdi was assassinated in 1977 and little of what he had promised ever materialized. The young women living in the squatter areas often felt obliged to leave school in order to take up paid work. Becoming a *murshida* was a reasonable alternative, as it was less of a low status profession than working in factories or domestic work. It was a new profession in health care, focusing on mothers' and children's health, supported by a foreign donor, and with a clear modern character as visible in the

PHOTO: UNKNOWN

The second group of *murshidat*, trained in 1988 and 1989.

availability of project transport and new uniforms, and with financial benefits such as the payment of overtime and a Ramadan bonus. The fact that the *murshidat* were government employed and therefore benefited from important advantages such as a tenured contract with a monthly salary, and the right to sick leave, maternity leave, and a fixed number of holidays per year, also contributed to the positive evaluation of the profession. The young women of the second cohort saw their training and employment therefore as a form of upward mobility and as a way to improve the social and economic status of their families.

The third cohort consisted mainly of young women who had been born in Saudi Arabia but were forced to settle with their families in Yemen in 1990 and 1991. As a result of Yemen's position in the UN Security Council, in which it stood against military attacks on Iraq, the governments of Saudi Arabia and the Gulf States changed the residence rights of Yemeni migrants.[2] Around 800,000 Yemenis returned to Yemen, and many settled in Hodeida, the first major city after the Saudi border. Within a year the population of Hodeida increased from 200,000 in 1990 to at least 300,000 inhabitants in 1991. The young returnee women who had benefited from the well-organized educational system in Saudi Arabia were forced to interrupt their schooling. Because unemployment was rampant in Hodeida, their male relatives were often unable to provide for their families. While these women probably would not have taken up paid labour in Saudi Arabia, they were forced to do so in Yemen. Brought up in a society in which paid labour of women was negatively valued and where only professions that required a high educational level, such as teaching and medicine, were seen as respectable for women, they often saw their employment as *murshidat* as a decrease of status and they tried to improve their position in different ways. This was further stimulated because they faced additional hardships as returnees from Saudi Arabia. Continuing their education to upgrade their qualifications and become a nurse, midwife, or even a doctor was one of the main strategies they employed. Moreover, they also wore Saudi-style covered dress in order to emphasize that they came from a modern country, where a high standard of living was combined with a conservative form of Islam.

The politics of development

Because the *murshidat* profession was a new phenomenon in Yemen, the three main actors in the project, the Dutch donor organization, Yemeni state institutions, and the *murshidat*, could interpret the profession differently. The Dutch donor organization emphasized the importance of training and employing women as health educators because they formed a link between the health centre and the local community and were therefore able to establish a primary health care system. The fact that the training of women also fit well in Dutch discourses on women and development was a side effect. Yemeni state officials saw the training of *murshidat* as a temporary solution for the shortage of female health personnel. Supporting primary health care was mainly seen as a gateway to foreign development aid while they preferred the introduction of highly sophisticated curative technology. The women trained as *murshidat* were mainly interested in continuing their education and in gaining a position of higher status than that of *murshida*. The fact that *murshidat* 'only' offered preventive services, and therefore had a relatively low status in the community as well as in the health establishment, made them long for higher positions.

In addition to the different interpretations of the profession and the subsequent negotiations that took place between the three main actors, local, national, and international developments strongly influenced the course of the project. The project was based on the assumption that social change could be effected through interventions – by government institutions and development organizations. Yet, whereas numerous development policies were designed, the success or failure of the project was mainly dependent on external factors outside of their control. For instance, the Gulf crisis and the subsequent presence of young, educated women in need of paid work had positive consequences for the project. Whether the project would also have been so successful without their presence will remain an unanswered question.

While the women of the first and second cohorts benefited from the fact that the profession was new and unknown, in the 1990s the *murshida* profession became a generally accepted type of work for women. On the one hand, this was a positive development. However, becoming integrated at the lowest echelons of the health system, this also meant that the profession lost its special status. The women trained during the 1990s no longer enjoyed the advantages of working in a new profession – this was the more so when they were no longer trained solely by foreign donor organizations but also by the Yemeni Ministry of Public Health. Nonetheless, the profession was still attractive for women of poor families because it was one of the few ways to obtain government employment for women with only six years of primary school. Hence, the *murshidat* can be seen both as pioneers and as pawns. They made strategic use of the opportunities available and in some cases transgressed gender boundaries. But in doing so, they also encountered new forms of (self-)discipline and social control. Whether and how they benefited from the opportunities or were restricted depended on a variety of factors. Of major influence were the historical period in which they entered the profession and the social and economic position of their families.

Marina de Regt recently received her Ph.D. degree at the University of Amsterdam, the Netherlands. Her dissertation is entitled 'Pioneers or Pawns? Women Health Workers and the Politics of Development in Yemen'. She is currently working for the Migrant Domestic Labour project at the ISIM.
E-mail: mderegt@pscw.uva.nl

Notes

1. In 1996 the Dutch government spent USD 37988 on development cooperation with Yemen. In 2002 the Dutch government increased its budget for Yemen to 50 million euro in order to support the Yemeni government's activities to fight terrorism and to alleviate poverty in the six poorest regions of the country.
2. While other foreign guest workers in Saudi Arabia and the Gulf States needed a Saudi sponsor (*kafil*) to obtain a residence permit, Yemenis had always been allowed to work without a sponsor and a residence permit. From 19 September 1990, Yemenis lost this special status.