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Original Article

The Community Action Program Works to Improve Mental Health at the District Level: The Evaluation of the Community Action Program in Districts of Iran

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Abstract

Objective: Three categories of interventions are considered for reducing the prevalence of mental disorders in Iran: mental health promotion, increasing mental health and social service utilization and controlling mental health risk factors. In this regard, we designed a community action program in a national plan to provide comprehensive social and mental health services (SERAJ) that were implemented as a pilot in three districts of Iran: Bardasir, Oslo, and Quchan. In this study, we have reviewed the results of this pilot project.
Method: This study was conducted based on the collaborative evaluation model; first, the program was described and the evaluation indicators of each component of the program were determined. Stakeholders were determined; also, data were collected through literature review, semi-structured interview, and focused group discussion and were analyzed by thematic analysis methods.
Results: The community action program consists of four components: A Memorandum of Understanding (MoU) between the departments of the districts, People's Participation House (PPH), Self-reliance Unit (SRU), and actions taken for stigma reduction. A total of 48% of the actions set out in the three MoU of three districts have been executed. The PPH was formed in all three districts. A total of 816 social referrals were admitted to SRU for which a self-reliance process has been initiated. Moreover, 47% of referrals have received services and at least 10 messages for stigma reduction and promoting mental disorders have been sent from different sources at the district level.
Conclusion: Strengthening vertical cooperation between the national and provincial levels is essential for the full implementation of the Memorandum of Understanding (MoU) and self-reliance processes. Referring individuals for receiving social support with collaboration between the primary and secondary programs reported to be successful, but feedback to the primary and secondary levels which provides basic and specialized services, is not transparent. Therefore, we suggest an electronic system as an option to solve this problem. The careful selection of representatives of the people's network and empowerment of PPH and directors of the district on community action skills are essential. The experiences of the governors and chairs of health networks of the three districts should be presented at a national conference.

Key words: *Community Participation; Health Literacy; Intersectoral Collaboration; Mental Health; Social Stigma*

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Rural health network with greater than three decades of experience and limited experience in designing models for providing mental health services, potential human resources for implementing services, massive native audiovisual media, partner organizations for psychosocial services, and politics and supports from high-level organizations are national capacities for implementing mental health services throughout the country. However, the inability of the health system to control external influences on people's mental health, lack of financial resources, unfair distribution of facilities in 31 provinces and 420 districts of the country to cope with mental disorders (with the prevalence of 23.6%) and the lack of provision of comprehensive primary health care in districts (70% of the population) are the challenges of providing mental health services in the country (1).

Mental health programs seek a method to improve the mental and social health and quality of life of target groups in the workplace and the lives of individuals. In general, the goals of the mental health program in the health system are prevention, early diagnosis of disorders, disease control and proper and sustainable follow up, and ultimately changing and improving the attitude of the community towards psychosocial illnesses (2). All aforementioned factors led to redesigning and implementing a plan to provide comprehensive social and mental health programs entitled "SERAJ", which was piloted in Bardsir, Osko, and Quchan districts.

SERAJ has three main programs: primary care services, secondary care services, and community action. By implementing community action programs (3, 4), intersectoral collaboration (5) is strengthened, people's participation is improved, social support units for self-reliance activities are established, but measures should be taken to reduce stigma (6). According to the Community Action Model for Improving Mental Health of the District (which has thoroughly been explained in another paper) is designed by using the experience from the comprehensive health plan of Qazvin province (one of the 31 provinces of Iran) during 2008 to 2013 and reviewing 2001, 2004, 2008, and 2011 mental health reports published by the World Health Organization (7). In this program, social support programs (social referral and self-reliance) are designed, which itself is the result of several other studies such as Designing Social Service Programs of Tehran Municipality, Integrating Social Health in The Primary Health Care System, and Social Marketing Model for Iranians' Desired Social Behaviors (8, 9). Community Action Program, as one of the programs of SERAJ, had been piloted in three districts of Iran. In this study, we aimed to evaluate the Community Action Program to determine its efficacy in improving mental health at the district level.

Materials and Methods

Study Characteristics

This study was conducted by a collaborative evaluation model. First, four components of the community action model were described:

1) Forming intersectoral collaboration,
2) Establishing People's Participation House (PPH),
3) Establishing Self-reliance Unit (SRU) to provide social support services
4) Promoting mental health messages and stigma reduction.

This pilot implementation took 20 months, and there was no control district for this before-after study.

A part of the organizational structure of the districts of Iran and the three main programs (primary care services, secondary care services, and community action), shown in red color, are provided in Figure 1.

Review of the Literature

The following keywords have been used first for review of the literature to collect data on the evaluation of community action mental health care services in Iran and the world: "Mental Health Service, Mental Healthcare, Mental Health Hygiene, Social care, Healthcare, Primary healthcare, Primary Care, Social Care Services, Social Care System, Social Service, Community Service, Community Participation, Community Involvement, Consumer Participation, Consumer Involvement, Public Participation, Community Action. We searched our keywords using "Google Scholar, PubMed, and Embase" motor engines for English publications and "rc.majlis.ir (Iranian Parliament Research Center), Irandoc.com, Magiran.com, SID.ir, Iranmedex.com" for publications in Persian. Subsequently, we drew the indices of mental health at the results chain. These indices included impact, outcome, output, process, and input. Documents were reviewed and a checklist was developed for the identification of mental and social services that needed to be prioritized. Then mental and social healthcare providers were listed to perform organizational analysis. At last, the research team designed a framework and developed a questionnaire for the collection of stakeholder opinions.

Semi-Structured Interview with Experts and Stakeholders

The power and influence of the stakeholders were considered and a selection was made among them. The intentional sampling method was used to recruit 10experienced experts at different levels,

including the General Director of Mental Health and Social Affairs of the Ministry of Health (the contractor), the project manager of SERAJ plan and the designer of the community action program (which is thoroughly explained in another study), the provincial mental health managers (three persons), the director of the health network of the district (three persons), governors (three persons), and social workers (three persons), members of the Governorate Council (20 persons) and PPH (20 persons).

A set of open-ended questions were used for conducting semi-structured interviews. Face-to-face interviews were arranged after the interview questions were sent to the interviewees via email. With the permission of the interviewees, all interviews were recorded on a digital audio recorder. A trained researcher, familiar with methods of in-depth interview was appointed as the interviewer. The main themes were determined following reviewing the interview's questions and the interviewee's responses. All questions were open-ended:

1) What has been accomplished after implementing the [desired component] (three items)?
2) What are the causes that led to more achievements (three items)?
3) What are the proper interventions to overcome the above weaknesses (three items)?

For analysis of the data collected through the interview, thematic analysis method was applied. Interviewees were coded from 1 to n, their opinions in response to each question were collected by the interviewer, and the information collected through the interview was categorized into the most appropriate theme. The number of opinions placed in each theme was then counted. Controversies were removed and responses were used for drafting.

Phase 3: Focus Group Discussions

In the next phase, the research team prepared a draft on how to evaluate a community action program to promote mental and social health services in districts. This draft consisted of four chapters and each was reviewed and edited by experts in a focus group discussion (FGD) session. A facilitator raised the questions in each session and ideas and opinions were collected by assigning a member as the session manager. The discussions were recorded with the group's consent and were analyzed by the thematic analysis method.

The following four questions were selected for each chapter as the main themes:

1) Do you agree with the provided draft?
2) Which part should be removed?
3) Which part should be added?
4) Which part should be revised?

The responses of the attendees were collected and then encoded. Attendees voted to finalize the responses to eliminate controversy in responses.

Finally, a table consisting of indicators was collected and analyzed. The collected data were reviewed by the steering committee and a consensus was reached on how to measure these indicators. Table 1 summarizes the expected outcomes for implementing a community action program, the indicators for the evaluation of each outcome, and their method of measurement.

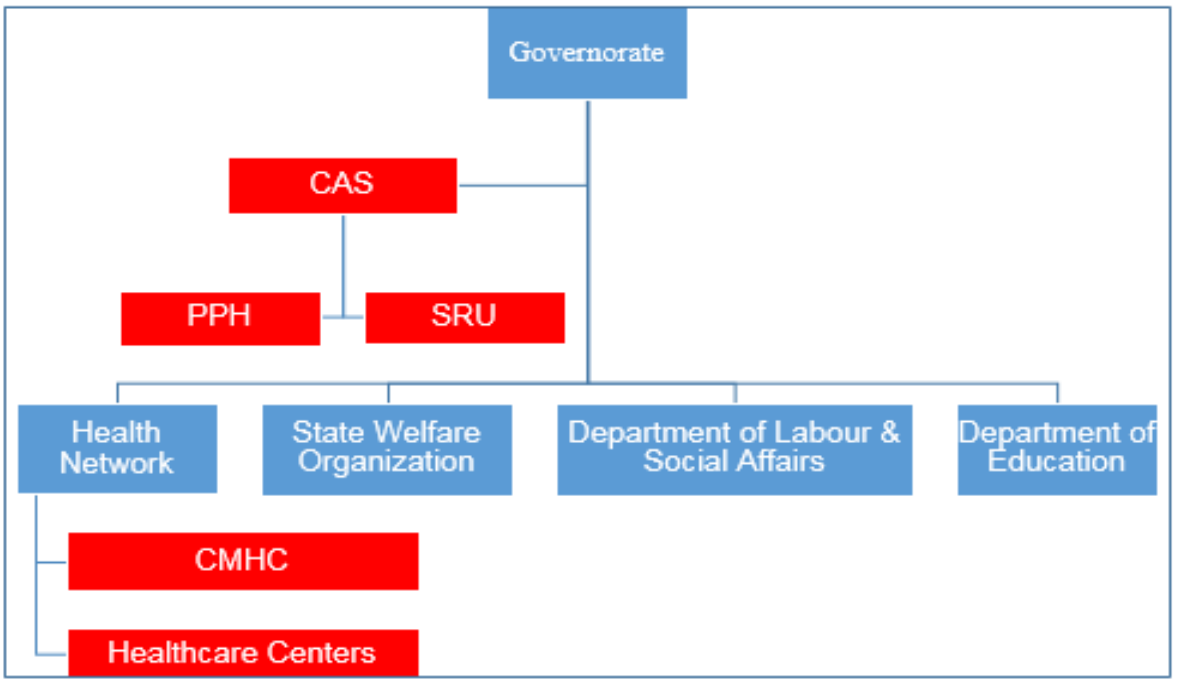


Figure 1. Organizational Structure of the Districts of Iran, Modified According to the Proposed Model for Mental and Social Health Services

CAS: Community Action Secretariat; PPH: People's Participation House; SRU: Self-reliance Unit; CMHC: Community Mental Health Center. Blue rectangles are the existing infrastructural organizations of Iran. Red rectangles are sectors according to our proposed model

Table 1. Indicators of Evaluation for Community Action Programs

Components	Expected deliverables	Indicators of evaluation	Measurement method
Formation of intersectoral collaboration	Community Action Secretariat	1) Employment of a worker; 2) Equipped with rooms and facilities; 3) Announcement of the formation of this secretariat	Observation and review of documents
	MoU*	A photo of signed MoU	Observation and review of documents
	Monitoring the MoU	1) the current condition of the tasks of the organizations mentioned in the memorandum (e.g., what Welfare Organization of the district has done so far based on MoU); 2) Identify achievements, weaknesses (improvement opportunities), and appropriate interventions to promote the implementation of the memorandum.	Interview and FGDs with Governorate Council and Health Volunteers
Establishing PPH	Forming PPH*	1) Approval of Formation of PPH; 2) Equipped with rooms and facilities; 3) List of members of PPH 4) First meeting report of the PPH	Observation and review of documents
	Empowering members of PPH	Documents for holding the workshops for members of the PPH along with the evaluation of the workshop	Observation and review of documents
	Monitoring PPH	Identify achievements, weaknesses (improvement opportunities), and appropriate interventions to promote the implementation of the memorandum	FGDs with People's Participation Council
Establishing SRU for providing social support services	Forming SRU*	1) Approval of Formation of SRU; 2) Equipped with rooms and facilities	Observation and review of documents
	Empowering members of SRU	Documents for holding the workshops	Observation and review of documents
	Monitoring the processes of SRU	1) Registered data including the number of patients and the services provided, broken down by self-reliance processes and results; 2) Identify achievements, weaknesses (improvement opportunities), and appropriate interventions to promote provision of social support and self-reliance	1. Observation and review of documents 2. FGDs with stakeholders
Promoting mental health messages and stigma reduction	Compiling messages	List of health messages	Observation and review of documents
	Publishing messages	1) Reporting distribution and installation of peripheral messages; 2) Reporting the distribution of mental health messages through people's networks	Observation and review of documents

*MoU: Memorandum of Understanding; PPH: People's Participation House; SRU: Self-reliance Unit; FGD: Focus Group Discussions.

Results

Actions Taken for Strengthening the Infrastructures

To implement the four components of community action programs, the following steps were taken during the pilot implementation:

1) Announcing the guideline of community action program by the Deputy Minister of Health and Medical Education which included how to form and operate the PPH; the Intersectoral Memorandum Framework and the method for calculating indicators for intersectoral collaboration; indications of social referral and self-reliance management; sending messages for improving mental health and reducing stigma
2) Holding meetings for advocacy with ministries and national organizations, announcing vertical supports to general offices and provincial units (forming vertical cooperation)
3) Justifying and educating governors and the deputies of all three districts in the Ministry of Health and Medical Education
4) Choosing, employing, and educating a social worker to take responsibility for the activities of the Community Action Secretariat (CAS) and to perform self-reliance affairs in the governorate
5) Opening the CAS in the governorate of all three districts.

Achievements and Challenges

The findings of the 12th intersectoral collaboration in the three districts are outlined in Table 2.

The PPH has been formed in all three districts and has been held for at least five monthly sessions. In Osko, ID cards were issued for members of the PPH. Also, PPH has communicated with the governor of Osko and 25000 leaflets of mental health were distributed through the health volunteers of PPH in the covered populations.

The status of social referral in the SRU is described in Table 3. As shown, 816 people were referred to SRU from primary and secondary programs. Then, individuals were interviewed and introduced to the appropriate social support authorities and 917 were introduced, among whom 46% received support.

The social support authorities included Drop-In Centers for Harm Reduction, Imam Khomeini Relief Committee, State Welfare Organization, Banks, Ministry of Education, Health Centers, Mine & Trade Administration, Governorate, Provincial Government, Technical and Vocational Training Organization, Insurance, Municipality, Center for the Treatment of Learning Disorders, Specific Diseases, Chain of Hope Association, Private Schools, Hope Entrepreneur Fund, Department of Youth and Sports, Self-reliance Marketplace, Factories, Seminary, village administrations, and the Courthouse.

SRU leads to accurate statistics of the damage, responsibility of some departments and accountability to the governance system, intersectoral collaboration, clarifying the referral path, establishing a center for damage and dilemma reduction, finding an executive position in the governorate, facilitating individuals' referral, and identifying a social support base in the governorate.

Although the integration of screening services, the treatment of common mental disorders, and the training of mental health and social health professionals in health centers are some ways for reducing the stigma of mental disorders and have been well implemented in all health care centers of the districts, recorded data show that on average 60% of the population was screened and entered the mental health care process. Also, other measures aimed at mental disorders stigma reduction have been implemented:

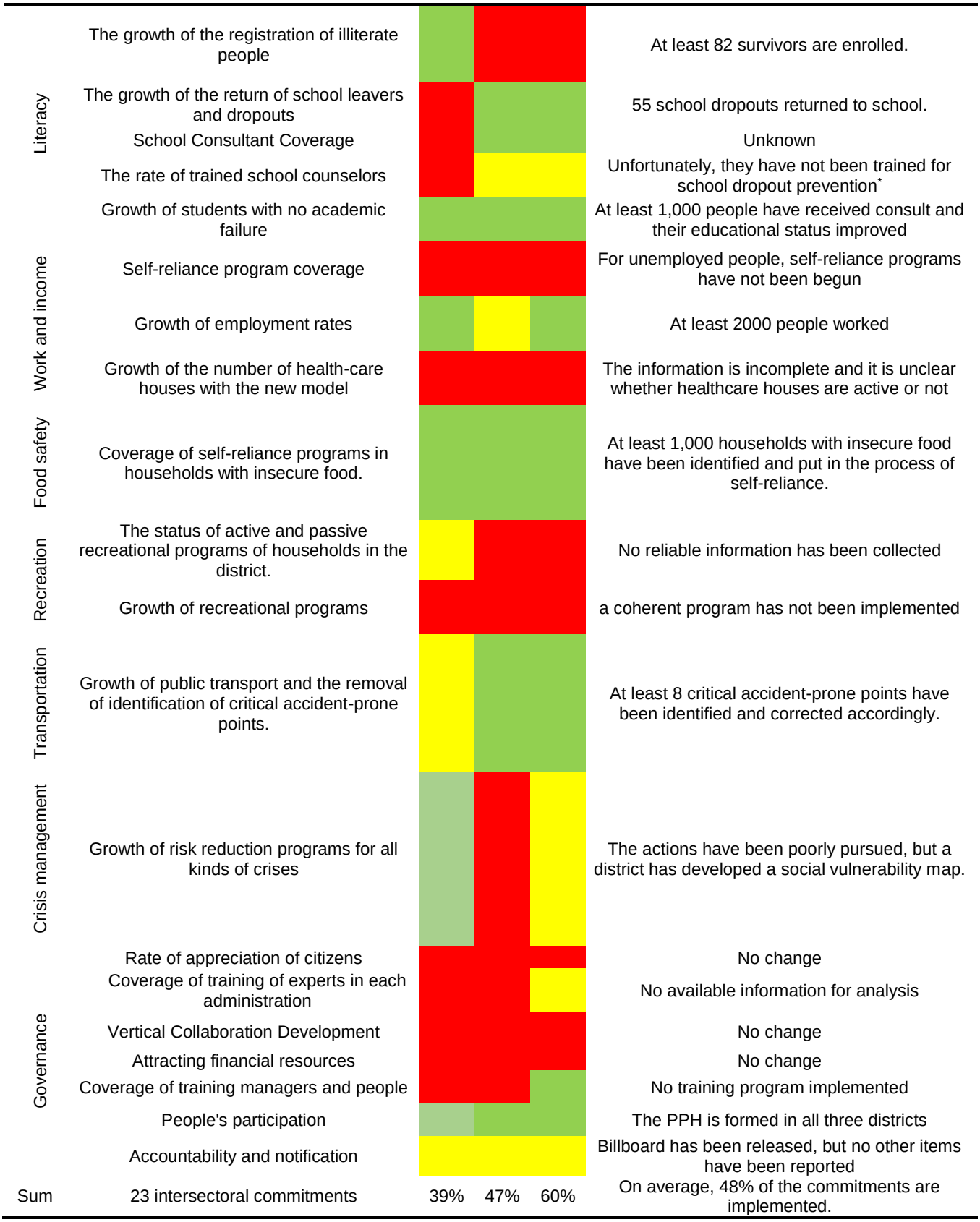
1) Educating the Governorate Council, health volunteers, and PPH
2) Establishing a community mental health center (CMHC), instead of single-specialized centers called psychiatric hospitals, establishing team-care, initiating preventive interventions at the second and third level for severe psychiatric disorders, telephone follow-up and home care
3) Transmission of mental health messages through PPH and health centers
4) Installing at least 10 preventive messages through billboards and banners in the district (Table 4).

Options for Promoting Community Action Programs

The options for promoting community action programs are summarized in Boxes 1-5.

Table 2. The Results of 12th Intersectoral Collaboration for Promoting Mental Health in Bardsir, Osko, and Quchan Districts

Field	Indicator	Quchan	Bardsir	Osko	Collected in 3 Districts
Childhood development	Growth of people's access to kindergartens				Seven kindergartens have been added
	Growth of nursery quality				Unknown
	Availability of children playgrounds				At least four children's playgrounds have been added



Red indicates that the corresponding index actions have not been implemented or have been negatively affected.
Yellow indicates that the corresponding index actions have been implemented, but progress information is not available or has not had satisfactory progress.
Green indicates that the corresponding index actions have been implemented and are progressing.

Table 3. The Status of Individuals' Social Referral to the SRU and the Results Separated by Each District Over 20 Months

District	Individuals Referred to SRU (n)	Referrals to 23 Different Social Support Authorities* (n)	Received Supports (n.)	Rate (%)
Osko	502	502	241	48
Bardsir	169	280	135	48
Quchan	145	135	47	34
Total	816	917	423	46

*A person may be referred to multiple social support authorities. SRU: Self-reliance Unit.

Table 4. Actions and Training Programs Implemented for Mental Disorders Stigma Reduction in Osko, Bardsir, and Quchan in 20 Months

Actions and Programs	Quchan	Bardsir	Osko
The number of people trained at workshops on mental disorders and stigma reduction			5306
Playing mental health messages from health centers through 24-hour electronic signage			daily
Installing Mental Health Messages in the banner at traffic-prone points	10	10	10
Distribution of Mental Health Messages through health volunteers in PPH			25000 leaflets
Distribute mental health messages in all departments	10		

Box 1. Options Suggested to Promote Intersectoral Collaboration in Community Action Program

The coordination of organizations at the national level for vertical support from the relevant departments of the district shall be more than before, this can reach by the establishment of a technical committee in the Health and Food Security Provincial Council. It is preferred that expectations of the offices be communicated to the city through the corresponding national department. This technical committee evaluates, corrects and finalizes the indicators, standards, existing regulations, and current gaps.

The issue of multiple permits for kindergarten should be reviewed in the districts' technical committee and the decision should be notified .

The list of environmental measures that reduce mental health risk factors should be reviewed for inclusion in the MoU with the participation of national, provincial and district stakeholders. For example: 1) Institute for the Intellectual Development of Children and Young Adults should work with the State Welfare Organization, Governorate, and Ministry of Education in case of childhood development. 2) Female empowerment programs should be implemented by the Women's and Family Workgroup, Ministry of Agriculture Jihad, State Welfare Organization, Ministry of Health, Women, Sports, and Youth's Basij. 3) The role of the Law Enforcement Force of the Islamic Republic of Iran in training, security, and discipline of the district. 4) The National Children's Week, the National Mental Health Week and other occasions should be labor divided in MoU and will be scheduled. 5) Employment counseling clinic should be established for individuals introduced by SRU. 6) The role of municipalities through the municipal organization should be more serious and targeted. 7) Interventions to reduce violence, addiction and promote social capital should be merged in this program.

The standard educational and empowerment program should be designed and provided for the members of the departments, CAS, SRU, PPH and city directors. Specific workshops for each of the inter-sectoral indicators should be designed and provided. Moreover, a standard questionnaire for evaluating recreational status should be set and a workshop on the management of recreational and leisure time activities should be held. Instructions should be compiled for collecting households below the poverty line, food insecurity, unemployment, etc., in collaboration with the National Organization of Statistics. The principles and techniques for promoting the spiritual health of the stakeholders in the district should be implemented.

An electronic system for recording the intersectoral performance of departments and calculating indicators in the CAS should be designed and implemented.

This secretariat should be supported to integrate into the official structure of the governorate.

Box 2. Options Suggested to Promote PPH in Community Action Programs

1. The way people work for PPH should be described step by step.
2. Visiting successful PPHs should be possible.
3. The district's officials and health network experts should be empowered with the principles of people's participation.
4. The method of program designing, advocacy, teamwork (including how to manage the meetings, division of labor and follow up), project management, and recognition of the city's anatomy and physiology, and how to choose the representative of the people, should be taught in the PPH.
5. People should have an active presence in monitoring the division of intersectoral labor.
6. Failure to identify or selecting the wrong representatives of people's networks and inviting people who are not representative has a detrimental effect on the performance of PPH.
7. Empowerment of members of the PPH and district directors is essential in community action skills.

Box 3. Options Suggested to Promote Self-Reliance in Community Action Programs

1. SRU should be integrated into the Welfare Organization. This requires designing an integrated social health service model, defining self-reliance, and developing evidence-based protocols with the cooperation of academic centers
2. SRU in the districts' governorate should have a technical committee with the participation of people and donors who supervise planning and coordination of the provision of supportive services.
3. Collaboration between primary and secondary programs and community action for referring individuals in need of social support has been successful, but no feedback has been sent to the primary and secondary levels. An electronic system is needed to solve this problem. In addition, this system should also work as a registry database meaning it should record all files and follow-up sessions.

Box 4. Options Suggested to Promote Actions for Stigma Reduction and Promoting Mental Health Literacy in Community Action Programs

1. Social marketing tools should be used to identify the causes of non-referral and the attitude of people towards mental disorders.
2. Evaluation of actions taken for stigma reduction in local regions as well as attempts to promote mental health literacy of mental disorders.
3. Integrating households' level of mental health literacy into their educational ID or participating in the relevant short courses on Electronic Health Records would be effective.
4. Ten prevention messages in mental health promotion should be determined and a guide to promoting these ten messages from different sources should be compiled.
5. The Public Relations of the governorate and districts' administrations should be educated to properly use their capacity to promote ten messages.

Box 5. Options Suggested to Promote Infrastructure strengthening in Community Action Programs

1. The shortage of manpower and lack of power to manage PPH, CAS, SRU affairs simultaneously is a major challenge. It is suggested that tasks related to intersectoral cooperation and the CAS be managed by the social worker located in the governorate; and tasks related to the SRU be managed by a social worker located in the Welfare Organization, thus resolving the physical space limitation.
2. It is necessary to determine the intersectoral financing system. The first option is to optimize provincial and district budgets, which can be implemented through participation of the general-director of budgeting at both provincial and district level by signing the MoU. The second option is the vertical support of the national organizations of related provincial and district units, which will be achieved through more reliable accreditations. The third option is seeking support from the Ministry of Health and Medical Education and the Social Affairs Organization to fund educational and applied research.
3. Local scientific and educational centers and local media be identified and be participated in an integrated MoU.
4. Ranking of agencies and rewarding should be based on the following criteria: regular attendance, timely action, transparency in reporting, creativity in implementation, intersectoral collaboration from other departments to address their problems, and engaging people in participation.
5. Health volunteers should present the prevalence and burden of mental disorders in Iran, suggest the possible options, and introduce SERAJ plan in a meeting with directors of their organization.
6. To reduce the number of meetings and avoid time wasting, spending only 20 to 50 % of the time used for Governorate Council meetings would suffice to educate chairs of departments.
7. Performance Monitoring of the four components of the community action program and applying corrective actions are the responsibility of the chair of health network of the district.
8. The Governor, members of the Governorate Council, members of the PPH, and Urban and Rural Municipalities should be educated on techniques and principles of governance.
9. For effective implementation of the community action program, a Q&A leaflet should be prepared and a booklet on causes of mental disorders should be published.

Discussion

The evaluation of the community action program shows that 48% of the agreed intersectoral measures has been implemented. The PPH was formed in all three counties. The SRU admitted 816 social referrals, filed their information, and started a self-reliance process which has provided supportive measures for 47% of the referrals. At least 10 mental disorder stigma reduction messages have been sent from different sources at the district level.

In Bardsir, the chairmen of the PPH were changed twice in 2 months. Several representatives of the PPH have not yet been selected. For sending health messages, a telegram channel, which is a popular and active social media in Iran, has been set up. On health occasions, messages are sent through telegrams or brochures to health volunteers and distributed to their target community. At the demands section of PPH, a survey has been designed and delivered to the delegates to submit their demands. Several activities were organized by PPH, including a festival so-called "healthy children, healthy family"; planting Willow trees to prevent soil erosion; almond planting; the environmental cleanup conference on the occasion of the Clean Day; and the hiking conference, along with the Kites Festival for children and parents at kindergarten, preschool and elementary schools. There are only three available briefings in Quchan district, while no document is available about conveying the people's demands to the governor or communicating messages to people's networks.

It seems that the establishment of a PPH requires step-by-step actions that should be designed and handled by practitioners like a cookbook. In many cases, we do not know how to select a representative of people in a group. The presence of people other than the people's representative in this council makes them irresponsive and unaccountable toward each other. Members of PPH should educate on basics such as how to compile program of the council, methods and principles of advocacy, how to manage meetings, how to do the division of labor and follow up, project management, and recognition of anatomy and physiology of the district. It took several months to regain people's trust so that conceptual participation is inclusive and includes nothing but empowerment of people.

There are numerous features of every message including its content, plan, location and time to be installed and removed, which all needs planning, and sometimes it requires qualitative field research to identify audience perspectives. Although the top 10 mental health promotion messages in the CAS have been debated in three districts, the information gathered does not indicate that the promotion was performed according to a timetable. In this context, all stakeholders, including the municipality and the community action team, need a standardized and flexible training workshop to promote stigma reduction messages. Using PPH was an innovative action in the distribution of messages, but the place of artists in this action is empty in all three cities.

An overview of the results of intersectoral collaboration (10) suggests that fulfilling the implementation requires complementary education for partners, integrated monitoring through electronic systems, and the creation of competition between agencies through ratings. A review of the experiences of stakeholders and partners in this project suggests that there is a misconception about the intersectoral collaboration-based division of labor (11). Although the division of labor is one of the methods of collaboration, the concept of intersectoral collaboration is wider. The intersectoral collaboration will not take place unless everyone feels responsible for improving the status of the social indicator (12). Another misconception about intersectoral collaboration is that people should not enter this process because the mechanism for people's participation is different, while following the definition of intersectoral collaboration, the involvement of all three public, private, and nongovernmental sectors is intended, not just governmental sectors (13). Therefore, there is no tracing of people in most of the activities defined to improve the indicators of the district. Based on the public participation ladder, members of the People's Participation Council must monitor the intersectoral division of labor (14-17).

Vertical cooperation, alongside horizontal cooperation, accelerates the achievement of expected indicators (18, 19). Vertical cooperation was targeted as one of the indicators of governance in this package, but in practice, the governor failed in this type of cooperation. This suggests that there was no opportunity or ability to market the mental and social health model for the governor and planners in the district; in other words, the skill of effective district governance should be strengthened especially in the field of ability to communicate effectively, facilitation, use of power, decision-making, policy-making, empowerment, negotiation, financing, monitoring, and institutionalization (12).

Evidence suggests that changes in outcome and impact indicators require at least 3 to 5 years of continuous and consistent work (12, 20, 21). During the pilot implementation which lasted for 20 months, two out of three governors were displaced, so as senior managers and their sub-managers, which affected the sustainability of the interventions and interrupted the implementation. In this regard, a more sustainable system for the management of the district should be implemented by the Ministry of the Interior. We recommend that a minimum term limit of four years be provided for governors, i.e., governors should at least serve four years in office.

The provision of social support services with the aim of self-reliance for socially injured people who are simultaneously suffering from mental illness take years (22). These services should be comprehensive,

sustainable, and take advantage of local capacities (22). Therefore, the provision of such services requires an organization; regarding Iran's infrastructure, State Welfare Organization could be one, which according to the Law on the Sixth Five-Year Economic, Cultural, and Social Development Plan for 2016 – 2021 is responsible for the health of all Iranian citizens. Transferring SRU to State Welfare Organization or the presence of a social workers in the governorate will increase the effectiveness of social support services at a specialized level.

Having named Community Action Secretariat (CAS) to implement the four actions outlined in the SERAJ Plan is illustrative, but the title of the Secretariat for Sustainable Development is also a good alternative, with the goal of intersectoral collaboration (23) and public participation (24), as well as monitoring economic, social, and environmental indicators. Therefore, if other national and provincial organizations were planning to launch strategic and development projects at the district level, they would not form a separate secretariat.

The progress of the Iranian Five-Year Economic, Cultural, and Social Development Plan over the past 2 decades has shown that the overall success of implementing programs depends on several factors, including monitoring, evaluation, and timely feedback. It has been shown that implementation and deployment require more time and effort than the need assessment stage and require patience and perseverance, especially in times of collaboration and teamwork, as collaborative work is costly and time-consuming at first, but it is more sustainable and effective (25). One of the main limitations of this study was the pilot duration; a 20-month pilot implementation at the district level is not sufficient to determine the effectiveness of this model; therefore, combining other quantitative data (by conducting before-after studies) to evaluate its success is essential (9). More studies should be conducted to evaluate the community action package to determine the main cause of achievements and challenges.

Limitation

The issue identified as the main challenge by the experts responsible for the CAS in the three districts was that authorities and representatives of the people and health network experts were not familiar with the principles and techniques of participation. Moreover, peoples' networks were not enough motivated and did not easily trust governmental departments to participate in programs. Furthermore, the lack of teamwork skills in people's networks is another challenge faced with the implementation of this plan.

Conclusion

Pilot implementations in Iran are not conducted successfully because either they are expanded before evaluation or have stuck in the pilot phase for a long time. The evaluation of the community action program shows that by implementing our proposed model, hidden barriers and challenges besides the facilitators become apparent. Solving such barriers and challenges before expanding the pilot throughout the country is of high importance. We suggest that the National Technical Committee be formed to integrate our options within the community action program, and after revising the program, a pilot study be conducted in several other districts. Moreover, we suggest that the experiences of the governors and health network directors of the three districts be presented at a national conference. This study showed that the community action program is efficient but to determine its effectiveness, it should be compared with the control districts.

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Conflict of Interest

The Authors declare no conflict of interest regarding publication of this article.

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