HEALTH SYSTEM TRANSFORMATION IN THE ISLAMIC REPUBLIC OF IRAN:
AN ASSESSMENT OF KEY HEALTH FINANCING AND GOVERNANCE ISSUES

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World Health Organization

CHAPTER 4
Public voice and participatory governance in the health sector: status quo and way forward

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KEY MESSAGES

This review took place in 2017 and 2018 within the context of implementation of the 2014 Health Transformation Plan (HTP). The impetus for reviewing participatory governance of the health sector in the Islamic Republic of Iran was the specific emphasis given in the HTP on social affairs; with it came the need to gain more insight into which participatory platforms in health work well and which work less well and why. Findings are grouped into three areas of participatory governance.

Organized forms of public engagement: civil society, civil society organizations, non-governmental organizations (NGOs), community-based organizations (CBOs), charities, etc.:

- Definitions, and with it, mandates, are blurred between the different types of civil society organizations in the Islamic Republic of Iran, bringing with it a certain level of duplication and fragmentation.

- Civil society organizations can be formal, semi-formal, and informal but those categories are fluid and can change according to the specific action taken in the health sector.

- Civil society plays a mediating role between the people, the Government and service providers.

- The creation of the Deputy Ministry for Social Affairs within the Ministry of Health is a crucial factor in providing an enabling environment for participation.

Participatory governance mechanisms available to the public:

- Formal citizen participation in health programmes was initially focused heavily on programme support and implementation rather than input into evaluation or decision-making. This has begun to change.

- Civil society networks, call centres and local, regional and national health assemblies are being supported and encouraged by the Government, demonstrating increasing recognition of the value of participatory governance in health programming and decision-making.

- The National Health Assembly is a potential opportunity for de-fragmenting participation, as it brings together the various, uncoordinated formal, semi-formal and informal structures working towards improving population health.

- A more formal legal framework may be required to ensure that participation becomes part of the health sector's modus operandi.

Intersectoral collaboration:

- The Secretariat of the Supreme Council for Health and Food Security, dedicated and resourced to foster multisectoral collaboration, is appreciated as highly relevant and useful to concretizing intersectoral work streams.

- A common understanding of multisectoral action is still needed across sectoral actors; this could help stimulate more joint projects and joint budgets.

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INTRODUCTION

Given the emphasis on participation and social affairs in the 2014 Health Transformation Plan, the World Health Organization (WHO), the Ministry of Health and Medical Education (MoHME) and the National Institute of Health Research (NIHR) of the Islamic Republic of Iran identified a critical need to better understand the status of existing participatory processes in the health sector. The idea was to gain an in-depth insight into where the real challenges lie and into what works well enough to scale up. The ultimate objective is to chart a path forward to improve health governance in the country, one of the key elements in further advancing towards the goal of universal health coverage in a sustainable, efficient and equitable manner.

This chapter thus focuses on participatory governance mechanisms in the Iranian health sector, specifically examining how public voice is taken into consideration into health sector policy-making and implementation. Based on these findings, options for strengthening and institutionalizing public participation in health are proposed, in view of enabling the Health Transformation Plan to reach its objectives of 'socialization as an underlying principle of all health-related work in the Islamic Republic of Iran *(1)*.

Three priorities for study were identified by the MoHME: organized forms of public engagement, including civil society, civil society organizations, NGOs, community-based organizations and charities; participatory governance mechanisms available to the public; and intersectoral collaboration. The objectives of the review within these three priority areas were therefore:

- Organized forms of public engagement, including civil society, civil society organizations, NGOs, community-based organizations, charities, etc.: to assess the current situation of health-related NGOs, philanthropic activities and the role of charities in translating public voice to action and community-based action in health

- Participatory governance mechanisms available to the public: to assess the status of public participation in health policies and programmes, the status of available participatory governance mechanisms and their functionality and

bottlenecks and opportunities for improved and systematic engagement of people on health sector issues

- Intersectoral collaboration: to assess the status of intersectoral collaboration in health policy and programmes and to gain insight into the link between intersectoral collaboration and participatory policy-making in view of a mutual strengthening of both initiatives

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REVIEW METHODOLOGY

The study is based on a literature review and key informant interviews. Co-authors coded and analysed the interview transcripts.

LITERATURE REVIEW

A literature review of published documents was undertaken in Farsi and English. For the English-language review, the following databases were searched: Cochrane, Google Scholar, JSTOR, Project Muse, and PubMed. The search terms included "Iran" combined with each of the following terms: participation; community health; participatory governance; participatory health governance; social participation; citizen consultation; citizen participation; community participation; community engagement; social engagement; patient participation; health; community health; health care; health system; health policy; public health; health decision making; health policy making; health promotion; community health planning; health education.

On Google Scholar, the number of hits generated with the above search terms was over 1000. The sorting function 'sort by relevant' was used to narrow down the number of hits on the search engine algorithm. The abstracts of the top 40 articles were thoroughly screened and reviewed for inclusion or exclusion. On Cochrane, the top 30 articles were screened. Many of these were already duplicates from the Google Scholar database. On JSTOR, 20 abstracts were thoroughly screened and reviewed. Many of the articles found were not duplicates from previous databases searched. From PubMed, 35 abstracts were thoroughly screened and reviewed; all other PubMed hits were duplicates of articles from the Google Scholar and Cochrane databases. On Project Muse, only a few hits were found and deemed not relevant for inclusion into the study. On the other search engines, most hits were duplicates; those which were not were duly included in study.

In total, 54 documents were deemed to be relevant for full-text review. The selection criteria were:

1) the studies are in English; 2) the studies must contain one or more search terms. The full-text documents were then reviewed for relevance with the study objectives. 34 were thus discarded, mainly based on a lack of a link to the country, the health sector, or participatory mechanisms. 20 English-language articles were finally included into the study. Four additional English-language articles were added in as suggestions from the Iranian team. All English-language articles' references were reviewed in an attempt to extract more references from the relevant documents. The reference mining led to the review of 190 further abstracts. From the abstracts read, 29 were deemed relevant for full-text review. Of the 29 articles read in full-text, 8 documents were deemed relevant to be included in the study.

In parallel, the Iranian team reviewed Farsi-language articles in the following database: health.barakatkns.com. The equivalent Farsi search terms for 'people', 'participation', and 'health' were used (people: مردم; participation: مشارکت; health: سلامت). 1232 hits came up, and the article titles were reviewed for relevance with the topic at hand. 65 articles were thus selected, and their abstracts reviewed. From the abstracts, 29 articles were selected for full-text review. 10 articles were deemed relevant for further scrutiny. These 10 articles' abstracts were translated so that the WHO team could review them in English. A joint decision was made between WHO and the Iranian team to include the full-text version of 3 of those Farsi articles based on relevance to the study objectives. One additional Farsi article was added to the 3 for inclusion into the study after mining the references of the 3 Farsi articles. Hence, the total reviewed articles were 36 (Box 4.1).

All 32 English-language documents were reviewed using the study objectives as a framework for analysis. The preliminary findings were presented to a government-led health sector stakeholder group in Tehran in October 2017. Based on the feedback and ensuing discussion, it was decided to add the Farsi-language literature review (mentioned above) and do primary qualitative data collection to fill knowledge gaps.

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Box 4.1: Articles included in literature review

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Due to the sparse nature of information gleaned from the literature review, much of the findings as described in further sections of this chapter are taken largely from the qualitative data gathered specifically for purposes of this review:

KEY INFORMANT INTERVIEWS

Key informant interviews and group interviews were conducted in February 2018 in Tehran and Qazvin provinces. Reflections from those interviews, together with the literature review, the October 2017 stakeholder meeting discussions, and subsequent exchanges between WHO, MoHME, and NIHR, helped shape a preliminary coding framework with broad common themes.

All interviews were transcribed into Persian (Farsi) and then translated into English by a certified translator. The analysis team analyzed the English translated transcripts by applying the coding framework to the interview transcripts, then modifying and adapting with additional new themes emerging from the data (deductive-inductive mixed approach).

The analysis was conducted by 4 people with differing institutional identities (1 WHO, 1 MoHME, 1 National Institute for Health Research, 1 independent) to ensure different points of view, and reduce confirmation bias. Each transcript was examined by at least 2 out of the 4 analysis team members. Every single coded phrase or text passage was reviewed by at least 3 out of 4 team members together through Skype and Webex sessions, where discordances and differing understandings were discussed in detail, and a consensus reached. If needed, the original Farsi transcripts were referred to in the attempt at really understanding what the interviewee meant and in which context. This process helped to validate the thematic codes which fed into the updated version of the coding framework.

In addition to the triangulation amongst coders during the analysis process, we also used the literature review to triangulate findings.

ORGANIZED FORMS OF PUBLIC ENGAGEMENT: CIVIL SOCIETY, CIVIL SOCIETY ORGANIZATIONS, NGOS, COMMUNITY-BASED ORGANIZATIONS AND CHARITIES

The study objectives addressed in this section were to assess the current situation of: health-related NGOs, philanthropic activities and the role of charities in translating public voice into action and community action in health.

DEFINITIONS OF CIVIL SOCIETY, NGOS, CHARITIES AND COMMUNITY-BASED ORGANIZATIONS

The Islamic Republic of Iran has a long history of civic engagement and philanthropy, which are enshrined in its culture and religious thought, especially in social spheres such as health. Although the imported term "civil society" was increasingly used in relation to civic activity in the late 1990s, its definition in the Iranian context has never been completely clear *(2, 3)*. What is clear is that the ideals represented by western notions of civil society and civic engagement have been in the Iranian psyche for centuries and have been influential in shaping social, political and economic life *(2)*. For example, religious charities, often described as the backbone of civil society in the country, and urban NGOs in some areas, provide valued social services (assistance to orphans and poor children, for example), and many do so in a truly participatory manner at local levels. The Directorate-General for NGOs and CBOs in the MoHME estimates that around 14,000 charities, NGOs, community funds or foundations exist in the country, with 10% of them working in the health sector; other religious entities are engaged in charity work *(4)*. Charity is therefore an integral part of community life in the country and an important vehicle for social participation of certain sectors of the population.

For purposes of this analysis focused on organized forms of civic engagement in the health sector, we draw on Hegel's view of civil society as a product of history *(5)*. In the Iranian context, this would mean regarding civil society as the collective internalization of a civic sense as well as the civic activity stimulated by it. In essence, individual charitable action and community support for the poor has always been part and parcel of the population's fabric.

The concept of civil society used in the international development world is anchored in the idea of the state and civil society being two separate entities, with civil society being explicitly 'non-state' in character, as an either opposing or complementary force to the state, depending on the context. However, if civil society is rather a product of a people's history, in the Islamic Republic of Iran the state has "historically stood at the top of society as a paternalistic figure with responsibility for welfare" *(2)*.

It is thus important to understand that, in the Iranian context, organized forms of civic engagement have blurred boundaries between the state and the people, especially in social sectors such as health where welfare and charitable activities often see the state and non-state actors working hand-in-hand. Due to government changes and the changing political context, there is also an evolving character to how civil society and civic action is viewed and played out in the Islamic Republic of Iran; it thus makes more sense in this context to understand civil society as a dynamic process rather than a static entity with definitive structures.

Keeping in mind this close interaction of state and society, charity and development and political, personal and financial ties in the Islamic Republic of Iran *(6)*, we discuss the principal terms linked to organized forms of public engagement.

The Director-General for NGOs and CBOs in the MoHME defined an NGO as "*an organization that is legal, non-profitable, independent and voluntary. It supports the well-being of the people, especially*

> In this chapter, we employ the term 'civil society' or 'civil society organizations' for all collective civic action for social purposes*, whether organized or not, whether through registered bodies or not. This encompasses non-governmental organizations (NGOs), charities, community-based organizations (CBOs), etc.
>
> *for this analysis, it is implied that the action takes place in the health sector

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> The term 'charity' is used more for **financing** charitable works whereas the term 'NGO' has the connotation of charitable **action.**

the disadvantaged class. This is the definition that we've added in the Ministry of Health, in particular the disadvantaged class." He went on to specify that *"charity or charity enterprises are more well-off people who want to do charity work, their work is more financial assistance. For example, they give cash to orphans or widowed women. The NGOs that we recognize as the NGO do the scientific work."*

According to the above-mentioned definition, NGOs are non-profit entities with no paid staff, independent of the Government or any political or religious agenda, mainly engaging in technical work and service delivery. While several NGOs do fit this definition, in practice many do not (for example, many NGOs do have paid positions). However, this definition helps greatly in getting a sense of what most NGOs are *most likely* engaging in, which many study interviewees confirmed was largely curative care and patient support linked to specific diseases, and how they *most likely* operate.

The insight provided by the Director-General on what a charity is links up closely with the Iranian (and Islamic) tradition of giving to the underprivileged, where there is need. Since the focus of the term 'charity' is on financial assistance more than anything else, NGOs are often seen as charities if they undertake fundraising and have wealthy donors. So, the same institution can be functionally both an NGO as well as a charity. As the CEO of the renowned cancer charity hospital Mahak confirmed in his interview, *"25 years ago, charity organizations were registered under Article 10 of the Law of the Parties in Iran…such as Mahak…but in essence and unofficially, all recognize Mahak as an NGO in Iran."*

Community-based organizations (CBOs) enjoy a long tradition in the Islamic Republic of Iran, especially in social sectors such as health, without necessarily being labelled as such. Indeed,

volunteer work is ingrained in community life, with a strong commitment to contribute to communities. CBO work is traditionally localized and grassroots in nature, rather informal in some places but formalized in others, and not traditionally under the direct control of the state nor private sector. One interviewee characterized CBOs as *"the association…that is formed by the local residents with a local identity. Its difference with an NGO is that it does not have bureaucracies of registration and is formed based on an identity."*

In many settings, however, especially during the reform movement of the 1990s, some CBOs were increasingly linked to or merged with State-sponsored health programmes due to the synergies and complementarities they offered. The Iranian government recognized the potential in using CBO channels for low-cost health programme delivery. In addition, much of the grassroots activities are often done in collaboration with institutions with close ties to State or parastatal entities, such as mosques, which inevitably lends itself to closer merging with government health activities.

Grassroots activities in health are also conducted by numerous informal social groups who are not registered with any government body. As the Director-General for NGOs and CBOs affirmed, *"A large number of organizations and social groups are into charity work, hundreds of thousands, but they do not have legal status".* This may be linked to a wish to stay as independent as possible from government intervention or religious convictions to stay anonymous while giving *(7).* Many of these informal (but at times, very well organized) social groups is serving the poor and underprivileged. They resemble CBOs quite closely in that they have close ties to local communities and are heavily dependent on community networks.

> Community-based organizations (CBOs) conduct **grassroots** work in health, with close ties to communities, and a focus on the poor and underprivileged

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Many of these informal groups work out of local mosques and use the infrastructure of clerical organizations *(2),* while remaining informal. Others have merged with organized health activities under the patronage of the Supreme Leader, making them de facto formal.

The notion of de facto formality also holds true for a plethora of health-related activities coordinated and funded by entities under the Supreme Leader. These organizations have vast resources and capacity, as well as trust and familiarity of communities as a basis of their support and influence. Minimum alignment of such informal health work with the goals and activities of the HTR would greatly benefit population health. The same is true of the work of other quasi-civil society institutions, such as the social services branch of the Basij paramilitary organization, which conducts health promotion and prevention and curative care. For example, in recent earthquake disaster relief efforts, the Basij worked alongside State representatives, although they were not the State's official representatives. Coordination of these activities, to reduce duplication and synergize efforts towards HTP goals, could create efficiency gains and win-wins for all sides.

CIVIL SOCIETY AS A MEDIATOR BETWEEN THE STATE AND THE PEOPLE

The notion of civil society organizations acting as a middleman (or middlewoman) between the state and the population came up repeatedly in our interviews and is supported by the broader literature. Ultimately, civil society in the Islamic Republic of Iran fills a vacuum in the health space between people's expressed needs and wishes and how the health sector is organized by the government to respond to those needs and wishes. Iranian civil society often facilitates communication on behalf of the people for various purposes: to obtain information from the health system, to provide ideas, give feedback, complain, etc. This mediator role is clearly illustrated by a civil society member from Qazvin province: *"the [civil society] person is so closely aligned with his or her group members that s/he constantly monitors the problems and demands and submits*

them to monthly meetings…Then we will prepare the minutes of the meeting. We send a correspondence with the minutes to various organizations. Suppose the problem is related to the municipality, we write down and officially declare that this person or group has such a problem and request the organization to resolve it. If it does not fix or underperform, we will send a copy to the Governor General."

One of the roles which Iranian civil society takes on is thus a functional platform for dialogue and exchange between the populace and the state, because they are more organized, have a distinct purpose, and are able to channel the information in a concise way. This role seems to be more of a one-way channel where needs are expressed bottom-up and decision-makers respond (or not). In terms of the HTP, given the necessary trade-offs in health investments which sanctions will render more acute, this civil society role of dialogue is actually a critical one for government to leverage in view of building consensus around those difficult decisions. In essence, it is a big value-add for the government to make this more of a two-way channel.

FUNDING FOR CIVIL SOCIETY ORGANIZATIONS

The funding situation for civil society organizations (CSOs) in the Islamic Republic of Iran is complex partly because CSOs are difficult to define in the first place. The same holds true for government-run programmes such as the Volunteer Women's Health Programme or the Community-Based Participatory Research Programme which are often mislabelled as 'NGOs' because of the social nature of their activities, although they are entirely government-funded. On the other hand, their reliance on volunteers and on the inherent motivation to participate existent in Iranian society means that these programmes can be executed at a relatively low cost.

Government funding, and moral and technical support in general, is a function of the overall general political environment favouring citizen action. Currently, solid support for population participation is demonstrated by the current government's

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creation of a Deputy Ministry for Social Affairs in 2016 within the MoHME, with the explicit aim of improving integration of participatory approaches into the modus operandi of the health sector. The Director-General for NGOs and CBOs, a newly created post under this Deputy Ministry, explained how his department is encouraging civil society growth: *"For example, the area of the University of Iranshahr covers a million inhabitants that [does] not have even one NGO….We had a session with the NGOs to set up their branch there and they did. Now nearly 15 NGOs are active in Iranshahr, and the same benefactors equipped the building also."* A current advisor to the Minister made the point clear as well in pointing out the objectives of the new Deputy Ministry: *"[The] Deputy for Social Affairs should have some budget to implement this pilot project, to empower the NGOs, to empower the communities, to train the charities."*

That being said, NGOs and charities do still rely heavily on private donations for their existence; the term 'charity', as described above, is in fact linked more to *financial* contributions to philanthropy rather than the charitable action per se. One parliamentarian interviewed even felt that public participation was mostly a question of financial contribution towards public goals: *"[S]trengthening people's participation [is] part of the approach…of [the] Ottawa Charter for Health Promotion. And financing is one of the aspects that people can contribute to…Now, on the financial contribution of our people, we should not forget an option; benefactors. Benefactors are doing great things in the field of health. We may have more than thousands of NGOs and CBOs, who are somehow helping in the field of health, or those who contribute to the construction [of health facilities]."*

The willingness of Iranian citizens to contribute, including with money, is seen increasingly by the Government as a means of achieving public health goals, such as those in the HTP. Given the renewed economic sanctions, the Government may have little choice, at least in the short term, in order to maintain a certain quality and quantity of health services and health system functioning. In-kind, moral and technical support will also be necessary, first to provide an enabling environment for civil society to operate and secondly to strengthen the capacity of civil society to contribute to public health goals.

THE GOVERNMENT'S APPROACH TO CIVIL SOCIETY WITHIN THE HEALTH TRANSFORMATION PLAN

Many interviewees described the current environment as open and enabling for testing, scaling up and institutionalizing participatory approaches. A Ministry official stated with regard to the Deputy Ministry for Social Affairs: *"The minister of health emphasized that he was not willing for the Social Affairs to just stay in the scope of the [central ministry]. All the universities and the deans of the universities [in the provinces] should know that the main mission of the Secretary, in this term, is regarding health as a social issue."*

However, an enabling macro-environment does not necessarily guarantee an enabling micro-environment at local or provincial levels. Interviewees also underlined that some (not all) Government entities not only lack confidence in the ability and utility of civil society/NGOs, but often view them as direct competitors instead of partners. One provincial civil society representative summed it up flatly: *"Our authorities…think we are going to take the position from them."*

In light of the objectives of the HTP and the difficult economic climate, the role of civil society should be smartly positioned, encouraged and leveraged. The perception that civil society is a rival to the State in health affairs exposes the acute need for capacity-building initiatives for government actors for better understanding civil society stakeholders in order to take advantage of their potential and strengths. This need is further underlined by another view expressed by an interviewee that the main route for civil society participation is through their votes for elected officials who make policies in parliament: *"Usually, people do not play a role in policy making. And these are people's representatives who can decide and plan in the field of policy. People do not directly*

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interfere in politics, but their representatives play a major role in policy making in the field of treatment. People reflect on their problems to their representatives. Representatives try to resolve problems in the area of public health with legislation." Such stances can only be counterbalanced by capacity-building initiatives aimed at working with government cadres to demonstrate the added value of pursuing joint goals with civil society.

In line with the need for government cadre capacity-building is the urgent need for government to take on a major coordination role to enable it to effectively steer the health sector – this means coordinating all activities within the health sector, even if they are carried out and implemented by civil society, quasi-state organizations, or others, and aligning them towards HTP objectives. Coordinating activities is not equal to controlling the activities, but rather harnessing the willingness of stakeholders to contribute to the HTP. This could be done, for example, by inviting such partners to the Supreme Council for Health and Food Security meetings (when necessary) or establishing a National Steering Committee for Health which includes all relevant stakeholders, or using part of the National Health Assembly forum to bring these particular stakeholders together with the explicit objective to coordinate among themselves.

In effect, government coordination with CBO and NGO actors is now more official with the creation of the Social Affairs Deputy Ministry. One parliamentarian interviewed emphasized: *"Certainly a … Vice Chancellor for Social Affairs was a positive and successful establishment within the MOH. That they identify the CBOs, organize them, and direct them to where it is needed, is definitely effective, and I think it was a positive work that, fortunately, [was] undertaken and should be strengthened."* For other important non-state or quasi-state actors in health, an exchange of information at the very least could avoid expensive duplication of and wasted resources. Streamlining all health sector activities, ensuring efficiency gains, and joining forces for a common goal is now more needed than ever.

Another theme which came up in the interviews was government responsiveness to people's stated needs and demands. Many people reported their disillusionment at the non-implementation of legal decrees and formal decisions for which they had advocated, underlying the need for systematic government follow-up to issues raised through the civil society medium. Encouraging civil society participation in the health sector logically means that government must also have a plan for follow-up…or at the very least, a good plan for communication and collaboration with civil society to ensure that the viewpoint of government (feasibility) is taken into consideration. Such a collaboration would also address the vital need for (constantly) building trust between government and civil society, both for sustainability of the work of many of these organizations, but also for it to fulfil its purpose in terms of feeding into the broader health sector goals, in this case, the HTP.

The MoHME is actively promoting collaboration between different charities, NGOs, and CSOs working on similar topics by supporting the formation of networks *(8),* with a national secretariat under the tutelage of the Ministry of Health. This initiative is focused not only on cross-civil society exposure but also for closer exchange on technical topics between civil society and MoHME as well. These kinds of initiatives help foster the enabling environment needed for civil society actors in health to flourish and contribute to public health objectives.

CHALLENGES FACING CIVIL SOCIETY ORGANIZATIONS IN THE HEALTH SECTOR

Organized forms of social action have a long tradition in the Islamic Republic of Iran, with much of the work done in the informal sphere. In fact, many civil society organizations, especially CBOs and faith-based charities, do not officially register with the government. The reasons may be the desire to remain truly independent of the government, a religiously motivated wish to remain anonymous, or cumbersome bureaucracy.

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These three possible reasons represent a challenge for CSOs while operating in the Islamic Republic of Iran's health sector. Cumbersome bureaucracy is being reduced by the current government -- for example interviewees emphasized the comparative facility and speed with which organizations are accorded licenses. Nevertheless, registration remains daunting without explicit Government support or a link to Government bureaucrats. The religiously motivated wish to remain anonymous is mainly relevant for financial contributions – the challenge is to ensure that this is respected while simultaneously making explicit which activities are being undertaken by whom in order to not duplicate activities and contribute coherently to a broader public health goal.

Independence from the Government is more difficult, as governments change, and collaboration is easier with some than with others. Nevertheless, a balance should be struck between coordination of civil society in order to take advantage of its full potential in meeting public health goals and the freedom of civil society to respond in its own way to community needs and demands. One interviewee said: *"Because the [public] organization is government-centred and wants everyone to serve it. But they [grassroots] want to have an independent identity. This is happening because [government] want[s] to take their freedom and do not treat them as partners."*

A significant challenge for some civil society bodies is lack of capacity, sometimes due to few or unpredictable resources, which may reduce their credibility and thus their impact. Interviews with civil society representatives often revealed a sense of improvisation. One representative said, *"[O]nly people who have been organized regularly and coherently with good rules and regulations will be able to resolve the problems they face."* In essence, a more systematic approach to the social work and a professionalization of its volunteers to some extent is needed.

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PARTICIPATORY GOVERNANCE MECHANISMS AVAILABLE TO THE PUBLIC

The study objectives addressed in this section were to assess: the status of public participation in health policies and programmes;, the status of available participatory governance mechanisms and their functionality and bottlenecks and opportunities for improved, systematic engagement of people in health issues.

INCREASING INTEGRATION OF A PARTICIPATORY APPROACH TO DECISION-MAKING IN HEALTH

The Government solicited people's participation in programmes such as primary health care and women's health immediately after the revolution, partly as a means of providing services at a low cost at a time when resources were scarce. Such initiatives included the Volunteer Health Worker programme, which began in 1992 with 200 women, mainly from low-income neighbourhoods in Tehran and had reached 100 000 women by 2007. In those early years, participation mainly involved implementing programmes designed by Government institutions, and this approach has not entirely disappeared.

Most of the programmes were implemented at a decentralized level, even if many were funded centrally; it is telling that almost all of the published articles reviewed for this chapter focused on local, community-based health programmes and initiatives. These programmes implemented at local level is another avenue, besides through civil society initiatives, for Iranian citizens to participate in health sector activities. Citizen participation in most of these mainly central government-funded programmes focused quite heavily on programme support and implementation. A clear separation of roles and responsibilities between those who fund and conceptualize the work, and those who execute, marks the approach of many of these programmes. Several studies pointed to the lack of opportunity for citizens to participate in areas such as monitoring and evaluation, and more importantly, in decision-making *(9)*. One study concluded that "according to the participants (of community-based health programmes), governmental

programmes have centralised decision-making and management processes and local volunteers have no role in selecting managers at different levels of a programme" *(10)*.

This began to change in the 1990s and early 2000s, mainly with municipal health programmes. For example, the Urban Health Equity Assessment and Response Tool (HEART) study allowed considerable local decision-making *(11, 12),* with discussions between community members and experts on how best to improve their health conditions -- and their decisions were taken up by municipalities in most places. The enthusiasm of the communities demonstrated the potential of involving local communities in issues that affect their daily lives. Similar pilot projects have effectively involved communities in the design, implementation and evaluation of health activities and programmes, largely confined to the local level. Most of the programmes capitalized on the long tradition of civic sense in the Iranian population.

Municipalities, most notably Tehran, were one of the driving forces in encouraging citizen participation in health. As a Neighbourhood Health House staff member in the Sharif district of Tehran mentioned in an interview, *"[T]he Tehran municipality, after years of taking care of the affairs by itself, dared to entrust the management of the affairs to the people. [Then]…this structure took shape and was sustained and the municipality…assumed the supportive role to help the people."* Indeed, a more direct link is seen between municipality decisions on health programming and feedback from communities and NGOs. Decision-makers at local and municipality levels have come to value feedback from programme volunteers relaying concerns of the community, and consider them carefully for health planning purposes. As one volunteer said, *"In principle we transfer the feedback of the community to [the municipality]. They get more familiar with the problems and demands of the people."*

The current central government has taken note; there is a palpable and growing recognition that some of the good pilot and project results must be capitalized on and fed into national-level

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policy-making. The 'socialization' of health, a term often mentioned in the Ministry of Health currently, is an excellent starting point.

FRAGMENTATION AND DUPLICATION NEED TO BE ADDRESSED

The numerous pilot programmes, municipal initiatives and project-based research are not well connected with each other, some ending up as one-off projects and others continuing independently. Moreover, many successful, well-run centrally-led projects were discontinued rather abruptly or relegated to lower priority, with little documentation or inadequate evaluation. This has led to fragmentation and duplication of efforts and a lack of consolidation of lessons learned and progress made.

The Government should spend time and resources on coordination, especially in difficult economic times when each rial counts. The jurisdiction of and services provided by centres such as municipal health houses, "people's participation" houses, health centres and health posts (Table 12) overlap to some extent, which may or may not correspond to a true community need, as they

arose in particular contexts. It would be useful to examine how municipal and centrally funded services and their respective approaches to participation, could explicitly complement and cross-learn from each other's' experiences.

Failing to adequately coordinate efforts at participation will not bring about the culture change envisioned in the MoHME committment to 'socialize' the way the health sector works. In the end, despite the gains made over the last few years, there are still many programmes and health initiatives run in a top-down way -- participatory decision-making is not yet a widespread phenomenon. A coordinated, holistic, and common approach to engaging the population will be necessary to ensure that efforts are channelled towards common public health goals.

A promising avenue in this regard are the local, provincial, and national health assemblies which are slowly taking shape in the Islamic Republic of Iran (more on this topic can be found in the next section). Targeted and participatory monitoring and evaluation of health programmes, together with citizen volunteers and the beneficiaries of the programmes, would also need to be undertaken and scaled up.

TABLE 4.1:
FACILITIES FOR PUBLIC PARTICIPATION IN HEALTH IN THE ISLAMIC REPUBLIC OF IRAN

Type of facility	Description
Municipal health houses and health clubs	In Tehran and many other cities, each district has a health house, which organizes clubs on health issues such as diabetes, ageing and blood transfusion to educate the public and patients. Some also provide consultation and counselling under the supervision of the municipality's director of health. All services are provided by volunteers.
Rural health houses	These primary care facilities under the supervision of the Ministry of Health and are run mainly by *behvarz,* who are from the same village and trained in basic health services by the Government. Some rural health houses also have volunteer staff who support the *behvarz* in service delivery and outreach.
Urban health posts	Same as rural health houses but located in urban areas
Comprehensive health centre (urban and rural)	These centres have trained, Government-employed, professional medical staff, who provide second-level service under the supervision of the Ministry of Health. They also supervise the health houses and health posts and are thereby involved in participatory activities.
People's participation houses	These are essentially community organizations governed and run by 21 volunteers representing different constituencies, including teachers, retired people, currently active workers, *Basij* and religious groups. The governing body brokers between decision-makers and the population in their catchment area.

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AVAILABLE PARTICIPATORY GOVERNANCE MECHANISMS AND THEIR FUNCTIONALITY

The mechanisms considered most relevant by the MoHME and WHO are listed below (without being exhaustive), with reflections on their functionality and challenges.

Civil society networks

The Ministry of Health through its Deputy Ministry for Social Affairs is investing in creating networks of NGOs working in the same health area, such as cancer. The President of the Mahak cancer hospital spoke about this initiative in his interview: *"[I]n recent years, a good move has been made in the Ministry of Health, indicating that the Ministry of Health believes in the role of NGOs in planning. The Deputy Minister of Health has helped to form a network of cancer NGOs. One year since the creation of this network, and because Mahak is the board chairman of this network, I can say that in this past year, the most important thing we did, was learned to sit and work together around the table."*

This acknowledgement demonstrates one of the principal reasons why such networks are so important for not only developing the civil society arena in the Islamic Republic of Iran but also for bringing together the different and differing inputs from various civil society actors into a coherent whole.

The Mahak president continued to elaborate: *"Currently, thirty-six NGOs involved in cancer are members of the network…in Iran as a whole with different areas of activity, different dimensions, and different expectations, which may still not be prepared to have a network together. We work together to run a network. Currently, according to the National Cancer Control Program, we are preparing a strategic plan for the network, to define the role of the network and the Ministry of Health as partners working together. And we think it's a golden era for the network to be able to create a protocol for collaboration with the government body and use it in the future."* Giving civil society the technical and moral support, and at times, resources, to increase its capacity to collaborate and find consensus allows it to have a more equal voice in government-led policies. At the same time, it also makes it easier for government to coordinate with civil society as it presents itself with a more united voice.

The initial networks which are the focus of MoHME support bring together registered NGOs, which mainly cover curative care; this could be expanded to CBOs, charities, faith-based charitable organizations, semi-governmental organizations, etc. Networks, such as the cancer one, with specifically stated objectives and a defined division of roles and responsibilities would allow for synergies and complementarities as well as promoting a culture of collaboration towards HTP goals. These networks could also assist in selecting the right people to participate in health assemblies, as discussed further below.

Call centre

The MoHME has set up a call centre as an innovative platform to gather citizen input through a dedicated phone line, managed by a unit within the

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EXAMPLES OF CIVIL SOCIETY NETWORKS IN IRAN:

- Maternal & child health care
- Family planning
- Case finding and follow-up for tuberculosis, malaria, mental disorders, diabetes and hypertension
- Diseases with limited symptomatic treatment
- Environmental health
- Occupational heath
- School health
- Oral health
- Elderly care
- Community based rehabilitation

MoHME CALL CENTRE STATISTICS

- Number of staff per shift: 50- 60
- Mean daily number of calls: 1500
- % of calls which resulted in filing a complaint: 10%

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Ministry, the Center for Accountability and Complaints of the Health System. A short three-digit number, 190, is allocated to this phone line and is fairly well-known by health system users. This was an initiative under the HTP, integrating various pre-existing complaint forums run by the MoHME, into one centre.

The previous forums were focused on complaints and were not always functional as it was not accorded a high priority. The importance given to this call centre for HTP implementation is attested by its opening hours of 24 hours a day and 7 days a week. As one call centre staff member put it, *"It is a great investment, because peoples' requests from any part of the country require government intervention and this is needed in decision making of senior executives to advance the goals of the transformation plan. It is notable that in the past, these were scattered, and the system was not coherent and focused."*

Major features of the call centre which enable it to focus on health transformation are:

- It has dedicated staff members to analyse call data and to follow up on feedback given

- It is not focused on complaints only, and is used for constructive ideas and suggestions, as well as real-time feedback on health services across the country

- There is a strengthened decentralized government network to ensure that more systemic bottlenecks are addressed in the right policy dialogue forums

A shift coordinator at the call centre underlined how it directly supports HTP objectives: *"We … use the information that people provide to us as a public oversight tool, to protect the rights of the service receivers and of the service providers, and to provide information needed by senior executives."*

One of the principal HTP objectives of reducing under-the-table payments to health providers has been effectively tackled with measures such as this call centre. Many of the citizen calls were made to report such payments, the need for which had been already addressed at the policy level with higher insurance reimbursement rates. A call centre staff member reported, *"One of the most important goals of the transformation plan was to protect the health system from unconventional payments that were common before the Transformation Plan...Tariff complaints… are reported to us by people. After the people's reports, and with the approval of the honourable Cabinet, a special committee has been set up to handle cases at provincial level…These complaints are dealt with legally and referred to the judicial authorities after review and verification. The function that this process has had for us [is]the unconventional payment has become close to zero."*

Such direct citizen feedback mechanisms are critical to ensure adequate reform implementation as well as popular support for the reforms. Such a mechanism requires a fairly heavy human resource investment – roughly 100 people work in the MoHME call centre – and is most valuable when used as a monitoring tool as it is in the Islamic Republic of Iran where feedback is collected systematically, analysed, and fed back into policy and implementation.

Local, provincial and national health assemblies

The health assembly initiative which began in 2016 aims not only at fostering participation in the health sector but also institutionalizing it for the long term. The idea is for health assemblies to take place at local, provincial, and national level on a regular basis; the MoHME is working with local and provincial health authorities to support and build capacity on this. 266 local health assemblies have taken place in 2017-18, 30 out of 31 provinces conducted a Provincial Health Assembly within the same time frame, and 2017 saw the launch of the 1st National Health Assembly.

These assemblies could consolidate the work of both the Government and the population towards health sector reform as laid out in the HTP. The format offers a platform for citizen input, coordination among citizens, communities and civil society, coordination between the State and the population and collective ownership of the HTP.

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As mentioned in previous sections, a long-standing tradition of civic action has always existed in some form at the grassroots. A local health assembly would serve to coordinate and consolidate this action and assist in institutionalizing local participatory structures to enable more feasible and implementable decisions. In addition, the local health assembly would be the ideal platform to bring together heterogenous civil society organizations working locally. It would also bring together the population as a whole with local civil society, giving those who may be less heard a voice as well. In essence, if developed well, local health assemblies have the potential to form the grassroots basis of local decision-making which, through provincial and national health assemblies, can link upwards to national policy-making. These reflections are not new and have already taken root in the MoHME; different formats are being tried and tested with the different regions at the moment.

Efforts to build effective community and civil society networks for health should represent the foundation for the local and provincial health assemblies. In Thailand, for example, the central-level National Health Commission Office provides technical support and capacity-building to strengthen networks at local levels with the aim of having better representation at their health assemblies *(13)*. The stronger and more functional the networks, the more representative the assembly delegates are of the people and communities they speak for. Another plus point of strengthening networks parallel to developing and refining the health assembly process is the intra-community coordination to present a position at the health assembly event that reflects collective views and not individual interests. The health assembly then transforms into a forum where dialogue leads to a compromise between a finite set of various coordinated positions.

THE NHA AS A POTENTIAL OPPORTUNITY TO DE-FRAGMENT THE APPROACH TO PARTICIPATION

The National Health Assembly concept has great potential to bring together a wide range of stakeholders to examine, discuss, and find viable solutions for health sector challenges, while simultaneously drawing on the same stakeholder base to help implement those very solutions.

The stakeholders brought together should include municipality staff working on health as well as central Ministry authorities, semi-governmental organization health programme volunteers, religious charities, scientific associations, research centres, trade unions, representatives from other sectors, representatives from judiciary organs etc. Such a broad stakeholder base exchanging on their respective health-related activities would assist greatly in reducing duplication and fragmentation between the various projects, pilots, and programmes co-existing in the Iranian health sector. Having the various stakeholders collaborate and coordinate with each other will not necessarily be easy; however, a platform such as the NHA could facilitate this greatly by providing an official annual event where exchange and debate can take place. The strength of the platform will be dependent on ensuring that all decisions taken via this platform are official, enforced and implemented.

The nascent National Health Assembly process in the Islamic Republic of Iran also serves as a potential channel for NGOs and charities to influence national-level health decision-making, thereby better connecting the local with the national. To date, much of the long-term local participatory programmes have remained local in nature – those that are centrally-funded tend to be one-off pilot projects which have not always taken hold as long-term institutions (with some notable exceptions). It would be an immense missed opportunity if the different needs, views, and willingness to contribute embodied in the multitude of local participatory health activities were not adequately channelled towards sustainable health goals as outlined in the HTP.

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The NHA also has the potential to build trust through regular dialogue between civil society actors and government institutions. Indications of misunderstanding and mistrust came up in interviews, with one interviewee stating, *"For the first time, people don't believe us. Because they have something in their mind, they don't believe the government sometimes…Especially, in our country … if they understand we are from the government, first time, they will look [at] us very cautiously. But later you have to show them that you are positive to them, then maybe they change their ideas."* Experience from other countries demonstrate that increased trust is one of the intermediate results from a well-planned policy dialogue *(14).* Increasing exposure to each other, and each other's differing mentalities, greatly fosters mutual respect for diverging views (thereby fostering trust).

COMMUNITY HEALTH BEHAVIOUR AND WOMEN'S EMPOWERMENT

Interviews repeatedly attested to community health volunteers' achievements in raising people's awareness and knowledge, thereby contributing to improving population health. Many volunteers themselves recounted stories of how community behaviours, especially with regard to health prevention and promotion, had indeed changed over time. In addition, community awareness on health determinants led them to act decisively at times, as explained in the following vignette:

"…In Kashan, close to Tehran…they understand the problem of motorcycle accidents is very prevalent in this area. So they decided and they went to the police officer. And they said according to our research in our area, [the] number of accident by motorcycle is very high and we want to ask you something. They said what you want from us. They said if somebody is coming to apply for motorcycling license please send them to us. Okay that's no problem. So they know this area. Somebody came to them and the address was in that area, they would send that person to the community, and they will talk to that person like; okay congratulations! You are going to get a motorcyclist

license, but remember so and so, and they go to the hospital and show him the people, who have been injured in the hospital. So they give him some information. After having this information, the number of accidents had been decreased. So that was a research before and after the intervention. That intervention was very simple that they needed the agreement with the police officer. So, something like this, very small thing, but the methodology is very important"

 --Former manager, Community-Based Participatory Research project

Another positive impact mentioned was the increased ability by citizens and communities to better identify and express their health needs, greatly facilitated by volunteer support. These achievements, in turn, led to volunteers feeling empowered by their work. The mostly female volunteers gained much informal influence due to their status, experience, and confidence *(15, 16).* Participation thus empowered women to support public sector decisions for their communities, without having a more formal role.

LEGAL FRAMEWORKS FOR PARTICIPATION

Currently, there is no formal legal guarantee of public participation in health in the Islamic Republic of Iran. One parliamentarian said, *"…laws [should] still be made so that more people are encouraged and contribute, I think there is still a lack."*

A culture of participation therefore depends on whether officials support it. One interviewee described the value placed on participation: *"…[T]oday the Minister strongly supported that all of the Vice-Ministers should strengthen socialization insights in their own specialized fields."* Another said that *"the Tehran municipality, after years of taking care of the affairs by itself, dared to entrust the management of the affairs to the people."* A former politician also stressed the importance of political support: *"The message is that when you go to community participation, the political issues are very important, and they can stop you or*

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accelerate you…[E]verybody likes doctors, capsules, ampules, you know, these are technical issues. But when it comes to the community, it is political issue. So it depends on the ideology of the person who is going to be the Minister or the President or anything else."

One way of encouraging and sustaining participatory governance and making it more immune to changes in Government is to anchor it in a clear legal framework. This may be easier said than done but it is worth reflecting on the possibility and preparing the ground for such a framework. A good example is the National Health Assembly process in Thailand which is an integral part of the National Health Act 2007; this Act obliges the Thai government to fund the National Health Commission Office to organize the Assemblies every year. This makes the Assembly process more stable over time even as different governments give different levels of support.

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INTERSECTORAL COLLABORATION

The study objectives addressed in this section were to assess: the status of intersectoral collaboration in health policy and programmes and the link between intersectoral collaboration and participatory policy-making in view of strengthening both initiatives.

THE SUPREME COUNCIL FOR HEALTH AND FOOD SECURITY AS A PLATFORM FOR HIGH-LEVEL INTERSECTORAL COLLABORATION

To establish a structure for intersectoral collaboration in health policy-making, two supreme councils were formed in 2001, which were subsequently merged into the Supreme Council on Health and Food Security in the fourth National Development Plan (2005–2010). This Council was approved by Parliament into a law which states that the President of the country must head the Council, and the Secretariat is to be provided by the MoHME. The Supreme Council's objectives are to:

- Make policies for health promotion and food security,

- Review and approve programmes and actions in health promotion and food security,

- Define and monitor basic indicators of health and food security,

- Approve national health standards for general development programmes,

- Approve the programme of the public health and food security service,

- Approve the monitoring structure and

- Establish coordination among relevant executive bodies for health and food security.

By the end of 2018, 15 meetings had been held, covering communicable diseases (e.g. HIV/AIDS, malaria, leishmaniasis), noncommunicable diseases, healthy edible oils, flour fortification, health education and promotion, healthy agricultural products, health equity, health of elderly people, early childhood development, sanitation, national health assemblies and promotion of physical activity.

One of the Council's objectives is to facilitate high-level intersectoral cooperation to improve the quality of life and equity in health. One interviewee described the high-level patronage of the Council: *"There is a very progressive law in relation to the Supreme Council for Health and Food Security, which was passed by the Parliament, for the fact that the head of this council is the President himself and nine to eleven ministers are present at the Supreme Council for Health."*

The Council thus includes the ministers of Health and Medical Education, Agricultural, Education, Commerce, Sport and Youth, Industry, Trade and Mines, Welfare and Social Security and the Interior; the National Standards Organization; the Environmental Protection Organization; and Iran Broadcasting.

The Secretariat, housed in the Ministry of Health, ensures day-to-day collaboration with other sectors on various determinants of health. The Secretariat is also closely involved in joint commissions with other ministries and sectors on health topics. The consistent feedback given by representatives of other sectors who were interviewed for this review was that the presence of this Secretariat greatly improved cross-sectoral relations by dedicating a unit which served as a focal point within the MoH for other sectors. In essence, intersectoral collaboration is initially based on building a relationship between sectors based on a common understanding of the issue at hand, the latter being a frequent barrier to collaboration. Having a MoH unit (the Secretariat) with staff members specifically assigned to work with other sectors allows for steady and regular dialogue to construct that very understanding jointly. One interviewee from the Ministry of Sport emphasized this point, *"One of our problems in the field of sport is that there has always been a conflict between those who studied in the field of sports, and the medical community …The distance between us has been an attitude, so, our beliefs did not allow us to get close together. And I would like to thank [the Secretariat of the Supreme Council] at the MOH, who provide the environment that brings the sport and medical communities together".*

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Besides being the implementing body of the Council, one of the key tasks of its Secretariat is to organize the National Health Assembly on a regular basis. The 1st Iranian National Health Assembly took place in 2017, and it has been conceptualized as a key platform for both participation and intersectoral collaboration. One interviewee highlighted, *"The community thinks about needs, the needs are … also [with] other sectors, and the point is that they are supported by the National Health Assembly, and this is the programme of the Ministry of Health.… This is the programme of Supreme Council of [Health and Food Security], so it is supported by political commitment."* By bringing together population groups to discuss health from their perspective, health is automatically viewed more broadly, going beyond the health sector – thereby making the Health Assembly platform an ideal mechanism for collaboration across sectors.

LOCAL LEVEL INTERSECTORAL COLLABORATION

Neighbourhood health councils and people's participation houses have been stimulating local intersectoral collaboration for years, with representatives of the Ministry of Education, the police force and local NGOs. In practice, at local level, the number of actors is limited and there is more familiarity among different stakeholders, allowing for an easier and more natural collaboration across sectors. Community health workers (the range of this type of work being done by either volunteers, urban health care workers, behvarz, and others) regularly reach out to other sectors as part of their core tasks and have the distinct advantage of community trust on their side, further facilitating intersectoral collaboration.

Local intersectoral work is supported by provincial health and food security working groups established by the provincial councils of planning and development, headed by the provincial governor. With dedicated resources, these working groups bring together local work on the social determinants of health and report problems to the Supreme Council. They also attempt to address shortages of funding for operationalizing decisions.

IMPROVING INTERSECTORAL COLLABORATION

Intersectoral collaboration in all countries is hindered by lack of common understanding of the concept, as different sectors perceive health and collaboration differently, and this was also found in our study. The result is often unclear roles and responsibilities and no clear lead sector, limiting the work that is done. Many of the interviewees from outside the health sector said that coordination should be improved. Coordination through joint budgets and sharing of data and information might be a solution, although it might be difficult to achieve in practice. As there is resistance to the issue, a formal agenda point on this topic may be useful to discuss in a Supreme Council meeting, in view of drafting clear rules and modus operandi of how joint budgets and data sharing should work. In addition, one interviewee suggested that third parties such as the Planning and Budget Organization or international organizations can play an important role in facilitating a solution on this topic.

At central level, much of the work on the determinants of health and intersectoral collaboration has been conducted in university research projects. The Supreme Council-supported working groups might form links with decentralized intersectoral action through community health workers and neighbourhood institutions.

Strong personal relationships and trust appear to be the basis for cooperation, and these should be fostered, with the Secretariat of the Supreme Council as the focal point. Interviewees from all sectors agreed that collaboration should be formalized, with written roles and responsibilities. Memoranda of understanding have been used successfully in the past and could be used more often for operationalization and monitoring of activities. An employee of the Road Maintenance Organization said, *"an MOU was signed between the Ministry of Health and Road Maintenance Organization. The main issue of the agreement is … improving the safety of villages for the people whose level of knowledge on safety is limited …. The most important point in this Memorandum is the use of the existing capacities of the health houses.*

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[The Road Maintenance Organization] executive officers in charge of … implementation of these plans were behvarz. The issue that was obvious in the implementation of these plans was that in the past, [our] trainers were somehow alien to the people, while behvarz are often well-known to the villagers, and a great intermediary for the two-way transfer of concepts."

Memoranda of understanding and formal agreements between Government institutions could also clarify the overlapping responsibilities of sectors. An example was given by a representative of the Ministry of Sports: *"We have a series of overlapping disciplines with the Ministry of Health that include sports nutrition, sports psychology and motor correction. These three fields overlap with the Ministry of Health, but according to the agreement we have together, the attempt is that the treatment section to be assigned to the Ministry of Health, and diagnosis and evaluation and the assistance to sports injury to be assigned to the Ministry of Sports and Youth."*

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CONCLUSIONS

A thriving civil society and an overall culture of participation depend on the political climate in any country, and this study reaffirms the principle for the Islamic Republic of Iran. The stronger the presence of pro-participation government officials, and the more interaction they foster with citizens, the more participation will become institutionalized and formalized. Participation and civic action is certainly not new to the Islamic Republic of Iran yet overlaps and duplications between the different types of civil society organizations – formal, semi-formal, and informal – still exist. More coordination is needed between the different participation initiatives to reduce fragmentation and channel volunteer enthusiasm and resources towards the common goal of the HTP. The local, regional, and national health assemblies potentially offer unique platforms for this coordination role.

This study confirmed that civil society in the Islamic Republic of Iran plays a valued mediator role between the state and the people; however, it is currently more of a one-way channel (from the people to the state). Creating a 2-way channel with more government-initiated interaction with civil society actors for policy dialogue and consensus-building is currently a missed opportunity. Again, platforms such as the health assemblies could be more smartly used to create and maintain such a channel.

Capacity-building of civil society through the promotion of networks and technical support can help civil society to participate more meaningfully. If this meets an enabling environment for participation which the Deputy Ministry for Social Affairs in the MoH is working to establish, civil society and community voices can be better harnessed towards HTP goals.

Intersectoral collaboration functions fairly well, with the Secretariat of the Supreme Council on Health and Food Security being a key player for coordination across sectors and providing concrete, funded support for cross-sectoral matters. However, there is room for improvement, especially in terms of formalizing collaborations, putting together joint work plans, and perhaps even pooling budgets cross-sectorally.

In conclusion, the potential to harness citizen's voice to move closer towards the collective goals of the HTP are not to be underestimated. Given the overall culture of motivated participation and structures which have been put in places over the last few years (National Health Assembly, Supreme Council for Health and Food Security, civil society networks, etc.), government actors have recently made good attempts at more systematically providing space for people's voice. Political will is the crucial factor which could dismantle inroads already made, especially in view of the current volatile situation on the world's stage with disproportionate effects on the Islamic Republic of Iran.

The Government should continue on its path towards the HTP, continue promoting the socialization of health through its Deputy Ministry for Social Affairs, and tread the dual track of supporting participatory governance mechanisms while simultaneously working with civil society to build capacity and ensure leaving no one behind.

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CHAPTER 4

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LIMITATIONS

Documentation in English on this topic, specific to the Iranian context, was limited and of variable quality. The Farsi-language literature helped in getting a more realistic and local insight into the citizen's voice and participation in the Islamic Republic of Iran but the article numbers were also small.

The qualitative data collected in interviews were varied and rich and enormously helpful in shedding light on this topic. However, the interviews unfortunately turned into very official WHO visits where frank expressions of thought may have been restricted in favour of more 'official' views. An attempt at mitigating this bias was made through honest exchanges between WHO and the Iranian team (co-authors) while interpreting the interviews. In addition, a few interviews at the end were deliberately conducted without WHO's presence. We also triangulated data with the document review and through the analysis process which was conducted by 4 people with differing institutional identities (1 WHO, 1 MoHME, 1 National Institute for Health Research, 1 independent).

The number of interviews was limited due to time and resource restrictions, and due to the applied nature of this study. Rather than being a strict academic exercise, we attempted to answer a burning policy question relevant to current health sector decision-making.

Lastly, we wish to acknowledge translation problems in the broad sense of the word – literal translation was assured through a certified translator but this did not reduce the barrier of varying cross-cultural understandings of certain words and phrases. This limitation was addressed by referring back repeatedly to the original Farsi transcripts during the analysis phase and cross-checking the meaning when needed.

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