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Agenda item 13

**STRENGTHENING COMMUNITY PROTECTION AND RESILIENCE:
REGIONAL STRATEGY FOR COMMUNITY ENGAGEMENT, 2023–2030
IN THE WHO AFRICAN REGION**

Report of the Secretariat

EXECUTIVE SUMMARY

1. The African Region faces a disproportionately high disease burden. The prevalence of non-communicable diseases, recurring health emergencies, natural disasters, and humanitarian crises put pressure on fragile health systems. Health inequities affect vulnerable populations due to various determinants. These require action from the whole of society and sectors beyond health.

2. Healthcare systems are highly complex social systems shaped by multiple factors, including professional training, institutional values, leadership competencies and priorities, and the wider socio-cultural and economic context. Consequently, communities should be considered integral components of health systems in ongoing efforts aimed at developing more responsive, equitable, and effective health policies for Universal Health Coverage (UHC) and health security.

3. The Astana Declaration on Primary Health Care, the UHC framework for action, and Regional Strategy for Health Security and Emergencies 2022-2030 (AFR/RC72/8) highlight systematic community engagement as a core component for successful implementation.

4. The proposed strategy will support Member States in engaging communities for healthier and more resilient populations by fostering relationships of trust between stakeholders to promote health, minimize risk, and mitigate the consequences of public health events. It provides guidance on leveraging existing community structures and institutionalizing community engagement at the interface between health, development, and humanitarian action. It prioritizes enhanced research, monitoring, and evaluation of community engagement approaches and integration of lessons learned to strengthen health systems and mitigate future emergencies.

5. The Regional Committee examined and adopted the strategy.

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INTRODUCTION

1.   The challenges affecting health and well-being in the African Region require whole-of-society and whole-of-government action. Less than 50% of the population has access to quality, essential health services.[1] Recurring disease outbreaks with high health, economic and social costs; natural disasters and humanitarian crises add pressure on fragile health systems.[2] Vulnerable groups are disproportionately impacted by health inequities.

2.   Suboptimal health service demand (the regional score is 67 out of 100 percent) affects coverage of essential interventions.[3] The health service disruptions during the COVID-19 pandemic reversed progress toward Universal Health Coverage (UHC). A reorientation of national health systems towards primary health care (PHC) is needed as a foundation for UHC and health security.[4]

3.   The Astana declaration on PHC,[5] the UHC framework for action[6] and the Regional Strategy for Health Security and Emergencies (AFR/RC72/8),[7] identified empowering people and communities as a core component of successful implementation. It is critical in increasing health intervention coverage, reducing inequities and improving efficiency, responsiveness, transparency and accountability, and building trust and resilience.

4.   A regional strategy for community engagement is proposed to build stronger, equitable and resilient health systems. "Community engagement" is defined as a "process of developing and maintaining relationships that enable stakeholders to work together to address issues and promote well-being. Here the concept of "community" is broadened to capture the continuum of connections and ongoing social interactions throughout the life course. It acknowledges that individuals are part of multiple, interconnected communities that continuously shape identity, choices, and behaviours.[8]

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[1]   World Health Organization (WHO). 2018. "The state of health in the WHO African Region: an analysis of the status of health, health services and health systems in the context of the Sustainable Development Goals."

[2]   Inzaule SC, et al. COVID-19 and indirect health implications in Africa: Impact, mitigation measures, and lessons learned for improved disease control. PLoS Medicine. 2021 Jun 23;18(6):e1003666; Ozili P. COVID-19 in Africa: socio-economic impact, policy response and opportunities. International Journal of Sociology and Social Policy. 2020 May 29.

[3]   WHO. 2018. "The state of health in the WHO African Region: an analysis of the status of health, health services and health systems in the context of the Sustainable Development Goals.".

[4]   Reorienting health systems to primary health care as a resilient foundation for universal health coverage and preparations for a high-level meeting of the United Nations General Assembly on universal health Coverage (A76/6), Seventy Sixth World Assembly

[5]   WHO, 2019. Declaration of Astana: Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018 (No. WHO/HIS/SDS/2018.61). World Health Organization.

[6]   WHO. UHC in Africa: a framework for action. No. WHO/HSS/HSF/2016.01. World Health Organization, 2016.

[7]   WHO. Regional strategy for health security and emergencies 2022–2030: report of the Secretariat. 72 (AFR/RC72/8, 2022). World Health Organization. Regional Office for Africa.

[8]   Evaluation of the WHO Community Engagement Research Initiative, WHO Western Pacific Regional Office, 2023, https://www.who.int/westernpacific/publications-detail/9789290620082. See also: WHO, Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021; WHO Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020 and WHO. COVID-19 global risk communication and community engagement strategy, December 2020-May 2021: interim guidance, 23 December 2020. World Health Organization; 2020.

Regional experience,[9] including Ebola virus disease (EVD) outbreak in West Africa[10,11] and COVID-19 across the Region[12,13] inform the strategy.

5.   This strategy strengthens community protection and resilience by outlining how governments can develop and sustain relationships of trust with diverse stakeholders and communities beginning when "all is well" as a foundation for collaboration in crisis times. It includes communities' participation in PHC, health promotion, and minimizing and mitigating risks and public health events. It provides guidance on leveraging existing service delivery mechanisms and community structures to institutionalize meaningful engagement at the interface of health, development, and humanitarian action. It also prioritizes enhancing research, monitoring, and evaluation and using lessons to inform future interventions.

SITUATION ANALYSIS AND JUSTIFICATION

Situational analysis

6.   The 47 Member States of the African Region are committed to the attainment of UHC. Substantial progress was registered between 2000 and 2019 in increasing health services coverage.[14] However, COVID-19 negatively impacted progress due to health service disruptions and changing health-seeking behaviour.[15]

7.   Between 2001-2022, 1843 substantiated public health events were recorded in the Region.[16] Zoonotic outbreaks increased by 63% in 2012-2022 compared to 2001-2011.[17] COVID-19 public health and social measures (PHSM) severely affected the informal sector, which constitutes 80-90% of economic activity in sub-Saharan Africa.[18] Increased human rights violations, gender-based violence, crime, racism, and marginalization were also reported.[19]

8.   The risk of disease and poor health and well-being is determined by environmental, social, and economic factors. Poverty, poor living and working conditions remain widespread and impact, inter alia, access to clean water, hygiene, and sanitation.[20] Unequal access to healthcare means disproportionate public health impacts and failure to achieve UHC.[21] The spread of diseases may

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[9]   Recent evidence synthesis highlighted the importance of ongoing community engagement in the Region and elsewhere, including: Adebisi et al. Risk communication and community engagement strategies for COVID-19 in 13 African countries. Health Promotion Perspectives. 2021;11(2):137; Anoko JN, et al. Community engagement for successful COVID-19 pandemic response: 10 lessons from Ebola outbreak responses in Africa. BMJ Global Health 2020; and Frimpong SO, et al. Community engagement in Ebola outbreaks in sub-Saharan Africa and implications for COVID-19 control: A scoping review. International Journal of Infectious Diseases. 2022 Dec 1.

[10]   Munodawafa D, et al. Monitoring and evaluating the Ebola response effort in two Liberian communities. Journal of community health, 2018, vol. 43, p. 321-327.

[11]   Ibid.

[12]   Mwakisha, J, et al. Kenya's experience: Factors enabling and impeding the COVID-19 response. Health Promotion Practice, 2023.

[13]   Phori, P, et al. Participatory Monitoring and Evaluation of the COVID-19 Response in the Africa Region. Health Promotion Practice, 2022.

[14]   WHO/AFRO. Tracking Universal Health Coverage in the WHO Africa Region, 2022

[15]   WHO. World Health Statistics 2023. Monitoring Health for the SDGs

[16]   WHO. In Africa, 63% jump in diseases spread from animals to people seen in last decade. 14 July 2022. (Accessed on 12 April 2022)

[17]   Ibid.

[18]   Ibid.

[19]   Ozili P. COVID-19 in Africa: socio-economic impact, policy response and opportunities. International Journal of Sociology and Social Policy. 2020 May 29.

[20]   Amzat, J, et al 'Social Determinants of Health in Africa', in R. Sooryamoorthy R, Khalema N (eds), The Oxford Handbook of the Sociology of Africa (2022); online edn, Oxford Academic, 18 Aug. 2022.

[21]   Ibid.

be exacerbated by uncontrolled globalization and rapid urbanization, as well as recurring and protracted humanitarian crises.[22]

9.   Such events and conditions expose individuals to social and environmental stressors, affecting health and well-being. In particular, toxic stress has been shown to increase one's risk for poor health across the life course.[23] Intergenerational trauma and exposure to socioeconomic adversity harm mental and physical health.[24]

10.   Community engagement offers an assets-based approach centred on well-being that links lived experience and the multi-level and complex dynamics of health. This has consequences for the practice of medicine, the design, delivery, and integration of health services and the orientation of health care systems.

11.   Community health workers (CHW) cadres and programmes can potentially strengthen health and community systems.[25] CHWs are strategically placed and have for a long time served to mobilize communities, bring services closer to the people and support emergency response efforts.

12.   Past efforts against influenza,[26] EVD,[27] and the COVID-19 pandemic[28] showed that community engagement positively impacted the uptake of PHSM and the prevention of disease transmission. Engaging communities in early warning systems enhanced system efficiency when human and financial resources were limited.[29] Overall, community engagement contributes to health systems strengthening and building community resilience.[30]

Justification

13.   Community engagement promotes equity and social justice. Intentionally embedding community engagement processes within health services planning and delivery, supports empowerment and ownership contributing to effective people-centred health promotion and disease prevention.[31,32] Aligning engagement practices with pre-existing community structures fosters sustainability, trust-building, and minimizes duplications.[33] Unfortunately, community engagement within health systems, PHC, and emergency management planning and implementation remains ad hoc.[34] Lack of resources, mistrust, and unaligned priorities pose

[22]   WHO. WHO emergency appeal: Humanitarian crisis in the Sahel. Geneva: World Health Organization; 2022.

[23]   Shonkoff J, et al. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." Pediatrics. 2012; 129(1).

[24]   Kivimaki et al. "Association between socioeconomic status and the development of mental and physical health conditions in adulthood: a multi-cohort study." Lancet Public Health. 2020; 19:30248-8.

[25]   WHO. Community Health Worker Programmes in the WHO African Region: Evidence and Options — Policy brief. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

[26]   WHO. Pandemic influenza preparedness and response: a WHO guidance document. World Health Organization; 2009.

[27]   WHO. WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017 (WHO/HIS/SDS/2017.15). Licence: CC BY-NC-SA 3.0 IGO.

[28]   Burgess RA, et al. The COVID-19 vaccines rush: participatory community engagement matters more than ever. The Lancet. 2021 Jan 2;397(10268):8-10

[29]   Sufri S, et al. A systematic review of community engagement (CE) in disaster early warning systems (EWSs). Progress in Disaster Science. 2020 Jan 1;5:100058.

[30]   Frimpong SO, Paintsil E. Community engagement in Ebola outbreaks in sub-Saharan Africa and implications for COVID-19 control: A scoping review. International Journal of Infectious Diseases. 2022 Dec 1.

[31]   WHO. Declaration of Astana: Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018. World Health Organization; 2019.

[32]   Adebisi YA, Rabe A, et al. Risk communication and community engagement strategies for COVID-19 in 13 African countries. Health Promotion Perspectives. 2021;11(2):137.

[33]   Ankomah SE, Fusheini A, Ballard C, Kumah E, Gurung G, Derrett S. Patient-public engagement strategies for health system improvement in sub-Saharan Africa: a systematic scoping review. BMC Health Services Research. 2021 Dec; 21:1-6.

[34]   Anoko JN, et al. Community engagement for successful COVID-19 pandemic response: 10 lessons from Ebola outbreak responses in Africa. BMJ Global Health 2020;4:e003121. doi:10.1136/ bmjgh-2020-003121

challenges.[35] Fragmented, suboptimal CHW programmes that lack sustainability have been major drawbacks.[36] Successful community engagement processes are not sustained, and lessons are not leveraged effectively.[37]

14.   Empowering people and communities to advocate for responsive and equitable policies, participate in planning and provision of services and adopt healthy behaviours is the foundation of PHC.[38] Strengthening mechanisms for community empowerment is a key component of people-centred services that contribute to UHC.[39] In addition, community engagement is central to Health Emergency and Preparedness and Response (HEPR)[40] and a core capacity in the International Health Regulation[41] and the Sendai framework.[42]

15.   This strategy contributes to attaining sustainable development goal 3 to "ensure healthy lives and promote well-being for all ages" through strengthening countries' capacities to build and sustain functional structures that foster whole-of-society involvement to achieve UHC and health security. It also addresses the Thirteenth General Programme of Work, 2019-2025 aiming to achieve measurable impacts on people's health and well-being.

THE REGIONAL STRATEGY

Aim

16.   To create an enabling environment for building long-term community engagement, protection and resilience. This will be achieved by empowering individuals and communities through enhanced health literacy, active participation in decision-making and the design, implementation, and evaluation of health and development initiatives.

17.   **Objectives**

(a)   To map and leverage existing community assets and structures as the foundation for engaging communities in PHC, promoting health and delivering health and social services, including emergency management.

(b)   To institutionalize community engagement and participation to strengthen PHC, health promotion, health and social service delivery, including emergency management; and

(c)   To strengthen interdisciplinary country capacities for research, monitoring and evaluation to document best practices and lessons learnt from community engagement efforts. These insights will be used to guide interventions in both individual countries and across the Region.

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[35] Ramsbottom A, O'Brien E, Ciotti L, et al. Enablers and barriers to community engagement in public health emergency preparedness: a literature review. Journal of community health. 2018 Apr;43(2):412-20.

[36] Ibid.

[37] Adebisi YA, Rabe A, et al. Risk communication and community engagement strategies for COVID-19 in 13 African countries. Health Promotion Perspectives. 2021;11(2):137.

[38] Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020. Licence: CC BY-NC-SA 3.0 IGO.

[39] WHO. UHC in Africa: a framework for action. No. WHO/HSS/HSF/2016.01. World Health Organization, 2016.

[40] WHO. Community Protection Subsystem: Overview of HEPR activities and items to be costed. Forthcoming (Draft)

[41] WHO. International health regulations (2005). World Health Organization; 2008 Dec 15.

[42] United Nations Office for Disaster Risk Reduction. Sendai Framework for Disaster Risk Reduction 2015-2030. Geneva: UNDSR; 2015.

Targets

18.   By 2025, at least 15 Member States and by 2027, at least 25 would have:

(a)   Mapped community assets and structures to create a knowledge base to inform future actions;

(b)   Co-developed procedures and guiding principles for involving communities in primary health care, health promotion, and health care delivery;

(c)   Collected and applied lessons from past experiences on community engagement in health promotion, service delivery and emergency management.

19.   By 2030, at least 37 Member States would have:

(a)   Mapped community assets and structures to create a knowledge base to inform future actions;

(b)   Co-developed procedures and guiding principles for involving communities in primary health care, health promotion, and health care delivery;

(c)   Collected and applied lessons from past experiences on community engagement in health promotion, service delivery and emergency management; and

(d)   Conducted assessments of the strategy's implementation at the country level.

Guiding principles and values

20.   **Community empowerment and protection:** Community protection entails community empowerment and building trust between stakeholders that enable the adoption of preventative and promotive health actions and PHSM. Community readiness demands building resilient communities that are prepared and ready to respond to any public health threat.

21.   **Whole-of-society and whole-of-government:** Multistakeholder and multisectoral collaboration, including non-health and private sectors, will improve effectiveness and manage the critical interdependencies across sectors and levels. A whole-of-society approach entails community empowerment where people have a say about their health and well-being.

22.   **All-hazards approach:** Although hazards vary in origin (natural, technological, societal) and impact, similar health system challenges result from them. An all-hazards approach can increase cost-effectiveness and robust responses.

23.   **Equity and social determinants:** The conditions in which people are born, grow, live, work, play, and age determine health and health equity, which can be worsened by discrimination, stereotyping, and prejudice based on sex, gender, age, race, ethnicity, or disability, among others. Addressing equity and social determinants through community engagement will deliver better health outcomes.

24.   **Governance and accountability:** Community engagement and participation supports inclusive governance and the development of responsive health policies and programmes. Actors should be accountable to local populations. Accountability based on people-centredness, transparency, and human rights ensures the rights, dignity, and safety of those affected, particularly vulnerable and marginalized populations.

Priority actions and interventions

Leveraging community structures

25.   Member States should develop or adapt tools to map existing community structures, assets and capacities, including community-based workforce, civil society organizations, and private sector actors.

26.   Member States should routinely map their community structures, including the initiatives, capacities, resources, and tools that support health promotion, health service delivery, and emergency management. This will contribute to building a knowledge base to inform future actions. Priority should be given to conducting national-level mapping and developing a plan for cascading to subnational levels.

27.   Member States should identify and address gaps and challenges to effective community engagement. This includes identifying and securing necessary resources, such as financial, personnel, technical and logistical support.

28.   Member States should leverage community-based assets and collaborate with stakeholders to conduct ongoing capacity building. This should use integrated training packages that cover health literacy and risk perception. Access to accurate health information needs to be improved to strengthen community engagement in health promotion, PHC and emergency management.

29.   Member States should engage and inform communities by working with existing community structures. Public health issues should be communicated regularly, and information should be shared using relevant and locally appropriate communication channels.

Institutionalization

30.   Member States should make community engagement an integral part of health promotion, emergency management, health service delivery, and disease prevention strategies and plans. This means having clear procedures or principles on how to include, implement, and monitor community engagement.

31.   Member States should adopt co-creation processes in designing preventive and health-promoting actions, public health and social measures, and other health care services. Enhance digitization and online forums for deliberations to improve participation of marginalized and vulnerable groups. These actions will help create health systems that are inclusive, equitable, adapted to local needs and able to deliver PHC, as well as address and recover from public health events. Additionally, Member States should enable community-based or -led approaches by providing support and resources.

32.   Member States should revitalize PHC structures, including community-based surveillance and community workforce. They should define roles, compensation, and career progression for community health workers (CHWs) to ensure their retention. Establish policies for managing, supervising, sustaining, and recognizing formal and informal community workers across different sectors involved in health promotion, disease prevention, and emergency response. This may involve a certification programme or policies for sustained remuneration. Additionally, capacity building for CHWs should be based on an integrated training package.

33.   Member States should strengthen links between established mechanisms and infrastructure for linking communities with policy-makers and decision-makers. This includes linking community-based surveillance, early warning systems, and communications channels with the relevant sectors that use this information to guide policy and action during the different phases of emergencies. Examples include creating two-way communication platforms such as call centres and social media channels or strengthening community health boards and committees and community feedback mechanisms.

34.   Member States should recognize and reinforce existing mechanisms that enable community members to participate in decision-making and provide feedback on the effectiveness of PHC and emergency services and equitable allocation of resources. They should establish accessible mechanisms to address concerns and complaints, especially in cases of harassment, sexual exploitation, or abuse.

35.   Member States should include community representation, especially of marginalized and vulnerable groups, in efforts to diversify and strengthen multisectoral and multistakeholder partnerships and coordination.

Research, monitoring, evaluation, and documenting lessons

36.   Member States should involve communities in M&E of health interventions, including those that promote health or address risky and harmful behaviours, as well as emergency interventions, including intra- and after-action reviews. This involvement should extend to intra-action and post-action reviews. Collaborate with multisectoral and multistakeholder partners to co-develop or update M&E systems and tools. Ensure consensus-building processes are used.

37.   Member States should generate evidence on the social, environmental and behavioural determinants of health and well-being, including causes of ill-health. This could include understanding the contexts of public health events and behavioural aspects contributing to alcohol and substance abuse. Additionally, they should synthesize evidence on relevant and effective local knowledge and practices.[43]

38.   Member States should generate accessible and high-quality public health, health systems and cross-sector data that can be broken down by age, sex, geographic location, social and economic status. These data should help assess health and well-being outcomes. Use effective communication strategies to translate knowledge and evidence into decision-making and intervention design.

39.   Member States should ensure that their Ministry of Health has the capacity to collect, analyse and act on social, environmental and behavioural evidence. This may involve integrating a behavioural insights function and appointing behavioural and social scientists, or anthropologists, among others. Collaborate with academic institutions capable of evaluating and analysing community engagement processes. These experts and academic partners should assist governments in using the evidence to inform plans and policies.

40.   Member States should promote the sharing of learnings from community-led interventions and community engagement in health promotion and health service delivery, including efforts from different phases of emergencies across local settings. Sharing of experiences could be done through cross-learning visits, mentoring systems, and publication of reports. Prioritize documentation of past experiences and develop user-friendly systems for capturing ongoing and future work. Governments with support from WHO should facilitate sharing of best practices and lessons across borders to inform policies and actions at all levels by developing a regional framework for sharing experiences.

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[43]   Data collection and research methods that could be considered include but are not limited to: Knowledge, Attitudes, and Practices (KAP) studies should be used in decision-making and evidence-based interventions. Participatory methods capturing both scientific evidence and traditional or existing knowledge and lived experiences of people, including vulnerable, marginalized, and hard-to-reach groups, should be used to ensure diverse views are captured. Conduct research to capture community engagement best practices. Use well-adapted research and learning methods that capture the effect, the processes that build trust and relationships, and the contextual factors affecting interventions.

Roles and responsibilities

41. **Member States should:**

(a)   Provide leadership in adapting priority interventions into the local contexts and implementing activities;

(b)   Take the lead in forming partnerships, including with civil society organizations, non-State actors and existing community engagement structures to support implementation;

(c)   Conduct high-level advocacy and leadership at all levels for integrating community engagement within PHC and other sectors; and

(d)   Recruit community health workers to support the health system in implementing the strategy;

(e)   Encourage cross-border cooperation and international stakeholder dialogues.

42. **WHO and other partners should:**

(a)   Create a clear regional implementation strategy or road map that outlines the step-by-step approach for adapting and executing the strategy. This should provide a clear communications plan and should incorporate social and behavioural science expertise in the implementation.

(b)   Build awareness and advocate for community engagement. This could be achieved by developing a clear communication strategy to foster a common understanding across all government services, with health leading the way.

(c)   Promote harmonization of PHC, health promotion, health and social services as well as hazard-specific technical guidelines and tools and sensitize stakeholders on their use to support strategy implementation.

(d)   Based on the experiences of country-level implementation of the strategy, develop a set of generic indicators of community engagement. These can be proposed for inclusion in routine health service data collection, such as intra- and after-action reviews and possibly joint external evaluations and risk analysis tools;

(e)   Provide technical support to Member States for the adaptation and assessment of the regional strategy and implementation of priority interventions, including cross-border actions;

(f)   Mobilize partners and donors to support the implementation of the strategy and advocate for an investment case for community engagement in PHC, health promotion and disease prevention; and

(g)   Promote and support multisectoral and multistakeholder collaboration and ensure accountability to local populations.

Resource implications

43.   Member States and partners developing, executing, and assessing community engagement in PHC, health promotion and disease prevention require more regular, systematic, and predictable financial and human resources. It is expected that the institutionalization of community engagement as integral to the health system will in the long term ensure predictable funding and capacity investment. To avoid fragmentation and underfunding, Member States should map and better leverage existing sources of community engagement funding including domestic, external, private and public resources.

Monitoring and evaluation

44.   M&E is crucial to meet the community engagement strategy's objectives and capture the processes that affect design and implementation. Baseline measures will need to be conducted to inform the M&E framework. Implementation will be tracked annually. Key performance indicators will be incorporated in the annual reports for IHR, community engagement framework, and global programme of work. The Regional Director will update the Regional Committee every two years.

CONCLUSION

45.   Community engagement connects the dots between health system actors, other sectors, and communities, which is critical to reducing the impact of all-hazard emergencies. Learnings from previous outbreaks and health emergencies that put pressure on already fragile health systems show that epidemics start in the community and end in the community.

46.   The strategy will support effective community engagement to help build resilient communities and health systems that can mitigate the effects of health and humanitarian emergencies from all hazards. Establishing credible sources of information on underlying causes of all-hazard emergencies and their prevention and making the information accessible as part of community empowerment is important. Promoting the documentation and sharing of experience will ensure that lessons learned can support more effective community engagement and people-centred health systems. Implementing this strategy to promote community protection and resilience will require adequate domestic funding.

47.   The Regional Committee examined and adopted the strategy.