

## MCDP Temporary Working Group

**From concept to confidence and uptake: involving communities in development and delivery of medical countermeasures for health emergencies**

MCDP temporary working group

### **Issue paper #2**

**From concept to confidence and uptake: involving communities in development and delivery of medical countermeasures for health emergencies**

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#### **A. Introduction**

Health emergencies and outbreaks can only be contained by individuals and communities adapting their behaviors to mitigate transmission and infection in conjunction with a health system that provides timely access and care. Communities are no longer defined only by geographic proximity. Instead, they can be interest or identity-based and may gather in physical or digital spaces. Most people are part of multiple communities at once. This new understanding and interpretation of communities has implications for how policy makers and practitioners engage them in between and during emergencies – along the pathway from development to delivery and uptake of medical countermeasures (MCM).

Medical countermeasures such as, but not restricted to, vaccines, therapeutics and diagnostics, are critical tools to diagnose, prevent, protect from or treat infectious diseases. They reduce morbidity and mortality and enable effective control of outbreaks, thereby reducing the likelihood of epidemics and pandemics. Other health interventions, including health guidance encouraging behavior change strategies such as handwashing or social distancing, and technologies, such as contact tracing, proximity detection apps or digital passports, also may be used alongside MCMs to reduce transmission and empower people to take steps to protect their health.

The extent to which the promotion of MCMs, health behaviors and technologies can achieve these outcomes is determined not only by the speed with which products can be developed and delivered to countries, communities and people, but also by the trust, health literacy and demand from those intended to use them. Proactive engagement and partnership with these stakeholders is critical before and during a public health emergency response to strengthen trust in health guidance, health workers and the government and understanding of MCMs and their proper usage to improve access and uptake once these medical, behavioral and technological interventions are recommended.

#### **Community involvement in MCM development**

In emergencies, MCMs, health guidance and technologies can mitigate pathogen transmission and infection, but only if communities are fully engaged and trust the interventions and the health system providing them. Most emergencies and outbreaks will have some MCMs or recommended health guidance that can be utilized, such as encouraging handwashing to prevent the spread of diarrheal disease, or utilizing smallpox vaccine to protect against mpox infection. However, when MCM are not yet available for a new pathogen, they may need to be quickly developed.

The importance and benefits of involving patients, patient advocacy groups, carers and communities throughout the lifecycle of medicines' development are well recognized (including [CIOMS](#), [FDA](#), [EUPATI](#), etc.). These stakeholders bring important and unique perspectives to the research, development, delivery and uptake lifecycle of new medicines and MCMs that need to be considered early. In particular, patients and community members can help ensure that MCMs are well adapted for use in resource-poor settings, challenging environments and contexts, and at the community level. In the MCM development process for COVID-19, their contributions included priority setting, optimizing clinical trial design and implementation, developing plain language explanations of complex clinical research issues, and providing patient experience data for regulatory decision-making. The Ebola and COVID-19 experiences also highlighted additional needs for improved MCMs by health workers.

During the COVID-19 pandemic, the urgency for the development of new MCMs activated fast track R&D processes. MCMs were made available earlier in product development cycles than in non-emergency times, e.g., through emergency use authorization mechanisms. However, existing models of practice for health worker, patient and public involvement were not adapted to these accelerated timelines. Even in contexts where well-developed mechanisms for patient and public involvement were in place, this vital contribution was often overlooked and underutilized. Limited engagement with key end-users – such as national/ sub-national and local emergency responders, health workers, patients, in particular women and members of vulnerable communities – early in the development of new or repurposed MCMs was a missed opportunity to build understanding, transparency and trust in scientists, medicines developers, and regulators and the processes through which they work to produce breakthroughs in product development, in anticipation of wider product delivery. Later on, confusion over how MCMs were developed so quickly and their limited track record in safety and efficacy contributed to concerns that may have affected COVID-19 vaccine uptake.

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#### **Community involvement for MCM delivery and partnerships**

Community systems and infrastructure have a long history of responding to emergencies. They display valuable contextual expertise and are trusted by communities. Enabled and supported health workers are at the center of community-led service delivery (including delivery of testing, proper MCM usage, health literacy and information, etc.) and accountability, and are central to any meaningful outbreak response. National responses to public health emergencies are strengthened through long-standing and continuous engagement of and partnerships with local community actors, including with religious leaders and local interfaith networks, youth, and women's groups, people living with disabilities and specific diseases, marginalized and vulnerable populations, caregivers, other community leaders and influencers (e.g., teachers, health workers, health service providers) and the private sector.

Community engagement approaches need to reflect the needs and characteristics of diverse communities. For example, particular emphasis should be given to engagement with vulnerable communities who bear the greatest risk and burdens of epi- or endemic zoonotic, neglected tropical and vector-borne diseases. Engagement should also be tailored to different types of end users and intersectional uptake barriers those groups face, such as communities with different faith and values systems, men, women, children and adolescents, communities that prefer indigenous knowledge systems, communities in hard-to-reach settings and communities living in unstable political climate. Special attention should be paid to reaching communities and people who are underserved and experience stigmatization. Special attention should be paid to reaching underserved, stigmatized, and politically unpopular populations. Considerations related to the use of health data, privacy, technology-specific access and health and digital literacy should be taken into account.

Partnerships and engagement should be sustained both during preparedness (non-emergency) and response (emergency), and underpinned by the systematic integration of behavioral science, effective risk communication and community engagement (RCCE), including risk/benefit communication, and the application of infodemic management (IM) approaches in between and during outbreaks. This is important because it is very difficult to establish effective relationships quickly during times of crisis, particularly given the complex information ecosystems and socio-behavioral nuances characteristic of public health emergencies, including the difficulty of access in certain situations of vulnerability, for example, those affected by conflicts or humanitarian emergencies or communities who have faced historic barriers to healthcare and social inclusion.

Existing partnerships and mechanisms for engagement enable the early involvement of communities in the MCM development pathway and to support delivery and promote community demand and uptake of public health guidance and MCM when they become more widely available. They also ensure that during an outbreak, before MCMs become widely available, there are opportunities to optimize the coherent implementation of public health and social measures that are necessary to prevent the spread of disease. Once MCMs are authorized and available for wider use, their uptake and use are also supported by the trust and cooperation that has been established between and within communities and response actors at national, sub-national and local levels.

#### **B. Purpose**

This issue paper is one of two deliverables developed by the Medical Countermeasures Delivery Platform (MCDP) temporary working group. A second issue paper is being developed on "Recommendations for the Set-Up of a Medical Countermeasures Delivery Partnership".

The proposed issue paper complements and contributes to other ongoing discussions described in section 4 "Alignment with existing processes and negotiations". Using the Health Emergency Preparedness and Response framework<sup>1</sup>, this paper outlines key intersections between the Access to Medical Countermeasures and Community Protection subsystems. Building on this framework, it defines and signposts key entry points for engagement with the public and priority populations and

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<sup>1</sup> Strengthening health emergency prevention, preparedness, response, and resilience. Geneva: World Health Organization; 2023

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other stakeholders who will benefit from new or repurposed MCMs and health guidance that are developed to tackle health emergencies.

The issue paper will highlight effective approaches to involving the public, priority populations and communities from the development to delivery, and demand and uptake of MCM and health guidance during health emergencies. The paper provides examples of good practice as well as areas where further work is needed for meaningful involvement of these groups to protect and build trust and uptake of MCMs.

This issue paper contributes to broader efforts to increase community protection with links to systems strengthening with a gender component and equity lens.

### C. Terminology and clarity of terms

We define here some concepts and terms commonly used throughout the paper:

- **Medical countermeasures:** Medical countermeasures (MCMs) are medicines and medical supplies that can be used to diagnose, prevent, or treat diseases related to chemical, biological, radiological, or nuclear (CBRN) threats or naturally occurring emerging diseases.<sup>2</sup>
- **Patient, public, and/ or community:** Wide group of people who are intended to benefit from medical countermeasures, including those who represent their interests, e.g. patient organizations, community-based groups, civil society organizations, etc.  
**Patient, public, and/ or community involvement:** active collaboration, interaction with and involvement of those intended to benefit from medical countermeasures in ways that allow their experiences and perspectives to influence decision-making regarding product development, delivery and uptake.
- **Community Health Worker:** Community health workers (CHWs) are health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors. This human resource group has enormous potential to extend health care services to vulnerable populations, such as communities living in remote areas and historically marginalized people, to meet unmet health needs in a culturally appropriate manner, improve access to services, address inequities in health status and improve health system performance and efficiency.
- **Good Participatory Practice (GPP):** A principle-based approach to effectively engage stakeholders in the design and conduct of prevention and treatment trials<sup>3</sup>. Relevant to health emergencies, the term Good Participatory Practice for Emerging Pathogens (GPP-EP) is often used. This relates to effective multi-stakeholder engagement in the design and conduct of prevention and treatment trials for emerging and re-emerging pathogens, i.e. with a specific application to health emergencies caused by these events.<sup>4</sup>
- **Community:** Can refer to a group of people who share a common interest or identity (e.g. religion, ethnic background, workplace, education, geography, etc.) which is not necessarily bound by physical proximity.
- **Community engagement:** the process of developing relationships and structures that engage communities as equal partners in the creation of emergency response solutions that are acceptable and workable for those they impact. This has a focus on active collaborations and partnerships. Term often used for health emergency response, i.e. the context for the delivery of medical countermeasures.
- **Risk communication communication:** the real-time exchange of information, advice and opinions between experts or officials and people who face a hazard or threat to their survival, health, or economic or social well-being, including describing the potential risks and probably

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<sup>2</sup> [What are Medical Countermeasures?](#), FDA

<sup>3</sup> [Good Participatory Practice \(GPP\) Guidelines – Ethical and effective stakeholder engagement throughout clinical trials and research agendas for HIV prevention and beyond](#), AVAC

<sup>4</sup> [Good Participatory Practice for trials of \(re-\)emerging pathogens \(GPP-EP\): Guidelines](#), World Health Organization

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benefits of MCMs and other pandemic responses, with the goal of improving health literacy which prepares people for proper use of MCMs.

- **RCCE:** An acronym for risk communication and community engagement (incl. risk/benefit communication) functions which are often grouped together in emergency responses as part of RCCE working groups and coordination committees to promote a harmonized approach to communicating and engaging with the public in an emergency.
- **Infodemic Management (IM):** An evidence-based approach for understanding and characterizing an infodemic – which is an overabundance of information, accurate or not, in the digital and physical space, accompanying an acute health event such as an outbreak or epidemic – with the goal of developing insights to improve health. Includes approaches such as social listening, tracking health misinformation and understanding the information environment, including digital spaces.
- **MCM development:** the development process of MCMs that includes early discovery science, laboratory-based product development and clinical research, product optimization and adaptation for easy use, evaluation in clinical trials to regulatory authorization for use, and post-market monitoring of safety and efficacy.
- **MCM delivery:** post-authorisation processes for getting the product to the end-user, including the marketing and demand component to uptake, as well as surveillance and monitoring of uptake and demand.

## D. Principles

Epidemics start and end in communities. Actions taken by those affected have an important impact on outbreak trajectories. Drivers of and responses to health emergencies are social and behavioral as much as they are biomedical. Adapting to these local realities is critical throughout the development and implementation of interventions, including MCMs.

Multiple frameworks and approaches are used to guide policy and practice related to patient, public and community involvement for health emergency response. Implicit across these is the recognition that the needs of those directly impacted by health emergency events should be placed at the forefront of response efforts. Many of these approaches are underpinned by universal ethical and moral principles of respect, equity, fairness, integrity, transparency, accountability, and autonomy.

Then, what does that mean for community involvement in MCM development and delivery?

- **Health systems should focus on the most vulnerable** and the needs of diverse populations – Health systems need to identify and prioritize populations that are most likely to be affected by an emergency. This means working with organizations, communities and individuals from these populations to develop health guidance, communications and MCMs that protect health, and are offered in ways that are culturally acceptable and relevant. This can be anticipated before an emergency strikes and foundational work to build trust and relationships in these communities should start now.
- **Fostering community agency** – Communities need to feel they have agency within response efforts to provide them with a sense of control and decision making. A sense of agency can counter the psychological impact of a health emergency and promote resilience. Self-testing, connection to care, and health literacy can add to a sense of agency and engagement in one's own health and the health of a community.
- **Partnering with communities in research** – Patients, the public and communities are essential to MCM development and delivery through their unique perspectives, knowledge, systems and infrastructures. These resources can help ensure that MCMs are well adapted for use and the community setting and in resource-constrained and environmentally challenging contexts. Community knowledge can feed into clinical trial feasibility and acceptability considerations and include marginalised and priority populations in product development. Protecting the rights of individuals and communities is also critical, especially when involved in MCM trials that include for-profit entities.

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- **Partnering with communities during the delivery of MCMs and health measures –** Communities are crucial to involve in implementation of MCMs and generating high demand and knowledgeable uptake of MCMs to protect population health, including by working through trained, equipped, protected and remunerated health workers and using community infrastructure to effectively deliver MCMs and the engagement of communities in the development, adaptation and delivery of health-related communication and messaging.
- **Building trust –** Trust in the MCMs and health guidance is dependent on many things including trust in the people and institutions producing and delivering the MCMs, the process by which the MCMs were produced, the regulatory frameworks used to determine their safety, efficacy and use, and the science upon which they were developed. Creating trust also requires transparency about motivations and expectations of all stakeholders and honesty on how decisions are reached about equity, prioritization, and allocation of resources. Building a reputation that is worthy of trust has to start before the emergency and will be dependent on the quality of engagement with communities who feel like their health system and government are meeting their needs.
- **Localized response –** Communities have the specific expertise and knowledge on how to adapt interventions to different groups, situations and contexts in order for them to be more feasible, appropriate, acceptable and accessible by all. In the case of clinical trials, this means taking in account both what is needed for well designed trials and what is feasible in different contexts, e.g. by leveraging trial-relevant community networks/ structures, and the follow-up and access to end-products after trials. For wider delivery of MCMs and adherence to health guidance, this means ensuring access, equity, and acceptability are taken into account.

### E. Lessons learnt during COVID-19 along the MCM pathway from product development to delivery and uptake

The use, development and delivery of MCMs during the COVID-19 pandemic serves as an important learning experience. Some pertinent experiences include:

- **Limited supply of existing MCM**, even for health workers, led to panic buying by individuals and countries from masks to gloves to hand sanitizer to ventilators, causing major shortages, especially in LMICs. Inadequate emergency preparedness planning also contributed to understocking of MCMs needed by health workers, use of expired stock, and poor allocation to high-need areas. A side effect of this was undermining popular trust in governments and the emergency response early in the pandemic.
- **Trust in health workers and the health system:** Health workers remain the most trusted source of health information. If they have adequate training and support, they can be strong advocates for uptake of MCM and health guidance, have more effective conversations with patients and address misinformation more successfully.
- **Timely equitable access to MCM, funding and access to market –** Despite the accelerated product development, early product delivery and distribution was skewed towards high-income countries. Inequity in distribution, allocation and uptake of MCM in many countries, left vulnerable populations unprotected. Despite many countries' efforts to promote equitable uptake of COVID-19 vaccines and treatments, major disparities remained. Social issues such as stigma, discrimination and harassment of groups of people further contributed to inequity of healthcare access and outcomes. Achieving equitable coverage of MCM lies at the heart of effective preparedness planning and response. Further, vaccine inequity may have contributed to vaccine hesitancy as low vaccine coverage contributed to the emergence and spread of new variants with immune escape behavior. Effective public health communication in favor of MCMs also depends on the availability of adequate and equitable supply.
- **Scientific uncertainty and inconsistent guidance** led to frequent updates to guidance for health workers, the general public, and people affected by the virus, causing confusion and anxiety. People wanted simple explanations of risk and how to reduce their risk of being infected with or transmitting COVID-19, which they were often unable to find in earlier phases of the response. They also want guidance on how and when to test, symptoms of infection, the availability and appropriateness of prevention and treatment measures. At times, guidance was perceived as confusing or impractical to follow, e.g. the recommendation to get a rapid diagnostic

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test (RDT) before traveling when there was a major RDT stockout, or the recommendation to socially distance or wear masks in multigenerational households. Conflicting scientific research published in low-quality peer-reviewed journals and public disagreement among experts also contributed to competing narratives in news coverage and discussion of the disease and spurred the spread of misinformation promoting the uptake of unproven treatments.

- **Stigmatization undermining demand for and uptake of MCMs**, stigmatization, or even criminalization, of affected individuals and populations can significantly undermine demand for MCMs and undermine community engagement efforts and trust in health authorities. Where stigma related to a disease exists, destigmatization should be central to community engagement efforts.
- **More than MCMs are needed to stay safe and healthy**. When movement restrictions and school closures were widely in place, this affected people's livelihoods and their children's education, and had side effects such as increased gender-based violence. Even if people were following public health guidance such as staying at home and using MCMs as directed, this behavior change could come at a cost. Therefore, social protection policies needed to be developed to protect populations from other emergency-related harms, such as to support people who are in isolation with food, or providing flexibility to health workers to offer telehealth visits.
- **Accelerated timelines** for product development and scientific research meant limited public engagement and understanding of the science behind medical breakthroughs. More efforts are needed to ensure that stakeholders are engaged in the design, conduct, and conclusion of trials especially during public health emergencies.
- **Complex, dynamic context** with MCMs being made available earlier in the product development cycle (e.g. via emergency use authorization), resulted in an implementation environment where certain MCM were still being evaluated and regulated in some countries but already widely used in others. This required specific attention to communication and engagement to ensure that policymakers, health workers and the public were educated about the process and how MCMs were evaluated for safety and efficacy.
- **A complex information environment** with increasing and widely circulating mis- and disinformation, highlighting the importance of addressing the public's questions, concerns and information gaps about how health guidance was developed, how MCMs were developed, how they would be distributed, who was prioritized, and why. Many countries received significant investments into new social and behavioral data collection systems within a short timeframe, resulting in data backlogs with regard to social and behavioral data, and limited capacity, trained workforce, access to data and supportive policies and processes to be able to analyze the data quickly enough to adapt to the evolving situation. There are opportunities to further strengthen country capacities to use social and behavioral science and to strengthen social listening and community feedback mechanisms to improve service delivery at national and subnational level. The information environment will likely become more complex in the future, and pandemic-era investments in understanding it can be leveraged to address other health priorities (e.g. mental health, cancer, antimicrobial resistance (AMR), routine immunization, etc.).
- **Pandemic fatigue** as the pandemic progressed. Levels of public engagement and cooperation decayed as more vaccines and boosters were introduced and new treatment options became available, due to popular perception that the COVID-19 pandemic had passed and risk perceptions and associated demand shifted. Conversely, if MCM delivery was long delayed and inequitable, levels of public engagement and cooperation also declined. As pandemic restrictions eased and people returned to socializing, schooling and working in ways similar to pre-pandemic, COVID-19 no longer stayed on top of mind. New health guidance and newer MCMs, especially test-and-treat, would therefore receive much less attention and uptake. Addressing pandemic fatigue means reframing how the emergency is discussed in ways that are relevant to individuals and their needs in the moment, not how it may have been communicated at the beginning of the pandemic. It is clear that an overfocus on the "acute" phase of the pandemic undermined resilience for a longer-term strategy and also delayed appropriate attention to long covid.
- **Partnerships with community systems and infrastructure**: Engagement with communities, including the private sector, was deprioritized in the early pandemic response. Though understandable in view of the situation – with risk communication using electronic media being the dominant approach early on and in-person engagement deemed risky for spreading the virus

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– this was a missed opportunity to engage with local-level community mobilization, for example, through civil society organisations. In addition, this disconnect undermined trust in national and subnational response efforts, in particular where there were limited pre-existing long-term partnerships between community groups, government agencies, and implementing partners. This also led to the rollout of interventions and communication that were not contextualized, optimized or adapted to community needs – more contextualized approaches were then implemented relatively late.

- **Government leadership and commitment to engaging the public and promoting trust in MCM:** Government commitment and ownership were important for effective RCCE and IM during the COVID-19 pandemic to communicate transparently to the public, engage with communities, improve access and delivery of MCMs making it easier to follow public health guidance. Ownership and endorsement from political leaders strengthened public health messaging and supported public trust and social cohesion. However, COVID-19 was also politicized and affected public discourse, especially around elections, which could fuel distrust in government response. There is an opportunity to engage government leaders and stakeholders early on, and to advocate for the recognition of the benefits of promoting health security and preparedness across line ministries to mitigate social and economic impacts of the emergency.

### F. Successful approaches and strategies for community involvement throughout MCM and health guidance development, delivery and demand

By supporting governments to consistently integrate a community-centric and user-focused perspective into their health systems, partners can not only increase the relevance and quality of public action (health policies, services, programs and products to better respond to population needs) but also increase the health system resilience, through inclusiveness and equity, active partnership, improved relationship with populations and higher satisfaction which will all bolster trust in authorities and the public as the foundation to adapt to future shocks. Community trust is at the center of most public health preparedness and response challenges, without which achieving high uptake of health guidance and MCMs in emergencies is extremely difficult, thereby affecting the ability for governments to contain outbreaks and dampen emergencies.

Building on the lessons learned from previous epidemics and pandemics including COVID-19, HIV, Ebola and the existing good practices, frameworks and guidelines, the following table outlines key entry points and contributions to support key stakeholders, including product developers, regulators, clinical researchers, governments and delivery partners to strengthen partnerships with communities and integrate community-centric and user-centric perspectives into the MCM development and delivery pathway. It is important to remember that multiple MCMs will likely be used by different populations at different times and that, unless a superior and widely accessible MCM is available, more MCM will likely need to be developed.

*Table 1: Community Involvement throughout MCM and health guidance development, delivery and demand*

Steps for development and delivery of MCMs and health guidance	Successful approaches for community involvement during an emergency response
<b>If none or limited MCMs exist:</b>	
When no MCM are available	<ul style="list-style-type: none"> <li>- Identify existing health behaviors that may reduce transmission (e.g. handwashing, masking, etc.)</li> <li>- Focus on harm reduction, thereby reducing risk of transmission or infection</li> <li>- Work with community members on feasibility/acceptability and testing of messages and promoted health behaviors and modify as appropriate</li> </ul>

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	<ul style="list-style-type: none"> <li>- Communicate what is known and what is not known, especially as new research and guidance is published</li> <li>- Tailor information and recommend behaviors for vulnerable and priority populations</li> <li>- Give people meaningful actions they can take, even if small ones (e.g. look in on an elderly neighbor)</li> </ul>
When limited MCM are available	<ul style="list-style-type: none"> <li>- Transparently communicate what MCM are available, their proper use, and who is prioritized to receive them and why, and explain what is being done to increase supply and ensure equitable access</li> <li>- Focus on promoting uptake among health workers (if appropriate)</li> <li>- Work with priority populations to increase uptake by most vulnerable people</li> </ul>
<b>If MCM needs to be developed</b>	
Discovery research, candidate identification and clinical trials	<ul style="list-style-type: none"> <li>- Develop/ strengthen epidemic/ pandemic rapid response capabilities as part of PPI mechanisms, as well as with CSOs, CBOs, patient organizations, including for example, on key steps of product specification/ development (governance, policy, advocacy)</li> <li>- Map and plan mechanisms for engagement across multiple stakeholders in the R&amp;D ecosystem, including with regulators, ethics committees, policymakers, lay publics and health providers.</li> <li>- Anticipate need for optimized and well-adapted products and clinical trials that are representative of the populations that are intended to benefit from the trialed intervention, i.e., inclusion of pregnant/ lactating women, children/ elderly populations, different racial groups and ethnicities, etc.</li> <li>- Fast-track discovery to clinical trial pipeline through established processes and mechanisms</li> <li>- Embed rapid GPP-EP as essential to inform key features of public health emergency-relevant clinical trial design and implementation – advance methods for rapid GPP-EP.</li> </ul>
MCM production / manufacturing and regulatory considerations	<ul style="list-style-type: none"> <li>- Develop methods and mechanisms for rapid, integrated collection of patient experience data for time pressured, public health emergency contexts</li> </ul>
Coordinated supply and demand flows and data sharing	<ul style="list-style-type: none"> <li>- Establish expert units to advise on socially and behaviourally informed legislation and regulations</li> </ul>
MCM Allocation	<ul style="list-style-type: none"> <li>- Involve community representatives and use behavioural science expertise to inform allocation frameworks in ways that account for structural drivers of health inequity</li> <li>- Ground-truth data on acceptance and demand for MCMs, including product preferences and timing of MCM shipments, to inform allocation decisions within the constraints of a supply-constrained environment</li> <li>- Conduct readiness assessments on strength of the system to delivery MCMs, especially to high-risk, underserved, and hard-to-reach populations that have been prioritized</li> <li>- Engage CSOs in the design of allocation frameworks and mechanisms; and in monitoring and accountability of allocation decisions</li> <li>- Engage in rapid consultations, recognizing that the emergency and epidemiological picture and recommendations change very quickly and that even insights that are a few weeks old can be outdated and not useful</li> </ul>
MCM Delivery, including demand and uptake	<p><b>In-country delivery</b></p> <ul style="list-style-type: none"> <li>- Engage established and functioning partnerships and existing coordination mechanisms to support timely delivery and transparent communication about delivery timelines.</li> </ul>

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	<ul style="list-style-type: none"> <li>- Work with communities to identify relevant MCM distribution locations that are convenient and acceptable to deliver MCMs</li> <li>- Engage communities, including with/through community-based health workers, in participatory planning and budgeting mechanisms and enhanced microplanning to reach all, including using social data, social mapping, and inclusion of underserved populations (e.g. ethnic minorities, refugees and/or vulnerable groups)</li> <li>- Engage CSOs in monitoring and accountability for allocation and delivery</li> <li>- Enable, resource, capacitate, equip and protect communities to meaningfully contribute to in-country delivery efforts</li> </ul> <p><b>Demand and Uptake</b></p> <ul style="list-style-type: none"> <li>- Use behavioural science, social listening and infodemic insights to understand social and behavioural drivers and inform communication and take interventions, including the collection, analysis, and visualization of social and behavioural data</li> <li>- Coordinate risk and risk/benefit communication so messaging is harmonized across leadership and institutions and identify and engage relevant RCCE technical committees</li> <li>- Promote MCM health literacy at the individual and community level</li> <li>- Leverage community feedback loops and accountability mechanisms, through coordination with local governance mechanisms and online and offline social listening (e.g., engagement with municipalities, health districts) and civil society and inter-agency coordination platforms to promote demand and proper use and to address service delivery challenges</li> <li>- Promote health literacy and demand through engagement of community leaders, community groups, faith institutions, workplaces, and other gathering points for prioritized communities</li> <li>- Co-create communications materials with communities, including pre-testing before widespread distribution</li> <li>- Address questions, concerns, information voids and circulating misinformation by updating communications, debunking myths and rumors</li> <li>- Promote post-marketing surveillance mechanisms (e.g. for AEFI, diagnostics) for the public to report feedback on their use of MCMs</li> </ul>
<b>Cross-cutting issues related to community involvement in MCM production, delivery, demand and uptake</b>	
Data protection and privacy	<ul style="list-style-type: none"> <li>- Communicate clearly how patient data is captured, used, and kept safe by the government</li> <li>- Offer ways for community members to obtain or correct their health records and request copies (e.g. for proof of vaccination)</li> </ul>
Community agency	<ul style="list-style-type: none"> <li>- Involve communities in preparedness, emergency response and monitoring efforts, including consultations in after-action reporting and making recommendations for improvement following the close of an emergency</li> <li>- Involve communities in simulations, planning and preparedness trainings and connect to networks involving CSOs and other stakeholders in the public</li> <li>- Communicate how communities are informing the research and development/roll-out processes</li> </ul>
Healthcare professionals	<ul style="list-style-type: none"> <li>- Recognize the dual role that HCPs have as providers of healthcare services and as community members and influencers and support them with capacity building to improve ability to communicate and advocate for healthy behaviors</li> </ul>

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#### **G. Next Steps**

This issue paper #2, together with #1, constitutes deliverables from the TWG, which concludes its current line of efforts as of the end of 2023. In 2024 onwards, the TWG does not plan to hold regular monthly meetings, but is kept open for potential contribution to relevant international processes and discussions, as necessary. The deliverables of this TWG, along with its collaborative process and network with key partners from a broad range of sectors since the announcement of the MCDP at the G7 Hiroshima Summit and the following TWG deliberations since May 2023, are expected to inform and inspire relevant ongoing global processes such as i-MCM-Net and INB discussions (see Annex for the list of relevant processes), helping to ensure equitable access to MCMs towards the next pandemic.

## MCDP Temporary Working Group

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### H. Annex

#### **1. Members of the MCDP TWG**

	Institution
UN organizations	<ul style="list-style-type: none"><li>- WHO</li><li>- UNICEF</li><li>- UNDP</li></ul>
Health agencies	<ul style="list-style-type: none"><li>- GAVI</li><li>- Global Fund</li><li>- UNITAID (MPP)</li><li>- FIND</li><li>- GHIT</li></ul>
IFIs	<ul style="list-style-type: none"><li>- World Bank</li><li>- ADB</li></ul>
Regional entities	<ul style="list-style-type: none"><li>- Africa CDC</li><li>- European Commission</li><li>- PAHO</li></ul>
Governments	<ul style="list-style-type: none"><li>- Canada, France, Germany, Italy, Japan, United Kingdom, United States of America</li><li>- India (the G20 Presidency in 2023), Brazil (the G20 Presidency in 2024)</li><li>- South Africa &amp; Norway ("Johannesburg Process" co-chairs and former ACT-A Facilitation Council co-chairs)</li></ul>
Civil society & implementing partners	<ul style="list-style-type: none"><li>- CSO representatives (STOPAIDS, EANNASO)</li></ul>

#### **2. Evidence reviewed**

- [ACT-A CSO Briefings – Key Lessons](#) (2023)
- [Five reasons why communities are key in the fight against COVID-19 – Lessons learnt from Ebola](#), IFRC
- [Lessons Learned from the RCCE Response to COVID-19 in the Eastern and Southern Africa Region](#), UNICEF; 2022
- UNICEF draft outline for UNICEF 2024 EB paper (internal draft)