Results Data suggested general agreement to use the same criteria in all levels of Norwegian health service. However, disagreement was identified when considering the lack of feasible implementation processes. Recurrent themes in the data were the municipalities' legal and financial lack of scope to set priorities under constraints, challenges regarding operationalising a supplementary physical, psychological and social mastery criterion, and prioritising in situations where the benefits are difficult to measure.
Discussion The many duties and responsibilities of municipal health and care make priority setting decisions more complex than in specialist health care. In summary, the Norwegian green paper on priority setting in municipal health and care services has presented a well-received recommendation. However, how to inevitably tackle the many complex, and sometimes wicked, prioritisation problems in practice remain unanswered.

81:oral EQUITY FOR ALL? A POLICY ANALYSIS OF PRIORITY TO REFUGEES AND ASYLUM SEEKERS' SEXUAL AND REPRODUCTIVE HEALTH IN NORWAY (2010–2019)

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Objective Migrants' health is conditioned by individual, social and structural determinants of health that are shaped by policies. Refugees and asylum seekers are of particular risk of sexual and reproductive health (SRH) issues, but few have studied whether and how their health is prioritized in policies. This study aims to assess how the SRH of refugees and asylum seekers is addressed in Norwegian health policies. Acknowledging that migration health is impacted by social determinants of health, this was given particular attention.
Methods A document review of relevant policies (2010-2019) on SRH and refugees and asylum seekers in Norway was conducted. Documents were analysed systematically in four steps, informed by the READ approach (Read, Extract, Analyse, Distil).
Results 14 policy documents were included. While migrants' health receives increased policy attention, this attention remains general in character. The national migrant health strategy (2013) was not followed by a specific policies or action plans. SRH issues of refugees and asylum seekers is not policy priority. This contrasts the decade long distinct policy priority and financial support to female genital mutilation (FGM) and forced marriage among migrants. FGM is seen as an area of concern across different policies on health alongside specific attention within violence polices. While social determinants of health and equality underpins general health policies in Norway, this was less prominent when polices discuss migrants and refugees' health, including their SRH. Addressing migrant health, including SRH and in particular FGM, was often presented as a matter of language problems, cultural barriers and harmful norms and practices. Other higher-level determinants, such as poverty and low education were rarely a focus in policies and in actions suggested for change.
Conclusion The SRH of refugees and asylum seekers is not a policy priority in migrant health policies nor in general health policies in Norway.

78:oral THE FAIR ALLOCATION OF SCARCE MEDICAL RESOURCES: A COMPARATIVE STUDY FROM JORDAN

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Objective Several studies have analyzed allocation strategies among different society groups based on 9 allocation principles; sickest-first, waiting list, prognosis, youngest-first, instrumental values, lottery, monetary contribution, reciprocity and individual behavior. Sometimes combinations, youngest-first and prognosis for example, can be considered. Our aim was to study the most important prioritization principles groups in Jordan.
Methods An online survey handling 3 situations of medical scarcity; (1) organ donation, (2) limited hospital beds during influenza epidemic, and (3) allocation of novel therapeutics for lung cancer, and a free comment option constituted the survey.
Results Seven hundreds and fifty-four responses were analyzed from five groups including religion scholars, physicians, medical students, health allied practitioners and lay people. The most important priority principle was 'Sickest-First' for the three scenarios among the surveyed groups, except for physicians in the first scenario where 'Sickest-First' and 'Combination-criteria' were of equal importance. In general, there were no differences between the examined groups compared to lay people in the preference of options for all scenarios, however physicians were more likely to choose the 'Combination-criteria' in both the second and third scenarios (OR 3.70, 95% CI = 1.62-8.44, and 2.62, 95% CI = 1.48-4.59; p-value = 0.00, 0.00 respectively), and were less likely to choose the 'sickest-first' as the single most important priority principle (OR 0.57, CI = 0.37-0.88, and 0.57; 95% CI=0.36-0.88; p-value = 0.01, 0.01 respectively). Out of 100 free-comments, 27 (27.0%) thought the 'social-value' of the patients should be considered, adding the 10th potential allocation principle.
Conclusion Our findings are concordant with literature in terms of allocating scarce medical resources. However, 'social-value' should be addressed when prioritizing scarce medical resources in Jordan, and probably other LMICs.

157:poster INTEGRATING HEALTH TECHNOLOGY ASSESSMENT AND THE RIGHT TO HEALTH IN SOUTH AFRICA: A QUALITATIVE CONTENT ANALYSIS OF SUBSTANTIVE VALUES IN LANDMARK JUDICIAL DECISIONS

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Objective Some have raised questions about potential tensions between health priority-setting and the right to health. South