

cost-effectiveness analyses (CEA) of IVF, a surprisingly difficult task. The aim of this article is to examine the theoretical underpinnings for CEA of IVF-treatment. I argue that at least two theoretical questions must be answered. First, what is the desired outcome of an IVF? It could be to cure biological infertility, or to cure unwanted childlessness. The former may imply the latter, but not vice versa. Curing unwanted childlessness can be achieved by other means than IVF. However, curing biological infertility is also problematic, as many of those who require IVF to become parents do not have infertility issues. Other reasons, such as sexuality or not having a partner, can also be a driving force behind IVF. Depending on how we understand the desired outcomes of IVF, it may lead to different CEA-results. Second, who is the IVF treatment for? IVF treatment is quite different from the majority of medical treatments, given that it entails two lives rather than one. While the IVF-procedure concerns an existing individual or couple, the aim of the procedure is to procreate a new individual. Therefore, one needs to take a stance on whether the benefits of IVF-treatment belong to the pregnant woman, the procreated child- or both. Finally, I show that there is a high elasticity in the chosen philosophical assumptions behind any CEA of IVF-treatment.

99:oral **RIGHTS PERSPECTIVE OF A DOCTORS' STRIKE IN KENYA**

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**Objective** In December 2011 doctors employed by the government of Kenya in public service went on strike. The strike involved total withdrawal of all services including emergency lifesaving treatment. The strike went on for a period of six weeks. This research seeks to critically examine the strike from a rights perspective to determine any justification or lack thereof.

**Methodology** The study is based on desktop and library materials. It examined the circumstances and contexts of the strike to enable an understanding of the status of health services and the nature of the demands by doctors. The obligations of the medical profession and ethical codes and rules of conduct for doctors were examined in relation to the strike. The right to health as provided for in the Constitution of Kenya 2010 and international instruments were critically analyzed. The rights of doctors and patients were explored while obligations of the government, the doctors and patients were scrutinized.

**Discussion** Analysis of the reasons for the strikes and status of public health services revealed violations of the right of patients to health as provided for in the Constitution of Kenya 2010. From a rights perspective the doctors strike action was within their rights as provided for in the Constitution of Kenya 2010. However, harm resulting from suspension of emergency services provided an argument against moral justification of the strike.

**Conclusion** The doctors were within their rights to go on strike as provided for in the Constitution of Kenya 2010 and labour laws of Kenya. The government failed in their obligation to provide acceptable standard of healthcare considering the resources available. However, comprehensive justification

of the strikes was difficult, considering the professional and ethical obligations of doctors to society and to patients.

144:poster **QUALITY OF PANDEMIC PRIORITY SETTING IN THE U.S**

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Priority setting during public health emergencies presents an enormous challenge for federal and state decision makers in the U.S.

**Objectives** We describe the degree to which U.S. priority setting adheres to established quality indicators and explore relationships between such indicators and states' demographic characteristics.

**Methods** Data includes the U.S. COVID-19 preparedness and response plan of January 2021 and individual state plans. Purposive sampling of 22 states from multiple geographic regions considered total population, % rural residents, income per capita, health ranking, and political leanings. State plans were sought online and using multiple contacts with state health and emergency preparedness departments.

We analyzed plans using a tool based on an established framework of quality indicators to evaluate priority setting, for example principles and criteria, stakeholder and public participation, publicity and accountability.

**Results** The national plan included 7 of 20 quality parameters, including attention to at-risk populations, a comprehensive list of resources and interventions to which priority setting would apply, publicity, and the use of (and efforts to improve) evidence for priority setting decisions. The US plan describes the importance of 'engag[ing] the American people' and various stakeholders to inform the federal response. Enforcement, accountability, incentives, and assessment of impact were not identified in the plan.

We obtained pandemic plans from 4 states and documents from 6 states that, while not explicitly labelled as pandemic plans, include priority setting. Analysis is in process; we expect to present results for 4-10 states.

**Discussion** The US plan's consideration of various scarce resources, public engagement, and equity concerns recognizes the disproportionate impact of COVID-19 among racial and ethnic minorities and low-income communities. However, its lack of accountability and assessment of impact on outcomes may hinder achievement of goals. Difficulty finding and obtaining state plans suggests a lack of publicity and transparency.

146:oral **SETTING PRIORITIES FOR CONNECTIONS AND ACTIVITIES DURING A PANDEMIC**

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