Introduction
The onset of the COVID-19 pandemic in early 2020 triggered reorganisation of hospital departments around the world as resources were configured to prioritise critical care. In spring 2020, NHS England issued national guidance proposing acceptable time intervals for postponing different types of surgical procedures for patients with cancer and other conditions. The ‘Consider-19’ study sought to investigate prioritisation decisions in practice, with in-depth examination of colorectal cancer surgery as a case-study, given recommendations that these procedures could be delayed by up to 12 weeks.

Methods
Twenty-seven semi-structured interviews were conducted with healthcare professionals between June – November 2020. A key informant sampling approach was used, followed by snowballing to achieve maximum regional variation across the UK. Data were analysed thematically using the constant comparison approach.

Results
Interviewees reported a spectrum of perceived disruption to colorectal cancer surgery in the early phase of the pandemic, with some services reporting greater scarcity of resources than others. Nonetheless, all reported a need to prioritise patients based on local judgments. Prioritisation was framed by many as unfamiliar territory, requiring significant deliberation and emotional effort. Whilst national guidance provided a framework for prioritising, it was largely left to local teams to devise processes for prioritising within surgical specialities and then between different specialities, resulting in much local variation in practice.

Discussion
The pandemic necessitated a significant change in practice as surgeons, in a tense and uncertain situation, found themselves having to navigate clinically, emotionally, and ethically-charged decisions about how best to use limited surgical resources. Whilst unavoidable, many felt uncomfortable with the task and the consequences for their patients. The findings point to a need to better support surgeons tasked with prioritising patients and raise questions about who should be involved in this activity.

Conclusion
With maternal mortality ratios higher than 100 per 100,000 live births in many low- and middle-income countries (LMICs), reducing these deaths features high on international public health agenda. In LMICs, mHealth interventions are increasingly being used to strengthen the health-care system and to empower patients. The objective of this study is to evaluate the effects of a smartphone application on maternal health knowledge and diet among pregnant Indian women.

Methods
A randomized controlled trial in one private hospital in the state Maharashtra, India was conducted. Pregnant women were onboarded when they were entering antenatal care. Allocation to the intervention and control group was based on the random assignments of numbers to the enrolled participants. Pregnant women in the intervention group were invited to download the application in addition to regular antenatal care. The control group only received regular antenatal care. The study duration was 12 weeks. App usage was monitored, maternal health knowledge and dietary intake were collected via telephonic interviews, background characteristics and medical history were obtained via the antenatal care provider.

Results
In total, 178 respondents completed all measurements (control = 83; intervention=95). Intervention participants had on average five sessions per week with the application. Preliminary results show that both the intervention and control group had improvements in all knowledge modules, but improvements were largest for the intervention group. Breast-feeding, physical activity and anaemia knowledge modules showed the largest difference between control and intervention group. Diversity in dietary intake also substantially increased most among respondents in the intervention group, with an increase of four food groups per week.

Discussion
mHealth seems a promising route to improve maternal health knowledge and behaviors among pregnant women in India. Future research steps include the roll-out of a multi-centre study to assess the effect of the smartphone application on health outcomes.
analysis involved assessing whether and how forcibly displaced people were prioritized in the COVID-19 national response plans. This was compared with the displaced populations identified in the host countries’ UNHCR Forced Displacement 2020 report.

**Results**

Only five countries among 86 analyzed prioritized forcibly displaced people in their COVID-19 national response plans. Among the top ten forcibly displaced people hosting countries, Uganda was the only one with an explicit prioritization of this vulnerable group. Although Turkey, Colombia, and Germany account for nearly one-fifth (6.6 million) of refugees, asylum seekers and Venezuelans displaced abroad, none of the COVID-19 response plans of these countries prioritized these populations.

**Discussion**

Few countries recognized forcibly displaced people as a vulnerable population in their COVID-19 response and preparedness plans. Governments may have incorporated actions and interventions for these vulnerable groups after publishing the COVID-19 response plans. It would be essential to evaluate the impact of this lack of prioritization on the health and wellbeing of these population groups.

**Conclusion**

We found some emphasis on PS according to contextual factors. For instance, LMICs receiving international donations presented more detailed descriptions of resources required, plans for allocating resources and improving internal accountability. HICs more likely described stakeholder participation, mechanisms for public communication, and explicit PS processes. However, no country included all twenty parameters of PS.

**Abstracts**

**110:oral**

PROFILE OF PRIORITY SETTING INCORPORATED TO COVID-19 RESPONSE PLANS IN 86 COUNTRIES IN THE WORLD

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Background The COVID-19 pandemic has imposed a burden on all health systems budgets and pushed policymakers to rapidly set priorities for resource allocation. This study aimed to identify quality parameters of priority setting (PS) incorporated in a sample of the national response plans.

Methods We reviewed a sample of COVID-19 national response plans from 86 countries across six regions of the WHO to assess the degree to which they included twenty quality indicators of effective PS. A quantitative descriptive analysis was used to explore the profile of PS according to independent variables.

Results The countries sampled represent 40% of countries in AFRO, 54.5% of EMRO, 45% of EURO, 46% of PAHO, 64% of SEARO, and 41% of WPRO. They also represent 39% of all HICs in the world, 39% of Upper-Middle, 54% of Lower-Middle, and 48% of LICs. No pattern in attention to PS quality indicators emerged by WHO region or country income levels.

As per the quality PS parameters, evidence of political will, stakeholder participation, use of scientific evidence/adoption of WHO recommendations were each found in over 80% of plans. Regarding the frequency of other parameters we found, description of a specific PS process (7%); explicit criteria for PS (36.5%); inclusion of publicity strategies (65%); mention of mechanisms for enforcing decisions, either for appealing decisions or implementing strategies to improve internal accountability and reduce corruption (20%); explicit reference to public values (15%); description of means for enhancing compliance with the decisions (5%).

**62:poster**

ADDRESSING PRIORITIZATION IN HEALTH CARE AMIDST A GLOBAL PANDEMIC

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Trade-offs abound in health care yet depending on where one stands relative to the stages of a pandemic, choice making may be more or less constrained. During the early stages of COVID-19 when there was much uncertainty, health care systems faced greater constraints and focused on the singular criterion of ‘flattening the curve’. As COVID-19 progressed and the first wave diminished (relatively speaking depending on the jurisdiction) more opportunities presented for making explicit choices between COVID and non-COVID patients. Then, as the second wave surged, again decision makers were more constrained even as more information and greater understanding developed. A similar pattern emerged in the third and fourth waves. Moving out of the pandemic to recovery, choice making becomes all the more paramount as there are no set rules to lean back into historical patterns of resource allocation. In fact, the opportunity at hand, when using explicit tools for priority setting based on economic and ethical principles, is significant. This paper focuses on how an explicit priority setting process can be applied both during a pandemic and in the aftermath as the pieces are being put back together. Differences in application relative to the given stage of the pandemic need to be understood so realistic expectations can be placed on those making the resource allocation decisions. In all cases, accountability must be upheld as a key objective even when timelines are seriously constrained and similarly explicit criteria must guide decision making in order to get the most in return for the limited resources available.

**63:oral**

HEALTH TECHNOLOGY ASSESSMENT AS PART OF A BROADER PROCESS FOR PRIORITY SETTING AND RESOURCE ALLOCATION

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Over the last two decades, economic evaluation of health technologies has developed enormously, affirming its importance within the pursuit of efficiency in the management of health care systems. One concern that has been raised with