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.

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/adoptions 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%).

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.