NORTHWEST HEALTHCARE RESPONSE NETWORK

Healthcare System Emergency Response Plan

Pediatric Surge Annex

Version 2, May 2026 – FINAL

Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Plan development and review by partner agencies	2020	Vicki L. Sakata, MD Josh Edrich, MPH
2.	Review and Update	2026	Vicki L. Sakata, MD

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Introduction: Overview and Background

Children (age<18 y/o) make up an estimated 25% of the U.S. population.[1] Within Washington State, based on 2024 US census estimates, there are approximately 1.7 million children, with nearly 430,000 under the age of 5.[1] Specific to the Northwest Healthcare Response Network (NWHRN), children make up 20-24% of the population of the 34 counties in our service area.[1]

In the event of a disaster or emergency, all hospitals, including those that are not necessarily pediatric trauma centers or specialized pediatric hospitals, may receive critically ill or injured patients. The unique needs of children make it necessary to identify and integrate thoughtful and special considerations into disaster preparedness, response, and recovery planning. Pediatric preparedness has historically been lacking[2,3] however, multiple studies have shown that with ongoing focused planning significant improvements in pediatric readiness and coordination can be attained.[4]

During a large-scale medical emergency (either a no-notice event such as an earthquake or prolonged event such as a pandemic), critically ill or injured children will present to any and all hospitals, which may be the hospital that is closest, most convenient or most familiar. A study done in King County, Washington showed this geographic disparity between where children live (and go to school) and the location of pediatric specialty hospitals. This study found that over 80% of pediatric subspecialty beds are in the Seattle King County central response zone, whereas 80% of the pediatric population live outside this zone.[5] In subsequent analysis this was found to be true in Pierce County as well, the second most populous county in the state. Nationally, this data continues to hold true which greatly underscores the need for all facilities to consider pediatric readiness.[6,7] This Annex provides planning and response guidance for all healthcare facilities in the NWHRN service area with special focus on non-pediatric facilities.

Pediatric planning has been a long-standing priority for NWHRN, with the first Pediatric Clinical Toolkit released in 2010 in King County. Since then through the continued dedication and work of many pediatric and non-pediatric providers, this surge annex and accompanying Pediatric Clinical Toolkit provides update guidance for the care of children during disasters throughout the state of Washington.

Purpose

The purpose of this Annex is twofold: 1) to provide healthcare with the information and tools they need to develop internal pediatric disaster response plans; and 2) to provide a concept of operations for a coordinated pediatric regional response in the NWHRN service area. The Annex describes the coordination of decision making, operations, communication and deactivation/recovery for pediatric disaster response.

Specifically, the purpose of the Annex is to:

1. Ensure that all in-patient hospital facilities will be prepared to care for pediatric patients and have disaster surge plans to accommodate pediatric surge.
2. Provide clinical resources (i.e. the NWHRN Pediatric Clinical Toolkit) especially for those not routinely caring for the pediatric patient.
3. Provide pediatric specific information needed to inform response coordination between healthcare and all stakeholders who are vital for a successful pediatric response, to include but not limited to: public health, prehospital agencies, Disaster Medical Coordinating Centers (DMCC), emergency management and any state and federal partners.
4. Provide pediatric specific information regarding patient tracking specifically addressing unique aspects pertaining to the care of pediatric patients: (i.e. unaccompanied minors, non-verbal, critically ill, etc.).
5. Define roles and responsibilities for healthcare, the NWHRN, LHJs, local response agencies, emergency management, state, and federal partners in pediatric preparedness and response.
6. Describe procedures for communication and coordination among public health, healthcare agencies and other local partners during a pediatric response.

Scope

This document is an appendix to the NWHRN's overall Healthcare Emergency Operations Base Plan. (See Appendix A) This Annex is intended to be used in conjunction with this and other planning documents and not as a stand-alone plan. The Pediatric Surge Annex is applicable for pediatric events necessitating local and/or regional healthcare response coordination among partners within jurisdictions encompassed by the NWHRN.

Planning Assumptions

All planning assumptions outlined in the NWHRN Healthcare Emergency Operations Base Plan apply to this Annex. Specific assumptions to this Pediatric Annex are as follows:

- All healthcare facilities will develop and maintain pediatric specific disaster plans.
- All healthcare facilities will maintain an updated list of their individual pediatric capabilities and resources to provide regional situational awareness in times of response.
- A child is defined in this Annex as any person less than 18 years of age.

Access and Functional Needs

This Annex acknowledges special pediatric populations to include pediatric group homes, palliative care, complex medical and medically fragile children. Please see Pediatric Clinical Toolkit (Appendix B) for details.

Concept of Operations

A. Activation of the Annex

- This Annex may be activated during any known or suspected scenario that warrants coordination between one or more healthcare organizations and other emergency response partners when the day-to-day resources and plans are insufficient to address the current or anticipated pediatric response needs. This activation may occur concurrently with the activation of other plans within and/or outside the area.
- A request for activation of this Annex may originate from any local healthcare organization, local and/or state Disaster Medical Coordination Center (DMCC), Local Health Jurisdictions (LHJ), emergency management agency, as well as the NWHRN Duty Officer and leadership.

B. Notification and Warning

Any partner organization can request NWHRN to activate prior to or during a disruptive event. Upon receiving a request to activate, the NWHRN leadership team and on-duty incident commander (IC) will activate the virtual Healthcare Emergency Coordination Center (HECC) and any internal positions necessary to respond to the disruptive event. Because NWHRN is a fully remote organization, internal positions activate and operate in a remote environment, responding in-person as necessary and as circumstances allow.

It is the responsibility of any healthcare partner who receives notification of and/or activation due to a pediatric surge event to notify NWHRN if coordination and assistance is needed.

NWHRN works with partner organizations through the varying organizational and reporting structures specific to their community. NWHRN reports to the organization leading patient movement, placement, tracking, and/or family reunification efforts for the disruptive event. Given NWHRN's role as an intermediary between the private and public sectors of Washington State healthcare, NWHRN urges partner organizations to follow the notification protocol of their local health jurisdiction. NWHRN will inform the appropriate Disaster Medical Coordination Center (DMCC) and appropriate partner organizations of NWHRN activation for patient movement, placement, tracking and/or family reunification events.

The Washington State Department of Health must be notified of healthcare evacuations given its role in healthcare facility licensing. In a long-term care (LTC) facility evacuation, the Washington State Department of Social and Health Services (DSHS) and/or DOH must be notified. Notification to these entities must be completed by the impacted facility(s) or NWHRN (by request)

C. Command, Control and Coordination

- An effective response to any disruptive event requires coordination, communication and awareness of each partner's role and responsibilities. Exact procedures will vary given the situation at hand, but when activated, the NWHRN Healthcare Emergency Coordination Center (HECC) supports and identifies needed action items and the operations needed to execute the needed mission. As mentioned above this annex is activated in conjunction with the NWHRN Healthcare Emergency Operations Base Plan to support response and coordination. Please refer to NWHRN Healthcare Emergency Operations Base Plan for details. (Appendix A)
- During a pediatric surge, the overarching goal is to ensure pediatric patients receive the best care possible given the situation at hand.
    - All healthcare facilities must maintain basic skills, equipment and training to emergently treat and stabilize a pediatric patient.
    - In the event of a large pediatric surge, especially those that may overwhelm pediatric specialty facilities, it is understood that the sickest and most complex pediatric patients should be cared for at facilities who maintain advanced pediatric care and pediatric subspecialty care. Less severely ill or injured pediatric patients should be placed in community or lower level pediatric care facilities. This approach is to help ensure the best care possible in the face of a pediatric surge.
- Essential Elements of Information (EEI): The use of situational awareness to inform a common operating picture for healthcare during an incident or event requires targeted and strategic data and information gathering from various organizations. Specific to a pediatric event this information may include, but not limited to:
    - Number and ages of ill or injured patients, triage categories, location and special clinical needs including specialty staff, space or supplies, family situational awareness, presence of unaccompanied minors for patient tracking purposes, etc.
    - For more information on EEI, see Appendix C, the NWHRN Situational Awareness Annex.

Roles and Responsibilities

Roles and responsibilities for all stakeholders to include healthcare, NWHRN, LHJs, local response agencies, emergency management, state, local, tribal and federal partners will be consistent with those outlined in the NWHRN Healthcare Emergency Operations Base Plan.

Specific Pediatric Roles and Responsibilities are as follows:

A. Primary Organizations

- Northwest Healthcare Response Network:
  - Maintain and update Coalition Pediatric Annex per Annex maintenance requirements listed below.
  - Fulfill roles and responsibilities as outlined in the NWHRN Healthcare Emergency Operations Base Plan.

- Local Health Jurisdictions (Public Health):
  - Acknowledgement and awareness of Coalition Pediatric Surge Annex.
  - Review internal protocols to identify and address any pediatric gaps. NWHRN is available to assist in closing those gaps.

- DMCC:
  - Where applicable, maintain and activate DMCC specific pediatric triage and distribution plans when needed.
  - Notify NWHRN when activated for a pediatric surge event by calling the 24/7 Duty Officer line at: 425-988-2897.
  - Supply EEI and situational awareness as needed to support coordinated response.
  - Acknowledgement and awareness of Coalition Pediatric Surge Annex.

- Emergency Management Agencies:
  - Acknowledgement and awareness of NWHRN Pediatric Annex.
  - Review internal protocols to identify and address any pediatric gaps. NWHRN is available to assist in closing those gaps.

- Hospitals:
  - Have and maintain a pediatric disaster plan which should include stabilization, consultation and transfer protocols for pediatric patients. This includes addressing pediatric patients in facility hospital evacuation, MCI and medical surge plans.
  - Ensure your pediatric patients and their families have a disaster plan, especially those patients with complex medical problems, specialty care requirements, medical durable equipment needs, etc.
  - Supply EEI and situational awareness as needed to support coordinated response.
  - When requested, update the Regional Pediatric Clinical Contact Information and the Regional Pediatric Surge Capacity Information (Appendix D and F).
  - Acknowledgement and awareness of NWHRN Pediatric Annex.

- Emergency Medical Services:
    - Have and maintain a pediatric disaster plan which should include stabilization, consultation and transfer protocols for pediatric patients.
    - Supply EEI and situational awareness as needed to support coordinated response.
    - Acknowledgement and awareness of NWHRN Pediatric Annex.

- Outpatient/Urgent Care:
    - Have and maintain a pediatric disaster plan which should include stabilization, consultation and transfer protocols for pediatric patients.
    - Ensure your pediatric patients and their families have a disaster plan, especially those patients with complex medical problems, specialty care requirements, medical durable equipment needs, etc.
    - Supply EEI and situational awareness as needed to support coordinated response.
    - Acknowledgement and awareness of NWHRN Pediatric Annex.

B. Supporting Organizations

- DOH
    - Maintain awareness of NWHRN Pediatric Annex.
    - Assist with resource requesting when possible given the situation at hand.
    - Request and coordinate federal assets as needed given the situation at hand.

- Federal
    - Coordinate with DOH when a response exceeds state resources.
    - Coordinate federal level resources, requests, and any national stockpiles of resources.
    - Military partners may support regional medical and non-medical response with resources, personnel, and coordination.

Logistics: Pediatric Resources

A. Pediatric Resource Requests

Requests for pediatric specific supplies will follow local resource request procedures either through the NWHRN and/or local jurisdiction as outlined in the NWHRN Healthcare Emergency Operations Base Plan. (See Appendix A)

B. Mitigation Strategies in Times of Scarce Resources

When an event overwhelms healthcare, resources may become scarce. Coordinated local, regional and statewide mitigation strategies are the key to maintaining patient care needs during times of scarce resources. Washington state adheres to the ethical principles of fairness, duty to care, duty to steward resources, transparency, consistency, proportionality and accountability as outlined by the National Academy of Medicine 2009 Letter Report. NWHRN maintains mitigation strategy resources and all pediatric specific protocols contained within these resources will be reviewed, updated and activated per plan. (See Appendix H)

C. Coalition Pediatric Capabilities

A list of in-patient pediatric capabilities is maintained in the Appendices listed below and updated per the "Authorities and Maintenance" section below. This information is critical for decision making in a large-scale pediatric event (e.g. evacuation of pediatric hospital) and should be kept in both hard copy and electronic versions.

Appendices D-F:

- Regional Pediatric Clinical Contact Information including Regional Group Homes for children with special needs (Appendix D)
- Summary WA State Pediatric Trauma Designations (Appendix E)
- Pediatric bed numbers and pediatric capabilities (Appendix F)

Special Considerations

A. Hospital Evacuation

a. It is understood that all facilities will maintain and exercise their own internal evacuation plans. This document does not replace the requirement for all healthcare facilities to have the following in place:
    - Internal Incident Command Systems (ICS) compliant with the National Incident Management System (NIMS)
    - Full building evacuation plans
    - Communication and coordination plans

b. Patients will be evacuated to equivalent level facilities when possible (e.g. PICU patients to PICU, NICU to equivalent NICU, etc.).

c. Each in-patient facility in NWHRN coalition service area with identified pediatric beds, should maintain and communicate with partners preferred evacuation destinations given geographic proximity, provider availability and potential transfer challenges (i.e. infrastructure damage).

B. Pediatric MCI

a. Pediatric Trauma Center Designations in WA State

For details on trauma designation definitions please refer to WAC 246-976-700

Level	Facility	Location
I	Harborview Medical Center	Seattle
II	Providence Sacred Heart	Spokane
II	Mary Bridge Children's Hospital	Tacoma
III	MultiCare Yakima Memorial	Yakima
III	Kadlec Regional Medical Center	Richland
III	Confluence Health	Wenatchee
III	Providence Everett	Everett

b. In the event of a large MCI, general regional and coalition MCI medical surge plans should be activated. As mentioned above, all DMCC's are responsible for maintaining pediatric triage and distribution plans to be activated when needed and as appropriate given their jurisdiction.
c. Pediatric Burn patients: WA state has only 1 designated Burn Center. All facilities need to be capable of treating and stabilizing pediatric burn patients. Please see NWHRN Burn Surge Annex for details regarding burn surge event.
d. In any MCI event pediatric patients should be triaged and prioritized by established pediatric MCI triage algorithms to include JumpSTART or SALT. Please see Pediatric Clinical Toolkit, Appendix B, for details.

C. Children with Special Needs

Children with special health care needs are defined by the Federal Maternal and Child Health Bureau, as those who have, or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

According to the 2023-2024 National Survey of Children's Health, produced by the Data Resource Center for Child and Adolescent Health, 22.8% of children under the age of 18 in the WA state have special healthcare needs. (footnote) It is vitally important that families of these children maintain disaster plans and emergency kits which address and accommodate their child's needs. See Pediatric Toolkit for family resources.

There are several pediatric group homes within the NWHRN coalition service area that care for high risk vulnerable pediatric populations. These patients require 24/7 care, are

primarily non-mobile and non-verbal. They depend on durable medical equipment and are vulnerable to infrastructure damage (i.e. loss of power, transportation, etc.). It is important for these institutions to maintain and exercise their internal disaster plans and remain connected with regional response planning. Appendix D contains a list of these locations and numbers of licensed beds.

General Pediatric Medical Care

Caring for children requires continued training especially for those who do not routinely care for children. Planning for children can be a daunting task. Therefore, Appendix B, the Planning and Caring for Pediatric and Neonatal Patients in Disasters: Inpatient and Outpatient Guidelines, 2025 (also known as the Pediatric Clinical Toolkit) is provided with step by step instructions on how to prepare and care for children during a disaster.

This clinical toolkit supplies information on pediatric triage, treatment, pharmacy, equipment, decontamination, security, behavioral health, infection control and neonatal preparedness and resuscitation, along with links to Just-In-Time training for basic pediatric skills.

Patient Tracking

Pediatric patients will be tracked to their final hospital destination per NWHRN Patient Tracking Appendix. (See Appendix G).

Transportation

Pediatric transport at times requires specific equipment and always requires appropriately trained staff. All healthcare facilities should have in place proper procedures to transport pediatric patients safely to the appropriate facility.

In a large event when a regional and/or state DMCC(s) has been activated, transport control will follow established procedures as outlined in the NWHRN Patient Movement Plan (Appendix I). Incident Command on scene will communicate with the appropriate DMCC to coordinate vehicle and destination.

There are several facilities within NWHRN coalition that maintain their own hospital pediatric transport vehicles. These are listed in Appendix F.

It is understood that there are limited EMS vehicles with pediatric capabilities. Therefore, it may be necessary to transport pediatric patients with staff from the referral institution to provide safe transport. Alternate means of transportation such as transit buses, facility shuttles and vans, “cabulances”, private vehicles etc. should also be considered and equipped with appropriate safety measures and staff when transporting children.

Reunification

Every healthcare facility will maintain internal procedures for family reunification. Planning for a Pediatric Safe Area (PSA) is key to pediatric security and pediatric tracking during response. Procedures for establishing a PSA are outlined in the Pediatric Clinical Toolkit. (See Appendix B)

If the event requires resources beyond what individual healthcare facilities can provide, then local, regional and/or federal Family Assistance Center plans can be activated and family reunification will follow designated procedures.

A. Cultural/Religious/non-English speaking Considerations

It is important to consider language barriers and varying cultural traditions that may affect how patients and their families respond in a disaster situation. This is especially true with children as their cognitive ability at certain ages may lead them to misinterpret what is happening to them and their families. Please see the Pediatric Clinical Toolkit (Appendix B) for more in-depth information and resources to address these important issues.

B. Unaccompanied Minor

If a child is discovered as having been separated from his or her parents, legal guardians, or other relatives and is not being cared for by an adult who by law or custom is responsible for doing so, that child is considered to be an unaccompanied minor[8]. Registration of these children (including documentation of identifying demographic and other data for unaccompanied children) into appropriate systems and tracking of those patients until they can be released to their custodial caregivers are essential elements that are needed to assure the timely and safe reunification of children with their families.

If these children are injured, medical treatment is a priority. However, simultaneously they need to be identified and tracked throughout their medical treatment. For those who are uninjured and unaccompanied plans for a Pediatric Safe Area need to be established and implemented during response. See Appendix B, Section 3 of the Pediatric Clinical Toolkit for details, forms and Job Action Sheets.

Demobilization and Recovery

A. Demobilization Indicators

Throughout the Annex activation, the HECC, in consultation with applicable partners, will determine the appropriate conditions to partially or fully demobilize and deactivate the Annex. Demobilization indicators may include:

- The pediatric healthcare impact from the incident is at a low level sufficient for ending response coordination.
- Partner agencies have deactivated any EOC/ECC and/or emergency response plans.

- The threat of a reoccurrence of the pediatric incident or similar events is sufficiently low to not require response coordination.

B. Demobilization Communications

The HECC, in consultation with any applicable partners, will communicate deactivation of the Annex to the same partners that received the activation notice. Annex deactivation will likely be communicated by, at a minimum, email or WATrac alerting tools.

Depending on the severity or scope of the incident, the NWHRN will lead and/or participate in an after-action process. If the NWHRN leads an after-action process, results will be communicated and distributed to partners following completion of the after-action report.

C. Recovery

After demobilization and during recovery the following activities should be completed:

- Return of any borrowed assets (e.g. equipment, staff).
- Debrief participating local, regional, and/or state partners with after action reports, discuss improvement plans, and create a coordinated approach to incorporating recommendations into future planning.
- Communications concerning payment and reimbursement for the response.
- Communication of any operational activities that need to be revised or continued.

Training and Exercise

Training on roles and responsibilities for all relevant partner agencies will occur following the adoption of the finalized Pediatric Surge Annex. The NWHRN assesses yearly the training and exercise needs of all coalition partners using a capabilities assessment, which informs the goals and objectives for training and exercising in the years to come.

Exercises of portions of this annex or attachments, including tabletops and functional will occur with healthcare organization, LHJs, and other relevant stakeholders. All trainings and exercises will involve post-event evaluations and/or After-Action Reports (See Appendix J) which will include Improvement Plans addressing Core Capabilities.

Authorities and Maintenance

A. Review Process and Annex Update

Sections of this Annex will be updated as needed based on the evolution of planning activities and partnerships or in coordination with Regional Improvement Plans after exercises or real-world incidents.

The Annex will be provided to the LHJs, healthcare organizations, and regional partners for review and input.

Following review, modifications will be made, and a copy will be provided to all regional partners. Healthcare organizations are expected to share the updated plan internally within their appropriate committees and with their leadership.

The NWHRN Board of Directors will be briefed when updates to this Annex are completed.

B. Maintenance

The Annex will be reviewed every three years or as needed following the process outlined above.

Appendices

A. NWHRN Healthcare Emergency Operations Base Plan
B. Planning and Caring for Pediatric and Neonatal Patients in Disasters: Outpatient and Inpatient Guidelines (Pediatric Toolkit)
C. NWHRN Situational Awareness Annex
D. Regional Pediatric Clinical Contact Information
E. WA State Pediatric Trauma Designations
F. Regional Pediatric Surge Capacity Information
G. NWHRN Patient Tracking Appendix
H. Scarce Resource Management and Crisis Standards of Care Overview and Materials
I. NWHRN Patient Movement Plan
J. After-Action Report Templates

Definitions & Acronyms

Definitions

Northwest Healthcare Response Network (NWHRN) – Is a regional Healthcare Coalition that leads a regional effort to build a disaster-resilient healthcare system through collaboration with healthcare providers, public health agencies and the community partners they depend on. NWHRN works to keep hospitals and other healthcare facilities open and operating during and after disasters, enabling them to continue serving the community.

Healthcare Emergency Coordination Center (HECC) – In the event of an emergency the NWHRN will activate the Healthcare Emergency Coordination Center (HECC) to facilitate situational awareness, resource matching, communications, and coordination among regional healthcare providers and partner agencies.

Acronyms

CDC – Center for Disease Control and Prevention
CSC – Crisis Standards of Care
DMCC – Disaster Medical Coordination Center
EMS – Emergency Medical Services
EOC/ECC – Emergency Operations/Coordination Center
ESF-8 – Emergency Support Function #8
HECC – Healthcare Emergency Coordination Center
JIS – Joint Information System
LHJ – Local Health Jurisdiction
LHO – Local Health Officer
MAC – Multi-agency Coordination
MAP – Mutual Aid Plan
MCI – Mass Casualty Incident
NIMS – National Incident Management System
NWHRN – Northwest Healthcare Response Network
OSHA – Occupational Safety and Health Administration
PIO – Public Information Officer
PSA – Pediatric Safe Area
WAC – Washington Administrative Code
WA State DOH – Washington State Department of Health

ENDNOTES

[1]U.S. Census Bureau. (2019, July 1). QuickFacts: Washington Population Estimates. Census Bureau QuickFacts. https://www.census.gov/quickfacts/fact/table/WA/PST045219;

[2]Institute of Medicine. 2007. Emergency Care for Children: Growing Pains. Washington, DC: The National Academies Press. https://doi.org/10.17226/11655.

[3]Disaster Preparedness Advisory Council and Committee on Pediatric Emergency Medicine. (2015, October 13). Ensuring the Health of Children in Disasters. American Academy of Pediatrics. https://pediatrics.aappublications.org/content/early/2015/10/13/peds.2015-3112

[4]Katherine E. Remick, Ashley A. Foster, Aaron R. Jensen, Regan F. Williams, Elizabeth Stone, Madeline Joseph, Gregory P. Conners, Kathleen Brown, Marianne Gausche-Hill, AMERICAN ACADEMY OF PEDIATRICS, Committee on Pediatric Emergency Medicine, Section on Surgery, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION, Pediatric Committee, AMERICAN COLLEGE OF SURGEONS, Committee on Trauma; Pediatric Readiness in the Emergency Department: Technical Report. Pediatrics February 2026; 157 (2): e2025075319. 10.1542/peds.2025-075319

[5]King MA, Koelemay K, Zimmerman J, Rubinson L. Geographical maldistribution of pediatric medical resources in Seattle-King County. Prehosp Disaster Med. 2010;25(4):326-332. doi:10.1017/s1049023x00008281

[6]Mayer ML. Disparities in geographic access to pediatric subspecialty care. Matern Child Health J. 2008 Sep;12(5):624-32. doi: 10.1007/s10995-007-0275-3. Epub 2007 Sep 19. PMID: 17879148.

[7]Hantman RM, Zgodic A, Flory K, McLain AC, Bradshaw J, Eberth JM. Geographic Disparities in Availability of General and Specialized Pediatricians in the United States and Prevalence of Childhood Neurodevelopmental Disorders. J Pediatr. 2024 Dec;275:114188. doi: 10.1016/j.jpeds.2024.114188. Epub 2024 Jul 14. PMID: 39004171; PMCID: PMC11560715.

[8]For definitions of “separated” vs “unaccompanied” minor see Annex E , Post-Disaster Reunification of Children: A Nationwide Approach, November, 2013.