and Web of Science. In addition to peer-reviewed sources, grey literature was manually retrieved from reports, policy documents, and digital resources of relevant international organizations responding to or researching conflict situations. Eligible studies had to: (i) be available in English, French, Italian, or Spanish; (ii) address armed conflicts' impact on COC and CAC; (iii) focus on conflict-affected populations regardless of demographics; and (iv) be published between 01.01.2010 and 31.07.2024.

Results: The ongoing data extraction process aims to capture the study details, while the specific COC/CAC aspects affected by armed conflicts are being deductively categorized using the World Health Organization's "Continuity of Care and Coordination of Care frameworks". Emerging themes will be identified inductively to refine relevant concepts. Data will be synthesized based on the extraction form and thematic analysis.

Conclusion: This systematic review aims to provide evidence-based recommendations on mitigating the destructive impact of armed conflicts on COC and CAC and supporting health service delivery during active wars and military confrontations.

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Lessons Learned from a Multi-Hospital Pediatric Disaster Full-Scale Surge Exercise

Arthur Cooper MD, John Jermyn MS, NREMT, George Foltin MD, Matthew Harris MD
New York City Pediatric Disaster Coalition, United States

Introduction: Children are frequently victims of disasters. However, gaps remain in pediatric disaster preparedness. The New York City Pediatric Disaster Coalition (NYCPDC) is funded by the NYC Department of Health and Mental Hygiene (DOHMH) to prepare NYC for mass casualty events that involve large numbers of children. On May 23, 2024, the NYC PDC conducted a pediatric disaster full-scale exercise testing surge, communications, and secondary transport. Participants included three NYC pediatric hospitals and the NYC Pediatric Intensivist Response Team (PIRT).

Methods: The full-scale exercise was prospectively designed with specific goals: to test and improve communications with staff and city agencies; to test and improve hospitals' pediatric surge capacity plans and response; to identify space, staffing, and equipment needs for pediatric disaster; and for hospitals to identify and triage patients requiring secondary transport to another facility.

In collaboration with the DOHMH, PDC designed a Master Scenario Events List (MSEL) along with other tools to measure strengths and weaknesses to be identified at each institution at a system level. PDC created an exercise evaluation guide to assess: Communications, Emergency Operation Plans, Surge, Patient Tracking, Patient Transfer, Supplies, and Staffing, utilizing a performance rating scale from 1-4 and qualitative reporting.

Results: This information was used to report lessons learned and challenges to the participants and DOHMH in an after-action report. An after-action report was written based on information from evaluation guides, site-specific and group hot-washes, and an after-action meeting.

Conclusion: This presentation will highlight the strengths, challenges, and lessons learned from the exercise. Conducting a multi-hospital pediatric disaster full-scale surge exercise produced lessons learned to address exercise gaps that can improve surge capabilities during future exercises and real-time events.

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Emergency Care Capacity Assessment in Conflict-Affected Southeastern Myanmar: A Pilot Study

Zaw Soe Htike MBBS[1], Derek Lubetkin MD[2,3], Giovanna DeLuca MD[4], Saw Thar Win[5], Htoo Nyi Nyi MBBS[6], Siraj Amanullah MD[4]
1. Mae Tao Clinic, Thailand
2. MaineHealth, United States
3. Coastal Maine Global Health Fellowship, United States
4. Brown University, United States
5. Ethnic Health Systems Strengthening Group, Myanmar
6. Civil Health and Development Network, Myanmar

Introduction: Following the 2021 military coup in Myanmar, widespread conflict and displacement have severely strained healthcare systems along the Myanmar-Thailand border. This pilot study assessed emergency care capacity in the southern Shan and Karenni States, located in the southeastern region of Myanmar.

Methods: Interviews were conducted utilizing a modified WHO hospital unit emergency assessment tool across seven healthcare facilities. Cluster analysis methods were used on the data to identify naturally occurring groups across a set of variables provided to investigate healthcare infrastructure. Upon examination of the dendrogram and utilizing Ward's algorithm, the data from the four clinics were grouped, while the three secondary hospitals were evaluated individually. Descriptive statistics were examined to understand the similarities and differences between locations.

Results: Four clinics and three hospitals were evaluated, and 162 facility characteristics were obtained. All facilities were found to provide basic emergency care services and have at least one emergent bed available, while only one hospital has a 24-hour emergency care unit. Strengths across facilities studied include management of acute respiratory distress, intravenous fluid administration, and burn management. Critical gaps across facilities include an absence of a dedicated triage area and a lack of formalized protocols, quality improvement measures, and reliable access to water and electricity.

Conclusion: This pilot study reveals strengths and gaps in emergency healthcare infrastructure within the southern Shan and Karenni States. These findings underscore the need for targeted interventions to strengthen emergency care capacity in this conflict-affected region, focusing on infrastructure, protocol development, and resource availability.

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