

**ATP 4-02.42**

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# **ARMY HEALTH SYSTEM SUPPORT TO STABILITY AND DEFENSE SUPPORT OF CIVIL AUTHORITIES TASKS**

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**June 2014**

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**Headquarters, Department of the Army**

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# Army Health System Support to Stability and Defense Support of Civil Authorities Tasks

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**\*This publication supersedes FM 8-42, dated 27 October 1997.**

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## Preface

This ATP establishes Army Health System (AHS) support doctrine and provides the guiding principles for the provision of medical support to stability and defense support of civil authorities (DSCA) tasks.

The principal audience for this publication is commanders, their staffs, medical planners, and personnel at all levels. Commanders, staffs, and subordinates ensure their decisions and actions comply with applicable United States (U.S.), international, and in some cases, host-nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of war and the rules of engagement. (See FM 27-10.)

This manual is a guide for providing AHS support to stability and DSCA tasks in an area of operations. This publication applies to the Active Army, Army National Guard/Army National Guard of the United States, and the United States Army Reserve, unless otherwise stated.

This publication implements or is in consonance with American, British, Canadian, Australian, and New Zealand (Armies) Standard 815, Blood Supply in the Area of Operations; Quadripartite Advisory Publication 256, Coalition Health Interoperability Handbook; and the following North Atlantic Treaty Organization Standardization Agreements:

| TITLE                                                                                                        | NUMBER |
|--------------------------------------------------------------------------------------------------------------|--------|
| Medical Employment of Air Transport in the Forward Area                                                      | 2087   |
| Allied Joint Medical Support Doctrine—Allied Joint Publication-4.10(A)                                       | 2228   |
| Training Requirements for Health Care Personnel in International Missions—<br>Allied Medical Publication-8.3 | 2249   |
| Allied Joint Doctrine for Civil-Military Cooperation—Allied Joint Publication-3.4.9                          | 2509   |
| Allied Joint Doctrine for Non-Combatant Evacuation Operations—Allied Joint<br>Publication-3.4.2              | 2514   |
| Allied Joint Medical Planning Doctrine—Allied Joint Medical Publication-1                                    | 2542   |
| Allied Joint Civil-Military Medical Interface Doctrine—Allied Joint Medical<br>Publication-6                 | 2563   |

Army Techniques Publication 4-02.42 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the text and the glossary. This publication is not the proponent for any Army terms. Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

The proponent of this publication is the U.S. Army Medical Department Center and School. The preparing agency is the Doctrine Literature Division, U.S. Army Medical Department Center and School. Send comments and recommendations on a DA Form 2028 (Recommended Changes to Publications and Blank Forms) to **Commander, U.S. Army Medical Department Center and School, ATTN: MCCS-FC-DL (ATP 4-02.42), 2377 Greeley Road, Suite D, Building 4011, JBSA Fort Sam Houston, Texas 78234-7731**; by e-mail to [usarmy.jbsa.medcom-ameddcs.mbx.ameddcs-medical-doctrine@mail.mil](mailto:usarmy.jbsa.medcom-ameddcs.mbx.ameddcs-medical-doctrine@mail.mil); or submit an electronic DA Form 2028. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale should be provided for all recommended changes to aid in the evaluation and adjudication of each comment.

# Introduction

Army Techniques Publication 4-02.42 examines the various situations in which Army medical personnel may be required to provide support for stability and DSCA tasks. While the Department of Defense (DOD) is not a provider of first resort in disasters, requests for support from U.S. forces may be required when military-unique capabilities (such as lift capability, engineering, or deployable medical support) exist that can expedite relief efforts during urgent, life-threatening situations.

This manual is a two-part publication. Part one of the ATP discusses AHS support to stability tasks and part two covers medical support to DSCA tasks. A summary of significant changes include—

- Adjustments in the stability discussion based on current doctrinal and terminology changes to include the change from stability and support operations to stability and DSCA tasks.
- The addition of the essential stability tasks.
- Building partner capacity as a stability principle and the medical capacity building activities that may be employed in support of this principle.
- Part two of the manual, which provides a separate discussion of AHS support to DSCA tasks, the National Response Framework (NRF), National Disaster Recovery Framework, and the DOD's role in the National Disaster Medical System (NDMS).

Army Techniques Publication 4-02.42 consists of seven chapters—

- Chapter 1 provides an overview of stability in operations, the primary stability tasks, national and DOD-level guidance, and the importance of ensuring that AHS support to stability tasks is regionally focused and conducted in consonance with the combatant commander's theater engagement strategy.
- Chapter 2 discusses the Department of State's Post-Conflict Reconstruction Essential Tasks matrix as it relates to the Army primary stability tasks. The chapter also provides the doctrinal description for three of the five Army stability tasks, medical aspects of the supporting initial and transformational response tasks, and corresponding health service support (HSS) and force health protection (FHP) considerations for each task.
- Chapter 3 discusses the employment of AHS assets in support of the primary stability tasks, the medical aspects of building partner capacity, the role of civil affairs, legal considerations, and AHS support to operations with a stability focus.
- Chapter 4 provides medical planning considerations for AHS support to joint operations and stability tasks to include transition and end state considerations.
- Chapter 5 provides a brief overview of the primary DSCA tasks, national and DOD-level guidance. This chapter also provides a brief description of medical aspects of the NRF, National Disaster Recovery Framework, and the NDMS.
- Chapter 6 provides legal considerations that may apply when providing medical support to DSCA tasks and a discussion of the support provided for each of the 10 medical functions.
- Chapter 7 describes the interorganizational and interagency coordination required in support of DSCA tasks, the process for requesting DOD assistance for support to civil authorities, some of the NDMS medical resources that may be employed during a disaster, as well as some of the participating organizations that may be involved in the relief effort.

## PART ONE

# Army Health System Support to Stability

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## Chapter 1

### Stability Overview

Stability tasks are conducted as part of operations outside the U.S. in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief. This chapter discusses the primary stability tasks, national- and DOD-level guidance, and the importance of ensuring that AHS support to stability tasks is regionally focused and conducted in consonance with the combatant commander's theater engagement strategy.

## SECTION I — STABILITY IN OPERATIONS

### STABILITY PRINCIPLES

1-1. Operations with a stability focus employ U.S. military capabilities to assist other U.S. government agencies, nongovernmental organizations, foreign governments, and international government organizations in planning and execution of disaster relief, reconstruction, and stabilization efforts in support of affected nations. Stability tasks are an important part of unified land operations and occur simultaneously, with combinations of offensive and defensive tasks. The focus of stability tasks is to identify, target, and mitigate the underlying causes of instability and set the conditions for long-term development by building the capacity of local institutions.

1-2. When conducting stability tasks, U.S. forces work to achieve the military end state not by any single means applied in isolation, but through the integrated, collective activities of all instruments of national and international power. The conditions that describe the desired end state are—

- A safe and secure environment.
- Established rule of law.
- Social well-being.
- Stable governance.
- Sustainable economy.

1-3. The stability principles are the basis for the Army's primary stability tasks and lay the foundation for building the long-term capacity of local institutions. The Army's stability principles are—conflict transformation, unity of effort, legitimacy and host-nation ownership, and building partner capacity.

## **PRIMARY STABILITY TASKS**

1-4. The joint stability functions are security, humanitarian assistance, economic stabilization and infrastructure, rule of law, and governance/participation. The joint stability functions mirror the five Department of State stability sectors, which are security, humanitarian assistance and social well-being, economic stabilization and infrastructure, justice and reconciliation, and governance and participation. The Army's primary stability tasks are—

- Establish civil security.
- Establish civil control.
- Restore essential services.
- Support to governance.
- Support to economic and infrastructure development.

1-5. The primary stability tasks (including the subordinate tasks for each area) are not performed in isolation, but are used as lines of effort to integrate with offensive and defensive tasks. Stability tasks are performed in various operational environments to include—

- Supporting a partner nation during military engagements in peacetime.
- Providing assistance after a natural or man-made disaster as part of a humanitarian-based limited intervention.
- Conducting peace operations to enforce international peace agreements.
- Supporting a legitimate host-nation government during irregular warfare.
- Establishing conditions during major combat operations that facilitate post-conflict activities.
- Conducting operations in a post-conflict environment following the general cessation of organized hostilities.

1-6. There are various types of joint operations conducted across the range of military operations including peacekeeping, noncombatant evacuation operations, foreign humanitarian assistance, and others. Varying types and levels of medical resources are required to support the stability tasks and ensure mission success. See Chapters 2, 3, and 4 of this manual for a discussion of each type of operation and the corresponding medical support required.

## **SECTION II — LEAD FEDERAL AGENCY**

### **DEPARTMENT OF STATE**

1-7. Within the U.S. government, the Department of State is the lead agency responsible for diplomatic initiatives and oversees program support for stabilization. The Department of State leads the whole of government approach to stabilization, which encompasses the efforts of numerous U.S. government departments and agencies, including the DOD components. To that end, the Department of State has developed the Post-Conflict Reconstruction Essential Tasks matrix, which is a detailed interagency document used by planners to identify specific requirements to support conflict transformation. The joint stability functions and Army primary stability tasks are derivatives of the stability sectors and the Department of State Post-Conflict Reconstruction Essential Tasks matrix.

### **UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT**

1-8. The Administrator of the U.S. Agency for International Development (USAID) serves as the Director of Foreign Assistance for the Department of State and the lead federal agency responsible for U.S. government foreign humanitarian assistance and interagency coordination. The USAID's Bureau for Democracy, Conflict, and Humanitarian Assistance contributes to this effort by bringing together a wide range of technical expertise and global operational capabilities essential to crisis prevention, response, recovery, and transition. The Bureau for Democracy, Conflict, and Humanitarian Assistance has nine offices, including the Office of Foreign Disaster Assistance and the Office of Civil-Military Cooperation.

1-9. The USAID's Office of Foreign Disaster Assistance is the U.S. government's lead for facilitating and coordinating assistance in response to both natural disasters and complex emergencies overseas. The Office of Foreign Disaster Assistance is responsible for coordinating and validating all requirements for DOD support to foreign humanitarian assistance or disaster relief before requests for assistance are submitted, even when the Department of State or USAID are not the originators of the specific request. The Office of Foreign Disaster Assistance Military Liaison Unit coordinates with the DOD prior to, during, and after disasters. Military Liaison Unit advisors are permanently based at the following DOD combatant commands:

- United States Africa Command.
- United States European Command.
- United States Central Command.
- United States Pacific Command.
- United States Southern Command.

1-10. The Office of Foreign Disaster Assistance Military Liaison Unit advisor based at U.S. Southern Command also provides coverage for U.S. Northern Command. See the USAID Field Operations Guide for Disaster Assessment and Response for additional information on military operations involving coordination with the Office of Foreign Disaster Assistance.

1-11. The Office of Civil-Military Cooperation is USAID's primary point of contact with the DOD. The Office of Civil-Military Cooperation provides the focal point for USAID interaction with U.S. and foreign militaries in formalized relationships through coordinated policy, planning, training, education, and outreach. Areas of interaction include foreign humanitarian assistance, disaster management countering violent extremism, security sector reform, conflict prevention and mitigation, counter insurgency, and post-conflict stabilization and reconstruction. The Office of Civil-Military Cooperation performs a number of functions to include the following—

- Coordinate and monitor USAID participation in military and interagency exercises.
- Provide a central coordination point of contact for pre- through post-conflict planning and operations between the USAID, DOD, and the Department of State.
- Provide coordination with non-U.S. military organizations (such as foreign nationals, United Nations [UN], North Atlantic Treaty Organization, and others), where appropriate.
- Provide pre-deployment training to U.S. military personnel participating with USAID in conflict zones, and to USAID personnel deploying to hostile environments.
- Facilitate interagency operations.
- Serve as coordinator and point of contact between nongovernmental organizations, USAID, and the military at the operational level.
- Facilitate joint DOD and USAID theater security cooperation planning and communication with the various combatant commands through the exchange of liaison officers and senior development advisors.

## MILITARY SUPPORT TO STABILIZATION

1-12. The U.S. military's primary contribution to stabilization is to protect and defend the population, which facilitates the personal security of the people and creates a platform for political, economic, and human security. Stability tasks are usually conducted to support a host-nation government or a transitional civil or military authority when no legitimate, functioning host-nation government exists. While the DOD is not a provider of first resort in disasters, requests for support from U.S. forces may be required when military-unique capabilities (such as lift capability, engineering, or deployable medical support) exist that can expedite relief efforts during urgent, life-threatening situations. Generally, military forces assist in establishing or restoring basic civil functions and protect them until a civil authority or the host nation is capable of providing these services for the local populace. They perform specific functions as part of a broader response effort, supporting the complementary activities of other agencies, organizations, and the private sector. When the host nation or other responsible agencies cannot fulfill their role, military forces may be called upon to significantly increase its role, including providing the basic civil functions of government.

1-13. Stabilization is a whole of government effort, with diplomacy, development, and defense considerations. The whole of government approach integrates the collaborative efforts of the departments and agencies of the U.S. government to work in partnership toward a shared goal. Unless the security environment supports the use of civilian agencies and organizations, U.S. military forces must be prepared to perform nonmilitary tasks that are normally the responsibility of others. The organizational structure, readiness, and wide range of capabilities (such as medical, engineering, and logistics) available within the force makes the U.S. Army uniquely suited to provide the necessary support in both permissive and nonpermissive environments. In some instances, Army units may initially operate without significant interagency involvement and transition operations to other elements of the U.S. government as conditions become more stable. In other cases, the efforts of Army units integrate with those of interagency partners from the outset.

1-14. Army Health System support to stability in operations is discussed in detail in subsequent chapters within this manual. See ADP 3-07, ADRP 3-07, and FM 3-07 for additional information on stability in operations.

## **SECTION III — NATIONAL STRATEGY AND DEFENSE POLICIES**

### **NATIONAL STRATEGY**

1-15. The focus of U.S. national strategy is to promote freedom, justice, and human dignity while working to end tyranny, to promote effective democracies, and extend prosperity through free trade and wise development policies. The U.S. national strategy also seeks to confront challenges within the strategic environment by leading a growing community of nations to defeat the threats of pandemic disease, the proliferation of weapons of mass destruction, terrorism, international crime, human trafficking, and natural disasters. The goal of U.S. national strategy is to make the world a safer, better place, where a community of nations live in relative peace by promoting political and economic freedom, peaceful relations within other nations, and universal respect for human dignity. The body of security strategy that shapes the conduct of stability tasks include the—

- National Security Strategy.
- National Defense Strategy.
- National Military Strategy.

1-16. A common thread throughout the strategy documents is interagency coordination and integration of efforts in support of stability tasks. Together with national policy, strategy provides the direction necessary to conduct operations in support of U.S. national interests.

### **POLICY DOCUMENTS**

1-17. Consistent with the national strategy, U.S. policy focuses on achieving unity of effort or cooperation through an integrated or whole of government approach to intervention. Integrating the planning efforts of all the agencies and organizations involved in the conduct of stability tasks is essential to long-term peace and stabilization.

### **NATIONAL SECURITY PRESIDENTIAL DIRECTIVE 44**

1-18. National Security Presidential Directive 44 outlines the President's vision for promoting the security of the U.S. through improved coordination, planning, and implementation of reconstruction and stabilization activities. The directive also assigns the Department of State as the lead agency responsible for overseas support to stability tasks and requires the Secretaries of State and Defense to coordinate and synchronize civilian and military efforts to ensure integrated planning. Stability tasks require the involvement of all U.S. departments and agencies with relevant capabilities to prepare, plan for, and conduct reconstruction and stabilization activities. These activities depend on the conditions of the operational environment and may occur with or without U.S. military engagement. This directive instructs U.S. government agencies to work with international partners on early warning systems, planning, conflict prevention, and conflict response. The Department of State's Office of the Coordinator for Reconstruction

and Stabilization is responsible for implementing the requirements of National Security Presidential Directive 44.

### **DEPARTMENT OF DEFENSE DIRECTIVE 5100.46**

1-19. Department of Defense Directive (DODD) 5100.46 defines DOD support for foreign disaster relief. The DODD defines foreign disaster relief as prompt aid that can be used to alleviate the suffering of foreign disaster victims. The directive also establishes policy guidance for foreign disaster relief operations.

1-20. Per DODD 5100.46, the DOD components will participate in foreign disaster relief operations upon request by the Department of State only after a determination is made that foreign disaster relief shall be provided. This directive does not prevent a military commander at the immediate scene of a foreign disaster from conducting prompt relief operations (upon request of host-nation authorities or the chief of mission) when time is of the essence and when, in the estimate of the commander, humanitarian considerations make it advisable to do so.

### **DEPARTMENT OF DEFENSE INSTRUCTION 3000.05**

1-21. The importance of stability tasks in achieving U.S. national goals and objectives is also discussed in DOD Instruction (DODI) 3000.05. The issuance of DODI 3000.05 updated DOD stability policy and assigned responsibility for the identification and development of U.S. military capabilities to support stability tasks. This instruction establishes stability tasks as a core military mission equivalent to combat or offensive and defensive tasks. The DODI outlines policy and assigns responsibility for planning, preparing for, and executing stability tasks. It is part of the broader U.S. government and international effort to establish or maintain order in states and regions while supporting national interests. The DODI lists restoring or providing essential services, repairing critical infrastructure, and providing humanitarian assistance as three of four primary tasks when conducting operations in support of stability. Medical capacity building or health system development would be a major part of those efforts. The DODI directs the—

- Development and maintenance of scalable capabilities and capacities to establish civil security and civil control, restore essential services, repair critical infrastructure, and provide humanitarian relief across the range of military activities.
- Preparation of DOD medical personnel and capabilities to meet military and civilian health requirements during operations with a stability focus.
- Development of policies and plans to maintain the strategic relevance of DOD language and regional proficiency capabilities.

1-22. Medical support and medical capacity building are major contributors to the successful execution of the primary stability tasks, and in some cases may be the primary tools used in shaping the environment, as military medical assistance is often more readily accepted by the affected nation.

### **DEPARTMENT OF DEFENSE INSTRUCTION 6000.16**

1-23. Department of Defense Instruction 6000.16 defines medical support to stability tasks as a core U.S. military mission that the DOD Military Health System must be prepared to conduct throughout all phases of conflict and across the range of military operations, including in combat and noncombat environments. The DODI directs that medical stability tasks receive priority comparable to combat operations and be explicitly addressed and integrated across all Military Health System activities (including doctrine, organization, training, materiel, leadership and education, personnel, facilities, and policy).

1-24. The Military Health System must be prepared to perform tasks assigned to establish, reconstitute, and maintain health sector capacity and capability for the indigenous population when host-nation, foreign, or U.S. civilian professionals cannot do so. The Military Health System must also be prepared to work closely with relevant U.S. government departments and agencies, foreign governments and security forces, global and regional international organizations, U.S. and foreign nongovernmental organizations (to include private sector individuals and for-profit companies). The DODI prohibits U.S. military medical

personnel from practicing outside their scope of privileges and their profession's scope of practice. The DODI also directs the—

- Safeguard (to the fullest extent possible) of personally identifiable information collected and used in support of medical stability tasks.
- Use of funding available for the conduct of medical support to stability tasks.

## **SECTION IV — REGIONAL FOCUS**

1-25. The ultimate goal of operations with a stability focus is to leave a society at peace with itself and its regional neighbors and sustainable by the host nation without external support. Theater Army and other Army units identified to support a combatant command are aligned to focus unit exercises and other training on a specific region.

## **THEATER ENGAGEMENT STRATEGY**

1-26. When conducting stability tasks, AHS support operations must be conducted in consonance with the combatant commander's theater engagement strategy. Army Health System support to stability tasks must also be thoroughly coordinated with the supporting assistant chief of staff, civil affairs operations (G-9) to ensure that all stability tasks conducted are part of the regional strategy for the area of operations. The medical commander can assist the combatant commander in planning medical support for the primary stability tasks. The G-9 is the staff element responsible for planning, coordinating, and synchronizing civil-military operations.

1-27. Stability task considerations were incorporated into the organizational design of the medical command (deployment support) (MEDCOM [DS]) which has civil affairs officers assigned to the staff. The civil affairs section within the MEDCOM (DS) assists the command in maintaining a regional focus on medical issues arising within the combatant commander's area of responsibility. Additional information regarding the civil affairs section within the MEDCOM (DS) is available in Chapter 3 of this manual.

## **THEATER SECURITY COOPERATION PLAN**

1-28. Joint Publication 3-22 defines security cooperation as DOD interactions with foreign defense establishments to build defense relationships that promote specific U.S. security interests, develop allied and friendly military capabilities for self-defense and multinational operations, and provide U.S. forces with peacetime and contingency access to a host nation. Security cooperation planning is a subset of joint strategic planning conducted to support the DOD's security cooperation program. This planning supports a combatant commander's theater strategy. Department of Defense Instruction 2205.02 directs combatant commands to develop annual execution plans for humanitarian and civic assistance activities (other than minimal cost humanitarian and civic assistance activities) within their area of responsibility. The DODI also directs combatant commanders to integrate and coordinate these activities into their overall security cooperation plan.

1-29. Combatant commanders focus joint strategic planning on their specific area of responsibility and develop strategies that translate national direction and multinational guidance into concepts to meet strategic objectives. Combatant commanders prepare security cooperation strategies in accordance with security cooperation objectives and DOD security cooperation guidance. Once developed, the combatant commander's security cooperation strategy is sent to the Chairman of the Joint Chiefs of Staff for review and on to the Secretary of Defense for final approval. These strategies serve as the basis for security cooperation planning. Collaboration among the combatant commands, Services, and sustainment agencies is essential. Equally important is the close coordination with interagency organizations and particularly with the U.S. ambassadors or chiefs of mission in the combatant commander's area of responsibility.

1-30. Security cooperation activities include programs and exercises conducted by U.S. forces to improve mutual understanding and interoperability with treaty partners or potential multinational partners. There are numerous funding sources and authorities for security cooperation. Key security cooperation programs

funded under Title 10, U.S. Code, that build partner capacity include, but are not limited to the—

- Combatant Commander's Initiative Fund.
- Joint combined exchange training.
- Humanitarian and civic assistance.
- The Developing Country Combined Exercise Program.
- Traditional commander activities.
- Multinational support funds.
- National Guard State Partnership Program.
- Department of Defense Regional Centers for Security Studies.
- Senior Service colleges and professional military education.
- Military academy student exchanges.
- United States Army Sergeants Major Academy.

1-31. Host-nation governments may refuse lethal support but eagerly accept other forms of assistance such as engineering, medical, transportation, and civil affairs support. Medical input and involvement in support of security cooperation activities must be present at the onset of planning and targeted towards the health challenges facing the host-nation military and, in conjunction with other U.S. agencies, civilian health initiatives through civil affairs operations and foreign humanitarian assistance. See JP 3-22 and FM 3-22 for additional information.

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## Chapter 2

# Essential Stability Tasks

The Army Medical Department participates across all of the primary stability tasks in an effort to provide AHS support to U.S. Army forces, unified action partners and when directed, the host nation. This chapter discusses the Department of State's Post-Conflict Reconstruction Essential Tasks matrix, provides the doctrinal description for three of the five primary stability tasks in accordance with ADRP 3-07, medical aspects of the supporting initial and transformational response tasks, and corresponding HSS and FHP considerations for each task.

### SECTION I — PRIMARY STABILITY TASKS

2-1. Stability tasks are typically conducted throughout all phases of conflict and across the range of military operations in permissive and nonpermissive environments. The types of stability tasks conducted during an operation are determined based on the situation. The host nation's ability (or inability) to meet the needs of the local populace also has a major impact on the types of tasks conducted and the duration of the mission. While each task focuses on a particular stability sector (such as security or economic stabilization and infrastructure), no one task is performed independent of the others, each task builds upon or supports the other in an effort to stabilize the host nation and restore normalcy. See JP 3-07 for additional information on the stability sectors.

### ESSENTIAL TASK LIST

2-2. The joint stability functions align with the Department of State stability sectors and the five Army stability tasks in an effort to achieve the desired end state and reestablishment of the host-nation institutions and infrastructure necessary to restore essential services. The primary Army stability tasks are derived from the Department of State's Bureau of Conflict and Stabilization Operations Post-Conflict Reconstruction Essential Tasks matrix.

2-3. The essential tasks matrix provides a list of key tasks and subtasks within each stability sector that are required to accomplish the desired end state. This essential task matrix is grouped into three intervention phases, which are used to assist in determining priorities for response and identifying lead responsibilities for coordination and execution of each task. In Army doctrine, those same phases are used to organize the subtasks for each of the primary stability tasks. The three phases are the—

- Initial response phase, which consists of tasks executed to stabilize the operational environment in a crisis state (during or immediately following a conflict or disaster where the security situation is unstable hindering the entry of civilian personnel) and provide a safe and secure environment.
- Transformation phase, which includes a broad range of post-conflict reconstruction, stabilization and capacity building tasks that are performed in a relatively secure environment free from most wide-scale violence, often to support broader civilian efforts.
- Fostering sustainability phase, which encompasses long-term efforts that capitalize on capacity building and reconstruction activities to establish conditions that enable sustainable development.

Direct AHS support to the *civil control* and *support to governance* Army stability tasks is primarily limited to traditional support of U.S. forces and unified action partners, which is covered at length in FM 4-02 and other Army Medical Department doctrinal publications and will not be covered in this manual. The medical assets provided in support of the three remaining stability tasks, which include *establish civil*

security, restore essential services, and support to economic and infrastructure development are a significant portion of the Army Medical Department's contribution to the overall reconstruction effort and eventual transition to a legitimate civil authority. Figure 2-1 below depicts how the selected Army stability tasks, joint stability functions, Department of State stability sectors, and several of the corresponding medical tasks (as outlined in the Post-Conflict Reconstruction Essential Tasks matrix) align to achieve the desired end state. See ADRP 3-07 and JP 3-07 for additional information.

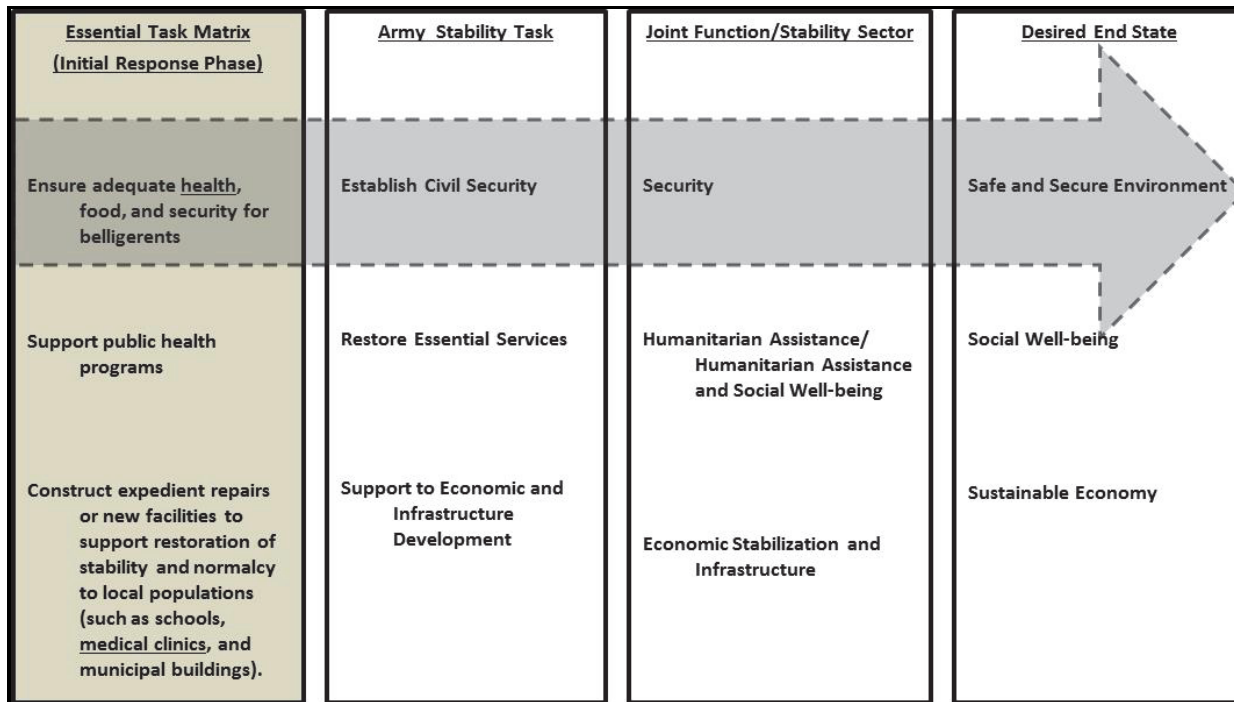


**Figure 2-1. Stability task alignment**

2-4. The HSS and FHP missions conducted in support of these three stability tasks may be the principle tools used in shaping the environment, as military medical assistance is often more readily accepted by the host nation. Sections II through IV of this chapter provide additional information on the AHS support required and medical considerations for each of the stability tasks being addressed. See ADRP 3-07, FM 3-07, and ATP 3-07.5 for a full description of the five primary Army stability tasks.

## SECTION II — ESTABLISH CIVIL SECURITY

2-5. When performing stability tasks a safe and secure environment is vital for the provision of AHS support to U.S. military forces and unified action partners and to meet the critical needs of the local populace. Even in a peacetime environment, U.S. military forces can be targeted for terrorist activities. Civil security involves providing for the safety of the state and its population, including protection from internal and external threats. Civil security consists of a diverse set of activities, ranging from enforcing peace agreements to executing disarmament, demobilization, and reintegration. Medical personnel must be prepared to defend themselves and their patients should the need arise. Therefore, during planning medical commanders must ensure the capability exists to transition quickly from stability tasks that support civil security to traditional support of conventional forces engaged in combat and that health risk assessments are conducted. During the initial response phase, medical personnel may be required to support the civil security stability task by *ensuring adequate health, food, and security for belligerents*.

## ENSURE ADEQUATE HEALTH, FOOD, AND SECURITY FOR BELLIGERENTS

2-6. As part of the initial response, basic health care may be required to support the relocation of former combatants, belligerents, and dislocated civilians. Army Health System support may also be required for detainees as part of the initial response to establish civil security. Due to previous lack of care and resources, these individuals may present serious health and hygiene issues. Medical assets required to support the civil security task should be tailored to the—size of the deployed force; level of hostilities that may be encountered; support requirements to host-nation personnel; and the anticipated duration of the mission.

2-7. Coordination is essential to ensure collaboration and gain access to assessments or other information that may be available regarding the state of host-nation health care, food processing, and agricultural (livestock, poultry, grain, vegetables, fruit, fish, fiber, and forestry) infrastructure. Assessment of host-nation health care and agricultural capabilities is vital to ensure that the focus and level of support provided by military forces meets the needs of the local populace and can be sustained by the host nation. Partnering with local medical authorities, the host-nation Ministry of Health, and Ministry of Agriculture helps to ensure that the care provided to the local populace is consistent with host-nation health care standards, applied in an equitable manner, and can be sustained by the host nation. This can help to build or restore confidence in and avoid disruption of the host-nation health care system. When veterinary or other medical expertise is not available in theater to provide the necessary support, coordination may be made via reachback to the continental U.S. support base to obtain the required resources. Medical considerations to ensure adequate health, food, and security for belligerents are listed in Table 2-1 below. A majority of the medical considerations outlined in this task may also apply for each of the other stability tasks as well and will not be repeated from task to task.

**Table 2-1. Medical considerations**

| <b>MEDICAL CONSIDERATIONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>STABILITY TASK: Ensure adequate health, food, and security for belligerents</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
| <ul style="list-style-type: none"> <li>Involve medical planners early in the planning process and ensure that Army Health System support plans have been thoroughly coordinated with the supporting assistant chief of staff, civil affairs operations, as well as all unified action partners. See Chapter 4 and Field Manual 8-55 for additional planning considerations.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <ul style="list-style-type: none"> <li>Coordinate with the— <ul style="list-style-type: none"> <li>United States Embassy country team.</li> <li>Host-nation Ministry of Health.</li> <li>Host-nation Ministry of Agriculture.</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <ul style="list-style-type: none"> <li>Ensure that medical stability tasks (other than minimal cost humanitarian and civic assistance activities) are conducted with the approval of the Secretary of State through the appropriate Chief of Mission and obtain any required diplomatic notes, temporary status of forces agreements, and or memorandums of agreement required to conduct Army Health System support operations in accordance with Department of Defense Instruction 2205.02.</li> </ul>                                                                                                                                                                                                                                                                            |  |
| <ul style="list-style-type: none"> <li>Coordinate with United States Agency for International Development, Department of Agriculture, the United Nations Country Representative, and nongovernmental organizations serving in the region to access food assistance programs and other resources available in support of stability tasks.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| <ul style="list-style-type: none"> <li>Coordinate with the supporting intelligence officer/section/unit for medical intelligence. Medical intelligence and/or medical information can also be obtained from the following organizations: <ul style="list-style-type: none"> <li>United States Army Public Health Command.</li> <li>National Center for Medical Intelligence.</li> <li>Centers for Disease Control and Prevention.</li> <li>World Health Organization and other associated organizations.</li> <li>Armed Forces Health Surveillance Center.</li> <li>United States Department of Agriculture's Foreign Agricultural Service.</li> <li>Food and Agriculture Organization of the United Nations.</li> <li>World Organization for Animal Health.</li> </ul> </li> </ul> |  |

Table 2-1. Medical considerations (continued)

| MEDICAL CONSIDERATIONS (CONTINUED)                                                 |                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>STABILITY TASK: Ensure adequate health, food, and security for belligerents</b> |                                                                                                                                                                                                                                                                                           |
| •                                                                                  | Ensure that medical support provided and programs implemented are consistent with internationally accepted standards and principles (such as The Sphere Project Humanitarian Charter and Minimum Standards in Humanitarian Response).                                                     |
| •                                                                                  | Ensure that medical personnel are trained and knowledgeable of language, social, religious, cultural, and political factors present in the host nation that may impact the provision of medical support.                                                                                  |
| •                                                                                  | Ensure that medical personnel are trained and knowledgeable of health threats and diseases prevalent in the region.                                                                                                                                                                       |
| •                                                                                  | Ensure that general threat, health threat, and medical intelligence considerations are integrated into medical support plans and orders.                                                                                                                                                  |
| •                                                                                  | Maintain awareness of the efforts of other unified action partner organizations operating in the area to avoid duplication, encourage synchronization of support, and ensure proper use of all available resources.                                                                       |
| •                                                                                  | Ensure that expenses incurred as a result of support to stability tasks (other than minimal cost humanitarian and civic assistance activities) are paid with funds specifically appropriated for such purposes in accordance with Department of Defense Instructions 2205.02 and 6000.16. |
| •                                                                                  | Ensure that the proper approval is obtained prior to the transfer or issue of medical supplies and equipment from the United States to the host nation.                                                                                                                                   |
| •                                                                                  | Determine which military medical treatment facilities are designated to provide care for detainees.                                                                                                                                                                                       |
| •                                                                                  | Inspect captured medical materiel (if available) to determine appropriateness for use in treatment of detainees.                                                                                                                                                                          |
| •                                                                                  | Coordinate with the chaplain or unit ministry team for information regarding religious-based dietary restrictions for hospitalized patients.                                                                                                                                              |
| •                                                                                  | Coordinate newly developed in-country public health programs within the framework of existing host-nation government programs. Provide technical assistance and training to ensure the establishment of sustainable programs that can be maintained by host-nation personnel.             |
| •                                                                                  | Provide veterinary support for examination of host-nation farm animals and stray animals in the area of operations to ensure epidemiological surveillance and control of endemic zoonotic diseases (to include investigation of unexplained deaths of livestock and wildlife).            |
| •                                                                                  | Provide immunizations for livestock owned by belligerents (when vaccines are available).                                                                                                                                                                                                  |
| •                                                                                  | Conduct inspections of water sources and food storage facilities to ensure wholesomeness, quality, and sanitation of subsistence and food sources.                                                                                                                                        |
| •                                                                                  | Evaluate the status of the host-nation agricultural production system and provide assistance, as needed.                                                                                                                                                                                  |
| •                                                                                  | Provide veterinary assistance to the host nation for development of alternate forms of agriculture/livestock production including herd health and animal husbandry programs to produce income and encourage economic growth, when authorized.                                             |
| •                                                                                  | Provide medical and veterinary training, health screenings, and employment assistance to belligerents, their family members, and local communities to encourage self-sufficiency and economic growth.                                                                                     |

### SECTION III — RESTORE ESSENTIAL SERVICES

2-8. Army forces establish or restore the most basic services and protect them until a civil authority or the host nation can provide them. Normally, U.S. military forces support civilian and host-nation agencies. When the host nation cannot perform its role, Army forces may provide this support directly to the host-nation population. The initial medical response tasks for restoration of essential services include—

- Providing for immediate humanitarian needs of the population (food, water, shelter, and medical support).
- Ensuring proper sanitation, purification, and distribution of drinking water.
- Providing interim sanitation, wastewater management, and waste disposal services.
- Supporting famine prevention and emergency food relief programs.

- Supporting shelter and nonfood emergency relief.
- Conducting medical support to stability tasks.
- Supporting public health programs.

## **PROVIDE FOR IMMEDIATE HUMANITARIAN NEEDS OF THE POPULATION**

2-9. The support provided as part of this task includes the provision of food, water, shelter, and medical support necessary to sustain the population until local civil services are restored. Food supplies used in support of foreign humanitarian assistance missions are usually quickly procured, often without proper specifications. Veterinary and preventive medicine support may be the primary services provided in response to this task to support efforts to maintain the safety and wholesomeness of the food supply and the availability of clean drinking water through the inspection of food storage facilities and water sources. Army Health System support considerations may also include—

- Coordination with USAID and relief organizations such as the UN World Food Program to ensure availability and proper distribution of food and water.
- Inspection of water sources and food storage facilities to ensure wholesomeness, quality, and sanitation of subsistence and food sources.
- Establishment of training for the host-nation government and local populace in food safety and inspection techniques to assist in ensuring proper food production and storage.
- Assessment of local food processing plants to either continue or return the processing plants to production.

## **ENSURE SANITATION, PURIFICATION, AND DISTRIBUTION OF DRINKING WATER**

2-10. Proper sanitation, purification, and distribution of drinking water are vital to ensure the public health of the host nation. Army veterinary and preventive medicine personnel may be called upon to assist in providing this support. Medical considerations for this task may include—

- Preventive medicine and veterinary support for the inspection of U.S. Army forces and unified action partners and when directed, host-nation water sources and food storage facilities to ensure wholesomeness, quality, and sanitation of subsistence and food sources.
- Instruction for host-nation personnel on basic water collection procedures, water testing (equipment training and maintenance), and the importance of water sampling and testing.
- Public health and sanitation training and education programs to include health risk communications for the local populace stressing the importance of proper personal hygiene and handwashing in the prevention of disease and nonbattle injuries and stopping the spread of disease.
- Assessment of support provided to ensure accomplishment of the desired effect and assist in planning follow-on support or transition responsibility to the host-nation government or unified action partners.

2-11. In most cases, the main effort for this task may be provided by other U.S. governmental agencies (such as the USAID Office of Foreign Disaster Assistance) or humanitarian organizations. Water is one of the humanitarian sectors funded by the USAID Office of Foreign Disaster Assistance through which assistance for water, sanitation, and hygiene projects may be provided.

## **PROVIDE INTERIM SANITATION, WASTEWATER MANAGEMENT, AND WASTE DISPOSAL SERVICES**

2-12. Like clean drinking water, proper sanitation, wastewater management, and waste disposal services are also critical tasks for the restoration of essential services. Inadequate disposal of waste and improper wastewater management are major threats to public health and can lead to a number of disease outbreaks.

Army Health System support for this task may include technical assistance and training to improve the public health system of the host nation as it relates to the preventive medicine aspects of sanitation including management and disposal of wastewater and waste products. Support for this task may also include preventive medicine support for—

- Field screening and analysis of water sources.
- Pest management and surveillance.
- Focal application of pesticides.
- Limited medical surveillance.

## **SUPPORT FAMINE PREVENTION AND EMERGENCY FOOD RELIEF PROGRAMS**

2-13. In response to a potential or actual food crisis, relief focuses on lifesaving measures to alleviate the immediate needs of the affected population. Support may include medical, logistics, transportation, and security. Those activities identified as humanitarian and civic assistance are specific programs authorized in legislation and controlled per Title 10, U.S. Code. Medical support during the initial response may include the following tasks:

- Monitoring and analyzing food security.
- Assessing the adequacy of local physical transport, distribution, and storage of food.

## **MONITOR AND ANALYZE FOOD SECURITY**

2-14. The Army Medical Department's role in support of the food security mission consists of food protection and defense tasks related to ensuring the wholesomeness and quality assurance of subsistence for U.S. forces, multinational partners, and when directed, host-nation food supplies. Army Health System support considerations for the food protection and defense tasks associated with monitoring and analyzing the food security situation and market prices may include providing veterinary support to—

- Conduct food sanitary audits of storage facilities and food processing plants to ensure that subsistence and food sources are inspected for food safety, security, wholesomeness, and quality assurance for consumption by U.S. forces (less U.S. Air Force installations when food will only be used for U.S. Air Force personnel), unified action partners, and the host nation, when directed.
- Assess and advise on proper storage of foods for consumption by U.S. forces, multinational partners, and host-nation personnel, when directed.
- Establish and publish a list of approved sources for procurement of subsistence from local host-nation commercial sources for consumption by U.S. forces and multinational partners.

2-15. When supporting stability tasks, knowledge of the roles and responsibilities of other unified action partners and the resources available facilitate coordination and ensure mission success. Agriculture and food security is also a USAID humanitarian sector where emergency initiatives are funded to address the immediate needs of the affected population to strengthen local capacity and resilience to disaster. Some USAID emergency initiatives may include support for distribution of seeds and tools to subsistence farmers, as well as assistance for emergency pest and pesticide management and disposal (including encouraging dissemination of disease-resistant crops). Support for emergency livestock programs (such as destocking, animal health programs, or providing feed for livestock in severe drought situations) may also be provided.

## **ASSESS THE ADEQUACY OF LOCAL PHYSICAL TRANSPORT, DISTRIBUTION, AND STORAGE OF FOOD**

2-16. Assessment of the host-nation transportation and distribution system is not a medical task. However, medical support may be required to ensure sanitation of transportation assets used to distribute food and for the assessment of food storage facilities. Army Health System support considerations for storage and distribution of food may include those tasks listed in paragraph 2-15 above as well as the following:

- Ensuring that transportation assets used to distribute food are cleaned and sanitized appropriately.
- Conducting assessments to determine vulnerability of stored and transported foods to ensure proper storage and handling of refrigerated or other temperature sensitive items for use by U.S. forces, unified action partners, and the host nation (when directed).

## **SUPPORT SHELTER AND NONFOOD EMERGENCY RELIEF**

2-17. Military forces offer significant support capability to the broader effort to provide adequate shelter and nonfood relief during humanitarian crises. The welfare and perceptions of host-nation populations are often central to the mission when conducting stability tasks. During the initial response, medical support may be required for the delivery of emergency medical supplies and equipment. Medical considerations for this task include—

- Ensuring that proper approval is obtained prior to the transfer or issue of U.S. medical supplies and equipment to the host nation.
- Maintaining awareness of other unified action partners operating in the area to avoid duplication of effort, encourage synchronization of support, and ensure proper use of all available resources.
- Ensuring that expenses incurred as a result of support to stability tasks (other than minimal cost humanitarian and civic assistance activities) are paid with funds specifically appropriated for such purposes in accordance with DODI 2205.02 and DODI 6000.16.

## **CONDUCT MEDICAL STABILITY TASKS**

2-18. Joint Publication 4-02 defines civil-military medicine as a discipline within operational medicine comprising public health and medical issues that involve a civil-military interface (foreign or domestic), including military medical support to civil authorities (domestic), medical elements of security cooperation activities, and medical civil-military operations. This portion of the restore essential services primary stability task encompasses the medical aspects of all of the primary stability tasks. The AHS tasks and considerations required to conduct medical stability tasks are discussed throughout this manual.

## **SUPPORT PUBLIC HEALTH PROGRAMS**

2-19. The military contribution to the public health sector, especially early in an operation, enables the complementary efforts of local and international aid organizations. The initial efforts of military forces aim to stabilize the public health sector. These efforts may include assessments of the medical and public health system such as infrastructure, medical staff, training and education, medical logistics, and public health programs. Following these initial response tasks, civilian organizations tailor their efforts to reforming the public health sector through health systems strengthening and other public health capacity building activities. The initial response tasks required to provide this support include—

- Assess public health hazards within their supported area including malnutrition, animal health, water sources, and sewer and other sanitation services.
- Assess existing medical infrastructure including preventive medicine and veterinary services, health care (physical and mental health) systems, and medical logistics.
- Evaluate the need for additional medical capabilities.
- Repair existing clinics and hospitals.
- Establish health risk communications programs.
- Operate or augment the operations of existing civilian medical facilities.
- Prevent epidemics through immediate vaccinations and prophylaxis as well as repairing sanitation facilities.

## SECTION IV — SUPPORT TO ECONOMIC AND INFRASTRUCTURE DEVELOPMENT

2-20. Support to economic and infrastructure development helps a host nation develop capability and capacity in these areas. It may involve direct and indirect military assistance to national, regional, and local entities. This task focuses on the physical aspects that enable the host nation's economic viability such as transportation, telecommunications, energy, and general infrastructure (such as hospitals, clinics, water treatment plants, and sanitation facilities). Medical personnel may be required to assist in—

- Protecting natural resources and the environment.
- Supporting general infrastructure reconstruction programs.

## PROTECT NATURAL RESOURCES AND THE ENVIRONMENT

2-21. Protecting a nation's natural resources is an extension of the requirement to secure and protect other institutions of the state. It also preserves the long-term economic development and investment capacity of a fragile nation. This capacity includes the revenues generated by the storage, distribution, and trade in natural resources. Rival factions often target these resources to finance illegitimate interests.

2-22. Medical support for this task may be required to address a wide range of issues including—

- Establishing injury prevention programs for mining operations.
- Establishing pollution control programs to eradicate toxic industrial materials preventing contamination and seepage into ground water.
- Eradicating pests and/or disease vectors that are injurious to humans, animals, and plants.

2-23. Medical support may also be required for the following initial response tasks:

- Protect water resources.
- Secure and protect postharvest storage facilities.
- Establish work programs to support agricultural development.
- Identify constraints to agricultural production.
- Assess health, diversity, and number of animals.
- Provide water and fodder for core reproductive groups.
- Destock livestock as appropriate.
- Provide veterinary services.
- Establish sanitary practices and procedures (production and processing).
- Improve food safety systems to facilitate agricultural trade.
- Prevent animal diseases and epidemics through immediate vaccinations and prophylaxis.

## PROTECT WATER RESOURCES

2-24. During the initial response, U.S. forces may be tasked to provide security for protection of key water sources and then train and equip host-nation personnel to provide this security. The Army Medical Department's role in support of this task does not include providing physical security or protection of host-nation water resources, but ensuring purity and sanitation for consumption and use by the deployed force, unified action partners, and the host nation, when directed. Army preventive medicine and veterinary personnel may be tasked to provide field screening and analysis of water sources (including ice and bottled water), technical assistance and training support for the host nation, and other sanitation support such as the tasks listed in paragraph 2-13 above. It is important to remember that bottled water does not guarantee purity and must be inspected prior to consumption. Army personnel and unified action partners should only consume water from U.S.-approved sources.

## SECURE AND PROTECT POSTHARVEST STORAGE FACILITIES

2-25. When conducting stability tasks, U.S. forces can assist host-nation farmers and local officials by providing security and/or expertise for protecting and securing postharvest storage facilities. While Army

medical personnel would not be tasked to provide physical security and protection of these facilities, Army units may be required to provide veterinary support for the inspection of storage facilities to ensure the wholesomeness, safety, and quality assurance of the host-nation food supply. Veterinary services and preventive medicine personnel may also assist by providing pest management support for grain storage facilities.

## **ESTABLISH WORK PROGRAMS TO SUPPORT AGRICULTURAL DEVELOPMENT**

2-26. Work programs and agricultural development projects must be coordinated with host-nation authorities and the Ministry of Agriculture to evaluate the potential economic impact of support provided by U.S. forces. Host-nation involvement helps to ensure that the programs are sustainable and aid is applied or distributed in an equitable manner. Coordination with and involvement of host-nation officials in the development of such programs and projects also helps to build support for the central government, foster self-reliance, and aid in stabilization efforts. Army medical personnel, in coordination with the supporting civil affairs element, USAID, and the U.S. Department of Agriculture, can facilitate the development and implementation of an agricultural assistance strategy as well as the establishment of work programs that support agricultural development. When authorized, Army veterinary services personnel organic to civil affairs units and veterinary detachments can support host-nation agricultural stabilization efforts by—

- Providing consultation services and training support for host-nation or indigenous personnel.
- Assisting in the development of veterinary laboratories.
- Assisting in vaccine production and the development of drug and vaccine distribution systems.
- Improving food plant sanitation.
- Assisting in the control of animal and zoonotic diseases.
- Establishing herd health and animal husbandry programs.
- Assisting in the development of alternate forms of agriculture/livestock production to produce revenue.

2-27. When tasked, U.S. military forces can provide engineer support, veterinary services, preventive medicine, transportation, and other capabilities to assist in agricultural development. However, no military occupational specialty or area of concentration exists among the Services for horticulture or crop-related farming, fish or aquaculture, poultry, or forestry. Therefore, we must rely heavily on the U.S. industrial base, other government agencies, nongovernmental organizations, and multinational partners to provide consultation services and expertise in these areas such as the—

- United States Agency for International Development Office of U.S. Foreign Disaster Assistance.
- United States Department of Agriculture—
  - Foreign Agricultural Service.
  - Forest Service.
  - Natural Resource Conservation Service.
- United Nations Food and Agriculture Organization and the World Food Program.

## **IDENTIFY CONSTRAINTS TO AGRICULTURAL PRODUCTION**

2-28. Information regarding land use, soil fertility, water and seed availability, environmental conditions, damage to crops or fisheries, and other related factors offer critical insight into the limitations or challenges faced by the host nation. The availability of breeding stock, crop storage facilities, fertilizer, veterinary medicines, fishing nets, and other essential items should also be assessed. During the initial response, Army veterinary services personnel, in coordination with USAID and the U.S. Department of Agriculture, may be tasked to assist in providing economic information describing constraints to agricultural production.

## **ASSESS HEALTH, DIVERSITY, AND NUMBER OF ANIMALS**

2-29. As part of the initial response, Army veterinary services personnel will require information regarding the health, diversity, and numbers of livestock to determine the type of support and military assets needed to assist in rebuilding the host-nation's agricultural sector. Information regarding the state of agriculture

and livestock in a particular region may be available through the U.S. Embassy country team or host-nation Ministry of Agriculture. Other U.S. governmental agencies such as USAID and the U.S. Department of Agriculture can also assist in assessing the condition of the host-nation agricultural sector. The USAID's Office of Foreign Disaster Assistance provides teams to conduct situation or disaster assessments and needs assessments to determine the type and amount of relief needed during the immediate response phase of a disaster. See the USAID Field Operations Guide for Disaster Assessment and Response for additional information.

### **PROVIDE WATER AND FODDER FOR CORE REPRODUCTIVE GROUP**

2-30. The health of local livestock can have an enormous impact on both the economy and public health of the host nation. Especially in areas where livestock are the backbone of the nation's economy. Lack of access to quality and adequate quantities of feed and clean water to sustain such a precious resource can devastate an already vulnerable population. Veterinary expertise and consultation support will be required to provide techniques to ensure proper growth as well as manage and enhance the reproductive capabilities of livestock. Army veterinary services personnel can assist in—

- Coordinating for access to and distribution of water and grain or other sources of fodder to sustain host-nation livestock and poultry.
- Establishing education and training programs to improve the health of people, livestock, poultry, and crops.
- Coordinating for distribution of high quality seeds and fertilizers to grow grain and other crops to sustain the livestock and people of the affected nation.

### **DESTOCK LIVESTOCK AS APPROPRIATE**

2-31. Reduction of stock or destocking (also known as emergency slaughter, depopulation, or off-take) of livestock and poultry refers to reducing the size of the herd or flock by selling or exchanging the animals for cash, feed, or food. During destocking, animals are either sold to traders or slaughtered and the meat is distributed to affected households for food. Natural or man-made disasters, disease outbreaks, and other emergencies can negatively impact livestock and poultry production and present a major health threat for the local populace.

2-32. Destocking may be required during livestock and poultry disease outbreaks to protect the health of core animals (often the best breeding animals) within the herd or flock and the host nation. During such emergencies, the nature and complexity of the disaster must be determined. The estimated duration, severity, and potential impact on livestock and poultry (including possible loss of livestock or poultry) must also be determined to ensure the proper response or intervention. Livestock and poultry owners and the host-nation government must be engaged and in agreement before any action is taken. Army veterinary services personnel are an invaluable resource during foreign humanitarian assistance missions and may be called upon to provide assistance in support of this task.

### **PROVIDE VETERINARY SERVICES**

2-33. Coordination with such agencies as the Department of State, USAID, host-nation Ministry of Agriculture, and other participating agencies is imperative to ensure the successful provision of veterinary services. The USAID Office of Foreign Disaster Assistance is the lead federal agency responsible for coordinating the U.S. government's response to declared disasters in foreign countries. As discussed in paragraph 2-30, USAID Office of Foreign Disaster Assistance and various offices within the U.S. Department of Agriculture are also involved in developing host-nation agricultural programs. Both agencies are frequently not on-site for executing programs, but rather contract with outside agencies for actual implementation. Army veterinary services personnel most often are already in-country and when tasked, have veterinary resources and a logistical support system capable of providing support to execute such programs. Army veterinarians can assist in developing courses of action to support the overall veterinary effort.

## **ESTABLISH SANITARY PRACTICES AND PROCEDURES FOR PRODUCTION AND PROCESSING OF FOOD**

2-34. In some cases, effective preventive measures to ensure food safety are nonexistent in many countries emerging from conflict or disaster. Therefore, assistance may be required for the establishment of sanitation audits, surveillance inspections, and other prevention and control programs to ensure sanitary practices and procedures for food production and processing. Assistance in providing this support may also be obtained through the U.S. Department of Agriculture's Foreign Agricultural Service, Food and Drug Administration, or the United Nations Food and Agriculture Organization. Veterinary and preventive medicine assistance provided in support of this task may include—

- Training and consultation services for host-nation or indigenous personnel.
- Assisting in conducting food protection vulnerability assessments.
- Improving food plant sanitation.
- Developing a host-nation food inspection system.
- Establishing standards and procedures for food labeling and product dating.
- Developing an inspection system for slaughter establishments to facilitate public health inspections.

## **IMPROVE FOOD SAFETY SYSTEMS TO FACILITATE AGRICULTURAL TRADE**

2-35. Capacity building support for the establishment of systems and safety standards to ensure food safety, wholesomeness, and quality assurance are similar to the tasks listed in paragraph 2-34 above for the establishment of sanitary practices for food production and processing. Veterinary services personnel may be required to assist in establishing host-nation education and training programs in food safety and inspection techniques as well as—

- Establishing host-nation meat, poultry, and egg inspection standards to ensure the freshness and quality of foodstuff for purchase by the local populace.
- Establishing standards for refrigeration, storage, warehousing, and transportation to guarantee security from weather, disease, spoilage, insects and animals.
- Providing training for host-nation personnel in collection, testing, screening, and inspection of food samples to identify foodborne pathogens and ensure food safety.
- Monitoring and evaluating food safety data to include those foods and food producing animals exposed to toxic industrial materials.

## **SUPPORT GENERAL INFRASTRUCTURE AND RECONSTRUCTION PROGRAMS**

2-36. General infrastructure reconstruction programs focus on rehabilitating the affected nation's ability to produce and distribute fossil fuels, generate electrical power, provide engineering and construction support, and offer municipal and other essential services to the local populace. As with the restore essential services stability task, support to general infrastructure programs requires a thorough understanding of the civil component of the area of operations. Civil affairs personnel support the collection of this information to inform the prioritization of programs and projects. Army Health System support for general infrastructure and reconstruction programs encompasses a wide range of tasks. Initial response tasks that may require AHS support include—

- Conducting expedient repairs or building new facilities to support the local populace (such as schools, medical clinics, and municipal buildings).
- Providing advice and assistance in developing medical schools and medical evacuation capability.
- Advising on the design of medical facilities (including veterinary hospitals and medical laboratories).
- Advising on the design of slaughter houses and working dog kennels.
- Establishing public health programs and resources.

- Establishing training programs to educate host-nation medical personnel on how to build and fit prosthetic limbs in response to land mine injuries.
- Providing training, education, medical materiel, and supplies to assist the host-nation military in building a functioning military medical system.

## Chapter 3

# Army Health System Support to Stability Tasks

Building partner capacity is recognized as one of the stability principles and is a major part of Army Medical Department support to stability tasks, including the medical expertise and consultation services provided by AHS support personnel to enhance medical capacity building in the public, private, and military health sectors of the affected nation. This chapter discusses the medical aspects of building partner capacity, the role of civil affairs, legal considerations, and AHS support to operations with a stability focus.

## SECTION I — BUILDING PARTNER CAPACITY

3-1. Building partner capacity encompasses the comprehensive interorganizational activities, programs, and engagements that enhance the ability of partners to establish security, governance, economic development, essential services, rule of law, and other critical government functions. Capacity building involves the transfer of technical knowledge and skills to the local populace and institutions in an effort to strengthen local and national institutions, facilitate the transfer of specialized skills, and promote effective policies and programs. The activities undertaken to build partner capacity seek to create an environment that fosters host-nation institutional development, community participation, human resources development, and strengthen managerial systems.

3-2. Building institutional host-nation capacity is essential to the successful conduct of stability tasks as it encourages the development of strong social, economic, and political infrastructure. Supported by appropriate policy and legal frameworks, capacity building is a long-term, continuing process, in which all participants contribute to enhancing the host-nation's human, technological, organizational, institutional, and resource capabilities. Working with unified action partners, the Army integrates the capabilities of the operating and generating force (including civil affairs and special operations forces personnel) to support capacity building efforts through security cooperation activities.

## MEDICAL CAPACITY BUILDING

3-3. The Army addresses the need to build capacity through security cooperation as a means to shape and prevent future conflict and strengthen U.S. partners abroad. Building medical capacity is a key element of this process, which focuses on developing a sustainable host-nation medical system by improving military and civilian health care capabilities. When supporting stability tasks, professional medical expertise and consultation support is critical to ensure the success of host-nation medical capacity building programs and projects. When building medical capacity, training or the establishment of host-nation health care education programs must often be instituted prior to the commencement of long-term stabilization projects to ensure that once restored, responsibility for those essential programs and services can be transitioned to the host nation and sustained by the local populace.

3-4. Traditional capacity building activities such as the establishment of public health programs, reconstruction of medical infrastructure, and development of community animal health care worker programs have had a major impact on the economy of struggling countries. However, no two situations are the same. Therefore, an assessment of existing infrastructure must be completed to determine the types of support required to stabilize the affected nation and a strategy must be developed to address the specific conditions present within the operational environment. Assessments of the host-nation education and health systems must be conducted to determine their status and the effectiveness of previous U.S. military,

host nation, and nongovernmental organization capacity building efforts. The results of completed assessments can then be used by the combatant commander to develop a regional strategy to mitigate existing health threats and broaden the medical capacity of the affected nation. Once assessments have been completed, targeted improvements can be made in close coordination with the host nation, joint task force, civil affairs personnel, the surgeon, and participating nongovernmental organizations to avoid duplication of efforts and ensure proper use of resources. See Chapter 4 and Appendix A for additional information on assessments.

3-5. In regions affected by persistent conflict, one of the primary assistance tasks may be to improve health systems near U.S. and multinational forces to encourage confidence in host-nation resources, decrease reliance on Army medical treatment facilities (MTFs), and eventually contribute to redeployment of U.S. forces. Training host-nation physicians in the use of ventilators is another example of targeted improvements that can be beneficial to both the local populace and Army medical personnel by permitting the transfer of patients from U.S. military MTFs to host-nation hospitals. Care must be taken to ensure that reestablished health care standards are appropriate for the local population and at a level that can be maintained by the existing host-nation medical infrastructure.

## **HEALTH CARE PROGRAM DEVELOPMENT**

3-6. In many undeveloped countries, medical specialties exist, although in limited numbers. For this reason, the provision of medical expertise and consultation support can greatly enhance medical capacity building efforts in the public, private, and military health sectors of the host nation. Through medical training and government outreach in these areas, the entire host-nation health care system can be improved. These programs enhance the skills of host-nation medical personnel and provide a method of interfacing with their peers on the latest developments in their field of expertise. This is especially helpful in countries that do not have established graduate medical education programs.

3-7. In order to develop viable and effective health care programs, a long-term commitment of assistance is required. The *quick fix* is not a solution for ensuring that adequate health care services will remain available to the host-nation civilian and military populations and will do little to further U.S. national goals for enhancing the stability of the host-nation government. Medical capacity building programs and other AHS support operations conducted to enhance the stability of the host nation must be well coordinated with all agencies concerned, including—

- Host-nation government officials including medical organizations and assets.
- Ambassador and the country team.
- Combatant command.
- Security assistance organization.
- United States Agency for International Development.
- Foreign internal defense augmentation force.
- Civil affairs forces.
- Special operations forces.
- World Health Organization.
- Private organizations and religious efforts.

3-8. During planning, particular attention should be given to the existence of legal authority or other considerations that impact the provision of training for host-nation personnel and to the need, in most cases, for reimbursement of the value of training or other services provided. It should be emphasized that the medical infrastructure and programs established through assistance from U.S. military forces must be broad based and provide support throughout the host nation. All resources must be evenly distributed to ensure unimpeded access and that primary health care is made available to all members of the affected population. This often requires convincing the host-nation government that the expense of hiring and training additional medical and public health personnel to provide services in rural areas will be justified to restore the confidence of the local populace. For example, the host-nation health care delivery system can increase access to primary care despite limited resources and a dispersed population. One method would be the use of nurse practitioners to provide primary care to rural areas. These practitioners could also provide training to local basic- and mid-level health care providers.

3-9. Health care programs should be tailored to meet the needs of the host nation. Initially, programs should target the basic health necessities, with emphasis on health education and other preventive measures. As the programs evolve, they must become institutionalized to ensure their continued success when U.S. military assistance is withdrawn.

3-10. If possible, interregional cooperation between neighboring countries and programs should be fostered. This assists in strengthening relationships between countries and also optimizes the use of scarce training and development resources. In most instances, resources will fall short of the needs of the affected population. There will rarely, if ever, be sufficient U.S. personnel, equipment, or supplies to provide care to the entire country, or even for the entire spectrum of disorders within a small area of the country. It must also be understood that the care of chronic disorders and uncorrectable conditions are beyond the scope of these programs. To provide continuity, these health care programs must be carefully coordinated with the host nation. They will also require a well-publicized focus to a given area as well as a schedule to provide return visits.

## **SECTION II — CIVIL-MILITARY OPERATIONS**

### **ROLE OF CIVIL AFFAIRS IN STABILITY**

3-11. Civil-military operations are the activities of a commander that establish, maintain, influence, or exploit relations between military forces and civil authorities (both governmental and nongovernmental) and the civilian populace in a friendly, neutral, or hostile operational area to facilitate military objectives and consolidate operational objectives. Civil-military operations may include activities and functions that are normally the responsibility of the local government. They may also occur, if directed, in the absence of other military operations. Refer to JP 3-57 and FM 3-57 for additional information.

3-12. The primary function of all Army civil affairs units is to provide the supported commander (combatant commander and below) with the capability to engage the civil component within the operational environment. All medical plans generated in support of stability tasks must be coordinated through the theater Army G-9. The assistant chief of staff, operations is responsible for planning and integrating the overall operations effort. The G-9 plans, coordinates, and provides staff oversight of civil affairs operations and civilian component issues through direct coordination with the assistant chief of staff, operations. The primary function of all Army civil affairs units is to provide the supported commander (combatant command and below) the capability to engage the civil component of the operational environment. Mission guidance and priorities from combatant commands provide regional focus. This focus includes prioritizing regional engagement actions and identifying foreign language requirements. Civil affairs units and personnel also develop detailed area studies and assessments, which include information regarding infrastructure, civilian institutions, and the attitudes and activities of civilian leaders, populations, and organizations.

3-13. Civil affairs support comes in the form of various centers, teams, and cells deployed to plan, enable, shape and manage civil affairs operations in support of joint and unified action partners. Civil affairs support in the area of operations may be provided by a variety of centers, teams, and cells.

### **CIVIL-MILITARY OPERATIONS CENTERS**

3-14. A civil-military operations center is an organization normally comprised of civil affairs personnel, established to plan and facilitate coordination of activities of the Armed Forces of the U.S. within indigenous populations and institutions, the private sector, intergovernmental organizations, nongovernmental organizations, multinational forces, and other governmental agencies in support of the joint force commander. The centers are standing deployable elements, intended to provide combatant and operational commanders with a primary technique to interface among the local populace and all organizations involved in civil-military operations.

## **CIVIL LIAISON TEAMS**

3-15. Civil liaison teams provide limited civil-military interface capability as a means for the exchange of information among indigenous populations and institutions, intergovernmental organizations, nongovernmental organizations, and other government agencies and has limited capability to link resources to prioritized requirements. The civil liaison teams are stand-alone teams of the civil-military operations center. The teams provide the supported level civil-military operations center with a storefront for civil affairs operations and civil-military operations coordination capability without interfering with regular staff functions.

## **CIVIL AFFAIRS PLANNING TEAMS**

3-16. Civil affairs planning teams develop complete civil affairs operation plans, policy, and programs that support the combatant commander's strategic civil-military operations plans. Civil affairs planning team members are well skilled in the military decisionmaking process and the joint operations planning process. As required, these teams augment the staffs of the combatant command, the Service component commands, or joint force land component command. The civil affairs planning teams also assist civil-military operations and military planners with integrating the supported joint commander's military campaign plan into wider political-military or comprehensive civil-military strategic plans.

## **FUNCTIONAL SPECIALTY CELLS**

3-17. Functional specialty cells consist of Army Reserve civil affairs personnel (both officer and enlisted) with unique civilian-acquired skill sets that align with the six civil affairs functional specialty areas, which are—rule of law, economic stability, governance, public health and welfare, infrastructure, and public education and information. Each civil affairs operation that a cell supports may require a different emphasis on skills and team composition. A wide variety of civilian skills may qualify for work in one of the six functional areas.

3-18. The teams listed above are not intended as an all-inclusive list, but to provide examples of the various types of civil affairs resources that may be available in the area of operations. Other civil-military support resources and organizations will be discussed in paragraph 3-33 below. Refer to ATP 3-05.40 and FM 3-57 for additional information on civil affairs support to stability tasks.

# **SECTION III — LEGAL CONSIDERATIONS**

## **ELIGIBILITY CRITERIA**

3-19. The legal aspects of stability tasks are important areas for commanders to consider. During the conduct of stability tasks, questions concerning the medical eligibility of beneficiaries, funding sources, and other legal issues will be encountered. Medical commanders must ensure that they receive adequate and timely legal advice prior to implementing programs or executing missions. Depending on the scenario, there may be designated groups of individuals authorized care who are normally not beneficiaries of the Military Health System, such as disaster victims, rescue workers, UN officials, civilian contractors, and/or host-nation civilians. The medical commander must determine who may receive care, how the government is to be reimbursed for the services provided and materiel expended, as well as the malpractice liability (to include credentialing and scope of practice of nonmilitary health care professionals). The medical commander is also responsible for ensuring that medical professionals are not required to work outside of their scope of practice, as such a violation can lead to loss of the practitioner's license and privileges. Additional information regarding legal considerations pertaining to foreign humanitarian assistance and selected sections of Title 10, U.S. Code, is provided in Appendix B.

3-20. Determination of eligibility for medical treatment and whether reimbursement is required for services rendered are made at the highest level possible in conjunction with the supporting staff judge advocate. Representatives from the Department of State and other military staff sections (such as the assistant chief of staff, civil affairs) may also need to be involved in the determination process. Each operation is unique, and the authorization for care is based on appropriate U.S. and international law, DODDs and DODIs,

applicable Army regulations, doctrine, and standard operating procedures. Determination of eligibility is also based on command guidance, practical humanitarian and medical ethics considerations, availability of U.S. medical assets (in relationship to the threat faced by the force), and potential training opportunities for medical forces. See FM 4-02 for additional information on eligibility for care determinations.

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**Note.** Any individual requesting medical care should receive a timely medical assessment of his condition. Even though the individual may not be eligible for treatment, life-, limb-, or eyesight-saving procedures warranted by the individual's medical condition are provided for stabilization and transfer to the appropriate civilian or host-nation MTF.

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## STANDARD OF CARE

3-21. Medical personnel are well-trained in and guided by the ethics of their profession. These ethical principles and medical training, combined with the requirements of international law (as it relates to the treatment of civilians during conflict, enemy prisoners of war, retained personnel, and civilian internees) help to ensure the ethical treatment of all sick and injured individuals that receive care in a military MTF. Therefore, the medical care provided to the host nation by U.S. military medical personnel conducting stability tasks must be consistent with the standard of care that applies for U.S. military personnel in the same geographic area.

3-22. The standard of care provided to sick, injured, and wounded Soldiers is the responsibility of the command surgeon. The command surgeon is also responsible for oversight of all medical support to the deployed force, including the standardization of treatment protocols, proper storage and safeguard of controlled substances, and documentation of medical encounters.

## MILITARY MEDICAL TRAINING CONSIDERATIONS

3-23. When conducting stability tasks, military medical training exercises are often conducted where medical personnel provide medical, dental, or veterinary support for local villages or neighborhoods. When properly coordinated and implemented, such exercises can be mutually beneficial to the host nation and U.S. forces. These exercises provide a forum for training medical personnel in the identification and treatment of diseases and conditions that are not common in the U.S. and provide the host-nation military or civilian medical personnel training on emerging technologies and medical protocols. The care provided (which is incidental to the training mission) as a result of the medical training exercises, can assist the affected country in overcoming the adverse impacts of the diseases and conditions treated and enhances the legitimacy of the host-nation government in the eyes of its citizens.

3-24. When conducting such exercises, commanders must ensure that the—

- Care provided during medical training does not negatively impact or disrupt the efforts of the host-nation health care system.
- Medical element does not give the impression of impropriety in the execution of their duties.
- Medical plan outlining the care to be provided or programs implemented is coordinated with the supporting civil affairs element, USAID, host-nation medical officials, and other participating nongovernmental organizations.
- Veterinary care provided does not undermine private veterinary practices or exceed government capabilities unless it will prevent the immediate loss of livelihoods as a result of that care.

## SECTION IV – MEDICAL SUPPORT TO STABILITY TASKS

3-25. The combination of primary tasks conducted in support of stability tasks is situation dependent. In some operations, the host nation can meet most or all of the population's needs and Army forces work with and through local authorities to provide the required support. While Army forces operating in a failed state may be required to directly support the well-being of the local populace and work with civilian agencies to restore essential services. Commanders use civil affairs operations to mitigate how the military presence affects the local population and vice versa. Civil affairs operations are important in establishing trust

between U.S. forces and civilian organizations required for effective, working relationships. Army Health System support to stability tasks encompasses a wide range of activities.

## **ARMY MEDICAL FUNCTIONS**

3-26. Army Health System support includes all mission support services performed, provided, or arranged by the Army Medical Department to support HSS and FHP mission requirements for the Army and unified action partners and is divided into ten medical functions. The ten medical functions are—

- Medical mission command.
- Medical treatment (organic and area support).
- Hospitalization.
- Medical evacuation (including medical regulating).
- Dental services.
- Preventive medicine services.
- Combat and operational stress control (COSC).
- Veterinary services.
- Medical logistics (to include blood management).
- Medical laboratory services (including both clinical laboratories and area laboratories).

3-27. The individual medical functions that make up AHS support are divided between HSS and FHP. The ten functions are interrelated and must be synchronized to ensure the appropriate level of support and maximize patient outcomes. The functions included as part of FHP focus on the preventive aspects of AHS support. While the HSS functions center on medical evacuation, medical logistics, and casualty care or the treatment aspects of AHS support.

## **MEDICAL MISSION COMMAND SUPPORT TO STABILITY TASKS**

3-28. Mission command is a key element in managing AHS support to offensive, defensive, stability, and DSCA tasks. Commonality of communications assets or mission command systems assist in defining the chain of command, receiving and disseminating medical intelligence that enables medical commanders to task-organize resources, develop plans, and execute the mission in the most timely and effective manner. It also assists in realigning and redeploying assets as support requirements change.

3-29. Most operations conducted in this environment involve joint and unified action partners as well as nonmilitary and nongovernmental agencies. As the participants are not all from the same organization, interoperability of modes of communication cannot be assured. If the communications equipment of the various participants is not compatible, a liaison/messenger system must be established until compatible equipment is obtained. In multinational operations, the liaison must be able to speak the language of the headquarters to which they are assigned or be able to communicate effectively through an interpreter.

3-30. In joint operations, the joint task force headquarters ensures that standardized reporting formats, times, and requirements are established early in the operation. Coordination networks and forums must also be established early on to enable collaboration among all participating agencies (to include multinational partners and nongovernmental organizations) to ensure proper planning and distribution of available resources. Various forums, Web sites, networks, and enablers already exist such as the:

- All Partners Access Network, which is an unclassified network providing interoperability and interconnectivity among international partners over common platforms. The All Partners Access Network fosters information exchange and collaboration between the DOD and any external country, organization, agency, or individual that does not already have access to traditional DOD systems and networks. The network can be accessed via the Web address posted in the references section of this manual.
- Reliefweb, which is a UN Web site that provides global disaster and crisis updates and analysis information to humanitarian relief organizations worldwide. The Web site can be accessed via the Web address posted in the references section of this manual.

- United Nations Cluster System, which are groups of humanitarian organizations in each of 15 main sectors of humanitarian action (including water, health, logistics, and others). The clusters serve as coordination forums to discuss and endorse strategic and operational decisions related to humanitarian assistance.

3-31. When supporting stability tasks, it is essential that all participants communicate effectively. A clear understanding of who is in charge and a spirit of cooperation must also be established, as civilian agencies, other federal and host-nation agencies, or the ambassador (chief of mission) may have primary responsibility for providing and coordinating support.

## **MEDICAL MISSION COMMAND ORGANIZATIONS**

3-32. The medical commander, in coordination with the theater Army G-9, supports and facilitates the execution of the combatant commander's theater engagement strategy in support of stability tasks and assists in shaping the security environment by working to improve the health conditions that exist within an affected nation. The medical mission command organizations assist the combatant commander in maintaining a regional focus by addressing medical issues that arise within the area of responsibility. The medical expertise and consultation services provided can assist host nations in improving medical capacity in both the public and private health sectors through the development and implementation of programs specifically designed to address particular health challenges faced by the affected population.

3-33. The medical mission command organizations provide the regional focus, communications, task organization, and technical supervision necessary to support the primary stability tasks. The medical mission command organizations are the—

- Medical command (deployment support).
- Medical brigade (support).
- Medical battalion (multifunctional).

3-34. The paragraphs that follow discuss stability and civil affairs support provided by these organizations. See FM 4-02 for a complete description of the medical mission command organizations.

### **Medical Command (Deployment Support)**

3-35. The MEDCOM (DS) serves as the senior medical mission command organization within the theater in support of the combatant command. The MEDCOM (DS), as the theater medical force provider, delivers the medical mission command necessary to provide quality health care in support of the deployed force. The MEDCOM (DS) is also staffed with civil affairs personnel that serve as the medical commander's link to the theater Army G-9 for planning and coordination regarding the medical aspects of civil-military operations.

3-36. The civil affairs section conducts area assessments and estimates of the impact of the local populace on MEDCOM (DS) operations to include the assessment of the host-/foreign-nation medical, dental, and veterinary infrastructure. The civil affairs section facilitates and develops assessments of host-nation medical infrastructure to assist the MEDCOM (DS) commander in planning and executing AHS support in the theater. This section develops cross-cultural communications to facilitate interpersonal relationships in a host-nation environment. It also assists the MEDCOM (DS) commander by—

- Maintaining a regional focus that encompasses the combatant commander's entire area of responsibility.
- Preparing medical assessments, estimates, and functional studies of how the host-nation civilian and military populations affect patient workloads in U.S. MTFs.
- Providing assistance to and liaisons for nongovernmental organizations and the International Committee of the Red Cross that offer medical treatment/supplies to the host nation involved in the conflict or operation.

3-37. The liaisons established with civilian, governmental, and nongovernmental health care authorities enable the senior medical command headquarters to actively monitor existing health threats, develop regional strategies to mitigate those threats, and enhance the host-nation government's legitimacy with the affected population.

**Medical Brigade (Support)**

3-38. The medical brigade (support) has one civil affairs officer assigned that is responsible for the integration of civil-military operations planning within the brigade. When no MEDCOM (DS) is deployed, the civil affairs officer in the medical brigade can also serve as the medical commander's link to the civil affairs personnel in the theater Army to ensure coordination and planning for AHS support to stability tasks. The medical brigade civil affairs officer facilitates and develops assessments of host-nation medical infrastructure to assist the medical brigade commander in planning and executing AHS support in the theater.

3-39. The brigade civil affairs officer assists the medical brigade commander in the execution of stability tasks by—

- Conducting area assessments of host-nation or foreign national medical infrastructure.
- Planning for and executing AHS support for stability tasks.
- Preparing medical estimates, assessments, and functional studies that describe the impact of the local populace on U.S. military MTFs.
- Working with the command judge advocate to advise the medical brigade commander regarding his legal and moral obligations to the indigenous civilian population.

**Medical Battalion (Multifunctional)**

3-40. The medical battalion (multifunctional) has no civil affairs personnel assigned, but provides mission command for such organizations as the—

- Medical company (area support).
- Medical company (logistics).
- Medical company (ground ambulance).
- Dental company (area support).
- Various medical detachments including the—
  - Medical detachment (blood support).
  - Medical detachment (veterinary service support).
  - Medical detachment (preventive medicine).
  - Medical detachment (COSC).

3-41. The medical units assigned or attached to the medical battalion (multifunctional) are the assets leveraged by the MEDCOM (DS) and medical brigade to provide the FHP and HSS necessary to conduct stability tasks. See FM 4-02 for additional information on medical mission command organizations.

**MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)  
SUPPORT TO STABILITY TASKS**

3-42. The medical treatment (organic and area support) function within the AHS applies across the range of military operations and consists of Roles 1 and 2 medical treatment support provided by organic assets or on an area basis for units that do not have medical personnel assigned. This support includes those measures necessary to locate, recover, resuscitate, stabilize, and prepare patients for evacuation to the next role of care and/or return to duty.

3-43. Organic medical treatment support is provided by the medical companies and troops within the brigade combat teams or armored cavalry regiments, brigade support medical company, and the medical company (area support). The medical company (area support) is an echelon above brigade-level asset responsible for providing Role 2 medical support. The primary tasks/purposes of medical treatment (organic and area support) are to provide—

- First aid (performed by nonmedical Soldiers in the form of self-aid, buddy aid, and or combat lifesaver support prior to the arrival of the combat medic or other health care personnel).
- Emergency medical treatment.
- Emergency dental care.

- Advanced trauma management (including blood, x-ray, and medical laboratory support at the Role 2 MTF).
- Forward resuscitative surgery (damage control surgery provided by the forward surgical team collocated with the Role 2 MTF).
- Routine sick call.
- Patient holding (not to exceed 72 hours).
- Preventive medicine measures (available at Role 2).
- Medical evacuation.
- Combat and operational stress control support (available at Role 2).

3-44. The Role 2 MTF has all of the capabilities available at Role 1 as well as x-ray, medical laboratory, essential dental care, and patient holding capability. See FM 4-02 for additional information.

3-45. Organic and area medical treatment support is critical for successful conduct of stability tasks due to troop ceilings or other constraints placed on the size of the deploying force. Initial medical treatment and other health care provided in support of foreign humanitarian assistance or disaster relief will most likely be provided in rudimentary facilities. The medical element must be able to quickly reach the disaster site with the right mix of medical specialties and also have the capability to interact with individuals affected by the incident in their own language.

3-46. During the initial phase of the operation, medical evacuation support may not be available. The medical commander must plan for the possibility of increased holding time of seriously injured or wounded patients for a number of hours or even days. Faced with this requirement, the medical commander may have to include a task-organized surgical capability to stabilize, treat, and care for patients. During this period, the only means of evacuation may be by vehicles/aircraft of opportunity. Support for such situations must be preplanned in advance to enable the medical commander to provide en route medical care for the most seriously injured on these backhaul missions. Planning considerations for medical treatment and hospitalization support to stability tasks are closely related and will be covered in paragraph 3-47 below.

## HOSPITALIZATION SUPPORT TO STABILITY TASKS

3-47. The hospitalization function in support of each stability scenario will differ. In many stability scenarios, the medical element is constrained in size, necessitating that some services (such as hospitalization) be provided outside of the area of operations. As the medical element is normally task-organized for the specific mission, AHS support resources or modules that are normally only deployed with a combat support hospital may be included in the task organization (even though the full hospital unit may not be deployed).

3-48. The Army Medical Department has a variety of skilled medical professionals who provide direct patient care, rehabilitative services, and consultation to other medical professionals in host nations. Many of these medical professionals provide ancillary services within the hospital, but may also be employed outside of the hospital setting when supporting stability tasks. Army Regulation 40-68 defines the primary care roles of nonphysician health care practitioners.

## PHYSICAL AND OCCUPATIONAL THERAPY

3-49. Physical and occupational therapists serve as physician extenders and aid in the prevention, evaluation, and treatment of neuromusculoskeletal conditions. Occupational therapy support is limited to the upper extremity. Occupational and physical therapists can provide evaluation and treatment for a wide range of developmental, neurological, or general medical conditions. These professionals can also assist in injury prevention, reducing morbidity, and decreasing the effects of disability through education using ergonomic principles. Occupational therapists are also involved in evaluation and treatment of chronic and acute behavioral health conditions and serve as members of the COSC team, capable of providing activity-based, goal-oriented treatment for Soldiers and civilians.

3-50. During foreign humanitarian assistance missions, these professionals can play a significant role in the development and implementation of health care programs. Based on the evaluation, individual or group treatment programs for patients with amputations or nerve injuries serve to increase functional independence as well as improve quality of life and morale. Therapists may also provide education and training support for host-nation health care personnel. The training and experience of occupational and physical therapists allows them to evaluate, treat, educate, and prevent disability and injury in patients of all ages (pediatrics to geriatrics).

3-51. In any operation involving deployment of Soldiers, occupational therapy and physical therapy support is based on anticipated patient workload (typically high orthopedic injuries and behavioral health) and the size of the medical element. Therapists work as primary care providers for patients with musculoskeletal problems. Prompt evaluation and treatment of these injuries enhances healing, expedites return to duty, and helps prevent evacuation out of the area of operations. Physical and occupational therapists also serve as health/fitness and injury prevention consultants for individuals and units.

## **NUTRITION CARE**

3-52. In operations with a stability focus, nutrition care support to the host nation is generally required for infants and the very old, for which a wide variety of dietetic challenges will need to be addressed. The same may also be true when conducting offensive and defensive tasks. Therefore, dietitians must be prepared to respond to the complex needs of such patients.

3-53. Nutrition care programs can significantly reduce the effects of malnutrition from an inadequate diet in children and adults. Nutrition care personnel can also aid in reducing morbidity and have an impact on the promotion of healthy lifestyles by designing and implementing education programs to teach local residents to prepare healthy meals from locally available foods. Programs can also be developed to enhance nutritional support and dietetics within the hospital setting by—

- Establishing standardized menus and diets.
- Providing patient counseling and developing individualized diets for specific medical conditions.
- Teaching the use of modified diets.
- Providing hands-on training to hospital food service personnel in preparing and serving meals.

3-54. In foreign humanitarian assistance operations, nutrition care services may involve the refeeding of a healthy population or working with an indigenous malnourished population. Nutrition care services may be provided directly to the host-nation population through nutrition assessment, therapeutic feedings, and population-based feeding programs or indirectly through dietetic programs. Direct nutrition care assistance may include planning for and providing special diets to host-nation civilian casualties or advising local care providers on nutrition support for wounds, injuries, or diseases. Assistance can also be provided in assessing the nutritional status of the general population and recommending ways to achieve optimum nutritional levels through locally available foods. Indirect nutrition care assistance may also be provided through consultation services to the host-nation medical education system in the development of nutritional care specialists and nutritional programs for children and adults.

## **NURSING SERVICES**

3-55. Within the nursing profession, there are a number of specialties, such as public health nurses (Area of Concentration 66B), certified nurse midwives (Area of Concentration 66W), family nurse practitioners (Area of Concentration 66P), and obstetric-gynecologic nurses (Area of Concentration 66G). These resources can be used to provide direct patient care to a host-nation population or serve in a teaching/consulting role in the development of educational programs for both the civilian population and local health care providers. Public health nurses typically focus on population health issues, such as tracking and education for prevention of disease, while midwives, family nurse practitioners, and obstetric-gynecologic nurses may be called upon to assist in establishing programs to improve maternal and child health such as the establishment of prenatal care programs, well-baby clinics, immunization programs, nutritional information, postpartum care and training, and other initiatives aimed at reducing infant mortality. Infant and maternal mortality rates are often key indicators of the state of the affected nation's health care system and can be instrumental in determining the type and level of support required.

## PHARMACY

3-56. Pharmacy personnel can be employed in some operations in a consultative role to assist host nations with the development of the pharmacology system within a hospital and to enhance training of pharmacy support personnel. Assistance could also be provided in such areas as inventory control and requisitioning; controlled substance handling, storing, and distribution procedures; establishment of pharmacy admixture programs; and formulary preparation.

## RADIOLOGY

3-57. As modern technology continues to surge forward, the field of radiology becomes more complex and diverse. State-of-the-art equipment and comprehensive diagnostic studies require continuing education and training to keep pace with new developments. Many countries do not have sophisticated radiology equipment like that found in U.S. treatment facilities. Developing countries need assistance and training in the use of new equipment and the diagnostic studies that can be accomplished with this equipment as they upgrade their capabilities. Consultation and the development of programs for education and training will run the gamut from relatively austere field equipment to state-of-the-art diagnostic equipment. A needs assessment must be accomplished to determine what capability is available and the areas in which the host nation wants to expand and enhance its capability.

## OPTOMETRY

3-58. Optometry services personnel provide eye examinations for eyeglass prescriptions so that optical fabrication elements supporting stability tasks can make corrective eyewear. Optometrists also have specialized equipment that can be used to identify eye injuries and infections which require referral.

## MEDICAL EVACUATION AND REGULATING SUPPORT TO STABILITY TASKS

3-59. Medical evacuation is the link between the successive roles of care in the AHS. It provides the means to transport a patient while providing continuous en route medical care. This capability enhances the prognosis of the patient. Medical regulating provides the means of directing the patient to the MTF best capable of delivering the required care.

3-60. When conducting stability tasks, medical evacuation support may not follow the traditional patient flow. It may also require longer lead times for coordination of issues, such as—

- Using civilian controlled airspace.
- Crossing national borders.
- Obtaining route approval.

3-61. Depending on the scenario and resources available, the doctrinal method of the higher role of care evacuating patients from the lower role may not be possible. The medical planner must ensure that the planned medical evacuation support is flexible and can be adapted to meet the realities of the situation. During the initial phase of the operation, medical evacuation support may not be available, making it necessary for MTFs to hold seriously injured or wounded patients for a number of hours or even days. Faced with this requirement, the medical commander may have to include a task-organized surgical capability to stabilize the patients sufficiently to withstand the delay in evacuation or the MTF may be required to increase the unit's capability to hold, treat, and care for these patients. In such situations, the only evacuation means may be by vehicle/aircraft of opportunity. With proper planning, the medical commander may be able to provide en route medical care for the most seriously injured patients transported on these backhaul missions.

3-62. During noncombatant evacuation operations, those persons who are injured, wounded, or ill are treated and stabilized by the medical element accompanying the evacuation force. Once stabilized, they are evacuated by the noncombatant evacuation force. In noncombatant evacuation operations conducted in an environment where there is no apparent physical threat to the evacuees, injured, wounded, or ill persons should be evacuated on dedicated medical platforms, if at all possible. In an uncertain or hostile

environment, the transportation assets used to insert and extract supporting military forces are normally used to evacuate the patients. The medical personnel accompanying the force provide en route medical care until the evacuation force reaches an intermediate staging base or other safe haven.

## **MEDICAL REGULATING**

3-63. Those evacuees requiring medical care are then transferred to dedicated medical evacuation platforms for further evacuation to MTFs capable of providing the required care. Medical regulating coordination is accomplished by the medical element accompanying the noncombatant evacuation operation force (using the organic communications capability of the force) to ensure that dedicated medical evacuation platforms are available for the transfer of patients when the evacuation force reaches the intermediate staging base or other safe haven. Additionally, this coordination ensures the availability of specialty care hospital beds in the supporting MTFs. Depending on the situation, the medical regulating function may be accomplished by the medical regulating officer in the medical battalion (multifunctional), medical brigade, MEDCOM (DS), theater patient movement requirements center, or the Global Patient Movement Requirements Center supporting the operation.

3-64. In foreign humanitarian assistance operations, medical evacuation is usually not a significant factor, as patients are treated wherever the treatment facility is established. In isolated cases, patients might be evacuated to a metropolitan area for more definitive care, but this is not the norm for these operations. However, medical evacuation platforms (especially helicopters) may be used to move the treatment element to the proposed site where the foreign humanitarian assistance operation is to be conducted. This is the more likely support scenario for the use of medical evacuation platforms.

## **EVACUATION POLICY**

3-65. The evacuation policy for the theater may only be a matter of hours or days. Soldiers who are injured, wounded, or ill and cannot be rapidly returned to duty are evacuated to MTFs at a support base in the continental U.S. or other safe havens. Medical planners should determine what the evacuation policy will be, and in cases where it is compressed, build the necessary evacuation platforms into the plan. An adequate treatment capability must also be included to ensure that patients are sufficiently stabilized to withstand the evacuation. When supporting stability tasks, the evacuation policy may be governed by such factors as the—

- Duration of the operation.
- Inadvisability of building a large military infrastructure in an operational area where the U.S. presence is intended to be minimal.
- Troop ceiling established for the operation.
- Anticipated patient workload.
- Anticipated level of hostilities.
- Availability of host-nation support.

3-66. The evacuation policy stated for the operation will influence the task organization of medical units supporting the mission. It will also dictate the number of evacuation platforms required to perform the mission efficiently. A short evacuation policy requires that the number of Army medical air and ground ambulance, as well as U.S. Air Force aeromedical evacuation resources, be increased for the mission.

## **MEDICAL LOGISTICS SUPPORT TO STABILITY TASKS**

3-67. Medical logistics plays a significant role in the delivery of health care in support of stability tasks. As most missions in stability scenarios are conducted within austere environments, the full complement of logistics capabilities and services may not be in place. The medical logistics planner must be flexible and innovative to be able to bridge the gap between requirements generated by the operation and the capability to provide the necessary Class VIII supplies and equipment. In order to ensure that the correct mix of medical supplies and equipment is obtained, the command surgeon must coordinate his specific requirements with the supporting medical logistics element.

3-68. When conducting stability tasks, coordination for Class VIII supply/resupply, medical equipment maintenance, optical fabrication, and blood management takes on an added importance. Prior to the operation, deploying medical units must determine the number of days of supply required. A list of critical or high demand Class VIII items is also prepared. Medical resupply sets and preconfigured push packages must be developed to maintain the appropriate stockage levels necessary to support early entry operations until replenishment line-item requisitioning is established.

3-69. Medical planners must also take into account all applicable treaties or agreements that exist within the area of responsibility. The supply chain may become hampered by customs if no agreements exist and the additional lead time must be considered when trying to get Class VIII into the country. Medical logistics planners must consider contract support, host-nation support, international standardization agreements, and other services (if available) as a means to augment and assist military capabilities.

3-70. In noncombatant evacuation operations, prior to deployment, the senior medical person accompanying the force must determine if special medical supplies or equipment are required to support evacuees. For example, if a significant number of evacuees will be infants and children, the medical equipment sets must be augmented with pediatric medicines and equipment. Under most circumstances, the Class VIII supplies and equipment the force brings with them is all they will have to operate with. In a nonhostile noncombatant evacuation operation, it may be possible to obtain some medical supplies and equipment locally, if the available supplies meet U.S. health care standards.

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**Note.** Maintenance support may not be available for medical equipment purchased locally due to nonavailability of repair parts within the medical logistics system. Such items should be purchased for one time use only. Caution must be exercised when acquiring medical supplies and equipment locally, as the supplies may not meet U.S. standards or be cleared for use by the Food and Drug Administration and equipment may not be approved for use aboard U.S. military aircraft.

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3-71. When supporting foreign humanitarian assistance operations, the medical logistics planner must coordinate transportation support and receive, sort, store, and distribute Class VIII materiel. Due to the remoteness of the operational site in foreign humanitarian assistance operations, the task of getting the supplies and equipment to the target location may be difficult. Depending upon the scope of the operation, there may also be donated medical supplies and equipment which must be handled, stored, and distributed. Medical logistics personnel must ensure that donated medical supplies and medical materiel purchased specifically for support to stability tasks are segregated from normal unit Class VIII for ease of tracking to avoid legal issues and accountability of funds.

3-72. Management of waste must also be considered when conducting stability tasks. The two types of waste generated by AHS support operations are medical and industrial waste. The medical commander is responsible for ensuring that this waste is properly handled, transported, and disposed of according to applicable regulations, agreements, and laws. Improper management of waste may adversely impact the health of the deployed force and local population.

## MEDICAL LABORATORY SUPPORT TO STABILITY TASKS

3-73. The Army's medical laboratory function consists of—

- Clinical laboratory services provided by the Roles 2 and 3 MTFs.
- Operational laboratory services provided by the area medical laboratory.

### CLINICAL LABORATORY SERVICES

3-74. Depending on the size of the force deployed, the specific mission to be accomplished, and the anticipated duration of the operation, medical laboratory assets may be employed in stability scenarios. If the mission includes deploying a Role 2 or Role 3 MTF in its entirety, organic clinical laboratory assets will be deployed as part of those facilities. However, in short-duration operations where the medical element is task-organized for the specific mission, a medical laboratory may not be deployed. Any required medical laboratory support would be provided by a facility outside the operational area.

3-75. All Role 2 MTFs provide basic clinical laboratory services within the theater. They perform basic hematology, urinalysis, microbiology, and serology procedures as well as receiving, maintaining, and transfusing blood products. The Role 3 combat support hospital performs procedures in biochemistry, hematology, urinalysis, microbiology, serology, and blood banking services in support of clinical activities.

### **AREA MEDICAL LABORATORY**

3-76. Medical laboratory capabilities will differ with the types of forces deployed in a given area of operations. As terrorist incidents can occur at any location, the supporting MTF must coordinate with the supporting preventive medicine team, veterinary team, or in-theater laboratories to obtain a full range of investigative services to identify suspected chemical and biological warfare agents and to test food and water for possible contamination.

3-77. The Army's area medical laboratory includes capabilities in theater validation and field confirmation of suspect chemical, biological, radiological, and nuclear (CBRN) agents, endemic diseases, and occupational and environmental health hazards. Its focus is the total health environment of the theater, not individual patient care. The area medical laboratory conducts studies in pest identification, the efficacy of pesticides, frequency of infectious agents, monitoring immune response, and transmission of zoonotic diseases, as well as theater validation and field confirmatory levels of identification of suspect CBRN samples/specimens in theater. Its personnel also function as consultants to hospital clinical laboratory services within the theater and may task-organize teams and deploy them forward to troubleshoot a particular problem.

3-78. Under DODI 6440.03, the area medical laboratory is also a participating member of the DOD Laboratory Network, which supports the Laboratory Response Network. As a member of the DOD Laboratory Network, the area medical laboratory is authorized to provide diagnostic services or other assessments pertaining to laboratory specimens referred for analysis, consistent with designated tests, procedures, agreements, and the mission of the Laboratory Response Network in support of DSCA tasks.

3-79. Medical laboratory services are typically among the primary medical functions required when providing AHS support to stability tasks, but are usually not a factor in noncombatant evacuation operations. Therefore, medical laboratory personnel and equipment are usually not included in the task-organized medical element that accompanies the noncombatant evacuation operations force due to the short duration of these missions. If the area of operations is suspected of being contaminated with chemical and biological warfare agents, noncombatant evacuation operations personnel should request assistance from the supporting preventive medicine team, chemical detection team, or in-theater laboratories which are trained to handle and identify chemical and biological warfare agents (such as the Army's Area Medical Laboratory or U.S. Navy land-based laboratory). In the absence of these supporting units, the noncombatant evacuation operations force should refer to FM 4-02.7 and ATP 3-11.37 for instructions on the collection and management of specimens/samples contaminated with suspected chemical and biological warfare agents.

### **DENTAL SUPPORT TO STABILITY TASKS**

3-80. Dental support to stability tasks ranges from traditional support for deployed U.S. forces to establishing and/or augmenting dental programs in security assistance and foreign humanitarian assistance operations. These types of operations encompass a wide variety of activities that require flexibility and innovation on the part of those involved.

3-81. Conducting a dental assessment prior to planning is important in understanding the dental health care needs of the population. All available medical intelligence data should be combined with information provided by the diplomatic mission to the host nation to determine dental requirements for the mission. If possible, personal observations by a dental officer should also be accomplished and continued involvement or consultation with a public health dentist is desirable. The senior dental officer should provide the assessment and recommendations to the command surgeon. These recommendations should include—

- Dental care goals and objectives.
- Concept of the dental operation.
- Manpower, materiel, and funding requirements.

- Standards of care.
- Milestones and timelines.

3-82. Dental assets have the potential to be important contributors to the conduct of stability tasks. While their primary role is to support U.S., multinational, and host-nation forces, they can also contribute by participating in dental-related civil affairs operations. When conducting stability tasks, dental support can contribute to a wide range of programs ranging from conducting small self-help dental programs in undeveloped rural areas to assisting the host-nation's dental care infrastructure within metropolitan areas. As with other medical support, the effectiveness of dental support is dependent on the mission. The following is a list of activities and programs for which dental assets may be used:

- Provide dental treatment to members of the local populace.
- Conduct oral hygiene classes and provide hygiene treatment in local communities.
- Assist in establishing community dental health programs.
- Assist in developing a host-nation military dental care system.
- Assist in training local dental care providers.
- Provide consultation and assistance on host-nation dental health care programs (for example, designing and administering a survey to determine the level of oral health of a population).

3-83. When working within the host-nation's medical infrastructure, U.S. military dental personnel must coordinate with the host-nation dental system from the local to the national level to ensure unity of effort. Dental personnel must be mindful not to introduce dental programs that cannot be supported by the host-nation's infrastructure once stability tasks are completed.

3-84. Dental programs and capacity building projects should be carefully coordinated with other governmental agencies through the command surgeon. All U.S. military dental support activities should be directed toward long-term benefits for the supported population and should not exceed the host nation's ability to continue the service once U.S. forces have departed. Early involvement of the host-nation government is essential to the planning process. Credit for the plan and its execution should always be attributed to the host-nation government. Dental planning consideration in support of stability tasks may include host-nation resources such as—

- Military dental assets and capabilities.
- Dental schools.
- Government dental licensure authority.
- Nondental health care personnel who are or can be involved in dental programs, such as public health nurses.
- Civilian dental practitioners.
- Dental auxiliary training and use.
- Dental supply sources.
- Dental laboratories.
- Public health programs.
- Public and private school systems.
- Mechanisms for dental care financing.
- Water distribution system and potential for fluoridation.
- Commercial marketing of oral health products.
- Media capability for mass awareness programs.
- Religious organizations' involvement in social and health-related activities.

3-85. Dental support may be provided to a variety of stability tasks, such as foreign humanitarian assistance or security assistance. Modified dental support approaches may be required for these operations. The dental threat in developing nations includes oral infections and dental caries; a high prevalence of oral developmental conditions such as cleft palate; and maxillofacial injuries due to combat and noncombat injuries. These countries typically have an inadequate dental care infrastructure to prevent and treat these conditions. Dental programs and operations can be conducted in conjunction with other AHS support operations or as separate activities. Direct delivery of care to host-nation populations in support of stability

tasks is an easily implemented and highly visible display of support (credit for the support should be to the host nation rather than to the U.S.). This type of support should only be considered as a short-term benefit. Dental support roles that provide a long-term benefit include—

- Conducting host-nation assessments to identify oral, dental, and maxillofacial needs and dental health capabilities.
- Assisting in building dental support infrastructure.
- Encouraging oral health promotion and disease prevention programs.
- Assisting in developing a military dental capability to prevent and treat oral, dental, and maxillofacial conditions.
- Providing assistance in planning for forensic dental operations.

3-86. Resources to accomplish these objectives are uniquely different from those required to treat U.S. Soldiers in the field. The medical planner must ensure that an appropriate mix of specialties and required equipment is task-organized for the specific mission. Dental equipment sets may require augmentation with equipment for providing care to children and for treating a higher incidence of gum disease. Teaching aids and preventive materials may be required. These differences should be included in the planning process and adequately funded.

3-87. Limitations on resources may significantly influence the level or scope of treatments, but there are certain standards for care that cannot be compromised. For example, these may include infection control, qualifications of care providers, selection of procedures, and standards required by host-nation law. Factors affecting the scope of practice may include lack of funding, inaccessibility of remote locations, and shortage of equipment and supplies. More traditional military dental support may be required for U.S. and host-nation troops in shows of force, peacekeeping operations, peace enforcement, and attacks and raids.

## **PREVENTIVE MEDICINE SUPPORT TO STABILITY TASKS**

3-88. Disease and nonbattle injuries in past wars have exceeded the number of Soldiers who were wounded in action. This is especially true when supporting stability tasks. The combined effects of endemic and epidemic diseases, Soldiers not acclimatized to the environmental conditions, poor sanitation, increased exposure to disease vectors, environmental contamination, and foodborne and waterborne diseases may have a catastrophic effect on mission accomplishment. All commanders must be prepared to counter the health threat by focusing leadership and command emphasis on water discipline programs, physical training, immunization/chemoprophylaxis, personal hygiene, and field sanitation. Field sanitation teams are the eyes of the commander; therefore, they must maintain close coordination and must accurately report on any potential health threats. The medical commander must not only be concerned with these activities for his own unit but also for the command as a whole. He must ensure that he has an integrated pest management program and that dining facilities are inspected. He must also ensure that all supported company-sized or larger units are trained to standard and have all authorized unit-level preventive medicine equipment and supplies on hand. For additional information on preventive medicine issues, refer to Army Regulation 40-5 and FM 21-10.

3-89. When planning for and conducting stability tasks, commanders must consider the factors that threaten the health of the deployed force, unified action partners, and the indigenous population. Personnel likely to serve in areas where stability tasks are conducted may enter with very little, if any, natural immunity to endemic diseases. The degree of cultural and social interaction required when supporting stability tasks, as well as the sharing of food, quarters, and recreational facilities with local nationals, may increase the exposure of personnel to diseases endemic to the host country. Stability tasks may last for extended periods of time (months or years) increasing the risk of contracting endemic disease. The enforcement of proper FHP measures is critical to minimize the risk to personnel.

## **HEALTH THREAT**

3-90. The health threat is traditionally evaluated for its impact on U.S. forces and military operations. In operations with a stability focus, the health threat must also be assessed in terms of its impact on the host nation and its people or supported insurgent forces. Stability tasks are often conducted in developing

nations where endemic and epidemic diseases are prevalent. The health threat is the driving force in the development of effective preventive medicine programs.

## ARTHROPODBORNE DISEASES

3-91. Few military personnel are aware of the magnitude of the health threat posed by arthropodborne diseases. These diseases are transmitted through the biting process of arthropods or by the physical transfer of disease-causing organisms. Operational commanders, medical planners and personnel operating in areas outside the continental U.S. must be aware of the total worldwide threat, as well as the specific threats in areas of potential and planned operations.

3-92. When conducting stability tasks, the level of sanitation, measures employed to control disease vectors, and the resources available to prevent and treat arthropodborne diseases varies. It must be remembered that military forces operating outside the continental U.S. are a highly susceptible population and are, therefore, at an increased risk.

3-93. In disease-endemic areas, the native population may appear fairly healthy. However, they can actually harbor subclinical infections of a disease, having been exposed to repeated infections since birth. The pathogen is kept at a low enough level by the host immune system that it is unable to break out as a serious clinical disease. This smoldering infection can be present at levels transmissible to U.S. forces, which may be completely devoid of immune protection from a specific disease. Once an individual is infected by the pathogen, it can reproduce or spread unchallenged. This results in combat ineffectiveness as care and treatment of Soldiers with disease and nonbattle injuries can negatively impact the mission by creating a drain on limited medical resources for treatment and possible evacuation of those affected.

3-94. Depending on the mission, the resources required to treat large areas for the control of arthropods may not be available. United States military forces must use preventive medicine measures to prevent the transmission and spread of arthropodborne diseases. These measures include—

- An arthropod repellent system, which consists of a topical skin repellent and clothing impregnation material.
- Insect netting.
- Aerosol insecticides.
- Periodic checks (using the buddy method) for ticks or other visible parasites.
- Restricting interaction with local domestic animals or wildlife.

3-95. During protracted conditions of conflict or when natural or man-made disasters occur, areas of a country previously endemic but now free of diseases (such as malaria, yellow fever, or plague) can expect a resurgence of these diseases. Naturally occurring diseases that have been unnaturally excluded from an area through public health controls can gradually reappear when conflict or disaster disrupts these controls. Disruption can occur due to a shortage of personal protective measures such as—

- Pesticides and arthropod repellents.
- Mosquito netting.
- Fuel to run public health equipment and vehicles.
- Supplies of treatment drugs, immunizations, and chemoprophylaxis agents.

## FOODBORNE AND WATERBORNE DISEASES

3-96. In areas with poor sanitation, locally procured foods pose a high risk of disease for U.S. military forces. Local standards for food preparation are often lacking or nonexistent when compared to U.S. standards. Food handlers are frequently carriers of diseases readily transmitted through prepared foods.

3-97. In regions affected by persistent conflict, potable drinking water is often scarce. Forces deployed cannot be assured of the safety or quality of local water supplies. Locally purchased ice poses the same health risks as food and water.

3-98. The risk of foodborne and waterborne diseases to forces supporting stability tasks can be minimized by command enforcement of basic preventive medicine principles. The risk of experiencing a foodborne illness must be weighed against the impact on relationships with host-nation personnel. Refusing to eat

with your host may be considered an insult; more harm than good may be done to the mission by your refusal. If possible, eat food prepared by U.S. military food service personnel; when not available, maximize the use of meals, ready to eat. Only drink water that has been treated to U.S. military standards and do not use locally prepared ice. Ensure adequate water disinfection supplies (such as chlorination kits, iodine tablets, and calcium hypochlorite) are available. Exercise caution when drinking unopened bottles or cans of locally produced soft drinks purchased on the economy.

3-99. Commanders should be alert to the possibility of terrorist attacks on or contamination of U.S. military water and food sources. Possible targets include fields or farms, food storage, processing/production facilities, transportation, water treatment plants and equipment, reservoirs, and water distribution systems. Use of local water treatment facilities may provide needed water sources for military forces conducting stability tasks. Such facilities may require upgrades to meet U.S. standards for drinking water and food. In all cases, they must be monitored closely and continuously by preventive medicine and veterinary services personnel.

3-100. The medical commander/command surgeon must ensure that preventive medicine measures, guidance on proper distribution of field sanitation equipment, and cross-training personnel are planned and task-organized as appropriate. In predeployment briefs, the medical commander/command surgeon must continually emphasize these points to the joint task force commander and senior leadership.

## **ENVIRONMENTAL INJURIES**

3-101. Heat injuries can quickly diminish the effectiveness of a force. The commander must enforce water consumption policy and ensure that Soldiers consume an adequate number of meals. Food intake is required to prevent the loss of calories, salt, and minerals through sweating. Until Soldiers are acclimatized and whenever possible, operations should be conducted in the cooler parts of the day to lessen the risk of heat injuries.

3-102. Cold injuries are preventable. Commanders must ensure that Soldiers are informed about the risk of cold injury. Further, they should be provided proper protective clothing and warming areas. This is important for Soldiers who are exposed to the cold when their activity level is at a minimum such as when performing guard duty. Dehydration also increases the risk of cold injury. Therefore, the commander must ensure that a liberal water consumption policy is enforced.

3-103. Injuries from exposure to industrial and occupational hazards pose a significant threat to Soldiers in all operations. Hazards from chemical substances arise from excessive airborne concentrations of mists, gases, vapors, fumes, or particulate matter, or contact with toxic liquids or solids. The toxic effects may be caused by exposure via inhalation, ingestion, or eye and skin contact. Early recognition of potential hazard areas is vital to Soldier protection. In countries affected by persistent conflict, the disruption or abandonment of industrial facilities can generate chemical hazards. These areas should be avoided, if possible. When this is not possible, appropriate protective measures must be employed to reduce the Soldiers' exposure. Preventive medicine personnel can provide command surgeons and all commanders with valuable assistance and guidance when dealing with industrial and occupational hazards.

3-104. Particular care should be taken when using existing or abandoned buildings such as bivouac areas or headquarters as these may contain indoor air contaminants (such as lead or asbestos). Further, the land surrounding industrial complexes may also be contaminated and present a potential hazard when used for storage or bivouac areas (such as fumes or vapors trapped inside tentage).

3-105. Army preventive medicine personnel and other medical professionals are specifically trained and equipped to collect, analyze, and interpret available information necessary to provide a clear assessment of the health threat. When the assessment includes oral, dental, or maxillofacial considerations, the public health dental officer has similar specialized training in this area. The veterinary preventive medicine officer can provide expertise in the public health ramifications of zoonotic diseases and biological and chemical warfare agents. These personnel can make recommendations for types of activities to be accomplished and their priority for support. Using these skills maximizes the efficient use of limited medical resources. For consultation purposes during the assessment, medical personnel conducting the assessment should have free access to all medical professionals within the DOD and the local medical community.

3-106. Medical planners must acquaint themselves with currently existing intelligence resources, which include national-level intelligence products such as those available through the National Center for Medical Intelligence and the Armed Forces Health Surveillance Center. These reports are specifically produced to support U.S. military operations conducted outside the continental U.S. and can be obtained through operational and medical intelligence channels (such as the medical brigade intelligence staff officer or the brigade surgeon's office). Refer to FM 4-02 for specific information.

3-107. As medical plans and operations progress, the requirements for additional medical intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated. When required, coordination should be completed with local agencies.

3-108. In operations conducted outside the U.S., the medical planner must be aware of the health threat posed by the disaster (such as continued flooding, earthquakes and aftershocks, or further explosions) and groups, factions, opponents, terrorists, or enemy forces operating within the area. This threat also includes directed energy weapons or devices (or conventional armaments), and the potential for terrorist attacks or incidents, including the use of chemical and biological warfare agents with or without weapons delivery systems. Army Health System support planning and force survivability necessitate that medical units remain abreast of the complete intelligence picture.

3-109. Preventive medicine efforts require close planning and coordination between preventive medicine personnel, command surgeons, and unit commanders to identify all health threats, define goals, promote preventive medicine measures, and prevent duplication of effort. Environmental injuries and diseases, field hygiene and sanitation, and other preventive medicine concerns may impact the health of U.S. forces employed in support of stability tasks. The forces employed are often small independent units with limited personnel.

3-110. When supporting stability tasks, the occurrence of disease and nonbattle injuries and environmental injuries lead to combat ineffectiveness and can adversely affect the success of the mission. In furthering U.S. national goals and objectives, Army preventive medicine personnel can be major contributors to military efforts when conducting stability tasks. The very nature of military preventive medicine is conducive to the types of activities that support U.S. policy objectives.

## ARMY PUBLIC HEALTH NURSES

3-111. Army public health nurses (Area of Concentration 66B) function as preventive medicine/public health officers and may be employed in support of stability tasks to promote, protect, optimize, and preserve the health and medical readiness of the population served. They conduct population-based health assessments to identify, analyze, interpret, and disseminate health information to mitigate and monitor health threats. Army public health nurses also—

- Conduct surveillance and epidemiologic investigations of disease outbreaks, injuries, and other health concerns.
- Develop countermeasures and recommend courses of action for the commander to prevent, contain, and minimize health threats.
- Identify and integrate community assets and resources that support the area of operations in promoting population health and quality of life.
- Provide health promotion and education on conditions of public, occupational, and military health importance.

3-112. These officers liaison with, and provide support to, military, civilian, and other governmental health authorities in garrison and during deployment in support of unified land operations. Public health nurses are assigned to the combat support hospital and the civil affairs section of the MEDCOM (DS).

## COMBAT AND OPERATIONAL STRESS CONTROL SUPPORT TO STABILITY TASKS

3-113. The health threat includes the stress threat. The stress threat encompasses all stressors in the environment that are likely to jeopardize the mission and the Soldier's current and future well-being. The stress threat can result in—

- Misconduct stress behaviors.
- Posttraumatic stress disorder.
- Combat and operational stress reactions.
- Neuropsychiatric disorders, including organic behavioral disorders.

3-114. Operations in support of stability tasks may have brief periods of extreme violence or prolonged periods of inactivity. These conditions can produce classic combat and operational stress reactions. The operations may even involve CBRN threats, which add the psychological and physical stressors of mission-oriented protective posture. However, the more common stressors are those of frustration, resentment, loneliness, and boredom. These stressors come from being in an unfamiliar land far from home; having limited privacy; being among unfamiliar and perhaps hostile people; and operating under restrictive rules of engagement. There is also often ready access to drugs and alcohol from local sources. Enemy tactics attempt to magnify these stressors and to provoke misconduct stress behaviors. These behaviors (such as insubordination and abuse of power) can turn the local population against the United States.

3-115. The host nation may have rudimentary concepts and resources for psychiatric care, behavioral health promotion, and social services delivery. These limitations could be the focus of enhancing the stability of the host-nation government, but only if cultural differences are fully taken into account.

3-116. Combat and operational stress control and behavioral health personnel have provided commanders with effective service in support of stability tasks during many past operations to include—

- Providing support to Soldiers in Operations Enduring and Iraqi Freedom, Operation New Dawn, Haiti, and others.
- Deploying as members of numerous peacekeeping task forces assigned to the Middle East.
- Organizing stress management teams which provided assistance to Soldiers, civilians, and Family members exposed to terrorist actions, or natural or man-made disasters.
- Advising a friendly government in the prevention and treatment of stress casualties among its military and paramilitary forces.

3-117. Combat and operational stress control assets in support of operations with a stability focus are task-organized and may include elements of the mental health sections of brigade units, multifunctional medical battalions, and COSC detachments and teams. The neuropsychiatric personnel assigned to hospitals can also be used to provide proactive stress control interventions. United States Air Force and Navy behavioral health assets in theater should also be identified and coordination accomplished when required.

## VETERINARY SUPPORT TO STABILITY TASKS

3-118. In accordance with DODD 6400.04E, the U.S. Army provides veterinary support for all DOD activities and federal agencies (except food inspection on U.S. Air Force installations). The veterinary capabilities required are diverse and comprehensive. These skills and abilities should be recognized in the formation of the country plan and the AHS support portion of the operation.

3-119. Army veterinary service's most challenging and nontraditional roles include enhancing the stability of the host-nation government and assisting in establishing programs that benefit the local populace. Veterinary service participation in foreign humanitarian assistance activities must be thoroughly coordinated through the U.S. country team. Coordination with such agencies as the Department of State, USAID, host-nation Ministry of Agriculture and other counterpart agencies may be required. The Army veterinarian is not a member of the U.S. country team. However, face-to-face coordination with relevant members of other U.S. governmental and host-nation agencies is essential if veterinary programs are to be successful.

3-120. Identified veterinary requirements usually come through the requesting combatant command surgeon's office as part of the theater AHS support plan or as a separate initiative. The plans directorate and operations directorate of the joint staff routes requests to the subordinate command that has area responsibility or can best meet the requirements. Supporting commands, coordinating with the combatant command surgeon's medical planner and the operations directorate staff prior to planning and tasking, help ensure that adequate veterinary support is provided.

3-121. Medical planner must determine the feeding policy, extent of local food procurement, type of available food storage facilities, zoonotic disease threat to U.S. forces, and required health care support for deployed military working dogs, and other government-owned animals. During the planning process, veterinary support packages can be tailored to respond to either food safety surveillance or animal health care missions. Veterinary support can also contribute to the success of AHS support to stability tasks by—

- Ensuring that subsistence and food sources are inspected for wholesomeness, quality, and sanitation.
- Providing care to government-owned animals (military working dogs and pack animals).
- Helping to improve the public health of the population with such programs as—
  - Public health and sanitation training.
  - Training in food hygiene, safety, and inspection techniques.
  - Animal husbandry programs (when specifically authorized).
  - Vaccinations for the control of communicable zoonotic diseases (such programs must be well coordinated to ensure the greatest effect).

3-122. In all military operations, the interrelationship of human and animal health, disease transmission, and economics is often complex and can affect the overall health of the country. Livestock animals (horses, cattle, goats, and hogs) and poultry affect both the economy and public health. The care and immunization of these important resources merit attention in the planning and resourcing of foreign humanitarian assistance operations. Consumable veterinary drugs and supplies necessary for care of livestock are not normally available through military supply channels. These supplies must be resourced and procured early in the mission planning and development phases of the operation. Veterinary personnel must coordinate closely with medical logistics personnel to maximize expenditure of limited resources.

3-123. In stability scenarios where the anticipated duration of the operation is sufficient to establish base camps of a semipermanent nature, Soldiers have a tendency to adopt local domestic and/or wild animals as unofficial mascots. Command policy should be established in accordance with current regulatory guidelines to address this issue prior to deployment. Local animals are a significant health threat in the transmission of zoonotic diseases to U.S. forces.

3-124. Veterinary support to counterinsurgency operations, foreign humanitarian assistance, nation assistance, and other joint operations can encompass a wide range of support. Veterinary personnel may provide training for supported forces in establishing a food procurement system, inspecting food, caring for military working dogs and pack animals, and caring for and managing livestock. The use of veterinary resources and expertise in counterinsurgency operations includes support to U.S. forces and assistance to host-nation military forces and civilians. The support of U.S. forces is largely characterized by traditional services rendered by the veterinary personnel, such as—

- Treating government-owned animals.
- Ensuring the wholesomeness and safety of U.S. military food supplies.
- Ensuring the local procurement process for food items maintains adequate standards for hygiene, safety, and quality assurance.

3-125. As medical involvement increases, veterinary personnel can assist in the assessment of host-nation veterinary programs. Of particular note, special operations forces personnel are early participants in counterinsurgency operations and their medical assets (the Special Forces medic and attached veterinary personnel) are trained in the basics of animal husbandry and food inspection. Coupled with their basic knowledge of animal and agricultural issues, language skills, and cultural expertise, they can interface with host-nation residents and assist in enhancing the economic stability of the affected country. They can also provide guidance, training, and treatment of the host-nation's military animal care program (pack animals,

livestock, and military working dogs). Veterinary services personnel can also assist in establishing a food procurement system or in enhancing an already existing system.

3-126. Well-developed veterinary programs can impact a wide range of areas (such as public health, medical, nutritional, and economic). These programs must complement the social, religious, and political factors present in the host nation. Proposed veterinary projects require the development and evaluation of programs which address the specific problem areas that tend to foster instability in a given region. For example, if the principal issue underlying conflict is a religious one, the application of a successful program to eradicate Brucellosis in goats will have little impact on the host-nation's stabilization efforts. On the other hand, if the central dilemma is an expanding population without economic growth, the insurgent may base his strategy on the host nation's inability to provide for basic needs such as food, fuel, clothes, and housing. In this situation, the use of a program to control hog cholera on small farms would increase pork production. The control of this disease will have a direct result of increased food production, increased income for the farmer, and perhaps of most importance, the ability to change the diet from one based on grain to one which includes meat. This improves the living status of the populace. Changes such as these directly attack the insurgent's principal issue, defuse the insurgent's psychological operations, and at the same time bolster the credibility and popular support of the host-nation government.

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**Note.** Veterinary personnel must ensure that the programs developed are in consonance with the customs, values, and religious ideologies of the local populace. For example: increased pork production in a Muslim or Jewish country, beef production in a Hindu country, or any of the above would be of little or no benefit if the citizens of the affected nation are vegetarians.

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3-127. The programs that are developed should focus on long-term projects. However, there are a number of programs which can be developed and require only short-term U.S. military involvement. These include—

- Training programs for the identification of veterinary diseases prevalent in the supported area.
- Training programs for local farmers (including women and children) on livestock and poultry care and management.
- Village-level external parasite control facilities (dipping vat construction projects).
- Animal husbandry training programs.
- Vampire bat control programs.
- Vaccination programs in which single dose application provides lasting immunity (such programs must be well coordinated and in consonance with existing vaccination programs).
- Water well and windmill construction in selected areas to improve animal grazing capabilities.
- Local control of toxic plants on grazing lands.

3-128. Long-term programs to improve animal health and increase production are optimal solutions for improving some of the environmental conditions. These programs are based on solid economic principles and include phasing out U.S. assistance. Such programs must be developed after extensive evaluation by regional experts. Programs requiring active participation by local financial institutions tend to be extremely successful. They provide incentive and produce tangible rewards. An example would be a requirement by local banks for livestock production loans to have the producer feed mineralized salt and vaccinate the cattle against foot and mouth disease in order to secure the loan.

3-129. Innovation and creativity are hallmarks of a successful nation assistance program. Veterinary support capabilities include—

- Assisting in veterinary and public health laboratory development.
- Assisting in vaccine production development.
- Training host-nation or indigenous personnel in treatment and animal husbandry skills.
- Assisting in the development of drug and vaccine distribution systems.
- Assisting in the development of disease control and eradication strategies.
- Improving food plant sanitation.
- Conducting epidemiological surveys.

- Assisting in animal disease and parasite control.
- Developing food inspection systems.
- Developing education and exchange programs.
- Serving as advisors.

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## Chapter 4

# Medical Planning for Stability

Planning for AHS support to stability tasks is the same process as used for traditional HSS and FHP missions. The AHS support estimate of the situation is the basic tool used by the medical planner. The considerations are similar, however, the range of options and courses of action are expansive. This chapter provides planning factors for AHS support to joint operations and stability tasks to include transition and end state considerations.

### SECTION I — PLANNING FOR CONTINGENCY OPERATIONS

4-1. Due to the uniqueness of operations with a stability focus, planning for potential scenarios requires initiative, flexibility, versatility, and improvisation to successfully complete established missions. When planning AHS support to stability tasks, medical planners must remain flexible and not rely solely on traditional methods of health care delivery. Medical planners must also explore all potential courses of action to be prepared to deal with unanticipated occurrences. As AHS support resources are scarce, the medical planner must ensure effective use of all available assets to provide adequate health care regardless of the scenario. Each mission in support of stability tasks is unique to the geographical area, mix of forces, and objectives of the operation. Therefore, the medical planner must—

- Be included early in the planning process.
- Ensure that all requirements which cannot be met by available medical resources are identified and action is taken to correct the deficiencies noted.
- Remain flexible to accommodate last minute requirements.
- Ensure that an accurate assessment of the health threat is made and measures to counter this threat are implemented.
- Remain receptive to new and innovative methods of providing the required support.
- Ensure that thorough coordination is accomplished on all aspects of the operation.

4-2. As stated earlier, U.S. military forces are not the lead agency responsible for support to stability tasks. They normally supplement the activities of U.S. and foreign government authorities, nongovernmental organizations, and multinational partners. When conducting stability tasks, many of the missions assigned to U.S. forces will be received as short-notice deployments, which limit the amount of time available to prepare. The sensitivity of the operational security level may also limit or restrict the number of individuals engaged in the planning process. Therefore, medical commanders must ensure that their units are administratively ready for short-notice deployments.

4-3. Updated medical intelligence on the health threat in the proposed area of operations must be maintained. This information is vital to ensure that the appropriate immunizations are provided and that all required chemoprophylaxis (such as for malaria) is on hand or available on short notice. Effective preventive medicine measures must also be planned to counter the specific health threats that may be present in the area of operations. The National Center for Medical Intelligence produces a range of resources that are available for deploying units to assist in planning for proper medical support and countermeasures when conducting stability tasks. The National Center for Medical Intelligence provides base line assessments of the infectious disease risk, environmental health risk assessments, blood safety index, and other products for the identification of potential threats to protect the health of the deployed force.

4-4. In current operations, the global resurgence of mosquito- and tickborne-diseases presents a serious health threat to troops operating in the regions affected. These diseases are spread through the bites of infected mosquitoes and ticks and currently, there are no vaccines available to prevent diseases such as—

- Dengue.
- Chikungunya.
- Malaria.
- Crimean-Congo hemorrhagic fever.
- Japanese encephalitis.
- Severe fever with thrombocytopenia syndrome virus.

4-5. To date, prevention of mosquito and tick bites is the best and only way to avoid infection. Therefore, personal protective measures (such as N, N-diethyl-meta-toluamide [DEET]) for exposed skin and permethrin for clothing) have been shown to be most effective at providing the best protection against arthropod bites, when applied according to instructions. Special clothing, equipment (such as bed nets), and supplies required for the theater must be available based on operations and contingency plans. Supplies and equipment that may also be required include sunscreen and military combat eye protection to counter the effects of bright sunlight.

4-6. To ensure mission success, planning must be thorough and the plan must be rehearsed. Rehearsing key actions allow participants to become familiar with the operation and to visualize the plan. Rehearsals take on an added importance in stability tasks to ensure synchronization and interoperability among the various participants.

## **SECTION II — TRANSITION AND END STATE**

### **TRANSITION**

4-7. Transitions mark a change of focus between phases or between the ongoing operation and execution of a branch or sequel. Transitions require planning and preparation well in advance of execution to maintain the momentum and pace of an operation. As the end state conditions of immediate stability tasks are met, many of the tasks that were performed by military and civilian personnel (government, contractor, or nongovernmental organizations) on a temporary basis are turned over as rapidly as possible to interim government officials.

4-8. A comprehensive transition plan includes specific requirements for all elements involved, summarizes capabilities and assets, and assigns specific responsibilities. The transition plan should be reviewed periodically with all participating organizations to ensure that planning assumptions are still valid and determine if changes in the situation require changes in the plan.

4-9. Termination of operations must be considered from the outset of planning and should be coordinated with the efforts of unified action partners. Properly conceived termination criteria are vital to ensuring that achieved military objectives endure. Further, development of a military end state is complementary to and supports attaining the specified termination criteria and national strategic end state. Commanders should be cautioned that the end state conditions could change during the operation and that the outcome envisioned by other participating organizations may differ.

### **TRANSITION PLANNING FOR MEDICAL SUPPORT TO STABILITY**

4-10. During transition operations, coordination between the outgoing and incoming commands is vital to ensure a smooth hand off and continuity of operations. Coordination should be made between the outgoing and incoming commands to determine if medical assets (personnel, equipment, and supplies) are required to be left behind including planning for disposal of equipment and supplies that cannot be redeployed.

4-11. Transition planning should begin well in advance of the arrival of the replacement organization. Objectives and measures of success should also be established including the commanders guidance on transition or termination of operations and desired end state to include a determination as to when the

transition begins and when it ends. Various other planning considerations should also be addressed including the following:

- Arrangements should be made for sharing medical information including medical intelligence/information about deployment areas for possible incorporation of data into contingency plans.
- Reception and integration of replacement or relief command element and liaison officers. Planning should also include development of relief in place schedules, procedures, and timeline for transition of the medical mission to incoming forces, as well as a transition synchronization matrix with major events and timelines.
- Transition support should also include recommendations for deployment priority and sequence into theater. If applicable, assistance should also be provided for coordinating the use of foreign national government and private health resources for civil-military operations and in support of government administration.
- Communicate specific national limitations, concerns, or sensitivities related to medical support with the incoming element.
- Be prepared to provide advice and assistance in establishing technical requirements for public health services and resources to support government administration (such as clinics, hospitals, pharmacies, food preparation and storage, ambulance transportation, medical personnel, and education). Assistance may also be required during transition operations to transfer military-run medical operations back to civilian authorities.
- Identify capability shortfalls, means to address medical shortfalls including consideration of leaving existing key assets in place with appropriate logistics support.
- Perimeter defense or base security plan and various other issues for incoming and outgoing forces during the transition period.
- Develop handover package, including transfer of lessons learned and acceptable level of achievement on existing medical civil and military projects to the incoming element.
- Establish mutually agreed criteria to set the preconditions before transition of command may occur including clear and distinct change of medical responsibilities and authority.
- Coordinate medical support or emergency medical treatment for reception, staging, onward movement, integration, and relief-in place between incoming and outgoing headquarters elements.
- Identify timing and prepare for formal transfer of responsibility for medical operations.

4-12. A health risk assessment relative to transition/termination of operations should be conducted and a strategy for mitigation of those risks should be developed. Relevant factors to consider may include—

- Decreased density of forces requiring greater reliance on medical evacuation assets.
- Increased vulnerability during large-scale road movements.
- Increased threat as the time of transition approaches.

## END STATE

4-13. The end state is a set of desired future conditions that the commander wants to exist when an operation ends. The end state should anticipate future operations and set conditions for transitions.

4-14. A clearly defined end state is essential for mission success. The end state should help commanders think through the conduct of operations and facilitate transition. Formal and informal assessments are used by commanders to assess progress towards achieving the desired end state and determine whether adjustments are needed.

**SECTION III — MEDICAL PLANNING CONSIDERATIONS FOR STABILITY****FOUNDATIONS FOR ARMY HEALTH SYSTEM SUPPORT**

4-15. The cornerstones of AHS support when conducting stability tasks are determined by the specific mission but can include—

- Planning for and providing direct health services to U.S., multinational forces, and host-nation military forces and, when authorized, U.S. government employees, civilian contractors, and UN personnel.
- Planning for and providing preventive medicine and veterinary services to host nation and civilian populations.
- Providing foreign humanitarian assistance and care to disaster victims.
- Enhancing readiness by real-time, hands-on training.
- Promoting and enhancing the growth potential of host-nation medical infrastructure.
- Planning for and developing programs which provide direct patient care support for both host-nation military and civilian populations.
- Planning for and providing health education and medical training for host-nation or U.S.-backed military or paramilitary forces.
- Providing traditional AHS support to conventional and unconventional forces to ensure the rapid return to duty of trained manpower.

4-16. Medical commanders and planners must exercise flexibility and initiative to enhance the potential for success of the AHS mission and to further national strategies. Although the missions assigned to medical units may be classified under general activities (such as disaster relief, support for counterinsurgency operations, or support to counterdrug operations), each will be unique to its specific situation. The unique setting for each stability mission is dependent upon the—

- Type of operation.
- Level of hostilities.
- Duration of the operation.
- Rules of engagement.
- Political climate.
- Economic status.
- Cultural influences and biases.
- Religious preferences.
- Other socioeconomic considerations.

4-17. Medical commanders and planners must recognize these influences, determine their significance, and incorporate them into the planning and decision-making process.

**SECTION IV — ARMY HEALTH SYSTEM SUPPORT TO JOINT OPERATIONS****JOINT OPERATIONS**

4-18. Missions in support of stability tasks will normally be joint or combined in nature. Therefore, it is important that medical personnel be familiar with the equipment and procedures of the other Services. Prior coordination and training is critical to ensure mission success. Continuous coordination among command surgeons will facilitate this process.

4-19. When participating in joint medical operations, it is important that Army medical personnel know how to load and unload patients on the ships and aircraft of other Services. Medical evacuation pilots must also have the appropriate deck-landing certification required to land on a ship and ensure prior coordination to avoid communications problems between Army air ambulances and U.S. Navy hospital ships.

## MILITARY ENGAGEMENTS IN PEACETIME

4-20. Military prevention activities often support U.S. diplomatic efforts before, during, and after a crisis. Prevention activities include military engagement and security cooperation efforts designed to reform a country's security sector and the deployment of forces designed to prevent a dispute or keep it from escalating or returning to violence. Military engagements in peacetime consist of all military activities that involve other nations and are intended to shape the international environment, improve mutual understanding, and improve interoperability with treaty partners or potential multinational partners. Military engagements may be long-term (such as training teams and advisors assisting foreign military forces) or short-term (such as multinational exercises). Hostilities or combat is not envisioned during military engagements in peacetime, however, terrorist attacks against deployed U.S. military forces are always possible. Military engagement activities in peacetime include the following types of joint operations:

- Military training events and exercises.
- Security assistance.
- Security force assistance.
- Joint combined exchange training.
- Recovery operations.
- Arms control.
- Counterdrug activities.

4-21. In joint operations (such as peace or counterdrug operations), the deployed force receives traditional AHS support. The medical force is task-organized to provide the support required for the operation. As these operations are normally short-term missions, the focus of the care provided is emergency medical treatment and advanced trauma management, with hospitalization provided by a designated facility outside the area of operations. However, in other operations, nontraditional methods of health care delivery are required or consultative and instructional roles may predominate.

4-22. There are numerous types of joint operations conducted in support of stability tasks and military engagements in peacetime. This section provides a discussion of the AHS support necessary to sustain Army personnel, unified action partners, and the host nation during operations with a stability focus.

## SECURITY ASSISTANCE

4-23. Security assistance is a group of programs authorized by the Foreign Assistance Act of 1961 (as amended) and the Arms Export Control Act of 1976 (as amended) or other related statutes by which the U.S. provides defense articles, military training, and other defense-related services by grant, loan, credit, or cash sales in furtherance of national policies and objectives. Security assistance is an element of security cooperation funded and authorized by the Department of State to be administered by the Defense Security Cooperation Agency (JP 3-22).

4-24. The security assistance program is an important instrument of U.S. foreign and national security policy. Security assistance programs that build partner capacity (funded under Title 22, U.S. Code) include, but are not limited to—

- Foreign military financing program.
- Foreign military sales.
- International military education and training.
- Economic support fund.
- Peacekeeping operations.
- Excess defense articles.
- Presidential drawdowns.

4-25. Security assistance also includes the employment of U.S. military teams to assist in training multinational partners. With the exception of traditional medical support to U.S. forces, military medical resources may not be used in all types of security assistance missions. However, they can be employed to

improve health-related quality of life issues and provide training opportunities for participating U.S. Army personnel. This support may include—

- Providing training and support in preventive medicine measures.
- Developing military training packages to enhance skills of medical paraprofessionals.
- Participating in the Department of State cultural exchange program by exchanging foreign military medical personnel for visits, training, and education and reciprocating by sending U.S. military personnel to the foreign country for similar experiences.
- Providing COSC training.
- Providing veterinary support for inspection of subsistence shipments to ensure food safety and quality assurance.
- Providing veterinary medical support for military working dogs and other government-owned animals.

4-26. Security assistance programs employ mobile training teams and small detachments to fulfill specific mission requests. Ideally, these teams and detachments would be specially trained in language, cultural, religious, and political factors affecting the region and available for immediate deployment. Army Health System support to security assistance programs may consist of personnel from any of the 10 medical functions. Army medical assets that are particularly effective in this arena are medical treatment, nursing, preventive medicine, COSC, dental, and veterinary resources. The U.S. Army Veterinary Service's most challenging and nontraditional roles include security assistance and assisting in establishing programs that benefit the affected population. Veterinary services personnel participation in security assistance activities must be thoroughly coordinated through the country team.

4-27. Medical logistics personnel would also be a valuable resource when supporting security assistance activities. Medical logistics personnel can assist a host nation by conducting an assessment of military and civilian medical logistics infrastructures and industries. In many countries, the formal medical supply system may be rudimentary in nature or may not exist. By establishing and institutionalizing this type of system, the host nation can—

- Develop a usage history on Class VIII items.
- Develop a standardized formulary.
- Develop a medical equipment maintenance program.
- Reduce costs by—
  - Purchasing in bulk.
  - Obtaining the best price through competitive shopping.
  - Establishing accountability procedures.
  - Managing stockage levels and cross-leveling inventories between civilian medical facilities.
  - Reducing supply losses due to improper dry and cold storage as well as outdated medications.
  - Identify critical shortfalls.
  - Establish product specifications.

4-28. Medical logistics personnel can provide training and instruction in such areas as:

- Materiel handling techniques.
- Storage requirements and techniques.
- Requisition procedures and formats.
- Control and accountability of medical equipment, supplies, and blood and blood products.
- Optical fabrication and assembly.
- Distribution techniques.
- Medical equipment maintenance and repair.
- Medical equipment set configuration.
- Stock rotation.
- Production of medical gasses.

## SECURITY FORCE ASSISTANCE

4-29. Security force assistance, as part of the civil security stability task, is conducted across the range of military operations. Joint Publication 3-22 defines security force assistance as DOD activities that contribute to unified action by the U.S. government to support the development of the capacity and capability of foreign security forces and their supporting institutions. Security force assistance activities are primarily conducted to assist host nations in building the capacity to defend against internal, external, and transnational threats to stability.

4-30. Security force assistance is a subset of the DOD's overall security cooperation initiatives that is used to improve the capability and capacity of the host nation by providing training, advisory support, consultation services and technical support. Security force assistance encompasses various activities related to the organizing, training, advising, equipping, and assessing foreign security forces and their supporting institutions, from tactical to ministerial levels. Security force assistance should not be confused with security assistance.

4-31. Advising plays an important part in security cooperation missions such as security force assistance. The progression and type of security force assistance activities employed is determined by the operational environment. Army Health System support to security force assistance may include the following activities:

- Conducting medical training exercises with foreign security forces at their home station or during combined operations.
- Providing medical consultation services to assist in the development of health-related programs to support foreign security forces.
- Providing medical evacuation support by air or ground ambulance for foreign security forces, when directed.
- Providing traditional AHS support to U.S. forces conducting security force assistance missions.

4-32. Refer to FM 3-07, FM 3-22, and ATP 3-07.5 for additional information on security force assistance.

## JOINT COMBINED EXCHANGE TRAINING

4-33. Joint combined exchange training is a program conducted overseas to fulfill U.S. forces training requirements and at the same time exchange the sharing of skills between U.S. forces and host-nation counterparts. Training activities are designed to improve U.S. and host-nation capabilities (JP 3-05). Army forces routinely participate in exchange programs, often at the small-unit level. Special operations forces use this program to improve their regional expertise while contributing to a combatant commander's theater security cooperation plan. Exchange of Special Operations Forces and conventional force liaison officers are essential to enhance situational understanding and facilitate staff planning for integrated operations.

4-34. Most operations conducted in a stability environment may involve nonmilitary and nongovernmental agencies. Participation of medical personnel in the Department of State cultural exchange program and other examples provided above for security assistance would also apply for joint combined exchange training. In combined operations, medical personnel must be able to speak the language of the units or organizations to which they are assigned or be able to communicate effectively through an interpreter.

## RECOVERY OPERATIONS

4-35. Recovery operations are operations conducted to search for, locate, identify, recover, and return isolated personnel, human remains, sensitive equipment, or items critical to national security (JP 3-50). Army Health System support to recovery operations primarily consists of traditional support to deployed Army and unified action partners participating in the mission, providing medical personnel to augment the personnel recovery coordination section (when needed), as well as medical treatment and behavioral health support for recovered persons. Medical support may also include veterinary support to monitor decontamination results of food or animals during recovery operations when conducted in a CBRN environment.

4-36. Army veterinary personnel are assigned to and deploy as organic members of U.S. Navy Marine Mammal Systems Explosive Ordnance Disposal Units. These personnel provide Veterinary Roles 1, 2, and 3 medical support to military working dolphins and sea lions that are assigned to recovery operations. This veterinary support generally reports through the U.S. Navy explosive ordnance chain of command and functions independent of other Army veterinary services units in the area of operations. Coordination between veterinary personnel assigned to U.S. Navy Marine Mammal Systems and other veterinary units is useful as they may be able to support and augment each other's capabilities. Veterinary services personnel assigned to Marine Mammal Systems provide direct supervision of U.S. Naval marine mammal transport and deployment operations. They also supervise food safety, hygiene, and storage for Marine Mammal Systems animal rations (frozen fish). Veterinary personnel detect, diagnose, and treat disease and injury of deployed Marine Mammal Systems animals, as well as direct and coordinate evacuation of these animals, as needed. See JP 3-50 and FM 3-50.1 for additional information on recovery operations.

## **COUNTERDRUG ACTIVITIES**

4-37. Department of Defense support to counterdrug operations consists of support provided by the DOD to law enforcement agencies to detect, monitor, and counter the production, trafficking, and use of illegal drugs (JP 3-07.4). Department of Defense support to counterdrug operations is an integral part of the national drug strategy and compliments the efforts of law enforcement agencies and host-nation governments. Army Health System support to counterdrug operations is limited and generally consists of the provision of HSS and FHP to sustain U.S. forces in the area of operations. Army veterinary services personnel provide care and treatment of military working dogs and other U.S. government owned or allied forces working dogs used in these operations and may become involved in developing animal husbandry programs which can, in turn, lead to the economic growth of the host nation and reduce its dependence on income generated by drug-related agriculture. Army medical evacuation resources may also be used to evacuate injured, ill, or wounded Soldiers involved in these operations.

## **NONCOMBATANT EVACUATION OPERATIONS**

4-38. Noncombatant evacuation operations are directed by the Department of State or other appropriate authority, in conjunction with the DOD, whereby noncombatants are evacuated from foreign countries when their lives are endangered by war, civil unrest, or natural disaster to safe havens as designated by the Department of State (JP 3-68). Noncombatant evacuation operations are conducted to evacuate civilian noncombatants and nonessential military personnel from locations in a foreign (host) nation during times of danger to a designated safe haven and may also include the evacuation of dependents, selected citizens of a host nation, or third country nationals. These operations are of short duration and consist of the rapid insertion of a force and temporary occupation of a safe area, and withdrawal upon completion of the evacuation. The amount of force used is normally limited to that required for self-defense and the defense of evacuees. The level of hostilities encountered varies with each specific mission. The key factor in planning for this type of operation is an accurate assessment of the politico-military environment in which the operation is to be conducted. When the political or security environment is believed to have deteriorated to the point where the safety of U.S. citizens is threatened, the ambassador (with Department of State approval) orders the departure of personnel eligible for evacuation assistance. For additional information, see JP 3-68 and FM 3-05.131.

4-39. Army Health System support to noncombatant evacuation operations is tailored to the size of the military force and the anticipated health needs of the evacuees. Efforts are also made to use the existing medical skills of the evacuees. The medical planner must be included in the mission planning as medical considerations and factors may influence the success of the mission. For example, seriously ill or injured evacuees may not be transportable until medically stabilized. Medical planning factors include—

- Assessment of the health threat.
- Anticipated duration of the operation.
- Size of the force.
- Anticipated number of evacuees.
- Anticipated level of hostilities to be encountered.

- Medical requirements for both the force and the evacuees (including the location for hospitalization, stress control support, medical equipment and supplies, and the rapid medical evacuation of those seriously injured or ill).
- Plan for patient flow with potential staging areas (safe havens) identified where additional treatment may be obtained.
- Potential for transferring diseases back to the U.S. or other home station.
- Evacuation or disposition of privately owned pets and government-owned animals.
- Potential sources of food supplies and water.
- Security provisions for patients and medical personnel.
- Availability of sanitation facilities.

4-40. Other medical considerations that may need to be addressed during noncombatant evacuation operations include—

- Will the Embassy and host nation provide medical support?
- Has the Embassy or joint task force coordinated medical evacuation procedures with the host nation?
- Where are host-nation health services?
- What are the capabilities of the host-nation and Embassy health services?
- What is the policy concerning seriously wounded or ill evacuees?
- Should the joint task force give noncombatant evacuation operation evacuees precedence over all other evacuees?
- What is the physical condition of all evacuees?
- Are air evacuation assets necessary? If so, does the joint task force commander need to prestage those assets nearby?
- What are the medical evacuation procedures?
- Which evacuees have special medical needs, such as pregnancy, infectious disease, exceptional family member, or pediatric health care problems?
- Will evacuees be able to bring five days of current medications with them?
- Are there age variations within the evacuation population (such as pediatrics, geriatrics, chronic diseases)?
- Are medical appliances required (such as hearing aids, glasses, prosthetic limbs)?
- How many privately owned animals of each species will be evacuated and what is the physical condition of each animal?
- What resources (such as food, cages, and leashes) are available to support the evacuated animals?

4-41. When supporting noncombatant evacuation operations, emergency medical treatment is provided to the deployed force and evacuees by medical personnel accompanying the force. Use of medical personnel among the evacuees should be maximized to provide routine care and monitor any sick, injured, or wounded evacuees. Hospitalization support is provided by the hospital(s) designated to support the mission. These MTFs are not located in the area of operations, but rather are located in an intermediate staging base or safe haven where patients are medically evacuated once they are extracted from the area of operations.

4-42. An evacuation notice is given to evacuees prior to the arrival of the noncombatant evacuation operational force. The notice should inform evacuees to bring any special medications and eyewear that may be required. Depending upon the mission, enemy, terrain and weather, troops and support available, time available, and civil considerations, a number of days of supply of medications can be recommended. However, this is no guarantee that the evacuees will have the recommended amount of medication in their possession.

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**Note.** The evacuation notice is prepared and distributed by the embassy. Coordination for including additional information in the evacuation notice must be accomplished prior to deployment.

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4-43. Noncombatant evacuation operations may also present unique preventive medicine challenges. While hostilities may or may not be a part of the operation, the very requirement for evacuation indicates that there is a disruption of normal services. Breakdowns in normal sanitary conditions, waste disposal, and the provision of health care may occur. Gathering large numbers of personnel in limited spaces while awaiting evacuation may aggravate these conditions. Measures may also need to be taken to prevent the transfer of exotic diseases to the U.S. or other home station. Predeployment training on field sanitation, use of arthropod repellent, and personal hygiene measures can increase the effectiveness of preventive medicine.

4-44. Due to the limited duration of most noncombatant evacuation operations, COSC personnel will not normally accompany the deployed force. However, once the noncombatant evacuation operations force and the evacuees reach the intermediate staging base or safe haven, COSC interventions in the form of after-action debriefings may reduce the incidence of stress-related problems. Predeployment training on stress identification and control as well as command emphasis on stress-related issues will also assist in maintaining positive mission focus and reducing the number of stress casualties and stress-induced misconduct during an operation. The environments in which many stability tasks occur can induce stress through feelings of loneliness, boredom, and alienation due to cultural and language differences. When conducting stability tasks, Soldiers may also be exposed to personal danger, injury of other unit personnel, or to injustices, suffering, or death of innocent people. Changing mission objectives and ambiguous rules of engagement can add greatly to the stress of the situation. Command emphasis should be placed on ensuring that control measures are implemented by unit commanders and subordinate leaders. Where feasible and within the limits of the troop ceiling, the medical plan should provide a 1- to 3-day medical holding capability for individuals suffering from acute stress. For additional information, refer to FM 6-22.5 and FM 4-02.51.

4-45. In noncombatant evacuation operations, the number of military working animals and authorized privately owned animals to be evacuated determines veterinary support structure that will be required. It is assumed for planning purposes that any noncombatant evacuation operation will be of short duration and that privately owned animals will accompany their owners or be evacuated on a separate military chartered flight. The evacuation of privately owned animals will be limited to normal small domestic animals, which include dogs, cats, guinea pigs, and hamsters. Birds will be handled on a case-by-case basis. No exotic animals such as snakes, monkeys, or endangered species will be evacuated. Even though euthanasia of privately owned animals is an option, this course of action is highly discouraged based on historical experience. During noncombatant operations, Army veterinarians must be present to—

- Administer all required vaccinations.
- Issue international health certificates.
- Coordinate with U.S. Customs officials.
- Provide animal health and husbandry care as required.

4-46. Planning for the evacuation of privately owned animals must also include required veterinary and animal husbandry support at any scheduled stopovers and at the point of debarkation. The use of chartered military airlift with in-flight veterinary support to evacuate privately owned animals is the best course of action if time, resources, and the level of hostilities permit.

## **STRIKES AND RAIDS**

4-47. Strikes are attacks conducted to damage or destroy an object or capability (JP 3-0). Strikes may be used to punish offending nations or groups, uphold international law, or prevent those nations or groups from launching an attack. Raids are operations conducted to temporarily seize an area in order to secure information, confuse an adversary, capture personnel or equipment, or to destroy a capability culminating with a planned withdrawal (JP 3-0). During strikes and raids, environmental (heat and cold) injuries may occur if there was insufficient time to acclimatize the force. Soldiers moving from a cold climate to a

tropical one may suffer from heat injuries. Planning for sufficient quantities of replacement fluids (water) can minimize this threat.

4-48. Army Health System support to strikes and raids generally consists of traditional AHS support to U.S. military forces. However, medical planning should also include the provision of AHS support for enemy prisoners of war, detained or retained personnel, and civilian casualties. The impact of the Geneva Conventions or other legal considerations on these operations should also be considered. See FM 4-02 and ATP 4-02.46 for additional information.

4-49. Strikes and raids are short in duration and are generally characterized by the rapid insertion of combat forces. Rapid movement of forces into and out of the area of operations during strikes and raids makes it necessary to use smaller, more mobile medical assets to provide the required support or evacuate sick, injured, or wounded Soldiers by air.

4-50. Medical evacuation of sick, injured, or wounded Soldiers from the area of operations may require coordination with the other Services. United States Air Force or U.S. Navy assets may be used to insert the force and may provide the only means of evacuating patients from the area of operations. Coordination for backhaul of patients on nonmedical transportation assets, establishment of an en route patient staging system, or the landing of Army air ambulances on U.S. Navy ships must be effected if the evacuation mission is to be successfully accomplished. Early coordination with joint service elements is essential to accomplish these evacuation tasks.

4-51. Medical logistics support for strikes and raids is primarily in the planning and preparation phases of these operations. Rapid insertion of combat forces and equally rapid extraction or reinforcement makes extensive resupply operations unnecessary. Planning for medical logistics support then focuses on the worst case of a force taking large numbers of casualties with delayed extraction or reinforcement. The command surgeon should consider the following issues and make recommendations to the tactical commander:

- Increase the number of combat gauze dressings, bandages, and tourniquets carried by the individual Soldier. The current improved first aid kit contains a number of expendable medical items such as the combat application tourniquet, combat gauze, pressure dressing, and nasopharyngeal airway. These capabilities increase Soldier survivability during dispersed operations and the expandable pouch allows for additional mission specific items.
- Plan sustainment in support of after action procedures. Due to the nature of operations such as strikes and raids, an increase in strenuous activity will require an increase in fluid intake. To counter this risk, it is recommended that each Soldier carry additional fluid (1 to 2 quarts) to prevent and/or treat dehydration.
- Develop a medical push-package with emphasis on intravenous fluids, dressings, tourniquets, bandages, splints, and other components (at the discretion of the command surgeon).

4-52. The role of preventive medicine in strikes and raids varies depending on the mission, environmental conditions, and the forces deployed. Early preventive medicine involvement in the planning phase of the operation is essential. The impact of endemic diseases may be reduced due to the short duration of many of these operations. Assessment of the health threat and its impact on the operation must be determined. Rapid response requirements and lack of time to acclimatize the troops to the environmental conditions (heat and cold) may play a significant role in the accomplishment of the mission. Soldiers must be sure to carry at least the minimum supplies of water purification tablets. In the event that normal resupply of water or extraction from the operational area is delayed, Soldiers may have to purify their own drinking water.

## SHOW OF FORCE

4-53. Show of force operations are designed to demonstrate U.S. resolve that involves increased visibility of U.S. deployed forces in an attempt to defuse a specific situation that, if allowed to continue, may be detrimental to U.S. interests or national objectives (JP 3-0). Show of force operations are military in nature but often serve both diplomatic and military purposes, underscore U.S. commitment to multinational partners, and influence other governments or politico-military organizations to refrain from belligerent acts. See JP 3-0 and ADRP 3-0 for additional information.

4-54. A show of force demonstrates a nation's resolve to use military force as an instrument of national power. The President and Secretary of Defense order these operations to bolster and reassure friends and allies. Medical support for these operations follows the traditional role of providing AHS support to a combat force. The size of the deployed force, the mission, duration of the operation, assessment of the health threat, evacuation policy, and the anticipated level of hostilities to be encountered determine the—

- Range of services to be provided.
- Size of the medical element.
- Anticipated patient load.
- Requirements for Class VIII and resupply.

4-55. The medical planner must be included early in the planning process to ensure that adequate AHS resources are planned for and committed to support the show of force and are capable of transitioning to a combat role, if required. In joint or combined operations, the medical package must be thoroughly coordinated with all parties involved to prevent duplication of resources or gaps in HSS and FHP coverage.

## **FOREIGN HUMANITARIAN ASSISTANCE**

4-56. Foreign humanitarian assistance consists of DOD activities conducted outside the U.S. and its territories to directly relieve or reduce human suffering, disease, hunger, or privation (JP 3-29). The Department of State and USAID are the lead federal agencies responsible for providing humanitarian assistance overseas. The DOD normally plays a supporting role when responding to requests for foreign humanitarian assistance and may not be responsible for determining the mission or specifying the participating agencies. The host nation is primarily responsible for providing the support necessary to sustain its citizens, while foreign humanitarian assistance provided by U.S. forces is designed to supplement or complement the efforts of the affected nation. Refer to JP 3-29 and Appendix B for additional information on the provision of foreign humanitarian assistance in accordance with Title 10, U.S. Code.

4-57. Foreign humanitarian assistance activities conducted by the DOD are limited in scope and duration and may be conducted to support other U.S. government departments or agencies, multinational partners, nongovernmental organizations, and intergovernmental agencies. These operations range from steady-state programs implemented through the theater security cooperation plan and/or theater campaign plan objectives of the supporting combatant commander, to limited contingency operations in support of another U.S. government agency or department. Foreign humanitarian assistance also includes foreign disaster relief and other activities that directly address a humanitarian need.

4-58. Foreign disaster relief is assistance provided to alleviate the suffering of foreign disaster victims, including victims of natural disasters and conflicts, refugees, stateless persons, internally displaced persons, and vulnerable migrants. Foreign disaster relief involves providing for the basic needs of the affected population (such as food, water, sanitation, health care, clothing, bedding, and emergency shelter). The support required also includes critical infrastructure and logistics necessary for the delivery of essential supplies and services.

4-59. When responding to requests for foreign humanitarian assistance, a rapid assessment of the operational area is required to ensure the proper provision of AHS support. Rapid tailoring of a medical element or the deployment of specialized medical response capabilities may also be required to address the health needs produced by the disaster. Army Health System support resources may be required to ensure that—

- Sufficient sanitation facilities are provided.
- Disease surveillance is conducted and disease vectors are controlled.
- Water sources used in the camps are inspected and water is treated, if required, to ensure potability.
- Food safety standards are maintained.
- Primary health care needs of the refugees are met.

4-60. Preventive medicine plays a key role in relief efforts as man-made or natural disasters can disrupt the ecological balance of the affected nation, causing potential outbreaks of disease. Measures to ensure

needed sanitation and pest management must be planned and implemented as soon as possible after a disaster occurs. Organization of educational efforts and other public health measures are also important aspects of preventive medicine support and may be required to help victims resist potential disease outbreaks.

4-61. Foreign humanitarian assistance operations involve direct patient care activities or consultative and instructional assistance. In many foreign humanitarian assistance operations, treatment elements are deployed to the theater and patients are treated at that location. In most of these operations, medical cases requiring long-term comprehensive care are not undertaken by military medical personnel; cases which can be treated and supported by the host nation are the more likely focus of these operations. If patients require evacuation to a hospital, they would most likely be transferred to a host-nation facility rather than a U.S. military MTF. Some foreign humanitarian assistance operations may require that medical support be provided to the host nation for hospitalized patients. This may take the form of consultative services between surgical specialties and the host-nation medical staff or direct patient care where specialists are there to perform certain specific types of surgical procedures.

4-62. Medical treatment and other health care may sometimes be provided in rudimentary facilities. The medical element must be able to quickly reach the disaster site with the right mix of medical specialties and have the capability to interact with victims in their own language through interpreters or other methods.

4-63. Combat and operational stress control measures should be applied during and after the operation. In some instances, stress control measures can be introduced to caregivers prior to their deployment to a disaster site. These measures are used to maintain effective performance and minimize posttraumatic stress disorder among caregivers, as well as victims.

## PEACE OPERATIONS

4-64. Peace operations is a broad term that encompasses multiagency and multinational crisis response and limited contingency operations involving all instruments of national power with military missions to contain conflict, redress the peace, and shape the environment to support reconciliation and rebuilding and facilitate the transition to legitimate governance (JP 3-07.3). Peace operations include peacekeeping operations, peace building post-conflict actions, peacemaking processes, conflict prevention, and military peace enforcement operations. The U.S. may conduct peace operations independently. However, peace operations are normally conducted under the sponsorship of the UN or another intergovernmental organization. For additional information see JP 3-07.3 and FM 3-07.31.

4-65. During peace operations, the medical treatment and hospitalization mission, for the most part, remains that of providing traditional AHS support to deployed forces. The beneficiaries of this support may include other Services, multinational forces, and U.S. government civilians and contractors, and UN officials. The medical commander or command surgeon should receive legal guidance in determining what categories of personnel are eligible for care.

4-66. Initially in most peace operations, the medical element is task-organized to provide routine sick call, emergency medical treatment, advanced trauma management, and preventive medicine. Patients with serious or life-threatening diseases, injuries, or wounds are stabilized for evacuation and transported to a supporting hospital outside of the area of operations. As the duration of the operation lengthens, augmentation with other services such as COSC, physical therapy, or occupational therapy may occur. However, peace operations often have fixed troop ceilings which limit the ability to expand services within the area of operations. In such instances, hospitalization support may not be available in the area of operations.

4-67. Veterinary support is also required in most peace operations. Due to the nature of these operations, field expedient food procurement systems may be established. Veterinary assistance is essential to ensure that only food that is safe for human consumption is procured. In these operations, military working dogs may be required to perform many tasks (such as guarding areas and conducting bomb searches). Veterinary support is required to sustain the use of these and other government-owned animals.

4-68. Medical logistics support for peace operations consists of traditional support to the deployed force. Due to austere staffing and troop ceilings placed on many of these missions, the medical logistics element

may be restricted in size. Other than delivery of medical materiel, the functions of receiving, storing, accounting for, requisitioning, repackaging, optical fabrication, and managing blood and blood products may be accomplished in another country or safe haven. Planning considerations include—

- Anticipated duration of the operation.
- Support available from multinational forces, and the host nation.
- Size of the in-country element.
- Level of hostilities to be encountered.
- Delivery mode and transportation availability.
- Number of customers to be supported.
- Design and maintenance of unique medical equipment sets to meet mission requirements.

## **PEACEKEEPING OPERATIONS**

4-69. Peacekeeping operations are undertaken with the consent of all major parties to a dispute, designed to monitor and facilitate implementation of an agreement (cease fire, truce, or other such agreement) and support diplomatic efforts to reach a long-term political settlement (JP 3-07.3). The primary purpose of peacekeeping operations is to establish a presence that inhibits hostile actions by the disputing parties to build or strengthen confidence in the peace process. The U.S. may participate in peacekeeping operations—

- As a lead nation.
- Contingent force.
- Unilaterally.
- By providing UN military experts (as UN military observers, UN military liaison officers, or UN military advisors) to support a mission.

4-70. The Army Medical Department's role in peacekeeping operations is to provide AHS support to the peacekeeping force. This force may consist of elements from the other Services or multinational forces. It may also include U.S. government civilian employees, civilian contractors, and UN officials. Due to the inherent neutrality of a peacekeeping force, it is important for medical units and personnel to adhere to the limitations of their stated mission. Only those missions involving host-nation personnel or facilities, which are authorized by the appropriate command authority, should be undertaken. Independent, unplanned medical foreign humanitarian assistance programs are not to be performed by AHS support elements of the peacekeeping force without prior approval.

4-71. The AHS support package for a peacekeeping force is often limited in size and must be carefully tailored to satisfy the unique mission requirements of the supported force. If a maneuver force is deployed, sufficient organic medical assets should be included in the force composition to ensure the proper level of support for the deployed force. Reachback support or generating force medical assets may also be required.

4-72. Preventive medicine measures must be employed and receive proper command emphasis to minimize the health threat. A complete assessment of the health threat must also be completed. During peacekeeping and other such operations, military personnel are at greater risk for disease and nonbattle injuries than combat-related injuries. Risk management (refer to ATP 5-19), unit refresher training, and subsequent management of identified risks will help reduce disease and nonbattle injury losses within the unit. For successful AHS support operations, the medical planner must ensure that—

- Preventive medicine support is sufficient for conducting medical and occupational and environmental health surveillance; identifying and assessing health threats and risks; providing operational health risk management support to commanders; and providing pest management services.
- Determination of eligibility of care for other than U.S. military members is accomplished. Refer to Chapter 3 of this manual and FM 4-02 for a discussion on eligibility for care determinations.
- The size of the medical element is sufficient to provide adequate care.
- Medical logistics links for resupply of Class VIII materiel are well defined.

- Medical evacuation platforms and routes are planned for and coordinated with the other Services, multinational forces, and the host nation.
- Veterinary support is sufficient for subsistence procurement, surveillance of subsistence, and care of military working dogs and other government-owned animals (as time and resources permit it).
- A mass casualty plan is prepared and provision for the practice of the plan is made.
- Credentialing, licensing, and scope of practice of medical personnel are determined and verified.
- Alternate AHS support assets are considered, and if appropriate, incorporated into the plan. These alternate sources may include, but are not limited to—
  - Diplomatic flights for medical evacuation or resupply.
  - Embassy and host-nation physicians, if available.
  - Multinational force capabilities for emergency medical treatment and hospitalization.

4-73. Contingency plans must be prepared for AHS support in the event of a withdrawal of the peacekeeping force or escalation of hostilities. If hospitalization support is not available within the area of operations, plans must be coordinated with those units providing the support. In light of the potential terrorist threat during peacekeeping operations, it is imperative that hospitalization support (location, services available, blood supply, and capacity) be available in the event of a mass casualty situation. The terrorist threat may also include the intentional contamination of food and water through the use of CBRN agents or toxic industrial material. Veterinary personnel inspect food for wholesomeness and quality. As such, preventive medicine and veterinary personnel may be the best qualified to—

- Evaluate such threats.
- Carry out surveillance.
- Conduct analysis and testing of suspect food and water.
- Provide guidance for handling and decontaminating food and water.

4-74. Behavioral health personnel have been used effectively to support a variety of peacekeeping missions. During peacekeeping operations, a major focus of behavioral health personnel is completion of behavioral health assessments and providing consultation support. When supporting peacekeeping missions, Army behavioral science officers can assist commanders in—

- Completing predeployment unit effectiveness surveys.
- Providing training and consultation related to stress management and unit cohesion.
- Completing behavioral health screenings and evaluations on all Soldiers during pre- and postdeployment and on selected individuals during deployment.
- Conducting predeployment family support briefings.

4-75. When supporting peacekeeping and other related operations, medical units employ passive defense measures to reduce their vulnerability against sabotage or terrorist incidents. These measures include such actions as light and noise discipline or restricting access into an area by channeling the flow of traffic through an area. For additional information on peacekeeping operations, refer to JP 3-07.3 and FM 3-07.

## MILITARY PEACE ENFORCEMENT OPERATIONS

4-76. Peace enforcement is the application of military force, or the threat of its use, normally pursuant to international authorization, to compel compliance with resolutions or sanctions designed to maintain or restore peace and order (JP 3-07.3). Peace enforcement operations are a form of combat, armed intervention, or the physical threat of armed intervention. They may include the enforcement of international sanctions and exclusion zones, protection of personnel providing foreign humanitarian assistance, and restoration of order. Peace enforcement operations may also include offensive and defensive tasks to establish or reestablish conditions conducive to peace, such as forcible separation of belligerents.

4-77. Peace enforcement operations are military intervention operations in support of diplomatic efforts to restore peace. They also establish the conditions favorable for the insertion of a peacekeeping force between hostile factions that may not be consenting to the intervention. Although the intent of peace

enforcement is to settle a political problem without resorting to violence, coercion is applied when necessary. Violence can easily escalate and AHS support plans must provide for the possibility of supporting the force in moderate to heavy combat. During peace enforcement operations, medical support elements are tailored to the—size of the peace enforcement contingent; level of hostilities to be encountered; and anticipated duration of the mission.

4-78. Army Health System support to peace enforcement operations generally include the provision of HSS and FHP in an austere environment. The medical planner must be included in the mission planning process to ensure that adequate AHS support resources are provided and the following considerations are addressed:

- Commander's intent and concept of operations.
- Health threat.
- Anticipated patient workload.
- Anticipated areas of patient density.
- Status of sanitation and disruption of garbage disposal, water, and sewer services.
- Anticipated civilian casualties requiring medical care, if it is a mission requirement.
- Anticipated enemy prisoners of war, detained, and retained personnel medical care requirements.
- Lengthening lines of communication.
- Medical evacuation (including evacuation out of the area of operations for more definitive care, patient collection points, ambulance exchange points, and the ambulance shuttle system).
- Location of hospitalization assets or services.
- Coordination with other unified action partners, and the host nation.
- Impact of terrain and environmental elements on the conduct of medical operations.
- Medical logistics requirements and procedures.
- Chain of custody and special handling requirements for suspect CBRN specimens.

## **FOREIGN INTERNAL DEFENSE**

4-79. Foreign internal defense is participation by civilian and military agencies of a government in any of the action programs taken by another government or other designated organization to free and protect its society from subversion, lawlessness, insurgency, terrorism, and other threats to their security (JP 3-22). The categories of foreign internal defense operations are—

- Indirect support, which emphasizes self-sufficiency and builds strong national infrastructure through economic and military capabilities.
- Direct support (not involving combat operations), which uses U.S. forces to assist the host-nation population or military forces directly (including operational planning assistance, civil affairs operations, intelligence and communications sharing, logistics, and training of local military forces).
- Combat operations (usually in self-defense), which requires a Presidential decision and serves only as a temporary solution until host-nation forces are able to stabilize the situation and provide security for the populace.

4-80. Joint medical personnel can be employed as indirect support or direct support during a foreign internal defense operation. The predominant types of engagement applied will depend on the make-up of host-nation military medical forces, the host-nation civilian health sector, and their respective roles in that nation's Internal Defense and Development program. For U.S. joint medical forces, HSS and FHP will include varying degrees of military-military activities and medical civil-military operations. In some countries the military and civilian health systems may be completely separate while in other nations the two systems may be integrated, necessitating a unified approach.

4-81. In determining AHS support requirements for foreign internal defense, the medical planner must tailor support based on the environment and the specific needs of the host nation. The goals and objectives of military medical support in this environment are defined in the commander's security cooperation plan. Each host nation has circumstances, which differ from its neighbors', and are unique to its own situation. These differences may include social, economic, cultural, military, and political realities within the

host nation. The medical planner must develop specific goals and objectives for each country within the region. In developing these goals and objectives, the medical planner must ensure that the—

- Medical plan is developed with the assistance of host-nation medical authorities.
- Medical plan enhances or compliments (rather than replaces) existing host-nation programs and is developed with the ultimate goal of transitioning responsibility for this support back to host-nation medical personnel.
- Host nation has the resources to continue the programs, if U.S. military effort is curtailed or discontinued. This is accomplished by ensuring that all AHS support operations include host-nation medical or military representatives.

4-82. The command surgeon takes a proactive role in helping to determine AHS support requirements of the various countries within his supported area of operations. Among the many sources of information which can be accessed are the—

- Host nation.
- National Center for Medical Intelligence.
- Armed Forces Health Surveillance Center.
- Centers for Disease Control and Prevention.
- Department of State.
- Defense Attaché.
- United States Army civil affairs units.
- United States Agency for International Development.
- World Health Organization.
- Pan American Health Organization.
- Local medical society or association.
- Nongovernmental organizations.
- International organizations.
- Religious organizations.

4-83. One of the goals of using military medical resources is to enhance the effectiveness of the host-nation government in the health care arena. The parameters used to assess the host-nation's health service needs will vary with each country. Assessment factors can include, but are not limited to—

- State of the general health of the population (to include nutrition).
- State of behavioral health, psychiatric, and social support services.
- State of dental health and dental care services.
- State of sanitation and personal hygiene.
- Impact of endemic and epidemic diseases.
- Status of water and water distribution systems.
- Health of livestock or poultry and veterinary medical capabilities available within the host-nation government and the private sector.
- Primary care capabilities, to include rural areas.
- Morbidity and mortality rates.
- Developmental stage of the host nation health care delivery system including—
  - Adequacy of secondary and tertiary hospital facilities.
  - Accessibility of the health care delivery system.
  - Education and training levels of health care professionals and technicians.
  - Adequacy of public health resources.
- Availability and production capability for prosthetic and orthotic devices.
- Existence of health education and health promotion programs provided for the general population.
- Education level of the general population.

4-84. Development of medical programs must be based on the real or perceived needs of the host nation. A balance between short- and long-term programs must be attained. Short-term programs (such as extraction of teeth) provide visibility and immediate recognition. However, long-term programs are the best means to resolve the population's dissatisfaction with the health care delivery system. They are also effective in improving the standard of living and quality of life. Long-term programs include such projects as—

- Veterinary care and animal husbandry.
- Constructing sanitation facilities.
- Training host-nation medical personnel.
- Providing nutrition and rehabilitative guidance.
- Providing dental public health programs.
- Providing health education.

4-85. Foreign internal defense programs that provide indirect support emphasize host nation self-sufficiency. In many developing nations, medical specialties exist, although in limited numbers. Consultation programs involving specialists to share knowledge and new techniques can be quite effective. These programs enhance the host-nation medical personnel's skills and provide a method of interfacing with their peers on the latest developments in their field of expertise. This is especially helpful in countries that do not have established graduate medical education programs.

4-86. To develop viable and effective health care programs, a long-term commitment of assistance is required. The quick fix is not a solution for ensuring that adequate health care services will remain available to host-nation civilian and military populations and may not further U.S. national goal for enhancing the stability of the host nation. Army Health System support operations conducted to enhance the stability of the host-nation government must be well coordinated with all agencies concerned, including the—

- Host nation and its medical organizations and assets.
- Ambassador and the country team.
- Security assistance organization.
- United States Agency for International Development.
- Special operations forces to include Special Forces, civil affairs, and military intelligence support operations units.
- Nongovernmental organizations.
- International health organizations.

4-87. Health care programs must be tailored to meet the needs of the host nation. They should target the basic health necessities initially, with emphasis on health education and other preventive measures. As the programs evolve, they must become institutionalized to ensure their continued success when U.S. military assistance is withdrawn.

4-88. Combat operations occur when U.S. forces are committed to a combat role in foreign internal defense programs. The medical plan should also include roles and functions for offensive and defensive tasks to provide host nation support against insurgents or terrorists.

## **COUNTERINSURGENCY**

4-89. Joint Publication 3-24 defines counterinsurgency as the comprehensive civilian and military efforts designed to simultaneously defeat and contain insurgency and address its root causes. United States involvement in counterinsurgency is based on several strategic objectives to include—assisting an established host-nation government as part of foreign internal defense; as an adjunct to U.S. major combat operations; or U.S. operations in an ungoverned area. United States military actions serve a supporting role in counterinsurgency operations. Once legally tasked by the President and the Secretary of Defense for commitment to defeat an insurgency, U.S. military forces assist the host-nation government in defeating the insurgency. For legal considerations concerning counterinsurgency operations, refer to FM 3-07 and FM 3-24.

4-90. When supporting a counterinsurgency, Army medical personnel may assist in the establishment of a viable medical infrastructure to attend to the health care needs of the host-nation military. The AHS organization supporting the operation must be capable of providing all facets of medical support from emergency medical treatment at the point of injury through hospitalization and convalescent care. Army Nurse Corps officers may serve as trainers emphasizing those skills necessary for emergency medical treatment, triage, mass casualty management, and nursing aspects of pre- and postoperative care management. They may also provide first aid training to host-nation military personnel. One of the key factors in maintaining high morale among Soldiers is the knowledge that if wounded, medical care will be available. Depending on the tactical situation, terrain, and other environmental conditions, treatment stations may be housed in caves, tunnels, existing buildings, or temporary shelters. Due to the fluidity of stability tasks, the treatment facility established should be 100 percent mobile and no larger than what is necessary to accomplish the mission.

4-91. Behavioral health activities in support of counterinsurgency operations are designed to meet specific missions. As the level of intensity and the duration of the mission increase, combat and operational stress-related problems also increase. It is expected that combat and operational stress reaction rates will not normally exceed 1:10 per wounded in action, with the primary problem being misconduct stress behaviors. These misconduct stress behaviors can include substance abuse, disruptive behavior, and some criminal acts. Misconduct stress behaviors may seriously interfere with the conduct of stability tasks unless prevented. Soldiers may also suffer from adjustment reactions, endemic psychiatric disorders, and drug and alcohol abuse.

4-92. Preventive medicine support for counterinsurgency operations may focus on the host-nation military or the local populace. Preventive medicine support for the host-nation military can take several forms and should be conducted in a phased approach.

4-93. Many of the health problems facing developing nations are public health related. Therefore, U.S. military preventive medicine assets can play a significant role in providing the necessary support. Host-nation participation is essential when developing programs to address these issues. Host-nation participation draws on local experience and expertise and ensures that programs developed are correctly implemented. Local participation also ensures that the programs being developed are not contrary to the political, economic, social, religious, and cultural practices and beliefs of the civilian population.

## COMBATING TERRORISM

4-94. Combating terrorism is defined as actions, including antiterrorism and counterterrorism, taken to oppose terrorism throughout the entire threat spectrum (JP 3-26). Antiterrorism consists of defensive measures used to reduce the vulnerability of individuals and property to terrorist acts, to include rapid containment by local military and civilian forces. Counterterrorism is defined as actions taken directly against terrorist networks and indirectly to influence and render global and regional environments inhospitable to terrorist networks. Counterterrorism is one of the core tasks for U.S. Special Operations forces as part of their role and additive capability to conduct offensive measures within the DOD's overall combating terrorism efforts. For additional information see JP 3-26 and FM 3-37.2.

4-95. The primary focus of medical units involved in combating terrorism is to provide AHS support to U.S. and friendly forces engaged in these operations. During counterterrorism and antiterrorism operations, the medical commander must implement measures to reduce the vulnerability of medical units to terrorist actions. A balance must be reached that maintains an appropriate level of vigilance, security, and confidence. This balance should not adversely impact the mission and result in undue suspicion and stress. The medical planner must be aware of the terrorist threat in the area of operations and incorporate appropriate safeguards and considerations into the AHS support operations plan. These considerations include—

- Medical—
  - Threat capability for the use of CBRN warfare agents and directed energy weapons/devices.
  - Provisions for laboratory support to identify suspect agents.
  - Special immunization or chemoprophylaxis for potential biological warfare agents.

- Command information stressing individual protective measures to include personal hygiene and sanitation.
- Provisions for safeguarding and inspecting food and water supplies.
- Provisions for the treatment of contaminated water sources.
- Combat and operational stress control resources for debriefing victims, rescuers, and caregivers after a terrorist attack.
- Provisions for suspect biological warfare and chemical warfare agent therapeutics.
- Medical evacuation under hostile fire or in adverse terrain (see ATP 4-25.13).
- Mass casualty situations.
- Augmentation or reinforcement of medical personnel, supplies, and equipment.
- Hospitalization (location and requirements).
- Plans for continued care or relocation in the event the MTF is the target of a terrorist attack.
- Dispersion of units.
- Care of government-owned animals used in combating terrorism operations.
- Task-organized specialized medical response teams.
- Nonmedical—
  - Terrorist threat.
  - Potential targets.
  - Terrorist bomb awareness and countermeasures.
  - Operations security.
  - Procurement of special security equipment, such as portable barriers and intrusion devices.
  - Protection of storage and distribution areas.
  - Security before, during, and after deployment to the area of operations.
  - Limitations of access to MTFs by reducing the number of entry and exit points.
  - Personnel screening of those seeking access to the facility.

4-96. Combat and operational stress control teams are an integral part of the military's support to personnel involved in operations to combat terrorism. The COSC team is a multidisciplinary element capable of rapid deployment in response to behavioral health emergencies occurring in the supported area of operations. The team's mission is to support the rapid return to duty of military personnel and prevention of posttraumatic stress disorders in captives and those persons closely associated with terrorist activity.

4-97. Although not all terrorist activities result in mass casualty situations, medical elements must plan for and be prepared to respond to mass casualty situations should they occur. Mass casualty exercises or rehearsals must be conducted to ensure the proper response and that the required internal and external coordination has been effected. Both planning and rehearsals must be flexible enough to account for any disruption or reduced capability that may result from a terrorist act. At a minimum, mass casualty exercises should be conducted at least twice a year, and more often in areas where the threat or risk of an attack is greater. Contingency plans must also be prepared to continue the AHS support mission, even if the MTF or medical unit is the target of the terrorist attack.

4-98. Veterinary services personnel may also play a key role in countering the terrorist threat, especially if the threat includes the employment of CBRN weapons. Veterinary personnel, therefore, must be alert to the potential use of these agents and report any suspected use to the appropriate authorities. Veterinary personnel are also needed to differentiate between normal animal deaths and those potentially caused by terrorists using biological or chemical warfare agents. Personnel, animals, and food supplies and sources (such as crops) are highly susceptible to biological agents. Veterinary personnel must be prepared to inspect suspect subsistence and care for affected animals. Further, military working dogs are trained to detect explosive materials which aid in the search for potential terrorist threats; these animals must be protected.

4-99. All newly assigned unit personnel should receive training that addresses the terrorist threat. The discussion can include the Soldier's role in combating terrorism and in mass casualty situations. It may also include information on what to do if the MTF is the target of a terrorist attack. Unit training should also be conducted on topics such as—

- Security.
- Bomb threat awareness and countermeasures.
- How to talk to terrorists or hostage takers until relieved by law enforcement experts.
- Dealing with bystanders of terrorist incidents.
- Psychological debriefing and medical management of hostages upon rescue or release.
- Force survivability.
- Chemical, biological, radiological and nuclear passive defense.

4-100. To ensure effective use of medical personnel, nonmedical personnel assigned to the unit should be instructed in support duties, such as driving, ensuring the security of the unit area, carrying litters, acting as messengers, and providing first aid in the minimal care area, as required.

## UNCONVENTIONAL WARFARE

4-101. Unconventional warfare consists of activities conducted to enable a resistance movement or insurgency to coerce, disrupt, or overthrow a government or occupying power by operating through or with an underground, auxiliary, and guerrilla force in a denied area (JP 3-05). These operations are normally of long duration and are predominantly conducted by indigenous or surrogate forces. These forces are organized, trained, equipped, supported, and directed in varying degrees by an external source. Unconventional warfare includes guerrilla warfare and other direct offensive, low-visibility, covert, or clandestine operations. It also includes the indirect activities of subversion, sabotage, intelligence collection, evasion, and escape. The primary forces used in unconventional warfare are Special Operations Forces.

4-102. The goal of medical operations in support of unconventional warfare is to conserve the fighting strength of insurgent forces. The goal is also to assist in securing local population support for U.S. and insurgent forces operating within joint special operations areas. Medical elements supporting insurgent forces must be mobile, responsive, effective in preventing disease, and returning the sick and wounded to duty. There is no safe rear area where the insurgents can take casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

4-103. In unconventional warfare, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points. This permits the remaining members of the insurgent force to continue fighting. Casualties at collecting points are later evacuated to the insurgent base or to a supporting medical facility. As the operation develops, evacuation of the more seriously wounded, injured, or diseased personnel to friendly areas is accomplished by establishing alternate covert evacuation networks if security does not permit the open use of U.S. military medical evacuation assets.

4-104. Army Health System support requirements within the joint special operations area differ from those of conventional forces. In unconventional warfare, battle casualties are normally fewer and the incidence of disease and malnutrition is often higher. Use of conventional military medical assets to support unconventional warfare can only be accomplished if it does not compromise the security of the mission. See JP 3-05 and ATP 3-05.1 for additional information.

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## PART TWO

# Army Health System Support to Defense Support of Civil Authorities Tasks

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## Chapter 5

### Defense Support of Civil Authorities Overview

Department of Defense Directive 3025.18 defines DSCA as support provided by U.S. Federal military forces, DOD civilians, DOD contract personnel, DOD Component assets, and National Guard forces (when the Secretary of Defense, in coordination with the governors of the affected states, request to use those forces in Title 32, U.S. Code status) in response to requests for assistance from civil authorities, or from qualifying entities for special events. Defense support of civil authorities tasks address the consequences of natural or man-made disasters, accidents, terrorist attacks, and incidents in the U.S. and its territories and are also known as civil support. This chapter identifies the primary DSCA tasks, as well as national and DOD-level guidance. This chapter also provides a brief description of medical aspects of the NRF, National Disaster Recovery Framework, and the NDMS.

#### SECTION I — DEFENSE SUPPORT OF CIVIL AUTHORITIES

5-1. Defense support of civil authorities tasks occur at all levels of war—tactical, operational, and strategic. When performing DSCA tasks, Soldiers work closely with federal, state, and local agencies and other civilian organizations to resolve conditions threatening lives, property, and domestic order. Within the U.S. and its territories, decisive action combines the elements of DSCA and as required, offense and defense to support homeland defense. In most domestic operations, Army forces perform only DSCA tasks. However, extreme emergencies, such as an attack by a hostile foreign power, may require simultaneous combinations of offensive, defensive, and DSCA tasks.

5-2. Like operations with a stability focus, DSCA tasks are different from other types of decisive action. Stability and DSCA tasks emphasize the employment of nonlethal force rather than the use of lethal combat power. Most tasks necessary to conduct DSCA are common to operations overseas. However, DSCA tasks are executed under very different conditions. Defense support of civil authorities is constrained by various laws to a greater degree than operations conducted in accordance with the Law of Land Warfare and The Hague and Geneva Conventions, as it requires the adaptation of systems and procedures intended for combat to a noncombat civilian-led structure.

## PRIMARY DEFENSE SUPPORT OF CIVIL AUTHORITIES TASKS

5-3. While DSCA tasks may require various types and levels of support, the primary purpose of such missions is to *save lives, alleviate suffering, and protect property*. The primary Army DSCA tasks are to—

- Provide support for domestic disasters.
- Provide support for domestic CBRN incidents.
- Provide support for domestic civilian law enforcement agencies.
- Provide other designated support.

## PRIMARY CHARACTERISTICS

5-4. Every domestic support mission is unique; however, there are four defining characteristics that shape the actions of leaders and commanders conducting DSCA tasks. The four primary characteristics of DSCA tasks are—

- State and federal laws define how military forces support civil authorities. Nearly all aspects of DSCA are defined by law including professional skills requirements for health care personnel and rules surrounding the provision of medical treatment for military personnel by civilian physicians. Leaders and commanders should consult their staff judge advocate before authorizing Soldiers to execute any task outside of the mission received through the chain of command.
- Civil authorities are in charge and military forces support them. The DOD is not the lead agency during DSCA. The primary civilian agency establishes the priority of effort for all domestic support missions, while the DOD executes DSCA tasks in support. Military units provide the necessary support, but do not receive orders from civilian agencies.
- Military forces depart when civil authorities can continue without military support. Military forces assist in establishing or restoring basic civil functions and hand over remaining tasks or duties to the appropriate civilian organization as soon as they are able to perform those duties without military support.
- Military forces must document costs of all direct and indirect support provided. Unless otherwise directed by the President or Secretary of Defense, all federal military support is provided on a reimbursable basis. The Stafford Act sets the guidelines for reimbursements to federal agencies and states from federal funds set aside in response to a Presidential declaration.

5-5. See ADRP 3-28 and JP 3-28 for additional information.

## SECTION II — NATIONAL AND DEFENSE POLICY

### NATIONAL POLICY

5-6. National policy governing DSCA can be found in federal law, presidential policy directives, executive orders, and DOD policy. This section is not intended as an all-inclusive list, but discusses several key federal laws and policy documents governing national preparedness guidelines in response to threats that pose the greatest risk to the security of the Nation, including acts of terrorism, cyber attacks, pandemics, and catastrophic natural disasters.

### STAFFORD ACT

5-7. The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 100-707, known as the Stafford Act) is the primary federal statute giving the President the authority to direct federal agencies, including the DOD, to provide assistance to state and local authorities during an incident. The purpose of this assistance is to save lives, alleviate human suffering, protect public health and safety, and lessen or avert the threat of a catastrophe. The Stafford Act authorizes the President to issue major disaster or emergency declarations in response to catastrophes that overwhelm state and local governments.

5-8. Department of Defense support in response to a domestic disaster or Presidential declaration of emergency is provided to assist primary or coordinating agencies. The types of military support provided may include aviation, communications, engineering, logistical, medical, public affairs, and other capabilities. Under the Stafford Act, the supported agency is required to reimburse the DOD for operating expenses out of funds made available to carry out this support. The law also sets the guidelines for reimbursement to federal agencies and states from federal funds set aside to support missions in response to a Presidential declaration.

## ECONOMY ACT

5-9. The Economy Act (Title 31 U.S. Code Section 1535) permits federal agencies, such as the DOD for requests for military support, to provide resources and services to other federal agencies on a reimbursable basis. Under the Economy Act, federal agencies participating in the NRF request and provide support to other federal organizations by executing interagency or intraagency reimbursable agreements for eligible expenditures. Requests for assistance in circumstances other than a declared emergency or disaster also fall under the Economy Act.

## POSSE COMITATUS ACT

5-10. Unless authorized by the U.S. Constitution or an Act of Congress, the Posse Comitatus Act (Title 18, U.S. Code Section 1385) in conjunction with DODI 3025.21, prohibits the use of DOD forces (active Army, Air Force, Navy, and Marine Corps) for direct enforcement of state or federal law or performing law enforcement activities. The Posse Comitatus Act does not—

- Apply to state National Guard forces in state active duty status and Title 32 status. State and territorial governors can use state National Guard forces for direct support of civilian law enforcement, but such use is a temporary measure and must be in accordance with state laws.
- Restrict the Coast Guard; even when under the operational control of the Navy, given that the Coast Guard has law enforcement power under Title 14, U.S. Code.

5-11. While use of federal military forces for direct law enforcement activities or providing security is prohibited (except on military installations), when authorized by the Secretary of Defense, military forces may provide indirect support to law enforcement agencies. This support is limited to logistics, transportation, and training assistance except when emergency authority applies. See ADP 3-28 and ADRP 3-28 for additional information.

## PUBLIC HEALTH SERVICE ACT

5-12. Under the Public Health Service Act, Title 42, U.S. Code, a state health office may request activation of the NDMS by the Department of Health and Human Services in a public health emergency situation without a Presidential disaster declaration. However, the state may be liable for costs incurred in this type of activation.

## PRESIDENTIAL POLICY DIRECTIVE 8

5-13. Presidential Policy Directive 8, National Preparedness, was established to facilitate an integrated, *all-of-Nation approach* to preparedness. The policy directs the development of a national preparedness goal that identifies the core capabilities necessary for preparedness and a national system to guide activities that will enable the Nation to achieve this goal. The national preparedness system will allow the country to track the progress of our ability to build and improve the capabilities necessary to prevent, protect against, mitigate the effects of, respond to, and recover from those threats that pose the greatest risk to the security of the Nation.

## DEFENSE POLICY

5-14. Department of Defense Directive 3025.18 establishes policy and provides guidance for execution and oversight of DSCA, when requested by civil authorities or by qualified entities. This directive authorizes immediate response authority for DSCA tasks, when requested and emergency authority has been granted

for the use of military forces under dire situations. Department of Defense Directive 3025.18 also mandates that all requests for DSCA be written and include a commitment to reimburse the DOD in accordance with the Stafford Act and the Economy Act, except for support to immediate response or mutual and/or automatic aid. Other applicable DOD policies are included throughout this publication.

### **IMMEDIATE RESPONSE AUTHORITY**

5-15. Under DODD 3025.18, in response to a request for assistance from a civil authority (under imminently serious conditions and if time does not permit approval from a higher authority), DOD officials (which includes federal military commanders, heads of DOD Components, and/or responsible DOD civilian officials) may provide an immediate response by temporarily employing the resources under their control, subject to any supplemental direction provided by higher headquarters to save lives, prevent human suffering, or mitigate great property damage within the United States. Immediate response authority does not permit actions that would subject civilians to the use of military power that is regulatory, prescriptive, proscriptive, or compulsory.

5-16. An immediate response shall end when the necessity giving rise to the response is no longer present (such as when there are sufficient resources available from state, local, and other federal agencies to respond adequately and that the agency or department has initiated response activities) or when the initiating DOD official or higher authority directs an end to the response. The DOD official directing a response under immediate response authority shall reassess whether there remains a necessity for the DOD to respond under this authority as soon as practicable but, if immediate response activities have not yet ended, not later than 72 hours after the request for assistance was received.

5-17. Support provided under immediate response authority should be provided on a cost reimbursable basis, where appropriate or legally required, but will not be delayed or denied based on the inability or unwillingness of the requester to make a commitment to reimburse the DOD.

## **SECTION III — PRIMARY DEFENSE SUPPORT OF CIVIL AUTHORITIES TASKS**

### **SUPPORT FOR DOMESTIC DISASTERS**

5-18. The Department of Homeland Security, through the Federal Emergency Management Agency is responsible for coordination of the federal government's response to natural and man-made disasters. The DOD is a supporting agency for all emergency support functions (ESF) within the NRF. The Department of Health and Human Services provides primary federal medical response elements during domestic emergencies. The Department of Health and Human Services, through ESF #8, Public Health and Medical Services, may request DOD medical assets in support of DSCA tasks. The U.S. Department of Agriculture provides the primary federal agricultural response for ESF #11, Agriculture and Natural Resources, which may request DOD veterinary assets in response to domestic disasters. The joint task force will coordinate all military medical actions with the National Health and Human Services Secretary Operations Center/NDMS Operations Support Center. Requests for military support to domestic disasters may occur at four levels—

- As directed by the governor for state National Guard forces.
- By Presidential declaration, at the request of the governor of the affected state.
- As directed by the Secretaries of the Army, Navy or Air Force for capabilities not assigned to combatant commanders (such as bases and installations).
- By immediate response authority, under certain conditions in urgent situations (as outlined in paragraphs 5-15 through 5-17 above).

5-19. During DSCA, active Army and Reserve Component personnel are integrated as a total force; therefore, medical commanders must thoroughly understand the parameters outlined in Title 10 and Title 32 of the U.S. Code and all applicable DOD directives for the provision of medical support. Upon

activation by the President and/or Secretary of Defense, medical forces will conduct operations in support of the DSCA mission, but will remain under the mission command of U.S. military commanders.

## **SUPPORT FOR DOMESTIC CHEMICAL, BIOLOGICAL, RADIOLOGICAL, AND NUCLEAR INCIDENTS**

5-20. Medical emergencies of national significance such as CBRN incidents and or pandemic influenza are likely to result in surge requirements that overwhelm the response capacity and resources of both medical facilities and health care providers. Department of Defense Directive 3150.08, DODIs 3020.52, and 6200.03 establish policy and assign responsibilities for the DOD consequence management response to a CBRN incident.

5-21. In the event of a CBRN incident, the President will direct any DOD response in support of a primary agency. The Secretary of Defense retains approval authority for the use of military personnel, units, and equipment for DSCA, to include support to CBRN consequence management. When the Secretary of Defense approves a request for DSCA during a CBRN incident, the Commander, U.S. Northern Command and Commander, U.S. Pacific Command are the supported combatant commanders for CBRN response within their respective areas of responsibilities as designated in the Unified Command Plan for a federal response. The DOD supports the NRF primary and coordinating agencies during domestic CBRN consequence management operations. Refer to JP 3-41 and FM 3-11.21 for more information regarding CBRN consequence management.

5-22. During DSCA, the AHS response to a CBRN incident may include, but is not limited to—

- Providing medical care to casualties at the mass casualty decontamination site and supervising the patient decontamination process at the patient decontamination site to ensure that no further injuries are caused.
- Providing en route care for patients from the incident site to an MTF or designated location for further care.
- Providing guidance to local responders in the management of CBRN casualties. This guidance may be on the correct use of antidotes, chemoprophylaxis, prevention of contamination spread in the MTF, patient decontamination at the MTF, and other related medical management procedures.
- Providing CBRN levels of identification and analysis.
- Providing guidance on the application of standard precautions for CBRN, especially preventive measures to prevent the spread of contagious agents.
- Managing, triaging, and treating mass casualties.

5-23. When a CBRN event occurs on a military installation, the installation medical authority (medical commander, installation MTF emergency manager, and or the Public Health Emergency Officer) provides the AHS initial response to the event site. Request for assistance from deployable medical organizations and staffs are initiated by the installation medical authority through military channels. Refer to Army Regulation 40-13 and DODI 6055.17 for more information.

5-24. Installation or base protection is a homeland defense mission. Detailed doctrine on installation emergency support requirements are outlined in ATP 3-11.42. Medical treatment facilities have unique capability to support the installation and installation responders through the issue of medical CBRN defense materiel, planning, and guidance provided by the public health emergency officers, and the application of the full range of available medical capability.

## **SUPPORT FOR CIVILIAN LAW ENFORCEMENT AGENCIES**

5-25. Support for civilian law enforcement agencies pertains to the restricted use of DOD resources to support civilian law enforcement within the U.S. and its territories. Department of Defense Instruction 3025.21 is a key DOD policy pertaining to defense support of civilian law enforcement agencies.

5-26. Department of Defense Instruction 3025.21 establishes policy for defense support to civilian law enforcement consistent with the needs of national security and military preparedness, while recognizing

and conforming to the legal limitations on direct DOD involvement in civilian law enforcement activities. This DODI mandates the review of training and operational programs to determine how and where assistance can best be provided to civilian law enforcement officials. It also directs the heads of the DOD components to inform the Chairman of the Joint Chiefs of Staff of all requests requiring approval of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs or the Secretary of Defense in accordance with this DODI. The directive also calls for the issue of implementing guidance including—

- Procedures for prompt transfer of relevant information to law enforcement agencies.
- Procedures for establishing local points of contact in subordinate commands for purposes of coordination with federal, state, tribal, and local civilian law enforcement officials.
- Guidelines for evaluating requests for assistance in terms of impact on national security and military preparedness.

## **OTHER DESIGNATED SUPPORT**

5-27. Other designated support during DSCA consists of preplanned routine support not related to disasters or emergencies such as major public events including—the Olympics, state funerals, inaugurations, and may extend to military augmentation of critical government services, as authorized by the President and directed by the Secretary of Defense. Firefighting within state and national lands is also included in this support.

## **SECTION IV — NATIONAL EMERGENCY MANAGEMENT**

### **NATIONAL RESPONSE FRAMEWORK**

5-28. The NRF is an essential component of the National Preparedness System mandated in Presidential Policy Directive 8 and serves as a guide to how the Nation responds to all types of disasters and emergencies. The NRF defines the capabilities necessary to save lives, protect property and the environment, and meet basic human needs. It also describes the guiding principles, roles and responsibilities, and structures for implementing nationwide response policy and operational coordination for any type of disaster or emergency regardless of scale, scope, or complexity. The NRF consists of a base document, 14 ESF Annexes (previously 15 ESFs, as ESF #14 was superseded by the National Disaster Recovery Framework), Support Annexes, and Incident Annexes. The annexes provide detailed information to assist with the implementation of the framework.

5-29. The response protocols and structures described in the NRF align with the concepts identified in the National Incident Management System. The structures and procedures within the NRF address incidents where federal support to local, state, tribal, territorial, and insular area governments is coordinated under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as well as incidents where federal departments and agencies exercise other authorities and responsibilities. The NRF is intended as an enabler for local, state, tribal, territorial, insular area, or federal government department or agency to carry out its authorities and meet its responsibilities under applicable laws, executive orders, and directives. The NRF incorporates a focus on the entire community, which includes the important roles that individuals, families, and households play in response activities. See Chapter 2 for additional information on the NRF and medical aspects of the ESFs.

### **NATIONAL DISASTER RECOVERY FRAMEWORK**

5-30. The National Disaster Recovery Framework is a guide that facilitates effective recovery support to states, tribes, and local jurisdictions impacted by a disaster and provide a flexible structure that enables disaster recovery managers to collaborate and function in a unified manner. The National Disaster Recovery Framework is consistent with the vision set forth in Presidential Policy Directive 8 and applies to all presidentially declared major disasters. The National Disaster Recovery Framework aligns with the NRF and replaces ESF #14, which addressed Long-Term Community Recovery. The NRF primarily addresses actions during disaster *response* or short-term immediate recovery efforts, while the National

Disaster Recovery Framework focuses on intermediate and long-term recovery needs. Key ESF #14 concepts are expanded in the National Disaster Recovery Framework and include recovery-specific leadership, organizational structure, planning guidance, and other components needed to coordinate continuing support to individuals, business, and communities. The National Disaster Recovery Framework also focuses on how best to restore, redevelop, and revitalize the health, social, economic, natural and environmental fabric of the community to build a more resilient Nation.

5-31. Like the NRF ESFs, the National Disaster Recovery Framework provides six recovery support functions, which serve as groupings of core capabilities that provide a structure to facilitate problem solving, improve access to resources, and foster coordination among state and federal agencies, nongovernmental partners and stakeholders. The ESF response activities and the efforts of the recovery support functions often occur simultaneously, as some of the responsibilities of the NRF frequently overlap with or transition to the National Disaster Recovery Framework. The DOD (through the U.S. Army Corps of Engineers) is the coordinating agency for Infrastructure Systems, which is one of the six recovery support functions.

5-32. Emergency Support Function #8 is linked closely with the Health and Social Services Recovery Support Function under the National Disaster Recovery Framework. The Health and Social Services Recovery Support Function may be activated as early as ESF #8, though initially to focus on planning and information sharing. The ESFs and recovery support functions coexist and share information about impacts and assistance provided while focusing on their respective core capability. There will be some overlap between ESFs and recovery support function missions, but as the ESF requirements diminish, the recovery support functions take over the residual response activities that are associated with recovery. When the transition takes place depends on the scope of the incident and the nature of the activities and tasks involved. From the earliest days following the disaster, ESF #8 will work closely with the Health and Social Services recovery support function field coordinator to synchronize the transition to long-term restoration activities as seamlessly as possible.

## NATIONAL INCIDENT MANAGEMENT SYSTEM

5-33. The National Incident Management System provides a core set of doctrine, concepts, principles, terminology, and organizational processes which enable nationwide coordination for incident management during disaster response operations. The National Incident Management System is not a static automated information system, but a framework that forms the basis for interoperability among federal, state, local and tribal government, nongovernmental organizations, and the private sector. The National Incident Management System works hand-in-hand with the NRF, as both are designed to ensure that incident management begins at the local level as the first line of emergency management and incident response, and that local jurisdictions retain control and authority over response activities within their areas. The National Incident Management System provides a template for incident management, while the NRF provides the structure and mechanisms for national-level policy governing response to domestic emergencies. Together, the NRF and the National Incident Management System help to ensure that all response partners use standard command and management structures to facilitate scalable, flexible, and adaptable operational capabilities.

5-34. The National Incident Management System is—

- A comprehensive, nationwide, systematic approach to incident management, including the incident command system, multiagency coordination systems, and public information.
- A set of preparedness concepts and principles for all hazards.
- Essential principles for a common operational picture and interoperability of communications and information management.
- Standardized resource management procedures that enable coordination among different jurisdictions or organizations.
- Scalable to enable use for all incidents (from day-to-day to large-scale).
- A dynamic system that promotes ongoing management and maintenance.

## NATIONAL DISASTER MEDICAL SYSTEM

5-35. The NDMS is an interagency partnership between the Department of Health and Human Services, DOD, Department of Homeland Security, and the Department of Veterans Affairs established to augment the Nation's medical response capabilities. The system combines federal and nonfederal resources into a unified response to meet natural and man-made disasters and support patient treatment requirements from military contingencies. The mission of the NDMS is to temporarily supplement federal, tribal, state, and local capabilities by funding, organizing, training, equipping, deploying, and sustaining a specialized and focused range of public health and medical capabilities. Components of the NDMS include—

- Medical response to a disaster area in the form of personnel (teams and individuals), supplies, and equipment.
- Patient movement from a disaster site to unaffected areas of the nation.
- Definitive medical care at participating hospitals in unaffected areas.

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**Note.** Activation of the NDMS does not necessarily mean that all active Army, Reserve Component, and National Guard are activated. Often, disaster medical assistance teams are activated to provide medical response, but the patient movement and definitive care components are not activated.

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5-36. The NDMS organizes a coordinated effort by federal partners (the Department of Health and Human Services, Department of Homeland Security, DOD, and the Department of Veterans Affairs), working in collaboration with the states and other public or private entities to provide health services, health-related social services, other human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency. The NDMS may also organize a coordinated effort for federal partners to be present at locations (for limited periods of time) specified by the Secretary of the Department of Health and Human Services on the basis that the Secretary has determined a location to be at risk of a public health emergency during the time specified in accordance with Public Law 107-188. The NRF utilizes the NDMS under ESF #8 to provide resources and assets to support federal activities.

5-37. Department of Defense Directive 6010.22 establishes policy for DOD participation in the NDMS. The DODD also directs the—

- Department of Defense components to supplement Department of Health and Human Services emergency medical care as part of the NRF.
- United States Transportation Command to provide necessary patient transportation assets to include medical crews and patient movement items when local needs exceed civilian transportation capabilities.
- Establishment of federal coordinating centers at designated Department of Veterans Affairs Hospitals and military medical treatment facilities.

## Chapter 6

# Army Health System Support to Defense Support of Civil Authorities Tasks

During DSCA, Army forces assist in responding to crises and relieving suffering by providing essential support services and specialized resources when the capabilities of civil authorities have been exceeded. This chapter discusses AHS support to DSCA tasks to include specific DOD medical responsibilities as part of the NDMS and the NRF under ESFs #8, Public Health and Medical Services and #11, Agriculture and Natural Resources. This chapter also provides legal considerations that may apply when providing medical support to DSCA tasks and a discussion of the support provided for each of the 10 medical functions.

## SECTION I — DEPARTMENT OF DEFENSE MEDICAL SUPPORT FOR DOMESTIC INCIDENTS

### DEPARTMENT OF DEFENSE SUPPORT TO THE NATIONAL DISASTER MEDICAL SYSTEM

6-1. The NDMS is a collaborative, asset sharing partnership between the DOD, Department of Homeland Security, Department of Health and Human Services, and the Department of Veterans Affairs to leverage federal and nonfederal resources in the continental U.S. to care for massive numbers of casualties generated in a domestic disaster or overseas conventional war. The DOD is a supporting agency within the NDMS, responsible for assisting in—

- Definitive medical care.
- Patient evacuation.
- Military health emergencies.

#### DEFINITIVE MEDICAL CARE

6-2. The DOD (along with the Department of Veterans Affairs) is responsible for coordinating NDMS definitive medical care in designated patient reception areas of the U.S., which will be accomplished through federal coordinating centers. Definitive medical care will be rendered by a nationwide network of voluntarily participating, preidentified, federal and nonfederal hospital services. The network includes an ability to track available beds by medical specialty. In a public health emergency, these services provide definitive medical care for victims.

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**Note.** The NDMS definition for definitive medical care is *to the extent authorized by the National Disaster Medical System in the particular public health emergency, medical treatment or services beyond emergency medical care, initiated upon inpatient admission to a National Disaster Medical System hospital and provided for injuries or illnesses resulting directly from a specified public health emergency or for injuries, illnesses, and conditions requiring nondeferrable medical treatment or services to maintain health when such medical treatment or services are temporarily not available as a result of the public health emergency.*

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## **PATIENT EVACUATION**

6-3. The DOD also has responsibility for coordinating the patient evacuation function of the NDMS. As part of this support the DOD coordinates with the U.S. Department of Transportation, the primary federal agency for ESF #1, to provide support for the evacuation of patients to definitive medical care under the NRF. At the request of the Department of Homeland Security or Department of Health and Human Services, the DOD may use available military transportation resources to evacuate patients from designated staging sites to NDMS patient reception areas. The U.S. Transportation Command's Defense Distribution Operations Center is responsible for the movement of NDMS patients who require en route medical care to include—accepting requests for movement of NDMS patients out of the disaster area, medical regulating, patient tracking, and coordinating patient transportation. Department of Defense support to the NDMS for patient evacuation may be reimbursed by the requesting agency.

## **MILITARY HEALTH EMERGENCIES**

6-4. After consultation with the Department of Homeland Security, the Assistant Secretary of Defense for Health Affairs may access the NDMS hospital network for definitive medical care in a military health emergency. A military health emergency declared by the Assistant Secretary of Defense for Health Affairs is deemed to be a public health emergency for purposes of the NDMS statute. In a military health emergency, NDMS nonfederal hospitals provide backup to available Department of Veterans Affairs and military medical services for military beneficiaries should the need arise. The DOD is responsible for funding patient evacuation and medical care for members of the armed forces. Use of DOD and Department of Veterans Affairs hospital services in a public health emergency is contingent on availability and appropriate approval.

## **DEPARTMENT OF DEFENSE ROLE WITHIN THE NATIONAL RESPONSE FRAMEWORK**

6-5. The DOD is a full partner in the federal response to domestic incidents and its support is fully coordinated through the NRF. When requested, and upon approval of the Secretary of Defense or at the direction of the President, the DOD provides support to DSCA during domestic incidents. Once support is requested and approved, a defense coordinating officer serves as the DOD single point of contact at the joint field office for requesting DOD assistance.

6-6. Emergency support functions are the primary federal coordinating structures within the NRF for delivering core response capabilities and provide the framework for coordinating federal interagency support in response to declared disasters and emergencies. The federal government and many state governments (as well as certain private-sector and nongovernmental agencies) organize resources and capabilities under 14 ESFs.

6-7. Each ESF consists of a coordinator, primary agency, and supporting agencies. Emergency Support Function coordinators and primary agencies are identified on the basis of authorities and resources. The DOD is considered a supporting agency for all ESFs within the NRF and serves as the coordinator and primary agency (through the U.S. Army Corps of Engineers) for ESF #3, Public Works and Engineering. The DOD is also the primary agency for aeronautical search and rescue (through the U.S. Air Force) under ESF #9, Search and Rescue. During domestic disasters, primary DOD functions in support of the federal medical response are outlined in ESFs #8, Public Health and Medical Services and #11, Agriculture and Natural Resources. For the purposes of this discussion, ESFs #8 and #11 will be the primary focus of the information provided to describe DOD support for the federal medical response. Refer to ADP 3-28 and ADRP 3-28 for additional information on defense support of civil authorities.

## **EMERGENCY SUPPORT FUNCTION #8, PUBLIC HEALTH AND MEDICAL SERVICES**

6-8. The Department of Health and Human Services serves as the coordinator and primary agency for ESF #8 responsible for supporting federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters. Emergency Support Function #8 provides the means for coordinated federal assistance to supplement state, tribal, territorial, and local

resources in response to—a disaster, emergency, or incident that may lead to a public health, medical, behavioral or human service emergency, including those that have international implications.

6-9. Under ESF #8, public health and medical services (such as patient movement, patient care, and behavioral health) and support to human services (such as addressing individuals with disabilities and others with access and functional needs) are delivered through surge capabilities that augment public health, medical, behavioral, and veterinary functions with health professionals, pharmaceuticals to include distribution and delivery of medical countermeasures, equipment and supplies, and technical assistance. These services are provided to mitigate the effects of acute and longer-term threats to the health and safety of the population and responders. Emergency Support Function #8 also disseminates public health information on protective actions related to exposure to health threats or environmental threats (such as threats to potable water and food safety) and provides supplemental assistance in the following functional areas:

- Assessment of public health/medical needs.
- Health surveillance.
- Medical surge.
- Health/medical/veterinary equipment and supplies.
- Patient movement.
- Patient care.
- Safety and security of drugs, biologics, and medical devices.
- Blood and tissue.
- Food safety and defense.
- Agriculture safety and security.
- All-hazards public health and medical consultation, technical assistance, and support.
- Behavioral health care.
- Public health and medical information.
- Vector control.
- Guidance on potable water, wastewater, and solid waste disposal.
- Mass fatality management, victim identification, and decontaminating remains.
- Veterinary medical support.

6-10. Emergency Support Function #8 may request DOD medical support to augment functions such as casualty clearing and staging, patient management and treatment, and support services (including surveillance, laboratory diagnostics, and confirmatory testing). Managing human remains, which encompasses remains collection, victim identification, remains transport, autopsy (if appropriate) mortuary affairs, and temporary internment of the dead, is also listed among the DOD functions in support of ESF #8.

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**Note.** Within the DOD, management, handling, and transport of human remains are logistics functions and are not performed by medical personnel.

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6-11. Under ESF #8, the Secretary of the Department of Health and Human Services assumes operational control of federal emergency public health and medical response assets (as necessary) in the event of a public health emergency, except for members of the Armed Forces, who remain under the authority and control of the Secretary of Defense. Department of Defense support to ESF #8 is subject to approval of the availability of resources and the approval of the Secretary of Defense. Table 6-1 on page 6-4 provides the full list of DOD functions under ESF #8.

**Table 6-1. Department of Defense support to emergency support function #8**

| <b><i>Department of Defense Functions</i></b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| •                                             | Alerts Department of Defense National Disaster Medical System federal coordinating centers (Army, Navy, and Air Force) and provides specific reporting/regulating instructions to support incident relief efforts.                                                                                                                                                                                                                                                                                                                                                                                                              |
| •                                             | Alerts Department of Defense National Disaster Medical System federal coordinating centers to activate patient reception plans in a phased, regional approach, and when appropriate, in a national approach.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| •                                             | At the request of the Department of Health and Human Services and in coordination with interagency partners, provides support for the evacuation and medical management of patient collection points (such as aerial ports of debarkation) to patient reception point (federal coordinating centers) and onward to National Disaster Medical System hospitals.                                                                                                                                                                                                                                                                  |
| •                                             | Using available Department of Defense transportation resources, in coordination with the National Disaster Medical System Medical Interagency Coordination Group, evacuates and manages victims/patients from the patient collection point in or near the incident site to National Disaster Medical System patient reception areas.                                                                                                                                                                                                                                                                                            |
| •                                             | Provides available logistical support (such as transportation) to public health/medical response operations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| •                                             | Provides available medical personnel for casualty clearing/staging and other missions as needed including aeromedical and/or rotary-wing air evacuation and medical treatment. Mobilizes and deploys available Reserve and National Guard medical units when authorized and necessary to provide support.                                                                                                                                                                                                                                                                                                                       |
| •                                             | Coordinates patient reception, tracking, and management of patients evacuated on Department of Defense assets to nearby National Disaster Medical System hospitals, Department of Veterans Affairs hospitals, and Department of Defense medical treatment facilities that are available and can provide appropriate care.                                                                                                                                                                                                                                                                                                       |
| •                                             | Deploys available medical, surgical, and behavioral health personnel for casualty clearing and staging, patient management, and treatment. Deploys health care providers to augment civilian hospital staff, federal deployable teams, and supports points of medical countermeasure distribution. Deploys chemical, biological, radiological, and nuclear medical subject matter experts and/or teams for technical consultation and/or medical support. Mobilizes and deploys available Active Component, Reserve, and/or National Guard medical units or individuals when authorized for public health and medical response. |
| •                                             | Provides deployable units (such as the Expeditionary Medical Support System, combat support hospitals, United States Navy hospital ships, and/or other Navy vessels) for patient medical and/or surgical care.                                                                                                                                                                                                                                                                                                                                                                                                                  |
| •                                             | Provides epidemiological and occupational health support, telemedicine, and other specialized medical support.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| •                                             | Provides available military medical personnel to assist Emergency Support Function #8 in the protection of public health (such as food, water, hygiene, wastewater, solid waste removal and disposal, vectors, hygiene, and vector control).                                                                                                                                                                                                                                                                                                                                                                                    |
| •                                             | Provides available veterinary military personnel to assist in the treatment of animals and in food protection activities. Provides available zoonotic and food surveillance data to Emergency Support Function #8 and # 11 partners (such as the Food and Drug Administration and United States Department of Agriculture).                                                                                                                                                                                                                                                                                                     |
| •                                             | Provides available Department of Defense medical supplies and materiel for use at points of distribution, hospitals, clinics, or medical care locations operated for exposed populations, incident victims, or ill patients. Provides available Department of Defense supplies and materiel for mass care centers.                                                                                                                                                                                                                                                                                                              |
| •                                             | Assists local, state, tribal, territorial, and insular area officials in the provision of emergency medical, surgical, and behavioral health care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| •                                             | Provides the use of functional Department of Defense medical treatment facilities within or near the incident area for medical care of individuals who are not beneficiaries of the Military Health System.                                                                                                                                                                                                                                                                                                                                                                                                                     |
| •                                             | Provides available assistance in managing human remains, including remains collection, victim identification, remains transport, autopsy (if appropriate), mortuary affairs, and temporary internment of the dead (if appropriate). Provides support to Family Assistance Centers.                                                                                                                                                                                                                                                                                                                                              |
| •                                             | Provides evaluation and risk management support through use of defense coordinating officers, emergency preparedness liaison officers, and Joint regional medical planners.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| •                                             | Provides available blood and tissue in coordination with the Department of Health and Human Services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| •                                             | Provides public health and medical surveillance, laboratory diagnostics, and confirmatory testing (such as the United States Army Medical Research Institute of Infectious Disease and United States Naval Medical Research Center) in coordination with the Laboratory Response Network and Department of Health and Human Services.                                                                                                                                                                                                                                                                                           |

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**Note.** The U.S. Army Corps of Engineers (through ESF #3, Public Works and Engineering) provides technical assistance, equipment, and supplies as required in support of the Department of Health and Human Services to accomplish temporary restoration of damaged public utilities affecting public health and medical facilities. In the event of a catastrophic mass fatality incident, the U.S. Army Corps of Engineers also assists with the temporary internment of the dead.

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## **EMERGENCY SUPPORT FUNCTION #11, AGRICULTURE AND NATURAL RESOURCES**

6-12. Emergency Support Function #11 is activated by the Department of Homeland Security/Federal Emergency Management Agency upon notification of a potential or actual incident that requires a coordinated federal response. The U.S. Department of Agriculture, as the coordinator for ESF #11, organizes the staff and support agencies based upon the following primary functions:

- Providing nutrition assistance.
- Responding to animal and agricultural health issues.
- Providing technical expertise in support of animal and agricultural emergency management.
- Ensuring the safety and defense of the Nation's supply of meat, poultry, and processed egg products.
- Protecting natural, cultural, and historical resources.

6-13. Table 6-2 below lists DOD functions in support of ESF #11.

**Table 6-2. Department of Defense support to emergency support function #11**

| <b>Department of Defense Functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Assesses the availability of Department of Defense food supplies and storage facilities capable of storing dry, chilled, and frozen food.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <ul style="list-style-type: none"> <li>Assesses the availability of Department of Defense transportation assets, material handling equipment, and personnel for support.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>Assesses the availability of laboratory and diagnostic support, subject-matter expertise, and technical assistance that may be provided.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Assists during animal and agricultural emergency response, as appropriate. Provides resources including senior Army Veterinary Corps officers to function as Defense Veterinary liaison officers and Defense Veterinary support officers (who serve as the onsite point of contact for Department of Defense veterinary functions) and other military specialists trained in foreign animal disease diagnosis, epidemiology, microbiology, immunology, entomology, pathology, and public health.</li> </ul>                                                                                                                         |
| <ul style="list-style-type: none"> <li>Provides laboratory support to assist and augment the capabilities of Animal and Plant Health Inspection Service.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>United States Army Corps of Engineers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <ul style="list-style-type: none"> <li>Provides expertise and resources to assist in the removal and disposal of contaminated and non-contaminated debris to include animal carcasses and debris affecting natural, cultural, and historical resources.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                         |
| <ul style="list-style-type: none"> <li>Provides emergency repair of damaged infrastructure and critical public facilities (such as temporary power, emergency water, and sanitation systems). Supports the reestablishment of critical navigation, flood control, and other water infrastructure systems, including drinking water distribution and wastewater collection systems. Where appropriate, activities to reestablish infrastructure (such as debris removal, and temporary housing mission) are closely coordinated with Emergency Support Function #11.</li> </ul>                                                                                             |
| <ul style="list-style-type: none"> <li>As Emergency Support Function #3 primary agency, requests Emergency Support Function #11 support to provide technical assistance to facilitate Emergency Support Function #3 efforts to obtain necessary regulatory (cultural and environmental) clearances for infrastructure reestablishment activities; seeks technical assistance from the Department of Homeland Security/Federal Emergency Management Agency Disability Coordinator to ensure that accessibility standards for those with disabilities and others with access and functional needs are addressed during infrastructure reestablishment activities.</li> </ul> |

## SECTION II – LEGAL CONSIDERATIONS

6-14. When providing medical support for DSCA tasks, a careful understanding of eligibility criteria is necessary to ensure that medical personnel know when and how they may or may not treat civilian casualties. There are also differences (for paperwork and tracking) between Title 32 military forces and Title 10, when medical treatment is provided by civilian physicians.

6-15. Department of Defense medical personnel, who have a current, valid, and unrestricted license to practice medicine (including osteopathic medicine, dentistry, or other health professions) and are properly licensed under Title 10 U.S. Code, Section 1094(d), may practice their profession on non-DOD personnel at any location authorized by the Secretary of Defense. This authorization is implied when the Secretary of Defense approves a request for medical units to deploy to the scene of a disaster or emergency pursuant to a request for assistance from civil authorities. Therefore, pursuant to a Secretary of Defense-approved mission assignment, DOD medical personnel can respond to an off-post disaster or emergency in any state, commonwealth, the District of Columbia, or territory. Medical personnel would be acting within the scope of Secretary of Defense-approved orders. Department of Defense health care providers will not face personal liability if there is a therapeutic misadventure while providing medical care and treatment during an emergency or disaster.

6-16. Both the Federal Tort Claims Act, Title 28, U.S. Code, and the Medical Malpractice Immunity Act (known as the Gonzalez Act), Title 10, U.S. Code, provide protection for DOD health care providers. The Gonzalez Act provides that an action under the Federal Tort Claims Act is the exclusive remedy for individuals seeking damages for alleged medical malpractice. Claimants must seek compensation from the U.S. Government and DOD health care providers are immune from liability for care given while acting within the scope of their medical duties. This includes incidents occurring off-post while treating civilian victims during an emergency or disaster.

6-17. Many states have statutory provisions that address the—

- Recognition of medical licenses issued by another state.
- Waiver of state licensure requirements for DOD medical personnel who enter the state solely to provide medical treatment to civilian victims of an emergency incident.

6-18. The statutory provisions for these states either automatically recognize a medical license issued by another state and allow the person holding such a license to render emergency medical aid and treatment; or if ordered by the state governor, exempt a medical person from the state's medical licensing requirement when practicing their skills or profession during the course of an emergency or disaster; or allows the state medical licensing board (for the duration of the emergency or disaster) to suspend any state requirement for a state medical license if the person has a valid license issued by another state.

## SECTION III – ARMY HEALTH SYSTEM SUPPORT

### ARMY HEALTH SYSTEM SUPPORT TO DEFENSE SUPPORT OF CIVIL AUTHORITIES

6-19. During DSCA, AHS support requirements will be tailored to meet the specific mission. Determining factors include the—type, severity, and geographic location of the incident; capabilities available within the local community; health threat; magnitude of the operation (local versus state or federal); and the anticipated patient workload. The support provided can range from routine AHS support for military personnel, to forces employed in support of law enforcement operations, and on-site triage, treatment, and hospitalization or evacuation of disaster victims. Specific guidance, authority, and legal advice should be obtained before beginning operations to ascertain eligibility criteria for treatment, what specific support can be provided, and where funding and/or reimbursement can be obtained.

6-20. The NRF activates the NDMS under ESF #8 for management and coordination of the federal medical response to major emergencies and federally declared disasters including—natural disasters; major transportation accidents; technological disasters; and acts of terrorism (to include weapons of mass

destruction). Upon activation of the NDMS, the DOD may be required to employ assets to assist in providing definitive medical care and patient evacuation or address a military health emergency.

6-21. National Disaster Medical System patients moved from a disaster area for definitive medical care are taken to a federal coordinating center patient reception area. The mission of the federal coordinating centers is to receive, triage, stage, track, and transport inpatients affected by the disaster to a participating inpatient hospital capable of providing the required definitive care. There are 15 MTFs within the DOD designated as federal coordinating centers, six of which are Army MTFs.

6-22. When providing medical support during a domestic emergency, the AHS may be called upon to provide assets from each of the ten medical functions to support the activation of an Army MTF designated as a federal coordinating center, support a military health emergency, or provide personnel to assist in the medical response.

## **HOSPITALIZATION**

6-23. Hospitalization in the generating force consists of fixed MTFs capable of providing definitive care to conclusively manage a patient's condition, which normally leads to rehabilitation, return to duty, or discharge from the Service. Within the NDMS, definitive medical care begins when disaster victims are admitted to a participating hospital. Once admitted, federal coordinating centers monitor the status of NDMS patients treated at associated medical facilities. The federal coordinating centers also coordinate fiscal information to support the processing of financial claims for reimbursement.

6-24. Definitive care within the DOD includes all of the capabilities embedded in the Military Health System, plus extraordinary preventive, restorative, and rehabilitative capacity that does not exist in facilities with lesser capabilities of care. Hospitals within the continental U.S. support base represent the most definitive medical care available within the Military Health System and are expanded to include Department of Veterans Affairs and civilian hospitals to meet the requirements of the NDMS. During DSCA, Army MTFs designated as federal coordinating centers may be activated/alerted to provide this support. Refer to ATP 4-02.5 for a discussion of hospitalization capabilities in the deployed force. See paragraph 6-2 for the NDMS definition of definitive medical care.

## **FEDERAL COORDINATING CENTERS**

6-25. Federal coordinating centers are facilities located in metropolitan areas of the U.S. responsible for the day-to-day coordination of planning and operations in one or more assigned geographic NDMS patient reception areas. During DSCA, any of the six Army fixed MTFs designated as federal coordinating centers can be activated/alerted as part of the NDMS to coordinate the reception and distribution of patients being evacuated to the area. Federal coordinating centers also—

- Recruit local civilian hospitals for participation in the NDMS and maintain local nonfederal hospital participation in the NDMS.
- Plan and execute NDMS exercises.
- Plan for patient reception area operations.
- Monitor and report primary receiving area bed availability.
- Manage NDMS patients in the federal coordinating center area of responsibility.
- Coordinate exercise development and emergency plans with participating hospitals and other local authorities in order to develop patient reception, transportation, and communications plans. See DODI 3020.47 for additional information on DOD participation in national exercises.

6-26. Army federal coordinating centers are managed by the MTF commander, who serves as the federal coordinating center director. A federal coordinating center coordinator is also assigned to assist the federal coordinating center director. The federal coordinating center coordinator is responsible for the day-to-day operation and readiness of the program. The federal coordinating center director and coordinator—

- Facilitate and maintain hospital enrollment and community support.
- Solicit and organize community support.
- Collect and report hospital bed availability.

- Coordinate patient reception area plans.
- Coordinate training and exercises.
- Coordinate local patient reception operations.
- Coordinate discharge and return of patients to their point of origin or other destination as authorized.
- Coordinate financial management.
- Coordinate logistical support.
- Facilitate communications.
- Coordinate critical information requirements.
- Coordinate public affairs.

6-27. In many operations not requiring activation of the NDMS, military hospitals may not be participants in providing direct patient care, hospitalization capability, or ancillary services, as local civilian medical facilities in/or close to the disaster area will have sufficient capability.

6-28. The two stages of activation for NDMS federal coordinating centers are alerted and activated. Each designation represents specific requirements for patient reception, tracking, and reimbursement. The alerted stage is the first stage when weather or events indicate a possible need for support. Should patient requirements dictate the need for NDMS beds, a patient reception area under management of one of the Army federal coordinating centers could be among the next to receive patients. However, patients would not be regulated to this patient reception area during the alerted stage. This status does not authorize reimbursement of federal coordinating center and/or patient reception area expenses incurred preparing for possible reception of patients. During this stage the federal coordinating centers could expect at least 24-hour notice of patient arrival. Once alerted, the federal coordinating center performs the following critical tasks:

- Establishes communications with the Global Patient Movement Requirements Center and coordinates periodic bed reporting in accordance with applicable instructions.
- Maintains daily monitoring of the U.S. Transportations Command Regulating and Command and Control Evacuation System.
- Establishes communications with all patient reception team leaders, Global Patient Movement Requirements Center, participating civilian hospitals, and other elements involved with federal coordinating center operations, including alerting Army Reserve personnel assigned to the federal coordinating center.
- Validates the capacity of patient reception areas including the ability to receive, triage, and distribute patients to participating hospitals.

6-29. The federal coordinating center Activated stage is the stage when federal coordinating center reimbursement for all patient reception activities is authorized based on the Federal Emergency Management Agency mission assignment. This status signifies that patients are to be regulated or have been regulated to a patient reception area under management of a federal coordinating center. During this phase, patients can be expected to arrive within 24 hours. During activation, the federal coordinating center performs the following critical tasks:

- Monitors the U.S. Transportations Command Regulating and Command and Control Evacuation System and the Joint Patient Assessment and Tracking System to determine arrival time(s) and the medical condition of patients.
- Conducts periodic U.S. Transportations Command Regulating and Command and Control Evacuation System bed reporting in accordance with Global Patient Movement Requirements Center instructions.
- Pre-positions required equipment and a minimum number of personnel at the patient reception area.
- Ensures that patient reception team members are notified and standing by to assemble at the patient reception area.
- Ensures ground transportation assets are prepared to transport patients.
- Ensures receiving member hospitals are prepared to receive patients.

- Ensures other support elements are prepared to assemble at the patient reception area in accordance with the established reception plan.

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**Note.** During the activated stage, federal coordinating centers must track and account for all operational expenses and may be required to validate the authenticity of NDMS patients for whom participating hospitals submit claims for reimbursement when the patients have neither health insurance nor eligibility for Medicare or Tricare.

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## **PATIENT RECEPTION AREAS**

6-30. National Disaster Medical System patient reception areas are geographic locations that contain one or more airfields, adequate patient staging facilities, and adequate local patient transport assets. Patient reception areas are generally established at a predesignated airfield, bus station, or railhead patient reception site. These areas support patient reception and transport to local voluntary, preidentified, nonfederal, acute care hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency.

6-31. Patients evacuated from a disaster area for definitive medical care, arrive at the respective patient reception area of the supporting federal coordinating center. Patients are met by a local medical team and are then off-loaded, triaged, and staged at the patient reception sites pending further medical regulating and ground transport to a participating NDMS hospital according to procedures developed by local authorities and the supporting federal coordinating center. Patients are transported to participating hospitals using locally available ground or air transport.

## **ROLE OF PARTICIPATING CIVILIAN HOSPITALS**

6-32. During domestic emergencies, civilian hospitals voluntarily commit their facilities to the NDMS (including participation in national exercises). When functioning as part of the NDMS, civilian medical facilities provide—

- Daily bed availability reports to the local federal coordinating center.
- Daily lists of admissions and dispositions for NDMS patients indicating the expected length of stay.
- Authorizations for release of information.
- Discharge summaries for each patient released from the NDMS.

6-33. Generally, participating hospitals are located within a 50-mile radius of the airport or military airfield that would be the likely arrival site for NDMS patients. This is to help ensure that local ground transport of patients to a participating hospital will require one hour or less. Hospitals beyond a 50-mile radius may be accepted for enrollment at the discretion of the federal coordinating center director. Hospitals volunteering to participate in the NDMS agree to commit a number of their acute care beds to support NDMS patients and participate in training and exercises sponsored by the federal coordinating center. Hospitals that admit NDMS patients are guaranteed reimbursement by the federal government.

## **MEDICAL MISSION COMMAND**

6-34. During DSCA, military forces are operating in support of federal, state, and local authorities which will require that the medical mission command system, organizations, and procedures be adapted to function within a noncombat, civilian-led structure. When supporting DSCA tasks, a key function of medical mission command is to coordinate, integrate, and synchronize AHS resources in support of interagency efforts. This support consists of medical assets from both the operating and generating force to include—

- Designated Army MTFs activated to function as NDMS federal coordinating centers as described in paragraph 6-21 above.
- Specialized medical capabilities such as the U.S. Army Medical Command's designation as the theater lead agent for medical materiel to provide medical logistics support to U.S. Northern Command during DSCA as described in paragraph 6-81 below.

- Deployable medical mission command organizations (medical command [deployment support], medical brigade [support], and the medical battalion [multifunctional]) designed to provide scalable and tailorable medical mission command modules, which can be expanded and augmented to respond to a broad range of mission requirements.

6-35. When performing DSCA tasks, interoperable information systems and tools are essential to ensure effective communications among all participating organizations. Operations conducted in a DSCA environment will involve nonmilitary, governmental, and nongovernmental organizations and agencies, making communications and interoperability key to mission success. Effective interagency coordination depends on collaboration, relationships, and training before, during, and after incidents.

6-36. All response efforts in support of domestic incidents are coordinated by civilian organizations within the U.S. government at the local, state, and federal level through the ESFs of the NRF. The NRF, using National Incident Management System principles, provides the structure and mechanism for a consistent, nationwide approach to domestic incident management regardless of the cause, size, or complexity. The National Incident Management System's incident command system provides a flexible approach to managing the ESFs.

6-37. There are five major components of the National Incident Management System including—preparedness, communications and information management, resource management, command and management, and ongoing management and maintenance. The DOD adheres to the principles of the National Incident Management System and incorporates all five components into DSCA and installation emergency management plans. For the purposes of this discussion, this section will only focus on the communications and information management and command and management components and their impact on medical mission command.

## **COMMUNICATIONS AND INFORMATION MANAGEMENT**

6-38. Incident response and emergency management activities in support of DSCA rely on communications and information systems that provide a common operational picture to all command and coordination sites. The National Incident Management System describes the requirements necessary for a standardized framework for communications and emphasizes the need for a common operational picture. The communications and information management component is based on the concepts of interoperability, reliability, scalability, and portability, as well as the resiliency and redundancy of communications and information systems. The National Incident Management System facilitates incident communications by encouraging the development and use of common communication plans and interoperable communications equipment, processes, standards, and architectures among emergency management and incident response organizations at the federal, state, tribal, and local levels through the—

- Standardization of the types of communications to include—strategic or high-level communications, tactical communications between command and support elements, support communications (such as communications among hospitals concerning resource ordering, dispatching, and tracking from logistics centers, as well as traffic and public works communications), and public address communications (including emergency alerts, press conferences, and other forms of media) that may be used to get information to the public.
- Coordination of communications policies and planning including the establishment of standardized terminology, procedures, and protocols to facilitate the flow of information. Technical parameters of equipment and systems and communications plans/strategies must also be coordinated and synchronized.
- Establishment of agreements that specify the communications systems and platforms (such as computers, networks, and information sharing mechanisms) to be used by participating organizations to facilitate planning.
- Standardization of equipment and training to ensure common interfaces and infrastructure; understanding of emergency management and incident response capabilities and limitations; and modernization and maintenance of communications systems and equipment.

## COMMAND AND MANAGEMENT

6-39. The command and management component of the National Incident Management System is designed to enable effective incident management and coordination by providing a flexible, standardized incident management structure. This component also describes the systems used to facilitate incident command and management operations. The systems used to support incident command and management operations are the—incident command system, multiagency coordination system, and public information, which are not static automated systems, nor do they mandate the use of a specific make, model, or brand of communications and information management system. However, these systems are fundamental elements of the National Incident Management System that provide the organizational framework that will be used to—

- Direct incident operations.
- Acquire, coordinate, and deliver resources to incident sites.
- Share information about the incident with the public.

6-40. Of the three systems mentioned above, the incident command system is the primary focus of this section to include the different types of commands that may be activated as part of the system. This information is provided to ensure that medical personnel are aware (for coordination purposes) of the management components that make up the system and the organizational structures being used. For a full description of the incident command system, multiagency coordination system, and public information see the National Incident Management System document on the Federal Emergency Management Agency Web site.

## INCIDENT COMMAND SYSTEM

6-41. Department of Defense Instruction 6055.17 establishes policy to ensure that DOD installation emergency management activities and procedures are in compliance with the National Incident Management System and the incident command system. Department of Defense Directive 3025.18 requires that all DSCA plans within the DOD be compatible with the National Incident Management System.

6-42. The incident command system is a form of management designed to enable effective coordination by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. The system is used to organize on-scene operations for a broad range of emergencies from small to complex incidents, both natural and man-made. The incident command system provides an organizational structure for incident management and guides the process for planning, building, and adapting that structure. The organizational structure of the incident command system is similar to that of the military and is organized around five major functional areas, which include—command, operations, planning, logistics, and finance/administration. The incident command system addresses incident command in terms of single incident command, area command, and unified command. The type and number of commands established during a disaster depend upon the size, complexity, or number of jurisdictions affected. During an emergency, the incident command is the only position within the incident command system that is always manned and there is only one incident command post per incident no matter how large the event becomes.

## Incident Command

6-43. An incident command is an organizational element responsible for the overall management of an incident and consists of an incident commander (either single or unified command structure) and any assigned supporting staff. The incident commander is the individual responsible for all incident activities, including the development of strategies and tactics as well as the ordering and release of resources. The incident commander has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. The incident commander is also responsible for the establishment of an incident command post and there is only one post established per event, no matter how large the incident becomes. The incident commander is generally supported by a command staff and general staff as depicted in Figure 6-1 on page 6-12.

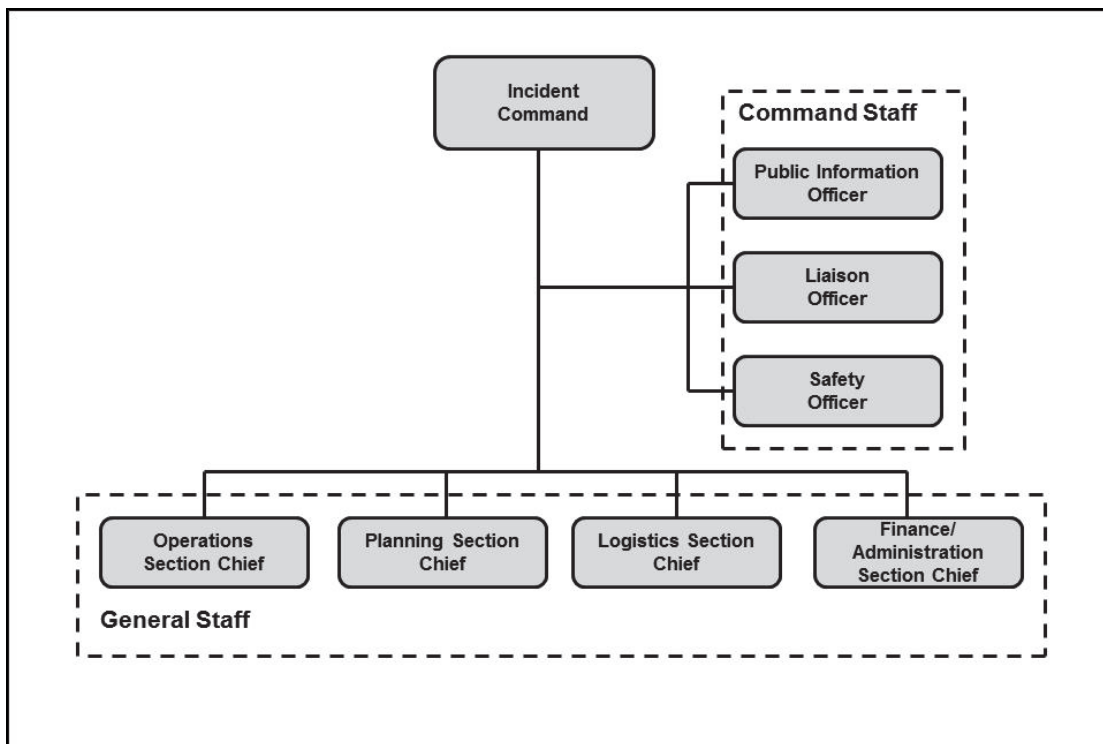


**Figure 6-1. Incident command structure**

**Note.** The civilian incident commander is generally supported by a command staff and a general staff, while the Army has coordinating staff, personal staff, and special staff.

### Area Command

6-44. An area command oversees the management of multiple incidents handled individually by separate incident command system organizations or provides oversight for management of a very large or developing incident involving multiple incident management teams. An area command is activated only if necessary, depending on the complexity of the incident and span-of-control considerations. An agency administrator/executive or other public official with jurisdictional responsibility for the incident usually makes the decision to establish an area command. When multiple incidents of different types occur, that do not have comparable resource or capability requirements, they are normally handled as separate incidents.

### Unified Command

6-45. A unified command is an incident command system application used when more than one agency has response authority for an incident or when incidents cross political jurisdictions. In a unified command, agencies work together through the designated members of the unified command (often the senior persons from organizations participating in the unified command) to establish a common set of objectives and strategies and a single incident action plan.

**Note.** The term *unified command* as defined by the incident command system differs from the military use of this term. During DSCA, military forces remain under the operational and administrative control of the military chain of command and work in support of the civilian incident commander.

## **Joint Field Office**

6-46. The joint field office is the primary federal incident management field structure responsible for providing support to on-scene efforts and conducting broader support operations that may extend beyond the incident site. The office is a temporary federal facility that provides a central location for coordination of federal, state, tribal, and local governments, as well as private and nongovernmental organizations with primary responsibility for response and recovery. The joint field office structure is organized, staffed, and managed in a manner consistent with the principles of the National Incident Management System. Although the joint field office uses an incident command system structure, the office plays a supporting role only and does not manage on-scene operations.

6-47. When tasked under ESF #8, the DOD is responsible for providing evaluation and risk management support through the use of defense coordinating officers, emergency preparedness liaison officers, and joint regional medical planners. Generally, DSCA requests that originate at the joint field office are coordinated with and processed through the defense coordinating officer for approval by the Secretary of Defense.

## **Defense Coordinating Officer**

6-48. Defense coordinating officers serve as DOD first responders during a natural or man-made disaster. The DOD maintains a permanently assigned Title 10, U.S. Code, active duty officer to serve as the defense coordinating officer (which, may be supported by a Defense coordinating element) in each Federal Emergency Management Agency region to plan, coordinate, and integrate DSCA with local, state, tribal, territorial, insular area, and federal agencies. The defense coordinating officer serves as Federal Emergency Management Agency's single point of contact at the joint field office for DOD support within each region responsible for (subject to change based on the situation)—

- Coordinating, validating, and processing requests for military support.
- Forwarding mission assignments to the appropriate military organization through DOD-designated channels.
- Assigning military liaisons to activated ESFs (as appropriate).

6-49. The Defense coordinating element consists of a staff and military liaison officers to facilitate coordination and support to activated ESFs. The defense coordinating officer is a key player in all local, state, tribal, territorial, insular area, federal, and DOD Homeland Defense and DSCA exercises. The defense coordinating officer is located at the joint field office or joint task force and coordinates closely with the joint task force medical staff and the combatant command's joint regional medical planning office in support of ESF #8. The defense coordinating officer also coordinates with state emergency managers, the state National Guard, and Federal Emergency Management Agency to assist in the preparation and review of requests for assistance or mission assignments to ensure suitability for performance by the DOD.

## **Emergency Preparedness Liaison Officer**

6-50. Department of Defense Instruction 3025.16 defines emergency preparedness liaison officer as a senior Reserve officer (typically colonel [O-6] or lieutenant colonel [O-5]) who is a representative of one of the Military Departments or Military Services trained in DSCA requirements, regulations and laws, and performs a liaison role in planning and coordinating Military Department and Military Service participation in support of civil authorities. Emergency preparedness liaison officers may be activated and employed by their department secretaries in support of DSCA tasks to serve as Service-specific experts assisting defense coordinating officers.

## **Joint Regional Medical Planner**

6-51. The joint regional medical planner is responsible for preparing and implementing DOD and U.S. Northern Command policies, procedures, directives, instructions, plans, and orders in support of Homeland Defense, Homeland Security, and DSCA tasks. Joint regional medical planners support the defense coordinating officer/defense coordinating element, and/or joint force commander by facilitating the medical capabilities necessary to save lives, reduce suffering, and preserve critical infrastructure. There are four joint regional medical plans and operations branches. Each branch is represented by an officer from the U.S. Army, U.S. Navy, and the U.S. Air Force providing expertise in joint medical plans and operations.

## **Joint Task Force**

6-52. When supporting DSCA tasks, the combatant commander may establish a joint task force to command federal military forces (except for U.S. Army Corps of Engineers resources). If a joint task force is established, consistent with operational requirements, its command element will be collocated with the senior leadership on site at the joint field office to ensure coordination or unity of effort. The collocation of the joint task force command element does not replace the requirement for the defense coordinating officer/defense coordinating element as part of the joint field office unified coordination staff. The defense coordinating officer remains the joint field office single point of contact for requests for DOD assistance.

## **MEDICAL COMMUNICATIONS**

6-53. The Medical Communications for Combat Casualty Care System is the deployable medical recording system for the AHS. The Medical Communications for Combat Casualty Care System is a ruggedized system-of-systems that integrates, fields, and supports a comprehensive medical information system, which enables documentation and maintenance of electronic medical records, streamlined medical logistics, and enhanced situational understanding for operational Army medical forces. The system consists of joint software along with government and commercial off-the-shelf products, which provide the tools needed to digitally record and transfer critical medical data from the point of injury or illness to medical treatment facilities worldwide.

6-54. Deployable medical forces use the Medical Communications for Combat Casualty Care System to gain access to patient histories, forward casualty resuscitation information, and deliver health care services remotely through system teleconferencing capabilities. The Medical Communications for Combat Casualty Care System also provides Army units with automated tools to facilitate patient tracking, medical reporting, and medical logistical support. Data captured via Medical Communications for Combat Casualty Care System populates databases used to make scientific and operational improvements to combat equipment and medical treatment techniques. In addition, combatant commanders use the Medical Communications for Combat Casualty Care System to access near real-time medical surveillance data, resulting in enhanced mission command and medical situational understanding.

6-55. The AHS communications network has interconnectivity with Army and joint global automated architecture systems to access Army mission command and sustainment systems. Department of Defense on-line portals are also available to provide access to information, forms, and e-mail. Access is restricted to eligible personnel (active duty military, reserve, civilian, retired, and guests). Federal coordinating center directors and coordinators may wish to gain access to the following online portals:

- Northern Command External Portal.
- Homeland Security Information Network, which is a national secure Web-based portal for information sharing and collaboration between federal, state, local, tribal, territorial, private sector, and international partners engaged in the homeland security mission.
- Transportation Command Regulating and Command and Control Evacuation System Web site.
- Department of Homeland Security Federal Emergency Management Agency Lessons Learned Information Sharing Web site. Registration is also required to access this site.

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**Note.** Federal coordinating center directors and coordinators may gain access to these online portals and various other sources of information through use of the Web site addresses and links posted in the references section of this manual.

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## **CRITICAL INFORMATION REQUESTS**

6-56. The federal coordinating center may be called upon to provide information updates to various agencies to include their higher command, the NDMS, Department of Health and Human Services incident response coordination team and regional emergency coordinators, DOD, and others. During the various stages of activation, a federal coordinating center should be prepared to respond to requests for critical information as shown in Tables 6-3, 6-4, and 6-5 on page 6-16.

**Table 6-3. Critical information requests during the alerted phase**

| <b><i>Federal coordinating center alerted critical information requests</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>During the alerted phase, should patient requirements dictate the need for National Disaster Medical System beds, a patient reception area under the management of the alerted federal coordinating center may receive the following critical information requests:</p> <ul style="list-style-type: none"> <li>• Is the federal coordinating center currently able to perform the impending mission? If not, why and how can it be mitigated? (Consider personnel, equipment, training, logistics, communications, and accessibility, as well as local and regional considerations.)</li> <li>• What is the federal coordinating center throughput and has it changed since the last report?</li> <li>• How soon after activation can the federal coordinating center receive the first patient load?</li> <li>• What is your current bed count (include number and type of beds available)?</li> <li>• Are Federal Emergency Management Agency funds authorized under a surge account? If so, be prepared to document the cost to pre-position equipment and supplies to reduce time required after activation to receive the first patient load.</li> </ul> |

**Table 6-4. Critical information requests during the activated phase**

| <b><i>Federal coordinating center activated critical information requests</i></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>The activated phase implies that federal coordinating center reimbursement for all patient reception activities is authorized. The activated phase signifies that patients are to be regulated or have been regulated to a patient reception area under the activated federal coordinating center. The activated federal coordinating center may receive the following critical information requests:</p> <ul style="list-style-type: none"> <li>• How many patients are expected and when (include the number of litter, ambulatory, critical care, medical, surgical, burn, psychiatric, and pediatric)?</li> <li>• How many and what acuity of patients have been regulated and/or have arrived at the patient reception area?</li> <li>• How many of each bed category does the federal coordinating center have remaining (this count should be tracked throughout the operation)?</li> <li>• What was the actual time the federal coordinating center received the first patients?</li> <li>• How many and what category of patients have been transported to which National Disaster Medical System hospitals?</li> <li>• How many patients have been received? <ul style="list-style-type: none"> <li>▪ What types of acuities?</li> <li>▪ Litter or ambulatory?</li> <li>▪ Which National Disaster Medical System hospitals were patients transported to?</li> </ul> </li> </ul> |

**Table 6-5. Critical information requests during deactivation**

| <b>Federal coordinating center deactivation critical information requests</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Once the federal coordinating center has been deactivated, the facility may be called upon to provide the following critical historical information:</p> <ul style="list-style-type: none"> <li>• How many and what categories of patients were received at the patient reception area?</li> <li>• How many patients are still in National Disaster Medical System hospitals? Which hospitals?</li> <li>• How many patients were discharged from National Disaster Medical System hospitals?</li> <li>• What equipment/supplies were used and require reimbursement?</li> <li>• What was the cost to the facility for reduction of staff in order to stand up and operate the patient reception team? Did the facility reduce clinic hours, cancel surgeries, and so on?</li> <li>• Of the hospitals asking for reimbursement, did they receive it in a timely manner?</li> <li>• Within seven days of the patient's release from National Disaster Medical System care, the federal coordinating center must provide the date of discharge, transfer, or release to Department of Health and Human Services or their designated representative.</li> <li>• What discharge planning information facilitation is required between the National Disaster Medical System hospital's case manager and Department of Health and Human Services?</li> </ul> |

6-57. As the lead agency for ESF #8, the Department of Health and Human Services determines the appropriateness of all requests for release of public health and medical information and is responsible for consulting with and organizing federal public health and medical subject matter experts, as needed. For additional information, see the NDMS Federal Coordinating Center Guide which can be accessed via the Web site address posted in the references section of this manual.

## **MEDICAL TREATMENT (ORGANIC AND AREA SUPPORT)**

6-58. The medical treatment function includes Roles 1 and 2 medical support provided by organic assets or on an area support basis by medical companies or detachments. The medical treatment capability encompasses first aid, emergency medical treatment, advanced trauma management, forward resuscitative surgery, routine sick call, patient holding, emergency dental care, casualty prevention measures, and COSC support.

6-59. A medical force package, such as a Role 2 medical company, may be task-organized based on specific mission requirements to provide triage and treatment, augmented with a surgical capability to stabilize disaster victims for evacuation out of the area of operations. This support could also involve emergency medical treatment or trauma care provided by a fixed MTF functioning as an activated NDMS federal coordinating center in response to a disaster. A Role 2 medical company may also be deployed to provide medical treatment for military personnel operating in support of a DSCA mission.

## **MEDICAL EVACUATION**

6-60. Medical evacuation occurs at the tactical, operational, and strategic levels and requires coordination and integration of Service component medical evacuation assets and processes with the DOD worldwide aeromedical evacuation system operated by U.S. Transportation Command. Army medical evacuation is accomplished by a combination of dedicated ground and air ambulances organized to provide direct, general, and area support within the joint operations area.

6-61. United States Air Force aeromedical evacuation is the movement of patients under medical supervision to and between medical treatment facilities by air transportation. The aeromedical evacuation system, which is administered by the U.S. Air Force Air Mobility Command, has unique aeromedical evacuation capabilities and plays a major role in the NDMS patient movement process. Aeromedical evacuation support is coordinated by the U.S. Transportation Command Global Patient Movement

Requirements Center and is used for day-to-day transportation of DOD patients. When necessary, the system can also be expanded to support the NDMS during a domestic disaster.

6-62. Patient movement within the NDMS includes patient evacuation, medical regulating, en route care, and patient tracking/in-transit visibility. The DOD coordinates patient movement for the NDMS in coordination with the Department of Transportation, other NDMS federal partners, commercial transportation companies, and other agencies (as required). The U.S. Transportation Command's Defense Distribution Operations Center is the single manager for movement of NDMS patients on DOD transportation assets and is responsible for—

- Accepting requests for movement of NDMS patients out of the disaster area.
- Regulating patients to the appropriate facility for definitive medical care.
- Tracking patients between the disaster area and definitive care reception sites.
- Coordinating patient transportation.

6-63. Transportation of NDMS patients may be accomplished by sea, ground, or air. Transportation by sea may be performed by the U.S. Navy Military Sealift Command, U.S. Coast Guard, Department of Transportation, commercial companies, or other agencies. Transportation by ground may be carried out by the U.S. Army Military Surface Deployment and Distribution Command, Department of Transportation, commercial companies, or other agencies, as applicable. Transportation by air may be accomplished through the U.S. Air Force Air Mobility Command, the Department of Transportation, commercial companies, or through other agencies as applicable.

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*Note.* To support military contingencies, the DOD (in cooperation with the Department of Transportation and U.S. commercial airlines) can activate the medical component of the Civil Reserve Air Fleet. The Civil Reserve Air Fleet consists of selected aircraft from commercial U.S. airlines, contractually committed to augment DOD airlift requirements in emergencies when the need for airlift capabilities exceeds military resources.

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## **DEPARTMENT OF DEFENSE SUPPORT FOR PATIENT MOVEMENT**

6-64. To support NDMS activation, the U.S. Transportation Command's Global Patient Movement Requirements Center formulates evacuation missions in conjunction with the Headquarters, Air Mobility Command's Tanker Airlift Control Center based on patient and medical equipment requirements, the location of available definitive care, and the availability of aircraft and crews.

6-65. In operations requiring the activation of the NDMS and when the DOD is tasked to provide patient evacuation support, U.S. Army medical evacuation assets (rotary-wing air and ground) will normally be used to move patients within the disaster area while U.S. Air Force fixed-wing assets are used to move patients out of the area of operations.

6-66. The Global Patient Movement Requirements Center is the DOD agency responsible for regulating patients from major disaster sites that require activation of the NDMS. In many operations (not requiring activation of the NDMS), military hospitals may not be participants in providing direct patient care, hospitalization capability, or ancillary services, as local civilian medical facilities will have sufficient capability. The command surgeon, in conjunction with the civilian medical community, will be instrumental in devising and implementing a medical regulating plan to control the flow of patients to the various civilian facilities.

6-67. Patient evacuation operations are coordinated by the Global Patient Movement Requirements Center, in conjunction with the Department of Transportation and others. National Disaster Medical System patient movement and reception missions are coordinated directly between the Global Patient Movement Requirements Center and the federal coordinating center. Local patient reception and distribution operations are coordinated directly between the federal coordinating center and local participating NDMS hospitals, as well as other local response organizations required to support patient reception operations.

6-68. The Global Patient Movement Requirements Center maintains a database of DOD, Department of Veterans Affairs, and nonfederal NDMS member hospital capacity available to support wartime contingencies, as well as domestic natural disasters or other emergencies and is prepared to immediately

solicit bed reports from federal coordinating centers to facilitate medical regulating. When alerted or activated, federal coordinating centers receive specific instructions from the Global Patient Movement Requirements Center for reporting of throughput and bed availability. These instructions typically include the time period during which reports are to be sent, the format to be followed, the mode of reporting, and points of contact.

6-69. Medical evacuation and medical regulating support provided during a domestic incident will differ depending upon the type of activity supported. Some operations occur on a routine basis and are detailed in support agreements with the local community. In other operations, patient evacuation support may be required due to a crisis such as an earthquake or flood. The patient evacuation role of U.S. Army air ambulances may also be expanded in these operations to include executing rescue missions (such as removing people from the roofs of their homes during a flood). Commanders must have clearly defined guidelines as to the scope of the operation and, where applicable, the funding mechanism for reimbursing the government for expenses incurred.

6-70. During DSCA, Army medical evacuation assets will also be required for the evacuation of military personnel deployed in support of civil authorities. Medical evacuation from Roles 1, 2 and between Role 3 hospitals is a Service component responsibility, while strategic medical evacuation from Role 3 hospitals is accomplished by U.S. Transportation Command.

## **MEDICAL REGULATING**

6-71. Medical regulating consists of the actions and coordination necessary to arrange for the movement of patients through the roles of care. This process matches patients with an MTF that has the necessary medical capabilities and ensures that bed space is available. Medical regulating facilitates the identification of patients awaiting evacuation, location of available beds, and coordination of transportation for the movement of patients from the site of injury or onset of illness through successive roles of medical care to an appropriate MTF. Department of Defense Instruction 5154.06 establishes policy for the implementation of Armed Services medical regulating during peacetime and contingency operation in accordance with DODD 3025.18.

6-72. The NRF provides detailed information on medical evacuation/medical regulating requirements and responsibilities during a federal response. When an NDMS federal coordinating center is in alerted status, the federal coordinating center director—

- Conducts periodic bed reporting in accordance with Global Patient Movement Requirements Center instructions.
- Maintains daily monitoring of the U.S. Transportation Command Regulating and Command and Control Evacuation System.
- Establishes communications with all patient reception team leaders, which are the other elements involved in federal coordinating center operations.
- Validates patient reception area throughput, including their ability to receive, triage, and distribute patients to member hospitals.

6-73. When a requirement for patient evacuation is identified and a Department of Homeland Security/Federal Emergency Management Agency mission assignment has been issued, the Global Patient Movement Requirements Center issues bed reporting instructions to those federal coordinating centers activated for patient reception. The Global Patient Movement Requirements Center receives the patient's medical information, determines the medical equipment needed for ground or air transport, coordinates movement to the federal coordinating center's patient reception area (airport, train station, bus depot, or other reception location) and communicates with the federal coordinating center concerning medical evacuation missions dispatched to evacuate patients from the disaster area to the patient reception area.

6-74. The Global Patient Movement Requirements Center liaison advises the federal coordinating center on patient movement policies and procedures. The Global Patient Movement Requirements Center also supports the federal coordinating center's responsibilities for bed reporting and coordinating with the center for patient movement via automated systems or by manual means. The Global Patient Movement Requirements Center liaison facilitates coordination between nonfederal NDMS hospitals under the federal coordinating center's purview and DOD MTFs as required. The Global Patient Movement Requirements

Center liaison may also assist in ensuring that required notifications are made and military patients are tracked.

6-75. In disaster relief operations, medical evacuation support is dependent upon the situation. If the disaster occurs within a heavily populated area, but there is little damage/injury done to local medical facilities/personnel, then patients may be cared for in existing local facilities. Evacuation to these facilities is by any form of conveyance available (emergency vehicles for the more seriously injured and privately owned or business transportation assets for the less seriously injured). However, if the disaster occurs in a remote area or if there is substantial damage/injury to local medical facilities and personnel, patients may initially require evacuation out of the disaster area for definitive treatment. Unless a military unit is in proximity of the disaster and is a first responder, the initial evacuation of accessible victims from the immediate disaster area will already be accomplished. However, military evacuation expertise in the extraction of victims from above and below ground may be required as rescue operations continue. Patients must be regulated to medical facilities within the disaster area to ensure that one facility does not become overwhelmed while another is sitting idle. However, this does not mean that a formal medical regulating system will be established. If patients are to be evacuated out of the area of operations by DOD evacuation assets and regulated into U.S. military, Department of Veterans Affairs, or civilian hospitals, the Global Patient Movement Requirements Center may be activated. The medical planner must remember that these operations are often headed by other than military personnel and the medical evacuation plan must be sufficiently flexible to support and complement the overall plan for the operation.

## **MEDICAL LOGISTICS**

6-76. The management of Class VIII supplies and equipment is critical during a disaster. Medical supplies and equipment may be donated in support of relief operations and can come in all different types of packaging, sizes, and amounts. These items must be received, sorted, repacked, and distributed to areas in need. Normally within a disaster area, no one organization is designated to provide this type of support. A task-organized medical logistics element may be deployed to provide the necessary support to include management, receipt, sorting, storage, repackaging, distribution, and accounting for donated medical supplies and equipment. If tasked, this element would also be responsible for the requisition, receipt, and accountability of Class VIII resources required, which cannot be met through donated materiel.

6-77. An assessment of the disaster area (to include coordination with other agencies or countries providing assistance) must be completed to determine what types and quantities of supplies and equipment are available or are anticipated to be donated and how many customers the element will support. The size of the medical logistics element deployed is dependent upon the size and anticipated duration of the operation, the quantity of materiel to be handled, and the number of customers to be supported.

6-78. Emergency Support Function #8 lists the DOD as the agency responsible for—

- Providing available logistical support to public health/medical response operations.
- Providing available DOD medical supplies for distribution to mass care centers and medical care locations being operated for incident victims with reimbursement to the DOD.

6-79. During a disaster, medical supplies and equipment are deployed from the Centers for Disease Control and Prevention's Strategic National Stockpile to protect the American public if there is a public health emergency (such as a terrorist attack, influenza outbreak, earthquake, or other disaster) severe enough to cause local supplies to run out. Emergency Support Function #8 may also request additional assistance from the DOD or Department of Veterans Affairs to provide medical equipment, durable medical equipment, and supplies (including medical, diagnostic, and radiation-detecting devices, pharmaceuticals, and biologic products) in support of immediate medical response operations and for restocking health care facilities in an area affected by a major disaster or emergency.

## **INTEGRATED MEDICAL LOGISTICS MANAGEMENT**

6-80. The Defense Logistics Agency is the DOD executive agent for Medical Materiel. During DSCA, the U.S. Army Medical Command is the designated theater lead agent for medical materiel to U.S. Northern Command. The Commander, U.S. Northern Command may designate one of the Service components to be the single integrated medical logistics manager. The theater lead agent for medical materiel and single

integrated medical logistics manager work together to develop the medical logistics support plan that synchronizes medical requirements/capabilities and Class VIII flow/distribution to joint task force supported medical units and DSCA tasks.

6-81. The theater lead agent for medical materiel uses the Army medical logistics system of existing Class VIII support infrastructure, contracts, and relationships in coordination with DOD logistics and transportation organizations and regional supply support activities. The theater lead agent for medical materiel may designate U.S. Army Medical Command master ordering facilities to provide medical logistics support to commander's joint task force deploying medical units. The master ordering facility provides Class VIII support through Defense Logistics Agency prime vendor contracted suppliers and other habitual sources of supply. The single integrated medical logistics manager synchronizes medical logistics support requirements of all deployed medical forces in the U.S. Northern Command joint operations area. The single integrated medical logistics manager coordinates with the theater lead agent for medical materiel and supported medical forces to develop the Class VIII concept of support. The medical battalion (multifunctional), medical logistics management center forward support team early entry element, medical logistics company, and the theater sustainment command's distribution management center are some of the enablers in providing medical logistics support to the joint task force in support of DSCA tasks. This capability helps ensure uninterrupted medical operations for all DOD medical units.

6-82. Other Class VIII resources and medical materiel assets are also available for DSCA such as federally managed stocks within the Centers for Disease Control and Prevention's Strategic National Stockpile as described in paragraph 6-79 above and other pre-positioned assets that may be used depending on the situation and size of the response required. Refer to the United States Army Medical Materiel Agency and Centers for Disease Control and Prevention Web sites, which can be accessed via the Web site addresses posted in the references section of this manual.

6-83. The primary DOD requisitioning system is the Defense Medical Logistics Standard Support. Deployed medical units requiring Class VIII must establish accounts with their supporting activity. Supported units use the Defense Medical Logistics Standard Support Customer Assistance Module to requisition Class VIII supplies. Class VIII requisitions flow through the theater lead agent for medical materiel designated master ordering facilities to Defense Logistics Agency prime vendor medical supply contracts to fill the requisitions. The supporting master ordering facilities are part of the defense working capital fund which is used for financial accounting, tracking, reimbursement, and auditing of Class VIII supplies expended in support of deployed Army forces. The theater lead agent for medical materiel conducts a postoperational financial reconciliation with other Service components as required. Units deploy with their full unit basic load of Class VIII. It is the Service component's responsibility to provide Class VIII resupply for their forces until the theater lead agent for medical materiel/single integrated medical logistics manager supply chain is established and operational.

## **MEDICAL EQUIPMENT MAINTENANCE**

6-84. Medical equipment maintenance support is accomplished by the medical equipment maintenance section of the medical logistics company. Medical maintenance requirements that are beyond the capability of the medical logistics company are provided by the master ordering facility designated by the theater lead agent for medical materiel. If tasked, the medical logistics company can assist in providing civilian medical equipment evaluations and services.

## **BLOOD SUPPORT**

6-85. As in contingency operations, blood support to DSCA tasks consists of U.S.-based resupply of blood and blood products. During domestic emergencies, blood support is provided for deployed forces in conjunction with support to ESF #8, which lists the DOD as the agency responsible for coordinating with the Department of Health and Human Services to provide available blood products.

## MEDICAL LABORATORY

6-86. The AHS medical laboratory function consists of clinical and operational capabilities. Operational laboratory support focuses on the total health environment of the theater, while clinical laboratory services are provided in support of individual patient care.

6-87. Operational laboratory support is provided by the area medical laboratory for theater validation and field confirmation levels of identification of suspect CBRN agents, endemic diseases, and occupational and environmental health hazards. Personnel within the area medical laboratory serve as consultants to hospital clinical laboratories and interface with preventive medicine teams, veterinary teams, forward deployed medical units, biological integrated detection system teams, and CBRN company elements operating in the theater. The area medical laboratory provides field confirmatory and theater validation levels of identification of suspect CBRN samples/specimens, as well as—

- Identification of pests.
- Studies in the efficacy of pesticides.
- Studies in the frequency of infectious agents.
- Immune response monitoring.
- Studies in the transmission of zoonotic diseases.

6-88. Clinical laboratory services are provided by Role 2 MTFs performing the basic procedures in hematology, urinalysis, microbiology, and serology that are necessary for the diagnosis and treatment of patients and the prevention of disease. Role 2 MTFs also receive, maintain, and transfuse blood products. Blood banking services are provided by the Role 3 combat support hospital. Clinical laboratory support in the Role 3 combat support hospital consists of procedures in microbiology, hematology, biochemistry, urinalysis, and serology in support of clinical activities.

## LABORATORY RESPONSE NETWORK

6-89. Due to the sophistication of health services within the U.S., many medical laboratories throughout the country have state-of-the-art equipment and may be called upon to respond during a national emergency. When disaster strikes, medical laboratory capabilities available at the local level are a community's first line of defense. However, once local capabilities are exceeded and the NRF is activated, the Centers for Disease Control and Prevention (through the Laboratory Response Network) have ready access to whatever level of sophisticated laboratory procedures or equipment that may be required.

6-90. The Laboratory Response Network is an integrated national and international network of laboratories (including state and local public health, federal, military, and international laboratories) that are fully equipped to respond quickly to the need for rapid testing, timely notification, and secure messaging of results associated with suspect acts of biological or chemical terrorism and other high priority public health emergencies. Laboratories within this network are designated as national, reference, or sentinel laboratories depending on the types of testing capabilities available and how infectious agents are handled to protect workers and the public.

6-91. Department of Defense Instruction 6440.03 directs the establishment and maintenance of a DOD Laboratory Network, which is a coordinated and operational system of defense laboratories, programs, and activities to provide actionable results for early detection, confirmation, response, and effective consequence management of—

- Acts of terrorism or warfare involving CBRN agents.
- Infectious disease outbreaks.
- Other all-hazards events requiring a DOD integrated incident response.

6-92. The DOD contributes scientific expertise to the Laboratory Response Network at the national level through the U.S. Army Medical Research Institute for Infectious Diseases and the Naval Medical Research Center. Other military-based laboratories also serve as reference laboratories for the Laboratory Response Network. Under DODIs 6440.03 and 6200.03, DOD laboratories that are members of or participate in the Laboratory Response Network are authorized to provide diagnostic services or other assessments pertaining

to laboratory specimens referred for analysis, consistent with designated tests, procedures, agreements and the mission of the Laboratory Response Network in support of DSCA tasks on a fully reimbursable basis.

6-93. The U.S. Army Medical Research Institute for Infectious Diseases is the only laboratory within the DOD equipped to safely study highly hazardous pathogens requiring maximum containment at Biosafety Level 4 and serves as the Army's national level representative to the Laboratory Response Network. As such, the U.S. Army Medical Research Institute for Infectious Diseases is responsible for collaborating with the Centers for Disease Control and Prevention to rapidly characterize suspected pathogens and assist in any biological contingency.

6-94. Emergency Support Function #11 tasks the DOD to assess the availability of laboratory and diagnostic support, subject matter expertise, and technical assistance that may be provided. These DOD assets include the Defense Threat Reduction Agency, Armed Forces Radiobiology Research Institute, U.S. Army Medical Research Institute of Chemical Defense, U.S. Army Public Health Command, the U.S. Army Nuclear and Chemical Agency, and the U.S. Army Research, Development and Engineering Command's Edgewood Chemical Biological Center.

6-95. Under ESF #11, the DOD is also responsible for providing laboratory support to assist and augment the capabilities of the Animal and Plant Health Inspection Service. Emergency Support Function #8 lists the DOD as the Agency responsible for providing medical surveillance, laboratory diagnostics, and confirmatory testing in coordination with the Department of Health and Human Services. Organic medical laboratory capabilities within the DOD Laboratory Network such as the Army's Area Medical Laboratory in the operating force, as well as assets available in the generating force may be tasked to assist in providing this support.

## **ARMED FORCES RADIOBIOLOGY RESEARCH INSTITUTE**

6-96. The Armed Forces Radiobiology Research Institute enables advancements in the protection of Soldiers and citizens. The mission of the Armed Forces Radiobiology Research Institute is to preserve the health and performance of U.S. military personnel and to protect humankind through research that advances understanding of the effects of ionizing radiation. The institute collaborates with other government facilities, academic institutions, and civilian laboratories in the U.S. and other countries to research the biological effects of ionizing radiation. The Armed Forces Radiobiology Research Institute also provides medical training and emergency response support through the Medical Radiobiology Advisory Team to manage incidents related to radiation exposure.

6-97. The Medical Radiobiology Advisory Team provides health physics, medical, and radiobiological advice to military and civilian mission command operations worldwide in response to nuclear and radiological incidents requiring a coordinated federal response. Through reachback, the deployed team of radiation medicine physicians and senior health physicists can call on the knowledge and skills of radiobiologists, biodosimetrists, and other research professionals at the Armed Forces Radiobiology Research Institute. The Medical Radiobiology Advisory Team—

- Augments the Defense Threat Reduction Agency Consequence Management Advisory Team.
- Provides direct support to the National Military Command Center, the Office of the Assistant to the Secretary of Defense (Nuclear Matters), response task force commanders, and combatant commanders.
- Participates in the planning and execution of DOD and U.S. interagency exercises involving radiological and nuclear scenarios.
- Supports two to three Army command post and field training exercises each year.
- Collaborates with other operational experts to conduct graduate-level continuing education through the Medical Effects of Ionizing Radiation Course and develop relevant information products.

## **PREVENTIVE MEDICINE**

6-98. Traditionally, disease and nonbattle injury rates within the deployed force are a key indicator of the overall health of the force. As in war, disease and nonbattle injuries are the primary health threat during

military operations in support of DSCA tasks and must also be assessed in terms of their impact on the civilian population in the affected area. Communication of the health risk, employment of preventive medicine measures (including personal protective measures), comprehensive medical surveillance activities, occupational and environmental health surveillance activities, inspection of potable water and field feeding facilities, and field hygiene and sanitation are critical and must be instituted and enforced early on to counter the health threat.

## **HEALTH THREAT**

6-99. In the aftermath of man-made or natural disasters, the health threat includes naturally occurring infectious diseases as well as—

- Epidemics and diseases endemic to humans and animals in the affected area.
- Environmental factors (such as heat, cold, humidity, and significant elevations above sea level).
- Zoonotic diseases transmissible to man.
- Poisonous animals, plants, and insects which are important considerations as causative agents of disease and nonbattle injury casualties.
- Diseases stemming from weapons of mass destruction (such as CBRN weapons).
- Behavioral and emotional health issues caused by prolonged periods of intense, continuous operations under all types of conditions that tax Soldiers to the limits of their endurance.

6-100. The disruption of public works, waste disposal facilities, and other life-support services often overwhelm the capabilities of local public health agencies creating an environment for a rapid increase in the number of environmental (heat and cold) injuries, disease vectors (rodents and arthropods), and the spread of food- and waterborne diseases. When a disaster strikes, the level of sanitation, measures employed to control disease vectors, and the resources available to prevent and treat arthropodborne diseases may vary. Increased understanding of the magnitude of the health threat posed by environmental health hazards, arthropodborne and other diseases, knowledge of how those diseases are transmitted (through arthropod bites or by physical transfer of disease-causing organisms), and the use of preventive medicine measures (such as topical skin repellents, insect netting, aerosol insecticides, and periodic checks for ticks and other visible parasites) can aid in preventing the spread of disease.

## **OCCUPATIONAL AND ENVIRONMENTAL HEALTH**

6-101. Injuries from exposure to occupational and environmental health hazards such as toxic industrial materials and noise pose a significant threat during a disaster. The environmental health threat includes climatic injuries (such as heat, cold, and altitude injuries) resulting from inadequate acclimatization to the area of operations and lack of proper clothing or equipment to protect from environmental conditions.

6-102. When supporting DSCA tasks, preventive medicine support may be requested by the local community when a hazardous material spill occurs or when unexplained contamination is found in surrounding wells or community water systems. Preventive medicine personnel may also participate in community assistance activities and public health programs to provide education on disease vectors, epidemiological investigations, and preventive medicine measures.

## **PREVENTIVE MEDICINE SUPPORT TO CIVIL AUTHORITIES**

6-103. During a disaster or national emergency, the DOD may be tasked to support federal, state, tribal, territorial, insular area, or local agencies by providing preventive medicine assets to assist ESF #8 in the protection of public health (such as food, water, wastewater, solid waste disposal, vectors, hygiene, and other environmental conditions). Preventive medicine personnel may also be called upon to—

- Provide guidance and assistance in restoring public health services.
- Conduct epidemiological investigations.
- Prepare and present educational programs in field hygiene and sanitation to victims of the disaster.

6-104. Emergency Support Function #8 may also request assistance from partner organizations in assessing potable water, wastewater, solid waste disposal, and other environmental health issues related to public health such as examining and responding to public health effects from contaminated water, conducting field investigations (including collection of relevant samples for laboratory analysis) and providing technical assistance and consultation. When supporting DSCA tasks, preventive medicine personnel can provide assistance and consultation support for—

- Control of arthropod vectors to include (with the concurrence of local authorities) providing technical advice concerning the suppression of mosquitoes, flies, lice, other arthropods, animals, and rodents.
- Investigation of disease outbreaks to include assisting local authorities by investigating reports of potential outbreaks. Findings resulting from these investigations are used to dispel rumors or provide early warning for local action if the threat is confirmed.
- Determination of immunization/prophylaxis requirements, to include assisting local health authorities when needed.
- Control of human waste, which if left unchecked, can lead to a number of disease outbreaks. Preventive medicine personnel can provide advice on the control of human waste to include construction and maintenance of improvised waste disposal devices (such as chemical toilets and other portable latrine systems, which can greatly reduce health hazards), which can be prepared for use until standard sanitary facilities can be restored.

6-105. Preventive medicine personnel can also provide technical advice to assist local authorities in recovery operations including technical advice on—

- Clearing debris from drainage structures.
- Collection and disposal of animal carcasses.
- Collection and disposal of food that has been condemned by local authorities.
- Preparation of homes for re-entry by homeowners (including technical advice on cleaning, disinfecting, and spraying homes that were affected by the disaster).

6-106. Army preventive medicine capabilities consist of preventive medicine detachments, teams, and staff officers responsible for providing support and consultation in the areas of disease and nonbattle injury prevention, field sanitation, entomology, sanitary engineering, and epidemiology to minimize the effects of environmental injuries, enteric diseases, vectorborne disease, and other health threats. Preventive medicine staff officers are also organic to the medical command (deployment support), medical brigade (support), medical battalion (multifunctional), and corps surgeons section at echelons above brigade that serve as command preventive medicine consultants and environmental sciences advisors.

## **COMBAT AND OPERATIONAL STRESS CONTROL**

6-107. Department of Defense Instruction 6490.05 directs the development of COSC programs, the establishment of requirements for activities that support behavioral health in military operations, and the early detection and management of combat and operational stress reactions in order to preserve mission effectiveness and warfighting capabilities and mitigate the adverse physical and psychological consequences of exposure to severe stress. Combat and operational stress reactions are experienced during all phases of unified land operations, making behavioral health support critical for mission success.

6-108. Behavioral health personnel play a major role in disaster relief efforts during DSCA by providing support to both the deployed force and civilian disaster victims, when directed. Under ESF #8, the DOD is tasked to provide available emergency medical support, which includes mental health support to assist federal, state, tribal, or local officials within the disaster area and the surrounding area. As an ESF #8 partner organization, the DOD may also be requested to—

- Provide assistance in assessing mental health and substance abuse needs (including emotional, psychological, psychological first aid, behavioral or cognitive limitations requiring assistance or supervision).
- Provide disaster mental health training materials for workers.

- Provide liaison with assessment training and program development activities undertaken by federal, state, tribal, or local mental health and substance abuse officials.
- Provide additional consultation and education as needed.

6-109. Department of Defense Instruction 6200.03 directs military commanders to ensure that disaster mental health services are available through a disaster mental health response team in response to an all-hazards incident by—

- Appointing a licensed behavioral health provider as the disaster mental health response team lead, who is trained in disaster mental health services and has overall responsibility for disaster mental health response team training and service implementation.
- Integrating disaster mental health preparedness and response with other DOD installation and military command emergency response plans.
- Entering into agreements (as needed) with other installations, Reserve Component units, National Guard units, and/or civilian providers for DOD installations to ensure access to a disaster mental health response team when the personnel and resources necessary to form a team are not present on a DOD installation.
- Delegating appropriate responsibilities for disaster behavioral health response to the MTF commander on installations where an MTF exists.

### **DISASTER MENTAL HEALTH RESPONSE TEAM**

6-110. Department of Defense Instruction 6200.03 defines disaster mental health as the provision of prevention, outreach, screening, triage, and psychological first aid, education, and referral services to individuals and groups who have had or may have had exposure to an all-hazards incident. The DODI also defines disaster mental health response team as the designated team that provides command consultation, prevention, outreach, screening, triage, and psychological first aid, education, and referral services following an all-hazards incident. According to the DODI, disaster mental health response teams shall—

- Consist of a multidisciplinary team, to include (at a minimum) individuals in each of the following areas:
  - Behavioral health (such as a psychiatrist, psychologist, social worker, psychiatric nurse practitioner, behavioral health technician, and/or licensed provider who is trained in acute behavioral health intervention).
  - Spiritual support (such as a chaplain and chaplain's assistant).
  - Family support (such as a community readiness consultant).
- Employ a licensed behavioral health provider serving as the disaster mental health response team leader.

6-111. The disaster mental health response team is responsible for—

- Coordinating with family assistance centers on military installations and other agencies as appropriate to arrange disaster mental health services to Family and community members impacted by an all-hazards incident.
- Establishing standard operating procedures in accordance with the National Institute of Health Publication Number 02-5138 that will include at a minimum—
  - The composition and role of the team.
  - A listing of available, locally trained resources (including contact information).
  - A description of local conditions and any identified high-risk groups.
  - A response plan for team activation.
  - Plans for conducting disaster mental health needs assessments and surveillance.
  - Required initial/periodic training.
- Establishing a plan for maintaining the individual psychological health of disaster mental health response team members in accordance with the Department of Health and Human Services Field Manual for Mental Health and Human Services Workers in Major Disasters and integrating the plan into the disaster mental health response standard operating procedure.

- Providing disaster mental health services to include prevention, outreach, screening, triage, psychological first aid, education, and specialty referrals to individuals and groups who may have been exposed to an all-hazards incident. These services are nonmedical services. Therefore, they do not involve medical or mental health record documentation.
- Training annually as part of the overall installation emergency management exercises in accordance with DODI 6055.17.
- Training at least quarterly as a disaster mental health response team, using evidence-based practices if available, to develop and maintain the competencies necessary to provide disaster mental health services. Training will cover, at a minimum, prevention, outreach, screening, triage, psychological first aid, education, and referral services for individuals and groups who have had or may have had exposure to an all-hazards incident. Training will also cover command consultation and ethical issues during disasters.
- Identifying and training primary and alternate disaster mental health team members for each role to ensure continuous access to disaster mental health services.
- Coordinating efforts with the public health environmental officer and integrating efforts of the disaster mental health response team into the overall public health emergency preparedness and response plan.

## **BEHAVIORAL HEALTH SUPPORT**

6-112. The adverse effects of stress not only impact the victims of an incident, but Family members, friends, rescue workers, medical personnel, and others supporting a disaster. Traumatic event debriefings (for victims, Families, and friends) and after-action debriefings (for caregivers and rescuers) enable the victims/participants to express their feelings, gain perspective from others involved, and to better understand the incident and their feelings concerning the event. These activities may reduce the incidence of combat and operational stress behaviors and aid in recovery.

6-113. Resiliency measures should be instituted for military personnel and others supporting an emergency prior to their deployment to a disaster site in an effort to counter the secondary trauma that caregivers and other first responders sometimes experience as a result of treating disaster victims. Stress control measures should also be applied during and after an operation as well, in an effort to mitigate the negative effects of the incident, maintain effective performance, and minimize posttraumatic stress disorders and other combat and operational stress behaviors among caregivers as well as victims.

6-114. Medical commanders and leaders at all levels must be proactive in establishing preventive measures and other mechanisms to assist in addressing combat and operational stress reactions, potentially traumatic events, and other behavioral health issues. Behavioral health activities (preventive measures and acute interventions) may be used to manage stress-related problems/reactions arising from traumatic events that occur during a national catastrophe (such as natural or man-made disasters to include pandemic influenza, hurricane, earthquake, or a singular incident such as a school bus accident which results in the death of or serious injury to the students).

6-115. Behavioral health assets needed to support the COSC mission during DSCA are available at various locations throughout the operational area. There are no COSC assets at Role 1. However, they are available at Role 2 as part of the mental health section of the brigade support medical company in the brigade support battalion and the medical company (area support) at echelons above brigade. Behavioral health assets are also present in the medical detachment (COSC) at echelons above brigade, which is usually assigned to the medical battalion (multifunctional). Support for disaster mental health response teams and other DOD behavioral health responsibilities under ESF #8 may be provided by the MTF located on the supporting installation or behavioral health personnel in the organizations listed above.

## **RELIGIOUS SUPPORT**

6-116. Army chaplains are trained to work closely with medical personnel and are trained to recognize signs of and administer support to Soldiers exposed to potentially traumatic events. Chaplains are also trained in the traumatic event management process and are able to assist facilitators.

6-117. Current DOD legal guidance generally prohibits chaplains from providing religious support to the civilian population. However, following large-scale disasters, local and state capabilities of all types, to include spiritual care, may be overwhelmed. In these situations, when directed, religious support teams may serve as liaison to nongovernmental organizations and faith-based organizations.

6-118. Incidental support may be provided to persons not affiliated with the Armed Forces during the execution of an authorized mission when the following criteria are met:

- The support must be individually and personally requested in an emergency situation, whereby the need is immediate, unusual, and unplanned.
- The need must be acute. Acute needs are those which are of short duration, prone to rapid deterioration, and in need of urgent and immediate care. The necessary provision of last rites is the clearest, but not the only example of such needs.
- The requested support must be incapable of being reasonably rendered by members of the clergy unaffiliated with the Armed Forces. Time, distance, and the state of communications may require such a determination to be made on the spot, by the incident commander with input from the chaplain, based on the information available at the time.
- The support must be actually incidental. Such support incurs no incremental monetary cost and does not significantly detract from the primary religious support role.

## **DENTAL SUPPORT**

6-119. Due to the capabilities available within the U.S. civilian health care system, dental support to DSCA tasks may be limited. Operational dental support (including emergency and essential dental care) to the deployed force is the primary role of Army dental personnel supporting civil authorities during a national emergency. Comprehensive dental care is another category of support that is normally found only in fixed facilities in the continental U.S. support base. Dental support provided during a national emergency ranges from traditional support to deployed military forces to the provision of emergency dental support (including treatment for maxillofacial injuries).

6-120. Emergency Support Function #8 may task Department of Health and Human Services components to request that the Department of Veterans Affairs and DOD provide available personnel to support dental care for disaster victims who are seriously ill, injured, or suffer from chronic illness and need evacuation assistance. The DOD may also be tasked to assist in reestablishing and augmenting civilian dental infrastructure following a disruption caused by a natural or man-made disaster or civil disturbance. In some circumstances, community assistance may be provided in remote locations for populations without reasonable access to dental care or on request from community-based prevention and education programs.

## **VETERINARY SUPPORT**

6-121. The U.S. Army Veterinary Services is the DOD executive agent for veterinary public and animal health services in support of all of the military Services (except for the food inspection mission on U.S. Air Force installations). The Army veterinary services mission encompasses food protection measures (to include food safety and food defense), veterinary public health, as well as medical care for military working dogs and other non-DOD owned government animals.

6-122. In the aftermath of a disaster, animals are also affected (including privately owned pets, livestock, and wild animals). The Pets Evacuation and Transportation Standards Act of 2006 (Public Law 109-308) was enacted to ensure that state and local emergency preparedness operational plans address the needs of individuals with household pets and service animals following a major disaster or emergency. Veterinary services personnel may be called upon to assist in providing the veterinary support necessary to ensure the safety of disaster victims, rescuers, caregivers, and the animals. Veterinary personnel may also be called upon to assist in the control of zoonotic diseases.

6-123. Department of Defense Instruction 6200.03 directs veterinary services personnel to coordinate and integrate veterinary public health and veterinary medical planning (such as veterinary mass medical care, veterinary medical logistics, and veterinary countermeasure acquisition and distribution). The DODI also directs increased surveillance, risk communication, food safety and protection, training, laboratory

diagnostics, field operations support that could include eradication of disease, identification of affected animals, animal quarantine implementation, euthanasia, carcass disposal, cleaning and disinfection, biosecurity, strategic vaccination and/or treatment for animals, wildlife management, and vector control. Veterinary services personnel are also responsible for providing subject matter expertise for DOD installations and/or military commands, as well as reporting to the appropriate public health environmental officer any circumstances suggesting a public health emergency. This is in addition to reports required by otherwise applicable surveillance systems, including non-DOD systems.

## **FOOD INSPECTION**

6-124. Emergency Support Function #11 lists the DOD as the agency responsible for assessing the availability of DOD food supplies and storage facilities capable of storing dry, chilled, and frozen food. Emergency Support Function #8 in cooperation with ESF #11 may request assistance from partner organizations to ensure the safety and security of federally regulated foods. The Department of Health and Human Services (through the Food and Drug Administration) has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of the U.S. Department of Agriculture Food Safety and Inspection Service.

6-125. Army veterinary units are capable of conducting sanitation inspection audits of food processing facilities for either military or commercial food production/processing and storage facilities to ensure the protection and quality of food, bottled water, and block or packaged ice. During a disaster, veterinary support may also be required to assist in foodborne illness investigations and provide assessment and guidance on temperature-abused foods.

## **CONTROL OF ZOO NOTIC DISEASES**

6-126. The veterinary public health mission provides support for monitoring endemic zoonotic disease threats of military significance. Emergency Support Function #8 may request support from other partner organizations, as appropriate, in—

- Assessing the threat of vectorborne diseases.
- Conducting field investigations (including the collection and laboratory analysis of relevant samples).
- Providing vector control equipment and supplies.
- Providing technical assistance and consultation on protective actions regarding vectorborne diseases.
- Providing technical assistance and consultation on treatment of victims of vectorborne diseases.

## **ANIMAL CARE AND AGRICULTURAL SUPPORT**

6-127. Emergency Support Function #11 lists the DOD as the agency responsible for assisting animal emergency response organizations, or others as requested. Under this ESF, the Army is responsible for providing resources, which include senior Veterinary Corps officers to function as Defense Veterinary Liaison Officers and Defense Veterinary Support Officers and other military specialists trained in foreign animal disease diagnosis, epidemiology, microbiology, immunology, entomology, pathology, and public health. These officers serve as on-site points of contact for DOD veterinary functions and may also be tasked to assist the U.S. Department of Agriculture in the control, treatment, and eradication of animal disease outbreaks. Additional support may include assisting in the care and treatment of sick and injured animals and control of those separated from their owners. Veterinary support for treatment and control of wild animals may also be required. In some cases veterinary personnel may perform euthanasia to prevent undue suffering of the animal.

6-128. The veterinary services animal care mission provides complete medical care for military working dogs and other non-DOD owned government animals located in the area of operations. The Army veterinary unit may be tasked to establish a veterinary treatment facility and provide triage and emergency medical treatment for injured working animals, including lifesaving emergency procedures. They may also provide veterinary care for military working dogs involved in search and rescue and, when authorized, to animals of other government and nongovernmental agencies participating in the relief effort.

## Chapter 7

# Interorganizational Coordination

The DOD conducts interorganizational coordination across the range of military operations in support of stability and DSCA tasks. This form of coordination involves many different communities of interest and is critical to mission success when conducting DSCA and stability tasks, which are governed by different authorities with considerably different organizational structures and stakeholders. This chapter provides a brief description of key DOD, U.S. governmental, nongovernmental, and multinational organizations supporting stability tasks. It also describes the process for requesting DOD assistance for support to civil authorities, some of the NDMS medical resources that may be employed during a disaster, as well as some of the participating organizations that may be involved in the relief effort.

### SECTION I — COORDINATION REQUIREMENTS

7-1. Joint Publication 3-08 defines *interorganizational coordination* (within the context of DOD involvement) as the interaction that occurs among elements of the DOD; engaged U.S. Government agencies; state, territorial, local and tribal agencies; foreign military forces and government agencies; intergovernmental organizations; nongovernmental organizations; and the private sector. Interagency coordination is also required when conducting stability and DSCA tasks and is the vital link between the U.S. military and other instruments of national and international power. However, interorganizational coordination encompasses a broader range of participants and more accurately reflects the level of support and unity of effort required among federal, state, tribal, and local organizations as well as the private sector and international partners when supporting stability and DSCA tasks.

### SECTION II — COORDINATION IN SUPPORT OF STABILITY TASKS

7-2. Coordination in support of stability tasks involves many U.S. government agencies such as the Department of State and the USAID. The DOD plays a supporting role when conducting stability tasks. Interorganizational and interagency coordination facilitates the synchronization of all elements of national and international power and provides the critical link that unites the DOD and all participating agencies in support of stability tasks.

## GOVERNMENTAL AGENCIES

7-3. The Department of State is the lead federal agency in support of stability tasks and is organized to provide—

- Foreign policy advice to the President.
- Nation-to-nation representation throughout the world.
- United States interdepartmental coordination in various nations with whom the U.S. has relations.
- Worldwide information services.

7-4. Key planners within the Department of State include the—

- *Secretary of State*, which is the principal foreign policy advisor to the President and is responsible for the overall direction, coordination, and supervision of U.S. foreign relations and for the interdepartmental activities of the U.S. government overseas.

- *Ambassador and the United States country team.* The U.S. country team is composed of senior representatives of all in-country U.S. government departments. The ambassador represents the President as Chief of Mission, but takes policy guidance from the Secretary of State through regional bureaus. The ambassador is responsible for all U.S. activities within the country to which accredited and interprets U.S. policies and strategies regarding the nation. The composition of the country team varies widely depending on specific U.S. national interests in the country, the desires of the Chief of Mission, the situation within the country, and the number and level of presence of U.S. agencies. The ambassador's authority does not, however, include the direction of U.S. military forces operating in the field when such forces are under the command of a U.S. area military command. The combatant commander usually participates as a member of the country team, even though he is not a member of the diplomatic mission and may not be physically located in the country.
- *Political advisor,* which is a Foreign Service officer from the Department of State. The Department of State assigns a political advisor to each combatant command and may authorize one to the American operational commander during multinational operations. The political advisor is a valuable asset possessing appropriate regional knowledge and language skills and can assist the combatant commander in translating political objectives into military objectives. Further, the political advisor can facilitate cooperation between the primary U.S. political and military actors. The political advisor often has the ability to move freely throughout an area of operations and work with a wide range of different parties that might not work with U.S. military personnel.

7-5. In addition to the Department of State and USAID, there are a host of other U.S. government and nongovernmental agencies involved in U.S. stabilization efforts around the world to include the U.S. Department of Agriculture and many others.

## **DEPARTMENT OF DEFENSE**

7-6. As mentioned in paragraph 7-2 above, the DOD may not be the lead player in interagency operations. When conducting stability tasks, the Office of the Secretary of Defense and the joint staff coordinate interagency operations at the strategic level. This coordination establishes the framework for coordination by commanders at the operational and tactical levels.

7-7. The combatant commander is the central point for plans and implementing theater and regional strategies that require interorganizational and interagency coordination. The combatant commander may establish an advisory committee to link the theater strategy to national policy goals and objectives of the Department of State and concerned ambassadors. Military personnel may coordinate with other U.S. government agencies while operating directly under the ambassador's authority, while working for a security assistance organization, or while assigned to a regional combatant command.

7-8. Coordination among DOD and other U.S. government agencies may occur in a country team or within a combatant command. Military personnel working in support of stability tasks must ensure that the ambassador and the combatant commander is aware of and approve all programs and determine command relationships for each operation.

7-9. In addition to the various numbered military units operating in support of stability tasks, there are also various augmentation teams (such as the provincial reconstruction teams, humanitarian assistance survey teams, and disaster assistance response teams) and other resources operating within the DOD that are actively engaged and available to provide the necessary support including the—

- Center for Excellence in Disaster Management and Humanitarian Assistance.
- Center for Disaster and Humanitarian Assistance Medicine.
- Defense Medical Readiness Training Institute.
- National Center for Medical Intelligence.
- Armed Forces Health Surveillance Center.

## **CENTER FOR EXCELLENCE IN DISASTER MANAGEMENT AND HUMANITARIAN ASSISTANCE**

7-10. The Center for Excellence in Disaster Management and Humanitarian Assistance was established by Congress and operates under the authority of the Secretary of Defense. The Center fulfills a worldwide mission to enhance civil-military coordination through collaborative partnerships, education and training, and applied research. The Deputy Assistant Secretary of Defense for Partnership Strategy and Stability Operations provides guidance through the Commander, U.S. Pacific Command, who exercises direct control of the Center. Additional information can be obtained via the Center for Excellence in Disaster Management and Humanitarian Assistance Web site, which can be accessed via the Web address posted in the references section of this manual.

## **CENTER FOR DISASTER AND HUMANITARIAN ASSISTANCE MEDICINE**

7-11. The Center for Disaster and Humanitarian Assistance Medicine was chartered in 1999 at the Uniformed Services University through Congressional funding to serve as an academic resource in the areas of foreign humanitarian assistance and disaster response medicine. The center is postured as the DOD focal point for academic aspects of medical support to stability tasks. Additional information can be obtained via the Center for Disaster and Humanitarian Assistance Medicine Web site, which can be accessed via the Web address posted in the references section of this manual.

## **DEFENSE MEDICAL READINESS TRAINING INSTITUTE**

7-12. The Defense Medical Readiness Training Institute is a DOD organization staffed by personnel from the U.S. Army, U.S. Navy, and U.S. Air Force. The Defense Medical Readiness Training Institute provides resident and nonresident joint medical readiness training courses and professional medical programs in the areas of:

- Trauma care.
- Burn care.
- Disaster preparedness.
- Foreign humanitarian assistance.
- Chemical, biological, radiological, nuclear, and high-yield explosives preparation/response.

7-13. Additional information can be obtained via the Defense Medical Readiness Training Institute Web site, which can be accessed via the Web address posted in the references section of this manual.

## **NATIONAL CENTER FOR MEDICAL INTELLIGENCE**

7-14. The mission of the National Center for Medical Intelligence is to prepare, coordinate, and disseminate integrated, all-source intelligence on health threats, foreign medical capabilities with the ability to enhance or harm U.S. interests and other medical intelligence of national security relevance. Additional information can be obtained via the National Center for Medical Intelligence Web site, which can be accessed via the Web address posted in the references section of this manual.

## **ARMED FORCES HEALTH SURVEILLANCE CENTER**

7-15. The Armed Forces Health Surveillance Center provides comprehensive health surveillance information to promote, maintain, and enhance the health of military and associated populations. The Armed Forces Health Surveillance Center serves as the focal point for sharing health surveillance products, expertise, and information by—

- Acquiring, analyzing/interpreting, disseminating information, and recommending evidence-based policy.
- Developing, refining, and improving standardized surveillance methods.
- Coordinating a global program of militarily relevant infectious disease surveillance.

## **MULTINATIONAL AND NONGOVERNMENTAL ORGANIZATIONS**

7-16. Nongovernmental and private volunteer organizations also play a major role in providing support to stability tasks. These organizations are frequently on the scene before military forces, are willing to operate in high risk areas, and will most likely remain long after military forces have departed. Because of their capability to respond quickly and effectively to crisis, nongovernmental and private volunteer organizations can lessen the amount of military resources that may be required to support stability tasks. Examples of such organizations include the—

- International Committee of the Red Cross.
- Médecins Sans Frontières/Doctors Without Borders.
- United Nations.
  - Office for the Coordination of Humanitarian Affairs.
  - High Commission for Refugees.
  - World Food Program.
  - Food and Agriculture Organization.
- Reliefweb.
- World Health Organization.
- Pan American Health Organization.
- World Organization for Animal Health.

### **INTERNATIONAL COMMITTEE OF THE RED CROSS**

7-17. The International Committee of the Red Cross works worldwide to provide humanitarian assistance for people affected by conflict and armed violence or by natural disaster occurring in a conflict area and to promote the laws that protect victims of war. The International Committee of the Red Cross is an independent and neutral organization, whose mandate is derived from the Geneva Conventions of 1949. For additional information, see the International Committee of the Red Cross Web site, which can be accessed via the Web address posted in the references section of this manual.

### **MÉDECINS SANS FRONTIÈRES/DOCTORS WITHOUT BORDERS**

7-18. Médecins Sans Frontières/Doctors Without Borders is an international medical humanitarian organization created by doctors and journalists in France in 1971. The organization provides assistance in more than 60 countries to populations in distress, victims of natural or man-made disasters, and victims of armed conflict. For additional information, see the organization's Web site, which can be accessed via the Web address posted in the references section of this manual.

### **UNITED NATIONS**

7-19. The UN is an international organization founded in 1945 after the Second World War by 51 countries committed to maintaining international peace and security, developing friendly relations among nations and promoting social progress, better living standards and human rights. Due to its unique international character, and the powers vested in its founding Charter, the Organization can take action on a wide range of issues, and provide a forum for its 193 Member States to express their views, through the General Assembly, the Security Council, the Economic and Social Council and other bodies and committees. Numerous elements of the UN provide support to stabilization efforts worldwide including the—

- Office for the Coordination of Humanitarian Affairs.
- High Commission for Refugees.
- World Food Program.
- Food and Agriculture Organization.

## Reliefweb

7-20. The reliefweb Web site, sponsored by the UN Office for Coordination of Humanitarian Affairs, was developed to serve as a source for reliable humanitarian information on global crises and disasters. The Web site is a specialized digital service that—

- Collects updates and analysis from global information sources around the clock.
- Delivers content such as country and disaster reports, maps, information graphics, job announcements and learning opportunities, and other events of interest to humanitarians.
- Enables humanitarian partners to analyze context and situations to make better decisions.

7-21. The site can be accessed via the Web address posted in the references section of this manual.

## World Health Organization

7-22. The World Health Organization is the directing and coordinating authority for health within the UN system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends. For additional information, see the World Health Organization Web site, which can be accessed via the Web address posted in the reference section of this manual.

## Pan American Health Organization.

7-23. The Pan American Health Organization, founded in 1902, is the world's oldest international public health agency. It provides technical cooperation and mobilizes partnerships to improve health and quality of life in the countries of the Americas. The Pan American Health Organization is the specialized health agency of the Inter-American System and serves as the World Health Organization's Regional Office for the Americas. Together with the World Health Organization, the Pan American Health Organization is a member of the UN system. For additional information, see the Pan American Health Organization Web site, which can be accessed via the Web address posted in the references section of this manual.

## WORLD ORGANIZATION FOR ANIMAL HEALTH

7-24. The World Organization for Animal Health is the intergovernmental organization responsible for improving animal health worldwide. The World Organization for Animal Health is recognized as a reference organization by the World Trade Organization and maintains permanent relations with 45 other international and regional organizations and has regional and subregional offices on every continent. For additional information, see the World Organization for Animal Health Web site, which can be accessed via the Web address posted in the references section of this manual.

## SECTION III — COORDINATION IN SUPPORT OF DEFENSE SUPPORT OF CIVIL AUTHORITIES

7-25. When conducting DSCA tasks, the DOD will be required to work with other federal agencies to provide the necessary support. In most operations in support of DSCA tasks, other U.S. governmental organizations will have primary responsibility as the lead federal agency, while the DOD plays a supporting role. This section provides a discussion of the coordination requirements and some of the organizations involved in the conduct of DSCA tasks.

## REQUESTS FOR DEPARTMENT OF DEFENSE ASSISTANCE

7-26. In most instances, the DOD conducts DSCA tasks in response to requests for assistance from other federal agencies. Defense support to civil authorities is normally provided when local, tribal, state, territorial, insular area, and federal resources are fully committed or when a capability unique to the DOD is required. The DOD typically provides support to DSCA tasks on a reimbursable basis, as required by the appropriate statutory authority.

7-27. When an event occurs and the President or Secretary of Defense approves support to civil authorities, the appropriate combatant commander is designated as the supported commander. In most cases, the Commander, U.S. Northern Command or U.S. Pacific Command will be designated as the supported commander. As necessary, the combatant commander activates and deploys an initial mission command element and follow-on joint task force to serve as the mission command node for designated DOD forces responding to an event or incident. Upon receipt of a request for assistance, the DOD uses the following criteria to evaluate the request for supportability:

- Legality (compliance with applicable laws).
- Lethality (potential use of lethal force by or against DOD forces).
- Risk (safety of DOD forces).
- Cost (who is funding the request and the impact on the DOD budget).
- Appropriateness (whether conduct of the requested mission is in the interest of the DOD).
- Readiness (effect on the DOD's ability to perform its primary national defense mission).

7-28. Once approved, the DOD provides the assets to fulfill the request. There are several situations where a request for assistance would be generated—prior to a Presidential declaration of a major disaster and/or emergency; after a Presidential declaration of a major disaster and/or emergency; and nonfederally declared disasters.

### **PRIOR TO A PRESIDENTIAL DECLARATION OF A MAJOR DISASTER OR EMERGENCY**

7-29. During the immediate aftermath of an incident that may qualify for assistance under the Stafford Act, the governor of the state in which an incident occurred may request that the President direct the Secretary of Defense to use DOD resources to perform emergency work that is essential for the preservation of life and property. The President may direct this emergency work for a period not to exceed ten days.

### **PRESIDENTIAL DECLARATION OF A MAJOR DISASTER OR EMERGENCY**

7-30. Once the President issues a major disaster and/or emergency declaration, the DOD is normally in direct support of a primary or lead federal agency. The request for assistance or mission assignment process following a presidential declaration of a disaster or emergency includes—

- Initial requests for assistance initiated by the primary federal agency.
  - Secretary of Defense or designated representative is the DOD approval authority.
  - Assets provided in support of a declared emergency are subject to the request for assistance evaluation criteria.
- Requests for assistance originating from the disaster site, which are initiated by the federal coordinating officer or senior civilian representative of the primary federal agency at the disaster site.
  - Secretary of Defense or designated representative is the approval authority for the DOD.
  - Requests are routed through the defense coordinating officer: Office of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs; and the Joint Director of Military Support.
  - Assets provided in response to a request are subject to the request for assistance evaluation criteria.
- Follow-on requests for assistance from the primary federal agency headquarters, which are initiated by the primary federal agency.
  - Secretary of Defense or designated representative is the approval authority for the DOD.
  - Requests are routed through the defense coordinating officer: Office of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs; and the Joint Director of Military Support.
  - Assets provided in response to a request are subject to the request for assistance evaluation criteria.

## NONFEDERALLY DECLARED DISASTER

7-31. Within the DOD, local military commanders and responsible officials from DOD components and agencies are authorized by the Secretary of Defense to provide support to save lives, prevent human suffering, and mitigate great property damage. Examples of nonfederally declared disasters include—mutual aid agreements for fire protection and immediate response. See paragraph 5-15 for a full description of immediate response authority.

## PRE-SCRIPTED MISSION ASSIGNMENTS

7-32. The Department of Homeland Security/Federal Emergency Management Agency uses mission assignments to task and reimburse other federal departments and agencies to provide direct assistance during emergencies and disasters. The mission assignment process has been expanded in recent years to include pre-scripted mission assignments, which are prepared in advance to facilitate an accelerated response and standardize the process of developing mission assignments. They specify the type of support or assignment required (such as personnel and equipment), statement of work, and projected cost to provide the support requested. All requests for DOD assistance are subject to the approval of the Secretary of Defense and are evaluated on a case-by-case basis.

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*Note.* Pre-scripted mission assignments are not *preapproved* mission assignments.

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## NATIONAL DISASTER MEDICAL SYSTEM REQUESTS FOR ASSISTANCE

7-33. Upon a state's request, the NDMS can provide personnel, equipment, supplies, and a network of hospitals working with state and local personnel to provide care and support to communities affected by a disaster. Once a state requests assistance, a mission assignment is generated by the Federal Emergency Management Agency. The mission assignment articulates which federal coordinating centers (or other capabilities) are activated and includes a funding citation and signed authorization. The mission assignment is then transmitted to the DOD and Department of Veterans Affairs points of contact in the form of a request for assistance.

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*Note.* It is important to note that generally the mission assignment will request capabilities to provide patient movement and reception and not necessarily to activate a specific federal coordinating center.

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7-34. Requests for DOD assistance are submitted through the Secretary of Defense's Executive Secretary, who forwards the request (Federal Emergency Management Agency mission assignment) to the Office of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs and the Joint Director of Military Support. The request for assistance (Federal Emergency Management Agency mission assignment) is forwarded to the Secretary of Defense for approval. Upon Secretary of Defense approval, the Joint Director of Military Support coordinates and forwards executive orders and/or operations orders to the applicable combatant command (such as the U.S. Northern, Pacific, or Southern Commands) and/or to the military Services as applicable, to direct the activation of DOD assets such as DOD federal coordinating centers. The combatant command issues a modification order to the standing executive order for DSCA to alert and/or activate the DOD federal coordinating center. The key steps in the formal processing of Federal Emergency Management Agency mission assignments are outlined in Table 7-1 on page 7-8.

**Table 7-1. Mission assignment/request for assistance process**

| Mission Assignment/Request for Assistance Process                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Step 1:</b> The governor of an affected state may request federal assistance under the provisions of the Stafford Act. The state coordinating officer requests federal assistance from the Federal Emergency Management Agency regional director or federal coordinating officer, as applicable.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <p><b>Step 2:</b> The Federal Emergency Management Agency regional director or federal coordinating officer coordinates the request with the appropriate regional Emergency Support Function #8 representative and forwards the request through the Regional Response Coordination Office or the Joint Field Office to the Department of Homeland Security Federal Emergency Management Agency National Response Coordination Center.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>Step 3:</b> To obtain support from National Disaster Medical System Partners, the Department of Homeland Security/Federal Emergency Management Agency federal approving official in the National Response Coordination Center issues a Federal Emergency Management Agency Form 90-129, <i>Mission Assignment</i> in accordance with the National Response Framework Financial Management Support Annex.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Step 4:</b> The National Response Coordination Center forwards approved mission assignments or requests for assistance for federal health and medical assets to the Department of Health and Human Services Secretary's Operations Center. Mission assignments/requests for assistance for assets that are solely provided by the Department of Defense are forwarded directly to the Secretary of Defense, Executive Secretary via the Department of Defense liaison in the National Response Coordination Center.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p><b>Step 5:</b> The Department of Health and Human Services Emergency Management Group of the Secretary's Operations Center convenes a National Disaster Medical System Patient Movement Coordination Group (formerly known as the Medical Inter-agency Coordination Group) to communicate mission requirements and establish an integrated concept of National Disaster Medical System operations. The Patient Movement Coordination Group is comprised of a representative(s) from each of the partner agencies (Department of Health and Human Services, Department of Defense, Department of Veterans Affairs, and Department of Homeland Security), especially when patient movement and definitive care are needed. The Department of Health and Human Services Secretary's Operations Center coordinates the completion of emergency support function mission assignment subtasking request form(s), as needed, in accordance with the National Response Framework Financial Management Support Annex.</p> |
| <p><b>Step 6:</b> The Department of Health and Human Services Secretary's Operations Center forwards mission assignment subtaskings to the Department of Veterans Affairs Readiness Operations Center, as applicable. The Department of Health and Human Services Secretary's Operations Center will also request that the Department of Homeland Security/Federal Emergency Management Agency issue a request for assistance through and approved and funded mission assignments directly to the Secretary of Defense, Executive Secretary. The Department of Health and Human Services Secretary's Operations Center coordinates with the Department of Health and Human Services National Disaster Medical System Operations Branch as applicable. The Department of Health and Human Services Secretary's Operations Center/Operations Division will notify the National Disaster Medical System Operations Branch when to alert, activate, and deploy response teams as applicable.</p>                        |
| <p><b>Step 7:</b> The Secretary of Defense's Executive Secretary forwards the request for assistance (Federal Emergency Management Agency mission assignment) to the Office of the Assistant Secretary of Defense for Homeland Defense and America's Security Affairs and the Joint Director of Military Support. The request for assistance (Federal Emergency Management Agency mission assignment) is forwarded to the Secretary of Defense for approval.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p><b>Step 8:</b> Upon Secretary of Defense approval, the Joint Director of Military Support coordinates and forwards execute orders and/or operations orders to the applicable combatant commands (such as the U.S. Northern, Pacific, or Southern Commands) and/or to the military Services (as applicable) to direct activation of Department of Defense assets, such as United States Transportation Command aeromedical evacuation patient assets and Department of Defense federal coordinating centers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>Step 9:</b> The Department of Veterans Affairs Readiness Operations Center forwards approved mission assignment subtaskings for medical assets from the Department of Veterans Affairs to the Office of the Department of Veterans Affairs, Under Secretary for Health. The Department of Veterans Affairs, Under Secretary for Health alerts or activates Department of Veterans Affairs' federal coordinating centers, as applicable.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## SECTION IV — NATIONAL RESPONSE RESOURCES

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

7-35. During a national emergency, the DOD may be called upon to assist civil authorities in responding to a disaster. The Department of Health and Human Services along with other government agencies will have the primary responsibility for leading the federal response for public health and medical support during a disaster or national emergency, while the DOD plays a supporting role. This section lists some of the resources available through the Department of Health and Human Services and other government organizations responsible for providing public health and medical services under ESF #8 in response to a disaster or national emergency.

7-36. The Department of Health and Human Services is the coordinator for ESF #8 and lead federal agency for all federal public health and medical response to public health emergencies and incidents covered by the NRF. The Secretary of the Department of Health and Human Services assumes operational control of federal emergency public health and medical response assets, as necessary, in the event of a public health emergency, except for members of the Armed Forces, who remain under the authority and control of the Secretary of Defense. As the lead agency for ESF #8, the Department of Health and Human Services determines the appropriateness of all requests for release of public health and medical information and is responsible for consulting with and organizing federal public health and medical subject-matter experts, as needed.

### NATIONAL DISASTER MEDICAL SYSTEM RESPONSE TEAMS

7-37. Immediate medical response capabilities are provided by assets internal to the Department of Health and Human Services (such as the NDMS, U.S. Public Health Service Commissioned Corps, and federal civil service employees) and supporting organizations for ESF #8. Medical response is the first component of the NDMS. This support includes personnel (teams and individuals), supplies, and equipment. The NDMS response teams include the—

- Disaster Medical Assistance Teams.
- National Medical Response Teams.
- Disaster Mortuary Operational Response Teams.
- International Medical Surgical Response Teams.
- National Veterinary Response Team.

#### Disaster Medical Assistance Teams

7-38. Disaster Medical Assistance Teams are mobile NDMS teams comprised of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff). The teams are designed as rapid response elements to supplement local medical care until other federal or contract resources can be mobilized, or the situation is resolved. The disaster medical assistance teams provide medical care during a disaster or other event. The teams are capable of rapidly deploying to a disaster or other major emergency to provide primary and acute care, triage of mass casualties, initial resuscitation, stabilization, advanced life support, and preparation of sick or injured patients for evacuation. These 35-person teams are self-sustaining for up to 72 hours. The teams include command/support/staff and health care provider positions with a standard equipment cache.

7-39. To augment the standard disaster medical assistance teams, there are highly specialized teams that deal with specific medical conditions such as crush injuries, burns, and mental health emergencies. These teams can be mobilized within 6 to 12 hours depending on team organization.

#### National Medical Response Teams

7-40. National Medical Response Teams provide medical care following a CBRN incident. This team is capable of providing mass casualty decontamination, medical triage, and primary and secondary medical

care to stabilize victims for transport to tertiary care facilities in a hazardous material environment. The basic deployment configuration of a National Medical Response Team consists of 50 personnel.

### **International Medical Surgical Response Teams**

7-41. The International Medical Surgical Response Team is an NDMS team of medical specialists who provide surgical and critical care during a disaster or public health emergency. Originally conceived to address the needs of U.S. citizens injured overseas, the International Medical Surgical Response Team role has expanded over the years to include both domestic deployments, including the World Trade Center Bombings and Hurricane Katrina, and international deployments, including the earthquakes in Bam, Iran, and Port au Prince, Haiti.

7-42. International Medical Surgical Response Team personnel are federal employees used on an intermittent basis to deploy to the site of a disaster or public health emergency and provide high quality, lifesaving surgical and critical care. As federal employees, International Medical Surgical Response Team personnel are protected by the Uniformed Services Employment and Reemployment Rights Act, Title 38, U.S. Code (Public Law 103-353), Federal Tort Claims Act, and Worker's compensation. Additionally, the International Medical Surgical Response Team employees' personal state licenses and certifications are recognized both nationally and internationally when deployed as federal employees. International Medical Surgical Response Team deployments often occur in austere environments where many of the conveniences of modern life are limited or unavailable. Personnel are deployed normally in 14 day periods or longer until local medical resources are sufficiently recovered or have been supplemented by other organizations. Between deployments, the International Medical Surgical Response Team works closely with other NDMS teams to recruit, train, and prepare experienced medical providers for deployment.

### **National Veterinary Response Team**

7-43. The National Veterinary Response Team is a cadre of individuals within the NDMS who have professional expertise in the areas of veterinary medicine, public health, and research. The National Veterinary Response Team provides assistance in identifying the need for veterinary services following major disasters, emergencies, public health, or other events requiring federal support and in assessing the extent of disruption to animal and public health infrastructures. The National Veterinary Response Team is a fully supported federal program with responsibilities that include—

- Assessing the veterinary medical needs of the community.
- Providing medical treatment and stabilization of animals.
- Conducting animal and zoonotic disease surveillance, as well as public health assessments.
- Providing technical assistance to assure food safety and water quality.
- Working to mitigate hazards.
- Providing care and support of animals certified as official responders to a disaster or emergency.

7-44. National Veterinary Response Team members are private citizens who have been approved as intermittent federal employees for activation in the event of a disaster. The teams are comprised of individuals with diverse expertise to include veterinarians, animal health technicians, pharmacists, epidemiologists, safety officers, logisticians, communications specialists, and other support personnel. Personnel are assigned to designated teams and train in preparation for what might be experienced during a response. National Veterinary Response Teams are enabled by a regional cache of equipment, supplies and pharmaceuticals, are compensated for their duty time by the federal government, and work within the incident command system framework. The teams provide assessments, technical assistance, public health, and veterinary services under the guidance of state and/or local authorities.

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**Note.** As intermittent federal employees, once the teams are activated, licensure is recognized by the state requesting assistance for the length of their deployment.

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7-45. This veterinary team supports the NRF mission requirements of the NDMS under ESF #8. The team also provides operational support to other federal partners such as the U.S. Department of Agriculture

under ESF #11, Agriculture and Natural Resources, and Federal Emergency Management Agency under ESF #6, Mass Care, in support of the Pets Evacuation and Transportation Standards Act.

## **PUBLIC HEALTH SERVICE COMMISSIONED CORPS**

7-46. The mission of the U.S. Public Health Service Commissioned Corps is to protect, promote, and advance the health and safety of our Nation. The U.S. Public Health Service Commissioned Corps achieves this mission through—rapid and effective response to public health needs; leadership and excellence in public health practices; and advancement in public health science. The U.S. Public Health Service Commissioned Corps can provide the following teams in support of a disaster:

- Rapid deployment force, which consists of five preidentified teams, each with 105 multidisciplinary staff. The teams serve on a rotating call basis, with the on call team capable of deploying within 12 hours of notification. Rapid deployment force teams have a built-in command structure and can provide mass care at shelters (including federal medical stations) and staff points of distribution and casualty collection points. Rapid deployment force teams can also conduct community outreach and assessments, among other functions.
- Applied public health team, which is composed of experts in applied public health and can function as a public health department in a box. Applied public health teams can deploy within 36 hours of notification and provide assistance in public health assessments, environmental health, infrastructure integrity, food safety, vector control, epidemiology, and surveillance.
- Mental health team, which consists of mental and behavioral health experts who assess stress and suicide risks within the affected population, manage responder stress, and provide therapy, counseling, and crisis intervention. Mental health teams can deploy within 36 hours of notification.

## **CENTERS FOR DISEASE CONTROL AND PREVENTION STRATEGIC NATIONAL STOCKPILE**

7-47. The Strategic National Stockpile is a national repository of antibiotics, chemical antidotes, antitoxins, life support medications, intravenous administration and airway maintenance supplies, and medical/surgical items. The Strategic National Stockpile is designed to supplement and re-supply state and local public health agencies in the event of a national emergency anywhere and at any time with the U.S. or its territories.

## **FEDERAL MEDICAL STATIONS**

7-48. The federal medical station is a deployable Department of Health and Human Services health care platform that can deliver large-scale medical services anywhere in the U.S. A team of approximately 100 personnel is needed to staff the federal medical station, which will consist of personnel provided primarily by the U.S. Public Health Service. Each federal medical station contains a 3-day supply of medical and pharmaceutical resources to sustain 250 stable primary care patients who require bedding services. Federal medical stations may also provide—

- Mass ambulatory vaccination services (using vaccinations supplied by the Strategic National Stockpile).
- Ambulatory prophylactic medication administration (using medications supplied by the Strategic National Stockpile).
- Prehospital triage and initial stabilization for up to 250 mass casualty patients.

7-49. Federal medical stations must be housed inside a structurally intact building that has approximately 40,000 square feet of space, a 10-person team for set up, electricity, heating, air conditioning, ventilation, and clean water. Reduced bed requirements can be accommodated in smaller facilities. Other operational requirements include bathroom, shower facilities, and billeting for staff. Contract support is also required for food, potable water, laundry, ice, medical oxygen resupply, and disposal of medical waste. The federal medical station can deploy inside the U.S. within 48 to 96 hours from the time of request to delivery and requires a 12-hour assembly time.

7-50. The Department of Health and Human Services also has a community outreach capability (also referred to as a *Go Bag*) that is capable of providing primary health care services far forward in a disaster area. This capability is a light strike team-based platform that is also staffed primarily by the U.S. Public Health Service. Each platform has basic medical and pharmaceutical resources to sustain 50 to 100 stable primary care ambulatory patients.

### **MEDICAL RESERVE CORPS**

7-51. The Medical Reserve Corps consists of organized medical and public health professionals who serve as volunteers in response to natural disasters and emergencies. The Medical Reserve Corps program provides the structure necessary to deploy medical and public health personnel in response to an emergency, as it identifies specific, trained, credentialed personnel available and ready to respond to emergencies.

### **FOOD AND DRUG ADMINISTRATION**

7-52. The Department of Health and Human Services, through the Food and Drug Administration, has statutory authority for—

- All domestic and imported food except meat, poultry, and egg products, which are under the authority of the U.S. Department of Agriculture's Food Safety and Inspection Service.
- Animal feed and for the approval of animal drugs intended for both therapeutic and nontherapeutic use in food and companion animals.

7-53. The Food and Drug Administration also works in cooperation with the Environmental Protection Agency and the U.S. Department of Agriculture to ensure the proper disposal of contaminated food or animal feed.

## **SECTION V — NATIONAL RESPONSE FRAMEWORK SUPPORT AGENCIES**

### **SUPPORT AGENCIES FOR EMERGENCY SUPPORT FUNCTION #8**

7-54. The NRF defines support agencies as those entities with specific capabilities or resources that support the primary agency in executing the missions of the ESFs. When an ESF is activated, support agencies are responsible for—conducting operations; participating in planning for short- and long-term incident management and recovery operations; assisting in the conduct of situational assessments; providing available personnel, equipment, or other resource support (as requested); and other necessary support. The General Services Administration and U.S. Postal Service are two of the federal organizations that serve as support agencies to ESF #8. The U.S. Postal Service, as one of the ESF #8 support agencies, is responsible for assisting in the distribution and transportation of medicine, pharmaceuticals, and medical information to the general public affected by a major disaster or emergency, as needed. This section describes several other support agencies for ESF #8 and the areas of responsibility of each organization. See the NRF ESF #8 Annex for additional information on the support provided.

### **DEPARTMENT OF AGRICULTURE**

7-55. The U.S. Department of Agriculture as the coordinator for ESF #11—

- Provides nutrition assistance including working with state agencies to determine nutrition assistance needs, obtain appropriate food supplies, arrange for delivery of supplies, and authorize the Disaster Food Stamp Program. These efforts are coordinated by the U.S. Department of Agriculture's Food and Nutrition Service.
- Ensures the safety and security of the Nation's commercial food supply (such as meat, poultry, and egg products) for incidents requiring a coordinated federal response and mitigates the effects of the incident on all affected parts of the U.S. population and environment. These efforts are coordinated by the U.S. Department of Agriculture's Food Safety and Inspection Service.

- Responds to animal and plant diseases and pests including the integration of federal, state, tribal, and local response to an outbreak of a highly contagious or economically devastating animal/zoonotic disease or an outbreak of a harmful or economically significant plant pest or disease. Through ESF #11 the U.S. Department of Agriculture's Animal and Plant Health Inspection Service coordinates with the Department of Health and Human Services to ensure that animal/veterinary issues are supported during natural disasters.
- Provides for the safety and well-being of household pets, to include animal evacuation and sheltering, which is conducted in conjunction with human evacuation and sheltering efforts. This is coordinated through the U.S. Department of Agriculture's Animal and Plant Health Inspection Service.

7-56. The Department of Agriculture's Animal and Plant Health Inspection Service also maintains the National Veterinary Stockpile, which provides the veterinary countermeasures animal vaccines, antivirals, therapeutic products, supplies, equipment, and response support services that states, tribes, and territories need to respond to damaging animal disease outbreaks. The National Veterinary Stockpile is equipped to deploy within 24 hours of approval countermeasures against the most damaging animal diseases, including Highly Pathogenic Avian Influenza, Foot-and-Mouth Disease, Exotic Newcastle Disease, and Classical Swine Fever. For additional information, see the Animal and Plant Health Inspection Service Web site, which can be accessed via the Web address posted in the references section of this manual.

## DEPARTMENT OF COMMERCE

7-57. The Department of Commerce touches the lives of the American people every day by working in partnership with businesses, universities, communities and our nation's workforce to promote job creation, economic growth, sustainable development, and improved standards of living for all U.S. citizens. The Department of Commerce is comprised of 12 different agencies responsible for a wide range of activities from weather forecasts to patent protection and is a supporting agency under ESF #8 through its National Oceanic and Atmospheric Administration.

7-58. Under ESF #8, the National Oceanic and Atmospheric Administration provides near real-time transport, dispersion, and prediction of atmospheric releases of radioactive and hazardous materials that may be used by authorities in taking protective actions related to the evacuation and sheltering of individuals affected by a disaster.

## NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION WEATHER RADIO

7-59. The National Oceanic and Atmospheric Administration Weather Radio is a nationwide network of radio stations broadcasting continuous weather information including National Weather Service warnings, watches, forecasts, and other hazard information 24 hours a day. In conjunction with the Emergency Alert System, the National Oceanic and Atmospheric Administration Weather Radio provides an *all-hazards* radio network, making it a single source for comprehensive weather and emergency information. The Secretary of Homeland Security can utilize the National Oceanic and Atmospheric Administration Weather Radio network to send target alerts anywhere in the country. In addition, this type of activation also activates the Department of Homeland Security/Federal Emergency Management Agency's Emergency Alert System network at the local level. The National Oceanic and Atmospheric Administration Weather Radio also broadcasts warning and post event information for all types of hazards: natural (such as earthquakes and volcano activity), man-made (such as chemical or environmental incidents), and terrorism-related.

## DEPARTMENT OF ENERGY

7-60. The Department of Energy works to ensure America's security and prosperity by addressing its energy, environmental, and nuclear challenges through transformative science and technology solutions. When supporting ESF #8, the National Nuclear Security Administration coordinates federal assets for external monitoring and decontamination activities for radiological emergencies based on criteria established by the state in conjunction with the Department of Health and Human Services. The National Nuclear Security Administration also provides (in cooperation with other federal and state agencies)

personnel and equipment, including portal monitors, to support initial screening and provides advice to assist state, tribal, territorial, insular area, and local personnel conducting screening/decontamination of individuals leaving a contaminated zone.

7-61. As a supporting agency under ESF #8, the Department of Energy has numerous capabilities, programs, and resources available through the National Nuclear Security Administration to assist in the public health and medical services response during a disaster including the—Radiological Assistance Program; National Atmospheric Release Advisory Capability; and the Federal Radiological Monitoring and Assessment Center.

### **RADIOLOGICAL ASSISTANCE PROGRAM**

7-62. The National Nuclear Security Administration's Radiological Assistance Program provides regional resources (personnel, specialized equipment, and supplies) to evaluate, control, and mitigate radiological hazards to workers and the public. The program also provides limited assistance in the decontamination of victims and assists state, tribal, and local officials in monitoring and surveillance of incident areas.

### **NATIONAL ATMOSPHERIC RELEASE ADVISORY CAPABILITY**

7-63. The National Nuclear Security Administration's National Atmospheric Release Advisory Capability provides near real-time transport, dispersion, and dose predictions of atmospheric releases of radioactive and hazardous materials that may be used by authorities in taking protective actions related to sheltering and evacuation of people.

### **FEDERAL RADIOLOGICAL MONITORING AND ASSESSMENT CENTER**

7-64. The National Nuclear Security Administration's Federal Radiological Monitoring and Assessment Center assists public health and medical authorities in—

- Determining radiological dose information.
- Providing coordinated gathering of environmental radiological information and data.
- Analyzing, evaluating, assessing, and interpreting consolidated data samples.
- Providing technical information.

### **DEPARTMENT OF HOMELAND SECURITY**

7-65. When supporting ESF #8, the Department of Homeland Security provides communications support in coordination with ESF #2, Communications and maintains situational understanding and the common operational picture via the Homeland Security Information Network. The Department of Homeland Security also—

- Assists in providing information/liaison with emergency management officials in NDMS federal coordinating center areas.
- Identifies and arranges for use of Department of Homeland Security/U.S. Coast Guard aircraft and other assets in providing urgent airlift and other transportation support.
- Directs the nuclear incident response team, when activated, and ensures coordination of team activities with the ESF primary agency and designated coordinating agency under the Nuclear/Radiological Incident Index.
- Works through the Interagency Modeling and Atmospheric Assessment Center to provide predictions of hazards associated with atmospheric releases for use in emergency response. The center provides a single point of contact for the coordination and dissemination of federal dispersion modeling and hazard prediction products that represent the federal position during an incident.
- Provides enforcement of international quarantines through the Department of Homeland Security/U.S. Coast Guard, Customs and Border protection, and Immigration and Customs Enforcement.

## **FEDERAL EMERGENCY MANAGEMENT AGENCY**

7-66. The Federal Emergency Management Agency provides logistical support for deploying ESF #8 medical elements required and coordinates the use of mobilization centers/staging areas, transportation of resources, use of disaster fuel contracts, emergency meals, potable water, base camp services, supply and equipment resupply, and use of all national contracts and interagency agreements managed by the Department of Homeland Security for response operations. The Federal Emergency Management Agency also provides total asset visibility through the use of Global Positioning System tracking services to enable visibility of ESF #8 resources through mapping capabilities and reports. The Agency also assists in arranging transportation to support evacuating patients who are too seriously ill or otherwise incapable of being evacuated in general evacuation conveyances and provides tactical communications support (such as deployable satellite and radio communications).

## **OFFICE OF INFRASTRUCTURE PROTECTION**

7-67. The Department of Homeland Security's Office of Infrastructure Protection also provides support to ESF #8. The Office of Infrastructure Protection provides situational understanding, cross sector coordination, and prioritized recommendations regarding critical infrastructure and key resources.

## **DEPARTMENT OF THE INTERIOR**

7-68. The Department of the Interior protects America's natural resources and heritage, honors the cultures and tribal communities within the U.S., and supplies the energy to power the Nation's future. The Department of the Interior is also an ESF #8 supporting agency. If available, the Department of the Interior provides appropriate personnel, equipment, and supplies (primarily for communications, aircraft, and the establishment of base camps for deployed federal public health and medical teams). Resources are assigned commensurate with each unit's level of training and the adequacy and availability of equipment. Emergency Support Function #4 or the Department of the Interior Operations Center is the point of contact for this support.

## **DEPARTMENT OF JUSTICE**

7-69. The Department of Justice supports ESF #8 by acting through the Federal Bureau of Investigation to conduct evidence collection and analysis of all CBRN related materials and controls potential crime scenes. The Department of Justice assists in victim identification, coordinated through the Federal Bureau of Investigation and provides legal advice for state, tribal, territorial, insular area, and local officials concerning identification of the dead consistent with cultural sensitivity practices. The Department of Justice also—

- Provides the Department of Health and Human Services with relevant information of any credible threat or other situation that could potentially threaten public health. This support is coordinated through the Federal Bureau of Investigations.
- Provides security for the Strategic National Stockpile, secure movement of needed medical equipment, supplies, blood and tissue, and quarantine enforcement assistance, if required.
- Establishes an adult missing person's call center and assists in the disposition of cases.
- Shares missing person's data with ESF #6, #8, ESF #13—Public Safety and Security, and the American Red Cross in support of identification of the dead and seriously wounded.
- Supports local death scene investigations and evidence recovery.
- Provides guidance, promulgates regulations, conducts investigations and compliance reviews, and enforces federal civil rights laws, including their application to emergency management.

## **DEPARTMENT OF LABOR**

7-70. The Department of Labor serves as a supporting agency under ESF #8 responsible for coordinating the safety and health assets of cooperating agencies and the private sector to provide technical assistance, conduct worker exposure assessments, and responder and worker risk management within the Incident

Command System. This assistance may include—24/7 site safety monitoring; worker exposure monitoring; health monitoring; sampling and analysis; development and oversight of the site-specific safety and health plan; and personal protective equipment selection, distribution, training, and respirator fit-testing. The Department of Labor also provides personnel and management support related to worker safety and health in field operations during ESF #8 deployments.

## **DEPARTMENT OF STATE**

7-71. The mission of the U.S. Department of State is to advance freedom for the benefit of the American people and the international community by helping to build and sustain a more democratic, secure, and prosperous world composed of well-governed states that respond to the needs of their people, reduce widespread poverty, and act responsibly within the international system.

7-72. As a supporting agency under ESF #8, the Department of State coordinates international activities related to CBRN incidents and events that pose transborder threats as well as naturally occurring disease outbreaks with international implications. The Department of State also—

- Contributes to the development of projections of the international consequences of the event (such as the spread of disease, quarantine, isolation, travel restrictions, pharmaceutical supply and distribution, and displaced persons) through coordination with foreign states and other international stakeholders, and assists in communicating real-time actions taken by the United States and U.S. projections of the international consequences of the event.
- Assists in coordination with foreign states concerning offers of support, gifts, offerings, donations, or other aid. This includes establishing coordination with partner nations to identify U.S.-validated immediate support in response to an incident.
- Acts as the health and medical services information conduit to U.S. Embassies/Consulates.

7-73. The Department of State's U.S. Agency for International Development also contributes to relief efforts as an ESF #8 supporting partner through the Agency's Office of Foreign Disaster Assistance. The Office of Foreign Disaster Assistance provides support to ESF #8 by facilitating the tracking and distribution of international support assets.

## **DEPARTMENT OF TRANSPORTATION**

7-74. The mission of the Department of Transportation is to serve the U.S. by ensuring a fast, safe, efficient, accessible, and convenient transportation system that meets our vital national interests and enhances the quality of life of the American people. As a supporting agency of ESF #8, the Department of transportation collaborates with the DOD, General Services Administration, and other transportation-providing agencies to provide technical assistance in identifying and arranging for all types of transportation, such as air, rail, marine, and motor vehicle and accessible transportation.

7-75. At the request of ESF #8, the Department of Transportation provides technical support to assist in arranging logistical movement support (such as supplies, equipment, and blood supply) from department resources, subject to applicable statutory requirements. When assisting in disaster response, the Department of Transportation also coordinates with the Federal Aviation Administration for air traffic control support for priority missions.

## **DEPARTMENT OF VETERANS AFFAIRS**

7-76. The Department of Veterans Affairs is a federal partner within the NDMS responsible for providing assistance to augment the Nation's medical response capabilities. As a supporting agency under ESF #8 (subject to the availability of resources and funding, and consistent with the Department's mission to provide priority services to veterans) when requested, the Department of Veterans Affairs —

- Coordinates with participating NDMS hospitals to provide incident-related medical care to authorized beneficiaries affected by a major disaster or emergency.
- Furnishes available Department of Veterans Affairs' hospital care and medical services to individuals responding to, involved in, or otherwise affected by a major disaster or emergency, including members of the Armed Forces on active duty.

- Designates and deploys available medical, surgical, mental health, and other health service support assets.
- Provides a Medical Emergency Radiological Response Team for technical consultation on the medical management of injuries and illnesses due to exposure to or contamination by ionizing radiation.
- Alerts Department of Veterans Affairs federal coordinating centers and provides reporting instructions to support incident relief efforts.
- Alerts Department of Veterans Affairs federal coordinating centers to activate NDMS patient reception plans in a phased, regional approach and when appropriate, in a national approach.
- Buries and memorializes eligible veterans and advises on methods for interment of the dead during national or homeland security emergencies.

## ENVIRONMENTAL PROTECTION AGENCY

7-77. The mission of the Environmental Protection Agency is to protect human health and the environment. The Environmental Protection Agency supports ESF #8 by—

- Providing technical assistance and environmental information for the assessment of the public health/medical aspects of situations involving hazardous materials, including technical and policy assistance in matters involving water and wastewater systems, for critical health care facilities.
- Providing support for public health matters for radiological incidents through the Federal Radiological Monitoring and Assessment Center and the Advisory Team for Environment, Food, and Health.
- Assisting in the identification of alternate water supplies and wastewater collection and treatment for critical health care facilities.
- Providing environmental technical assistance (such as air monitoring) and information in the event temporary interment is necessary and/or human remains are contaminated.

## AMERICAN RED CROSS

7-78. The American Red Cross is a supporting agency under the NRF in a number of emergency support functions, most notably ESF #6, Mass Care, Emergency Assistance, Housing, and Human Services. The American Red Cross works with state, tribal, and local authorities to function as a direct provider of disaster relief services including emergency sheltering through use of the National Shelter System, feeding, basic first aid support, disaster-related health and mental health counseling, disaster assessment, family reunification, and public information. As a support agency for ESF #15, External Affairs, the American Red Cross coordinates disaster messaging with federal communicators and provides critical disaster relief and preparedness information to the public through proactive media outreach. Under ESF #8, the American Red Cross serves to support the Department of Health and Human Services in the provision of blood products.

7-79. The mission of the American Red Cross is to prevent and alleviate human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors. As an ESF #8 supporting agency, the American Red Cross provides emergency first aid, consisting of basic first aid and referral to appropriate medical personnel and facilities, supportive counseling, and health care for minor illnesses and injuries to incident victims in mass care shelters, the joint field office, selected incident cleanup areas, and other sites deemed necessary by the primary agency. The American Red Cross also—

- Provides for disaster related health and behavioral health needs through direct services and or referrals as necessary.
- Assists community health personnel subject to staff availability.
- Provides supportive counseling for family members of the dead, for the injured, and for others affected by the incident.
- Provides mortality and morbidity information to requesting agencies.
- Provides information regarding behavioral health surveillance and behavioral health trends to requesting agencies.

- Supports NDMS evacuation through the provision of services for accompanying family members/caregivers in coordination with federal, state, tribal, and local officials.
- Provides available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes. Assistance consists of administrative support, logistical support, or health services support within clearly defined boundaries.
- Acquaints families with available health resources and services, and makes appropriate referrals.
- At the request of the Department of Health and Human Services, coordinates with the American Association of Blood Banks Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism to provide blood products and services as needed through regional blood centers.
- Supports reunification efforts through its “Safe and Well” Web site and in coordination with government entities as appropriate.
- Refers all concerns regarding animal health care, safety, or welfare to American Veterinary Medical Association contact(s) in the disaster area. These contact people are veterinarians affiliated with national, State, county, or local veterinary associations.

7-80. The American Red Cross also maintains the National Shelter System database, which contains information for over 56,000 potential shelter facilities and is used to track and report shelter information during disasters. This tool enables emergency managers and disaster workers to identify the location, managing agency, capacity, current population, and other relevant information of all shelters operated in response to disasters. Information contained in the National Shelter System assists the American Red Cross, Federal Emergency Management Agency, state and local emergency management, and nongovernment organizations in developing strategies to ensure prompt and effective mass care services. The system also serves as a planning tool before disaster strikes. The American Red Cross National Shelter System Web site, which can be accessed via the Web address posted in the references section of this manual. For additional information, see the American Red Cross Web site and other social media platforms.

## **SECTION VI — OTHER EMERGENCY RESPONSE RESOURCES**

### **EMERGENCY ALERT SYSTEM**

7-81. The Federal Communications Commission designed the Emergency Alert System as a tool for the President to quickly send important emergency information to the Nation using radio, television, and cable systems. The Emergency Alert System may also be used by state, tribal, and local authorities to deliver alerts and warnings. The system is required to deliver all Emergency Alert System messages visually and aurally to be accessible to persons with hearing and vision disabilities. The Department of Homeland Security’s Federal Emergency Management Agency is installing a satellite-based distribution network as part of ongoing improvements to the national alert and warning system, providing an alternative path for the President and authorized officials to send emergency messages to the public and to the state emergency operations centers. Using a satellite-based system allows Federal Emergency Management Agency to reach all state entry point facilities more reliably, especially during conditions where landline communications are disrupted, such as during flooding and earthquakes. While the federal coordinating center is tasked with the regulatory authority over the Emergency Alert System, Department of Homeland Security/Federal Emergency Management Agency is the Emergency Alert System executive agent for the White House. As such, the Department of Homeland Security/Federal Emergency Management Agency is responsible for the overall operation of the Emergency Alert System.

7-82. After a presidential activation order is issued, the Department of Homeland Security/Federal Emergency Management Agency can access the facilities of broadcast stations and other communications providers across the Nation within several minutes. The Emergency Alert System is also available for state, tribal, territorial, insular area, and local use, but such use is voluntary on the part of the participant and would be preempted by a national activation. State, tribal, and local governments maintain supporting plans to cover Emergency Alert System operations. The Department of Homeland Security/Federal Emergency Management Agency coordinates Emergency Alert System management issues with state, tribal, and local authorities.

## MOBILE EMERGENCY RESPONSE SUPPORT

7-83. The Department of Homeland Security/Federal Emergency Management Agency Mobile Emergency Response Support provides mobile telecommunications, operational support, life support, and power generation assets for the on-site management of all-hazard activities. Mobile Emergency Response Support provides a deployable broadcast radio capability for multimedia communications, information processing, logistics, and operational support to Federal, State, tribal, and local authorities during incidents requiring a coordinated federal response. Mobile Emergency Response Support is a valuable recovery resource to update the public and affected population.

## NATIONAL PREPAREDNESS NETWORK

7-84. The National Preparedness Network (also known as PREPnet) is a Department of Homeland Security/Federal Emergency Management Agency television broadcast network capable of reaching large portions of the public in an impacted area with survival and recovery information before, during, and after catastrophic events. The network delivers information via cable television, satellite services, personal digital devices, cell phones, and webcasts to both the public at large and emergency responders. As a scalable Department of Homeland Security asset, National Preparedness Network capabilities span a spectrum from simple public service announcements on up to 24 hours a day/7 days a week broadcast of recovery information to victims wherever they may have relocated.

## RECOVERY RADIO SUPPORT

7-85. The Department of Homeland Security/Federal Emergency Management Agency works with local broadcasters to set up Recovery Radio support when commercial broadcast capabilities are damaged or impaired. Recovery Radio provides official response and recovery information to local stations on an hourly basis. Distribution can be provided through the Emergency Alert System network. All broadcasters are required to have equipment to monitor and air Emergency Alert System programs, and most primary Emergency Alert System stations have portable, remote pick-up equipment that can be installed in the Joint Information Center. Alternatively, telephone or two-way radio can be used to deliver programming to the Emergency Alert System distribution point. The Recovery Radio Network is implemented by a team whose size depends on the scope of the incident.

## FEDERAL EMERGENCY MANAGEMENT AGENCY NATIONAL SHELTER SYSTEM

7-86. The Federal Emergency Management Agency's National Shelter System is a coordinated nationwide database of emergency shelter information where thousands of profiles of potential shelter resources, as well as virtually any type of facility associated with the care of disaster survivors, are maintained. Reports from the National Shelter System list the location and capabilities of available shelters (such as evacuation, general, Americans with Disabilities Act Compliant, pet friendly, and medical). Information contained in the National Shelter System is submitted by the local, tribal, state, and voluntary resettlement agency entities operating these settlements. The system also includes an enhanced mapping function that allows emergency management professionals to see in real time, shelter locations, critical infrastructure, flood plains, fault lines, and other geospatial elements.

7-87. The Federal Emergency Management Agency is also working to ensure the system is interoperable with the Red Cross National Sheltering System and several other commercial emergency management programs, allowing data to be shared between systems, and eliminating the need to enter data in multiple applications. The system is available to emergency management professionals with a demonstrated need for this information. Use of the system is free of charge and accessible from any internet connection, 24 hours a day seven days a week. The National Shelter System also includes information on the following types of shelters:

- Medical shelters, shelter-in-place locations.
- Household pet shelters, kitchens.
- Points of distribution, warehouses.

- Warming, cooling, and respite centers.
- Embarkation, debarkation, and reception processing sites.
- Any type of shelter or facility related to the management of the people affected by the operation.

## **RADIATION EMERGENCY ASSISTANCE CENTER/TRAINING SITE**

7-88. The Oak Ridge Institute for Science and Education's Radiation Emergency Assistance Center/Training Site positions the U.S. Department of Energy as an international leader in emergency medical response to radiation incidents. The Radiation Emergency Assistance Center/Training Site staff is available 24 hours, seven days a week to deploy and provide emergency medical consultation for incidents involving radiation anywhere in the world. The Radiation Emergency Assistance Center/Training Site provides direct support for the National Nuclear Security Administration's Office of Emergency Response and the Federal Radiological Monitoring and Assessment Center.

7-89. The Radiation Emergency Assistance Center/Training Site is also uniquely qualified to teach medical personnel, health physicists, first responders and occupational health professionals about radiation emergency medical response. The Radiation Emergency Assistance Center/Training Site also operates a cytogenetic biodosimetry laboratory, where chromosome aberration analysis is used for ionizing radiation dose assessment.

## Appendix A

# Army Health System Support Assessments

Medical missions in support of stability tasks require comprehensive planning and prior coordination to ensure success. Conducting assessments are an important part of that process. This appendix provides a tool for use in assessing the health care delivery system and medical needs of a host nation or U.S.-backed group.

## SECTION I — MEDICAL SUPPORT ASSESSMENTS

### ASSESSMENTS

A-1. Assessment is the determination of progress toward accomplishing a task, creating an effect, or achieving an objective (JP 3-0). Assessments are continuous, precede and guide operations, and conclude each operation or phase of an operation. Army Health System support assessments must be completed prior to operations in support of stability tasks in order to determine the medical needs of the host-nation government and military, capabilities available, and the condition of existing health care infrastructure. At a minimum, assessments should include—

- Monitoring the current situation to gather relevant information.
- Evaluating the status of existing capabilities and infrastructure against a recognized standard and measuring overall progress toward the desired end state.
- Recommending or directing actions for improvement.

A-2. Measures of performance, measures of effectiveness, and indicators are measurement tools used in the assessment process. When conducting stability tasks, measures of performance are used to track implementation of an activity or program and identify tasks accomplished. Examples of measures of performance for medical support to stability tasks may include an increase in the number of—medical personnel trained, treatment facilities constructed, and health care programs successfully implemented. Measures of performance and measures of effectiveness are criteria only or forms of indicators for evaluation and do not represent the assessment. While measures of performance are a critical aspect of the assessment process and aid in identifying tasks accomplished, focusing on performance only and not effect can lead to faulty conclusions.

A-3. Measures of effectiveness are used to assess changes in behavior, capability, or operational environment that are tied to measuring the attainment of an end state, achievement of an objective, or creation of an effect (JP 3-0). Measures of effectiveness signify changes in conditions (both positive and negative) and are commonly tracked in formal assessment plans. Examples of measures of effectiveness when providing medical support to stability tasks may include—decreases in mortality rates, increased access to medical care, and lower rates of infection.

A-4. Indicators provide insight into measures of effectiveness and measures of performance. Where practical, measures of effectiveness and performance for foreign humanitarian assistance should be based on a common standardized set of key indicators used throughout the community of practice (including international, governmental, and nongovernmental organizations). One such tool is The Sphere Project for Humanitarian Charter and Minimum Standards in Humanitarian Response, which suggests key indicators for the provision of water, sanitation, food, health, shelter, and nonfood items in disasters, and establishes voluntary minimum standards for each sector. See ADRP 5-0 and ADRP 3-07 for additional information on the assessments process.

## TYPES OF ASSESSMENTS

A-5. There are various types of assessments available for use including the—

- *District Stability Framework*, which is discussed in greater detail in Section II below.
- *Interagency Conflict Assessment Framework*, which is a tool that enables an interagency team to assess conflict situations and supports U.S. Government interagency planning for conflict prevention, mitigation, and stabilization.
- *The Sphere Project*, which is a voluntary initiative that brings a broad range of humanitarian organizations together to work toward a common goal—to improve the quality of assistance provided and establish suggested measures of accountability for participating organizations, donors, and the affected population.
- *Occupational and Environmental Health Risk Assessment and the Occupational and Environmental Health Site Assessment* as outlined in NTRP 4-02.9/AFTTP 3-2.82\_IP/ATP 4-02.82, which is used to identify and provide recommendations to manage occupational and environmental health threats and the source of those threats.
- United States Agency for International Development's Office of Foreign Disaster Assistance *Situation Assessment, Disaster Assessment, or Needs Assessment*, which are used to determine the type and amount of relief needed during the immediate response phase of a disaster.

## HEALTH THREAT ASSESSMENT

A-6. A critical element of the medical assessment is a thorough appraisal of the health threat. This assessment includes the health threat to the deploying force and residents in the area of operations. The U.S. Soldier is placed at increased risk when conducting stability tasks as the incidence and exposure to infectious diseases and environmental hazards are greater in man-made or natural disaster areas and in developing nations. The health threat is derived from established intelligence channels and from a variety of informational sources within and outside the military.

A-7. The ability to obtain, interpret, and use medical intelligence is critical to the success of the AHS mission. Regardless of whether the operation is conducted within the U.S. or abroad, man-made and natural disasters can cause a resurgence of diseases once thought to be at low epidemiological levels and may also result in environmental contamination. A combination of factors can result in the spread of communicable diseases in epidemic proportions and increased opportunity for exposure to CBRN hazards. These factors are—

- Disruption of sanitation services (such as garbage disposal or sewer systems).
- Contamination of food and water.
- Development of new breeding grounds for rodents and arthropods (such as in rubble or stagnant pools of water).
- Disruption of industrial operations.
- Dispersion of biological or radiological waste by improper handling or terrorist activity.
- Spread of contamination by people, vehicles, or animals leaving the affected area.

A-8. Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the area of operations which are significant to AHS support or general military planning. Until medical information is processed, it is not considered to be medical intelligence. Medical information pertaining to foreign nations is processed by the National Center for Medical Intelligence. Health threat information related to foreign nations can also be obtained through—

- The U.S. Army Public Health Command.
- The Centers for Disease Control and Prevention.
- The American Public Health Association.
- Armed Forces Health Surveillance Center.

A-9. Should medical personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it to their supporting intelligence element.

## SECTION II — DISTRICT STABILITY FRAMEWORK

A-10. The District Stability Framework was created by the DOD and USAID for use by both military and civilian personnel to identify underlying causes of conflict and instability in a region, develop programs to address and decrease the root causes of instability and conflict, and measure the effectiveness of programs being implemented. The District Stability Framework is used to gather information concerning the cultural environment, operational environment, perceptions of the local populace and other information for use in identifying, prioritizing, monitoring, and adjusting programs targeted at decreasing the causes of conflict and instability. See ADRP 3-07 and FM 3-07 for a complete discussion of the District Stability Framework.

## ASSESSMENT TOOLS

A-11. The District Stability Framework provides tools to assess measures of performance, measures of effectiveness, and changes in overall stability. It should be used to create stabilization plans and provide data for the Interagency Conflict Assessment Framework, which has a strategic national or regional focus. The Framework consists of four basic steps, to include:

- Situational understanding, which employs the political, military, economic, social, information, infrastructure, physical environment, and time (PMESII-PT) and area, structure, capabilities, organizations, people, and events (ASCOPE) models to describe the operational environment.
- Analysis, where tools such as the sources of instability analysis and tactical stability matrix are used to examine potential sources of instability.
- Design, which is the step where stability activities are developed to address the objectives identified by the tactical stability matrix and target systemic causes of instability.
- Monitoring and evaluation, which measures stability efforts and achievements based on performance (activity completion), impact (effects achieved by individual activities), and overall stability (conditions and trends).

## DESCRIBING THE OPERATIONAL ENVIRONMENT

A-12. The District Stability Framework uses the PMESII-PT and ASCOPE methodologies to describe the operational environment. These models can also be used by medical planners (normally at the strategic level) to analyze the operational environment for the provision of AHS assets in support of stability tasks. These models (as outlined in Figure A-1 on page A-4) are used to examine the local environment and achieve a broader understanding of the stability conditions and the underlying factors that cause or influence those conditions. See FM 4-02 for a full discussion on the medical aspects of the operational variable.

| Variables                                                                                                            |                            | Factors                                                                                                                                                          | Medical Aspects                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Political</b> – political actors, agendas, government capacity and capability.                                    | A<br>S<br>C<br>O<br>P<br>E | Key elements of the formal, informal, and shadow systems of government that significantly influence the local population.                                        | <ul style="list-style-type: none"> <li>Existence/involvement of host-nation ministry of health.</li> <li>Impact of religious or cultural beliefs on access to medical care.</li> <li>Health status of population.</li> </ul>                                                                                        |
| <b>Military</b> – capabilities in the area of operations (equipment, mission, resource constraints).                 | A<br>S<br>C<br>O<br>P<br>E | Key elements that may influence the security situation.                                                                                                          | <ul style="list-style-type: none"> <li>Availability of military medical infrastructure.</li> <li>Disease and nonbattle injury rates among host-nation military.</li> <li>Existence of field medical units.</li> </ul>                                                                                               |
| <b>Economic</b> – trade, development, finance, institutional capabilities, geography, and regulation.                | A<br>S<br>C<br>O<br>P<br>E | Key elements that influence economic activity in the area.                                                                                                       | <ul style="list-style-type: none"> <li>Availability of veterinary medical support.</li> <li>Disease rates among food producing and work animals.</li> <li>Access to seed and other agricultural resources.</li> </ul>                                                                                               |
| <b>Social</b> – demographics, migration trends, urbanization, living standards, literacy/education level, and so on. | A<br>S<br>C<br>O<br>P<br>E | Key elements that describe or could influence traditional social dynamics in an area.                                                                            | <ul style="list-style-type: none"> <li>Effects of urbanization on disease rates and spread of infection.</li> <li>Education/ literacy rates and impact on public health practices.</li> <li>Status of sanitation facilities relative to living conditions.</li> </ul>                                               |
| <b>Information</b> – means of communication, media, telecommunications, and word of mouth.                           | A<br>S<br>C<br>O<br>P<br>E | Key elements that facilitate the transfer of information to and among the local population.                                                                      | <ul style="list-style-type: none"> <li>Access to mass media and information systems for communication of health risks and other public health alerts.</li> <li>Availability of telephones, computers, and radio.</li> </ul>                                                                                         |
| <b>Infrastructure</b> – basic facilities, services and installations.                                                | A<br>S<br>C<br>O<br>P<br>E | Effects on physical infrastructure such as sewage, water, electricity, educational facilities, health facilities, and transportation.                            | <ul style="list-style-type: none"> <li>Number of functioning medical treatment facilities.</li> <li>Access to toilets, showers, and bathing facilities.</li> <li>Electricity and running water.</li> </ul>                                                                                                          |
| <b>Physical Environment</b> – geography and man-made structures in the operational area.                             | A<br>S<br>C<br>O<br>P<br>E | Key elements of the operational environment such as climate and weather, topography, natural resources, man-made structures, and other environmental conditions. | <ul style="list-style-type: none"> <li>Effects of climate and weather on— <ul style="list-style-type: none"> <li>Disease vectors.</li> <li>Acclimatization issues pertaining to heat, cold, or altitude.</li> <li>Medical evacuation operations.</li> </ul> </li> <li>Presence of toxic flora and fauna.</li> </ul> |
| <b>Time</b> – duration of the operations.                                                                            | A<br>S<br>C<br>O<br>P<br>E | Effect of time on an operation.                                                                                                                                  | <ul style="list-style-type: none"> <li>Effects of time on the— <ul style="list-style-type: none"> <li>Provision of medical care.</li> <li>Types of diseases and injuries which may occur.</li> </ul> </li> </ul>                                                                                                    |
| <b>Legend:</b> ASCOPE area, structure, capabilities, organizations, people, and events                               |                            |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                     |

Figure A-1. Medical aspects of the operational variables

## **SECTION III — MEDICAL SUPPORT ASSESSMENT**

A-13. As discussed in Section II above, there are numerous resources available for use in the assessments process including the area study and assessment format used by civil affairs personnel. The area study process is common to all civil affairs personnel and contains information (specific to areas assigned to U.S. forces) that supports planning for contingency and other operations with a stability focus. The area assessment is used to update the area study and covers data specific to all six of the civil affairs functional areas (including information regarding public health, agriculture, food, and environmental management). Figure A-2 provides an outline of the area assessment that addresses public health, agriculture, and food. Figure A-2 on page A-6 is provided only as a guide and is not intended as an all-inclusive list. Food protection, access to veterinary services, and other considerations may also be added for a more complete assessment of the host-nation's agricultural capacity.

| Civil Affairs Area Study and Assessment                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>VIII. FOOD AND AGRICULTURE.</b>                                                                                                           |  |
| <b>A. General Conditions and Problems.</b>                                                                                                   |  |
| 1. Importance of agriculture in total economy.                                                                                               |  |
| 2. Extent of agricultural productivity and self-sufficiency.                                                                                 |  |
| 3. Principal problems.                                                                                                                       |  |
| 4. Attitude of farm population.                                                                                                              |  |
| <b>B. Agricultural Geography.</b>                                                                                                            |  |
| 1. Locations of principal farm areas.                                                                                                        |  |
| 2. Types of soil.                                                                                                                            |  |
| 3. Influence of climate and topography.                                                                                                      |  |
| 4. Types of crops.                                                                                                                           |  |
| 5. Farm to market road net.                                                                                                                  |  |
| <b>C. Agricultural Products and Processing.</b>                                                                                              |  |
| 1. Livestock and dairy products (types, amounts, methods of processing, refrigeration, warehousing).                                         |  |
| 2. Crops (types, amounts, methods of processing, storage).                                                                                   |  |
| 3. Poultry (types, amounts, methods of processing, storage, refrigeration).                                                                  |  |
| <b>D. Agricultural Practices.</b>                                                                                                            |  |
| 1. Extent of mechanization.                                                                                                                  |  |
| 2. Improvement programs.                                                                                                                     |  |
| 3. Conservation programs.                                                                                                                    |  |
| 4. Pest and disease control.                                                                                                                 |  |
| <b>E. Land-Holding System and Reform Programs.</b>                                                                                           |  |
| <b>F. Fisheries.</b>                                                                                                                         |  |
| 1. Commercial (number, companies, location, type of fish, type of crafts, fishing areas, methods of processing, storage, annual production). |  |
| 2. Private (policy, rules, regulations, type of fish, fishing areas).                                                                        |  |
| 3. Restocking program.                                                                                                                       |  |
| 4. Problem areas.                                                                                                                            |  |
| <b>G. Forestry.</b>                                                                                                                          |  |
| 1. Reforestation program.                                                                                                                    |  |
| 2. Importance of forestry to the country.                                                                                                    |  |
| 3. Forestry services or administration.                                                                                                      |  |
| 4. Hunting (controls, laws, regulations, and types of game).                                                                                 |  |
| 5. Products and their processing.                                                                                                            |  |
| <b>H. Agencies, Institutions and Programs.</b>                                                                                               |  |
| 1. Government.                                                                                                                               |  |
| 2. Private.                                                                                                                                  |  |
| <b>I. Food Products.</b>                                                                                                                     |  |
| 1. Type.                                                                                                                                     |  |
| 2. Quantity.                                                                                                                                 |  |
| 3. Processing.                                                                                                                               |  |
| 4. Location, size, ownership of warehouses.                                                                                                  |  |
| 5. Types and quantity of food supplies stored.                                                                                               |  |
| <b>J. Applicable Laws and Regulations Governing Food and Agriculture.</b>                                                                    |  |

Figure A-2. Civil affairs area study and assessment

| Civil Affairs Area Study and Assessment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>IX. ENVIRONMENTAL MANAGEMENT.</b><br><br><b>A. General Conditions and Problems.</b><br><br><b>B. Pollution Control and Environmental Management Organizations.</b><br><br><b>C. Laws and Regulations.</b><br><br><b>D. Sources of Pollution.</b><br>1. Air.<br>2. Water.<br>3. Soil.<br><br><b>E. Health Hazard.</b><br>1. Immediate and present threats.<br>2. Near-term.<br>3. Mid-term.<br>4. Long-term.                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>X. PUBLIC HEALTH.</b><br><br><b>A. Organization.</b><br>1. National level.<br>2. Other levels.<br>3. Biographical sketches of key personnel.<br><br><b>B. General Conditions and Problems.</b><br><br><b>C. Agencies and Institutions.</b><br>1. Hospitals.<br>a. Number.<br>b. Capacity (number of beds).<br>c. Location and condition of facilities (for example, back-up electrical system).<br>2. Other medical facilities.<br>a. Public.<br>b. Private.<br><br><b>D. Medical Personnel.</b><br>1. Numbers (doctors and nurses).<br>2. Location.<br><br><b>E. Medical Equipment and Supplies.</b><br>1. Surgical and dental equipment.<br>2. Testing equipment.<br>3. Drugs.<br>a. Availability.<br>b. Shortages.<br>4. Other supplies.<br><br><b>F. Diseases.</b><br>1. Predominant types.<br>2. Control programs. |

Figure A-2. Civil affairs area study and assessment (continued)

| Civil Affairs Area Study and Assessment                  |  |
|----------------------------------------------------------|--|
| <b>G. Environmental Sanitation.</b>                      |  |
| 1. Regulations governing food and drugs.                 |  |
| 2. Water control and supply.                             |  |
| 3. Disposal of sewage and waste.                         |  |
| <b>H. Public Welfare.</b>                                |  |
| 1. Organization.                                         |  |
| a. National level.                                       |  |
| b. Other levels.                                         |  |
| c. Biographical sketches of key personnel.               |  |
| 2. Major social problems.                                |  |
| a. Juvenile delinquency.                                 |  |
| b. Alcohol and narcotics abuse.                          |  |
| c. Unemployment.                                         |  |
| d. Poverty and dependency.                               |  |
| 3. Public assistance.                                    |  |
| a. Basis upon which granted.                             |  |
| b. Types of relief and medical care provided.            |  |
| 4. Agencies, institutions, and programs.                 |  |
| a. Social insurance.                                     |  |
| b. Health insurance.                                     |  |
| c. Accident insurance.                                   |  |
| d. Old age, disability, and survivors' pensions.         |  |
| e. Unemployment.                                         |  |
| f. Family assistance.                                    |  |
| g. Other.                                                |  |
| 5. Welfare services (government and private).            |  |
| a. Child welfare (adoption, maternal).                   |  |
| b. Emergency and war relief.                             |  |
| c. Relief and public assistance.                         |  |
| (1) For mentally and physically handicapped.             |  |
| (2) For aged and indigent.                               |  |
| 6. Institutions.                                         |  |
| a. Orphanages (number, location, and capacity).          |  |
| b. Homes for the aged (number, locations, and capacity). |  |
| c. Physical therapy (number and location).               |  |
| 7. Programs.                                             |  |
| a. Recreational.                                         |  |
| b. Vocational.                                           |  |
| c. Health.                                               |  |
| d. Child care.                                           |  |
| 8. Welfare personnel.                                    |  |
| a. Professional standards.                               |  |
| b. Volunteer assistance.                                 |  |
| c. Number available by type of organization.             |  |
| 9. Financial and legal.                                  |  |
| a. Financial plan (how funds are obtained).              |  |
| b. Laws and regulations.                                 |  |
| c. Organizational structure.                             |  |
| 10. Regulations governing public welfare                 |  |

Figure A-2. Civil affairs area study and assessment (continued)

## **MEDICAL MISSION RECONNAISSANCE CHECKLIST**

A-14. Medical missions in support of stability tasks require comprehensive planning and prior coordination to ensure success. The information and products resulting from the assessments as discussed in Sections II and III above serve as the basis for planning AHS support operations and lay the ground work for medical capacity building efforts to assist the host-nation government in regaining stability. In addition to assessments, medical mission reconnaissance checklists are also valuable tools and can be used for completing an investigation of the mission area prior to deployment of a medical team.

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## **Appendix B**

# **Sections of Title 10, United States Code, Pertaining to Foreign Humanitarian Assistance**

The information in this appendix is for information purposes only. Medical commanders should ensure that a legal opinion from the staff judge advocate has been obtained prior to the execution of any missions conducted, which are governed by the sections of Title 10, U.S. Code, discussed in this appendix.

## **SECTION I — TITLE 10, UNITED STATES CODE, SECTION 401**

### **MEDICAL, DENTAL, AND VETERINARY SUPPORT TO HUMANITARIAN AND CIVIC ASSISTANCE**

B-1. Humanitarian and civic assistance is governed by Title 10, U.S. Code, Section 401, which specifies that these activities—

- Must be carried out in conjunction with host-nation military or civilian personnel.
- Shall complement and may not duplicate any other form of social or economic assistance that may be provided to the host nation by any other department or agency of the U.S. government.
- May not be provided directly or indirectly to any individual, group, or organization engaged in military or paramilitary activities.
- May not be provided unless the Department of State specifically approves such assistance.

B-2. Section 401 defines humanitarian and civic assistance as the—

- Medical, dental, and veterinary care provided in areas of a country that are rural or are underserved by medical, dental, and veterinary professionals respectively, including education, training, and technical assistance related to the care provided.
- Construction of rudimentary surface transportation systems.
- Well drilling and construction of basic sanitation facilities.
- Rudimentary construction and repair of public facilities.

B-3. This assistance complements, but does not duplicate any other social or economic assistance that is being provided by other U.S. departments or agencies. These activities serve the basic economic and social needs of the people of the country concerned and—

- Support the civilian leadership.
- Benefit a wide spectrum of the community.
- Are self-sustaining (once completed) or supportable by host-nation civilian or military agencies once U.S. assistance is withdrawn.

B-4. Department of Defense support to humanitarian and civic assistance projects or activities in any host nation require specific prior approval of the Department of State. Department of Defense foreign humanitarian assistance programs promote the—

- Security interests of both the U.S. and the host nation.
- Specific operational readiness skills of U.S. military forces participating in the activities.

B-5. Expenses incurred as a direct result of providing humanitarian and civic assistance under this section to a foreign country shall be paid out of funds specifically appropriated for such purposes to include the following:

- Travel, transportation, and subsistence expenses of DOD personnel providing such assistance.

- The cost of any equipment, services, or supplies acquired for the purpose of carrying out or supporting the activities, including any nonlethal, individual, or small team equipment or supplies for clearing land mine or other explosive remnants of war that are to be transferred or otherwise furnished to a foreign country in furtherance of the provision of assistance under this section.
- The cost of any equipment, services, and supplies provided in any fiscal year may not exceed \$10,000,000.
- Nothing in this section may be interpreted to preclude the incurring of minimal expenditures by the DOD for purposes of humanitarian and civic assistance out of funds other than funds appropriated, except that funds appropriated to the DOD for operations and maintenance (other than funds appropriated pursuant to paragraph [a] {4} of Section 401) may be obligated for humanitarian and civic assistance under this section only for incidental costs of carrying out such assistance.

## **SECTION II — TITLE 10, UNITED STATES CODE, SECTION 402**

### **TRANSPORTATION OF HUMANITARIAN RELIEF SUPPLIES TO FOREIGN COUNTRIES**

B-6. The transportation of humanitarian relief supplies to foreign countries is governed by Title 10, U.S. Code, Section 402. Notwithstanding any other provisions of law, and subject to section 402 subsection (b), the Secretary of Defense may transport to any country, without charge, supplies which have been furnished by a nongovernmental source and which are intended for humanitarian assistance. Such supplies may be transported only on a space available basis.

B-7. The Secretary of Defense may not transport supplies under subsection (a) unless the Secretary determined that the—

- Transportation of such supplies is consistent with U.S. foreign policy.
- Supplies to be transported are suitable for humanitarian purposes and are in usable condition.
- Legitimate humanitarian need exists for such supplies by the people or entity for which they are intended.
- Supplies will in fact be used for humanitarian purposes.
- Adequate arrangements have been made for the distribution of such supplies in the destination country.

B-8. The President shall establish procedures for making the determinations required under paragraph B-6 above. Such procedures shall include inspection of supplies before acceptance for transportation. It shall be the responsibility of the donor to ensure that supplies to be transported under this section are suitable for transport. Supplies transported under this section may be distributed by an agency of the U.S. government, a foreign government, an international organization, or a private nonprofit relief organization. Supplies transported under this section may not be distributed, directly or indirectly to any group or organization engaged in a military or paramilitary activity.

## **SECTION III — TITLE 10, UNITED STATES CODE, SECTION 404**

### **FOREIGN DISASTER ASSISTANCE**

B-9. Foreign disaster assistance is governed by Title 10, U.S. Code, Section 404, which states the President may direct the Secretary of Defense to provide disaster relief outside the U.S. to respond to man-made or natural disasters when necessary to prevent loss of lives or serious harm to the environment. Assistance under this section may include transportation, supplies, services, and equipment.

B-10. Under this section, not later than 48 hours after the commencement of disaster relief activities to provide assistance, the President shall transmit to Congress a report containing notification of the assistance provided and proposed to be provided, as well as a description of the following information (if available):

- The natural or man-made disaster for which assistance is necessary.
- The threat to human lives presented by the disaster.
- The U.S. military personnel and material resources that are involved or expected to be involved.
- The disaster relief that is being provided or is expected to be provided by other nations or public and private relief organizations.
- The anticipated duration of the disaster assistance activities.

B-11. Transportation services authorized under Section 404 subsection (b) may be provided in response to a man-made or natural disaster to prevent serious harm to the environment, when human lives are not at risk, only if other sources to provide such transportation are not readily available.

## **SECTION IV — TITLE 10, UNITED STATES CODE, SECTION 2557**

### **EXCESS NONLETHAL SUPPLIES**

B-12. The provision of nonlethal excess supplies for humanitarian relief, domestic emergency assistance, and homeless veteran's assistance is governed by Title 10, U.S. Code, Section 2557. The Secretary of Defense may make available for humanitarian relief purposes any nonlethal excess supplies of the DOD. In addition, the Secretary may make nonlethal excess supplies of the DOD available to support domestic emergency assistance activities. The Secretary of Defense may make excess clothing, shoes, sleeping bags, and related nonlethal excess supplies available to the Secretary of Veterans Affairs (without reimbursement) for distribution to homeless veterans and programs assisting homeless veterans. In this section, the term nonlethal excess supplies means property, other than real property, of the DOD, that is—

- Excess property, as defined in DOD regulations.
- Not a weapon, ammunition, or other equipment or material that is designed to inflict serious bodily harm or death.

B-13. Excess supplies made available under this section to support domestic emergency assistance activities shall be transferred to the Secretary of Homeland Security. The Secretary of Defense may provide assistance in the distribution of such supplies at the request of the Secretary of Homeland Security. This section does not constitute authority to conduct any activity which, if carried out as an intelligence activity by the DOD, would require a notice to the intelligence committees under Title V of the National Security Act of 1947, Title 50, U.S. Code (Public Law 112-277).

## **SECTION V — TITLE 10, UNITED STATES CODE, SECTION 2561**

### **HUMANITARIAN ASSISTANCE**

B-14. To the extent provided in defense authorization acts, funds authorized to be appropriated to the DOD for a fiscal year for foreign humanitarian assistance shall be used for the purpose of providing transportation of humanitarian relief and for other humanitarian purposes worldwide. The Secretary of Defense may use the authority provided by Section 2561, subparagraph (1) to transport supplies intended for use to respond to, or mitigate the effects of an event or condition, such as an oil spill, that threatens serious harm to the environment, but only if other sources to provide such transportation are not readily available. The Secretary may require reimbursement for costs incurred by the DOD to transport supplies under Section 2561, subparagraph (a) (2). To the extent provided in appropriate acts, funds appropriated for humanitarian assistance for the purposes of this section shall remain available until expended.

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# Glossary

The glossary lists acronyms with Army and joint definitions. This ATP is not the proponent publication for any terms.

## SECTION I – ACRONYMS AND ABBREVIATIONS

|                    |                                                                                                    |
|--------------------|----------------------------------------------------------------------------------------------------|
| <b>ADRP</b>        | Army doctrine reference publication                                                                |
| <b>ADP</b>         | Army doctrine publication                                                                          |
| <b>AHS</b>         | Army Health System                                                                                 |
| <b>AR</b>          | Army regulation                                                                                    |
| <b>ASCOPE</b>      | area, structure, capabilities, organizations, people, and events                                   |
| <b>ATP</b>         | Army techniques publication                                                                        |
| <b>CBRN</b>        | chemical, biological, radiological, and nuclear                                                    |
| <b>COSC</b>        | combat and operational stress control                                                              |
| <b>DA</b>          | Department of the Army                                                                             |
| <b>DOD</b>         | Department of Defense                                                                              |
| <b>DODD</b>        | Department of Defense directive                                                                    |
| <b>DODI</b>        | Department of Defense instruction                                                                  |
| <b>DSCA</b>        | defense support of civil authorities                                                               |
| <b>ESF</b>         | emergency support function                                                                         |
| <b>FHP</b>         | force health protection                                                                            |
| <b>FM</b>          | field manual                                                                                       |
| <b>G-9</b>         | assistant chief of staff, civil affairs operations                                                 |
| <b>HSS</b>         | health service support                                                                             |
| <b>JP</b>          | joint publication                                                                                  |
| <b>MEDCOM (DS)</b> | medical command (deployment support)                                                               |
| <b>MTF</b>         | medical treatment facility                                                                         |
| <b>NDMS</b>        | National Disaster Medical System                                                                   |
| <b>NRF</b>         | National Response Framework                                                                        |
| <b>PMESII-PT</b>   | political, military, economic, social, information, infrastructure, physical environment, and time |
| <b>UN</b>          | United Nations                                                                                     |
| <b>U.S.</b>        | United States                                                                                      |
| <b>USAID</b>       | United States Agency for International Development                                                 |

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# References

## REQUIRED PUBLICATIONS

These documents must be available to intended users of this publication.

ADRP 1-02, *Terms and Military Symbols*, 24 September 2013.

[<http://armypubs.army.mil/doctrine/ADP\\_1.html>](http://armypubs.army.mil/doctrine/ADP_1.html)

JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*, 8 November 2010.

[<http://www.dtic.mil/doctrine>](http://www.dtic.mil/doctrine)

*National Disaster Recovery Framework*, September 2011. [<http://www.fema.gov/national-disaster-recovery-framework>](http://www.fema.gov/national-disaster-recovery-framework)

*National Incident Management System*, December 2008. [<http://www.fema.gov/national-incident-management-system>](http://www.fema.gov/national-incident-management-system)

*National Response Framework*, Second Edition, May 2013. [<http://www.fema.gov/national-response-framework>](http://www.fema.gov/national-response-framework)

## RELATED PUBLICATIONS

These documents contain relevant supplemental information.

## NORTH ATLANTIC TREATY ORGANIZATION STANDARDIZATION AGREEMENTS

These documents are available online at <https://nsa.nato.int> (password required).

2087, *Medical Employment of Air Transport in the Forward Area*, Edition 6, 30 October 2008.

2228, *Allied Joint Medical Support Doctrine—Allied Joint Publication-4.10(A)*, Edition 2, 3 March 2006.

2249, *Training Requirements for Health Care Personnel in International Missions—Allied Medical Publication-8.3*, Edition 2, 14 June 2013.

2509, *Allied Joint Doctrine for Civil-Military Cooperation—Allied Joint Publication-3.4.9*, Edition 2, 8 February 2013.

2514, *Allied Joint Doctrine for Non-Combatant Evacuation Operations—Allied Joint Publication-3.4.2*, Edition 2, 14 May 2013.

2542, *Allied Joint Medical Planning Doctrine—Allied Joint Medical Publication-1*, Edition 1, 3 November 2009.

2563, *Allied Joint Civil-Military Medical Interface Doctrine—Allied Joint Medical Publication-6*, Edition 1, 4 October 2011.

## AMERICAN, BRITISH, CANADIAN, AND AUSTRALIAN ARMIES PUBLICATION AND STANDARD

These documents are available online at <http://www.abca-armies.org> (password required).

256, *Coalition Health Interoperability Handbook*, Edition 3, April 2013.

815, *Blood Supply in the Area of Operations*, Edition 1, 21 October 1991.

## UNITED STATES CODE (TITLES AND LAWS)

These documents are available online at <http://www.gpoaccess.gov/uscode/index.html> or <http://uscode.house.gov>.

Title 10, *Armed Forces*.

Medical Malpractice Immunity Act, Chapter 55. (Public Law 94-464)

Title 14, *Coast Guard*.

Title 18, *Crimes and Criminal Procedures*.

Posse Comitatus Act, Part I, Section 1385.

Title 22, *Foreign Relations and Intercourse*.

Arms Export Control Act of 1976, Chapter 39. (Public Law 94-329)

Foreign Assistance Act of 1961, Chapter 32. (As amended.) (Public Law 87-195)

Title 28, *Judiciary and Judicial Procedure*.

Federal Tort Claims Act, Sections 1346(b) and 2671–2680.

Title 31, *Money and Finance*.

Economy Act, Sections 1535 and 9701.

Title 32, *National Guard*.

Title 38, *Veterans' Benefits*.

Uniformed Services Employment and Reemployment Rights Act, Sections 4301–4333.

(Public Law 103-353)

Title 42, *The Public Health and Welfare*.

Public Health Security and Bioterrorism Preparedness and Response Act of 2002. (Public Law 107-188)

Public Health Service Act, Chapter 6A.

Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) of 1988.

(Public Law 100-707)

Pets Evacuation and Transportation Standards Act of 2006. (Public Law 109-308)

Title 50, *War and National Defense*

National Security Act of 1947. (As amended.) (Public Law 112-277)

## **DEPARTMENT OF DEFENSE PUBLICATIONS**

Most Department of Defense publications are available online at <http://www.dtic.mil/whs/directives/>.

DODD 3025.18, *Defense Support of Civil Authorities (DSCA)*, 29 December 2010.

DODD 3150.08, *DOD Response to Nuclear and Radiological Incidents*, 20 January 2010.

DODD 5100.46, *Foreign Disaster Relief*, 6 July 2012.

DODD 6010.22, *National Disaster Medical System (NDMS)*, 21 January 2003.

DODD 6400.04E, *DOD Veterinary Public and Animal Health Services*, 27 June 2013.

DODI 2205.02, *Humanitarian and Civic Assistance (HCA) Activities*, 2 December 2008.

DODI 3000.05, *Stability Operations*, 16 September 2009.

DODI 3020.47, *DOD Participation in the National Exercise Program (NEP)*, 29 January 2009.

DODI 3020.52, *DOD Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Preparedness Standards*, 18 May 2012.

DODI 3025.16, *Defense Emergency Preparedness Liaison Officer (EPLO) Programs*, 8 September 2011.

DODI 3025.21, *Defense Support of Civilian Law Enforcement Agencies*, 27 February 2013.

DODI 5154.06, *Armed Services Medical Regulating*, 20 October 2011.

DODI 6000.16, *Military Health Support for Stability Operations*, 17 May 2010.

DODI 6055.17, *DOD Installation Emergency Management (IEM) Program*, 13 January 2009.

DODI 6200.03, *Public Health Emergency Management Within the Department of Defense*, 5 March 2010.

DODI 6440.03, *DOD Laboratory Network (DLN)*, 10 June 2011.

DODI 6490.05, *Maintenance of Psychological Health in Military Operations*, 22 November 2011.

## **JOINT PUBLICATIONS**

Most joint publications are available online at [http://www.dtic.mil/doctrine/new\\_pubs/jointpub.htm](http://www.dtic.mil/doctrine/new_pubs/jointpub.htm).

JP 3-0, *Joint Operations*, 11 August 2011.

JP 3-05, *Special Operations*, 18 April 2011.

JP 3-07, *Stability Operations*, 29 September 2011.  
 JP 3-07.3, *Peace Operations*, 1 August 2012.  
 JP 3-07.4, *Counterdrug Operations*, 14 August 2013.  
 JP 3-08, *Interorganizational Coordination During Joint Operations*, 24 June 2011.  
 JP 3-22, *Foreign Internal Defense*, 12 July 2010.  
 JP 3-24, *Counterinsurgency*, 22 November 2013.  
 JP 3-26, *Counterterrorism*, 13 November 2009.  
 JP 3-28, *Defense Support of Civil Authorities*, 31 July 2013.  
 JP 3-29, *Foreign Humanitarian Assistance*, 3 January 2014.  
 JP 3-41, *Chemical, Biological, Radiological, and Nuclear Consequence Management*, 21 June 2012.  
 JP 3-50, *Personnel Recovery*, 20 December 2011.  
 JP 3-57, *Civil-Military Operations*, 11 September 2013.  
 JP 3-68, *Noncombatant Evacuation Operations*, 23 December 2010.  
 JP 4-02, *Health Service Support*, 26 July 2012.

## MULTISERVICE PUBLICATIONS

Most multiservice publications are available online at [www.apd.army.mil](http://www.apd.army.mil).  
 ATP 3-11.37/MCWP 3-37.4/NTTP 3-11.29/AFTTP 3-2.44, *Multi-Service Tactics, Techniques, and Procedures for Chemical, Biological, Radiological, and Nuclear Reconnaissance and Surveillance*, 25 March 2013.  
 ATP 3-11.42/MCWP 3-38.1/NTTP 3-11.36/AFTTP 3-2.83, *Multi-Service Tactics, Techniques, and Procedures for Installation Emergency Management*, 26 April 2013.  
 FM 3-07.31/MCWP 3-33.8/AFTTP 3-2.40, *Multi-Service Tactics, Techniques, and Procedures for Conducting Peace Operations*, 26 October 2003.  
 FM 3-11.21, *Multiservice Tactics, Techniques, and Procedures for Chemical, Biological, Radiological, and Nuclear Consequence Management Operations*, 1 April 2008.  
 FM 3-24/MCWP 3-33.5, *Counterinsurgency*, 15 December 2006.  
 FM 4-02.7/MCRP 4-11.1F/NTTP 4-02.7/AFTTP 3-42.3, *Multiservice Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*, 15 July 2009.  
 FM 21-10/MCRP 4-11.1D, *Field Hygiene and Sanitation*, 21 June 2000.  
 NTRP 4-02.9/AFTTP 3-2.82\_IP/ATP 4-02.82, *Occupational and Environmental Health Site Assessment*, April 2012. <<https://ndls.nwdc.navy.mil>> (CAC required)

## ARMY PUBLICATIONS

Most Army doctrinal publications are available online at <http://www.apd.army.mil>.  
 ADP 3-07, *Stability*, 31 August 2012.  
 ADP 3-28, *Defense Support of Civil Authorities*, 26 July 2012.  
 ADRP 3-0, *Unified Land Operations*, 16 May 2012.  
 ADRP 3-07, *Stability*, 31 August 2012.  
 ADRP 3-28, *Defense Support of Civil Authorities*, 14 June 2013.  
 ADRP 5-0, *The Operations Process*, 17 May 2012.  
 AR 40-5, *Preventive Medicine*, 25 May 2007.  
 AR 40-13, *Radiological Advisory Medical Teams*, 1 October 2012.  
 AR 40-68, *Clinical Quality Management*, 26 February 2004.  
 ATP 3-05.1, *Unconventional Warfare*, 6 September 2013.

ATP 3-05.40, *Special Operations Sustainment*, 3 May 2013.  
ATP 3-07.5, *Stability Techniques*, 31 August 2012.  
ATP 4-02.5, *Casualty Care*, 10 May 2013.  
ATP 4-02.46, *Army Health System Support to Detainee Operations*, 12 April 2013.  
ATP 4-25.13, *Casualty Evacuation*, 15 February 2013.  
ATP 5-19, *Risk Management*, 14 April 2014.  
FM 3-05.131, *Army Special Operations Forces Noncombatant Evacuation Operations*, 16 November 2009.  
FM 3-07, *Stability Operations*, 6 October 2008.  
FM 3-22, *Army Support to Security Cooperation*, 22 January 2013.  
FM 3-37.2, *Antiterrorism*, 18 February 2011.  
FM 3-50.1, *Army Personnel Recovery*, 21 November 2011.  
FM 3-57, *Civil Affairs Operations*, 31 October 2011.  
FM 4-02, *Army Health System*, 26 August 2013.  
FM 4-02.51, *Combat and Operational Stress Control*, 6 July 2006.  
FM 6-22.5, *Combat and Operational Stress Control Manual for Leaders and Soldiers*, 18 March 2009.  
FM 8-55, *Planning for Health Service Support*, 9 September 1994.  
FM 27-10, *The Law of Land Warfare*, 18 July 1956.

### OTHER PUBLICATIONS

Department of Defense, *National Defense Strategy*, June 2008.  
Department of Health and Human Services, *Field Manual for Mental Health and Human Services Workers in Major Disasters*, January 2000.  
Department of State, *Post-Conflict Reconstruction Essential Tasks*, 1 April 2005.  
Emergency Support Function #1, *Transportation Annex*, May 2013.  
Emergency Support Function #3, *Public Works and Engineering Annex*, May 2013.  
Emergency Support Function #6, *Mass Care, Emergency Assistance, Housing, and Human Services Annex*, May 2013.  
Emergency Support Function #8, *Public Health and Medical Services Annex*, May 2013.  
Emergency Support Function #9, *Search and Rescue Annex*, May 2013.  
Emergency Support Function #11, *Agriculture and Natural Resources Annex*, May 2013.  
Emergency Support Function #13, *Public Safety and Security Annex*, May 2013.  
Emergency Support Function #15, *External Affairs Annex*, May 2013.  
Geneva Conventions of 12 August 1949.  
Hague Conventions of 1899 and 1907.  
National Institute of Health Publication Number 02-5138, *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence*, 2002.  
National Military Strategy, February 2011.  
National Security Presidential Directive 44, *Management of Interagency Efforts Concerning Reconstruction and Stabilization*, 7 December 2005.  
National Security Strategy, May 2010.  
Presidential Policy Directive/PPD-8: *National Preparedness*, 30 March 2011.  
The Sphere Project, *The Sphere Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response*, April 2011 Edition.  
United States Agency for International Development, *Field Operations Guide for Disaster Assessment and Response*, Version 4.0, September 2005.

## WEB SITES

All Partners Access Network. <<http://community.apan.org/default.aspx>>  
 American Red Cross. <[www.redcross.org](http://www.redcross.org)>  
 American Red Cross National Shelter System. <<https://nss.communityos.org/cms/>>  
 American Red Cross, Safe and Well. <<https://safeandwell.communityos.org/cms/>>  
 Animal and Plant Health Inspection Service.  
 <[www.aphis.usda.gov/animal\\_health/emergency\\_management/nvs.shtml](http://www.aphis.usda.gov/animal_health/emergency_management/nvs.shtml)>  
 Center for Disaster and Humanitarian Assistance Medicine. <[www.cdham.org/](http://www.cdham.org/)>  
 Center for Excellence in Disaster Management and Humanitarian Assistance. <[www.coe-dmha.org/](http://www.coe-dmha.org/)>  
 Centers for Disease Control and Prevention. <<http://www.cdc.gov/phpr/stockpile/stockpile.htm>>  
 Defense Medical Readiness Training Institute. <[www.dmrta.army.mil](http://www.dmrta.army.mil)>  
 Department of Homeland Security Federal Emergency Management Agency Lessons Learned  
 Information Sharing. <<https://www.llis.dhs.gov>>  
 Federal Emergency Management Agency. <[www.fema.gov/nims](http://www.fema.gov/nims)>  
 Homeland Security Information Network. <<http://dhs.gov/homeland-security-information-network>>  
 International Committee of the Red Cross. <[www.icrc.org/eng](http://www.icrc.org/eng)>  
 Médecins Sans Frontières/Doctors Without Borders. <[www.doctorswithoutborders.org/](http://www.doctorswithoutborders.org/)>  
 National Center for Medical Intelligence. <<https://www.intelink.gov/ncmi/index.php>>  
 National Disaster Medical System (NDMS) Federal Coordinating Center Guide.  
 <[www.ritn.net/WorkArea/DownloadAsset.aspx?id=2147483772](http://www.ritn.net/WorkArea/DownloadAsset.aspx?id=2147483772)>  
 Northern Command External Portal. <<https://registration.noradnorthcom.mil/gateway/default.aspx>>  
 Pan American Health Organization. <[www.paho.org/hq](http://www.paho.org/hq)>  
 Reliefweb. <<http://reliefweb.int/>>  
 Transportation Command Regulating and Command and Control Evacuation System.  
 <<https://www.trac2es.transcom.mil/>>  
 United States Army Medical Materiel Agency. <[www.usamma.army.mil/index.cfm](http://www.usamma.army.mil/index.cfm)>  
 World Health Organization. <[www.who.int/en/](http://www.who.int/en/)>  
 World Organization for Animal Health. <<http://www.oie.int/>>

## PRESCRIBED FORMS

None.

## REFERENCED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site ([www.apd.army.mil](http://www.apd.army.mil)).

DA Form 2028, *Recommended Changes to Publications and Blank Forms*, February 1974.

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9 June 2014

By order of the Secretary of the Army:

**RAYMOND T. ODIERNO**

*General, United States Army  
Chief of Staff*

Official:

A handwritten signature in black ink, appearing to read "Gerald B. O'Keefe". The signature is fluid and cursive, with the first name "Gerald" being the most prominent.

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