FIELD MANUAL
NO. 8-42

FM 8-42
HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 4 December 1990

MEDICAL OPERATIONS IN LOW INTENSITY CONFLICT

TABLE OF CONTENTS

PREFACE

This field manual establishes the medical doctrine and provides the principles for conducting medical operations in a low intensity conflict (LIC) environment. It is designed for use by personnel involved in health service support (HSS) planning for LIC, command surgeons, at all levels of command, and their staffs.

References herein to activities of terrorist and insurgent organizations, and to concepts of operations of foreign governments are made for illustrative and informational purposes only. The presence of the material in this manual does not constitute United States (US) Army advocacy or approval of practices that are prohibited by US law or policy.

The proponent of this publication is the Academy of Health Sciences, U.S. Army. Users of this publication are encouraged to submit comments/recommendations to improve this product. Comments should be keyed to the page, paragraph, and line(s) of text where the change is recommended. Reasons should be provided for each comment to facilitate understanding and complete evaluation of the comments/recommendations. Send comments/recommendations on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Commandant, Academy of Health Sciences, U.S. Army, ATTN: HSHA-TLD, Fort Sam Houston, Texas 78234-6100.

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

CHAPTER 1

OVERVIEW OF LOW INTENSITY CONFLICT

Section I. INTRODUCTION

1-1. General

a. Planning for and executing medical missions across the LIC continuum requires flexibility and adaptability. This chapter provides a brief orientation to LIC, its operational categories, and the role of the command surgeon.

b. Under some circumstances, medical operations in low intensity conflict (MEDOLIC) may serve a somewhat different role from their traditional combat service support (CSS) role in conventional warfare. The provision of HSS and medical education may play a more direct role in countering the threat in LIC.

c. Medical operations and programs may be an integral element in some LIC psychological operations (PSYOP) and civil affairs (CA) efforts.

d. For additional information on LIC, refer to Field Manual (FM) 100-20.

1-2. Definition

a. Low intensity conflict is a political-military confrontation between contending states or groups below conventional war and above the routine, peaceful competition among states. It frequently involves protracted struggles of competing principles and ideologies. Low intensity conflict ranges from subversion to the use of armed force. It is waged by a combination of means employing political, economic, informational, and military instruments. Low intensity conflicts are often localized, generally in the Third World, but contain regional and global security implications.

b. United States LIC policy recognizes that indirect, rather than direct, applications of US military power are often the most appropriate and cost-effective ways to achieve national goals. The principal US military instrument in LIC is security assistance. Security assistance may take the form of training, equipment, combat support (CS), and CSS. Where friends and allies are involved in LIC, the object of US security assistance is to ensure that military institutions are able to provide security for both the citizens and the government. The US may also engage in combat operations when vital national interests cannot be adequately protected by other means. When a US response is called for (or when US assistance is requested by a host nation [HN]) and approved by the national command authority (NCA), the mission is developed in accordance with the principles of international and domestic law. These principles affirm the inherent right of states to use force in individual or collective self-defense against an armed attack.

c. Medical operations in LIC can be defined as encompassing all military medical actions taken or programs established to further US national goals, objectives, and missions in a LIC environment. These actions and programs, while basically involving the provision of quality health care, may differ to some degree from the traditional CSS role of the Army Medical Department (AMEDD) in both war and peace. These medical operations can play a significant and proactive role in enhancing HN stability by—

- Assisting with the refinement or development of the military medical infrastructure.
- Providing and maintaining the basic necessities of life for the general population through HN civilian medical programs.
- Providing assistance to repair, improve, or establish basic services once hostilities have ceased.

1-3. Low Intensity Conflict Imperatives

The LIC imperatives apply in all operational categories and are—

- Political dominance.
- Unity of effort.

- Adaptability.
- Legitimacy.
- Perseverance.

a. Political Dominance. In LIC operations, as in all military operations, political objectives drive decisions at the strategic level. While the individual operator need not be driven by political motives, it is important for the leadership at the tactical level to recognize the importance of political objectives in planning and executing the tactical mission.

b. Unity of Effort. Military leaders in LIC must integrate their efforts with other governmental agencies so that all gain mutual advantage. Planning must address the military contribution to initiatives that are political, economic, and psychological as well as military in nature.

c. Adaptability. The skill and willingness to change or modify structures or methods to make them applicable to the situation characterize adaptability.

d. *Legitimacy.* This is the willing acceptance of the right of a government to govern, or for a group or agency to make and enforce decisions. It is the perception that authority is genuine and effective and that it uses proper agencies for reasonable purposes.

e. Perseverance. Low intensity conflicts rarely have clear beginnings or ends marked by decisive actions culminating in victory. They are, by nature, protracted struggles. Even those short, sharp contingency encounters which do occur are better assessed in the context of their contribution to long-term objectives. Perseverance is the patient, resolute, persistent pursuit of national goals and objectives for as long as necessary to achieve them.

1-4. Historical Perspective

a. The LIC environment is not a new phenomenon; however, in the past 30 years there has been a dramatic surge in its occurrence. In his address to the 1962 graduating class at the United States Military Academy, West Point, New York, President John F. Kennedy remarked–

> "This is another type of war, new in its intensity, ancient in its origins. War by guerrillas, subversives, insurgents, assassins; war by ambush instead of combat, by infiltration instead of by aggression...seeking victory by eroding and exhausting the enemy instead of engaging him. It requires...a whole new kind of strategy, a wholly different kind of force... "

b. Almost since its inception, the US Army has been involved in some form of LIC. From the French and Indian Wars, the settling of the West, through the Philippine insurrection, and up through modern involvement in the Caribbean, Central America, and the Middle East, Americans have fought in a LIC environment.

c. Because of the uniqueness of LIC, the threat environment may take many forms. The actual scenario is based on—

- Country or countries involved.
- Social, economic, and political factors at play in the area.
- Level of organization and financial status (or backing) of the threat forces.

d. The range of potential activities that fall within the broad spectrum of LIC are numerous. The AMEDD, moving from its traditional CSS role, has the responsibility of responding to the LIC continuum. This is accomplished by developing plans and procedures to maximize the effectiveness of military medicine and to support the objectives of the unified or combined commands.

e. For some nations facing internal or external threats to their national security and independence, the US may provide economic and military assistance to help prevent or defeat the threat. (A detailed discussion of security assistance programs is contained in FM 100-20.) The Department of State has responsibility for all aspects of foreign assistance. The United States Agency for

International Development (USAID) administers developmental assistance programs. There are five major security assistance programs—all of which fall under the control of the Department of State. The Department of Defense (DOD) administers two programs: International Military Education and Training (IMET) and Foreign Military Financing (FMF), both cash and credit. The Department of State and USAID administer the remaining three programs: Economic Support Fund, peacekeeping operations, and commercial export sales.

1-5. Low Intensity Conflict Operational Categories

Low intensity conflict is divided into four broad operational categories; they are—

a. Support for Insurgency and Counterinsurgency. The security interests of the US may lie with either an incumbent government or with the insurgents. What primarily distinguishes insurgency from counterinsurgency and from the other categories is the principle objective they are supposed to achieve. The primary objective in insurgency is to overthrow the government. The primary purpose of counterinsurgency is to prevent the overthrow of the government. Both insurgency and counterinsurgency rely on political motivation. Operational techniques in insurgency and counterinsurgency require a mildimensional approach. It is important to be included early on in the mission planning. Early planning will maximize the effectiveness of HSS resources. In counterinsurgency, health service support can alleviate a major cause of discontent (health and quality of life issues); prevent mobilization based on those issues; and help mobilize the population. For information concerning the HSS aspects to support for insurgency and counterinsurgency, refer to Chapter 2.

b. Combatting Terrorism. The aim of combatting terrorism is to protect installations, units, and individuals from the threat of terrorism. Combatting terrorism is an umbrella term covering antiterrorism (defensive actions for force protection) and counterterrorism (offensive measures against terrorists) actions taken to oppose terrorism throughout the operational continuum. In combatting terrorism, programs are designed which provide coordinated action before, during, and after terrorist incidents. From an operational perspective, combatting terrorism is a campaign directed toward a strategic goal of removing the threat. For information on the HSS aspects of combatting terrorism, refer to Chapter 3.

c. Peacekeeping Operations. Peacekeeping operations are military operations which maintain peace already obtained through diplomatic efforts. A peacekeeping force supervises and implements a negotiated truce. The force operates strictly within the parameters of its terms of reference, doing neither more nor less than its mandate prescribes. A distinguishing feature of these operations is that the force is normally forbidden to use violence to accomplish its mission. In most cases, it can use force only for self-defense. For information concerning the HSS aspects of peacekeeping operations, refer to Chapter 4.

d. Peacetime Contingency Operations. Peacetime contingency operations often take place away from customary support facilities. These operations often require deep penetration and temporary establishment of long lines of communication (LOC). These operations may be conducted in a medically demanding or potentially hostile environment. They form a large operational category that includes many diverse actions (ranging from humanitarian assistance to land, sea, or air strikes against centers of hostility). Peacetime contingency operations may require the concentration of violent action or the exercise of restraint and the selective use of force. For information concerning the HSS aspects of peacetime contingency operations, refer to Chapter 5.

1-6. Medical Threat Assessment

A critical element of the medical assessment, for any mission, is a thorough appraisal of the medical threat to deploying forces and to the residents of a HN. This is particularly true in LIC scenarios as the incidence and exposure to endemic disease is greater in developing nations. The medical threat is derived from a variety of informational sources outside of the military, as well as through formal intelligence channels. The medical planner should consider the following points:

a. The ability to obtain, interpret, and use intelligence is critical to the success of a medical mission. This is essential in the LIC arena due to the more direct role played by medical forces and the greater vulnerability of these forces to the medical threat.

(1) 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 areas of operations (AO), and is significant to military planning. Until medical information is appropriately processed (ordinarily on a national level by the Armed Forces Medical Intelligence Center [AFMIC]), it is not considered to be medical intelligence.

- Medical epidemiologic information is available from international sources such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO).

- Direct contact with health authorities by health professionals may yield useful information. Caution must be used when collecting medical information from local sources. The reliability of local information is dependent upon—

- Resources available to collect the information, to include the experience and training of individual collector.

- Political considerations impacting on reporting the information.

(2) Full use of the special training of the preventive medicine (PVNTMED) officers and personnel (to provide a clear assessment of the threat and to make recommendations for types of activities and their prioritization) is essential to ensure the wise use of limited resources. Prevention and control of diseases or conditions which impede HN personnel from achieving their own success have a high priority for action. Preventive medicine personnel are specifically trained and equipped to collect, analyze, and interpret health information. Preventive medicine personnel should have free access to all types of specialists within the medical force and HN to consult with during the threat assessment.

(3) Medical planners must acquaint themselves with the various intelligence products which currently exist for their use. The medical planners must be familiar with national level intelligence products such as the Medical Capabilities Studies (MEDCAPs) and Disease Occurrence Worldwide (DOWW). These reports are specifical produced to support US military medical operations. These reports can be obtained through operational and medical intelligence channels. Refer to FM 8-10-8 and Appendix A for specific information on requesting intelligence products.

(4) As medical plans and operations progress, the requirements for additional intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated.

(5) Medical planners must make themselves aware of enemy weapons capabilities. For example, nuclear, biological, and chemical (NBC) munitions (Appendix B), or potential employment options such as terrorist acts or artillery fires. Planning for HSS operations and force survivability necessitate that units remain abreast of the complete intelligence picture.

b. Should HSS personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it (FM 8-10-8) to their supporting intelligence element (Intelligence Officer [US Army] [S2]/ Assistant Chief of Staff [Intelligence] [G2]).

Section II. MEDICAL INVOLVEMENT IN LOW INTENSITY CONFLICT

1-7. General

United States involvement in the LIC arena is expanding some of the traditional roles of CS and CSS elements. Of particular note are the varied roles that HSS (Appendixes C through G) and other CSS units will accomplish through medical operations and programs in LIC. These newly defined roles

require that the HSS planner be proactive in developing HSS plans. These operation plans (OPLANs) must meet the commander's guidance and intent and support US national goals and objectives. These plans are based on the missions, tasks, and the forces supported in the AO. The command surgeon plays a pivotal role in the development of plans and the implementation of programs within the commander's geographic AO. Refer to paragraph 1-9 for a discussion of the command surgeon's duties and responsibilities.

1-8. Foundations for Medical Programs Conducted in Low Intensity Conflict

a. The cornerstones of MEDOLIC include—

- Planning for and providing direct health care services to US and allied military forces.
- Furtherance of US national goals and objectives.
- Enhancement of medical readiness by real-time, hands-on training. This training is conducted in an unfamiliar venue, involving diseases not normally widespread in the US, and in varying public health conditions.
- Promotion and enhancement of the growth potential of a HN medical infrastructure.
- Planning for and developing programs which provide direct patient care for both HN military and civilian populations.
- Planning for and providing medical education and training for HN or US-backed military or paramilitary forces.

b. Flexibility and initiative are required to enhance the potential for success in this environment.

c. Many of the medical missions conducted in the LIC environment will be in support for insurgency and counterinsurgency operations. These new missions will shape and define what role the US military medical programs will play in overall LIC operations.

- Combined HN and US HSS to the indigenous population is essential to reduce a medically-related threat. Health service support has proven to be one of the most effective resources to gain support of a population. Medical assistance is constructive in nature and is generally welcomed rather than feared and rejected. A high premium is placed on available US health service resources because of—
- The extensive health hazards prevalent in most developing nations.
- The general shortage of HN medical personnel and facilities.
- Health service support operations conducted in a HN must not exceed the capabilities of the HN or its health professionals. When US assistance is withdrawn, the HN must be capable of continuing these programs. If the HN or its health professionals cannot continue the programs, the HN's legitimacy may be undermined. For example, prevention and education are two low technology options which are more easily sustained than high technology treatment or rehabilitative support.
- Refer to Chapter 2 for a detailed discussion of the HSS aspects in support for insurgency and counterinsurgency.

1-9. Command Surgeon

a. The command surgeon is instrumental in planning, developing, and implementing military medical programs and support in the LIC environment.

b. The number of personnel in LIC operations may be restricted and a full contingent of medical personnel may not be deployed on a specific mission. The senior medical officer assigned to the operational force will serve as the command surgeon. Additionally, a formal chain of command is established within the task-organized force as the command surgeon does not act unilaterally, but rather acts within the context of the task force.

c. The duties and responsibilities of a command surgeon include, but are not limited to, the following:

- Advising on the health services of the command and of the geographical territory within the commander's AO.

- Advising on the medical effects of the environment and of NBC weapons on personnel, rations, and water.

- Determining requirements for the requisition, procurement, storage, maintenance, distribution management, and documentation of medical, dental, veterinary, and optical equipment and supplies.

- Determining the requirements for HSS personnel and making recommendations concerning their assignment.

- Planning and coordinating medical training in the command, as required.

- Coordinating with medical unit commanders for continuous HSS.

- Submitting to higher headquarters those recommendations on professional medical problems which require research and development.

- Recommending uses of captured Class VIII supplies in support of enemy prisoners of war (EPWs) and other recipients.

- Advising on medical intelligence requirements, including the examination and processing of captured medical supplies and equipment.

- Planning and coordinating (internally and externally) the following HSS operations:

  - The system of treatment and patient evacuation (including aeromedical evacuation by Army air ambulance units and air movement of patients by United States Air Force [USAF] evacuation units).

  - Dental services.

  - Veterinary food inspection, animal care, and veterinary PVNTMED activities of the command, as required.

  - Preventive medicine services.

  - Nursing services.

  - Medical laboratory and blood bank services.

  - Medical supply, optical, and maintenance support, including technical inspection and status reports.

  - Humanitarian and civic assistance (HCA) programs.

  - Mental health and combat stress control.

  - Rehabilitation and nutrition services.

  - Medical aspects of rear area protection, if applicable.

  - Assignment of medical units.

  - Preparation of reports regarding medical and other hospital administrative records of injured, sick, and wounded personnel, if applicable.

  - Automatic data processing requirements for HSS.

  - Collection and analysis of operational data from on-the-spot adjustments in the HSS structure and for use in postwar combat and materiel development studies.

1-10. Surgeon's Role in Low Intensity Conflict

The role of the command surgeon in LIC includes the duties and responsibilities specified in paragraph 1-9. The elements of assessing, problem solving, planning, and coordinating programs take on added importance in LIC.

a. Assessment.

(1) Medical assessments (Appendix H) must be carefully and comprehensively completed. They need to include such areas as–

- Health status of the HN's military and civilian communities.

- Potential medical threat under various operational scenarios.

- Available medical resources and assets from within the US military, other US government agencies, civilian and religious organizations, and the HN.

(2) An axiom of US assistance is that outside aid should only be provided when all resources of the geopolitical unit in need have been fully and efficiently used.

(3) Current and timely medical intelligence (paragraph 1-6 and Appendix A) is an important aspect in preparing a comprehensive medical assessment.

(4) Updated assessments should be maintained on each specific geopolitical area within the commander's AO.

b. Problem Solving. Due to the uniqueness of the LIC environment, planning for operations in the potential scenarios requires initiative and possible improvisation to successfully complete established missions. As medical planners, command surgeons must not become inflexible in their thinking, or rely solely on the traditional methods of health care delivery to accomplish their missions. In LIC, the AMEDD is being assigned new roles and missions. Health service support planners must explore all potential alternative courses of action to fulfill these roles. They must also be prepared to deal with unanticipated complications. As medical resources will be scarce and the care provided will normally be austere, the planner needs to be flexible enough to maximize the use of these resources.

c. Planning.

(1) It is important that HSS planning be proactive. It should be initiated at the earliest possible phase in the plan's development. Early planning can help to ensure that–

- Adequate HSS assets are available.

- Requirements which cannot be completed by medical elements are identified and appropriate action taken.

- An accurate assessment of the medical threat is included in the plan.

(2) The medical plan (Appendix I) is formulated to support the many aspects of an operation. The plan furthers the accomplishment of US national goals and objectives. If medical programs are developed independently and without integration into the plan, they may in fact hinder, rather than further, US national goals and objectives for the region.

(3) If a command surgeon is not designated on a specific operation, the senior medical officer assigned assumes this role. Thorough planning in the early stages of the mission development must still be accomplished and coordinated.

d. Coordination.

(1) The planning and execution of operations requires thorough coordination prior to implementation. This coordination ensures that—

- Duplication of services and/or missions does not occur.

- The mission is executed properly.

- Interoperability exists between the services in such areas as communications.

- Adequate CSS resources are allocated for the mission. This includes all classes of supply and the means to resupply the operation.

- Scarce resources are used effectively and efficiently.

- Operational security requirements are met.

(2) In LIC, coordination is not limited only to the military forces operating within the geographical area, but extends to other US agencies, civil and religious organizations, and the HN.

(3) Thorough coordination during the planning process ensures that the final plan—

- Attains US national goals and objectives.
- Satisfies the requirements of the HN.
- Can be accomplished with the resources available.
- Provides a favorable climate for the acceptance of the government program by the populace.
- Does not bypass or discourage the full application of all appropriate HN resources to the problem.

(4) The importance of HCA programs in both counterinsurgency and peacetime contingency operations will increase with our commitments in LIC. The command surgeon plays an integral role in developing courses of action which enhance programs being developed or implemented within the region.

(5) A sample standing operating procedure (SOP) for a medical element deployed in LIC is provided in Appendix J.

CHAPTER 2

HEALTH SERVICE SUPPORT ASPECTS OF SUPPORT FOR INSURGENCY AND COUNTERINSURGENCY OPERATIONS

2-1. General

a. The operational category of support for insurgency and counterinsurgency provides the greatest challenges and is the most complex. The possibility exists, in this category, that the traditional roles and methods of employment of US military forces may be reversed (CSS or CS elements entering the theater prior to the combat units). The uniqueness of operations in this environment requires thoroughly coordinated planning and flexibility on the part of commanders to successfully accomplish assigned missions.

b. Agencies of the federal government (other than the DOD) normally exercise overall direction of efforts in support for insurgency and counter-insurgency. The US military actions serve a supporting role. Once legally tasked by the NCA for commitment to support or defeat an insurgency, US military forces assist either HN governments or insurgent movements.

c. For the legal considerations concerning insurgency and counterinsurgency operations, refer to FM 100-20.

2-2. Insurgency

a. Insurgency is an organized, armed political struggle whose goal may be the seizure of power through revolutionary takeover and replacement of the existing government. In some cases, however, insurgency is undertaken to break away from government control and establish an autonomous state within traditional ethnic or religious territorial bounds. It may even be conducted to extract limited political concessions that are unattainable through less violent means.

b. Insurgences succeed by mobilizing human and material resources to provide both active and passive support. Mobilization produces skilled workers and fighters, raises money, and acquires weapons, equipment, and supplies of all kinds. Mobilization grows out of intense popular dissatisfaction with existing political and social conditions. Active supporters consider conditions intolerable. They are willing to risk death in violent confrontation with their government to effect change. The insurgent leadership articulates their dissatisfaction, placing the blame on the government and offering a program to improve conditions. The insurgent leadership then provides organizational and management skills to transform disaffected people into an effective force for political action. Ultimately, the insurgents need the active support of a majority of the politically-active people and the passive support of the greater part of the population.

c. This dynamic process may take place within any political system, including a democracy. Insurgency arises when the government is unable or unwilling to redress the demands of important social groups and when its opponents use violence to change the government's position. Insurgencies are coalitions of disparate forces united by their common opposition toward the government. To the extent that these coalitions find common ground, their prospects improve. Their differences are compromised, negotiated, and influenced as groups evolve. To be successful, an insurgency must develop unifying leadership, doctrine, and organization, and a vision of the future. Only the seeds of these elements are present when an insurgency begins; the insurgents must continually review and revise them.

d. For information on insurgences and the framework for analysis of insurgent movements, refer to FM 100-20.

2-3. Medical Operations Role in Supporting an Insurgency

Depending upon the needs of the insurgent movement, the political, social, and economic issues involved, the resources available, and the existence of clear, legal authority, medical operations may entail advice and—

- Training in PVNTMED and sanitation. Information on PVNTMED and sanitation subjects is contained in FMs 8-250, 8-33, 21-10, 21-10-1, and 10-52; technical bulletin, medical (TB MED) series; and WHO reports and publications.

- Assisting in the establishment of a viable medical organization to attend to the medical needs of the insurgents. The medical organization supporting the insurgent is normally austere. It must provide all facets of the health care spectrum from emergency medical treatment (EMT) at the point of injury through hospitalization and convalescent care. Field nurses may serve as trainers emphasizing those skills necessary for EMT; triage; mass casualty management; surgical procedures; and postoperative basic skills. These nurses may also provide first aid training to the insurgent 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 LIC operations, the treatment station established should be no larger than that necessary to accomplish the mission. It should be 100 percent mobile.

- Assisting in the planning of health care programs. These programs may be for the populace once the insurgents have attained the position to implement them. Development of HSS programs must be based on the real or perceived needs of the populace. A balance between short-term and long-term programs must be attained. Short-term programs (such as extraction of teeth) provide visibility and immediate recognition. Long-term programs, however, 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. Long-term programs include such projects as veterinary care (Appendix C); building of sanitation facilities (Appendix D); training of medical personnel, nutrition and rehabilitation guidance (Appendix G); immunizations; and health education.

2-4. Counterinsurgency

a. The internal defense and development (IDAD) strategy is the full range of measures taken by a nation to promote its growth and protect itself from subversion, lawlessness, and insurgency. It focuses on building viable institutions (political, economic, military, and social) that respond to the needs of the society. Developmental programs, carefully planned, implemented, and publicized, can serve the interests of population groups and deny exploitable health issues to the insurgents.

b. The fundamental thrust of the IDAD strategy is toward preventing the escalation of internal conflict. Should insurgency occur, emphasis is placed on holding down the level of violence. The population must be mobilized to participate in IDAD efforts. Thus, IDAD is an overall strategy for the prevention of insurgency; or if an insurgency should develop, for counterinsurgency activities. Prevention is accomplished through—

- Forestalling and defeating the threat posed by insurgent organizations.

- Working to correct conditions that enhance their chances of success.

c. Quality of life issues, such as the availability of health care, can be prominent issues that motivate insurgents to demand change. A thoroughly planned and coordinated IDAD strategy (which implements the needed health care reforms and focuses on other quality of life issues) can motivate the population to support the HN government rather than the insurgent group. These programs can enhance the legitimacy of the HN government while undermining the legitimacy of the insurgent group.

d. For further information on counter-insurgency, refer to FM 100-20.

2-5. Medical Operations in Support of Security Assistance Organizations

a. United States military actions in support of an insurgency or counterinsurgency should be part of a coordinated blend of available instruments of national power, designed to achieve clearly defined political objectives. United States military support to insurgences and counterinsurgencies normally centers on security assistance program administration efforts that complement those of other government agencies. For the most part, the US military role will be to provide military training, technical training, and intelligence and logistical support. Operations by US forces in support of a HN conducting counterinsurgency include—

- Intelligence operations.
- Joint-combined exercises.
- Civil-military operations, including CA and PSYOP.
- Humanitarian or civic assistance.
- Logistical support operations.

b. Military medical resources may not be used in all categories of missions; however, they can be employed to improve health related quality of life issues and deficiencies to enhance the effectiveness of military medical training. This support is given by such means as–

- Providing training and support in PVNTMED measures.
- Developing military training packages to enhance skills of medical paraprofessionals.
- Participating in the Department of State cultural exchange program by exchanging US and foreign military medical personnel for visits, training, and education.

c. The foreign internal defense augmentation force is a conceptual, composite organization which augments the security assistance organization (SAO). When constituted, the foreign internal defense augmentation force operates under a US unified command or subordinate joint task force (JTF). Its foreign internal defense (FID) mission is to assist SAOs with training and operational advice, and to provide assistance to HN forces. It employs mobile training teams (MTTs) and small detachments to fulfill specific mission requests. Ideally, this force should be a specially trained, area-oriented, mostly language qualified, and ready force. Medical augmentation to the foreign internal defense augmentation force can be provided to some extent in all of the HSS functional areas. Particularly effective in this arena are medical, nurses, PVNTMED, dental, and veterinary resources.

d. The remainder of this chapter discusses medical planning considerations and medical operations which can be employed in the LIC environment.

2-6. The Goals and Objectives of Military Health Service Support in Foreign Internal Defense

a. Foreign internal defense is the participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. Foreign internal defense is the US role in the IDAD strategy.

b. The goals and objectives of military HSS in this environment are defined in the commander's regional strategy. Each HN has circumstances which differ from its neighbors' and are unique to its own situation. These characteristics include social, economic, cultural, military, and political realities within the HN. The medical planner needs to develop specific goals and objectives for each country within the region.

c. In developing these goals and objectives, the medical planner ensures that the—

- Plan is developed with the HN's assistance.
- Plan enhances rather than replaces the HN's existing programs.
- Host nation has the resources to continue the programs if the US military effort is sharply curtailed or discontinued.
- Host nation receives the credit for the program rather than the US military. This is accomplished by ensuring that all medical operations include representatives of the HN or its military.

2-7. The Role of Military Health Service Support in Foreign Internal Defense

a. As with the goals and objectives, the actual role of military HSS is defined in the commander's regional strategy. It is important that. any HSS operations conducted in LIC are thoroughly planned, coordinated, and included in this strategy.

b. The specific role of military medicine in FID varies depending upon the stage of development and the political, economic, military, and social situations of the country where employed. However, some general roles are to—

- Assist the HN in identifying the health needs of the population.
- Work in concert with the HN in developing programs aimed at the resolution of potential or actual health problems.
- Provide guidance for the development of the HN's medical infrastructure.
- Develop, in concert with the HN, training standards to be used by the HN.
- Develop and document the minimum and basic medical supplies and equipment levels for the conduct of HN operations and programs.
- Assist the HN's health planners in prioritizing health care needs which are competing for scarce resources.
- Train HN personnel to administer and maintain programs without outside assistance.

c. Regardless of the specific medical missions, the US military role should be *unobtrusive.* The HN government must be seen as leading the effort to improve the quality of life for the populace, thus making the desired positive impression. Concern for the health of the people must be viewed as a central precept of the HN government, not as a program driven by outside American influences.

d. The role of military HSS in a foreign country is determined by the US Ambassador, who is responsible for and has authority over all US Government activities within the country. Actions by military medicine will be fully integrated with the general plan of the US country team. The scope of activities by military medicine is also limited by acts of Congress. (Refer to FM 100-20, Appendixes A and B.) The emerging role of military medicine in counterinsurgency operations involves a long-term commitment in consonance with US national policy and goals and the socioeconomic environment of the HN. The *quick fix* should be avoided, as it only raises the expectations of the populace, and when US assistance is withdrawn may leave the HN government without the capability to sustain the same level of care. This situation results in increasing the population's dissatisfaction with their government.

2-8. Determining the Health Service Needs of a Host Nation

a. In consonance with and under the direction and guidance of the US Ambassador, country team, and applicable laws, the command surgeon takes a proactive role in helping to determine the health service needs of the various countries. There are, however, various organizations and individuals who can assist in identifying medical needs. These include—

- Host Nation.
- Armed Forces Medical Intelligence Center.
- State Department.
- Defense Attache Officer.
- World Health Organization.
- United States Agency for International Development.
- Religious organizations.

b. Regardless of how the requirement is initially determined, the command surgeon must be brought into the planning process at the earliest possible time. This ensures that the necessary military medical resources are allocated to accomplish the mission.

c. As one of the major goals of using military HSS resources is to enhance the stability of the HN government, the parameters used to assess the HN health service needs will vary with each country. Assessment factors include, but are not limited to—

- State of general health of the population, especially nutrition.
- State of mental health services.
- State of dental health and dental care services.
- Sanitation and personal hygiene.
- Impact of endemic diseases.
- Status of farm animal health and veterinary services.
- Primary care capabilities, to include rural areas.
- Morbidity and mortality statistics.
- Developmental stage of the HN health care delivery system.
- 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 department resources.
- Availability and production capability for prosthetic and orthotic devices.
- Existence of medical training and education programs targeted at the general population.
- Status of health care resources.
- Education level of the general population.

d. An assessment checklist is provided in Appendix H.

2-9. Health Service Support Needs of the Host Nation Military

An assessment of the HN's military medical infrastructure and capabilities (similar to the civilian sector) should be completed. The morale of the fighting soldier is often dependent upon the knowledge that he will receive adequate and timely medical attention when wounded or ill. If the HN's military medical infrastructure does not have the capability to provide this type of responsive medical we, the effectiveness of the fighting force may suffer. Assessment factors include, but are not limited to—

- Status of field sanitation and personal hygiene practices.
- Stage of development of the medical organization, including the professional development of medical and paraprofessional personnel.
- Level of training combat medics receive for providing initial medical care.
- Status of combat stress control prevention and management of stress reactions.
- Status of the medical logistics system, including development of standardized medical equipment sets for field operations.
- Existence of field medical units, including command and control elements.
- Level of recruitment and training of civilian health care professionals for duty with the military.
- Status of an immunization program for the armed forces.
- Level of malnutrition among the armed forces.
- Status of a medical evacuation system.

- Educational level of members of the armed forces.
- Status of unit and individual training in self-aid and buddy aid in the armed forces.
- Development of rehabilitative services such as occupational and physical therapies and protocols.
- Status of veterinary services.
- Stage of development of (or improvement of) a military hospitalization system.
- Existence of medical and nursing training programs and standards of training.

2-10. Medical Humanitarian and Civic Assistance

a. Medical HCA includes assistance to a HN such as medical, dental, and veterinary care provided in rural areas of the country. A medical mission reconnaissance checklist is provided in Appendix K. This assistance complements, but does not duplicate, any other social or economic assistance that is being provided by other US departments or agencies. These activities serve the basic economic and social needs of the people of the country concerned; they—

- Support the civilian leadership.
- Benefit a wide spectrum of the community.
- Are self-sustaining (once completed) or supportable by the HN civilian or military agencies.

b. Department of Defense HCA programs promote the—

- Security interests of both the US and HN.
- Specific operational readiness skills of the armed forces who participate in the activities.

c. Humanitarian and civic assistance programs carried out under the authority of Title 10, United States Code, Chapter 20, Part 1 of Subtitle A, may not be provided (directly or indirectly) to any individual, group, or organization known to be engaged in military or paramilitary activities.

d. Humanitarian and civic assistance projects or activities in any foreign country require specific prior approval of the Secretary of State for such assistance.

2-11. Health Care Program Development

a. In order to develop viable and effective health care programs, a long-term commitment of assistance is required. As stated in paragraph 2-7, the *quick fix* is not a solution for ensuring that adequate health care services will remain available to the HN population and military. Additionally, the *quick fix* solution may not further US national goals for enhancing the stability of the HN government.

b. Medical operations conducted to enhance the stability of the HN government must be well coordinated with all concerned agencies, such as the—

- Host nation itself and its medical organizations and assets.
- Ambassador and the country team.
- Military assistance advisory group.
- United States Agency for International Development.
- Foreign internal defense augmentation force.
- Civil affairs elements.
- Special operations forces.
- World Health Organization.
- Private organizations and religious efforts.

c. Particular attention should be given to the existence of legal authority for providing training to HN personnel and to the need, in most cases, for reimbursement of the value of training or other services provided.

d. It should be emphasized that the medical infrastructure which evolves through assistance from US forces must pervade throughout the country and be broad based. It cannot only be concerned with urbanized areas, but must make primary care available to rural areas also. This often requires convincing the HN government that the expense of hiring and training additional medical and public health personnel for providing rural area services will be justified by the amount of support for the government it quickly generates. For example, the HN system can increase access to primary care despite limited resources and dispersed population. One method is to use nurse practitioners to provide primary care in rural areas. These practitioners could also provide training to local basic and middle level health care providers.

e. The health care programs are tailored to meet the needs of the HN. They should target the basic health necessities initially, with emphasis on health education and on other preventive measures. As the programs evolve, they must become institutionalized to ensure their continued success when US military assistance is withdrawn.

f. If possible, *interregional* cooperation between neighboring countries and programs should be encouraged. This assists in strengthening relationships between countries and also optimizes the use of scarce resources in the training and development arenas.

g. Resources in most instances will fall short of need. There will rarely, if ever, be sufficient US 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 of uncorrectable conditions are beyond the scope of these programs. To provide continuity, these health care programs (carefully coordinated with the HN) will require—

- A well-published focus to a given area.
- A schedule to provide return visits.

CHAPTER 3

HEALTH SERVICE SUPPORT ASPECTS OF COMBATTING TERRORISM

3-1. General

a. Terrorism and the threat of terrorism have become a reality in the modern world. Terrorism can occur throughout the operational continuum. It is defined as the unlawful use or threatened use of force or violence against people or property to coerce or intimidate governments or societies, often to achieve political, religious, or ideological objectives. Combatting terrorism consists of those actions (including antiterrorism and counterterrorism) taken to oppose terrorism.

b. The tactics used by terrorists include, but are not limited to, bombings, hijackings, assassinations, and kidnappings. The immediate objectives of terrorism are—

- Recognition.
- Coercion.
- Intimidation.
- Provocation.
- Insurgency support.

c. Further information on combatting terrorism is contained in FM 100-20 and FM 100-37.

3-2. Antiterrorism

Antiterrorism consists of those defensive measures used to reduce the vulnerability of personnel, family members, facilities, and equipment to terrorist acts. This includes the collection and analysis of information to accurately assess the magnitude of the threat. (For the collection of medical information, refer to paragraph 1-6 and FM 8-10-8.)

3-3. Counterterrorism

Counterterrorism is comprised of those offensive measures taken to prevent, deter, and respond to terrorism. Health service support elements are not directly involved in the counterterrorism aspects of an operation. However, these HSS elements provide traditional HSS to US and friendly forces engaged in these operations.

3-4. Planning Considerations for Health Service Support Aspects of Combatting Terrorism

a. The commander must plan for and conduct active programs which reduce his units vulnerability to terrorist actions. A balance must be reached that maintains an appropriate level of vigilance, security, and confidence. This balance should not adversely impact on the mission and result in undue suspicion, stress, and a siege mentality.

b. The medical planner must be aware of the terrorist threat in the planned AO. He must incorporate appropriate safeguards and considerations into the HSS plan. These considerations include, but are not limited to—

(1) *Medical.*

- Threat capability for the use of NBC weapons/agents (Appendix B).
- Provisions for laboratory support to identify suspect agents.
- Special immunization or prophylaxis for potential biological agents.
- Command information stressing individual protective measures to include personal hygiene and sanitation.
- Provisions for safeguarding and testing food and water supplies.
- Provisions for the treatment of contaminated water sources.
- Stress control resources for debriefing victims of a terrorist attack.
- Provisions for suspect agent therapeutics.
- Medical evacuation under hostile fire or in adverse terrain.
- Mass casualty situations.
- Augmentation or reinforcement of me dical personnel, supplies, and equipment.
- Evacuation and hospitalization.

- Plans for continued care in the event the medical treatment facility (MTF) is the target of a terrorist attack.
- Care of government-owned animals used in antiterrorism operations.
- Task-organized rapid response teams. (Refer to Appendix L for information on *non-table of organization and equipment* medical teams.)

(2) *Nonmedical.* (Refer to FM 1OO-37 for additional information.)

- Terrorist threat.
- Potential targets.
- Terrorist bomb awareness and countermeasures.
- Operational 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 AO.
- Limiting access to MTFs by reducing the number of entry and exit points.
- Screening personnel seeking access to the facility.

3-5. Preparation and Training

a. It is not sufficient to only plan for mass casualty situations. All plans must be practiced by those who will participate when they are implemented. Both planning and practice must be flexible enough to account for the disruption and reduced capability which may result from a terrorist act. By using practice situations, the commander ensures that the required internal and external coordination has been affected. The practice also ensures that the unit or MTF personnel are familiar with their duties and assignments during an actual situation. At a minimum, the mass casualty plan should be exercised at least twice yearly, and more often in highly vulnerable locations. Contingency plans must also be prepared to conduct the medical mission, even if the MTF is the terrorist target.

b. All newly assigned personnel should be provided with an orientation that addresses—

- The terrorist threat.
- Their role in combatting terrorism and in mass casualty situations.
- What to do if the MTF is the target of terrorists.

c. Unit training should be conducted on topics such as—

- Security.
- Terrorist bomb awareness and countermeasures.
- How to talk to terrorists or hostage takers until relieved by law enforcement experts.
- Dealing with bystanders to terrorist incidents.
- Psychological debriefing and medical management of hostages upon rescue or release.
- Force survivability.
- Nuclear, biological, and chemical defense.
- Other pertinent topics.

d. To more effectively use medical personnel, nonpatient care personnel assigned should be instructed in support duties, such as—

- Driving.
- Ensuring the security of the unit area.
- Carrying litters.

CHAPTER 4

HEALTH SERVICE SUPPORT ASPECTS OF PEACEKEEPING OPERATIONS

4-1. General

a. Peacekeeping operations are military operations conducted with the consent of the belligerent parties to a conflict to maintain a negotiated truce and to facilitate a diplomatic resolution. The US may participate in peacekeeping operations under the auspices of an international organization, in cooperation with other countries, or unilaterally. Peacekeeping operations support diplomatic efforts to achieve, restore, or maintain peace in areas of potential or actual conflict.

b. For information concerning the organization and force composition of peacekeeping forces, refer to FM 100-20.

4-2. The Army Medical Department Role in Peacekeeping Operations

a. The primary mission of the AMEDD is to provide HSS to the peacekeeping force. This force may consist of elements from one or a number of the services, and may be a multinational force.

b. A theater medical evacuation policy is established based on the capabilities of the in-country medical resources. The evacuation policy normally permits only limited treatment and holding capability in-country with evacuation from the AO for definitive treatment.

c. Due to the inherent neutrality of a peacekeeping force, it is important for AMEDD units and personnel to adhere to the parameters of their stated mission. Only those missions involving HN personnel or facilities which are authorized by the command authority should be accomplished. Independent, unplanned medical civic assistance programs are not to be undertaken by the medical element of the peacekeeping force.

4-3. Planning Considerations for the Health Service Support Aspects of Peacekeeping Operations

a. The HSS package for a peacekeeping force is often constrained in size; therefore, it must be carefully tailored to satisfy mission-unique requirements. Preventive medicine measures (Appendix D) must be employed and receive command emphasis to minimize the medical threat. The disease and nonbattle injury (DNBI) rate is more significant on these operations than are combat wounds. Stress factors in peacekeeping operations may cause stress disorders. These disorders include misconduct reactions (unacceptable behavior) which may threaten success of the peacekeeping mission. Mental health and stress control personnel can help prevent or manage these complications (Appendix F).

b. The medical support package for a peacekeeping operation must be specifically tailored to meet the needs of and be compatible with the size of the supported force. If a brigade or division force is deployed, sufficient organic medical resources should be included in the force composition. Additionally, augmentation from corps assets (corps support slice) may be required.

c. For successful medical operations, the medical planner must ensure that—

- The size of the HSS element is sufficient to provide adequate but austere care.
- Logistical links for resupply of Class VIII supplies are well defined.
- Medical evacuation means and routes are planned for, as well as effecting the necessary coordination with other services and allied nations.
- Veterinary support is sufficient for surveillance of foodstuff and care of government-owned animals.
- A mass casualty plan is prepared and provision is made for the practice of the plan.
- Alternate sources of HSS 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 HN physicians, if available.
- Allied nation capabilities for emergency care and hospitalization.

- Contingency plans are required for HSS in the event of the withdrawal of the peacekeeping force or the escalation of hostilities. If hospitalization support is not available within the immediate area, plans must be coordinated with those units providing hospitalization support. In light of the potential terrorist threat in peacekeeping operations, it is imperative that hospitalization (location, characteristics, laboratory, blood supply, and capacity) support be available in the event of a mass casualty situation.

- Health service support elements 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 within the area. Additional information on passive defense measures is contained in FM 100-37.

CHAPTER 5

HEALTH SERVICE SUPPORT ASPECTS OF PEACETIME CONTINGENCY OPERATIONS

5-1. General

a. Peacetime contingency operations are politically sensitive military activities normally characterized by the short-term, rapid projection or employment of forces in conditions short of war. They are often undertaken in crisis avoidance or crisis management situations requiring the use of military instruments to enforce or support diplomatic initiatives.

b. This chapter discusses the HSS considerations and planning factors for the major types of operations in this category. Each of these operations is unique to the mission, size of the force, and the level of hostilities encountered. The HSS package will vary with each operation. However, maximum use of the organic assets of the force employed should be accomplished. Additional tailoring or reinforcement of these organic assets is accomplished to meet the anticipated need.

c. Information on the military aspects of these operations is contained in FM 100-20.

5-2. Shows of Force and Demonstrations

a. Shows of force and demonstrations lend credibility to a nation's promises and commitments; increase its regional influence; and demonstrate its resolve to use military force as an instrument of national power. Additionally, the NCA orders these operations to bolster and reassure friends and allies.

b. Health service support for shows of force and demonstrations follows the traditional role of providing HSS to a combat force.

(1) The size of the combat force, the mission, the duration of the operation, the assessment of the medical threat, and the anticipated level of hostilities to be encountered determine–

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

(2) The medical planner must be included early on in the planning process for the mission. This is to ensure that adequate HSS resources are planned for and committed to support the operation. Further, if it is a joint or combined operation, the HSS package must be thoroughly coordinated with all parties involved to ensure there is not a duplication of or gap in the HSS.

5-3 Noncombatant Evacuation Operations

a. Noncombatant evacuation operations (NEO) are conducted to relocate civilian noncombatants from locations in a foreign country. These operations are normally conducted to evacuate US citizens whose lives are in danger; however, they may also include the evacuation of HN or third country citizens. These operations are of short duration and consist of rapidly inserting a force, occupying an objective, and a planned withdrawal. The amount of force used is normally limited to that required for self-defense and the defense of the operation. The level of hostilities encountered varies with each specific mission. The key factor in planning for this type of operation is the correct appraisal of the politico-military environment in which the operation is to be conducted.

b. Health service support to NEO is tailored to the size of the military force and the anticipated medical needs of the evacuees. Every effort is made to use the existing medical skills of the evacuees.

c. 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 medical 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, medical equipment and supplies, and the rapid medical evacuation of those seriously injured or ill).
- Potential for transferring diseases back to the US.
- Evacuation or disposition of privately-owned pets.
- Potential sources of food supplies and water.

5-4. Rescue and Recovery Operations

Rescue and recovery operations are sophisticated actions requiring precise execution, especially when conducted in hostile environments. They may be clandestine or overt. They may include the rescue of US or friendly foreign nationals or the location, identification, and recovery of sensitive equipment or items critical to US national security. The level of hostilities to be encountered will vary with each specific operation.

a. Rescue Operations. It is essential that HSS requirements are identified early in the planning process and incorporated into the operations plan. The medical condition (including age, nutrition, and the physical and mental condition) of the individuals or groups to be rescued needs to be determined so that appropriate medical personnel, equipment, and supplies are available. Other planning considerations include, but are not limited to the—

- Medical threat.
- Period of time the patients will need to be sustained before reaching definitive care.
- Anticipated level of hostilities and risk factors for the rescue party.
- Type and level of medical care those to be rescued have been receiving.

b. Recovery Operations. These operations receive HSS based on the requirements of the supported force. The medical support package is task organized to provide an appropriate mix of medical personnel, equipment, and supplies. Additional medical personnel may also be required if there is a potential for NBC contamination.

5-5. Strikes and Raids

The US conducts strikes and raids for specific purposes other than gaining or holding terrain. Strikes and raids can support rescue and recovery operations, or destroy or seize equipment or facilities which demonstrably threaten national collective security interests. They can also support counter-drug operations by destroying narcotics production or transshipment facilities, or supporting a host government's actions in this regard.

a. Planning.

(1) Conventional HSS planning (FM 8-55) is required to meet the needs of the forces deployed. However, because these operations may be conducted in areas without established military support bases, the only support available may be that which was preplanned and accompanied the force. Health service support planning, therefore, must be comprehensive, thoroughly coordinated, and flexible enough to meet unanticipated requirements. Additionally, sufficient medical resources must accompany the lead forces to ensure that medical care can be provided prior to the arrival of the main body of CSS elements.

(2) The terrain, weather, medical threat, and mission requirements may dictate that special equipment (such as mosquito netting or mountaineering equipment) will be required to accomplish the mission. The HSS planner must ensure that sufficient quantities are available to the medical personnel for their own use and, if need be, by their patients.

(3) In these short-duration operations, characterized by the rapid insertion of a combat force, environmental (heat and cold) injuries may

occur if there was insufficient time to acclimatize the force. For example, when moving troops from a cold climate to a tropical area, they may suffer from heat injuries. Proper planning can minimize this threat.

(4) Health service support planning should also include—

- Anticipated medical care requirements for EPWs, detained or retained personnel, and civilian casualties.
- Effects of the Geneva Conventions (FM 8-10) or other legal considerations on these operations.

(5) The medical evacuation of sick, injured, or wounded soldiers from the AO may require coordination with the other services. United States Air Force or Navy assets may be used to insert the force and may provide the only means of evacuating patients from the AO. Coordination for the backhaul of patients on nonmedical transportation assets, establishment of a mobile aeromedical staging facility (MASF), or the landing of Army air ambulances on US Navy ships must be affected if the evacuation mission is to be successfully accomplished.

(6) The HSS planner must also ensure that combat stress control personnel are available to debrief soldiers who are injured or wounded or who suffer from battle fatigue.

b. Urbanized Terrain. Throughout history, operations have been conducted on urbanized terrain. Some recent examples include Hue, Beirut, and Panama City. Military operations on urbanized terrain (MOUT) are those military actions planned and conducted on a terrain where man-made structures impact on the tactical options available to the commander. This terrain is characterized by a three-dimensional battlefield, having considerable rubble, ready-made fortified fighting positions, and an isolating effect on all combat, CS, and CSS elements. In this environment, the requirements for a sound and understandable HSS plan cannot be overstated. Of concern to medical and tactical planners, alike, is the need to plan; train; prepare; and equip for the location, treatment, and evacuation of wounded from under, above, and at ground level. Additional information on combat in builtup areas is contained in FM 90-10 and FM 90-10-1.

(1) *Medical threat.* Military operations conducted in builtup areas result in significant differences in both the frequency and types of diseases and wounds experienced.

- Civilian populations may experience increasing disease rates as well as less common diseases as a direct result of the environmental conditions imposed by MOUT. Human defenses to all endemic diseases are reduced by–
  - Lack of hygiene.
  - Exposure.
  - Hunger.
  - Anxiety.
- The deliberate introduction of infectious diseases via water, food, aerosols, human carriers, or contaminated material can be expected from some adversaries (Appendix B).
- The razing of structures creates rodent and arthropod shelters. The interruption of water and sewer systems, disruption of garbage collection and health services, and the presence of carrion combine to promote the rapid expansion of rodent and arthropod vector populations and the endemic and epidemic diseases they transmit.
- Secondary wounding missiles will be common from the abundance of glass, steel, and stone. Building collapses will result in more numerous crush injuries. An increased potential for burns and inhalation injuries will result from burning fuels, vehicles, and structures; from smoke produced by these fires; and from toxic fumes and smoke generated by obscurants. Burns and smoke inhalation injuries will be further complicated by injuries from fuel air and other explosive devices.

(2) *Equipment requirements.* Materiel requirements for adequate HSS in MOUT includes unique equipment, especially for the extraction and

evacuation of casualties. This equipment can include, but is not limited to—

- Axes, crowbars, and other tools to break through barriers.

- Special harnesses; portable block and tackle equipment; ropes; grappling hooks; collapsible stretchers; light-weight collapsible ladders; heavy gloves; and casualty blankets with shielding for lowering casualties from buildings or moving them from one building to another at some distance above the ground using pulleys.

- Equipment for the safe and quick retrieval from craters, basements, sewers, and subways. Casualties may have to be extracted from beneath rubble and debris.

- An increase in wounds and trauma injuries can be anticipated and will result in additional requirements for intravenous (IV) fluids and IV starter sets. Individual soldiers may carry these fluids to hasten their availability and shorten the time between wounding or injury and the initiation of vascular volume replacement. This also reduces the weight and cube of supplies carried by the medical treatment teams. In situations where troops are suffering from severe heat exhaustion or environmental injuries, such as heat stroke, the fluid may be taken orally if an IV starter set is not available.

- Air ambulances equipped with a rescue hoist may be able to evacuate casualties from the roofs of buildings or may be able to insert needed medical personnel and supplies.

- Effective communications face many obstacles during MOUT. Line of sight radios are not effective and individual soldiers will normally not have access to radio equipment. The use of alternate forms of communications, such as markers, panels, or field expedients (fatigue jackets or T-shirts), which can be displayed by the wounded or injured soldiers indicating where they may be found should be considered.

(3) *Medical evacuation.*

- Medical evacuation in the MOUT environment is a labor-intensive effort. Due to rubble, debris, barricades, and destroyed roadways, much of the evacuation effort must be accomplished by manual litter teams. When this occurs, an ambulance shuttle system or a litter shuttle should be established.

- Casualty collecting points should be established at relatively secure areas accessible to both ground and air ambulances. Collecting points should be designated in advance of the operation and should—

- Offer cover from enemy fires.

- Be located as far forward as the tactical situation permits.

- Be identified by an unmistakable feature (natural or man-made).

- Allow rapid turnaround of ambulances.

- Be well - separated from fuel and ammunition depots, motor pools, reserve forces, or other lucrative enemy targets, as well as civilian hazards such as gas stations or chemical factories.

(4) *First aid skills.* Self-aid, buddy aid, and combat lifesaver skills are essential. Due to the isolated nature of this combat environment, injured and wounded soldiers may not be reached by the combat medic for extensive periods of time after the injury or wound has been sustained.

(5) *Civilian casualties and refugees.*

(a) In MOUT, civilian casualties occur. To the greatest extent possible, civilian casualties should be treated by local HN medical personnel and facilities. The injuries sustained by the civilian population can be caused by direct action (such as being caught in a cross fire) or by indirect action (such as the collapse of a structure which was weakened by military action). In either case, humanitarian assistance may be required to

perform lifesaving procedures. Once stabilized, these casualties are transferred to a HN facility. The HSS planner must, therefore, plan for additional logistics support; higher than normal medical supply stockage levels; additional equipment; and augmentation or reinforcement of the deployed medical assets.

(b) In addition to the casualties mentioned above, the number of refugees may increase rapidly as the operation progresses. Due to the potential overcrowding, lack of sanitary facilities, and increased requirements for potable water and food supplies, the medical threat to both the civilian population and military personnel will become unacceptable. Coordination with the HN medical infrastructure should be accomplished to provide essential health services to the refugee population.

(c) Health service support planners must ensure that the potential requirements for providing humanitarian assistance and PVNTMED measures to the civilian community are incorporated early on in the plan. This is necessary to ensure that the level of HSS to our forces is not degraded by the civilian casualty or refugee situation. Specific planning considerations include—

- Estimated patient work load and types of injuries.
- Requirements for the rendering of emergency pediatric, obstetrical, and gynecological care.
- Duration of the operation and hour of day in which the operation is initiated.
- Population density in the AO.
- Location and availability of Class VIII.
- Availability of sanitary facilities.
- Location of refugee camps or holding areas and anticipated duration of stay in area.
- Location and availability of potable water.
- Location and availability y of local food supplies or Class I.
- Endemic diseases and pest management.
- Veterinary resources for ensuring the wholesomeness of locally procured food supplies and surveillance for use in humanitarian activities.

5-6. Peacemaking Operations

a. Peacemaking operations are intended to establish and restore peace and order through the use of force. The US conducts these operations when it is in the national interest to stop a violent conflict and to force a return to political and diplomatic methods. The US typically undertakes peacemaking operations at the request of appropriate national authorities in a foreign country. It may also conduct these operations to protect US citizens as part of an international, multilateral, or unilateral operation.

b. Health service support elements are tailored to the size of the peacemaking force; the level of hostilities to be encountered and the anticipated duration of the mission. The requirements for HSS of this type of mission are to provide medical care in an austere environment with medical evacuation out of the AO for more definitive care. The HSS planner should be included in the mission planning process to ensure that adequate medical resources are provided. The HSS planner should consider, but not be limited to, the following:

- Medical threat.
- Anticipated patient load.
- Anticipated areas of patient density.
- Sanitation and disruption of garbage disposal, water, and sewer services.
- Anticipated civilian casualties requiring medical care.

- Anticipated EPW medical care requirements.
- Lengthening LOCs.
- Medical evacuation, including collecting points, ambulance exchange points, and ambulance shuttle systems.
- Location of hospitalization assets or services.
- Coordination with other service branches, allies, and HN.
- Operations conducted on urbanized terrain.
- Medical supply and resupply requirements and procedures.

5-7. Unconventional Warfare

a. Unconventional warfare (UW) is a broad spectrum of military and paramilitary operations. These operations are normally of long duration, and 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 UW are special operations forces (SOF). (For additional information concerning SOF, refer to Appendix M.)

b. The goals of medical operations in support of UW are to conserve the guerrilla forces' fighting strength and to assist in securing local population support for US and resistance forces operating within joint special operations areas (JSOAs).

c. Medical elements supporting the resistance forces must be mobile, responsive, and effective in preventing disease and restoring the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a *logistical* problem.

d. In an UW situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points. This permits the remaining members of the resistance force to continue fighting. Casualties at collecting points are later evacuated to the guerrilla base or to a guerrilla medical facility. As the operation develops, evacuation of the more seriously wounded, injured, or diseased personnel to friendly areas is accomplished by establishing clandestine evacuation nets if security does not permit using aeromedical evacuation.

e. Medical requirements within the JSOA differ from those posed by conventional forces. In UW, battle casualties are normally fewer and the incidence of disease and malnutrition is often higher.

f. Overlaying conventional military medical assets on UW operations can only be accomplished if it does not compromise the security of the mission.

5-8. Disaster Relief

a. Disaster relief operations provide emergency assistance to victims of natural or man-made disasters abroad. These operations are responses to requests for immediate help and rehabilitation from foreign governments or international agencies. They may include—

- Refugee assistance.
- Food programs.
- Medical treatment and care.
- Other civilian welfare programs.

b. Medical assistance requires a rapid assessment of the medical needs produced by the disaster and the rapid tailoring of a medical element to deal with the disaster.

- Preventive medicine plays a key role in the relief effort as natural disasters can disrupt

the ecological balance, causing potential outbreaks of disease. Measures to ensure needed sanitation and pest management must be planned for and implemented as soon as possible after the occurrence. Organization of education efforts and other public health measures to help victims resist potential disease outbreaks are important aspects of PVNTMED and community health nurse support.

- The medical treatment rendered is austere and may possibly be provided in rudimentary facilities.

- The medical element must be able to rapidly reach the disaster site with the right mix of medical specialties. Deploying a medical facility which is too late or too cumbersome does not provide the effective assistance needed.

- The medical element should have the capability to interact with victims in their own language.

- Stress control measures should be applied before, during, and after the operation. These measures are used to maintain effective performance and minimize posttraumatic stress disorder among care givers, as well as victims.

APPENDIX A

SOURCES OF INFORMATION FOR LOW INTENSITY CONFLICT OPERATIONS

A-1. General

Commanders and staffs should use their established intelligence channels to obtain much of their medical intelligence requirements for their specific missions. This listing of informational sources is provided as a guide and is not an all-inclusive listing. Refer to FM 8-10-8 for information on requesting intelligence products.

A-2. Information Sources

Information sources include–

a. Armed Forces Medical Intelligence Center
Fort Detrick, Frederick, Maryland 21701-5004

(1) The AFMIC is a joint agency of the military departments. It is the primary Scientific and Technical Production Center for foreign general medical intelligence (GMI) and medical scientific and technical intelligence (S&TI) within the DOD.

(a) Intelligence products include–

- Medical Capabilities Studies which are prepared on most countries of the world. They identify environmental factors, medical capabilities of both military and civilian medical sectors, indigenous infectious diseases, and poisonous flora and fauna.

- Disease Occurrence Worldwide which is prepared monthly. This publication presents current intelligence and information on military significant diseases throughout the world.

- Scientific and technical intelligence products which are prepared on military significant research and development of medical relevance within foreign military and civilian scientific communities.

- The Weekly Wire which is an electronic message that transmits current medical intelligence items of interest to the medical planner.

- The Medical Facilities Handbook, a four-volume reference set on hospital facilities with major geographical areas worldwide. Each volume provides an alphabetical listing of major medical facilities within each foreign country. Specific information provided on each hospital includes location, bed space, available medical capabilities, emergency capabilities, x-ray, laboratory and ambulance services, plus other relevant information.

(b) The Armed Forces Medical Intelligence Center can respond to time-sensitive Quick Reaction (QR) intelligence production requests from the user community. A QR tasking may be accepted if the requirements of the task can be completed in a maximum of 40 man-hours of analytical work. Responses can be requested telephonically and are provided to the requester in hard copy.

(c) The Armed Forces Medical Intelligence Center has an Emergency Operations Center (EOC). The EOC is prepared to respond to crisis situations where intelligence requirements are needed to support military medical operations. Upon activation, the EOC is manned on a 24-hour basis.

(d) Armed Forces Medical Intelligence Center support can be obtained through intelligence channels or, should the situation demand, direct contact with the center. The following information is provided in the event that direct contact is required:

Letter address:
Director
Armed Forces Medical Intelligence Center
ATTN: AFMIC-OPS
Building 1607, Fort Detrick
Frederick, MD 21701-5004

Message address:
DIRAFMIC FTDETRICKMD//
AFMIC-ZA//

Telephone numbers:
Director's Office
AUTOVON: 343-7511
Commercial: (301) 663-7511

Tie-line from District of Columbia area:
393-1839, Extension 7511 or 7603
FTS: 935-7511
AFMIC Medical Intelligence Integration Officer
AUTOVON: 227-8233
Commercial: (202) 697-8233

Secure phone:
KY2201, STU II: ID No. 03305
AUTOVON: 343-7511
Commercial: (301) 663-7511

(2) Additional information concerning AFMIC intelligence products can be found in DOD 6420.lR and FM 8-10-8.

b. Department of Defense Armed Forces Pest Management Board (AFPMB).

(1) The AFPMB is a tri-service organization encompassing the entire pest management community within DOD. The Board is tasked with providing vector control advice and assistance to the DOD, Office of the Joint Chiefs of Staff (OJCS), and the unified commands.

(2) The AFPMB has a Contingency Advisory Group (CAG) which is a standing body within AFPMB to address pest management issues relating to deployable forces. The CAG seeks solutions to problems identified by past contingency operations or member experience, and responds to requests for guidance or information from field sources. The Contingency Liaison Officer (CLO) has the primary mission to support contingency and readiness issues and the requirements in the operational vector control and PVNTMED arena. This officer gives the highest priority to responding to requests from operational commands for information or assistance, including on-site visits upon request.

(3) The AFPMB can assist in contingency planning and operations by—

- Providing current information on the specific vectorborne disease threat in any part of the world, and the potential impact on military operations.
- Coordinating on-site evaluations of disease vector problems in any part of the world by appropriate area experts.
- Advising operational planners on how to ensure that no gaps exist in vectorborne disease control coverage in any deployment scenario. The ready availability of vector control information from all the services can save considerable time and effort on the part of operational planners not familiar with that subject area.
- Recommending the most practical vector control methods for a given situation—from back-pack sprayers to vehicle-mounted sprayers for control in small areas, to aerial spray by dedicated USAF fixed-wing aircraft capable of controlling vectors over hundreds of square miles.
- Identifying resources (personnel, equipment, military units) appropriate for providing vector surveillance and control in given situations.
- Assisting in developing training materials to emphasize the importance of personal protective measures in disease prevention.

(4) The Defense Pest Management Information Analysis Center (DPMIAC) is a part of the AFPMB. Services include—

- Technical consultation on vectors and pests, as well as management of natural resources within the scope of the DOD and other federal agencies.
- Retrospective bibliographic literature searches on pest management and natural resources as requested.
- Selective Disseminations of Information (SDIs) in specific areas of coverage. (Users may request one or more SDI categories on which they wish to receive periodic bibliographic updates.)

- Distribution of a monthly Technical Information Bulletin which highlights current information on pesticides, hazardous waste, natural resources, and medical entomology.

- Dissemination of the Global Pesticide Resistance Inventories for countries throughout the world.

- Development and distribution of Disease Vector Ecology Profiles (DVEPs) of foreign countries, throughout the world. These profiles provide tabular summaries on the epidemiology, mode of transmission, and bionomics of arthropod disease agents and their vectors, and other epidemic diseases, as well as information on hazardous and venomous animals.

- Maintenance, publication, and distribution of the Directory of DOD Pest Management Professionals and Natural Resource Managers.

(5) Inquiries should be addressed to:

Executive Director
Armed Forces Pest Management Board (AFPMB)
ATTN: Contingency Liaison Officer
Forest Glen Section
Walter Reed Army Medical Center
Washington, DC 20307-5001
MSG Address: AFPMB WASHINGTON, DC

c. Army and Air Force Center for Low Intensity Conflict (CLIC), Langley Air Force Base (AFB), Virginia 23665-5000. The CLIC produces CLIC PAPERS which are an informal, occasional publication sponsored by the Center. They are dedicated to the advancement of the art and science of the application of the military instrument of national power in the LIC environment.

d. Current and past articles published in *Military Review* by the US Army Command and General Staff College, Fort Leavenworth, Kansas 66027-6910.

e. World Health Organization, Director, Division of Communicable Diseases, 1211 Geneva 27, Switzerland. The WHO has reports on PVNTMED and sanitation subjects which may be germane to LIC missions.

f. Your servicing military or civilian library which can provide bibliographic information on areas of specific interest.

APPENDIX B

NUCLEAR, BIOLOGICAL, AND CHEMICAL WARFARE CONSIDERATIONS

B-1. Threat

a. The potential for the employment of NBC weaponry against a deployed US force must be considered a condition of the battlefield by commanders at all levels. The ease of NBC employment, the difficulty of identification and treatment, and most importantly, the publicity value of even a minor biological agent attack lends itself well to the LIC environment. The use of an agent, either chemical or biological, would rapidly focus international attention on the US force deployed, its mission, training, and readiness posture to protect itself. Further, a terrorist organization claiming responsibility for the attack would receive media attention which is frequently their goal. In this regard, chemical agents with their historical shock value would be particularly well suited from the terrorist standpoint to gain the maximum psychological impact.

b. The ability of small organizations (especially terrorists) to either produce or procure supplies of chemical or biological warfare agents has been documented. The degree to which such agents pose a threat against a deployed US force is dependent upon the goals and objectives of the terrorist organizations. As such, the degree of threat must be developed from the standard threat indicators formula—capabilities + intentions = threat. This threat must be addressed as a part of the overall threat identification process. Protective procedures can be developed by the commander following this NBC threat assessment. Protective measures for a commander to consider fall into the following categories:

- Training.
- Protection.
- Detection and identification.
- Prophylaxis.
- Contaminant avoidance.
- Decontamination (patients, personnel, and materiel).

B-2. Biological Weaponry

a. Biological weaponry ranges in spectrum from sophisticated, specifically engineered infectious microorganisms and toxins produced in modern biotechnology laboratories, to simple expedient food contaminants employed by insurgents or terrorists in the LIC arena. Gross contamination of water supplies or ingestion of adulterated foodstuffs present the most likely mode of biological agent delivery. Commonly used techniques which have been employed in the LIC arena include—

- Sharpened stakes (Punji stakes) smeared with human or animal waste to cause infection in addition to the actual puncture wound.
- Water source contamination using infectious waste (discarded bandages or medical dressings), animal and human excreta, or remains. This also includes contamination of ice sources.
- Contamination of locally procured foodstuffs with infectious organisms.
- Direct contamination of foodstuffs by locally hired cooks and food handlers sympathetic to or coerced by insurgents or terrorists.

b. In considering the threat posed by biological weaponry, the primary means of protection available to US forces remains those PVNTMED measures directed in the deploying unit's Processing for Overseas Replacement/ Movement (POR/POM) operating procedures, that is, maintaining current immunization status. Once deployed, the most effective means to counter a biological threat is through a rigorous field sanitation program incorporating water and food inspection by qualified personnel, a certification program for the hire of local nationals, and a health care program to closely monitor the health of the command. In this last case, health care personnel must be alert to any increase in infectious disease rates or disease cases not commonly found in the AO, and keep the commander informed as they occur. Medical observation continues to be the

primary warning available as field biological agent detectors are not available.

c. Suspected or confirmed incidents of biological warfare are reported through the Special Telegraphic Reports of Selected Diseases (RCS MED-16[R4]). Format for report is provided in AR 40-400 and through NBC reporting procedures as outlined in FM 3-3.

d. Treatment of biological agent patients is based on symptomatic indicators.

B-3. Chemical Weaponry

a. Chemical weaponry provides the terrorist or insurgent with a capability to produce casualties and capture media attention as does no other single weapon at his disposal. Chemical agents are relatively easy to make and to employ; their effects are immediate and dramatic; in short, they are ideal weapons in the political-military media wars of LIC. Chemical weapons are used for their injury or death production mechanism, especially the well-known variety of toxins and incapacitating agents. It is this last category which most potentially threatens the deployed US force. Possible means by which agents can be employed include:

- Terrorist or insurgent chemical attack using locally made low-strength agents.
- Water source contamination.
- Contamination of foodstuffs.
- Direct contamination of foodstuffs by locally hired cooks and food handlers.
- Terrorist or insurgent chemical attack using chemical weapons provided through a country sympathetic to terrorist cause.
- Indirect exposure to irritant and riot control agents.

b. Although not classed as chemical agents (weapons), incendiary/flame munitions, phosphorus compounds, and irritants (CS and CN) will most likely be encountered by US Army forces in a LIC environment.

c. The NBC defense principles of training, prevention, contamination avoidance, detection, protection, and decontamination apply in LIC as well as mid- to high-intensity conflict. United States forces must try to avoid or limit the spread of contamination. Chemical protective measures for US forces involved in deployments generally fall into two categories: detection and avoidance, or physical protection. As is the case of biological agent protection, a thorough food and water sanitation program greatly reduces the possibility of a clandestine chemical assault achieving its goal. In the area of an overt chemical attack, or indirect exposure, physical protection measures and supporting equipment are readily available to the force commander for detection and protection. Detection and decontamination are essential to enable units to decrease their mission-oriented protection posture (MOPP) level. Individud and unit training on basic soldier skills and leader tasks with emphasis on preparing and reacting to NBC attack, MOPP gear use, and identification, detection, and warning procedures are the keys to protection of the force.

d. Signs, symptoms, first aid, patient decontamination, and medical treatment procedures for chemical agent casualties or military chemical injuries are provided in FM 8-285.

B-4. Nuclear Weaponry

a. The employment of nuclear weapons in a LIC environment is not likely; however, commanders must be prepared for their use. The impact of nuclear weapons would rapidly escalate a LIC environment into a major conflict.

b. The use of radioactive material to contaminate food and water supplies is a more likely method of employment by insurgent or terrorist organizations. Monitoring food and water is a must. Special laboratory support and devices may be required.

c. Food suspected of being contaminated with radioactive material must be inspected by veterinary personnel. They will determine if the food can be used as is, decontaminated then used, or must be destroyed.

d. Preventive medicine personnel will evaluate the water supply to determine if it is safe to consume.

B-5. Operations Under NBC Conditions

Operations under NBC conditions for US forces will cause additional concerns for medical units. Increased incidence of heat casualties may occur due to prolonged wearing of MOPP gear. An increased number of psychological casualties may also occur from personnel thinking they were exposed to chemical agents. Additionally, if persistent blister agents are used, significant resources may be required to care for these patients. Due to the slow wound healing, these injuries require a long and intensive treatment process.

APPENDIX C

VETERINARY SUPPORT IN LOW INTENSITY CONFLICT

C-1. General

The veterinary service can contribute to the success of the MEDOLIC mission objectives by helping to improve the public health of the population with such programs as: immunizations for zoonotic animal diseases; public health and sanitation training and training in food hygiene, safety, and inspection techniques. In LIC, the interrelationship of human and animal health, disease transmission, and economics is often complex. It can affect the overall health status of the country. Livestock animals (horses, cattle, and hogs) affect both the economy and public health. The care and immunization of these important resources merit attention in the planning and resourcing of HCA 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.

C-2. Support for Counterinsurgency

The use of veterinary resources and expertise in counterinsurgency includes support to US troops, assistance to HN military forces, and the enhancement of the stability of the HN government.

a. The support of US troops is largely characterized by traditional services rendered by the veterinary service, such as—

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

b. As US military medical involvement increases, the veterinary service can assist in the assessment of the HN's veterinary programs. They can provide guidance, training, and treatment of the HN's military animal care program (including pack animals and military working dogs). Further, the veterinary service can assist in establishing a food procurement system (if one does not exist) or in enhancing an already existing system.

c. The US veterinary service's most challenging and nontraditional roles include enhancing the stability of the HN government and assisting in establishing programs that benefit the HN's populace. Veterinary service participation in HCA activities must be thoroughly coordinated, through the country team. Coordination with such agencies as the Department of State, USAID, the US Department of Agriculture, and HN counterpart agencies may be required. (The US Army veterinarian is not a member of the country team. Face-to-face coordination with relevant members of other US governmental and HN agencies, however, is indispensable if veterinary programs are to be successful.)

(1) The USAID is responsible for helping HNs improve their health care systems (including veterinary care). The US Department of Agriculture is often involved with developing these programs. Both agencies are frequently not on-site for executing programs, but rather contract with outside agencies for the actual implementation.

(2) The US military often has veterinary resources and the logistical support system already in-country to execute and effectively promote such programs. The military veterinarian (after thorough research, coordination, and assessment of his capabilities and resources) can develop courses of action to support the overall veterinary effort.

d. Well-developed veterinary programs have the ability to impact across a wide range of interests (such as public health, medical, nutritional, and economic). These programs must complement the social, religious, and political factors present in the HN. Proposed veterinary programs require the development and evaluation of programs which address the specific problem areas that tend to foster the insurgency in a given region. For example, if the principal issue underlying the insurgency is a religious one, the application of a successful program to eradicate *brucellosis* in goats

will have little impact on the HN's ability to survive the insurgency. On the other hand, if the central dilemma is an expanding population without economic growth, the insurgent may base his strategy on the HN's inability to provide for the 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. This disease control 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 gives the populace the perception that their status in life is improving. 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 HN government.

e. In developing, coordinating, and establishing US military veterinarian support to the FID effort, several factors must be considered.

(1) The primary issue is to determine the specific veterinary support required. If the mission is a combination of activities, then priorities must be established. Once the mission is established, the level of veterinary resources and assets available is determined, then the following considerations may apply:

- Human and animal disease prevalence data.
- Status of agricultural production systems.
- Determination of the local names for common diseases.
- Climatic factors (rainfall, temperature, dry and wet seasons).
- Soil factors (pH, deficiencies).
- Agriculture economics (market systems, cooperatives, banking).
- Infrastructure (roads, rivers, electric power).
- Availability of animal foodstuffs.

(2) The programs which are designed and developed must consider all of the factors presented in paragraph C-2*e*(1) above. The programs which are developed should focus on long-term projects, as the *quick fix* should also be avoided in this arena. However, there are a number of programs which can be developed which could require only short-term US military involvement. These include, but are not limited to—

- Vaccination programs in which single dose application provides lasting immunity.
- Village-level external parasite control facilities (dipping vat construction projects).
- Vampire bat control programs.
- Water well and windmill construction in selected areas to improve animal grazing capabilities.
- Local control of toxic grazing plants.

(3) Long-term programs to improve animal health and increase production based on solid economics with the phaseout of US assistance are optimal solutions for changing some of the environmental conditions that insurgents focus on. Such programs must be developed after extensive evaluation by regional experts. Programs requiring active participation by local financial institutions have a tendency to be extremely successful. They provide incentive, produce tangible rewards, and succeed. 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 hoof-and-mouth disease in order to secure the loan.

C-3. Combatting Terrorism

The veterinary service should be involved in the planning to counter the terrorist threat. The veterinary service may play a key role in anti-terrorism. The terrorist threat may include the employment of NBC weapons. Veterinary service

personnel, therefore, must be alert to the potential use of these agents and report any suspected use to the appropriate authorities. Personnel, animals, and food supplies and sources (such as crops) are highly susceptible to biological agents. Veterinary personnel must be prepared to inspect suspect foodstuffs and care for affected animals.

C-4. Peacekeeping Operations

Veterinary support is required in most peacekeeping operations.

a. Due to the nature of these operations, field expedient procurement systems may be established. Veterinary assistance in ensuring that the food procured is safe is essential.

b. In these operations, military working dogs may be required to perform many tasks. Veterinary support is required to sustain the use of these and other government-owned animals.

C-5. Peacetime Contingency Operations

a. Noncombatant Evacuation Operations. The required veterinary support in NEO depends upon the planned length of the operation and whether privately-owned pets will be abandoned, euthanized, or retrograded.

(1) If privately-owned pets are retrograded with the evacuees, veterinary support is required to ensure that exotic foreign animal diseases are not transferred to the US. If the pets are to be euthanized, veterinary support is required to ensure that the process is conducted in a safe and humane manner.

(2) During NEO requiring several days to complete, the prevention of food and waterborne diseases is important. In these operations, local food supplies are normally used to feed the evacuees while they are in the assembly area. As a result of the factors leading up to the necessity to conduct a NEO, the food supplies are often severely deteriorated. This subsistence requires careful inspection by highly trained and experienced personnel to ensure food wholesomeness, hygiene, and safety.

b. Humanitarian Assistance. Food supplies used in disaster relief operations are normally quickly procured, often without proper specifications, and usually approximate native diets. Veterinary personnel can help to ensure that only safe and wholesome food supplies are used. Further, veterinary service personnel can assist in the control of the spread of zoonotic diseases.

c. Security Assistance Surges. These operations normally consist of providing logistic support to a friendly or allied nation facing an imminent threat.

(1) *Food.* If the logistic support includes transporting subsistence, there will be an increased demand to inspect this cargo for wholesomeness. The conditions imposed by short notice operations may stress food due to the lack of refrigeration or other factors, thereby requiring additional inspections.

(2) *Animals.* The assistance provided may include government-owned working dogs or military pack animals. These animals will require veterinary support to sustain them and to ensure they remain disease free.

d. Unconventional Warfare. Veterinary personnel may provide training to indigenous guerrilla forces in establishing a food procurement system, inspecting food, caring for military working dogs and pack animals, and caring for and managing livestock.

APPENDIX D

PREVENTIVE MEDICINE SUPPORT IN LOW INTENSITY CONFLICT

D-1. General

a. Environmental disease, field hygiene and sanitation, and other PVNTMED concerns impact on the health of US forces employed in LIC. In LIC, the forces employed are often small independent units with limited personnel. The occurrence of DNBI and environmental injuries can adversely affect the success of the mission.

b. In furthering US national goals and objectives, military PVNTMED can be a major contributor to any US effort in a LIC environment. The very nature of military PVNTMED is conducive to the types of activities that support US policy objectives.

D-2. Medical Threat

a. General. The medical threat is traditionally evaluated for its impact on US forces and US military operations. In LIC, it must also be assessed in terms of its impact on the HN and its people. Low intensity conflicts often occur in developing nations where endemic disease and health deficiencies are prevalent. The medical threat is the driving force in the development of effective PVNTMED programs for both the US forces deployed and the HN across the operational continuum.

b. Arthropod-Borne Diseases.

(1) Few military personnel are aware of the magnitude of the medical threat posed by arthropod-borne diseases. These diseases are transmitted through the biting process of arthropods or by the physical transfer of disease organisms. Health service support planners and personnel operating in areas outside of the continental United States (OCONUS) must be aware of the total worldwide threat, as well as the specific threats in areas of potential and planned operations.

(2) In LIC, the level of sanitation, measures employed to control disease vectors, and the resources available to prevent and treat arthropod-borne diseases will vary. It must be remembered that US forces operating OCONUS are a highly susceptible population and are, therefore, particularly at risk when conducting LIC operations.

- In disease-endemic areas, the native population may appear fairly healthy. Actually, they can harbor low-level infections of the 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 a new host by arthropods. United States forces may be completely devoid of immune protection from a specific disease. Once they are infected by the pathogen being introduced into their system, it can reproduce unchallenged. The disease goes unchecked until it runs its course or terminates in the death of the host. In both cases, the individual is no longer effective in accomplishing his mission. Further, a portion of the available medical resources must be allocated to his care and treatment, and possible evacuation.

- Depending upon the mission, the resources required to treat large areas for the control of arthropods may not be available. United States forces are required to use personal protective measures to prevent contracting arthropod-borne diseases.

(3) During protracted conditions of conflict, areas of a country previously endemic but now free of diseases (such as malaria, yellow fever, and the 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 disrupts these controls, such as a shortage of —

- Pesticides.
- Fuel to run public health equipment and vehicles.
- Supplies of treatment drugs.

c. Foodborne and Waterborne Diseases.

(1) In areas of poor sanitation, locally-procured foods pose a high risk of disease for the LIC forces. Public health standards for food preparation to which US forces are accustomed are often absent in foreign countries. Further, food handlers are often carriers of disease that can be readily transmitted to unsuspecting patrons with the purchased food as the disease vehicle.

(2) Potable drinking water will be scarce in LIC operations. Low intensity conflict forces 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) The risk of foodborne and waterborne diseases to LIC forces can be minimized by command enforcement of basic PVNTMED principles.

- The risk of experiencing a foodborne illness must be weighed against the impact on relationships with your HN 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 US military food service personnel. Maximize the use of meals, ready-to-eat (MREs).

- Only drink water that has been treated to US military standards (usually 5 parts per million [ppm] chlorine residual). Do not use locally prepared ice. Ensure adequate water disinfection supplies (iodine tablets and calcium hypochlorite) are available.

(4) Commanders should be alert to the possibility of terrorist attacks on or contamination of US military water sources. Possible targets include water treatment plants and equipment, and water distribution systems.

(5) Use of local water treatment facilities may provide needed water sources for LIC forces. Such facilities may require upgrades to meet US drinking water standards. In all cases, they must be monitored continuously by US PVNTMED personnel.

d. Environmental Injuries.

(1) Heat injuries can quickly diminish the effectiveness of a fighting force. Commanders must enforce a liberal water consumption policy. They must also ensure that soldiers consume an adequate number of meals. Food intake is required to prevent the loss of calories, salt, and minerals through sweating. When possible, operations should be conducted in the cooler parts of the day to lessen the risk of heat injuries.

(2) 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. The commander, therefore, must ensure that a liberal water consumption policy is enforced.

D-3. Preventive Medicine Support for an Insurgency

a. The type and comprehensiveness of PVNTMED support for an insurgency depends on the needs of the insurgent movement and the legal authority to provide the support. For the insurgent forces, the incidence of disease and injury can be very high and can significantly reduce their combat effectiveness. The health risk to the insurgents is due in part to their–

- Limited number of personnel.
- Austere logistical system.
- Austere health care infrastructure.
- Tactical conditions.
- Environmental conditions.
- Disease prevalence.

b. A second aspect of insurgent support is concerned with the civilian population. As insurgent forces gain control over sections of the country, they

may need to provide basic services to the population that can no longer be provided by the local government. In this case, the effort would be to assist in providing public health and sanitation measures.

D-4. Preventive Medicine Support for Counterinsurgency

a. Host Nation Military.

(1) Preventive medicine support for the HN military can take several forms and should be conducted in a phased approach.

(a) The medical threat facing the HN military is evaluated and the PVNTMED measures to counter these threats are determined.

(b) An assessment of the HN military's capability to implement the required PVNTMED measures is completed.

(c) A PVNTMED plan is developed.

(d) When the plan is implemented, HN military participation is essential. Host nation military participation—

- Uses the local experience and expertise.
- Ensures that programs developed are correctly implemented and are not contrary to local political, economic, social, religious, and cultural practices and beliefs.
- Actively involves the chain of command to continue and institutionalize the programs.

(2) The types of programs which can be developed include–

- Field sanitation and personal hygiene training.
- Immunizations.
- Nutrition and food sanitation training.
- Water purification.
- Training a cadre of HN PVNTMED specialists to continue programs once US support is withdrawn.

b. Host Nation Civilian Population.

(1) Because many of the health problems in developing nations are conducive to public health and PVNTMED solutions, US military PVNTMED assets can play a significant role. Programs which can reduce the health risk and enhance the health status of the population include—

- Developing potable water systems.
- Introducing pest management methods and procedures.
- Enhancing or establishing waste disposal procedures.
- Enhancing maternal and child health care nutrition education.
- Administering immunizations.
- Other programs using the full gamut of PVNTMED expertise and experience.

(2) The PVNTMED measures and programs must be fully integrated into other HSS and civil-military activities (such as clinical, dental, veterinary, or engineering).

D-5. Preventive Medicine Support in Combatting Terrorism

The terrorist threat may include the intentional contamination of food and water, to include the use of NBC agents (Appendix B). As such, PVNTMED 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 treatment operations.

D-6. Preventive Medicine Support in Peacekeeping Operations

Peacekeeping forces are generally under strict size constraints and operate with an austere logistical support structure. It is essential, therefore, that a complete analysis of the medical threat be done. This analysis ensures that the medical assets are adequate for the needs of the deployed forces. Predeployment training on field sanitation and personal hygiene measures is necessary. The actual combat wounds which will be incurred in these operations are minimal. Disease and nonbattle injuries and environmental injuries will have the most impact on these forces. The majority of these conditions are preventable. Early refresher training and command emphasis on PVNTMED measures will decrease the threat to the peacekeeping force.

D-7. Peacetime Contingency Operations

a. The role of PVNTMED in peacetime contingency operations varies depending on the mission, the environmental condition, and the deployed force. Early involvement in the planning phase of the operation is essential. Assessment of the medical 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.

- The impact of endemic diseases may be reduced due to the short duration of many of these operations.

b. Noncombatant evacuation operations may present unique PVNTMED considerations. While hostilities may or may not be a part of the operation, the very requirement for evacuation indicates there is disruption of normal services. Breakdowns in the normal sanitary conditions, waste disposal, and health care may occur. Congregation of large numbers of personnel in limited spaces awaiting evacuation may aggravate these conditions. Measures may need to be taken to prevent the transfer of exotic diseases to CONUS.

c. Disaster relief and humanitarian assistance operations may be the most common noncombat operations in peacetime contingency operations. The PVNTMED role varies depending on the type of mission, location, and duration of the support. United States government agencies (such as the State Department or the Agency for International Development) in coordination with the HN will take the lead in these activities. United States Army PVNTMED personnel will support these ongoing activities.

D-8. Preventive Medicine Support

Preventive medicine personnel are uniquely qualified to provide the command with an assessment of the medical threat. They can address HSS to the deployed force, HN populace, refugees, EPWs, and other military units. Specialists within PVNTMED include—

a. Preventive Medicine Officer.

(1) The preventive medicine officer (PMO) is a physician who is a specialist in PVNTMED. He is knowledgeable in—

- Prevention of communicable and tropical diseases.

- Epidemic disease control procedures.

- Environmental medicine issues.

(2) This officer is knowledgeable in deployment-related medical problems and in the medical threats in developing countries.

(3) The PMO is able to–

- Assess the impact of endemic diseases on US troop populations.

- Provide advice on PVNTMED measures.

- Interface with the local public health officials regarding health problems that are affecting both the local population and US forces.

b. Community Health Nurse.

(1) The community health nurse (CHN) is educated and experienced in the public health nursing sciences. The CHN specializes in the following areas:

- Disease containment education.
- Critical assessment of community health needs.
- Immunization programs.
- Nutritional assessment of the HN populace.

(2) The CHN coordinates with and acts as a liaison to the HN public health program staff.

(3) This officer has a broad knowledge of diseases of public health significance. The CHN can assist in reducing the adverse impact on endemic diseases by recommending or implementing intervention strategies. Additionally, the CHN is able to identify the cause and intervene in epidemics, and to improve general health conditions.

(4) The CHN can provide assistance in a number of scenarios, such as health problems associated with refugee populations, EPW camps, and displaced persons.

c. Environmental Science Officer/Sanitary Engineer.

(1) This officer is knowledgeable in the following areas:

- Field sanitation.
- Drinking water source selection.
- Water purification and pollution control.
- Disease prevention.
- Waste handling and disposal.
- Food service sanitation.
- Environmental stress.

(2) This environmental science officer can work independently or as part of the PVNTMED team. He can provide direct assistance to resolve specific problems, recommend PVNTMED measures to the commander, and provide required training.

(3) Historically, the lack of field hygiene and sanitation in the field environment has resulted in the loss of soldier effectiveness. The environmental science officer can assist in reducing this risk as well as improving conditions for the surrounding civilian population.

d. Entomology Officer. The entomology officer is specially trained to—

- Provide advice and assistance to commanders relating to—
  - Disease-causing arthropods.
  - Use of personal protective measures.
  - Strategies for the application of pesticides.
- Provide surveillance and identification of significant arthropods.
- Provide specialized training.
- Assist in epidemiological investigations of arthropod-borne disease outbreaks. These outbreaks may be either naturally occurring or introduced by the migration of human or animal reservoirs.

e. Preventive Medicine Specialist.

(1) The PVNTMED specialist is oriented and trained to handle PVNTMED issues

encountered in field operational settings. Capabilities include–

- Food service sanitation.
- Drinking water purification.
- Personal hygiene.
- Waste handling and disposal.
- Pest management.
- Environmental stress.

(2) This specialist can provide training and conduct inspections in the areas delineated in (1) above.

(3) The PVNTMED specialist can operate independently or as part of the PVNTMED team.

APPENDIX E

DENTAL SUPPORT IN LOW INTENSITY CONFLICT

E-l. General

a. This appendix addresses the roles of dental services in MEDOLIC that do not involve support to US Forces in armed conflict. Planning for the traditional role of dental services (that of providing dental support to US Forces) follows the guidelines presented in FM 8-26 and other emerging doctrine on HSS to combat operations. Dental support to US Forces engaged in armed conflict is tailored to—

- Tactical situation.
- Size and type of troop populations.
- Anticipated length of deployment.
- Knowledge of the dental fitness of the units involved.
- Knowledge of endemic or environmental factors that may influence oral health.

b. The unique role dental services have in LIC is in support of operations not involving direct US military force. United States Army dental assets may be employed during medical operations conducted in LIC. This may include the evaluation and treatment of significant oral, dental, and/or maxillofacial disease or conditions; the assessment of the HN dental infrastructure; or the dental professional care issues. This assessment and care may include either the HN civilian or military populations.

c. In developing countries, oral infections like periodontal disease and dental caries are endemic. The prevalence of oral developmental conditions like cleft palate is very high. Further, severe maxillofacial injury occurs, often a result of armed conflict. Developing countries typically have an inadequate dental care infrastructure to prevent or treat these conditions. In most operations involving FID or the USAID there is a role for dental service support.

d. Although direct delivery of care to HN populations during HCA operations is an easily implemented and highly visible display of US support, it has only a short-term benefit. Other dental support roles that have long-term benefits include—

- Assessing of HN to identify oral, dental and maxillofacial problems, and dental health capabilities.
- Assisting in building dental support infrastructure.
- Training dental professional and auxiliary personnel.
- Providing dental technical assistance.
- Assisting in developing military medical capability to prevent and treat oral, dental, and maxillofacial conditions.
- Providing assistance in planning for forensic dental operations.

e. Resources to accomplish the objectives listed are uniquely different than those in the tables of organization and equipment (TOE) for field dental support to wartime. Tailoring of dental assets, both manpower and materiel, with capabilities beyond those of typical field dental units, is necessary. These differences should be included in planning and appropriately resourced.

E-2. Dental Service Support

a. Dental assessment is important to understanding the dental health care needs of the population. Data and information from dental professional literature, WHO, PAHO, the American Dental Association (ADA) Council on ADA Sessions and International Relations, and AFMIC should be combined with information provided by the diplomatic mission in the HN to assist in determining dental requirements for the mission. If possible, personal observation by a dental officer should be accomplished prior to completion of operational plans. In some cases provision of a

comprehensive description of the dental situation is, in itself, of assistance to the supported country or insurgent population.

b. The senior dental officer involved should provide the assessment and recommendations to the command surgeon. Recommendations should be made as to the dental care goals and objectives; concept of operations; the manpower, materiel, and funding requirements; standards of care; and milestone time lines. Continued dental participation in the planning process is important.

c. Continued involvement or consultation from a specialist in dental public health in assessment, planning, and evaluation of programs is desirable.

d. The involvement of HN or insurgent personnel early in the plan development is essential. These personnel can ensure that the legal, social, cultural, and religious implications of the plan are considered. During implementation, the HN or insurgent group should be highly visible. The US personnel should play a supporting role.

e. Host nation resources to consider in dental planning might include–

- Military dental situation.
- Dental schools.
- Government dental licensure authority.
- Nondental health personnel who are or can be involved in dental programs (community 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 systems (for fluoridation capability).
- Commercial marketing of oral health products.
- Media capability for mass awareness programs.
- Religious organizations' involvement in social and health-related activities.

f. Dental programs and operations can be conducted in conjunction with other medical operations. They can also be conducted as separate activities.

g. Periodic program evaluation to assess the results of operations should be included in operations plans. The dental annex to after action reports should be forwarded to the senior dental officer in the chain of technical or command authority. Lessons learned should be provided to personnel involved in doctrine and training development.

APPENDIX F
COMBAT STRESS CONTROL AND MENTAL HEALTH SERVICES IN LOW INTENSITY CONFLICT

F-1. Introduction

a. Low intensity conflicts may have brief periods of extreme violence or prolonged periods of siege. These conditions can produce classic "disaster shock" or battle fatigue. The operations may even involve NBC threats which add the psychological stressors of MOPP. However, the more usual stressors are those of frustration, resentment, loneliness, and boredom. These stressors come from being in unfamiliar lands far from home; among unfamiliar and perhaps hostile people; and with rules of engagement that limit even self-defense. There is also often ready access to drugs and alcohol. Enemy tactics attempt to magnify these stressors and to provoke misconduct stress reactions. These reactions can sap the Army's and the national will. The HN may have rudimentary concepts and resources for psychiatric care, mental health promotion, and social services delivery. These limitations could be the focus of enhancing the HN government stability, but only if cultural differences are fully taken into account.

b. Combat stress control and mental health personnel have provided commanders with effective service in many previous LICs. They have and will continue to provide mental health support to all categories of LIC. For example, mental health personnel—

- Provided support to soldiers in Vietnam.
- Were members of numerous peacekeeping task forces assigned to the Middle East.
- Organized stress management teams which provided assistance to soldiers, civilians, and family members exposed to terrorist actions, or natural or man-made disasters.

c. The following tables briefly describe a number of approaches, principles, and techniques used in the prevention and treatment of battle fatigue and stress reactions associated with LIC. Mental health personnel have the capability to assist commanders in implementing these strategies.

F-2. Low Intensity Conflict Issues and Mental Health Recommendations and Actions

Tables F-1 through F-4 provide mental health recommendations for the four operational categories of LIC.

Table F-1. Mental Health Recommendations for Low Intensity Conflict Issues—Support for Insurgency and Counterinsurgency

Support for Insurgency and Counterinsurgency Issues	Recommendations and Actions
—Cultural conflicts. —Language barriers. —Unfamiliar terrain. —Climate differences.	Develop effective sponsorship program.
—Difficulty identifying the enemy.	—Establish HN education program with emphasis on understanding local culture, values, practices, and pressures affecting HN people.
—Reaction to hit-and-run tactics.	—Provide time for soldiers to debrief on their experience.
—Support troops live in comparative luxury to combat soldiers.	—Do not overbuild support base.
—Soldier and family unclear concerning Army's mission in the area.	—Using a variety of media, continue to explain unit mission.
—Continuing the fight with slow progress.	—Educate soldiers on realities of the mission.
—Dealing with extended periods of no activity.	—Provide relevant training during lulls.
—Inability to decisively engage the opposition.	—After completion of operations, conduct debriefings. Discuss what occurred, individual reactions, and feelings, strengths, and weaknesses of the operation. Link accomplishments with unit goals.
—Host nation support roles may be indirect, such as for training only and not combat.	—Leadership clearly communicates soldiers' roles, rules of engagement, and reason or rationale for rules to HN leadership and own forces.

Table F-2. Mental Health Recommendations for Low Intensity Conflict Issues—Combatting Terrorism

Combatting Terrorism Issues	Recommendations and Actions
—Shock of the event. —Sudden violation of familiar, safe setting. —Loss of control. —Hostile feelings (repressed or expressed). —Feelings of dependence. —Observation of atrocities. —Feelings of impotence. —Regressive behaviors. —Relocation and isolation responses. —Positive identification with terrorists. —Sense of being a victim. —Negative feelings about own country.	—A multidisciplinary stress management team assists victims, family members, and staff involved in terrorist or hostage situations. A variety of individual and group techniques are used to help return persons to normal functioning and to reduce the impact of posttraumatic stress disorders.

Table F-3. Mental Health Recommendations for Low Intensity Conflict Issues—Peacekeeping Operations

Peacekeeping Issues	Recommendations and Actions
—Isolation. —Boredom. —Cultural alienation. —Repetitious or routine duties. —Overtime, sense of nonsignificant mission. —As mission continues over the years, increase in fixed facilities versus austerity for soldier on the front line. —Lack of understanding of cultural and political issues of other nations making up peacekeeping force.	—Develop and maintain unit cohesion initiatives. —Job rotation, job cross training. —Trips and recreation in host nation. —Job expansion, job rotation. —Continuous emphasis on importance of the mission. Be clear on US role. —Push mobile support packages forward or reduce glamor of fixed facilities in the rear. —Establish effective orientation and cultural exchange programs.

Table F-4. Mental Health Recommendations for Low Intensity Conflict Issues—Peacetime Contingency Operations

Peacetime Contingency Operations	Recommendations and Actions
—Sudden unit deployment.	—Develop program for soldiers and families to receive timely information.
—Unplanned catastrophe or incident (no textbook solution).	—Develop cohesive unit with strong individual and group problem-solving skills.
—Small unit activity has great political interest.	—Develop strategy to keep soldiers focused on mission.
—Cultural and language differences.	—Implement a sponsorship program for soldiers and families with HN input.
—Lack of freedom of movement.	—Develop support system to fight isolation.
—Post traumatic stress of helpers.	—Implement debriefing process.
—Unclear or misunderstood purpose or mission.	—Clearly and regularly articulate unit missions. Develop unit goals based on mission priorities.
—Feelings of isolation and frustration.	—Ensure social support system and activities to support cohesion.
—Lack of typical military base operations.	—Develop mobile system to support operations.
—Excessive security (develop bunker mentality).	—Ensure security is in balance with the threat.

F-3. Mental Health Activities in Support of Low Intensity Conflict Operations

a. Support for Insurgency and Counter-insurgency. Mental health support is designed to meet specific missions. As the level of combat intensity and the duration of the mission increase, combat stress related problems also increase. It is expected that battle fatigue rates will not normally exceed 1:10 per wounded in action. Organic mental health staff use the combat stress principles of proximity, immediacy, and expectancy in treating battle fatigued soldiers. However, the main problem will be misconduct combat stress reactions. These misconduct combat stress reactions can include substance abuse, commission of atrocities, and acts of undiscipline. Misconduct combat stress reactions may seriously interfere with the LIC mission unless prevented. It is expected that soldiers will suffer from adjustment reactions endemic psychiatric disorders, and drug and alcohol abuse.

b. Combatting Terrorism. Stress management teams are an integral part of the military's approach to helping personnel involved in a terrorist situation. The team's mission is to support the rapid return to duty and to preclude post-traumatic stress disorders in captives and those persons closely associated with a terrorist activity. This team is a multidisciplinary group and should be on call to rapidly deploy to a selected site. Experiences with the bombing of the Beirut United States Marine Corps force, Transworld Airlines hyjacking, the Achille Lauro release, andother incidences have demonstrated the requirement for stress management teams. The treatment principles and approaches parallel those used in the treatment of battle fatigue.

c. Peacekeeping Missions. Selected mental health staff should accompany US peacekeeping task forces. Historically, these task forces require reinforced organic logistics and HSS. Mental health staff have been used effectively to support a variety of peacekeeping missions. Mental health officers can assist commanders in completing predeployment unit effectiveness surveys, provide training and consultation related to stress management and unit cohesion, and complete mental health screenings and evaluations. During peacekeeping operations, the focus is on mental health assessment and consultation.

d. Peacetime Contingencies. Mental health support is designed to meet the unique needs of the situation. Mental health personnel have a history of providing assistance during NEO and a variety of disaster relief situations. Support is provided to assist soldiers and their families or in some cases the civilian population to minimize the effects of sudden separation or loss of loved ones. Mental health expertise is most useful in reducing support or emergency assistance personnel stress during times of continuous operations. Crisis intervention and short-term treatment approaches are used.

F-4. Basic Mental Health Approaches During Low Intensity Conflict Operations

a. Unit Assessments. These are provided during predeployment or reconstitution.

b. Command Consultations. Consultations are available at all echelons.

c. Training. General program education, life-coping skills, recognition of stressors, and stress symptoms are appropriate topics.

d. After Action Debriefing. Debriefings are conducted in support of combat or special operations, terrorist incidents, or other significant actions.

e. Treatment. Soldiers and families are treated for problems associated with LIC.

f. Evaluations. Mental health evaluations to screen soldiers with maladaptive behaviors are provided.

g. Alcohol and Drug Abuse Prevention and Control Program. Staff expertise and support for the implementation of this program is provided.

F-5. Mental Health Task Organization

Mental health professionals are organic to combat divisions. Commanders can task organize tables of distribution and allowances (TDAs) mental health staff to support LIC contingencies or activate psychiatric (OM) teams. In the mid 1990s, the Army will field combat stress control detachments and companies. These units are part of the Medical Force 2000 TOE organizations. Personnel will be organized and trained to provide mental health support across the spectrum of combat.

APPENDIX G

REHABILITATION SUPPORT IN LOW INTENSITY CONFLICT

G-1. General

At all levels of conflict, temporary physical and mental incapacitation and medical conditions are not the only human prices to be paid. Potential lifelong reminders (such as loss of limb, disfigurement, paralysis, and chronic intestinal conditions) must also be dealt with. Rehabilitation support is a resource that can—

- Contribute to maximizing the return-to-duty potential of soldiers (US, allied, and HN or US-backed group).
- Participate in disaster relief and HCA programs.
- Enhance HN stability through the growth potential of the HN medical infrastructure.

G-2. Allied Health Fields

The allied health fields of occupational therapy (OT), physical therapy (PT), and dietetics are not established in some Third World countries. In those countries where these fields do exist, they continue to practice at a technician level and are underused. The US Army's rehabilitative support programs have grown out of necessity due to reduced physician staffing levels in the 1970's. These support personnel have developed a level of practice which permits evaluation and treatment of patients upon referral from nonphysicians.

a. Based on clinical experience, physical and mental recovery from injuries is most successful with early treatment. Rehabilitation refers to restoring an individual to his former level of activity through training and therapy; in the past, this has required long-term care and sophisticated equipment; therefore, these resources have been avoided due to perceived logistical problems. However, most physical and occupational therapies can be done manually. Most orthopedic injuries also recover faster when treated early and with active measures.

b. Dietitians serve as consultants to commanders and recommend the use of locally available foodstuffs and their nutritional value.

G-3. Occupational Therapy

a. The planning considerations include—

- Participation on combat stress control teams, when these teams are deployed.
- Upper extremity sprains, strains, and fracture injuries being managed as far forward as practical.
- Upper extremity artificial limbs (prosthetics) or splinting (orthotics) expertise in fitting or training:
- Capabilities of the HN medical system.

b. Direct assistance can be given to host nations by contributing to the rehabilitation of military and civilian casualties. If full recovery is not possible (as with head injuries, strokes, amputations, or contractures caused by burns), Third World nations usually do not have the OT resources to teach the casualty alternative skills for daily living. On HCA operations, OT personnel can screen and treat children with developmental delays.

c. Indirect assistance (which has long-term health care and economic benefits) is provided by serving as a consultant to the HN medical educational system in developing OT practices and protocols.

G-4. Physical Therapy

Although PT personnel work with all diagnoses (surgical, medical, thoracic, and neurological), minor and moderate orthopedic injuries (bone, joint, and soft tissue) are numerous. These orthopedic injuries can overwhelm the medical assets better used to care for major injuries. Physical therapists provide primary evaluation and treatment of musculoskeletal injuries. This skill reduces the need for orthopedic surgeons to become involved in routine cases. The planning considerations include—

- Lower extremity artificial limbs (prosthetics) or splinting (orthotics) expertise in fitting and training.
- Burn care requirements.
- Capabilities of the HN medical infrastructure. Direct assistance can be given, for example, by—
  - Working with US or HN physicians in evaluating military and civilian casualties.
  - Providing, instructing, or supervising physical rehabilitation using equipment at hand or improvised.
  - Number of children affected by developmental delays caused by poor nutrition or disease.

G-5. Nutrition Care

a. Combat casualties are treated as far forward as possible. If held for more than 72 hours, patients may require special diets (soft, liquid, or forced fluids).

b. Humanitarian and civic assistance operations and enhancing the capabilities of the HN medical infrastructure can be accomplished. Refeeding a basically healthy population or working with an indigenous malnourished population are two common LIC scenarios. An example of direct assistance is the planning for and providing of special diets to the HN military and civilian casualties or advising HN care providers on nutrition support for wounds, injuries, and disease. Assistance can also be provided in assessing the nutritional status of the general population and recommending ways to achieve optimum nutritional levels with the local available foodstuffs. An example of indirect assistance is achieved by serving as a consultant to the HN medical education system in developing nutritional care specialists and nutritional programs for children.

APPENDIX H

MEDICAL ASSESSMENT CHECKLIST
SAMPLE FORMAT

H-1. General

a. This appendix provides a tool for use in assessing the health care delivery system and the medical needs of a HN or US-backed group. This checklist is intended only as a guide and may be modified for use as the situation dictates.

b. This checklist is arranged by category of information. The more detailed the information obtained, the better this checklist will aid the medical planner in correctly assessing the medical requirements and developing the requisite programs for alleviating the identified deficiencies. Additional information in the form of brochures, magazine articles, or newspaper articles or advertisements of medical facilities, health service education programs, and medical equipment or supplies available will also assist in the planning effort.

c. The mission reconnaissance checklist presented in Appendix K is of a more limited scope and is intended for the assessment of a specific village or district.

H-2. Medical Assessment Checklist

COUNTRY _____ DATES VISITED _____ TO _____

GENERAL INFORMATION

Name of Location _____

Map Grid Coordinates _____

Topography (such as mountains or desert) _____

Climate (such as tropic or arctic) _____ _____

Temperature Ranges:

Summer _____ to _____ _____

Winter _____ to _____ _____

Significant Seasonal Variants (such as monsoon season) _____

Availability of Water

Source	Quality	Quantity	Contaminants

Epidemiology

Disease	Occurrence

Leading Causes of Death

Status of Sanitation Impacting on the Overall Health

Insects, Plants, and Animals of Medical Importance

Religious, Social, and/or Political Factors of Medical Importance

II. CIVILIAN HEALTH SERVICES

Organization and Administration (to include public and private)

Public Health Laws

Accessibility to Care (to include both physical, social, and financial barriers)

Comments on Overall Quality of Civilian Health Care

Significant Individuals

Name Title

III. MILITARY MEDICAL SERVICES

Force Strength

Active Reserve

Organization and Administration

Policies and Programs

Physical Fitness Standards

Medical Logistics and Blood Management

Medical Evacuation and Regulating

Hospitalization

Preventive Medicine

Dental

Veterinary

Pharmacy, Laboratory, and X-ray

Combat Stress/Neuropsychiatric

Nursing

Paraprofessionals

Military Medical Training and Education Programs

Course/School	Location	Type of Training

Comments on the Overall Quality of Military Care

Significant Individuals

Name	Title

MEDICAL MATERIEL

Production Capability

Product	Quantity	Demand

Stockpiles

Product	Quantity	Demand

Products Obtained from Outside Sources

Product	Quantity	Demand

Equipment Repair Capability

Type of Equipment	Source of Repair

MEDICAL RESEARCH AND DEVELOPMENT

Institutes

Name	Location

Significant Individuals

CIVILIAN MEDICAL TRAINING

Name	Location	Type of Training

Other Comments

VII. HOSPITAL DATA

Please rate capabilities
1 (minimal) through 5 (excellent)

NAME	LOCATION	MILITARY	CIVILIAN	PEACETIME CAPACITY	WARTIME CAPACITY	ROAD ACCESS	AIR ACCESS	RAIL ACCESS	WATER ACCESS	HELIPORT	ER	OR	ICU	ORTHOPEDICS	NEUROSURGERY	OBSTETRICS	X-RAY	LAB	BLOOD BANK	PHARMACY	PHYSICAL THERAPY	DIALYSIS	PSYCHIATRY	COMMENTS

SAMPLE

THIS IS A SAMPLE FORMAT

APPENDIX I

HEALTH SERVICE ASSESSMENT PLANNING

Section I. HEALTH SERVICE SUPPORT ESTIMATE

I-1. General

a. Planning for HSS operations in LIC is the same process used for HSS operations in the more traditional AMEDD roles. The HSS estimate of the situation is the basic tool used by the medical planner. A detailed discussion of each subparagraph of the HSS estimate is provided in FM 8-55. The information contained in this appendix supplements the discussion in FM 8-55. The considerations are similar; however, the range of options and courses of action are expanded. These expanded options include missions and functions not accomplished during the more traditional HSS operations (such as the assessment of the medical infrastructure of a HN).

b. All of the categories of the HSS estimate are presented in paragraph I-2. Some of the categories may seem contrived when applying them to a LIC situation. The medical planner must, therefore, interpret the categories and apply the pertinent information or modify the category to fit the operational scenario. For example, in discussion of opposition groups, it is conceivable that an organized opposition may not be apparent in a country where a HCA program or disaster relief effort is being conducted. The medical planner should, therefore, consider those situations and factors which could foster an insurgency or the formation of opposition groups and focus the HSS operations to correct anticipated deficiencies, thereby eliminating the possible threat.

c. Paragraphs I-3 through I-5 contain a format for preparing the veterinary, PVNTMED, and dental estimates.

d. The examples provided in this section do not include all possible scenarios or information needed to complete an estimate. They are included for illustrative purposes only.

I-2. Format for the Health Service Support Estimate

(Classification)

HEALTH SERVICE SUPPORT ESTIMATE OF THE SITUATION

Headquarters
Location
Date, time, and zone

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area (if required); sheet number and name (if required); edition and scale.*

1. MISSION: *(Statement of the overall HSS mission and category of operation to be supported [such as support for insurgency and counterinsurgency, combatting terrorism, peacekeeping, or peacetime contingency].)*

2. SITUATION AND CONSIDERATIONS:

a. Enemy (opposition) situation. *(In LIC this could include terrorist groups, insurgents, labor unions, HN forces, or other opposition groups or political factions found in the particular HN.*

(Classification)

(Classification)

This subparagraph is viewed as groups opposed to the US-backed and supported groups, HN, and US national interests.)

(1) Strength and disposition. *(Included in this category are strongholds, areas sympathetic to the opposition group, or the size and type of organization of the opposition group.)*

(2) Combat efficiency. *(Information on any actual combat units or guerrilla forces, their training status, and their level of experience and expertise can be identified here. The level of HSS training and the development of a health care delivery system can also be discussed.)*

(3) Capabilities. *(Information on the actual capabilities of an opposition group to wage armed combat, or the potential of the group to initiate such action is included. Consideration should be given to the possibility of an opposition force being able to employ NBC weaponry.)*

(4) Logistic situation. *(This can include information on how well supplied the opposition force is with food clothing, or other vital logistic factors. The financial backing and availability of future support from outside individuals [such as from narcotic traffickers] or countries can also be included.)*

(5) State of health. *(Health service support resources available to the opposition group and their location or the general health status of this subpopulation should be considered.)*

(6) Weapons. *(This includes the types and quantities of weapons; amount of ammunition availability of NBC and directed energy weapons; sources and outside backing for obtaining weapons; and the potential for improving the state of the arsenal.)*

b. Friendly situation. *(This subparagraph is addressed from the perspective of the HN or US-backed group and US national interests.)*

(1) Strength and disposition. *(This could include information on the armed forces, guerrilla forces, strongholds, sympathetic areas, and support of the general populace.)*

(2) Combat efficiency. *(This includes the state of military and medical professional training and experience of the HN military or US-backed group; status of the development of a professional medical corps [including administrative, ancillary care, nursing, dental and veterinary specialties]; training in first aid [self-aid, buddy aid, and combat lifesaver skills] within the fighting forces; existence of formal TOE type units; level of training in PVNTMED measures, including personal hygiene and sanitation the development of its military and medical infrastructure; and, CS and CSS available to the force.)*

(3) Present and projected missions. *(This includes HN restrictions and limitations on the scope and objective of the mission the visibility of the HN to its population in implementing the programs, and the capability of the HN to continue the programs once US assistance is withdrawn.)*

(4) Logistic situation. *(This includes both the medical and nonmedical logistic situation. Information on the status of food clothing, or other vital logistic factors affecting the friendly forces should be included. Location of resupply points or activities, coordination for depot maintenance, and procedures for supply or resupply if the support facility is not located in the AO should be included. If the HN is not supplying the logistic support, an indication of the sources of support and the potential for continuance of support should be included.)*

(Classification)

(Classification)

(5) Rear battle plan. *(This includes information on combatting terrorism measures or force security operations, if applicable.)*

(6) Weapons. *(This includes those weapons and riot control agents available to the force.)*

c. Characteristics of the area of operations. *(Included in this are geographical barriers and political borders)*

(1) Terrain. *(Special considerations include the effects on limiting the access to and availability of health care services for the general population; regionalizatin of the population which does not have access to improved roads; effects on camouflaging and protecting insurgents or guerrillas; or MOUT considerations and requirements.)*

(2) Weather. *(This includes seasonal weather, for example, which may further isolate villages and sections of the population due to flooding, or its adverse effect on a disaster relief mission or any other significant role it may play in an operation being planned.)*

(3) Civilian population. *(The civilian population takes on added importance in planning missions for the LIC environment. Often times, the civilian population is, in fact, the focus of the mission. A thorough understanding of the culture, language, political, economic, religious, and social situation of the populace involved is a crucial element in planning LIC operations. If conventional military operations are being undertaken in the area, the effect these operations have on the civilian population must be considered. The requirement for prosthetics, orthotics, and training of alternative daily living activities and skills of civilian victims of land mines or other combat-related traumatic injuries should also be considered. Estimates of civilian casualties resulting from MOUT operations requiring medical attention and the impact and number of refugees requiring medical care, preventive medicine, and veterinary support should be included.)*

(4) Flora and fauna. *(As in all military operations, personnel must be familiar with the particular plants, animals, and arthropods which are found in the operational environment. In LIC, this is important, as the resources available to control arthropod and rodent populations may not be available in LIC. This results in exposing the deployed forces to a greater incidence of disease and injury. The animal population of the region may play a significant role in the economic development of the region, and may, therefore, be the focus of the operation [refer to Appendix C].)*

(5) Local resources. *(In LIC scenarios, the availability of resources in the HN plays a significant role in shaping the CSS requirements of the deployed force. Availability of food, water, hospitalization services, and means of evacuation are only a few of the considerations in planning the CSS for an operation. Coordination needed to affect the HN support in the treatment of civilian casualties resulting from military operations should also be included.)*

(6) Other. *(This includes, but is not limited to, language capabilities and requirements; educational levels of the general population and HN military or US-backed group; state of development of the medical infrastructure for both the HN and the military; primary care capabilities; adequacy of secondary and tertiary hospital facilities; access to the health care delivery system; education and tranning levels of health care professions; morbidity and mortality statistics; availability of prosthetic and orthotic devises; education and training for rehabilitation programs; adequacy of sanitation facilities; religion; and status of the medical evacuation system. The availability of and access to radios, televisions, and other forms of communications are significant factors in developing training and educational programs focused on the populace.)*

(Classification)

(Classification)

d. Strengths to be supported. *(This section of the estimate should be modified as required to fit the LIC mission. In some operations, such as peacekeeping operations, the type of support provided is mainly of a traditional type, and the supported population can be accurately projected. In other operations, such as the support for insurgency and counterinsurgency, the supported population may not be as easily defined. The requirements to support SOF elements with conventional medical resources should also be considered. Additionally, in LIC operations there will often be either a multiservice or multinational force involved. Health service support considerations should therefore, be thoroughly coordinated to ensure that duplication of services are avoided [consideration should also include HN, missionary, or other agency medical services and programs, if applicable]. Some of the classifications listed below pertain to categories recognized by the Geneva Conventions and may or may not be applicable to the planned operation.)*

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Enemy prisoners of war.

(7) Indigenous civilians. *(This is an important category and should be predicted as accurately as possible.)*

(8) Retainees. *(Enemy medical personnel are not considered as EPWs and should be identified as soon as possible to assist in providing medical care in the EPW compound.)*

(9) Internees.

(10) Others. *(Refugees from areas experiencing violent confrontations or oppression resulting from insurgency or counterinsurgency operations or from other countries should be included.)*

e. Health of the command. *(With the limited number of forces employed in LIC operations and their increased risk of exposure to arthropods, rodents, and endemic diseases, it is important to ensure all PVNTMED measures are taken.)*

(1) Acclimation of troops. *(When dealing with the limited troop ceilings normally associated with LIC operations, it is important to ensure that all appropriate preventive measures are taken.)*

(2) Presence of disease. *(This includes the endemic diseases which are not at a clinically significant level in the native population. Deploying forces may not be immune and the incidence of endemic diseases may increase with the disruption of* services *[such as sanitation and garbage disposal]. The status of potable water, water sources, and sanitation facilities in rural areas should be evaluated.)*

(Classification)

(Classification)

(3) Status of immunizations. *(This category may apply to both the military and civilian populations. The US military forces should receive all appropriate immunizations prior to deployment. The immunization of children against common childhood diseases can have a significant impact on the morbidity and mortality statistics of a nation.)*

(4) Status of nutrition. *(This category may apply to both the military and civilian populations and is a significant consideration when planning programs for children.)*

(5) Clothing and equipment. *(Considerations for specialized clothing and equipment necessary to operate in a particular climate or on a particular type of terrain should be included. Examples of clothing and equipment requirements are mosquito netting, jungle fatigues, winter parkas, skis, or mountain climbing equipment.)*

(6) Fatigue. *(The fatigue factor must be monitored as fatigue can contribute to lowering the resistance to disease and stress reactions.)*

(7) Morale. *(This is an important consideration when dealing with a HN military or a US-backed group. The availability and quality of medical care if wounded plays a significant role in the morale of a fighting force.)*

(8) Status of training. *(This was mentioned earlier in regard to military and professional training levels of the HN or US-backed groups. It can also be applied to the preparation of the US forces for the accomplishment of their mission in the LIC environment [instruction in language, customs, or the ability to operate in an advisory or teaching capacity].)*

(9) Other, as appropriate.

f. Assumptions. *(Assumptions may be required as a basis for initiating planning or preparing the estimate. Assumptions are modified when specific planning guidance and factual data become available.)*

g. Special factors. *(Mention items of special importance in the particular operation to be supported such as the requirement to provide combat stress management after a terrorist incident to victims, security forces, and care givers.)*

3. HEALTH SERVICE SUPPORT ANALYSIS:

a. Patient estimates. *(Indicate rates and numbers by type of unit, if providing traditional HSS. If providing HCA, indicate types and numbers of cases to be treated.)*

(1) Number of patients anticipated. *(This entry can apply to the types and numbers of patients expected to be treated on HCA projects and disaster relief operations. The medical planner and medical professionals must determine what type of cases will be accepted. Caution must be exercised to ensure that the operation is directed at providing treatment to those who will benefit the most and avoid over expenditure of scarce resources to treat exotic or interesting cases.)*

(Classification)

(Classification)

(2) Distribution within an area of operations (space). *(This can include planning for operations to visit isolated villages [Appendix K] or in a disaster area.)*

(3) Distribution in time during the operation (evacuation time). *(This may include the time factors to reach isolated villages, to medically evacuate US personnel from the area for further treatment, or to provide aid during disaster relief operations.)*

(4) Areas of patient density. *(This could include the size of the villages and their relationship to one another; whether establishing a centrally located treatment station would benefit the population of a number of villages; areas under siege or where potential violence is anticipated pockets of injured in a disaster relief operation or mass casualties resulting from terrorist actions.)*

(5) Possible mass patients. *(This could include lucrative targets for terrorist acts [such as the Marine barracks in Beirut], areas experiencing an epidemic, or locations in a disaster relief operation.)*

(6) Lines of patient drift and evacuation. *(Although this is more fitting for conventional warfare scenarios, refugee evacuations do occur in LIC operations when insurgents or guerrillas try to establish strongholds within a city or region.)*

b. Support requirements.

(1) Evacuation. *(When limited US or allied health service elements are deployed in an AO, such as a peacekeeping operation thorough planning and coordination are required to ensure that adequate medical evacuation resources are available for routine care or mass casualty situations. Consideration must also be given to assessing the medical evacuation system within the HN or the US-backed group and providing suggestions or developmental plans for improving or establishing a formal evacuation system.)*

(2) Hospitalization. *(In LIC scenarios, hospitalization of US forces may not be possible in the immediate AO. It is, therefore, necessary to ensure that thoroughly coordinated plans with other US forces or commands, allied forces, or the HN are implemented to provide the anticipated hospitalization requirements. In assessing the HSS requirements for the HN the medical planner must consider the availability and adequacy of primary care; the adequacy and accessibility of the secondary and tertiary hospital system the size, training, and experience of the HN's pool of medical and nursing professionals; and the status of the HN or US-backed groups military hospitalization system.)*

(3) Medical supply, optical, and maintenance. *(Medical supply and maintenance of biomedical equipment are of a significant importance in developing nations. Medical planners must ensure that the HCA programs do not introduce the population to medicines, such as antibiotics, that will not be available to the people once US support is withdrawn. In the same line of thought, providing high technology medical equipment may not accomplish what was intended if the HN does not have the trained technicians to operate it, or to repair or replace the equipment once it malfunctions.)*

(4) Medical laboratory service. *(For US operational forces, medical laboratory service may be provided outside of the AO and, therefore, coordination for transportation of specimens and*

(Classification)

(Classification)

resulting reports must be established. Within the HN the considerations may include developing a medical laboratory system within the HN military, or expanding the functions of the existing laboratories to process environmental specimens or suspected chemical and biological agents.)

(5) Blood management. *(This can include the availability of a safe blood supply for US forces or establishing a blood procurement, processing, and banking program for the HN or US-backed group.)*

(6) Veterinary services. *(The care and treatment of government-owned animals, food procurement, food inspection and HCA programs to increase the productivity and value of the HN's livestock [refer to Appendix C] can be included.)*

(7) Preventive medicine services. *(These services are important in protecting deployed US forces as well as tools used to increase the quality of life of the HN population or US-backed groups [refer to Appendix D].)*

(8) Dental services. *(This could include dental programs coming under HCA operations [refer to Appendix E].)*

(9) Command, control, and communications. *(In LIC, it is important that clear and concise lines of command are established and that military assistance is provided in consonance with the other agencies involved in the operation [Ambassador, country team, USAID, and other US agencies]. In assessing the HN military needs, the establishment of both command and technical channels for medical operations is essential.)*

(10) Others. *(This can include combat stress control [Appendix F] and the production of and requirements for prosthetic and orthotic devices and the training required for successful rehabilitation [Appendix G]).*

c. Resources available. *(Consider all sources available within the AO.)*

(1) Organic medical units and personnel. *(This includes US, allied forces, HN, or US-backed groups resources, or assistance available through the embassy.)*

(2) Attached medical units and personnel.

(3) Supporting medical units. *(This could include support provided by US or allied forces outside of the immediate AO, such as hospitalization provided in another country.)*

(4) Civil public health capabilities and resources. *(In LIC, this resource may be the focus of the operation. Assessment as to quality, quantity, and type of resources play an important role in shaping many of the operations conducted. This element may also include any medical missionary resources in the AO. Coordination for support and emergency medical treatment is required when due to military actions civilian casualties are generated.)*

(5) Detained opposition medical personnel.

(6) Medical supplies and equipment. *(Considerations should include the HN's ability to use and service equipment and the availability of medicines within the HN once US support is withdrawn.)*

(Classification)

(Classification)

(7) Medical troop ceiling.

d. Courses of action. *(As a result of the above considerations and analysis, determine and list all logical courses of action which support the commander's operational plan and accomplish the HSS or medical operation mission. Consider all SOPs, policies, directives, US, HN, or international laws, and procedures in effect. Courses of action are expressed in terms of WHAT, WHERE, WHEN, HOW, AND WHY.)*

4. EVALUATION AND COMPARISON OF COURSES OF ACTION:

a. *Compare the probable outcome of each course of action to determine which one offers the best chance of success. This may be done in two steps:*

(1) *Determine and state those anticipated difficulties which will have a different effect on the courses of action.*

(2) *Evaluate each course of action against each significant difficulty to determine strengths and weaknesses inherent in each.*

b. *Compare all courses of action listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluation.*

/s/ _____
Command Surgeon

Annexes (as required)

DISTRIBUTION: (Is determined locally.)

I-3. Format for the Veterinary Estimate

Headquarters
Place
Date, time, and zone

VETERINARY ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

1. MISSION: *(Statement of specific veterinary mission in support of various operations [support for insurgency and counterinsurgency, combatting terrorism, peacekeeping, or peacetime contingency].)*

(Classification)

(Classification)

2. SITUATION AND CONSIDERATIONS:

a. Enemy (opposition) situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to veterinary concerns.)*

(1) Strength and disposition of animals.

(2) State of health of the animals.

(3) Capabilities.

b. Friendly situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to veterinary concerns.)*

(1) Size and posture of Class I supply system.

(2) Types of rations to be used.

(3) Status and source of Class I supplies.

(4) Strength and disposition of animals.

(5) Status of veterinary supply.

(6) Reliance of the HN economy on its livestock and ranching industry.

(7) Evacuation or retrograde of animals to CONUS.

c. Characteristics of the area of operations. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to veterinary concerns.)*

(1) Terrain.

(2) Weather.

(3) Civilian population.

(4) Flora and fauna. *(This can include the agricultural products for feeding the livestock and predators which can endanger the livestock.)*

(5) Local resources.

(6) Other. *(Customs, culture, economic, religious, and social considerations that affect the care and management of livestock can be included.)*

d. Strengths to be supported. *(Normally a table is used to include food inspection support and animal support, if applicable.)*

(1) Army.

(Classification)

(Classification)

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Enemy prisoners of war (if applicable).

(7) Indigenous civilians.

(8) Detainees.

(9) Retainees.

(10) Others. *(This category can also include refugees.)*

e. Health of animals of the command.

(1) Origin of animals.

(2) Presence of disease.

(3) Status of immunizations.

(4) Status of diagnostic tests.

(5) Status of nutrition.

(6) Care and management.

(7) Fatigue.

f. Assumptions.

g. Special factors. *(This can include coordination requirements with the HN or US-backed group, outside religious agencies, international health groups, and other US agencies [USAID and the Department of Agriculture].)*

3. ANALYSIS:

a. Veterinary service personnel estimate.

(1) Distribution of Class I installations.

(2) Distribution of subsistence (perishable and nonperishable).

(3) Local procurement.

(Classification)

(Classification)

(4) Extent of inspection load of indigenous foods.

(5) Estimate of animal casualties.

(6) Establishing a food procurement system for the HN military or US-backed groups.

(7) Evacuation of animal casualties.

b. Veterinary support requirements.

(1) Food inspection.

(2) Environmental health.

(3) Veterinary supply.

(4) Hospital treatment.

(5) Evacuation.

(6) Other (civil-military). *(Establishing training programs, developing a veterinary service infratructure, and developing economic programs in conjunction with the HN or civilian banking industry can be included. Coordination with HN veterinary personnel or Ministry of Health or Agriculture or other appropriate agencies is required.)*

c. Veterinary resources available.

(1) Organic veterinary personnel.

(2) Attached veterinary units.

(3) Supporting veterinary units.

(4) Civil veterinary public health personnel.

(5) The veterinary troop ceiling.

(6) Veterinary personnel from other US agencies or allied forces.

(7) Status of veterinary supply.

d. Courses of action. *(As a result of the above considerations and analysis, determine and list all logical courses of action which will support the commander's operational plan and accomplish the HSS mission. Consider all SOPs, policies, and procedures in effect. Courses of action are expressed in terms of WHAT, WHEN, WHERE, HOW, and WHY.)*

4. EVALUATION AND COMPARISON OF COURSES OF ACTION:

a. *Determine the probable outcome of each course of action listed in paragraph 3d (above) when opposed by each significant difficulty identified. This may be done in two steps:*

(Classification)

(Classification)

(1) *Determine and state those anticipated difficulties that will have an equal effect on the courses of action listed.*

(2) *Evaluate each course of action against each significant difficulty to determine strengths and weaknesses inherent in each course of action.*

b. *Compare all courses of action listed in terms of significant advantages and disadvantages or in terms of the major considerations that emerged during the above evaluation.*

5. CONCLUSIONS:

a. Indicate whether the mission set forth in paragraph 1 (above) can or cannot be supported.

b. Indicate which course of action can best be supported from the veterinary service standpoint.

c. Indicate the disadvantages of nonselected courses of action.

d. List the deficiencies in the preferred course of action that must be brought to the attention of the commander.

/s/ _____
Veterinary Staff Officer

Annexes *(as required)*

DISTRIBUTION:

(Is determined locally and includes the command surgeon.)

I-4. Example Format for the Preventive Medicine Estimate

Headquarters
Location
Date, time, and zone

PREVENTIVE MEDICINE ESTIMATE OF THE SITUATION

References: *List all maps, overlays, charts, or other documents required to understand the plan. References to a map will include the map series number and country or geographic area, if required sheet number and name, if required edition; and scale.*

(Classification)

(Classification)

1. MISSION: *(Statement of the specific PVNTMED mission in support of various operations [such as support for insurgency and counterinsurgency, combatting terrorism, peacekeeping, or peacetime contingency.)*

2. SITUATION AND CONSIDERATIONS:

a. Enemy (opposition) situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to PVNTMED concerns.)*

(1) Communicable diseases in threat force or opposition.

(2) Threat sanitation levels.

(3) Threat public health capabilities.

(4) Level of field sanitation training.

(5) Nuclear, biological, and chemical capabilities.

(6) Laser capabilities.

b. Friendly situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to PVNTMED concerns.)*

(1) Status of PVNTMED individual and unit supplies.

(2) Operational situation.

(3) Types of rations used.

(4) Unit PVNTMED readiness.

(a) Field sanitation team training and equipment.

(b) Individual and unit PVNTMED measures training and enforcement.

(5) Potable water.

(a) Sufficient production and distribution units.

(b) Sufficient availability and quantity.

(6) Availability of aircraft for aerial spray operations.

(7) Status of HN public health system.

(8) Status of sanitation facilities.

(9) Access to and availability of clean water in HN communities.

(Classification)

(Classification)

(10) Status of immunizations for children.

(11) Status of community health education programs.

(12) Off-limit establishments.

c. Characteristics of the area of operations.

(1) Terrain. *(Discuss the following questions.)*

(a) Does the area of operations favor arthropod/vector populations?

(b) Is the area of operations at a high altitude?

(c) Is there water available?

(d) How will the terrain affect pest management?

(2) Climate and weather. *(Discuss the following questions.)*

(a) Will the season affect disease transmission?

(b) Will the season affect heat or cold injuries?

(c) Will the season affect disease vectors?

(d) Will the season affect the water supply?

(e) Will the season affect pest management operations?

(3) Civilian population. *(Discuss the following subjects.)*

(a) Endemic diseases.

(b) Epidemic diseases.

(c) Sources of disease on main supply route.

(d) Disease immunization status.

(e) Water treatment standards.

(f) Waste disposal practices.

(g) Nutritional standards.

(h) Civilian medical support and public health system.

(4) Flora and fauna. *(Discuss the following subjects.)*

(a) Arthropods in the area of operations.

(Classification)

(Classification)

(b) Arthropods resistant to pesticides.

(c) Venomous animals and insects.

(d) Poisonous plants.

(5) Enemy prisoners of war, if applicable. *(Discuss the following subjects.)*

(a) Presence of disease.

(b) Number of detained public health officers.

(c) Disease immunization status.

(d) Nutritional standards.

(6) Other.

d. Strengths to be supported.

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Enemy prisoners of war, if applicable.

(7) Indigenous civilians. *(This category is important if planning HCA programs.)*

(8) Detainees.

(9) Retainees.

(10) Others. *(This can include refugees.)*

e. Health status of the command.

(1) Origin of the troops.

(a) Are they acclimated to the environment (heat, cold, altitude)?

(b) What are the endemic diseases?

(2) Presence of disease.

(3) Immunization status.

(Classification)

(Classification)

(4) Status of nutrition.

(5) Clothing and equipment.

(6) Fatigue and resistance to disease.

(7) Other.

f. Assumptions.

(1) *Is the assumption really necessary for the solution?*

(2) *Will the results change if the assumptions are not made?*

g. Special factors. *(Coordination requirements with HN or US-backed group, outside religious groups, international health groups, and other US agencies. Additionally, the impact culture, customs, or religious beliefs on providing PVNTMED services should be discussed.)*

3. ANALYSIS:

a. Estimates.

(1) Tasks involving arthropods and rodents.

(a) Disease and injury threat assessment.

(b) Survey and identification of requirements.

(c) Control requirements.

(2) Tasks involving environmental health.

(a) Heat.

(b) Cold.

(c) Water.

(d) Sanitation.

(e) Waste disposal.

(3) Tasks involving disease.

(a) Epidemiology.

(b) Immunizations.

(c) Prophylaxis.

b. Requirements.

(1) Supplies.

(Classification)

(Classification)

(2) Equipment.

(3) Civil and military support.

c. Resources available.

(1) Organic PVNTMED personnel.

(2) Attached PVNTMED personnel.

(3) Supporting PVNTMED personnel.

(4) Status of unit field sanitation teams.

(5) Civilian public health personnel.

(6) Detained enemy (opposition) health personnel, if applicable.

(7) Preventive medicine troop ceiling.

(8) Preventive medicine supply status.

d. Preventive medicine courses of action. *(Determine, as a result of the above analysis, all logical courses of action which support the commander's operational plan and accomplish the HSS mission. Courses of action are expressed in terms of WHAT, WHEN, WHERE, HOW, and WHY.)*

4. EVALUATION AND COMPARISON OF PREVENTIVE MEDICINE COURSES OF ACTION: *(Compare each course of action against the obstacles that will be encountered and against the casualties which could result from inaction.)*

5. CONCLUSION: *(Decide which course of action will best fulfill the mission. List the major advantages and disadvantages of the selected course of action.)*

/s/_____
Preventive Medicine Staff Officer

Annexes *(as required)*

DISTRIBUTION: *(Is determined locally and includes the command surgeon.)*

I-5. Example Format for the Dental Estimate

Headquarters
Location
Date, time, and zone

DENTAL ESTIMATE OF THE SITUATION

(Classification)

(Classification)

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required edition and scale.*

1. MISSION: *(Statement of the specific dental mission in support of various operations [such as support for insurgency and counterinsurgency, combatting terrorism peacekeeping, or peacetime contingency].)*

2. SITUATION AND CONSIDERATIONS:

a. Enemy (opposition) situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to dental concerns.)*

(1) Strength and disposition.

(2) Combat efficiency.

(3) Capabilities.

(4) Logistic situation.

(5) State of health. *(This could include the impact that dental disease has on the opposition's readiness.)*

(6) Weapons.

b. Friendly situation. *(Information contained in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to dental concerns.)*

(1) Strength and disposition.

(2) Combat efficiency.

(3) Present and projected operations. *(This category can include limitations and restrications placed on the operation by the HN or due to social standing and religious beliefs.)*

(4) Logistics situation.

(5) Weapons.

c. Characteristics of the area of operations. *(Information in this section of the estimate is similar to that contained in paragraph I-2; however, it is tailored to dental concerns.)*

(1) Terrain.

(2) Weather.

(3) Civilian population. *(Status of oral health and factors adversely affecting oral health should be included.)*

(4) Local resources. *(This can include recess to and availability of local [civilian HN military, or US-backed group] dental services.)*

(Classification)

(Classification)

(5) Other. *(This can include the state of nutrition and diet and its impact on oral health.)*

d. Strengths to be supported.

(1) Army.

(2) Navy.

(3) Air Force.

(4) Marines.

(5) Allied forces.

(6) Enemy prisoners of war (if applicable).

(7) Indigenous civilians. *(This category is of significant importance when planning HCA programs.)*

(8) Detainees.

(9) Retainees.

(10) Others. *(This category can include refugees.)*

e. Oral health of the command (or population supported).

(1) Present oral health.

(2) Processing for overseas replacement dental requirements upon arrival in theater met or not met.

(3) Dental preventive measures and education programs currently available.

f. Assumptions.

g. Special factors. *(Coordination requirements with HN or US-backed groups, outside religious groups, international health groups, and other US agencies. The impact of culture, customs, or religious beliefs on providing dental services can also be included.)*

3. ANALYSIS:

a. Dental service personnel estimate.

b. Patient estimates. *(Indicate rates and numbers by type of unit, or HCA or disaster relief operations.)*

c. Support requirements and resources available.

(1) Supply and equipment.

(a) Requirements. *(The requirements for electricity to run equipment and quantities of dental materials and medications are examples of information to include.)*

(Classification)

(Classification)

(b) Availability. *(Source of logistic supply and resupply should be included.)*

(c) Limiting factors. *(This can include the effect the austere environment has on the dental mission isolation of villages, or other factors impacting on performing the dental mission.)*

(2) Transportation.

(a) Requirements. *(This can include transportation requirements for both the dental providers and the civilian popukation to reach a treatment area.)*

(b) Availability.

(c) Limiting factors. *(For example, the requirement to reach a village by foot or on a pack animal may limit the amount and type of equipment which can used.)*

d. Evacuation.

(1) Requirements. *(This could include considerations of what is available through allied forces, HN [civilian and military], or US-backed group resources.)*

(2) Availability.

(3) Limiting factors. *(This can include information for evacuation of US or allied forces or evacuation requirements for indigenous civilians for more definitive care within the HN or abroad.)*

e. Hospitalization.

(1) Requirements.

(2) Availability.

(3) Limiting factors.

f. Miscellaneous. *(Indicate any special or unusual organizational or other logistical considerations.)*

g. Special factors. *(This can include coordination requirements with the HN or US-backed groups, outside religious agencies, international health groups, and other US agencies.)*

4. EVALUATION AND COMPARISON OF DENTAL COURSES OF ACTION:

a. *Determine the probable outcome of each course of action listed in paragraph 3g (above) when opposed by each significant difficulty identified.*

b. *Compare all significant advantages and disadvantages.*

5. CONCLUSIONS:

a. Indicate whether the mission set forth in paragraph 1 (above) can or cannot be supported.

(Classification)

(Classification)

b. Indicate which course of action can best be supported from the dental service standpoint.

c. Indicate the disadvantages of nonselected courses of action.

d. List the deficiencies in the preferred course of action that must be brought to the attention of the commander.

/s/ _____
Dental Surgeon

Annexes *(as required)*

DISTRIBUTION:

(Is determined locally and includes the command surgeon.

Section II. HEALTH SERVICE SUPPORT OR MEDICAL OPERATIONS PLAN

I-6. General

a. Once the HSS estimate is completed, the medical planner can proceed with developing the HSS plan for the proposed operation. As with the estimate, the same planning process for developing the traditional HSS or medical operations plan is used for LIC.

b. In this section the format for the HSS or medical operations plan and appropriate annexes is provided.

c. Paragraphs I-8 through I-10 provide the medical operations plan format for veterinary, PVNTMED, and dental services.

I-7. Format for the Health Service Support or Medical Operations Plan

Copy _____ *of* _____ *copies*
Headquarters
Location
Date, time, and zone

References: *List all maps, overlays, charts, or other documents required to understand the plan. Reference to a map will include the map series number and country or geographic area, if required; sheet number and name, if required; edition; and scale.*

Time Zone Used Throughout the Plan: *(Included only if used as the initial plan or if a major organization is to be affected.)*

Task Organization: Annex A (Task Organization) *(task organization may appear here, in paragraph three, or in an annex.)*

1. SITUATION: *(Provide information essential to understanding the plan.)*

a. Enemy (opposition) forces. *(Emphasis on capabilities bearing on the plan by terrorist groups, insurgents, labor unions, HN forces, or other opposition groups or political factions found in*

(Classification)

(Classification)

a particular country. This subparagraph is viewed as groups opposed to the US-backed or supported groups, HN, and US national interests. Also, in LIC scenanios, information concerning grievances, causes for unrest, or other pertinent data can be included.)

b. Friendly forces. *(This is addressed from the perspective of the HN or US-backed group and US national interests. Emphasis is also placed on HSS functions or medical operations and responsibilities for higher and adjacent units.)*

c. Attachments and detachments. *(May be published as an annex pertaining to task organization. In a LIC scenario, HN, other US agencies or military services, or US-backed groups who will participate in the operation can be indicated in this subparagraph.)*

d. Assumptions. *(Include the minimum required for the planning process.)*

2. MISSION: *(Statement of the overall HSS or medical operations mission and category of operation to be supported [insurgency and counterinsurgency, combatting terrorism peacekeeping, or peacetime contingency].)*

3. EXECUTION:

a. Surgeon's concept of support for the medical operation. *(First lettered subparagraph provides a concise overview of planned HSS or medical operation.)*

b. Major medical command and control headquarters. *(The second lettered subparagraph identifies the major medical control headquarters and lists the tasks or missions assigned to it.)*

c. Other medical units. *(The third and subsequent lettered subparagraphs identify the remaining medical units in turn and list their respective tasks and missions.)*

d. Evacuation policy. *(The next to the last lettered subparagraph discusses the evacuation policy by phases of the operation if applicable.)*

e. Coordinating instructions. *(The final lettered subparagraph contains any coordinating instructions that may be appropriate to ensure continuity in HSS or the medical operation. This coordination should include requirements for interface with other US services, allied forces, HN, US-backed groups, other US agencies, country team, or social and religious groups, and international agencies, as deemed appropriate.)*

4. SERVICE SUPPORT:

a. Supply. *(Refer to SOP or another annex whenever practical.)*

(1) General supply. *(Provide special instructions applicable to medical units. Also consider stockage levels for all classes of supply, as units will be operating in an austere environment and at extended distances from the full complement of CSS resources.)*

(2) Medical supply (to include blood and blood products). *(Provide special procedures applicable to the operation.)*

(a) Requirements. *(For sustaining the US, allied, or multinational force.)*

(Classification)

(Classification)

(b) Procurement. *(Provide detailed information on resupply and stockage levels required for the austere environment in which the operation will be conducted.)*

(c) Storage. *(Special procedures and equipment [such as refrigerators] requirements for maintaining storage and appropriate shelf life of medical supplies in an austere environment should be included.)*

(d) Distribution. *(This should include the method of distribution and any limitations or restrictions that are applicable. Additionally, if special transportation requirements exist, they should also be noted.)*

(3) Supplies required to accomplish LIC missions and not for the sustainment of the US, allied, or multinational force (HCA, disaster relief, or other category of LIC mission).

(a) Requirements. *(Includes estimates of the population to be supported or the number of patients anticipated to be treated; materials required for teaching or training health professionals; and medical educational programs for the population at large.)*

(b) Procurement. *(The funding source should be identified and procedures for obtaining the supplies described, as well as, any limitations or restrications on the use of the supplies should be included.)*

(c) Storage. *(Requirements for refrigeration or other special handling should be included.)*

(d) Distribution. *(Limitations and restrictions, as well as, transportation requirements should be included.)*

(e) Coordination. *(Interservice, allied force, US agencies, HN government, international groups, or other interested or involved parties should be included.)*

(4) Medical supply activities. *(This includes the location of the medical supply activity supporting the AO and means of communicating requests for resupply.)*

(5) Salvaged medical equipment and supplies.

(a) *For sustainment of the US force.*

(b) *For sustainment of LIC operational missions.*

(6) Captured enemy (opposition) medical supplies, if applicable. *(Should include disposition instructions.)*

(7) Civilian medical supplies. *(Should include resources for operation missions and training activities.)*

(8) Other medical supply matters.

b. Transportation and movements. *(This includes medical use of various transportation means.)*

(Classification)

(Classification)

(1) General. *(Transportation in LIC scenarios often times includes moving the medical team from one treatment area or medical mission area to another. Transportation is often a critical factor in accomplishing the LIC mission.)*

(2) Ground. *(The availability of ground evacuation assets to sustain US forces should be discussed. Additionally, the assessment and development of a ground evacuation system and the training requirements for HN personnel [if applicable] can also be included.)*

(3) Rail. *(If available the treatment locations could be established along the railway or it could provide a means for the civilian population to travel to a treatment area or to move the medical team and equipment.)*

(4) Water. *(Considerations should include both inland and at sea transportation requirements or assets and the availability of ship board facilities for evacuation to and treatment.)*

(5) Air. *(The availability of aeromedical evacuation support for the supported force should be discussed. Additionally, the assessment of aeromedical evacuation requirements for a HN or US-backed group, the development of a medical evacuation system and the training of appropriate personnel can be discussed depending upon the category of LIC mission.)*

(6) Movement control and traffic regulation, if applicable.

c. Services.

(1) Services to medical units and facilities. *(Include information on the following services: laundry, bath, utilities, fire-fighting, construction real estate, graves registration, and religious, personnel and finance.)*

(2) Medical equipment maintenance.

(a) For the sustainment of US force.

(b) For the sustainment of the LIC operational mission, including teaching medical equipment repair skills.

d. Labor. *(Include policies, agreements, or arrangements on the use of civilian or other personnel for labor.)*

e. General maintenance. *(This includes priority of maintenance and the location of repair facilities.)*

5. EVACUATION, TREATMENT, AND OTHER HEALTH SERVICES:

a. Evacuation.

(1) Evacuation of supported US, allied, or multinational forces, including evacuation policy, medical regulating, en route medical care, and modes of transportation.

(a) Requirements to include mass casualty situations.

(Classification)

(Classification)

(b) Units. *(Include information on the units providing this support and appropriate communications information.)*

(c) Other. *(This can include information on assets which may be used in an emergency, such as diplomatic flights.)*

(2) Evacuation of HN civilians or military, US-backed groups, or other categories of personnel including any limitations and restrictions.

(3) Assessing and developing an evacuation system for a HN or US-backed group including any limitations and restrictions.

(4) Other activities pertaining to evacuation functions in a LIC scenario.

b. Treatment.

(1) Treatment of supported US, allied, or multinational forces, including arrangements for hospitalization, mass casualty situations, or other treatment considerations.

(a) Policies. *(Treatment and hospitalization policies to include civilians, EPW, or other category of personnel.)*

(b) Units. *(This includes information concerning the location, capabilities, and communications means of units providing support.)*

(c) Other. *(This can include information on other medical assets which may be used in an emergency, such as the embassy physician.)*

(2) Treatment of HN civilian or military personnel, US-backed groups, or other categories of personnel. *(This includes limitations and restrictions, hours of operation, and procedures to cover emergencies and mass casualty situations.)*

(3) Assessing and developing a primary care system for the HN or US-backed group; adequacy of secondary and tertiary hospitals; or other treatment related missions.

c. Veterinary. *(Refer to paragraph I-8.)*

d. Preventive medicine. *(Refer to paragraph I-9.)*

e. Dental. *(Refer to paragraph I-10.)*

f. Other health services. *(This includes information pertinent to the other HSS functions and services: medical laboratory service, blood management, combat stress control, prosthetic and orthotic devises and required training, and required command, control, and communications.)*

6. MISCELLANEOUS: *(Address areas of support not previously mentioned which may be required or needed by subordinate elements in the execution of their respective HSS mission: command post locations, signal instructions, medical intelligence, claims, special reports that may be required and international or HN support agreements affecting HSS.)*

/s/ _____
(Commander/Command Surgeon)

(Classification)

(Classification)

Appendixes

DISTRIBUTION: *(Is determined locally.)*

I-8. Format for the Veterinary Service Portion of the Health Service Support or Medical Operations Plan

Veterinary Service

1. Food inspection.
   a. Procurement inspection policy.
   b. Units. *(Provide location, hours of operation, or other pertinent information.)*
   c. Captured and/or contaminated ration inspection policy.
2. Evacuation policy.
3. Hospitalization. *(Provide location of units providing this support.)*
4. Dispensary service. *(Provide treatment locations and hours of operation.)*
5. Veterinary care plans and programs for HN livestock.
6. Training and education programs for HN personnel.
7. Development of HN military veterinary infrastructure.

I-9. Format for Preventive Medicine Portion of the Health Service Support or Medical Operation Plan

Preventive Medicine

1. Medical threat. *(From the PVNTMED estimate, give a brief overview of the threat.)*
   a. Environmental injuries.
   b. Diarrhea.
   c. Arthropod.
   d. Other.
2. Concept of support.
   a. Individuals.
   b. Units.

(Classification)

(Classification)

c. Major units.

d. Preventive medicine teams.

3. Responsibilities.

a. General policies. *(State policies applying to all soldiers within the command.)*

(1) Individual PVNTMED measures.

(2) Specific policies.

b. Unit commanders.

(1) Environmental injuries.

(2) Diarrhea.

(3) Arthropod

(4) Other.

c. Specific unit commander's responsibilities.

I-10. Format for the Dental Service Portion of the Health Service Support or Medical Operations Plan

Dental Service

1. Assignment of responsibilities. *(Provide information concerning treatment locations, hours of operation, and services available at each location.)*

2. Detection.

3. Prevention, to include developing educational programs for the HN populace.

4. Treatment, to include available services, outreach programs, or other pertinent information.

5. Reporting, as required by command policy, regulation, HN agreements and laws, and unit SOPs.

6. Evacuation and hospitalization requirements.

7. Mass casualty plans.

8. Supplies and training materials.

9. Miscellaneous dental matters.

(Classification)

APPENDIX J
DEVELOPMENT OF MEDICAL ELEMENT STANDING OPERATING PROCEDURES

J-1. General

a. Medical elements employed in LIC often have a high turnover rate of personnel. To ensure continuity of programs and to facilitate the orientation of newly assigned personnel, it is important that a SOP be developed. This SOP should be quite detailed and cover all aspects of the medical element operations, such as—

- Medical procedures and services.
- Medical evacuation procedures.
- Supply and resupply procedures (both medical and nonmedical materiel).
- Unit administration.
- Medical records and administration.
- Mass casualty plans.

b. This appendix provides a skeletal outline of topics which should be included in the element's SOPs. It may be modified to meet the needs of the unit. The SOP should be updated on a regular basis.

c. Procedures should be formally established within the element to include out-briefings by the departing commander on the adequacy and scope of the SOP.

J-2. Orientation of Newly Assigned Personnel

a. Newly assigned personnel must be adequately oriented to their new positions. On tours of duty with a duration of 6 months to 1 year, it is important that personnel have ready access to procedures and guidelines to rapidly assimilate them into the operation. This enhances their effectiveness and optimizes their contribution to the unit mission. In many LIC environments, US Army Reserve units may perform their 2 weeks of active duty for training in OCONUS medical elements. A thorough orientation on their role and the procedures to be followed enhances the training they receive.

b. Orientation should include, but not be limited to, the following:

- Unit's goals, objectives, and mission.
- Unit history.
- Cultural, political, and economic considerations of the HN.
- Language requirements and, if personnel are not fluent in the HN's language, availability of interpreters and cross-referenced language dictionaries (such as a Spanish-English dictionary). The element should develop its own cross-referenced training aid with common medical questions and phrases for use by nonfluent personnel. (Department of the Army Pamphlet 40-3, Medical Service Multilingual Phrase Book, provides medical phrases in the following languages: English, French, Danish, German, Greek, Italian, Dutch, Norwegian, Turkish, and Portuguese.)
- Medical threat in the region.
- General threat and protective measures needed to ensure individual survivability, to include terrorism awareness (refer to paragraph 3-4 and FM 100-37 for additional information).
- Standards of conduct both in the military setting and in the civilian community.
- Administrative, personnel, and finance support.
- Specific job related information and procedures.
- Population served and eligibility for care.

c. If facilities are available to make training aids, such as film strips, the portions of the orientation dealing with topics which remain fairly constant can be standardized. These topics can include the cultural, economical, and political considerations of the HN and the unit history. If this is not possible, a prepared briefing and handouts can be used.

J-3. Standing Operating Procedures

The SOP may include, but not be limited to, the following:

a. Medical Evacuation.

- Procedures.
- Responsibilities of each person (requester, medical officer, or evacuation element).

b. Medical and Dental Services and Clinics.

(1) A number of standard elements should be covered for all medical and dental services and clinics. These are—

(a) Organization and functions.

(b) Administration, including policies, goals, and objectives, reporting requirements, duties and responsibilities, location, and hours of operation.

(c) Examination procedures.

(d) Treatment protocols.

(e) Medical supply and resupply procedures, and equipment availability and maintenance availability.

(f) Infection control (procedures to be followed to reduce the threat of infection in an austere environment).

(g) Equipment and supplies listing or locally determined medical equipment set for operations away from the permanent clinic site.

(h) Eligibility for care.

(i) Safety.

(j) Fire evacuation plan.

(k) Host nation coordination requirements.

(l) Inservice education requirements and continuing education programs.

(m) Standing committees, such as for quality assurance, credentialing, or other medical specific committees.

(n) Accident reporting.

(o) Personal appearance and behavior standards.

(p) Electrical power requirements and means to support requirements.

(2) Considerations for specific services and clinics are—

(a) Dental services.

- Radiographic procedures and biomedical equipment repair requirements and availability.
- Personal protection, such as gloves and mask.
- Requirements for refrigeration.
- Recovery of precious metals.

(b) Pharmacy services.

- Formulary which covers the prescribing procedures, alphabetical listing of drugs, and a therapeutic category listing.
- Signature cards.
- Controlled substance inventory, dispensing requirements, register, destruction procedures, discrepancy report, and requisitions.
- Access letters.
- Key control.
- Intravenous admixture program.
- Pharmacy waste disposal.

- Humanitarian and civic assistance involvement, requirements, and mission.
- Work report including inpatient and outpatient bulk order and sterile products.
- Requirements for refrigeration.

(c) Laboratory services.

- Infection and chemical hazard control.
- Requirements for refrigeration.
- Procedures and logistics of blood banking.
- Procedures for hematology laboratory.
- Procedures for biochemistry and clinical chemistry laboratory.

Procedures for bacteriology and parasitology.

(d) Anesthesia services.

- Standards.
- Duty roster and on-call requirements.
- Master list of clinical procedures.
- Equipment checklists.
- Classification of patients.
- Narcotics control.
- Infection control in work area.
- Anesthesia carts.
- Disposition of syringes and needles.
- Storage of combustibles and cleaning schedule.
- Quality control procedures for equipment.

(e) Surgical services.

- Scheduling procedures, to include after-hour and emergency cases.
- Aseptic (sterile) technique.
- Maintenance of registry.
- Scrub attire and surgical hand scrub procedures.
- Environmental safety.
- Electrosurgical unit safety.
- Operating room environmental sanitation.
- Counts of sponges and sharps.
- Bullet removal—evidence and property custody document.
- Death procedures.
- Notifications.
- Autopsy, to include coordination with HN health officials or compliance with valid agreements.
- Disposition.
- Cardiac arrest procedures.
- Traffic patterns.
- Transportation of patients to and from the operating room.
- Transportation of sterile, clean, and dirty equipment.

- Evacuation of personnel and patients during contingencies.
- Handling of contaminated needles and syringes.

(f) Central Materiel Supply.

- Loading and unloading of the steam sterilizer.
- Sterilization process monitors.
- Shelf life of sterile items to include labeling.
- Tray setup and wrapping procedures to include cleaning and preparing of equipment supplies for sterilization.

(g) Nursing services.

- Nursing notes.
- Scope of nursing practices.
- Plan for nursing care.
- Method of documentation.
- Assignment of personnel.
- Infection control.
- Special category patients.
- Procedures offered by Radiology services.
- Admission and discharge.
- Procedures for cardiopulmonary resuscitation.
- Procedures for cardiac arrest.
- Mass casualty care plan.
- Preoperative preparation of the patient.
- Postoperative care of the patient.
- Procedures for care of patient with indwelling catheters.
- Care of intravenous equipment and injection site.
- Tracheotomy care.
- Thermometer care.
- Bedpan and urinal washing and disinfecting facilities.
- Infectious waste disposal.
- Hand washing requirements and procedures.
- Isolation procedures for patient care.
- Death procedures.
- Notifications.
- Autopsy, to include coordination with HN health officials or compliance with valid agreements.
- Dispositions.
- Requirements for coverage of outpatient clinics and HCA missions.

(h) Mass casualty procedures.

- Planning and training requirements.
- Medical cadre positions and duties.
- Nonmedical personnel positions and duties, including litter teams and perimeter guard, crowd control, and information personnel.

- Location of services to include triage, delayed care, immediate care, minimal care, and expectant care areas.

(i) Biomedical equipment repair and maintenance.

- Maintenance request procedures.
- Scheduled maintenance.
- Receipt of new equip ment.
- Requesting repair parts.

(j) Veterinary services.

- Care of government-owned animals.
- Food inspection.
- Protocol for post exposure rabies prophylaxis.
- Humanitarian and civic assistance missions.

(k) Preventive medicine services

- Food service sanitation.
- Foodborne illness outbreak investigation.
- Water quality surveillance.
- Climatic injury prevention.
- Entomology and pest control.
- Humanitarian and civic assistance programs.
- Sexually transmitted diseases prevention and control (to include human immunodeficiency virus [HIV]).
- Infectious disease reporting (MED-16).
- Field sanitation team training.
- Radiation and NBC protection.

(l) Radiology services.

- Exposure area.
- Darkroom.
- Infection control.
- File room.
- Untoward reaction to contrast material procedures.
- Emergency drug tray.
- Disposition of used needles and syringes.
- Security.
- Dealing with the critically ill inpatient.
- Radiation safety rules for nonradiology personnel.
- Radiation protection in diagnostic radiologic examinations.
- Shielding of patient and technician.
- Recovery of silver.
- Electrical and mechanical safety rules.
- Routine radiographic views.
- Weekly processor tests.
- Quality control procedures.

- Filing procedures.

(m) Emergency medical treatment.

- Functions.
- Scope of practice of MOS 91A/B personnel.
- Scope of practice of MOS 91C personnel.
- Mass casualty operations.
- Medical evacuation procedures.
- Blood alcohol testing.
- Animal bites.
- Protocol for post-exposure rabies prophylaxis.
- Preexposure rabies prophylaxis.
- Sexually transmitted diseases.
- Reporting of unusual occurrences.
- Routine care of HN military and dependents.
- Specialty clinics for HN civilians.
- Preemployment physicals for HN civilian employees.
- Routine medical care for HN contract civilian employees.
- Medical treatment for chemical and biological agent casualties.

c. Medical Rapid Response Team.

(1) Threat information.

(2) Organization and functions.

(3) Implementation of team to include coordination with HN, if applicable.

(4) Medical equipment and supplies.

(5) Command, control, and communications.

(6) Geneva Conventions.

(7) Tasking organizations to include medical element, aviation element, and military police element.

(8) Intelligence requirements and signal operating instructions.

(9) Bomb discovery and disposal.

d. Medical Readiness Training Exercises.

(1) Definition and scope.

(2) Location.

(3) Employment and deployment.

(4) Coordinator responsibilities.

(5) Mission planning and execution.

(6) Equipment and supply requirements.

(7) Duration of exercise.

(8) Medical mission reconnaissance checklist (Appendix K).

(9) Accounting.

(10) After action reporting requirements and special distribution.

e. Medical Supply and Maintenance.

(1) Stockage levels to include rotation of stock.

(2) Procedures for resupply to include time lines.

(3) Coordination requirements.

(4) Procedures for medical maintenance (organic and depot).

f. General Supply and Maintenance.

(1) Stockage levels.

(2) Procedures for resupply to include time lines.

(3) Coordination requirements.

(4) Procedures for organic and depot maintenance and repair.

APPENDIX K

MEDICAL MISSION RECONNAISSANCE CHECKLIST

SAMPLE FORMAT

K-1. General

a. The individual medical mission under a HCA program requires comprehensive planning and prior coordination to ensure success. This appendix provides a checklist for completing a reconnaissance of the mission area prior to deployment of a medical team.

b. The terminology used to describe the different levels of the health care delivery system and its health care professionals in a particular country may vary from that provided in this checklist. The checklist, therefore, should be modified to conform to the health care delivery system in the AO.

K-2. Sample Medical Mission Reconnaissance Checklist

Name of Village _____
Grid _____
Sheet # _____

A. Resources Available in Village and Surrounding Vicinity.

1) Communications means and accessibility.

a. Communications means: Telephone _____ Telegraph _____ Other _____

b. Type of road network: Paved _____ Dirt _____ Path _____

2) Health workers.

a. *Health guardian: _____

b. *Midwife: _____

c. *Health representative: _____

3) Other personnel available.

a. School teacher: _____

b. Village leader: _____

c. Others: _____

4) *Nearest medical clinic.

a. Distance: _____

b. Transportation available: _____

*Terms for these individuals or organizations may vary between health care delivery systems.

c. Number and type of staff (to include specialties): _____

_____

(1) *Name of the head nurse:_____

(2) *Name of the health promoter: _____ _____

(3) Other: _____ _____

5) *Nearest district or regional medical clinic.

a. Distance: _____ _____

b. Transportation available: _____ _____

c. Number and type of staff: _____ _____

(1) *Name of the physician (social service) _____

_____

(2) Others: _____

6) *Nearest hospital (public and private) and type of hospital. _____

_____

a. *Area hospital: _____ Distance:_____

b. *Regional hospital:_____ Distance:_____

c. *National hospital:_____ Distance:_____

7) Private physicians.

a. Name: _____

b. Address: _____

c. Specialty: _____

B. Health Information.

1) Size of population.

a. Adults: _____

b. Children: _____

c. Infants: _____

2) Housing and accessibility of hygiene and sanitation measures.

a. Number of houses and typical type of construction to include heating: _____

b. Latrines: _____

c. Water pump: _____

d. Water source and how used (bathing, laundry, and cooking): _____
_____

3) Endemic diseases.

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

4) Five leading causes of death.

a. Adults: _____

b. Children: _____

c. Infants: _____

5) Veterinary information.

a. Number of:

(1) Cattle: _____

(2) Horses/mules: _____

(3) Goats: _____

(4) Pigs: _____

(5) Dogs/cats: _____

b. Number of animals which died in the last 3 months: _____

c. Causes or reasons of deaths: _____
_____

6) Dental care information.

a. General level of oral health: _____

b. Endemic oral diseases: _____

c. Availability of dental care: _____

d. *Names of dental care providers: _____

7) General living conditions.

a. Clothes: _____
Shoes: _____ Barefoot: _____

b. Housing: _____

c. Electricity: _____ _____

d. Number of family radios/TVs: _____ _____

e. Stores: _____ _____

f. Crops: _____ _____

g. Main food sources: _____ _____

h. Main sources of income: _____
_____ Average family income: _____

8) Type of health care to be given. _____
_____
_____
_____

9) Estimation on reliability of information.
_____
_____

C. Transportation Information.

1) Air.

a. Pilots who flew assessment teams: _____
_____

b. Adequate landing zone for:

(1) UH-1: _____

(2) UH-60: _____

(3) CH-47: _____

(4) Other: _____

c. Travel time: _____

2) Ground.

a. Type of vehicle: _____

b. Travel time: _____

c. Special requirements (such as snow chains): _____

_____

d. Other: _____

D. Security Information.

1) Threat: _____

2) Host nation and US security forces in the area: _____

_____

3) Agency responsible for providing security and crowd control:

_____

E. Diagram of Mission Area.

1) Draw diagram (place on back of sheet). Include information on village or town, stream flow, cattle chutes, corrals, and cemeteries.

2) Explain on-site triage. _____ _____

_____ _____

3) Explain patient flow. _____ _____

_____ _____

4) Others/remarks. _____ _____

_____ _____

F. Items Required to Support Mission.

_____

_____

G. Photographs of Significant Features and People.

_____

H. Assessment Made by: OIC/NCOIC _____

Physician/nurse _____

Others _____

I. Expected Date of Mission. _____

APPENDIX L

DEPLOYABLE MEDICAL TEAMS

L-1. General

a. This appendix contains brief descriptions of deployable medical teams a commander may want to use in his AO. These teams may not be appropriate in each instance; however, this information may be helpful in determining requirements. *These teams are not fixed TOE teams, but are task organized from the commander's resources for specific missions.* Supply and resupply (all classes) functions remain the responsibility of the headquarters forming the task force. If sufficient CSS is not available within the AO, the task force commander must ensure adequate coordination occurs to meet supply and resupply functions. One source of detailed information on these types of teams is Commander, 7th Medical Command, ATTN: AEMPO, APO NY 09102.

b. One or more teams may be deployed on a specific mission. The senior medical person deployed (unless otherwise designated) provides the medical command and control required. He also coordinates the team's effort for mission accomplishment.

L-2. Medical Rapid Response Assessment Team

The medical rapid response assessment team (MRRAT) assesses the situation and determines medical assets required for a specific mission. The MRRAT is task organized and personnel on the deploying team are contingent upon the type, magnitude, and location of the incident (such as a national disaster or terrorist incident).

L-3. Triage Team

The triage team sorts patients into categories (minimal, immediate, delayed, and expectant); administers lifesaving fluids; controls hemorrhage; performs cutdowns; and does minor emergency debridements, tracheotomies, and chest tube insertions.

L-4. Treatment and Stabilization Team

This team is normally a follow-on medical force package to increase expertise and abilities available to the triage team for more complete stabilization of casualties. The mission includes the performance of completion amputations; significant debridement; lifesaving laparotomies; basic bowel resections; ileostomies; and colostomies. This team does not render definitive care but stabilizes and evacuates the patient to the next echelon of care.

L-5. Surgical Team

The surgical team performs emergency surgical and medical procedures directed toward the prevention and treatment of shock, and the treatment of patients requiring emergency intensive care. Employment of this team is normally in association with a triage or treatment and stabilization team or as augmentation to an already established MTF.

L-6. Veterinary Service Team

The veterinary service team performs emergency veterinary medical support. Capabilities include food inspection; zoonotic and foodborne disease control; ante and postmortem examination of food animals; and veterinary PVNTMED functions.

L-7. Environmental Sanitation Team

This team performs emergency environmental sanitation support including investigation, identification, evaluation, and recommendations to improve sanitation of food facilities, housing, water supplies, and waste disposal. Teams are deployed when sanitary conditions in a crisis action area dictate the need for environmental sanitation support or when existing MTFs require augmentation.

L-8. Community Health Nursing Team

This team plans and manages disease containment education and immunization programs to curtail or prevent the spread of communicable disease among host populations. The team is managed by a community health nurse who is proficient in public health science. It specializes in disease containment

programs where changing host behavior or altering host infectivity are a means of control.

L-9. Stress Management Team

Victims of disaster, hostage, or terrorist situations suffer a high incidence of acute, chronic, and post-traumatic (delayed) stress disorders in addition to medical and surgical injuries. Treatment of these disorders in the acute phase can prevent the development of many chronic or delayed reactions. This team provides mental health treatment services and initiates preventive treatment measures to individuals or groups involved as victims of disasters, terrorist activities, and hostage situations. Teams are task organized from mental health and stress control personnel depending upon the numbers of people involved in the specific incident and the nature of the incident.

L-10. Other Teams

Other teams that may be considered are–

- Airfield reception.
- Chemical and biological sampling.
- Dental.
- Entomology.
- Environmental engineering.
- Epidemiology.
- Evacuation.
- Radiological advisory medical.

L-11. Health Service Logistics Package

This is not a medical team, but a predesignated Class VIII push package of high demand consumables. The push packages are designed based on local requirements.

APPENDIX M

HEALTH SERVICE SUPPORT OF SPECIAL OPERATIONS FORCES

M-1. Special Operations

a. Special operations (SO) are military operations conducted by forces of the DOD in pursuit of US national goals and objectives. These forces are specially trained, equipped, and organized to accomplish strategic, operational, and tactical missions.

b. Special operations may be conducted during periods of peace or hostility. They may support conventional operations, or they may be prosecuted independently when the use of conventional forces is either infeasible or inappropriate.

M-2. Department of the Army Special Operations Forces

The five component elements of Army SOF are:

- Special forces (SF).
- Rangers.
- Psychological operations.
- Civil affairs.
- Special operations aviation (SOA).

M-3. The Threat to Special Operations Forces

The threat to SOF varies with the environment, geographic area, mission, and level of conflict. The specific threat to SOF encompasses the same threat facing conventional forces. Further, from the moment SOF are inserted in small groups into an area by land, sea, or air, they must be able to—

- Survive.
- Operate deep in opposing force-held areas without being detected.
- Work closely with friendly, indigenous personnel.

M-4. Special Operations Forces Missions

a. Special operations forces missions are normally conducted as joint or combined operations across the operational continuum. In accordance with Section 167, Title 10, United States Code, the following are the principal SOF missions:

- Direct action (DA).
- Special reconnaissance (SR).
- Unconventional warfare (refer to paragraph 5-7).
- Foreign internal defense.
- Civil affairs.
- Psychological operations.
- Counterterrorism.
- Humanitarian assistance.
- Special operations search and rescue (SOSAR).
- Other missions as directed by the NCA.

b. Special operations forces can provide an extra dimension to the battlefield through their unique and flexible capacity to affect operations in the deep, close, and rear battle areas.

M-5. Command and Control

a. Special operations forces are theater-level assets. Operational and tactical level commanders request SOF through the Unified Commander in Chief. The SOF command and control element is established at any headquarters, combined or US, employing SOF. This ensures that unique mission requirements and employment procedures are met.

b. The Commander in Chief directs theater SO and the employment of SOF through his

subordinate special operations command (SOC). The theater SOC is a joint command that controls Army, Navy, and Air Force SOF. As strategic assets, SOF elements are deployed to the theater of operations and placed under SOC operational control.

c. Special operations forces units do not have an organic combined arms capability and are not designed for sustained combat operations. Special operations forces require the support or attachment of other combat, CS, and CSS units. Special operations forces units are entirely dependent upon the resources of the theater army to support and sustain their operations.

M-6. Army Special Operations

a. The SF group is a unique combat arms organization capable of planning, conducting, and supporting SO activities in all operational environments and across the operational continuum. Special Forces units are characterized by the quality, motivation, training, and individual skill of their members. These characteristics produce units with superb collective skills, able to adapt well to dynamic, complex situations.

(1) The SF group consists of a group headquarters and headquarters company, a group support company, and three SF battalions. The group can operate as a single unit, but normally the battalions plan and conduct operations from widely separated locations.

(2) The SF company consists of a company headquarters (‘‘B” detachment) and six operational detachments ("A" detachments or ODAs). The ODA (twelve-man team) is the basic SF unit and is specifically designed to conduct SO activities in remote areas. This unit can operate for extended periods with a minimum of external direction and support. The high-grade structure and experience level of the ODA is required to permit it to develop, organize, equip, train, and advise or direct indigenous military and paramilitary organizations of up to battalion size. For other SO activities that do not require its full capabilities, the ODA serves as a manpower pool from which SF commanders organize tailored SF teams to execute specific missions.

b. The Ranger regiment is a unique light infantry unit capable of planning, conducting, and supporting SO activities. The Ranger regiment provides the NCA with the capability to deploy a credible military force quickly to any region of the world. The primary Ranger mission in SO is to conduct DA operations best accomplished by conventional light infantry forces using special techniques. Ranger DA operations may support or may be supported by other SO activities, or they may be conducted independently or in conjunction with conventional military operations.

c. The SOA regiment is a unique Army aviation unit that provides dedicated combat aviation support to Army and other SOF. This support is provided in all operational environments and across the operational continuum. Because of current force structure and contingency requirements, the regiment does not operate as a single unit. Instead, it tailors SOA battalion or company task forces to perform specific missions. The primary mission of SOA assets is to clandestinely penetrate hostile and sensitive airspace to conduct and support SO activities.

d. The Civil Affairs, Foreign Internal Defense, and unconventional warfare (CA FID/UW) battalion is a specialized CA unit that plans and conducts civil-military operations in support of SOF. The CA FID/UW battalion employs specialized, regionally oriented, and language qualified CA teams. The teams train, advise, and assist US and indigenous forces in the conduct of civil-military operations that support both FID and UW missions.

e. Psychological operations are planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, and objective reasoning. These operations ultimately influence the behavior of foreign governments, organizations, groups, and individuals. Army PSYOP units may be employed by the NCA in pursuit of national security objectives. These PSYOP may be designed to—

- Maintain the support of groups and nations friendly to the US.
- Gain support and cooperation of neutral countries.

- Strengthen or alter alliances.
- Deter a nation from aggression.
- Induce the surrender of hostile forces.

M-7. Organic Health Service Support Capability

The organic HSS capability of SOF units is extremely austere. Consequently, SOF are dependent upon the conventional HSS structure for medical support in theater. Special operations forces missions require organic assets to perform Echelon I (unit level) and Echelon II (division level) medical care. Echelon III (corps level) and Echelon IV (communications zone [COMMZ] level) medical care must be provided to the force.

a. Special Forces.

- The SF group has the capability to perform Echelon I and Echelon II medical care. Individual care consists of self-aid and buddy aid, combat lifesaver, and aidman (SF medic) care. There are two SF medics assigned to each ODA. The SF medic is often the sole source of medical care for his ODA and the indigenous personnel (and their families) with whom his ODA interfaces. Medical assets within the SF group can provide limited support in the following areas:
  - Preventive medicine.
  - Medical intelligence.
  - Veterinary and dental medicine.
  - Laboratory support for clinical diagnosis.
  - Minor surgery.
  - Short-term trauma management.
- A flight surgeon and physician assistant are assigned to each SF battalion. At the forward operating base, the flight surgeon and physician assistant can perform advanced trauma management procedures and provide limited resuscitative care. However, medical evacuation to the forward operating base is unlikely due to the considerable distances that may separate the ODAs from this base. Further, the forward operating base has a PVNTMED noncommissioned officer capable of providing medical threat evaluation and limited direct PVNTMED support.
- The SF operating base has a flight surgeon, dental officer, veterinary officer, medical operations officer, medical logistics officer, and an environmental science officer assigned. At this level, the medical officers perform primarily as staff advisors to the group commander and provide medical staff assistance to the deployed SF battalions.

b. Rangers.

- The Ranger regiment has the capability to perform Echelon I and limited Echelon II care. Echelon III care must be provided to the force.
- Rangers have organic HSS similar to conventional light infantry battalions; however, they do not have an aid station (treatment squad) capability.
- A general medical officer and physician assistant are assigned to each Ranger battalion. The Ranger companies are assigned military occupational specialty (MOS) 91A and 91B medical specialists.

c. Special Operations Aviation.

- Special operations aviation has a flight surgeon and a psychiatrist assigned at group level.
- Special operations aviation is dependent on area HSS from units it is supporting (typically the SF operating base).
- Special operations aviation units do not have specifically designated medical aircraft with a primary mission of medical evacuation.

d. Civil Affairs and Psychological Operations.

- Civil affairs and PSYOP units have no organic HSS. They are dependent on area HSS from the theater medical command.

- Psychological operations units also require timely and accurate information on all public health and host nation support initiatives to accomplish their mission.

M-8. Planning for Health Service Support of Special Operations Forces

Special operations forces units require HSS similar to other combat, CS, and CSS units. They also need timely and accurate medical intelligence to counter the medical threat. The support should include but not be limited to patient evacuation and medical regulating hospitalization; combat stress control; PVNTMED services; veterinary services; laboratory services; health service logistics; blood management; and dental services.

M-9. Patient Evacuation and Medical Regulating

Aeromedical evacuation of SOF is indicated only when it will not compromise the mission. Health service support planners must ensure there is adequate medical evacuation capability both intertheater and intratheater. If SOF assets are used, as will probably be the case in intratheater evacuation, medical assets must be on board to provide medical care en route. Health service support planners must ensure that SOF has its own evacuation policy to allow return of critical SOF MOSS to their units instead of being evacuated out of theater. Early coordination must be made with in-theater Air Force assets or supporting SOF Air Force assets to ensure timely intertheater evacuation capability.

M-10. Hospitalization

Special operations forces do not have an organic Echelon III surgical capability. They rely on the standard medical command hospitalization system for its patients in the combat zone and at echelons above corps. When the sensitivity of a particular mission dictates strict operations security, the SOC must coordinate with the medical command to establish facilities capable of handling patients on a classified basis.

M-11. Combat Stress Control

a. Combat fatigue cases should be managed as far forward as possible to—

- Preclude unnecessary loss of personnel.

- Hasten return to duty.

- Prevent overburdening the medical evacuation system.

b. Army SOF do not have organic medical combat stress teams and support is required from the theater.

M-12. Preventive Medicine

A major shortfall of SOF HSS is the lack of PVNTMED assets. The nature of SOF operations places its personnel at serious risk to disease and environmental injury. Education and thorough indoctrination to the medical threat in the AO is required. Surveillance proceduresand personal protective measures to be taken must be continuously reinforced. These PVNTMED measures will enhance the health and operational readiness of the SF elements. The SF group has limited PVNTMED assets and capabilities to plan, coordinate, and supervise PVNTMED programs. The SF PVNTMED NCO provides technical assistance to the unit field sanitation teams and advises the commander on the control measures required to protect the force. Theater PVNTMED assets are required to provide area support (such as aerial spraying and larviciding and to support other SOF units).

M-13. Veterinary Services

Special Forces groups have limited veterinary services. When veterinary services are required in more than one location or when the SOF is larger than two deployed forward operating bases (FOBs), veterinary support must be augmented. Theater assets must perform the majority of the food inspection missions.

M-14. Medical Laboratory Services

The SF group ODA is the only SOF unit with a limited laboratory capability. The SO medical sergeant (MOS 18D) is trained to provide basic clinical laboratory tests and procedures in support of UW or FID missions. Echelon III laboratory support is required from the theater.

M-15. Health Service Logistics and Blood Management

The medical sections of all SOF units maintain a Class VIII (medical supply) basic load to support initial operations. The SF group and battalion medical sections are the only SOF elements with organic medical supply personnel. No SOF unit has an organic medical equipment maintenance capability. These units receive routine health service logistics through their supporting area support medical battalion. This support includes Class VIII supplies, oxygen, resuscitative fluids production, optical fabrication, medical equipment maintenance support, and blood storage and distribution. To fill operational requirements in support of a UW or FID, SF medical supply personnel at the Special Forces Operational Base (SFOB) and FOB requisition bulk Class VIII supplies directly from the supporting medical command medical supply, optical, and maintenance battalion. Army special operations forces may also supplement their health service logistics effort with foreign national medical supplies, particularly during unconventional warfare operations.

M-16. Dental Services

The SF group is the only SOF unit with an organic dental capability. The group's medical section includes a dental team, and SF medics at all levels can provide emergency dental care. All other SOF units rely on dental teams at the supporting area support medical battalion unit for all their dental care.

M-17. Interrelated Missions

As previously stated, SOF units conduct five basic missions and have a number of collateral capabilities. Special operations forces elements conduct UW, FID, counterterrorism, DA, and SR operations across the spectrum of conflict. Mission priorities vary from theater to theater. These elements are specifically tailored to organize, equip, train, direct, control, and support indigenous forces in FID and UW operations. They also perform SR, DA, and counterterrorism operations and other missions requiring their collateral capabilities. Although each mission is treated separately, they are all interrelated. Some situations will dictate that a committed SOF element conduct more than one mission at the same time.

M-18. Unconventional Warfare

a. Unconventional warfare is a broad spectrum of military and paramilitary operations, normally of long duration, predominantly conducted by indigenous or surrogate forces who 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. Unconventional warfare also includes the indirect activities of subversion, sabotage, intelligence collection, and evasion and escape.

b. The goals of medical operations in support of unconventional warfare are to conserve the guerrilla force's fighting strength and to assist in securing local population support for US and resistance forces operating within Unconventional Warfare Operations Areas (UWOA).

c. Medical elements supporting the resistance forces must be mobile, responsive, and effective in preventing disease and restoring the sick and wounded to duty. There is no safe rear area where the guerrilla takes his casualties for treatment. Wounded and ill personnel become a tactical rather than a logistical problem.

d. In an unconventional warfare situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collection points, thus permitting the remaining members of the resistance force to continue to fight. Casualties at these collection points are later evacuated to the guerrilla

base or guerrilla medical facility. As the operational area develops, more seriously injured or diseased personnel are evacuated to friendly areas. Clandestine evacuation nets are established if security does not permit using aeromedical evacuation.

e. Medical requirements within the UWOA differ from those posed by conventional forces. Battle casualties are normally fewer and the incidence of disease and malnutrition is often higher.

M-19. Foreign Internal Defense

a. Foreign Internal Defense the participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. These operations are US efforts to support a friendly government facing a threat to its internal stability and security. The purpose of these operations is to protect internal development efforts that focus on the economic and social aspects of the nation's structure. Foreign internal defense is not exclusively a SOF mission. It is a joint and interagency activity in which SOF participate. The primary SOF mission in this interagency activity is to organize, train, advise, and assist host nation military and paramilitary forces.

b. Civil-military operations that focus on the relationship between US military forces and the indigenous population are critical for FID operations. Medical services have proven to be one of the most effective ways to gain support for the host nation government. Medical assistance is constructive in nature and is generally welcomed, rather than feared. Medical assistance programs are requested by the host government. They are aimed at —

- Improving basic standards of living and health.
- Involving the local population.
- Enhancing the prestige of local authorities.

c. Medical support may include providing medical treatment, education in basic sanitary procedures, hygiene and preventive medicine, providing sanitary facilities, waste disposal and controls, improving drinking water, and conducting immunization programs.

M-20. Counterterrorism

a. Counterterrorism operations are offensive measures taken by civilian and military agencies of a government to prevent, deter, and respond to terrorism. The primary mission of SOF in this interagency activity is to apply specialized capabilities to preclude, preempt, and resolve terrorist incidents abroad.

b. Counterterrorism operations are either overt or covert in nature. They are characterized, in contrast to unconventional warfare, as being of short duration and specifically targeted. During counterterrorism operations, tailoring of units and equipment is required. Medics are needed at all levels of the operation, and medical equipment is selectively chosen for the operation.

c. Health service support planning involves studying the mission and the area of operations to determine medical requirements. Equipment is kept to a minimum to support emergencies and routine illnesses. Special packing of the equipment is considered, especially for raid-type missions, to make essential items immediately accessible. Premission medical training concentrates on emergency medical treatment, advanced trauma management, and treatment of mass casualties.

M-21. Direct Action

a. Special operations forces DA missions are combat operations conducted or directed primarily by SOF in hostile or denied areas beyond the operational capability of tactical weapon systems and conventional maneuver forces. Direct action operations are normally limited in scope and duration, but they may include long-term stay-behind operations. These operations typically involve the interdiction of critical lines of communications or other target systems and the

abduction, rescue, or recovery of selected personnel or sensitive items of material.

b. Medical support of SOF DA operations is generally directed toward provision of evacuation and hospitalization. Since the majority of SOF DA missions are conducted beyond the forward line of own troops (FLOT), aerial medical evacuation is required to remove casualties from the field. Echelon III HSS is required on an area support basis from the theater medical command.

M-22. Special Reconnaissance

a. Special reconnaissance is an intelligence collection activity conducted beyond the operational capabilities of tactical collection systems to obtain or verify information about the activities and resources of a target, organization, or group. Special operations forces SR missions are generally of short duration and involve small elements (squads, teams, split-teams). SR missions are "deep" operations conducted beyond the FLOT primarily in support of intelligence requirements of strategic importance.

b. Since SR missions are conducted deep in hostile or denied territory, medical support is austere. Since aerial medical evacuation of SOF casualties would compromise the mission, the units rely on Echelon I (self-aid and buddy aid, combat lifesaver, and medical sergeant [MOS 18 D]) until the mission is accomplished and the team is extracted.

c. Comprehensive medical intelligence is critical for SOF SR missions. The medical threat requires evaluation of preventive medicine and counter threat measures to protect SR elements from exposure to disease and injury.

GLOSSARY

ACRONYMS, ABBREVIATIONS, AND DEFINITIONS

ADA American Dental Association

AFB Air Force Base

AFMIC Armed Forces Medical Intelligence Center

AFPMB Armed Forces Pest Management Board

AMEDD Army Medical Department

Antiterrorism see *combatting terrorism*

AO area of operations

APO Air Post Office

attn attention

AUTOVON automatic voice network

CA civil affairs

CAG Contingency Advisory Group

CH cargo helicopter

CHN community health nurse

Civil affairs—(DOD) those phases of the activities of a commander which embrace the relationship between the military forces and civil authorities and people in a friendly country or area or occupied country or area when military forces are present. Also called CA.

Civil war a war between factions of the same country; there are five criteria for international recognition of this status: the contestants must control territory, have a functioning government, enjoy some foreign recognition, have identifiable regular armed forces, and engage in major military operations.

CLIC Army and Air Force Center for Low Intensity Conflict

CLO Contingency Liaison Officer

Combatting terrorism—(DOD) actions, including antiterrorism (defensive measures taken to reduce vulnerability to terrorist acts) and counterterrorism (offensive measures taken to prevent, deter, and respond to terrorism) taken to oppose terrorism throughout the entire threat spectrum.

COMMZ communications zone

CONUS continental United States

Counterinsurgency—(DOD) those military, paramilitary, political, economic, psychological, and civic actions taken by a government to defeat insurgency.

Counterterrorism see *combatting terrorism*

Country team the executive committee of an embassy, headed by the chief of mission, and consisting of principal representatives of the government departments and agencies present (for example, the Departments of State, Defense, Treasury, Commerce, and the US Information Agency, USAID, Drug Enforcement Agency, and Central Intelligence Agency).

Crisis an incident or situation involving a threat to the United States, its territories, citizens, military forces, and possessions or vital interests that develop rapidly and create a condition of such diplomatic, economic, political, or military importance that commitment of US military forces and resources is contemplated to achieve national objectives.

CS combat support

CSS combat service support

DA direct action

DNBI disease and nonbattle injury

DOD Department of Defense

DOWW Disease Occurrence Worldwide

DPMIAC Defense Pest Management Information Analysis Center

DVEP Disease Vector Ecology Profiles

EMT emergency medical treatment

EOC emergency operations center

EPW enemy prisoners of war

FID Foreign Internal Defense

FLOT forward line of own troops

FM field manual

FMF Foreign Military Financing

FOB forward operating base

Foreign Internal Defense—(DOD) participation by civilian and military agencies of a government in any of the action programs taken by another government to free and protect its society from subversion, lawlessness, and insurgency. Also called FID.

Foreign military sales—(DOD) that portion of United States security assistance authorized by the Foreign Assistance Act of 1961, as amended, and the Arms Export Control Act of 1976, as amended. This assistance differs from the Military Assistance Program and the International Military Education and Training Program in that the recipient provides reimbursement for defense articles and services transferred.

FTS Federal Telecommunications System

GMI general medical intelligence

Guerrilla warfare—(DOD, NATO) military and paramilitary operations conducted in enemy held or hostile territory by irregular, predominantly indigenous forces. See also *unconventional warfare.*

HCA humanitarian and civic assistance

HIV human immunodeficiency virus

HN host nation

Host nation–(DOD, NATO) a nation which receives the forces and/or supplies of allied nations and/or NATO to be located on, or to operate in, or to transit through its territory.

HSS health service support

Humanitarian assistance assistance provided by DOD forces, as directed by appropriate authority, in the aftermath of natural or man-made disasters to help reduce conditions that present a serious threat to life and property. Assistance provided by US forces is limited in scope and duration and is designed to supplement efforts of civilian authorities that have primary responsibility for providing such assistance.

Humanitarian and Civic Assistance such assistance shall include: medical, dental, and veterinary care provided in rural areas of a country, construction of rudimentary surface transportation systems, well drilling or refurbishing, and construction of basic sanitation facilities; rudimentary construction and repair of public facilities. Also called HCA.

ID identification

IDAD internal defense and development

IMET International Military Education and Training

Informational actions communication with a foreign government, its supporters, its opponents, and others to explain one's own policies and actions.

Infrastructure in an insurgency, the leadership organization and its system for command and control. In a broader sense, the systems of communications and the institutions which support the political and economic functions of a society.

Insurgency—(DOD, NATO) an organized movement aimed at the overthrow of a constituted government through use of subversion and armed conflict.

Internal defense and development the full range of measures taken by a nation to promote its growth and protect itself from subversion, lawlessness, and insurgency. Also called the IDAD strategy.

IV intravenous

JCS Joint Chiefs of Staff

JSOA joint special operations area

JTF joint task force

LIC low intensity conflict

LOC lines of communications

Low intensity conflict political-military confrontation between contending states or groups below conventional war and above the routine, peaceful competition among states. It frequently involves protracted struggles of completing principles and ideologies. Low intensity conflict ranges from subversion to the use of armed force. It is waged by a combination of means, employing political, economic, informational, and military instruments. Low intensity conflicts are often localized, generally in the Third World, but contain regional and global security implications. Also called LIC.

Low intensity conflict imperatives prerequisites for the successful planning and conducting of low intensity conflict operations. These include: political dominance, unit y of effort, adaptability, legitimacy, and perseverance.

MAP Military Assistance Program

MASF mobile aeromedical staging facility

MD Maryland

MEDCAP Medical Capabilities Study

Medical operations in low intensity conflict those activities which encompass all military medical actions taken or programs established to further US national goals, objectives, and missions in a low intensity conflict environment. Also called MEDOLIC.

Military Assistance Programs–(DOD) that portion of the US security assistance authorized by the Foreign Assistance Act of 1961, as amended, which provides defense articles and services to recipients on a nonreimbursable (grant) basis. Also called MAP.

Military civic action—(DOD) the use of preponderantly indigenous military forces on projects useful to the local population at all levels in such fields as education, training, public works, agriculture, transportation, communications, health, sanitation, and others contributing to economic and social development, which would also serve to improve the standing of the military forces with the population. (US forces may at times advise or engage in military civic actions in overseas areas.)

MOPP mission-oriented protection posture

MOS military occupational specialty

MOUT military operations on urbanized terrain

MRE meals, ready-to-eat

MRRAT Medical Rapid Response Assessment Team

msg message

MTF medical treatment facility

MTT mobile training team

NATO North Atlantic Treaty Organization

NBC nuclear, biological, and chemical

NCA national command authority

NCO noncommissioned officer

NCOIC noncommissioned officer in charge

NEO noncombatant evacuation operations

no number

NY New York

OCONUS outside of the continental United States

ODA operational detachment "A"

OIC officer in charge

OJCS Office of the Joint Chiefs of Staff

OPLAN operations plan

OT occupational therapy

PAHO Pan American Health Organization

Peacekeeping operations military operations conducted with the consent of the belligerent parties to a conflict, to maintain a negotiated truce and to facilitate diplomatic resolution of a conflict between the belligerents.

Peacetime contingency operations politically sensitive military operations normally characterized by the short-term, rapid projection or employment of forces in conditions short of war.

PMO preventive medicine officer

POM preparation for oversea movement (units)

POR preparation of replacements for oversea movement

ppm parts per million

Psychological operations—(DOD) planned operations to convey selected information and indicators to foreign audiences to influence their emotions, motives, objective reasoning, and ultimately the behavior of foreign governments, organizations, groups, and individuals. The purpose of psychological operations is to induce or reinforce attitudes and behavior favorable to the originator's objective. Also called PSYOP.

PSYOP psychological operations

PT physical therapy

PVNTMED preventive medicine

QR quick response

Routine, peaceful competition the condition of relations among states in which each seeks to protect and advance its interests by political, economic, and informational means without employing violence.

S&TI scientific and technical intelligence

S2/G2 Intelligence Officer (US Army)/Assistant Chief of Staff, G2 (Intelligence)

SAO Security Assistance Organization

SDI Selective Disseminations of Information

Security assistance—(DOD) groups 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 United States 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 Organization all DOD elements located in a foreign country with responsibilities for carrying out security assistance management functions. For example, military assistance advisory groups, military missions and groups, liaison groups, defense attache personnel, and other groups which perform security assistance functions. Also called SAO.

SF Special Forces

SFOB Special Forces Operating Base

SO special operations

SOA special operations aviation

SOC special operations command

SOF special operations forces

SOP standing operating procedures

SOSAR special operations search and rescue

SR special reconnaissance

TB MED technical bulletin, medical

TDA table(s) of distribution and allowance

Terrorism—(DOD) the unlawful use or threatened use of force or violence against individuals or property to coerce or intimidate governments or societies, often to achieve political, religious, or ideological objectives.

TOE table(s) of organization and equipment

TV television

UH utility helicopter

Unconventional warfare—(DOD) abroad spectrum of military and paramilitary operations conducted in enemy-held, enemy-controlled, or politically sensitive territory. Unconventional warfare includes, but is not limited to, the interrelated fields of guerrilla warfare, evasion and escape, subversion, sabotage, and other operations of a low visibility, covert, or clandestine nature. These interrelated aspects of unconventional warfare may be prosecuted singly or collectively by predominantly indigenous personnel, usually supported and directed in varying degrees by (an) external source(s) during all conditions of war or peace. Also called UW.

US United States

USAF United States Air Force

USAID United States Agency for International Development

UW unconventional warfare

UWOA Unconventional Warfare Operations Areas

WHO World Health Organization

REFERENCES

SOURCES USED

These are the sources quoted or paraphrased in this publication.

Joint and Multiservice Publications

DOD 6420.lR. *Organization and Function of the Armed Forces Medical Intelligence Center (AFMIC).* 25 April 1986.
JCS Publication 1-02. *DOD Dictionary of Military and Associated Terms.* 1 December 1989.
FM 100-20. *Military Operations in Low Intensity Conflict AFP 3-20.* August 1990.

Army Publications

FM 8-10-8. *Medical Intelligence in a Theater of Operations.* 7 July 1989.
FM 8-55. *Planning for Health Service Support.* 15 February 1985.

DOCUMENTS NEEDED

These documents must be available to the intended users of this publication.

AR 40-400. *Patient Administration.* 1 October 1983.
DA Pamphlet 40-3. *Medical Service Multilingual Phrase Book.* 31 May 1971.
FM 3-3. *NBC Contamination Avoidance.* 30 September 1986.
FM 8-10. *Health Service Support in a Theater of Operations.* 2 October 1978.
FM 8-26. *Dental Services.* 9 September 1980
FM 8-33. *Communicable Diseases in Man.* 20 June 1985.
FM 8-250. *Preventive Medicine Specialist.* 27 January 1986. (Change 1, September 1986).
FM 8-285. *Treatment of Chemical Agent Casualties and Conventional Military Chemical Injuries.* NAVMED P-5041/AFM 160-11. February 1990.
FM 10-52. *Field Water Supply.* 27 February 1985.
FM 21-10. *Field Hygiene and Sanitation.* 22 November 1988.
FM 21-10-1. *Unit Field Sanitation Team.* 1 0ctober 1989.
FM 90-10. *Military Operations on Urbanized Terrain (MOUT) (How to Fight).* 15 August 1979.
FM 90-10-1. *An Infantryman's Guide to Urban Combat (How to Fight).* 30 September 1982.
FM 100-37. *Terrorism Counteraction.* 24 July 1987.

READINGS RECOMMENDED

These readings contain relevant supplemental information.

AR 40-5. *Preventive Medicine.* 1 June 1985.
AR 40-562. *Immunization Requirements and Procedures.* 7 October 1988.
DA Pamphlet 27-1. *Treaties Governing Land Warfare.* 7 December 1956.
DA Pamphlet 27-1-1. *Protocol to the Geneva Conventions of 12 August 1949.* 1 September 1979.
FM 1-103. *Airspace Management and Army Air Traffic in a Combat Zone.* 30 December 1981.
FM 3-100. *NBC Operations.* 17 September 1985.
FM 19-15. *Civil Disturbances.* 25 November 1985.
FM 19-30. *Physical Security.* 1 March 1979.
FM 19-40. *Enemy Prisoners of War, Civilian Internees, and Detained Persons.* 27 February 1976.
FM 21-11. *First Aid for Soldiers.* 27 October 1988 (Change 1, August 1989).
FM 27-2. *Your Conduct in Combat Under the Law of War.* 23 November 1984.
FM 27-10. *The Law of Land Warfare.* 18 July 1956.
FM 31-20 (C). *Doctrine for Special Forces Operations (U).* 20 September 1989.
FM 41-10. *Civil Affairs Operations.* 17 December 1985.
FM 90-8. *Counterguerrilla Operations.* 29 August 1986.
FM 100-10. *Combat Service Support.* 18 February 1988.
FM 100-26. *The Air-Ground Operations System.* 30 March 1973.
FM 100-27. *USA/USAF Doctrine for Joint Airborne and Tactical Airlift Operations.* AFM 2-50. 31 January 1985 (Change 1, March 1985).
FM 100-103. *Army Airspace Command and Control in a Combat Zone.* 7 October 1987.

INDEX

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:

THOMAS F. SIKORA
Brigadier General, United States Army
The Adjutant General

DISTRIBUTION:

Active Army, USAR, and ARNG: To be distributed in accordance with DA Form 12-11-E, requirements for FM 8-42, Medical Operations in Low Intensity Conflict (Qty rqr block no. 4930), and FM 8-10, Health Service Support in a Theater of Operations (Qty rqr block no. 0810).

☆U.S. GOVERNMENT PRINTING OFFICE:1990 -527 -027/20094