

## APPENDIX D

**MULTINATIONAL OPERATIONS****D-1. General**

Multinational operations are those military actions that encompass two or more countries. These operations serve two purposes. First is the simple combination of numbers. Countries associate themselves in military operations to bring their separate military forces together into a more powerful combined force. Increasingly, however, multinational operations serve a political purpose. The combined efforts of two or more countries lend legitimacy to the enterprise, demonstrating broad international approval of the operation. For example, in the Persian Gulf War of 1991 (Operation Desert Storm), even token military contributions by small countries added their moral and political backing to the international effort to force Iraq out of Kuwait.

**D-2. Alliances and Coalitions**

There are two types of multinational forces: alliances and coalitions. These forces must create a structure that meets the needs, diplomatic realities, constraints, and objectives of the participating nations.

*a. Alliances.* Alliances are long-standing agreements between or among nations for the attainment of broad, long-term objectives. An example of an alliance is the North Atlantic Treaty Organization (NATO).

*b. Coalitions.* Coalitions, on the other hand, are *ad hoc* agreements between two or more nations for a common action (the attainment of a short-term objective).

**D-3. Command Structure of Multinational Forces***a. Alliances.*

- (1) Alliances are characterized by years of cooperation among nations. In alliances—
  - Agreed-upon objectives exist.
  - Standard operating procedures have been established.
  - Appropriate plans have been developed and exercised among the participants.
  - A developed TO exists, some equipment interoperability exists, and command relationships have been firmly established.
- (2) Alliances are normally organized under an integrated command structure that provides unity of command in a multinational setting. The key ingredients in an integrated alliance command are that a single commander will be designated, that his staff will be composed of representatives from all member

nations, and that subordinate commands and staffs will be integrated to the lowest echelon necessary to accomplish the mission. Figure D-1 depicts a multinational alliance under an integrated command structure.

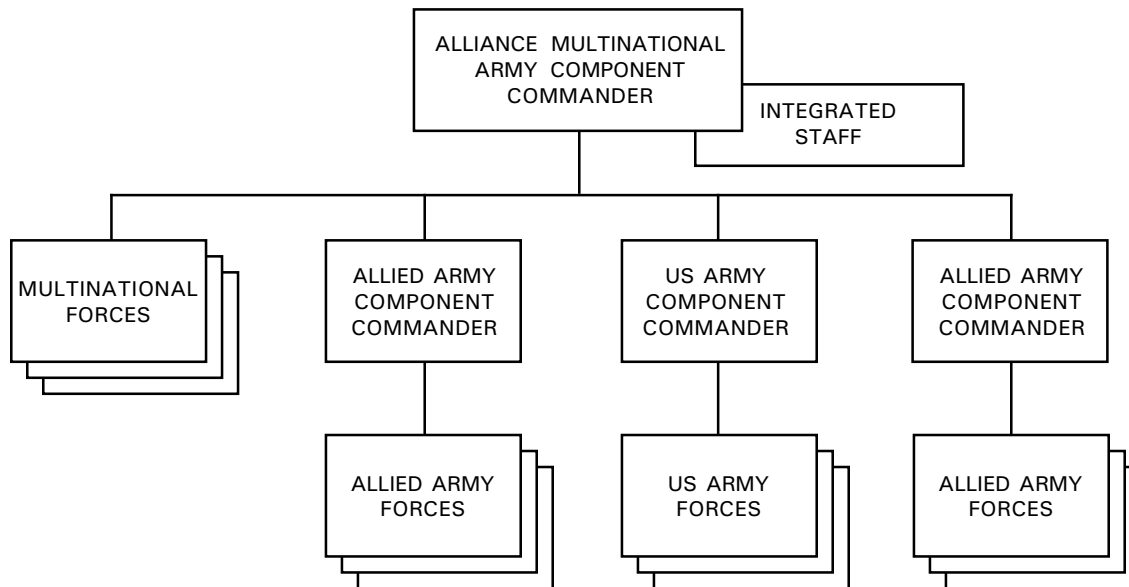


Figure D-1. Multinational army command structure alliance (national subordinate formations).

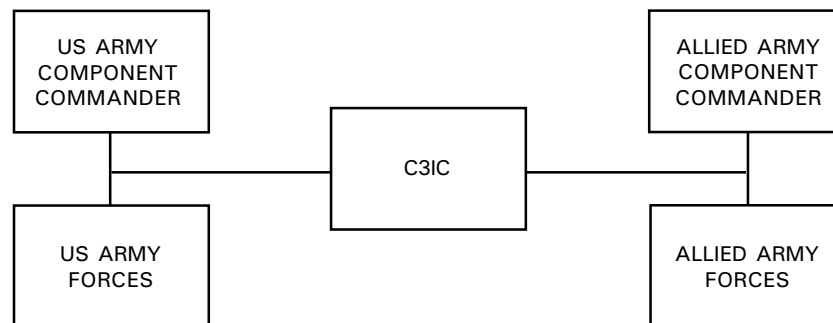
(3) Another form of alliance is the lead nation command structure. This structure may exist in a developing alliance when all member nations place their forces under the control of one nation. This means that the lead nation's procedures and doctrine form the basis for planning and coordinating the conduct of operations. Although this type of arrangement is unusual in a formal alliance, such a command structure may have advantages under certain treaty circumstances. A lead nation command in an alliance may be characterized by a staff that is integrated to the degree necessary to ensure cooperation among multinational or national subordinate army formations.

b. *Coalitions.* Coalitions are normally formed as a rapid response to an unforeseen crises and, as stated above, are *ad hoc* arrangements between two or more nations for a common action.

(1) During the early stages of such a contingency, nations rely upon their military command systems to control the activities of their forces. Therefore, the initial coalition arrangement will most likely involve a parallel command structure (Figure D-2). Under a parallel command, no single multinational army commander is designated. Usually member nations retain control of their national forces. Coalition decisions are made through a coordinated effort among the participants. A coalition coordination, communications, and integration center (C3IC) can be established to—

- Facilitate exchange of intelligence and operational information.

- Ensure coordination of operations among coalition forces.
- Provide a forum for resolving routine issues among staff sections.



LEGEND:  
 \_\_\_\_\_ COMMAND

*Figure D-2. Coalition parallel command structure (forces under national control).*

(2) As a coalition matures, the members may choose to centralize their efforts through establishing a lead nation command structure (Figure D-3). A lead nation command is one of the less common command structures in an *ad hoc* coalition. A coalition of this makeup sees all coalition members subordinating their forces to a single partner, usually the nation providing the preponderance of forces and resources. Still, subordinate national commands maintain national integrity. The lead nation command establishes integrated staff sections, with the composition determined by the coalition leadership.

#### **D-4. Rationalization, Standardization, and Interoperability**

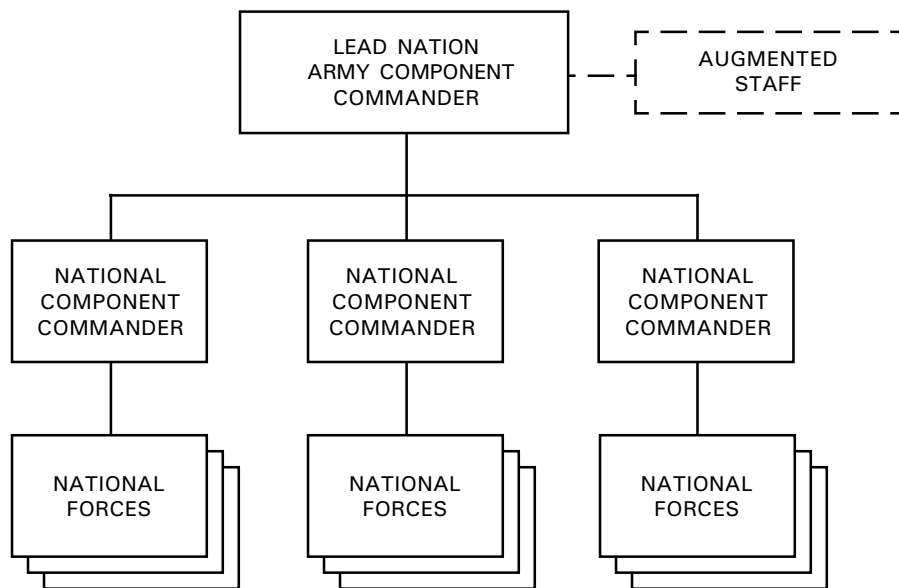
One of the most difficult aspects of multinational operations concerns the rationalization, standardization, and interoperability (individually defined in the Glossary) of equipment, supplies, and procedures. This task is compounded by differences in terminology, language, and doctrine.

*a. Communications.* To ensure mission success, it is imperative that communications are quickly established with all participating nations.

(1) Initial communications can be facilitated by exchanging liaison teams who will provide direct interface with the participating nations. When possible, liaison personnel should be deployed early in the planning/organization phase of the operation.

(2) Compatible communications equipment may pose a severe problem for the multinational force. Even within joint operations, the US experiences interoperability problems with communications

equipment; these difficulties are magnified when US forces are engaged in multinational operations. Depending upon the size of the multinational force, one nation may be required to provide communications equipment to all elements for C2 purposes. The planning for and effective use of messengers and wire communications may also assist in alleviating this situation.



LEGEND:  
 ————— COMMAND AND CONTROL  
 - - - - - LIAISON/COORDINATION

Figure D-3. Lead nation command structure (augmented staff and multinational subordinate formations).

*b. Standardization.* Within alliances, standardization can be accomplished in many areas. The specifications and requirements for equipment, treatment protocols, and procedures can be developed by working groups and adopted for use by each nation. An example of this is the NATO standard litter which can be interchangeably used in all ambulances employed by the member nations. In coalitions there is not sufficient time permitted to reach standardization agreements of this nature. Due to the short duration and limited purpose of these arrangements, there is usually only sufficient time to standardize principles and time-sensitive procedures, such as report formats or radio frequencies to be used, rather than materiel development issues.

*c. Command and Control.* As coalitions are *ad hoc* agreements of countries sharing a common interest, it may not be possible to establish C2 over all participants as each nation may have its own specific requirements which limit the authority it will permit international or national commanders to exercise over

its forces. Thus, command in the formal sense may not exist, and a system of cooperation may be required in its place. Hasty agreements must be made to formulate workable methods. These are always specific to the situation and must be decided by commanders and staffs, taking into consideration the mission, requirements, and capabilities of the participating forces.

#### **D-5. Combat Health Support Issues**

The US military has a sophisticated, state-of-the-art field health care delivery system. When engaged in multinational operations, the US may be called upon to provide health care to the forces of allied or coalition partners engaged in the ongoing operation. Factors which may impact on the delivery of this care include—

*a. Eligible Beneficiaries.* Early in the CHS planning process, a determination must be made as to who will be eligible beneficiaries for care in US MTFs. This determination should be made at the highest possible level with the advice of the Staff Judge Advocate as it will impact on the medical force structure to be deployed and the expenditure of funds on Class VIII materiel required to support the eligible population.

*b. Funding.* The funding and/or reimbursement aspects of the operation should be clearly delineated at the outset of the operation. Multinational operations are often conducted under the auspices of nongovernmental agencies, such as the UN. The CHS planner must know what the mechanisms for reimbursement are and what methods of resupply are to be used.

*c. Differences in Languages.* Interpreters will be required to assist medical personnel in treating soldiers from other nations who do not speak English. Department of the Army Pamphlet 40-3 provides basic medical questions and responses in the languages of the NATO members, but must be supplemented by locally produced guides for languages not included.

*d. Endemic Disease.* When treating soldiers from other nations, the health care provider must be familiar with the endemic diseases in the soldier's native homeland. These diseases may or may not be endemic in the AO. Treating soldiers with varying endemic diseases may require medications not normally stocked by the treatment element. As these diseases may not be familiar to the health care providers, additional consultation with specialists may be required.

*e. Religious and Cultural Differences.* Religious and cultural differences will exist between the different forces. Health care providers must be aware of any cultural norms or religious beliefs which affect the delivery of health care. These differences may be encountered in areas such as the use of blood and blood products or dietary restrictions. By the health care provider being aware of and considering these cultural differences and religious beliefs, cooperation of the patient for the treatment regime may be facilitated.

*f. Nuclear, Biological, and Chemical Threat.* Each nation will have different methods and materiels for safeguarding their troops from the effects of NBC weaponry. This may result in different levels of protection for the various forces participating in the operation. The CHS planner must consider the various levels of protection to ensure that adequate health care support can be provided in the event that NBC weaponry is employed.

## D-6. Combat Health Support Considerations

The command surgeon will be required to establish policies and procedures which will affect the type and quantity of CHS available to the participating forces. As a minimum, the following factors should be considered—

### a. *Patient Evacuation and Medical Regulating.*

- The evacuation policy for the theater/operation must be established during the initial planning phase because much of the medical force structure to be deployed is dependent upon this policy.
- It must be established who will perform medical evacuation missions and what assets (platforms and personnel) will be used. (Is one nation the primary evacuator or will each nation evacuate their own patients?)
- It must further be determined where patients from the different member nations will be evacuated to (such as to the nearest facility regardless of nationality or to a facility established by their own nation).
- The communications interface (type of radio, frequency, and request format) must be standardized to facilitate the receipt of the request and expedite the dispatch of the evacuation platform.
- Additional policies may be required on the exchange of litters, blankets, and other types of medical equipment accompanying the patient, on the backhaul of Class VIII and blood on ambulances, and on transferring a patient from one nation's evacuation system to another.

b. *Hospitalization.* The array of hospital assets within a TO or deployed for an operation is dependent upon the nature and duration of the operation, the anticipated patient work load, and the theater evacuation policy. In multinational operations, it needs to be determined which nations will provide hospitalization and, once that is established, what capabilities these assets have. Standards of medical care, credentialing, scope of practice, and ancillary care available will differ between participating nations. A clear understanding of the medical capabilities of each nation's facilities is an essential requirement for the CHS planner to ensure that a duplication of services does not occur and that all elements of care are provided for. Further, the participating nations must establish at what point a patient within the health care delivery system of one nation will be returned to his own nation's system.

c. *Combat Health Logistics.* Different nations have different standards for collecting and testing blood as well as for the production of pharmaceuticals and medical equipment. Due to the stringent regulation of blood and blood products and the production of pharmaceuticals in the US, these Class VIII items will normally only be procured through the US forces Class VIII system for use with US troops. Funding and reimbursement mechanisms must be identified and formalized if the US Class VIII system is used to resupply other nations' MTFs.

d. *Preventive Medicine Services.* Preventive medicine programs are essential in reducing morbidity and mortality due to DNBI. In a multinational force, the PVNTMED personnel must be familiar

with the cultural and religious differences of the participating nations. Field sanitation and personal hygiene practices are not universally the same in all nations; in some nations, these practices do not exist. To ensure that endemic diseases of a particular nation are not introduced to the other participating forces, disease surveillance, pest management, and personal protective measure programs must be initiated and enforced. Inspection of bivouac areas, feeding facilities, potable water supplies, and waste disposal and sanitation facilities must be an ongoing effort. In addition, ensuring that operations are in compliance with federal, state, local, and HN environmental laws, regulations, policies, and standards will help to prevent an imbalance from occurring in the ecosystem. Such an imbalance occurring in the ecosystem should be avoided because it could make human health and disease conditions worsen.

*e. Dental Services.* Dental services within the multinational force may be the responsibility of each participating nation. If care is to be provided by one nation, it would normally only consist of emergency dental procedures to provide for the immediate relief of pain and discomfort.

*f. Area Medical Support.* A comprehensive plan must be established to ensure that all participants have access to medical care and services. Whether one nation provides all of the essential services or each nation is responsible for its own care (or some combination of the two), a comprehensive plan which delineates the access to and interconnectivity of support must be provided. Units or elements without organic CHS resources must receive Echelons I and II support on an area support basis and these support requirements must be incorporated into the supporting units' OPLAN.

*g. Veterinary Services.* The AMEDD is the DOD Executive Agent for Veterinary Services within the US Army. Its missions of ensuring food wholesomeness and quality and providing medical care to government-owned animals are an essential service in stability and support operations. The US forces may have the only deployable veterinary resources and may be required to perform their missions for the entire multinational force.