CHAPTER 3

COMBAT HEALTH SUPPORT TO STABILITY OPERATIONS AND SUPPORT OPERATIONS

3-1. General

Commanders are used to thinking about changes in the direction and depth of the battle and adjusting battle plans to achieve objectives. Stability and support operations require attention to factors which may be absent in war. The political dimension lies at the core of stability and support operations. The objective of these operations is to support a political resolution of problems affecting US national interests.

3-2. Noncombatant Evacuation Operations

a. Noncombatant evacuation operations are conducted to evacuate civilian noncombatants and nonessential military personnel from locations in a foreign (host) nation during time of endangerment to a designated safe haven. These operations are normally conducted to evacuate US citizens whose lives are in danger from a hostile environment or natural disaster. They may also include the evacuation of US military personnel and dependents, selected citizens of a HN, or third country nationals. These operations are of short duration and consist of rapidly inserting a force, occupying an objective, and withdrawing as planned. 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. Combat health support to NEO is tailored to the size of the military force and the anticipated health needs of the evacuees. Every effort is made to use the existing medical skills of the evacuees.

c. The CHS 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. Combat health support 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, stress control support, 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 and government-owned animals.
- Potential sources of food supplies and water.
- Security provisions for patients and medical personnel.

3-3. Domestic Support Operations

Traditionally, the US Army has been called upon to assist federal, state, and local governments in times of need. There are four basic categories of domestic support activities (or support to domestic civil authorities) which may be provided. These are disaster assistance, community assistance, environmental assistance, and law enforcement support. (For additional information on domestic support operations, refer to FM 100-19 and the Federal Response Plan [FRP] for Public Law [PL] 93-288, as amended.)

a. Disaster Assistance. The Federal Emergency Management Agency (FEMA) is the federal government's executive agent for implementing federal assistance during disaster relief operations.

(1) Disaster assistance includes those humanitarian and civil defense activities, functions, and missions in which the Army has legal authority to act. The Army provides disaster assistance to states, the District of Columbia, territories, and possessions. Assistance is based upon requests from civil authorities and usually as a result of natural or man-made disasters such as hurricanes, typhoons, earthquakes, or massive explosions. The US Army is the lead agency for urban search and rescue under the provisions of PL 93-288. The Emergency Support Function (ESF) #8 is the Health and Medical Services Annex of the FRP. The purpose of this function is to provide US government assistance to supplement state and local resources in response to public health and medical care needs following a significant natural disaster or man-made event. Assistance provided under ESF #8 is directed by the Department of Health and Human Services (DHHS) through its executive agent, the Assistant Secretary for Health, who heads the US Public Health Service (USPHS). Resources will be furnished when state and local capabilities are overwhelmed and medical and/or public assistance is requested from the federal government. Emergency Support Function #8 will be implemented upon the appropriate state-level request for assistance following the occurrence of a significant natural disaster or man-made event and a determination has been made that a federal response is warranted.

(2) At the onset of the operation, criteria for eligibility of care (such as disaster victims, civilian rescue workers, military retirees and families, and/or other individuals in the disaster area) must be established and disseminated to all supporting units. A determination must also be made as to when this eligibility ends and the patients once again become the responsibility of the local medical infrastructure. Further, a determination must be made of what supplies and services are reimbursable and what governmental agency or organization is responsible for this reimbursement.

(3) Once tasked to provide the support, an assessment of the operational area is required. This is used to determine the correct mix of CHS resources to be employed and the level of support required. (Depending upon the specific situation, this could entail small selected specialty teams or complete organizations such as a CSH.) For command, control, and coordination, it is important for the

military headquarters to be established in a location that will facilitate coordination/liaison. Ideally, the military headquarters can be collocated with the civilian agency in charge of the disaster relief operations.

- The CHS planner must include in his assessment the—

  - Endemic diseases prevalent in the AO (even those considered to be at a low epidemiological level).

  - State of the public works and services (sanitation [including sewer systems], water sources, and garbage pickup).

  - Availability of local medical facilities, personnel, and resources and services being provided by other non-DOD and nongovernment agencies.

  - Numbers of anticipated patients and types and categories of injuries and diseases expected. Consideration must also be given to the type of equipment available in field medical equipment sets (MESs) and what types of equipment will be required to augment these sets. Disaster victims will range in age from newborns to the very old; the type of equipment required for pediatric and geriatric patients is not contained in the standard MES.

  - Anticipated length of the operation.

- The US Army CHS provided in disaster assistance operations may include—

  - Traditional CHS to the employed US Army forces.

  - Management of mass casualty situations (to include triage, treatment, and evacuation) (Appendix J).

  - Delivery of direct medical, nursing, and other health care and services to victims of the disaster.

  - Medical evacuation support out of the immediate disaster area to supporting area hospitals.

  - Preventive medicine support to temporary camps to reduce rodent and arthropod breeding grounds; establish sanitation facilities; provide training (education) in field sanitation, personal hygiene, and PMM; and inspect water supplies (to include ice).

  - Veterinary support for livestock, pets, and/or wild animals that are injured or dislocated and for the inspection of food stuffs for wholesomeness and quality.

  - Combat health logistics support to replenish exhausted medical supplies and equipment and management, storage, and distribution of donated medical supplies and equipment.

- Mental health support to victims and caregivers.
- Dental support on an emergency basis and for maxillofacial injuries.
- Occupational therapy (OT) and physical therapy (PT) to provide preventive and restorative care support.
- Nutrition care and dietetics counseling and education.

- The CHS requirements can be met in a number of different ways depending upon the specific situation, such as—
  - Military medical personnel may be used to assist in staffing local facilities.
  - A military field hospital (such as a CSH) could be deployed to the disaster area.
  - Medical evacuation assets could be used to move patients from the immediate disaster area to a MEDDAC or MEDCEN, or a civilian hospital in the surrounding area for further care.
  - The National Disaster Medical System (NDMS) could be activated. (The NDMS is a nationwide medical mutual aid network between federal and non-federal sectors that includes medical response, patient evacuation, and definitive medical care.)

(4) A communications capability between military participants and civilian agencies must be established. Ambulances must have a long-range communications capability compatible with their civilian counterparts in order to coordinate with hospitals and rescue/emergency vehicles. Units deploying for operations in disaster areas should have all authorized communications equipment on hand. If equipment is not compatible with the civilian counterparts, arrangements must be made to establish a liaison/messenger system or additional equipment must be borrowed or procured.

(5) Refer to Appendix K for additional information on disaster assistance operations.

b. Community Assistance. Community assistance operations are the most frequently conducted domestic support operations. These operations use Army resources to support civilian organizations which promote the general welfare of the community. These missions and operations include public works, education, and training. Additionally, mutual support agreements concerning medical, police, or emergency services may be established with local communities in compliance with existing regulations and directives. The AMEDD has provided assistance to local communities such as—

- Rescue and evacuation through the Military Assistance to Safety and Traffic (MAST) Program. This program uses US Army air ambulances to evacuate severely injured civilians from the place of the incident (automobile accident or job site injury) to an appropriate hospital.
- Rescue of stranded civilians in times of floods, wild fires, or other life-threatening disasters.

- Use of a MEDDAC or MEDCEN as a trauma center for serious injuries when the capability does not exist in the adjacent civilian community, or if the military hospital is closest to the accident (once stabilized, patients are further evacuated to a civilian hospital).

- Use of the US Army Institute of Surgical Research Burn Center for severely burned civilians when other burn care facilities are not available.

- Participation in community health care programs such as health screening and educational presentations.

- Provision of immunization and medical screening clinics (in conjunction with state and local agencies) in rural areas where civilian medical assets are limited.

c. Environmental Assistance. Environmental assistance operations aid civil authorities in preserving, protecting, and enhancing the environment. The US Army strategy rests on the four pillars of compliance, restoration, prevention, and conservation. Compliance includes responding to small-scale hazardous material spills and regulatory support to other government agencies. Restoration involves cleaning up contamination from past operations. Prevention is developing and sharing new technologies that reduce pollution generation. Conservation focuses on the preservation of natural and cultural resources such as wetlands preservation and fighting wildland fires. Army support in these areas may be initiated under disaster assistance or may be executed under separate authority. In the face of a substantial environmental threat, military medical expertise from the US Army Center for Health Promotion and Preventive Medicine (USACHPPM) may be employed. On a smaller scale, a civilian community experiencing a small toxic spill may request PVNTMED support from a neighboring installation to assist in the assessment process.

d. Law Enforcement Support. Operations in support of law enforcement include assistance in counterdrug operations, assistance for civil disturbances, special security operations, combatting terrorism, explosive ordnance disposal, or similar activities. Constitutional and statutory restrictions and corresponding directives and regulations limit the type of support provided. Combat health support will be limited in law enforcement support activities and will normally follow the traditional role of CHS for deployed forces and veterinary support for government-owned animals used in these operations.

3-4. Foreign Humanitarian Assistance

Foreign humanitarian assistance programs relieve or reduce the results of natural or man-made disasters or other conditions such as human pain, disease, hunger, or deprivation that present a serious threat to life or result in great property damage or loss. Humanitarian assistance provided by US forces is limited in scope and duration. It is designed to supplement or complement the efforts of HN civil authorities or agencies that may have primary responsibility for providing humanitarian assistance. Most foreign humanitarian assistance is conducted as joint or multinational operations. The most common operations are disaster relief and refugee programs. (Refer to Appendix L for information on the provisions of Title 10, US Code.)

a. Disaster Relief.

(1) 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.

(2) Combat health support assistance requires a rapid assessment of the health needs produced by the disaster and the rapid tailoring of a medical element to deal with the disaster or deployment of SRTs, if required.

- 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 educational efforts and other public health measures to help victims resist potential disease outbreaks are important aspects of PVNTMED support.
- Medical treatment and other health care will most likely have to be provided in rudimentary facilities.
- The CHS element must be able to quickly reach the disaster site with the right mix of medical specialties.
- The CHS element should have the capability to interact with victims in their own language.
- Stress control measures should be applied during and after the operation. (In some instances, stress control measures can be introduced to caregivers prior to their deployment to the disaster site.) These measures are used to maintain effective performance and minimize post-traumatic stress disorder among caregivers, as well as victims.

b. Refugee Operations. Refugee operations may entail the rescue of individuals fleeing a nation and the establishment of temporary safe havens to house and care for these people. Combat health support resources may be required to ensure that—

- Sufficient sanitation facilities are provided.
- Disease surveillance is conducted and disease vectors are controlled.
- Water sources used in the camps are inspected and water is treated, if required, to ensure potability.

- Food wholesomeness standards are maintained.
- Primary health care needs of the refugees are met.

3-5. Security Assistance

a. Through security assistance programs, the US provides defense materiel, military training, and defense-related services by grant, loan, credit, or cash sales to further its national policies and objectives. The Security Assistance Training Program has two primary subcomponents:

- International Military Education and Training Program.
- Foreign Military Sales Program.

b. Military CHS resources may not be used in all types of missions; however, they can be employed to improve health-related quality of life issues. They are also successful in providing effective training for the participating US Army personnel. This support is given by such means as—

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

c. The foreign internal defense (FID) augmentation force is a conceptual, composite organization which augments the Security Assistance Organization (SAO). When constituted, the FID augmentation force operates under a US unified command or subordinate joint task force (JTF). Its 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 specially trained, area-oriented, mostly language qualified, and available for immediate deployment. Combat health support augmentation to the FID augmentation force can be provided to some extent in all of the CHS functional areas. Particularly effective in this arena are medical treatment, nursing, PVNTMED, stress control, dental, and veterinary resources.

3-6. Nation Assistance

a. Determining the Heath Service Needs of a Host Nation.

(1) 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 within his area of responsibility (AOR). Among the many sources of information are the—

- Host nation.
- Armed Forces Medical Intelligence Center.
- Department of State.
- Defense Attaché.
- United States Army CA units.
- United States Agency for International Development (USAID).
- World Health Organization (WHO).
- Nongovernmental organizations.
- Private volunteer organizations.
- Religious organizations.

(2) 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 CHS resources are allocated to accomplish the mission.

(3) As one of the goals of using military CHS resources is to enhance the effectiveness of the HN government in the medical arena, 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 the general health of the population (to include nutrition).
- State of MH, psychiatric, and social support 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 available.
- Primary care capabilities, to include rural areas.
- Morbidity and mortality rates.

- 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 health education and health promotion programs targeted at the general population.
- Veterinary medical capabilities in government, industry, and private sectors.
- Status of health care resources.
- Education level of the general population.

(4) An assessment checklist is provided in Appendix E and a medical mission reconnaissance checklist is provided in Appendix M.

b. Health Care Program Development.

(1) In many Third World countries, medical specialties exist, although in limited numbers. Consultation programs involving specialists to share knowledge and new techniques can be quite effective. These programs enhance the HN medical personnel's skills and provide a method of interfacing with their peers on the latest developments in their field of expertise. This is especially helpful in countries which do not have established graduate medical education programs.

(2) In order to develop viable and effective health care programs, a long-term commitment of assistance is required; the *quick fix* is not a solution for ensuring that adequate health care services will remain available to the HN civilian and military populations. Further, the *quick fix* solution may not further US national goals for enhancing the stability of the HN government.

(3) Combat health support 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.
- Security Assistance Organization.

- United States Agency for International Development.
- Foreign internal defense augmentation force.
- Civil affairs elements.
- Special operations forces (SOF) (Appendix N).
- World Health Organization.
- Private organizations and religious efforts.

(4) 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.

(5) 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 health 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 health care delivery system can increase access to primary care despite limited resources and a 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.

(6) 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.

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

(8) 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) require a well-publicized focus to a given area and a schedule to provide return visits.

c. Additional Information. Information on Title 10, US Code is contained in Appendix L.

3-7. Support to Counterdrug Operations

Combat health support to counterdrug operations is limited in nature.

a. The veterinary service provides care and treatment of MWDs used in these operations. Further, the veterinary support may become involved in developing animal husbandry programs which can, in turn, lead to the economic growth of the HN and reduce its dependence on income generated by drug-related agriculture.

b. United States Army medical evacuation resources may also be used to evacuate injured, ill, or wounded soldiers involved in these operations.

3-8. Combatting Terrorism

a. *General*.

(1) Terrorism has 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.

(2) The tactics used by terrorists include bombings, hijackings, assassinations, and kidnappings. The immediate objectives of terrorism are recognition, coercion, intimidation, and provocation. Terrorism is a tactic that is used across the operational continuum.

(3) Further information on combatting terrorism is contained in Joint Publication (Joint Pub) 3-07.2 and FM 100-20.

b. *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 1-5, Appendix A, and FM 8-10-8.)

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

d. *Combat Health Support Planning Considerations*.

(1) The CHS commander must plan for and conduct active programs which reduce his unit's 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 and stress.

(2) The CHS planner must be aware of the terrorist threat in the planned AO. He must incorporate appropriate safeguards and considerations into the CHS OPLAN. These considerations include—

- Medical.
  - Threat capability for the use of NBC weapons/agents and DE weapons/devices.
  - Provisions for laboratory support to identify suspect agents.
  - Special immunization or chemoprophylaxis for potential BW agents.
  - Command information stressing individual protective measures to include personal hygiene and sanitation.
  - Provisions for safeguarding and inspecting food and water supplies.
  - Provisions for the treatment of contaminated water sources.
  - Stress control resources for debriefing victims, rescuers, and caregivers after a terrorist attack.
  - Provisions for suspect BW and CW agent therapeutics.
  - Medical evacuation under hostile fire or in adverse terrain (FM 8-10-6).
  - Mass casualty situations (Appendix J and FM 8-10-1).
  - Augmentation or reinforcement of medical personnel, supplies, and equipment.
  - Hospitalization (location and requirements).
  - Plans for continued care in the event the MTF is the target of a terrorist attack.
  - Dispersion of units.
  - Care of government-owned animals used in combatting terrorism operations.
  - Specialty response teams (Appendix I).
- Nonmedical.
  - Terrorist threat.
  - Potential targets.

- Terrorist bomb awareness and countermeasures.
- Operations security.
- Procurement of special security equipment, such as portable barriers and intrusion devices.
- Protection of storage and distribution areas.
- Security before, during, and after deployment to the AO.
- Limitations of access to MTFs by reducing the number of entry and exit points.
- Personnel screening of those seeking access to the facility.

e. Preparation and Training.

(1) Although not all terrorist activities result in mass casualty situations, medical elements must plan for and be prepared to respond to mass casualty situations should they occur. All plans must be practiced by those who will participate when the plans 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 CHS commander ensures that the required internal and external coordination has been effected. 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 CHS mission, even if the MTF is the terrorist target.

(2) All newly assigned personnel should be provided with an orientation that addresses the terrorist threat. The discussion can include the newly assigned personnel's role in combatting terrorism and in mass casualty situations. It can include information on what to do if the MTF is the target of terrorists.

(3) 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.

(4) To more effectively use medical personnel, nonpatient care personnel assigned to the unit should be instructed in support duties, such as driving, ensuring the security of the unit area, carrying litters (FM 8-10-6), acting as messengers, and providing first aid in the MINIMAL care area, as required.

3-9. Peace Support Operations

Peace support operations encompass a wide range of activities which establish or sustain peaceful conditions or foster the conditions essential to establishing peace. Peace support operations include essentially diplomatic activities to support diplomacy in peacekeeping and peace enforcement. Other activities which support peace operations may include humanitarian assistance (paragraph 3-4) and nation assistance (paragraph 3-6).

a. Peacekeeping Operations. Traditional peacekeeping operations include such activities as monitoring and supervising truces to facilitate diplomatic efforts to reach a political settlement of the dispute. The AMEDD role in peacekeeping operations is to provide CHS to the peacekeeping force. This force may consist of elements from the other Services or may be a multinational force. It may also include US government civilian employees, civilian contractors, and UN officials.

(1) 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 care.

(2) Due to the inherent neutrality of a peacekeeping force, it is important for CHS 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 humanitarian assistance programs are not to be undertaken by the CHS element of the peacekeeping force.

(3) The CHS package for a peacekeeping force is often limited in size; therefore, it must be carefully tailored to satisfy mission-unique requirements. Preventive medicine measures must be employed and receive command emphasis to minimize the medical threat. The DNBI rate is more significant in these operations than are combat wounds. Operational factors in peacekeeping operations may cause stress disorders. These disorders include misconduct stress behaviors which may threaten the success of the peacekeeping mission. Mental health and CSC personnel can help prevent or manage these complications.

(*a*) The CHS 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. Further, augmentation from corps assets (corps support slice) may be required.

(*b*) For successful CHS operations, the CHS planner must ensure that—

- Preventive medicine support is sufficient to identify the medical threat and to provide pest management.
- The size of the CHS element is sufficient to provide adequate care.
- Combat health logistics links for resupply of Class VIII supplies are well defined.
- Medical evacuation platforms and routes are planned for and coordinated with the other Services, allied nations, or coalition forces.
- Veterinary support is sufficient for subsistence procurement and surveillance of foodstuffs and care of government-owned animals.
- A mass casualty plan is prepared and provision for the practice of the plan is made.
- Alternate sources of CHS 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 nations and coalition forces capabilities for emergency care and hospitalization.
- Contingency plans are prepared for CHS in the event of the withdrawal of the peacekeeping force or the escalation of hostilities. If hospitalization support is not available within the AO, 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 support (location, services available, blood supply, and capacity) be available in the event of a mass casualty situation.
- Combat health 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.

(4) For additional information on peacekeeping operations, refer to Joint Pub 3-07.2, FM 100-20, and FM 100-23.

b. Peace Enforcement Operations. Peace enforcement operations are a form of combat, armed intervention, or the physical threat of armed intervention. They are used to compel compliance with international sanctions or resolutions and include combat operations to establish or reestablish conditions conducive to peace, such as forcible separation of belligerents.

(1) Peace enforcement operations are military intervention operations in support of diplomatic efforts to restore peace. They also establish the conditions favorable for the insertion of a peacekeeping force between hostile factions that may not be consenting to the intervention. Although the intent of peace enforcement is to settle a political problem without resorting to violence, coercion is applied when necessary. Violence can easily escalate and CHS plans must provide for the possibility of supporting the force in moderate to heavy combat.

(2) Combat health support elements are tailored to the—

- Size of the peace enforcement contingent.
- Level of hostilities to be encountered.
- Anticipated duration of the mission.

(3) The requirements for CHS in this type of operation are to provide medical care in an austere environment with medical evacuation out of the AO for more definitive care. The CHS planner should be included in the mission planning process to ensure that adequate CHS resources are provided. The CHS planner should consider, but not be limited to, the following:

- Commander's intent and concept of operations.
- Medical threat.
- Anticipated patient work load.
- Anticipated areas of patient density.
- Sanitation and disruption of garbage disposal, water, and sewer services.
- Anticipated civilian casualties requiring medical care, if it is a mission requirement.
- Anticipated EPW medical care requirements.
- Lengthening LOC.
- Medical evacuation (including patient collecting points, ambulance exchange points (AXPs), and the ambulance shuttle system).
- Location of hospitalization assets or services.
- Coordination with the other Services, allies, coalition partners, and HN.
- Operations conducted on urbanized terrain.

- Combat health logistics requirements and procedures.

3-10. Show of Force

a. A show of force lends credibility to a nation's promises and commitments; increases its regional influence; and demonstrates its resolve to use military force as an instrument of national power. Further, the National Command Authorities (NCA) order these operations to bolster and reassure friends and allies.

b. Combat health support for show of force follows the traditional role of providing CHS to a combat force.

(1) The size of the combat force, the mission, the duration of the operation, the assessment of the medical threat, the evacuation policy, 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 CHS planner must be included early on in the planning process for the mission. This is to ensure that adequate CHS resources are planned for and committed to support the show of force and are capable of transitioning to a combat role, if required. Further, if it is a joint or combined operation, the CHS package must be thoroughly coordinated with all parties involved to prevent a duplication of or a gap in the CHS coverage.

3-11. Support for Insurgencies and Counterinsurgencies

The arenas of support for insurgency and counterinsurgency provide the greatest challenges and are the most complex programs in stability and support operations. In these areas, the possibility exists 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 these settings requires thoroughly coordinated planning and flexibility on the part of the commander to successfully accomplish his mission. Agencies of the federal government (other than DOD) normally exercise overall direction of efforts in support for insurgency and counterinsurgency. 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. For the legal considerations concerning insurgency and counterinsurgency operations, refer to FM 100-20.

a. Insurgency. 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.

(1) Insurgencies 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 confrontations 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 managerial 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.

(2) 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, 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.

(3) The CHS requirements for support of an insurgency are determined by the—

- Needs of the insurgent movement.
- Political, social, and economic issues involved.
- Resources available.
- Existence of clear, legal authority.

(4) Combat health support operations may entail advice and—

- Training in PMM and sanitation. Information on PVNTMED and sanitation topics is contained in—
  - Field Manuals 8-10-7, 8-33, 8-250, 21-10, and 21-10-1 and Technical Manual (TM) 5-632.
  - Technical Bulletin, Medical-series.

- Armed Forces Medical Intelligence Center products. (Refer to FM 8-10-8 for additional information on AFMIC products.)
- World Health Organization reports and publications.
- Pan American Health Organization reports and publications.

- Assisting in the establishment of a viable medical infrastructure to attend to the medical needs of the insurgents. The CHS organization supporting the insurgents is normally minimally staffed. It must provide on a limited basis all facets of the health care spectrum from EMT at the point of injury through hospitalization and convalescent care. Army Nurse Corps officers may serve as trainers emphasizing those skills necessary for EMT; triage; mass casualty management; and nursing aspects of pre- and postoperative management. 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 stability and support operations, the treatment station established should be no larger than that necessary to accomplish the mission. It should be 100 percent mobile.

- Assisting in planning health care programs. These programs may be for the populace once the insurgents have attained the position to implement them. Development of CHS programs must be based on the real or perceived needs of the populace. A balance between short- 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 and quality of life. Long-term programs include such projects as—
  - Veterinary care and animal husbandry.
  - Building of sanitation facilities.
  - Training of medical personnel.
  - Providing nutrition and rehabilitation guidance.
  - Providing dental public health programs.
  - Providing health education.

(5) Unconventional warfare (UW) is a broad spectrum of military and paramilitary operations. It is a tactic which insurgent forces may choose to use. These operations are normally of long duration and are predominantly conducted by indigenous or surrogate forces. These forces are organized, trained, equipped, supported, and directed in varying degrees by an external source. Unconventional warfare includes guerrilla warfare and other direct offensive, low-visibility, covert, or clandestine operations. It also includes the indirect activities of subversion, sabotage, intelligence collection, evasion,

and escape. The primary forces used in UW are SOF. (For additional information concerning SOF, refer to Appendix N.)

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

- Combat health support elements supporting the insurgent forces must be mobile, responsive, and effective in preventing disease and returning 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.

- In a UW situation, indigenous medical personnel may provide assistance during combat operations by establishing casualty collecting points. This permits the remaining members of the insurgent force to continue fighting. Casualties at collecting points are later evacuated to the 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.

- Combat health support 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.

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

b. Counterinsurgency.

(1) *Internal defense and development strategy.* 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.

- 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.

- 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.

(2) *Goals and objectives of military combat health support in foreign internal defense.*

- Foreign internal defense is the US role in the IDAD strategy. It 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.

- The goals and objectives of military CHS 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 CHS planner needs to develop specific goals and objectives for each country within the region.

- In developing these goals and objectives, the CHS 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 CHS operations include representatives of the HN or its military.

(3) *The role of military combat health support in foreign internal defense.*

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

- The specific role of CHS 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.
- 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. To facilitate this end, press coverage of counterinsurgency, humanitarian assistance, or nation assistance operations should focus (photographs and stories) on the actions of the HN participants and not on US involvement. Where possible, the US role should be more advisory, consultative, or training in nature, enhancing the HN practitioners skills, thereby enabling him to provide the direct patient care to his nation's citizenry.
- The role of military CHS in a foreign country is determined by the US ambassador (except when the US military forces are under the command of the combatant commander), who is responsible for and has authority over all US government activities within the country. Actions by CHS personnel/units will be fully integrated with the general plan of the US country team. The emerging role of CHS in counterinsurgency operations involves a long-term commitment in consonance with US national policy and goals and the socioeconomic environment of the HN. As stated in paragraph 3-6*b*, the *quick fix* should be avoided, as it only raises the expectations of the populace. When US assistance is withdrawn, the *quick fix* solution 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.

(4) *Combat health 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 care, the effectiveness of the fighting force may suffer. Assessment factors include—

- Status of field sanitation and personal hygiene practices.
- Status of an immunization program for the armed forces.
- Level of training combat medics receive for providing initial medical care.

- Status of a medical evacuation system.
- Existence of field medical units (including command and control [C2] elements).
- Status of unit and individual training in first aid (self-aid, buddy aid, and combat lifesaver skills) in the armed forces.
- Stage of development of the medical organization, including the professional development of medical and paraprofessional personnel.
- Stage of development of (or improvement of) a military hospitalization system.
- Status of the CHL system (including the development of standardized MESs for field operations).
- Status of CSC prevention programs and management of stress cases.
- Status of dental services.
- Existence of medical and nursing training programs and standards of training.
- Level of recruitment and training of civilian health care professionals for duty with the military.
- Status of malnutrition among the armed forces.
- Educational level of members of the armed forces.
- Development of rehabilitative services such as OT and PT and treatment protocols of veterinary services.

3-12. Attacks and Raids

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

a. Planning.

(1) Conventional CHS planning (FM 8-55) is required to meet the needs of the forces deployed. 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. Combat health

support planning, therefore, must be comprehensive, thoroughly coordinated, and flexible enough to meet unanticipated requirements. Sufficient CHS resources must accompany the lead forces to ensure that—

- Medical care can be provided.
- Preventive medicine measures are instituted by the initially deployed forces.

(2) The mission, enemy, terrain, troops and time available (METT-T) factors and medical threat requirements may dictate that special equipment (such as mosquito netting or mountaineering equipment) be required to accomplish the mission. The CHS planner must ensure that sufficient quantities are available for use by medical personnel 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. Planning for sufficient quantities of replacement fluids (water) can minimize this threat.

(4) Combat health support planning should also include the anticipated medical care requirements for EPW, detained or retained personnel, and civilian casualties. It should also consider the 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 USN 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 USN ships must be effected if the evacuation mission is to be successfully accomplished. Early coordination with joint service elements is essential to accomplish these evacuation tasks.

(6) The CHS planner must also ensure that CSC personnel are available to debrief soldiers who are injured or wounded, or who suffer from BF.

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. Of concern to medical and tactical planners alike, is the need to plan, train, prepare, and equip for this environment. The CHS mission will include the location, treatment, and evacuation of wounded from under, above, and at ground level. Additional information on combat in built-up areas is contained in FM 90-10 and FM 90-10-1.

(1) *Medical threat.* Military operations conducted in built-up 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.
- The razing of structures creates rodent and arthropod shelters. The factors which combine to promote the rapid expansion of rodent and arthropod vector populations and the diseases they transmit include—
    - Interruption of water and sewer systems.
    - Disruption of garbage collection.
    - Disruption of health care services.
    - Presence of carrion.
    - Damage to food storage and preparation facilities.
- 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.
    - Smoke produced by these fires.
    - Toxic fumes and smoke generated by obscurants.
    - Fuel-air and other explosive devices.
- Stressors, such as the presence of civilians who may be hostile, increase the risk of misconduct stress behaviors and subsequent post-traumatic stress disorders among US forces.

(2) *Equipment*. In MOUT, it is essential for CHS elements to have the capability for the extraction and evacuation of casualties from above and below ground level. Materiel requirements include—

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

- Special harnesses; portable block and tackle equipment; ropes; grappling hooks; collapsible litters; 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, storm drains, sewers, and subways. Casualties may have to be extracted from beneath rubble and debris.

- Intravenous (IV) fluids and IV starter sets in additional quantities to treat the increase in wounds and trauma injuries which are anticipated. 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, the fluid may be taken orally if an IV starter set is not available.

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

- Effective communications that 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 carries or 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 and other ground vehicles.

- 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.

- For additional information on medical evacuation in this environment, refer to FM 8-10-6.

(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 that was weakened by military action). In either case, humanitarian assistance may be required to perform lifesaving procedures. Once stabilized, these patients are transferred to a HN facility. The CHS planner must, therefore, consider the requirements for—

- Additional logistics support.

- Higher than normal medical supply stockage levels.

- Additional medical equipment.

- Increased staffing of PVNTMED personnel.

- 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.

- When large numbers of refugees are experienced, the medical threat to both the civilian and the military populations will become unacceptable. This is due to the potential overcrowding of facilities, the lack of sufficient sanitary facilities, and the increased requirements for potable water and food supplies.

- Coordination with the HN medical infrastructure should be accomplished to provide essential health services to the refugee population.

(*c*) Combat health support planners must ensure that the potential requirements for providing humanitarian assistance and PMM to the civilian community are incorporated into the plan. This

is necessary to ensure that the level of CHS 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 providing emergency pediatric, obstetrical and gynecological, and geriatric care.
- Duration of the operation and hour of day in which the operation is initiated (such as at midnight when most people are inside their homes or at 0700 when people are leaving for work).
- Population density in the AO.
- Location and availability of Class VIII materiel.
- Availability of sanitation facilities.
- Location of refugee camps or holding areas and anticipated duration of stay in the area.
- Location and availability of potable water.
- Location and availability 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.