CHAPTER 4

SPECIFIC FUNCTIONAL AREA CONSIDERATIONS IN STABILITY OPERATIONS AND SUPPORT OPERATIONS

This chapter discusses specific concerns of the various AMEDD functional areas as they pertain to stability and support operations. The area medical support functional area applies across the continuum of stability and support operations and will not be discussed separately. As area medical support concerns providing CHS to units without organic CHS capability, the constrained size of the forces deployed in stability and support operations necessitates that this function be applied throughout stability and support operations planning. For additional information on the AMEDD functional areas, refer to FM 8-10 and FM 8-55.

Section I. COMMAND, CONTROL, COMMUNICATIONS, COMPUTERS, AND INTELLIGENCE

4-1. General

Command, control, communications, computers, and intelligence (C4I) are the key ingredients to managing CHS missions in stability and support operations. Commonality of communications means, a delineated chain of command, and up-to-date medical intelligence will enable the CHS commander to task-organize his resources, develop a plan, execute the mission in the most timely and effective manner, and be able to realign and redeploy his assets as support requirements change.

4-2. Considerations

a. In stability and support operations, it is essential that all participants communicate effectively. Most operations conducted in this environment will be joint or combined in nature and may also involve nonmilitary and nongovernmental organizations and agencies. As the participants are not all from the same organization, interoperability of communications means cannot be assured. If the communications equipment of the various participants is not compatible, then a liaison/messenger system must be established until compatible equipment is either borrowed or procured. In combined operations, the liaison needs to be able to speak the language of the headquarters to which assigned or be able to communicate effectively through an interpreter.

b. In joint operations, the JTF headquarters ensures standardized reporting formats, times, and requirements are established early in the operation. With the proliferation of Service component forms and local formats governed by parent unit standing operating procedures (SOPs), it is unlikely that participating Service units/personnel will report similar types of information at similar times. It is essential, therefore, that the Army service component surgeon be prepared to develop an internal SOP to incorporate newly established routines and emergency actions/procedures. The degree of administrative support required for an operation is dependent upon the type of operation. For example, in disaster assistance operations, the C4I headquarters must ensure that it provides all of its own administrative support (supplies, equipment, shelter, subsistence, and water) as these items and services may not be available in the disaster area.

c. In stability and support operational scenarios, a clear understanding of who is in charge and a spirit of cooperation must be established, as civilian agencies, other federal and HN agencies, or the ambassador may have the primary responsibility for providing and coordinating support.

d. The legal aspect of stability and support operations is an important area for the commander to consider. Depending upon the scenario, there may be designated groups of individuals authorized care who are normally not beneficiaries of the military health care system, such as disaster victims, rescue workers, UN officials, civilian contractors, or HN civilians. The CHS commander must determine who may receive services, how the government is to be reimbursed for these services and materiel, and what is the malpractice liability (to include credentialing and scope of practice of nonmilitary health care professionals).

Section II. PATIENT EVACUATION AND MEDICAL REGULATING

4-3. General

Patient evacuation is the link between the successive echelons of care in the CHS system. It provides the means to transport a patient while providing continuous medical care en route. This capability enhances the prognosis of the patient. Medical regulating provides the means of directing the patient to the MTF best capable of providing the required care.

4-4. Patient Evacuation and Medical Regulating Support to Stability and Support Operations

a. During NEO, those persons who are injured, wounded, or ill are treated and stabilized by the medical element accompanying the NEO force. Once stabilized they are evacuated by the NEO force.

(1) In NEO conducted in a permissive environment (no apparent physical threat to the evacuees), sick, injured, or wounded persons should be evacuated on dedicated medical platforms, if at all possible. In an uncertain or hostile environment, the transportation assets used to insert and extract the NEO force are normally used to evacuate the patients. The medical personnel accompanying the force provide en route medical care until the NEO force reaches an intermediate staging base (ISB) or safe haven. Those evacuees requiring medical care are then transferred to dedicated medical evacuation platforms for further evacuation to MTFs capable of providing the required care.

(2) Medical regulating coordination is accomplished by the medical element accompanying the NEO force (using the organic communications capability of the force) to ensure dedicated medical evacuation platforms are available for transferring patients to when the NEO force reaches the ISB or a safe haven. Additionally, this coordination ensures the availability of specialty care hospital beds in the supporting MTFs. The medical regulating function is accomplished with the medical group, brigade, or command MRO, the TPMRC, or the Global Patient Movement Requirements Center (GPMRC) supporting the operation.

b. Patient evacuation and medical regulating conducted in domestic support operations will differ with the type of activity supported.

(1) Some operations occur on a routine basis and are detailed in support agreements with the local community. For example, the MAST program uses Army air ambulances to evacuate severely injured civilians from the place of the incident (automobile accident or job site) to the appropriate area hospital.

(2) In other operations, patient evacuation capability may be required due to a crisis such as an earthquake or flood. This support may be required at the community level (localized flooding limited to a small geographical location) or at a state or federal level (such as in major earthquakes or hurricanes). The patient evacuation role of US Army air ambulances may also be expanded in these operations to include executing rescues using the rescue hoist (for example, removing people from the roofs of their homes in floods).

(3) The commander must have clearly defined guidelines as to the scope of the operation and, where applicable, the funding mechanism for reimbursing the government for the expenses incurred.

(4) In operations requiring the activation of the NDMS and when the DOD is tasked to provide evacuation support, US Army evacuation assets (air and ground) will normally be used to move patients within the disaster area while USAF fixed-wing assets are used to move patients out of the AO.

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

(6) The FRP provides detailed information on patient evacuation/medical regulating requirements and responsibilities during federal responses.

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

d. In disaster relief operations, medical evacuation support is dependent upon the situation. If the disaster occurs within a heavily populated area, but there is little damage/injury done to the local medical facilities/personnel, then patients may be cared for in existing local facilities. Evacuation to these facilities is by any form of conveyance available (emergency vehicles for the more seriously injured and privately owned or business transportation assets for the less seriously injured). However, if the disaster occurs in a remote area, or if there is substantial damage/injury to local medical facilities and personnel, patients may initially require evacuation out of the disaster site for definitive treatment. Unless a military unit is in proximity of the disaster and is a first responder, the initial evacuation of accessible victims from the immediate disaster area will already be accomplished. However, military evacuation expertise in the

extraction of victims from above and below the ground may be required as rescue operations continue. Patients must be regulated to medical facilities within the disaster area to ensure that one facility does not become overwhelmed while another is sitting idle. This does not, however, mean that a formal medical regulating system is established, such as the DOD uses. If patients are to be evacuated out of the AO by USAF evacuation assets and regulated into US military, Department of Veterans Affairs (DVA), or civilian hospitals, the GPMRC may be activated. The CHS planner must remember that these operations are often headed by other than military personnel and the medical evacuation plan must be sufficiently flexible to support and complement the overall plan for the operation.

e. The factors to consider in planning for patient evacuation in combatting terrorism operations include—

- Using medical and nonmedical transportation assets to evacuate casualties in mass casualty situations. If nonmedical assets are used, planning should include augmenting these assets with medical personnel to provide en route medical care.

- Applying techniques for evacuating patients under hostile fire or on adverse terrain (from rubble or from above or below ground level). (For additional information, refer to FM 8-10-6.)

- Ensuring security measures (such as establishing checkpoints, screening personnel and vehicles, and limiting access to the MTF area) are implemented.

Section III. HOSPITALIZATION AND TREATMENT

4-5. General

The hospitalization and treatment function in support of each stability and support operational scenario will differ. In many stability and support operational missions, the CHS element is constrained in size, necessitating that some services (such as hospitalization) be provided outside of the AO. As the CHS element is normally task-organized for the specific mission, CHS resources that are only deployed with a hospital may be included in the task organization (even though a hospital unit will not be deployed).

4-6. Nonphysician Health Care Practitioners

The AMEDD has a variety of skilled medical professionals who provide direct patient care, rehabilitative services, and consultation to other medical professionals in HNs or in domestic support operations. Many of these medical professionals provide ancillary services within the hospital, but during stability and support operations may also be employed outside of the hospital setting. (Army Regulation 40-48 defines the primary care roles of nonphysician health care practitioners.)

a. Physical and Occupational Therapy. These disciplines can help prevent as well as evaluate and treat neuromusculoskeletal conditions as physician extenders, with OT limited to the upper extremity.

Additionally, OT and PT can provide evaluation and treatment for a wide range of developmental, neurological, or general medical conditions across the life span. These professionals can also assist in injury prevention, reducing morbidity, and decreasing the effects of disability through education using ergonomic principles. Occupational therapists are also involved in evaluation and treatment of chronic and acute MH conditions and serve as members of the CSC team.

(1) In nation and humanitarian assistance, these professionals can play a significant role in the development and implementation of health care programs. Based on evaluation, individual or group treatment programs for patients with amputations or nerve injuries serve to increase functional independence as well as improve quality of life and morale. Therapists are also skilled in teaching health care members from the HN. Occupational and physical therapists' training and experience allow them to evaluate, treat, educate, and prevent disability and injury across the life span (pediatrics to geriatrics).

(2) In any support operation involving deployment of soldiers, OT and PT support is based on anticipated patient work load (typically high orthopedic injuries and MH) and size of the medical element. Therapists work as primary care providers for patients with musculoskeletal problems. Prompt evaluation and treatment of these injuries enhances healing, expedites RTD, and helps prevent evacuation out of the AO. In addition to patient care, PTs and OTs serve as health/fitness and injury prevention consultants both to individuals and to units. Occupational therapists serve as members of CSC teams and provide activity-based, goal-oriented treatment for soldiers and civilians.

b. Nutrition Care.

(1) In stability and support operations, nutrition care programs can significantly reduce the effects of malnutrition from an inadequate diet in children and adults and also reduce morbidity. Dietitians can also have an impact in promoting healthy lifestyles by designing and implementing education programs to teach local residents to prepare healthy meals from locally available foodstuffs. Programs can also be developed to enhance nutritional support and dietetics within the hospital setting by—

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

(2) In humanitarian assistance operations, nutrition care services may involve the refeeding of a healthy population or working with an indigenous malnourished population. Nutrition care services may be provided directly to the HN population or indirectly through HN dietetic programs. An example of direct assistance is the planning for and providing of special diets to HN civilian casualties or advising HN care providers on nutrition support for wounds, injuries, or diseases. Assistance can also be provided in assessing the nutritional status of the general population and recommending ways to achieve optimum

nutritional levels of locally available food stuffs. An example of indirect assistance is serving as a consultant to the HN medical education system in the development of nutritional care specialists and of nutritional programs for children and adults.

(3) In disaster relief operations, nutrition care services involve the feeding of disaster victims, rescue workers, and caregivers. Dietitians and hospital food service specialists can assist in assessing, planning for, and implementing centralized feeding sites for victims left homeless or without the ability to prepare their own meals and for the disaster relief workers. Nutrition care specialists can also assist in planning for and implementing food distribution centers for victims. Further, they can assist or augment local civilian hospital operations by assessing and providing specialized nutrition care to patients.

c. Nursing Services. Within the nursing profession, there are a number of nurse practitioners, such as nurse midwives. These resources can be used to provide direct patient care to a HN population or can serve in a teaching/consulting role in the development of educational programs for both the HN population and the HN health care providers. Additional nursing specialties, such as community health nurses, can also be used to develop educational programs and provide direct patient care and consultation. For example, a community health nurse could develop a maternal and child health care program and establish a well-baby clinic.

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

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

f. Optometry. Optometry services provide eye examinations for eyeglass prescriptions so that optical fabrication elements supporting stability and support operations can make corrective eyewear. Further, optometrists have specialized equipment that can be used to identify eye injuries and infections which require referral.

4-7. Hospitalization and Medical Treatment in Support of Stability and Support Operations

In many stability and support operational scenarios and missions (such as attacks and raids or counterdrug operations), the deployed force receives CHS in the traditional manner. The CHS force is task-organized to

provide the support required for the operation. As these operations are normally of short duration, the focus of the care provided is EMT and ATM, with hospitalization provided by a designated facility outside of the AO. However, in other operations, nontraditional methods of health care delivery are required or consultative and instructional roles may predominate.

a. In NEO, EMT is provided to the NEO force and the evacuees by the medical element accompanying the force. Hospitalization support is provided by the hospital(s) designated to support the mission. These MTFs are not located in the AO, but rather are located in an ISB or safe haven where patients are medically evacuated to once they are extracted from the AO.

(1) The NEO force should maximize the use of medical personnel among the evacuees to provide routine care and to monitor any sick, injured, or wounded evacuees.

(2) The evacuation notice given to the evacuees prior to the arrival of the NEO force should specify that the evacuees bring special medications and eyewear with them. Depending upon the METT-T, a number of days of supply of medications can be recommended; however, this is no guarantee that the evacuees will have that many days of supply in their possession. (The evacuation notice is prepared and distributed by the embassy. Coordination for including information in the evacuation notice must be accomplished prior to deployment.)

b. In domestic support operations, medical care, treatment, and hospitalization requirements for each specific operation will be unique.

(1) Determining factors include the type of activity being conducted, capability of the local community, geographical location of the incident/mission, medical threat, magnitude of the operation (local versus state or federal), and the anticipated patient work load. The support provided can range from routine CHS to forces employed on law enforcement operations to on-site triage, treatment, and hospitalization of disaster victims. A medical force package may be task-organized to the specific situation, such as an Echelon II medical company providing on-site triage and treatment, augmented with a surgical capability to stabilize nontransportable disaster victims for evacuation out of the AO; or, it could entail support provided by a fixed MEDDAC located in proximity to a mass casualty situation (such as a gas line explosion in the local community) where the MEDDAC provides trauma care in its facilities to the victims.

(2) Specific guidance, authority, and legal advice should be obtained prior to implementation of these operations to ascertain who are eligible beneficiaries, what specific support can be provided, and where funding and/or reimbursement can be obtained.

c. Humanitarian assistance operations involve direct patient care activities or consultative and instructional assistance. In many humanitarian assistance operations, treatment elements are deployed to the AO and the patients are treated at that location. In most of these operations, medical cases requiring long-term comprehensive care are not undertaken; cases which can be treated and supported by the HN are the more likely focus of these operations. If patients require evacuation to a hospital facility, the facility concerned would most probably be a HN facility rather than a US military one. Some humanitarian assistance operations may entail the delivery of health care to hospitalized patients. This may take the form

of consultative services between surgical specialties and the HN medical staff, or direct patient care where specialists are there to perform certain specific types of surgical procedures.

d. In disaster relief operation, the requirements for military hospitalization support will depend upon the type of disaster, the extent of damage to the local medical infrastructure and the availability of services within the locality, the numbers of individuals requiring medical care, and the expected duration of the required support. For example, if a disaster occurred in an isolated locality, the number of patients requiring support would not reach the numbers affected in a disaster that occurred in a metropolitan area. However, due to the isolated geographical area, medical care and hospitalization facilities may not be available; significant field medical resources may be required to be deployed to the area. On the other hand, in the metropolitan area, large numbers of casualties may be generated; however, there may be sufficient medical resources that were unaffected by the disaster in other areas of the city. These unaffected resources may limit the need for deploying field medical units to the disaster site. In these operations, the key ingredient for managing the hospitalization and treatment aspects is to conduct a comprehensive on-site assessment to determine what resources are available and what resources are required.

e. In combatting terrorism operations, hospitals and other MTFs must have contingency plans for mass casualty situations (Appendix J) and for the evacuation of the patients under their care if they become the target of a terrorist incident.

(1) Hospitals normally have plans for the conduct of mass casualty operations and periodically conduct rehearsals of these plans. These plans can be implemented, if required, in combatting terrorism operations should a terrorist incident occur which generates sufficient casualties to overwhelm the available medical resources. Considerations for this plan include—

- Establishing triage and treatment areas.
- Activating a control element and personnel support pool.
- Limiting access to the facility through the use of barriers to canalize entry and exit points.
- Screening personnel entering and exiting the facility.
- Establishing medical response teams to deploy to the incident site, if required.
- Coordinating with other medical facilities in the area to disperse casualties in order to enhance patient care.

(2) In some stability and support operational scenarios, terrorist incidents may occur in areas where hospitalization assets are not available. Available medical resources within the community would stabilize the casualties for evacuation out of the immediate AO for the required hospital care.

(3) Contingency plans for the dispersion and transfer of patients and the treatment and hospitalization of new casualties is also required in the event the hospital and/or treatment facility is the object of the terrorist attack.

f. In peace support operations, the medical treatment and hospitalization mission, for the most part, remains that of providing traditional CHS to the deployed forces.

(1) The beneficiaries of this support may include other Services, allies, or coalition forces and US government civilians and contractors, and UN officials. The CHS commander/surgeon should receive legal guidance in determining what categories of personnel are eligible for care.

(2) The size of the deployed force, anticipated duration of the operation, the evacuation policy, and the anticipated level of hostilities determines the size of the medical element. Initially in most peace support operations, the medical element is task-organized to provide routine sick call, EMT, ATM, and PVNTMED. Patients with serious or life-threatening diseases, injuries, or wounds are stabilized for evacuation and evacuated to a supporting hospital outside of the AO. As the duration of the operation lengthens, augmentation with other services such as CSC, PT, or OT may occur. However, peace support operations often have fixed troop ceilings which limit the ability to expand services within the AO. Hospitalization support will normally not be available in the AO.

g. In support of insurgency operations, the medical infrastructure of the insurgent forces is usually austere or rudimentary. Besides providing direct patient care to the insurgents and their families, programs for training combat medics and other health professionals and establishing a limited hospitalization capability are required. This type of mission is usually conducted by SOF personnel; however, augmentation with conventional CHS personnel may be required.

Section IV. PREVENTIVE MEDICINE

4-8. General

Preventive medicine efforts require close planning and coordination between PVNTMED personnel, command surgeons, and unit commanders to identify all medical threats, define goals, promote PMM, and prevent duplication of effort.

a. Environmental injuries and diseases, field hygiene and sanitation, and other PVNTMED concerns impact on the health of US forces employed in stability and support operations. The forces employed are often small independent units with limited personnel. In stability and support operations, the occurrence of DNBI and environmental injuries create combat noneffectiveness and 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 stability and support operations. The very nature of military PVNTMED is conducive to the types of activities that support US policy objectives.

4-9. Medical Threat

a. General. The medical threat is traditionally evaluated for its impact on US forces and US military operations. In stability and support operations, it must also be assessed in terms of its impact on the HN and its people or the supported insurgent forces. Stability and support operations often occur in developing nations where endemic and epidemic diseases are prevalent. The medical threat is the driving force in the development of effective PVNTMED programs.

b. Arthropodborne Diseases.

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

(2) In stability and support operations, the level of sanitation, measures employed to control disease vectors, and the resources available to prevent and treat arthropodborne diseases varies. It must be remembered that US forces operating OCONUS are a highly susceptible population and are, therefore, at an increased risk.

(*a*) In disease-endemic areas, the native population may appear fairly healthy. They can actually harbor subclinical 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 US forces. United States forces may be completely devoid of immune protection from a specific disease. Once they are infected by the pathogen, it can reproduce unchallenged. This results in an individual who is no longer effective in accomplishing his mission. Further, a portion of the limited medical resources available must be allocated to his care, treatment, and possible evacuation.

(*b*) Depending on the mission, the resources required to treat large areas for the control of arthropods may not be available. United States forces must use PMM to prevent contracting arthropodborne diseases. These measures include—

- An arthropod repellent system (consisting of a topical skin repellent and clothing impregnation material).
- Insect netting.
- Aerosol insecticides.
- Periodic checks (using buddy method) for ticks or other visible parasites.

(3) During protracted conditions of conflict or resulting from natural or man-made disasters, areas of a country previously endemic but now free of diseases (such as malaria, yellow fever, or plague)

can expect a resurgence of these diseases. Naturally occurring diseases that have been unnaturally excluded from an area through public health controls can gradually reappear when conflict or disaster disrupts these controls. Disruption of these controls can occur due to such things as a shortage of—

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

c. Foodborne and Waterborne Diseases.

(1) In areas of poor sanitation, locally procured foods pose a high risk of disease for stability and support operations forces. United States standards for food preparation are often absent. Food handlers are frequently carriers of diseases readily transmitted through prepared food.

(2) Potable drinking water is often scarce in stability and support operations. Forces deployed cannot be assured of the safety or quality of local water supplies. Locally purchased ice poses the same health risks as food and water.

(3) The risk of foodborne and waterborne diseases to stability and support operations forces can be minimized by command enforcement of basic PVNTMED principles.

(*a*) The risk of experiencing a foodborne illness must be weighed against the impact on relationships with 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.

(*b*) If possible, eat food prepared by US military food service personnel; when not available, maximize the use of meals, ready to eat (MREs).

(*c*) Only drink water that has been treated to US military standards. Do not use locally prepared ice. Ensure adequate water disinfection supplies (iodine tablets and calcium hypochlorite) are available. Exercise caution when drinking unopened bottles or cans of locally produced soft drinks purchased on the economy.

(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, reservoirs, and water distribution systems.

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

(6) The CHS commander/surgeon must ensure that PMM, guidance on proper distribution of field sanitation equipment, and cross-training personnel are planned for and task-organized as appropriate.

In predeployment briefs, the CHS commander/surgeon must continually emphasize these points to the TF commander and senior leadership.

d. Environmental Injuries.

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

(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.

(3) Injuries from exposure to industrial and occupational hazards pose a significant threat to soldiers in stability and support operations. Hazards from chemical substances arise from excessive airborne concentrations of mists, gases, vapors, fumes, or particulate matter, or contact with toxic liquids or solids. The toxic effects may be caused by exposure via inhalation, ingestion, or eye and skin contact. Early recognition of potential hazard areas is key to soldier protection. Since the disruption or abandonment of industrial facilities in Third World countries can generate chemical hazards, these areas should be avoided, if possible. When this is not possible, appropriate protective measures must be employed to reduce the soldiers' exposure. Preventive medicine personnel can provide command surgeons and all commanders with valuable assistance and guidance when dealing with industrial and occupational hazards. Particular care should be taken when using existing or abandoned buildings as bivouac areas or headquarters as these may contain indoor air contaminates (such as lead or asbestos). Further, the land surrounding industrial complexes may also be contaminated and present a potential hazard when used for storage or bivouac areas (such as fumes or vapors trapped inside tentage).

4-10. Preventive Medicine Support to Stability and Support Operations

a. 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 a disruption of normal services. Breakdowns in the normal sanitary conditions, waste disposal, and provision of 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. Predeployment training on field sanitation, arthropod repellent use, and personal hygiene measures can increase the effectiveness of PVNTMED.

b. Preventive medicine resources may be used to support federal, state, or local domestic support operations when authorized. This assistance may be provided in the following areas:

(1) *Disaster assistance*. In the aftermath of man-made or natural disasters, the disruption of public works and waste disposal may create an environment for the rapid increase in the number of disease vectors (rodents and arthropods). Preventive medicine personnel can provide guidance on the control of these vectors through pest management practices. Further, PVNTMED personnel can—

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

(2) *Environmental assistance*. Preventive medicine services may be requested by the local community when a hazardous material spill occurs or when unexplained contamination is found in surrounding wells or community water systems.

(3) *Community assistance*. Preventive medicine personnel may participate in community activities, such as public health programs, to provide educational presentations on disease vectors, epidemiological investigations, and PMM.

c. The PVNTMED role varies in foreign disaster relief and humanitarian assistance depending on the type of mission, location, and duration of the support. United States Government agencies (such as the DOS or the USAID), in coordination with the HN, will take the lead in these activities. United States Army PVNTMED personnel will support ongoing activities.

d. The terrorist threat may include the intentional contamination of food and water through the use of NBC agents. (Veterinary personnel inspect food for wholesomeness and quality.) As such, PVNTMED and veterinary personnel may be the best qualified to—

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

e. Peacekeeping forces are generally under strict troop ceilings and operate with an austere logistical support structure. It is essential, therefore, that a complete assessment of the medical threat be done. This assessment ensures that the CHS assets are adequate for the needs of the deployed forces. Command emphasis on PMM is essential and these measures should be included in predeployment training. 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 PMM will decrease the medical threat effects to the peacekeeping force.

f. The type and comprehensiveness of PVNTMED support for an insurgency depend on the needs of the insurgent movement and the legal authority to provide the support. For the insurgent forces, the incidence of DNBI 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, limited health care infrastructure, tactical conditions, environmental conditions, and disease prevalence. It is also influenced by their field sanitation and personal hygiene practices. 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 is to assist in providing public health and sanitation measures.

g. Preventive medicine support for counterinsurgency operations can focus on the HN military organization or on the civilian populace.

(1) *Host-nation military*.

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

- The medical threat facing the HN military is evaluated and the PMM to counter these threats are determined.
- An assessment of the HN military's capability to implement the required PMM is completed.
- A PVNTMED plan is developed.
- The chain of command must be actively involved to continue and institutionalize the programs.

(*b*) The types of programs which can be developed include—

- Field sanitation and personal hygiene training (FMs 21-10 and 21-10-1).
- Immunizations.
- Nutrition and food sanitation training.
- Water purification.
- Disease and injury surveillance.
- Training a cadre of HN PVNTMED specialists to continue programs once US support is withdrawn.

(2) *Host-nation civilian population.*

(*a*) 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. When the plan is implemented, HN participation is essential. Host-nation participation uses the local experience and expertise and ensures that programs developed are correctly implemented. This participation also ensures that the programs are not contrary to local political, economic, social, religious, and cultural practices and beliefs.

(*b*) Programs which can reduce the health risk and enhance the health status of the population include—

- Establishing a disease surveillance program for identification and early detection of arising health problems.
- Developing potable water systems.
- Introducing pest management methods and procedures.
- Enhancing or establishing waste disposal procedures.
- Enhancing maternal and child health care and nutrition education.
- Administering immunizations.
- Applying other programs using the full gamut of PVNTMED expertise and experience.

(*c*) The PMM and programs must be fully integrated into other CHS and civil-military operations (CMO) (such as clinical, dental, veterinary, or engineering).

h. The role of PVNTMED in attacks and raids varies depending on the mission, the environmental conditions, and the forces deployed. Early PVNTMED 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.
- Soldiers must ensure they carry at least the minimum supplies of water purification tablets. In the event the normal resupply of water or extraction from the AO is delayed, the soldier may have to purify his own drinking water.

Section V. VETERINARY SUPPORT

4-11. General

a. The US Army provides veterinary support for all DOD activities and federal agencies (except for USAF food inspection on USAF installations). The veterinary capabilities required are diverse and comprehensive. These skills and abilities should be recognized in the formation of the country plan and the CHS portion of OPLANs.

b. Identified veterinary requirements usually come through the requesting Commander in Chief (CINC) surgeon's office as part of the theater health service support plan or as a separate initiative. The Plans and Policy Directorate (J5)/Operations Directorate (J3) staff routes requests to the subordinate command that has area responsibility or can best meet the requirements. Supporting commands, coordinating with the CINC surgeon's medical planner and the J3 staff prior to planning and tasking, help ensure that adequate veterinary support is provided.

c. Veterinary support can contribute to the success of CHS operations in stability and support operations by—

- Ensuring that subsistence and food sources are inspected for wholesomeness, quality, and sanitation. (Preventive medicine personnel inspect water sources.)
- Providing care to government-owned animals (MWDs, pack animals, and military mascots).
- Helping to improve the public health of the population with such programs as—
  - Vaccinations for the control of communicable zoonotic diseases.
  - Public health and sanitation training.
  - Training in food hygiene, safety, and inspection techniques.
  - Animal husbandry programs (when specifically authorized).

d. In stability and support operations, 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, goats, 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 humanitarian assistance operations. Consumable veterinary drugs and supplies necessary for care of livestock are not normally available through military supply channels. These supplies must be resourced and procured early in the mission planning and development phases of the operation.

e. Veterinary personnel must coordinate closely with PVNTMED personnel to maximize expenditure of limited resources.

4-12. Veterinary Support to Stability and Support Operations

a. In NEO, the number of military/DOD civilian pets to be evacuated determines the required veterinary support structure. It is assumed for planning purposes that any NEO will be of short duration; pets will accompany their owners or be evacuated on a separate military chartered flight. Further, no hot meals will be served to the evacuees until evacuation to a safe haven is complete.

(1) Pet evacuation will be limited to normal domestic pets to include dogs, cats, guinea pigs, and hamsters. Birds will be handled on a case-by-case basis. No exotic pets will be evacuated.

(2) Even though euthanasia of military pets is an option, historical experience highly discourages this COA. The military's public image would be severely tarnished.

(3) Military veterinarians must be present to—

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

(4) Planning for pet evacuation must also include required veterinary and husbandry support at any scheduled stopovers and at the point of debarkation.

(5) The use of chartered military airlift with in-flight veterinary support to evacuate military pets is the best COA if time, resources, and level of hostilities permit.

b. Veterinary support may be required in both domestic and foreign disaster assistance operations to ensure the quality and wholesomeness of the food supply. Food supplies used in disaster relief operations are usually quickly procured, often without proper specifications. These supplies normally approximate native or regional diets. Veterinary personnel ensure that only safe and wholesome food supplies are used. Further, in the aftermath of a disaster, such as a hurricane, there will be many animals (privately owned pets, livestock, or wild animals) wandering through the disaster site. Some of these animals may be injured or ill. Veterinary personnel are required to effectively deal with this problem for the safety of the disaster victims, rescuers, care givers, and the animals. Further, veterinary personnel can assist in the control of zoonotic diseases.

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

(1) If the logistic support includes transporting subsistence, there will be an increased demand to inspect this cargo for safety and wholesomeness. The conditions imposed by short-notice deployments

may stress food supplies due to the lack of refrigeration or other factors, thereby requiring additional inspections.

(2) The assistance provided may include MWDs or other government-owned animals. These animals require veterinary support to sustain them and to ensure they remain disease free.

d. Department of Defense support to counterdrug operations is an integral part of the national drug strategy and compliments the efforts of law enforcement agencies and HN governments. Veterinary support to counterdrug operations includes—

- Caring for the government-owned animals used in these operations.

- Assisting a HN in developing alternate forms of agriculture/livestock production to produce or increase revenue. This assists in decreasing their dependency on drug crops.

e. Veterinary personnel should be involved in the planning to counter the terrorist threat. Veterinary support may play a key role in antiterrorism. The terrorist threat may include the employment of NBC weapons. Veterinary personnel, therefore, must be alert to the potential use of these agents and report any suspected use to the appropriate authorities. Veterinary personnel are also needed to differentiate the normal deaths of animals from those potentially caused by terrorists using BW or CW agents. Personnel, animals, and food supplies and sources (such as crops) are highly susceptible to biological agents. Veterinary personnel must be prepared to inspect suspect subsistence and care for affected animals. Further, MWDs are trained to detect explosive materials which aid in the search of potential terrorist activities; these animals must be sustained.

f. Veterinary support is required in most peace support operations.

(1) Due to the nature of these operations, field expedient food procurement systems may be established. Veterinary assistance is essential to ensure that only safe food is procured.

(2) In these operations, MWDs may be required to perform many tasks (such as guarding areas and conducting bomb searches). Veterinary support is required to sustain the use of these and other government-owned animals.

g. Veterinary support to insurgency and counterinsurgency operations, humanitarian assistance, and nation assistance includes—

(1) Veterinary personnel that may provide training to supported insurgent forces in establishing a food procurement system, inspecting food, caring for MWDs and pack animals, and caring for and managing livestock.

(2) The use of veterinary resources and expertise in counterinsurgency operations includes support to US troops and assistance to HN military forces and civilians.

(*a*) The support of US troops is largely characterized by traditional services rendered by the veterinary personnel, such as—

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

(*b*) As CHS involvement increases, veterinary personnel can assist in the assessment of the HN's veterinary programs. Of particular note, SOF personnel are early participants in counterinsurgency operations and their medical assets (the Special Forces [SF] medic and attached veterinary personnel) are trained in the basics of animal husbandry and food inspection. Coupled with their basic animal and agriculture knowledge, language skills, and knowledge of the culture, they easily interface with the HN residents and can be effectively used to enhance HN economic stability. They can provide guidance, training, and treatment of the HN's military animal care program (pack animals, livestock, and MWDs). Further, the veterinary service can assist in establishing a food procurement system or in enhancing an already existing system.

(3) The US Veterinary Service's most challenging and nontraditional roles include nation assistance and assisting in establishing programs that benefit a HN's populace. Veterinary personnel participation in nation assistance activities must be thoroughly coordinated through the country team. Coordination with such agencies as the DOS, USAID, the US Department of Agriculture (USDA), and HN counterpart agencies may be required. (United States Army veterinary personnel are not members 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.) The USAID is responsible for helping HNs improve their health care systems (including veterinary care). The USDA is often involved with the development of these programs. In many cases, these agencies are not on-site for executing programs, but rather contract with outside agencies for the actual implementation. The US military often has veterinary resources and the logistical support systems already in-country to execute and effectively promote such programs. Military veterinary personnel (after thorough research, coordination, and assessment of capabilities and resources) can develop COAs to support the overall veterinary effort.

(*a*) Well-developed veterinary programs can impact 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 an insurgency in a given region. For example, if the principal issue underlying an 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. The control of this disease will have a direct result of increased food production, increased income for the farmer, and perhaps of most importance, the ability to change the diet

from one based on grain to one which includes meat. This improves the living status of the populace. Changes such as these directly attack the insurgent's principal issue, defuse the insurgent's psychological operations, and at the same time bolster the credibility and popular support of the HN government.

NOTE

Veterinary personnel must ensure the programs developed are in consonance with the local customs, values, and religious ideologies. For example: it would do no good to increase pork production in a Muslim or Jewish country, beef production in a Hindu country, or any of the above if the people are vegetarians.

(*b*) In developing, coordinating, and establishing US military veterinary support to the FID effort, several factors must be considered. 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 available is determined. The planning considerations include—

- State of development of HN veterinary infrastructure.
- Accessibility and affordability of HN veterinary services.
- 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.
- Status of immunizations and chemoprophylaxis for livestock.

(*c*) The programs that are developed should focus on long-term projects. As stated in paragraph 3-6*b*, the *quick fix* should be avoided in this arena. However, there are a number of programs which can be developed and require only short-term US military involvement. These include—

- 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 plants on grazing lands.

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

(*e*) Innovation and creativity are hallmarks of a successful nation assistance program. Veterinary support capabilities include—

- Assisting in veterinary laboratory development.
- Assisting in vaccine production development.
- Training HN or indigenous personnel in treatment and animal husbandry skills.
- Assisting in the development of drug and vaccine distribution systems.
- Assisting in the development of disease control and eradication strategies.
- Improving food plant sanitation.
- Conducting epidemiological surveys.
- Assisting in animal disease and parasite control.
- Developing food inspection systems.
- Developing education and exchange programs.
- Serving as advisors.

h. In all stability and support operational scenarios where the anticipated duration of the operation is sufficient to establish base camps of a semifixed nature, soldiers have a tendency to adopt local domestic and/or wild animals (such as the mongoose during the Vietnam War) as unofficial mascots. The command

should establish a policy and provide guidance on this issue prior to deployment. The unofficial mascot has the potential to be a significant medical threat in the transmission of zoonotic diseases to US forces.

Section VI. DENTAL SUPPORT

4-13. General

a. The dental role in stability and support operations ranges from traditional support to deployed US forces to dental programs in foreign humanitarian assistance and domestic support operations.

b. An in-depth discussion of the provision of dental support is provided in FM 8-10-19.

4-14. Dental Assessment

a. Dental assessment in advance of planning is important in understanding the dental health care needs of the population. Data, information, and medical intelligence should be combined with information provided by the diplomatic mission to the HN to determine dental requirements for the mission. If possible, personal observations by a dental officer should be accomplished. (Continued involvement or consultation with a dental public health officer is desirable.)

b. The senior dental officer should provide the assessment and recommendations to the command surgeon. These recommendations should include—

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

c. The early involvement of the supported HN government or insurgent forces is essential in the plan development process. Credit for the plan and its execution should always be given to the HN government or forces that are being supported.

d. Dental planning considerations may include HN resources such as—

- Military dental assets and capabilities.
- Dental schools.

- Government dental licensure authority.
- Nondental health care personnel who are or can be involved in dental programs, such as 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 system and potential for fluoridation.
- Commercial marketing of oral health products.
- Media capability for mass awareness programs.
- Religious organizations' involvement in social and health-related activities.

4-15. Dental Support to Stability and Support Operations

a. Dental support in US domestic support operations is limited. This is due to the well-developed dental infrastructure in this country. The primary role of US Army dental assets would be to reestablish and to augment the civilian dental infrastructure when it is temporarily disrupted by natural or man-made disasters or civil disturbances. In some circumstances, community assistance may be provided in remote locations for populations without reasonable access to dental care or on request from community-based prevention and education programs.

b. When approved by the NCA, there may be dental support to a variety of stability and support operational missions, such as humanitarian assistance or nation assistance. Modified dental support approaches may be required for these operations. The dental threat in developing nations includes oral infections and dental caries; a high prevalence of oral developmental conditions such as cleft palate; and maxillofacial injuries due to combat and noncombat injuries. These countries typically have an inadequate dental care infrastructure to prevent and treat these conditions. Dental programs and operations can be conducted in conjunction with other CHS operations or as separate activities.

(1) Direct delivery of care to HN populations in nation assistance operations is an easily implemented and highly visible display of support (credit for the support should be to the HN rather than to the US). It should only be considered as a short-term benefit. Dental support roles that provide a long-term benefit include—

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

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

(3) The limitation on resources may significantly influence the level of care or scope of treatments, but there are certain standards for care that cannot be compromised. For example, these may include infection control, qualifications of the care provider, selection of procedures, and standards required by HN law. The factors affecting the scope of practice include lack of funding, inaccessibility of remote locations, and shortage of equipment and supplies.

c. More traditional military dental support may be required for US and HN troops in shows of force, peacekeeping operations, peace enforcement, and attacks and raids.

Section VII. COMBAT STRESS CONTROL AND MENTAL HEALTH SERVICES

4-16. General

a. Stability and support operations may have brief periods of extreme violence or prolonged periods of inactivity. These conditions can produce classic BF. The operations may even involve NBC threats which add the psychological and physical stressors of mission-oriented protective posture (MOPP). However, the more usual stressors are those of frustration, resentment, loneliness, and boredom. These

stressors come from being in an unfamiliar land far from home; having limited privacy; being among unfamiliar and perhaps hostile people; and operating under restrictive ROE. There is also often ready access to drugs and alcohol from local sources. Enemy tactics attempt to magnify these stressors and to provoke misconduct stress behaviors. These behaviors (such as insubordination and abuse of power) can turn the local population against the US.

b. The HN may have rudimentary concepts and resources for psychiatric care, MH promotion, and social services delivery. These limitations could be the focus of enhancing the HN government's stability, but only if cultural differences are fully taken into account.

c. Combat stress control and MH personnel have provided commanders with effective service in many previous stability and support operations. They have and will continue to provide MH support to all activities in stability and support operations. For example, MH personnel—

- Provided support to soldiers in Vietnam and more recently in Somalia, Haiti, and Bosnia.

- Provided stress control for US personnel and psychiatric inpatient and outpatient care for Cuban and Haitian refugees at Guantanamo, Cuba.

- Were members of numerous peacekeeping TFs 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.

- Advised a friendly government in the prevention and treatment of stress casualties among its military and paramilitary forces.

d. The stress control assets in stability and support operations are task-organized and may include elements of the MH sections of division units, area support medical battalions (ASMBs), and corps CSC detachments and companies. The neuropsychiatric personnel of hospitals can also be used to provide proactive stress control interventions. United States Air Force and USN MH assets in theater should also be identified and coordination accomplished when required.

e. For further information on CSC, refer to Appendix O of this manual, FM 8-51 and FM 22-51.

4-17. Combat Stress Control Support to Stability and Support Operations

a. Stress management teams are an integral part of the military's approach to helping personnel involved in combatting terrorism operations. The team's mission is to support rapid return to effectiveness 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 US Marine Corps Force, the Oklahoma City Federal Office Building, the Kohbar Towers in Dhahran, and other incidents have demonstrated the requirement for

stress management teams. The prevention and treatment principles and approaches parallel those used in the treatment of BF.

b. Selected MH staff should accompany US peacekeeping TFs. Historically, these TFs require reinforced organic logistics and CHS. 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.
  - Providing training and consultation related to stress management and unit cohesion.
  - Completing MH screenings and evaluations on all soldiers during pre- and post-deployment and on selected individuals during deployment.
  - Conducting predeployment family support briefings.
- During peacekeeping operations, the focus is on MH assessment and consultation.

c. Mental health activities in support of insurgency and counterinsurgency operations are 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 BF rates will not normally exceed 1:10 per WIA. Organic MH staff use the combat stress principles of proximity, immediacy, expectancy, and simplicity in treating BF soldiers. However, the main problem will be misconduct stress behaviors. These misconduct stress behaviors can include substance abuse, acts of indiscipline, and some criminal acts. Misconduct stress behaviors may seriously interfere with the stability and support operational mission unless prevented. It is expected that soldiers will suffer from adjustment reactions, endemic psychiatric disorders, and drug and alcohol abuse.

d. Due to the limited duration of most NEO, CSC personnel will not normally accompany the deployed force. However, once the NEO force and the evacuees reach the ISB or safe haven, CSC interventions in the form of after-action debriefings may reduce the incidence of stress-related problems.

e. Mental health assistance may be required in some domestic support operations. Mental health activities (preventive measures and acute interventions) may be used to manage stress-related problems/reactions arising from traumatic experiences (such as natural or man-made disasters or a singular incident such as a school bus accident which results in the deaths of or serious injuries to the students). The adverse effect of the stress not only affects the victims of the incident but also family members, friends, rescue workers, and care givers. Critical incident stress debriefings (for victims, families, and friends) and after-action debriefings (for care givers and rescuers) enable the victims/participants to express their feelings, gain perspective from others involved in the experience, and to better understand the incident and their feeling concerning it. These activities may reduce the incidence of post-traumatic stress disorders in this population.

Section VIII. COMBAT HEALTH LOGISTICS

4-18. General

a. Combat health logistics plays a significant role in the delivery of health care in stability and support operations. As most missions in stability and support operations are conducted within an immature theater, the full complement of logistics capabilities and services may not be in place. The CHL planner must be flexible and innovative to be able to bridge the gap between requirements generated by the operation and the capability to provide the necessary Class VIII supplies and equipment.

b. In order to ensure that the correct mix of medical supplies and equipment is obtained, the command surgeon must coordinate his specific requirements with the CHL element.

c. The CHS commander is responsible for ensuring that medical and industrial waste generated by CHS operations is correctly handled, transported, and disposed of according to applicable regulations, agreements, and laws. Improper management of these wastes may adversely impact the health of the deployed force and local population.

d. In joint operations, the major subordinate US Army CHL agency may be appointed as SIMLM which is the DOD Executive Agent for all Class VIII supplies and equipment. This necessitates the early involvement of the CHL planner in the planning process. For additional information on the SIMLM, refer to Joint Pub 4-02.

4-19. Combat Health Logistics Support to Stability and Support Operations

a. Prior to the deployment in NEO, the senior medical person accompanying the force determines if there are any special medical supply or equipment requirements which the deploying force must take along to provide continuous medical support to the evacuees. For example, if a significant number of evacuees will be infants and children, MESs must be augmented with pediatric medicines and medical equipment. Under most circumstances, the Class VIII supplies and equipment the force brings with them is all that they will have to operate with. In a permissive NEO, it may be possible to obtain some medical supplies and equipment locally, if the available supplies meet with US medical supply standards. (Medical equipment purchased locally may not be able to be maintained due to nonavailability of repair parts within the CHL systems. It should be purchased for a one time use only.) Caution must be exercised when acquiring medical equipment locally, as the equipment may not be approved for use aboard USAF aircraft.

b. In disaster assistance operations, the management of Class VIII supplies and equipment is critical to the successful completion of the support operation.

(1) A task-organized CHL element is established to provide for the management, receipt, sorting, storage, repackaging, distribution, and accounting for donated medical supplies and equipment. It is also responsible for the requisition, receipt, and accountability of Class VIII resources required which cannot be met through donated materiel. Normally within a disaster area, there is no one organization that

would accomplish this type of function. The medical supplies and equipment donated in relief operations come in all different types of packaging, sizes, and amounts. It must be received, sorted, repacked, and distributed to areas of need. A task-organized CHL element can provide this necessary support.

(2) An assessment of the disaster area (to include coordination with other agencies/countries providing assistance) must be accomplished to determine what types and quantities of supplies and equipment are available or are anticipated to be donated, and how many customers the element will support.

(3) The size of the CHL element deployed is dependent upon the size and anticipated duration of the operation, the quantity of materials to be handled, and the number of customers to be supported.

c. In humanitarian assistance operations, the CHL planner must obtain and coordinate transportation, and receive, sort, store, and distribute Class VIII materiel. Depending upon the scope of the operation, there may also be donated medical supplies and equipment which must be handled, stored, and distributed. Due to the remoteness of the operational site in humanitarian assistance operations, the task of getting the supplies and equipment to the target location may be difficult. The CHL planner must consider the METT-T factors and the—

- Scope of the operation and its unique requirements.
- Availability of HN support.
- Availability of Class VIII supplies and services within the local community.
- Coordination requirements with non-DOD agencies, allies, coalition partners, HN, and religious and charitable organizations.
- Quantities and types of donated Class VIII materiel.
- Requirements for handling, repackaging, storing, and distributing donated materiel.
- Sources of funding for Class VIII materiel.
- Availability of structures for storage of materiel (to include refrigeration capability).
- Delivery mode and transportation requirements.
- Security and accountability of controlled substances.
- Cultural and ethical implications of certain medical items (such as blood and blood products).

d. In nation assistance programs, CHL personnel can assist a HN by conducting an assessment of the military CHL and civilian medical logistics infrastructures and industries.

(1) In many countries, a formal CHL system is not established or is rudimentary in nature. By establishing and institutionalizing this type of system, the HN can—

- Develop a usage history on Class VIII items.
- Develop a standardized formulary.
- Reduce costs by—
  - Purchasing in bulk.
  - Obtaining the best price through competitive shopping.
  - Establishing accountability procedures.
  - Managing stockage levels and cross-leveling inventories between MTFs.
  - Lessening inventory losses due to improper storage, inadequate refrigeration, and outdated medications.
- Identify critical shortfalls.
- Establish product specifications.

(2) Combat health logistics personnel can provide training and instruction in the numerous functional areas within this field. Assistance may be provided in such areas as—

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

e. In peace support operations, the CHL mission is the traditional support to a deployed force. Due to the austere staffing and troop ceiling placed on many of these missions, the CHL element may be

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

- Anticipated duration of the operation.
- Support available from allies, coalition forces, and HN.
- Size of the in-country element.
- Level of hostilities to be encountered.
- Delivery mode and transportation requirements.
- Number of customers to be supported.
- Design and maintenance of unique MESs to meet mission requirements.

f. Combat health logistics support for attacks and raids is primarily in the planning and preparation phases of these operations. Rapid insertion of combat forces and equally rapid extrication or reinforcement will not necessitate extensive resupply operations. Planning for CHL then focuses on the worst case of a force taking large numbers of casualties with delayed extrication or reinforcement. The command surgeon should consider the following issues and make recommendations to the tactical commander:

- Increase the number of dressings and bandages carried by the individual soldier. The current first-aid pouch will easily hold two dressings or a dressing and bandage.
- Have each soldier or every other soldier carry one 500 milliliters (ml) of IV fluid to treat dehydration or hypovolemia. (In cases of heat injury, if an IV starter kit is not available, the soldiers can drink the solution.)
- Develop a medical push package with emphasis on IV fluids, dressings, bandages, and splints, and with other components at the discretion of the command surgeon. Class VIII containers must be clearly marked and not include nonmedical items.

Section IX. MEDICAL LABORATORY SUPPORT

4-20. General

Depending upon the size of the force deployed, the specific mission to be accomplished, and the anticipated duration of the operation, medical laboratory assets may be employed in stability and support operational

scenarios. If the deployment includes deploying an Echelon II or above MTF in its entirety, then the organic medical laboratory assets will be deployed. However, in short-duration operations where the CHS element is task-organized for the specific mission, a medical laboratory may not be deployed. Any required medical laboratory support would be provided by a facility outside the AO.

4-21. Medical Laboratory Support to Stability and Support Operations

a. Medical laboratory services are usually not a factor in NEO. Medical laboratory personnel and equipment are normally not included in the task-organized medical element that accompanies the NEO force due to the short duration of these operations. If the AO is suspected of being contaminated with a BW or CW agent, NEO personnel should request assistance from the supporting PVNTMED team, chemical detection team, or in-theater laboratories which are trained to handle and identify BW and CW agents (such as the theater area medical laboratory [TAML]/area medical laboratory [AML] or USN land-based laboratory). In the absence of these supporting units, the NEO force should refer to FM 8-10-7 for instructions on the collection and management of specimens/samples contaminated with suspected BW and CW agents.

b. Medical laboratory capabilities will differ with the types of forces deployed in a given AO. As terrorist incidents can occur at any location, the supporting MTF must coordinate with the supporting PVNTMED team, veterinary team, or in-theater to obtain a full range of investigative services to identify suspected BW and CW agents and to test food and water for possible contamination.

c. Due to the sophistication of health services within the US, many medical laboratories throughout the nation have state-of-the-art equipment and are readily available. Community assistance and disaster relief assistance at the local level initially may require the use of organic medical laboratory capabilities of the military unit providing support. However, once a domestic support operation exceeds the local community level and the FRP is activated, the USPHS and the Centers for Disease Control have ready access to whatever level of sophisticated laboratory procedures/equipment they require.