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ALLIED JOINT MEDICAL FORCE HEALTH PROTECTION DOCTRINE

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NORTH ATLANTIC TREATY ORGANIZATION

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NATO LETTER OF PROMULGATION

14 November 2025

1. The enclosed Allied Joint Medical Publication AJMedP-4, Edition B, Version 1, ALLIED JOINT MEDICAL FORCE HEALTH PROTECTION DOCTRINE, which has been approved by the nations in the MILITARY COMMITTEE MEDICAL STANDARDIZATION BOARD, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 2561.

2. AJMedP-4, Edition B, Version 1, is effective upon receipt and supersedes AJMedP-4, Edition A, Version 1, which shall be destroyed in accordance with the local procedure for the destruction of documents.

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4. This publication shall be handled in accordance with C-M(2002)60.

Thierry POULETTE
Major General, FRA (A)
Director, NATO Standardization Office

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Documents Database for the complete list of existing reservations.	

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
FIN	Force Health Protection is controlled by national legislation and in some areas, there are some contradictions with the standard. The full implementation of the standard requires additional resources with are subject of further planning.
FRA	For the Chemical, Biological, Radiological and Nuclearl (CBRN) domains, France will strictly limit the application of this STANAG to occupational health.

Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Documents Database for the complete list of existing reservations.

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TABLE OF CONTENTS

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CHAPTER 1 INTRODUCTION

1.1 AIM

1. The Allied Joint Medical Force Health Protection Doctrine is subordinate to AJP-4.10(C) Allied Joint Doctrine for Medical Support and MC 0326/4 NATO Principles and Policies of Medical Support; and, aligns with AJP-3.14 Allied Joint Doctrine for Force Protection. The purpose is to provide a framework for how the alliance addresses Force Health Protection (FHP) in support of military operations.

2. Standard-Related Documents supporting this Allied Joint Medical Publication (AJMedP) are listed in Annex A. Allied Medical Publications (AMedPs) and other publications relevant to this AJMedP are listed in Annex B. All should be consulted for more detailed guidance in their respective subject areas.

1.2. SCOPE

Chemical, biological, radiological and nuclear (CBRN) medical support is not addressed in this publication. There is, however, a need for close cooperation between FHP, CBRN MED and CBRN personnel and entities, in particular with regard to the surveillance for, investigation of and response to potential incidents. STANAG 2596 AJMedP-7 Allied Joint CBRN Medical Support Doctrine provides the framework for the medical aspects of CBRN defence.

1.3 DEFINITIONS

1. FHP is defined as all medical efforts to promote or conserve physical and mental well-being, reduce or eliminate the incidence and impact of disease, injury and death and enhance operational readiness and combat effectiveness of the forces. Accordingly, non-medical measures (e.g. workplace safety regulation) are not included in the definition of FHP.

2. FHP falls under the broad umbrella of Force Protection (FP) defined as all measures and means to minimize the vulnerability of personnel, facilities, materiel, operations, and activities from threats and hazards to preserve freedom of action and operational effectiveness of the force, thereby contributing to mission success.

1.4. IMPORTANCE OF FHP

1. Force readiness can be negatively impacted by disease and non-battle injuries (DNBI). The aim of FHP is to reduce the burden of DNBI through timely and appropriate

application of the best possible population health support and public health protection measures.

2. Maximizing operational and individual health readiness requires application of FHP through the entire deployment cycle.

1.5. FHP STANDARD

Allowing for operational constraints, the practice of FHP should be evidence-based and consistent with accepted best practices/standards.

1.6. FHP APPROACHES

1. **One Health.** One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people and the ecosystems in which they operate[1]. The practice of FHP operates at the intersection of human health, animal health, and environmental health. The promotion of a One Health approach in NATO acknowledges that the health of humans, animals and the environment interact and collectively represent the spectrum of public health concerns for NATO forces. For example, a high percentage of diseases of operational significance to military populations are zoonotic (e.g. anthrax, avian influenza, campylobacter, rabies, Lyme disease, Q Fever, Ebola Virus Disease, etc) making both animals and their environment an important consideration in both human health risk assessments and in developing preventive measures. A One Health FHP approach requires cooperation between FHP, Veterinary Services and Environmental Protection Services, among others.

2. **CBRN.** FHP should be addressed in tight conjunction with CBRN MED and CBRN, to establish mutual support, establish common situational understanding of areas of common interest, and maintain the ability to participate in joint staff processes and advice to commanders.

3. **Medical Intelligence and Medical Information (MI2).** MI2 are key enablers of FHP and are covered in STANAG 2547. Medical Information is also covered in STANAG 2481 Medical Information Collection and Reporting.

[1] Adapted from Ghai, R.R., Wallace, R.M., Kile, J.C. *et al.* A generalizable one health framework for the control of zoonotic diseases, the Centers for Disease Control and Prevention About One Health, and the World Health Organization's One Health Initiative.

1.7. RESPONSIBILITIES FOR FHP

1. **Nations.** Health, including FHP, is a national responsibility. With Transfer of Authority, the NATO commander shares this responsibility.

2. **Commanders.** The duty of care for all personnel rests with the commander. This encompasses the full spectrum of health and medical issues including FHP.

3. **Medical Advisors.** While a command responsibility, FHP is predicated on informed health risk analysis and management. Medical advisors (MEDAD) have the responsibility for advising the commander on FHP. This advice is informed by input from the various subject matter experts working within the domain of FHP.

4. **Individuals.** All personnel have an individual responsibility for FHP, in particular by adhering to recommended health protection practices and taking care to maintain their physical and mental health.

1.8. IMPORTANCE OF COMMAND EMPHASIS

Command direction and emphasis may be the most critical aspect of FHP – preventable health harms usually do not result from a failure of public health interventions or recommendations, but rather represent a failure to implement them.

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CHAPTER 2 FHP RISK MANAGEMENT

2.1. INTRODUCTION

1. AJP-3.14 is the NATO doctrine on FP. FHP must be integrated into the FP Risk Management Process. This serves three functions:

   a. It allows the FP environment to be described in a fulsome and consistent fashion.

   b. It enables the commander to make informed decisions related to health protection programs and other FHP efforts.

   c. It maintains the visibility of FHP amongst the broader array of FP considerations.

2. Effective FHP is contingent on timely and accurate application of the Risk Management Process as outlined in AJP-3.14. This is a cycle that includes establishing the context, risk assessment (to include risk identification, analysis and evaluation), and risk treatment or management. Monitoring and review, and communication and consultation with stakeholders continues throughout. This cycle is depicted in Figure 1.

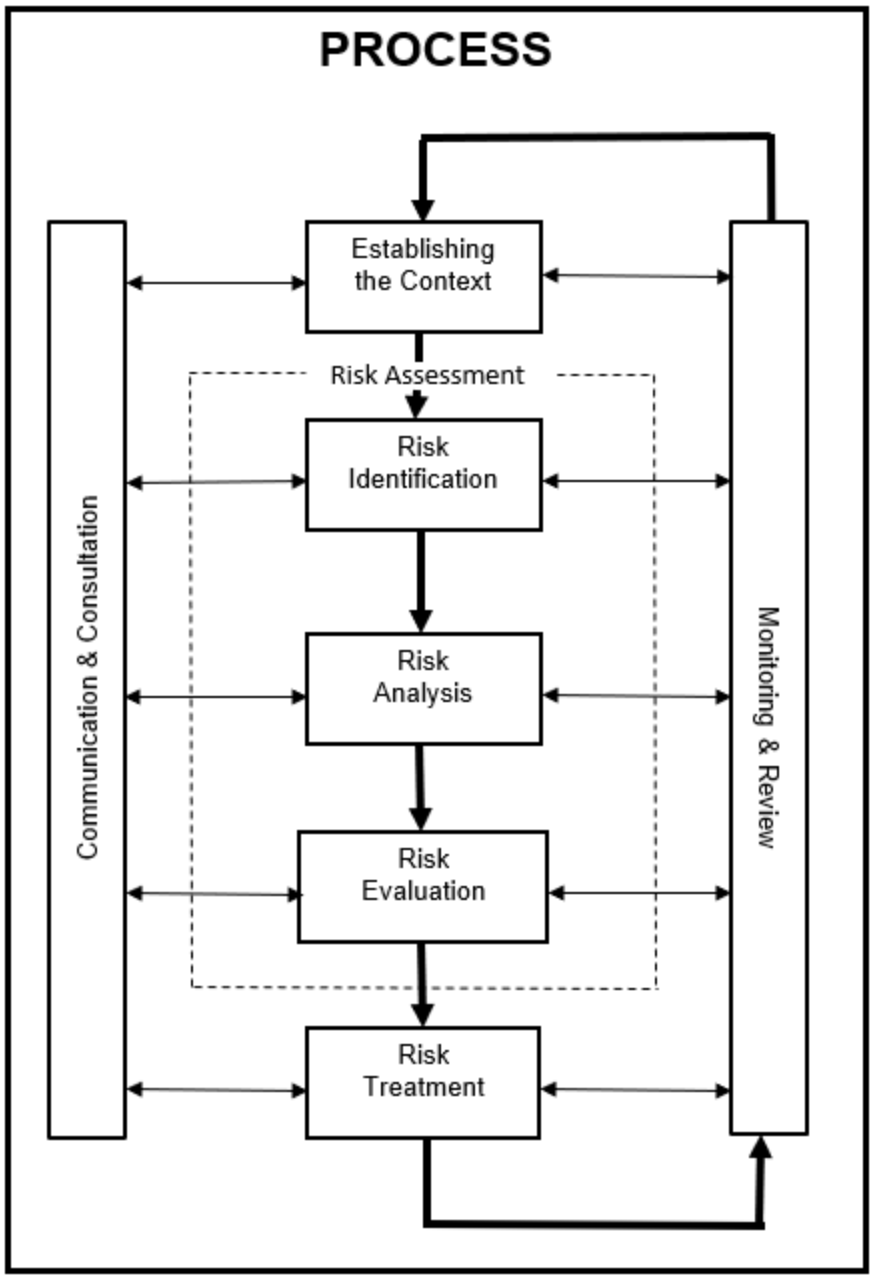

Figure 1: Risk Management Process as applied to Force Protection (see AJP-3.14, chapter 3: Force Protection Process)

2.2 ESTABLISHING THE CONTEXT

1. As part of the Operations Planning Process (OPP), it is essential that medical advisors understand the context of the activity and what must be done for mission success, so that they can subsequently identify the FHP risks. It is paramount, therefore, that medical staff are present and contribute throughout the entire OPP.

2. Key contextual factors that medical advisors must understand to establish effective FHP include the environment, the population at risk (PAR), the mission and the commander's intent. As these may shift over time, continuous situational awareness is necessary to adapt FHP plans according to changing needs.

2.3. HEALTH RISK IDENTIFICATION

1. Health risk identification begins with identifying health hazards. A hazard is not the same as a risk in that it does not alone connote likelihood/probability of exposure. Rather, a health hazard simply refers to any element, within a defined space and time, with the potential to cause harm to health.

2. In the FHP domain, hazards arise from both natural and anthropogenic (e.g. industrial) sources. These may include:

a. environmental hazards, such as environmental conditions likely to cause harm such as heat, cold, and altitude;

b. endemic hazards, such as infectious diseases and Biological Agents of Operational Significance that are not deliberately released, but pose a hazard to the health of the PAR;

c. chemical hazards, such as toxic industrial chemicals and chemical hazards derived from pharmaceuticals;

d. biological hazards, such as live organisms, toxins and biological hazards that may arise in the military context, e.g. close-quarters accommodations, dining facilities, medical facilities;

e. radiological hazards, such as material or events that release ionizing (alpha, beta, gamma radiation and neutrons) and non-ionizing radiation (including directed energy);

f. nuclear hazards, such as weapons or events that result in nuclear fission/fusion reactions;

g. explosive (and ballistic) hazards, which cover all consequences of explosive activity on human bodies including industrial accidents.

3. Identification of health hazards is often closely aligned with and/or addressed through the medical intelligence cycle.

4. Health hazards are constantly evolving. Their identification and characterization is a continuous process.

5. New information related to health hazards should be entered into a NATO medical communication and information system (see AJMedP-5 Allied Joint Doctrine for Medical Communications and Information Systems (MedCIS)).

2.4. HEALTH RISK ANALYSIS

1. The health risk analysis establishes the set of hazards that are anticipated to be the most important. It is founded on the knowledge gained having established the context of the mission, and identified the potential risks. Medical intelligence assessments may inform health hazard prioritization.

2. In the FHP context, the health risk analysis consists of a criticality assessment and a vulnerability assessment:

a. The criticality assessment identifies the assets and capabilities of one's own force that are critical to mission success. Simply put, these are the elements that, if compromised by a health hazard, could in turn compromise the mission. For example, for a mission to secure territory, a critical asset might be the land force, and a critical capability might be for that land force to conduct patrols.

b. The vulnerability assessment determines the susceptibility of an asset or capability to degradation from a health hazard, prior to any additional prevention or mitigation of the hazard. The result is the identification of deficiencies or weaknesses that render critical assets vulnerable to health hazards. Continuing the same example above, a vulnerability could be that the force has no natural immunity to an endemic disease in the area, where that endemic disease causes rapid onset paralysis. This in turn could compromise the ability to conduct patrols.

3. As described in AJP-3.14, this analysis permits the estimation in the next step, Health Risk Evaluation, of the potential impact the health hazard could have on the mission, and thus define the need for preventive or mitigation measures.

2.5 HEALTH RISK EVALUATION

1. The health risk evaluation establishes the potential impacts of the hazards identified in the health risk analysis. It provides the commander and the FHP staff an understanding to what extent a mission could be compromised by a health hazard. Broadly speaking this includes the evaluation of the:

a. exposure to the hazard(s);

b. probability that such exposure will cause an adverse health effect;

c. the anticipated impact (severity) of the hazard on the outcome of interest, e.g., individual and/or population health, mission success

2. Developing a full evaluation for all possible hazards is not practical. Emphasis, at least initially, should be on those thought to be the most important. Medical intelligence assessments may inform health hazard prioritization.

3. Often, a qualitative scale is used, e.g., risk is negligible, low, moderate, high or extremely high. The important point is that the evaluation capture likelihood and severity aspects of the hazard of interest. Estimating severity requires judgement and may be influenced by factors such as perspective (e.g., individual vs. population health), consequences for the mission, type(s) of acute and future health effects, risk tolerance, etc. In this respect, a health hazard might be assessed as high because it has the ability to affect (simultaneously) a large number of personnel (even if only with relatively mild symptoms, e.g., travellers' diarrhea, heat stress), or has very severe health effects (even if relatively few personnel are affected, e.g., Ebola), or for a variety of other reasons.

4. Risk evaluations can be developed using a variety of tools. A common approach is to use a risk matrix that combines probability and severity (on separate axes (see Table 1)) to yield a qualitative risk estimate. In turn, the estimate is explicitly linked to an outcome of interest such as mission success, future medical consequences or important individual health endpoints (Table 2).

5. Presenting risk before and after implementation of preventive measures is a robust way of communicating and underlines the expected effect of these measures.

SEVERITY	PROBABILITY				
	Frequent	Likely	Occasional	Seldom	Unlikely
Catastrophic	Extremely high	Extremely high	High	High	Moderate
Critical	Extremely high	High	High	Moderate	Low
Marginal	High	Moderate	Moderate	Low	Low
Negligible	Moderate	Low	Low	Low	Low

Table 1: Health risk assessment matrix (adapted from USAPHC TG-230). Risk categories (extremely high, high, moderate or low) reflect the interplay of hazard probability and hazard severity.

Risk Level	Potential consequences to operations and force readiness
Extremely High	Near-term: Loss of ability to accomplish the mission Long-term: Significant investment of future medical surveillance and medical provider resources
High	Near-term: Significant degradation of mission Long-term: Notable future medical surveillance activities and related resources anticipated
Moderate	Near-term: Degradation of mission capabilities Long-term: Notable future medical surveillance activities and related resources anticipated
Low	Near-term: Little or no impact on the mission Long-term: No specific medical action required

Table 2: Examples of risk categories and associated potential implications (adapted from USAPHC TG-230).

6. Ideally, an evaluation will be supported by quantitative estimates, e.g., numeric probabilities of immediate or future health harms. For example, if a military member deploys to an area where Japanese encephalitis (JE) is a hazard, their risks can be estimated based on:

a. Exposure. The probability of being infected with JE virus. In an endemic country, this might be in the order of 1/1,000 deployed persons.

b. Consequence. For JE is the likelihood of developing clinically relevant disease, or some other negative outcome thereof. Clinical JE is usually only manifest in a small proportion (about 1/250) of exposed persons.

c. Health risk. Using the outcome of clinically relevant disease, can be expressed as

Exposure x consequence = health risk

In this example, the product of exposure (1/1,000) and consequence (1/250) = health risk of 1/250,000. As about 25% of clinical cases of JE result in death, the analogous quantitative health risk for death = 1/1,000,000.

7. Expressing quantitative risk against a deployed population can also be important. For example, if the individual likelihood of clinical JE is estimated at 1/250,000 and 10,000 persons are exposed, then the potential for any cases can be approximated as risk for clinically relevant disease (1/250,000) x size of contingent (10,000) = 1/25.

8. The approach used to develop an evaluation should be well documented and, to the extent possible, transparent. Assumptions and limitations should be identified, and confidence in the estimate of risk should be explicitly stated (e.g., is it likely to be near the true value, or is there substantial uncertainty about the estimate(s)).

9. As health hazards and information related to them change, evaluation is a continuous process.

2.6. HEALTH RISK TREATMENT

1. The FP doctrine in AJP-3.14 indicates “risk treatment is to reduce the level of risk to a level which is acceptable to the commander/risk owner.” In the FHP context, this concept is generally known as risk management. In broad terms, it is a systematic way to selecting the best course of action under uncertain conditions. It is not necessarily risk avoidance. It allows decision makers to achieve their goals by reducing the likelihood that their freedom to act will be limited by matters outside of their control.

2. Applied to FHP, health risk management (HRM) refers to processes, decisions, health protection interventions and/or other controls that comprise the response to a health hazard. They can be applied at any time in the deployment cycle, for example pre-deployment vaccinations, administrative and other measures intra-deployment and medical screening and recommended clinical treatments post-deployment.

3. If health protection interventions or other controls are being considered as part of the response, decision-making should include assessment of the anticipated harms and benefits. For example, while providing reliable and evidence-based benefit, preventive medical interventions such as vaccination may also result in adverse medical effects. The benefit of using a public health intervention should outweigh harms – whether in terms of health protection (i.e. protection of the individual and/or group against a health hazard) and/or mission benefit.

4. HRM encompasses all aspects of health protection, i.e. it is not limited to medical professionals applying medical interventions. For example, a command requirement to use appropriate eyewear and hearing protection in designated areas is management; as is enforcement by command and/or medical personnel of personal hygiene, hand washing, fraternization standards, general safety standards and use of insect bite prevention methods. To repeat a statement made in Chapter 1: Command direction and emphasis may be the most critical aspect of FHP – preventable health harms usually do not result from a failure of health interventions, but rather represent a failure to use them.

5. HRM includes communication, whether targeted to specialized medical personnel, commanders, allied medical or command elements and/or all deployed personnel.

2.7. MONITORING AND REVIEW

1. The FP doctrine in AJP-3.14 indicates “monitoring and review is required to validate the effectiveness of overall FP measures, actions and tasks, to make necessary adjustments, to ensure that risk controls are implemented and enforced to standard, and that a feedback mechanism is in place”.

2. Applied to FHP, evaluation is intended to verify that risk evaluation and management are accurate, up-to-date and working as intended. It can involve a range of approaches – from walkthroughs of accommodation and eating areas to formal investigations of outbreaks, occupational exposures and post-deployment illnesses.

3. Fundamental to FHP program evaluation is ongoing and robust health surveillance. Health surveillance is defined as *“…the continuous, systematic collection, analysis, interpretation, and dissemination of health-related data”*[2]*. Deployment health surveillance refers to health surveillance in support of deployed NATO forces (see Chapter 4).*

4. Monitoring and review should occur throughout the process to provide the ability to identify weaknesses and to make changes or adjustments to controls based on performance, changing situations, conditions, or events. Commanders must review

[2] NATOTerm (26008).

actions and processes to ensure that lessons learned and best practices are recorded. As applicable, evaluation information should be fed into the NATO Joint Analysis Lessons Learned database to inform future action(s).

2.8. COMMUNICATION AND CONSULTATION

1. The FP doctrine in AJP-3.14 indicates “communication and consultation with commanders and staff should take place during all stages of the FP risk management process. It is important to address perceptions of risk. These perceptions can vary due to differences in values, needs, assumptions, concepts and concerns. Communication and consultation should facilitate truthful, relevant, accurate and understandable exchanges of information.”

2. To facilitate timely and effective FHP-related decision-making, medical advisors must have direct access to the chain of command.

3. Timely and unfettered lines of communication between military medical authorities of troop contributing nations are a priority.

4. As required, medical advisors may need to discuss FHP matters, e.g., outbreaks[3], with local, host-country, home-country and/or international public health authorities. This should be done with care to ensure information security.

5. FHP personnel are experts in health risk communication. They must communicate command-endorsed FHP direction with their supported military populations in manners that support evidence-based information sharing and ultimately improve adherence with public health measures.

6. In combined joint operations, FHP personnel should share information with other nations and levels of command, to support a common health operating picture.

[3] This includes Public Health Emergencies of International Concern as defined in the World Health Organizations’ International Health Regulations (http://www.who.int/topics/international_health_regulations/en/, accessed November 30, 2023).

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CHAPTER 3 COMMAND AND CONTROL

3.1. SENIOR MEDICAL ADVISOR

Allied Command Operations (ACO) MEDAD is the senior medical advisor to the NATO Strategic Commander. Based on command direction, ACO MEDAD provides FHP guidance to medical staffs of the NATO Joint Force Commands/Joint Command. ACO MEDAD also is responsible for integration of FHP information into the command, control, communications, computers and intelligence (C4I) system(s)[4].

3.2. DEPLOYED HEADQUARTERS

1. At the operational level, responsibility for co-ordination and integration of FP rests with J3. Medical planners support this process by providing relevant FHP information to J3.

2. FHP processes and programs are ideally managed through a Force Health Protection Cell (FHPC) established and located within the MEDAD's staff.

3. FHPC staff functions can include:

   a. Developing and/or coordinating HRA and consequent HRM recommendations (see Chapter 2).

   b. Developing and/or coordinating environmental and industrial site assessments.

   c. Preventive medicine programs.

   d. Carrying out FHP program evaluation and improvement, and assurance that FHP measures are centrally coordinated on multinational-sites to maximize effect.

   e. Advising on force health readiness.

   f. Interpreting and making recommendations and program improvements based on information received from NATO Deployment Health Surveillance Capability (DHSC).

   g. Managing the deployment health surveillance system.

[4] See AJMedP-5 Allied Joint Doctrine for Medical Communications and Information Systems (MedCIS)

h. Supporting/maintaining FHP programs in any other way(s) that are necessary.

4. The need to address food protection, including water safety and defence, may be integrated into the FHP cell, or in other ways under the JMED, provided that there are positions for SME with the relevant expertise required.

5. The FHP cell should be able to interact with CBRN, Environmental Protection and Veterinary Services personnel, to approach FHP according to the “One Health” principles, and to contribute to the HQs ability to predict and react to events in a comprehensive and holistic manner. Functions such as veterinary advisor (VETAD) and CBRN Medical may be integrated in the FHP cell or otherwise within the JMED.

CHAPTER 4 FORCE HEALTH PROTECTION PROGRAM AREAS

4.1 INTRODUCTION

1. FHP is interdisciplinary and requires a coordinated and comprehensive approach to maximize effectiveness.

2. The main program areas of FHP, each described below, are:

   a. Deployment health surveillance.

   b. Communicable disease control and prevention (including Infection Prevention and Control).

   c. Occupational and environmental health.

   d. Field hygiene and sanitation.

   e. Mental and physical health/preparedness.

   f. Oral health, dental fitness (readiness).

3. Diseases of animals also affect the risk for disease in humans. Whilst protection of animal health is duty of veterinary medical services, collaboration is necessary to assure total FHP under a One Health concept of collective health. Food and water safety and defence, veterinary services and prevention of animal diseases are addressed in STANAGs listed in Annex B.

4.2. DEPLOYMENT HEALTH SURVEILLANCE

STANAG 2535 is the NATO standard for and provides extensive guidance on Deployment Health Surveillance (DHS). As described therein, the objectives of DHS are:

   a. "*Detect, as soon as possible, occurrences of public health incidents or outbreaks, natural or not, that may jeopardize NATO capacities and missions.*

   b. *Assess the public health burden of death, diseases, injuries, syndromes or consequences of exposure to environmental or occupational risk factors in terms of limiting operational capabilities and for which preventive or counter-measures could be applied.*

   c. *Identify under which circumstances some of these diseases occur.*

   d. *Evaluate implemented preventive measures.*

e. *Identify relevant medical research fields*".

4.3. COMMUNICABLE DISEASE CONTROL AND PREVENTION

1. A variety of diseases can affect military personnel. In the near term, communicable disease hazards are often a priority as they have the potential to quickly affect a substantial proportion of deployed personnel.

2. Identification, assessment and management of communicable disease hazards follow the principles outlined in chapter 2. Assessment must begin pre-deployment to allow full medical preparation of deploying personnel (e.g., through hazard identification, health risk estimation, health risk mitigation such as immunization[5] and other measures) including the identification and acquisition of required medical materials.

3. Arthropod vectors (e.g., mosquitoes, sand flies, ticks) and associated diseases (e.g., malaria, dengue, chikungunya) can significantly erode mission capabilities. HRM for arthropod-associated hazards include surveillance for and control of vectors and other pests, e.g., repellents, bed nets, pesticides. These approaches are detailed in STANAG 2048 Deployment Pest and Disease Vectors Surveillance and Control.

4. Good sanitation and hygiene is an essential component of communicable disease control.

4.4. INFECTION PREVENTION AND CONTROL (IPC)

1. IPC is intended to prevent and control infections acquired through the application of medical care or in medical care settings.

2. A robust IPC program protects patient health and enhances force readiness.

3. Minimally, medical treatment facilities (MTF) are to adhere to basic IPC tenets including use of routine (standard) practices common to medical practice. It is understood that specific standards may vary by nation; the goal is to reduce the risk of infection to the greatest extent possible [6].

4. Ideally, the IPC program will adhere to best medical practices for IPC quality control and assurance, training, education, accountability and oversight.

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[5] SRD-7 to AJMedP-4 Vaccination Catalogue Within the NATO & PfP Forces.

[6] See description in World Health Organization Publication *Standard precautions in Health C*are (https://www.who.int/docs/default-source/documents/health-topics/standard-precautions-in-health-care.pdf; accessed December 04, 2023).

5. Antimicrobial-resistant microorganisms (ARO) are those that have developed resistance to the action of one or more antimicrobial agents. In general, routine precautions suffice for management of patients colonized by ARO. The requirement for additional precautions, e.g., contact precautions, should be assessed on a case-by-case basis.

6. Transfer of patients between MTF including to home country can result in spread of ARO. This can be addressed through use of appropriate IPC precautions and open dialogue between sending and receiving facilities.

4.5. OCCUPATIONAL AND ENVIRONMENTAL HEALTH

1. Occupational and environmental health (OEH) hazards are present in almost all military circumstances. They include physical (heat, cold, noise, accidents), chemical (solvents, lead, pesticides), and biological (malaria, rabies, shigella) hazards. The source can be natural or man-made. These hazards may be associated with acute and/or chronic effects.

2. Identification, assessment and management of OEH hazards follow the principles outlined in chapter 2.

3. OEH hazards are diverse and can require specialized equipment and knowledge to identify and manage them. For this reason, OEH activities are ideally managed through a dedicated occupational health program.

4.6. FIELD HYGIENE AND SANITATION

Maintaining high levels of sanitation and hygiene (including oral hygiene) protects against a variety of hazards. Troop contributing nations minimally are to apply basic sanitary principles to all aspects of their operations. These include: appropriate waste management and disposal[7]; safe and effective prevention and control of pests; and, promotion and facilitation of personal hygiene.

4.7. FOOD AND WATER PROTECTION

1. Food and water hygiene and safety have impact on the risk for disease and form a special area of FHP.

[7] Also see AJEPP-2 Environmental Protection for Military Camps in NATO Operations.

2. Food associated diseases (e.g., norovirus, Salmonella spp.) continue to impact NATO operations. Thus, food safety[8] and defence is a priority and should be applied through all stages of food procurement[9], storage, distribution, and preparation.

3. Food facilities must be regularly inspected and audited by suitably qualified and experienced personnel. If identified risks cannot be adequately ameliorated, use of microbiologically "safer" food sources is recommended.

4. Safe drinking water is an operational necessity. Failure to provide adequate quantities of potable water can result in significant DNBI rates, e.g., due to dehydration and/or communicable diseases. The operational goal is to provide drinking water that meets national home country quality/safety standards. Where this is difficult to achieve, the commander might decide to accept additional drinking water-associated risk.

5. To optimize water protection and safety, appropriate standards, processes, expertise, time and equipment should be made available[10].

4.8. MENTAL AND PHYSICAL HEALTH/PREPAREDNESS

1. Operational environments present psychological and/or physical stressors. Injuries resulting from these sources can, in the aggregate, outpace those resulting from other causes (e.g., infectious diseases, occupational exposures).

2. Commanders at all levels, medical personnel and individual soldiers have a responsibility to maintain and protect mental and physical health.

3. Identification, assessment and management of mental and physical hazards follow the principles outlined in chapter 2.

4. Programs to support mental and physical health (including injury prevention) can be broad and might involve subject matter experts (and programs) outside the normal cadre of medical experts, e.g., healthy living and eating experts, social and addictions counsellors and programs, physical fitness coordinators.

5. Maintaining and protecting mental health through the entire deployment cycle is a priority. Relevant NATO publications in this domain include: STANAG 2565 A

[8] Described/amplified in AMedP-4.6 Food Safety, Defence, and Production Standards in Deployed Operations and AMedP-4.7 Inspection of Food Services Catering Facilities in Deployed Operations.
[9] Described/amplified in AMedP-4.5 Audit Principles and Risk Assessment of Food Processors and Suppliers Providing Food to the Military
[10] Described/amplified in AMedP-4.9 Requirements for Water Potability during Field Operations and in Emergency Situations.

Psychological Guide for Leaders across the Deployment Cycle; AMedP-8.6 Forward Mental Health Care; AJMedP-1 Allied Joint Medical Doctrine Planning.

4.9 ORAL HEALTH CARE

1. Oral health care is an integral element of operational medical support and a force enabler. It is a national responsibility to prioritise both elements of oral health care delivery which directly influence force availability.

   a. Pre-deployment oral health care includes the delivery of regular screening, preventive and operative care in order to force generate military personnel to a high standard of dental fitness AMEDP-4.4. This significantly reduces preventable disease non-battle injury DNBI on operations and optimizes inter-operability between deployed NATO Defence Dental Services.

   b. Deployed oral health care includes the management of oral disease and emergency care including trauma. Dental casualties are proportionate to the number of personnel deployed, the duration and nature of the deployment. Dental operational capability is therefore scalable depending on the requirements of the particular mission AMEDP-8.13. Deployed oral health care maintains force availability in theatre.

2. Additional relevant NATO publications in this domain are listed in Annex B.

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CHAPTER 5 EDUCATION AND TRAINING

5.1. GENERAL

Effective education and training will create the capability and willingness to execute FHP programs thereby aiding in the maintenance of an effective fighting force.

5.2. OVERARCHING EDUCATION AND TRAINING GOALS (MEDICAL)

1. The NATO training objective is for personnel to meet the requirements indicated by AMedP-8.3 Training Requirements for Health Care Personnel in International Missions and AJP4.10 (C). Applied to FHP, the minimum training objectives at each level are:

a. Individual Education and Training. Field hygiene and first aid training, knowledge of FHP and its contribution to military readiness.

b. Key Personnel Education and Training. Ability to integrate FHP into strategic level medical force planning. Ability to assume senior medical positions in static or deployed HQs.

c. Staff (HQ) Education and Training. Capability to develop FHP programs and to coordinate multinational FHP measures.

d. Collective Education and Training. FHP as a medical support component in accordance with AJP-4.10(C).

2. Contingent on mission requirements, health care personnel should be briefed on:

a. The overarching FP process in the Joint Operational Area (JOA) including the commander’s intent and priorities for FHP.

b. The FHP process in the JOA including how it is integrated into FP.

c. Command, control and communication of health risks in the JOA.

d. FHP matters in the JOA including hazards, populations at risk, programs and processes, reporting requirements, and health promotion.

e. Health care structure in the JOA (location and capabilities of facilities, medical standards, costs, role of local military medical services, etc.).

f. Relevant medical actors including Host Nation authorities, international organizations and non-governmental organizations.

3. All deploying personnel should be briefed on basic FHP, including information specific to the JOA. Ideally, this will be done before and during deployment.

ANNEX A STANDARDS-RELATED DOCUMENTS

The following Standards-Related Documents (SRD) have been approved as amplifying documents to AJMedP-4. SRDs will be developed with the underlying principle of being as detailed as required to facilitate understanding and implementation whilst also remaining practical in their scope. The SRDs listed below will are the responsibility of the respective custodian nations.

SRD-1 to AJMedP-4: HEAT STRESS CONTROL AND HEAT CASUALTY MANAGEMENT – Custodian: United States of America

SRD-2 to AJMedP-4: PREVENTION AND MANAGEMENT OF COLD-WEATHER INJURIES – Custodian: United States of America

AJMedP-4-3: ALTITUDE ACCLIMATIZATION AND ILLNESS MANAGEMENT – Custodian: United States of America

SRD-4 to AJMedP-4: FIELD HYGIENE AND SANITATION – Custodian: United States of America

AJMedP-4-5: UPDATED U.S. PUBLIC HEALTH SERVICE GUIDELINES FOR THE MANAGEMENT OF OCCUPATIONAL EXPOSURES TO HIV AND RECOMMENDATIONS FOR POST EXPOSURE PROPHYLAXIS – Custodian: Belgium

AJMedP-4-6: UK GUIDELINE FOR THE USE OF HIV POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE, 2015 – Custodian: Belgium

SRD-7 to AJMedP-4: VACCINATIONS CATALOGUE WITHIN THE NATO & PfP FORCES – Custodian: Mil Med CoE

SRD-8 to AJMedP-4: PROTECTION OF HEARING – Custodian: Netherlands

AJMedP-4-10: WHO EXPERT CONSULTATION ON RABIES – Custodian: Belgium

SRD-11 to AJMedP-4 : SUMMARY OF KEY POINTS - WHO POSITION PAPER ON RABIES VACCINE – Custodian: Belgium

SRD-12 to AJMedP-4 : ENVIRONMENTAL HEALTH RISK ASSESSMENT AND SURVEILLANCE – Custodian: Sweden

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ANNEX B RELATED DOCUMENTS

NATO Policy and Concepts

MC 326/4 NATO Principles and Policies of Operational Medical Support

Allied Joint Publications

STANAG 2528 AJP-3.14 Allied Joint Doctrine for Force Protection

STANAG 2228 AJP-4.10 Allied Joint Doctrine for Medical Support

Allied Joint Medical Publications

STANAG 2542 AJMedP-1 Allied Joint Medical Planning Doctrine

STANAG 2547 AJMedP-3 Allied Joint Doctrine for Medical Intelligence

STANAG 2562 AJMedP-5 Medical Communications and Information Systems (MedCIS)

STANAG 2596 AJMedP-7 Allied Joint CBRN Medical Support Doctrine

STANAG 2598 AJMedP-8 Allied Joint Medical Doctrine for Military Health Care (MHC)

Allied Medical Publications

Oral Health and Dental Fitness

STANAG 2465 AMedP-1.17 Tasks and Skills for Appropriate Staffing of Dental Personnel for Operational Deployment.

STANAG 6544 AMedP-1.21 Safety Standards for Deployed Dental Care.

STANAG 2466 AMedP-4.4 Dental Fitness Standards for Military Personnel and the NATO Dental Fitness Classification System.

STANAG 2584 AMedP-6.1 The Civil-Military Planning Process on Oral Health Care and Deployment of Dental Capabilities in all Operations with a Humanitarian Component

STANAG 2453 AMedP-8.13 The Extent of Dental and Maxillo-Facial Treatment at Role 1-3 Medical Support.

Food and Water Safety

STANAG 2937 AMedP-1.18 Operational Rations for Military Use.

STANAG 2556 Food Safety, Defence and Production in Support of NATO Operations:

AMedP-4.5 Audit Principles and Risk Assessment of Food Processors and Suppliers Providing Food to the Military.

AMedP-4.6 Food Safety, Defence and Production Standards in Deployed Operations.

AMedP-4.7 Inspection of Food Services Catering Facilities in Deployed Operations.

AMedP-4.12 Food and Water Defence.

AMedP-4.14 Food and Water Safety, Defence and Production in NATO Naval Operations.

STANAG 2136 AMedP-4.9 Requirements for Water Quality During Operations.

Medical Information

STANAG 2481 AMedP-3.2 Medical Information Collection and Reporting.

Health Surveillance

STANAG 2535 AMedP-4.1 Deployment Health Surveillance.

Occupational and Environmental Health

STANAG 2048 AMedP-4.2 Deployment Pest and Vector Surveillance and Control.

STANAG 2582 AJEPP-2 Environmental Protection for Military Camps in NATO Operations.

STANAG 7141 AJEPP-4 Joint NATO Doctrine for Environmental Protection During NATO-led Military Activities

Communicable Disease Control

STANAG 2557 AMedP-4.11 Measures to Reduce Risk of Transfer of Biological Hazards During Troop and Materiel Movement.

Animal Care and Welfare and Veterinary Support

STANAG 2538 AMedP-8.4 Animal Care and Welfare and Veterinary Support during All Phases of Military Deployments.

Mental and Physical Health Preparedness

STANAG 2565 AMedP-8.10 A Psychological Guide for Leaders across the Deployment Cycle

STANAG 2564 AMedP-8.6 Forward Mental Healthcare

STANAG 2235 AMedP-4.8 Pre- and Post- Deployment Health Assessments.

STANAG 2249 AMedP-8.3 Training Requirements for Health Care Personnel in International Missions

Other Publications

United States Army Public Health Command. 2013. Technical Guide 230 - Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel.
https://ph.health.mil/PHC%20Resource%20Library/TG230-DeploymentEHRA-and-MEGs-2013-Revision.pdf

World Health Organization International Health Regulations. 2005.
https://www.who.int/publications/i/item/9789241580410

World Health Organization Publication. 2007. Standard precautions in Health Care.
https://www.who.int/publications/m/item/standard-precautions-in-health-care

AJMedP-4(B)(1)