

NATO STANDARD

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**ALLIED JOINT CIVIL-MILITARY
MEDICAL INTERFACE DOCTRINE**

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NORTH ATLANTIC TREATY ORGANIZATION

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NATO LETTER OF PROMULGATION

5 November 2015

1. The enclosed Allied Joint Medical Publication AJMedP-6, Edition A, Version 1, ALLIED JOINT CIVIL-MILITARY MEDICAL INTERFACE 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 2563.
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Edvardas MAZEIKIS
Major General, LTUAF
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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
FRA	<p>Paragraph 2.3.6 and Annex A: the French doctrine provides for the separation, within the concept of “Medical Intelligence”, of health risk assessment, under the shared responsibility of health experts and other subject-matter experts, and intelligence of a medical nature strictly falling under the intelligence chain. French health professionals contribute to medical intelligence in compliance with the ethical principles of international humanitarian law (including the Geneva conventions), the law of armed conflict and professional secrecy, and for the sole purpose of enabling the optimal prevention and management of medical problems in the forces that they support.</p> <p>Paragraph 3.1.3.2: Armed Forces medical capabilities are determined by the operational contract that has been set within the national context. The acquisition or the development of capabilities take place within this context.</p> <p>Paragraph 4.1.2: the French doctrine does not provide for the integration of Armed Forces medical staff into the J9 function. JMED staff is involved in the J9 function through collaborative staffing.</p>
LVA	LVA will use this document only after the interministerial working groups established MOU and SOP.
USA	<p>The USA supports and endorses the purpose and intent of AMedP-6; however, the USA does not subscribe to the language in paragraph 2.1.2, 2.5 and Annex A on “international humanitarian law”. Rationale. The Department of Defense (DOD) uses the term “law of war” or “law of armed conflict” pursuant to Department of Defense Directive (DODD) 2311E and the DOD Law of War Program. This reservation is similarly noted in noted in the Reservations section of AJP-3.4(A) on pages x and xi.</p>
<p>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 Document Database for the complete list of existing reservations.</p>	

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CHAPTER 1 THE ALLIANCE CONCEPT OF THE CIVIL-MILITARY MEDICAL INTERFACE

1.1. INTRODUCTION

1.1.1. General

1. According to the Comprehensive Political Guidance (CPG), endorsed by NATO Heads of State and Government at the Riga Summit on 29 November 2006, NATO while having no requirement to develop capabilities strictly for civilian purposes, needs to improve its practical co-operation, taking into account existing arrangements, with NATO members and partners, relevant international organizations and, as appropriate, non-governmental organizations in order to collaborate more effectively in planning and conducting operations.

2. At the Bucharest Summit in 2008, NATO Heads of State and Government endorsed a set of pragmatic proposals to develop and implement NATO's specific contribution to an international comprehensive approach. Specifically, the Alliance will improve its own crisis management instruments and strengthen its ability to work effectively with other actors.

3. At the Lisbon Summit in 2010, the idea of "Smart Defence" was introduced, and later agreed at the Chicago Summit in 2012. Smart Defence means pooling and sharing capabilities, setting priorities and coordinating efforts within NATO better. A number of smart defence projects was established, among these the project "Multinational Medical Treatment Facilities, Modular Approach".

4. In regard to the provision of medical support at the civil-military interface, operations such as the deployment of the NATO Response Force (NRF) in response to the request of the Pakistani government for support of the earthquake stricken region in northern Pakistan¹ or the involvement of the International Security Assistance Force (ISAF)² medical support in reconstruction efforts in Afghanistan have shown the urgent need for a common doctrinal basis in order to conduct medical support based on agreed standards and procedures.

5. This document outlines the principles that govern military support at the interface with civilian populations, authorities and organizations. It provides guidance on the operational environment related to concerted medical civilian and military planning and the actions required in this context for medical support in all types of NATO missions. It highlights the different responsibilities and the medical capabilities available to the commander to successfully undertake a mission using the capability based approach to operations.

¹ October 2005 to January 2006.

² Created at the North Atlantic Treaty Organization's (NATO) Bonn Conference in December 2001.

6. Confidence and trust is necessary at all levels of command to facilitate common understanding and intent with civilian participants. This will promote appropriate partnership and an operational portal for free flow of knowledge required for the maintenance of the common operational picture.

1.1.2. Aim

The aim of this document is to provide the framework for medical support at the civil-military interface. The delineation of responsibilities on the one hand, but also the depiction of limitations on the other hand will set the basis for the definition of general principles, the introduction into concerted medical planning and command and control as well as to provide civil-military medical guidance for training, education and exercises.

1.1.3. Scope

1. This document refers directly to MC 326/3 NATO Principles and Policies of Operational Medical Support, in particular Chapter 5 Military Medical Responses to Disaster Relief and Consequence Management Situations. It should also be read in conjunction with AJP-4.10(B) Allied Joint Medical Support Doctrine, AJMedP-1 Allied Joint Medical Planning Doctrine and MC 551 Medical Support Concept for NRF Operations. Additionally it specifies civil-military medical support principles in line with MC 411/1 NATO Military Policy on Civil-Military Co-operation (CIMIC) and AJP-3.4.9 Allied Joint Doctrine for Civil-Military Cooperation.

2. This publication replaces Allied Medical Publication-15 (AMedP-15) Military Medical Support in Humanitarian and Disaster Relief. However, the scope of this document is wider in terms of all relevant relations and actions of NATO military medical support in support of the mission and in co-ordination with a broader spectrum of civilian actors³.

3. Third parties can apply for medical support at NATO and support will be provided by NATO after North Atlantic Council (NAC) approval. NATO member states can also access civilian advice and expertise available within NATO through the Civil Emergency Planning Committee (CEPC) immediately. For partner nations there is also the need for NAC approval. The NATO commander's decision, based on his own intent, higher direction and guidance and staff expertise from J9 and medical staff, will determine initiation, scope and duration of civil-military medical support provided.

³ For usage of the term *civilian actors* please see Definitions and Explanations, Para. 1.2.12.

1.2. DEFINITIONS AND EXPLANATIONS

1.2.1. Health

Health is defined by the World Health Organization (WHO) as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

1.2.2. Civil-Military Medical Interface

1. Civil-Military Co-operation (CIMIC) is defined as the co-ordination and co-operation, in support of the mission, between the NATO commander and civil actors, including the national population and local authorities, as well as international, national and non-governmental organizations and agencies.

2. The term Civil-Military Medical Interface takes all possible interactions and relationships into account. It covers treatment and evacuation of both military and civilian patients within a continuum of care in a humanitarian operational Theatre. However, the expression is broader in terms of going beyond the boundaries of operational design. Areas of interaction and co-operation are for example usage of civilian scientific and expert sources for the development of military medical policy and doctrine as well as the use of civilian medical expertise in the preparation of operational plans or the adoption of medical training standards for military medical purposes.

1.2.3. Civil-Military Liaison

The aim of civil-military liaison is to provide the co-ordination necessary to facilitate and support the planning and conduct of operations (AJP-3.4.9). Appropriate civil-military liaison may also be established at all levels not only as a pre-requisite for concerted planning and conduct of an operation, but also as a framework for current or potential future co-operation in various fields. From the medical perspective civil-military liaison is required at the political level and from the Strategic Commands' Medical Advisors to the Joint Force Commands' and Joint Commands' Medical Advisors down to Medical Directors at tactical level. They will transfer liaison authority to subordinate medical personnel where appropriate. Liaison is not unidirectional. Consequently representatives from the civilian authorities and organizations should be in close relation with military headquarters and forces.

1.2.4. Support to the Civil Environment and Support to the Force

Depending on the Commander's decision, support to the civil environment can involve a wide range of military medical resources including information, personnel, materiel, equipment, communications, facilities, specialist expertise or training. Conversely the Commander may also require significant civilian support from within the area of operations.

1.2.5. Host Nation Support

Host Nation Support (HNS) is civil and military assistance rendered in peace, crisis or war by a host nation to NATO and / or other forces and NATO organizations which are located on, operating on / from or in transit through the host nation's territory. HNS seeks to provide the NATO Commander and the sending nations with support available in the form of materiel, facilities and services including area security and administrative support in accordance with negotiated arrangements between the sending nations and / or NATO and the host government. AJP-4.10(B) provides an overview of those areas of medical support suitable for HNS. It also points out that from the medical standpoint, resource availability, compatibility of equipment, interoperability of medical support structures (both civilian and military), acceptability of procedures and quality and standards of medical care available should be carefully considered.

1.2.6. Civil Emergency Planning

Civil Emergency Planning provides NATO with essential civilian expertise and capabilities in the fields of terrorism preparedness and consequence management, humanitarian and disaster response and protecting critical infrastructure. The aim of civil emergency planning in NATO is to collect, analyse and share information on national planning activity to ensure the most effective use of civil resources for use during emergency situation, in accordance with Alliance objectives. It enables Allies and Partner nations to assist each other in preparing for and dealing with the consequences of crisis, disaster or conflict. Civil Emergency Planning is a national responsibility and civil assets remain under national control at all times. However, at the NATO level, national intentions and capabilities are harmonized to ensure that jointly developed plans and procedures will work and that necessary assets are available. The main roles of Civil Emergency Planning in NATO reflect the fundamental security tasks of the Alliance and consist of civil support for the military under Article 5 and Non-Article 5 crisis response operations (CRO), support for national authorities in civil emergencies and the protection of civilian populations.

1.2.7. The Civil Emergency Planning Committee

The Civil Emergency Planning Committee (CEPC) is the top NATO advisory body for the protection of civilian populations and the use of civil resources in support of NATO's objectives. The CEPC is the key player in all Civil Emergency Planning done at NATO, including civil support to military operations. It coordinates planning in several areas, to ensure – when necessary – civil support for the Alliance's military operations or support for national authorities in civil emergencies. The CEPC reports directly to the North Atlantic Council (NAC). It meets twice a year in plenary session, at the level of the heads of the national civil emergency planning organizations from NATO and partner countries. Permanent sessions are conducted on a weekly basis, where countries are represented by their nation delegation to NATO. It coordinates and provides direction and guidance to four specialized groups covering the areas of civil protection; transport; industrial supply and communication; public health, food and

water. Amongst these specialized groups it is the Joint Health Food and Agriculture Group (JHFAG) that is dealing public health, food and water.

1.2.8. Humanitarian Operations

A Humanitarian Operation is specifically mounted to alleviate human suffering where responsible civil actors in an area are either unable or unwilling to adequately support a population. A Disaster Relief Operation is a specific type of a Humanitarian Operation.

1.2.9. Humanitarian Assistance

Humanitarian Assistance (HA) is, as part of an operation, the use of available military resources to assist or complement the efforts of responsible civil actors in the operational area or specialized civil humanitarian organizations in fulfilling their primary responsibility to alleviate human suffering. In contrast to a Humanitarian Operation, Humanitarian Assistance may not be the main purpose of an operation, but could be delivered based on a subordinate and possibly implied task and as such will always be delivered in a supporting role of the military.

1.2.10. Disaster Relief

Disaster Relief is the organised response to alleviate the situation resulting from a catastrophe (natural or manmade). The aims of disaster relief are to save life and lessen suffering, limit damage and restore essential services to a level that enables local authorities to cope. Characteristics are fast response and unusual patient patterns. Due to their nature these operations include a large portion of medical support. In certain cases where medical assistance is in the focus of the operation the medical force might even be in the lead and therefore be supported by the components of a joint force.

1.2.11. Consequence Management

Consequence Management (CM) is the use of reactive measures to mitigate the destructive effects of attacks, incidents or natural disasters. This includes the effects of terrorism including effects from Weapons of Mass Destruction (WMD). Medical Consequence Management therefore may be similar to those measures used in Disaster Relief Operations while taking the specialty of medical support in a Chemical, Biological, Radiological, Nuclear (CBRN) environment into account.

1.2.12. Civilian Actors

Civilian actors include Governmental as well as Non-Governmental Organizations (NGOs), International Organizations (IOs) and the Host Nation's Civilian Authorities and population. These actors are further defined in Chapter 4, Command and Control.

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CHAPTER 2 PRINCIPLES FOR THE CIVIL-MILITARY MEDICAL INTERFACE

2.1. MISSION TYPES

2.1.1. Article 5 Operations

Humanitarian assistance during an Article 5 Operation very likely will have to be executed alongside high intensity operations and large capacities of military medical support most probably are required. Depending on the area of operations (AO), and their capacity, suitability and availability, significant medical host nation support (HNS) could be utilised whereas the involvement of NGOs and IOs in high intensity situations may be less likely due to security concerns.

2.1.2. Non Article 5 Crisis Response Operations and Related Activities

1. Non Article 5 Crisis Response Operations (NA5CRO) can be described as multifunctional operations that encompass those political, military, and civil activities, initiated and executed in accordance with international law, including international humanitarian law, contributing to conflict prevention and resolution and crisis management, or serve humanitarian purposes, in the pursuit of declared Alliance objectives.

2. Military forces may be employed in a variety of NA5CRO situations. The NAC may agree to direct such operations, or they could be conducted within a bilateral or multinational context. Military involvement in these operations could range from support of humanitarian operations or disaster relief to enforcement of sanctions or embargoes to Counterinsurgency (COIN). In many cases these NA5CRO will even impact Article 5 operations as well.

3. Beyond the pure support role of sustaining the deployed forces, joint medical support acts as a mission component in NA5CRO by supporting the initial restoration of essential services and facilities, by providing humanitarian assistance, and by contributing to the reconstruction and development of the local health sector within the framework of the civil-military interface. This expanded role and the potential medical contributions, which are addressed in current medical doctrine, should be taken into consideration throughout all operational phases from early planning onward, according to the principles laid down in this publication.

4. The range of NA5CRO and related activities is described in detail in AJP-3.4(A) and related documents. Each type of NA5CRO and related activities has its own implications and therefore has to be approached accordingly.

5. The following types of NA5CRO will regularly require specific medical support considerations at the civil-military interface as follows:

- a. Peace Support Operations. Peace Support Operations (PSOs) may be described as operations that impartially make use of diplomatic, civil, and military means, normally in pursuit of UN Charter purposes and principles, to re- store or maintain peace. Such operations may include conflict prevention, peacemaking, peace enforcement (PE), peacekeeping (PK), peacebuilding, and/or support to humanitarian assistance.⁴ In many cases during peace support operations health care will be provided to the civilian population as part of the reconstruction and stabilization effort of the mission. Medical staffs at every level must primarily support the operational objectives set by the commander. However, they also must provide appropriate advice on risks and limitations of medical support to local civilian patients. Although medical assets will be tasked to provide health care aimed at creating short-term effects, the implementation of a sustainable, locally provided, long-term solution should be given the highest priority.

- b. Non Combatant Evacuation Operations.⁵ Generally, a force committed to a Non Combatant Evacuation Operation (NEO) should have the capability to provide security, reception and control, movement, and emergency medical support for the civilians and unarmed military personnel to be evacuated. Although medical support assets are not primarily designed for medical support to specific civilian patients (for example expectant mothers and children), a NEO will require the involvement of medical capabilities that are tailored to the composition of the group to be evacuated, but that are not represented in the military medical forces. Consequently, a thorough assessment of potential patients within the group must be conducted as a prerequisite for the effective provision of health care in such an operation.

- c. Humanitarian Assistance Operations including Disaster Relief. The types of Humanitarian Assistance (HA) Operations within the framework of Support to Civil Authorities / Military Assistance to Civil Authorities are described in detail in AJP-3.4 (A) and related documents. These operations regularly require specific medical support planning. More than this, medical forces can even be in the focus of the operation. In the latter case the medical contribution to the Operational Planning Process (OPP) will have a deep impact on the operational design and medical forces could be in a supported role. The main objective of medical support to a humanitarian assistance / disaster relief operation is to improve the provision of care to the civilian population. The action is taken to fulfill the request of a nation to NATO or to implement a United Nations (UN) Security Council Resolution.

⁴ Refer to AJP-3.4(A), *Allied Joint Doctrine for Non-Article 5 Crisis Response Operations*.

⁵ See AJP-3.4.2, *Allied Joint Doctrine for Non-Combatant Evacuation Operations*, for further information.

- d. Medical Humanitarian Assistance. Medical Humanitarian Assistance (MHA) is the provision of humanitarian medical aid by military health services, deployed on the field to support forces for the conduct of combat or security related operations. Such medical humanitarian assistance should be provided in accordance with the CIMIC objectives in order to be coherent with the civil-military operations. As medical support to NATO troops remains the highest priority, the medical humanitarian assistance is of lower priority. The military medical support should be always reversible in order to be able to treat a peak of military casualties. Medical goals at the interface have to be harmonized among NATO and nations. They should actively contribute to the mission objectives, avoid redundancy with other available assets and optimize the medical footprint with regard to actions at the civil-military interface. Thus, the use of the military medical facilities in humanitarian assistance has to be tailored to the military requirements of operational phases.

2.2. MILITARY MEDICAL HUMANITARIAN ASSISTANCE

2.2.1. Relations at the Civil-Military Medical Interface

1. Relationships with the non military medical organizations, such as local authority / governmental structures, NGO or IO agencies, should be established as early as possible. Medical planners must constantly refer to the commander's intent and the mission goals in order to determine where and how to deliver optimized military support. Indeed, the re-establishment of indigenous medical structures should retain primacy as the provision of humanitarian relief is primarily a function of humanitarian and development agencies. Thus it is essential to assess the health situation and to take advice from the co-ordinating civilian authority or humanitarian agency for the provision of medical humanitarian operations.
2. During humanitarian assistance / disaster relief operations, Military Medical Services in NATO will rather act as "sub-contractors" to provide medical expertise and capabilities to the wider relief effort. Medical support is deployed for humanitarian specific tasks either in a permissive or in a non-permissive environment. In the latter case military medical support assets might be the only available means and capability. The higher the intensity of a crisis, the more likely will be the involvement of military medical assets. Lower intensity and longer duration crises require handover from military to international civilian actors, until local providers are capable of assuming responsibility and tasks. The relation between intensity, duration and involvement of military, international and indigenous civilian actors is expressed in Figure 1. In any event, military medical forces must get into a position to handover responsibility for the humanitarian medical task at the earliest opportunity.

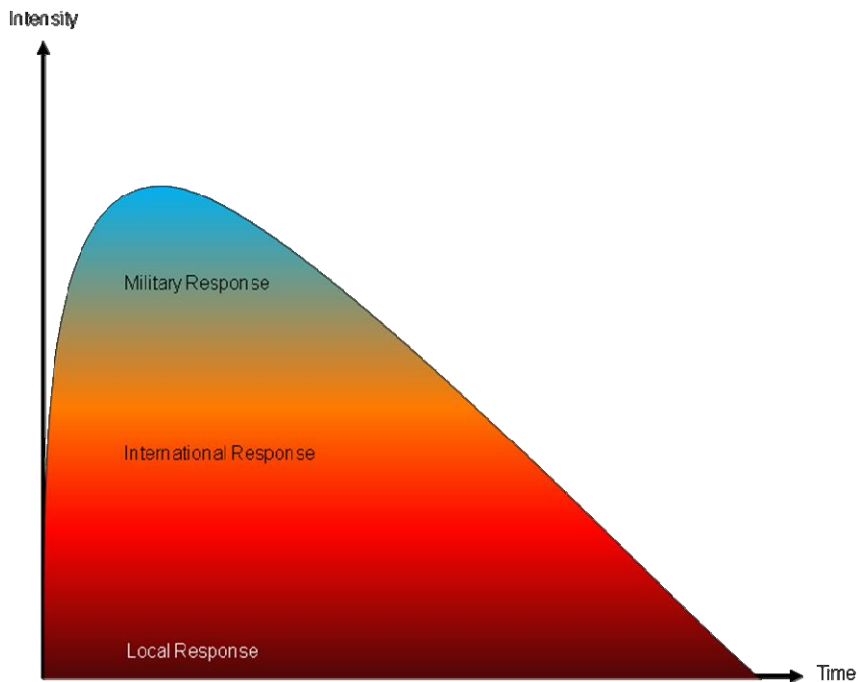


Fig. 1: Military, International and Local Crisis Response

2.2.2. Principles

There are a number of principles involved in the provision of aid in humanitarian assistance and disaster relief operations. These are:

- a. Military medical support will be provided at no cost to receiving states. Costs might be recoverable from the international organizations seeking assistance depending on the situation and a Memorandum of Understanding (MOU) to be developed.
- b. Military assistance will only be provided on request of an international organization, partner or member nation.
- c. When practical, MOU should be issued prior to any operation.
- d. The UN Office for Co-ordination of Humanitarian Affairs (OCHA) states in its principles that humanitarian and disaster relief operations should generally be conducted unarmed. Nevertheless, if the security of the force cannot be guaranteed by the stricken country, adequate protection must be provided and thus the right endorsed for the military personnel of self-defence remains.

2.3. GUIDING MILITARY MEDICAL PRINCIPLES

2.3.1. Guidelines

1. ACO Directive 83-2 provides the overarching guidance for military medical services involvement with humanitarian assistance and support to governance, reconstruction and development.⁶

2. The independence of humanitarian agencies and the “humanitarian space” in which they operate must be respected. Use of NATO assets for humanitarian aid should be limited to those circumstances described in the UN OCHA Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies, and the provision of health support should be handed over to civilian personnel at the earliest appropriate opportunity. Good communication and cooperation are essential.

2.3.2. Ethics

Wherever possible, military medical forces will seek to provide immediate life, limb and eye saving care to not entitled individuals that present or are presented to them where no alternative care provider exists. In all cases, the action of individual healthcare professionals must comply with all relevant international laws and the recognized ethics of their profession.

2.3.3. Partiality and Impartiality

Military assistance – including medical – may be provided to allies on a partial basis. However, military medical treatment in emergency/life-threatening situations must be impartial just as well as military humanitarian assistance must be impartial.

Moreover, medical assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of suffering must be guided solely by need, and priority must be given to the most urgent cases. Casualties who are members of opposing forces must also be treated in line with this principle. Medical personnel have a responsibility to report violations of this principle to an appropriate authority.

2.3.4. Cultural Competence

An understanding of diversity, civil values, customs, ethnicity, religion and culture is fundamental to apply the appropriate methods of support.

⁶ AD 83-2, *Allied Command Operations (ACO) Guidance for Military Medical Services Involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development (March 2010)*.

2.3.5. Standards of Healthcare

Medical support should reach standards acceptable by the receiving country and also by participating nations. The aim is to provide a standard of medical care as close as possible to normal peacetime medical standards of the receiving country while being acceptable – at least in outcome – to the providing countries. It is crucial that the involved actors agree on standards the receiving nation can sustain in the long term.

2.3.6. Medical Confidentiality

1. Usual considerations with respect to confidentiality must apply in all operational scenarios. Patient medical information must be protected and to the extent possible only be shared between medical care providers and not with other non-medical entities. Specific policies on sharing of medical information must be developed in concert with local medical authorities and possibly with medical NGOs.

2. The privileged relationship established between medical personnel and patient must not be exploited to provide intelligence. However, open sources of collective information (such as local atmosphere, strength and general aspects of the local population, health situation, refugees or displaced persons and epidemics) should be incorporated into the commander's decision making process. Medical intelligence is intended to reduce both NATO force and civilian casualties. Medical intelligence should therefore be conducted by medical personnel.

2.3.7. Continuity of Care

Military provision of initial patient treatment creates the obligation to pursue care up to the recovery stage. While the aim is to ensure a continuity of care, the handover to civilian health care providers should be aspired at the earliest suitable opportunity. Medical evacuation within the area of operations must be ensured in order to enable the patient to reach the appropriate medical facility in the area of operations within the required timeframe.

2.3.8. Patient Tracking and Regulating

Patient tracking is the precise and continuous monitoring of the locations and the intended destination of the patient in the medical treatment and evacuation chain (AJP-4.10(B)). Keeping track of all personnel once they have been introduced into any medical treatment and evacuation chain is of crucial importance. One of the purposes of Patient Tracking is to serve as a basis for Patient Regulating. Patient Regulating is a process of control and co-ordination to ensure patients are evacuated to medical treatment facilities which are best capable of providing the required treatment, and having the required numbers and type of beds available. Appropriate information flow for multinational military patients in civilian facilities as well as for civilian patients in military facilities requires additional efforts. Close liaison and information exchange have to ensure that patients crossing civil-military boundaries can still be tracked and managed. The current Medical Information and Co-ordination System (MEDICS)

project within NATO (still not operational; expected date unknown), which aims at enabling and improving multinational medical support solutions in NATO operations, shall provide tracking and regulation of all patients (civilian, military, NATO and non-NATO nationalities).

2.3.9. Emergency Care

Wherever possible emergency care is a priority for military healthcare provision in order to provide an efficient first line service to the majority of the population. Patients with chronic diseases should be referred to local medical resources to avoid creating a dependency on military resources..

2.4. GUIDING PRINCIPLES OF CIVILIAN ORGANIZATIONS

2.4.1. Constraints and Restraints

1. From most civilian organizations' point of view it is of utmost importance to retain their identity as independent, neutral and impartial humanitarian bodies. Therefore they aim at a clear delineation of their activities from those carried out by military forces. While maintaining a dialogue with armed forces at all levels, these organizations preserve their independence of decision-making and action. In their relations with military medical forces IOs and NGOs specializing in the provision of healthcare will always try to ensure that their activities are not perceived as a contribution to the military effort. Imperative for civilian actors is to retain an ensured "Humanitarian Access" meaning the unimpeded access to the population at risk in consent of all conflict parties.

2. While military forces are designed to provide stability and security, civilian organizations will not automatically recognize the force posture as a prerequisite for their own safety. On the contrary the military presence might even be seen as a risk factor for deployed civilian health care providers in cases where the population does not acknowledge clear distinction between military and civilian assets.

2.4.2. Civilian Standards for the Employment of Military Assets

Certain standards have been agreed by civilian humanitarian actors on the use of military assets. The most important standards are:

- a. Military will only be employed on request of a civilian "Humanitarian Co- coordinator".
- b. Engagement of military assets is a "means of last resort", only considered in the absence of adequate civilian assets to accomplish a certain task.

- c. All humanitarian engagement has to retain a “Civilian Character”, so military assets will only be in a supporting role.
- d. All military effort has to be limited in time and scope, providing a clear “exit strategy” for the handover to civilian actors.
- e. All military assets have to respect the UN Code of Conduct.

These standards cannot be entirely accepted by the military, as operational planning is driven by differing imperatives. But these standards need to be known to military medical planners and recognized as a primary guide to civilian attitudes towards the military.

2.4.3. Relations to Military Actors

In peacetime many civilian organizations maintain a dialogue with national military authorities and with the NATO Command Structure as such. They exchange views and information on areas of possible interaction with a view to establish mutual understanding of roles and mandates in order to create mutual trust and respect. This attitude may result in formal agreements or other arrangements between civilian and military bodies. Other organizations might be reluctant to co-operate with the military at all depending on the principles that guide these organizations.

2.4.4. Common Activities

1. While the provision of direct care for a population is generally seen as a non-military task, potential interaction from the civilian perspective in the area of healthcare encompasses the following activities:
 - a. Medical information sharing.
 - b. Complementary provision of education and training, e.g. hygiene training or first aid training.
 - c. Participation in military medical exercises.
 - d. Participation in civil exercises (e.g. Euro-Atlantic Disaster Response Co-ordination Centre (EADRCC) exercises).
 - e. Planning of a concerted civil-military response to major incidents.
 - f. Synergetic, but not competing efforts in the mitigation of the consequences of a humanitarian disaster.
 - g. Utilization of military medical assets for medical support to the members of civilian organizations based on bilateral agreements.

2. In all cases civilian organizations will make their decisions based on an assessment on the benefit of civil-military co-operation against the background of their status of neutrality and impartiality.

2.5. STRATEGIC VIEW

1. Undertaken under the principles of humanity and impartiality, engagement by NATO medical personnel in Reconstruction and Development (R&D) / Sector Security Reform (SSR) activities will assist R&D of the Host Nation (HN) health sector. It is essential that military medical personnel support the HN plan for basic healthcare. Mentors must focus on preventive medicine, patient transfer skills, nursing and post-operative care to facilitate capability building, rather than direct care to the community, as this activity although well intentioned can undermine HN medical care providers, NGOs and the HN government. NATO medical personnel must hold strict observance to medical ethics and conform to international humanitarian law.

2. Medical engagement in humanitarian assistance for emergency cases and in health sector governance, and R&D, is a key requirement for current and contingent NATO operations. When undertaken in line with the principles outlined above and by the “ACO Guidance for Military Medical Services Involvement with Humanitarian assistance and Support to governance, reconstruction and Development”, immediate healthcare needs of the HN population may be addressed, and efforts to promote development in liaison with those others involved can become coherent. This in turn will help the HN population in both the short to medium term. Activities such as Medical Civil Assistance Projects (MEDCAPS) should be carefully considered and coordinated to avoid unintended consequences.

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CHAPTER 3 OPERATIONS AT THE CIVIL-MILITARY MEDICAL INTERFACE

3.1. PLANNING CONSIDERATIONS

3.1.1. Introduction

1. This chapter describes the planning of civil-military medical aspects contributing to operations. While AJMedP-1 Allied Joint Medical Planning Doctrine provides an overview of the medical contribution to the operational planning process (OPP) in general, this chapter describes the medical contribution specifically for the civil-military medical interface. However, work is under way to make NATO's operational planning better suited for and more compatible with the intent of working within the International community. The outcome of this work will determine the extent of revision required in planning documents that will be put to nations for their approval.

2. Strategic planning consideration do not only address the civil-military interface in Theatre, but they also refer to the involvement of civilian actors' e.g. with regard to the generation of civilian capabilities or expertise.

3.1.2. Phases of Operations

The different phases of operations are described in AJP-3. However, when considering the civil-military medical interface and the provision of optimized medical support, the delineation between initial phase / acute crisis, stabilization and force withdrawal / achievement of a normal situation is an important area for further discussion:

- a. Initial phase / acute crisis. During this phase the establishment of early liaison is of utmost importance. The balance between military medical support and support provided by civilian organizations will largely be a result of the overall threat level. The more secure the environment is, the more feasible the reduction of military medical support and the enhancement of civilian medical support will be.
- b. Stabilization and Reconstruction. The core military role in supporting stabilization activities and reconstruction efforts is to contribute, along with other actors, to a safe and secure environment to enable the non-military efforts. Stabilization encompasses actions undertaken by or in co-ordination with indigenous national authorities, mandated authorities or other civil agencies, to maintain or bring about a safe and secure environment. This phase starts with a complete build-up of liaison and ends with the transition phase where handover of the responsibility for the provision of health care to local civilian authorities and / or IOs and NGOs takes place. Reconstruction and Development (R&D) of the

civilian health care system, although is principally a civilian led activity, may require military medical advice and involvement.

- c. Withdrawal. If the medical condition of the civilian population or the sufficiency of the civilian health care system is part of the desired end state, medical advice to the commander will be crucial for mission termination.

3.1.3. Capabilities

1. All planning for the civil-military medical interface has to be conducted with a focus on the actual requirement for the deployment of medical assets. Where civilian patients must be taken care of, age, gender, and patterns of diseases or injuries should be thoroughly analyzed. Where exact figures are not available the analysis needs to be replaced by an estimate.

2. Medical support planning in this context will often identify the requirement for capabilities that are not represented among military medical force structures such as obstetrics and paediatrics capabilities. A timely planning for the requisite specialists, if needed via bilateral or other agreements should initiate the request / acquisition of these capabilities⁷.

3. After a humanitarian disaster has occurred, requirements for the deployment of medical support assets change from surgical capabilities in the beginning to capabilities needed for treatment and prevention of diseases as the operation progresses. Hence the demand for medical support needs to be projected to the expected scenario upon the earliest possible deployment, but also to the anticipated scenario at later stages of the operation.

4. Specific considerations depending on the situation should apply. Planning principles are:

- a. Surgery to save or to restore the majority of patients.
- b. No comprehensive measures in case of significant patient flow in order to keep means for the majority (triage).
- c. Short hospitalization span to optimize turn over and to keep the maximum of availability.
- d. Initial assessment of epidemiological situation.

⁷ According to the MC position on stabilization and reconstruction: "The military can support stabilization and reconstruction within available means ..." a possible solution could be the use of "Functional Specialists", identified through the assessment process and provided by Nations. Another possibility might be the use of the CEP organization.

- e. Therapeutic protocols adapted to the local health situation.
- f. Rely on the civilian structures and public health information systems as early as possible.

3.1.4. Lessons Learned

Observations from the civil-military medical interface should contribute to the lessons learned process and therefore be inserted into the NATO lessons learned database hosted by NATO Military Medical Centre of Excellence (MilMedCOE) in Budapest. In the context of this publication observations and lessons identified from civilian organizations are of specific interest. They need to be analysed and to be taken into account not only for the review of medical plans, but also for the review of AJMedP-6.

3.2. CIVIL-MILITARY MEDICAL ASPECTS OF THE CONTRIBUTION TO THE OPERATIONAL PLANNING PROCESS

3.2.1. Medical Reconnaissance

It is important to execute a timely and complete reconnaissance with the participation of medical subject matter experts. The medical staffs that are embedded into the reconnaissance team must possess adequate knowledge and experience in the provision of medical support at the civil-military medical interface. By a request to CEPC, a Rapid Reaction Team (RRT), composed of the necessary required experts, can extend the reconnaissance team. ACO DIR 80-90 dated 27 Aug 2008, states procedures to be adopted to enable HQs and units to formally access to civilian advice and expertise available through the HQ NATO Civil Emergency Planning (CEP) organization.

3.2.2. Review of the Situation

To conduct an analysis of the situation at the civil-military medical interface, the following aspects have to be taken into account:

- a. Civilian health care system.
- b. Health care providers and authorities.
- c. Health care infrastructure, equipment, supplies and personnel, hygiene.
- d. Health status of the population, main concerns, epidemiological challenges.
- e. Involved organizations (government, NGO, IO) and their executive relationships.

- f. Medical situation of displaced personnel.

3.2.3. Mission Analysis

The purpose of the mission analysis is to clearly define what must be achieved. During the Mission Analysis assigned and implied tasks concerning the civil-military medical interface must be identified as well as potential areas for combined planning with civilian bodies. Limitations, either constraints or restraints, mainly define the balance between medical support to own troops and involvement in civilian health care matters. They also refer to the responsibilities of civilian actors that must not be taken over by military medical assets.

3.2.4. Evaluation of Factors

1. The determination of the population at risk (PAR) leads to the number of civilian population including refugees and displaced persons to be taken account of. Other factors addressing the civil-military medical interface are listed at 2.2.1 above. At this point of the planning process they are thoroughly analyzed. Conclusions drawn from those factors that include civil-military aspects become part of the comprehensive medical support concept.

2. In CBRN environments military medical support may on occasions be the only operational medical asset available. Military medical support to the civilian population in such an environment might therefore require a more substantial medical footprint. This should be borne in mind during the planning process.

3.2.5. The Operational Design

1. Political, strategic, and operational level planning staffs will refer their planning considerations including the identification of objectives to a desired end state at each level. Medical conditions related to a desired end state require the involvement of the medical staff, eventually supported by CEPC civilian medical experts, in the development of the operational design.

2. In many cases the civilian actors' Centres of Gravity (COG) will be their cohesion and their ability to co-ordinate their efforts in a manner that allows them to provide their assistance in an efficient way. Knowing their COGs is crucial since the developing capabilities of NGO and IO will determine the point of handover from military to civilian medical support and therefore have an impact on the exit strategy of the force.

3. Medical actions along the lines of operation have to be synchronized with the overall effort. Reconstruction of the civilian health care sector must be fully in line with the overarching military support to stabilization activities and reconstruction efforts.

4. If medical conditions are described within the desired end state, the medical staff will have to contribute to the measurement of effectiveness and to the development of criteria for success as well. As an example, these could be epidemiological indicators such as morbidity and mortality rates or the number of hospitals and personnel employed in the health care sector in relation to the size of the population.

5. A transition strategy as part of the medical support plan needs to contain the necessary conditions to be achieved before military medical forces can successfully disengage from Theatre. Elements pertaining to the civil-military medical interface have to be regarded with special caution, as they might engender the most demanding long- term commitments.

3.3. HUMANITARIAN ASSISTANCE

1. As long as military medical support is involved it must not compete with civilian actors but work in a complementary way. As not to be contradictory in effect, the basic premise for medical support during all humanitarian actions is to encourage a culture of ownership and self-sustainment within the local medical structures

2. As there is no mandate to develop specific medical elements for humanitarian operations, military medical services have to tailor forces as appropriate as possible for the mission requirements out of existing structures. Employing reserve elements or civilian resources might mitigate the specific capability shortfalls encountered.

3. Medical humanitarian assistance and medical support of a humanitarian / disaster relief operation occur in different contexts but refer to the same principles. The delivery is based on the invitation or at least the permission of indigenous authorities. The various spectrum of actions provided during such operations includes:

- a. All actions conducted by healthcare specialists like medical care, emergency care, surgery and resuscitation, hospitalization in medical facilities, medical evacuation, preventive medicine, epidemiology, force health protection, medical intelligence, medical expertise, medical advice to civilian and military authorities, co-ordination with NGOs and other agencies, education and forensic aspects.
- b. Pharmaceutical services such as medical and material supply and distribution to the local population. Provision of expertise to the local pharmaceutical structures and co-ordination with the NGOs / donors.
- c. Veterinary aspects, including animal medicine, epidemic prevention and audits for food and water surveillance.

- d. Dental care and prevention.
- e. Hygiene, including food hygiene, waste management and waste water management.
- f. Medical education and information of civilian population and local medical professionals.

3.4. GOVERNANCE, RECONSTRUCTION AND DEVELOPMENT

3.4.1. Introduction

1. NATO operations during complex emergencies have highlighted a new challenge for military medical services: By expanding their role to encompass the care of civilians and capacity building they can contribute to stability. These efforts have to be as coordinated, efficient or effective as they could be. There is a clear link between the health and security and interaction between the military and humanitarian organizations and implications of military medical services involvement in the civilian health sector. Lessons learned from operations and scientific research indicates that military medical services must continue to deliver medical care for civilians, but that it could be enhanced. In delivering healthcare the relationship between the military and humanitarian organizations improves.

2. During operations the need to bring about stability to permit disengagement, without a return to crisis, remains. Without the provision of appropriate healthcare, crisis resolution is unlikely. Today's interventions may be simple in concept but they are more sophisticated in outlook; they are certainly about individuals but they must also take into account the entire population of a nation and the generations to come, as they strive for restoration of self-sufficiency.

3. Military medical services must be prepared to deliver medical care to sick and injured civilians alongside wounded servicemen. Capacity is most likely small, the problem vast and any possible level of involvement is difficult to quantify. The change on emphasis from surgical treatment to public health and primary care initiatives could improve the response but even so a perfect solution may remain elusive. As security improves the host nation's government and humanitarian organizations can become increasingly effective, ultimately taking over full responsibility. Co-ordination is vital to achieve any success; however coherence and integration would be better. For this to happen the military must work with those humanitarian organizations who feel that their principles are not threatened, and respect those who feel the opposite is true. The real challenge, and perhaps the greatest prize, appears to lie in the field of development. The military medical service must engage with this early. Security considerations may mean that they are the only agency who can, and without it recovery would be slow and disjointed.

Success would ensure health is secured in a sustainable way and have the secondary effect of reduced reliance on the military.

3.4.2. Health and Health Care Systems

1. A clear mandate to the commander with regard to military support to reconstruction and development will include direction and guidance for the military role in the civilian health care sector. Military forces will usually facilitate civilian entities to take care of reconstruction and development. Due to the considerable number of actors involved an integrated approach is crucial to overall success during military operations. Adequate reconstruction of the health care sector may be one key condition for enduring peace and stability in the country to be supported.
2. In order to contribute effectively, medical staff involved in health care reconstruction and development must be capable of understanding structures and mechanisms of health care systems in different countries. Health care systems can generally be described in three different dimensions: the steering function, financial mechanisms and systems organization. On request CEPC can provide experts within its Planning Boards and Committees (PB&Cs). The knowledge and expertise is available and can be used.
3. Based on the WHO definition of health given in chapter 1, health care includes not only direct patient care, but also a viable sanitation system, available and adequate nutritious food and potable water, control of communicable disease, protection from exposure to hazardous wastes and materials, as well as protection from the physical and psychological dangers of conflict. The health sector then includes all aspects, resources, personnel and infrastructure with a significant impact upon the health of a population or individual.

3.4.3. Facilitation of Resources

1. While direct medical care to civilian patients might promise quick and achievable results, sustainable projects that restore and build capacities achieve longer and wider spread results than limited scope direct patient care projects. Such projects enable the primarily responsible civilian actors to take over responsibility for patient care. Thus, the military medical effort should be wholly collaborative and inclusive to all involved stakeholders. Balanced medical advice will have to weigh immediate mission requirements against desirable long-term stabilization effects.
2. In the health sector, military medical staff may also have the expertise to assist with the assessment of demands for health services and the development of project proposals. Where this expertise is not directly available within a deployed medical staff, reach back information can be provided by national authorities, Ministry of Health, Ministry of Development or equivalent in the sending nation.

3. A successful medical infrastructure project can make a substantial difference to the local population served by the facility and provide a contribution to the overall reconstruction effort at the same time. In addition to this a credible effort supports the aim of earning trust in the military operation on the civilian side. It is vital that such an investment is safeguarded for the long-term by ensuring the project lies within a wider health programme and is sustainable in terms of staff, equipment, supplies, training and local community commitment. Provision of sophisticated medical equipment with excessive demands on power supply or maintenance has to be avoided.

4. Medical engagement within the HN, including veterinary assistance and dental assistance, and providing emergency medical care for humanitarian reasons, especially to those injured as a result of the conflict, is encouraged, as this serves the prime humanitarian principle of humanity, and may contribute to efforts to promote stabilization. Medical/Dental/Veterinary Civil Assistance Projects (MEDCAPs/DENTCAPs/ VETCAPs) focusing on military medical care to populations in developing countries are often established by contributing nations. They generally provide short-term medical care to a part of the population that does not have access to sufficient healthcare. The benefits of these programmes are limited by the disadvantage of not providing sustainable care. In contrast Medical Outreach should be established which is defined as a planned medical engagement activity meeting in sign and execution meets the principles described in the “UN OCHA Guidelines on the Use of Military and Civil Defence Assets to Support United Nations Humanitarian Activities in Complex Emergencies”. AD 83-2 further details on Medical Outreach, and on how such activity would contribute to Governance, Reconstruction and Development (G, R&D). The Medical Advisor (MEDAD) / Medical director need to advise the commander accordingly.

3.4.4. Basic Health Packages

The definition of a basic health package must be developed in close co-ordination with the local government. As stated in chapter 2, the main reference points will be prevailing standards prior to the crisis as well as standards accepted by nations participating in the operation.

3.4.5. Priorities

Priorities for health sector reconstruction should be developed by the receiving country and WHO strategic guidance while international actors maintain a supporting role. These priorities depend on the overall health situation. They must be reviewed frequently as the operation progresses. They will regularly include a basic package of health services. Examples of other priorities are as follows:

- a. Establishment of health prevention and promotion programs.
- b. Improvement of co-ordination of health services.

- c. Improvement of the quality of maternal and child health care.
- d. Strengthening of the delivery of integrated communicable disease control programs.
- e. Reduction of prevalence of malnutrition.
- f. Strengthening of health surveillance.
- g. Development of health care financing.

3.4.6. Training and Mentoring

1. Human resource availability in the civilian health care sectors may be limited. The education of personnel employed in the health care sector and the appropriate training and mentoring will be key for the overall development of the health care system. Helping the host nation develop self-sustaining, culturally appropriate education and training capabilities will allow incremental building of future capability and capacity for their health sector.
2. Structured healthcare teaching programs, mutual case presentations among military and civilian medical personnel, shared clinical cases and conferences add to the training methods and principles as described in Chapter 5 of this publication.
3. Annex B provides a detailed view on the possible military role in health care system development (delivery or development).

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CHAPTER 4 COMMAND, CONTROL AND COORDINATION

4.1. INTRODUCTION

1. The requirement for a flexible CIMIC command and control architecture is described in AJP-3.4.9 Allied Joint Doctrine for Civil-Military Cooperation. Although the composition of headquarters will in most cases be mission tailored, medical issues will be an ever-present factor in this co-ordinated effort and personnel must be made available for planning of actions at the civil-military medical interface. CIMIC Groups deployed into the Joint Operations Area (JOA) must contain the necessary medical level of expertise.

2. Medical Staffs at all levels - including CIMIC Centres which provide initial points of contact and liaison - must be prepared to support the commander's CIMIC goals with appropriately trained individuals. The Medical Director of a Joint Force, supported by his specialists, advises the Commander on all relevant aspects of medical support in relation to civilian actors or provided to civilian population. In addition to this, medical functional area experts may be integrated into the J9 function in order to ensure the adequate provision of experienced medical expertise to all CIMIC planning activities.

3. Liaison among military medical staffs and civilian medical actors is the key to the co-ordination of medical actions at the civil-military interface. Where appropriate, designated liaison officers will maintain liaison to civilian bodies. Vice versa civilian organizations may be invited to provide liaison functions to military headquarters and units. There are other possibilities, too (see "The United Nations Civil-Military Co-ordination (UN-CMCCOORD) Officer Field Handbook"). Taking into account the circumstances other possibilities of co-operation are possible, which can reach to better co-operation than liaison.

4.2. CIVILIAN ORGANIZATIONS AND AGENCIES

1. A complex civil sector will be a feature of all operations and many will have a particular interest in, or relevance to, the medical environment and should be considered as part of the overall solution. Civilian organizations are responsible for a wide range of activities of which medical care might only be a part. It is critical that medical personnel involved in CIMIC activities fully understand the mandate, role, structure, methods and principles of these organizations. Any perception by IOs and NGOs that military forces are becoming involved directly in the provision of humanitarian assistance is likely to raise concerns – predominantly because it jeopardizes their impartiality status. The degree of involvement will vary depending on the type and nature of the organization and may range from command and control via co-operation, co-ordination to co-existence.

2. Strategic medical liaison among NATO and civilian organizations during peacetime will mainly be established by Joint Health Food and Agriculture Group (JHFAG) through the Civil Emergency Planning Committee (CEPC). With regard to planning and conduct of operations, liaison will be established by Allied Command Operations (ACO) at the strategic level and the Joint Force Commands at the operational level down to the Medical Directors at the tactical level.

4.2.1. Indigenous Authorities

1. The ultimate goal is to handover the responsibility for health care to the primarily responsible indigenous authorities. Early and appropriate liaison is required in order to identify actors responsible for health care organization and provision. Therefore a thorough analysis on health care structure and organization from the political ministerial level down to the level of health care providers must be conducted in order to identify key players and procedures. This should be conducted during mission analysis.

2. In most cases International Organizations (IOs) and Non-Governmental Organizations (NGOs) will have established contact to local administrative structures prior to the arrival of military forces. In cases where medical forces enter the Theatre prior to the deployment of IOs and NGOs the Medical Director of the Joint Force may be the first external medical authority making contact with local authorities. Consequently a stable relationship between the Medical Director and local authorities can become a prime enabler for evolving multilateral relations when IOs and NGOs enter the Theatre.

4.2.2. International Organizations (IOs)

1. While countless International Organizations are active in the medical field and may be involved in the Theatre, the following paragraphs detail four of the most important organizational areas warranting further consideration.

2. The most prominent among the International Organizations (IO) is the United Nations (UN) within which, the World Health Organization (WHO) is recognized as a key player in the field of health care. The WHO has been appointed as the directing and coordinating authority for health within the United Nations system. It feels responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. The WHO has a salient role in co-ordinating global alert systems on disease surveillance.

3. The International Committee of the Red Cross (ICRC) is an impartial, neutral and mission statement independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance. It directs and co-ordinates the international relief

activities conducted by the national Red Cross Societies in situations of conflict. It also endeavours to prevent suffering by promoting and strengthening humanitarian aspects of international law and universal humanitarian principles. Ensuring health care is one area of assistance which requires taking the organization into account when it comes to the coordination of international health related efforts.

4. The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian organization, providing assistance without discrimination as to nationality, race, religious beliefs, class or political opinions. The Red Crescent is used in place of the Red Cross in many Islamic countries. Its mission is to improve the lives of vulnerable people by mobilizing the power of humanity. Vulnerable people are those who are at greatest risk from situations that threaten their survival, or their capacity to live with an acceptable level of social and economic security and human dignity. Often, these are victims of natural disasters, poverty brought about by socio-economic crises, refugees, and victims of health emergencies. The Federation's role is carrying out relief operations to assist victims of disasters, and combines this with development work to strengthen the capacities of its member National Societies. The Federation's work focuses on four core areas: promoting humanitarian values, disaster response, disaster preparedness, and health and community care. The unique network of National Societies - which cover almost every country in the world - is the Federation's principal strength. Co-operation between National Societies gives the Federation greater potential to develop capacities and assist those most in need. At a local level, the network enables the Federation to reach individual communities. IFRC is therefore a most likely partner in Humanitarian Operations. The Federation, together with National Societies and the International Committee of the Red Cross, make up the International Red Cross and Red Crescent Movement.

5. In 2003, a strategic partnership between NATO and the European Union (EU) was institutionalized. Among other fields, capability development has been addressed by their partnership. SG(2003)0245 constitutes the framework of coherent and mutually reinforcing capability development between NATO and the EU. This also provides the necessary basis for co-operation in the realm military medical support principles.”

6. The vision of the African Union (AU) is an integrated, prosperous and peaceful Africa. The AU is Africa's premier institution and principal organization for the promotion of accelerated socio-economic integration of the continent. An example for co-operation among NATO and AU has been the NATO provision of airlift for AU peacekeepers in Sudan from June 2005 to December 2007. Depending on political and military strategic guidance, medical support could become involved in future NATO activities in support of the AU.

4.2.3. Non-Governmental Organizations (NGOs)

1. NGOs are voluntary organizations that are not usually funded by governments and that do not reflect governmental policy. They are predominantly private, self-governing, non-profit organizations dedicated to alleviating human suffering by promoting education, health care, economic development, environmental protection, human rights, conflict resolution, and encouraging the establishment of democratic institutions and civil society.

2. NGOs specializing in health care are numerous. These organizations regularly emphasise their status of providing health care in a neutral, impartial and independent manner. Having to act unescorted, impartiality is their primary means of 'force protection' in a possibly hostile, insecure environment of unrest or armed conflict. Thus all relation to the military will be carefully governed by the requirement not to be regarded as affiliated to a single belligerent party.

4.2.4. Co-ordination

1. The UN Office for the Co-ordination of Humanitarian Affairs (OCHA) has developed a cluster approach aiming at the co-ordination and harmonization of humanitarian activities in Theatre. In many respects in the provision of health care in these operational Theatres the crucial criterion for success will be the willingness and the ability of governmental, non-governmental and international organizations to be co-ordinated by an overarching function provided by OCHA.

2. Military medical forces will benefit from integrating the cluster approach of the OCHA in order to optimize the medical footprint in the JOA and also promote their own exit strategy. However, it must be ensured that such involvement does not interfere with the primary goals and objectives set by the commander.

4.2.5. Communication

1. Methods of communication between NATO medical staffs and civilian actors must be defined and agreed at the commencement of any civil-military co-operation. They will generally refer to the overall communication rules that are established in Theatre.

2. Medical Directors or their delegated subject matter experts at all levels will communicate with their civilian points of contact using all available means of electronic communication to achieve close connections and timely exchange of information. As a significant part of the co-ordination efforts will have to take place in bi- or multilateral meetings, it is of utmost importance that the medical staffs are properly manned in order to allow for appropriate military representation.

4.2.6. Media

Military medical personnel must be sensitive to the fact that many NGOs rely on public support and funding for their continued presence in operational Theatres. The competition for a prominent role in media coverage has to be considered as a strategic goal that will permeate all practical NGO activity, as well as significantly influence the relations to the military. Thus any individual called upon to present during a media presence must be able to deliver a coherent position that is not damaging to the public perception of any NGOs. This effort of civil-military interaction is governed by the public affairs policy of the force and not subject to specific medical considerations to be laid down in this doctrine.

4.3. INTERFACE TO OTHER STAFF FUNCTIONS

1. Alike the CIMIC function at all levels medical matters at the civil-military interface are an integral part of all joint functional area activity and require specific interactions. Annex A suggests considerations and activity to be undertaken with, and by J functional areas other than J9 additional to those described in AJP-4.10(B).
2. The J9 function of the overall CIMIC co-ordination requires the creation of a special relationship between medical staff and J9 staff regarding all civil-military issues. While the Medical Director retains the responsibility for all medical aspects including those that address the civil-military interface, in some cases the integration of medical personnel into the J9 staff and subordinate structures can provide a flexible structure that enables the joint staff to plan and conduct medical activities at the interface.
3. The integration of medical staff into the Joint Operations Planning Group (JOPG) and into the Joint Operations Centre (JOC) as depicted in AJMedP-1 – to ensure necessary medical contributions to the Operational Planning Process (OPP) and the conduct of military operations – will appropriately cover the requirements of the civil-military interface during all stages of operational planning.

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CHAPTER 5 EDUCATION AND TRAINING

5.1. GENERAL

5.1.1. Overarching Issues

1. Effective education and training will create the capability and willingness to provide adequate medical support at the interface, as alignment of medical procedures and clear delineation of medical responsibilities will prevent medical competition and unnecessary repetition of health care structures, and will provide the greatest opportunity for optimized medical efficiency.
2. Education and training may not only focus on mission related issues but can be much more generic. It will regularly include training on NATO civil and UN procedures. Co-ordination of such training will inevitably prove to be mutually beneficial in generating a greater understanding of military and civilian capabilities and their individual working practices.
3. To achieve unity of efforts a joint training activity with civil actors should be considered. Common purposes, limitations and different roles and responsibilities should be the outputs of such activity.
4. Medical and healthcare specialists generated from civilian resources would benefit from a basic operational training specific to mission enabling them to fulfill their specialized functions in a military environment.

5.1.2. General Medical Understanding

1. Military medicine is highly specialized due to the environment and conditions it is frequently practiced in, but above all, it is part of medicine. As such, military health care personnel are educated and trained in medicine as are their civilian counterparts.
2. The indispensable focus on professional medical development mandates the usage of civilian scientific and expert sources for the development of military medical policy and doctrine or the adoption of medical training standards for military medical purposes. Commonalities created by this common basis may greatly facilitate relations at the civil-military medical interface.

5.2. MISSION RELATED EDUCATION AND TRAINING

5.2.1. Education and Training for Deployed Troops

1. As a preparation for deployment to a specific area and being directly relevant for the success of the mission, this aspect should receive particular attention.
2. Military medical personnel, and the personnel supporting them, should be briefed not only on the general aspects of their mission, but also of their particular medical aspects. These should include:
 - a. An update on the health situation in the JOA including the populations at risk and the possible threats.
 - b. Information on the health care structure in the JOA (location and capabilities of facilities, medical standards, costs, role of local military medical services etc).
 - c. Identification of all relevant medical actors such as indigenous authorities (state or opposition), IOs and NGOs.
3. Depending on the mission requirements, military health care personnel should be trained to be able to care for local populations. While basic language skills are desirable, military health care providers should be specifically aware of:
 - a. Social, cultural and political peculiarities of local populations, including possible regional conflicts.
 - b. Standards delivered by IOs and NGOs.
 - c. Limitations of healthcare to be delivered from military to civilian population.
 - d. Specific constraints and restraints in the JOA.

5.2.2. Education and Training for Local Medical Health Care Authorities and Providers

1. At the earliest opportunity, indigenous authorities and health care providers, IOs and NGOs should be made aware of the military medical support, means and capabilities, and what military health care providers can and cannot do within the scope of their mission. Co-operation should be explored and developed on this base.
2. The overall end state should be sustainable, locally provided, health care in the JOA. To develop and achieve this, education of the local civilian authorities and health care providers in the JOA, through counselling, mentoring and possible

coaching programmes may be initiated. Participation of medical personnel in mentoring teams will refer to the overall concept of enabling local authorities, organizations and agencies to help themselves based on self-sustaining education and training programmes.

5.2.3. Common Education and Training

1. Upon arrival in the JOA, adequate training, ideally in tandem with their civilian counterparts, should be organized to fuse the civil-military medical interface. Training for management of global health threats and additionally the management of Theatre mass casualties (MASCAL) should be one of the first objectives for co-operation between all the local health care providers in the JOA.

2. The following education and training aspects should be co-ordinated between all the health care actors in the JOA. It should be noted this list is not exhaustive and provides only key issues for early resolution:

- a. Health care goals in the JOA and the way to achieve them.
- b. Key medical principles: continuity of care, clinical timelines, standards of care, emergency care.
- c. Planning for different mission types or health threats including MASCAL.
- d. Clinical considerations.
- e. Medical confidentiality.
- f. Financial aspects.
- g. Legal aspects.
- h. Format of education and training.

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ANNEX A	LINKAGES ADDRESSING THE CIVIL-MILITARY MEDICAL INTERFACE (IN ADDITION TO SPECIAL RELATIONSHIP TO J9)
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BRANCH	
J1	<ul style="list-style-type: none"> • Liaison over medical support requirements to Prisoner of War (POW) camps. • Terms and conditions of medical support for locally employed civilians. • Identification and provision of specialist manpower (such as linguists) related to medical support. • Patient tracking and casualty reporting for patients that cross civil-military boundaries. • Medical staff manning and qualifications.
J2	<ul style="list-style-type: none"> • Requests for Information (RFI). • Identification of civilian medical infrastructure in Joint Operations Area (JOA). • Medical Intelligence Assessments. Medical Staff may provide a useful source of information on matters including local industrial hazards, and the spread of endemic diseases. • The overall relationship between Medical Intelligence and the 2's intelligence cycle is delineated in AJMedP 3 Medical Intelligence.
J3	<ul style="list-style-type: none"> • Medical support to civilian population in current operations. • Assistance in preparing medical aspects of CIMIC maps / products / overlays. • Liaison with HN / local authorities on infrastructure support matters for medical installations. • Impact assessment of the use of local resources / access to medical facilities.
J4	<ul style="list-style-type: none"> • Host-Nation Support (HNS) / Civil-Military Resource Management. • Possible use of transportation and other resources where necessary to support medical tasks at the civil-military medical interface. • Co-ordination of medical logistics related to humanitarian operations or assistance.
J5	<ul style="list-style-type: none"> • Advise on the considerations of both short and long term civil medical factors that will affect the Joint Campaign Plan. • Advice on civilian medical support, disease control and provision of water. • Planning the medical aspects of civil-military operations. • Contribution to all operational and contingency planning groups to ensure that medical factors are properly accounted for and that military operations are coherent with the activities of friendly • Preparation of CIMIC medical inputs to long term plans, such as post conflict rehabilitation and reconstruction.
BRANCH	

J6	<ul style="list-style-type: none">• Provision of medical information and patient confidentiality considerations with civilian patient tracking.• Advice on balancing the need to communicate with civilian agencies versus Operations Security requirements.
J7	<ul style="list-style-type: none">• Education and training for civilian and military personnel with particular focus on planning of operations, Lessons Learned, and sharing of best practices.
J8	<ul style="list-style-type: none">• The co-ordination of financial and contractual matters between force elements and the Host Nation (HN) or other civil agencies.
J9	<ul style="list-style-type: none">• As described in detail within the main body of the document.
Legal	<ul style="list-style-type: none">• Advice on International Humanitarian Law / Law of Armed Conflict.• Legal interpretation of Status of Forces Agreements (SOFA) and Memoranda of Understanding (MOU).
PAO	<ul style="list-style-type: none">• Political implications and sensitivities of civil-military medical liaison and operations.

ANNEX B	POSSIBLE MILITARY ROLES IN HEALTH CARE SYSTEM DEVELOPMENT (DELIVERY OR DEVELOPMENT)
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B.1. INTRODUCTION

The following proposals to possible military roles in health care system development are based on the “Program Management Plan, Afghan National Security Forces Healthcare Sector Reach Back Project, Planning Document for Healthcare System Improvement and Integration for the Afghan National Security Forces” of the Centre for Disaster and Humanitarian Assistance Medicine (CDHAM). This document does not focus on the Afghanistan situation but provides more general proposals for use in various scenarios in the context of health care system development. Beside current NATO policy and doctrine, it has been influenced by numerous scientific publications on the topic – amongst others the publications of Colonel Martin CM Bricknell, DM MMedSci FFPH FIHM, have to be mentioned.

B.2. COMMAND RESTRUCTURING FOR MEDICAL SYSTEM DEVELOPMENT

1. Experiences from the situation in Afghanistan showed that the Command Surgeon in the Combined Security Transition Command-Afghanistan (CSTC-A) has taken much of the lead in initiating and coordinating medical development programs but does not have full control or reporting lines related to all the major medical projects currently ongoing or planned. There also is a Medical Advisor for the ISAF as a whole and a Medical Advisor (similar in rank and function to a Command Surgeon) for each of the four regional ISAF commands. If a single individual had full authority over all the military funded or operated medical system development efforts it would greatly help the efficiency and accountability of these efforts.

2. Any already existing command structure for medical system development in a Host Nation (HN) may be somewhat fragmented and uncoordinated. The courses of action in relation to medical command system restructuring may be:

- a. Consider consolidation or simplification of the military medical command structure in the HN.
- b. Have personnel sufficient in quality and quantity assigned to any national or multinational Medical Advisor’s / Command Surgeon’s office.
- c. Expand medically related roles and activities of the Provincial Reconstruction Teams (PRTs), and offer standardized pre-deployment training for the medical personnel assigned to PRTs.

3. Appointing a high-ranking Medical Officer to be in direct charge of:

- a. All the military funded health-related programs (including those awarded to civilian contractors).
- b. The medical components of the PRT’s.

- c. The medical Embedded Training Teams (ETTs).
- d. The deployed military medical personnel.
- e. The support assets for the military medical facilities,

would be very useful in improving the Co-ordination of the HN health care sector reconstruction effort.

4. The Medical Advisor within the NATO operational HQ probably could not fill this proposed role quite as well because of the frequent international rotation of this position and because the respective NATO force does not control most of the current funding devoted to medical reconstruction. Similarly, a civilian “chief” based at a member Nation’s Embassy or within the HN public health authorities would not be as effective because of being “outside” the military chain of command. The authors of the “Program Management Plan (Afghan National Security Forces Healthcare Sector Reach Back Project)” did recognize the difficulties and complicated nature of command system reorganization, but offered as a reminder example the remarkable success of the unified medical system command utilized in reconstructing the Japanese healthcare system after World War II.

5. There is great potential for PRTs to carry out effective health care system reconstruction efforts and conduct evaluation studies of these efforts. A standardized training program for PRT personnel is required, and reasonable input and emphasis into this program on health care development should be undertaken. NATO PRTs should be encouraged to undertake coordinated healthcare system development efforts. Frequent Co-ordination meetings between all the PRTs would be helpful at consolidating and standardizing the PRTs’ work related to healthcare.

6. The staff - national and / or multinational - dealing with medical R&D in a HN needs to be robust in number and qualification considering the scope of work such a group must cover. Additional personnel, including clerical and contract management staff, if assigned, would allow to being even more responsive, productive, and better able to issue and monitor more civilian and NGO contract work.

7. Whenever there is turnover in any national or multinational Command Surgeon / Medical Advisor positions it would be very helpful if the providing Nation or Command Organization be notified as early as possible in order that early dialogue with the newly assigned personnel can be facilitated to review the management plan for R&D, and maintain continuity in carrying out a HN Security Forces medical reach back project with other coordinating NGO, National Governmental Agencies, academic and private-sector partners.

B.3. HEALTH AND HEALTH CARE SYSTEMS

1. A clear mandate to the commander with regard to military support to R&D will include direction and guidance for the military role in the civilian health care sector. Military forces will usually facilitate civilian entities to take care of R&D. Due to the considerable number of actors involved an integrated approach is crucial to overall success during military operations. Adequate support to the reconstructions efforts of the health care sector may be one key condition for enduring peace and stability in the country to be supported.

2. In order to contribute effectively, medical staff involved in supporting health care R&D must be capable of understanding structures and mechanisms of health care systems in different countries. Health care systems can generally be described in three different dimensions: the steering function, financial mechanisms and systems organization. On request CEPC can provide experts within its PB&Cs. The knowledge and expertise is available and can be used.

3. Based on the WHO definition of health given in chapter 1, health care includes not only direct patient care, but also a viable sanitation system, available and adequate nutritious food and potable water, control of communicable disease, protection from exposure to hazardous wastes and materials, as well as protection from the physical and psychological dangers of conflict. The health sector then includes all aspects, resources, personnel and infrastructure with a significant impact upon the health of a population or individual.

B.4. INFRASTRUCTURE

B.4.1. Medical Logistics and Supply

1. A critically important component of a high quality health care delivery system is the provisioning of needed pharmaceuticals, equipment, and medical consumables through an efficient, cost-effective and accountable medical logistics and supply system. Implementing a medical logistics system should be of high priority in any COA due to its potential direct positive effects on every other aspect of the healthcare delivery system.

2. A fully coordinated, responsive, and monitored logistics system is required that applies to all kinds of healthcare facilities throughout the HN. The establishment of a reliable medical supply system needs to ensure anticipatory management capabilities which encompasses amongst others infrastructure, personnel trained in logistics, a logistics tracking capability, a system for monitoring personal accountability, a capable communications backbone, a reliable electric power system and transportation assets to transfer medical supplies from medical depots to healthcare facilities. In Detail:

- a. Expand the HN's medical logistician training to include civilians.
 - b. Emplace incentives (both financial and non-financial) and contracts for student enrolment and retention.
 - c. Develop a medical supply depot system for the HN with accessibility to this system also for private health care facilities.
 - d. Obtain organic or dedicated contractual transportation assets for the HN.
 - e. Establish systems for reliable scheduled communication between healthcare facilities and logistics depots.
 - f. Establish systems of inventory recording, tracking, cycling, and auditing for the major healthcare facilities throughout the country.
3. Aspects of a medical logistics system that need to be implemented are:
- a. Consistent use of serial number labelling and regularly performed inventories to track items by serial number.
 - b. Recording and keeping updated property books for each major healthcare facility.
 - c. Development of schedules for cycling of inventories of perishable or degradable items.
 - d. Developing standardized pre-packaged equipment sets, and ensuring subsequent equipment acquisition contracts use these predetermined sets.
 - e. Having logistics personnel trained to match equipment orders to the types of supplies that are available and needed.
 - f. Developing a standardized set of logistics publications and a standardized catalogue system.
 - g. Staffing and empowering personnel sections in the HN authorities to perform regular inventory audits and report these to supervisory personnel.
4. If the logistics systems do not have their own "organic" vehicles and utilize contract vehicles instead, then that would minimize initial capital expenditures in overhead. Initial funding for any "organic" vehicles would need to include contractual agreements for maintenance, fuel, and operational costs.

5. Once trained civilian medical logisticians are available, the HN should develop a medical depot system similar to any logistics system already initiated. This would involve a centralized national depot, and smaller depots in each of the locations where major health care facilities are found.

6. Regular communications need to be established between the major health care facilities and the depots to ensure that equipment and materials orders are issued in time to prevent shortages. With simplification of the supply ordering process the HN should each establish a “watchdog” office or specific assigned personnel to monitor for diversion or the private use of governmental supplies. A reimbursement mechanism also needs to be developed so that the “private” and non-governmental organization (NGO) operated hospitals can order materials from the HN depots.

B.4.2. Biomedical Equipment Maintenance and Repair

1. The importance of biomedical equipment repair derives from its potential positive impact on almost all other aspects of the healthcare delivery system. Courses of action for improving the medical equipment situation in the HN are:

- a. Expand the HN training program for biomedical equipment repair technicians to include trainees for the HN and develop training programs for healthcare facility engineers.
- b. Emplace incentives and contracts for the trainees for the logisticians.
- c. Contract with NGO’s to supply biomedical equipment repair technicians and facilities engineers, and cycle these workers around the country to fix existing broken medical equipment.
- d. Eventually, have HN obtain control over medical equipment selection for all major healthcare facilities in the country.

2. HN healthcare facilities may have medical equipment that either remains in original packaging unused or is broken and left unrepaired because of the lack of biomedical engineering support. There is a critical need for the training of biomedical equipment technicians to correct these challenges.

3. Programs should be augmented through development of an official HN certification process for biomedical equipment technicians. Initially, biomedical equipment repair training should be conducted at military facilities utilizing the existing courses, and then expanded with adding more military and / or contract instructors, and expanding existing courses into a new broader aspect course. A number of the student positions should be reserved for candidates who would then work for the HN upon coursework completion and certification by the HN program.

4. Final goals of the training system would be to have the courses conducted entirely by HN trainers and to supply sufficient graduates each year to meet the needs of healthcare facilities on a national basis.

5. Taking into account the amount of broken and non functional medical equipment across the country and the relatively extended timeframe to train enough HN repair technicians, NGO-based contracts to hire experienced repair technicians should be enacted. These technicians could initially operate in a “journeyman” mode, travelling from facility to facility (perhaps with protective military security escort) to fix broken equipment. Rotation of some of these technicians back to the HN training facilities could be done to maintain the number of instructors as well as to identify sites where the trainees could obtain equipment that needs repair or maintenance.

6. In addition to biomedical equipment technicians, training of healthcare facilities engineering personnel (for installation, operation, maintenance, and repair of hospital water, sanitation, power and other facility-based systems) may be identified as important for the HN. Initially, (similar to the considerations noted above for repair technicians) NGO contracts for these engineering personnel to serve existing health care facilities could be issued, and eventually after sufficient HN trainees are available, the NGO contractors could be replaced by HN personnel.

7. The HN should eventually establish control over the ordering of major capital medical equipment for all health care facilities within the HN (as noted in the section on Medical Logistics and Supply above). That will help to prevent acquisition of unnecessary equipment, or expensive and complicated equipment with no maintenance and repair tail. Any new equipment orders should also routinely include contractual agreements for maintenance (including training of facility staff in equipment operation) and spare parts. The HN should also further establish a standardized list of required and recommended equipment for clinics and hospitals to denote specific approved brands or manufacturing companies for medical equipment. Building staff capability to undertake complete control of ordering all medical equipment for the HN healthcare facilities would be a desirable long term goal for the HN.

8. Until basic healthcare needs are better met throughout the country, especially in rural areas, obtaining tertiary-care medical equipment should be of low priority and deemphasized. One exception to this could be the acquisition of computed tomography (CT) scanners for regional healthcare facilities. Use of these scanners could greatly improve the care of patients suffering blunt truncal trauma or closed head injury. There may be a large number of victims of vehicle- pedestrian accidents throughout the country, and this number will probably increase greatly as the road systems improve and more higher speed vehicles are on the roads. An important aspect of the operation of the CT scanners noted above that would be critical is to ensure that there is up front funding for maintenance, spare parts, and training in scan interpretation for the radiologists, and training in scanner operation for the radiology technicians.

B.4.3. Construction of New Health Care Facilities

1. At an initial stage of an operation, no single agency or organization in the HN may have accurate information on the exact location or number of health care facilities or staff (particularly the basic and comprehensive health clinics) within the country.
2. Allegedly existing in the country may be either not actually in existence, located in remote areas not near any population centre, in high risk areas for flooding, or were constructed but then suffered roof collapse from snow and are unusable. In addition, many of allegedly constructed clinic buildings may be not actually or fully staffed with medical personnel.
3. Courses of action in relation to construction of new health care facilities may include:
 - a. Utilize the PRTs and NGO's to conduct a country-wide survey of the location and staffing of health care facilities and relay the survey findings to the HN public health authorities (if HN Security Forces facility data are included, then such a database may fulfil its purpose).
 - b. Use the survey findings for the HN public health authorities in consultation with local leaders, to identify places that need new facilities constructed or staff assigned, particularly those with significant numbers of HN Security Forces or beneficiaries present.
 - c. With HN public health authorities develop a more effective monitoring and compliance program for any new health care facility construction.
4. A pressing need may occur to conduct a reliable country-wide survey to determine the location and staffing of the existing clinic facilities in order to identify underserved areas for which additional new medical facilities will need to be constructed or where new medical personnel will need to be assigned. One way to obtain some of this information would be to request known facility location reports from existing Provincial Reconstruction Teams (PRTs). For the survey to be complete and reliable, the several provinces which are not currently covered by PRTs or similar activities will need to have survey personnel assigned either from an adjacent PRT or from a designated survey team loaned from the HN public health authorities, international military or contracted NGO's. The survey information needs to be communicated to the HN public health authorities who would then determine which specific geographic areas need to have new clinics built and which need medical personnel assigned. This determination would need to be done with local leader notification and input. Careful monitoring of the construction contractors for any new medical facilities is needed to ensure timely completion of any construction project and adherence to the contract building codes. Early consultation with and involvement

of the local religious and political leaders will be critical in determining exact locations for new facilities and in arranging security for the healthcare staff of these facilities. To better ensure acceptance and use of new facilities, consideration of local customs and beliefs and incorporation of these factors into the facility design (such as complete visual separation of entrances and waiting areas for adult males and females in “traditional” rural areas for example) is very important.

5. Construction of some of the new clinics designated as “HN Police Forces Clinics” within the security perimeter of police compounds would be effective in improving public relations for the HN Police Forces as well as increasing access for the public to these clinics. This would be particularly helpful in underserved border provinces.

6. There could be evidence that numerous provinces of the country do not have either a provincial or regional hospital. These provinces should receive priority for construction of new medical facilities (at least comprehensive clinics if not hospitals), and the HN public health authorities should have control (again with local leader consultation and input) over the site selection. This would enable more reliable delivery of promised services to residents of these provinces.

B.4.4. Administration (Hospital Administrator Development)

1. In a HN lack of leadership and higher level administrative knowledge and skills may have been identified as widely problematic for healthcare. If so, operational guidelines for mentoring and developing the hospital administrator personnel for the HN Security Forces hospitals should be established. At least one military mentor person should be assigned to each of the HN Security Forces hospitals, with the tasked goal of mentoring the HN administrative personnel and helping their professional development at each of these hospitals.

2. In summary, courses of action in relation to hospital administrator development may include:

- a. Develop a degree training program at HN central facilities for healthcare administration.
- b. Develop focused short term courses in leadership and in healthcare administration for HN Security Forces and HN public health facility administrators.
- c. Initiate and continue leader mentoring program at HN Security Forces facilities and have NGO contractors or assigned military personnel provide similar service to HN public health facility administrators.

3. Provision of administrator mentors (via NGO contracts) similar to the military setup noted above for the civilian hospitals at regional and provincial level would be

helpful. Developing leadership and health administration training programs (both degree programs at HN central facilities and shorter practical courses for the personnel already serving in leadership or administrative positions) also would be very helpful in improving healthcare facility operation in a HN. A leadership training program for the HN military personnel may be initiated which should also be useful for civilian administrators.

4. In more detail an extensive and ambitious sequence of assigned duties for such mentors should encompass to:

- a. Conduct an assessment of each hospital's resources and needs to identify administrative priorities;
- b. Complete monthly status reports (in conjunction with the HN hospital commander) on administrative progress, and use this reporting system to help develop intra-hospital staff communications;
- c. Demonstrate safe operation and maintenance of the hospital's major medical equipment;
- d. Implement clinical medical and nursing protocols for care for the most common conditions seen at the hospital;
- e. Implement a functional and standardized medical records system, pharmacy tracking system, laboratory operation system, and inventory standardization program;
- f. Implement a quality improvement performance process for clinical medical and nursing programs;
- g. Implement short and long term continuing medical education programs for physician and nursing staffs;
- h. Implement preventive medicine, force protection, and aeromedical evacuation protocols; and
- i. Ensure integration of the hospital's disaster, mass casualty, and pandemic plans with the regional and national plans.

B.5. MEDICAL COMMUNICATIONS

1. Implicit in many of the courses of action stated beforehand is the capability to communicate effectively across geographic, linguistic, and organizational barriers within the country. In a HN that may be only rarely possible and yet must be improved if any HN Security Forces integration and development recommendations are to have a reasonable chance of success.

2. Courses of action for improving communications related to health care in a HN may be:

- a. The HN public health authorities, HN military forces Surgeon General's Office, HN police forces leadership, and HN authorities of communication and higher education should each select representatives to meet together to discuss and select communications vehicles and other appropriate new vehicles as they become available.
- b. The HN may be a technologically limited country. In such a situation introducing "leapfrog" technologies to meet required communications goals seems desirable. By that is meant the transcending of historical pathways through the introduction of highly efficient tools that tunnel through obsolete methods that might otherwise require significant infrastructure development. Cell phones have been an example within the past twenty years. In fact, any proposed communications solutions for medical informatics (used to reference any medically-relevant information, including logistics, transport, vital records, pharmaceuticals, telemedicine, epidemiology, and so forth) should be familiar, accessible, inexpensive, robust, resilient, and often dual-use. Whenever possible, solutions have to be culturally and religiously acceptable, politically neutral, HN-driven (or at least not be a direct complete importation of ideas and technologies from NATO and Partner Nations), and offer opportunities for internal micro-economic development.
- c. Respective capabilities certainly exist and several may seem desirable for use within any proposed HN Security Forces medical infrastructure. Amongst others the capabilities in Voice Communications, SMS Text Messaging, One-to-Many Broadcasting, Disaster Management, Google Earth, Electronic Medical Libraries, and Telemedicine may be considered for utilization.

B.6. PRIMARY CARE

B.6.1. Basic Health Packages

The definition of a basic health package must be developed in close co- ordination with the local government. As stated in chapter 2, the main reference points will be prevailing standards prior to the crisis as well as standards accepted by nations participating in the operation.

B.6.2. Maternal and Child Health Improvement

1. The state of perinatal maternal and child health may be identified as a key national priority for the HN. If better access to higher quality perinatal care is necessary and to be developed, then morale may be enhanced by knowing that spouses and daughters have been cared for properly, and the tragedies of perinatal mortality are prevented.
2. Courses of action in relation to maternal and child health for the HN could be:
 - a. Train more midwives and Obstetrics and Gynaecology (OB / GYN) physicians, utilizing more training mentors, along with a national scope survey of the number and location of skilled birth attendants to better determine needed training program output numbers.
 - b. Develop incentives for more females to enrol in these programs and work in rural and border areas.
 - c. Expand the training for community health care workers and the availability of family planning and contraception services for the HN.
3. The most direct way to address the maternal mortality problem in a HN is to train and supply more skilled birth attendants capable of managing normal deliveries and able to recognize and refer high-risk delivery patients.
4. Training husband-and-wife teams for rural health care work would be another way to circumvent possible cultural difficulty in a HN of females working outside the home. Significant financial incentives from the HN would add further appeal. While many women in urban locations would permit gynaecologic and obstetric care by male health care providers, this may not be true in the provinces, so predominately women need to be trained both at the midwife level and as physicians in OB / GYN, and incentives need to be developed to encourage more females to enter these training programs.
5. Expansion of the number of OB / GYN physicians in practice will also allow the population better access to probably underprovided gynaecologic services such as

perennial fistula repair. More rotations by expatriate OB / GYN physicians and experienced labour and delivery nurses at HN hospitals would also be useful for mentoring HN healthcare providers. These foreign-trained medical personnel could be obtained from the military or other countries, as well as short term volunteers from NGOs. The post-residency OB / GYN fellowship training program at CURE International Hospital in south Kabul serves as a good model for additional skills development for OB / GYN physicians. To better determine the output requirements for all for the skilled birth attendant training programs and the OB / GYN residencies, a survey to determine the rough number and distribution of these healthcare workers throughout the country needs to be undertaken; this would probably be best accomplished by contracting with an NGO to complete this.

6. Along with an expansion of obstetrical care, education programs conducted by community health workers for family planning and contraception should be greatly increased and made more accessible to HN members. This may be best accomplished by establishing and expanding a “train the trainer” program. Additional funding for the delivery of contraceptives will consequently be needed from NGO’s.

7. Basic health care community worker programs, with dissemination of these individuals to rural and border areas, would also help positively impact maternal and child health in HN family members by providing better prenatal and nutritional education for mothers. The United Nations Children’s Fund (UNICEF) may need to continue extensive nutrition efforts until such time as the HN has enough resources to take over this responsibility. Improvements in nutrition for the rural HN population will also depend on concurrent agricultural and economic development.

8. Expanding existing teaching facilities of the HN to include classes for instructors for the basic community healthcare workers should be done establishing NGO contracts for classroom construction, training equipment, and instructor time. These instructors, once they complete the program, could then train more instructors at the regional hospital level, with further dissemination of the instructors then to the local level throughout the country. This would help make basic public healthcare more consistently and completely available in areas currently underserved.

B.6.3. Family Medicine

1. Similar to the situation with Emergency Medicine, Family Medicine may not be a well developed specialty in the HN, yet has a great deal to offer in providing primary healthcare services which are the core of a basic public health care system.

2. Courses of action in relation to the specialty of Family Medicine in a HN may be to:

- a. Obtain (either military or NGO contracted) clinical faculty to choose a residency program curriculum and staff respective training programs; and

- b. Develop agreements with clinical facilities to provide clinical training sites (including inpatient rotations, especially obstetrics).

3. While inpatient care is part of the training for Family Medicine physicians in almost all NATO and Partner Nations, the bulk of the training is conducted in outpatient facilities. So training programs in Family Medicine in a HN could utilize existing comprehensive health centres as their main training sites (cooperative agreements would still need to be made with hospitals, particularly those providing obstetrical care, for the residents to obtain clinical rotations on selected inpatient services). Very long term goals for the specialty (as noted above for other specialties) are to develop a certification and recertification exam and process.

B.7. HOSPITAL CARE / ADVANCED CARE

B.7.1. Trauma Care and Emergency Medicine Improvement

1. Trauma care is a critically important health care system component, particularly for the HN Security Forces. The HN Security Forces may be suffering combat casualties (e. g. from battles with insurgent elements and with well armed illicit drug dealers). Standards related to combat casualty evacuation and staged care may not be well implemented in the HN. Most of the combat casualty evacuation for the HN Security Forces may be initially operated by international military.

2. Courses of action in relation to trauma care and emergency medicine development could be:

- a. Establish / Expand military medic course to include HN trainees, instruction in public health measures and in ambulance operations.
- b. Establish / Expand trauma care training for HN regional hospital staff, and develop a trauma case referral system.
- c. Develop core faculty for starting emergency medicine as a specialty, and obtain supplemental salaries for these physicians.
- d. Develop CME programs in basic emergency medicine and trauma care for physicians' already in practice and expand the direct clinical mentoring of these physicians.
- e. Expand the HN civilian ambulance service and develop training for ambulance personnel (including administrative).
- f. Planning of an aeromedical evacuation system for the HN with provision of additional focused training for the initial selected aeromedical

personnel, and anticipate the need for future expansion of this service with both more personnel and more dedicated aircraft.

3. The first stage in combat casualty care is the provisioning of first aid on the battlefield. To address this, the HN has to establish a Combat Medic course. The obligatory length of service for those receiving basic military training should be set at 4 to 6 years, with extension of service obligation (such as for 8 to 10 years) for those receiving more advanced training (as for the medic or medical logistics programs for example). This service extension allows the military to retain members with more advanced training and skills for an extended amount of time rather than just act as a training conduit for the civilian sector. Because of the overall importance of addressing broad public health issues, training in some basic public health subjects (sanitation, disease prevention, etc.) needs to be added to existing combat medic courses. Future consideration may be the expansion of HN medic schools, with addition of major training sites or facilities in regional areas, in order to meet the increased demand for more HN trainees. Existing medic training programs could also serve as a useful basic training program for civilian HN or NGO operated urban ambulance system personnel as ambulance services are developed for the whole country. Supplying these civilian services with trainees obviously would require expansion of the existing HN medic programs.

4. Close teamwork is required between HN military and police forces in combating terrorist and criminal elements, and the combat casualty care needed by both forces is the same. Training positions in the HN medic training programs should be for military and police personnel. Having the same proportion of medics in the HN military and police forces (3% to 4% of total personnel), would be appropriate.

5. Mentoring of the HN military regional hospital physicians by international military physicians and trauma surgeons is needed to help initiate a staged trauma care system for the HN Security Forces. Standards of quick “damage control” surgery to be provided by field or peripheral hospitals with subsequent quick transfer of the patients to a definitive surgical care hospital in a regional centre may be needed to establish in the HN Security Forces. Assistance may be necessary in this development by conducting trauma courses for the physicians at the HN Security Forces hospitals. The course should be translated into the language of the HN and then co-taught by selected HN physician-trainees who would subsequently serve as core faculty for the course. Mentors could also supervise trauma case simulations and mass casualty drills for HN Security Forces physicians.

6. Even if the specialty of Emergency Medicine does not exist in the HN, this specialty has been recognized as a key component of civilian and military medical care delivery and trauma systems globally. The HN Security Forces should select some of its physicians (who express interest and volunteer) to receive emergency medicine residency training in other countries, and then return to the HN to start a physician-training program at the military hospitals. For the lesser-trained physicians or those from other specialties who are already staffing the emergency rooms at the

military hospitals, short courses conducted by international military and / or contract physicians (such as Advanced Cardiac Life Support etc.) could be used in the short term to improve their knowledge and skills in emergency medicine. After completion of a series of short courses, an exam could be offered to certify the trained physicians as “second level” emergency physicians. In future years, when there are adequate numbers of residency trained emergency physicians, these physicians can take over the instruction courses for the “second level” emergency physicians.

7. Based on an assessment of the local situation it may be necessary to update the medical education of the physicians who have graduated from medical school in the HN but received an inadequate education. A type of “continuing medical education” (CME) program could be further and more broadly developed to improve the medical knowledge and care skills of the medical school graduates in the HN who were possibly inadequately trained.

8. A very long term goal for emergency medicine (this goal in fact applies to all the other medical specialties and allied health fields in the HN) to keep in mind is the eventual development of a national specialty board organization, certification and periodic recertification process.

9. A possibly pervasive difficulty in developing Emergency Medicine physician specialists may be standard practice in the HN for almost all of the physicians on staff at a particular hospital or clinic to leave the hospital or clinic in the early afternoon to go to their private medical practice where they spend most of the rest of the working day (where they earn from private patients much more income than they receive from their government or military salary). Many HN healthcare facilities may be almost completely devoid of on-site physician coverage in the afternoons and overnight because of this practice. Because Emergency Physicians usually cannot have a profitable “private practice” in Emergency Medicine, additional salary funding is needed for them to eliminate this “private practice income gap” (and thereby attract higher quality applicants to the specialty and better enable them to provide the 24 hour a day staffing of the emergency department required for quality patient care and resident supervision). This same base salary supplementation, if also applied to some of the other specialties, would enable better in-hospital coverage in the afternoons and better resident supervision in the various residency training programs.

10. Another aspect of trauma care to consider is ambulance evacuation of combat casualties and of trauma victims (such as victims of road traffic accidents). This service may be initially performed by international military, but eventually this service should be operated by the HN Security Forces independently. Tactical vehicles selected and the regular ambulances selected should be whenever possible the same model as are already in common use throughout the HN to support ease of repair and maintenance. As the road net in the HN is improved through new highway construction, the need for the tactical style ambulances will decrease and so less expensive regular ambulances could be purchased as replacements. After acquisition of these vehicles, the drivers and medics staffing them will need training and mentoring in addition to

that provided by the basic combat medic course. This training and mentoring will need to encompass both, emergency driving techniques, patient loading, and patient management in transit. Military mentors (these could be the same personnel as already involved with the HN Security Forces medic program) will be initially needed to assist with this training. It will also be important to train and mentor administrators for the ambulance service, and develop a link for the service with the medical logistics supply system discussed above. Once more trained personnel and vehicles are available, ambulance services should also be expanded in all regions of the country.

11. The issue of aeromedical evacuation for the HN Security Forces has to be considered and implemented, too. The more rapid transport of battlefield casualties to trauma surgery facilities by helicopter has been shown to greatly reduce mortality and morbidity in combat casualties, and the availability of this service is a morale booster for troops. Difficulties in initiating an aeromedical evacuation system for the HN Security Forces include the greater expense for purchase, operation, and maintenance of helicopters compared to ground ambulances, the geographical and climatic conditions limiting flying operations. Extensive training for the aeromedical teams will have to be provided beyond the standard combat medic training, probably at an early stage outside the country. Because of costs, availability, and probably very limited demonstrable benefits for public health, extension of aeromedical evacuation for the HN civilian population will not be practical for a foreseeable future.

B.7.2. Anaesthesiology

1. Lack of training in delivery of anaesthesia (including preoperative evaluation, intraoperative monitoring, recognizing and treating intraoperative complications, and post-operative and recovery care) have been noted to be a widespread problem in many clinical facilities throughout the HN. It may occur that there are very few anaesthesia machines in the country, and most facilities may utilize intravenous barbiturates for induction and intravenous ketamine as the main anaesthetic agent.
2. So courses of action in relation to anaesthesiology could be amongst others:
 - a. Assign more anaesthesia mentors (both anaesthesiologists and nurse anaesthetists) to HN main and regional military hospitals, and some of the larger clinics serving the HN Security Forces, and utilize similar mentoring at the HN public health and NGO hospitals.
 - b. Obtain simulator mannequins for short term training courses at the major HN military hospitals and / or HN medical schools for anaesthesia staff.
 - c. Ensure any provision of anaesthesia machines includes extended instruction in their use, maintenance, and repair, and inclusion of an ongoing reliable supply of anaesthetic gases.

- d. Eventually develop physician residency training programs in anaesthesiology and a certification process for anaesthesiologists, nurse anaesthetists, and anaesthesia technicians.

3. In company with any possibly occurring donation of anaesthesia machines with instruction in their use at facilities, clearly standardized instruction and mentoring in anaesthesia delivery is needed throughout the country. Purchase and use of simulator training at the main HN military hospitals and HN medical schools for physicians would be a useful early training initiative for this. Expansion and more direct mentoring of a HN “anaesthesia technician” training program would be helpful as a temporary measure until more physicians could be fully trained in anaesthesiology and distributed to outlying facilities.

B.7.3. Optometry Services and Ophthalmology

1. Any possible existing public health care system in a HN may not explicitly mention anything related to Optometry services, or just specify that vision screening charts shall be available in the district and provincial hospitals, and that “eye care” (for ophthalmic trauma and selected ophthalmic diseases) will be available in the provincial and regional hospitals. However there may appear to be a huge need in the country for the provision of optometry services.

2. Courses of action in relation to optometry services and ophthalmology may include:

- a. Have all HN Security Forces recruits receive full vision screening early in their training, and also receive prescription eyeglasses if deficient visual acuity is identified. This will entail using either dedicated HN Security Forces or contract personnel for vision exams, lens grinding, and fitting (and repair) of eyeglasses.
- b. Arrange availability of optometry services at (at least) regional hospital level for HN Security Forces and HN public health, to include visual acuity exams, lens grinding, and eyeglass fitting. This could entail the use of rotating rather than permanent optometry staff depending on the caseload.
- c. Utilize an NGO involved with vision care to coordinate the donation of used eyeglasses from other countries on at least a rotating basis for the major health care facilities.
- d. Once the healthcare system is more mature, develop ophthalmology as a specialty.

3. It may happen that HN surgeons perform surgical procedures more by “feel” than by sight, and also exhibit unsafe facial proximity to surgical wounds because of

their poor uncorrected eyesight. Many persons in the general population also may have poor uncorrected eyesight. This of course makes them more prone to accidents such as being struck by vehicles and it would also make them unsafe drivers of vehicles.

4. While not as important at an initial state as development of primary care services, eventual development of ophthalmology as a specialty in the HN will be useful. The same steps for other specialties as noted above (obtaining faculty, starting a residency, developing board certification and recertification) would apply.

B.7.4. Mental Health and Drug Abuse Treatment Programs

1. Because of prolonged warfare and insurgent activity in a HN, there is thought to be a very high incidence of depression, anxiety, and Post-Traumatic Stress Disorder (PTSD) throughout the country. HN Security Forces members are thought to be at particular risk for having mental health problems. There may be very limited services available for care for patients with PTSD and, in fact, for all other psychiatric disorders in the HN. One of the goals of a basic package of health services is the provision of adequate mental health counselling services for all HN individuals and the integration of these services into primary care. The desired community healthcare worker level services are to include basic psychological screening, psychological first aid, crisis management, substance abuse screening and referral.

2. Courses of action in relation to mental health and drug abuse treatment programs for the HN Security Forces include:

- a. Expand training in mental health and drug abuse treatment for both basic health care workers as well as for physicians in practice.
- b. Ensure mental health training (to include aspects of Child and Adolescent Psychiatry) is included in the standard curriculum for medical and nursing students at HN education facilities.
- c. Further develop psychiatry residency programs at national mental health hospitals, assist this program in affiliation with national military facilities, and develop clinical rotations in psychiatry for other residents such as Family Medicine.
- d. Assist in obtaining funding support for the other components of a national strategy for mental health services”.
- e. Support economic and agriculture development to lessen dependence on drug trade.

3. Expansion of mental health services for the HN Security Forces and the general public may be needed at both the district and provincial hospital level, particularly in

the problematic provinces. These services will need to be provided by non-psychiatrist physicians and non-physician health care workers, so additional training in mental health issues will need to be given to these health care workers. Training in the pharmacology and clinical use of psychotropic and anti-seizure medications for physicians at the provincial and district hospital levels (and in the basic medical school curriculum) will allow expansion of the use of these meds to these hospital levels, thereby broadening treatment options for the general population and not requiring patients to travel to only specialized hospitals to receive these medications.

4. There may be very few fully trained psychiatrists available in the HN, and there may be no adequate postgraduate training in psychiatry. Correcting this will require obtaining and mentoring psychiatry faculty and developing both inpatient and outpatient psychiatry services. Additional initial clinical faculty for this program will need to be supplied by international military or contracted through the HN to NGO's. Graduates of the psychiatry residency could provide the country with the specialty leadership needed to carry out the mental health provisions of a basic public health system, and could eventually take over operation of the residency itself from the expatriate faculty.

5. As Family Medicine residencies develop in the HN, providing clinical rotations for these residents in inpatient and outpatient psychiatric care would provide additional support for improved mental health training. Longer term future goals for mental health in the HN could include development of degree training programs in Psychology, Social Work, and Psychiatric Nursing, and development of a national certification and recertification exam and process. There may be no clinically operational programs in Child and Adolescent Psychiatry anywhere in the entire country, so development of these services and providers along with those noted above will be important.

6. A draft Strategic Plan on Mental Health may comprise the following priorities:

- a. Capacity Building (development of human resources for mental health care).
- b. Integration of Mental Health into Primary Care (integration of mental health with general services; organization of services at different levels of health care).
- c. Psychological First Aid for Adults and Children.
- d. Mental Health Directorate in the HN.
- e. Legislation.
- f. Public Mental Health.

- g. Work with Voluntary Organizations.
- h. Education Support to Families with Mentally Ill Persons.
- i. Research to Support Services.

7. Illicit drug use (particularly opiates) may continue to be a major problem in the HN given the predominance of drug cultivation in a number of provinces and so providing a readily available and inexpensive source of drugs. HN Security Forces members are probably at approximately the same risk for drug use as other members of the HN population. Drug trade may account for a large economic export from the country. Even though alternative livelihood programs may be promoted by international organizations, the income generated by drug sales cannot be consistently matched by any other current agricultural crop. Further parallel development of agricultural systems in the HN may be critical to correcting this economic situation. Alternative employment opportunities for the population, for example after further economic infrastructure development, could also promote counter narcotics activities and give the citizens other ways of making money rather than by selling drug sources.

8. Comprehensive substance abuse treatment programs should be created, comprising outreach activities, group and individual counselling, individualized treatment plans and other “wrap around” services to be provided to HN Security Forces recruits. HN Security Forces healthcare personnel must be trained to recognize signs and symptoms of drug abuse and dependence, with referral of the affected individuals to established effective treatment programs. In addition, since injection drug use may have increased among the HN population, substance abuse treatment utilizing evidence-based best medical practices should be provided to those with drug dependence to ensure these individuals receive health care and social support as part of their path to recovery from drug addiction and integration back into society.

B.8. OTHER SERVICES

B.8.1. Other Allied Health Services

1. An Institute for Health Sciences (IHS) and / or an Allied Health Professions Institute (AHPI) may already exist or have been established in a HN. A number of Allied Health training programs may have been started by or proposed for such IHS and / or AHPI. HN medical schools may have expressed interest in starting a number of new Allied Health Programs and in taking over some of the existing IHS training. Current programs offered by an IHS may fall under the supervision of the HN public health authorities whereas the main training programs at the HN medical schools (medicine, dentistry, paediatrics, degree nursing) may all fall under the supervision of the HN education authorities.

2. Possible courses of action to be considered in relation to Allied Health Fields are to transfer to or begin at HN medical schools (and some at the major hospitals of

the HN Security Forces) the following programs (some new faculty may need to be obtained and agreements reached with the teaching hospitals and clinics to provide appropriate clinical facilities and equipment for some of these; not included here are programs already detailed in program management considerations above):

- a. Nursing equivalent of the U.S. “Licensed Practical Nurse” (LPN); a shorter length program than that for the baccalaureate nurses and focused on practical clinical care.
- b. Short postgraduate courses for nurses such as Emergency Nursing, Post-surgical Recovery Nursing, Obstetrical nursing, Infection Control, Burn Therapy, Intensive Care Nursing, and Employee Health, among others.
- c. Radiology technician.
- d. Ultrasound technician.
- e. Computed Tomography technician (+ / - MRI technician).
- f. Laboratory technician.
- g. Preventive Medicine technician.
- h. Prosthetic technician.
- i. Optometry technician.
- j. Respiratory therapy (this may not be a high priority for the HN at an initial state because of the lack of ventilators throughout the country and because nurses can be trained to provide basic respiratory therapy services).
- k. Medical records technician.
- l. Medical billing and finances technician (once a national healthcare reimbursement system is adopted).
- m. Nursing assistant.
- n. Therapy assistant.
- o. Operating room technician.
- p. Dental hygienist.

- q. Food service technician.
- r. Orthopaedics technician.
- s. Specialty service technicians (such as endoscopy technician, cardiac catheterization technician, angiography technician, etc.).
- t. Graduate nursing programs such as Nurse Anaesthesia, Advanced Clinical Practice Nursing, etc. (after maturation of the nursing baccalaureate program).
- u. Speech therapy.
- v. Veterinary Medicine.
- w. Physician assistant.
- x. Pharmacist.
- y. Pharmacy assistant.

3. Starting a number of these proposed Allied Health training programs will be dependent on (and will need to wait on) acquisition or development of specific infrastructure (such as acquisition of ventilator machines by hospitals before Respiratory Therapy could be started, and acquisition of ultrasound machines before Ultrasound Technician could be initiated, etc.).

4. Transferring of any existing IHS programs to KMU would involve shifting the ministerial oversight to HN education authorities from HN public health authorities. This however would seem to be more effective than possibly existing division of training program oversight, as this shift would allow HN public health authorities to concentrate more on healthcare delivery monitoring, and would allow the faculty of HN medical schools to be more efficiently utilized in teaching all medically related degree programs.

5. As an example from the situation in Afghanistan, the microbiology faculty at Kabul Medical University (KMU) could provide lectures for the medical students, the nursing students, the laboratory technician students, etc. The current leadership of KMU has expressed interest in running all the Allied Health training programs even though a number of these might not be considered “higher” education.

6. If all the Allied Health Programs do come under the supervision of the HN education authorities, it will be very important for the HN education authorities to maintain regular communication with the host nation public health authorities and receive feedback from the HN public health authorities on whether the training programs are meeting the expectations of the HN public health authorities in terms of

healthcare delivery quality. This communication and feedback could be achieved by having regular formal meetings between representatives of both authorities to discuss and review education and healthcare delivery relationship issues (as has been done in Iraq for example where a similar ministerial structure is operative).

B.8.2. Dental Services

1. Provision for dental services may not exist in the HN or only exist within the HN Security Forces, particularly at the respective recruit training centres.
2. Courses of action in relation to dental services may include:
 - a. Have the HN Security Forces recruit trained dentists directly and a sufficient number of dental students at HN medical schools to adequately staff the HN Security Forces recruit training facilities, and the regional HN Security Forces hospitals.
 - b. Have the HN Security Forces obtain enough dental technicians or hygienists through an AHPI or its own (at HN Security Forces major hospitals) training programs to adequately staff all of its facilities.
 - c. Provide brief instruction in dental health as part of the combat medic training program.
3. Dental students may be already in training alongside the medical students at HN medical school. Experiences from current operations in providing an essential package of hospital services (EPHS) lists that a dentist and dental technician are to be assigned to each district hospital, but does not otherwise specify dental services under the EPHS. It would probably be of benefit to have dental hygienists or technicians provide services on a rotating basis to comprehensive health care centres because of the high caseload for each district hospital dentist and the difficulty that many patients may have to access the district hospital just to receive dental services.

B.8.3. Veterinary services

1. Provision of veterinary services is of relevance to the HN Security Forces regarding its use of dogs for search and rescue and for tracking of criminals and terrorists, and for use of mules or horses in roadless areas for transport. Also in the NATO and Partner Nations' military, veterinarians are often utilized to direct and monitor food safety programs, and this could be adopted by the HN Security Forces. Possible courses of action in relation to veterinary care are:

- a. Have the HN Security Forces leadership ensure there is access to veterinary care for HN Security Forces animals at designated HN Security Forces facilities.
- b. Support further development of a veterinary training program (this might most efficiently be redeveloped at HN Medical schools since many of the basic courses for this would be the same as for the medical and dental students as noted above).

2. Although not as directly relevant to the HN Security Forces, there may be a major need in the country for veterinary services to take care of livestock, especially with the provision of immunization programs. That operation and supervision of veterinary services in the HN may be under the HN authorities of agriculture, and not under the HN authorities of public health.

B.9. PUBLIC HEALTH SURVEILLANCE

B.9.1. Primary Purposes

1. The primary purposes of a surveillance system are to collect data on the health status and / or risk factors for disease in a population and to analyze, interpret, and utilize the data in a manner that will lead to prevention and control of disease. The current status of health surveillance plans, initiatives, and current programs in a HN may be significantly limited. Health surveillance may vary widely by province and district, NGO mandate and interest, and may be focused on disease-specific-health concerns. Communicable diseases may cause a high percentage of all morbidity and mortality in the HN. Most of these conditions could be preventable with basic public health measures and by immunizations. Establishment of potable water, sanitation systems, environmental pollution controls, education on safe injections, blood transfusion and basic hygiene would go far to limit the adverse health impacts of many environmental conditions.

2. The HN healthcare system may lack reliable data concerning morbidity, mortality, level of education, birth rate, and many other key health indicators. Possibly even a reliable basic system of Vital Statistics may not exist in country yet to monitor births and deaths. It is of significant priority that all military and non-

military actors in a HN work together with the HN Security Forces and HN public health authorities to create a sustainable public health surveillance system.

B.9.2. Challenges for building a surveillance infrastructure

1. The lack of security for civilian healthcare personnel caused by insurgents and drug traffickers may be a key factor in the regional inequities in surveillance infrastructure.
2. There may be several “bright spots” of well educated, key personnel trained in public health, but a general lack of depth of public health training, knowledge and understanding of public health systems throughout the HN health care system. For many complicated reasons, including unreliable communications, lack of middle management capacity, and corruption, the focus of health care, both civilian and military, may be on curative medicine and not prevention. For preventive medicine to be effectively enacted two major changes will be required – the curative health care system will need to mature and a cultural shift to emphasize prevention at all levels of the HN public health and population will need to occur.
3. Corruption and nepotism may exist or remain as barriers to success and misallocation of funds continues to support projects generated by high-level governmental officers which are outside the purview of public health surveillance. Establishing a reliable audit process in the HN public health authorities with initial mentoring will be necessary to correct this.
4. Lack of the conceptual idea of “systems management” and a “healthcare systems” approach with no real logistical expertise, especially in the civilian healthcare sector may have grave implications for viable public health success. Sometimes the HN military forces may have grasped the concept of medical logistics and may be used as a model for the civilian sector and other systems in addition to logistics (as noted above).
5. A Lack of ownership by the governance for the healthcare and public health needs of the country may reflect the negative impact of the humanitarian response as well as the infancy of the self-efficacy of any new (democratic) government.
6. Possibly there may be too many layers for NGO Co-ordination with HN public health authorities in place for prioritization of NGO activity.
7. Lack of access i.e.: poor roads, isolated facilities, misdistribution of physicians (predominantly urban with few in rural and border areas), lack of and misdistribution of ancillary healthcare workers and laboratory workers.
8. Gender inequalities in seeking and obtaining healthcare.

9. Population illiteracy and little health education for the public limit marketing opportunities for surveillance and so do not facilitate social engineering for cultural change for public health, health behaviours and surveillance.

10. Lack of capacity related to poor biomedical equipment repair and maintenance capability.

B.9.3. Other Facts Bearing on the Problem

1. Any long term successes in whatever HN need to be HN-led with motivated and engaged HN public health authorities in concert with the HN security forces.

2. Support and vision of the HN public health authorities' leadership and the HN military forces Surgeon General are strong factors in the ability to accomplish public health success.

3. A national strategy for reconstruction and a HN national developmental strategy may include health surveillance activities and acknowledge the importance of public health surveillance, but plans may encompass activities to far in future.

4. The ability to work successfully with motivated NGOs; supports a successful leadership and can advance the "adopt-a-hospital" (or facility) concept which would foster more collaboration on public health issues.

5. Generally recommended courses of action to be considered for Public Health Surveillance may be:

- a. Firstly recognition that the main purpose for any surveillance system is to provide data for action. Robust data systems have the potential to be used not only for assessing the health status of the country and provinces, but could be used and integrated with national logistics and financial systems. The creation of a culture of data-driven healthcare that can be measured must begin with the leadership of the HN public health authorities and HN Security Forces and be driven forward, with full implementation of the health management information system (HMIS).
- b. The HN public health authority needs to be the policy developing agency in the HN government. Allied Health Professions Institute (APHI) needs to be empowered to be the public health implementing agency of the HN public health authority. Surveillance needs to be centralized under the APHI. Within the HN Security Forces, the Epidemiology Section of the Office of the Surgeon General must be developed to act as both. This will require selection of a strong and educated leader with vision and capability to drive a cultural change towards surveillance and prevention.

- c. Regional centres need to be developed around the country and trained and staffed to fully function in all aspects of civilian and military public health including surveillance and outbreak response. After the regional centres are trained by APHI with outside assistance, APHI needs to begin training provincial level public health and surveillance personnel and eventually, reach down to the district level to do the same. Utilizing the logistic and communications infrastructure that may be developed by the HN military forces at the regional level could be a major step in the correct direction. Co-ordination between the military and civilian sectors will be required to begin the process and complete integration should be the goal at the regional level.
- d. A system of Vital Records needs to be established under the APHI. National standard birth and death certificates must be developed and should be maintained at the provincial, if not district, level. Monthly reporting should be mandatory to the APHI using a standard report format. HN Security Forces systems all must feed into the HN public health authority system and could enter at either the regional or national level.
- e. Within the HN public health authority, future contractual obligations for the participating NGO's need to include capacity for surveillance activities (both disease-specific and in the general health areas) and some form of independent accountability process needs to be in place to assure compliance.
- f. Embedded mentors and trainers for the HN Security Forces health system (helping with logistics support, hospital capacity building, medical / nursing education, and combat casualty care) may have been successful. Lessons learned from these programs can be used to provide policy and guidance for further nation-building and health diplomacy projects. The development of a similar civilian-oriented system of mentorship led by national or multinational agencies or organizations should go far. The educational venue of choice in a HN is most likely mentorship and not a didactically based learning modality; literacy aside, training and hands-on mentorship may be the viable modes of education for the populace and seem to be the way forward. Doctrine, policy, and further nation-building activities should be structured around this type of learning / educational process.
- g. Surveillance information in displaced and nomadic populations is sparse and needs to be researched and communicated to the HN public health authorities. Specific contracted survey teams will be needed for this.
- h. The current available information on population mental health status may be abysmal and in need of a surveillance system. The incidence of

violence and abuse directed at females, depression, and suicide may be very high and probably underreported and the problems of child abuse and depression may be almost completely unreported in a country. To initiate social changes to deal effectively with these problems and to know the factors involved in these are imperative and research needs to be applied to assist with these changes.

6. This may be enlarged by additional specific recommendations for courses of action for Public Health Surveillance taking into account the respective situation in a HN.

B.9.4. Facilitation of Resources / Effective Use of Resources

1. While direct medical care to civilian patients might promise quick and achievable results, sustainable projects that restore and build capacities achieve longer and wider results than limited scope direct patient care projects. Such projects enable the primarily responsible civilian actors to take over responsibility for patient care. Thus, the military medical effort should be wholly collaborative and inclusive to all involved stakeholders. Balanced medical advice will have to weigh immediate mission requirements against desirable long-term stabilization effects.

2. In the health sector, military medical staff may also have the expertise to assist with the assessment of demands for health services and the development of project proposals. Where this expertise is not directly available within a deployed medical staff, appropriate reach back capability will provide specific functional support. Information can be provided by national authorities, Ministry of Health, Ministry of Development or equivalent in the sending nation.

3. A successful medical infrastructure project can make a substantial difference to the local population served by the facility and provide a contribution to the overall reconstruction effort at the same time. In addition to this a credible effort supports the aim of earning local trust and public support. It is vital that such an investment is safeguarded for the long-term by ensuring the project lies within a wider health programme and is sustainable in terms of staff, equipment, supplies, training and local community commitment. However, full consideration of the resources implication should be considered well in advance, acknowledging that reconstruction efforts, including their financial aspects, are not a military responsibility. Provision of sophisticated medical equipment with excessive demands on power supply or maintenance has to be avoided.

4. Medical/Dental/Veterinary Civil Assistance Projects (MEDCAPs/DENTCAPs/VETCAPs) focusing on military medical care to populations in developing countries are often established by contributing nations. They generally provide short-term medical care to a part of the population that does not have access to sufficient healthcare. MEDCAPs/DENTCAPs/VETCAPs spend short periods in local facilities before they move on to another pre-determined site. The benefits of these programmes are limited

by the disadvantage of not providing sustainable care. MEDCAPs/DENTCAPs/VETCAPs must not be applied as a possible solution. The MEDAD needs to advise the commander accordingly.

B.10. PRIORITIES

Priorities for health sector reconstruction should be developed by the receiving country and WHO strategic guidance while international actors maintain a supporting role. These priorities depend on the overall health situation. They must be reviewed frequently as the operation progresses. They will regularly include a basic package of health services. Examples of other priorities are as follows:

- a. Establishment of health prevention and promotion programs.
- b. Improvement of co-ordination of health services.
- c. Improvement of the quality of maternal and child health care.
- d. Strengthening of the delivery of integrated communicable disease control programs.
- e. Reduction of prevalence of malnutrition.
- f. Strengthening of health surveillance.
- g. Development of health care financing.

B.11. TRAINING AND MENTORING

1. Human resource availability in the civilian health care sectors may be limited. The education of personnel employed in the health care sector and the appropriate training and mentoring will be key for the overall development of the health care system. Helping the host nation develop self-sustaining, culturally appropriate education and training capabilities will allow incremental building of future capability and capacity for their health sector.

2. Structured healthcare teaching programs, mutual case presentations among military and civilian medical personnel, shared clinical cases and conferences add to the training methods and principles as described in Chapter 5 of this publication.

B.12. MEASURING THE EFFECTIVENESS OF THE HEALTH CARE SYSTEM RECONSTRUCTION EFFORTS

1. Measures of effectiveness (MOE) are in common use today in many areas of life suggesting that in modern society quantification is irresistible. The armed services use quantitative methods to analyze and explain their actions to their leaders, policy-makers, and the public they serve. For better or worse, the interpretation of MOE frequently forms the structure on which senior military leaders base their orders. Consequently, the need to carefully select MOE is paramount. However, not carefully considered or poorly chosen measures have a multitude of negative effects.

2. In determining measures of effectiveness for HN Security Forces integration and healthcare reconstruction efforts these should be closely aligned with the objectives of the HN Security Forces leadership.

3. In addition, they should correspond with the UN Millennium Development Goals focused on health:

- a. To reduce child mortality,
- b. Improve maternal health, and
- c. To combat HIV / AIDS, malaria and other infectious diseases.

4. Based on experience from current operations survey categories asking to establish MOE's should address the following:

- a. Care delivery is religiously acceptable.
- b. Care delivery is ethnically acceptable.
- c. Care delivery is culturally acceptable for both genders.
- d. Care delivery is equal for all eligible beneficiaries.
- e. Care is communicated in a locally appropriate language.
- f. Women think their care is adequate and appropriate.
- g. Patient needs are being met.
- h. Patients can get to care in a reasonable time once they seek it.⁸

⁸ WHO standard is care within 5 km, although the possible remoteness of much of rural HN will make this standard impossible to ensure for all of the population.

5. For the catchment area beneficiaries, issues that could be tracked as metrics (letters a-e, l-o, and z are probably most important and most easily tracked):
- a. Number of deaths from delayed care.
 - b. Incidence of morbidity from delayed care.
 - c. Maternal mortality.
 - d. Life expectancy.
 - e. Perinatal mortality.
 - f. Prevalence of low-weight-for-age.
 - g. Unmet curative care percentage.
 - h. Healthcare providers per capita.
 - i. Annual school days missed age 12 and below.
 - j. Percentage of births attended by skilled health personnel.
 - k. Number of patients transported to or from healthcare facility by healthcare transportation.
 - l. Number of deaths under age 5 from acute respiratory infection (ARI).
 - m. Number of deaths under age 5 from diarrhoea.
 - n. Number of deaths under age 1.
 - o. Percentage of children under age 13 attending school.
 - p. Incidence of anaemia in females <age 50.
 - q. Incidence of malnutrition by mid-arm circumference.
 - r. Incidence of reported domestic abuse.
 - s. Number of females in protective care from abuse.
 - t. Female primary school enrolment.
 - u. Percentage of children under 14 attending school.

- v. Narrowing of maternal birth-age window.
- w. Reduction in overall maternal pregnancies.
- x. Increase in birth spacing.
- y. Landmine injuries numbers.
- z. Number of confirmed vaccination doses administered.
- aa. Incidence of measles.
- bb. Incidence of tetanus.

6. It is important to have a balance between quantitative and qualitative when creating MOE's in a HN because most likely social relationships are the key to measuring success in country. In addition, qualitative measures in a HN may be very difficult to measure given the lack of familiarity of much of the rural population with self-assessment surveys.

7. A separate set of MOE's both direct and indirect, may need to be developed for determination of the effect of health care system improvements on counterinsurgency. Specific personnel will need to be contracted to carryout monitoring of these MOE's. A partial list of these MOE's could include:

- a. Mortality rate from penetrating trauma.
- b. Number of non-lethal penetrating trauma cases.
- c. Presentation rates for cases with psychiatric diagnoses.
- d. Number of males over age 12 in school.
- e. Number of males over age 15 employed in civilian sector.
- f. Local economic activity indicators.

8. A more detailed list of MOE's (expected outcomes) referenced in the same sequence as the topics in a project management plan, with proposed timelines, addressing the most important aspects of the project management plan and being achievable in realistic time frames needs to be established taking into account the specific situation of the HN.

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See:

- AAP-6(2014) NATO Glossary of Terms and Definitions
- AMedP-13(A) NATO Glossary of Medical Terms and Definitions
- NATO TERMINOLOGY DATABASE

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A

ACO	Allied Command Operations
ACT	Allied Command Transformation
AHPI	Allied Health Professions Institute
AIDS	Acquired Immunodeficiency Syndrome
AJMedP	Allied Joint Medical Publication
AJP	Allied Joint Publication
AMedP	Allied Medical Publication
AOO	Area of Operations
AU	African Union

C

CBRN	Chemical, Biological, Radiological, Nuclear
CEPC	Civil Emergency Planning Committee
CDHAM	Centre for Disaster and Humanitarian Assistance Medicine
CEP	Civil Emergency Planning
CIMIC	Civil-Military Co-operation
CPG	Comprehensive Political Guidance
CJTF	Combined Joint Task Force
CM	Consequence Management
CME	Certified Continuing Medical Education
COA	Course of Action
COG	Centre of Gravity
COMEDS CPG	Committee of the Chiefs of Military Medical Services in NATO Comprehensive Political Guidance
CRO	Crisis Response Operation
CSTC-A CT	Combined Security Transition Command – Afghanistan [USA] Computed Tomography

D

DENTCAP	Dental Civil Assistance Project
DJTF	Deployable Joint Task Force

E

EAPC	Euro-Atlantic Partnership Council
EADRCC	Euro-Atlantic Disaster Response Co-ordination Centre
EPHS	Essential Package of Hospital Services
ETT	Embedded Training Team
EU	European Union

H

HA	Humanitarian Assistance
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HN	Host Nation
HNS	Host Nation Support

I

ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IHS	Institute for Health Sciences
IO	International Organization
ISAF	International Security Assistance Force

J

JALCC	Joint Analysis Lessons Learned Centre
JHFAG	Joint Health Food and Agriculture Group
JOA	Joint Operations Area
JOC	Joint Operations Centre
JOPG	Joint Operations Planning Group

K

KMU	Kabul Medical University
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L

LPN	Licensed Practical Nurse
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M

MASCAL	Mass Casualty
MC	Military Committee
MEDAD	Medical Advisor
MEDCAP	Medical Civil Assistance Project
MEDICS	Medical Information and Co-ordination System
MHA	Medical Humanitarian Assistance
MMSOP WG	Military Medical Structures, Operations and Procedures Working Group
MOE	Measures of Effectiveness
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging

N

NAC	North Atlantic Council
NATO	North Atlantic Treaty Organization
NEO	Non Combatant Evacuation Operation
NGO	Non Governmental Organization
NRF	NATO Response Force

O	
OCHA	UN Office for Co-ordination of Humanitarian Affairs
OPP	Operational Planning Process
P	
PAO	Public Affairs Officer
PAR	Population at Risk
PB&C	Planning Boards and Committees
POW	Prisoner of War
PRT	Provincial Reconstruction Team
PTSD	Post-Traumatic Stress Disorder
R	
R&D	Reconstruction and Development
RFI	Request for Information
RRT	Rapid Reaction Team
S	
SOFA	Status of Forces Agreement
SSR	Sector Security Reform
U	
UN	United Nations
UNICEF	United Nations Children's Fund
V	
VETCAP	Veterinary Civil Assistance Project
W	
WHO	World Health Organization
WMD	Weapons of Mass Destruction

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ANNEX E

LIST OF REFERENCES

REFERENCE PUBLICATIONS

The following are the principal references used for this document:

- | | | |
|----|---------------------------|---|
| a. | 1st Geneva Convention | Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field |
| b. | 2nd Geneva Convention | Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of Armed Forces at Sea |
| c. | UN-CM COORD OFHB | United Nations Civil-Military Co-Ordination Officer Field Handbook |
| d. | MC 133/4 | NATO's Operational Planning System |
| e. | MC 324/3 | The NATO Military Command Structure |
| f. | MC 326/3 | NATO Principles and Policies of Medical Support |
| g. | MC 327/2 | NATO Military Policy for non-Article 5 Crisis Response Operations |
| h. | MC 334/2 | NATO Principles and Policies for Host Nation Support |
| i. | MC 343/1 | NATO Military Assistance to International Disaster Relief Operations |
| j. | MC 411/1 | NATO Military Policy on Civil-Military Co-operation (CIMIC) |
| k. | MC 551 | Medical Support Concept for NATO Response Force (NRF) Operations |
| l. | AD 80-90 | Access to Civil (Civil Emergency Planning) Expertise |
| m. | AD 83-1 (Ed.2) | ACO Directive for Medical Support to Operations |
| n. | AD 83-2 | ACO Guidance for Military Medical Services Involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development |
| o. | AD 85-8 | ACE Medical Support Principles, Policies and Planning Parameters |
| p. | STANAG 2437(7) - AJP-1(D) | Allied Joint Doctrine |
| q. | STANAG 2190(2) - AJP-2(A) | Allied Joint Doctrine for Intelligence, Counter Intelligence and Security |
| r. | STANAG 2490(3) - AJP-3(B) | Allied Doctrine for Joint Operations |

- s. STANAG 2532(1) - AJP-3.13 Allied Joint Doctrine for the Deployment of Forces
- t. STANAG 2528(1) - AJP-3.14 Allied Joint Doctrine for Force Protection
- u. STANAG 2509(2) - AJP-3.4.9(A) Allied Joint Doctrine for Civil-Military Cooperation
- v. STANAG 2182(2) - AJP-4(A) Allied Joint Logistic Doctrine
- w. STANAG 2506(3) - AJP-4.4(B) Allied Joint Movement and Transportation Doctrine
- x. STANAG 2234(3) - AJP-4.5(B) Allied Joint Doctrine for Host Nation Support
- y. STANAG 2230(3) - AJP-4.6(B) Allied Joint Doctrine for the Joint Logistic Support Group
- z. STANAG 2512(2) - AJP-4.9(A) Allied Joint Doctrine for Modes of Multinational Logistic Support
- aa. STANAG 2228(3) - AJP-4.10(B) Allied Joint Medical Support Doctrine
- bb. STANAG 2542(1) - AJMedP-1 Allied Joint Medical Planning Doctrine
- cc. STANAG 2546(1) - AJMedP-2 Allied Joint Doctrine for Medical Evacuation
- dd. STANAG 2547(1) - AJMedP-3 Allied Joint Medical Doctrine for Medical Intelligence
- ee. STANAG 2561(1) - AJMedP-4 Allied Joint Medical Force Health Protection Doctrine

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