

FM 8-42

**COMBAT HEALTH SUPPORT
IN
STABILITY OPERATIONS
AND
SUPPORT OPERATIONS**

HEADQUARTERS, DEPARTMENT OF THE ARMY

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COMBAT HEALTH SUPPORT IN STABILITY OPERATIONS AND SUPPORT OPERATIONS

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PREFACE

This field manual (FM) establishes the combat health support (CHS) doctrine and provides the principles for providing CHS in stability operations and support operations. It is designed for use by personnel involved in CHS planning for stability operations and support operations and command surgeons (at all levels of command) and their staffs.

The proponent of this publication is the United States (US) Army Medical Department Center and School (AMEDDC&S). Send comments and recommendations on Department of the Army (DA) Form 2028 directly to the **Commander, AMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-6175.**

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

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CHAPTER 1

COMBAT HEALTH SUPPORT PERSPECTIVE**1-1. General**

Although the Army's primary focus is to fight and win our nation's wars, it is often employed in stability and support operations. In stability and support operations, the Army executes missions in both peace and conflict: what combat does occur is limited to the minimum necessary to support the political objectives. The primary recipients of combat service support (CSS) in stability and support operations are likely to be civilians (US or foreign), rather than US combat forces as in war. The CHS planner must be capable of adapting traditional methods of health care delivery, leveraging technology, and establishing new procedures to meet the challenges presented.

1-2. Stability and Support Operations

a. Stability and support operations are conducted in the political-military environments of peace and conflict. In both, the role of the Armed Forces is to aid in the protection and promotion of national objectives without resort to war. Conflict is distinguished from peace by the introduction of organized political violence. Yet, it is a situation that remains amenable to solution by political means with military support. In peacetime, the Army prepares for war and effects deterrence by its demonstrated capabilities. In addition, military resources are used in peacetime as a matter of economy in government. Stability and support operations can include—

- Noncombatant evacuation operations (NEO).
- Foreign humanitarian assistance and disaster relief.
- Combatting terrorism (counterterrorism and antiterrorism [Appendix A]).
- Nation assistance.
- Security assistance.
- Support to counterdrug operations.
- Support to counterinsurgencies.
- Arms control and disarmament.
- Domestic support operations, to include domestic humanitarian assistance and emergency services.
- Peace operations.
- Support to insurgencies.

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- Shows of force and demonstrations.
- Strikes and raids.

b. In stability and support operations, the provision of CHS and health education plays a more direct role in countering both the medical and general threats. Combat health support in stability and support operations can be defined as those actions encompassing all military health-related activities taken or programs established to further US national goals, objectives, and missions. These actions and programs may differ to some degree from the traditional CHS role (delivery of quality health care) of the Army Medical Department (AMEDD) in war. For example, these CHS operations can play a significant and proactive role in nation assistance by—

- Assisting with the development and refinement of the host-nation (HN) medical infrastructure.
- Providing and maintaining the basic necessities of life for the general population through HN civilian medical programs.
- Providing assistance in establishing, repairing, or improving basic health and sanitation services.

1-3. Principles

a. The principles of war apply in stability and support operations, although they may require adaptation to meet the challenges presented (refer to FM 100-5 for an in-depth discussion of these principles). A number of principles that guide actions within the stability and support operations arena are also well established. These principles are—

(1) *Objective.* The CHS commander directs every CHS operation towards a clearly defined, decisive, and attainable objective. The military effort must be integrated with the total effort in achieving the strategic aims and culminating in the desired end state. The CHS commander must—

- Understand the strategic, operational, and tactical aims.
- Set appropriate objectives.
- Execute the CHS mission.

(2) *Unity of effort.* The CHS commander must seek unity of effort toward every objective. In stability and support operations, the problems requiring military action are so complex and of such magnitude that no single agency can overcome them. Further, it is important that the participating agencies (Appendix B) work toward the same purposes. The unified efforts of all participants are required. Planning must address the military contribution to stability and support operational initiatives that are political, economical, psychological, and military in nature. The other participants may include—

1-2

- Other Services.
- United States governmental agencies.
- Allies.
- Coalition partners.
- Host nation.
- Nongovernmental organizations (NGOs).
- Private volunteer organizations (PVOs).
- Religious groups.

(3) *Legitimacy.*

(a) Legitimacy involves sustaining the people's willingness to accept the right of the government to govern or of a group or agency to make and carry out decisions. (For example, in counterinsurgency operations, CHS programs and initiatives must not undermine the confidence people have in their nation's government. Combat health support operations must compliment, not detract from, the legitimate authority of a HN government.)

(b) United States military forces are also concerned with the legitimacy issue when involved with foreign intervention. Combat health support, due to its acceptance by the civilian population, can assist in mitigating the adverse impact that other US military interventions may cause in the region.

(4) *Perseverance.* In stability and support operations, strategic goals may be accomplished by long-term involvement, plans, and programs. Short-duration operations will occur, but these operations must also be viewed as to their impact on the long-term strategic goals. Therefore, the CHS planner must prepare for the measured, protracted application of the military CHS capability to support the strategic goals and work toward the desired end state.

(5) *Restraint.* Stability and support operations place constraints on the potential actions that can be accomplished and the rules of engagement (ROE) governing these actions. Imprudent action outside the ROE may, in fact, have a detrimental effect on the attainment of strategic goals and objectives. All forces participating in stability and support operations, therefore, must incorporate restraint and adherence to established laws, regulations, policies, and norms to ensure the furtherance of the military objectives.

(6) *Security.* The security of US forces abroad is paramount. Commanders and planners must be aware of the ever-present danger that can exist from various groups, factions, or other governments. Commanders must continually perform risk assessments to ensure the safety of all operations (Appendix C). Even in a peacetime environment, US military forces can be targeted for terrorist activities. The commander must ensure that his forces remain vigilant, implement active and passive security measures, and can

transition from a peacetime operation to a combat response, if required. (For example, CHS planners must ensure the capability exists to transition from humanitarian activities to the traditional support of conventional forces engaged in combat.) Further, CHS personnel must be prepared to defend themselves and their patients should the need arise.

b. Especially in stability and support operations, the political arena within which missions are to be accomplished is of considerable importance. As in all military operations, political objectives drive decisions at the strategic level. While the individual operator need not be driven by political motives, it is important for the leadership to recognize the importance of political objectives in planning and executing the mission.

1-4. Logistics Preparation of the Theater

a. Logistics preparation of the theater is a systematic approach for planning for the logistics (force structure, resources, and strategic lift) needed to support the commander's plan. This process focuses on identifying the resources currently available in the theater of operations (TO) for use by friendly forces and ensuring access to them. These planning actions include—

- Identifying and preparing bases of operations.
- Selecting and improving lines of communications (LOC).
- Projecting and preparing forward logistics bases.
- Forecasting and building operational stock assets forward and afloat (FM 100-17-1).

b. This process is essential to ensure that sufficient CHS resources are allocated and correctly distributed within the TO. In stability and support operations, where brigade-sized or smaller organizations may enter the TO first, the only logistics available to them may be what they bring with them. In the CHS arena, contracting for HN support may not be possible as quality assurance standards are stringently enforced. Further, our medical equipment and repair parts may be beyond the technology available in the HN.

c. Stability and support operational missions will be joint or multinational (Appendix D) in nature. The CHS planner must include the availability of resources of the other Services, the HN, and other participating nations, agencies, and organizations within the TO. This ensures that the employment of the resources available are maximized and that a duplication of services does not occur.

1-5. Medical Threat Assessment

a. A critical element of the CHS assessment is a thorough appraisal of the medical threat. This assessment includes the medical threat to the deploying forces and to the residents in the area of operations (AO). The US soldier is placed at more risk in stability and support operational scenarios as the incidence

and exposure to infectious diseases and environmental hazards are greater in man-made or natural disaster areas and in developing nations. The medical threat is derived through established intelligence channels and from a variety of informational sources outside the military.

b. The ability to obtain, interpret, and use medical intelligence is critical to the success of the CHS mission. Regardless of whether the operation is conducted within the US or abroad, man-made and natural disasters can cause a resurgence of diseases once thought to be at low epidemiological levels and may also result in environmental contamination. A combination of factors can result in the spread of communicable diseases in epidemic proportions and increased opportunity for exposure to nuclear, biological or chemical (NBC) hazards. These factors are—

- Disruption of sanitation services (such as garbage disposal or sewer systems).
- Contamination of food and water.
- Development of new breeding grounds for rodents and arthropods (such as in rubble or in stagnant pools of water).
- Disruption of industrial operations.
- Dispersion of biological or radiological waste by improper handling or terrorist activity.

(1) Medical intelligence is the product resulting from the collection, evaluation, analysis, integration, and interpretation of all available general health and bioscientific information. Medical intelligence is concerned with one or more of the medical aspects of foreign nations or the AO and which is significant to CHS (Appendix E) or general military planning. Until medical information is processed, it is not considered to be medical intelligence. Medical information pertaining to foreign nations is processed by the Armed Forces Medical Intelligence Center (AFMIC). Medical threat information in AOs within the US can be obtained from—

- The United States Army Medical Command (USAMEDCOM).
- United States Army Medical Department medical centers (MEDCENs) and medical department activities (MEDDACs) within the immediate area.
- The United States Civil Affairs (CA) and Psychological Operations Command.
- Local public health officials.
- The American Public Health Association (FM 8-33).
- The Centers for Disease Control.

(2) The special training of preventive medicine (PVNTMED) personnel, as well as other medical professionals, is used to provide a clear assessment of the medical threat. Preventive medicine personnel are specifically trained and equipped to collect, analyze, and interpret health information. When

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the assessment includes oral, dental, or maxillofacial considerations, the dental public health officer has similar specialized training in his field. The veterinary PVNTMED officer can provide expertise in the public health ramifications of zoonotic diseases and biological warfare (BW) and chemical warfare (CW) agents. These personnel can make recommendations for types of activities to be accomplished and their priority for support. Using these skills maximizes the efficient use of limited CHS resources. For consultation purposes during the assessment, the medical personnel conducting the assessment should have free access to all medical professionals within the CHS force and the local medical community.

c. Combat health support planners must acquaint themselves with the currently existing intelligence products. These products include national-level intelligence products such as the Medical Capabilities Studies and Disease Occurrence Worldwide. These reports are specifically produced to support US military CHS operations conducted outside the continental United States (OCONUS). These reports can be obtained through operational and medical intelligence channels (such as the medical brigade S2 [Intelligence Officer, US Army] or the corps surgeon's office). (Refer to FM 8-10-8 for specific information.)

d. As CHS plans (Appendix F) and operations progress, the requirements for additional medical intelligence will occur. All such requirements should be requested through intelligence channels as soon as they are validated; when required, coordination should be effected with local agencies.

e. In OCONUS operations, the CHS planner must make himself aware of the medical threat posed by the disaster (such as continued flooding, earthquakes and aftershocks, or further explosions) and groups, factions, opponents, terrorists, or enemy forces operating within the AO. This threat also includes the potential use and capabilities of weapons systems and munitions, such as NBC (Appendix G), directed-energy (DE) weapons or devices, or conventional armaments, and the potential for terrorist attacks or incidents, including the use of CW and BW agents without weapons delivery systems. Combat health support planning and force survivability necessitate that CHS units remain abreast of the complete intelligence picture.

f. The medical threat includes the stress threat. The stress threat encompasses all stressors in the environment that are likely to threaten the mission and the soldier's current and future well-being. The stress threat can result in—

- Misconduct stress behaviors.
- Post-traumatic stress disorder.
- Battle (conflict) fatigue (BF).
- Neuropsychiatric (NP) disorders, including organic mental disorders.

g. Should CHS personnel gain information of potential medical intelligence value while in the performance of their duties, they are required to report it to their supporting intelligence element (FM 8-10-8).

h. For additional information on infectious diseases and their prevalence, refer to FM 8-33.

i. For additional information on the medical threat and intelligence preparation of the battlefield, refer to FM 8-10-8 and FM 8-55.

1-6. Foundations for Combat Health Support Programs

a. The cornerstones of CHS in stability and support operations are determined by the specific mission but can include—

- Planning for and providing direct health services to US, allied, coalition, and HN military forces and, when authorized, US government employees, civilian contractors, and United Nations (UN) personnel.
- Planning for and providing PVNTMED and veterinary services to HN and civilian populations.
- Providing humanitarian care and assistance to disaster victims.
- Enhancing readiness by real-time, hands-on training. (This training is conducted in an unfamiliar venue, involving diseases not normally widespread in the US or which are normally at low epidemiological levels. These missions are conducted in varying public health conditions.)
- Promoting and enhancing the growth potential of a HN medical infrastructure.
- Planning for and developing programs which provide direct patient care support for both HN military and civilian populations.
- Planning for and providing health education and CHS training for HN or US-backed military or paramilitary forces.
- Providing traditional CHS to conventional and unconventional forces to ensure the rapid return to duty (RTD) of trained manpower.

b. The CHS commanders and planners must exercise flexibility and initiative to enhance the potential for success of the CHS mission and to further national strategies.

c. Although the missions assigned to medical units may be classified under general activities (such as disaster relief, support for counterinsurgency operations, or support to counterdrug operations), each will be unique to its specific situation. The unique setting for each stability and support operational mission is dependent upon—

- Type of operation.
- Level of hostilities.

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- Duration of the operation.
- Rules of engagement.
- Political climate.
- Economic status.
- Cultural influences and biases.
- Religious preferences.
- Other socioeconomic considerations.

Combat health support commanders and planners must recognize these influences, determine their significance, and incorporate them into the planning and decision-making process.

1-7. Command Surgeon

a. The command surgeon is instrumental in planning, developing, and implementing CHS programs. Due to the necessity to task organize the forces employed in stability and support operations and established troop ceilings for operations, the number of medical personnel employed may be limited. In many cases, the CHS commander is dual-hatted as the command surgeon.

b. The duties and responsibilities of the command surgeon include—

- Determining requirements and providing oversight for—
 - Requisition, procurement, storage, maintenance, distribution management, and documentation of combat health logistics (CHL), to include blood management.
 - Combat health support personnel.
 - Financial management of resources allocated and expended.
- Planning and coordinating transportation requirements in excess of organic capability.
- Planning and coordinating with the CHS commanders, task force (TF) commanders, or other elements, units, or agencies for continuous CHS.
- Submitting to higher headquarters those recommendations on professional medical problems that require research and development. (In developing nations, this responsibility takes on added significance as unfamiliar diseases may be encountered.)

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- Recommending uses of captured (or abandoned) Class VIII or locally available medical supplies in support of detainees, enemy prisoners of war (EPW), HN personnel, and other recipients.
- Advising on the—
 - Health of the command.
 - Combat health support resources available within the AO.
 - Medical effects of the environment and of NBC or DE weapons systems and devices on personnel, Class VIII materiel, rations, and water.
 - Medical intelligence requirements.
- Planning and coordinating (internally and externally) the following CHS operations:
 - Medical evacuation by US Air Force (USAF) or US Navy (USN) resources or resources from the civilian community, HN, allies, or coalition partners.
 - Medical treatment to include hospitalization in medical treatment facilities (MTFs) established by the other Services, allies, coalition forces, or HN. (This includes MTFs afloat.)
 - Dental services. (The senior dental officer assigned serves as the command dental surgeon for the purpose of coordinating dental activities for the command surgeon.)
 - Veterinary food inspection, animal care, veterinary PVNTMED activities of the command, and civic assistance programs within the local community.
 - Preventive medicine services.
 - Nursing services.
 - Medical laboratory services.
 - Humanitarian assistance and disaster relief programs.
 - Mental health (MH) and combat stress control (CSC) programs.
 - Rehabilitation support.
 - Nutrition care services.
 - Combat health support aspects of rear area protection.
 - Recommendations on the assignment and/or attachment of medical units and/or personnel.

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- Combat health support assessments, estimates, and plans.

1-8. Command Surgeon's Role

The command surgeon's role includes the duties and responsibilities specified in paragraph 1-7. The elements of assessing, problem solving, planning, and coordinating programs takes on an added significance in stability and support operations.

a. Assessing.

(1) Combat health support assessments must be carefully and comprehensively completed. They need to include such areas as—

- Health status of population groups (such as disaster victims or HN's military).
- Potential medical threat under various operational scenarios.
- Availability of CHS resources from all sources.

(2) In operations conducted OCONUS, US assistance should only be provided when all resources of the requesting state are exhausted or overwhelmed.

(3) Current and timely medical intelligence and information (paragraph 1-5) is an important aspect in preparing a comprehensive CHS assessment (Appendix E).

(4) Updated assessments should be maintained on each specific country or geographical area within the commander's AO.

b. Problem Solving. Due to the uniqueness of the stability and support operational missions, planning for potential scenarios requires initiative, flexibility, versatility, and improvisation to successfully complete established missions. As CHS planners, command surgeons must not become inflexible in their thinking or rely solely on the traditional methods of CHS delivery. Combat health support planners must explore all potential alternative courses of action (COAs). They must also be prepared to deal with unanticipated occurrences. As CHS resources are scarce, the CHS planner must maximize their effective use to ensure adequate health care regardless of the scenario.

c. Planning.

(1) Involvement early in the planning process and inclusion on the advance party assists in ensuring that—

- Adequate CHS assets are available.

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- Requirements that cannot be met by the available CHS resources are identified and action is taken to correct the deficiencies noted.

- An accurate assessment of the medical threat is made and measures to counter this threat are implemented.

(2) Stability and support operations require coordinated actions with other US and foreign military forces and both private and public civilian agencies.

d. Coordinating.

(1) The conduct of CHS in stability and support operations requires thorough coordination prior to implementation. This coordination ensures that—

- Duplication of services and/or missions does not occur.
- The mission is executed properly.
- Interoperability exists between the Services and other participating agencies/nations in areas such as communications.

- Adequate CSS resources are allocated for the mission. This includes all classes of supply and the means to resupply the operation.

- Scarce resources are used effectively and efficiently.
- Operations security (OPSEC) is not compromised.

(2) In stability and support operations, coordination is not limited only to the military forces operating within the AO, but extends to all other participants.

(3) Thorough coordination during the planning process ensures that the final plan—

- Contributes to the accomplishment of the desired end state.
- Satisfies the requirements of the civil authorities or the HN.
- Can be accomplished with the resources available.
- Provides a favorable climate for the acceptance of the government program by the targeted population.
- Does not bypass or discourage the full application of all local or HN resources to the situation.

1-9. Army Medical Department Battlefield Rules

a. The AMEDD Battlefield Rules define the focus of the CHS system in both war and stability and support operations. These Battlefield Rules in order of precedence are to—

- Maintain a presence with the soldier (being there).
- Maintain the health of the command.
- Save lives.
- Clear the battlefield.
- Provide state-of-the-art care.
- Ensure the early RTD of sick, injured, or wounded soldiers.

b. In stability and support operations, PVNTMED plays an important role in the focus of health care delivery, as the major cause of soldier noneffectiveness in this environment is disease and nonbattle injuries (DNBI). In many situations, CHS personnel will arrive in the AO before combat and combat support (CS) troops. Effective measures to counter the medical threat will reduce the number of soldiers who become ill from endemic diseases (morbidity and mortality rates) and will enhance the ability to rapidly return soldiers to duty once stricken by disease. Combat stress control will also reduce DNBI and stress casualties and promote mission effectiveness. During conflicts and contingency operations, wounded soldiers are quickly evacuated from the battlefield to established MTFs within the AO, or provided evacuation to the continental United States (CONUS) or another designated support base. During Operation Just Cause, wounded soldiers were stabilized at MTFs established at the airfield and immediately evacuated to Brooke Army Medical Center and Wilford Hall Medical Center in San Antonio, Texas, for definitive and restorative care. The care provided our forces is as sophisticated as possible in the immediate AO with comprehensive and definitive care available in the support base. Rapid medical evacuation with the provision of en route medical care enables the patient to be cared for during evacuation to the destination MTF.

1-10. The Law of Land Warfare

a. The conduct of armed hostilities on land is regulated by the Law of Land Warfare. This body of law is inspired by the desire to diminish the evils of war by—

- Protecting both combatants and noncombatants from unnecessary suffering.
- Safeguarding certain fundamental human rights of persons who fall into the hands of the enemy, particularly prisoners of war, the wounded and sick, and civilians.
- Facilitating the restoration of peace.

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