Chapter 13

PREVENTIVE MEDICINE AND THE OPERATION PLAN

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INTRODUCTION

Operation plans (OPLANS) are large-scale deliberative processes, accomplished by unified commands during the calm of peacetime to minimize the negative effects on rational tactical and strategic planning caused by the emotions and confusion of rapid deployments. The plans provide a basic framework for a military operation to combat specific potential threats, defining such things as the chain of command, initial employment of forces, logistical support, medical support, and any other details that would help direct the conduct of operations against that specific threat.

There are nine unified commands in the US military forces, each with different responsibilities: Atlantic Command, European Command, Southern Command, Pacific Command, Central Command, Special Operations Command, Transportation Command, Space Command, and Strategic Command. These are commonly abbreviated as "CINCs" (colloquially named for the title of the Commanding General: Commander-in-Chief). Of the nine CINCs named above, the first five are unified combatant commands, responsible for specific geographic regions (AORs or Areas of Responsibility) of the world. Each CINC, in conjunction with the Joint Chiefs of Staff, identifies the major threats to the United States from within his AOR and deliberately develops OPLANS to address each of those threats if a contingency situation should arise. Examples of regional threats that could be anticipated, and for which OPLANS could be developed, include the invasion of South Korea by North Korea, the invasion of Kuwait and Saudi Arabia by Iraq, or a missile attack on the United States from Cuba. The OPLANS for each regional threat are given and referenced by specific numbers.

Guided by the OPLANS of the CINCs, each component service of a unified command devises a plan to support the master, or basic, CINC OPLAN, defining in increased detail its methods and means of implementing the plan. Component units configure their personnel, equipment, and training to support these plans. To test the plans, the component services and the CINCs engage in exercises patterned on the threat scenarios. They use the force structure designated by the OPLANS for actual implementation of the OPLAN. These exercises provide a way to assess the effectiveness and feasibility of implementing the OPLAN—they serve as a reality check. The OPLANS are living documents, subject to continual revision to reflect new concepts, lessons learned, better intelligence (such as increased or decreased enemy capability), new technology, and better ideas.

THE PREVENTIVE MEDICINE OFFICER'S ROLE IN OPLAN DEVELOPMENT

The Preventive Medicine Officer (PMO) should become familiar with all the major OPLANS for his or her unit or AOR and evaluate the adequacy of the planning preparation. There is no rigid format for an OPLAN; traditionally, though, Annex Q is the Medical Services section of the OPLAN, and Appendix 7 is the Preventive Medicine section. Within each of these sections, the format is not rigidly structured; guidance is offered in the Joint Chiefs of Staff publication.(See Reference f below.) In addition to Annex Q and Appendix 7, the PMO may be best informed and equipped to provide input into several other sections, such as the Medical Intelligence section (Appendix 11) and the Veterinary section (Appendix 12). Information addressing the following issues may also best come from the PMO: biological and chemical warfare, enemy prisoners of war, care of refugees, public health aspects of the reconstruction of friendly and enemy states, and other humanitarian assistance projects. Major OPLANS should be updated and verified annually.

THE PREVENTIVE MEDICINE OFFICER'S CONTRIBUTIONS TO THE OPLAN

In this chapter, Appendixes 7, 11, and 12 from a CENTCOM OPLAN, which were devised for an extensive operation, are used as a well-detailed example of the types of contributions preventive medicine can make to an OPLAN. This can serve as guidance and a checklist for a PMO required to develop an OPLAN de novo. All OPLANS may not require the amount of preventive medicine input shown here, but the preventive medicine contribution to Appendix 7 should be maximized. The regional command and its component services follow the specifications in an OPLAN very carefully, so it is exceedingly important to plan for and detail all possible issues that could arise during an operation,

especially those that could be ignored during the confusion of an operation—from predeployment to redeployment. The example should be cut, elaborated, updated medically and scientifically, and otherwise tailored to the operation profile and the AOR threat. The importance of certain issues will vary by region or country of deployment, the intensity of combat, the geographic expanse, and other specific threats. Many of the entries in this OPLAN example have generic applications to other regions. But do not use this example for its specific medical information or for its references, as these are constantly changing.

Note the following points: all paragraphs must have a classification (eg, Unclassified, Confidential, Secret, Top Secret—shown here by the placeholder (X), and italicized text represents the author's commentary.

APPENDIX 7 TO ANNEX Q TO USCINCCENT OPLAN ### (X)
PREVENTIVE MEDICINE SERVICES (X)

(X) REFERENCES: *Listing all references can save time for both the writer and the users of the OPLAN. These references are for illustration purposes only—they are not necessarily current, nor is the list necessarily thorough.*

a. (X) *Control of Communicable Diseases Manual*. 17th ed; Chin J, ed.; American Public Health Association, 2000. (NAVMED P-5038; USA FM 8-33)

b. (X) *Contingency Pest Management Pocket Guide*; Armed Forces Pest Management Board, 1998. Technical Information Memorandum No. 24.

c. (X) *Immunizations and Chemoprophylaxis*. AR 40-562, NAVMEDCOMINST 6230.3, AFR 161-13, CG COMDTINST M6320.4D; *1 Nov 1995*.

d. (X) *Health Information for International Travel, (1996–97).* HSS Publication No. (CDC) 93-8280, Centers for Disease Control and Prevention, Atlanta, Ga: *1997*.

e. (X) *General Recommendations on Immunization*. US Department of Health and Human Services, Centers for Disease Control and Prevention; *MMWR*; Vol. 43(RR-1); *1994*.

f. (X) *Doctrine for Health Service Support in Joint Operations*. Preliminary coordination 11 Aug 2000. Joint Publication 4-02.

g. (X) *Core Curriculum on Tuberculosis*. US Department of Health and Human Services, Centers for Disease Control.

h. (X) *Disease Vector Ecology Profile* (by country). Defense Pest Management Information Analysis Center, Forest Glen Section, Walter Reed Army Medical Center, Washington, DC.

i. (X) *Medical Reference Guide*. Travel Health Information Service, Shoreland Medical Marketing, Inc., Milwaukee, Wis; *Updated regularly*.

j. (X) *Venomous Snakes of the Middle East*. Defense Intelligence Agency, Armed Forces Medical Intelligence Center, Ft. Detrick, Md; DST-1810S-469-91.

k. (X) *The Risk of Disease and Non-Battle Injury to US Forces in Southwest Asia*. Division of Preventive Medicine, WRAIR, Washington, DC; 1994.

l. (X) *Staying Healthy in Southwest Asia*. Division of Preventive Medicine, WRAIR, Washington, DC; 1994.

m. (X) *Heat Illness: A Handbook for Medical Officers*. US Army Research Institute of Environmental Medicine, Natick, Mass; USARIEM Technical Note 91-3; Jun 1991.

n. (X) *Sustaining Health and Performance in the Desert: A Pocket Guide to Environmental Medicine for Operations in Southwest Asia*. US Army Research Institute of Environmental Medicine, Natick, Mass; USARIEM Technical Note 91-2; Dec 1990.

o. (X) *Travel and Routine Immunizations.* Thompson RF, Shoreland Medical Marketing, Inc., Milwaukee, Wis.

p. (X) *Health Hints for the Tropics*. 12th Edition, 1998. Published and distributed by The American Committee on Tropical Medicine and Traveler's Health of the American Society of Tropical Medicine and Hygiene.

q. (X) Immunization for Biological Warfare Defense. (*Nov 1993*) DOD Directive 6025.3.

r. (X) Medical Environmental Disease Intelligence and Countermeasures (MEDIC), Defense Intelligence Agency, Armed Forces Medical Intelligence Center, Ft. Detrick, MD. Updated every 6 months.

1. (X) Purpose. To provide a comprehensive concept of operations, define the threat, and assign tasks for preventive medicine support of the Basic Plan.

2. (X) Abbreviations, Definitions, and Assumptions. *Note: This list is for demonstration purposes only; it may not be complete, accurate, or current.*

a. (X) Abbreviations. *Make sure all abbreviations used in the Annex are listed here.*

(1) AFMIC—Armed Forces Medical Intelligence Center
(2) AOR—area of responsibility
(3) ARCENT—US Army component, US Central Command
(4) ASD(HA)—Assistant Secretary of Defense (Health Affairs)
(5) BW—biological warfare
(6) CENTAF—US Air Force component, US Central Command
(7) CENTCOM—USCENTCOM; the joint regional command, US Central Command
(8) CHPPM—Center for Health Promotion and Preventive Medicine
(9) CINC—Commander-in-Chief; also can refer to the regional command (eg, CENTCOM)
(10) CINCCENT—Commander in Chief, US Central Command
(11) CONPLAN—Concept plan
(12) CW—chemical warfare
(13) DEET—N,N-diethylmeta-toluamide insect repellent
(14) DIA—Defense Intelligence Agency
(15) DNBI—Disease, nonbattle injury
(16) DPMIAC—Defense Pest Management Information Analysis Center
(17) EPW—enemy prisoner of war
(18) ER—emergency room
(19) FRAGORD—fragmentary order
(20) HCA—humanitarian civic assistance
(21) HIV—human immunodeficiency virus
(22) ICU/CCU—intensive care unit/cardiac care unit
(23) JCS—Joint Chiefs of Staff
(24) MEDIC—Medical Environmental Disease Intelligence and Countermeasures
(25) MOPP—mission-oriented protective posture
(26) NAMRU—Naval Medical Research Unit
(27) NAVCENT—US Navy component, US Central Command
(28) NBC—nuclear, biological, and chemical
(29) NCO—Noncommissioned Officer
(30) NEPMU—US Navy Environmental and Preventive Medicine Unit
(31) OCONUS—outside the continental United States
(32) OPLAN—operation plan
(33) OPORD—operation order
(34) PM—preventive medicine
(35) PMO—Preventive Medicine Officer
(36) PPM—personal protection measures
(38) STD—sexually transmitted disease
(39) TAML—Theater Area Medical Lab
(40) TB—tuberculosis
(41) WRAIR—Walter Reed Army Institute of Research

b. (X) Definitions.

(1) (X) Component Surgeon—The ARCENT, CENTAF, or NAVCENT Surgeon in theater or their designated in-theater representatives.

(2) (X) Theater Surgeon—The CENTCOM Surgeon, when deployed to the theater; otherwise, this is the Command Surgeon designated by the CENTCOM Surgeon in his or her place. This may be the Component Surgeon from the component with the largest in-theater representation.

(3) (X) Theater Medical Surveillance Team—A team of medical and scientific experts with its own inherent rapid diagnostic laboratory capability that is assigned directly to the Theater Surgeon. The team's major purpose is to minimize casualties, in part by establishing a theater network of disease surveillance, investigating disease outbreaks, identifying health hazards, and providing a high level of preventive medicine technical expertise not normally found in

one location in a combat zone. The Theater Area Medical Lab is the Army unit currently fielding this function.

c. (X) Assumptions.

(1) (X) That US forces must be entirely self-sufficient in their PM support and that host-nation or allied coalition PM services cannot be expected to be adequate or even present.

(2) (X) That the target region will harbor a plethora of infectious diseases to which US military forces will be immunologically naïve and therefore be more susceptible to increased morbidity and mortality than the indigenous people.

(3) (X) That current and specific disease prevalence information reflecting actual "field conditions" may not be available from US military medical intelligence sources or international health organizations before deployment.

(4) (X) That the specific types and prevalence of health threats will change throughout the deployment.

3. (X) Concept of Operations. A PM program that (1) is included in initial operation planning, (2) is deployed and installed with the earliest forces, and (3) is fully supported by the command will result in effective implementation of measures required to minimize disease and injury. Institution of a thorough disease surveillance network, employment of a forward diagnostic laboratory, continual education of commanders and service members, and utilization of immunizations and the highest possible standards of sanitation and hygiene are the simple keys to maintaining combat effectiveness and overcoming what have been historically the greatest medical threats to the mission. Continual reevaluation of effectiveness, anticipation of problems, and flexibility in theater PM policies are required to accommodate newly discovered or developing health threats.

a. (X) Theater Preventive Medicine Priorities.

(1) (X) Disease Surveillance. Obtaining immediate disease surveillance data is the key to filling the gap in current, country-specific disease intelligence and the key for early identification of disease and injury trends during the operation. A theater medical surveillance team must deploy early with the initial forces to the theater, must possess a rapid diagnostic laboratory capability, and must fall under the direct control of the Theater Surgeon. A tri-service network of all medical treatment facilities will report centrally to the Theater Surgeon using the weekly JCS Disease Reporting format (see Tab A to Appendix 7). In this manner, timely disease outbreak information will be obtained for trend analysis and for disease investigation.

(2) (X) Disease Outbreak Investigation. PM assets will investigate disease outbreaks locally. To ensure accurate disease surveillance during the initial stages of deployment, outbreaks must be thoroughly investigated with laboratory assistance. The theater medical surveillance team, with its diagnostic laboratory capability, can aid unit PM assets during large-scale outbreaks or those of cryptic etiology. All outbreak results must be reported to the Theater Surgeon for trend analysis and theater disease awareness.

(3) (X) Predeployment and Initial Deployment Preparation. Medical, specifically PM, personnel must alert and caution commanders and service members about preventable medical problems likely to arise as a result of geo-environmental changes and the high tempo of activity during the initial phases of deployment. Factors that should be addressed include injuries due to lifting or dropping objects and other accidents, proper nutrition, time zone acclimatization (jet lag), climatic acclimatization, water intake, and psychological stressors.

(4) (X) Climatic Injury Prevention. Medical assets within each respective unit must make commanders and service members aware of the dangers, prevention, and treatment of heat and cold injuries. During the early phase of deployment, commanders and senior NCOs must be aware of physical activity precautions and acclimatization measures.

(5) (X) Potable Water. PM assets must ensure proper source selection for all water (including ice) sources. They must continually verify water quality and perform periodic inspections of all utilized water facilities (eg, bottled water, bulk chlorinated supplies, well water, local tap water).

(6) (X) Food Safety. No bulk food sources for service members will be used unless inspected and sanitarily approved by US military PM or veterinary personnel. Periodic inspection of products while in storage is required (see also Appendix 12 Veterinary Services).

(7) (X) Personal Hygiene Measures. Unit-level medical assets must provide education and

training for all service members to ensure awareness of basic personal hygiene measures.

(8) (X) Dental Hygiene. Dental problems are a potential cause of high morbidity among personnel living under stress and in field conditions. Dental hygiene must be continually emphasized and dental statistics closely monitored for adverse trends.

(9) (X) Theater Arthropod Vector Control. Education of service members in use of PPMs and provision of area control measures are the responsibility of unit PM assets. All aerial spraying will be coordinated through the Theater Surgeon. The use of herbicides is prohibited except as coordinated with the JCS through the Theater Surgeon.

(10) (X) Other Environmental Threats. When other environmental hazards are identified or anticipated, PM assets must bring these to the attention of commanders so that service member education and protection against the threats are provided. Examples of environmental hazards include altitude, dusts, and intense sunlight.

(11) (X) Combat Stress. All medical assets must be continually alert for subtle manifestations of combat stress. Diagnoses should be communicated per the JCS reporting format to the Theater Surgeon. The Theater Surgeon is responsible for identifying the extent of this problem, informing the Command, and recommending activation or supplementation of Combat Stress teams. Education of commanders, senior NCOs, and service members in identifying common presentations must also emphasize the need to treat combat stress as an illness and not a mental weakness. Early recognition results in effective treatment and early return to duty. Periodic service member and commander meetings should be organized by medical assets or commanders or both to elicit and discuss individual concerns that could give rise to stress reactions.

(12) (X) Redeployment Considerations. Because service members will constantly be exiting the AOR, redeployment medical considerations must be contemplated and addressed early in the operation; they must also be updated continually to reflect the most current medical problems arising within the AOR. While the redeployment program is a Command program, the medical assets are key to providing timely and appropriate advice concerning its extent. At a minimum, individual medical records should contain a notice of the service member's deployment to the AOR, diseases prevalent within that area, and clinical precautions to be taken when medical problems arise. Redeployment medical briefings should be conducted before service members leave the AOR to address topics such as STDs, signs and symptoms of endemic diseases, education on terminal drug prophylaxes (when needed), and awareness of possible psychological readjustment problems. Appropriate medical screening (eg, blood tests, tuberculin skin tests) should be conducted at this time. Terminal prophylaxes, if indicated (eg, the AOR is in a malarious region), should be emphasized and the full drug regimens should be given to the service member as he or she leaves the AOR.

b. (X) Immunizations and Chemoprophylaxes. Comprehensive and precise information will be promulgated in a CENTCOM FRAGORD to the CONPLAN OPORD.

(1) (X) General. The CENTCOM Surgeon Preventive Medicine Office has prepared and published guidance on immunizations and chemoprophylaxes. This information is an essential part of this Appendix and has been provided to Components and Service Headquarters under separate cover to obtain quad-service consensus and compliance on this vital aspect of service members' preparation for deployment. The objective is to deploy personnel with the right immunological profile quickly and effectively in time of crisis.

(2) (X) Specific Immunizations. *(Note: Currency and applicability of these immunizations to the region of deployment may change.)* Precise guidance in the FRAGORD will cover these issues: routine immunizations for diseases such as hepatitis A (vaccine or immune globulin alternative), influenza, measles, rubella, meningococcal meningitis (quadrivalent vaccine), polio (oral vaccine), tetanus-diphtheria, typhoid fever, varicella, yellow fever, and plague; special immunizations for diseases such as hepatitis B, rabies, Rift Valley fever, pneumococcal infection, Japanese encephalitis, and cholera; and chemoprophylaxes for malaria and other diseases. *Determining the status of a predeployment tuberculin skin test may be indicated.*

(3) (X) Vaccination Against Biological Agents. (Dependent on DoD Decision Process in Execution Planning)

(a) (X) General. Reference P provides guidance concerning immunization for BW de-

fense. When appropriate and subject to exceptions approved by the Chairman of the JCS, the following personnel will be immunized against validated BW threat agents for which suitable vaccines are available in sufficient time to develop immunity before deployment to high-threat areas:

1 (X) Personnel assigned to high-threat areas.

2 (X) Personnel predesignated for immediate contingency deployment (eg, crisis response).

3 (X) Personnel identified and scheduled for deployment on an imminent or ongoing contingency operation to a high-threat area.

(b) (X) Approval Sequence for Nonlicensed Vaccines. HQ CINCCENT submits a BW threat analysis to the Chairman of the JCS. The Chairman, in consultation with the CINC, the Service Chiefs, and the Director of DIA, will validate and prioritize the BW threat. This prioritized list is then forwarded through the ASD(HA) to the Executive Agent (US Army). The Executive Agent consults with the Service Secretaries and the Chair of the Armed Forces Epidemiological Board. The Board makes recommendations on the safety and effectiveness of the vaccines, and the coordinated recommendations go forward to the ASD(HA). The ASD(HA) then coordinates with the Chairman, JCS, before issuing vaccinations guidance.

(c) (X) Specific Vaccines. *Discuss various vaccines for BW agents that may be encountered. Include a statement about the safety and effectiveness of the vaccine, its Food and Drug Administration licensure, its vaccination schedule, the lag period before attaining protective immunity, the booster schedule, any contraindications or potential adverse side effects, the availability of vaccine, and any alternative or additional countermeasures to address the threat (eg, antibiotics, disinfectant procedures).*

1 (X) *Address population to be vaccinated (eg, everyone, front-line troops only, pilots, medical personnel).*

2 (X) *Address indications for proceeding with BW agent vaccinations (eg, on unambiguous threat of BW attack), whether to inoculate before deployment, whether to complete vaccine series before deployment, or whether to delay deployment until immunity is gained.*

(d) (X) Differential Diagnosis for Certain BW or CW Agents. *Similar information to that included in Table 13-1 may be helpful to deploying or deployed medical personnel as a handy synopsis of material that may be difficult to research before deployment.*

(4) (X) Chemoprophylaxes Against Biological and Chemical Agents. Because of the possible BW and CW threats, nerve agent and BW agent prophylaxes may be required. All service members should be knowledgeable in the use of these chemoprophylaxes.

(a) (X) BW Prophylaxis.

1 (X) Specific BW Agent. *Present the medical defenses against each specific agent (eg, vaccine, antibiotic, combination).*

a (X) *If a chemoprophylactic agent (eg, antibiotic) is used as a countermeasure after exposure to the agent, delineate how it would be distributed (eg, given to each service member, kept with medical personnel), when and how often it would be administered, and how long it would be continued.*

2 (X) Specific BW Agent. *See above.*

(b) (X) CW Prophylaxis. *Present each of the chemoprophylaxes that may be used by the service member in the event of CW attack.*

1 (X) Chemoprophylaxis #1. *Describe the reason for usage, when the medication or injection should be administered, how often it should be given, and for how long it should be continued.*

a (X) *Address how units should distribute the chemoprophylaxis. Also stress the need for service member education on instructions for usage and usual side effects.*

2 (X) Chemoprophylaxis #2. *See above.*

(c) (X) Training and Education.

1 (X) Service Members. Commanders will ensure that, in addition to the standard personal and unit training in BW and CW, all service members receive training and demonstrate knowledge in the use of the BW and CW chemoprophylaxes.

2 (X) Health Care Workers. All service members who are involved in the direct health care of

TABLE 13-1

DIFFERENTIAL DIAGNOSIS OF CHEMICAL NERVE AGENT, BOTULINUM TOXIN, AND STAPHYLOCOCCAL ENTEROTOXIN B INTOXICATION FOLLOWING INHALATION EXPOSURE

	Chemical Nerve Agent	Botulinum Toxin	Staphylococcal Enterotoxin B
Time to Symptoms	Minutes	Hours (12–48)	Hours (1–6)
Nervous System	Convulsions, twitching	Progressive paralysis	Headache, muscle ache
Cardiovascular System	Slow heart rate	Normal rate	Normal or rapid rate
Respiratory System	Difficulty breathing, airway constriction	Normal, then progressive paralysis	Nonproductive cough; in severe cases: chest pain, difficulty breathing
Gastrointestinal System	Increased motility, pain, diarrhea	Decreased motility	Nausea, vomiting, diarrhea
Ocular	Small pupils	Droopy eyelids (conjunctival injection)	May have "red eyes"
Salivary	Profuse, watery saliva	Normal, but swallowing difficult	May be slightly increased salivation
Death	Minutes	2–3 days	Unlikely
Response to Atropine and 2 PAM-Cl*	Yes	No	Atropine may reduce gastrointestinal symptoms

*pralidoxime chloride
Source: US Army Medical Research Institute of Infectious Diseases. *Medical Management of Biological Casualties Handbook*. 2nd ed. Fort Detrick, Md: USAMRIID; 1996.

patients should be familiar with protocols to administer special vaccines, identify BW and CW agent exposure, and handle and treat BW and CW casualties, according to their level of expertise.

c. (X) Medical Intelligence Sources. See Appendix 11.

d. (X) Command Responsibilities.

(1) (X) Component Commands. Through their Command Surgeons, the component commands ensure implementation of PM countermeasures to health threats and compliance by service members with these countermeasures.

(a) (X) Component commands should recognize that PM assets provide disease surveillance, investigate health hazards (including disease outbreaks), provide specific advice concerning implementation of PM countermeasures, and provide feedback to commanders on the effectiveness of PM countermeasures.

(b) (X) Component commands ensure that PM personnel are fully integrated into mission planning, logistics, and operations for early implementation of PM guidance and to avoid poorly planned contingency measures in the future.

1 (X) PM assets must be included in advance-party activities and site surveys and should be deployed in the earliest phase of operations.

2 (X) Command emphasis should include high priority for PM logistical needs to fulfill the PM mission, to include communications, computer, and vehicular support.

(2) (X) Subordinate Unit Commands. Subordinate commands are responsible for unit compliance with theater PM countermeasures. Important specific measures are as follows but are not limited to these listed.

(a) (X) Field Sanitation Teams. Ensure that units have designated, equipped, and trained

field sanitation teams and that these teams deploy with equipment to the theater.
(b) (X) Disease Surveillance. Ensure compliance by unit medical assets with weekly disease surveillance reports per JCS format.
(c) (X) Environmental Threats. Ensure that environmental threats are identified and addressed and that proper precautions are implemented.
(d) (X) Water Safety. Ensure that all water for service member use is potable.
(e) (X) Food Safety. Ensure that all foods, food production facilities, and food handlers are sanitarily approved.
(f) (X) Pregnancy. Ensure that no pregnant service member deploys to the AOR.
(g) (X) STDs. Ensure compliance with theater policy discouraging sexual intercourse.
(h) (X) Pets. Ensure enforcement of "no pets, no mascots" policy.
(i) (X) Combat Stress. (See Section 3.a.11). Provide command support for a combat stress program and for treatment.
(j) (X) Redeployment. Anticipate redeployment and ensure all service members receive medical outprocessing before redeployment as prescribed by the Theater Surgeon.

e. (X) Theater Laboratory Support.
(1) (X) A laboratory with rapid diagnostic capability will accompany the early initial deployment as part of the theater medical surveillance team. The laboratory maintains diagnostic capabilities to support disease surveillance activities, investigate environmental health threats, and provide rapid identification of BW agents.
(2) (X) As the theater develops, the theater medical support system will fully complement, support, and integrate PM efforts in the theater of operations, to include providing laboratory support.

f. (X) Veterinary Support. See Appendix 12.

g. (optional) (X) Enemy Prisoners of War. PM and veterinary assets must assist in site location decisions, design, and maintenance of EPW camps. Specific responsibilities include ensuring proper environmental and sanitary location of the EPW site; proper number, type, and maintenance of sanitation and hygiene facilities; hygienic handling of food and water supplies; insect control; administration of immunizations, if necessary; EPW education in PM measures; disease surveillance of the camp; and disease outbreak investigation.

i. (optional) (X) Humanitarian Civic Assistance. When US military forces oversee HCA programs, as with refugee populations and disaster management, PM and veterinary assets must be included in the initial planning stages to determine short- and long-term goals, attainability and impact of relief measures, and breadth of impact of those measures on the target population. During the conduct of the HCA, PM assets continually assess the general health of the target population, conduct disease surveillance, investigate and address health threats, and reevaluate the direction of the HCA operation. When medical relief operations are conducted in conjunction with civilian nongovernmental organizations, PM assets must work directly with the leadership of those organizations in establishing goals and priorities to produce broad-based improvements in the health of the population, in the organization of the operation, and in the allocation of labor in these projects.

4. (X) Health Threat. *Research and annually (or more frequently) update the information in this section. The information offered below may not be current or accurate for the particular region of deployment. Many units will rely on this guidance alone as the sole direction for planning.* The priority of health risks will vary among the targeted countries, vary according to season, and change during the deployment. The risks of disease in several categories can be predicted and should be anticipated in medical planning. However, current medical intelligence must be gathered (Section 3.a.3, 3c, and Appendix 11) before deployment and must be continually updated during the deployment.

a. (X) Diseases of Operational Importance. The following are ubiquitous and are not AOR-specific. However, they may become even more significant under conditions of high stress and poor hygiene.
(1) (X) Acute Respiratory Infections. Climatic changes, fatigue, fine airborne dusts, and service member crowding can all contribute to high levels of acute respiratory infections. Countermeasures aimed at decreasing the risk factors should be implemented.
(2) (X) Dermatological Conditions. Hot and dry, hot and wet, and cold and wet climates are all encountered within the CENTCOM AOR. Service member education should include foot and skin care appropriate to the environment.

(3) (X) Heat- and Cold-related Problems. Heat-related injuries can be a significant category of illness if command attention is not paid to adequate hydration, proper work-rest cycles, and acclimatization. In addition, cold temperatures (even freezing temperatures) can be encountered in the desert, as well as in the mountainous areas. Commanders and senior NCOs must be aware of nighttime drops in temperature and ensure that preventive measures are implemented.

b. (X) Diseases with Short Incubation Periods (usually less than 15 days).

(1) (X) Acute Diarrheal Disease. Acute diarrheal disease constitutes the greatest immediate disease threat to the health of the force. Emphasis must be placed on the principles of field sanitation and hygiene if DNBI rates are to be kept to a minimum. Prophylaxis is not generally indicated but may be required in special circumstances, as determined by the Theater Surgeon.

(2) (X) Enteric Protozoal Diseases. Proper food preparation and water treatment will minimize acquisition of these diseases.

(3) (X) Malaria. Malaria is a serious threat in certain areas (see Section 3.b.2). For service members entering these areas, compliance with chemoprophylaxis and other preventive measures must be ensured through education and command influence.

(4) (X) Typhoid and Paratyphoid Fevers. Again, proper food and water treatment and handling will minimize risk of contracting these. Fly control by screening, proper garbage disposal, and other sanitary practices are needed. Typhoid fever immunization may be indicated.

(5) (X) Arboviral Fevers. There is a plethora of arthropod-borne viral diseases within the general AOR (eg, sandfly fever, West Nile fever, Crimean-Congo hemorrhagic fever, Sindbis fever, dengue). A high degree of suspicion, with keen disease surveillance and a forward rapid diagnostic laboratory, can provide early identification of these diseases. Commanders must enforce the use of PPMs, with judicious use of area and regional insect control measures.

(6) (X) Sexually Transmitted Diseases. Incubation periods may vary from days to years. All known STDs exist within the AOR. The restrictions and anxieties accompanying military operations make sexual relations a potential outlet for these tensions. As a result, "common source" infections from contacts with the limited female population, as well as with indigenous people, could make STDs a major risk. Penicillin-resistance can be assumed. HIV screening for OCONUS travel should be done in accordance with service regulations. Avoiding exposure is the key to prevention.

(7) (X) Meningococcal Meningitis. Crowded conditions exacerbate the spread of meningitis. Immunization and adequate physical spacing of individual personnel are measures commanders and PMOs should enforce.

(8) (X) Cholera. Proper food preparation and water treatment will minimize acquisition of cholera.

c. (X) Diseases with Long Incubation Periods (usually greater than 15 days).

(1) (X) Enterically Transmitted Acute Viral Hepatitides (A and E). Immunization (in the case of hepatitis A) and proper food and water sanitation will minimize these threats.

(2) (X) Schistosomiasis. Acquisition is by exposing skin to fresh water sources (eg, by wading or swimming). These activities should be avoided.

(3) (X) Parenterally Transmitted Acute Viral Hepatitides (B, C, and D). Exposure via blood transfusions, contaminated needles, and contaminated wounds may occur in the field setting or possibly through substandard medical treatment (eg, when rendered by allied or coalition forces). Drug abuse may occur even in well-controlled combat zones. Sexual transmission can also be an avenue for these infections.

(4) (X) Leishmaniasis. Adequate use of PPMs to prevent sandfly bites must be emphasized.

(5) (X) Tuberculosis. The endemicity of TB in the AOR, as well as its high prevalence in some allied and coalition forces, could account for a high rate of exposure of US service members. Multidrug resistance should be presumed. Early identification of active TB cases in indigenous or other non-US camp workers (eg, food handlers) can minimize personnel exposure. Redeployment PPD testing is required.

(6) (X) Sexually Transmitted Diseases. See Section 4.b.6.

d. (X) Insect and Arthropod Vectors. Diseases transmitted by arthropod vectors (eg, mosquitoes, sand flies, ticks, lice, fleas) are numerous and will have a significant effect on the health of the force unless PPMs are enforced. Examples of disease these vectors carry include plague, flea-borne ty-

phus fever, tick-borne relapsing fever, louse-borne typhus fever, and louse-borne relapsing fever. The use of the following are required of all personnel: (1) clothing treatment (permethrin), (2) "buddy checks," (3) personal insect repellents, (4) insect bar (mosquito netting with suspension system) sprayed with permethrin, and (5) proper wearing of the uniform (sleeves down). All personnel should sleep under insect bars.

e. (X) Pets. Domestic animals (eg, dogs, cats, sheep, goats) or wild animals (eg, monkeys, rodents, reptiles) are not to be kept as pets or mascots. These animals are infected with a variety of zoonotic diseases that can be transmitted to humans. They can also harbor vectors capable of transmitting diseases that have a high potential for adversely affecting the health of the command, including rabies, African tick typhus fever, Q fever, Crimean-Congo hemorrhagic fever, and leishmaniasis.

5. (X) Tasks. *This is the section where tasks are apportioned to various levels of the Command and down to the Component Services. Central Command is used here as an example. By delineating specific tasks in the OPLAN, emphasis and verification of the importance of the task is established and specification of distinct responsibilities can be assigned. Note that heavy emphasis is placed on Theater Medical Surveillance because this has been a chronically weak area in PM theater support.*

a. (X) US Central Command. Through the CENTCOM Surgeon, USCINCCENT provides command support for PM initiatives and issues. The CENTCOM Surgeon will ensure that health-related issues in the theater are brought to the attention of USCINCCENT as well as the Component Surgeons, project and identify DNBI casualty trends before they become significant, and ensure that PM issues are addressed and preventive measures are instituted. Important specific corollary responsibilities include the following.

(1) (X) Establish a theater disease surveillance network. A theater medical surveillance team (see 3.e), under direction of the CENTCOM Surgeon, will deploy to the theater with the advance party to accomplish the following:

(a) (X) Initiate the theater disease surveillance network.

(b) (X) Analyze disease surveillance data.

(c) (X) Investigate disease outbreaks and other health hazards.

(d) (X) Provide an on-site, technologically advanced diagnostic capability, to include BW agent identification.

(e) (X) Provide education and guidance in special health-related issues to health care providers, commanders, and service members.

(2) (X) Ensure that Component Surgeons comply with periodic disease surveillance reporting according to the JCS reporting format.

(3) (X) Ensure that Component Surgeons receive disease surveillance findings and proper guidance in addressing health issues.

(4) (X) Ensure PM education and training of appropriate personnel (eg, health care providers, commanders, service members).

(5) (X) Before deployment, and as other indications arise, identify immunization and chemoprophylaxis requirements for the theater.

(6) (X) Ensure that redeployment issues are addressed in a timely fashion.

b. (X) Components. *(The services: US Army, Navy, Air Force, and Marine Corps.)*

(1) (X) Will institute effective PM countermeasures; comply with the DNBI Surveillance Program; provide for and effectively employ PM resources to meet their own or joint missions; and ensure commanders are kept informed of the health of their commands.

(2) (X) Will submit the Weekly Medical Surveillance Report. DNBI data will be logged and reported by all deployed units using the JCS Weekly Medical Surveillance Report format (see Tab A, Appendix 7). These weekly reports will be forwarded from all medical facilities, beginning from Aid Station level to each subsequent higher level until reaching the office of the Theater Surgeon. The theater medical surveillance team (or the theater PMO) will collect these reports and analyze the data. If the CENTCOM Surgeon is not the Theater Surgeon, the theater Surgeon will forward these reports to CENTCOM Surgeon's Office weekly.

(3) (X) ARCENT, as executive agent, will provide veterinary coverage within the theater of operations.

(4) (X) Will ensure all deploying personnel are briefed by PM or other medical personnel on the following issues.

(a) (X) Endemic diseases, specifically the infectious disease risk as outlined in MEDIC.
(b) (X) Water and food consumption. No food or water is to be consumed unless first approved by US military medical authorities. Personnel must know proper water treatment procedures and recognize unsafe food and water situations.
(c) (X) Proper field sanitation techniques.
(d) (X) Use of permethrin clothing treatment and DEET lotion.
(e) (X) Personal hygiene.
(f) (X) Prevention of environmental (heat and cold) injuries.
(g) (X) Inappropriateness of maintaining pets or mascots in theater, including the diseases carried by these animals and the dangers of handling snakes, spiders, scorpions, and centipedes.
(h) (X) Sexually transmitted diseases.
(i) (X) Malaria (and other) chemoprophylaxis, if indicated.

(5) (X) The Theater Area Medical Laboratory deploys with its own diagnostic laboratory capability. Other laboratory support can be provided by ... *(list all higher-level laboratory capabilities within or near the AOR, whether fixed facility, afloat, or mobile)*.

(6) (X) CENTAF will provide fixed-wing aerial spraying capability.

c. (X) Commanders' Responsibilities. Commanders at all levels are responsible to maintain the health of their personnel.

(1) (X) Commanders should recognize that medical and PM assets provide disease surveillance, investigate health hazards (including disease outbreaks), provide specific advice concerning implementation of PM countermeasures to health threats, and provide feedback to commanders on the effectiveness of those countermeasures.

(2) (X) Commanders should fully integrate PM personnel into mission planning, logistics, and operations for early implementation of PM guidance.

(a) (X) PM assets must be included in advance-party activities and site surveys and should be deployed in the earliest phase of operations.
(b) (X) Command emphasis should include high priority for PM logistical needs to fulfill the PM mission, to include communications, computer, and vehicular support.

(3) (X) Commanders are responsible for the following specific PM measures, which will affect the health of the service members.

(a) (X) Field Sanitation Teams. Ensure that units have designated, equipped, and trained field sanitation teams and that these teams deploy with equipment into the theater. Note: This unit responsibility is often overlooked or intentionally avoided, resulting in serious PM problems upon deployment.
(b) (X) Disease Surveillance. Ensure that medical assets comply with weekly disease surveillance reports per the JCS format. Provide command support for the theater medical surveillance team in acquiring data.
(c) (X) Disease Outbreak Investigations. Provide command support for all disease outbreak investigations by medical assets and the theater medical surveillance team.
(d) (X) Preventive Medicine Advisories. Ensure PM precautions are implemented and enforced.
(e) (X) Environmental Threats. Ensure that environmental threats are identified and addressed and that proper precautions are implemented. Ensure that time is allowed for time-zone, altitude, and climatic acclimatization by newly arrived personnel. Enforce water discipline (especially if MOPP gear is worn). Provide equipment for service members to be protected from other environmental threats (eg, dust, sun).
(f) (X) Use of Personal Protection Measures. Ensure all service members are educated in measures to protect themselves from arthropod vectors. Ensure service members are provided with equipment and means for protection from these vectors.
(g) (X) Personal Hygiene. Ensure all service members receive education and training in personal hygiene; ensure this guidance is practiced.
(h) (X) Water Safety. Ensure all water sources are inspected, treated, and sanitarily approved before being used. Ensure periodic inspections of these sources.
(i) (X) Food Safety. Ensure that all food stuffs, food handlers, and mess facilities are pe-

riodically inspected and sanitarily approved. Ensure that all food stuffs are procured from US military–approved production facilities.

(j) (X) Pregnancy. Ensure that no pregnant service member deploys to the AOR; all service members identified in theater as being pregnant will be reassigned out of the AOR as soon as possible.

(k) (X) HIV Screening. Ensure compliance with HIV screening in accordance with service regulations.

(l) (X) Sexually Transmitted Diseases. Ensure that sexual intercourse is discouraged in accordance with theater policy. Ensure that service members receive training in awareness and prevention of STDs.

(m) (X) Pets. Ensure that no pets or mascots are kept by service members in the theater.

(n) (X) Combat Stress. (See Section 3.a.11.) Provide command support for a combat stress program and for treatment. Ensure that personnel have free access to these programs without subsequent discrimination.

(o) (X) Redeployment. Ensure that all service members receive medical briefings and medical outprocessing as prescribed by the Theater Surgeon before redeployment. When applicable, ensure that all service members are aware of terminal chemoprophylaxis and have received all necessary medication before redeployment.

6. (X) Coordinating Instructions.

a. (X) Unit Surgeons. Unit Surgeons must maintain close, continual contact with PMOs, PM detachments, and the theater medical surveillance team to obtain current information on the status of health risks and threats and to identify their concerns about health issues that may arise within their units. The Unit Surgeons coordinate the delivery of disease surveillance reports to their Component Surgeon and for PM support when required from veterinary units, PM units, and the theater medical surveillance team.

b. (X) Preventive Medicine Units. PM units must keep commanders and medical personnel informed of health concerns as they arise. They must convey all information on potential health threats, outbreak investigations, and health hazards to Unit and Component Surgeons, as well as to the theater medical surveillance team. PM units coordinate with veterinary assets and the theater disease surveillance team for additional support when required.

c. (X) Veterinary Assets. Veterinary assets must provide the Component Surgeon, theater disease surveillance team, and Theater Surgeon with timely activity reports, as well as report health hazards and potential disease threats within their areas of responsibility.

d. (X) Component Surgeons. Component Surgeons must keep the Theater Surgeon apprised of disease surveillance data from their respective components. They must coordinate through their subordinate units to provide timely disease reporting, institution of PM measures, and compliance with theater PM guidance.

e. (X) Theater Area Medical Lab. As the theater medical surveillance team, the TAML coordinates through the Component Surgeons for the establishment of a theater disease reporting network, the investigation of disease outbreaks and health hazards, and the implementation of other special PM measures to address casualty prevention issues. The team advises components through the Theater Surgeon on precautions and preventive measures to be instituted when adverse health trends are recognized in the surveillance data.

f. (X) Theater Surgeon. The Theater Surgeon coordinates through the Component Surgeons for overall theater casualty prevention and minimization. The Theater Surgeon keeps the Component Surgeons informed of the results of the analyzed data from the disease surveillance network so precautions and countermeasures can be instituted.

Although the Joint Disease Surveillance report is a JCS requirement for all deployments, awareness of this requirement or understanding of the report format and mechanism for reporting is often limited. For this reason, it should be included as a Tab to Appendix 7 for convenient reference. Remember that the report can be tailored to identify special diseases and problems (see paragraph 4 of the form) that may be sentinel issues for the AOR (eg, malaria, tick-borne encephalitis, "rashes," asthma). Also note that references and specific scientific details are subject to change based on region of deployment and current medical thinking.

TAB A TO APPENDIX 7 TO ANNEX Q TO USCINCCENT OPLAN *NUMBER* (X)

JOINT DISEASE SURVEILLANCE REPORT (X)
Ref: USCENTCOM Reg 525-1 Annex P Weekly Medical Surveillance Report *(USCENTCOM Reg 525-1 is a CINC-specific Regulation, published by the CINC, which stipulates duties and requirements of all components on deployment to the CINC's AOR.)*
1. (X) Instructions. This report applies to Service components participating in all joint exercises and operations, including those commanded by Joint Task Force and Sub-Unified Command organizations.

a. (X) Frequency. A timely, comprehensive medical surveillance program can inform commanders of the health of their commands and identify trends that can be attacked before significant casualties occur. Component Surgeons will report disease and injury incidence in the enclosed format. Reports will be sent weekly to the responsible Unified Command Surgeon, and are due within 5 days after the end of the reporting week. Within components, data should be collected from the levels where initial diagnosis is made to ensure that reports include cases involving loss of duty time without hospitalization. The basis for this report is INITIAL DIAGNOSIS OF NEW CASES, not initial complaint, hospital admission, or follow-up visits.

b. (X) Application. For Army and debarked Marine and Navy components, the primary level for data collection should be the Battalion Aid Station or equivalent; for the Air Force component, the primary level should be in the Air Transportable Clinic if present or the Squadron Medical Element if not. For the shipboard Navy and embarked Marines, the primary level should be Sick Bay. Components are encouraged to implement this reporting format at the levels where data are collected and to automate the format within existing data processing systems.

c. (X) Other Details.

(1) (X) This is not a hospital admission/disposition report. At medical treatment facilities with inpatients and holding capabilities, only two types of cases should appear in this report: those INITIALLY DIAGNOSED at "sick call" or equivalent held for the facility staff, collocated units, and walk-ins and those emergency cases that bypassed lower reporting levels during evacuation.

(2) (X) In facilities where patients from other services are seen for initial diagnosis, report cases by service in separate reports or in a single consolidated report, per the component Command Surgeon's guidance. Where applicable, list other service average strength as "unknown" and briefly explain in paragraph 5.

(3) (X) To simplify reporting, battle and nonbattle injuries should be reported in appropriate general diagnostic categories but listed by type in paragraph 5. "Battle injuries" are those caused during hostile actions directly by munitions or other weapons (eg, bullet or shrapnel wounds) or by their proximal effects (eg, burns from battlefield explosions, lacerations from flying debris). All others are reported as nonbattle injuries, including those occurring on the battlefield but not associated with munitions, weapons, or direct hostile action (eg, injuries from vehicles accident not caused by enemy action).

(4) (X) It is important from a PM standpoint to identify in paragraph 5 any unusual or recurring causes of medical visits. The surveillance report content will be used to achieve a unified understanding of and response to the theater PM challenges. The actual format of the surveillance report will be provided on execution of the OPLAN (Exhibit 13-1).

APPENDIX 11 TO ANNEX Q TO USCINCCENT OPLAN #### (X)

MEDICAL INTELLIGENCE SUPPORT TO MILITARY OPERATIONS (X)

Input to the Medical Intelligence section of an OPLAN often is best provided by the PMO. All possible sources for medical intelligence should be listed. During the scramble of a deployment, this allows subordinate units to obtain current information directly from the sources.

The following Appendix from CENTCOM is an example. Note that the information is fairly generic and can apply to all regional commands. Exact sources and telephone numbers and information in this example may not be accurate or current.

EXHIBIT 13-1

USCENTCOM WEEKLY MEDICAL SURVEILLANCE REPORT

(CLASSIFICATION)

WEEKLY MEDICAL SURVEILLANCE REPORT*

1. TO: _____ DTG SUBMITTED: _____

OPERATION/EXERCISE: _____

2. FROM (COMPONENT/UNIT/SECTION): _____

   a. REPORTING PERIOD (DTG to DTG): _____

   b. AVERAGE TROOP STRENGTH DURING REPORTING PERIOD: _____

3. **GENERAL DIAGNOSTIC CATEGORIES**

NEW CASES

_____ a. HEAT/COLD INJURIES (H/C). Heat stroke, heat cramps, heat exhaustion, dehydration, sunburn, frostbite, chilblain, hypothermia

_____ b. GASTROINTESTINAL ILLNESSES (G-I). Diarrhea, gastroenteritis, dysentery, gastritis, food poisoning, constipation, intestinal parasites

_____ c. RESPIRATORY ILLNESSES (RES). Upper respiratory infections, colds, bronchitis, asthma, pneumonia, pharyngitis, otitis, sinusitis

_____ d. DERMATOLOGICAL ILLNESSES (DER). Viral rashes or lesions, cellulitis, fungal or bacterial infections, contact dermatitis, dermatitis caused by insect bites, skin ulcers, eschars

_____ e. OPHTHALMIC ILLNESSES/INJURIES (EYE). Conjunctivitis, eye infections or irritations, corneal abrasions, foreign bodies, solar injury, laser injury, trauma not associated with trauma reported under Orthopedic/Surgical Injuries, para 3g

_____ f. PSYCHIATRIC ILLNESSES (PSY). Depression, situational reactions, anxiety, neuroses, psychotic reactions, suicide attempts, behavioral reaction to medication or substance abuse

_____ g. ORTHOPEDIC/SURGICAL INJURIES (INJ). Fractures, sprains, lacerations, abrasions, internal injuries, burns and thermal injuries (not sunburn), nonenvenomating animal bites (usually mammal or reptile), other trauma; includes battle, nonbattle, occupations, and recreation incidents

_____ h. MEDICAL ILLNESSES (MED). Cardiac-related problems such as chest pain and hypertension; neurological problems such as headaches, convulsions, and syncopal episode; allergic reactions including systemic reactions to venomous bites and stings; hepatitis; urogenital illnesses not associated with sexually transmitted disease; internal conditions not related to trauma (eg, appendicitis)

_____ i. SUBSTANCE ABUSE (ABU). Abuse of alcohol, illegal drugs (including marijuana), pharmaceuticals (prescribed or unprescribed), or other substances

_____ j. DENTAL (DEN). Dental injury, disease, or conditions requiring care by a dentist

_____ k. FEVERS OF UNDETERMINED ORIGIN (FUO). Fevers not apparently associated with diagnosed illness or injury

_____ l. SEXUALLY TRANSMITTED DISEASES (STD). Gonorrhea, syphilis, chlamydia, genital herpes, pelvic inflammatory disease, venereal warts/chancres

4. **SPECIAL DIAGNOSTIC CATEGORIES**

NEW CASES

Diseases, injuries or medical conditions of special interest within the command or as directed by higher authority (eg, malaria, barotrauma), including cases already reported under a General Diagnostic Category (eg, the number of Orthopedic/Surgical Injuries that were sports-related).

a. _____

b. _____

(Continue as necessary)

5. **COMMENTS/REMARKS**: Clarify or explain specific entries in paragraph 3 and 4, as needed. Reference applicable paragraph and subparagraph.

*This format is provided for illustrative purposes only. Categories and specific diseases will vary by regions.

1. (X) Situation.
    a. (X) Enemy. Refer to Annex B.
    b. (X) Friendly. Refer to Basic Plan.
    c. (X) Assumptions. See Preventive Medicine Appendix 7 to Annex Q.
2. (X) Mission. Support the mission outlined in Basic Annex Q.
3. (X) Execution. All deployed medical assets will provide the Theater Surgeon with appropriate medical intelligence feedback when appropriate or as required. Medical assets upon redeployment will also provide the Component Command Surgeons' Offices and the USCENTCOM Surgeon's Office with a debriefing in the general format of the AFMIC "Medical Information Report," but all items may not apply to the mission. Information should be as complete as possible. (The briefing may be handwritten.)
    a. (X) Intelligence Sources. The following medical intelligence sources may be helpful for mission planning purposes and for obtaining current information.
        (1) (X) Armed Forces Medical Intelligence Center. Can provide specific summaries of current medical intelligence, by country. Can provide a Quick Response report to high priority medical intelligence requests that require less than 40 person-hours of research. They also publish MEDIC, which includes suggested PM countermeasures and Medical Capabilities Studies for most countries within the CENTCOM AOR. Specific medical threats are also published on a weekly basis, disseminated by weekly electronic message traffic. AFMIC Operations telephone: DSN 343-7574; Commercial (301) 619-7574; Fax -2649 (Secure), -2409 (Unclassified). All lines are STU-III compatible.
        (2) (X) Defense Pest Management Information Analysis Center. Publishes Disease Vector Ecology Profiles for many countries within the CENTCOM AOR. Provides current and extensive information on medical zoological threats (eg, arthropods [spiders, ticks, mosquitoes, etc.], leeches, snakes, some parasites, some poisonous plants), by specific country or by geographic distributions of specific threats. Telephone: DSN 295-7479; Commercial (301) 295-7479.
        (3) (X) US Navy Environmental and Preventive Medicine Unit #7 (NEPMU-7). Located in Sigonella, Italy, NEPMU-7 publishes Annual Disease Risk Assessment Profiles for countries within the AOR. It constitutes a major source for medical threat estimation and general PM recommendations; specific consultation and updates by NEPMU-7are also available. Telephone: DSN 314-XXX-XXXX, Commercial 011-XX-XX-XXX-XXXX, Secure 011-39-XX-XXX-XXXX.
        (4) (X) Center for Health Promotion and Preventive Medicine. The Center houses experts in all PM specialties who can address broad PM issues, as well as highly technical and arcane topics. These issues include epidemiology, entomology, communicable diseases, bioenvironmental engineering, occupational medicine, water and air quality, and medical readiness. Telephone: 1-800-222-9698 (24 hours); DSN 584-7374, Commercial (410) 436-7374; Fax -7301 (secure).
        (5) (X) Walter Reed Army Institute of Research. The Preventive Medicine Division is a collection point for PM information, technical experts, and points of contact for many PM and disease aspects of most countries within the AOR. They have extensive in-house experience with theater disease surveillance, investigation, and research on numerous PM issues pertinent to the AOR. Telephones: DSN 285-9600; Commercial (301) 319-9600; Fax -9104.
        (6) (X) US Army Medical Research Institute of Infectious Diseases. This institute is a source of information on infectious diseases, including the latest medical research, BW agents, vaccine developments, and therapeutic regimens. Telephone: DSN 343-2772/2833; Commercial (301) 619-2772/2833; Fax -4625.
        (7) (X) Naval Medical Research Unit #3 (NAMRU-3). This regional research center, located in Cairo, Egypt, conducts medical research on diseases within the CENTCOM AOR. NAMRU-3 is the source of specific disease information and scientific developments and can be contacted directly for practical medical experience within the AOR. Commercial telephone 011-202-284-1375, Fax -1382.
        (8) (X) US Air Force Institute for Environment, Safety, and Occupational Health Risk Analysis, Force Health Protection and Surveillance Branch. This branch has expertise in epidemiology, health promotion, biostatistics, and database development. Telephone: DSN XXX-XXXX; Commercial (XXX) XXX-XXXX; Fax -XXXX.
        (9) (X) USAF School of Aerospace Medicine. The School has consultants in epidemiology, ento-

mology, communicable diseases, bioenvironmental engineering, occupational medicine, food sanitation, and medical readiness. Telephone: DSN 240-3500; Commercial (210) 536-3500; Fax -3419.

(10) (X) Armstrong Labs. Formerly a part of the Air Force, this is now a private organization that works on a fee/contract basis. DSN 240-2002, comm (210) 536-2002, fax –2025.

b. (X) Medical Intelligence Estimates. See Preventive Medicine Appendix 7. *This is also the section in which to emphasize disease threats within the local population that may affect combat service support and civil affairs efforts by US military personnel.*

c. (X) Environmental Health. See Preventive Medicine Appendix 7. *Identify key features in the area that could affect the health of military personnel, to include the status of public infrastructure (eg, water, sewage), industrial pollutants and other industrial hygiene threats, and zoonotic disease threats.*

d. (X) Non–US Military Health Care Infrastructure. *List all host-nation military medical facilities that can be used within the AOR. List their capabilities, to include location (state miles or time from airports or known US military compounds or ports), beds, specialties available, operating capabilities, diagnostic equipment, reputation of facility and doctors, and any other specific information that may become important when choosing a facility for US casualties.*

(1) (X) Host-Nation Military Hospital #1. #1 Hospital is the military hospital on the ZZZ Air Base. It is a 300-bed multi-specialty hospital. It is about 30 minutes away from Yippee Kiyay Apartments. It is expandable to 1,000 beds in a contingency. It also is the referral hospital for decompression sickness. It has a 20-bed, level II ER and an ICU/CCU with 10 beds.

(2) (X) Host-Nation Facility #2. #2 military hospital is available, but mass casualty cases or trauma should not be taken here. Instead, refer to the nearby University Hospital.

e. (X) Civilian Facilities. *As with the host-nation military medical facilities (see above), list all the host-nation civilian hospitals that can be used within the AOR, as well as their capabilities and reputation, if known.*

(1) (X) Host-Nation Civilian Hospital #1. #1 Hospital is comparable to some of the best hospitals in the United States. It is an ultramodern, complete, multi-specialty hospital. It is located approximately 10 minutes from the Marriott Hotel in the capital city. It is available for use by all US forces through a previously arranged agreement.

f. (X) Tasks. See Preventive Medicine Appendix 7 for surveillance and reporting.

APPENDIX 12 TO ANNEX Q TO USCINCCENT OPLAN NUMBER (X)

VETERINARY SERVICES (X)

The Veterinary appendix to Annex Q of the OPLAN may become the responsibility of the Command PMO for review (if not for generation of the entire document). The following covers generic topics important for the CENTCOM AOR. When adapting this appendix for another AOR, it should, of course, be tailored to the region, operation, and availability and safety of food sources within that AOR. As in the other OPLAN appendixes, each paragraph must have a security classification.

1. (X) Purpose. To provide the concept of operations and assign tasks for veterinary support of the Basic Plan. The threat is outlined in Appendix 7, Preventive Medicine.

2. (X) Assumptions. See Appendix 7, Preventive Medicine.

3. (X) Concept of Operations. Within the theater, US military veterinary assets must inspect and approve all bulk food sources in the theater, including both non–US sources and US government prepackaged, acquired, or produced foods. Food production facilities not located within the United States must be inspected periodically and sanitarily approved by military veterinary authorities for continued usage. The theater veterinary officer maintains a list of approved host-nation food sources.

a. (X) Preventive medicine assets within the theater are responsible for periodic inspection and sanitary approval of food preparation and handling techniques in food production facilities.

b. (X) When non–US military personnel are involved in food preparation and handling, the Theater Surgeon is responsible for setting health standards for the hiring of these employees, as well as standards of health to be maintained for continued employment. Medical and preventive medicine assets must ensure implementation of these standards, verify the continued state of good health of these employees, and ensure that proper food handling standards are being taught to these employees. Food handler certificates, issued by military preventive medicine assets, must be obtained by all food handlers.

c. (X) Contaminated rations or rations suspected of contamination by NBC agents must be inspected and tested by veterinary personnel before issue or consumption.

d. (X) Captured rations must be first certified for use by veterinary food inspectors before distribution or consumption.

e. (X) Veterinary assets must be informed of suspected or confirmed endemic animal and zoonotic disease occurrences. They are responsible for advising the Theater Surgeon on appropriate treatment and prevention protocols and monitoring the implementation of these programs.

4. (X) Health Threat. See Appendix 7.

5. (X) Tasks. Veterinary support will be provided by _____ (*usually the Army*). The Veterinary Services, under the direction of the Theater Surgeon, have the following theater responsibilities. The Xth Unit located in _____(*location*) will maintain all veterinary files within the CENTCOM AOR.

a. (X) Weekly Activity Reports. Submit a Veterinary Service Weekly Activity Report to the theater disease surveillance team and the Theater Surgeon. This report will cover activities concerned with animal medicine, food inspection, zoonotic diseases, and other significant events.

b. (X) Food Safety. Inspect and approve all foodstuff sources used by US military personnel within the theater. Military veterinary services will also conduct periodic sanitary inspections of bulk food supplies and the facilities from which these originate. Locally acquired foodstuff must be inspected and approved before purchase, before entry into the theater supply system or issue, and periodically while in storage.

(1) (X) Contaminated Rations. Contaminated rations or rations suspected of contamination by NBC agents must be inspected and tested by veterinary personnel before issue or consumption. Decontamination of rations contaminated by these agents is a unit responsibility.

(2) (X) Captured Rations. Captured rations must be first certified for use by veterinary food inspectors before consumption or distribution.

c. (X) Zoonotic Diseases. Provide theater consultation, as needed, for zoonotic diseases and their vectors.

d. (X) Rabies Program. Draft the theater rabies and animal bite protocol for the Theater Surgeon. Address the quarantine, handling, diagnosis, and disposition of animals suspected to be rabid.

e. (X) Antivenins. Locate and coordinate procurement of appropriate antivenins against venomous threats within the AOR.

f. (X) Military Working Dogs. Ensure the safety of the food supply and the health care of military working dogs.

6. (X) Coordinating Instructions. The Theater Surgeon will ensure there is a senior veterinary officer on the medical staff and maintain close contact with ancillary veterinary medical staffs.

SUMMARY

Appendixes 7, 11, and 12 of the Annex Q of each of a CINC's operation plans should be thorough and detailed, written well in advance, and constantly updated. These appendixes provide the preventive medicine–related guidance by which the components can make their own preparations for their missions. In the chaos accompanying mission preparation, robust CINC OPLANS assist the subordinate component commands by reducing the chances of accidental omission of critical information and decreasing the likelihood of ill-conceived planning by serving as a checklist. They also provide a ready source of mission and regionally oriented information for each specific OPLAN, thereby decreasing the need for multiple-source research. Premission planning is excellent preventive medicine.