



**COUNCIL OF
THE EUROPEAN UNION**

**Brussels, 3 June 2014
(OR. en)**

10530/14

**CSDP/PSDC 331
POLMIL 54
CIVCOM 107**

COVER NOTE

From: European External Action Service
To: Delegations
Subject: Comprehensive Health and Medical Concept for EU-led Crisis Management
Missions and Operations

Delegations will find attached EEAS document 00559/6/14.

Encl.: EEAS document 00559/6/14

EUROPEAN EXTERNAL ACTION SERVICE



EUROPEAN UNION MILITARY STAFF

Civilian Planning and Conduct Capability - CPCC

Brussels, 30 April 2014

EEAS 00559/6/14

CSDP/PSDC 559

CONCEPT

From: European External Action Service
To: Delegations
Subject: Comprehensive Health and Medical Concept for EU-led Crisis Management Missions and Operations

Delegations will find attached the Comprehensive Health and Medical Concept for EU-led Crisis Management Missions and Operations, which was agreed by the EUMC on 8 April 2014 and endorsed by CIVCOM on 16 April 2014.

Comprehensive
HEALTH AND MEDICAL CONCEPT
for
EU-LED CRISIS MANAGEMENT
MISSIONS AND OPERATIONS

A common approach defining the medical concept for EU-led civilian and military
Common Security and Defence Policy missions and operations.

TABLE OF CONTENTS

REFERENCES	7
PREAMBULE.....	9
A. INTRODUCTION.....	11
(A) HELSINKI HEADLINE GOAL CATALOGUE:	12
(B) LISBON TREATY	12
(C) INFLUENCING FACTORS OF A COMMON EU HEALTH AND MEDICAL CONCEPT:	14
a. <i>Changes in Society:</i>	14
b. <i>Changes in Medicine:</i>	15
c. <i>Changes in European Foreign Policy and the Military:</i>	15
d. <i>Changes in the Global Environment:</i>	15
e. <i>Changes in Threat:</i>	15
B. PURPOSE.....	16
C. SCOPE	16
D. EU MEDICAL SUPPORT PLANNING PROCESS.....	17
(A) CRISIS RESPONSE STRATEGIC PLANNING	17
(B) OPERATIONAL PLANNING	17
(C) DURING AND AFTER MISSIONS AND OPERATIONS.....	18
E. HEALTH AND MEDICAL SUPPORT PRINCIPLES AND GUIDELINES.....	18
(A) BASIC PRINCIPLES AND GUIDELINES	18
a. <i>Compliance with International Law and Standards</i>	19
b. <i>Medical Ethics and Rules for involvement in host nation's medical service</i>	19
c. <i>Quality and Standards of Health and Medical Care</i>	20
d. <i>Preservation of Health and Prevention of Disease</i>	21
e. <i>Complexity of Medical Responsibilities</i>	21
f. <i>Time-Related Constraints of Health and Medical Care</i>	22
g. <i>Triage</i>	23
h. <i>Continuity of Care</i>	24
i. <i>Fitness for Evacuation</i>	24
j. <i>Medical Documentation</i>	25
k. <i>Medical Confidentiality</i>	26
l. <i>Language Skills and Communication with Patients</i>	26
(B) MEDICAL CAPABILITIES AND CONSEQUENT MEDICAL OPERATIONAL GUIDELINES	26
a. <i>Comprehensive and Sufficient Health and Medical Planning</i>	27

<i>b. Responsibility</i>	28
<i>c. Authority</i>	29
<i>d. Coordination and Cooperation</i>	29
Coordination of medical assets:.....	29
Cooperation with other medical providers and users:.....	29
Medical Liaison:.....	30
Data exchange:.....	30
Patient Regulating / Patient Tracking:.....	30
Medical Evacuation Resources Coordination:.....	30
<i>e. Standardisation</i>	30
<i>f. Fitness and Health Standards</i>	31
<i>g. Health and Medical Support Quality Structure</i>	31
Adequacy:.....	31
Medical Staff:.....	32
Readiness and Flexibility:.....	32
Adequacy in Exceptional Circumstances:.....	32
Definitive Treatment:.....	32
Medical Supply and Resupply Rates and Standards:.....	32
<i>h. Theatre Holding Policy</i>	32
<i>i. Provision of Treatment to Third Parties and Local Population / Eligibility of care</i>	33
Emergency Treatment:.....	33
Provision of Non-emergency Treatment to Third Parties:.....	33
Provision of Non-emergency Treatment to Local Population:.....	33
<i>j. Naval operations</i>	33
<i>k. Special Operation Forces</i>	34
<i>l. Financing</i>	34
Civilian Missions:.....	34
Military Operations:.....	34
(C) MULTINATIONALITY AND CONTRACTING.....	35
(D) AUDITING.....	36
F. HEALTH AND MEDICAL SUPPORT ORGANISATION.....	36
(A) MEDICAL PLANNING RESPONSIBILITIES.....	37
(B) MEDICAL FUNCTIONAL AREAS.....	39
<i>a. Medical Command and Control (Medical C2)</i>	39
C2 Capability:.....	39
National points of contact:.....	39
Organisation:.....	40
<i>b. Medical Communication and Information System (MedCIS)</i>	40
<i>c. Medical Intelligence (MEDINTEL)</i>	40
<i>d. Preventive Medicine and Medical Force Protection</i>	41
Preventive Medicine Capability:.....	41

Preventive Medicine Organisation:.....	42
Preventive Medicine Responsibility:	42
<i>e. Medical Evacuation (MEDEVAC)</i>	42
MEDEVAC Planning Determinants:	43
Medical Evacuation Assets Responsibility:	43
MEDEVAC Coordination:	43
MEDEVAC Capabilities:	44
MEDEVAC Definitions of three main categories:	44
Evacuation Priorities:.....	45
Aeromedical Evacuation Requirements:.....	45
<i>f. Medical Logistics</i>	45
Unique Characteristics of Medical Logistics:	45
Medical Stocks:	46
Responsibility for the Medical Logistic System:	46
Blood:	46
(C) PERSONNEL.....	47
<i>a. Medical Manpower</i>	47
<i>b. Mortuary Affairs</i>	47
<i>c. Health Related Legal Aspects</i>	47
(D) MEDICAL INFORMATION MANAGEMENT	47
(E) PUBLIC INFORMATION (PI).....	48
(F) WELFARE AND SPIRITUAL WELLBEING.....	49
G. MEDICAL PLANNING	49
(A) EU MEDICAL SUPPORT PLANNING PROCEDURES	49
<i>a. Risk and Resources Related Planning</i>	49
<i>b. Medical Intelligence</i>	49
<i>c. Casualty Estimate</i>	50
<i>d. Coordination with medical services of MS and non-EU TCN</i>	51
<i>e. Coordination with other organisations</i>	51
(B) BASIC GUIDELINES FOR THE EU MEDICAL PLANNING	51
<i>a. EU-led Mission and Forces Medical Capability</i>	51
<i>b. In Country / Host Nation Support (HNS) Capability</i>	52
<i>c. Command and Control (C2), Communications and Information System (CIS)</i>	52
Medical Command and Control in Military Operations:	53
Medical Command and Control in Civilian Missions:.....	54
<i>d. Medical Treatment</i>	54
<i>e. Medical Evacuation Capability</i>	55
<i>f. Theatre Holding Policy</i>	55
<i>g. Preventive Medicine</i>	56
<i>h. Personnel</i>	56
<i>i. Medical Logistics Capability</i>	57

<i>j. Funding Principles for Health and Medical Support</i>	57
ANNEX A: MEDICAL TREATMENT FACILITIES (MTFS)	58
ROLE 1 MTF.....	58
<i>Capabilities</i>	58
<i>Additional Capabilities</i>	58
ROLE 2 MTF.....	58
<i>Role 2 Tasks</i>	58
<i>Role 2 Basic Medical Treatment Facility</i>	59
<i>Role 2 Enhanced (2E)</i>	59
<i>Additional Role 2 Capabilities</i>	59
ROLE 3 MTF.....	60
<i>Role 3 Capabilities</i>	60
<i>Additional Role 3 Capabilities</i>	60
<i>Economies of Scale</i>	60
ROLE 4 MTF.....	60
<i>Role 4 Tasks and Capabilities</i>	61
ANNEX B	62
MEDICAL SUPPORT ESTIMATE (FOR HQ ALONG THE CHAIN OF COMMAND)	62
<i>SITUATION AND FACTORS:</i>	62
<i>MEDICAL SUPPORT ANALYSIS:</i>	63
<i>EVALUATION AND COMPARISON OF COURSES OF ACTION:</i>	64
<i>MEDICAL SUPPORT PLAN:</i>	64
ANNEX C	65
FACTORS AFFECTING FACT FINDING MISSION ASSESSMENT - CHECKLIST.....	65
SHORT HOSPITAL EVALUATION - CHECKLIST	66
ANNEX D	68
MEDICAL KITS:.....	68
PERSONAL FIRST AID KIT FOR CIVILIAN MISSIONS	69
CAR TRAUMA KIT FOR CIVILIAN MISSIONS	70
ANNEX E	71
LIST OF ABBREVIATIONS:	71

REFERENCES

- A. Helsinki European Council 10 and 11/12/1999 Presidency Conclusions.
- B. EU Military Rapid Response Concept (5654/09), dated 23/01/2009.
- C. European Security Strategy (Council Doc 15895/03), dated 08/12/2003.
- D. Civil Military Co-ordination (CMCO), (14457/03), dated 07/11/2003.
- E. Headline Goal 2010 (6309/6/04 REV 6), dated 04/05/2004, endorsed 18/06/2004.
- F. EU Battlegroups Concept (13618/06), dated 05/10/2006.
- G. Consolidated versions of the Treaty on European Union and the Treaty on the functioning of the European Union (Treaty of Lisbon 13/12/2007 plus amendments, Council Doc 655/08), dated 15/04/2008.
- H. Constitution of the World Health Organisation, Preamble (as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100)) and entered into force on 7 April 1948.
- I. Health and Medical Support Principles ARES (2011) 290250 (Council: st 7733/11).
- J. Health and Medical Support Concept for Military EU-led Crisis Management Operations (10901/07 REV 1), dated 05/07/2007.
- K. Military Support to EU Disaster Response (Council Doc 9462/3/06), dated 13/12/2006.
- L. Medical Support Manual for United Nations Peacekeeping Operations, 2nd Edition, 1999.
- M. European Union Concept for Military Strategic Planning (Council Doc. 10687/08), dated 16/06/2008.
- N. Civil-Military Cooperation (CIMIC) Functional Planning Guide for EU-led Crisis Management Operations (Council Doc 12265/02), dated 27/09/2002.
- O. EU Concept for Logistic Support for EU-led Military Operations (8641/11), dated 04/04/2011.
- P. UN/DHA-Geneva, Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief (REV 1), dated 01/11/2007.
- Q. The Geneva Conventions, dated 12/08/1949.
- R. Additional Protocols to the Geneva Conventions, dated 08/06/1977.
- S. The Hague Conventions, dated 29/07/1899 and 18/10/1907.
- T. EU Concept for Civil-Military Co-operation for EU-led Military Operations (11716/08), dated 11/07/2008.
- U. The Host Nation Support (HNS) Concept for EU-led Crisis Management Operations (10603/06 REV 1) dated 15/07/2006.
- V. Council Decision 2011/871/CFSP of 19 December 2011 establishing a mechanism to administer the financing of the common costs of European Union operations having military or defence implications (Athena).
- W. EU Concept for Military Command and Control (11688/08), dated 16/06/2008.
- X. EU Concept for Military Intelligence Structures on EU Crisis Management and EU-led Military Operations (14092/10), dated 27/09/2010.
- Y. EUMC Glossary of Acronyms and Definitions (5884/11), dated 28/01/2011.

PREAMBULE

This Comprehensive Health and Medical Concept for EU-led Crisis management Missions and Operations supersedes the Health and Medical Support Concept for Military EU-led Crisis management Operations (10901/07 REV1), dated 05/07/2007.

The concept sets out medical support principles for the guidance of Commanders, Head of Missions and their staff, and to provide functional direction to the medical staff, in order to optimize health and healthcare support on EU led Crisis-management missions and operations.

Such an approach is welcomed to serve the best interest of staff, according to a mode that is compatible within means, capability and purpose of the Mission and Operations.

Modalities cannot take a one-size fits-all-form and must be tailored based on the authority structures and existing architecture of civilian CSDP missions and Delegations inter alia, to be aligned with the individual needs and existing commitments of the EU, the Member States and personnel. Due to the specificities of the environment where Civilian Missions are deployed, emergency response times and availability of specialist resources are not expected to be optimal in all circumstances and mitigation measures will be put in place. These mitigation measures may vary but will typically include; training, equipment, communications, medical personnel and transport means. CPCC, acting as OHQ, has no medical staff and/or medical support concept for civilian missions. While no standard comprehensive CSDP civilian concept is fully established, the CPCC possesses articulated modalities and standards for the implementation of Duty of Care in the provisions of medical and health care, agreed with the Member States and guides CPCC with regard to Health and Medical practise. The means of exercising Duty of Care differs from Mission to Mission, considering needs, constraints, circumstances and resources, and is met by the most effective compositions of resources available to the Mission, whether it be by medical staff employed as missions members and/or staff recruited as part of a service contract with a medical service provider.

The concept should act as a guide for operational plans, directives and training for deployment on missions and operations and aims to furnish Commanders and Head of Missions, as well as their medical advisors, with concise and consistent guidance for the optimal provision of medical support. The concept informs the estimate of resources required, and thus underpins the health and medical risk assessment process, and forms the basis for the medical annex to OPLANS. Member States are requested to utilize the guidance contained within this concept in the training and preparation of their personnel pre-deployment, and that their deployed personnel should follow the principles therein, notwithstanding formal command states.

This edition of the Comprehensive Health and Medical Concept for EU-led Crisis management Missions and Operations builds on the experience following implementation of the previous editions on current and past operations and missions. This concept will contribute to the further development of guidelines in light of continued experience on operations and missions and as such engagement with deployed medical advisors/staff must be continuous and essential.

A. INTRODUCTION¹

1. In 1999 the European Union Council decided at the Helsinki meeting² to develop

"(25) ... the Union's military and non-military crisis management capability as part of a strengthened common European policy on security and defence."

The document defines furthermore

"(28)... the European Council has agreed in particular the following:

- *cooperating voluntarily in EU-led operations, Member States must be able, by 2003, to deploy within 60 days and sustain for at least 1 year military forces of up to 50,000-60,000 persons capable of the full range of Petersberg tasks;*
- *new political and military bodies and structures will be established within the Council to enable the Union to ensure the necessary political guidance and strategic direction to such operations, while respecting the single institutional framework;*
- *modalities will be developed for full consultation, cooperation and transparency between the EU and NATO, taking into account the needs of all EU Member States;*
- *appropriate arrangements will be defined that would allow, while respecting the Union's decision-making autonomy, non-EU European NATO members and other interested States to contribute to EU military crisis management;*
- *a non-military crisis management mechanism will be established to coordinate and make more effective the various civilian means and resources, in parallel with the military ones, at the disposal of the Union and the Member States."*

Finally the Council announced in Annex IV:

"Also in order to assume these responsibilities, the Union will improve and make more effective use of resources in civilian crisis management in which the Union and the Members States already have considerable experience. Special attention will be given to a rapid reaction capability."

¹ The introduction is very detailed and lengthy by intention, many footnotes have been added to explain or define contents more precisely because this concept should not only be used for EU MS contributing to civilian and military missions and operations but be disseminated to other actors for potential contribution or cooperation as well.

² Reference A

All these measures will be taken in support of the Common Foreign and Security Policy and they will reinforce and extend the Union's comprehensive external role. With the enhancement and conservation of military and civilian crisis response tools, the Union will be able to resort to the whole range of instruments from diplomatic activity, humanitarian assistance and economic measures to civilian policing and military crisis management operations."

2. One of the first concrete steps to strengthen the Common Security and Defence Policy was made by setting up military assets. This included the development of the EU Military Rapid Response Concept (Ref. B³), which has the aim of providing a conceptual basis for the conduct of EU-led Crisis Management Operations (CMOs) requiring a rapid response. This development must be seen in parallel to the European Security Strategy (ESS)⁴, adopted by the European Council on 12 December 2003, identifying broader European Security and Defence Policy (ESDP) missions and tasks than those explicitly listed in Article 17(2) Treaty on European Union (original version). Consequently, military medical arrangements must be capable of meeting such requirements if necessary.
3. It is the strength of the EU to be able to react to a crisis by civilian and military means. This is reflected as such in the document on Civil Military Co-ordination (Ref. D).

(A) Helsinki Headline Goal Catalogue:

4. As a next step the military capabilities required to fulfil these missions have been listed in the Helsinki Headline Goal Catalogue (Reference E), which integrates the development of Battlegroups (BGs) within the overall capability development and the EU BG Concept (Ref. F). Since 2007 European Union BGs have been available as high readiness forces on a short notice to move.

(B) Lisbon Treaty

5. The Lisbon Treaty of 2007 outlines the spirit of European Union interests to act outside the Union and to cooperate with kindred spirits: "*The Union's action on the international scene shall be guided by the principles which have inspired its own creation, development and enlargement, and which it seeks to advance in the wider world: democracy, the rule of law, the universality and indivisibility of human rights and fundamental freedoms, respect for human dignity, the principles of equality and solidarity, and respect for the principles of the United Nations Charter and international law. The Union shall seek to develop relations and build partnerships with third countries, and international, regional or global organisations which share the principles referred to in the first subparagraph.*"⁵
6. The possible areas of activities have been defined as:
"The Union shall define and pursue common policies and actions, and shall work for a high degree of cooperation in all fields of international relations, in order to:

³ Document dated 24/01/2003, now revised.

⁴ "A Secure Europe in a Better World (European Security Strategy, Ref. B)".

⁵ Extract from Reference G, Title V, Chapter 1, Article 21, 1.

- (a) safeguard its values, fundamental interests, security, independence and integrity;
- (b) consolidate and support democracy, the rule of law, human rights and the principles of international law;
- (c) preserve peace, prevent conflicts and strengthen international security, in accordance with the purposes and principles of the United Nations Charter, with the principles of the Helsinki Final Act and with the aims of the Charter of Paris, including those relating to external borders;
- (d) (e) (f)
- (g) assist populations, countries and regions confronting natural or man-made disasters; and
- (h) promote an international system based on stronger multilateral cooperation and good global governance."⁶

7. The Treaty emphasises on the duality of possible missions and describes feasible missions: "*The common security and defence policy shall be an integral part of the common foreign and security policy. It shall provide the Union with an operational capacity drawing on civilian and military assets. The Union may use them on missions outside the Union for peace-keeping, conflict prevention and strengthening international security in accordance with the principles of the United Nations Charter. The performance of these tasks shall be undertaken using capabilities provided by the Member States.*"⁷
8. Furthermore the treaty encourages the integration and cooperation in alliances: "*The policy of the Union in accordance with this Section shall not prejudice the specific character of the security and defence policy of certain Member States and shall respect the obligations of certain Member States, which see their common defence realised in the North Atlantic Treaty Organisation (NATO), under the North Atlantic Treaty and be compatible with the common security and defence policy established within that framework.*"⁸
9. All these objectives, now summarised in the 'Lisbon Treaty', led to the establishment of the European Union External Action Service (EEAS) on January 01, 2011. Although both are now part of EEAS, the Civilian Planning and Conduct Capability (CPCC) continues to provide civilian mission capabilities whilst all military strategic capabilities are continued to be provided by the European Union Military Staff (EUMS).
10. Having to meet the full range of Common Security and Defence (CSDP) tasks and in tackling all the challenges with the maximum flexibility has led to an increased need for adequate Health and Medical Support.
11. Health is defined by the World Health Organisation (WHO) as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Ref. H). As a result Health and Medical Support in EU-led missions and operations should always consider the relevant aspects of this definition⁹.

⁶ Extract from Reference G, Title V, Chapter 1, Article 21, 2.

⁷ Extract from Reference G Title V, Chapter 2, Section 2, Article 42, 1.

⁸ Extract from Reference G Title V, Chapter 2, Section 2, Article 42, 2.

⁹ Social well being includes a number of areas, such as welfare, payment, housing, which are outside of the medical responsibilities and will therefore not be dealt with in detail.

12. The aim of Health and Medical Support in civilian missions and military operations is to support the mission and operation through conservation of manpower, preservation of life and health and minimisation of residual physical and mental disabilities.
13. Appropriate medical support makes a major contribution to both force protection and morale through the prevention of disease, rapid evacuation and treatment of the sick, wounded and injured and the return to duty of as many individuals as possible.
14. There is no single well-defined European Union medical standard. Regulations and legislation for medical education, treatment, confidentiality up to approval of drugs are quite similar but still vary between EU Member States.
15. Since each Member State's own Ministry of Defence will define its own "Health and Medical Policy for Military Operations" it was necessary to draft a similar document for EU led civilian missions (Ref. I).
16. The "Health and Medical Support Concept for Military EU-led Crisis Management Operations" (Ref. J) has been a successful tool to define and provide adequate military medical support in the past, especially for BGs and missions. Medical, once a negligible and subordinate domain, is becoming more and more important. Although many Member States agreed on this, it must be said that this development is not being picked up by each country or organisation to the same extent. Especially the changes regarding the pre-planning of medical issues and the contribution of medical experts to operations developed somewhat different. For that reason a revised respectively new Health and Medical Concept has to set state of the art standards for medical support in civilian and military missions and operations.

(C) Influencing Factors of a common EU Health and Medical Concept:

17. A common EU Health and Medical Concept has to reflect all the emerging challenges, not only dealing with the need of individual care even in small sized missions but also focusing on the changes in the global environment:

a. Changes in Society:

Public expectations regarding the quality of the medical support provided in theatre continue to increase, always asking for the highest standards of the sending nations. Public opinion and political reactions are sensitive to media, exactly reporting the coverage of health and medical support to deployed personnel and investigating on each fatal exit. Whilst accepting that missions and operations can be a hazardous occupation, public opinion does not accept avoidable risks or its personnel being deployed unprepared for the task at hand. Consequently, there is a requirement for the health and medical service to be maintained at a very high standard before, during and after any deployment.

Furthermore employers have increasing legal responsibilities to protect their employees' health and often (part of) this responsibility is mandated to the commander or Head of Mission. As both the European Union as well as the Member States' military leadership wish to meet these standards for each mission an effective and reliable medical support system has to be put in place in order to improve troop morale and maintain

the trust of our personnel, the wider public and its political leadership and decrease the cost of possible rehabilitation.

b. Changes in Medicine:

Medicine has become a highly specialised and technical area and especially Military Medicine has led the way in many instances. Due to the circumstances in recent operations the military medicine had to introduce new or modified procedures, timelines and algorithms. In addition to that Military Medicine needed to also broaden beyond the traditional clinical domains and to include disciplines such as preventive medicine, medical intelligence, epidemiological surveillance and screenings, telemedicine, occupational and environmental health and forensic medicine. Whenever appropriate these changes have also been introduced into civilian missions (e.g. modified hostile environment training and the standardized First Aid Kit that was procured for EU civilian missions).

c. Changes in European Foreign Policy and the Military:

The main focus of CSDP is conflict prevention and crisis management operations. Due to budget reasons police forces, governmental relief organizations, technical emergency services and military forces decreased in size but at the same time the emphasis shifted towards training each single individual to become a specialist. Organisations and forces are becoming smaller as fewer people produce more impact; consequently there is a larger loss of capability if an individual becomes unfit for duty. European military forces have found it increasingly difficult to recruit and retain medical professionals, whilst medical equipment has been more difficult to fund from restricted budgets. On top of that medical shortfalls have become a severe limitation upon operational capability, thus limiting the freedom of action for the European Union. Consequently, multinational medical support options have become increasingly necessary and require more complex co-ordination at each staff level.

d. Changes in the Global Environment:

Changes in global climate, economy and technology pose new challenges and result in geo-political areas of interest which may become focal points for possible future operations. Some predictable basic characteristics of those operations need to be considered for medical planning and capability development. These characteristics include, but are not limited to, the following features:

- Global engagement,
- Extended lines of communication,
- Difficult conditions (climatic, geographic, socio-cultural and epidemiologic),
- High operational tempo,
- Extended sustainability,
- No or very limited host nation support available,
- Public opinion less supportive of long engagements.

e. Changes in Threat:

Beside the conventional scenarios, civilian society and EU missions alike now face the threat of asymmetric conflict and terrorism. Although in many countries civil protection is primarily the responsibility of civilian authorities, the unique capabilities in areas such as diagnosis and care for casualties, as developed by the military, continue to be called upon.

18. To accomplish these new challenges not only the possibility of using military medical support assets and capabilities to enhance EU Disaster Response (Ref. K) has to be taken into account. To a greater degree all efforts have to be made for a multinational and multi-institutional approach to medical support tasks, including support to the host nation and other entities (NGOs, other allies, other international organisations even civilian support to small military forces) working in the joint operational area. When functioning properly this mutual support can lead to a common solution that will open options for burden sharing, economy of scale, modular capability development and efficient use of limited national resources. But as a precondition the medical support doctrine and concepts of each civilian and military partner must be as similar as possible. Therefore this concept entails similar conceptual details as used by the United Nations (UN) (Ref. L) and NATO.
19. Furthermore medical staffs operate in a highly specialised and multifaceted environment, which involves linkages and interfaces with all staff elements.
20. In addition, Health and Medical Support guidance must be governed by specific medical factors such as EU Member States' medical standards and regulations and, whenever appropriate and possible, evidence based medicine.
21. This 'Health and Medical Concept for EU-led Crisis Management Missions and Operations' is based on the former 'Health and Medical Support Concept for Military EU-led Crisis Management Operations' (Ref. J) but integrates all new developments in the medical area, including experience and lessons from recent operations.

B. PURPOSE

22. The purpose of this document is to provide a comprehensive concept for Health and Medical Support in EU-led crisis management missions and operations in order to facilitate in theatre cooperation and to promote an optimum health care for the EU's CSDP personnel in a continuum of care.

C. SCOPE

23. This document includes principles, policies, guidelines and planning procedures and serves as a basis for other medical support documents of civilian and military staff, including multinational EU Headquarters (HQ) in order to ensure overall compatibility of Health and Medical concepts, plans, structures and procedures, taking into account the wide spectrum of possible operations and the developments of modern medicine.
24. It sets standards of Health and Medical Support, which are coherent to the appropriate extent with those established in current medical documents of other international actors (NATO, UN, AU, OSCE, GOs, NGOs and other IOs). This concept does not address the specific clinical aspects of medical care.
25. This document should be reviewed and updated regularly, usually every three years.

D. EU MEDICAL SUPPORT PLANNING PROCESS

26. This chapter is intended as an overview of the medical aspects¹⁰ to EU strategic planning. Because there is only one EU Concept for Military Strategic Planning (Ref. M) this document has already been the basis for both, the civilian and military planning process.

The architecture of the military planning process requires a series of interactions at different levels.

(A) Crisis Response Strategic Planning

27. Crisis response strategic planning is conducted in response to an existing or emerging crisis. The Political and Security Committee (PSC) identifies and addresses a crisis situation. A comprehensive approach to crisis response strategic planning implies accurate and up-to-date information and contacts with military and civilian medical authorities or other organisations in or near the area where the EU-led operation or mission might take place. Possible fields of further coordination and/or cooperation with civilian or military structures within and/or outside the EU should be identified. Once a decision has been made to send a Fact Finding Mission (FFM), the participation of medical experts has to assure access to detailed information about the medical situation in the designated mission area, the possibility or need for cooperation and/or coordination with other military or civilian medical structures, the availability of host nation medical infrastructure and possible health related risks and to facilitate negotiations with medical or other authorities concerned. Specific considerations on possible relevant medical issues are necessary.
28. If the Council, based on preliminary work, decides to consider possible EU involvement in a crisis situation, EUMS Medical Staff officers will contribute to the further strategic planning process with medical specialist input (feasibility and related health risks), i.e. medical resources and support structures, environmental health risks, infectious diseases, preventive medicine countermeasures, possible medical Host Nation Support (HNS), medical evacuation and medical aspects of humanitarian aid. If necessary intensified contacts with other involved bodies within EU, with MS or other states and/or NATO as well as with UN, OSCE, GOs, NGOs and other IOs will be established at this stage.

(B) Operational Planning

29. When the Council decides to select an option for detailed development, the Operation Commander (OpCdr) will develop, after selecting a military strategic option, the Concept of Operations (CONOPS) and the Operation Plan (OPLAN). These plans include chapters on Health and Medical Support based upon coordination with EU MS in line with the requirements for the Health and Medical Support as defined by the OpCdr. At this stage, the potential non-EU Troop Contributing States (TCNs) are kept informed for these requirements.

¹⁰ See Ref. M: strategic, operational, and tactical.

30. During this phase the OpCdr, through his Medical Advisor¹¹, will conduct an assessment of the medical support capabilities. In civilian crisis management missions the principles and processes are comparable, the main difference is the overall responsibility of the Civilian Operations Commander, Director of Civilian Planning and Conduct Capability (CPCC) and the direct responsibility of the Head of Mission for his/her mission.
31. The Force Generation process will include specific medical requirements and multinational medical support arrangements. Force Generation could even lead to the decision to outsource all medical support to contracted companies.
32. Dissemination of medical intelligence as well as other medical information relevant for the planning purposes is necessary.

(C) During and after Missions and Operations

33. Commanders and Head of Missions of EU-led CMOs, MS and non-EU TCN are responsible for the continuous monitoring of and the appropriate reporting on the Health and Medical situation in the area of operations. If deemed necessary the existing Health and Medical Support is to be evaluated and adjusted (e.g. extension or reduction of deployed medical forces, further multinational approaches, preconditions for medical contributions to CIMIC¹²).
34. Throughout the mission, relevant findings have to be written down as lessons identified and evaluated by the appropriate branch with the assessment of the medical staff at the different levels of command. The results will be used to improve this Health and Medical Concept as well as any related documents at all respective levels.

E. HEALTH AND MEDICAL SUPPORT PRINCIPLES AND GUIDELINES

(A) Basic Principles and Guidelines

35. The Health and Medical Concept establishes the basis and the framework for effective planning and implementation of a combined and joint multinational Health and Medical Support which reflects the pre-defined medical standards within the EU.
36. Specific Health and Medical Support principles and guidelines, taking into account the EU Principles of Logistic Support for military EU-led CMO (Ref. O), should be the basis for the planning and execution of Health and Medical Care during any kind of civilian or military mission or operation. These are related to the code of medical ethics that govern the actions of medical personnel, to the rules of conduct that express the

¹¹ Medical Advisor: The senior medical staff officer in a formation headquarters responsible for ensuring that the commander and his staff are properly aware of the health and medical implications of their actions and any issues connected to the operation. As such, the Medical Advisor has direct access to the Operation Commander, Head of Mission or Force Commander, for issues in the health and medical domain. The Medical Advisor may also be the Force or Theatre Medical Director.

¹² Support CIMIC with medical expertise during the creation of CIMIC plans as outlined in Ref. N.

humanitarian conscience of the MS¹³ and to the comprehensive and demanding definition of health by the WHO¹⁴ and the Geneva Conventions¹⁵.

37. Listed are basic principles and guidelines that should always govern the realisation of Health and Medical Care on behalf of EU-led missions and CMOs.
- (a) Compliance with International Law and Standards (including, when applicable, the law of armed conflict),
 - (b) Medical Ethic Rules and Rules for involvement in host nation's medical service,
 - (c) Quality and Standards of Health and Medical Care,
 - (d) Preservation of Health and Prevention of Disease,
 - (e) Time-Related Constraints of Health and Medical Care,
 - (f) Triage,
 - (g) Continuity of Care,
 - (h) Fitness for Evacuation,
 - (i) Medical Documentation.

a. Compliance with International Law and Standards

38. The conduct of medical activities will comply with the Charter of the United Nations, international laws and standards including, if applicable, the law of armed conflict (Refs. Q, R, S). In circumstances where the specific provisions of the law of armed conflict may not be directly applicable, the human international law dictates the minimum acceptable standard. Without any adverse distinction founded on the ground of racial or ethnic origin, sexual orientation, religion or belief, age and disabilities, or on any other similar criteria, all entitled sick, injured, wounded and shipwrecked, to whichever party they belong, shall be treated on the basis of their clinical needs within the medical resources available and within the mission's constraints. They shall be respected and protected. In all circumstances they shall be treated humanely, taking also into consideration religious and socio-cultural factors, and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition.

b. Medical Ethics and Rules for involvement in host nation's medical service

39. Medical Ethics - Whereas medical ethics are universal there is still a lack of additional guidelines for deployment and disaster relief. These values commonly apply:
- a. Autonomy - right to refuse or choose a treatment (*Voluntas aegroti suprema lex*)
 - b. Beneficence - acting in the best interest of a patient (*Salus aegroti suprema lex*)
 - c. Non-maleficence - do not harm (*Primum non nocere*)
 - d. Justice - distribution of scarce health resources, in other words: who gets the treatment (fairness and equality)
 - e. Dignity - right of patient and physician
 - f. Truthfulness and honesty - Concept of informed consent¹⁶

¹³ As stated in the Treaty of Amsterdam: A high level of human health protection shall be ensured in the definition and implementation of all community policies and activities.

¹⁴ Ref. H.

¹⁵ Ref. Q.

40. For the involvement of EU or contracted medical personnel in Crisis Management Missions and Operations some additional rules have to be considered. When interacting with the medical system of a host nation (HN) the following rules should be respected. The list below should be seen as a minimum, but not as completed:
- a. Do not compete or disturb the local medical system,
 - b. Do not start a treatment without the possibility to continue or finish it,
 - c. Do consider local medical capabilities and capacities for after-care,
 - d. Act culturally sensitive and
 - e. Coordinate all HN related medical efforts with other organisations in theatre.

Furthermore military medical services should also be very careful on the participation in CIMIC activities as they are seen as 'a combat support function to achieve the commander's aim'¹⁷. This may lead to a break of the Geneva Convention's rules of impartiality.

41. In addition ethics specifically tailored to the reality of disaster relief operations or missions in such an environment should be considered as a support for the involved medical personnel. Recent operations revealed that such rules have been missed (e.g. on how to select patients if there are too many for the medical treatment facility to take care of, what to do with premature babies in an over-crowded hospital, etc.) but can only be prepared on a national basis to be in line with different national regulations.

c. Quality and Standards of Health and Medical Care

42. Medical standards are not only different between MS, they may even differ within a MS. It is obvious that the high level of medical care usually found in the capitals or major cities is hard to find in non-populated rural regions, mountainous regions or on some islands. Furthermore the legislation concerning medicine, state supervision, the medical education system and statutory health insurance differs between EU countries, resulting in different algorithms for treatment, level of care and life expectancy.
43. Military medicine is highly specialised due to the environment and extreme conditions it is frequently practised in. Military procedures may therefore not always be the same as those practised during peacetime although the outcome has to be the same. Exactly the same applies for medical care provided in civilian CSDP missions. The quality of operational Health and Medical Support to EU-led missions and operations has to meet standards acceptable to all MS, whilst providing adequate information to the potential TCNs, prior their decision to support the EU's CSDP action.
44. The overall aim of all medical care on missions and operations is to achieve outcomes of treatment equal to results of medical treatment in the sending state.¹⁸ The application of this principle must be guided by the

¹⁶ More details can be found either in national medical literature or on the internet like http://en.wikipedia.org/wiki/Medical_ethics

¹⁷ Similar definition can be found in Reference T, E. 15

¹⁸ In any case the standard of a comparable environment should be set as defined minimum. It may not be visible to achieve a sending state's capital standard in a rural region of a non-permissive mission area.

principles embodied within the concepts of Continuous Improvement in Healthcare Support on Operations¹⁹, and, if applicable, Evidence Based Medicine and war surgery.²⁰

d. Preservation of Health and Prevention of Disease

45. Health and Medical Support plans must include detailed measures for the prevention of physical and psychological disease and injury to all deployed mission personnel or military forces as a key factor of personnel sustainability.
46. These measures are not limited to the period of deployment but may include preparatory measures before deployment (e.g. fitness screening, vaccination, malaria prophylaxis) and follow-up measures after deployment (e.g. psychological support), both within national responsibility.

e. Complexity of Medical Responsibilities

47. Health Care and Medical Support is a national responsibility²¹. At least the minimum level of Role 1 / General Practitioner / first emergency support has always been national organised. Presently, budget restrictions and a changing political climate, lead to having more and more smaller contingents, lack of medical personnel and assets as well as lack of MEDEVAC rotary wing assets. This is forcing Member States to seek for affordable solutions while keeping the required standards.
48. Health and Medical Care is provided on a basis ranging from the whole spectrum of preventive medicine (i.e. preventive medicine in the true sense of the word, epidemiology, occupational medicine, assessing environmental factors, veterinary medicine including food and water control), emergency medical care including first aid and early surgical interventions as well as intensive care and follow-up medical procedures, to evacuation within theatre and out-of theatre as well as definitive specialised care.
49. As a general rule in civilian missions MS / TCN are unlikely to include the full range of medical support in their contingent. Notwithstanding that, MS / TCN remain responsible for proper preparation and follow-up after deployment for which the responsibility is generally transferred to the Civilian Operation Commander, whilst being executed by the respective Head of Mission. He or she will arrange the medical procedures funded by the mission's budgeted.
50. A similar situation may apply for military operations. Depending on the total strength of a military operation and the respective contribution of MS / TCN, MS / TCN may be reluctant to contribute even a small national medical support element. Bearing in mind the overall responsibility of the Operation Commander for proper medical planning, MS / TCN can be asked to establish Memorandums of Understanding (MOUs) / Technical Arrangements (TAs) between each other on medical support or to rely on Athena funded Medical Treatment Facilities and MEDEVAC assets.

¹⁹ Continuous Improvement in Healthcare Support on Operations is also called 'Clinical Governance' as a national program.

²⁰ The term "best medical practice" is not used by intention as there is no common agreed definition.

²¹ This may not apply for contracted personnel from a legal point of view. Nevertheless MS are highly interested in an adequate medical system even for contracted nationals.

51. In all missions and operations there will be an Operation Commander's or Head of Mission's responsibility in the sense of occupational safety and occupational medicine. This obligation relates to all mission owned facilities and common funded institutions, not only towards MS's and TCN's personnel but also and moreover towards contracted personnel. In addition the Operation Commander / Head of Mission will arrange adequate health insurance and/or health support on behalf of contracted international and local staff.
52. Disregarding national regulations concerning documentation, medical data collection, hygiene control and epidemiology / preventive medicine the Operation Commander, in civilian missions executed by the Head of Mission, has the overall responsibility to organise and ensure:
- Assessment of the local Health and Medical infrastructure, to liaise with local health authorities and care providers, possibly consolidated by technical arrangements. (in line with Ref. U)
 - To liaise with other stakeholders within the Area of Operation for medical coordination, whilst establishing technical arrangements (TA) if deemed necessary.
 - Patient evacuation and coordination, including patient tracking and tracing.
 - Preparation for medical incidents like mass casualty (MASCAL) and epidemics.
 - Collection of medical statistics, including epidemiological records. Standardised epidemiological records should be maintained and made available by all MS and non-EU TCN.
 - In environments having a higher casualty load, the collection of medical data for a trauma registry.
 - Implementing sufficient hygiene checks, occupational safety and medicine.
 - Continuous Improvement of Medical Care program.
 - The handover of medical documentation to the respective person or to the sending MS / TCN when leaving the mission or operation.
53. The EU Concept for Logistic Support (Ref. O) elaborates also on this duality. On the one hand the responsibility for provision of (Health and Medical) Support remains ultimately with the TCNs, on the other hand the Operation Commander / Head of Mission and the OHQ / HQ structure has also a responsibility, there termed as '*Collective Responsibility*'.

f. Time-Related Constraints of Health and Medical Care

54. Resuscitation and stabilisation of all patients (this includes wounded, injured and ill) should be initiated in the field as soon as possible. A proportion of severely wounded casualties, mainly after severe bleeding or in shock, will even then deteriorate or remain unstable.
- After a high qualified first aid, which must be seen as mandatory, the time to start sufficient surgical treatment as well as the choice of the appropriate medical treatment facility are decisive factors for the clinical outcome.
- Accordingly to timelines in a civilian European environment the principal medical planning timeline for deployments should be to provide Surgery for critically injured patients within one hour, generally called "the golden hour"²². However, when this is not feasible (as determined by the operational planning process

²² The "Golden Hour" refers to 'Patients in Shock'. As an average less than 10% of patients need immediate surgical intervention.

and combined operational and political risk management) the timelines listed below can be seen as a common agreed minimal standard:

- **Enhanced first aid:** Immediate life saving measures applied by personnel having received a tactical combat casualty care course or comparable civilian training. Bleeding and airway control for the most severely injured casualties to be achieved within **10 minutes** of wounding.
- **Damage control resuscitation:** Measures commenced by emergency medical personnel within **1 hour** of wounding.
- **Damage control surgery:** (DCS)²³ Depending on the specific and individual requirement the aim is to be able to provide damage control surgery within **1 hour**, but **no later than 2 hours** of wounding.

These casualties will require surgery as soon as possible, primarily within the first hour of trauma management.

g. Triage

55. Casualties should be sorted into priorities according to the urgency of their clinical needs. Triage is the technique used to determine the initial treatment priority at the scene of an incident, on arrival in a medical facility as well as for assessing evacuation priority for subsequent onward transfer in the casualty chain. Triage is essential when several events leading to casualties occur simultaneously and the numbers exceed the capacity of the medical treatment facilities. Triage ensures the most care for the greatest number of casualties and the maximum utilization of available medical personnel, equipment, and facilities. The goal is to optimize care for the maximum number of salvageable patients. Patients who will do well with a minimum level of care are thus distinguished from those who will die despite maximal care. Attention is addressed to those who will benefit most from optimal care and rapid surgical intervention. The categories for Triage have to follow common standards and must be known at least by all deployed medical personnel.
56. Conventional Triage: Under normal circumstances, based on the individual needs of each patient, a priority "P" system of classification may be used.²⁴
- Priority 1 - Urgent: assigned to cases that require resuscitation and surgery / treatment urgently
 - Priority 2 - assigned to cases that require possible resuscitation and / or early surgery / treatment
 - Priority 3 - assigned to cases that may still require surgery / treatment but may be delayed longer than P1 and P2.
57. Catastrophic Triage: In a Mass Casualty situation (MASCAL), a situation in which an excessive disparity exists between the casualty load and the medical capabilities locally available for its management, time-consuming individual treatment and evacuation might temporarily have to be withheld from those patients who would place a high demand on medical resources. This allows the same resources to be concentrated

²³ Damage Control Surgery serves to maintain the vital and organ functions.

²⁴ The "P"-system is one of different possibilities to classify and decide whether a patient can wait or should receive immediate surgical support. No matter which system is used, these 'conventional' triage classification systems used under normal conditions have no category for moribund patients. (Examples for national standards can easily be found on the internet, e.g. "[http://ids.nic.in/UK%20Doctrine/UK%20\(12\).pdf](http://ids.nic.in/UK%20Doctrine/UK%20(12).pdf)" Joint Medical Doctrine Joint Warfare Publication 4-03)

on a larger number of casualties instead. The classification into treatment categories, shown by coloured tags, is generally used²⁵:

- T1 (Red) - Immediate Treatment: Casualties requiring emergency life-saving treatment including surgery that have a high probability to survive. Procedures should not be time consuming. If medical attention is not provided, the patient will die. Any compromise to this casualty's respiration, persisting haemorrhages and or failing shock control could be fatal.
- T2 (Yellow) - Delayed Treatment: Casualties who may need surgery or major surgery but whose general condition permits a delay in surgical treatment without unduly endangering life or limb.
- T3 (Green) - Minimal Treatment: "Walking Patients", having relatively minor injuries, may not require stabilization or monitoring. They can usually take care of themselves with self-aid or with the aid of non-medical personnel.
- T4 (Black)²⁶ - Expectant Treatment: Casualties with serious or multiple injuries with a low chance to survive even when time consuming and intensive treatment could be provided. These casualties should not be neglected but receive comfort measures, pain medication, if possible. They have to be re-triaged and, when the MASCAL is under control, treated.

58. Additional categories may be used for helicopter MEDEVAC requests, using a so-called 9-liner, a non-medical document. As EU missions and operations may have to deal with helicopter providing nations, using the 9-liner, this procedure is more specifically detailed in Annex D.

h. Continuity of Care

59. Patients passing through the medical system must be given care, which is continuous, relevant and progressive. During all stages of evacuation the provision of qualified medical care must be guaranteed.

i. Fitness for Evacuation

60. The clinical condition of the patient will govern the priority, timing, means and destination of evacuation. Coordination by experienced medical regulating staff is required at each stage.

61. In all missions and operations having their own medical evacuation system this task should be done by the Patient Evacuation Coordination Cell (PECC), as part of and/or closely linked to operational command.

62. Concerning the evacuation itself from the point of wounding (POW) at the frontline or scene of incident, recent experience showed an increased survival rate when patients being evacuated were supported by highly qualified medical staff, so-called "Medical Emergency Response Teams" (MERT)²⁷.

²⁵ The Triage technique is quite old but different approaches converged over the recent years. Nearly similar definitions and markings may be found on the internet and in handbooks (e.g. "<http://en.wikipedia.org/wiki/Triage>", "http://www.operationalmedicine.org/TextbookFiles/FMST_20008/FMST_1421.htm", in the British Joint Medical Doctrine Joint Warfare Publication 4-03, in the Major Incident Medical Management and Support (MIMMS) handbook.)

²⁶ Some nations use "Blue" instead of "Black"; "Black" then being used for the dead.

²⁷ "Medical Emergency Response Teams" (MERT): Usually emergency medicine specialists on helicopters, led by a trained emergency physician. Having a physician on board it is not only possible to administer

j. Medical Documentation

63. Medical records contain medical information on a patient including personal medical details, his/her clinical history, as well as medical care and evacuation requirements and support provided.
64. Patient documentation procedures should be clear and comprehensive, always respecting the international recognized rules of medical confidentiality. Medical documentation should be interoperable throughout the area of operations, therefore preferably provided in English²⁸ if drawn up in a multinational Medical Treatment Facility or a national facility being part of a multinational medical network.
65. At national contingent's level, using only national echelons of medical treatment, there will be no need for a single person (mission member, soldier) to carry special medical documents except the international vaccination booklet.

Personnel joining a mission or an operation without or with limited national medical support should carry in addition to the vaccination booklet a short personal medical summary, preferably in English²⁹, to be handed over to the attending physician, stating:

- basic medical data (e.g. eyesight, weight, body size, blood pressure)
- medical risks (allergies, drug intolerance),
- history of relevant diseases and past surgeries,
- prostheses and medical implants,
- pending treatments and long-term medications,
- prophylactic measures (e.g. malaria prophylaxis),
- relatives to be informed (as on a "Next of Kin"-List (NOK), usually a personnel administration issue).

In cases where personnel have to rely fully on other nations for medical support both the Operation Commander in military operations and the Head of Mission in civilian missions may request a medical certificate stating the results of a pre-deployment medical examination concerning the physical, psychological and dental fitness for the mission or operation.

66. Copies of patient's documents and digitised medical records, when available, must move with the patient through the evacuation system until reaching Role 4 / definitive care. Also when leaving the mission or operation it must be ensured by the Head of Mission or Operation Commander that procedures for handing over of copies of medical documents, provided during the deployment, are in place.

highly sophisticated medical emergency measures but to decide on the appropriate Medical Treatment Facility to deliver the respective patient.

²⁸ In the medical domain English is recognized as the universal language as all relevant publications are by journals written in English and international medical conferences are held by using English language.

²⁹ If the whole mission or operation including the medical providers and the host nation is using another common language this language may be chosen. Otherwise medical correspondence should be in English as it is commonly recognized in the medical domain.

67. The original documents (clinical records, including post-mortem reports and evidence related to deaths in theatre) must be accurately maintained for the use of national or international audit and inquiries and later be stored by the concerned medical treatment facility as required by national legal regulations (e.g. how to be stored, how long, who is responsible for).

k. Medical Confidentiality

68. Patient medical information must be respected and protected. The legal restraints concerning the passing on of personal medical data are fairly similar but not equal within the European Union. In addition the medical law for physicians may differ. Especially in the military and police environment concerning the involvement of superiors there are some differences in consuetude.³⁰ Where medical interests of patients are concerned, superiors (chain of command) and medical personnel often only share limited common ground, the extent of which to be defined by the patient's national rights and the medical personnel's national legal restraints.³¹
69. Medical data may be communicated to individuals or organisations on a strict need to know basis. Appropriate medical authorities should be informed of particular cases where confidentiality may be an issue and may need to be reinforced, for instance in the case of very important persons. The mission's information policy has to take into account this sensitive issue.
70. All personnel, including accidentally involved non-medical personnel (e.g. operation centre's personnel operating the radio and receiving emergency calls) have to comply with the rules of medical confidentiality during and after the operation.

l. Language Skills and Communication with Patients

71. The ability to communicate between a patient and the medical staff is a key element of patient care. For effective provision of care, patient and medical staff must be able to communicate with each other. Especially in a multinational Medical Treatment Facility this has to be taken into consideration early on in the planning phase and the necessary measures (e.g. multinational teams, multilingual medical personnel, liaison teams or translators) have to be taken prior to the establishment of a Medical Treatment Facility.
72. Some MS / TCN may consider preparing additional translator capabilities to support their personnel in cases of an accident or disease.

(B) Medical Capabilities and consequent Medical Operational Guidelines

73. The medical resources and assets are usually distributed into four tiers or echelons on a progressive basis to conduct treatment, evacuation, resupply and other functions essential to the maintenance of the health of the

³⁰ e.g. consuetude = legal custom; A military superior or police superior in some nations is allowed to get information on the health state of his /her personnel including details of treatment, even if the exact diagnosis is not always reported, whereas other countries tend to limit the dissemination of medical information to 'expected duration of treatment' (doctor's certificate) and the restrictions for work.

³¹ Neither a breach of law of patient's rights is acceptable nor forcing medical personnel to openly act against their national legal obligations.

mission or force. The EU concept adapts to this structure by categorising all component medical facilities into four Roles (see Annex A), defined according to the minimum clinical capability available to a facility, not its capacity, staffing or manoeuvrability.

Usually not all echelons are available within the area of operation. Their locations will be determined by the risk assessment and the casualty estimates, the latter provided by medical experts, and the time required for transportation from the point of wounding or sickness to the required treatment facility.

The choice of facilities will be influenced by the availability and type of transport assets to be utilised (ground evacuation, rotary wing or fixed wing) and the length and difficulty of the evacuation route (including daytime and weather conditions), which ultimately determine time as crucial factor.

Further influencing factors are the operational environment and limitations, availability of telemedicine assets and the Theatre Holding Policy.

74. To develop a concept of medical support that ensures the achievement of the medical aim, it is necessary to apply the Health and Medical Support principles and guidelines to the fundamental levels of professional medical care:
- a. Preventive medicine and Primary care³²,
 - b. Stabilisation of vital functions (Enhanced First Aid) and Damage Control Resuscitation; (Role 1 level),
 - c. Damage Control Surgery (DCS); (Role 2 level),
 - d. Surgery including post-operative and intensive care; (Role 3 level) and
 - e. Definitive treatment (including secondary surgery) and rehabilitation. (Role 4 level).
75. Care is normally provided in a progressive manner through the four Roles that identify the function, capability and resources of medical elements; from the point of wounding or sickness where ideally the first qualified medical treatment should take place through evacuation to surgery and/or other specialised care and eventually to definitive treatment and rehabilitation. Specific injuries or diseases might require bypassing a Role as they require specialist care at an early stage. Treatment capabilities available to each Role are intrinsic to the next higher Role. The capability of a Role may be enhanced to meet the specific requirements of a mission through "mission tailoring".
76. Listed below are the operational guidelines of Health and Medical Support, which relate to operational support, from the EU policy level to the planning constraints level.

a. Comprehensive and Sufficient Health and Medical Planning

³² The term 'Primary care' is used by intention. It stands for (e.g. http://en.wikipedia.org/wiki/Primary_care) 'the health services by providers who act as the principal point of consultation for patients within a health care system.' The term formerly used was Primary Health Care. Since the Declaration of Alma-Ata has been adopted at the International Conference on Primary Health Care (PHC), 6-12 September 1978, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, the term stands for a program. The primary health care approach has since then been accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health For All".

77. Health and Medical Support must be an integral part of any contingency and operational planning. Early consultation with medical authorities must be included in the political and operational risk management. Planning for Health and Medical Support of EU-led Crisis Management Missions and Operations has to take into account complicating factors such as the number of individual MS and non-EU TCN involved in each mission / operation, variations in national standards of medical care and equipment, the political complexity and dynamic nature of each operational scenario and the differences in individual national objectives, mission goals and restrictions for their participation in missions and operations.
78. Health and Medical Support planning must be specific for each operation and must meet the demands of geography and climatic variations, individual national needs and communications requirements. Medical capabilities must be in balance with the assessed risks to the deployed forces / mission. Factors such as hostile or criminal/terrorist interference and the availability of medical resources must be also taken into account. The estimation of risks and the production of predicted casualty rates³³ is the responsibility of the planning and operational staff (CJ3, J3 or equivalent) in cooperation with the Medical Advisor (CJMED, JMED or equivalent) and his/her medical staff.
79. The medical resources available at the outset of any mission or operation must be sufficient to, based on predicted daily rates, collect, evacuate, treat and hospitalise all casualties and other patients that present themselves whilst taking into account possible mass casualty situations. Plans must be capable of swift implementation and be flexible enough to manage rapidly changing operational demands.

b. Responsibility

80. MS TCN and non-EU TCN retain the ultimate responsibility for the provision of Health and Medical Support to their deployed citizens (mission personnel) and forces.
- As a basic rule, units and formations should deploy with appropriate medical assets tailored to their anticipated employment in order to ensure a comprehensive Health and Medical Support for all deployed personnel during the whole mission. For small operations and missions or for small national contributions this may be an impossible task to fulfil.

MS are at liberty to arrange their medical support in several ways:

- agreements with other MS, EU TCN and/or non-EU TCN,
- (commercial) organisations directly contracted and paid by the sending nation or with
- mission funded or common funded solutions

in order to prevent unnecessary redundancy and to economise critical medical resources. The Core Planning Team for a mission / operation has to consider, evaluate and plan different possibilities. After the Call for Contribution or the Force Generating conference the Operation or Force Commander / Head of Mission, supported by the Medical Director or Medical Advisor (JMED), may be tasked to mediate and coordinate such agreements.

³³ This includes the prediction of accidents and diseases on an average basis, tailored to the mission area, season and mission tasks.

81. For the mission or operation the Operation Commander, in consultation with troop contributing MS and non-EU TCN, is responsible for determining the Health and Medical Support requirements for his / her multinational mission or forces.
82. On transfer of authority (TOA), the Operation or Force Commander / Head of Mission will be responsible for the Health and Medical Support of assigned forces or mission as delegated. The prerequisite for the delegation of medical responsibilities to a commander is the presence in his/her staff of appropriate medical representation - sufficient in rank, number, training and experience. For smaller missions and operations the minimum requirement will be in theatre support by external medical specialists to be established by the Operation Commander.³⁴

c. Authority

83. Troop contributing MS and non-EU TCN retain full control over their own resources, until such time as they are released to the civilian or military Operation Commander.
84. The civilian or military Operation Commander is authorised to request information on the quantity and quality of specified medical assets designated to support EU missions and operations, which will be under his/her command.
85. Furthermore, the Operation Commander is authorised to evaluate the specified designated medical assets during the build-up to Transfer of Authority (TOA). This may include the assessment of medical units prior to deployment, and inspection as required of specific medical assets. The Operation Commander can delegate this authority to his/her Medical Director or Medical Advisor (JMED).

d. Coordination and Cooperation

Coordination of medical assets:

86. In an operation or mission national medical systems of care and evacuation should be retained as much as possible. However, nations are encouraged to achieve economies of scale through multinational (MN) solutions and the coordination of both military and civilian medical services (contractors, experts via telemedicine, HNS). The Head of Mission or the Force Commander should have redistribution authority in order to cope with casualty peaks within his/her mission or force to coordinate patient flow to the adequate MTF at the suggestion of his/her Medical Director or, in smaller missions, Medical Advisor.³⁵

Cooperation with other medical providers and users:

87. Cooperation between civilian and military EU CSDP missions and operations, national military and civilian authorities as well as with international organisations is essential.

³⁴ Small military or civilian mission will not have mission owned medical advisory personnel. In this instance the Head of Mission or Field Commander must be supported by CPCC / the dedicated OHQ, which provides medical expertise and guidance support, including auditing, on demand and on short notice.

³⁵ In smaller missions / operations this may be the task and exercised by a contracted health care provider.

Medical Liaison:

88. To coordinate and cooperate in the mission and with other actors an efficient liaison system between contingents of MS, non-EU TCN and theatre medical resources such as hospitals, evacuation control cells, other involved structures (such as governmental organisations, IOs and NGOs) and the Force Medical Director / Medical Advisor must be established.

Data exchange:

89. Information exchange of civilian and military Health and Medical Support data between MS, non-EU TCN and EU authorities is essential for the efficient management and coordination of support to EU missions or forces. This is not limited to patient's file to be handed over to the Medical Treatment Facility he/she is referred to but also includes data related to patient tracking and occupational medicine. The data flow as well as agreements for the data exchange, including the confidentiality regulations, has to be prepared in advance.

Patient Regulating / Patient Tracking:

90. The process of control and coordination to ensure patients are evacuated to medical treatment facilities which are best capable of providing the required treatment, and having the required number and types of beds available, is a critical element of the medical care system, and must be functional at all times during a mission. Furthermore, a system to precisely and continuously monitor in near-real time the location and the intended destination of the patient in the medical treatment and evacuation chain has to be included. A system like this requires dedicated staff, having appropriate CIS capable of providing the requisite visibility of the status of medical facilities, evacuation assets and casualty flow. This task can be executed by medical staff personnel or by a contracted company.

Medical Evacuation Resources Coordination:

91. The planning and execution of effective medical evacuations are to be based upon the evacuation policy developed by CPCC for civilian missions, by the appointed OHQ for military operations, and implemented within theatre by the civilian Head of Mission or military Force Commander. The provision of resources will be coordinated by the Medical Director or Medical Advisor, to be supported by medical experts in smaller missions. This may comprise assets from a number of sources, including common use theatre assets, national owned assets, Host Nation Support and contracted or Third Party Logistic support.
92. To execute this task with experienced personnel in large missions, FHQ staff should be reinforced by a Patient Evacuation Coordination Cell (PECC). In smaller missions this task may be provided by the Medical Director or Medical Advisor or by contacted companies.

e. Standardisation

93. Health and Medical concepts, plans, structures and procedures must be understood and agreed by all MS and potential non-EU TCN should accept them in order to become TCNs.
94. MS and non-EU TCN should strive to maximise standardisation where possible (compatibility, interoperability, interchangeability or commonality as appropriate and achievable) in order to optimise

multinational medical care. Medical materials, particularly blood and blood products, must meet EU MS and internationally recognised quality assurance standards for the care of patients.³⁶

95. The majority of EU MS are NATO nations or members of the Partnership for Peace (PfP). NATO medical documents could be used following their official distribution to all EU MS whenever it deems appropriate³⁷. These documents could at that case be seen as a tool for setting standards in order to improve the interoperability, although EU MS may agree on different especially higher standards to meet national standards set by EU MS legislation.

f. Fitness and Health Standards

96. Individuals allocated for EU-led Crisis Management missions and operations must achieve, prior to deployment, the basic standards of individual fitness, health and preparation, including vaccination, predetermined by the policy of the MS as well as of possible non-EU TCN. These standards have to reflect the specific demands of the mission.
97. As long as a MS purely relies on own medical structures national defined standards of individual fitness, health and preparation, including vaccination may be defined nationally. In any case basic fitness and health standards including advice on vaccinations³⁸ and preparatory measures³⁹ will be defined by medical specialists during the preparation phase. These advices will be included in the Call for Contribution respectively in the manning conference's requirements. Depending on developments and experiences during the mission the medical advices will be reviewed on a regular basis and may be adjusted by the mission's / operation's Medical Director or Medical Advisor.
98. Except for personnel relying on purely national health support the result of the pre-deployment medical examination has to be certified⁴⁰ and handed over to the Head of Mission in civilian missions and on request to the Force Commander in military missions.

g. Health and Medical Support Quality Structure

Adequacy:

99. Medical resources in theatre must be designed adequately to provide, from the outset of the mission⁴¹, sufficient capabilities to all required levels of support. They must expand progressively as the mission /

³⁶ Respecting the requested MS minimum standards sets the limit for any purchasing of medical supplies, in particular obtaining blood or blood products, outside EU member states. The tendering authority is responsible for care and attention of the EU MS and internationally recognized standards.

³⁷ NATO Standardization Agency has started to further declassify STANAGs from 'NATO unclassified' to 'Public' and has published an increasing number on the internet (<http://nsa.nato.int/nsa/>, Current Standards)

³⁸ In general vaccination is a purely national issue although the request for 'Yellow Fever' vaccination may be a mandatory host nation request as well as a vaccination against Rabies may be mandatory as there are not enough vaccination facilities in the area of operation.

³⁹ e.g. acclimatisation period, mosquito and sand fly protection, malaria prophylaxis.

⁴⁰ Template for Medical Certificate, which should be seen as a minimal level example, is attached in Annex D.

⁴¹ This rule cannot entirely apply for Fact Finding Mission (FFM) or Information Gathering Missions (IGM), even for this missions appropriate health and fitness standards and in mission support must be considered,

force strength expands and risk increases, and still be available in non-permissive situations (e.g. skirmish, insurgence, civil war or combat situations) until all personnel has left the area of operations. This prerequisite must also be taken into account for contracted health and medical support that 'force majeure' is not a reason to finish the support to the mission or operation⁴².

Levels of Health and Medical Care will be provided as appropriate to each EU operation and should be tailored to the mission. This will usually include Enhanced First Aid and Role 1 to Role 2 capabilities in theatre, multinational medical support arrangements and arrangements with other organisations in theatre, civilian contractors or host nation support to assure the quality of required medical support.

Medical Staff:

100. Whilst overall policy, direction and control of medical activity are vested in the various key medical offices, implementation is effected through a comprehensive staff structure. To achieve a full operational and coordinating capability, it is crucial that the medical personnel are identified in a timely manner by CPCC or the parent HQ and MS / non-EU TCN, and are fully trained in the medical management of operations according to their job descriptions well before deployment.

Readiness and Flexibility:

101. Medical units must be as mobile and responsive and at the same state of readiness and availability as the mission or force they support, whilst remaining capable of meeting the demands of evolving operational scenarios⁴³.

Levels and distribution of medical materiel must be sufficient to achieve and maintain designated levels of readiness, sustainability and mobility to provide the required capability during peace, crisis and conflict.

Adequacy in Exceptional Circumstances:

102. Furthermore medical resources must have a surge capability to deal with peak casualty rates in excess of expected daily rates, accepting the fact that these peaks may be beyond the capability of first responders / regional MTFs to provide adequate care to all affected (MASCAL).

Definitive Treatment:

103. Time and resources consuming definitive treatment and rehabilitation will be provided under national responsibility.

Medical Supply and Resupply Rates and Standards:

104. National medical support contingents, provided by EU or Non-EU Troop Contributing Nations, must deploy with an agreed quantity of medical supplies as identified by planners of the CPCC or the appointed OHQ in consultation with MS and based on the risk assessment and the casualty estimates. Contracted medical support should meet the same level of sustainability.

Policy and planning for the resupply of medical materiel are medical matters, which directly affect patient care. Therefore effective means of auditing usage and replenishment must be established.

h. Theatre Holding Policy

defined and planned in advance.

⁴² But usually in case of force majeure the costs increase due to extra pay.

⁴³ This does not mean that specialised personnel will necessarily be allocated in any case to particular units in peacetime but that they will be prepared to be readily available when required.

105. The theatre holding policy is a command decision. From the outset of an operation the Head of Mission or Force Commander, on advice of his/her Medical Advisor⁴⁴, must establish a theatre holding policy in concert with the operational, national and medical planning staffs. A separate but shorter evacuation policy may be established by the MS, non-EU TCN or components. This policy will indicate the maximum length of time (days) that a patient will be allowed in the theatre for treatment, recovery and return to duty. Patients who are not expected to return to duty within that period or who cannot be provided with the appropriate treatment in theatre should be evacuated out of theatre as soon as they are considered suitable for evacuation.

i. Provision of Treatment to Third Parties and Local Population / Eligibility of care

Emergency Treatment:

106. Although the Operation Commander, Head of Mission and Force Commander have the authority to limit the availability of Health and Medical Support to third parties, acute emergency treatment of life threatening trauma or illness should be provided within the medical resources availability and mission's constraints⁴⁵ to meet international statutory provisions⁴⁶. Issues related to the reimbursement of provided medical support should ideally be decided upon in advance.

Provision of Non-emergency Treatment to Third Parties:

107. Policy must be established during the medical planning process regarding the entitlement of non-mission personnel to health and non-emergency medical care. Medical staffs may promote the advantages of economies of scale through the application of different modes of multinational medical support or arrangements with other organisations in theatre.

Provision of Non-emergency Treatment to Local Population:

108. Provision of medical support can be part of the mission's task but in general the mission's medical support is tailored to meet the mission's own requirements. The Provision of Health and Medical Support to the local population is normally limited to first emergency medical support measures within means and capabilities. Influence on the local health and medical system created serious problems in the past therefore any competition with and disrespect of local healthcare systems must be strongly avoided. (see E. a. (b)). Usually most policies concerning local population's non-emergency support, established during the medical planning process, will refrain from the provision of direct support to the local population.

j. Naval operations

109. Often the limited number of available medical treatment facilities, personnel, rotary wing assets and supplies on board ships as well as the vast distances encountered at sea when attempting to evacuate a patient to the next appropriate hospital create enormous challenges for the planning of maritime operations from the start. Albeit the planning timelines and the expected outcome should not be neglected there may be situations where all the 'land conditions' may not be met. Therefore an increased effort has to be made

⁴⁴ In small missions without own Medical Advisor this support will be delivered by CPCC, OHQ or EUMS.

⁴⁵ Generally the term "within means and capabilities" is used.

⁴⁶ Medical support in case of emergency ('Duty to Rescue' or 'Denial of Assistance') is part of the International Humanitarian Law, was stated in the United Nation's Security Council Resolution 1296 ('Protection of Civilians during Armed Conflicts') and is part of many national legislation.

focusing on supporting naval operations by adequately equipped ships (e.g. hospital ships, tender, amphibious assault ships, aircraft carriers), by evacuation lines with equipped and medical manned helicopters, by assessed hospitals ashore and, in the specific case of Naval Operations carried out in Blue water, by considering the employment of a mission tailored Medical Treatment Facility, like a Role 1 including a surgical module (innovative technical solutions should be considered).

k. Special Operation Forces

110. Neither military nor police special operations can usually be planned so well in advance that a MEDEVAC chain and hospitals can be put in place. In addition to that special operations are often small size operations, taking place in remote areas.
111. Although it often remains difficult to effectuate, all medical doctrine applies for Special Operation Forces too. For this reason SOF units have successfully established own medical structures, special medical training for non-medical personnel far beyond 'normal' First-Aid-Training and acquired special medical equipment, tailored to their needs.
112. If involved in special operations, usually on short notice, JMED and his/her staff should prepare the MEDEVAC from the pick-up point to the appropriate Medical Treatment Facility.

l. Financing

Civilian Missions:

113. The mission is responsible for the health insurance for the missions' personnel. This insurance must cover individual costs related to medical treatment and transport. Beyond the individual health insurance, the mission, approved in the OPLAN, will cover the costs for an adequate health and medical support system, including MEDEVAC, if assessed necessary.

Military Operations:

114. Depending on the size of an operation the arrangements may be different in military operations and civilian missions. As a general rule Health and Medical Support is a national responsibility, therefore financed by the contributing EU MS or non-EU TCN⁴⁷ themselves. In smaller missions there is often a lack of medical support at the appropriate level. The provision of Health and Medical Support is therefore, to a certain extent, eligible for reimbursement as common costs through the ATHENA mechanism. (e.g. the costs of emergency medical evacuation of persons taking part in exploratory missions and preparations by military and civilian personnel with a view to a specific EU military operation, when medical treatment cannot be provided in theatre (Ref. V)). In the active phase of operations emergency medical evacuation (MEDEVAC), Role 2 and 3 services and facilities at theatre operational element level, such as airports and disembarkation ports approved in the operation plan (OPLAN) may also be covered through this

⁴⁷ The common agreed rule is: 'Costs lay where they fall.' For small countries having only small contributions it was not possible to afford the requested level of medical support by own means. On the other hand major MS have been reluctant to pay the medical support for all other troop contributing nations.

mechanism. Operational costs for additional Role 1⁴⁸ or 2 Medical Treatment Facilities can be covered, if requested by the Operation Commander and approved by the Special Committee.

(C) Multinationality and Contracting

115. By encouraging multinational coordination and cooperation, including contracted international or national medical support, scarce medical resources can be used more effectively, economies of scale can be achieved and unnecessary redundancies can be prevented. Therefore strong efforts to achieve such coordination and cooperation have to be made as early as possible at an early stage during the planning process of an EU-led mission. Economies of scale can be achieved by different approaches (definitions from the '*EU Concept for Logistic Support for EU-led Military Operations*' are used):

- a. Tender and contracts,
- b. Bi-/multilateral agreements / arrangements,
- c. *Logistic Role Specialist Nation (LRSNs)*⁴⁹,
- d. *Logistic Lead Nations (LLNs)*⁵⁰,
- e. Multinational Modular Medical Units (M3U).

116. Planning EU-led Crisis Management Missions and Operations can become more complicated by the involvement of various MS and potential non-EU TCN. Several important aspects have to be considered and dealt with in the respective agreements, contracts, SOMA or SOFA⁵¹, *Memoranda of Understanding (MOUs)*⁵² and/or Technical Arrangements (TAs) when preparing multinational or contracted Health and Medical Support:

- a. Function and mission of medical units,
- b. Legal status of (contracted) medical units towards conflict parties,
- c. Line management in the medical chain of command,
- d. Contributing MS and non-EU TCN incl. certification,
- e. Command relationship,
- f. Distribution of responsibilities and tasks in medical unit structure,
- g. National requirements (medical technical standards, treatment regimes, regulations and duties),
- h. Language barriers,
- i. Funding,
- j. (Medical-) legal aspects⁵³,

⁴⁸ At least Role 1 is normally considered as national responsibility.

⁴⁹ Similar to Ref. O: A Troop Contributing Nation (TCN) assumes the responsibility of (*Logistic*) *Medical Role Specialised Nation* when it assumes the responsibility for procuring and providing a specific medical capability and/or service for all or part of the multinational force / mission within a defined geographical area for a defined period of time.

⁵⁰ Similar to Ref. O: A TCN can be a (*Logistic*) *Medical Lead Nation* if it assumes the overall responsibility for organising and co-ordinating an agreed broad spectrum of medical support for all or part of the multinational force / mission, including headquarters, within a defined geographical area for a defined period of time. The Lead Nation can concurrently provide capabilities as a Role Specialized Nation.

⁵¹ SOMA: Status of Mission Agreement; contract of a civilian mission with the host nation. SOFA: Status of Forces Agreement; contract of a military operation with the host nation.

⁵² EU does usually not use Memoranda of Understanding; SOMA / SOFA are followed directly by Technical Arrangements. Nevertheless MOUs may exist between TCNs or from preceding missions.

⁵³ E.g. aspects of liability concerning malpractice, possible harms caused by materiel or medical products including blood, handling of medical qualified data etc.

- k. Medical documentation and hand-over of documents by leaving the mission,
 - l. Theatre holding policy,
 - m. National caveats,
 - n. Eligibility for treatment,
 - o. Medical logistics and blood supply / blood safety,
 - p. Auditing mechanism and frequency.
117. To take advantage of economies of scale, Health and Medical Support may be provided by medical units composed of more than one MS / non-EU TCN or mixed with contracted personnel. A Multinational Modular Medical Unit (M3U) is a Medical Treatment Facility (MTF) where normally a single MS or non-EU TCN is providing the nucleus and the structure and that is capability based in a modular approach supplemented/ augmented by other MS and non-EU TCN.
118. Medical procedures, protocols, standards and professional qualifications should be common, mutually agreed, trained and complied with by all contributors to a M3U. To achieve defined common minimal standards in M3Us or to assess the standards of contracted medical support or Medical Treatment Facilities an agreed Medical Evaluation Manual should be used.

(D) Auditing

119. To create confidence in and to guarantee the security of the supported personnel through multinational medical solutions or contracted international / host nation medical support an auditing system by independent medical specialists, performed on a regular basis, must be in place.
120. Depending on the size of mission and medical support these audits should be conducted routinely, preferably every half year on behalf of the Head of Mission / commander who owns the overall responsibility. He or she will receive the reports and should inform the TCN on the results of the evaluation.
121. Notwithstanding the responsibility of the Head of Mission / commander for the mission's / operation's medical support, MS or TCN themselves may also initiate a medical audit, executed by EEAS medical specialists, to be presented to CIVCOM / EUMC level.
122. For an extensive assessment of a Medical Treatment Facilities by medical specialists the use of a structured and easily comprehensible Medical Evaluation Manual is strongly advised.

F. HEALTH AND MEDICAL SUPPORT ORGANISATION

123. The aim of this section is to provide the basic policies behind a generic concept of Health and Medical Support which can be applied across the whole spectrum of EU-led missions and Operations to a standard acceptable for all MS and in line with peacetime medical standards, taking into account a possible hostile or military environment.

124. Medical capabilities and capacities assigned to any EU-led mission or operation must be sufficient and have at least the same level of readiness, deployability, flexibility and sustainability as the mission or forces they support.
125. Comprehensive medical plans are essential to permit a rapid, efficient and flexible response and to provide a medical support capability that must be complete, coherent and present from the initial deployment until the end of any operation.

(A) Medical Planning Responsibilities

126. Medical staffs operate in a very close interface with all other staff areas to establish the required coordination of resources and support for the medical plans. The extent of this interface in a military environment is shown in diagrammatic form at Figure 1. The list is neither exhaustive nor definitive but demonstrates clearly the areas where medical planners need to work in unison with other staff areas. As the naming of the functions by J1 up to J9 may be different in civilian missions the tasks to be fulfilled remains similar, so the interlacing of medical personnel in staff work remains unchanged.
127. Whenever possible assistance should be provided through Host Nation Support (HNS) in arranging for local support of the medical plan (Ref. U). As it is likely that medical units will be used during information campaigns, this may pose additional requirements on the medical structure, in accordance with command intent (Ref. T).

J1 - Personnel & Administration

Medical Personnel qualifications	International Law (e.g. Geneva Conventions)
Medical Personnel assignments	Medical Discharges
Patient Tracking	Boards of Inquiry/Inquests
Patient Welfare & Spiritual Matters (including religious and socio-cultural factors)	Medical Surveillance
Deceased Personnel	Disability Pensions
	Health and Medical Support for Detainees

J2 - Intelligence

Medical Intelligence	CBRN Risks
Geographic Factors: Climate, Terrain	Disease and Non Battle Injury Rates
Endemic and Epidemic Diseases	Environmental Health

J3 - Operations

Equipment Development	Casualty Estimates (also J2 and J5)
Contingency Plans	Medical Evacuation Plans
Force Protection and Operational Planning	Current & Future Operations
Major Incident Plan	

J4 - Logistics

Movement	Infrastructure
Host Nation Support	Power Supply
Supply and Resupply	Accommodation
Equipment Support	Waste Disposal / Black water
Procurement	Medical Logistics

J5 - Plans

CONOPS Medical part	Force Generation Medical assets
OPLAN Medical part	Reports & Information to EU MS and TCN

J6 - CIS

Medical Information System	Medical Communications
Patient Tracking	Telemedicine

J8 - Resources & Finance

Contracting Support	HNS
---------------------	-----

J9 - Civil-Military Cooperation

Cooperation and liaison with civil environment (including liaison with IOs, NGOs)	Religious and socio-cultural factors
CIMIC activities	Winning of hearts and minds
Humanitarian Assistance (including Refugees)	Comprehensive approach

Figure 1. Illustrative interface between Medical and other Staff Functions. Regardless of the possible different structure of an EU-led civilian mission the interlacing remains similarly.

(B) Medical Functional Areas

128. Based on a comprehensive medical planning process following early participation in reconnaissance, the resources and capabilities required to meet the demands of the medical tasks can best be described within the following functional areas:
- a. Medical Command and Control (Medical C2), including CIS support and medical intelligence (MEDINTEL)⁵⁴ (para 131-140),
 - b. Preventive Medicine and Medical Force protection, Sound preventive medicine, epidemiological and medical force protection programme (para 141-147),
 - c. Medical Evacuation (MEDEVAC) (para 148-157),
 - d. Medical Logistics: Reliable medical logistic system (para 158-168),
 - e. Medical treatment, including measures against CBRN/ hazardous materials threats are integrated however this concept does not address the specific aspects of medical care (see para 24).

An examination of these functional areas, in the context of the principles, offers a coherent and comprehensive Health and Medical concept of operations, which can be applied to the range of potential EU-led missions and Crisis Management Operations.

a. Medical Command and Control (Medical C2)

C2 Capability:

129. The medical staffs at all commands levels must be capable of planning, executing, controlling, supporting and auditing the full range of Health and Medical Support functions. It must be capable of providing a seamless system of control of treatment, evacuation and passage of information from point of injury or falling ill throughout evacuation to definitive treatment and / or release from hospital. It must also be capable of passing prompt and accurate operational medical advice to Head of Missions and military commanders and, in civilian missions, pertinent general medical information to CPCC respective to superior HQ's medical staff in military missions.
- Early participating of experienced medical personnel in Fact Finding Missions / Information Gathering Missions and timely, accurate medical intelligence, from whatever source, is required.

National points of contact:

130. Notwithstanding that the mission's or forces' medical staff has to conduct its duty to support the mission or operation and follow the hierarchical structure in order to inform the Head of Mission or Force Commander and the Civilian or Military Operation Commander, it can be adequate to inform national points of contact simultaneously and early, especially in cases of serious casualties or need for strategic evacuation. This may ensure an early information of next of kin, facilitate the (transport) procedures and bridge language problems.

⁵⁴ The abbreviation 'MEDINTEL' is used by purpose instead of 'MEDINT'. The intelligence community uses the suffix 'INT' to describe sources (e.g. OPSINT = OPen Sources INTelligence; HUMINT = HUMAn INTelligence, as the classical espionage; ELINT = ELectronic signals INTelligence), whereas Medical Intelligence is an own intelligence speciality.

Organisation:

131. Depending on the size of the respective HQ a Head of Medical Services must be appointed for civilian missions. For military operations a JMED / Medical Director⁵⁵ must be appointed within EU HQ. He or she is accountable to and is allowed direct access to the respective Head of Mission / Commander as his/her Medical Advisor (Ref. W) concerning medical matters.

The Medical Director / Head of Medical Services / JMED should be supported by an appropriate number of qualified and experienced medical staff, depending on the size of mission. Within the EU Operational and Force HQ's the medical staff has its own staff element, Likewise this should be addressed in a similar way within EU-led civilian missions.

132. Smaller missions and operations or such missions and operations relying on contracted providers delivering medical expertise may not have a mission owned medical C2 structure. In this case CPCC or the appointed military HQ will support the Head of Mission or Force Commander by providing Medical Advisor's expertise and, on request, auditing capabilities.

133. Plans must state functional medical responsibilities, lines of accountability and the methods used to achieve these, including the flow of directives, orders and feedback.

The following functions should be reflected⁵⁶:

- a. Plans,
- b. Operations,
- c. Preventive Medicine / Medical Intelligence,
- d. Medical Evacuation / Transport Coordination,
- e. Medical Logistics,
- f. Appropriate administrative support.

b. Medical Communication and Information System (MedCIS)

134. The task of planning, executing and coordinating Health and Medical Support has to be fulfilled by a trained medical staff at each level of command. To properly fulfil their mission, there is a need to allocate the most effective CIS means in order to maintain reliable communications with the chain of command, all medical units in the field and collect all relevant medical data from theatre.

135. In order to enable coordination of national and multinational Health and Medical Support, sufficient CIS-support capable of meeting the specific medical requirements (e.g. medical confidentiality, specialist consultation, etc.) should be dedicated to support medical staff at all command levels.

⁵⁵ JMED / Medical Director: The functional head of medical services in a formation or theatre of operations. The Medical Director usually has the additional responsibilities of being the Medical Advisor to a senior commander.

⁵⁶ Depending on the size and type of operation, multiple functions could be covered by a single expert.

*c. Medical Intelligence (MEDINTEL)*⁵⁷

136. An essential requirement of medical support is the availability of MEDINTEL from the initial planning stage throughout the operation as well as during and after redeployment. MEDINTEL is not part of Intelligence (see Ref. X). MEDINTEL serves several essential purposes at the strategic and operational levels of planning and is important to the medical planning, preventive medicine and operational staffs. MEDINTEL provides the basis for action throughout the range of medical operations.
137. The intelligence required for medical planning and operations must be comprehensive, rapidly available, accurate and up to date.
138. Medical staffs are responsible for developing medical intelligence requirements in order to enable the staff to efficiently request, acquire and disseminate the finished intelligence products needed. Therefore the gathering of medically related information is a common and continuous task for all medical personnel in missions and operations.

d. Preventive Medicine and Medical Force Protection

139. A primary responsibility of medical support is the maintenance of health through the prevention of disease and injury (BI / DNBI) as during missions they will be an ever-present risk to personnel.
140. In the medical context, Force Health Protection is the conservation of the working or fighting potential of a force so that it remains healthy, mission / combat capable and available to the Head of Mission / commander. Force Health Protection focuses on defining and implementing mitigating measures to counter the debilitating effect of environmental and occupational health risks, industrial hazards (EIHH⁵⁸), diseases and selected special weapon systems and includes preventive measures for personnel, systems, and operational forces or the mission.
141. Medical support plans must include provision for preventive medical measures and the means to implement them in a timely and effective way.

Preventive Medicine Capability:

142. Preventive medicine measures must include:
- a. Recommendations for the minimum standard of health, preparedness and physical, dental and mental fitness for all individuals to be deployed to a specific region and specific mission to avoid having susceptible individuals being exposed to unnecessary health risks.
 - b. Identification of all possible risks and threats to the health of all personnel deployed in a specific

⁵⁷ Medical Intelligence: That category of intelligence resulting from collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information that is of interest to strategic planning and to medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors. (see www.wikipedia.org/wiki/Medical_intelligence) It is not allowed to use MEDINTEL for the purpose of harming opposing forces through, for example, military actions such as targeting.

⁵⁸ EIHH = Environmental and Industrial Health Hazards

Area of Operations (AOO) or Theatre of Operations (TO), ranging from terrain, climate, endemic and epidemic disease, special environmental and occupational hazards, health threat controls for waste (human, hazardous, medical) disposal.

- c. In case of CBRN attacks or in case of exposure to toxic industrial materials (TIM), the medical and non-medical surveillance systems must be capable of detecting contamination by these agents in order to assist in implementing quick and adequate counter-measures.
- d. Identifying, auditing and supervising necessary or/and legal preventive and controlling measures and advising Commanders / Heads of Mission on their implementation, to include the recommendation of a theatre policy on immunisation and prophylactic measures and on the appropriate training of all personnel, especially on measures to prevent food-, water- and vector-borne diseases.
- e. Gathering of epidemiological and other medical statistics and information.
- f. Advising on and auditing the quality of water and food, sanitary facilities, waste disposal and management of grey and black water⁵⁹.
- g. Advising Head of Missions / commanders on the overall health risk and threats to their personnel and the constraints they may place on the operational plan.

Preventive Medicine Organisation:

143. Implementation of preventive health measures begins during the Fact Finding Mission (FFM)⁶⁰ or Information Gathering Mission (IGM) during the pre-deployment stage and continues throughout the deployment, irrespective of overall changes in the conduct of the operation, and must extend well into the post-deployment period. They involve every individual in the operational theatre, who must be aware of the necessary personal protective measures and be trained accordingly. Medical force protection must therefore be in place from the outset of the mission / operation and must extend from the Brussels level down to unit /Field Office and below. Its shape and size will be mission dependent but must be capable of providing preventive medicine advice at every level of operational command. Depending on the size of the staff, this advice could come from a single medical officer having multiple medical responsibilities or from a larger preventive medicine staff, specialised in hygienic and preventive health care.

Preventive Medicine Responsibility:

144. Establishing objectives and executing baseline health surveillance are fundamental national responsibilities in the pre-deployment phase. However, the OpCdr and the Head of Mission / Force Commander share this responsibility in order to ensure that personnel are medically (including dental and mental health) fit and prepared for duty upon arrival in the mission or in Theatre of Operations (TO).
145. Due to the benefit of having a common preventive approach the Medical Advisor or the Medical Director should give early preventive guidance, possibly within the OPLAN. In theatre preventive medical activities, starting from site surveys and those measures listed above, must be organised by the Medical Advisor or Medical Director. In military missions the lead nation (LN) or role specialist may normally utilise that

⁵⁹ Black water (waste) is a relatively recent term used to describe water containing faecal matter and urine. It is also known as "brown water", "foul" water, or as sewage. It is distinct from grey water or "sullage", the residues of washing process.

⁶⁰ A FFM / IGM should consider the inclusion of medical personnel qualified on the different aspects of medical planning, preventive medicine and HNS.

nation's concept.

e. Medical Evacuation (MEDEVAC)

146. MEDEVAC⁶¹ is the movement of patients using dedicated assets under medical supervision to Medical Treatment Facilities. This requires skilled medical personnel and specific assets. Qualified movement of casualties in accordance with modern medical standards doesn't only consist of transportation to a suitable Medical Treatment Facility alone but is part of the continuum of treatment and care. Because of this it is a medical responsibility.

The principles and policies mentioned before dictate the organisation and capability of the medical evacuation support system.

The overall capability and capacity of treatment resources required in theatre will be determined by the medical estimate and such as influenced by evacuation capability. The more problematic the evacuation between two levels of care, the greater the treatment capability that may be required at the lower level.

MEDEVAC Planning Determinants:

147. Key determinants in establishing a comprehensive and capable medical evacuation system are:

- a. Theatre Holding Policy (see F. b. (h))
- b. Fitness for Evacuation (see F. a. (i))
- c. Time-Related Constraints of Health and Medical Care (see F. a. (f))

Medical Evacuation Assets Responsibility:

148. The overall responsibility for planning and executing an effective MEDEVAC system as well as its overall direction within the scope of the Head of Mission's or Force Commander's orders lies with the Medical Director / Medical Advisor⁶² and his/her staff. He/she will have to coordinate with all relevant operational and logistic staffs in theatre. Detailed evacuation concepts should be established applying the following principles:

- a. Evacuation from point of injury to Role 1 Medical Treatment Facility is in principle a national responsibility. This rule may apply in large, especially military missions. Wherever possible multilateral solutions should be considered. In smaller missions the primary evacuation can be outsourced (e.g. to civilian companies).
- b. Evacuation from Role 1 to Role 2 and/or Role 3 is a mission's responsibility.
- c. Evacuation to Role 4 is a national responsibility Depending on the mission or the status of the personnel this may be part of an insurance package.

⁶¹ CASEVAC (CASualty EVACuation) is defined as transport of patients either not accompanied by special trained medical personnel or using non dedicated assets (e.g. using a bus for the less injured in case of a mass casualty incident).

⁶² Medical support will be provided by CPCC or the appointed OHQ, or on request by the EUMS through its medical specialists in order to support small sized missions and operations.

MEDEVAC Coordination:

149. To guarantee the requested timelines MEDEVAC assets must be dedicated or at least on priority call.
150. Transport means should be coordinated by medical planning staff and can comprise assets from a number of sources, including contracted resources and Host Nation support:
- a. **Intra-Theatre** assets appropriate to the mission may include:
 - ground assets (armoured/non armoured, wheeled or tracked),
 - air assets (fixed and rotary wing),
 - maritime assets (Role 1 or 2 afloat, hospital ships).
 - b. **Inter-Theatre** assets will also be mission dependent. The most likely option will be the use of fixed wing aircraft, but depending on the nature of the theatre of operation and movement distances involved other options such as helicopters or ships might also be available,.

If the mission or operation has its own medical force the coordinating task should be supported by a Patient Evacuation Coordination Cell (PECC).

MEDEVAC Capabilities:

151. Regardless of the size of the mission or operation, a medical evacuation system must have the following capabilities to achieve its mission:
- a. The ability to evacuate casualties to a medical care facility on a 24/7 basis, in all weather, over all terrain and in any operational scenario.
 - b. The provision of medical sustainment of the casualty throughout the journey, using appropriately trained medical staff and medical equipment as required by the clinical condition of the patient.
 - c. The ability to regulate the flow and kind of patients when circumstances require and to enable accurate patient tracking throughout evacuation.
 - d. Responsive and flexible evacuation assets with appropriate communication means.

At any time during MEDEVAC to the appropriate Medical Treatment Facility, personnel involved has to maintain all applicable standards of care.

MEDEVAC Definitions of three main categories:

152. In general MEDEVAC units are described in terms of where exactly in the chain of evacuation they are positioned.

153. There are three main categories of MEDEVAC:

- a. Forward MEDEVAC provides transport for patients from the point of wounding to the initial Medical Treatment Facility. Because it is mandatory to meet clinical timelines, this kind of MEDEVAC is increasingly done by rotary assets. Forward MEDEVAC can be to a Medical Treatment Facility of any Role and should bring the patient, where possible, to the most appropriate level of care within the timelines. This doesn't necessarily mean the closest Medical Treatment Facility⁶³. Forward MEDEVAC needs to be configured to meet the same protection levels as the forces or the mission personnel in the area they are required to enter have adapted, e.g. armoured

⁶³ It is for the emergency medicine physician on board in coordination with the Patient Evacuation Coordination Cell to decide whether the next Medical Treatment Facility within the timelines for heavy injured patients will be taken or the risk to overstretch the time limit is counterbalanced by a more appropriate care using a higher qualified Medical Treatment Facility.

vehicles when entering a high risk area. MEDEVAC assets must reach the seriously injured casualty with skilled medical aid (e.g. doctors, nurses or paramedics) with competences that include experience of pre-hospital environment including ATLS, within one hour of wounding. The level of pre-hospital emergency care skills required will be determined by the estimate and likelihood of injury.

- b. Tactical MEDEVAC is the evacuation of casualties within the Theatre of Operation, transporting patients between different Medical Treatment Facilities, usually but not always to a higher level. Tactical MEDEVAC can be conducted by ground or air, using rotary or fixed wing assets.
- c. Strategic MEDEVAC is essentially the evacuation of casualties from theatre to their respective home countries. Depending on the solutions MS and potential non-EU TCN have come up with during the Force Generation Process, this may imply patients to be transported via other MS or potential non-EU TCN or even temporarily to an out of theatre safe area. For military operations Strategic MEDEVAC is ultimately a national responsibility, nevertheless bi- or multilateral agreements between MS and/or non-EU TCN or cover by a high risk insurance are an efficient way to share scarce resources of MEDEVAC aircraft, equipment and evacuation teams. In case of non-availability of military means, considerations should be given to the use of civilian charter aircraft for strategic evacuation with a caveat on their ability to fly 24/7 into the operational theatre.

Evacuation Priorities:

154. Casualties who require evacuation must be sorted into priorities, based on their clinical need. The international military medical community agreed on internationally used nine-liner displays:⁶⁴
- A - Urgent: to be at a hospital facility (R2 or R3) within 120 minutes of first notification.
 - B - Priority: to be at a hospital facility (R2 or R3) within 4 hours of notification.
 - C - Routine: to be at a hospital facility (R2 or R3) within 24 hours of notification.

Aeromedical Evacuation Requirements:

155. A proper aeromedical evacuation system requires:
- a. A Patient Evacuation Coordination Cell (PECC) for the coordination of tactical and strategic MEDEVAC.
 - b. A medical organisation staffed with specialised aeromedical personnel to prepare patients for evacuation and to manage them en-route (Casualty Staging Units).
 - c. Aircraft that is appropriate for the task, in particular capable of carrying stretchers securely and to enable medical management en-route. The aircraft must be readily available to the medical personnel, preferably on a 24/7 basis. If these assets are not dedicated, procedures must be established to be able to re-task them in-flight if a medical urgency presents itself.
 - d. Specialised medical equipment cleared for safety and medical efficacy during in-flight use.

f. Medical Logistics

Unique Characteristics of Medical Logistics:

156. An efficient, reliable, well-regulated and cost-effective medical logistic system is fundamental for any medical support. The medical logistic system:

⁶⁴ The original US 9-liner is partially different (e.g. using more categories).

- a. Plays a key role in patient care management and must be able to respond rapidly to clinical demands because of the complex inter-dependence between treatment capability and the availability of medical materiel,
- b. Requires tight controls and specialised management due to the technical nature of medical materiel, their often limited shelf life and its sensitivity to storage and transport conditions (for example cold chain management (CCM) and medical gases),
- c. Is governed by extensive EU MS and international regulations⁶⁵, e.g. IATA.

Medical Stocks:

157. Medical stocks are granted protected status under the relevant international conventions and protocols of the law of armed conflict (LOAC). They should be stored in such a manner that attacks against mission's installations, assets or personnel, including military objectives cannot endanger their safety. This is especially the case with medical gases like oxygen.
158. The final configuration of medical logistics systems will be mission dependent. It must however have the following capabilities:
 - a. Enable contingents of MS or non-EU TCN, especially those elements providing centralised support such as medical treatment facilities or hospitals, to be self-sufficient from the start of their deployment and in line with the sustainment statement specified by EU Force planning staff, i.e. having sufficient Days of Supply in store.
 - b. Provide the end-user with a straightforward and reliable system.
 - c. Provide a re-supply system capable of delivering rapidly and theatre-wide.
 - d. Provide a policy or a system for the management of hazardous medical waste.
 - e. Provide an audit system which is cost-effective, straightforward and does not put constraints on demand or supply.

Responsibility for the Medical Logistic System:

159. Notwithstanding policies and overall responsibilities of MS and non-EU TCN, the coordinating responsibility for planning and executing an effective and efficient medical logistics system lies with the respective Head of Mission or Commander.

Blood:

160. The availability of safe blood and blood products is essential. The supply of safe blood and blood products is a critical issue and must be guaranteed at all levels at which surgery is offered. In hostile environments there may be a need to supply AIR MEDEVAC teams with blood. The operational requirement will be for an in-theatre system as part of the overall cold chain management, capable of:
 - a. Receiving blood and blood components to a standard acceptable to participating EU MS and non-EU TCN.
 - b. Moving, storing and distributing blood and blood components.
 - c. Maintaining continuity of records from donor to recipient⁶⁶.

⁶⁵ In a multinational operation effort should be given to develop commonality of drugs and medical stores.

⁶⁶ The basic examination of donated blood (e.g. for HIV, Hepatitis B and C) is commonly agreed. But the identification of the donor is not standard all over the world.

- d. Collecting, processing and testing blood on an emergency basis⁶⁷.
161. Although the general principle is that MS and non-EU TCN are responsible for the supply of blood to their own patients this is not always feasible. For a more efficient solution, a common approach should be considered, coordinated by the medical staff.
162. Advice on the use of medical supplies close to their expiry date, including blood and blood products, will be provided by the medical staff on a case-by-case basis, drawing on legal expertise as appropriate.

(C) Personnel

163. There is a considerable interface between the functions of medical support and personnel support. They are enhanced during the initial planning stages and continue long after an operation is finished. Consequently, the working relationship between medical and personnel staffs must be well developed and relevant personnel concerns should be integrated in medical plans.

a. Medical Manpower

164. The size, shape and capability of medical organisations are dictated by the type of mission / operation, health threat scenario and number of personnel / troops deployed. Medical personnel issues that impact most obviously on the overall medical concept of operations are:
- a. The fitness and health standards of individuals and the method of auditing these standards.
 - b. The professional medical capability and standards of training required and the means of ensuring them.
 - c. The necessity to take into account multilingual and cultural requirements in treating patient populations.

b. Mortuary Affairs

165. Planning for and handling of mortuary affairs are primarily a personnel / J1 function. Procedures have to clearly identify national and multinational responsibilities.

c. Health Related Legal Aspects

166. For each operation, the medical planning staff, in conjunction with legal advisors, will address issues concerning both national and international law including, when appropriate, the law of armed conflict, such as
- a. Handling of medical data.
 - b. Extent of Health and Medical Support to local population, refugees and prisoners of war, the so-called eligibility of care.
 - c. Implementation of national recommendations concerning preventive measures,
 - d. Handling of complaints.
 - e. Responsibilities of medical personnel.

⁶⁷ Especially administration of full blood or direct donor to receiver is not commonly agreed and different regulated by law in European Union.

- f. Liability of medical personnel when treating patients in a MN environment.

(D) Medical Information Management

167. The efficient management of medical information, particularly regarding patients, is a vital element of competent Health and Medical Support planning and therefore the basis for maintaining a complete overview at all levels. This also means that medical information management has an important influence on the improvement of the Health and Medical Support to the mission.
168. Information has to be distributed rapidly in a standardised manner⁶⁸ to all authorised personnel based on a strict need to know basis and taking into account regulations and laws of the contributing nations. Personnel tracking and reporting are primarily personnel / JI functions. Principal areas of medical concern will be:
- a. The provision of statistics for epidemiological and administrative purposes and early assistance in the detection of attacks by Weapons of Mass Destruction (WMD), defined as being of Chemical, Biological, Radiological or Nuclear (CBRN) origin.
 - b. Establishing a disease surveillance system, based on signs and symptoms, to trigger further investigation, preventive countermeasures or other command action to reduce the adverse impacts of health threats.
 - c. Patient tracking and regulating depends upon the passage of timely and accurate medical information. This requires the maintenance of medical records at every level of care and the use of clear and comprehensive patient documentation procedures.
 - d. Medical documentation should be interoperable throughout the theatre of operations and all national contingents. Copies of patient documents must move with the patient throughout the evacuation system to definitive care. Electronic data storage devices (patient information/identification carriers (PIC), e.g. standardised emergency cards) can increase the quality of care if interoperability is assured.
 - e. Notification of serious sickness and injury must be rapid, accurate and dynamic, using standardised procedures and involving the personnel staff at the various HQ to establish a competent system for patient tracking. Delayed, incomplete or wrong information will produce much national public and political disquiet, unnecessary administrative effort and distress for both patients and relatives.
 - f. Accurate production of clinical evidence for official national or international inquiries; this may include evidence gathered post-mortem in case of deaths in theatre.

(E) Public Information (PI)

169. The nature of journalism to gather and to publish information as early as possible and the increased speed of information exchange through the development of communication techniques has rendered the mass media an important factor to be considered in planning and conducting an operation. Information on potential or existing risks and incidents affecting the health of EU or Non-EU TCN's personnel or others is particularly sensitive and may cause rumours and inappropriate reactions. Appropriate confidentiality must be maintained in order to protect all involved.

⁶⁸ In order to coordinate this topic an agreed format should be established by the respective OHQ / HQ. If once agreed a common format may become part of this concept, providing a template.

170. The public information office must be coordinated with all key EU team elements, including medical staff, to ensure all target audiences are fully and accurately informed about the progress of the mission / operation. Medical personnel, including contracted personnel, have to be instructed on their contact with media representatives.

(F) Welfare and Spiritual wellbeing

171. The general welfare of patients is an important element of health and therefore of interest for the medical support planner. Particular issues like personal mail, contacting relatives, management of personal effects, spiritual welfare and religious last rites are mainly the responsibility of the CJ-1 staff at each level. Religious and socio-cultural customs may impact upon aspects of medical care (e.g. diet). Medical staff elements have to work in close cooperation with the respective staff areas.

G. MEDICAL PLANNING

(A) EU Medical Support Planning Procedures

172. The operational environment for EU-led missions and operations may be characterised by mission or force elements in remote locations far from lines of communication, making medical resupply, patient evacuation, hospitalisation and preventive medicine services difficult. Additionally, casualties could even be primarily caused by ‘disease and non-battle injury’ (DNBI) and be spread over wide areas. Consequently, the mission or force must be provided with an appropriate mix of medical resources to ensure that medical support provides all necessary medical functions. It must also cope with language barriers and be able to operate in a multinational environment. High emphasis must be placed on preventive medicine programmes to reduce the incidence of food and water-borne diseases, insect and rodent-borne diseases and environmental impacts. A clear (medical) mission must be given from the outset of the planning process, including guidance on whether or not medical care will be provided to third parties (e.g. refugees, local population).

Listed below are the procedures, which should govern the planning for Health and Medical Support by the medical staffs along the chain of command during any EU-led civilian mission or military operation.

a. Risk and Resources Related Planning

173. Medical planning must take into account the task analysis including medical health objectives and decisive points, such as:

- a. Risk assessment, which also leads to
- b. Casualty estimate and
- c. Time and space factors.

The task for the EU Force is the basis for the medical planning process. Analysed objectives and decisive points will lead the Health and Medical Support plan.

b. Medical Intelligence

174. The basis for all medical risk assessments is, besides the operational intelligence inputs about force, capabilities and intent of a possible enemy⁶⁹, having access to comprehensive, rapidly available, accurate and up to date medical intelligence, providing information on:
- a. Geographic factors such as climate, topography, flora and fauna, which may each have their specific effects on health.
 - b. Epidemiological data on endemic diseases, their types and prevalence; the current prophylactic measures, resistant strains, treatment, etc.
 - c. Outbreaks of diseases
 - d. Hygiene and sanitation.
 - e. Special environmental and industrial health hazards (EIHH) such as radiation hazards, toxic industrial hazards (so called Toxic Industrial Chemicals (TIC)), pollution etc.
 - f. The acquisition, threatened use and/or actual use of weapons of mass destruction (WMD) defined as chemical, biological, nuclear or radiological (CBNR) materials by national or other actors (e.g. terrorists)
 - g. Medical resources and infrastructure available in the Theatre of Operation (e.g. availability and possible use of Host Nation Support, IOs and NGOs).

A detailed list of medical intelligence requirements is to be included in EU generic plans. MS and non-EU TCN are responsible for providing the Operation Commander, Head of Mission / Force Commander with all medical intelligence requested, in accordance with their national capabilities.

c. Casualty Estimate

175. The calculation of possible or likely casualties provides an estimate of the numbers of DNBI (disease and non-battle injury) and, in case of hostilities, the number of battle casualties (BC) to be expected. Casualty estimates are expressed in numbers per day. These numbers and the dispersion of forces or mission are main determinants in the overall size and shape of the required medical support. It is essential that they are calculated as early as possible and updated on a regular basis once a mission is launched.
- a. DNBI Rate – A detailed analysis of DNBI data from historical and current sources will enable medical and operational staffs, working in concert, to produce a provisional DNBI rate for the operation. DNBI rates provide a technical estimation of the probable rate of diseases and injuries not resulting from combat, which can be expected in the mission / operation once deployment starts. DNBI is expressed as a daily rate (% per day) and is mission dependent, dynamic, related to the level and nature of activity, acclimatisation, training and living conditions of the deployed personnel. A comprehensive DNBI analysis should produce preventive medicine measures, including a recommended policy on immunisation, prophylaxis and pre-deployment education.
 - b. BC Rate – The BC rate is the operational estimate of the number of battle casualties, which will result from operations in theatre. This number will include Killed, Captured, Missing in Action (KCMIA) personnel, as well as Wounded in Action (WIA), Died of Wounds (DOW) and Battle Stress (BS) casualties. Determination of this estimate is the responsibility of the operational staff in

⁶⁹ This includes each kind of opponents, also terrorists.

consultation with the medical staff. Casualty rates are expressed as a daily rate. Like DNBI rates they are dynamic and change with operational imperatives. Even in operations, which do not include combat, casualties could, however, result from the operational environment (e.g. from residual mines, snipers etc.). These casualties would also be counted as “battle casualties”.

d. Coordination with medical services of MS and non-EU TCN

176. To support the preparation and conduct of EU-led missions and operations and to coordinate medical issues, medical experts from MS, non-EU TCN or other international organisations may be invited to support from the earliest planning stages, according with the agreed procedures.

e. Coordination with other organisations

177. The need for coordination of action with other organisations and agencies such as NATO, UN DPKO, UNHCR, UN-OCHA, WHO or humanitarian organisations (e.g. IFRC, ICRC or NGO's) depends on type and scale of an operation. The purpose of that coordination may range from the exchange of information to practical hands-on cooperation in theatre. The required level of coordination to be ensured by e.g. the JMED or Liaison Officers.

178. The maintenance of staff to staff contacts and appropriate information exchange with relevant international organisations / agencies outside the scope of missions and operations will facilitate future coordination in times of crisis.

(B) Basic Guidelines for the EU Medical Planning

a. EU-led Mission and Forces Medical Capability

179. Effective medical support to EU-led missions and operations is fundamental to mission success as the provision of appropriate, robust and visible support contributes to the credibility of the EU mission. By the prevention of disease, the rapid treatment of patients and if deemed appropriate - their medical evacuation or recovery and eventually return to duty, the medical services make a key contribution to EU mission force protection, sustainability and as a consequence to the morale of the deployed mission or forces. For this reason Health and Medical Support has to be planned according to the standards of the sending MS. However, it is also essential that every attempt will be made to achieve economies of scale because:
- a. Medical assets are expensive to procure and often difficult to obtain;
 - b. Medical assets available in one Theatre of Operation cannot be used or shared with a different regional theatre, even if not used to their full capacity,
 - c. All medical assets, but particularly Role 3 facilities, require substantial logistic and engineer effort to sustain them even when they are not deployed.
180. Maximum effort must be made to tailor medical support to the predicted requirements. Some contingents may have an abundance of assets while others may lack all but the basics. EU Mission and EU Force medical planners must therefore aim to find a balance in the capabilities that are made available. In huge missions and operations, especially military ones, the most cost-effective approach will be to have a single

nation take on the role of so-called Lead Nation (LN) in order to provide and/or coordinate all medical support.

b. In Country / Host Nation Support (HNS) Capability

181. The quality and quantity of medical resources available in a Theatre of Operations is an important factor in determining the size and capability of the medical organisation to be established. A key issue will be the standards of medical care available, compared to EU Force or EU mission and national contingent criteria. As more in-country HN support becomes available for mission or force use, less has to be offered by contributing MS and/or non-EU TCN. The overall in-country HNS capability is assessed through issuing Requests for Information (RFIs), medical intelligence and sending out teams during pre-deployment Medical Fact Finding Missions / Information Gathering Missions. The final result will of course depend fully on the willingness and political decision by the receiving nation to make resources available to the incoming mission or force⁷⁰.
182. HN resources that may be used by MS and/or non-EU TCN include:
- a. patient transportation assets (air, land and maritime), for intra-theatre MEDEVAC and possibly for strategic MEDEVAC,
 - b. treatment capability at every level of care but particularly at Role 3,
 - c. medical logistics support, the provision of drugs, including necessary Cold Chain Management (CCM), consumables, disposables, and blood products⁷¹,
 - d. essential non-medical support, including the use of buildings, clean water, power, disposal of waste, laundry, local staff, etc.

c. Command and Control (C2), Communications and Information System (CIS)

183. A clear-cut medical C2 is the key to efficient Health and Medical Support. The medical C2 organisation in the OHQ and at theatre level must be capable of contributing to planning, sustaining, supervising, controlling, and assessing the full range of Health and Medical Support functions⁷². It must also be capable of passing prompt and accurate operational advice to respective Head of Mission / Commanders. The medical C2 structure must be able to provide the respective hierarchy with visibility on immediate implications and potential consequences of their decisions. In addition, the C2 organisation must be capable of patient regulating and patient tracking. As a whole this must be supported by an efficient and reliable medical CIS. All this may be outsourced and contracted depending on the size and resources of the mission.
184. Health and Medical Support to all levels of command is planned and initiated by one or more medical planners within the core planning team at CPCC or the responsible OHQ level, working closely with medical planning staffs of the contingents of the MS and non-EU TCN. The result of their work is crucially dependent upon:

⁷⁰ The above mentioned ethical rule of not harming the host nation medical system applies always.

⁷¹ The use of Host Nation blood support is very sensitive and should be accepted by all sending nations.

⁷² For small missions this support will be provided by CPCC / EUMS or the Lead Nation or a supporting nation.

- a. The ensuing selection of both an experienced Medical Director / Medical Advisor⁷³ directly accountable and with direct access to the respective Head of Mission / Commander as well as Senior Medical Officers (SMO) on behalf of the MS and non-EU TCN contingents;
- b. Clearly established lines of medical accountability and command and control agreed to by all MS and non-EU TCN. Depending on the size of both mission and contributing contingent, each MS and non-EU TCN should ideally identify a SMO, representing their medical staffs;
- c. Clearly understood policies, directives and orders including common understanding of standards of medical treatment and medical evacuation;
- d. Early sharing of possible national caveats⁷⁴ and a timely discussion on their potential effects on the medical planning process;
- e. Early provision of valid and comprehensive medical intelligence products as well as early provision of comprehensive results of Medical Fact Finding Missions / Information Gathering Missions relevant for the medical planning process;
- f. Establishing an effective system for the coordination and direction of patient evacuation by medical staffs at all levels from unit level / Field Office level upwards⁷⁵;
- g. Comprehensive and capable medical and information management system, as well as patient tracking capabilities;
- h. Prompt, accurate and active flow of medical information at every level;
- i. Liaising at every level including receiving State(s) and with any relevant NGO's/IO in theatre;
- j. Prompt and comprehensive, on-going and after-action analysis of operational medical data, to provide a basis for future planning and lessons learned.

Medical Command and Control in Military Operations:

185. In military operations Operational Control (OPCON)⁷⁶ of all units is usually transferred to the Operation Commander at OHQ level by the MS and non-EU TCN. The OHQ's Associate Chief of Staff Combined Joint Medical Cell (ACOS CJ Med), or equivalent, is responsible for planning, coordinating and conducting the Health and Medical Support in line with the Operation Commander's directives and within the limitations to the OPCON given to the Operation Commander. As Medical Director, the OHQ ACOS JMED, or equivalent, has the mandate to give guidance on all technical matters and on the quality of care as provided by all medical units within the mission. This includes the supervision of all mentioned areas including the coordination of all patient transport from point of wounding until they have returned to their home country.

⁷³ Depending on the size of the mission

⁷⁴ This includes national minimum health and medical standards, acceptable risks and especially handling of blood products. Not solved national caveats may exclude this MS / non-EU TCN from the mission.

⁷⁵ Inconclusively this task is provided by the mission as this task may be outsourced and provided by other organisations, Host Nation Support or contractors.

⁷⁶ Operational Control: the authority delegated to a commander to direct forces assigned so that the Cdr may accomplish specific missions or tasks which are usually limited in function, time, or location; to deploy units concerned, and to retain or assign tactical control of those units. It does not include authority to assign separate employment of components of the units concerned. Neither does it, of itself, include administrative or logistic control.

186. At FHQ level the ACOS JMED, or equivalent, will receive functional guidance from OHQ JMED and will be responsible for planning, coordinating and conducting the Health and Medical Support at theatre level in line with the Force Commander's directives. Being the Medical Advisor at the operational / tactical level, the FHQs ACOS JMED, or equivalent, has the mandate to give guidance in all technical matters and the quality of Health and Medical Support over all medical forces. This includes all technical matters, the coordination of patient transport and the overall direction of the medical management of MASCAL situations.
187. All details concerning the tasks of ACOS JMED on OHQ or FHQ level will be part of OHQ / FHQ Standard Operating Procedures (SOPs).
188. Medical forces at Role 1 level usually will be part of the units and battalions they support. Medical forces at Role 2 level and above are normally assumed to be theatre assets.
189. In big scale military operations medical forces at Role 2 level and above will often be organised as medical companies or will be integrated into Medical Task Forces (MedTF) under OPCON of the FHQ. A Medical Task Force usually is the equivalent of a battalion, comprising similar staff and support elements, several medical treatment facilities and multiple medical evacuation assets in a modular and capability based approach.

Medical Command and Control in Civilian Missions:

190. In civilian missions CPCC, acting as OHQ, has currently no medical staff but is supported by EUMS military physicians or MS medical experts on request. Therefore a Medical Director providing the military OHQ Medical Advisor function doesn't exist. Nevertheless CPCC will support each mission in the medical domain as far as necessary, including Medical Fact Finding Missions / Information Gathering Missions.
191. Whilst smaller civilian EU-led missions that have to rely on other organisations or contractors are supported by CPCC for all medical related topics, those larger civilian missions will get a Medical Director or at least a Medical Advisor at Force Headquarters' level.
192. The civilian mission's Medical Director / Medical Advisor is directly accountable and with direct access to the respective Head of Mission. He or she will have the combined responsibility of both ACOS JMED OHQ and FHQ, as described in 185. and 186. for organic as well as for contracted medical services.

d. Medical Treatment

193. In planning the overall medical treatment capability required to support an operation, the key is to achieve the right balance between medical capability at each level and the ability to evacuate between them. Evacuation and treatment are inextricably linked and cannot be planned in isolation. The aim is to:

- a. ensure that at every level, medical treatment is of a standard acceptable to all national contingents and as close as possible to prevailing peacetime medical standards⁷⁷,
- b. to avoid duplication at all levels, by allocating the appropriate amount of effort and medical resources, while ensuring that the medical mission can be met, within the constraints of Theatre Holding Policy.

The Medical Treatment Facilities are detailed described in Annex A.

e. Medical Evacuation Capability

194. The evacuation plan will be developed to support the overall treatment capacity required at each level of care in-theatre. However, the limitations on the evacuation of patients will have a direct impact on the requirements for holding patients. The more difficult the evacuation between levels is, the greater the holding capability each level requires will be. Evacuation will be determined by the operational environment, length and quality of evacuation routes, and the availability of suitable evacuation assets. Resources will be coordinated by Medical Director / Medical Advisor / ACOS JMED and may include in-country support. At any stage of the evacuation process casualty staging units may be required. The principal medical planning timeline must be to provide Damage Control Resuscitation at least within one hour of injury (see 54.).

f. Theatre Holding Policy

195. Theatre Holding Policy (see F. b. (h)) is the key to balancing the treatment capability available at each level of care against the MEDEVAC assets required to provide casualties with the best possible medical care. It is expressed as the maximum number of days, which a patient receiving treatment may be held in theatre.
196. Evacuation policies of shorter duration may be required when the adequate level of care cannot be provided. If, due to disease or injury, it is not to be expected that a patient will return to duty (RTD) within the specified time, he/she should be repatriated as soon as possible. The management of patients in any Theatre of Operations is a dynamic process, taking into consideration a large number of important planning and operational factors.
197. The evacuation policy has a number of purposes:
- a. To balance the medical capability and limit the need for unnecessarily sophisticated resources in-theatre;
 - b. To ensure that, while the less seriously ill and injured are managed and return to duty (RTD) at the correct level, more serious cases are evacuated to appropriate treatment facilities;
 - c. To initiate treatment as quickly as possible;
 - d. To ensure that all in-theatre medical support facilities remain capable of reacting rapidly to operational imperatives.

⁷⁷ Except for MASCAL situations the aim to be achieved is to reach the same result of medical treatment as it could be expected in the sending state under comparable conditions.

198. The Theatre Holding Policy is:

- a. A command and/or national decision, advised and monitored by the medical staffs, to be promulgated by the Head of Mission / Force Commander, on the advice of the Medical Director / Medical Advisor,
- b. Mission dependent. In addition to which it will be influenced by the availability of assets, constraints on movement, operational imperatives, weather and topography,
- c. Dynamic, in order to be able to respond to rapidly changing situations⁷⁸,
- d. To be influenced by other factors in the absence of tactical imperatives, including public expectations, national policy, cost of strategic evacuation, welfare, etc.

g. Preventive Medicine

199. The shape and size of in-theatre preventive medicine/veterinary capability will be dictated by:

- a. The dispersal of the mission or force to be supported and the theatre topography,
- b. The overall risks and threats to health from climate, diseases and special environmental and occupational hazards,
- c. The preventive measures available, their technical nature and the efforts required to implement them,
- d. The capability of national contingents to implement preventive measures independently.

The collective preventive medicine educational, training, implementation and monitoring requirements of the mission or force must also be considered.

200. Preventive medicine will play a major part in any given Medical Fact Finding Mission / Information Gathering Mission and later on must be adequately represented in the Force Headquarters or Mission Headquarters. The requirement for preventive medicine expertise will be for formed units as well as individual deployed experts. The provision of this capability lends itself well to a Lead Nation approach in bigger operations / missions but does not negate the need for expertise at the national or unit level to oversee the implementation of these measures.

201. Furthermore, a policy must be issued at CPCC / OHQ level, as early as possible and well in advance to the deployment, regarding prophylactic measures, including immunisations, which must be received on time by all those to be deployed into the Theatre of Operation. This policy should be part of the OPLAN and must cover training and measures to be taken prior to deployment; those to be continued in theatre, and those that will apply once re-deployed.

202. While EU cannot direct the MS and non-EU TCN to implement this policy, a uniform prophylactic policy should be encouraged, as it will add to interoperability, a decrease of medical requirements, reduce the risk for the individual and contribute to mission success.

⁷⁸ E.g. the outset of an operation requires a short evacuation policy dictated by the medical assets in-theatre. As medical assets build-up, the evacuation policy increases as operations develop. Finally, as the Force scales down, the evacuation policy shortens to a minimum.

h. Personnel

203. Medical considerations regarding personnel will pervade all aspects of the plan, including:
- a. numbers of personnel involved, general and medical training standards and terms of service,
 - b. legal issues, both international and national, particularly regarding the medical management of refugees, detainees and non-entitled civilians,
 - c. management of medical information, particularly regarding patients, for both casualty tracking and long-term administrative purposes,
 - d. general welfare matters,
 - e. financial and budgetary controls.

i. Medical Logistics Capability

204. The medical support plan⁷⁹ ensures that all medical facilities are self-sufficient for the majority of necessary commodities (to be defined), from the moment of deployment and in keeping with the sustainment statements as specified by mission planning staff and medical planners. It should also provide the user(s) with a system capable of rapidly delivering medical commodities theatre-wide. In addition, an audit system is strongly recommended to be implemented, which is cost-effective and does not cause an increase in demand or need for supplies, according to current quality standards.

j. Funding Principles for Health and Medical Support

205. Following the principle of cost efficiency, Health and Medical Support to a given EU mission or operation can become eligible for allocation and attribution of incremental costs through the mission budget, including a mission's high risk insurance for the deployed personnel or through the ATHENA mechanism (Ref. V).
206. As the mission budget as well as ATHENA is reviewed and amended regularly it is important that medical planning reflects the available funding regulations. This will enable MS and non-EU TCN to generate a suitable funding solution whilst facilitating the Force Generation Process for Health and Medical Support.

⁷⁹ This plan will not apply to contracted medical services directly. Nevertheless medical contractors have to proof to fulfil the requirements.

ANNEX A: MEDICAL TREATMENT FACILITIES (MTFS)⁸⁰

1. MTFs should, where appropriate, be as mobile and robust as the units they need to support, taking into account the time related constraints of medical care and the provision of medical evacuation assets. The term Role 1 to 4 was introduced in the military medical field to define the four tiers in which Health and Medical Support is organised but is also used in the civilian environment as well as on behalf of medical systems in missions that are civilian in nature. An integral part of the definitions of capabilities is the determination of its output. A medically qualified physician will provide supervised care at every Role.

Role 1 MTF

2. The Role 1 MTF provides primary healthcare, specialised first aid, triage, resuscitation and stabilisation. In general Role 1 support is a national responsibility and must be easily accessible to all force or mission personnel. The size of Role 1 facilities and the resources required need to be mission-tailored.

Capabilities

3. Role 1 Health and Medical Support is integral or allocated to a unit. It comprises the provision of:
 - a. Specialised first aid, triage and immediate life-saving and stabilisation measures.
 - b. Basic occupational and preventive medical advice to the chain of command.
 - c. Routine sick calls and the management of the minor sick and injured for immediate return to duty (RTD).
 - d. Casualty collection from point of injury.
 - e. Preparation of casualties for evacuation to a higher level MTF, including patient tracking, evaluating and reporting.

Whenever a national contingent is unable to meet these criteria Health and Medical Support through agreements with other TCN or institutions should be negotiated.

Additional Capabilities

4. Medical capabilities and standards at Role 1 level will vary considerably, depending on the type of mission and national policies and resources. Very limited holding capacity, primary dental care, basic laboratory testing or initial stress management capabilities can be considered as possible enhancements at Role 1 MTF.

Role 2 MTF

Role 2 Tasks

5. To provide for reception and triage of casualties, resuscitation and treatment shock to a higher level than at Role 1 MTFs. It will routinely include damage control surgery and may include a limited holding capability for casualties until they can be returned to duty or evacuated. Role 2 may be enhanced to provide basic secondary care including surgery, Intensive Care Unit (ICU) and nursed beds / wards.

⁸⁰ Definitions of Medical Treatment Facilities by Role 1 up to Role 4 derive from military planning of casualty treatment, using different levels or echelons. These definitions are applicable to civilian Medical Treatment Facilities or mission medical services, mainly focusing on casualty treatment. Therefore the term "forces" is used but is equivalent to "mission".

6. The deployment of Role 2 MTFs is mission dependent, especially when:
 - a. Large numbers of personnel are involved or high numbers of casualties can be expected,
 - b. Geographic, climatic or operational factors may limit medical evacuation capability to Role 3 by extending feasible lines of communication.
 - c. Size and/or distribution of the force does not warrant the deployment of a full Role 3 capability.

Due to the versatility of the Role 2 MTF, this medical unit can be further sub classified into Role 2 Basic and Role 2 Enhanced.

Role 2 Basic Medical Treatment Facility

7. Role 2 Basic MTF can be a light, highly mobile MTF designed to support component formations. They act as a focal point for Role 1 MTFs in the formation, but may be bypassed if circumstances, clinical situation and resources allow. A Role 2 Basic MTF is able to conduct triage and advanced resuscitation procedures up to damage control surgery (DCS). It will usually evacuate its surgical cases to a Role 3 for further stabilisation and possible surgery before evacuation to Role 4.
8. In addition to Role 1, Role 2 Basic MTF will include the following functions:
 - a. Resuscitation led by a specialist medical officer with all elements required to support it,
 - b. Routine DCS with post-operative care,
 - c. Field laboratory capability,
 - d. Basic imaging capability, e.g. X-ray or ultrasound,
 - e. Reception, regulation and evacuation of patients,
 - f. Limited holding capacity.

Role 2 Enhanced (2E)

9. Role 2E MTFs are effectively small field hospitals. They provide basic secondary healthcare built around surgery, ICU and nursed beds. In comparison with Role 2 Basic MTF, Role 2E MTFs are able to stabilise post-surgical cases for evacuation to Role 4 without needing to put them through a Role 3 MTF first.
10. In addition to Role 2 Basic MTF, Role 2E will include:
 - a. Surgery,
 - b. Surgical and medical intensive care capability,
 - c. Nursed beds,
 - d. Enhanced field laboratory including blood provision,
 - e. Casualty decontamination facilities for Chemical (CW) and Biological (BW) Warfare casualties, dependent on the operational risk assessment.

Additional Role 2 Capabilities

11. Role 2 MTF may also include preventive medicine and environmental health capabilities, primary dental care, stress management, psychiatry or psychology, telemedicine and the capability to coordinate patient evacuation through the PECC positioned at staff level.

Role 3 MTF

12. Role 3 MTFs are designed to provide secondary healthcare within the restrictions of the Theatre Holding Policy. Role 3 Health and Medical Support is deployed hospitalisation and the elements required to support it.

It will only be deployed where:

- Relatively large numbers of personnel are involved,
- In-country resources are inadequate or inappropriate, whilst Role 3 support is deemed necessary,
- Theatre of Operations is too far from home base and no other possibilities to get appropriate support by neighbouring countries are available.

Role 3 Capabilities

13. Role 3 basically includes surgery, ICU, nursed beds and diagnostic support. Depending on mission characteristics it includes a mission-tailored variety of clinical specialities, focussed on the provision of emergency medical care. Its minimum capability also includes:
- a. Sufficient holding capacity to allow for diagnosis, treatment and holding of those patients, who are expected to return to duty after receiving adequate treatment,
 - b. Resupplying of Role 2 MTFs,
 - c. Control of and or ready access to patient evacuation assets.

Although not yet commonly recognized, Role 3 MTFs should provide CT-scan capability as well.

Additional Role 3 Capabilities

14. Role 3 supports may require the provision of additional medical capabilities as appropriate. These might include:
- a. Specialist surgery (neuro-surgery, maxillo-facial, burns, etc.),
 - b. Additional medical specialities (Internal medicine, neurology, intensive care, ophthalmology, dentistry, forensic pathology), including specialised nursing.
 - c. Advanced and specialist diagnostic capabilities to support those clinical specialist present (MRT scan, arthroscopy, sophisticated lab test, etc.),
 - e. Preventive medicine and environmental health capacity, and medical treatment of operational stress disease where not provided at Role 1 or 2 MTFs,
 - f. Veterinarian capacity for food and water inspection.

Economies of Scale

15. Maximum use should be made of in-country resources, where present and of a standard acceptable to Mission or Force medical planners. In addition to that, MS should be encouraged to join forces / assets in order to achieve high end efficiency whilst reducing cost, e.g. by applying LN/RSN⁸¹ or similar concepts.

⁸¹ Lead Nation / Role Specialist Nation

Role 4 MTF

Role 4 Tasks and Capabilities

16. A Role 4 MTF provides the full spectrum of definitive medical care that usually cannot be deployed to theatre or is too time consuming to be conducted there, like specialist surgical and medical procedures, reconstructive surgery, rehabilitation and convalescence.

Role 4 medical care is usually highly specialised, time consuming and normally provided in the casualty's country of origin, but it also may be provided through bi- or multi- national arrangements in another country.

ANNEX B

Medical Support Estimate (for HQ along the chain of command)

Headquarters

Location

Date, Time & Zone

References: List all relevant maps, overlays, charts and documents.

MISSION: Statement of the overall medical mission.

SITUATION AND FACTORS:

Enemy:

- (1) Strength and disposition.
- (2) Combat efficiency.
- (3) Capability.
- (4) Logistic Situation.
- (5) State of health.
- (6) Weapons (include CBRN capability).

Ground:

Climate:

Civilian population:

- (1) possible need for humanitarian aid;
- (2) Preventive medical support;
- (3) possible CIMIC activities.

Local Resources / Host Nation Support:

Friendly Forces:

- (1) Allied Forces.
- (2) Army.
- (3) Navy.
- (4) Air Force.
- (5) Special Operation Forces.
- (6) PsyOps.

Eligibility of Care / Additional Strengths to be supported:

- (1) International contracted staff;
- (2) Local contracted staff;
- (3) Enemy prisoners of war (including Enemy medical personnel) / detainees;
- (4) GO / civilians / IDPs / refugees;
- (5) IO/NGOs;

(6) IC / embassy staff;

(7) Others.

Health (Preventive medicine measures):

(1) Acclimatisation of troops.

(2) Presence of disease.

(3) Status of immunisation.

(4) Clothing and equipment (Personal Protective Equipment, cold weather, hot weather, mosquito nets etc).

(5) Stress management.

(6) Status of training.

(7) Hygiene.

(8) Security in operations.

(9) Other⁸².

Assumptions: (Assumptions may be modified when specific planning guidance or factual data becomes available).

MEDICAL SUPPORT ANALYSIS:

Casualty Estimates:

Medical Support Requirements:

(1) Role 1

(2) Role 2

(3) Role 3

(4) Role 4

(5) Host Nation Support

(6) Evacuation:

Tactical/Strategic;

Road, rail, sea & air;

Armoured / non-armoured.

(7) Medical supply, including Blood management.

(8) Veterinary.

(9) Preventive medicine.

(10) Dental.

(11) Psychiatric medicine/psychology.

(12) Command, Control and Communications.

Resources Available:

(1) Organic medical units and personnel.

(2) Attached medical units and personnel.

(3) Supporting medical units.

(4) Host Nation Support / In-country resources.

(5) Detained enemy medical personnel.

(6) Medical supply.

⁸² Including epidemiological surveillance/counter measures, e.g. BIOFORCE.

(7) Budgeting.

Courses Of Action:

As a result of the above considerations and analysis, list all logical courses which support the Commander's plan and accomplish the medical mission.

EVALUATION AND COMPARISON OF COURSES OF ACTION:

Selection of the best course of action.

MEDICAL SUPPORT PLAN:

ANNEX C

Factors affecting Fact Finding Mission Assessment - Checklist

1. FACTORS

FIELD	AREA
GEOGRAPHIC FACTORS	Climate
	Topography
	Flora
	Fauna
SOCIAL FACTORS LOCAL POPULATION	Socio-Cultural factors
	Religious practices
	Nutritional status
	Medical support
DISEASES	Endemic diseases (Type/Prevalence)
	Epidemic diseases (Type/Prevalence)
	Local prophylactic measures
	Treatment
	Resistant strains
ENVIRONMENTAL FACTORS	Special environmental hazards, such as: - Radiation hazards - Pollution - Toxic industrial hazards (TIC & TIM)
MEDICAL INFRASTRUCTURE AND CAPABILITIES	Medical resources available in the theatre of operations, including those of potentially opposing forces, such as: - Medical facilities - Special medical equipment - Evacuation means, ambulances - Local medical specialist expertise
MILITARY CAPABILITIES OF POTENTIALLY OPPOSING FORCES	Including CBRN warfare capability
MEDICAL LOGISTICS	Power supply
	Safe drinking water / Quality control
	Medical re-supply
	Disposal of hazardous waste

2. OVERALL SITUATION

3. SHORTFALLS

4. ASSESSMENT

Short Hospital Evaluation - Checklist

Hospital Assessment Sheet - Information below may be collected through interviews with hospital staff and not by inspection only

City:		<small>Form of Coding</small>		
Name:		Public	Priv	Number of beds
UTM Grid:				
Phone:		Radio: _____		
Ambulance:	<input checked="" type="checkbox"/> Remark:	24	7	Number
Helicopter Pad:	<input checked="" type="checkbox"/> Remark:	24	7	
Emergency Room:	<input checked="" type="checkbox"/> Remark:	24	7	Number of beds
Ultrasound:	<input checked="" type="checkbox"/> Remark:	24	7	Number
X-ray:	<input checked="" type="checkbox"/> Remark:	24	7	Number
CT-Scan:	<input checked="" type="checkbox"/> Remark:	24	7	Number
Magnetic Resonance Imaging:	<input checked="" type="checkbox"/> Remark:	24	7	Number
Laboratory:	<input checked="" type="checkbox"/> Remark:	24	7	
Bacteriology:	<input checked="" type="checkbox"/> Remark:	24	7	
Blood bank:	<input checked="" type="checkbox"/> Remark:	24	7	
Theater:	<input checked="" type="checkbox"/> Remark:	24	7	Number of tables
General Surgery:	<input checked="" type="checkbox"/> Remark:	24	7	
Trauma Surgery:	<input checked="" type="checkbox"/> Remark:	24	7	
Neuro Surgery:	<input checked="" type="checkbox"/> Remark:	24	7	
Vascular Surgery:	<input checked="" type="checkbox"/> Remark:	24	7	
Oral Maxillo-facial Surgery:	<input checked="" type="checkbox"/> Remark:	24	7	
Recovery Room:	<input checked="" type="checkbox"/> Remark:			Number of beds
Intensive Care Unit:	<input checked="" type="checkbox"/> Remark:			Number of beds
Burn ward:	<input checked="" type="checkbox"/> Remark:			Number of beds
Ward:	<input checked="" type="checkbox"/> Remark:		Single Room	Number of beds
Heart Catheter Cardiology:	<input checked="" type="checkbox"/> Remark:	24	7	Number of beds
Sterilisation:	<input checked="" type="checkbox"/> Remark:			
Pharmacy:	<input checked="" type="checkbox"/> Remark:			
Meals provided to the patient:	<input checked="" type="checkbox"/> Remark:			
Form of payment:	<input type="checkbox"/> Remark:			

European External Action Service - European Union Military Staff - LOG OR
 Udo Sand Wagner, MD - Tel: +3222514334
 Kortenbosjean 100, B-1000 Brussels - bern.s.wagner@eeas.europa.eu

Page - 1 -

Specialities					
Orthopaedics:	<input checked="" type="checkbox"/> Remark:	24	7		
Gynaecology:	<input checked="" type="checkbox"/> Remark:	24	7		
Obstetrics:	<input checked="" type="checkbox"/> Remark:	24	7		
Urology:	<input checked="" type="checkbox"/> Remark:	24	7		
Ear-Nose-Throat:	<input checked="" type="checkbox"/> Remark:	24	7		
Neurology:	<input checked="" type="checkbox"/> Remark:	24	7		
Ophthalmology:	<input checked="" type="checkbox"/> Remark:	24	7		
Dermatology:	<input checked="" type="checkbox"/> Remark:	24	7		
Pediatrics:	<input checked="" type="checkbox"/> Remark:	24	7		
Internal Medicine:	<input checked="" type="checkbox"/> Remark:	24	7	Number of beds	
Tropical Medicine:	<input checked="" type="checkbox"/> Remark:	24	7	Number of beds	
Gastro-Enterology:	<input checked="" type="checkbox"/> Remark:	24	7	Number of beds	
Isolation Ward:	<input checked="" type="checkbox"/> Remark:			Number of beds	
Outpatient					
Out-patient Clinic:	<input checked="" type="checkbox"/> Remark:	24	7		
General Practitioner:	<input checked="" type="checkbox"/> Remark:	24	7		
Additional					
Pathology:	<input checked="" type="checkbox"/> Remark:	24	7		
Dental Care:	<input checked="" type="checkbox"/> Remark:	24	7		
Physiotherapy:	<input checked="" type="checkbox"/> Remark:	24	7		
Additional remarks:					
.....					
.....					
.....					
.....					
.....					

ANNEX D

Medical Kits:

Harmonization of (personal) medical equipment has always been difficult as MS and non-EU TCN used and use different equipment. Existing standardization agreements do no longer reflect the up-to-date technical standard. Using the experience of recent military operations⁸³ and developments in civilian emergency medicine the recommended content of personal First Aid Kits dramatically changed. As common agreed rule the equipment of the injured person is always used first, therefore everybody has to have knowledge about the equipment of his or her comrade. In general, this is not a problem in national and branch homogenously organised military units, but creates problems in joint and combined (multinational) military operations, and even more in civilian missions. To allow a similar standard of equipment and facilitate effective First Aid training CPCC made the standardised personal First Aid Kit and Car Trauma Kit element of a framework contract for personal security items (among others helmets, protective vests).⁸⁴

⁸³ The use of tourniquets, new styled bandages as well as blood clotting agents increased the survival rate of heavily injured soldiers significantly.

⁸⁴ The framework contract implies some more medical items: a defibrillator and a sterile needle set.

Personal First Aid Kit for civilian missions

Listed in the framework contract⁸⁵ as "**6. Personal Medical Trauma Kit**", recommended *expiry date of medical supplies* are: "*At time of dispatch, all medical items with an expiry date must have 2 years of shelf life remaining or 75% of their original shelf life remaining -whichever is the greater.*"

#	Item Description	Group / Indication	Amount
1	Bag - compartmentalised, Leg strap / belt hook / detachable, Dimensions: 20 cm x 20 cm x 8 cm (approximate), Colour: sand / olive / blue / black (not camouflage)	Container	1
2	Individual military-type trauma bandage, 'Israeli' type 6'' trauma wound dressing	Hemorrhage	1
3	Individual military-type trauma bandage, 'Israeli' type 4'' trauma wound dressing	Hemorrhage	1
4	'Quickclot' ACS+ impregnated sponge	Hemorrhage	1
5	Combat Application Tourniquet (CAT)	Hemorrhage	1
6	Chest Seal 'Asherman' type	Pneumo-thorax	1
7	Face mask - miniature type	Resuscitation (CPR)	1
8	Rhino-pharyngeal cannula 18G	G tube	1
9	'cool pack' - gel dressing	Burns	1
10	Sterile compress 2 of (each): 5x5 cm, 10x10 cm	General	4
11	Crepe bandage 100mm x 4.5M	General	1
12	Crepe bandage 50mm x 4.5M	General	2
13	'micropore' or similar 25mm x 10m	Medical tape	1
14	Triangular bandage	General	1
15	Medical scissors "rough cut" type	Wound exposure	1
16	Alcohol free wipes	Cleaning	6
17	Nitrile (non latex, non powdered) gloves	Personal protection	3 Pair
18	Head torch ,Multi LED type, adjustable output	Light - working	1
19	Chemical light sticks (cyalume), white & red, min 8 hour duration	Light - signaling	2
20	Permanent marker pen, black	Patient marking – triage indication	1
21	Whistle	Attention gaining	1

⁸⁵ Publication Reference: EuropeAid/128511/C/SUP/MULTI

Car Trauma Kit for civilian missions

Listed in the framework contract, Annex V, as "**7. Vehicle / Mass Casualty Kit**", using the same requirements for expiry date as the personal First Aid Kit (see above).

#	Description	Group / Indication	Amount
1	Thomas Bag' or similar, zip closure, compartmentalised, carry straps of sufficient size to contain the following required items:	Container	1
2	Individual military-type trauma bandage 'Israeli' type 4'' trauma wound dressing	Haemorrhage	6
3	Individual military-type trauma bandage 'Israeli' type 6'' trauma wound dressing	Haemorrhage	2
4	Individual military-type trauma bandage 'Israeli' type 8'' trauma wound dressing	Haemorrhage	1
5	'Quickclot' ACS+ impregnated sponge	Haemorrhage	4
6	Combat Application Tourniquet (CAT)	Haemorrhage	3
7	Chest Seal 'Asherman' type	Pneumo-thorax	3
8	Face mask - 'Laerdal pocket mask' type	Resuscitation (CPR)	2
9	Rhino-pharyngeal cannula 18G	Obstruction of the respiratory tract	2
10	"G" tube: set of small, medium and large	Obstruction of the respiratory tract	2 sets
11	Burn dressing, large size	Burn	2
12	Burn dressing, small	Burn	2
13	"Cool pack" gel	Burn	2
14	Aluminium blanket	Burn, shock	3
15	Neck brace - adjustable	Neck Protection	1
16	Sam splint Splint -	Multiple uses	2
17	Triangular bandage	Multiple uses	4
18	Sterile compresses 5cm x 5 cm	Multiple uses	10
19	Sterile compresses 10cm x 10 cm	Multiple uses	10
20	Crepe bandage 100mm x 4.5M	Multiple uses	4
21	Crepe bandage 50mm x 4.5M	Multiple uses	4
22	'micropore' tape 25mm x 10m	Multiple uses	4
23	elastic bandage 7.5cm x 4.5M	Multiple uses	1
24	Opsite dressing 5cm x 10m	Multiple uses	1
25	Splinter tweezers	Multiple uses	1
26	Eye compress	Eye protection	2
27	Aureomycin or similar - 5 ml tube	Eye protection	1
28	Steri-strip (pack)	Wound closure	10
29	Medical scissors 'rough-cut' type	Wound uncovering	2
30	Saline solution - 5 cc bottle	Wound flushing	10
31	Alcohol free wipes	Cleaning	20
32	Isobetadine or similar - 50 ml tube	Local disinfectant	1
33	Nitrile (non latex, non powdered) gloves	Personal protection	10 pair
34	Folding stretcher (reinforced cloth)	Casualty transport	1
35	Belt cutter	Seat belt cutter	1
36	Head torch Multi LED type, adjustable output	Light - working	2
37	Chemical light sticks 'cyalume' 2 of each: white + red + green min 8 hour duration	Light - signalling	6
38	Notepad - small, pen or pencil	Patient notes	1
39	Permanent marker pen, black	Patient marking - triage indication	1
40	Whistle	Attention gaining	1

ANNEX E

List of Abbreviations:

Although abbreviations are scarcely used in this concept to make it readable, especially for readers outside the medical and support domain, abbreviations are common in missions, medicine and, above all things, in military.

Letter	Abbreviation	Full version
A	ACO	NATO Allied Command Operation; (at Mons, BE)
	ACOS	Assistant Chief of Staff
	ACT	NATO Allied Command Transformation (at Norfolk, Virginia, US)
	AOO	Area of Operations
B	BC	Battle Casualty
	BG	Battlegroup
	BS	Battle Stress
	BW	Biological Warfare
C	C	Combined (multiple nations), used in combination with other abbreviations
	C2	Command and Control
	C3	Command, Control and Communication
	C4I	Command, Control, Communication, Computer and Intelligence
	CASEVAC	Casualty Evacuation; transport of patients by non-dedicated assets and / or without medical company
	CBRN	Chemical, Biological, Nuclear and Radiological
	CCM	Cold Chain Management
	CIMIC	Civil-Military Cooperation
	CIS	Communications and Information System
	CJ	Combined (multiple nations) Joint (multiple services); Staff officer or element
	CJ 1	Staff officer or staff element, responsible for personnel and administration
	CJ 2	Staff officer or staff element, responsible for intelligence and security
	CJ 3	Staff officer or staff element, responsible for operations
	CJ 4	Staff officer or staff element, responsible for logistics
	CJ 5	Staff officer or staff element, responsible for plans
	CJ 6	Staff officer or staff element, responsible for signal, communication, IT
	CJ 7	Staff officer or staff element, responsible for training
	CJ 8	Staff officer or staff element, responsible for finance and contract / resource management
	CJ 9	CIMIC
	CJMED	Combined (multiple nations) Joint (multiple services) Staff Officer Medical
	CMC	Crisis Management Concept
	CMCO	Civil Military Co-ordination
	CMO	Crisis Management Operation
	CONOPS	Concept of Operations
	COS	Chief of Staff
	CPCC	Civilian Planning and Conduct Capability

	CSDP	Common Security and Defence Policy
	CSU	Casualty Staging Unit
	CT-Scan	Computer Tomography Scan; X-ray diagnostic delivering 3D imaging
	CW	Chemical Warfare
D	DCS	Damage Control Surgery
	DNBI	Disease and Non-Battle Injury
	DOS	Days of Supply
	DOW	Died of Wounds
E	EEAS	European Union External Action Service
	EIHH	Environmental and Industrial Health Hazards
	ELINT	Electronic signals intelligence
	ESDP	European Security and Defence Policy
	ESS	European Security Strategy
	EU	European Union
	EUMS	European Union Military Staff
F	FFM	Fact Finding Mission
	FHP	Force Health Protection
	FHQ	Force Headquarters
G	GO	Governmental Organisation
H	HN	Host Nation
	HNS	Host Nation Support
	HoM	Head of Mission
	HQ	Headquarters
	HUMINT	Human Intelligence; the classical espionage
I	IATA	International Air Transport Association
	ICU	Intensive Care Unit
	IGM	Information Gathering Mission
	IO	International Organisation
	IT	Information Technology; may involve computer and telecommunication
J	J	Joint (multiple services / branches); e.g. air force plus army; used in combination with other abbreviations or numbering
	J1 (up to J9)	Generally used term for staff officer function in a staff organization; see CJ
K	KCMIA	Killed, Captured, Missing in Action
L	LN	Lead Nation
	LOAC	Law of Armed Conflict
M	MASCAL	Mass Casualty (situation)
	MedCis	Medical Communication and Information System
	MedCIS	Medical Communication and Information System
	MEDEVAC	Medical evacuation
	MEDINTEL	Medical Intelligence
	MedTF	Medical Task Force
	MERT	Medical Emergency Response Teams

	MN	Multinational
	MOU	Memorandum of Understanding
	MRT	Magnetic Resonance Tomography; magnetism based diagnostic delivering 3D imaging, other term is NMRI
	MS	Member State(s)
	MTF	Medical Treatment Facility/ies
	M3U	Multinational Modular Medical Unit
N	NATO	Northern Atlantic Treaty Organization
	NGO	Non-governmental organisation
	NMR	Nuclear Magnetic Resonance; Diagnostic Method based on magnetism
	NMRI	Nuclear Magnetic Resonance Imaging
	NOK	Next of Kin
O	OHQ	Operation Headquarters
	OpCdr	Operation Commander
	OPCON	Operational Control
	OPLAN	Operation Plan
	OPSINT	Open Source Intelligence
	OSCE	Organisation for the Security and Co-operation in Europe
P, Q	PECC	Patient Evacuation Coordination Cell
	PI	Public Information
	POW	Prisoner of War; sometimes used for Point of Wounding
	PSC	The Political and Security Committee
R	RFI	Request for Information
	RSN	Role Specialist Nation
	RTD	Return to Duty
S	SMO	Senior Medical Officer
	SOFA	Status of Forces Agreement (military force's contract with host nation)
	SOMA	Status of Mission Agreement (civilian mission's contract with host nation)
	SOP	Standard Operational Procedure
	STANAG	NATO Standardization Agreement
	STANREC	NATO Standardization Recommendation (less binding than a STANAG)
T	TA	Technical Arrangement
	TCN	Troop Contributing Nation
	TEU	Treaty on European Union
	TIC	Toxic Industrial Chemicals (rarely used)
	TIM	Toxic Industrial Materials (rarely used)
	TO	Theatre of Operations
	TOA	Transfer of Authority
U, V	UN	United Nations
W	WHO	United Nations World Health Organization
	WIA	Wounded in Action

	WMD	Weapons of Mass Destruction
X, Y, Z		
