NATO STANDARD

AJMedP-4

ALLIED JOINT MEDICAL FORCE HEALTH PROTECTION DOCTRINE

Edition A Version 1

JULY 2018

NORTH ATLANTIC TREATY ORGANIZATION

ALLIED JOINT MEDICAL PUBLICATION

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

NATO STANDARDIZATION OFFICE (NSO)

NATO LETTER OF PROMULGATION

27 July 2018

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

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

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

Zoltán GULYÁS
Brigadier General, HUNAF
Director, NATO Standardization Office

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RESERVED FOR NATIONAL LETTER OF PROMULGATION

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RECORD OF RESERVATIONS

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

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
DEU	No. 1.5.2 DEU reserves the right not to accept and not to use the term "operational" in connection with the duty of care for personnel. The duty of care for the personnel rests with the commander. Consequently the term “operational” has to be deleted as the command responsibility is clearly assigned to the Commander.
GBR	Whilst GBR acknowledges the Multinational Modular Approach as described in AJP-4.10(B), the current GBR national preference is for a Lead Nation (LN) approach. When GBR offers medical capability as the LN, it will provide all the required medical equipment, training and evaluation required and Troop Contributing Nations (TCNs) only provide personnel (who have undertaken the TCN□s non-medical redeployment training). As a result, there may be instances where GBR may not wholly apply/implement the requirements of AMedP-1.6 (as referred to in this publication). In these instances, every effort will be made to discuss the operational and evaluation requirements with Allied Command Operations, the designated Joint Forces Command and the NATO evaluation body.
Note: The reservations listed on this page include only those that were recorded at time of promulgation and may not be complete. Refer to the NATO Standardization Document Database for the complete list of existing reservations.	

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CHAPTER 1 INTRODUCTION

1.1 AIM

1. This document is a revision to AJMedP-4 Allied Joint Medical Force Health Protection Doctrine. It is: subordinate to AJP-4.10(B) Allied Joint Doctrine for Medical Support; takes MC 0551 Medical Support Concept for NRF Operations and MC 0326/3 NATO Principles and Policies of Medical Support into account; and, aligns with AJP-3.14 Allied Joint Doctrine for Force Protection.

2. As an Allied Joint Medical Publication, this document includes guidance amplified in subordinate medical publications such as:

a. Allied Medical Publications (AMedPs). Examples include AMedP-4.1 Deployment Health Surveillance and AMedP-4.2 Deployment Pest and Vector Surveillance and Control; and,

b. Standards Related Documents (SRDs). Examples include SRD AJMedP-04-1: Heat Stress Control and Heat Casualty Management and SRD AJMedP-04-8: Protection of Hearing.

3. SRDs relevant to this AJMedP are listed in Annex A. AMedPs and other publications relevant to this AJMedP are listed in Annex B. All should be consulted for more detailed guidance in their respective subject areas.

1.2 DEFINITIONS

1. TTF Number: 2011-1810 defines Force Health Protection (FHP) as: “All medical efforts to promote or conserve physical and mental well-being, reduce or eliminate the incidence and impact of disease, injury and death and enhance operational readiness and combat effectiveness of the forces”.

2. FHP falls under the broad umbrella of Force Protection (FP), itself defined in TTF Number: 2002-0021 as: “All measures and means to minimize the vulnerability of personnel, facilities, equipment and operations to any threat and in all situations, to preserve freedom of action and the operational effectiveness of the force.”

1.3 IMPORTANCE OF FHP

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

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

1.4 FHP STANDARD

The goal is to use FHP to provide the best possible care to the target force(s). In this respect and allowing for operational constraints, the practice of FHP should be evidence-based and consistent with accepted best practices/standards.

1.5 RESPONSIBILITIES FOR FHP

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

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

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

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

1.6 IMPORTANCE OF COMMAND EMPHASIS

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

1.7 COMMUNICATION

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

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

3. As required, MEDADs may need to discuss FHP matters, e.g., outbreaks[1], with local, host-country, home-country and/or international public health authorities.

4. Medical Intelligence (MedIntel) and Medical Information are key enablers of FHP and are covered in AJMedP-3 Allied Joint Medical Doctrine for Medical Intelligence. Medical Information is also covered in STANAG 2481 Medical Information Collection and Reporting.

CBRN is not addressed in this publication, though the concepts discussed may also be applied in this domain.

[1]This includes Public Health Emergencies of International Concern as defined in the World Health Organizations' International Health Regulations (http://www.who.int/topics/international_health_regulations/en/, accessed July 25, 2016).

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CHAPTER 2 HAZARD IDENTIFICATION, RISK ASSESSMENT AND RISK MANAGEMENT

2.1 INTRODUCTION

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

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

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

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

2. Effective FHP is contingent on a timely and accurate cycle of hazard identification, risk assessment, risk management and program evaluation. This cycle is depicted in Figure 1.

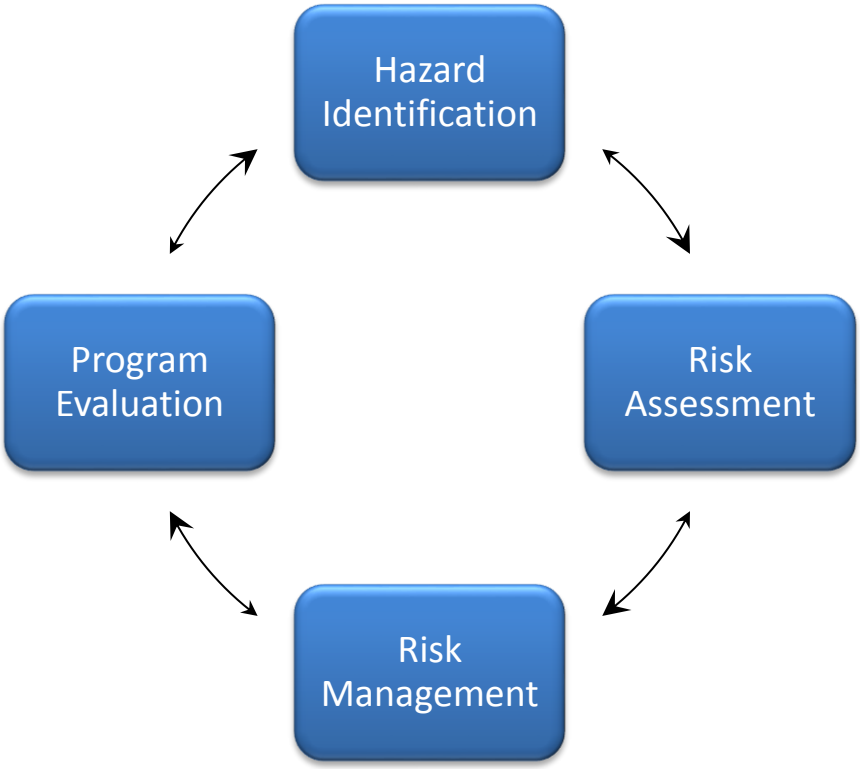

Figure 1: FHP cycle, adapted from Figure B.1 in AJP-3.14.

2.2 HEALTH HAZARD IDENTIFICATION

1. Health hazard refers to any source of potential damage, harm or adverse health effect. In the FHP domain, hazards generally arise from biological (e.g., animals, plants and microorganisms), environmental (e.g., heat, cold, altitude), natural (e.g., chemical, physical) and anthropogenic (e.g., industrial) sources. A hazard is not the same as a risk in that it does connote likelihood.

2. Identification of health hazards is a critical step of the FHP cycle. It is often closely aligned with and/or addressed through the MedIntel cycle.

3. Health hazards change and their identification and characterization is a continuous process.

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

2.3 HEALTH RISK

1. Irrespective of the analytic context, the term “risk” is predicated on uncertainty and is therefore future oriented.

2. For a given health hazard, there is an associated health risk, which is estimated through integration of exposure and consequence information. For example, if a military member deploys to an area where Japanese encephalitis (JE) is a hazard, his/her risks can be estimated based on:

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

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

c. Health risk. Using the outcome of clinically relevant disease, can be expressed as the product of exposure (1/1,000) and consequence (1/250) = 1/250,000. As about 25% of clinical cases of JE result in death, the analogous quantitative health risk for death = 1/1,000,000.

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

4. Rather than a pure likelihood estimate, risk can also imply impact. When used this way, it represents a composite measure of likelihood and severity. Unlike likelihood, which can be purely quantitative, estimating severity requires judgement and may be influenced by factors such as perspective (e.g., individual vs. population health), consequences for the mission, type(s) of acute and future health effects, risk tolerance, etc.

5. Assessment of health risk must be compatible with and feed into the broader FP process. As described in AJP-3.14, risk in the FP context is used in the sense described at para. 2.10: *"Risk is a function of the value of the asset and is compared to the potential impact of the exploitation of vulnerabilities by threats and hazards. This phase answers the question "What are the odds (probability) of something going wrong and what is the effect or impact (severity)?" The effect could be mission failure, injury, or loss due to a threat exploiting vulnerabilities or a hazard. It considers the risk or likelihood of an event or incident adversely impacting mission, capabilities, people, equipment, or property, and completes the risk assessment by systematically presenting a methodology to obtain a standardized level of risk. Risks must be identified by checking the cause, the event, and the effect of the risk."*

2.4 HEALTH RISK ASSESMENT

1. AJP-3.14 describes a FP risk assessment process that: *"…considers four points and should include a prioritization of the risks to support the decision-making process:*

a. *probability or likelihood that an incident caused by threat or hazard will occur.*

b. *probability or likelihood that a specific vulnerability will be exploited.*

c. *the impact on mission success in terms of numbers killed or numbers and degree of injury to personnel, damage to materiel or facilities, loss or corruption of information, or other mission-impinging factors, such as morale, that are caused by the degree of impact or severity of the threat.*

d. *the proximity of the risk*."

2. The health risk assessment (HRA) needs to be compatible with the overall FP risk assessment process and, at its most basic, should include estimation of:

a. exposure to the hazard(s).

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

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

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

4. A FHP-based HRA can express risk in a number of ways. Often, a qualitative scale is used, e.g., risk is negligible, low, moderate, high or extremely high. The important point is that the HRA capture likelihood and severity aspects of the hazard of interest. In this respect, a health hazard might be assessed as high because it has the ability to affect (simultaneously) a large number of personnel (even if only with relatively mild symptoms, e.g., travelers' diarrhoea, heat stress), or has very severe health effects (even if relatively few personnel are affected, e.g., Ebola), or for a variety of other reasons.

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

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

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

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

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

6. Ideally, a HRA will be supported by quantitative estimates, e.g., numeric probabilities of immediate or future health harms.

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

8. As health hazards and information related to them change, HRA is a continuous process.

2.5 HEALTH RISK MANAGEMENT

1. In broad terms, risk management: "*involves a systematic approach to setting the best course of action under uncertainty by identifying, assessing, understanding, making decisions on and communicating risk issues…It does not necessarily mean risk avoidance…Rather risk management equips organizations to make decisions that are informed by an understanding of their risks, and ultimately to respond proactively to change by mitigating the threats, and capitalizing on the opportunities*…".[2]

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

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

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

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

[2]Source: Government of Canada Guide to Risk Management (http://www.tbs-sct.gc.ca/hgw-cgf/pol/rm-gr/girm-ggir/girm-ggirtb-eng.asp; accessed July 25, 2016)

2.6 PROGRAM EVALUATION

1. The FP doctrine in AJP-3.14 indicates: "***Supervise and Evaluate****...The purpose…is to ensure that risk controls are implemented and enforced to standard and that a feedback mechanism is in place. As with the rest of the risk management process, supervision and evaluation must occur throughout all phases of an operation or activity*".

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

3. AMedP-1.6 Medical Evaluation Manual provides the overarching "*framework for nations to certify their own medical capabilities and also for the medical evaluation of multinational medical modules and units, when formed to support NATO operations*".

4. Fundamental to FHP program evaluation is ongoing and robust health surveillance. Defined in AMedP-4.1 Deployment Health Surveillance (DHS) is *"…the continuous, systematic collection, analysis, interpretation, and dissemination of health-related data' with respect to deployed NATO forces".*

5. The goal of evaluation is to inform the need for change(s) to the FHP approach and to validate points of sustainment.

6. As applicable, evaluation information should be fed into the NATO Joint Analysis Lessons Learned database to inform future action(s).

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CHAPTER 3 COMMAND AND CONTROL

3.1 SENIOR MEDICAL ADVISOR

Allied Command Operations (ACO) MEDAD is the senior medical advisor to the NATO Strategic Commander. Based on command direction, ACO MEDAD provides FHP guidance to medical staffs of the NATO Joint Force Commands/Joint Command. ACO MEDAD also is responsible for integration of FHP information into the command, control, communications, computers and intelligence (C4I) system(s)[3].

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

3.2 DEPLOYED HEADQUARTERS

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

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

3. FHPC staff functions can include:

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

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

   c. Preventive medicine programs such as developing and/or coordinating food/water safety and defence audits.

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

   e. Advising on force health readiness.

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

   g. Managing the deployment health surveillance system.

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

CHAPTER 4 FORCE HEALTH PROTECTION PROGRAM AREAS

4.1 INTRODUCTION

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

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

   a. Deployment health surveillance.

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

   c. Occupational and environmental health.

   d. Hygiene and sanitation.

   e. Food and water safety.

   f. Mental and physical health/preparedness.

4.2 DEPLOYMENT HEALTH SURVEILLANCE

1. AMedP-4.1 is the NATO standard for and provides extensive guidance on Deployment Health Surveillance (DHS). As defined therein, the objectives of DHS are:

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

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

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

   d. *Evaluate implemented preventive measures.*

   e. *Identify relevant medical research fields*".

4.3 COMUNICABLE DISEASE CONTROL AND PREVENTION

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

2. Identification, assessment and management of communicable disease hazards follow the principles outlined in chapter 2. Assessment must begin pre-deployment so as to allow full medical preparation of deploying personnel (e.g., through hazard identification, health risk estimation, health risk mitigation such as immunization[4] and other measures) including the identification and acquisition of required medical materials.

3. Arthropod vectors (e.g., mosquitoes, sand flies, ticks) and associated diseases (e.g., malaria, dengue, chikungunya) can significantly erode mission capabilities. HRM for arthropod-associated hazards include surveillance for and control of vectors and other pests, e.g., repellents, bednets, pesticides. These approaches are detailed in AMedP-4.2 Deployment Pest and Vector Surveillance and Control.

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

4.4 INFECTION PREVENTION AND CONTROL (IPC)

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

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

3. Minimally, medical treatment facilities (MTF) are to adhere to basic IPC tenets including use of Routine (Standard) Practices[5].

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

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

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

4.5 OCCUPATIONAL AND ENVIRONMENTAL HEALTH

1. Occupational and environmental hazards (OEH) are prevalent in almost all military circumstances. They include natural (e.g., heat, cold, sun exposure, altitude, dust, animals) and man-made (e.g., noise, accidents, particulates) physical hazards, natural and synthetic chemicals, and a variety of other things. These hazards may be associated with acute and/or chronic effects.

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

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

4. Animals present physical (e.g., bites) and biologic hazards (e.g., rabies[6], envenomation). Pets should not be kept by troops, and other animals should be avoided. Attention to sanitation and hygiene will help to prevent animal-related problems from developing[7]. Management of working animals is addressed in AMedP-8.4 Animal Care and Welfare and Veterinary Support during all phases of Military Deployments.

4.6 FIELD HYGIENE AND SANITATION

1. Maintaining high levels of sanitation and hygiene (including oral hygiene) protects against a variety of hazards. Troop contributing nations minimally are to apply basic sanitary principles to all aspects of their operations. These include: appropriate waste management and disposal[8]; safe and effective prevention and control of pests; and, promotion and facilitation of personal hygiene.

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[4]Immunization is addressed by AMedP-23 National Military Strategies for Vaccination of NATO Forces
[5]See description in World Health Organization Publication *Standard precautions in Health C*are (http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf; accessed July 25 , 2016) and the Public Health Agency of Canada publication *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings* (http://publications.gc.ca/site/eng/440707/publication.html; accessed July 25, 2016)
[6]For the NATO approach to use of rabies biologics see AMedP-4.3 Human Rabies Prophylaxis in Operational Settings.
[7]Described/amplified in AMedP-26 Veterinary Guidelines on Major Transmissible Animal Diseases and Preventing their Transfer.
[8]Also see AJEPP-5 Joint NATO Waste Management Requirements during NATO-led Military Activities.

4.7 FOOD AND WATER PROTECTION

1. Food associated diseases (e.g., norovirus, *Salmonella* spp.) continue to impact NATO operations. Thus, food safety[9] and defence is a priority and should be applied through all stages of food procurement[10], storage, distribution, and preparation.

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

3. Safe drinking water is an operational necessity. Failure to provide adequate quantities of potable water can result in significant DNBI rates, e.g., due to dehydration and/or communicable diseases.

4. The operational goal is to provide drinking water that meets national home country quality/safety standards. Where this is difficult to achieve, the commander might decide to accept additional drinking water-associated risk.

5. To optimize water protection and safety, appropriate standards, processes, expertise, time and equipment should be made available[11].

4.8 MENTAL AND PHYSICAL HEALTH/PREPAREDNESS

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

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

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

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

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

5. Maintaining and protecting mental health through the entire deployment cycle is a priority. Relevant NATO publications in this domain include: STANAG 2565 A Psychological Guide for Leaders across the Deployment Cycle; AMedP-8.6 Forward Mental Health Care; AJMedP-1 Allied Joint Medical Doctrine Planning; and, AJP-4.10 (B) Allied Joint Doctrine for Medical Support.

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CHAPTER 5 EDUCATION AND TRAINING

5.1 GENERAL

1. The goal is to train personnel to meet or exceed applicable civilian standards.

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

5.2 OVERARCHING EDUCATION AND TRAINING GOALS (MEDICAL)

1. The NATO training objective is for personnel to meet the standards delineated in MC 0326/3, MC 0551 Medical Support Concept for NRF Operations, AMedP-8.3 Training Requirements for Health Care Personnel in International Missions and AJP-4.10 (B). Applied to FHP, the minimum training objectives at each level are:

   a. Individual Education and Training. Knowledge of FHP and its contribution to military readiness.

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

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

   d. Collective Education and Training. FHP as a medical support capability in accordance with MC 326/3, MC 0551 and AJP-4.10(B)

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

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

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

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

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

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

f. Relevant medical actors including indigenous authorities, IOs and NGOs

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

ANNEX A STANDARDS RELATED DOCUMENTS

Standards Related Documents (SRD) have been adopted as amplifying documents to AJMedP-4 enabling the development of a more concise document. SRDs will be developed with the underlying principle of being as detailed as required while also remaining practical in their scope in an effort to preserve their utility. The SRDs listed below will remain the responsibility of the respective custodian nations who will update the SRDs as required.

1. SRD AJMedP-04-1: HEAT STRESS CONTROL AND HEAT CASUALTY MANAGEMENT – Custodian: United States of America

2. SRD AJMedP-04-2: PREVENTION AND MANAGEMENT OF COLD WEATHER INJURIES – Custodian: United States of America

3. SRD AJMedP-04-3: ALTITUDE ACCLIMATIZATION ANDILLNESS MANAGEMENT – Custodian: United States of America

4. SRD AJMedP-04-4: FIELD HYGIENE AND SANITATION – Custodian: United States of America

5. SRD AJMedP-04-5: UPDATED US PUBLIC HEALTH SERVICE GUIDELINES FOR MANAGEMENT OF OCCUPATIONAL EXPOSURES TO HUMAN IMMUNODEFICIENCY VIRUS AND RECOMMENDATIONS FOR POST EXPOSURE PROPHYLAXIS – Custodian: Belgium

6. SRD AJMedP-04-6: UK GUIDELINE FOR THE USE OF HUMAN IMMUNODEFICIENCY VIRUS POST-EXPOSURE PROPHYLAXIS FOLLOWING SEXUAL EXPOSURE, 2015 – Custodian: Belgium

7. SRD AJMedP-04-7: VACCINATIONS CATALOGUE WITHIN THE NATO & PfP FORCES – Custodian: Mil Med CoE

8. SRD AJMedP-04-8: PROTECTION OF HEARING – Custodian: Netherlands

9. SRD AJMedP-04-9: PREVENTIVE MEASURES FOR AN OCCUPATIONAL HEALTH PROGRAMME – Custodian: Poland.

10. SRD AJMedP-04-10: WHO EXPERT CONSULTATION ON RABIES – Custodian: Belgium

11. SRD AJMedP-04-11: WHO GUIDE FOR RABIES PRE AND POST EXPOSURE PROPHYLAXIS IN HUMANS – Custodian: Belgium

12. SRD AJMedP-04-12: ENVIRONMENTAL HEALTH RISK ASSESSMENT – Custodian: Sweden

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ANNEX B REFERENCE

B.1 Military Committee Publications

MC 326/3	NATO Principles and Policies of Operational Medical Support
MC 0551 Operations	Medical Support Concept for NATO Response Force (NRF)

STANAGs

STANAG 2565	A Psychological Guide for Leaders across the Deployment Cycle

Allied Joint Publications

AJP 3.14	Allied Joint Doctrine for Force Protection
AJP-4.10	Allied Joint Medical Support Doctrine

Allied Joint Environmental Protection Publication

AJEPP-5	Joint NATO Waste Management Requirements during NATO-led Military Activities

Allied Joint Medical Publications

AJMedP-1	Allied Joint Medical Doctrine Planning
AJMedP-3	Allied Joint Medical Doctrine for Medical Intelligence
AJMedP-5	Allied Joint Doctrine for Medical Communications and Information Systems (MedCIS)

Allied Medical Publications

AMedP-1.6	Medical Evaluation Manual

AMedP-3.2	Medical information collection and reporting
AMedP-4.1	Deployment Health Surveillance
AMedP-4.2	Deployment Pest and Vector Surveillance and Control
AMedP-4.3	Human Rabies Prophylaxis in Operational Settings
AMedP-4.5	Audit Principles and Risk Assessment of Food Processors and Suppliers Providing Food to the Military
AMedP-4.6	Food Safety, Defence, and Production Standards in Deployed Operations
AMedP-4.7	Inspection of Food Services Catering Facilities in Deployed Operations
AMedP-4.9	Requirements for Water Potability during Field Operations and in Emergency Situations
AMedP-8.6	Forward Mental Health
AMedP-8.3	Training Requirements for Health Care Personnel in International Missions
AMedP-8.4	Animal Care and Welfare and Veterinary Support during all phases of Military Deployments

B.2 Other Publications

Government of Canada Guide to Risk Management. 2012.
http://www.tbs-sct.gc.ca/hgw-cgf/pol/rm-gr/girm-ggir/girm-ggirtb-eng.asp

Public Health Agency of Canada. 2013. Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.
http://publications.gc.ca/site/eng/440707/publication.html

United States Army Public Health Command. 2013. Technical Guide 230 - Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel.
http://phc.amedd.army.mil/PHC%20Resource%20Library/TG230.pdf
World Health Organization International Health Regulations. 2005.
http://www.who.int/ihr/publications/9789241596664/en/
World Health Organization Publication. 2007. Standard precautions in Health Care.
http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf

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