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MULTINATIONAL MEDICAL SUPPORT

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NORTH ATLANTIC TREATY ORGANIZATION

ALLIED JOINT MEDICAL PUBLICATION

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NATO LETTER OF PROMULGATION

16 April 2019

1. The enclosed Allied Joint Medical Publication AJMedP-9, Edition A, Version 1, MULTINATIONAL MEDICAL SUPPORT, 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 6505.
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4. This publication shall be handled in accordance with C M(2002)60.

for 

Zoltán GÜLYÁS
Brigadier General, HUNAF
Director, NATO Standardization Office

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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
FRA	<p>France adheres to the concepts of MSN, MRSN and MLN, but does not support the MFN concept. While France is in favour of defining the overarching multinational medical support framework, implementation of the MFN concept requires long-term work on capability development. France sees it as a loss of responsiveness and, possibly, strategic autonomy. Besides, the French medical support concept relies on very light and mobile structures and therefore does not allow an easy development of medical and surgical structures based on that concept.</p>
GBR	<p>General. In principle, the United Kingdom (UK) continues to support the development of multinational approaches to the provision of medical support on Alliance operations and initiatives such as Smart Defence and the Framework Nations Concept. The UK believes that to date, the only proven approach is the Lead Nation approach and that multinational approaches such as pooling and sharing and framework nations groupings remain conceptual in nature and unproven in application. Therefore, the UK national preference is for a Lead Nation approach to deployed multinational medical treatment facilities. The UK believes that the modular approach is useful for nations when defining the functional component parts of a medical treatment facility. In addition, the approach assists medical commanders and planners in identifying the interoperability requirements needed to successfully operate a group of modules as a whole capability. In the context of multinational approaches, the approach is of similar value; however, its value is currently limited when seeking solutions to problems generated by factors such as differing national:</p> <p>Defence priorities; legislation and policy; medical education and regulation; and, clinical standards and governance.</p> <p>Chapter 4. The UK adopts a specific form of the Lead Nation approach in the context of medical treatment facilities. This approach is necessary to obviate complex factors relating to national sovereignty that often act as barriers to 'medical multi-nationality'. These barriers include differences in nations legislation and policy; medical education and regulation; professional roles; and, clinical standards and governance. In addition, the UK believes that its approach promotes, achieves and maintains high levels of interoperability which is an essential requirement. In the specific context of a multinational medical treatment facility, the UK (as the Lead or Troop Contributing Nation) currently understands the Lead Nation approach to mean:</p>

	<p>(1) The Lead Nation is responsible for the planning and execution of the assigned medical mission; AMedP-9.1 VI Edition A Version 1</p> <p>(2) The Lead Nation has OPCOM or OPCON authority over forces assigned from Troop Contributing Nations;</p> <p>(3) The Lead Nation has responsibility for all appropriate capability lines of development (for example, NATO DOTMLPF-I: Doctrine, Organization, Training, Material, Leadership, Personnel, Facilities, Interoperability);</p> <p>(4) Troop Contributing Nations will provide personnel only (with the required specialist skills) to work within the Lead Nation construct;</p> <p>(5) The assigned Troop Contributing Nations' forces must meet the Lead Nation's familiarisation, training, exercise, rehearsal and certification requirements; and,</p> <p>(6) The authorities, responsibilities and requirements will be detailed in a bi-lateral agreement(s) between the Lead Nation and Troop Contributing Nation(s)</p>

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

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CHAPTER 1 FUNDAMENTALS OF MULTINATIONAL MEDICAL SUPPORT

1.1 INTRODUCTION

1.1.1 Purpose and Scope

The purpose of Allied Joint Medical Publication (AJMedP)-9 Multinational Medical Support is to provide guidance to those involved in health service support planning for defence planning, operations and exercises. The successful planning, execution and support of military operations require a clearly understood and widely accepted doctrine, and this is especially important when operations are to be conducted by Allied, multinational or coalition forces.

AJMedP-9 is closely linked to AJP-4.10 and AJMedP-1. AJMedP-9 describes multinational solutions focusing on the tactical level, whereas AJMedP-1 explains planning procedures within NATO headquarters.

1.1.2 Medical Support in future Alliance Operations

As a critical force enabler, multinational medical capabilities significantly contribute to the overall success of NATO and coalition operations. The shift to more expeditionary operations and the reinforcing of the Alliance collective security responsibility has significant implications for medical support of NATO operations. Forces might be deployed in all kinds of environment, locations and circumstances, including:

- to locations with a high level of health threats and risks;
- at much greater distances than previously necessary and operating along extended and perhaps very limited lines of communications (LOC);
- environments where Allied operations are limited or denied by the adversary's anti-access area denial (A2AD) capabilities;
- with little or no Host Nation Support (HNS);
- in dense urban areas with a large civilian population making opposing forces elusive; and,
- on operations involving hybrid, asymmetric or non-linear warfare.

This operational environment dictates that deployable medical capabilities are mobile, agile and robust in both expeditionary and in territorially-based high intensity operations. In addition, in operational environments where the adversary's A2AD capabilities poses a significant threat and as a result, deployed medical capabilities may be required to provide prolonged treatment and care at the various roles of care present in theatre.

1.1.3 Multinational Solutions

Nations are ultimately responsible for the medical support of their deployed forces and have various medical support options available to them ranging from exclusive national support to multinational modular provision such as a Framework Nations Concept (FNC). Multinational solutions offer nations and the Alliance a number of benefits including capability development opportunities and greater cost and sustainment efficiency; hence, NATO encourages multinational solutions in the delivery of medical support.

1.1.4 Multinationality and Interoperability

Multinational medical support is identified as a model, which, depending on the specific situation, can effectively and efficiently contribute to force flexibility and the optimal use of specific national expertise and capabilities. Moreover, a **multinational medical support approach facilitates interoperability**, engenders and reinforces mutual trust and transparency among contributing nations and ensures that wounded and ill personnel have access to effective medical care. Multinational medical support has a potential to enhance effectiveness and efficiency as well as NATO's credibility.

1.1.5 Enabling Multinationality

An effective command and control (C2) architecture that includes clearly defined, delineated and devolved responsibilities is essential to all medical support operations. The demands of the future operating environment and newer approaches to multinationality such as FNC will likely challenge traditional 'singular' and/or horizontal notions of C2 (for example, certain responsibilities could be shared between medical commanders) and require that some responsibilities traditionally held at higher command levels are devolved to much lower levels in order to be effective. This dictates that 'vertical' and 'horizontal' coordination between the multinational medical elements supported by a real-time or near real-time multidimensional common operating picture (time and space) of the battlespace and communications, will be critical to mission effectiveness and success. In addition, effective liaison and coordination with other functional areas¹ will be essential. More than ever, standardization is a critical prerequisite for the successful implementation of multinational medical support, not only in doctrine, structures, operations, and procedures², but also common education, training and exercises.

¹ Such as J3 Operations, J4 Logistics and J5 Plans.

² Standing Operating Procedures (SOP) are to be written in English language, allowing smooth, quick and easy integration of personnel replacement/reinforcement from another nation. Names of drugs, remedies, consumables, manuals to the equipment must be written in English language as well. However, in order to facilitate understanding, education and training, these SOPs may be replicated in the native language of TCNs.

1.2 BENEFITS AND CHALLENGES OF MULTINATIONAL MEDICAL SUPPORT

1. The aim of multinational medical support is to effectively and efficiently support Alliance operation and continuous improvement in the quality of care and outcomes based on synergy, interoperability and learning effects.

2. There are a number of **benefits** that may be exploited:

- a. Multinational solutions have the potential to significantly contribute to NATO's defence planning in critical shortfall areas;
- b. Multinational medical approaches offer the Alliance and nations a mechanism by which to meet acute operational requirements within their means;
- c. Sharing of resources through multinational solutions results in increased efficiency of deployed healthcare and helps avoid duplication of effort;
- d. Diversity among deployed health forces offers opportunities to increase the effectiveness of military healthcare;
- e. Multinational contributions can balance the medical footprint across the theatre of operations and in addition, enable flexible and agile medical support solutions;
- f. Multinational solutions facilitate functional burden sharing and they allow nations, even smaller ones, to benefit from multinational health support. Benefits in this sense include not only access to medical treatment for deployed forces but the development of national medical capabilities;
- g. Enhanced cooperation and interoperability on a multinational basis reinforces mutual trust and transparency among nations and thereby facilitates sharing of best practices allowing the force access to high quality care;
- h. Multinational solutions will likely foster greater peacetime cooperation integration through common training and exercises; and,
- i. Through its multinational medical support efforts, the NATO medical community will build upon its many successes in recent operations and further enhance its professional reputation and credibility in the wider NATO and non-NATO communities.

3. The current and potential future international security environment and global economic realities demand that the NATO medical community challenge issues and factors (both thematic and practical) that have in the past tended to block or discourage multinational approaches to medical support. There are a range of challenges to be addressed in the planning and execution of deployed multinational medical support including:

- a. The formation of an effective medical Command, Control, Communication, Computer and Information (C4I) system that can draw and share data from multiple national sources and a logistic system based on national lines of support that is able to collectively serve a multinational population in theatre.
- b. Differences in national force capabilities and operating procedures may impose constraints on the ability of a multinational force to integrate effectively. Issues that may need to be addressed are differences in operating procedures (military and clinical), technical compatibility of equipment and individual cultural perspectives. By way of example, procedural or tactical differences between national approaches to medical support may present the force with instances or situations that will be particularly challenging and require significant mitigation efforts by all. The harmonization of operating procedures and protocols, creating common standards, education, training, exercises, and evaluation will however significantly reduce the likelihood of their occurrence and the need for significant mitigation.
- c. Language barriers create communication difficulties that may lead to differences in interpretation of the mission or assigned tasks. At the tactical level, medical elements and staff must be able to communicate with each other and, the ability to communicate between patient and medical staff is a key element in medical care. Thus, education aiming at certified language skills according to agreed language proficiency levels is mandatory. Whilst English is the common language used in the execution of multinational operations, key documents such as SOP and clinical and operational guidelines can be replicated in a TCN's native language(s). This will enhance understanding and facilitate activities such as education, training and evaluation.
- d. Lack of interoperability due to inadequate compliance with defined standards can cause technical and procedural difficulties. Hence, nations need to be encouraged to engage in the development of respective common agreements and their application.
- e. National caveats and restrictions can hamper the ability to interact properly and to support each other. Furthermore, legal aspects may limit the degree of multinational integration and interaction at every level. Thus, nations must understand, respect and acknowledge such limitations and strive for acceptable common solutions for the benefit of the mission and patients. In addition, the interpretation and use of professional roles can vary between nations and thus requires enhanced mutual understanding and challenging training and exercises prior to operations. All of these factors will require careful exploration and examination in order to effect multinational solutions.

- f. Differences between medical command philosophies and structures of participating nations require careful definition, delineation and where appropriate, devolution of responsibilities and authorities. Clearly defined responsibilities, and appropriate authorities prior to and during deployment in order to overcome or avoid differences between contributing nations or between nations and the NATO command structure. Guidelines, both generic and specific must be established to clarify responsibilities and how they relate to the planning and conduct of operations. Furthermore, such responsibilities will be determined according to the specific circumstances of each operation and agreed by the TCNs and commands involved.

1.3 MODES AND PRINCIPLES OF MULTINATIONAL MEDICAL SUPPORT

1. The purpose of this document is to describe the key modes of multinational medical support:

- a. **Medical Single Nation Concept (MSN)**,
- b. **Medical Role Specialist Nation Concept (MRSN)**,
- c. **Medical Lead Nation Concept (MLN)**, and
- d. **Medical Framework Nations Concept (MFN)**.

2. Medical units provide the different capabilities needed within the end-to-end medical support system in order to ensure medical support to an operation.

- a. In the **MSN** Concept one nation provides medical unit(s) with all the required capabilities.
- b. In the **MRSN** Concept several national medical units each provide capabilities, together forming the end to end medical support system.
- c. In the **MLN** Concept several nations will organize for a mission or operation in a Multinational Medical Unit (MMU) under the lead of one Lead Nation.
- d. In a **MFN** Concept several nations will organize on a permanent basis in a (standing) Multinational Integrated Medical Unit (MIMU), coordinated by a Framework Nation.

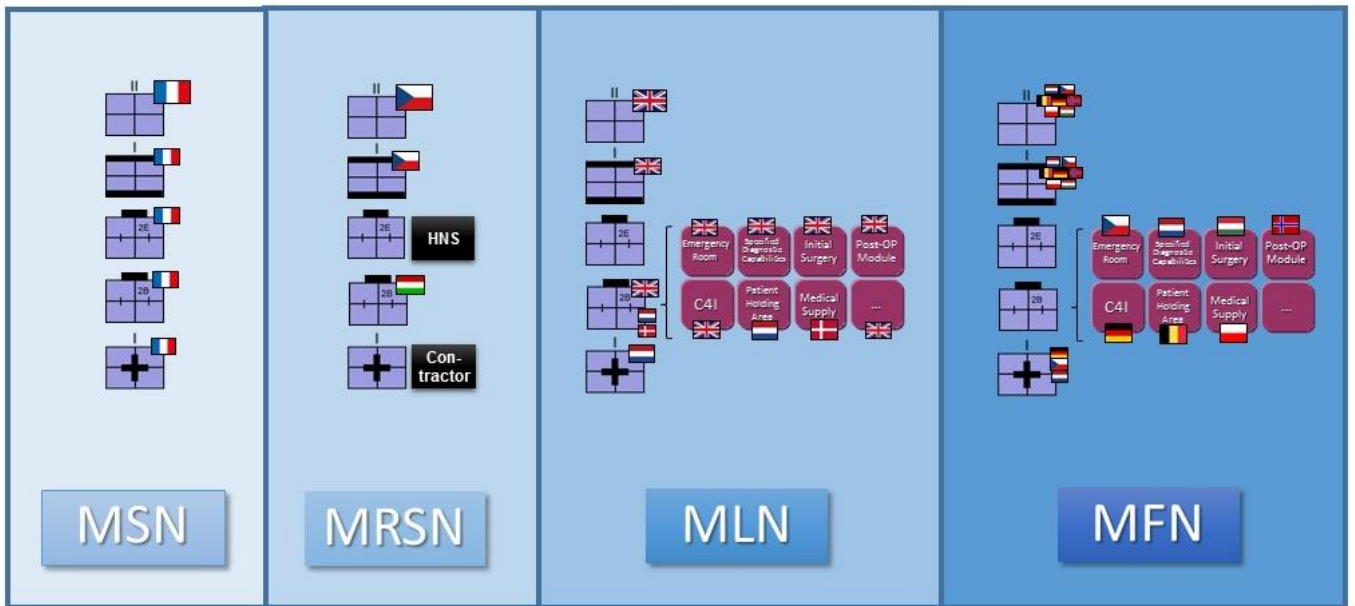


Figure 1: Examples for MN Medical Modes

3. As a consequence, the four modes show different levels of multinationality as well as duration as depicted in figure 2.

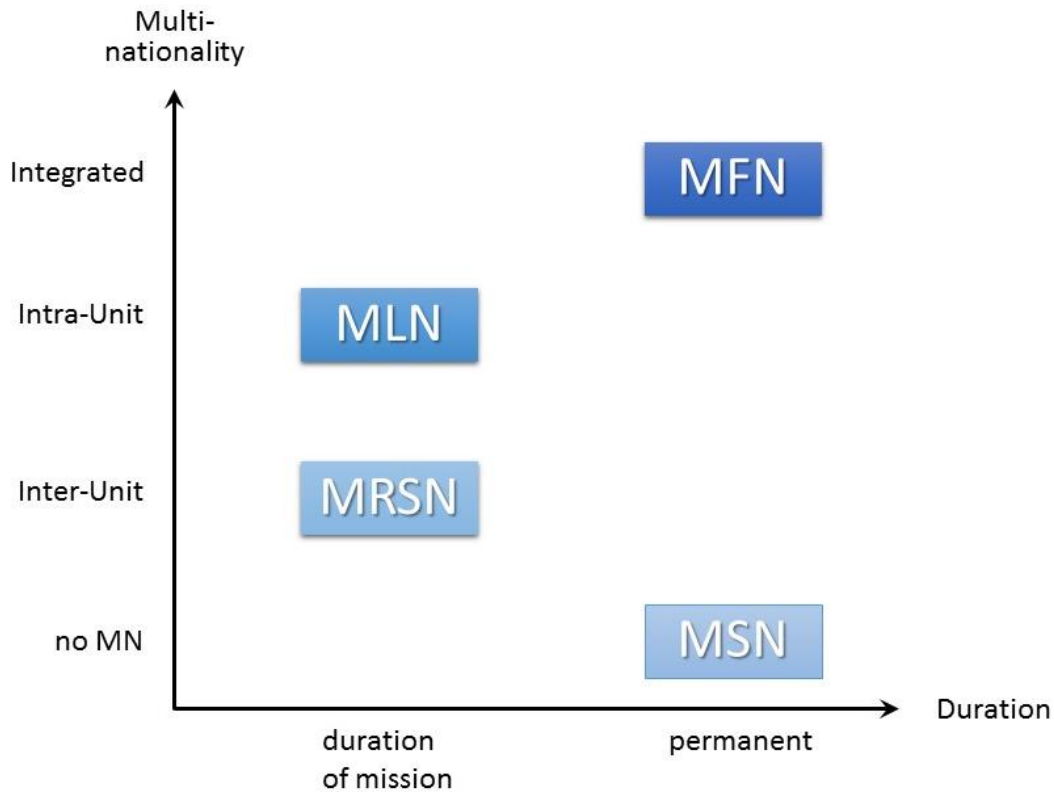


Figure 2: Differentiation concerning level of multinationality and duration

4. For all modes of multinational medical support there are **four main principles** that will be applicable in any type of operation:

- a. As the employer of their military personnel, nations retain their legal duty of care and are **ultimately responsible** for the health of their forces at all times.
- b. Upon Transfer of Authority (TOA) to the NATO Commander, the **Commander** assumes a shared responsibility for the health and welfare of TCN's forces. Implicit in this, is the responsibility of NATO commanders to ensure that the medical support provided is in accordance with the medical principles, policies and directives established and agreed by the Alliance as directed in MC326 NATO Principles and Policies of Medical Support.

- c. **TCNs** are responsible for ensuring that the principle of 'clinical need' is the principal factor governing the priority, timing and means of medical care and patient evacuation afforded to a patient; this includes provision of care to captured persons and prisoners of war in accordance with domestic and international law.
- d. All **medical professionals** within the multinational medical support system are responsible for their individual clinical practice at all times, according to the regulations and standards of their respective countries

1.4 PREREQUISITES FOR IMPLEMENTATION

All four modes of multinational medical support, and the specific prerequisites for their implementation, will be detailed in this document in terms of: definition; roles and responsibilities; funding; legal issues; duration of support; C2 relationships; and, quality management. Generic prerequisites for all modes of multinational medical support are outlined in this chapter.

1.5 ROLES AND RESPONSIBILITIES

1. **Nations** are primarily responsible for the health and welfare of their deployed forces and as such, have a 'duty to care' for their forces.

2. On Transfer of Authority (TOA), the **NATO commander** will usually be granted coordinating authority over the medical assets deployed to support a mission. This coordinating authority is exercised in the execution of a given operation. In exercising medical coordinating authority, the Medical Director (MEDDIR), on behalf of the NATO commander, may:

- a. Establish a specific C2 system³ to ensure continuous in-transit care during patient evacuation.
- b. Support to ensure safe shelter, food, water and sanitation within the Joint Operations Area (JOA).
- c. Determine the minimum standards of individual first aid, health and hygiene to be achieved within the theatre.
- d. Require reports on existing bi- and multilateral medical agreements that have been established,
- e. Develop and establish new medical Host Nation Support (HNS) requirements, as well as initiate, participate, coordinate and conduct negotiations for them.
- f. Evaluate medical intelligence/information about possible deployment areas and incorporate this data into plans.
- g. Determine the placement of medical units in the AOR and coordinate the operations.
- h. Coordinate and track medical treatment and the transport of the patients.
- i. Establish epidemiological health surveillance of the whole deployed force.
- j. Direct appropriate education and training, and propose immunisation policy and programmes for disease prevention and control within the force.
- k. Direct environmental monitoring/ occupational hygiene measures.
- l. Determine the theatre holding policy.
- m. Propose the use of CBRN medical counter-measures including the administration of prophylactics.

3. TCN medical professionals are responsible for their own professional practice in accordance with their national legislation and policy. TCNs are responsible for coherence and compliance of their national clinical standards, practices and procedures with relevant international law and NATO policies and guidelines.

1.6 FUNDING

1. Funding of national contributions is the responsibility of the contributing nations in accordance with established NATO procedures. The primary funding mechanism remains “costs lie where they fall”, which means that nations cover all the costs associated with their participation in an operation. Only costs not attributable to a specific nation and agreed as eligible for Common Funding can be assumed by NATO; such costs will be limited to minimum military requirements in direct support of the military aspects of the operation.⁴

2. Memoranda of Understanding (MOU) between contributing nations and NATO bodies such as SHAPE will be required and will include specific detail on the funding of medical support including the funding of infrastructure, operations and maintenance costs and reimbursement of medical goods or services

1.7 LEGAL ARRANGEMENTS

1. Bi- or multinational agreements on medical support documents must conform to recognized NATO procedures and practices and should not contradict the domestic law of the nations involved. As there are also international legal considerations for some nations, legal advice is critical during all phases of medical support negotiations.

2. As is the custom in modern international relations, Status of Forces Agreement's (SOFA) govern the relationship concerning the presence and activities of a force in a foreign territory. NATO and PfP SOFAs and supplementary arrangements resolve many issues pertinent to medical support in a foreign territory. Nations which do not have an existing SOFA with the country involved may require a supplemental agreement which recognizes an existing SOFA or the creation of a mission specific SOFA as a foundational document.

3. The hierarchy of agreements and arrangements provided used in this publication is Status of Forces Agreement (SOFA), Memorandum of Understanding (MOU), Technical Arrangement (TA) and Statement of Requirement (SOR); other structures may be used as necessary and appropriate.

³ Including a reliable, secure and effective medical communications and information system (CIS).

⁴ Where military common funding is concerned – the military budget and the NATO Security Investment Programme (NSIP) – the guiding principle for eligibility is the “over and above” rule: “Common funding will focus on the provision of requirements which are over and above those which could reasonably be expected to be made available from national resources.” NATO Office of Resources website (accessed 25 Jan 17).

1.8 DURATION

The duration of multinational medical support within the different modes, should be agreed in the force generation process. The agreement should be formalized in the TOA agreement and in MOUs between the nations concerned and SHAPE.

1.9 COMMAND AND CONTROL RELATIONSHIPS

1. Coordination and integration of assets from multiple nations through collaborative planning, deployment and utilization requires an effective C2 structure, an information network that can draw and share data from multiple national sources, educational programs ensuring common understanding and operational standards as well as an organization based on national lines of support that is able to collectively serve a multinational population in theatre.

2. C2 arrangements will be developed for each operation in coordination with contributing nations. In situations where multinational solutions are used, the TOA will define C2 relationships to be applied (OPCOM, OPCON, TACON, or other relationships).

3. The **MEDDIR** is responsible for coordinating the entire chain of medical support. To achieve that task, the MEDDIR will ensure the Standing Operating Procedures (SOPs) are accurate, adapted, integrated and complied with by all capabilities part of medical support system.

4. To enable a flexible configuration and enhancement of MN medical elements, it might be necessary, to form a **MN Medical Task Force**, which includes all health service support contributions under tactical command of the MEDDIR.

1.10 QUALITY MANAGEMENT, CLINICAL STANDARDS AND TASKS

1. Continuous Improvement in Healthcare Support on Operations (CIHSO) is the process by which best practice is shared, and challenges acknowledged and reflected upon, in order to learn from experience and to optimize healthcare support on deployed operations. It provides assurance that the healthcare provided is meeting the standards expected.

2. TCNs are responsible for ensuring that medical support provision is conducted in accordance with the operation medical rules of eligibility (MRE) including the universal provision of acute emergency care (sometimes referred to as 'Life-Limb-Function'). It is however acknowledged that the NATO commander may limit the latter as a result of operational risk factors and in order to ensure adequate provision for the Force based upon the advice of the Medical Advisor (MEDAD)

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CHAPTER 2 MEDICAL SINGLE NATION CONCEPT

2.1 INTRODUCTION

There will be instances where nations have the means and are willing to provide medical support to their own and other nations' forces solely through national means. Provision to other nations' forces can be achieved on a 'declared'⁵ or bilateral basis.

2.2 DEFINITION

The provision of deployed end-to-end medical support to a MN force by a TCNs own medical support capabilities.

2.3 ROLES AND RESPONSIBILITIES

1. All aspects of paragraph 1.5 apply.
2. Where a nation provides medical support through national means, the NATO commander will, on TOA, assume and retain certain responsibilities and authorities. The nature and extent of these will be detailed in the TOA agreement. Therefore, every effort should be made by TCNs to support the commander and his/her medical staff in achieving the optimal balance of medical provision across the whole of the theatre of operations.
3. During NATO operations, units and formations should deploy and redeploy with a coherent medical structure tailored to their anticipated employment. Under normal circumstances, nations will expect to have first call on their national medical assets. However, during peak periods when patient numbers are above normal or anticipated levels the force commander will need to take appropriate action to utilize the full medical capacity and capability of the force. This may include redistribution of assets within the force. The authority to take such action is defined in MC 319 NATO Principles and Policies for Logistics. If used, such authority should only be exercised temporarily and in extraordinary situations.

2.4 FUNDING

All aspects of paragraph 1.6 apply.

⁵ Contributing to the Combined Joint Statement of Requirement (CJSOR) or Theatre Capability Statement of Requirement (TCSOR) through a Transfer of Authority (TOA) to the designated NATO Commander.

2.5 LEGAL ARRANGEMENTS

1. The legal considerations and arrangements for MSN deployed medical support are as previously described in paragraph 1.7.
2. Where national caveats and restrictions exist, it is the MSN TCNs responsibility to ensure that these are declared in accordance with NATO policy. In the operational scenario where a MN force is deployed and MN medical elements are present, the MSN will engage with the MEDDIR and other medical commanders in order to ensure that national caveats are respected. The MEDDIR will ensure that common theatre procedures are developed that take into account any national caveats, mitigate resulting gaps and avoid any tensions or conflicts; the MSN will support the MEDDIR in his task.

2.6 DURATION

1. All aspects of paragraph 1.8 apply.
2. The operation duration will be determined by the North Atlantic Council in consultation with SACEUR, COM JFC and the CJTF commander. TCNs are responsible for ensuring that the required level of medical support is maintained throughout the period of deployment (including rotation and redeployment) as agreed in the COM JFC OPLAN and CJSOR/TCSOR and TOA.

2.7 COMMAND AND CONTROL RELATIONSHIPS

1. All aspects of paragraph 1.9 apply.
2. C2 relationships will be clearly articulated in the TOA. In instances where the NATO commander's C2 authority is limited, TCNs are responsible for ensuring that their medical support activities are coordinated with all other theatre medical support activities through the MEDDIR. In addition, national medical elements must make every effort to synchronize their deployed battle rhythm with that of the deployed HQ CJMED. The TCN is responsible for ensuring that their medical capabilities have an adequate C2 structure.

2.8 QUALITY MANAGEMENT, CLINICAL STANDARDS AND TASKS

1. All aspects of paragraph 1.10 apply.
2. TCNs are responsible for ensuring that the medical support they provide is compliant with relevant national as well as NATO clinical standards and that the standard of care is at least equal to that provided at the home base. The operational environment and conditions (factors such as tempo and intensity) may have an impact on the TCN's ability to ensure that national standards and procedures can be wholly reproduced in the operational environment. Where this is the case, the TCN will ensure that all risks are captured and necessary mitigations are put in place; the risk assessment and management plan will be shared with all relevant authorities (national and NATO).

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CHAPTER 3 MEDICAL ROLE SPECIALIST NATION CONCEPT

3.1 INTRODUCTION

A medical role specialist nation (MRSN) is a nation or organization that possesses particular specialist medical capabilities (for example, MEDEVAC and TACEVAC) that it can provide as part of the deployed medical support system. The deployed capability may serve part or the whole of the force.

3.2 DEFINITION

One nation or organization, that assumes the responsibility for providing a specific capability for all or part of the multinational force within a defined space and time period.

3.3 ROLES AND RESPONSIBILITIES

1. All aspects of paragraph 1.5 apply.
2. This MRSN is responsible to the JFC commander for providing services such as organization, equipment, support and manpower required for the availability of such capability. The principle responsibilities of a Medical Role Specialist Nation (MRSN) are:
 - a. During the preparation and planning phase, the MRSN will establish close cooperation with JFC about the exact capability to be provided. This will usually be set out in a statement of requirement (SOR) in terms of capability and will likely include:
 - i Establishing the resources required in order to deliver the capability.
 - ii Writing SOP to enable the TCN to be supported.
 - iii Establishing the infrastructure requirements if needed and participating in the design of facilities as necessary.
 - iv Establishing communications with other TCNs providing medical support in theatre and co-developing integration plans and common SOP. Particular focus must be on 'seams' within the deployed care pathway (intra-theatre) and between those supporting the theatre (for example, strategic evacuation – inter-theatre).

- v Devise and implement an adequate C2 architecture with direction to 'test and adjust' once deployed.
 - vi Developing the MOU and methods for recovering costs from supported nations
- b. During the deployed phase the MRSN will:
- i Ensure the provision of all necessary resources needed to support the capability involved.
 - ii Manage and maintain all infrastructure and facilities associated with the task for which it has been given responsibility.
 - iii Ensure the terms of MOUs, TAs and contracts are still accurate and SOP applied.
 - iv Ensure that integration plans are executed and common SOP are adhered to.
 - v Synchronize MRSN battle rhythm with that of the whole medical support system.
 - vi Establish reporting systems in accordance with the JFC OPLAN and theatre policy.
3. If a new nation or a new organization assumes MRSN responsibility from an existing nation/organization provider it may choose to accede, in every respect, to the terms of MOU and SOP already in place.

3.4 FUNDING

1. All aspects of paragraph 1.6 apply.
2. The MRSN will provide initial funding to establish the capability designed. If some elements of funding are to be shared between nations, it is the MRSN's responsibility to negotiate with the contributing nations. Common funding might be available to support MRSN activity and should be initiated by the MRSN via SHAPE which will include the agreed amount within its annual budget where appropriate.

3.5 LEGAL ARRANGEMENTS

1. All aspects of paragraph 1.7 apply.
2. The legal basis for any arrangement between a MRSN and a supported nation or a NATO commander will be established at the same time as the financial. Arrangements must be established for nations rotating into the defined geographical area and during the defined period of the MRSN responsibility to become supported nations if they so choose. This may be through the development of a separate MOU with the MRSN or by the extension of an existing multilateral arrangement.
3. Where national caveats and restrictions exist, it is the MRSN TCN's responsibility to ensure that these are declared in accordance with NATO policy. In the operational scenario where a MN force is deployed and MN medical elements are present the MRSN will engage with the MEDDIR and other medical commanders in order to ensure that national caveats are respected. The MEDDIR will ensure that common theatre procedures are developed that take into account any national caveats, mitigate resulting gaps and avoid any tensions or conflicts; the MRSN will support the MEDDIR in his task.

3.6 DURATION

1. All aspects of paragraph 1.8 apply.
2. When a nation or an organization assumes the task of MRSN for a designated capability, the agreed duration of the task is to be set either through a formal MOU, or similar agreement. This must be agreed between the MRSN and SHAPE or designated JFC or as part of the force generation process. The formal agreement establishing a MRSN must include clear provisions on the manner in which the nation/organization concerned may terminate its role. In order to ensure the long term sustainability of an operation, SHAPE or the designated JFC must prepare options/plans to ensure that the designed MRSN responsibility can be transferred to another nation/organization during the course of the operation.
3. If another nation or organization cannot be found to assume the MRSN designed responsibility, plans should be prepared to enable the required capability to be provided by individual contributing nation.

3.7 COMMAND AND CONTROL RELATIONSHIP

1. All aspects of paragraph 1.9 apply.
2. COM JFC is responsible for the overall delivery of medical support to the force. The MEDDIR is responsible for coordinating the entire chain of medical support. To achieve that task, the MEDDIR will ensure that SOP are adapted, accurate and followed by all capabilities part of medical support system. MRSN remain responsible for the internal functioning and compliance with NATO standards.

3.8 QUALITY MANAGEMENT, CLINICAL STANDARDS AND TASKS

1. All aspects of paragraph 1.10 apply.
2. The quality of the medical support provided should be no less than that which the MRSN would expect to provide to its own forces and in case of a non-NATO capability or a private organization, the quality of care must be in accordance with agree NATO standards.
3. The quality standards to be met should be based upon the conditions laid down in the appropriate medical STANAGs.

CHAPTER 4 MEDICAL LEAD NATION CONCEPT

4.1 INTRODUCTION

Medical capabilities may be provided by medical units composed of different contributions of several nations participating in an operation. If a medical capability is set up IAW Medical Lead Nation Concept, a Lead Nation has to be identified. These multinational medical units (MMUs) offer a way to contribute to an overall operational effort within limited resources when one nation is capable of providing the nucleus of the unit and/or the command structure around which the rest of the unit can be formed through augmentation or provision of complementary units from other nations.

4.2 DEFINITION

Forces generated under a 'lead nation' are commanded by an officer from that nation, (augmented with Liaison Officers, and potentially staff officers, from across the multinational force). The lead nation is responsible for planning and executing the operation, to which others contribute National Contingents and National Contingent Commanders.

4.3 ROLES AND RESPONSIBILITIES

1. All aspects of paragraph 1.5 apply.
2. A **Medical Lead Nation** (MLN) for medical support assumes overall responsibility for coordinating and/or providing an agreed spectrum of medical support capabilities for all or a part of a multinational force within a defined geographical area. In a NATO operation, more than one LN could be designated to provide a specified range of medical support. MLN must ensure that the capabilities chosen provide the required level of care and are ultimately responsible that they are sufficiently equipped, manned, trained and evaluated in order to meet the operational requirements.

The roles and responsibilities of the MLN and the troop contributing nations (TCNs) will vary depending on the operational requirements and the agreements put in place between the parties. Included in this is a clear and detailed description of the capability being provided by the MLN and TCNs and how they are integrated into the whole capability construct. TCNs may agree to provide various capabilities ranging from providing personnel or equipment capability only to the provision of complete modules; the levels of capability provided will be guided by the agreements between the MLN and the TCNs.

3. Multinational Medical Task Forces need to rely on a C4I capability that manages to merge national systems into a multinational common operating picture (MCOP). Therefore, the lead nation will be responsible for establishing a multinational C4I architecture capable of integrating subordinate medical units as well as connecting the task force internally and along the chain of command.
4. Additional responsibilities of the Lead Nation include:
 - a. Communication and IT.
 - b. Force protection and intelligence.
 - c. Supply (i.e. food, water, ammunition).
 - d. Transportation and construction of the modules / facility.
 - e. Essential services - Power, water, sanitation and waste, cooling and heating.
5. **Medical Module Provider.** The modular approach offers opportunities to provide modules within required medical support capabilities. Nations may offer their available modules during force generation within the context of operational planning without becoming capability specialists. This choice is particularly flexible. Furthermore, the modular approach can contribute to the mitigation of shortfalls in specific medical capability targets within the context of defence planning. Providers of medical modules are responsible for ensuring that their contributions meet agreed standards detailed in relevant NATO and national policy documents.

4.4 FUNDING

1. All aspects of paragraph 1.6 apply.
2. The primary funding mechanism remains “costs lie where they fall”, which means that nations cover all the costs associated with their participation in an operation. Only costs not attributable to a specific nation and agreed as eligible for common funding (CF) will be assumed by NATO; such costs will be limited to minimum military requirements in direct support of the military aspects of the operation. A number of critical theatre-level enabling capabilities, previously considered a national responsibility, can also be considered for CF. These capabilities will be put under the operational control of the theatre commander and will be listed in the OPLAN as part of the TCSOR. The Lead Nation approach is the preferred option for assembling and maintaining the required capability from their own and other nations’ forces, but with CF paying for the deployment, installation and running of the provided capability and costs agreed as eligible for CF will be borne by the Military Budget and the NATO Security Investment Programme (NSIP) and shared by all member nations.

4.5 LEGAL ARRANGEMENTS

1. All aspects of paragraph 1.7 apply.
2. All TCNs must satisfy the provisions of their domestic law and relevant international law; included in this is domestic legislation pertaining to medical provision and practice. Hence, the MLN and the TCNs must agree to a legal framework within which to conduct their mission. The MLN and TCNs must be guided by legal advisors in the planning of the operation and have access to national legal advice during operations. In addition, all the contributing nations must be clear on each nation's legal restrictions and agreed mitigating procedures put in place.
3. Administrative, legal and financial agreements between TCNs and the MLN will be captured in a MOU.
4. Support arrangements for the MMU must be mutually agreed upon and documents must conform to recognized NATO policies and should not contradict the domestic law of the nations involved. As there are also likely to be international legal considerations, formal legal advice is critical during all phases of medical support negotiations. Status of Forces Agreements (SOFA) may also apply if the presence of forces in a foreign territory is undertaken with the consent of the nation involved.

4.6 DURATION

1. All aspects of paragraph 1.8 apply.
2. The duration of provision under the MLN approach will be detailed in the TOA agreement and the CJSOR/TCSOR.

4.7 COMMAND AND CONTROL RELATIONSHIP

1. All aspects of paragraph 1.9 apply.
2. In general, the planning and provision of services will not differ substantially from those that the MMU components have been trained to provide within their own national forces. However, C2 within a MMU will be more challenging and its organization and preparation will need to reflect that. The MMU will require a designated commander who in turn will need clearly defined authority over the subunits that comprise it. Realistically this should be OPCON.
3. This model is based on the idea of the Lead Nation "hosting" some other nations for collaboration as regards the personnel, which will work according to LN procedures.
4. Members of TCNs can integrate and work in different units inside the MMU.

5. All medical supply and all equipment for every unit is normally provided by the LN; however, there may be instances where the LN and TCN agree that the TCN provides equipment and supplies. Where this is the case, great care must be taken not to compromise interoperability and operations through lack of commonality

4.8 QUALITY MANAGEMENT, CLINICAL STANDARDS AND TASKS

1. All aspects of paragraph 1.10 apply.

2. MLN have to ensure the capabilities provided, meet the appropriate clinical standards and the required level of care. In addition, they are ultimately responsible for sufficiently equipped, manned, trained and evaluated MMU in order to meet the defined operational requirements.

3. The level and quality of care provided by a MMU must be acceptable to all nations contributing assets to the MMU and in accordance with all applicable STANAGs. The specific requirements will be detailed in the COM JFC OPLAN and further in separate technical agreements between the nations involved.

4. Common training, exercising and certification of personnel from both MLN and TCNs is essential for the conduct of effective deployed operations. The MLN retains overall responsibility for ensuring that all personnel are subject to this preparation and TCNs must support MLN in meeting this responsibility. (this constitutes the effective application of the principles settled by NATO medical doctrine in its document "Medical Evaluation Manual").

CHAPTER 5 MEDICAL FRAMEWORK NATIONS CONCEPT

5.1 INTRODUCTION

In 2014, NATO Council endorsed the “Framework Nations Concept” (FNC).⁶ The purpose of the FNC is to assist Allies in delivering the capabilities required, both quantitative and qualitative, identified through the NATO Defence Planning Process (NDPP), to meet NATO’s Level of Ambition and successfully undertake the three essential core tasks of the 2010 Strategic Concept: collective defence; crisis management; and cooperative security.

5.2 DEFINITION

1. The FNC proposes that groups of nations (referred to as ‘framework groupings’) come together voluntarily to create a platform on which to help maintain, consolidate and improve current capabilities and provide a foundation for the joint development and provision of capabilities to the Alliance that have been identified through the NDPP. The underpinning basis of the concept is that those Allies that maintain a broad spectrum of capabilities provide a framework for other Allies to plug into with well developed, distinct capabilities, particularly in areas of excellence that they have focused their capability development on.

2. Medical support is one cluster within FNC, in the following referred to as **Medical Framework Nations Concept** (MFN). The principles of MFN are as follows:

- a. MFN is a concept for force development with voluntary nations creating a coherent set of medical forces and capabilities.
- b. MFN is neither in competition with nor duplicating the efforts of NATO (and EU) bodies and initiatives like MMSOP or Smart Defence TIER 1.15. Indeed, MFN efforts will likely contribute significantly to and enhance these initiatives.
- c. MFN will contribute the achievement of NDPP targets.
- d. MFN will optimize NATO's medical capability by reaching a higher level of multinational integration.
- e. **Multinational Integrated Medical Units** (MIMU), as results of MFN, aim to generate, support and maximize the mission effectiveness and optimizing contributing nations’ capabilities.

⁶ NATO International Staff, 14 May 2014, Document PO(2014)0308.

5.3 ROLES AND RESPONSIBILITIES

1. All aspects of paragraph 1.5 apply.
2. National sovereignty remains paramount throughout. The responsibilities of Allies to provide for their own defence and to meet their obligations to the Alliance remain unchanged. Furthermore, the MFN has no bearing on the sovereign decision making rights of individual Allies.
3. A significant characteristic of the MFN approach that differentiates from approaches as MLN is its 'flat' structure. Not one single nation has the role as leader, however, in order to make the MFN approach viable, the contributing nations may agree that a nation take on the role of '**Framework (Coordinating) Nation**' (FN) who is responsible for facilitating the coordination and cooperation of the grouping. It is important to note that whilst the FN may take on these coordination and cooperation roles, the FN is not necessarily in lead for a MN unit of the grouping. Specific FN **coordinating responsibilities** will be agreed by the framework grouping; these may include:
 - a. Programme and project management.
 - b. The development of a grouping statement of requirement and 'statements of module contributions' from the group member nations.
 - c. Gap analysis between the requirements and contributions – identification of the 'delta' and developing an action plan.
 - d. The development of an agreed grouping procurement strategy and plan.
 - e. Standardization, interoperability, training and evaluation activities including joint multinational exercises.
 - f. The provision of key enabling capabilities for MIMU, particularly in the areas of C2 and logistic support. It is paramount to find efficient solutions for these capabilities; otherwise a MIMU will not be able to fulfill its mission in high tempo-operations.
4. **Group Member Nations** will determine the regulatory arrangements as part of the framework grouping and contribute equitably to the provision of usable capability as well as to the planning of a cohesive broad spectrum of capabilities within the grouping. The modular approach offers nations the opportunity to provide modules within required medical support capabilities and Group Member Nations may offer their available modules to the grouping. Furthermore, the modular approach can contribute to the mitigation of shortfalls in specific medical capability targets within the context of defence planning. Providers of medical modules are responsible for ensuring that their contributions meet agreed NATO and agreed grouping standards.

5.4 FUNDING

1. All aspects of paragraph 1.6 apply.
2. The funding of national contributions to a MIMU is the responsibility of contributing nations in accordance with established NATO policy and procedures. It normally falls under the provision of “shared multinational costs”. Multinational costs for medical care are to be negotiated between the nations concerning reimbursement.

5.5 LEGAL ARRANGEMENTS

1. All aspects of paragraph 1.7 apply.
2. The MFN Grouping will develop mutually agreed “generic arrangements” that can easily be applied to MOU and TA for operations or exercises. The MOU and TA will specify arrangements and form the legal foundation for bilateral and multilateral cooperation. Formal legal advice (including 'commercial/procurement' legal advice where equipment procurement and contracting is involved) is critical during all phases of MFN negotiations and arrangements and agreements must conform to recognized international law, NATO procedures and practices and will not contradict the domestic law of the nations involved.

5.6 DURATION

1. All aspects of paragraph 1.8 apply.
2. A key principle of MFN is for the alliance to have the ability to draw medical support from a coherent set of medical forces and capabilities to support ongoing and future operations. There are two main considerations in relation to duration and MFN. First, the duration of the framework grouping as a whole and second, the duration of framework grouping nation’s commitments on operations. The duration of a nation’s commitment to a grouping will be dependent on a number of factors such as the contributing nation’s ambition and intent, political direction and economic and industrial factors. The duration of a nation’s commitment to the grouping will be articulated in the MOU or TA underpinning the grouping.
3. Nations’ commitments to particular operations will require careful and detailed planning in order to ensure that operations receive the required levels of medical support and the credibility of the MFN approach is maintained. Brief and small-scale operations may present few challenges in terms of duration whilst medium, large-scale and enduring operations may present significant challenges. Hence, it is critical that framework groupings and grouping member nations plan capability contributions in accordance with NDPP and national defence planning assumptions and scenarios and, commit capability that is sustainable. As is the case with other forms of national contribution, TCNs are responsible for providing modules and capability for the duration of the period stated in the CJSOR/TCSOR and TOA

5.7 COMMAND AND CONTROL RELATIONSHIPS

1. All aspects of paragraph 1.9 apply.
2. In the Force Generation Process, MFN offers the opportunity that a Framework Nations Grouping (FNG) contributes medical capabilities as if it were a nation, for example, bringing in a MIMU into the CJSOR/TCSOR.
3. The authority on MIMUs delegated to a MN commander can take several forms. The most common is the Operational Control (OPCON), when the commander has the delegated authority to direct forces assigned so that he can accomplish specific missions or tasks, which are usually limited by 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. The Commander may have Operational Command (OPCOM) when he can assign missions or tasks to subordinate commanders, to deploy units, reassign forces and retain or delegate operational and/or tactical control as he deems necessary (does not include responsibility for administration).

5.8 QUALITY MANAGEMENT, CLINICAL STANDARDS AND TASKS

1. All aspects of paragraph 1.10 apply.
2. The aim of MFN is a coherent set of deployable, interoperable and sustainable medical forces that are soundly equipped, trained and commanded. Standardization, or the development and implementation of NATO agreed concepts, doctrine, procedures and designs, of multinational medical support is paramount for and a pivotal enabler to the effective delivery of interoperable medical contributions to allied joint forces.
3. For a MIMU, MFN nations must develop detailed SOP providing a common working environment, clinical protocols and guidelines in order to ensure a high quality of care.
4. The Commander of a MIMU (or on his behalf, in a Medical Treatment Facility, the Clinical Director) will be required to confirm that all healthcare providers of the unit possess the appropriate credentials required. Moreover, he/she ensures that all entities will follow the agreed SOP.
5. Within a respective module, the contributing nation is fully responsible for quality management and ensuring compliance with agreed standards of care and best medical practice.
6. The Commander of a MIMU (or on his behalf, in a Medical Treatment Facility, the Clinical Director) will coordinate any open quality issues and the CIHSO process. Part of CIHSO is operational and tactical level oversight.

Medical Framework Nations Concept (MFNC) – Role 2B MIMU at VIGOROUS WARRIOR 2017

The feasibility of a MFNC MIMU was tested during the LIVEX VIGOROUS WARRIOR 2017 at LEHNIN Training Area in 04 September 2017. A seven nations' Role 2B Medical Treatment Facility (MTF) has been designed, prepared, trained and tested in a LIVE EXERCISE. Concept and design (see figure 3) of this MFNC MIMU has been developed in the Framework Nations Concept (FNC) Cluster Medical Support, belonging to the Framework Grouping lead by Germany.

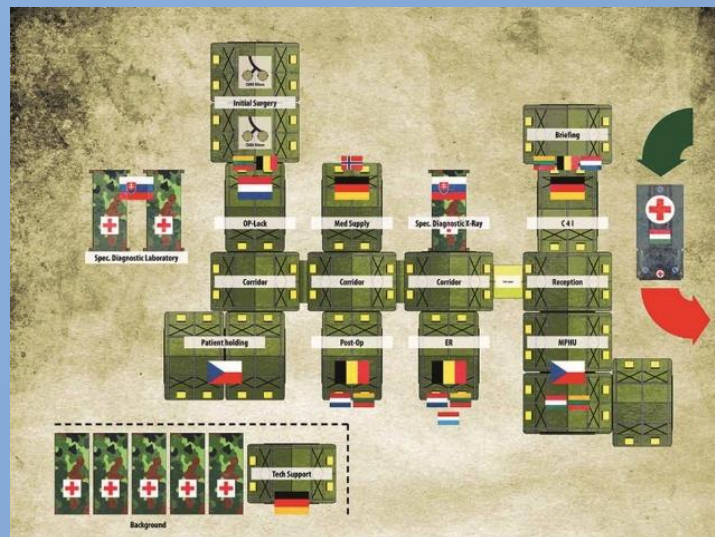


Figure 1: Medical Framework Nations Concept Role 2B

SOP, SOI and all aspects of connectivity had been established in the forefront of the exercise, being the cornerstones of the excellent performance during the exercise. However, the results of this exercise underlined the importance of further harmonization especially in the fields of (medical) logistics and mobility.



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CHAPTER 6 DOTMLPFI SYNOPSIS OF MULTINATIONAL MEDICAL SUPPORT

6.1 INTRODUCTION

Medical standardization encompasses all activities that affect requirements in the fields of Doctrine, Organization, Training, Material, Leadership, Personnel, Facilities, and Interoperability.

6.2 SYNOPSIS

Mode	Medical Single Nation Concept (MSN)	Medical Role Specialist Nation Concept (MRSN)	Medical Lead Nation Concept (MLN)	Medical Framework Nations Concept (MFN)
Doctrine	<ul style="list-style-type: none"> Sound medical doctrine lays the foundation for a common understanding of multinational medical support. Therefore, agreed medical doctrine is the prerequisite for standardization in all other fields 			
	<ul style="list-style-type: none"> One nation for the whole medical system. 	<ul style="list-style-type: none"> International system, units at national level. 	<ul style="list-style-type: none"> Lead Nation System, TCN plugging in at unit Level. 	<ul style="list-style-type: none"> Framework system, fully integrated at unit level.
Organization	<ul style="list-style-type: none"> Medical peacetime structures at all levels within nations, from the strategic to the tactical level, need to be flexible, responsive and sustainable to ensure the generation of capable and effective multinational medical support. 			
	<ul style="list-style-type: none"> Organization is primarily based upon national structures. 	<ul style="list-style-type: none"> Organization tailored to meet the operational requirement. 	<ul style="list-style-type: none"> Organization tailored to meet the operational requirement. 	<ul style="list-style-type: none"> MN peacetime structures (MIMU) being established on a permanent basis
Training	<ul style="list-style-type: none"> There is an increased need to have standardized education, training and exercises to ensure that a high standard of care is maintained throughout the healthcare continuum. Common training and exercises of combined health care teams and units needs to be based on standardized agreed tactics, technics, and procedures. 			
	<ul style="list-style-type: none"> In accordance with national training requirements. 	<ul style="list-style-type: none"> Combination of national and JFC training requirements. 	<ul style="list-style-type: none"> Agreed programme training and MRX between MLN and TCNs. Led by the MLN. 	<ul style="list-style-type: none"> Training and exercises being coordinated and conducted multinationally on a permanent basis.

Material	<ul style="list-style-type: none"> In addition to the common use of already existing material, standardization of equipment and supplies is of utmost importance. If nations decide for common development and procurement based on agreed capability requirements and standards they can take decisive steps towards the availability of readily available medical support. 			
	<ul style="list-style-type: none"> Primarily a national responsibility. 	<ul style="list-style-type: none"> Primarily a national responsibility. 	<ul style="list-style-type: none"> Primarily a MLN responsibility. 	<ul style="list-style-type: none"> Whenever possible material is based on MN procurement (e.g. M3U) and therefore harmonized.
Leadership	<ul style="list-style-type: none"> Military medical leadership encompasses the process and the medically qualified personnel influencing others to accomplish the multinational medical support mission by providing purpose, direction, motivation, and professional medical guidance. It contributes substantially to the fulfillment of the overall NATO mission. Therefore, NATO member states should have military medical leaders on every level of command who are capable at its best to fulfill the demands of their specific assignment both in peacetime and on operation. This includes the requirement for appropriate education and training. 			
	<ul style="list-style-type: none"> National command. 	<ul style="list-style-type: none"> International command. 	<ul style="list-style-type: none"> International Command by Lead Nation. 	<ul style="list-style-type: none"> NATO command responsibility, Framework Nation coordinated.
Personnel	<ul style="list-style-type: none"> The establishment of liaison elements as well as mutual exchange of personnel among military medical services from different nations facilitates mutual understanding and transparency as well as it allows building trust during peacetime establishment and upon deployment. Furthermore, the integration of personnel into multinational medical treatment and training facilities contributes to the harmonization of healthcare capabilities and skillsets. 			
	<ul style="list-style-type: none"> Personnel provided trained and certified by MSN. 	<ul style="list-style-type: none"> Personnel provided trained and certified by MRSN. 	<ul style="list-style-type: none"> Personnel provided by MLN and TCNs. Training provided by MLN and TCNs with MLN responsible for MRX and certification. 	<ul style="list-style-type: none"> Personnel, and training provided by all TCNs of the Framework Grouping. MFN is responsible for MRX and certification.
Facilities	<ul style="list-style-type: none"> Medical treatment facilities should be planned and designed in a way that allows accommodating MN health support in accordance with agreed standards. 			
	<ul style="list-style-type: none"> National Medical Units. 	<ul style="list-style-type: none"> National Medical Units. 	<ul style="list-style-type: none"> MMU. 	<ul style="list-style-type: none"> MIMU.
Interoperability	<ul style="list-style-type: none"> Interoperability will be a key for success in future Alliance operations. Independent of the current national approaches all medical services in NATO should continuously increase their interoperability 			
	<ul style="list-style-type: none"> Only at level of customer of care. 	<ul style="list-style-type: none"> At medical C2 level (inter unit). 	<ul style="list-style-type: none"> Facility level interoperability (intra unit). 	<ul style="list-style-type: none"> Medical Task Force level interoperability (unit).

ANNEX A GLOSSARY OF ABBREVIATIONS AND ACRONYMS

ABBREVIATIONS AJMedP-9

ACO - Allied Command Operations

AOR - Area of Responsibility

C2 - Command and Control

C4I - Command, Control, Communication, Computer and Information

CBRN - Chemical, Biological, Radiological and Nuclear

CIHSO - Continuous Improvement in Healthcare Support on Operations

CIS - Communications and Information Support

CJTF - Combined Joint Task Force

CJMED - Combined Joint Medical Staff

CJSOR - Combined Joint Statement of Requirement

CJTF - Combined Joint task Force

CN - Contributing Nations

COM - Commander

CSU - Casualty Staging Unit

DCS - Damage Control Surgery

DNBI - Disease and Non-Battle Injury/Injuries

FHP - Force Health Protection

FN - Framework Nation

FNC - Framework Nations Concept

FNG – Framework Nation Grouping

HN - Host Nation

HNS - Host Nation Support

JFC - Joint Forces Command

JOA - Joint Operations Area

LN - Lead Nation

LOC - Line of Communication

MASCAL - Mass Casualty

MC Military - Committee

MCOP - Multinational Common Operating Picture

MedCIS - Medical Communications and information systems

MEDDIR - Medical Director

MEDAD - Medical Advisor

MEDEVAC - Medical Evacuation

MFN - Medical Framework Nation

MLN - Medical Lead Nation

MRSN - Medical Role Specialized Nation

MSN - Medical Single Nation

MTF - Medical Treatment Facility

NDPP - NATO Defence Planning Process

NSE - National Support Element

OPCON - Operational Control

OPLAN - Operational Plan

PECC - Patient Evacuation Coordination Cell

RSN - Role Specialization Nation

SMO - Senior Medical Officer

SOFA - Status of Forces Agreement

SOP - Standing Operating Procedure

SOR - Statement of Requirement

STANAG - Standardization Agreement

TA - Technical Agreement

TCN - Troop Contributing Nation

TOA - Transfer of Authority

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ANNEX B LIST OF REFERENCES

“THE GENEVA CONVENTIONS OF 1949”, (INCORPORATING THE HAGUE PROTOCOLS OF 1907)

PO(2010)0169	THE ALLIANCE’S STRATEGIC CONCEPT
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MC 0319/2	NATO PRINCIPLES AND POLICIES FOR LOGISTICS
MC 0326/3	NATO PRINCIPLES AND POLICIES OF MEDICAL SUPPORT
MC 0327/2	NATO MILITARY POLICY FOR NON-ARTICLE V CRISIS RESPONSE OPERATIONS
MC 0343/1	NATO MILITARY ASSISTANCE TO INTERNATIONAL DISASTER RELIEF OPERATIONS (IDRO)
MC 0411/2	NATO MILITARY POLICY ON CIVIL-MILITARY COOPERATION (CIMIC)
MC 0472	NATO MILITARY CONCEPT FOR DEFENCE AGAINST TERRORISM
MC 0551	MEDICAL SUPPORT CONCEPT FOR NATO RESPONSE FORCE (NRF)
MC 0572	NATO MILITARY MEDICAL VISION AND OBJECTIVES 2007-2016
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STANAG 1208 ED. 3	MINIMUM REQUIREMENTS OF EMERGENCY MEDICAL SUPPLIES ON BOARD SHIPS - AMEDP-1.9 ED A V1
STANAG 2037 ED. 9	NATIONAL MILITARY STRATEGIES FOR VACCINATION OF NATO FORCES - AMEDP-23
STANAG 2061 ED. 5	PROCEDURES FOR DISPOSITION OF ALLIED PATIENTS BY MEDICAL INSTALLATIONS
STANAG 2087 ED. 7	FORWARD MEDICAL EVACUATION
STANAG 2122 ED. 4	REQUIREMENT FOR TRAINING IN CASUALTY CARE AND BASIC HYGIENE FOR ALL MILITARY PERSONNEL - AMEDP-8.15
STANAG 2126 ED. 6	FIRST-AID DRESSINGS, FIRST AID KITS AND EMERGENCY MEDICAL CARE KITS (STUDY)
STANAG 2128 ED. 6	MEDICAL AND DENTAL SUPPLY PROCEDURES - AMEDP-1.12 EDITION A VERSION 1
STANAG 2132 ED. 3	DOCUMENTATION RELATIVE TO INITIAL MEDICAL TREATMENT AND EVACUATION - AMEDP-8.1 EDITION A
STANAG 2179 ED. 3	MINIMUM REQUIREMENTS FOR MEDICAL CARE OF WOMEN IN JOINT/COMBINED OPERATIONS - AMEDP-8.9 EDITION A VERSION 1
STANAG 2182 ED. 2	ALLIED JOINT LOGISTIC DOCTRINE - AJP-4 EDITION A (STUDY)

STANAG 2190 ED. 2	ALLIED JOINT DOCTRINE FOR INTELLIGENCE, COUNTER-INTELLIGENCE AND SECURITY - AJP-2 EDITION A VERSION 2
STANAG 2228 ED. 3	ALLIED JOINT DOCTRINE FOR MEDICAL SUPPORT - AJP-4.10 EDITION C VERSION 1 (STUDY)
STANAG 2230 ED. 3	ALLIED JOINT DOCTRINE FOR THE JOINT LOGISTIC SUPPORT GROUP - AJP-4.6 EDITION B VERSION 1
STANAG 2231 ED. 1	PATIENT DATA EXCHANGE FORMAT FOR COMMON CORE INFORMATION - AMEDP-5.1 EDITION A VERSION 1
STANAG 2234 ED. 3	ALLIED JOINT DOCTRINE FOR HOST NATION SUPPORT - AJP-4.5 EDITION B VERSION 1
STANAG 2235 ED. 3	PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENTS - AMEDP-4.8 EDITION A VERSION 1
STANAG 2249 ED. 2	TRAINING REQUIREMENTS FOR HEALTH CARE PERSONNEL IN INTERNATIONAL MISSIONS - AMEDP-8.3 EDITION A VERSION 1
STANAG 2292 ED. 1	ALLIED JOINT DOCTRINE FOR NATO ASSET VISIBILITY - AJP-4.11
STANAG 2347 ED. 2	MEDICAL WARNING TAG - AMEDP-8.8
STANAG 2348 ED. 5	BASIC MILITARY HOSPITAL (CLINICAL) RECORDS - AMEDP-8.2 EDITION B VERSION 1
STANAG 2437 ED. 7	ALLIED JOINT DOCTRINE - AJP-01 EDITION D (STUDY)
STANAG 2451 ED. 4	ALLIED JOINT DOCTRINE FOR CHEMICAL, BIOLOGICAL, RADIOLOGICAL AND NUCLEAR DEFENCE - AJP-3.8 EDITION A VERSION 1 (STUDY)
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STANAG 2466 ED. 3	DENTAL FITNESS STANDARDS FOR MILITARY PERSONNEL AND A NATO DENTAL FITNESS CLASSIFICATION SYSTEM - AMEDP-4.4 EDITION A VERSION 1
STANAG 2474 ED. 2	RECORDING OF OPERATIONAL IONIZING RADIATION EXPOSURE FOR MEDICAL PURPOSES AND MANAGEMENT OF DOSIMETERS - AMEDP-7.8 ED A V1
STANAG 2490 ED. 3	ALLIED JOINT DOCTRINE FOR THE CONDUCT OF OPERATIONS- AJP-3 EDITION B (STUDY)
STANAG 2506 ED. 3	ALLIED JOINT MOVEMENT AND TRANSPORTATION DOCTRINE - AJP-4.4 EDITION B VERSION 1
STANAG 2509 ED. 2	ALLIED JOINT DOCTRINE FOR CIVIL-MILITARY COOPERATION - AJP-3.4.9 EDITION A VERSION 1
STANAG 2512 ED. 2	ALLIED JOINT DOCTRINE FOR MODES OF MULTINATIONAL LOGISTIC SUPPORT - AJP-4.9 EDITION A VERSION 1

STANAG 2523 ED. 2	ALLIED JOINT DOCTRINE FOR SPECIAL OPERATIONS - AJP-3.5 EDITION A VERSION 1
STANAG 2525 ED. 1	ALLIED JOINT DOCTRINE FOR COMMUNICATION AND INFORMATION SYSTEMS - AJP-6 (STUDY)
STANAG 2526 ED. 1	ALLIED JOINT DOCTRINE FOR OPERATIONAL-LEVEL PLANNING - AJP-5 (STUDY)
STANAG 2528 ED. 2	ALLIED JOINT DOCTRINE FOR FORCE PROTECTION - AJP-3.14 EDITION A VERSION 1
STANAG 2532 ED. 1	ALLIED JOINT DOCTRINE FOR THE DEPLOYMENT OF FORCES - AJP-3.13
STANAG 2538 ED. 2	ANIMAL CARE AND WELFARE AND VETERINARY SUPPORT DURING ALL PHASES OF MILITARY DEPLOYMENTS - AMEDP-8.4 EDITION A
STANAG 2542 ED. 1	ALLIED JOINT MEDICAL PLANNING DOCTRINE - AJMEDP-1 (STUDY)
STANAG 2543 ED. 1	STANDARDS FOR DATA INTERCHANGE BETWEEN HEALTH INFORMATION SYSTEMS (STUDY)
STANAG 2544 ED. 1	REQUIREMENTS FOR MILITARY ACUTE TRAUMA CARE TRAINING - AMEDP-8.12
STANAG 2547 ED. 2	ALLIED JOINT DOCTRINE FOR MEDICAL INTELLIGENCE - AJMEDP-3 EDITION A VERSION 1
STANAG 2548 ED. 3	MANAGEMENT OF POST DEPLOYMENT SOMATOFORM COMPLAINTS - AMEDP-8.14 EDITION A VERSION 1
STANAG 2553 ED. 1	NATO PLANNING GUIDE FOR THE ESTIMATION OF CHEMICAL, BIOLOGICAL, RADIOLOGICAL AND NUCLEAR (CBRN) CASUALTIES – AMEDP-7.5
STANAG 2554 ED.1	HUMAN IMMUNODEFICIENCY VIRUS (HIV) POST-EXPOSURE PROPHYLAXIS MEASURES
STANAG 2559 ED. 2	HUMAN RABIES PROPHYLAXIS IN OPERATIONAL SETTINGS - AMEDP-4.3 EDITION A VERSION 1
STANAG 2560 ED. 2	MEDICAL EVALUATION MANUAL - AMEDP-1.6, 1.7, 1.8 EDITION A VERSION 1
STANAG 2561 ED. 1	ALLIED JOINT MEDICAL FORCE HEALTH PROTECTION DOCTRINE - AJMEDP-4
STANAG 2562 ED. 1	MEDICAL COMMUNICATIONS AND INFORMATION SYSTEMS (MEDCIS) - AJMEDP-5 EDITION A VERSION 1
STANAG 2563 ED. 2	ALLIED JOINT CIVIL-MILITARY MEDICAL INTERFACE DOCTRINE - AJMEDP-6 EDITION A VERSION 1
STANAG 2564 ED. 1	FORWARD MENTAL HEALTHCARE – AMEDP-8.6 EDITION A VERSION 1
STANAG 2565 ED. 1	A PSYCHOLOGICAL GUIDE FOR LEADERS ACROSS THE DEPLOYMENT CYCLE - AMEDP-10 (STUDY)
STUDY 2566	SUICIDE PREVENTION - AMEDP-8.11 (STUDY)
STANAG 2571 ED. 1	MINIMUM TEST REQUIREMENTS FOR LABORATORY UNITS OF IN THEATRE MILITARY MEDICAL TREATMENT FACILITIES (MTFS) - AMEDP-8.5 EDITION A VERSION 1

STANAG 2596 ED. 1	ALLIED JOINT MEDICAL DOCTRINE FOR SUPPORT TO CHEMICAL, BIOLOGICAL, RADIOLOGICAL AND NUCLEAR (CBRN) DEFENSIVE OPERATIONS - AJMEDP-7 EDITION A VERSION 1
STUDY 2598	ALLIED JOINT MEDICAL DOCTRINE FOR MILITARY HEALTH CARE (MHC) – AJMEDP-8 (STUDY)
STANAG 2939 ED. 5	MINIMUM REQUIREMENTS FOR BLOOD, BLOOD DONORS AND ASSOCIATED EQUIPMENT - AMEDP-1.1 (STUDY)
STANAG 3204 ED. 8	AEROMEDICAL EVACUATION – AAMEDP-1.1 EDITION A VERSION 1
AAP- 6 ED 2015	NATO GLOSSARY OF TERMS AND DEFINITIONS (ENGLISH AND FRENCH)
ACO DIR 80-90	ACCESS TO CIVIL (CIVIL EMERGENCY PLANNING) EXPERTISE
ACO DIR 83-1 (ED 1)	MEDICAL SUPPORT TO OPERATIONS (SEPTEMBER 2010)
ACO DIR 83-2	ALLIED COMMAND OPERATIONS (ACO) GUIDANCE FOR MILITARY MEDICAL SERVICES INVOLVEMENT WITH HUMANITARIAN ASSISTANCE AND SUPPORT TO GOVERNANCE, RECONSTRUCTION AND DEVELOPMENT (MARCH 2010)
ACT DIR 75-2/T AD 85-8	MEDICAL JOINT FUNCTIONAL AREA TRAINING GUIDE ACE MEDICAL SUPPORT PRINCIPLES, POLICIES AND PLANNING PARAMETERS (OCTOBER 93)
IMS	MEDIO-LEGAL RESPONSIBILITY IN MULTINATIONAL FIELD HOSPITALS IN THE CONTEXT OF NATO OPERATIONS, OCTOBER 2016.

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