

TABLE OF CONTENTS

		Page
CHAPTER	1. THE MEDICAL THREAT.....	1-1
CHAPTER	2. MEDICAL INTELLIGENCE.....	2-1
CHAPTER	3. PLANNING FOR MEDICAL INTELLIGENCE	
Section	I. Intelligence Preparation of the Battlefield.....	3-1
Section	II. Planning Requirements.....	3-2
CHAPTER	4. MEDICAL INTELLIGENCE SOURCES	
Section	I. Strategic Sources.....	4-1
Section	II. Tactical Sources.....	4-4
CHAPTER	5. ACCESS TO MEDICAL INTELLIGENCE	
Section	I. Strategic Level.....	5-1
Section	II. Tactical Level.....	5-3
Section	III. Low-Intensity Operations Level.....	5-4
APPENDIX	A. SAMPLE INTELLIGENCE REQUIREMENTS.....	A-1
APPENDIX	B. REPORTS.....	B-1
APPENDIX	C. INSTRUCTIONS FOR PREPARING DD FORM 1497, INTELLIGENCE PRODUCTION REQUIREMENT.....	C-1
APPENDIX	D. INSTRUCTIONS FOR REQUEST FOR ONE-TIME AND SECONDARY DISSEMINATION OF INTELLIGENCE PUBLICATIONS.....	D-1
GLOSSARY	Glossary-1
REFERENCES	References-1
INDEX	Index-1

MEDICAL INTELLIGENCE IN A THEATER OF OPERATIONS

PREFACE

This manual furnishes guidance to commanders, medical staff officers, military intelligence officers and noncommissioned officers (NCOs), and other personnel concerned with the use of medical intelligence in planning or conducting military operations at all levels of command. It answers the following questions: What is the medical threat? What is medical intelligence? Who needs medical intelligence? Who is responsible for producing medical intelligence? How does one obtain medical intelligence? Information in this publication is applicable across the spectrum of conflict.

The provisions of this publication are the subject of the North Atlantic Treaty Organization Standardization Agreement (STANAG) 2084 (INT) (Edition No. 5) — Handling and Reporting of Captured Enemy Equipment and Documents.

The proponent of this publication is the Academy of Health Sciences. Submit changes for improving this publication on DA Form 2028 (Recommended Changes to Publications and Blank Forms), and forward it to **Commandant, Academy of Health Sciences, US Army, ATTN: HSHA-TLD, Fort Sam Houston, Texas 78234-8100.**

Unless otherwise stated, whenever the masculine gender is used, both men and women are included.

CHAPTER 1

THE MEDICAL THREAT

1-1. Teachings of Hippocrates of Cos.

About 400 B.C., Hippocrates of Cos, a Greek practitioner and teacher of medicine, taught that to investigate medicine one must foresee the effects of—

- The seasons.
- The wind and heat and cold.
- The quality of the water.
- The terrain of a city.

He considered these elements critical to learning about a city where one is a stranger. He felt that if these things were studied, one would know the diseases that exist, how to treat those diseases, and, most importantly, how to prevent them. From this information one could also determine the epidemics that may occur.

1-2. Combat effectiveness of the soldier.

Today, as in the time of Hippocrates of Cos, knowing the medical threat is just as important. Commanders and health service support (HSS) planners must determine the medical threat that targets the soldiers. They must study the composite of all ongoing or potential enemy actions and environmental conditions that will reduce the combat effectiveness of the soldier by wounding him, injuring him, exhausting him physically or mentally, or causing him disease.

1-3. Modern warfare and the medical threat.

The characteristics of modern warfare that define the medical threat include the following

a. Significant increases in wounded casualties beyond the capability of the HSS system to provide timely medical care.

b. Enemy combat operations in friendly rear areas interdicting lines of communication and disrupting vital combat support and combat service support activities. This will seriously impact on the ability of HSS personnel to retrieve and evacuate wounded, sick, and injured soldiers and provide them timely medical care.

c. Prolonged periods of intense, continuous operations under all types of conditions that tax soldiers to the limits of their physiological and emotional endurance.

d. Premeditated attack upon medical organizations, personnel, or Class VIII, medical materiel; although this action is not currently anticipated, it may occur. Also, a steady erosion of battlefield medical resources will result from—

- The level of combat intensity, heavy use of supplies, and the ever-increasing range of indirect fire weapons.
- The enhanced lethality, wounding capability, and destructive properties of munitions.
- The collateral and residual effects of conventional, nuclear, biological, and/or chemical weapons.
- The actions of terrorists (individuals or groups) directed against defenseless targets, especially to hospitals and medical facilities.

e. Infectious diseases that pose a major threat to combat forces. These may be in the form of naturally occurring diseases or diseases introduced by a biological weapon.

f. Environmental factors such as extremes in temperature and altitude and the presence of poisonous animals, plants, and insects. These are important considerations as causative agents of disease and injury casualties.

g. Application of advanced technologies to enhance existing weapons and munitions and the development of new weapon systems. These may provide the health service support system with new diagnostic and treatment challenges. Excellent examples of technology driven developments that we may confront include—

- Engineered biochemical compounds used as biological warfare agents.
- Genetically engineered microorganisms used as biological warfare agents.
- Directed energy weapons consisting of high- and low-energy lasers and high-energy microwave, radio frequency, and particle weapons.
- Enhanced blast effect weapons used against personnel.
- New flame and incendiary compounds and munitions.
- Enhanced nuclear weapons with increased lethality from radiation.
- Possible mind-altering agents.

1-4. Historical incidents and the medical threat.

Commanders, health service support planners, military intelligence officers and NCOs, and other personnel at all levels of command can learn much from

studying the medical threat in past battles or military involvements. When historical incidents are studied, you must focus on the following questions:

- Were commanders aware of the medical threat to their soldiers?
- Did they consider the medical threat in making their plans?
- To what degree did the medical threat affect the outcome of the operations?
- Were the operations successful because of the commanders' efforts to counter the medical threat?
- Were the operations unsuccessful because of a lack of effort to counter the medical threat?

1-5. Health service support planning in historical examples.

Some historical examples of military experiences that can be attributed to proper or improper HSS planning are—

a. French wars. Some of the greatest fiascos in military history have been the result of a breakdown in hygiene and disease control. Even though history holds Napoleon as a great leader, he failed to appreciate the medical threat.

(1) For example, in 1803 when Napoleon sent a force of 22,000 men to suppress a rebellion in the French colony of Haiti, 20,000 men died from yellow fever. As a result, Haiti achieved independence with little French opposition. It was clearly a lack of good judgment to send a force into an area where yellow fever was epidemic—there being no vaccine against yellow fever or no other prophylactic measure to control it.

(2) Another example of the lack of appreciation for the medical threat occurred in 1812 when Napoleon invaded Russia. He had an army that numbered in excess of 600,000 soldiers. His central fighting force, which numbered anywhere between 232 to 300 thousand soldiers, was reduced to a mere 90,000 soldiers when Moscow was captured. The exact distribution of casualties by cause may never be known, but the majority (approximately 80 percent) were due to disease (diphtheria, dysentery, and typhus and exhaustion); only 20 percent were actual battle casualties. On the retreat to France, the army met with harsh winter conditions. Additional battle casualties and casualties due to disease and nonbattle (cold) injury reduced Napoleon's army even more. By the time the last of the soldiers had crossed the river Niemen to the German bank, 40,000 remained; only 1,000 of these were ever again fit for duty.

b. World War I.

(1) As an example of the benefits which may be accrued from heeding the lessons of other armies, consider the disease of tetanus. In World War I

in France where the soil was particularly rich in bacteria that cause tetanus, this disease was a constant danger to the wounded. The British troops, for example, had a rate of 52 tetanus cases per 1,000 wounded. Of these tetanus casualties, 90 percent died. The tetanus antitoxin had been developed before the war, but British medical authorities did not immunize because of the uncomfortable side effects of chills, fever, and injection pain caused by the antitoxin. The US Army recognized this medical threat and immunized the troops with the tetanus antitoxin prior to deploying to France. Consequently, the US Army had negligible tetanus rates, and the lives of many US soldiers were saved.

(2) Chemical agents were used extensively throughout the war. Countless chemical agents were experimented with; however, the chemical agents that were most effective and thus most often used were phosgene and mustard. Numerous medical personnel suffered from cross contamination with mustard during patient treatment. This put tremendous burden on health care capabilities. It is unfair to judge the errors committed in the past based on the knowledge subsequently gained from the experience. This experience, however, taught the Army Medical Department (AMEDD) that HSS personnel must protect themselves first from the effects of these chemical agents. Since warfare has become increasingly sophisticated, this caution also applies to self-protection from the effects of nuclear, biological, and chemical (NBC) weapons.

c. Operation “Urgent Fury” in Grenada. The importance of knowing and appreciating the medical threat is as important now as it was in past battles or military involvements. As recently as 1983, the “no-notice” deployment of US forces in Grenada did not offer ample time to research and prepare a medical intelligence assessment of the operational environment. Little information was available prior to the invasion to indicate the medical threat from indigenous insects, plants, and unsafe water supplies. The effects of the heat in a tropical environment were known; however, the short lead time for deployment of combat troops did not allow for the issue of lightweight jungle fatigues. Existing supplies of insect repellents were inadequate and were quickly exhausted. Combat commanders promptly recognized the need to offset potential performance degradation from the environment. Had additional time been available—

- *Water discipline would have been emphasized throughout the deployment.* The incorrect assumption that potable water would be readily available led to—

- Inadequate resources to supply water.
- Insufficient command emphasis on assuring that troops drank sufficient amounts of safe water.

Too many soldiers became casualties because of dehydration.

- *The lightweight jungle fatigue uniforms would have been issued to US forces prior to deployment.* The battle dress uniform proved to be too hot and

heavy in a tropic environment. The lightweight jungle fatigue uniform was subsequently sent from Fort Bragg, North Carolina, and alleviated the problem.

- *Provisions for an adequate resupply of insect repellent and bed nets would have been made.*

- *US forces would have been cautioned to protect themselves against a species of extremely aggressive ants.*

- *US forces would have been warned to stay away from the “manchineel” tree, an indigenous poisonous plant.* Some soldiers developed blisters on their bodies after sweeps through the jungle and underbrush. The task force leadership quickly considered the possibility that mustard agent, a chemical agent that burns and blisters the skin, had been employed by enemy forces. The local inhabitants, however, identified the manchineel tree as the source of the problem. Inhabitants in the Caribbean avoid this tree and its fruit because the caustic sap can greatly irritate one’s skin and eyes.

1-6. Estimating the patient workload.

FM 8-55 explains the differences among disease, nonbattle injury, and wounded in action. It tells the planner how to estimate probable patient workload, and it includes charts showing these comparisons in several wars.

CHAPTER 2

MEDICAL INTELLIGENCE

2-1. Intelligence language.

What is medical intelligence? The term medical intelligence was first introduced into the US Army and military intelligence community during World War II. To understand it, you must first know the meaning of -

a. Information. In intelligence usage, information is unevaluated material of every description that may be used in the production of intelligence.

b. Intelligence. Intelligence is the product resulting from collection, processing, integration, analysis, evaluation, and interpretation of available information concerning foreign countries or areas.

c. Strategic intelligence. Strategic intelligence is required by national and allied decision makers to formulate policy and military plans at national and international levels. Strategic intelligence and tactical intelligence differ primarily in level of application, but they may also vary in terms of scope and details.

d. Tactical intelligence. Tactical intelligence is required by corps level and below commanders—

- To develop an estimate of the situation.
- To project enemy intentions in sufficient time to select and execute the most effective friendly course of action to defeat the enemy.

The purpose of tactical intelligence is to obtain and provide decision makers with reliable information about the enemy, weather, and geographical features as quickly as possible. Tactical intelligence seeks to discover the type, strength, location, organization, capabilities, and behavior of enemy forces; their direction and speed of movement; and their intentions. It includes information about weather and terrain within the operational area and their effects on friendly and enemy operations. Tactical intelligence is critical to support command decisions such as mission-oriented protection posture (MOPP) levels.

e. Scientific and technical intelligence. Scientific and technical intelligence (S&TI) is the product resulting from the collection, evaluation, analysis, and interpretation of foreign scientific and technical information that covers—

- (1) Foreign developments in basic and applied research and in applied engineering techniques.
- (2) Scientific and technical characteristics, capabilities, and limitations of all foreign military systems, weapons, weapons systems, and other materiel, the research and development related thereto, and the production methods employed for their manufacture.
- (3) Related technology pertaining to materiel operations and logistics support.

f. Technical intelligence.

(1) Technical intelligence is knowledge of foreign technological developments and the performance and operational capabilities of foreign materiel which have or may eventually have a practical application for military purposes. Technical intelligence consists of five functional areas:

- Communications-electronics (CE) intelligence.
- Weapons-munitions intelligence.
- Nuclear, biological, and chemical intelligence.
- Medical intelligence,
- Mobility intelligence.

(2) Technical intelligence provides the commander the most up-to-date assessment of enemy equipment. It can also inform commanders about state-of-the-art technology of the enemy.

(3) See FM 34-54 for a description of the mission and organization of battlefield technical intelligence assets in the theater.

2-2. Aspects of medical intelligence.

Medical intelligence, which is a functional area of technical intelligence, is that category of intelligence resulting from the collection, evaluation, analysis, and interpretation of *foreign* medical, biotechnological, and environmental information. It includes intelligence on—

- Endemic or epidemic diseases, public health standards and capabilities, and the quality and availability of health services.
- Medical supplies, medical services, health service facilities, and number of trained HSS personnel.
- Location-specific diseases, strains of bacteria, insects, harmful vegetation, snakes, fungi, spores, and other harmful organisms.
- Foreign animal and plant diseases especially those diseases transmissible to humans.
 - Health problems relating to the use of local food supplies,
 - Medical effects of and prophylaxis against chemical and biological agents and radiation.
- The impact of newly developed *foreign* weapons systems as they relate to casualty production.
- An enemy force as it relates to his state of health and fitness or his use of special antidotes.

- An area of operations such as altitude, heat, cold, and swamps that in some way may affect the health of the command or HSS operations.

2-3. The significance of medical intelligence.

Medical intelligence is critical to strategic and tactical planning and operations to conserve the fighting strength. It is a highly technical area which must be complete (collected, evaluated, analyzed, and interpreted) so that the end product is technically accurate and contains all required information.

a. At the strategic level, the objective of medical intelligence is to contribute to the formulation of national and international policy predicated in part on foreign military and civilian capabilities of the medical or biological scientific community.

b. At the tactical level, the objective of medical intelligence is to provide *intelligence* evaluation and analyses of the following factors in the theater:

- Conditions concerning people or animals.
- Epidemiological information (incidence, distribution, and control of infectious diseases).
- Plants.
- Enemy's field health service support.
- New weapons systems or employment methods that could alter health service support planning factors.
- Medical implications of contamination from NBC weapons based on employment tactics and chemical or biological agents used.
- Antidotes to protect against the nuclear, biological, or chemical threat.
- Weather and/or terrain implications.

Medical intelligence also assists in identifying captured enemy materiel and equipment and how it can be used in treating enemy prisoners of war (EPW).

2-4. The commander and medical intelligence.

Medical intelligence, therefore, provides the commander with that knowledge of *foreign* civilian and military medical, biotechnological, and environmental information to conduct his operation. Chapter 3 explains the development of the estimate of the situation to determine the requirements for medical intelligence.

CHAPTER 3

PLANNING FOR MEDICAL INTELLIGENCE

Section I. INTELLIGENCE PREPARATION
OF THE BATTLEFIELD

3-1. Intelligence preparation of the battlefield process.

To effectively fight the AirLand Battle (ALB), the commander must have detailed knowledge of the weather, enemy, and terrain in an area of operations. Climate, terrain, and local conditions have major impacts on the conduct and outcome of a war. The commander must understand the nature, uses, and reinforcement of terrain. He must also understand how weather affects troops and equipment. To retain the initiative in the ALB, he must be able to operate in adverse conditions and during periods of limited visibility. Intelligence preparation of the battlefield (IPB) is the key. During peacetime, IPB builds an extensive data base for each potential area in which a unit may be required to operate. It analyzes this data base to determine the impact of the weather, enemy capabilities, and terrain on the operation. Detailed information on the functions of IPB is contained in FM 34-3. A brief description of these IPB functions follows:

a. Function one is battlefield area evaluation. In this function, the friendly area of operations and the areas of interest are determined to narrow the IPB process to a specific area of the battlefield.

b. Function two is terrain analysis. In this function, the focus is on the military aspects of the terrain and their effects on friendly and enemy capabilities to move, shoot, and communicate. Analysis of the following factors reduces uncertainties of the effects of terrain on combat operations:

- Observation and fields of fire.
- Cover and concealment.
- Obstacles.
- Key terrain.
- Avenues of approach and choke points.

c. Function three is weather analysis. This function deals with the physical elements of climate and weather, soils and substrates, hydrography, and atmospheric conditions. The following are of particular interest to the medical and military planner:

- Land and sea relationships.
- Temperature and humidity.
- Precipitation as snow, ice, or rain.
- Winds and currents.

- Visibility and light conditions.
- The particulate content of air and water.
- The extent and type of pollution contamination or tainting.

d. Function four is *threat evaluation*. In this function, the analyst conducts a detailed study of enemy order of battle and constructs doctrinal templates depicting how the enemy would fight if not restricted by weather or terrain.

e. The fifth and last step of the IPB process is *threat integration*. The objective of threat integration is to relate enemy doctrine to the weather and terrain to determine how the enemy might actually fight within the area of operations and interest.

3-2. Stating requirements.

Commanders and staffs provide direction for the intelligence effort by articulating the priority intelligence requirements (PIR) and information requirements (IR) needed in the decision-making process. To ensure that intelligence provides the basis for timely tactical decisions, commanders and staffs must plan and control intelligence operations with the same level of interest and personal involvement that they devote to combat operations. In particular, they must assure that intelligence is distributed to meet their subordinates' requirements.

3-3. The challenge.

The extended, integrated, and continuous battlefield in the AirLand Battle presents an unprecedented challenge to the HSS planner as well as to the tactical commander. The evaluation of medical intelligence requirements begins when the commander receives a mission, analyzes it, and issues planning guidance. Based on this guidance, the commander's staff prepares the staff estimates that the commander requires to develop his concept of operations. This initial process of mission planning supports the collection of information needed to build an intelligence preparation of the battlefield data base. The commander must have accurate and adequate data to support his plan for executing simultaneous deep, close, and rear operations.

Section II. PLANNING REQUIREMENTS

3-4. Stating priorities.

Health service support plays a key role in developing and maintaining combat power. HSS planning becomes an intense and demanding process. The planner must know the who, what, when, and where of tactical plans to develop flexible, responsive support for each element supported. His actions must be active rather than reactive. This means that HSS planners must anticipate future requirements and develop HSS plans far enough in advance so as to

permit a systematic examination of all factors in a projected operation. The historical form of stating priorities is the PIR list produced in coordination with the Assistant Chief of Staff, G2 (Intelligence) and combat force commander. Each item on the PIR list is known to have an impact on the success of the combat mission. Requirements without a critical impact on the mission are put on the IR list.

3-5. Estimate of the situation.

The initial step in the HSS planning sequence is the development of the HSS estimate (or an appreciation of the situation). This estimate, described in FM 8-55, may be either written or oral, depending on the level at which it is developed. In this logical and orderly examination of all the factors affecting the accomplishment of the mission, the HSS planner must conduct a thorough evaluation of the enemy situation and the area of operations from the standpoint of their effects on the health of the command and health service support operations. From his specialized point of view, the HSS planner must consider the enemy's—

- **Strength, disposition, and combat efficiency.** (What is his ability to inflict casualties, both combat and disease? What are the medical implications of operations in a contaminated environment from NBC weapons based on employment tactics and chemical or biological agents used? What are the requirements for individual and collective NBC protection? Is eye protection needed? Is body armor needed? Who in the friendly force will be truly at risk and under what conditions?)
- **Ability to generate combat casualties by causing injury or disease.** (What are the medical aspects of employment, weapon fills, and contamination from NBC weapons? Who in the friendly force will be truly at risk and under what conditions?)
- **Ability to impact the HSS operations of the command.** (Does he have new weapons systems or employment methods that could alter health service support planning factors?)
 - Health and fitness. See paragraph 3-6c.
 - Field HSS system (medical organization, training, supplies, and facilities). (What type of medical care can friendly prisoners of war expect from the enemy?)
 - Attitude toward the Geneva Conventions. (Is he a signatory to the Geneva Conventions? Will he attack or has he been known to attack the HSS system?)

3-6. Characteristics of the area of operations.

The area of operations may have some significant effects on the number of casualties as well as their collection and evacuation. Some of the characteristics of the area of operations which must be considered by the HSS planner are:

a. Terrain. Topography has a direct effect on the incidence of combat casualties. Natural conditions may favor large populations of insects which commonly are vectors of many diseases and therefore could directly increase the incidence of disease. Mountains, forests, and swamps can be expected to constrain evacuation resources. The duration of hazards from chemical and biological warfare agents may increase in the forest where the air is still and the foliage is thick.

b. Weather and climate. Weather influences the incidence of frostbite, hypothermia, snowblindness, trench foot, dehydration, sunburn, heat exhaustion, heat stroke, battle fatigue, and other medical manifestations that detract from combat effectiveness. Tropical, desert, and tundra conditions favor the growth of insect populations that can greatly increase the incidence of disease casualties. Humidity may affect storage life of medical supplies and equipment. Precipitation affects available water supply, may impact on hospital site selection, and may damage unprotected supplies. Temperature variations may require special protection of medical supplies and may increase patient load because of heat and cold injuries. Severe weather also produces an increase in disease cases. Additionally, weather impacts on the level of degradation incurred while in MOPP 4 and thus has a direct impact on heat casualty volume.

c. Civilian population and enemy prisoners of war. Wartime stress and physical damage can lead to rapid deterioration of urban and rural utilities such as electricity, water, and sewage services. Consequent increases in civilian communicable disease could present a threat to which friendly forces are vulnerable. Enemy prisoners of war and refugee populations also tend to be sources of communicable disease.

d. Flora and fauna. Certain animal diseases or toxic plants may affect movement or the condition of troops, equipment, and/or animals. Such movement may introduce plant or animal disease into the continental United States (CONUS) or other allied countries resulting in economic loss. For instance, introduction of certain diseases such as African Swine Fever into Europe from Africa or the Iberian Peninsula could devastate the swine industry in Northern Europe. Some countries have very strict regulations and quarantine procedures concerning importation of animals and plants into their country.

- EXAMPLES:
1. England requires a 6-month quarantine for military dogs before entering.
 2. The United States requires that soil be removed from equipment being retrograded to CONUS from Europe.

e. Disease. The effects of major diseases are delayed because of incubation periods. Knowledge of potential losses to malaria, dengue, sandfly fever, typhus, and other endemic disease is invaluable in determining appropriate preventive and control measures. These measures include requirements for immunization, chemoprophylaxis, immunoprophylaxis, vector control, or other appropriate measures. Should time not allow for

immunizations, this information will be essential in estimating disease rates and, thereby, projecting strength changes in maneuver units.

f. Local resources. Information on the availability or location of such items as food, water, pharmaceuticals, and medicinal gases (oxygen) and their quality control procedures will affect requirements for supply stockage levels and transportation.

g. NBC threat. The effects of NBC warfare could be severe on medical operations. The NBC threat must be evaluated and included in the overall planning concept for determination of recommendations such as MOPP. Commanders must ensure that units and personnel are prepared to survive, defend, and continue operations in or near a contaminated area. Presence of critical facilities such as nuclear power plants or chemical plants could impact on medical operations. The Bhopal and Chernobyl incidents are excellent examples of how these facilities could impact on medical operations.

3-7. Intelligence production requirements.

In the planning phase of an operation, the medical intelligence PIRs and IRs are identified. If appropriate answers cannot be obtained from available intelligence publications, an intelligence production requirement or information requirement may be developed and forwarded through intelligence channels. (See Appendix C for instructions on the preparation of DD Form 1497.) The intelligence production requirement (IPR) or IR will be reviewed by the Intelligence Officer (S2), G2, or Director of Security or up or down to the level where the desired information is available. These requests could conceivably be passed up to the primary source of the Department of Defense's (DOD's) strategic intelligence, the Defense Intelligence Agency (DIA). In this case, DIA may validate the requirements and submit them to the Armed Forces Medical Intelligence Center (AFMIC), Building 1607, Fort Detrick, Maryland 21701-5004. (See Appendix A for sample medical intelligence requirements.) Chapter 4 will cover the background, mission, and strategic responsibilities of AFMIC.

3-8. Responsibilities of leadership.

Responsibilities of the command surgeon or major medical organization in the technical intelligence (TECHINT) arena include but are not limited to—

- Coordinating and assisting medical TECHINT activities within the command.
- Assisting the G2 or Intelligence Directorate, Joint Military Staff (J2) and Assistant Chief of Staff (Operations and Plans) (G3) or Operations Directorate (J3) with the integration of medical TECHINT into estimates, tactical plans, and studies.
- Coordinating, storing, safeguarding, and handling captured medical materiel.

3-9. Health service support plans.

The medical commander or the medical staff officer (including the Chief, Medical Operations Center, Division Support Command) at each level must modify his plans to fit each situation as it arises. He must remain constantly abreast of the tactical and HSS situations. He must continue to plan for the next operation while operating the HSS for the current operation. ALB emphasizes flexibility with diversification of planning and operations. Accordingly, all HSS plans which support tactical operations must be flexible. They must have alternatives which can be used during the course of the operation to meet rapidly changing situations. Alternatives that the tactical commander is considering must also be considered by the HSS planner.

3-10. Changing and modifying health service support plans.

The medical commander or the medical staff officer must be in a position to receive information from medical elements under his control or technical supervision so that he can direct changes and modifications in existing plans according to the requirements of the situation. As the HSS planner, he must be alert to the magnitude of problems which might confront him in nuclear, biological, chemical, and/or directed energy warfare. The unique conditions to be encountered in such warfare require a case-by-case analysis of each situation. An example:

You are the commander of a combat support hospital under the 99th Medical Group. You have received a new group operation order for an offensive operation that requires the relocation of your hospital to support tactical operations. With this change in your mission and area of operations, your medical intelligence requirements will also change. You must restate your requirements by using the estimate of the situation. After reassessing the situation, you discover a need for medical intelligence on the possible employment of biological agents by the enemy. **YOU MUST MAKE YOUR PRIORITY INTELLIGENCE REQUIREMENTS AND INFORMATION REQUIREMENTS KNOWN TO YOUR S2 or G2** so that this information can be collected if it is not already available. Following this, medical intelligence teams of intelligence organizations will analyze and rapidly disseminate the intelligence to the G2 for dissemination to you, other commanders, and appropriate medical personnel. (See Section II, Chapter 4, for further discussion of channels used in obtaining medical intelligence in a theater of operations.)

3-11. Integrating medical intelligence.

If medical intelligence confirms or reveals a new threat based on the types of wounds or the types of diseases being treated, the appropriate medical staff officer advises the tactical commander. Tactical planners can use this information to counter these threats, and HSS planners can use the intelligence to develop HSS responsive to the demands of the area of operations.

CHAPTER 4

MEDICAL INTELLIGENCE SOURCES

Section I. STRATEGIC SOURCES

4-1. Armed Forces Medical Intelligence Center.

The strategic requirements of health service support planners for medical intelligence are supported by the Armed Forces Medical Intelligence Center. The center is the sole producer of required medical scientific and technical intelligence and general medical intelligence for the Department of Defense. It responds to requests from the Army, Navy, Air Force, and Marine Corps for medical intelligence. AFMIC provides its services to any person or group within the US Government that has a legitimate "need to know" such as planners, research and development personnel, and policy makers. Individuals having a mission-related requirement for the intelligence must have the required security clearance. In some special cases, these services are also provided to friendly governments.

4-2. Directive to establish.

On 9 December 1982, DOD Directive 6420.1 established the AFMIC as a joint agency of the Military Departments. It is subject to the authority, direction, and control of the Secretary of Defense and under the management of the Secretary of the Army as Executive Agent. The Secretary of the Army exercises this authority through the Deputy Chief of Staff for Intelligence and The Surgeon General of the Army. AFMIC consists of a director, deputy director, technical assistant to the the director, and a staff of military and civilian professional, technical, administrative, and clerical personnel.

4-3. Mission and functions.

The mission and functions of the Armed Forces Medical Intelligence Center are to—

a. Produce required foreign medical scientific and technical intelligence and general medical intelligence (GMI).

(1) Medical S&TI is knowledge on basic and applied biomedical phenomena of military importance including biological, chemical, psychological, and biophysical factors. An example of a medical S&TI product is the "Medical Effects of Non-Ionizing Electromagnetic Radiation—LASER (U)."

(2) GMI considers factors such as infectious disease, presence of lice and parasites, sanitation, poisonous plants and animals, the environment, and the life sciences infrastructure which may affect human performance capability and well being. An example of a GM I product is the study on "Medical Capabilities Study: Democratic People's Republic of Korea (U)."

b. Produce foreign biological warfare intelligence studies and reports on the capabilities of foreign countries to acquire, develop, produce, or employ as a weapon any agent of biological origin.

c. Produce intelligence studies on the medical aspects of foreign chemical warfare capabilities.

d. Provide timely medical intelligence support to the following:

- (1) DOD components.
- (2) National level intelligence production agencies.
- (3) Other federal agencies as required.

e. *Organize* and execute medical aspects of the DOD Foreign Medical Materiel Exploitation Program (FMMEP). Exploitation of foreign medical materiel involves the acquisition, laboratory analysis, and field evaluation of items of military medical materiel or medical materiel of foreign origin.

f. *Coordinate* the acquisition, exploitation, and disposition of foreign medical materiel obtained in support of DOD FMMEP.

g. *Plan*, coordinate, and provide intelligence studies in accordance with DOD Scientific and Technical Intelligence production policies and procedures.

h. *Prepare* medical intelligence funding and manpower requirements for submission to the DOD general defense intelligence program.

i. Manage and maintain the medical intelligence data base and the medical portion of the DOD scientific and technical intelligence data base.

j. Provide quick reaction responses on foreign medical intelligence to DOD elements and other government agencies as required.

k. Assist in debriefing personnel on matters related to medical intelligence.

l. Sponsor medical intelligence briefings and training for selected reserve and active military units and individual mobilization designees as required.

m. Maintain coordination and liaison with members of the intelligence community on matters involving medical intelligence.

n. Provide the medical intelligence advisor to the Military Services.

o. Comply with medical intelligence collection management and production tasking policies and procedures established by DIA and the Executive Agent.

p. Provide coordinated collection requirements for medical intelligence in accordance with DOD Directive 5000.11 for the DOD intelligence community.

q. Administer contracts funded outside the general defense intelligence program when there is a technical or administrative advantage in so doing.

r. Transmit a *Weekly Wire* of current medical developments.

4-4. Publication of medical intelligence.

As stated in Chapter 2, medical intelligence products are the *result* of the collection, evaluation, analysis, and interpretation of information concerning the medical aspects of foreign countries that have immediate or potential impact on policies, plans, and operations. To achieve this, AFMIC employs analysts who range in expertise from bacteriology to veterinary medicine. The key word in the definition of medical intelligence is “foreign.” The AFMIC as well as other US intelligence agencies cannot legally produce intelligence on US Forces or on the United States and its territories. Publication of medical intelligence is driven by consumer requirements or needs.

4-5. Responsibilities.

AFMIC maintains a delicate balance: reports must be general enough so they can be understood by the intelligence layman but detailed enough to be technically accurate and trusted by the medical consumer. Understanding AFMIC’s responsibilities in the intelligence production cycle will give you, the consumer, a better picture of what this organization can do and how it can best serve your unit.

4-6. Medical intelligence products.

Some of the most frequently requested AFMIC products are listed below. To order these products, see paragraph 5-4.

- **Medical Capabilities Study (MEDCAP).** Each study covers a single country or geographic area. It discusses eight topics: environmental health factors, disease information, public health services, military medical services, civilian health care delivery, medical personnel and training, medical materiel, and research and development. MEDCAPs have been completed on 95 percent of the countries of the world. They are updated no less often than every 5 years.
- **Disease Occurrence--Worldwide.** This publication is a monthly summary of worldwide human disease outbreaks of military importance.
- **Medical Facilities Handbook.** The Medical Facilities Handbook is a four-volume reference set on hospital facilities with major geographical areas worldwide. Each volume provides an alphabetical listing of major medical facilities within each foreign country. Specific information provided on each hospital includes location, bed space, available medical capabilities, emergency capabilities, x-ray, laboratory and ambulance services, plus other relevant information.
- ***Weekly Wire.*** This electronic message transmits a preliminary analysis of current foreign medical developments. Material that is available for exploitation is described in the *Weekly Wire*. If there is user interest, AFMIC coordinates exploitation activities and provides a study report.

- Various scientific and technical studies. These studies include biological effects of electromagnetic radiation, HSS planning factors, toxin research, biomedical technology capabilities, and chemical and biological warfare capabilities.

Section II. TACTICAL SOURCES

4-7. Responsibility for intelligence in a theater of operations.

In a theater of operations, intelligence is the staff responsibility of the S2 or G2 and those specialized military intelligence units in the combat zone. The medical staff officer in coordination with the supporting intelligence officer establishes priority information requirements and information requirements. These requirements are incorporated into the collection plan of the supported tactical unit. The requests are forwarded through intelligence channels (S2 or G2) up to the level where the desired information or intelligence is available. These requests could conceivably be passed to the echelons above corps intelligence center (EACIC). Theater and theater army requirements emanate from the EACIC to the military intelligence company (technical intelligence) for collection. The military intelligence company (technical intelligence) has the battlefield intelligence mission and is the intelligence community's interface with the medical community.

a. The military intelligence company (technical intelligence) has a nuclear, biological, and chemical and medical intelligence platoon that conducts evaluations and analyses in the areas of NBC and medical technical intelligence.

b. The nuclear, chemical, biological, and medical platoon-

- Is instrumental in gathering the data from the various medical units and nonmedical units within the theater.

- Has medical intelligence production and evaluation capabilities.

- Will evacuate foreign medical materiel and time sensitive items for the Army.

- Within a theater, captured items are exploited at predesignated collecting points at corps and echelons above corps. Technical intelligence teams are sent forward of the corps collecting points to examine captured enemy equipment at or near the scene of acquisition and to arrange for evacuation to the captured materiel exploitation center (CMEC) if necessary. The CMEC is located in the theater rear (communications zone) near medical supply routes and theater air and seaports of debarkation. Captured medical equipment and supplies are evacuated through medical supply channels. They normally go through Supply Officers (S4s), division medical supply officers, and medical supply, optical, and maintenance (MEDSOM) battalions. Final disposition of captured medical items rests with the corps MEDSOM battalion or the communications zone MEDSOM battalion.

- Medical materiel and equipment captured from the enemy are considered neutral and protected property and are not to be intentionally destroyed. If these items are considered unfit for use or they are not needed for US and allied forces, noncombatants, or EPW patients, they may be abandoned for use by the enemy. Since captured medical personnel are familiar with their medical supplies and equipment, the captured items are especially valuable in the treatment of EPWs. Use of these captured items for EPWs and the indigenous population helps to conserve other medical supplies and equipment. (See FM 8-10 and FM 27-10.)

4-8. Reporting information.

Medical units are responsible for preventing disease, treating and returning soldiers to duty, and evacuating patients. Medical personnel are responsible for reporting information gained through casual observation of activities in plain view in the discharge of their duties. This does not violate the law of war obligations of the United States nor constitute grounds for denial of protected status to them. Five hypothetical scenarios are offered to illustrate the point.

Scenario 1. A medical vehicle is on a routine mission. Several hundred refugees are observed moving in the direction of an Army field hospital. Many of the refugees are wounded or sick.

In this scenario, the sick and wounded civilians may seek treatment at the US Army field hospital. Reporting this information would assist the hospital in its planning (that is, as to whether any or all of the refugees could be treated or whether other hospitals should be alerted). Reporting this information would not constitute an act harmful to the enemy.

Scenario 2. Same initial scenario. Medical personnel on the vehicle come upon wounded enemy soldiers abandoned by their comrades after a recent battle with allied forces.

In this scenario, article 25 of the Geneva-Wounded and Sick (GWS), 12 August 1949, requires that all parties to the GWS search for and collect the wounded and sick on the battlefield. Reporting this information not only is consistent with but also is required by the GWS. Such a report would not constitute an act harmful to the enemy.

Scenario 3. Same initial scenario. The medical vehicle and personnel are fired upon by enemy soldiers.

In this scenario, while such information may be harmful to the enemy, the enemy's act must be reported in that it constitutes a violation of the law of war. A report also might prevent other medical vehicles from being placed at unnecessary risk in traveling through the area in question.

Scenario 4. Same initial scenario. The medical personnel observe several enemy soldiers who have infiltrated U.S. lines to a position near a U.S. airfield. The soldiers are equipped with heat-seeking surface-to-air missiles.

In this scenario, heat-seeking missiles are “fire and forget” weapons; once fired, they seek out a readily available target regardless of its character. As an example: in the event a heat-seeking missile is launched at an enemy fighter and the fighter eludes the missile or employs an expendable countermeasure (such as a flare) that would draw off the missile, the missile then would seek another target which may include a medical evacuating aircraft or civilian airliner. The act of the medical personnel in reporting their sighting would be harmful to the enemy, but it was not undertaken as their primary mission. The sighting occurred during the discharge of their humanitarian duties, and reporting it is not prohibited by the language contained in GWS or Additional Protocol I.

Scenario 5. Same initial scenario. The medical personnel observe an enemy patrol.

In this scenario, disclosure of this information undoubtedly would be harmful to the enemy, but the reporting of an incidental observation does not constitute an abuse of the responsibilities of medical personnel contained in the GWS. The law of war is not a suicide pact requiring protected persons to forsake the safety of their comrades while protecting the military maneuvers of the enemy. So long as this information is discovered in the course of the discharge of their regular duties, and not in the performance of information gathering missions outside their humanitarian duties, medical personnel have not violated the provisions of the GWS and would be entitled to continued protection.

4-9. The Spot Report and the Preliminary Technical Report.

Medical personnel who gain information through casual observation of activities in plain view in the course of the discharge of their humanitarian duties will report it to their supporting intelligence element (S2 or G2) quickly, completely, and accurately using the Spot Report (SALUTE format). If the Spot Report pertains to captured enemy equipment, the Preliminary Technical Report (PRETECHREP) will also be prepared. (The Spot Report alerts the supporting intelligence element of the newly acquired information and equipment. The PRETECHREP provides more detailed information about specific items of equipment that have been obtained or captured.) Instructions on the preparation of the Spot Report and the PRETECHREP and on the handling of captured enemy equipment are described in Appendix B.

4-10. Required reports and reporting requirements.

Specific required intelligence reports and reporting requirements are specified by the S2 or G2 in a unit standing operating procedure (SOP) or the

intelligence annex to the operations order. If a unit medical officer desires subordinate units to report medical information, he should coordinate with the S2 or G2 to have these requirements specified as above. After the information is thoroughly analyzed and evaluated, pertinent intelligence will be provided to all units through S2 or G2 intelligence reports. In all tactical situations, therefore, the supporting S2 or G2 will be the primary source of tactical intelligence.

CHAPTER 5

ACCESS TO MEDICAL INTELLIGENCE

Section I. STRATEGIC LEVEL

5-1. Medical intelligence for specific requirements.

How do you, the user, obtain medical intelligence to meet your specific medical requirements? First, you determine if your requirements can be satisfied by existing AFMIC medical intelligence publications that, if not held at your command, may be available from other offices in your chain of command. If significant requirements remain unanswered, then you may submit a DD Form 1497 (Intelligence Production Requirement), in accordance with DIA's guidelines as set forth in Appendix C through your supporting intelligence unit or staff, the appropriate major command, and the US Army Intelligence Agency (AIA) to the Defense Intelligence Agency. This IPR, once validated by the DIA, becomes a formal task for AFMIC and is assigned to an analyst with the subject expertise. The center will then—

- Complete data base searches.
- Identify collection gaps.
- Task collectors.
- Receive and analyze information.

Once the study is complete, AFMIC assists DIA in identifying interested consumers in addition to the requestor. The study is subsequently published and disseminated by DIA to the requestor and all other interested consumers.

5-2. The QUICK RESPONSE process.

Unfortunately the intelligence process is time consuming and lengthy and is reserved for major studies. Consequently, a shorter, more responsive procedure called the QUICK RESPONSE (QR) process has been established. To request medical intelligence, AFMIC may be contacted directly by telephone, letter, or by message. (See paragraph 5-7.) If the AFMIC staff determines that they can answer the request within 5 working days or less, they will process the request as a QR. If the request cannot be processed as a QR, the requestor will be notified and advised as to how AFMIC will proceed. The quick response process is especially useful for obtaining—

- The latest intelligence on a subject that was published several years earlier.
- Intelligence on a topic that may be politically important at present.
- Intelligence that is more specific than that presented in a publication.

The response can be in a variety of formats as well, either written (message or letter) or oral (telephone call or formal briefing). The QR process not only provides the consumer with the most current intelligence on a specific topic, but it also allows AFMIC analysts to receive feedback on changing consumer interests.

5-3. The *Weekly Wire*.

Consumers not on distribution for the *Weekly Wire* can request to be added to the address list by contacting AFMIC directly.

5-4. Inter-agency document requests.

Requests for one-time dissemination of specific intelligence products must be submitted on DD Form 1142 (Inter-agency Document Request) (See Appendix D). A comprehensive listing of medically oriented intelligence publications, which can be obtained on DD Form 1142, is contained in the Scientific and Technical Intelligence Register (STIR) (U), DST-2660Z-003A-85. The STIR is normally maintained by the supporting intelligence unit or staff or may be obtained on DD Form 1142.

5-5. Disseminating medical information.

Army commands are encouraged to contact AFMIC to determine how their requirements (especially those not met by finished intelligence) can best be served. Conversely, HSS personnel at all echelons can make significant contributions to the intelligence data base by forwarding trip reports on theater visits or other health and medical surveys through the supporting intelligence unit or staff to AFMIC.

5-6. Requesting intelligence support.

In every case, except for Quick Response tasking, the initiation of a request for intelligence support should begin at the requestor's supporting intelligence unit or staff.

5-7. Requesting support from the Armed Forces Medical Intelligence Center.

With access to all-source information available throughout the intelligence community, AFMIC can respond to a wide variety of consumer interests. In addition, AFMIC can assist commands in identifying how they can best use medical intelligence. The Armed Forces Medical Intelligence Center can be contacted by any of the following methods:

- Letter address: Director
Armed Forces Medical Intelligence Center
Building 1607, Fort Detrick
Frederick, MD 21701-5004
- Message address: DIRAFMIC FTDETRICKMD//AFMIC-ZA//
- Telephone numbers: Director's Office
AUTOVON: 343-7511
Commercial: (301) 663-7511
Tie-line from District of Columbia area:
393-1839, Extension 7511 or 7603
FTS: 935-7511

AFMIC Pentagon Liaison Officer
 AUTOVON: 227-8233
 Commercial: (202) 697-8233

- Secure phone: KY2201, STU II: ID No. 03305
 AUTOVON: 343-7511
 Commercial: (301) 663-7511

Section II. TACTICAL LEVEL

5-8. Identifying intelligence requirements in a tactical environment.

As stated in Chapter 3, medical staff officers must identify their intelligence requirements to their supporting intelligence element (S2 or G2). It is through this channel that HSS personnel gain access to all tactical intelligence support. Through the various intelligence reports provided by the S2 or G2 in response to user requirements, HSS planners will obtain the necessary information to plan for and execute HSS operations. It must be emphasized, though, that intelligence elements respond best to user requirements and may not collect this information automatically.

5-9. Providing medical intelligence assistance.

Intelligence elements (S2s or G2s of tactical or operational units) or military intelligence units may request specialized medical intelligence assistance from the combat zone, communications zone, and continental United States, as required. Plans, intelligence, and operations sections of the headquarters of the medical command and the medical group, brigade, or battalion coordinate this medical intelligence support in the theater. Medical units maybe required to provide specialized medical intelligence assistance. Examples of requirements are to—

- a. Examine new information concerning non-US health problems.
- b. Examine training material used by foreign medical services.
- c. Conduct investigations of disease resulting from endemic or epidemic pathogens and suspected enemy biological agent employment.
- d. Conduct investigations of casualties resulting from enemy nuclear, biological, chemical, and directed energy operations.
- e. Conduct investigations of new weapons systems or methods of employment that could change casualty/patient medical management.
- f. Accomplish initial examination and evacuation of medical captured enemy equipment and materiel.
- g. Compile environmental data pertinent to health aspects of military operations.

- h.* Provide limited analysis of enemy drugs, serums, and antibiotics.
- i.* Assist in evaluating the human effects of enemy NBC weapons.
- j.* Provide information and data on medical aspects of enemy combat operations.
- k.* Investigate prevalence of diarrhea and susceptibility of friendly troops to diseases associated with food and water consumption in unsanitary or polluted environments.

Section III. LOW-INTENSITY CONFLICT OPERATIONS LEVEL

5-10. Responsibility for intelligence in a low-intensity conflict.

In low-intensity conflict operations as in other tactical operations, a supporting intelligence element (S2 or G2) should exist at some point in the medical unit's chain of command. This element, whether civilian or military, will be the primary source and point for the HSS planner to access the necessary intelligence for the execution of HSS operations.

5-11. Obtaining medical information.

In low-intensity conflict operations, medical information may be obtained from—

- Military assistance advisory groups (MAAG).
- United States embassies.
- Unified commands.
- Other sources such as—
 - Emergency programs, Veterinary Service, United States Department of Agriculture.
 - Center for Disease Control.
 - World Health Organization.
 - Host nation authorities.
 - Operating units within the areas of concern.
 - Local or governmental police.
 - Peacekeeping forces.

APPENDIX A

SAMPLE INTELLIGENCE REQUIREMENTS

This appendix shows some sample intelligence requirements identified after completing the HSS estimate. The sole purpose of these samples is to show planners what type of questions they may have when developing their intelligence requirements based on their assigned mission. It is not meant to be a model format or a comprehensive list. Remember you must base your requirements on your SPECIFIC OPERATION AND SITUATION.

a. Strategic level examples.

(1) You are the Army's Blood Program Officer. You know that the threat has increased its blood collection capabilities. You know that this is a key indicator in the preparation for war. For planning purposes you want to know how their system works in case we capture any of their equipment that we may be able to use to our advantage. The following is a list of questions you may have. How does the threat handle blood banking? What is the threat's concept of operation? What type of equipment does the threat have? What supplies will the threat use? What are the locations of the threat's blood storage and distribution centers? What are the blood types of the threat's forces? What is the breakdown? What types of blood products is the threat using? Are there any other specific or unique blood and blood products or solutions? What are the sources of the threat's blood—civilian and military? What kind of processing procedures does the threat use, if any, to ensure the safety of their blood supply? What is the incidence or prevalence of such diseases as hepatitis and HIV antibodies? What testing measures is the threat using for acquired immune deficiency syndrome?

(2) You are the commander of the XXth Medical Brigade that is to be deployed to Anytown, Euralandia. Your mission is to provide HSS to all units operating within the 10th (US) Corps area of operations and other forces, as directed. It is early autumn. You expect to complete your mission by the end of autumn. In normal years, snow begins falling about mid-November and severe cold sets in during the latter half of December. The following is a list of questions you may have: How will terrain and weather degrade medical equipment and the health and performance of deployed personnel? What are the optimal routes and methods of evacuating casualties in the theater of operations?

b. Tactical level examples.

(1) You are a preventive medicine officer in a medical command. You are updating your health service support plan. You want to know the following about the threat. What communicable diseases are present in the area, and to what level of endemicity? Is there any resistance to chemoprophylactic medications? Are disease carrying arthropods resistant to available pesticides? What significant climatic, topographic, and socio-economic factors are present which might relate to disease endemicity and transmission? What is the quality of the water? What water supplies are available? How is disposal of waste handled in the area? What communicable diseases are present in the force? What are the threat's nuclear, *biological*, and chemical *capabilities*? Does he possess laser weapons or laser range finders?

(2) You are a veterinary officer in a medical command. You are updating your health service support plan. You want to know the following about the threat.

(a) What types of crops are grown in the area to include the—

- Method of growing and harvesting.
- Method of marketing.
- Effect of seasons.
- Types of agricultural and zoological insects and diseases.
- Types and amounts of feed used for livestock.
- Types and amounts used for human consumption.
- Quality and sanitation of food.

(b) You are also interested in knowing what animals carry diseases such as Leptospirosis, Anthrax, Brucellosis, and Rabies that are contagious to man. You need to know the kinds and locations of transportation and the state of repair. You are interested in the biographical data on veterinarians to include—

- Number and duties.
- Training.
- Names and locations of veterinary colleges.
- Area of shortages.

c. Low-intensity conflict operations example: You are the senior medical officer of a peacekeeping force in Anytown, Euralandia. Your mission is to provide health service support to the US Multinational Peacekeeping Force. The mission of the US contingent is to establish an environment that will facilitate the withdrawal of foreign military forces from Anytown, Euralandia, and to assist the Euralandian Government and the Euralandian Armed Forces in establishing sovereignty and authority over the Anytown area. Initially, the peacekeeping force was warmly welcomed by the local populace. The operation was intended to be of short duration. However, recent intelligence assessments indicate that terrorist threats to US personnel and facilities in Anytown are extremely high and increasing. Additionally, there is a deterioration of the political and military situation since the arrival of the peacekeeping force. You must update your health service support plan to increase your readiness in the event of a mass casualty situation involving the peacekeeping force. To provide on-scene immediate medical care (triage, field medical treatment, evacuation, and definitive medical care) you want to establish well-understood mass casualty procedures to include a medical regulating team and aeromedical evacuation and casualty distribution

procedures. Additional mass casualty transportation may be obtained from the division transportation officer or corps support command's movement control center. You need specific intelligence tailored to your specific operational needs—

- Does the threat employ weapons that can alter the health service support planning factors?
- What are the requirements for individual and collective protection?
- Who in the peacekeeping force will be truly at risk and under what conditions?

APPENDIX B REPORTS

THIS APPENDIX IMPLEMENTS STANAG 2084 (EDITION NO. 5)

B-1. Spot Report.

The Spot Report is used to report all information about the enemy and the acquisition of equipment or technical documents. It is to be submitted by the capturing unit or intermediate command echelons. It must be transmitted by the fastest means available. The format is narrative, including all points of information contained in the SALUTE outline, and may include photographs, maps, or anything else that may help convey the full meaning of the information being reported.

- a. *Size* –describe the number of personnel seen or the size of the object.
- b. *Activity* –describe what the enemy was doing.
- c. *Location* –give grid coordinates or direction from a known point, including distance and azimuth from the known point.
- d. *Unit* –describe any patches or clothing, distinctive signs or symbols, or identification numbers on equipment.
- e. *Time* –state the time the activity was observed.
- f. *Equipment* –describe or identify all equipment associated with the activity.

B-2. Preliminary Technical Report.

The Preliminary Technical Report follows the Spot Report and provides additional information on captured enemy equipment. It is used to report a general description of the equipment and any technical information of immediate tactical importance. It is to be submitted by the capturing unit. It must be transmitted by the quickest possible means. Format for the PRETECHREP is as follows:

- a. Type of equipment and quantity.
- b. Date and time of capture.
- c. Location (map reference).
- d. Capturing unit and circumstances of capture.
- e. Enemy formation from which captured.
- f. Brief description with distinguishing marks, and if possible, manufacturer.
- g. Technical characteristics with an immediate value including information of any photographs available.

- h.* Time and origin of message.
- i.* Present location of disposal of captured enemy equipment.

NOTE

Medical materiel and equipment captured from the enemy are considered neutral and protected property and are not to be intentionally destroyed. The medical materiel and equipment will be left in place if it cannot be evacuated. See paragraph 4-7b.

B-3. Captured Enemy Equipment.

Captured enemy equipment must be placed under guard in order to prevent looting, misuse, or destruction before the arrival of the technical intelligence teams. The equipment is to be clearly tagged or otherwise marked by the capturing unit so as to avoid defacing. The procedure is as follows:

a. Identification letters. Equipment is to be marked showing the nationality of the capturing force by the national identifying letters.

b. Designation of capturing units. This is to include the service to which the unit belongs.

c. Serial Number. Units are to give each item a serial number and should record the dispatch of the equipment in a war diary.

d. Date - time of capture.

e. Place of capture (with map coordinates).

f. Summary of circumstances under which the equipment was found.

B-4. Nuclear, Biological, and Chemical Warning and Reporting System.

This system provides commanders and units of actual or predicted NBC hazards. It is the key in limiting the effects of NBC attacks. FM 3-3 discusses the following six standard reports used to exchange information:

a. NBC 1—Observes initial report giving basic data.

b. NBC 2—Report used for passing evaluated data.

c. NBC 3—Report used for immediate warning of predicted contamination and hazard areas.

d. NBC 4—Report used for passing monitoring and survey results.

e. NBC 5—Report used for passing information on areas of actual contamination.

f. NBC 6—Report used for passing detailed information on chemical or biological attacks.

APPENDIX C

INSTRUCTIONS FOR PREPARING DD FORM 1497, INTELLIGENCE PRODUCTION REQUIREMENT

C-1. Prepare the DD Form 1497 to request production of a study if you have a medical intelligence requirement which cannot be satisfied by existing publications. Submit requests as follows:

THRU: Supporting intelligence unit or staff
Major command
OTSG

Commander, US Army Intelligence Agency
ATTN: AIA-IPD
Washington, DC 20310-1015

TO: Defense Intelligence Agency
ATTN: RTS-2A
Washington, DC 20301

C-2. The following numbers are keyed to the various blocks of the sample DD Form 1497 as shown in Figures C-1 and C-2:

1. Security Classification: Enter the highest security classification of information appearing on the form.

2. Subject of Requirement: Enter a short descriptive title of the requirement, and indicate the security classification of the title in parentheses. Whenever possible, the title should be unclassified. If the requirement is for production of a standardized product on a specific geographic area, both the title of the product and the geographic area should be indicated.

3. DIA Control Number: Omit. This number is assigned by DIA for internal control purposes. In the case of an IPR accepted for S&TI production, this number will be identified in the DIA response and will later appear on any S&TI tasking which the IPR supports.

4. Requesting Agency: Enter the name and address of the organizational element originating the production requirement.

5. Requesting Agency Control Number: Enter the unique control number assigned by the requesting agency to this requirement for use in production monitoring and discussions between DIA, the validating organization, and the requester. This number usually contains the requesting agency's identifier, the fiscal year, and a serially sequenced number (for example, MIIA 82-210).

6. Requesting Agency Priority: This two-character set reflects a combination of two priority systems. The first character, a number between 1 and 7, is assigned by the IPR originator and reflects the subject-country priority designation contained in the Joint Chiefs of Staff (JCS) document "Intelligence Priorities for Strategic Planning (IPSP)." The second character, a letter between A and F, is assigned by the military department intelligence chief, the unified or specified command J2, or other final endorser to DIA. It

should reflect the endorser's evaluation of the importance of the requirement in terms of the requester's mission. This priority system is based upon the following coding

<i>Code</i>	<i>Definition</i>
	Satisfaction of the IPR is:
A	of critical importance
B	of major importance
C	of considerable importance
D	of moderate importance
E	of some importance
F	of interest.

This system permits endorsers to rank their internal needs even if many of the gee-topical subjects being routinely treated are assigned a low priority under the IPSP. DIA looks to the endorsers for their assessments of relative priorities among subordinates' requests. It is anticipated that, over a period of one year, endorsers forwarding a large number of IPRs may rank some IPRs in each category of the priority spectrum. Both the IPSP and the endorser's ranking will be considered by DIA in deciding whether or not the requirement can be accepted/approved for DIA-sponsored production.

7. Date of Request: Enter the date the requirement was prepared or submitted by the originator.

8. Date Required: Specify an exact date, a quarter within a fiscal year, or a fiscal year in which the finished product is required. Explain in Block 10 any special negative impact if the product is delayed beyond this date.

9. Form and Frequency of Response: Select/check a product type. If requirement is for recurring (or even one-time) report, include the desired frequency of updating, or if periodic publication of a series of products is desired, indicate preferred frequency.

10. Intelligence Requirement: This portion must be as explicit as possible to be useful to the DIA task manager and to the production element analysts. The following will be specifically included:

a. **Statement of Requirement:** Describe fully the subject matter to be covered and the desired scope of treatment. Identify and explain any special problems or issues to be examined. If the requirement is for updating or continued production of an existing intelligence document, identify it by both long and short titles.

b. **Guidance:** Include any special requirements or factors which bear on the preparation or presentation of the product. Level of detail and/or degree of accuracy should be explained as necessary. Specific comments should be entered, as appropriate, concerning the time frame of the subject matter to be considered in the product, special formats or graphic presentations desired, and security classification or releasability restrictions. In addition, known publications which bear on the requirement or which

partially satisfy the requirement should be listed. An explanation regarding the inadequacy of the documents in fulfilling the requirement should be included.

c. Intended Use of Product: To assist task managers and analysts in fully understanding the intelligence product being requested and to ensure that the requirement is afforded the proper production priority and that the priority assigned to corresponding collection efforts is commensurate with the need for production, this portion must provide specific information on the intended use of the product. If the product is required in support of contingency or war planning, reference should be made to the appropriate plan; if no plan exists, the command's mission which justifies the product should be described. A general statement regarding the level of dissemination of the product within the organization should also be included.

11. Validation of Requirement: This indicates that the requirement has been validated. It is an acknowledgment by those reviewing the IPR that the requested information is needed, that the request cannot be satisfied by the requesting or reviewing component, and that the assigned priority is correct.

12. Endorser's Comments: This allows the endorser to emphasize any relevant points, to include: reason why requester cannot fulfill the requirement; verification that no existing products fully satisfy the requirement; or the impact envisioned if the requirement is not satisfied.

13. Recommended Producer: May be left blank on an S&TI IPR.

14. Name, Grade, Phone, and Message Address of Contact Officer: Enter the requested data (including secure telephone number, if service is available, as well as AUTOVON or commercial telephone number) concerning the person who may be contacted for further information.

15. Security Classification: As in Block 1, enter the highest security classification of information appearing on the form, plus the downgrading or declassification instructions as applicable.

NOTE:

If additional space is needed, please use continuation sheets of 8 1/2" x 11" bond paper. As a reminder, the appropriate classification (if applicable) needs to be marked at the top and bottom of each continuation sheet used.

1 SECURITY CLASSIFICATION (of information on form) UNCLASSIFIED		INTELLIGENCE PRODUCTION REQUIREMENT (SEE INSTRUCTIONS ON REVERSE)	
2 SUBJECT OF REQUIREMENT (Short title and its classification) Aeromedical Evacuation Soviet/Warsaw Pact (U)			3 DIA CONTROL NUMBER Leave blank
4 REQUESTING AGENCY (Organization name and address) Academy of Health Sciences, US Army ATTN: HSHA-CDS Fort Sam Houston, Texas 78234-6100		5 REQUESTING AGENCY CONTROL NUMBER 8X-023	6 REQUESTING AGENCY PRIORITY 3
		7 DATE OF REQUEST 15 Aug 8X	8 DATE REQUIRED 1Q FY8X
9 FORM AND FREQUENCY OF RESPONSE (Check and fill in applicable blocks) <input type="checkbox"/> Hardcopy product <input type="checkbox"/> Other (e.g. Computer tape, photos) _____ <input checked="" type="checkbox"/> Update/revision of existing product <input type="checkbox"/> New publication: <input type="checkbox"/> Scheduled product with regular updating <input type="checkbox"/> A periodic or one-time request <input checked="" type="checkbox"/> Product will require updating on following frequency <u>Biennial</u>			
10 INTELLIGENCE REQUIREMENT (Include statement of requirement, specific guidance on desired content & format, & intended use of product) Soviet/Warsaw Pact aeromedical evacuation information is needed to have a better understanding of Soviet/Warsaw Pact aeromedical (helicopter) evacuation and to determine if they are striving for Geneva Convention protection for this capability. Additionally, by having a more definitive insight into the methods of evacuation, the combat developer will have a clearer understanding of Soviet/Warsaw Pact medical doctrine. Literature review does not reveal that this information is available in any document. Specific areas we are interested in are as follows: 1. Do they visualize employing helicopters in an aeromedical evacuation role? 2. If so, what kind (type) of helicopters? Are these dedicated for aeromedical evacuation? 3. Do they have a certain number of helicopters dedicated for aeromedical evacuation? 4. What are their patient carrying capacities? 5. Are they marked with Geneva Convention approved red cross markings? 6. What equipment and crew do they carry? <p style="text-align: center;">(See Continuation Sheet) (use additional sheets, if needed)</p>			
11. VALIDATION OF REQUIREMENT (Affirmation of need, unavailability of data and IPR priority) (THIS LINE IS TO BE COMPLETED BY MAJOR COMMAND.) (Endorser's name, title, signature and date) (THIS LINE IS TO BE COMPLETED BY FINAL VALIDATING AUTHORITY.) (Endorser's name, title, signature and date)			
12. ENDORSER COMMENTS (e.g. impact on mission of not having data) (THIS BLOCK MAY BE COMPLETED BY MAJOR COMMAND.)			
13. RECOMMENDED PRODUCER (e.g. A command, service production element or DIA) (ENTER IF KNOWN.)			
14 NAME, GRADE, PHONE, AND MESSAGE ADDRESS OF CONTACT OFFICER JOHN E. DOE MAJ, MS, AUTOVON 471-XXXX COMDT, AHS, FT SAM HOUSTON, TX//HSHA-DTD//		15. SECURITY CLASSIFICATION (And downgrading, if applicable) UNCLASSIFIED	

DD Form 83 Sep 1497

Previous edition is obsolete

Figure C-1. Sample of completed DD Form 1497.

UNCLASSIFIED

HSA-CDS

SUBJECT: Aeromedical Evacuation Society/Warsaw Pact

Item 10. (Continued)

7. What type unit configurations are they organized in and to whom do they provide support?

8. What does their doctrine say about their employment?

9. Are these helicopters armed? Are the crew members armed?

10. What kind of medical training do the crew members undergo?

This information will be used to compare the Soviet/Warsaw Pact aeromedical evacuation capabilities with that of the US and to upgrade our capabilities if feasible. It will also give us better insight as to the overall Soviet/Warsaw Pact medical support system.

UNCLASSIFIED

Figure C-2. Sample of completed DD Form 1497 Continuation Sheet.

APPENDIX D

**INSTRUCTIONS FOR REQUEST FOR
ONE-TIME AND SECONDARY DISSEMINATION
OF INTELLIGENCE PUBLICATIONS**

D-1. REQUEST FORMAT: DOD components and other accredited government agencies submit requests on DD Form 1142. A separate form is required for each document requested. A sample of completed form is in Figure D-1. Letter requests will be accepted if DD Form 1142s are not available. Letter requests must contain the same document descriptive data as would be provided by the DD Form 1142. Priority requests may be submitted by message and must contain the document short title and/or report numbers. For non-DIA products, more complete data should be provided including the originating agency.

D-2. PREPARATION OF DD FORM 1142:

- Requests from organizational elements other than the validation element must have certification in the "Reference/Remarks" block by the validating element that the request has been reviewed and approved and that it cannot be fulfilled from command resources.
- The completed DD Form 1142 will be classified on the basis of the information entered on the form. If classified titles are used, the classification of the title will be indicated. The classification of the request should be kept as low as possible to facilitate processing.
- Requests for Special Intelligence/Special Activities Office (SI/SAO) documents should indicate requested documents are S1 or SAO products. If the request contains S1 or SAO information, the request must be submitted through appropriate S1 or SAO channels as prescribed in applicable security directives.
- The same procedures are applicable for microfiche copies of intelligence documents, but the requester will state in the "Title/Subject" block that microfiche is preferred or acceptable.
- Four copies of DD Form 1142 are required for DIA processing. One copy will be returned with the requested document or annotated to indicate action taken.

* U.S. GOVERNMENT PRINTING OFFICE: 1982-370-420

INSTRUCTIONS - USE TYPEWRITER - CLASSIFY REQUEST IF NECESSARY

INTER-AGENCY DOCUMENT REQUEST [If classified info is entered, enter appropriate classification] ← STAMP CLASSIFICATION IF APPLICABLE

TO DIA ATTN: RTS-2A WASHINGTON, DC 20301	FROM SAGA (Gen Purp Forces Div) OJCS WASHINGTON, DC 20301	DATE OF REQUEST 22 Jul 8X	CHARGE NUMBER DIA Acct Number
DESCRIPTION OF MATERIAL SOURCE/AUTHOR (Originating Agency and Post or Individual) DIA			LENDING AGENCY REPORT DATE DUE Leave blank
TITLE/SUBJECT Soviet Aircraft Order of Battle (U) SUR UA770 D311S (DIA Library Call Number; enter if known)			RETAIN NO RECORD
DOCUMENT NUMBER DDI-1300-101-8X			RESERVED FOR USE OF LENDING AGENCY LEAVE BLANK
IAC NUMBER (Leave blank)	PUBLICATION DATE Jan 8X	CLASSIFICATION SECRET	
MATERIAL IS REQUESTED FOR RETENTION ONLY XX 1 Aug - 30 Sep 8X			
REFERENCE/REMARKS Use for: (1) additional bibliographic information (2) urgency or priority of request (3) shipping instructions (4) authorization or validation			
MATERIAL RECEIVED	DATE	SIGNATURE	

DD FORM 1 JUN 56 **1142** [If classified info is entered, enter appropriate classification.] ← STAMP CLASSIFICATION IF APPLICABLE **1**

Figure D-1. Sample of completed DD Form 1142.

GLOSSARY

ACRONYMS AND ABBREVIATIONS

AFMIC	—Armed Forces Medical Intelligence Center
AIA	—Army Intelligence Agency
ALB	—AirLand Battle
AMEDD	—Army Medical Department
ATTN	—attention
Aug	—August
AUTOVON	—automatic voice network
CE	—Communications-Electronics
CBM	—chemical, biological, and medical
CMEC	—captured materiel exploitations center
CONUS	—continental United States
DA	—Department of the Army
DC	—District of Columbia
DD	—Department of Defense
DIA	—Defense Intelligence Agency
DIRAFMIC	—Director, Armed Forces Medical Intelligence Center
Div	—division
DOD	—Department of Defense
EACIC	—echelons above corps intelligence center
EPW	—enemy prisoner of war
FM	—field manual
FMMEP	—Foreign Medical Materiel Exploitation Program
Ft	—Fort
FTDETRICKMD	—Fort Detrick, Maryland
FTS	—Federal Telecommunications System
FY	—fiscal year

GMI	—general medical intelligence
G2	—Assistant Chief of Staff, G2 (Intelligence)
G3	—Assistant Chief of Staff, G3 (Operations)
GWS	—Geneva-Wounded and Sick
HIV	—human immunodeficiency virus
HSS	—health service support
IPB	—intelligence preparation of the battlefield
IPR	—Intelligence Production Requirement
IPSP	—Intelligence Priorities for Strategic Planning
IR	—information requirements
J2	—Intelligence Directorate, Joint Staff
J3	—Operations Directorate, Joint Staff
Jan	—January
JCS	—Joint Chiefs of Staff
Jul	—July
MAAG	—military assistance advisory groups
MAJ	—major
MD	—Maryland
MEDCAP	—medical capabilities study
MEDSOM	—medical supply, optical, and maintenance
MOPP	—mission-oriented protective posture
MS	—Medical Service Corps
NBC	—nuclear, biological, and chemical
NCOs	—noncommissioned officers
OTSG	—Office of The Surgeon General
PIR	—priority intelligence requirements

PRETECHREP	—preliminary technical report
QR	—quick response
S2	—Intelligence Officer (US Army)
S4	—Supply Officer (US Army)
SALUTE	—Size
	—Activity
	—Location
	—unit
	—Time
	—Equipment
SAO	—Special Activities Office
Sep	—September
SI	—special intelligence
S&TI	—scientific and technical intelligence
SOP	— standing operating procedures
STANAG	—standardization agreement
STIR	—Scientific and Technical Intelligence Register
TECHINT	—technical intelligence
TX	—Texas
US	—United States
1Q	—first quarter

REFERENCES

REQUIRED PUBLICATIONS

Required publications are sources that users must read in order to understand or to comply with this publication.

FIELD MANUALS (FM)

3-3	NBC Contamination Avoidance
3-4	NBC Protection
3-100	NBC Operations
8-55	Planning for Health Service Support
34-1	Intelligence and Electronic Warfare Operations
34-3	Intelligence Analysis
100-5	Operations
101-10-1/1	Staff Officers' Field Manual—Organizational, Technical and Logistical Data (Volume 1)
101-10-1/2	Staff Officers' Field Manual—Organizational, Technical and Logistical Data Planning Factors (Volume 2)

DEPARTMENT OF DEFENSE FORMS (DD FORMS)

1142	Inter-Agency Document Request (AR 381-19)
1497	Intelligence Production Requirement (S&I USAAGPC Baltimore, MD 21220 Only) (DIAI 57-5)

RELATED PUBLICATIONS

Related publications are sources of additional information. They are not required in order to understand this publication.

DEPARTMENT OF THE ARMY PAMPHLET (DA PAM)

25-30	Consolidated Index of Army Publications and Blank Forms
-------	---

FIELD MANUALS (FM)

8-10	Health Service Support in a Theater of Operations
27-10	The Law of Land Warfare
34-25	Corps Intelligence and Electronic Warfare Operations

- 34-37 Echelons Above Corps Intelligence and Electronic Warfare Operations
- 34-52 Intelligence Interrogation
- 34-81/AFM 105-4 Weather Support for Army Tactical Operations

PROJECTED PUBLICATIONS

Projected publications are sources of additional information that are scheduled for printing but are not yet available. Upon print, they will be distributed automatically via pinpoint distribution. They may not be obtained from the USA AG Publications Center until indexed in DA Pamphlet 25-30.

FIELD MANUAL (FM)

- 34-54 Battlefield Technical Intelligence

CIVILIAN SOURCE

Great Books of the Western World
Hippocratic Writings, published by Encyclopedia Britannica, Inc., 1952.

INDEX

	Page
AFMIC	3-5, 4-1, 5-2
letter address.....	5-2
message address.....	5-2
mission and functions.....	4-1
responsibilities.....	4-3
secure phone.....	5-3
telephone numbers.....	5-2
AIA	5-1
ALB	3-1
Captured enemy equipment	2-3
abandoning.....	4-5
CMEC.....	4-4
collecting points.....	4-4
evacuation.....	4-4
indigenous population.....	4-5
MEDSOM battalion.....	4-4
reporting.....	4-7
tagging.....	B-2
use by EPWs.....	4-5
Command surgeon	3-5
responsibilities.....	3-5
DD Form 1142	5-2, D-1, D-2
DD Form 1497	3-5, 5-1, C-1, C-4
DIA	3-5
DOD Foreign Medical Material Exploitation Program	4-2
General medical intelligence	4-1
HSS estimate	2-3, 3-3, 3-5
area of operations.....	3-3
evaluation of the enemy situation.....	3-3
HSS planning	3-2
directed energy warfare.....	3-6
NBC warfare.....	3-3, 3-6
planners.....	3-2, 3-3, 5-3
Intelligence	2-1
and the commander.....	3-1
communications-electronics.....	2-2
medical (see medical intelligence)	
mobility.....	2-2
nuclear, biological, and chemical.....	2-2
production (see DD Form 1497)	
scientific and technical.....	2-1
strategic.....	2-1
tactical.....	2-1, 4-7
technical.....	2-2
weapons-munitions.....	2-2
Intelligence preparation of the battlefield	3-1
battlefield area evaluation.....	3-1
terrain analysis.....	3-1
threat evaluation.....	3-2
threat integration.....	3-2
weather analysis.....	3-1

	Page
List	
priority intelligence requirements.....	3-3
intelligence requirements.....	3-3
Medical intelligence.....	2-3, 4-3
and the commander.....	2-3
aspects of.....	2-2
assistance.....	5-3
at strategic level.....	2-3
at tactical level.....	2-3
QUICK RESPONSE.....	5-1
Medical scientific and technical intelligence.....	4-1
Medical threat	
in French wars.....	1-3
in Grenada.....	1-4
in modern warfare.....	1-1, 1-2
in World War I.....	1-3, 1-4
new threat.....	3-6
studying the.....	1-1
teachings of Hippocrates of Cos.....	1-1
Military intelligence company (technical intelligence).....	4-4
nuclear, chemical, biological, and medical platoon of the.....	4-4
Reporting information.....	4-5, 4-6
health and medical surveys.....	5-2
humanitarian duties.....	4-5, 4-6
NBC warning and reporting system.....	B-2
PRETECHREP.....	4-6, B-1
SALUTE.....	B-1
SPOT REPORT.....	4-6, B-1
trip reports.....	5-2
Requirements	
information.....	2-1, 3-2
	3-5, 5-4
low-intensity conflict operations example.....	A-2, A-3
priority intelligence.....	3-2, 3-5
requirements list (see List)	
strategic examples.....	A-1
tactical examples.....	A-1, A-2
Studies	
biological warfare intelligence.....	4-1
disease occurrence—worldwide.....	4-3
medical capabilities.....	4-3
medical facilities handbook.....	4-3
on medical aspects of foreign chemical warfare capabilities...	4-1
various scientific and technical.....	4-4
<i>Weekly Wire</i>	4-3, 5-2
Tactical	
commanders.....	3-6
planners.....	3-6
situation.....	3-6
Technical intelligence teams.....	4-4

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:

WILLIAM J. MEEHAN II
Brigadier General, United States Army
The Adjutant General

DISTRIBUTION:

Active Army, USAR, and ARNG: To be distributed in accordance with DA Form 12-11E, requirements for FM 8-55, Planning for Health Service Support (Qty rqr block no. 836) and FM 30-16, Battlefield Technical Intelligence (Qty rqr block no. 279).