OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

JAN 17 2025

Dear Mr. Chairman:

The Department's response to section 732 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), "Department of Defense Pandemic Preparedness," which requires the Secretary of Defense to develop a strategy for pandemic preparedness and response, is enclosed. While every effort was made to meet our projected suspense identified in the latest interim response, the nature and complexity of this issue, along with the required coordination with Departmental stakeholders, resulted in our response taking longer than expected.

This report describes the substantial progress the Department has made toward developing this strategy. It also describes how the Military Health System supports the Department's strategy to prepare for outbreaks of pandemic influenza and other infectious diseases. It also describes the activities that are being undertaken prior to a pandemic to mitigate risk, increase resilience, and reduce the threat upon the force and its beneficiaries.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families. I am sending similar letters to the other congressional defense committees.

Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

JAN 17 2025

Dear Mr. Chairman:

The enclosed report is submitted in response to section 732 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), which requires the Secretary of Defense to develop a strategy for pandemic preparedness and response. While every effort was made to meet our projected suspense identified in the latest interim report, the nature and complexity of this issue, along with the required coordination with Departmental stakeholders, resulted in our response taking longer than expected.

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Thank you for your interest in the health and well-being of our Service members, Veterans, and their families. I am sending similar letters to the other congressional defense committees.

Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

The Honorable Mitch McConnell
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

JAN 17 2025

Dear Mr. Chairman:

The enclosed report is submitted in response to section 732 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), which requires the Secretary of Defense to develop a strategy for pandemic preparedness and response. While every effort was made to meet our projected suspense identified in the latest interim report, the nature and complexity of this issue, along with the required coordination with Departmental stakeholders, resulted in our response taking longer than expected.

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Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

The Honorable Ken Calvert
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

JAN 17 2025

Dear Mr. Chairman:

The enclosed report is submitted in response to section 732 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116-283), which requires the Secretary of Defense to develop a strategy for pandemic preparedness and response. While every effort was made to meet our projected suspense identified in the latest interim report, the nature and complexity of this issue, along with the required coordination with Departmental stakeholders, resulted in our response taking longer than expected.

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Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Betty McCollum
Ranking Member

[redacted]

Report to the Congressional Defense Committees

Department of Defense Pandemic Preparedness

January 2025

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $24,005 which includes $0 in expenses and $24,005 in DoD labor.

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Table of Contents

"Messieurs, c'est les microbes qui auront le dernier mot"
(Gentlemen, it is the microbes who have the last word)

Louis Pasteur, circa 1870

1. Introduction

This report is submitted in response to section 732 of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021 (Public Law 116–823) (hereafter "section 732"), which requires the Secretary of Defense (SecDef) to develop a strategy for pandemic preparedness and response. This report will discuss how the Military Health System (MHS) supports the Department of Defense (DoD) strategy to prepare for outbreaks of pandemic influenza and other infectious diseases. It will also describe activities to detect outbreaks, mitigate risks, and reduce the threat that pandemic influenza and infectious disease poses to the force and its beneficiaries.

By issuing the Functional Campaign Plan (FCP) for Pandemics and Infectious Diseases (P&ID), the Department has made substantial progress in revising its existing pandemic and infectious disease strategy as required by section 732, although further work is needed to fully meet section 732's requirements. As required by section 732(b), an assessment of the MHS response to the coronavirus disease 2019 (COVID-19) pandemic is attached to this report.

2. Executive Summary

Infectious disease has been a continuous and persistent threat to military forces and operations for centuries, both on and off the battlefield. Analyses conducted by the National Museum of Civil War Medicine showed during the Civil War diseases such as typhoid fever incapacitated more military personnel than combat injuries. Pasteur's pessimism in the quote above was prescient—despite millions of dollars in military health research, the threat of infectious disease to military personnel will never be fully eradicated. Microbes have proven their resiliency to mutate into more virulent strains and resist human interventions including medical countermeasures (MCMs). The risk is not just with infectious disease in humans. The impact of a novel infectious disease pandemic involving plants or animals can have catastrophic impacts on the world's ecosystem and seriously damage the world's food supply.

This report describes how the MHS supports the DoD strategy to prepare for outbreaks of pandemic influenza and other infectious diseases and the activities that are being undertaken prior to an "operationally significant" infectious disease or an infectious disease of national or international significance to mitigate risk, increase resilience, and reduce the threat upon the force and its beneficiaries. This report will also describe the Department's latest FCP for P&ID, which replaced the Department's Global Campaign Plan (GCP) for PI&ID. The DoD-level plan was completed by U.S. Northern Command (USNORTHCOM) and approved by the then-Commander, U.S. Northern Command (CDRUSNORTHCOM), in October 2021, consistent with the CDRUSNORTHCOM's responsibility in the Unified Command Plan for planning of DoD efforts in support of the U.S. Government's (USG) response to PI&ID. In addition, the then-CDRUSNORTHCOM subsequently approved the USNORTHCOM plan for P&ID Response.

3. Approach

This report was prepared using information received from the Office of the Secretary of Defense, the Office of the Joint Staff Surgeon, the Combatant Commands (CCMDs), the Military Departments (MILDEPs), and the Defense Health Agency (DHA).

4. Background

DoD and the MHS have long maintained a spectrum of capabilities necessary to prevent, prepare for, mitigate, and respond to infectious disease outbreaks, such as those experienced over the past two decades including severe acute respiratory syndrome (SARS), Middle East respiratory syndrome coronavirus (MERS-CoV), H1N1 influenza, Ebola, and Zika. The DoD capabilities in this area range from global health engagement activities to improve partner nations' public health capabilities and interoperability, biosurveillance assets across the world to monitor emerging infectious diseases, specialized health care personnel, including epidemiologists and public health officers, and stockpiles of pandemic medical supplies and equipment. These capabilities also include pandemic planning, a public health emergency management (PHEM) response framework, and a research and development infrastructure which includes laboratories and manufacturing facilities to study diseases and develop MCMs.

An "operationally significant" infectious disease (natural, accidental, or deliberate) is a condition that may significantly impact the Department's ability to maintain readiness, meet National Defense Strategy objectives, or significantly increase requests for DoD assistance. Such diseases may occur in humans, animals, or plants. Disease characteristics may include high transmissibility, high severity, high likelihood of impact on freedom of movement of DoD materiel and personnel, or high likelihood of impact on force health protection (FHP) due to insufficient natural protection or MCMs.

Because a pandemic could potentially impact every component of the Department's ability to perform its mission, oversight of pandemic preparedness and response activities is performed by the Assistant Secretary of Defense for Homeland Defense and Hemispheric Affairs (ASD(HD&HA)). The ASD(HD&HA) also serves as the DoD Domestic Crisis Manager and represents the Secretary of Defense and the Under Secretary of Defense for Policy on White House and interagency councils and committees related to public health and medical disaster event preparedness and response, in collaboration with the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Appendix A is a list of selected DoD officials responsible for pandemic preparedness and response planning activities.

5. Current Guidance Related to Pandemic and Infectious Disease Planning

The Department has made substantial progress in revising its existing pandemic and infectious disease strategy as required by section 732. In October 2021, the then-CDRUSNORTHCOM, consistent with the CDRUSNORTHCOM's responsibility in the Unified Command Plan for planning of DoD efforts in support of the USG's response to PI&ID, approved the DoD FCP for

P&ID – 21. This plan is not by itself an executable plan, but rather it serves as the foundation for the CCMDs to develop their own P&ID plans.

In February 2022, USNORTHCOM published its plan for "Pandemics and Infectious Diseases Response," which describes USNORTHCOM's P&ID response in the USNORTHCOM area of responsibility (AOR). These documents, along with the planned revision of Department of Defense Instruction (DoDI) 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019, will be the foundation of the Department's P&ID response as required by section 732. A discussion of these documents follows.

DoD FCP for P&ID

The purpose of the DoD FCP for P&ID is "to ensure DoD is prepared to mitigate the effects of pandemics and infectious diseases to sustain the readiness of personnel, execute DoD missions worldwide, and support civil authorities, as directed, in response to a pandemic or infectious disease outbreak." The DoD FCP for P&ID describes USNORTHCOM's responsibility for planning DoD efforts in support of the USG response to P&ID, in coordination with other CCMDs, the Joint Staff, the MILDEPs, and appropriate USG Agencies. The plan requires USNORTHCOM to establish collaborative forums to develop integrated plans among the CCMDs, Defense Agencies, the MILDEPs, other USG Agencies, allies, and partner nations. An example of these forums are the USNORTHCOM-lead Pandemics and Infectious Disease Coordination Conference and Defense Intelligence Agency's National Center for Medical Intelligence (NCMI)-led Viral Supremacy Exercise which are conducted annually.

The DoD FCP for P&ID is not an executable plan. It is a planning framework that provides the strategic foundation for the CCMDs and Defense Agencies to address P&ID issues unique to their respective AOR and problem set. Execution of the DoD FCP for P&ID is through each of the regional supporting plans of the CCMDs with physical areas of responsibility and operational execution is synchronized by the Chairman of the Joint Chiefs of Staff (CJCS) in his role as the Global Integrator. The DoD FCP P&ID supersedes the March 2013 DoD GCP for PI&ID.

The DoD FCP for P&ID incorporates lessons learned from exercises and real-world operations including the COVID-19 pandemic, Zika, Ebola, MERS-CoV, and SARS, the Joint Staff "In-Stride-Review," and findings and outcomes from the P&ID Coordination Conference and Viral Supremacy Exercises.

USNORTHCOM "Pandemics and Infectious Diseases Response" Command Plan

USNORTHCOM's Plan for P&ID Response provides the overarching planning guidance for USNORTHCOM's response operations to an operationally significant infectious disease outbreak in its AOR ranging from a localized epidemic (outbreak likely to remain restricted to a limited geographical area—local or State level) to a pandemic (high potential for rapid and continuous national and global spread). This plan is intended to address biological pathogen impacts and provide mitigation measures to reduce the risk to force and risk to mission. It also superseded USNORTHCOM's plan for Response to Pandemic Influenza, which focused singularly on pandemic influenza.

The USNORTHCOM P&ID Response Plan was developed in accordance with the revised DoD FCP P&ID and incorporates insights from several recent outbreaks including H1N1 Pandemic Influenza (2009), MERS-CoV (2012), H7N9 Avian Influenza (2013), Ebola Virus Disease (2014), Zika Virus (2015), and COVID-19 (2019). The plan was also informed by subject matter experts and findings from the Pandemics and Infectious Diseases Coordination Conference and Viral Supremacy Exercises.

DoDI 6200.03

DoDI 6200.03 is the designated policy to guide DoD Components to prepare for and respond to public health emergencies. The current version (2019) clarified the definition of a DoD-declared public health emergency (PHE), provided additional guidance on the process for declaration of an emergency, and provided new tools for managing the incident such as the Health Protection Condition (HPCON) framework. The HPCON framework has proven to be a significant component to the DoD response to the COVID-19 pandemic. The DoDI directs an all-hazards approach, meaning the DoDI does not provide prescriptive actions for specific illnesses or health conditions. Instead, it takes a high-level approach to outline roles and responsibilities, reporting relationships, and procedures that would guide initial response activities for a variety of different types of public health emergencies. The DoDI provides operational guidance to installations on preparedness and response and authorizes installation commanders to take emergency actions to limit the impact of health threats on DoD personnel and missions. These emergency health powers are authorized following the declaration of a PHE on the installation. The DoDI also provides guidance to the commander or director of DoD military medical treatment facilities (MTFs) on preparedness and response activities within the MTF and in support of the installation, including specific guidance on situational standards of care when resources are insufficient to meet the health care needs of all beneficiaries.

6. Exercises

a. Exercise Activity

DoD FCP for P&ID – 21 includes the following exercise activities:

- The CJCS is tasked with advocating for, including, and integrating DoD P&ID exercises into the CJCS exercise program;

- CCMDs with physical areas of responsibility are tasked with participation in planning conferences and P&ID tabletop planning and other exercises, as required. The following are examples of past CCMD P&ID exercise activities:

    - The U.S. European Command (USEUCOM) Surgeon conducted USEUCOM's last pandemic exercise, Trifecta Vector, in September 2018, to identify gaps and finalize the USEUCOM P&ID plan. The USEUCOM Surgeon also coordinated and participated in Component pandemic exercises, including Medusa Vector 2016 with U.S. Navy Europe and GänseJäger 2017 with U.S. Air Forces Europe. USEUCOM includes biological scenarios in some of the Jackal Stone series of command level

exercises. The USEUCOM Surgeon has been involved with planning and participation in the yearly Viral Supremacy pandemic exercise organized by USNORTHCOM and the NCMI.

- The U.S. Special Operations Command (USSOCOM) Surgeon participates in the Viral Supremacy Pandemic Tabletop Exercise annually to ensure synchronization with the greater whole of government response plans.

- U.S. Space Command (USSPACECOM) participates in the Viral Supremacy exercise and P&ID Coordination Conference. The USSPACECOM P&ID Response Plan was signed on October 14, 2021;

- U.S. Africa Command (USAFRICOM) holds P&ID exercises regularly. African Lion is the recent exercise that the command held on the continent during the COVID-19 pandemic, and this exercise included execution of a robust FHP mitigation plan. Exercises in USAFRICOM that do not include a medical component are required to have a contingency plan for an infectious disease outbreak should one occur. All other exercises that occurred during the pandemic took COVID-19 into consideration.

- U.S. Central Command (USCENTCOM) states that it does not host Joint exercises specific to pandemic preparedness; however, pandemic related training objectives have been integrated into exercises such as Eager Lion or Eagle Resolve.

- DoD FCP for P&ID – 21 tasks the Services with addressing biennial installation planning conferences, installation P&ID tabletop planning exercises, and installation coordination visits. The MILDEPs are responsible for FHP of forces under their jurisdiction during day-to-day operations. Examples of pandemic and infectious disease preparedness activities by the MILDEPs include the following:

  - The Air Force regularly exercises its P&ID plans in accordance with DoDI 6200.03 and in accordance with applicable Air Force instructions (AFIs), to ensure a PHE response exercise (e.g., disease containment plan exercise or mass prophylaxis plan exercise) and a mass casualty exercise are conducted annually, either in conjunction with host installation or tenant command exercises or as stand-alone events. After action reports are completed promptly following exercises to identify corrective actions as well as to capture lessons learned. AFI 10-2519, "Public Health Emergencies and Incidents of Public Health Concern," December 10, 2019, directs the annual conduct of a PHE exercise (e.g., disease containment or mass prophylaxis plan) and a mass casualty exercise in conjunction with installation or command chemical, biological, radiological, and nuclear exercises or as a stand-alone event in accordance with DoDI 6200.03.

  - The Navy holds pandemic exercises at least biannually in coordination with the appropriate Combatant Commander, in accordance with Office of the Chief of Naval

Operations (OPNAV) Instruction 3500.41B, "Pandemic and Infectious Disease Policy," July 12, 2021.

- Navy Medicine Readiness Training Commands and Units (NMRTC/U) conduct pandemic influenza response exercises on an annual basis as required by OPNAV and U.S. Navy Bureau of Medicine and Surgery (BUMED) policy, and BUMED monitors compliance. Additionally, BUMED Emergency Preparedness has a training and exercise program integrating NMRTC/U participation in Commander, Navy Installations Command and Marine Corps Installations Command installation-based pandemic response exercises. In addition, BUMED Instruction 3500.5A, "Pandemic Infectious Disease Policy," September 15, 2021, aligns with this higher authority guidance and requires exercise of P&ID plans and responsibilities biennially.

- On June 29, 2021, BUMED, in conjunction with OPNAV N3 and N5, conducted a 1-day influenza pandemic tabletop exercise across all numbered Fleets. In addition to exercising P&ID plans BUMED staff participate annually in a variety of tabletop exercises with other offices (i.e., Joint Requirements Office, Joint Program Executive Office) which identify any Navy Medicine gaps to mature plans and inform future policy.

<u>Based upon the DoD FCP for P&ID – 21, the Services</u>:

- Ensure their plans identify potential second and third order effects of an extended P&ID environment on their ability to sustain operations; provide FHP to Service members; and maintain installation support requirements.

- Ensure installations and MTFs have designated public health emergency officers (PHEOs) to facilitate P&ID planning, exercises, and operational response.

- Ensure that a PHE response exercise (e.g., disease containment plan exercise or mass prophylaxis plan exercise) and a mass casualty exercise are conducted annually, either in conjunction with host installation or tenant command exercises or as stand-alone events.

- Conduct FHP program training and exercises that include the following:

  - Educational sessions for health, medical, and other response personnel;

  - Conduct annual pandemic and infectious disease related training including routine hand washing, cough and sneeze etiquette, social distancing techniques, healthy lifestyle, workplace disinfection protocols, self-care, family care, and protective behaviors for individuals and families;

  - Enhance public health awareness information and education targeting base populace; and

- Perform personal protective equipment (PPE) respiratory protection fit-testing for critical personnel (develop plan to provide just-in-time or surge fit-testing for additional personnel, as required).

b. Exercise Planning/Resources

Based upon the DoD FCP for P&ID – 21:

- The Defense Threat Reduction Agency (DTRA) will support the design, development, and execution of biological-threat-specific exercise scenarios as requested by CCMDs, the Office of the Secretary of Defense, the Joint Staff, or, as appropriate, other Federal Departments and Agencies for domestic and overseas exercises and training events, including workshops, seminars, and tabletop exercises;

- An FHP program includes planning, training and exercises, intelligence support, health risk assessment, health risk management, and health risk communication. FHP measures are used to organize the FHP program elements for implementation. The development and maintenance of the FHP program needs to be ongoing and continuously refined to ensure relevance and viability of all potential measures when employed to reduce vulnerabilities to adverse effects of disease.

A description of Navy, Air Force, and DHA P&ID exercise planning guidance and activities follows:

Navy

Navy guidance specifies pandemic exercises should be physical in nature and maximize participation. Scenario design is critical for future pandemic preparedness. Emphasis should be made to encourage personnel to consider areas of improvement in the current system and evaluate what new systems may need to be stood up within a short time. Exercises should include reviewing the HPCON levels, PPE and measures, institution of Continuity of Operations Plans, and testing the information technology infrastructure for ability to support virtual private networks for prolonged work from home scenarios. If the plan for pandemic vaccine distribution or administration is to use a novel scheduling technology, it should be practiced during pandemic exercises. Introducing new technology in an already complex crisis may be inevitable. Exercises that foster resilience and integrate these new technologies may mitigate against their burden on an already stressed health care infrastructure.

Additionally, institutional resilience is heavily built upon resilience at the level of individual personnel. Personnel should be encouraged to include their families during pandemic preparedness exercises to better anticipate the impact a pandemic would have beyond the work environment. Finally, a review of mental health and provider/first responder wellness systems should be carried out as part of the exercise.

BUMED reviews NMRTC/U pandemic exercise planning, participation, and corrective actions via a proactive emergency preparedness assist visit program, which includes an annual detailed

review of emergency management and public health related exercises conducted at the facility level.

BUMED maintains a Training and Exercise Employment Plan that documents all Navy Medicine deployable asset field training and exercise participation. For example, Navy Medicine Forward Deployable Preventive Medicine Units have an annual exercise and evaluation cycle that includes infectious disease outbreak scenarios in their training. The Training and Exercise Employment Plan is evaluated annually by BUMED M7 to ensure medical personnel and units can meet their requirements which includes biodefense.

Air Force

Within the Air Force, installation exercise planning and execution are managed by the Wing Inspection Team. The Wing Inspection Team plans, executes, and monitors corrective action requirements. Medical inputs, in accordance with AFI 10-2519 are managed by the wing Medical Emergency Manager (MEM). Medical groups are authorized to utilize Installation Medical All-Hazards Response funds to provide the resources needed for pandemic exercises.

DHA

DHA's Emergency Management (EM) Program was created in 2021 under the DHA J3. The DHA EM Program, staffed by one full time civilian, is currently conducting mission analysis and coordinating emergency management activities with its Military Service partners. Plans include the creation of an annual Agency tabletop exercise. Prior to their transition to the DHA, MILDEP MTFs organized pandemic and other emergency-related exercises at the local level in collaboration with the installation disaster/event management team to meet Joint Commission requirements.

7. Funding Required Capabilities

Pandemic preparedness and response capabilities, similar to all capabilities, compete for funding with other Departmental priorities in the Department's planning, programming, and budgeting process.

8. Global Health Engagement

Importance of DoD Global Health Engagement (GHE) activities in DoD pandemic preparedness and response

DoD GHE[1] activities are strategic enablers that help the Department achieve its strategic goals by advancing partnerships, supporting readiness, and promoting like-minded allies as well as international norms and standards. GHE activities are aligned with the National Security Strategy, National Defense Strategy, National Biodefense Strategy, and the USG Global Health Security Strategy (GHSS).

GHE activities are relevant during planning, coordination, and partnership development prior to a pandemic as well as during a pandemic response. These sustained efforts can facilitate access and influence, strengthen alliances, build partner capacity, foster health security both domestically and globally, and enhance Joint Force readiness, all while supporting CCMD Campaign Plans. GHE activities can be conducted bilaterally or multilaterally, or as part of multilateral alliances and initiatives. They promote transparency, coordination, and cooperation, help to advance international norms and standards, and enable DoD to gain a common operating picture with our interagency and international partners.

Many GHE activities, such as biosurveillance and cooperative threat reduction activities, support FHP and security cooperation objectives. CCMD initiatives to build and support multinational health security alliances are particularly relevant to pandemic preparedness and response; these initiatives represent an effective and appropriate contribution to the multi-sectoral Global Health Security Agenda (GHSA). The GHSA is an international initiative focused on enhancing global capabilities and capacities to prevent, detect, and respond to infectious disease threats. It is a valuable tool in helping identify infectious disease preparedness gaps within our partner nations, thereby targeting opportunities to build their capabilities, enhance their resilience, and increase DoD's interoperability with them. These efforts also enhance communication with partner nation militaries on their health security needs and priorities, encourage their engagement in the multi-sectoral GHSA, and promote military-civilian collaboration, which are key DoD responsibilities under the GHSS.

Another DoD responsibility under the GHSS is to assist and support the U.S. response to pandemics and other infectious disease threats when required, in coordination with U.S. Agency for International Development (USAID) Bureau for Humanitarian Assistance or the Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response. In general, this involves providing unique DoD response capabilities, such as logistics, transport,

[1] DoDI 2000.30, "Global Health Engagement (GHE) Activities," July 12, 20217, defines GHE as "[i]nteraction between individuals or elements of DoD and those of a [partner nation's] armed forces or civilian authorities, in coordination with other U.S. Government departments and agencies, to build trust and confidence, share information, coordinate mutual activities, maintain influence, and achieve interoperability in health-related activities that support U.S. national security policy and military strategy. GHE activities establish, reconstitute, maintain, or improve the capabilities or capacities of the [partner nation's] military or civilian health sector, or those of the DoD."

security, and medical evacuation and treatment, when critical capacity gaps cannot be easily addressed by other Departments and Agencies.

Global Health Liaisons

While there is no official DoD definition for "global health liaisons," a few DoD positions relevant to global health do include "liaison" as part of the position title. These include U.S. Public Health Service officers from other USG Departments and Agencies (e.g., HHS and the Centers for Disease Control and Prevention (CDC)) or military health officers from key U.S. partner nations (e.g., the United Kingdom, Canada, Germany, Japan, and France)) working within the Department in a liaison capacity. All these liaison officers have played an important role DoD's coordination with other Federal departments and agencies or partner nations during the COVID-19 pandemic, as does a U.S. Navy physician who serves as the DoD liaison to CDC.

While the Department has transitioned from assigning full-time medical officers to U.S. missions, the Navy will continue to support CCMD requirements through temporary duty assignments. Other forward deployed DoD health personnel are permanently stationed in locations and in positions that, while not officially listed as liaisons, could be considered to be serving—at least in part—in international liaison roles. By virtue of their ongoing research collaborations with host nation military and civilian health colleagues, Army and Navy personnel serving in locations outside the United States could fit in this category (see additional information below). For the last several years at the request of U.S. Indo-Pacific Command (USINDOPACOM), an Army officer assigned to the Armed Forces Research Institute of Medical Sciences (AFRIMS) in Bangkok has been detailed to the U.S. Joint Military Attaché Group at the U.S. Embassy to support broader military-to-military health collaboration with Thailand and with other southeast Asian nations at the Association of Southeast Asian Nations (ASEAN) Center for Military Medicine hosted by the Royal Thai Army in Bangkok.

Several U.S. military medical personnel are assigned to NATO commands and organizations in positions that serve to advance NATO medical interoperability and readiness. These include medical personnel working within Medical Advisor (known as Joint Medical) offices at Supreme Headquarters Allied Powers Europe / Allied Command – Operations, Allied Command Transformation, and Joint Forces Command Brunssum. There are two Navy officers at the NATO Military Medicine Centre of Excellence in Budapest, Hungary, and starting this year, an Air Force officer will be overseeing medical courses at the NATO School in Oberammergau, Germany.

Finally, U.S. military officers assigned as Security Cooperation Officers in U.S. Embassies and Consulates throughout the world serve a key role in developing and maintaining relationships with host nation military colleagues in support of U.S. Mission and CCMD objectives. While these officers rarely have a health background, they are often called to serve as "global health liaisons" since health is often an area of interest for the host nation, the U.S. Mission and/or the CCMD. Nearly 50 of these officers oversee the execution of Department of Defense HIV/AIDS Prevention Program (DHAPP) activities by local national U.S. Embassy employees with their partner nations. Since the beginning of the COVID-19 pandemic, these same officers have been

at the forefront of international health-related humanitarian assistance funded using DoD's Overseas Humanitarian, Disaster, and Civic Aid appropriation.

The next three sections contain information regarding the scope of MILDEPs' GHE activities (which may increase in the future in response to CCMD requirements), and regarding the placement and utilization of "global health liaisons."

Air Force GHE Activities

The Air Force established its International Health Specialist (IHS) program in 2000. About 400 personnel across the United States Air Force (USAF) Total Force currently hold an International Health Specialist Special Experience Identifier, with 62 active duty personnel with Special Experience Identifiers serving on 13 teams supporting 5 CCMDs with physical AORs in full time dedicated IHS billets. The remainder serve as a ready resource for emerging and ongoing GHE requirements, with specific skills and culture/language capabilities aligned to specific requirements. The Air Force has four medical Military Personnel Exchange Program (MPEP) billets, which are 1:1 exchanges of medical officers with Australia, Canada, and the United Kingdom, fostering interoperability. Additional medics are assigned to designated Air Advising units (e.g., Mobility Support Advisory Squadrons), and USAF medical personnel are tasked to support medical education and training of international students through Embedded Training Teams and Mobile Training Teams at the USAF School of Aerospace Medicine and elsewhere.

Air Force experience has shown that greater in-person contact with partner nations enhances communication and coordination in steady-state and crisis. The Air Force assigns numerous IHS positions outside the United States as discussed above and is exploring the possibility of embedding additional positions within Security Cooperation Organizations in countries prioritized by CCMDs with physical areas of responsibility. Such assignments would offer several potential benefits: building trust, strengthening relationships, broadening knowledge of partner nation health system and capabilities; improving integration of GHE within the spectrum of Security Cooperation activities at the country level; facilitating assessment, monitoring, and evaluation of GHE programs; and improving coordination of DoD GHE with other USG agencies in the country.

Additional goals for Air Force GHE include:

- Increase total multi-year GHE programs with an established and executed Assessment, Monitoring, and Evaluation Plan;

- Integrate focused Air Force Medical Service core capabilities to support agile combat employment and enhance operations in denied environments;

- Increase GHE integration with joint, combined, multinational exercises;

- Ensure GHE programs and activities are part of commands' deliberate operational planning processes;

- Utilize exercises to assess/evaluate military medical capabilities;

- Utilize exercises to practice and assess military medical interoperability; and

- Conduct GHE programs and activities that enhance Global Health Security in response to increased demand and USG guidance.

Army GHE Activities

The U.S. Army Medical Department (AMEDD) provides long term, contingency and emergency affiliation and support to the international community in response to pandemics, natural disasters, and other humanitarian crises. The following are the cornerstones of AMEDD support to the international community:

- Participate, support, and encourage the international community to comply with the World Health Organization International Health Regulations purpose and scope "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade;"

- Provide active membership in and support to international and national alliances and organizations involved in international/national health and military health care support to military, civilian, and indigent populations—for the latter especially those at risk;

- Maintain a responsive and robust organizational structure that provides the full range of medical capabilities to the USG, DoD, and the U.S. Army to respond to pandemic threats, humanitarian crises and man caused and natural disasters; and

- When authorized, provide the full range of medical materiel, supplies, and equipment, including pharmaceuticals and blood in response to pandemics, humanitarian crises, and naturally and non-naturally occurring disasters.

Staffing:

- AMEDD has the full range of medical specialties in institutions and deployable organizations ready to deploy individually or corporately, in support of DoD and Army assigned missions. These specialists are fully trained and qualified in their specialties and have proven experience in delivering specialized services in a variety of circumstances and conditions, worldwide on a nearly immediate basis.

- Some organizations are forward stationed/deployed which due to proximity to event or circumstance, provide immediate consultation and support as required.

- Several specialties, including operational medicine, veterinary, public health and logistics are predisposed to providing services and consultation within their specialties to

ameliorate human suffering and the effects of pandemics, humanitarian crises, and man-made and natural disasters.

- In some circumstances, beyond and including AMEDD, U.S. Army personnel are available to receive "just in time" training and preparation to support international health crises such as the Ebola outbreak as well as response to requirements to support civilian (national and international) communities during multiple pandemics, humanitarian crises and man-made and natural disasters (e.g., tsunami response in Indonesia, Japan and the Philippines; and most recently, COVID-19).

Liaisons and Exchanges:

- AMEDD is an active participant in the DoD and U.S. Army programs for Subject Matter Exchange, MPEP, the Engineer and Scientist Exchange Program (ESEP), and the Foreign Liaison Officer Program.

- The U.S. Army is active in the Subject Matter Exchange Program through short term and longer-term exchanges. The most prominent is the provision of short-term familiarization and orientation visit for foreign medical professionals in the multiple areas of medical specialty. Typically, these feature CCMD escorted visits to DoD and Army medical capabilities. A recent innovation is the Visiting Subject Matter Exchange Program (up to 30 days) during which a Visiting Subject Matter Exchange individual joins a teaching section of the U.S. Army Medical Center of Excellence and provides instruction and familiarization to U.S. and international students enrolled in the U.S. Army Medical Center of Excellence Leadership Training Center programs. Israel is the first country to participate in the Visiting Subject Matter Exchange Program.

- AMEDD hosts MPEP officers from Germany and Australia. The German officer is an instructor in the U.S. Army Medical Center of Excellence Leadership Training Center while the Australian exchange has been a long-term mission involved with doctrine development. The Australian exchange is a reciprocal exchange with a U.S. officer stationed in Australia.

- AMEDD has been a long-term participant in the ESEP program that enables medical scientists to participate in research and development, experimental, and orientation familiarization activities with AMEDD and DoD centers of excellence. The predominant centers involve surgical, disease and blood research, prosthetics, and rehabilitation.

- AMEDD has long hosted a Medical Liaison Officer program, which has since been adopted and expanded by the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)). Since the 1940s, AMEDD has deployed a U.S. Liaison Officer to the United Kingdom.

International Research and Development Collaboration and International Labs:

- The U.S. Army Medical Research and Development Command (USAMRDC) is a formidable cooperative medical research and development capability. With decades of international collaboration, USAMRDC has over 1,500 information and data exchange agreements and cooperative research and development agreements with foreign partners. USAMRDC hosts an open access research portal that can accept, and in some cases provide funding for, relevant medical research initiatives.

- Through the Walter Reed Army Institute for Research, USAMRDC provides leadership for an expansive network international clinical research sites and reference laboratories that enable military and civilian scientists to identify, anticipate, and counter emerging infectious disease threats of greatest relevance to U.S. and allied militaries. These include AFRIMS in Thailand, the U.S. Army Medical Research Directorate Africa in Kenya, Nigeria, Tanzania and Uganda, and the Republic of Georgia-based Richard M. Lugar Center for Public Health Research. The common thread among the labs is that they are all jointly staffed by U.S. Army and host nation scientists.

GHE Skill Identifiers for Army Veterinary Corps Officers:

- Veterinary Corps Officers are a critical addition to the DoD GHE mission and to pandemic preparedness and mitigation due to their expertise in One Health, food safety, animal medicine, and public health. The newly approved Army Veterinary Corps GHE skill identifiers ensure that Veterinary Corps Officers with the skill identifiers have the appropriate knowledge, skills, and abilities to perform GHE missions. This supports readiness, interoperability, the National Defense Strategy (Strengthen Alliances and Attract New Partners) and Biden Administration Interim National Security Strategic Guidance goals (reinvigorating and modernizing global alliances and partnerships).

- The Army is the sole provider for Veterinary Services across the Joint Force. Army Veterinary Services routinely provides support for USAF and U.S. Navy GHE missions such as Balikatan, Continuing Promise, Pacific Partnership, and multiple Defense Institute of Medical Operations missions, to name a few of many examples. Army Veterinary Corps Officers must bring a set of knowledge, skills, and abilities on these missions commensurate with that of their USAF and U.S. Navy counterparts. The two-tier skill identifier ensures that Veterinary Corps Officers who earn the skill identifiers have appropriate GHE-related knowledge, skills, and abilities.

- In 2009, the Army Veterinary Corps designed and implemented a resident two phase Veterinary Support to Stability Operations course that provides a critical set of knowledge, skills, and abilities to support veterinary GHE. Over 500 veterinary personnel have completed this course to date, and implementation of the Veterinary Corps GHE skill identifiers will enable this specialized training to be appropriately leveraged for GHE-related billets and missions.

- Veterinary Corps officers began applying for the new skill identifiers on October 1, 2021, which will optimize Veterinary Corps officer talent management for GHE support provided by the Army Veterinary Corps to the Joint Force. Beginning on October 1, 2022, the appropriate tier of the Army Veterinary Corps GHE skill identifiers was applied against 90 selected billets. These are existing billets in which Veterinary Corps officers have GHE execution duties (Field Veterinary GHE Specialist skill identifier), or GHE planning, training, doctrine/policy development, strategic advising or other GHE-related staff officer duties (Senior Veterinary GHE Specialist skill identifier). Addition of the appropriate level of Veterinary Corps GHE skill identifier to these existing billets will ensure that officers selected to fill these positions have the necessary knowledge, skills and abilities to perform their GHE-related duties.

Table 1 describes the Army Veterinary Corps GHE Skill Identifiers.

Table 1: Army Veterinary Corps Global Health Engagement Skill Identifiers

Army Veterinary Corps Global Health Engagement Skill Identifiers	
Field Veterinary GHE Specialist	***Senior Veterinary GHE Specialist***
Targeted Ranks: CPT & junior MAJ	*Targeted Ranks:* mid-grade to senior MAJ and above
Examples of Proposed Authorizations to be Coded with the SIs (not all inclusive)	
Medical Detachment (Veterinary Service Support) CPT/MAJ billets, Civil Affairs Battalion CPT billets, Special Forces Group CPT billets	Army Medical Department instructor MAJ billets; Geographic CCMD LTC billets; Army Forces Command COL staff officer billet; staff officer billets at Army Public Health Command, DHA, others
Requirements for Each SI Level	
Completion of Phase 1 & 2 of Veterinary Support to Stability Operations	Completion of requirements for Field Veterinary GHE Specialist
Completion of the Military Veterinary Medical (Veterinary Defense Support of Civil Authorities) Course	Completion of 12 credits of distance learning graduate education courses from the Uniformed Services University of Health Sciences Global Health & GHE Certificate Program: • Global Health 1: Fundamentals of Global Health • Global Health 2: Advanced Topics in Global Health • Global Health 3: Global Health Engagement
NA	Successful operational deployment on at least one military GHE activity
	Successful completion of at least 12 weeks of cumulative experience in one or more of the following categories: (1) GHE operational experience, (2) expeditionary operational experience in a joint, multiagency, or coalition environment, and/or (3) staff officer experience related to GHE

Navy GHE Activities

Since the establishment of the Global Health Specialist program in 2017, Navy Medicine has qualified over 270 Medical Department officers with a GHE Specialist Additional Qualification Designator. The Navy's Global Health Engagement Office is aggressively pursuing the growth of GHE capabilities and participation across all Corps of the Medical Department. The desire is

to also include enlisted personnel by creating a training pipeline and explore implementation of a Navy Enlisted Classification or Secondary Navy Enlisted Classification.

Current GHE billets are located with the Naval Component Commands at Pacific Fleet, Naval Forces Southern Command, Naval Forces Europe/Africa, and Naval Forces Central Command; BUMED Headquarters and Regions (Naval Medical Forces Pacific/Atlantic); and there are affiliated billets at Uniformed Services University of the Health Sciences (USUHS) Center for Global Health Engagement and the Office of the Secretary of Defense.

CCMD GHE Activities

CCMDs with physical AORs appear to be uniquely postured to increase partner nation pandemic response through GHE; however, there are some limitations unique to such CCMDs. For example, DoD is not the USG lead for international pandemic preparedness. The responsibility for pandemic preparedness uniformly rests in the civilian Ministries of Health. There are some mechanisms for a CCMD to coordinate preparedness strategies directly with host nation stakeholders in a more regional approach. For example, USAFRICOM works with militaries in the African Partnership Outbreak Response Alliance (APORA), and USINDOPACOM engages with the military medical section of ASEAN, which addresses health preparation plans and strategies with the civilian/military enterprise.

Based upon DoD FCP for P&ID – 21

USNORTHCOM: CCMDs should conduct targeted theater security cooperation (TSC) and building partner capacity (BPC) activities in coordination with other USG agencies to bolster and integrate partner nation capacity to respond to P&ID, and to improve the interoperability and effectiveness of civilian and designated military critical responders. TSC and BPC activities in CCMD AORs include GHE activities such as medical health surveillance, readiness, training, and exercises. Further, TSC and BPC activities are designed to ensure success by shaping perceptions and influencing behavior of both adversaries and allies.

Preparation should also include incorporating P&ID into exercises and developing partnership capacity (see DoD FCP-P&ID paragraph 3.c.(3) Partner Nation Support line of effort and Annex N for planning tasks).

BPC, particularly through exercises and training during steady state fosters resilience, which has proven beneficial during actual outbreaks by reducing partner needs, reducing disease burden in the AOR, expanding military partnership activities in other areas, and building confidence, thus dissuading reliance on competitors.

CCMDs should build regional military-to-military partnerships for P&ID preparedness and response.

USAFRICOM: GHE is an opportunity for wider reach and to connect NATO allies/partner nations. One example is the African Partner Outbreak Response Alliance which brings together 27 African countries to discuss disease outbreak response and prevention. During the pandemic

USAFRICOM held two APORA events virtually, which included rapid response team training and monthly calls with the APORA executive board. Additionally, these GHEs could be tied more closely together across the CCMDs with physical areas of responsibility and aligned with the GHSA.

USCENTCOM: USCENTCOM does not have dedicated funding for pandemic preparedness and competes for funds with existing priorities and activities such as Security Cooperation engagement programs, or Humanitarian/Civic Assistance projects. DTRA, in its Cooperative Threat Reduction role in support of USCENTCOM, does have flexibility within this area, and while each CCMD with a physical AOR can influence these activities, it cannot conduct direct mil-to-civ engagement within this space based existing title 10 activities in the USCENTCOM AOR.

USEUCOM: USEUCOM ensures timely and effective communication among DoD and interagency partners, along with its NATO partners and other host nation partners to build a shared understanding of the P&ID challenges to ensure synchronized plan development for global engagements and activities. Designated P&ID GHE liaisons are needed to maintain and communicate with stakeholders through the planning process, and to represent their respective CCMDs P&ID equities. Additionally, USEUCOM GHE continues to build and incorporate GHE pandemic response plans into P&ID exercises with various stakeholders.

USSOCOM**:** USSOCOM conducts GHE as part of its authorities as they align with mission requirements.

DTRA, in coordination with NCMI, produces futures research and modeling and simulation of other nation's resilience to pandemics, infectious disease, and biological events identifying and articulating plausible scenarios with multiple second and third order effects to inform U.S. policy development, contingency planning, exercises, and operations.

9. U.S. Navy Health Protection Research

Health Protection research as defined as the research and development (R&D) efforts to develop infectious diseases diagnostics and countermeasures to mitigate health threats to the warfighter are a critical focus of the Navy Medicine Research and Development (NMR&D) enterprise. Communities within Navy Medicine include but are not limited to physicians with subject matter expertise in infectious disease research and preventive medicine, scientists in the microbiology, entomology, and biochemistry communities. Within the civilian corps of Navy Medicine, there are numerous scientific and research positions that are focused on mitigating the threats of infectious diseases. In addition to infectious diseases, the core capabilities throughout the enterprise also include warfighter health, performance, and operational support; combat casualty care; bioeffects risk mitigation and countermeasures; and physical, mental, and behavioral health. There is no formal active-duty career track within the medical R&D community, as compared to the formal career track for the active-duty acquisition community.

10. FHP Personnel and Guidance

DoD includes pandemic preparedness as part of its overall preparedness efforts for public health emergencies. DoDI 6200.03 is the designated policy to guide DoD Components to prepare for and respond to public health emergencies caused by all-hazards incidents. FHP guidance to Service members on activities to be taken during a pandemic or severe influenza season is provided by the ASD(HA), DHA, and the Military Services.

PHEOs and MEMs

DoDI 6200.03 identifies the PHEO as the principal public health and medical advisor for the installation commanders. The Instruction requires every installation commander to designate a PHEO. Usually, PHEOs are drawn from installation MTFs and are required to be clinicians with training in public health and possess a SECRET clearance at a minimum. In many locations, the PHEO is the head of Preventive Medicine or Aerospace Medicine, and the MTF commander or director will recommend the PHEO to the installation commander for appointment. DoDI 6200.03 requires at least one alternate public health emergency officer (APHEO) to assist the PHEO, though this person is not required to be a clinician and is often drawn from public health or other medical programs. PHEOs are also required at MILDEP headquarters level as well as at the CCMDs to advise the Component head and Combatant Commander. These PHEOs are often full-time positions and folded into other public health or medical programs, such as the CCMD's medical planning program or Surgeon's office. PHEOs and alternates are required to complete the "PHEM Course," a designated training on management of PHE, including preparedness, response, and recovery.

In the response to COVID-19, PHEOs and APHEOs played a key role by assisting commanders with understanding the impact of the pandemic on their installation's mission, personnel, and beneficiary population and what actions are appropriate based on the current situation. In the early months of the response before HPCON levels were standardized across DoD, PHEOs advised on protective actions that should be taken to mitigate the risk of COVID-19. Once the HPCON standards were in place, PHEOs still were required to provide specific recommendations to the installation commander. Later in the pandemic, the Secretary of Defense provided guidance on changing HPCON levels[2] and PHEOs were still needed to evaluate the impact of COVID-19 on the installation as well as in the local community to properly advise the commander on possibly changing the HPCON level. PHEOs also advised on travel restrictions, contact tracing, restriction of movement (ROM), and the closure of installation facilities such as food service, gyms, and child development centers. When vaccines became available, PHEOs advised commanders on the most effective and efficient methods to vaccinate the installation's population, particularly mission essential personnel. DoDI 6200.03 also requires a MEM for every DoD MTF. MEMs concentrate specifically on resource management and emergency planning for the MTF, but they are also frequently the points of contact between installation emergency management personnel at the MTF. Alternate Medical Emergency Managers (AMEMs) provide additional support. MEMs and AMEMs have the same

[2] Secretary of Defense Memorandum, "Guidance for Commanders on Risk-Based Changing of Health Protection Condition Levels During the Coronavirus Disease 2019 Pandemic," May 19, 2020.

training requirements as PHEOs for completing the PHEM Course and may be either military or civilian personnel. Each MILDEP has a headquarters-level MEM to support the MTFs and deals with policy-related issues, requirements, and other medical readiness activities. The CCMDs may offer support to the MTFs but do not have designated MEMs. With the DHA assuming administrative functions for the MTFs, DHA will work with the MILDEPs to clarify expectations and support for MEMs.

The requirement for planning for public health emergencies in DoDI 6200.03 was updated in 2019 to encompass all DoD Components and includes programs located off installations and those without public health or medical assets under their command. Every DoD entity is required to include public health emergencies into their emergency preparedness and response planning.

Supplemental FHP Guidance

As noted above, DoDI 6200.03 provides all-hazards guidance without addressing specific illness or health conditions. With ongoing events, such as with a pandemic, additional FHP guidance is necessary to provide disease-specific information and guidelines. While the DoDI assigns the responsibility for developing these measures to the ASD(HA), during the COVID-19 response this responsibility was elevated to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)). The demand signal for additional FHP supplements came from a variety of sources; however, many were developed in response to changing CDC guidelines and restrictions.

Other DoD FHP supplements were developed based upon identified needs for clear guidance from the MILDEPs or from changing needs in the field. A listing of the FHP Supplements published during the COVID-19 pandemic can be found by topic area in Appendix B and by supplement number in Appendix C. All DoD pandemic-related was consolidated into the "Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance," first issued by the USD(P&R) on April 4, 2022.

HPCON Levels

DoDI 6200.03 included the first DoD-wide reference to the HPCON framework. Originally developed by the USAF, the HPCON framework was incorporated DoD-wide in DoDI 6200.03 as a tool for managing risk communications. It was recognized as an approach to provide transparency to the installation population and provide clear guidance on protective actions that would be required as conditions changed. The HPCON framework provides a stratified method of grouping protective actions by the severity of the health event. For less severe incidents, less protective measures would be appropriate; more severe incidents would require more restrictive measures. The framework is similar to the Force Protection Condition construct DoD uses for security threats. The HPCON framework has five levels with the lowest level being HPCON 0, representing normal operating conditions. HPCON A through the highest level, HPCON D, indicate rising health threats. Worsening conditions would drive the HPCON level toward HPCON D, and improving conditions would change the HPCON level toward HPCON A. In practice, with the COVID-19 response, the HPCON framework has proven its utility for an

operational management tool for modifying protective measures on installations as conditions have evolved. Supplemental guidance from the SecDef[3] provided clear, quantitative thresholds for changing HPCON levels while also providing installations the flexibility to determine the specific protective action appropriate for that location based on critical mission requirements, personnel needs, and other unique factors.

DoD employed a sixth level, HPCON B+, from mid-2020 to early 2022 to indicate more restrictive actions than HPCON B but not as restrictive as HPCON C. The Consolidated COVID-19 FHP Guidance[4] streamlined the HPCON structure back to five levels by removing HPCON B+. Appendix D is the updated HPCON framework and the FHP activities for each level as of April 4, 2022.

DoDI 6200.03 authorized installation commanders to set the HPCON levels for their installations. It encouraged them to coordinate with other DoD installations nearby for consistency in messaging. The shortcoming to this approach is that it does not address broader coordination across a theater or CCMD or evenly globally. To improve coordination, in April 2021 the SecDef delegated authority to change HPCON levels for the COVID-19 pandemic to the MILDEPs,[5] which could be further delegated in writing to a level no lower than the installation commander. This change provided the MILDEPs the latitude to determine the best approach for their chain of command. Regardless, the decision to change HPCON levels reflects a careful analysis of the level of transmission in the community and on the installation and the trajectory of the change (increasing or decreasing transmission) as well as the capacity of MTF and civilian hospitals to provide care. This approach was updated in subsequent guidance[6] to account for COVID-19 vaccination rates and higher fidelity transmission data. Appendix E details guidance provided to commanders on the use of HPCONs during the COVID-19 pandemic.

DoDI 6200.03 authorizes military installation commanders to declare public health emergencies on their installations to respond to significant health events, such as COVID-19. The DoDI requires installation PHE declarations to automatically terminate in 30 days, unless renewed and re-reported by the military commander.

Due to the ongoing nature of the COVID-19 response, the duration of DoD public health emergencies declared under DoDI 6200.03 was extended to 90-day intervals to reduce the administrative burden on military commanders of repeated renewals and to allow commanders to focus on response and mitigation activities. Appendix E also lists the extensions of DoD-declared Public Health Emergencies during the COVID-19 response.

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[3] Ibid.
[4] Under Secretary of Defense for Personnel and Readiness Memorandum, "Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance," April 4, 2022.
[5] Secretary of Defense Memorandum, "Guidance for Commanders' Risk-Based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic," April 29, 2021.
[6] Under Secretary of Defense for Personnel and Readiness Memorandum, "Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance," April 4, 2022.

The Navy conducted the following FHP activities in response to the COVID-19 pandemic, which can be used during other pandemics and infectious disease outbreaks:

- The Navy quickly provided "Just in Time" Contact Tracing training to health care providers via the regular monthly tri-service "Epi Training." The Navy also developed a Navy e-Learning course for contact tracing to train lay tracers. Current platforms with easier to use teaching modules include partnerships with educational institutions using Canvas Learning Management System or partnering with various USUHS departments to develop e-Learning tools (USUHS will also be switching to Canvas soon). E-learning platforms developed for universities are meant to be used with little computer programmer support. More skilled educators can increase the complexity of training modules utilizing graphic user interface without advanced computer programming knowledge;

- The Navy's Forward Deployable Preventive Medicine Units can be requested as a Unit Type Code related to the desired capabilities (Preventive Medicine, Laboratory Services, etc.). The Army also has similar capability. All MILDEPs must recognize the availability of Unit Type Codes of public health personnel that are available.

- PHEOs are strongly encouraged in the PHEM course to develop the networking and informal working groups necessary before a pandemic so that knowledge can be shared immediately as it is emerging, particularly at a local and regional level.

The Air Force provided guidance for specific FHP activities to be undertaken during pandemics. These activities are the following:

- Identify Public Health Requirements:

    - Monitor public health advisories (Federal, State, and local) and update the communicable disease response coordinator and members of the planning committee when a communicable disease is in the geographic area assigned;
    - Monitor developments that might result in staff not being able to report to work, such as identifying school closures;
    - Establish protocols for monitoring and tracking communicable disease related staff absences;
    - Identify requirements for augmentation for contact tracing and from where those augmentees will come;
    - Establish protocols for training contact tracing augmentees to ensure capability during an outbreak or surge in cases to identify close contacts;
    - Establish protocols for monitoring the evaluation and diagnosis of hospitalized patients, volunteers, and staff with symptoms of a communicable disease;
    - Establish protocols for education/training for personnel service functions re. pandemic mitigation efforts (commissary, Base Exchange, Force Support Squadron, etc.);
    - Ensure Occupational Health shop visits include pandemic mitigation assessment (for example, Air Force Materiel Command depots);

- Establish protocols for 24-7 communication or request for information collection (Facebook, 24-hour phone line, 24-hour operations?);
- Identify public health-specific resource/manpower requirements and constraints for prolonged (ongoing) response operations; and
- Establish protocols to seek risk-based pause of "normal" public health operations based on local pandemic response requirements.

- Implement ROM protocols, as required:

  - Social Distancing;
  - Quarantine; and
  - Isolation.

- Conduct Disease Testing and Surveillance procedures/capacities:

  - Ensure appropriate surveillance based on symptoms are conducted to assess threats to public health through the use of Electronic Surveillance System for Early Notification of Community-Based Epidemics (ESSENCE);
  - Ensure appropriate screening based on symptoms is conducted to assess threats; and
  - Ensure appropriate diagnostic testing based on symptoms is conducted to assess threats.

- Implement HPCON framework response requirements by phase:

  - Implement risk communication needs and protocols; and
  - Identify recommended response actions.

11. Medical Supplies and Equipment

a. Prepositioned Supplies and Equipment

DoD policy directs elements within DoD to store and preposition pandemic stockpiles. The strategy includes pandemic response materiel prepositioned and maintained at three storage location types and corresponding release authorities: strategic storage sites under OASD(HA) release authority; intermediate storage sites under the CCMD release authority; and local MTF stocks for MTF patient care currently under the release authority of the respective CCMD with physical areas of responsibility. DHA has the lead for supporting MTF health care workers (HCWs) during a pandemic response.

DoD strategic stocks include pre-pandemic H5N1 & H7N9 bulk vaccine which are vendor managed through use of interagency agreements with the HHS Biomedical Advanced Research and Development Authority (BARDA), and antiviral medications (Tamiflu and Relenza) stored at three Defense Logistics Agency (DLA) distribution sites and the U.S. Army Medical Materiel Center – Europe. Prepositioned stocks at intermediate storage locations include antiviral medications and antibiotics. Local stocks held at the MTFs for patient care include antiviral

medications, antibiotics, and PPE. Stocks at the strategic and local storage sites are managed in accordance with policy, established DoD planning factors, and are at 100 percent of required levels. Stockpiles of antiviral medications at the intermediate storage locations are at required levels.

The Air Force has identified preventive medicines and the equipment related to trauma stockpiled to support the CCMDs for the first months of a pandemic event. The Air Force also reviewed the pandemic PPE requirements and utilized lessons learned to revamp current pandemic PPE target goals for supply on hand. For medical equipment, the Air Force reviewed the readiness and maintenance of the ventilators, oxygen generation, oxygen concentration equipment and laboratory testing equipment. The result was improved availability of these items and the procurement of additional equipment to increase capability.

Blood

The Armed Services Blood Program (ASBP) serves as the single integrated blood product support system, comprised of the ASBP Division in DHA, the MILDEPs, and CCMDs with physical areas of responsibility. The ASBP Division coordinates the ASBP under the direction and authority of DHA. DHA works with the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight to coordinate policy for the MHS related to the blood program.

The ASBP functions under the regulatory guidance of the Food and Drug Administration (FDA) and ASBP assets are accredited by the American Association of Blood Banks and the College of American Pathologists in accordance with the activities performed and associated MTF accreditation requirements.

The ASBP's COVID-19 pandemic response efforts are outlined below:

- Blood Product Inventories: Evaluation and monitoring of the total number of blood product inventories took place within hours of DHA launching the COVID-19 response. Additional reporting quickly evolved to include weekly collections from blood donors and quota compliance to support the blood mission within the CCMDs. ASBP continues daily and weekly monitoring of blood products and frozen stockpiles ensures that the ASBP can mitigate shortfalls, plan and mitigate blood drive collections and cross-level when necessary.

- Defense Support of Civil Authorities (DSCA): Both the USNS Comfort and the USNS Mercy were supplied with ASBP blood products. ASBP was fully integrated with the Federal Emergency Management Agency (FEMA) as a Level 1 member of the AABB International Disaster Task Force. The ASBP helped to coordinate air transportation support to deliver blood products to Guam when all commercial cargo flights were suspended. ASBP has supported the American Association of Blood Banks Task Force throughout the duration on the pandemic.

- Implementation of CDC Guidelines: The ASBP leadership quickly adapted guidance from the CDC regarding PPE and social distancing precautions. This allowed the ASBP

to continue to support the blood mission while minimizing risk of donors and staff contracting the virus.

HHS BARDA and DoD were essential partners in the deployment and leverage of the Independent Blood Centers infrastructure that collected over 650,000 doses of COVID-19 convalescent plasma (CCP) and distributed over 500,000 doses to hospitals. At one point during the pandemic there was collection and distribution of over 25,000 doses of CCP to hospitals to ensure the nation had adequate supply. Over 60 percent of the Nation's blood supply comes by way of collections from these same Independent Blood Centers, but during the pandemic BARDA supported approximately 75 percent of the Nation's CCP requirements.

During the early stages of the COVID-19 pandemic, CCP emerged as a potential treatment to decrease the severity of the illness and aid in recovery of patients that had become infected with COVID-19. The blood industry began efforts to manufacture CCP at the onset of the pandemic and the military blood program quickly implemented a plan to keep pace with the global industry in this effort. By April 2020, the DoD began to manufacture CCP.

In late May 2020, DoD was directed to embark on a campaign to collect 8,000-10,000 units of CCP. DHA was assigned the task for overseeing the CCP campaign. The initial foundation that had been laid by the ASBP enabled the successful implementation of the CCP campaign. The 4-month CCP collection effort represented an early test of DHA's ability to mobilize efforts across the MILDEPs, the Joint Staff, and internal DHA resources, including specialized equipment to collect CCP. The DHA leadership team achieved SecDef's goals of collecting 10,000 units by September 30, 2020. This effort called upon leaders in DoD blood programs, medical affairs, logistics, information operations, contracting, education & training, research and development, TRICARE, strategic communications, legal, and financial management to coordinate their activities in support of a larger DoD mission.

Implementation of a new biologic (e.g., CCP) is driven by the blood banking industry and regulatory requirements. ASBP was in lock step with the FDA and American Association of Blood Banks throughout the CCP production and distribution processes. ASBP operationalized the CCP program following all regulatory requirements and recommended protocols. During the COVID-19 response, ASBP procured equipment to increase freezer storage capacity as well as apheresis machines to collect CCP. Frozen red blood cell stockpiles are also available around the globe; however, throughout the pandemic the utilization of the ASBP frozen inventory was low. As of this writing the following CCMDs have CCP inventories available should therapeutics be needed in the operational environment: USAFRICOM, USCENTCOM, USEUCOM, and USINDOPACOM. The Navy Fleet augmented freezer capabilities to ensure CCP inventories were available aboard large carriers. As of May 2021, the Navy removed all CCP from ships; however, CCP can be quickly moved to a ship if necessary. Overall, the ASBP sustained the mission of ensuring blood products were available across the DoD throughout the pandemic and stands ready to support the nation as needed.

b. DLA Warstopper Program

DLA provided a full description of the DLA Warstopper Program in a report to the House Armed Services Committee in 2021. The following information was taken from that report:

Background

The FY93 NDAA emphasized protecting the stability of the industrial base to specifically produce "war stopper" identified items. In response, DLA established the industrial preparedness "Warstopper" Program. The DLA Warstopper Program is the Department's primary industrial readiness program for consumable surge requirements in sustainment. The program is designed to incentivize industry to meet consumable sustainment readiness requirements for which business would otherwise not have a business case to support. This program has a proactive industrial base strategy for warfighter go-to-war items. The Warstopper Program funds about one hundred contracts, most of which are for medical readiness.

How the DLA Warstopper Program Works

- DLA consolidates and submits a yearly Operations and Maintenance budget requirement for the Warstopper Program. This budget requirement covers all DLA supply chains.

- The DLA Warstopper budget requirement is based on existing investment requirements as well as emerging requirements developed from the program's yearly industrial base risk analysis process.

- The program has three major categories of investments: readiness investments to support go-to-war material availability, capability retention to support the access to critical capability in financial jeopardy, and industrial analysis to support risk analysis and investment decision making.

  - The readiness investments all require the supplier to rotate the material to the best of their ability to maintain item freshness and relevance. The readiness investments typically fall into one of the following categories:

    - Fees to guarantee the timely delivery of commercial material in the quantity and timeliness needed to support a contingency. An example of this is for pharmaceuticals needed in 24 or 48 hours to quickly fill the USNS Mercy to set sail.
    - Fees to stage raw material or long lead time components with a manufacturer to quickly produce end items in the quantity and timeliness needed. An example of this are the components staged by the manufacturer to quickly surge ventilators during the COVID-19 pandemic.
    - Fees to rotate Government purchased material with commercial demand to ensure freshness when needed during a surge. An example of this is the N95 respirator.
    - Fees to stage critical raw material at lower tiers in the supply chain that affect many readiness end-items. An example of this is staging 300M steel ingots and

purchasing time within the mill's monthly production schedule to provide the needed capability for known items that surge in wartime.
    - Provide Government equipment to a manufacturer to increase the manufacturer's capacity to support the Department's readiness requirement. An example of this is the equipment the program provides to each operational rations vendor to surge meals-ready-to-eat.

- The capability retention support typically falls into one of the following categories:

    - Funding a supplier's fixed costs for maintaining a financially unviable critical capability required to support future surge demand, and where the costs and time to reconstitution the capability would be excessive. An example of this is funding aerospace propellants critical for satellites. The business model for these propellants has shifted and industry requires support to remain viable.
    - Funding cold supply chain industrial analysis that validates technical data, sourcing and requirements to provide material for extended weapons system life cycles. An example is the F-33 engine. This is an aging platform that has many items in a "cold" status and requires supply chain and engineering analysis to identify the best methods of sourcing the required parts.

- Industrial analysis investments are completed yearly to support the industrial base report to Congress. These analyses are typically generated based on the following:

    - Customer input from operational issues.
    - Contracting support staff input based on industrial issues observed during the acquisition process.
    - Analysis of DLA data that provide insight on potential industrial capability issues.

- The DLA Warstopper Program currently is funded at approximately $45 million per year.

Economic and National Security Benefits of DLA Warstopper Program

- The historical return on investment for the Warstopper Program is 7:1 when measured against the war reserve offset provided by the program. In other words, the Warstopper program uses an industrial strategy to provide equivalent readiness to war reserve. However, the Warstopper Program can cover an equivalent war reserve investment at significantly lower cost.

- The Warstopper Program has provided critical go-to-war material to the warfighter in every contingency and many declared national emergencies since 1993. This includes Meals Ready to Eat, lifesaving medical material, and critical weapon system components.

- The most recent example of the program's impact was during COVID. To date the program has provided over 6.4 million N95 respirators to the DoD as well as other critical PPE and 8,000 ventilators.

12. Review of MHS Infectious Disease Research

USUHS and its Research Enterprise have reviewed the role of the DoD in "reviewing and updating research on infectious diseases and preventive medicine conducted by the military health system" as required by section 732. The USUHS Research Enterprise review focused on three aspects of the MHS Research Enterprise in response to the probability of future pandemics. Those were:

- The required capabilities as laid out in section 732;
- USUHS's recommendations on the factors that need to be considered to achieve those capabilities; and
- USUHS's specific contributions to those factors.

The findings of the USUHS Research Enterprise review identified the required DoD/MHS research capabilities including:

- Versatile and Reactive Research Capabilities. The United States and the DoD/MHS Research Enterprise have rarely predicted the source or timing of future pandemics successfully. For over a decade, the focus of preparation has been on the next severe influenza pandemic, akin to the 1918 influenza pandemic, or on a novel strain of bird influenza. Except for the variant swine influenza pandemic of 2009, which had limited additional impact compared to most seasonal influenzas, influenza as a pandemic threat beyond seasonal impact has failed to materialize. Similarly, despite significant preparations for the next big bioterrorism event after the 2001 anthrax attacks, no such threat has materialized. While such preparations and exercises for influenza were conducted, the United States dealt with unanticipated threats from Ebola, Chikungunya, Zika, and both SARS CoV-1 and SARS CoV-2 virus pandemics highlighting that Department's ability to predict the future infectious disease threats is limited and imperfect. Despite ongoing international efforts to catalogue and characterize viruses (e.g., the USAID-funded PREDICT program), define potential hotspots and areas of human- animal interface for spillover events, it should be assumed there is low probability the Department will predict the next threat before it is recognized.

- Solid Research Foundation. Reviewing and updating research on infectious diseases and preventive medicine conducted by the MHS alone is not sufficient to accomplish the critical long-term needs of the DoD for pandemic preparedness and associated research. Awareness of this limitation can help shape the military research plans for the future in infectious diseases and preventive medicine to prevent or mitigate the impact of the next pandemic on U.S. forces, and by extension, the nation. Broadly speaking, the most likely pathogens that will cause the next pandemic include vector borne diseases (usually spread by mosquitoes) and respiratory pathogens. Whether one of these, or some other unexpected threat—such as Ebola—will occur is nearly impossible to predict. Therefore, the broader focus should be on ensuring a solid research foundation exists to pivot to any new threat, rather than a focus on any single or multiple pathogens as providing a

potential solution. It is important to shore up and invest in broad capabilities to understand the epidemiology, determine the natural history, have the clinical research capacity to respond, and develop countermeasures against the types of pathogens that have pandemic potential.

- Long-term Research. As we have seen with the SARS-CoV-2 (COVID-19) pandemic, when it comes to developing licensed products, DoD has difficulty competing with the pharmaceutical industry in the rapidity of product licensure. However, the DoD developed, tested, or supported the platforms for innovation that ultimately led to both viral vector borne and mRNA vaccine technology which underpin the vaccines currently licensed across the United States for SARS-CoV-2. These capabilities were developed over decades. For example, the currently licensed Ebola vaccine came to fruition after investments in understanding the Ebola virus that began over 45 years ago, which was driven largely by DoD investments.

- DoD-Focused Research System. The DoD research enterprise is not optimized for pandemic prediction and response due to several factors:

  - Research conducted by DoD labs has been placed under a university-based model of proposal-based funding. This works for universities, but impedes operations in a Government-based organization due to inherent challenges of additional administrative and financial requirements, which private organizations do not have to deal with.

  - Officers selected for senior research leadership positions in DoD research laboratories frequently lack a research background. It can take up to 2 years before they fully understand the institution they are leading (just in time for them to move to their next assignment), which impairs their ability to serve as strong and credible advocates among peer organizations.

  - Research priorities continually change, which impedes the long-term investment needed for product development, which can take decades.

  - Research organizations, especially overseas, are having difficulty filling their positions and attracting talented researchers for the future. Military personnel assigned to the laboratories or MHS facilities do not have a well-defined pathway of career advancement.

13. DoD Global Emerging Infections and Surveillance

a. Improving Surveillance, Detection, and Response

The Armed Forces Health Surveillance Division (AFHSD) at the Public Health Directorate under the Assistant Director for Combat Support of the Defense Health Agency and its Integrated Biosurveillance branch maintains situational awareness and early warning capabilities through:

- Daily monitoring of event-based and indicator-based health surveillance where health surveillance data analyzed and vetted by team of epidemiologists. Direct Collaboration and information sharing with USG Interagency partners (Department of Homeland Security (DHS) and its National Biosurveillance Integration Center, the CDC's Global Disease Detection Center, the Defense Intelligence Agency and its NCMI as well as the MILDEP Public Health Centers (i.e., the U.S. Army Public Health Command (APHC), the Navy and Marine Corps Public Health Center, and the U.S. Air Force School of Aerospace Medicine).

- Syndromic surveillance at all U.S. MTFs through ESSENCE to track trends in clusters or outbreaks of illness on a real-time (daily) basis.

- Partnering with State health departments to expand situational awareness of health events in civilian communities near military installations and vice versa;

- Sharing of health surveillance information distributed to military and USG interagency stakeholders through weekly updates, executive summaries, and surveillance summaries (e.g., Ebola and COVID-19);

- Collaborating with the National Geospatial Agency for posting health events and reports in the Health Surveillance Explorer mapping application. This application is broadly linked to CDC, World Health Organization, the NCMI (especially for military-relevant country infectious disease risk assessments, foreign health ministry websites), the CIA-Factbook (for general information on country capabilities, population, economy and infrastructure capabilities), and Travax service for travelers (which includes medical specialist points of contact, location and data on medical centers, hospitals and medical services and surgery/blood bank capabilities in each country) in order to present a consolidated report.

Global Emerging Infections Surveillance (GEIS)

DoD established the GEIS program in 1997 following a Presidential Decision Directive to improve the Department's infectious disease surveillance, prevention, and response capabilities to better protect the health of the military force. The mission of GEIS is to increase battlespace awareness and improve Total Force Readiness in support of the CCMDs via a global laboratory network focused on mitigating the threat of emerging infectious diseases to U.S. military personnel. Since its inception, the GEIS program has focused on the rapid and accurate detection of infectious disease threats to DoD interests around the globe. The GEIS program operates through a global network of Army, Navy, and Air Force laboratories positioned in strategic locations worldwide. These laboratories are engaged on the front lines of global infectious disease surveillance with access to geographic locations experiencing diseases of regional/global health concerns that could impact U.S. military operations and have developed strong and long-standing relationships with allies, partner nations, U.S. interagency partners and international public health authorities (e.g., the World Health Organization). Laboratory confirmed pathogen identification, epidemiological data, and other related information are shared through these collaborations and provide critical details about emerging or expanding infectious

disease threats around the world that may impact the health of the Force. GEIS is one of the main funding sources maintaining critical laboratory and epidemiology infrastructure at all laboratories outside the United States, allowing DoD to maintain a worldwide biosurveillance capability.

The GEIS Program Office, which operates under the AFHSD at DHA, supports a global network of highly qualified DoD laboratories (20 DoD laboratories and/or public health organizations worldwide as of June 2021) positioned in strategic locations to provide on-the-ground infectious disease surveillance and outbreak response in support of the U.S. Armed Forces and the CCMDs with physical areas of responsibility. Providing timely communication about operational public health threats and FHP recommendations is critical to enabling CCMD decision making and mission success. Prompt detection of infectious disease threats allows for earlier deployment of preventive measures and informs the development of new countermeasures, including vaccines, therapeutics, and PPE. These measures, when strategically implemented in an efficient manner, improve FHP and increase operational freedom of movement and access.

Through its interaction with the GEIS network of laboratory partners, the GEIS Program Office can provide early accurate detection of emerging infections that potentially threaten FHP and global health security so that preventive measures can be taken to decrease the risk of mission failure. On a regular basis, the GEIS Program Office coordinates directly with the CCMD Surgeon's Office to review its Theater Campaign Plans and capture operational infectious disease concerns. The GEIS Program Office uses this information to determine funding for surveillance efforts among its network of laboratory partners in four main focus areas: antimicrobial resistant and sexually transmitted infections; enteric infections; febrile and vector-borne infections; and respiratory infections. The result is up-to-date surveillance on infectious disease threats that improves battlespace awareness, informs FHP, supports regional security objectives, and improves survivability in austere environments.

Navy

The NMR&D laboratories with infectious diseases capabilities excel in detection and surveillance for early warning and awareness of pandemics. NMR&D laboratories have surveillance sites in multiple strategic nations throughout the world often working in partnership with host nation Ministries of Health, military, or academic collaborators to collect data in remote regions where access may otherwise be challenging. There is a clear need for such data, and the immediacy of this need has never been greater.

NMR&D laboratories have been working in the area of pandemic preparedness and response around the world since the 1940s with the inceptions of Naval Medical Research Unit (NAMRU) laboratories located in Cambodia (NAMRU-2) (via establishment at the Rockefeller Institute) and Italy (NAMRU-3). In addition, the establishment of NAMRU-6 in Lima, Peru, in 1983 provided an additional global presence outside the United States. In addition, the laboratories at Naval Medical Research Center (NMRC) in Silver Spring, Maryland, and Naval Health Research Center (NHRC) in San Diego, California, provide additional capacity to DoD operational units and the MHS towards pandemic preparedness. Funding of NMR&D continental United States

(CONUS) and outside the continental United States (OCONUS) based infectious disease research activities is approximately $40-50M per year.

b. FHP Information to the CCMDs with Physical AORs

Providing surveillance information that is relevant to the FHP decision-making needs of the CCMDs with physical areas of responsibility is fundamental to the GEIS mission. To achieve this, GEIS has implemented the Data-to-Decision initiative (D2D) which strives to improve the availability of timely, actionable information from GEIS-funded projects for CCMDs with physical areas of responsibility. Through the D2D initiative, the GEIS Program Office routinely monitors findings from GEIS-funded activities with its partner laboratories and provides monthly summaries of these findings to the CCMDs with physical areas of responsibility in a concise format that highlights emerging threats in their areas of responsibility. In addition, the GEIS Program Office distributes SPOT reports when new findings reveal a threat that requires immediate notification to the CCMDs with physical areas of responsibility or other DoD stakeholders. Lastly, D2D monthly infectious disease summaries are distributed to the CCMDs with physical areas of responsibility and their components' FHP Officers, MHS Travel Clinics, Services Global Health Engagement Program Offices and to the MILDEPs' Infectious Diseases and Preventive Medicine Communities.

USNORTHCOM does not review DoD systems for health surveillance and detection or the levels of funding and investment in laboratories, but does leverage these systems throughout the plan:

- Environment Emerging Risks: Genetic changes to known pathogens that make them more virulent, transmissible, or resistant to available vaccines and treatments are unpredictable events that require continuous public health surveillance and intelligence assessments;

- Presumptive Detection. There are numerous ways in which initial detection could occur, including presentation of disease in humans or animals, detection through syndromic surveillance, alerts from environmental surveillance systems or international partners, and normal operations and surveillance efforts conducted by law enforcement or other departments and agencies. Biosurveillance occurs through the myriad of passive and active interagency detection capabilities. AFHSD and MILDEP laboratories provide ongoing surveillance of high-risk pathogens and provide regular reporting to the DoD community. DoD resources, such as the DoD Laboratory Network support detection and presumptive identification of biological threats. The NCMI also provides information on infectious disease, pandemic warning, MCMs, health hazards, foreign military medical capabilities and infrastructure, medical science and technology developments, and biosafety and biosecurity issues;

- Detection. Biological detectors are not deployed in all metropolitan areas throughout the Nation. Detection and confirmation of a biological incident may likely take longer in cities without environmental detection systems. Detectors do not detect all biological

agents or pathogens. Public health surveillance systems, such as syndromic surveillance (e.g., ESSENCE), may provide the first indication of an emerging contagious disease.

- Surveillance. AFHSD is the central, integrated customer-focused epidemiologic and global health surveillance resource for the U.S. Armed Forces. The Armed Forces Health Longitudinal Technology Application and MHS GENESIS laboratory infectious disease test results, and reportable medical events surveillance through Disease Reporting System internet or successor system will provide the medical information for awareness of an increase and spread in diseases of pandemic potential and concern.

Responsibilities of CCMDs with physical areas of responsibility:

- Integrate medical intelligence, environmental surveillance, and health surveillance efforts in collaboration with DoD Components and other international and federal agencies via early warning systems to identify potential health threats.

- Work with the State Department, as necessary, to examine applicable international agreements to ensure that deployed forces and other personnel working for DoD receive appropriate care and required information and ensure health surveillance and immunization tracking are implemented in accordance with applicable international agreements.

In addition to the responsibilities listed above, USEUCOM identified the need for more robust bio-surveillance in 2015 during the Ebola crisis, and the Counter Bio-threats Cell (was established. The purpose of the Counter Bio-threats Cell is to conduct continuous assessments of bio-surveillance from host nation, international, DoD, and other USG sources to provide continuous situational awareness and early warning and indicators for infectious diseases. Additionally, the Counter Bio-threats Cell maintains relationships with DoD, interagency, NATO, and other host nation partners for sharing of medical information and intelligence. During USNORTHCOM's hosted Viral Supremacy Exercise in 2020, the Counter Bio-threats Cell was highlighted as a best-practice and benchmark for the CCMDs with physical areas of responsibility.

GEIS has sought to align its research efforts with the CCMDs with physical areas of responsibility, which includes identifying priority pathogens and clarifying the Commander's priority countries and strategic objectives. GEIS sends out regular reports including the SPOT report with updates on infectious disease outbreaks and is also providing sequencing support to identify SARS-CoV-2 variants on the continent. Focus areas for the CCMDs are as follows:

- USCENTCOM: GEIS provides funds to start or continue numerous surveillance projects, and CCMD input is sought as part of that process. Part of the input from each CCMD with a physical AOR includes identifying regional priorities for surveillance.

- USSOCOM: Provides input to the annual GEIS research prioritization activities, identifying studies where USSOCOM may have interest or equities. GEIS has improved reporting of research studies, including interim updates, which inform FHP decisions for

special operations forces deployed worldwide. As a globally deployed force, USSOCOM is in regular contact with the other CCMDs, Department of State, and partner nations to ensure the care of Service Members outside the reach of conventional DoD health service support;

- USEUCOM: Provides an assessment and prioritization of countries, regions, partnerships, and surveillance issues to inform new proposals for GEIS projects in USEUCOM's AOR. Updates to USEUCOM surveillance priorities improve prevention and surveillance for infectious diseases that may impact the USEUCOM mission and members of the Armed Forces.

c. Laboratory Readiness in Support of the Pandemic Response

The COVID-19 pandemic demonstrated the critical role that GEIS plays in coordinating the DoD laboratory response to large-scale public health threats to military forces. By providing centralized coordination and funding for DoD laboratories engaged in infectious disease surveillance, GEIS was able to mobilize a laboratory-based response to emerging threats that would otherwise take months of planning and preparation before meaningful results materialized. As an example, early in the pandemic the GEIS Program Office was able to coordinate the distribution of critical Research Use Only real-time polymerase chain reaction assays to 17 different globally positioned MILDEP laboratories and large deck U.S. Navy ships to ensure these facilities had the means to conduct SARS-CoV-2 surveillance that was both rapid and reliable (e.g., early detection of the COVID-19 outbreak on the USS Theodore Roosevelt). For many of these locations, these real-time polymerase chain reaction assays were the first tool available to conduct surveillance and detection of SARS-CoV-2.

GEIS was also able to leverage partnerships that existed within the DoD Global Respiratory Pathogen Surveillance Program to quickly pivot towards pandemic response in early 2020. This program, which is overseen by GEIS, was initiated in the 1970s for the purpose of conducting influenza surveillance and has evolved over the years to include a broad array of respiratory pathogens. As COVID-19 became a global threat in early 2020, GEIS was able to direct supplemental funds to key partners within this program to expand testing for SARS-CoV-2 and provide visibility on the impact of the virus within DoD populations. Efforts were even made to conduct retrospective testing of DoD specimens collected through this program to identify when and where SARS-CoV-2 first emerged in DoD populations. The retrospective testing detected the first DoD case of SARS-CoV-2 case in mid-January 2020.

The COVID-19 pandemic has also highlighted how critical is to track infectious disease outbreaks and the evolution of viral pathogens utilizing the latest whole genome sequencing technology. Since 2017, GEIS has led this endeavor within the DoD. The GEIS Next-Generation Sequencing and Bioinformatics Consortium was established to coordinate, standardize, and harmonize surveillance efforts among select CONUS and OCONUS DoD laboratory partners. The GEIS Next-Generation Sequencing and Bioinformatics Consortium has been at the forefront of analyzing SARS-CoV-2 samples for the presence of emerging variants. Since March 2020, the Consortium has supported the sequencing and phylogenetic analysis of over 7,000 SARS CoV-2 samples from 86 locations within DoD. When combined with

epidemiologic and clinical data, this information can assist with identifying emerging variants that can impact the efficacy of diagnostics, increase disease transmission and/or severity, effect the chances of re-infection, or reduce the effectiveness of therapies or vaccines. Expanded in response to the COVID-19 pandemic, the Next-Generation Sequencing and Bioinformatics Consortium now includes a total of 13 DoD partner laboratories, which has maximized whole genome sequencing capabilities and increased SARS-CoV-2 testing and characterization. This provides the ability to track variants of concern and variants of interest during the pandemic and answers key scientific questions for DoD leadership. In May 2021, GEIS was tasked by the Deputy Secretary of Defense to expand whole genome sequencing of positive SARS-CoV-2 cases across the DoD.

d. Interagency and International Communication

The CCMDs with physical areas of responsibility are the primary customers of GEIS-funded surveillance and information products. As a result, the GEIS Program Office makes a significant effort to coordinate its activities with each of the CCMDs with physical areas of responsibility. Each year the GEIS Program Office publishes alignment documents of the CCMDs with physical areas of responsibility that highlight the Theater Campaign Plan objectives for each of these CCMDs and provide country and pathogen priorities for each AOR. These documents inform GEIS laboratory partners as they develop proposals for GEIS-funded surveillance studies in advance of each fiscal year.

GEIS also indirectly supports GHE objectives of the CCMDs with physical areas of responsibility by fostering longstanding relationships with host nations and regional allies (including host nation militaries) through the numerous collaborations that exist between GEIS network laboratories and their regional partners. Through these efforts, the GEIS network contributes to the broader global health security objectives by establishing enduring, reliable partnerships with nations that have a shared stake in the security and prosperity of each region. These relationships not only support FHP, but also provide vital strategic advantages that allow access to populations or information on circulating pathogens of military relevance. Using this approach, GEIS has been able to create long-term surveillance programs that assist CCMDs with physical areas of responsibility and DoD decision makers, local host nation and regional collaborators, as well as support for DoD medical product development. The GEIS program has become a vital/critical funding and support mechanism for the DoD Service laboratories and has thus created a global network of expert military, civilian, and local contract personnel (e.g., scientists, technicians, epidemiologists) who have many years of specialized training and experience.

The GEIS program relies heavily on its network of DoD laboratory partners, but also depends on other external partners to fill specific gaps or niches within the network. Intra- and interagency collaborations augment surveillance knowledge in areas of strategic interest that may not be covered by GEIS projects and ensure that the CCMDs with physical areas of responsibility and Joint Forces have timely information concerning circulating infectious disease threats needed for FHP planning. The GEIS program strives to not only maintain existing partnerships, but also to work towards establishing new partnerships to enhance the network and ensure long-term program viability. Though budget constraints have reduced the extent to which GEIS can

collaborate with other federal agencies, the GEIS Program Office continues to maintain relationships with partners in Department of State, CDC, FDA, DTRA, and the National Aeronautics and Space Administration. The GEIS Program shares the annual surveillance portfolio and ongoing activities across CCMDs with physical areas of responsibility with interagency partners and with other DoD Components to prevent duplicative efforts, share information, and to leverage from the strength of each organization.

14. DoD Overseas Laboratories

The DoD overseas medical research laboratory network is a critical DoD FHP asset. Army and Navy overseas laboratories and field sites are positioned in critical locations throughout the world, where they collaborate with partner nations to identify and mitigate current and emerging infectious disease threats. Their ongoing GEIS-funded biosurveillance efforts, their countermeasure research and development efforts, and their readiness to support outbreak response efforts when needed, provide shared benefit to DoD and partner nations. The overseas labs also contribute to interoperability through their training activities and the conduct of joint research projects. This results in an increased skill proficiency of the host nation's health workforce, thus playing an essential role in establishing and maintaining DoD relationships with partner nations.

A concrete example of the mutual benefit of the overseas labs to both DoD and partner nations is the key contributions made during the current pandemic. They are the cornerstone of a robust network of approximately 400 respiratory disease surveillance sites in over 30 countries, with 3 labs conducting whole genome sequencing. These efforts provide timely and actionable information to DoD preventive medicine personnel, senior leaders, and CCMD and component surgeons to inform decision-making about how to best protect personnel and allow them to stay in the fight. At the same time, DoD is sharing important epidemiologic information and/or patient-specific diagnostic test results with its partner nations. Since these are cooperative activities being conducted within host nation facilities, the technical assistance and the training required to perform COVID-19 viral testing translates into increased partner nation capabilities.

<u>Navy</u>

The overseas laboratories of NAMRU-2 in the Pacific (located in Cambodia), NAMRU-3 headquartered in Sigonella, Italy, and NAMRU-6 in South America (headquartered in Lima, Peru) maintain active infectious disease research and surveillance activities in coordination and consultation with other Federal Departments and Agencies, regional partners, U.S.-based universities, and host nation government agencies throughout their respective AOR. Activities include, but are not limited to, zoonotic influenzas, respiratory and febrile diseases in humans, vector-borne disease distribution and transmission, as well as other endemic and emerging illnesses of concern to leaders of CCMDs with physical areas of responsibility and host nation public health entities. The U.S.-based NMR&D laboratories, NMRC, and NHRC provide support to U.S. military operational units and the MHS, providing additional disease surveillance capacity to the overseas laboratories and robust infectious disease research portfolios. This NMR&D network of laboratories, in collaboration with entities mentioned above, support global

health security by providing the ability to rapidly respond to emerging outbreaks that could become the next pandemic.

The NMR&D laboratory capabilities allow for the detection and molecular identification of a wide range of highly transmissible pathogens that have outbreak potential and could result in a pandemic. The work done at these laboratories is critical for surveillance and identification of infectious disease threats since other sources of reliable information where these laboratories are located is often limited or lacking or, in some cases, reliable information is not shared with the USG. NMR&D laboratories have state-of-the art detection equipment and highly trained personnel, serving as a platform for infectious disease surveillance and ensuring pre-pandemic preparedness and the ability to pivot to pandemic response when the need arises. NMR&D laboratories have Next Generation Sequencing and advanced bioinformatic analysis capabilities along with far-forward pathogen identification and characterization mobile laboratory capabilities that can be deployed in response to suspected outbreaks. These capabilities allow DoD to detect not only known pathogens, but also those pathogens that are unknown and potentially more threatening. Identification of novel pathogens allows public health professionals to apply the appropriate risk mitigation strategies and start the process of combating the new pathogen with treatment and prevention strategies before it reaches a pandemic level.

In addition to these fixed and deployable surveillance and detection activities, NMR&D laboratories have a robust infectious disease research portfolio aimed at development of vaccines, therapeutics, and detection and diagnostic assays. NMRC has additional capabilities to produce molecular and immunologic reagents in their accredited production facility that directly feeds into deployed assays across DoD and the Federal Government for biosurveillance and other activities. They also maintain the Navy Infectious Disease Diagnostic Laboratory, a College of American Pathologists-accredited and Clinical Laboratory Improvement Program-certified laboratory that conducts high complexity clinical diagnostic testing for military MTFs and in support of outbreak investigations. The availability of these cutting-edge technologies, infrastructure, and scientific expertise within the NMR&D infectious disease research and diagnostic portfolio facilitates rapid pivoting to respond to events that are poised to become the next pandemic. This was demonstrated by the NMR&D response to COVID-19. NMR&D provided critical support during outbreaks aboard Navy ships, diagnostic testing across the globe (NMRC, NHRC, NAMRU-2, NAMRU-3, and NAMRU-6), training and laboratory enhancements to partners around the globe, stood up efforts to develop vaccines and therapeutics, expanded efforts in critical viral variant sequencing and characterization. NMR&D quickly launched the largest longitudinal, prospective study of SARS-CoV-2 among active duty service members in the DoD, known as the COVID-19 Health Action Response for Marines. While these efforts are not inclusive, they demonstrate the capabilities and power of the NMR&D enterprise that contributes to the Department's pandemic preparedness.

USEUCOM

USEUCOM emphasizes the overall value of the overseas laboratories, and funding and investments of the laboratories should be maintained and expanded. The laboratories provide a

key point of contact for collaboration with international partners in host nations in the AOR on research and surveillance projects.

USSOCOM

USSOCOM does not have organic laboratory capabilities and relies heavily on overseas DoD medical laboratories to aid the detection, identification, and diagnosis of health conditions in deployed U.S. and partner nation forces. Additionally, these laboratories are leveraged during GHE activities to develop the working relationship and capabilities of host nation facilities so they may be in a position to support USSOCOM operations.

15. DHAPP

The Department of State Office of the Global AIDS Coordinator is responsible for coordination and oversight of the President's Emergency Plan for AIDS Relief (PEPFAR) program and all global HIV activities funded with U.S. dollars. The PEPFAR program receives about $6B U.S. dollars annually. DHAPP is the implementation arm of the DoD PEPFAR program along with USAID, CDC, the HHS, the Health Resources and Services Administration, and the Peace Corps.

DHAPP is a medical security cooperation program with the mission to build capable military partners through military-specific, culturally focused, HIV/AIDS prevention and assistance and to establish HIV-free, medically ready military members and beneficiaries. DHAPP is the implementing agency for global military to military (mil-mil) HIV prevention and treatment services and receives funds from the Department of State's Office of the U.S. Global AIDS Coordinator and Defense Health Program (DHP) through the Congressional Special Interest in the Defense health budget.

DHAPP receives about $138M U.S. dollars ($130M from the Office of the U.S. Global AIDS Coordinator and Health Diplomacy and $8M dollars from DHP) annually. These funds are used to implement programming in 51 countries around the globe, predominately on the African continent. For over 20 years, DHAPP has been working to strengthen military health systems by providing training and assistance across the full HIV cascade including prevention, care and treatment. A significant number of military partners have achieved or are approaching HIV epidemic control, a main goal of the program. Ancillary achievements include military clinical laboratory accreditation; improved clinical data management systems; improved military HIV policies to promote human rights and protect health information of military members; and, better trained and equipped military HCWs. Consequently, the health systems of the military partners were better prepared to support their national responses to the COVID-19 pandemic.

Costs related to the Navy DHAPP are found at Appendix F and Appendix G details FY 2021 DHAPP Achievements.

16. Activities to Limit Spread of Infectious Disease among Beneficiaries

a. Role of DoD in the National Disaster Medical System (NDMS)

The NDMS is a Federal interagency partnership among HHS, the Department of Veterans Affairs (VA), DHS, and DoD. Established in 1984, the wartime mission of NDMS is the movement and treatment of military casualties from wartime contingencies to DoD MTFs, VA Medical Centers, participating civilian NDMS hospitals, or the TRICARE-reimbursed network. Although there has not been a requirement to activate NDMS for a military contingency, DoD has supported many NDMS domestic missions under the auspices of DSCA.

The DoD may provide available resources and support with SecDef approval to NDMS in response to a declaration of national emergency, PHE, or major disaster, when directed by President or consistent with the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, other applicable laws and policies, and the NDMS Federal Partners Memorandum of Agreement.

DoD has two missions within NDMS—patient movement and the placement of patients in health care facilities for definitive medical care. During a military contingency, military casualties would arrive at a DoD or a VA Federal Coordinating Center (FCC) and transfer to either a DoD MTF, a VA Medical Center, a participating civilian NDMS hospital, or a facility in the TRICARE-reimbursed network. During a catastrophic domestic event, civilian inpatients are received by either a DoD or VA FCC and are then transferred to an NDMS participating civilian hospital for care. DoD is an active participant in NDMS interagency planning and preparedness activities and stands ready to support its interagency partners when civilian patient movement resources are insufficient to meet State or territory requirements. DoD most recently provided NDMS patient movement support to both the U.S. Virgin Islands and Puerto Rico in response to Hurricanes Irma and Maria in 2017.

The ability to surge military and civilian medical capabilities during either an overseas major military contingency or national-level catastrophic natural disaster is a significant challenge across the Federal Government. A successful approach in addressing this issue could also provide a secondary benefit to the nation in its response to pandemics or major outbreaks of infectious disease. DoD is currently conducting the following four analyses:

1) The NDMS Pilot Program;
2) DoD FCC DOTmLPF-P[7] Change Recommendation (DCR);
3) DoD Medical Surge Capability Based Assessment (in support of the NDMS Pilot);
4) DoD Multi-Modal Patient Movement (MM-PM) Analysis.

[7] The abbreviation DCR stands for DOTmLPF-P stands for Doctrine, Organization, Training, materiel, Leadership, Personnel, Facilities, and Policy Change Recommendation.

The first three analyses are designed to address shortfalls and capabilities related to medical surge requirements while the last analysis is intended to enhance DoD patient movement capabilities using modalities other than DoD fixed-wing aircraft.

The NDMS Pilot Program

Section 740 of the NDAA for FY 2020 requires the SecDef to carry out an NDMS Pilot Program to enhance the interoperability and medical surge capability and capacity of the NDMS. The National Center for Disaster Medicine and Public Health (NCDMPH), a component of USUHS, was chosen as the Office of Primary Responsibility.

The NDMS Pilot is expected to achieve a sustainable model for military and civilian medical readiness by strengthening interoperable partnerships and enhancing the capacity and agility of the NDMS. This will be accomplished by establishing partnerships with public, private, and nonprofit healthcare organizations. It will be conducted in collaboration with the Secretaries of Veterans Affairs, Homeland Security, Health and Human Services, and Transportation and will be conducted over 5 years at five locations nationally. A Federal interagency working group nominated the five sites that were subsequently approved by the ASD(HA), the individual designated as the Federal lead for the NDMS Pilot. Those sites are Sacramento, California; Denver, Colorado; Omaha, Nebraska; San Antonio, Texas; and the National Capital Region.

In the initial assessment, the NDMS Pilot systematically identified critical issues facing the NDMS. The NDMS Pilot is currently conducting the Project Implementation, working with partners at each of the five sites to develop, test, validate, and scale potential solutions aimed at improving the capacity and interoperability of the NDMS. Pilot exercises, including tabletop, functional, and full-scale, are also being conducted to identify needs and assess the effectiveness of adopted solutions. Alongside site projects, NCDMPH is conducting national studies to investigate key constraints and identify areas of opportunity for meeting the medical requirements of a large-scale combat operation. Finally, the NDMS Pilot will iteratively test and scale efforts nationwide.

Currently, the NDMS Pilot is in Year Three of the 5-year program. To date, the NDMS Pilot has completed five national studies and three additional studies are ongoing. Across the five sites, the NDMS Pilot is working with its civilian partners to execute 40 individual projects and multiple exercises.

In addition to the ongoing national studies, site projects, and exercises, the NDMS Pilot continues to support USNORTHCOM in the development of the Integrated CONUS Medical Operations Plan, including two full-time NDMS Pilot staff. The NDMS Pilot works actively with USNORTHCOM to align activity timelines and advance the shared medical readiness mission.

DoD FCC DCR

FCCs are the reception point for patients moved via DoD aeromedical evacuation assets (both for military operations and natural disasters). FCCs receive casualties and are responsible for moving patients to the appropriate military or civilian medical treatment facility for definitive care. Except for the initial stages of recent conflicts in Afghanistan and Iraq and Hurricane Katrina, the number of patients processed by DoD FCCs during contingencies over the past 2 decades has not over-stressed their patient load capacity. These relatively low patient numbers have produced limited data points for assessing the impact of large number of casualties entering the U.S.-based health system. Unclassified planning projections for future conflicts posit armed conflict with peer and near-peer adversaries could result in up to 1000 casualties in a day for several weeks, far outpacing existing Federal and civilian inpatient capacity. The NDMS Pilot Project (discussed above) is a program to enhance interoperability and address medical surge capability and capacity shortfalls within NDMS. Because FCCs are the only patient reception point for patients moved on Federal aeromedical aircraft (DoD and FEMA contracted air ambulances), and because DoD FCCs have not experienced patient definitive care requirements at the levels of magnitude described earlier, the ASD(HA) initiated the DoD FCC DCR to identify requirements needed to sustain large scale operations and identify potential shortfalls in meeting mission requirements. The FCC DCR was approved by the Joint Staff on October 31, 2023. The first action required in the DCR is to conduct an FCC Retention Study to determine whether DoD should maintain the FCC mission, and if so, how this mission should be organized. The FCC Retention Study is anticipated to take 12 months to complete.

DoD Medical Surge Capability Based Assessment (in support of the NDMS Pilot)

In addition to the report to Congress being prepared on the first phase of the NDMS Pilot Program (described above), House Report 116–453, accompanying H.R. 7617, the DoD Appropriations, 2021, also requested a two-part report. The first part is a description of the pilot program, including partnerships established and evaluation metrics. This part of the report will be prepared by USUHS and will be submitted together upon completion of the second part.

The second part of the report will be prepared by the ASD(HA). This part involves:

“a threat assessment of the most likely homeland defense scenarios requiring medical surge capability and capacity; an evaluation of departmental resources that are most likely to be required in response, and projected shortages of equipment, supplies, or personnel; how the NDMS could be better leveraged in future emergencies; current and projected medical surge plans; and a detailed cost estimate for the Department to plan, prepare for or respond to the most likely emergencies requiring medical surge capability and capacity.” This analysis began in November 2022 and is estimated to be completed by the summer of 2024.

MM-PM Analysis for Contingencies and DSCA Operations

On May 28, 2019, the Joint Staff released Joint Requirements Oversight Council Memorandum (JROCM) 049-19, which endorsed the development of a DCR for MM-PM (i.e., transport modalities other than DoD airframes) Patient Movement and assigned U.S. Transportation

Command to serve as the lead organization for implementation. The DCR will address identified gaps in the ability of the Joint Force to plan, coordinate, synchronize, and execute MM-PM.

Task 4 of JROCM 049-19 assigned OASD(HA) and the Office of the Assistant Secretary of Defense for Homeland Defense and Hemispheric Affairs, as co-Offices of Primary Responsibility, with responsibility for "conduct[ing] an analysis to identify requirements, assess[ing] current and programmed capabilities, and recommend[ing] DOTmLPF-P solutions to improve the ability of DoD to provide MM-PM in support of Defense Support of Civil Authorities (DSCA)," given that DoD may be asked to move large numbers of civilian casualties in the event of a catastrophic natural disaster (e.g., New Madrid Seismic Zone or Cascadia Subduction Zone earthquakes) or an attack on the homeland by a peer or a near-peer adversary. These events will exceed the Department's capability to provide aeromedical evacuation. While the JROCM's original focus was in support of DSCA, it was determined to expand the scope of the DCR to MM-PM in Support of Catastrophic Events in the Homeland. The analysis began in January 2023 and is expected to conclude in the summer of 2024.

b. Pandemic Operations

i. Public Health, Medical Surge, Administrative, and Veterinary

The Air Force delineated its operational approach to pandemic preparedness and the Navy conducted a similar review based upon their response to the COVID-19 pandemic. A detailed discussion of these efforts follows.

Air Force

The Air Force identified 14 activities to be undertaken to enhance pandemic infectious disease preparedness. These activities are identified below and are based upon the specific response stage:

- Stage 0 – Current Operational Status: Current baseline MTF capacity/operational capability delineated.
- Stage 1 – Patient Care Expansion (existing equipment/manpower only): Emergency care expansion capabilities utilizing assigned staff, infrastructure, and equipment; assessed/delineated as needed.
- Stage 2 – Patient Care Expansion (staff/equipment augmentation needed): Plan addresses pre-identified capability to expand care utilizing locally available manpower/equipment.
- Stage 3 – In-Patient Capacity Expansion: Inpatient capacity expanded with MTF facility modifications.
- Stage 4 – Alternate Care Site (ACS): Capability to utilize installation facilities outside MTF to expand care capability.

- Small MTFs/Clinics with No Inpatient Capacity (N/A may apply): Plan addresses efforts necessary to secure care where current care provision needs exceed capability. Staff qualification/experience, equipment limitations, and/or facility limitations require coordination of emergency care with local & regional hospitals.

Identification of Pandemic Response Planning Factors

- Delineate clinical operations requirements:

  - Define highly infectious disease training requirements (DHA Market coordination, specific bargaining unit employee requirements, and provider extenders);
  - Establish MTF status/trend reporting protocols; and
  - Identify Air Force Medical Service/DHA staffing report requirements.

- Delineate resource optimization needs (MTF, local hospitals, patient movement, etc.):

  - Maximize telehealth operations;
  - Identify behavioral health needs (patient and staff);
  - Establish ancillary services revision plan;
  - Delineate resource consolidation protocols;
  - Identify staffing plans (ex: transition clinical-capable personnel admin roles to direct clinical, outpatient to in-patient) protocols;
  - Shift outpatient providers to augment inpatient care to maximize capacity (if applicable);
  - Identify MTF visitor policy revisions (includes protocols for care givers accompanying patients);
  - Identify civilian/contractors' re-alignment needs.

- Identify MTFs' roles in local emergency management and NDMS operations.

Provision of Service Requirements: Determine the medical capacity to diagnose, treat and prevent the transmission of a communicable disease.

- Identify core response capacities:

  - Identify strategies for maintaining core missions;
  - Prioritize critical and non-essential services;
  - Identify process for coordinating service curtailment with DHA;
  - Identify minimum staffing needs;
  - Assess strategies for maximizing number of staff available for direct patient care;
  - Identify installation population at risk (PAR) and level of care requirement (for example, geriatric, bariatric, adolescents(s);
  - Estimate PAR category level of care requirement (ex: geriatric, bariatric, adolescents);
  - Establish mass testing tracking system;
  - Prioritize critical and non-essential services;
  - Identify ancillary services result notification processes.

- Identify mitigation procedures to meet mission needs for at least 96 hours:

    - Identify criteria for determining when to cancel existing appointments and/or convert to virtual/telehealth;
    - Identify criteria for determining when to refer patients to other MTFs or community facilities;
    - Establish protocols for implementing rapid patient discharges;
    - Establish procedures for prompt screening and segregating of suspect patients at all entrances, emergency departments, outpatient areas, and inpatient areas identified;
    - Establish procedures to continue care for labor and delivery, emergency services, and other non-disease related care procedures;
    - Identify high risk population notification process; and
    - Create methodology to manage an increase in demand for vulnerable population clinical services (pediatrics, geriatrics, disabled, or serious chronic conditions or addictions).

Develop a Surge Capacity Strategy

- Define number of isolation patients that will trigger conversion of normal rooms to isolation rooms;
- Define number and location of potential beds to be re-assigned as isolation rooms;
- Identify negative air flow rooms/ventilation capabilities;
- Identify facility space adaptable for use as expanded inpatient beds;
- Establish procedures for re-allocating non-isolated patients to other rooms; and
- Identify MTF clinical and non-clinical personnel needs.

Develop an ACS Strategy

- Assess or define ACS facility/space requirements;
- Assess or define ACS staffing requirements;
- Assess or define ACS standards of care;
- Assess or define ACS mechanisms for creating patient records, logs;
- Eliminate non-essential functions;
- Identify ACS fiscal requirements identified;
- Assess or define ACS sustenance needs (food, water, etc.);
- Assess or define ACS waste planning (solid waste, sewage, etc.);
- Assess or define ACS equipment needs;
- Assess or define ACS patient transport needs (medications, supplies, equipment);
- Assess or define ACS patient information (essential clinical and medication-related) transfer needs; and
- Assess or define procedures for communicating ACS relocations with patients and their families.

Identify Resource and Asset Requirements

- Address resource conservation measures; prioritize limited patient care equipment, pharmaceuticals, and other resources identified.

- Identify resource need requirements; estimate essential staff care materials and equipment and PPE to sustain operations for eight-weeks identified.

- Identify and address guidelines for obtaining and replenishing supplies and equipment:

  - OPRs for obtaining needed resource requirements and coordinating additional equipment needs via MEDLOG Identified;
  - Medications and related supplies;
  - Access to and distribution of War Reserve Materiel assets;
  - Access to and distribution of MTF, local, State, or Federally sourced caches and stockpiles;
  - Medical supplies, including PPE; and
  - Non-medical supplies.

- Match resource supplementation protocols with market/region capabilities, including:

  - Supply shortage work-arounds (e.g., PPE), including strategies for using normal and alternative procurement channels identified;
  - Resource and asset sharing with other health care organization protocols identified;
  - Method for tracking and reporting available quantities of consumable medical supplies including PPE;
  - Procedures for providing the supplies and materials necessary to adhere to recommended infection prevention and control practices; and
  - Protocols for engaging health department and health care coalitions when MTF experiences (or anticipate experiencing) supply shortages.

Establish MCM Dispensing Protocols

- Estimate required MCM quantities;
- Establish protocols for rapidly administering MCMs to personnel;
- Establish specific counseling, screening, tracking and reporting requirements related to the vaccines;
- Prioritize vaccine administration during times of shortages or gradual distributions of supplies;
- Establish methodology to document vaccine administration to staff outside the facility; and
- Plan for providing MCMs to staff.

Determine Public Health Requirements

- Monitor public health advisories (Federal, State, and local) and update communicable disease response coordinator and members of the planning committee when a communicable disease is in the geographic area assigned;
- Monitor developments that might result in staff not being able to report to work, such as identifying school closures move to staff management;
- Establish protocols for monitoring and tracking communicable disease related staff absences staff management;
- Identify need for augmentation for contact tracing and where those augmentees will come from;
- Establish protocols for training contact tracing augmentees to ensure capability during an outbreak or surge in cases to identify close contacts;
- Establish protocols for monitoring the evaluation and diagnosis of hospitalized patients, volunteers, and staff with symptoms of a communicable disease;
- Establish protocol for education/training for personnel service functions regarding pandemic mitigation efforts (e.g., commissary, Base Exchange);
- Shift occupational health shop visit to include pandemic mitigation assessment (for example, Air Force Materiel Command depots);
- Establish protocols for 24-7 communication or requests for information collection (for example, Facebook, 24-hour phone line, 24-hour operations);
- Identify public health-specific resource/manpower requirements and constraints for prolonged (on-going) response operations; and
- Establish protocols to seek risk-based pause of "normal" public health operations based on local pandemic response requirements.

Establish Protocols for ROM

- Social Distancing;
- Quarantine; and
- Isolation.

Ensure Disease Testing and Surveillance Procedures/Capacities

- Ensure appropriate symptom-based surveillance is conducted to assess threats to public health through the use of ESSENCE;
- Ensure appropriate symptom-based screening is conducted to assess threats; and
- Ensure appropriate symptom-based diagnostic testing is conducted to assess threats.

Identify Key/Appropriate Personnel Needed to Support PHE/Pandemic Response

- Plan for workforce shortages;
- Assign responsibility for conducting a daily assessment of staffing status/needs;
- Identify strategies for collaborating staffing shortages with local and regional partners;
- Establish system to monitor/review HCW associated disease transmission;

- Identify MTF Incident Command System, command and control, and reporting protocols;
- Identify MTF staff support (housing, transportation, and incident stress debriefing) needs;
- Identify MTF staff family support needs (dependent care, pet care, communication);
- Identify MTF staff telework support needs;
- Establish strategy for mitigating loss of contracted/part-time MTF employees employed by local civilian health care and required to increase support to their other employers during an outbreak or pandemic;
- Establish strategies to protect high risk staff who may require extensive telework, private office, etc.;
- Establish method to inform and train reallocated staff in accordance with their anticipated roles and responsibilities;
- Establish mechanisms to avoid staff burnout (HCW and non-HCW);
- Establish mechanisms to provide psychological support for HCWs considerations; and
- Identify alternating teams (A & B) for each critical functional area.

Conduct Emergency Management Planning at the Installation Level

- Mass casualty operations; and
- PHE response.

Determine Operational Requirements for Patient Decontamination

- Reception and care plans;
- Training requirements;
- Resource needs and contingency plans; and
- Manning requirements.

Identify Patient Transportation Requirements

Develop HPCON Framework Responses Requirements by Phase

- Risk communication needs and protocols; and
- Recommended response actions.

Navy

U.S. Navy personnel and families live and work on bases in across the world and call them "home." As host nations implemented national and local decrees restricting movements and closing non-essential establishments, U.S. forces enacted parallel measures. These changes were implemented in collaboration with the host nation government to mitigate the spread of COVID-19 and protect U.S. forces and families and host nation personnel.

U.S. Naval Forces and the Fleet continue their missions of conducting maritime operations, even as they seek ways to help fight the coronavirus and recover from the impact it has had. Forces stand ready throughout their theaters, and command leadership remains committed to taking

every measure possible to protect the health of forces, as well as local residents. Warships, submarines, and aircraft continue their patrols to deter and defend against threats to the United States, NATO, and partner nations.

In addition, the surface Navy and operational commanders sent COVID-19 mitigation guidance to the fleet and built contingencies in the event another deployed ship experienced an outbreak. Lessons learned from the March 2020 outbreak on the USS Theodore Roosevelt aided the Navy Medicine response to the USS Kidd outbreak, limiting the scope of the outbreak on the ship. In the weeks preceding this first positive case onboard, the crew of the USS Kidd was already applying the Navy's COVID-19 lessons learned. Sailors began to make and wear cloth face masks. They conducted a quarantine and isolation drill to determine how to segregate sick and healthy crew members on a ship with limited space. One sailor was medically evacuated to the United States after experiencing shortness of breath. The U.S. Pacific Fleet redirected the amphibious assault ship USS Makin Island, with its robust medical facility that includes an intensive care unit, ventilators, and additional testing capability, to rendezvous with the Kidd. On April 23, 2020, eight medical personnel from Naval Hospital Jacksonville boarded the Kidd with an Abbott machine to test the crew for COVID-19. The response team implemented a number of steps to mitigate the spread, such as administering N-95 masks to the entire crew, increasing the cleaning frequency for common areas and making sure Sailors washed their hands or used sanitizer before going into common areas such as the galley.

The mission of Navy Medicine is to maintain readiness, quality, and health for supported forces and family. The COVID-19 pandemic has continuously challenged this mission as the virus spread across the country and throughout the world. Navy Medicine's response is a story of resilience, adaptability, intuition, and innovation. Despite the turmoil of the year, one factor has remained constant: teams onboard Navy Medicine at all echelons worked diligently to protect community members, support the tenant installations and host nations in mitigating COVID-19 spread, and to ensure the readiness of warfighters.

Navy Medicine's recent and ongoing experience with COVID-19 has demonstrated challenges and vulnerabilities that impact warfighter continuity of operations during pandemics. To maintain its strategic advantage, Navy Medicine is leveraging lessons learned during COVID-19. In terms of public health capacity, Navy Medicine increased its bio-surveillance capacity by leveraging advanced diagnostic technologies developed by the Chemical and Biological Defense Program. The Chemical and Biological Defense Program's research, development, test, and evaluation programs provide dual use capabilities to the Services that can be used during pandemics and infectious disease outbreaks as was demonstrated during COVID-19. The technologies developed by the Chemical and Biological Defense Program are deployed increasingly farther forward due to rapid changes in the ease of use in these technologies. As diagnostic capabilities become smaller and easier to use, the Navy can enhance public health capacity while making little to no change in medical personnel numbers within the Fleet.

The Navy Medicine Clinical Communities have utilized their own internal communication networks to distribute best practices and socialize resources amongst all their members. This includes documents posted on the BUMED M5 High Reliability Organization SharePoint site, within a COVID-19 resource library. Additionally, all the Clinical Communities have dedicated

time in each of their Sub-Community and Advisory Board meetings to discuss lessons learned and updates from commands relating to COVID-19. The Clinical Communities utilized their communication channels to distribute locally-developed process documents—e.g., for sterilization techniques for PPE and the standardization of approaches.

Many of the Clinical Communities began developing and disseminating newsletters to their membership bodies—notably, the Female Force Readiness Clinical Community releases the "Preserving Women's Health during COVID-19" newsletter. Each of the Clinical Communities utilize its dedicated knowledge management platform (on SharePoint or milSuite) to ensure appropriate documents are being stored and are accessible by all members.

The Psychological Health Clinical Community assists COVID-19 front line providers to support short- and long-term psychological sequelae of this, and future pandemics. Furthermore, Navy Medicine's Caregiver Occupational Stress Control program (governed by BUMED Instruction 6300.24) was primed to address any potential provider burnout, compassion fatigue, and vicarious trauma injury.

Members of the Trauma Clinical Community are actively involved in the Defense Committee on Trauma Committee on En-Route Combat Casualty Care and have shared COVID-19 protocols and PPE guidance with the MILDEP and Coast Guard medical communities. Several members have provided input on national triage protocols, joint trauma system Clinical Practice Guidelines, and local triage and mass critical care protocols. The Trauma Clinical Community has representation on national boards for both Society of Critical Care Medicine and American College of Chest Physicians, whose focuses include austere critical care, disaster medicine, and mass critical care events.

Additionally, the Clinical Communities began developing standard operating procedures and other lessons learned documents to better prepare personnel for similar crises. The Clinical Communities were involved in the development of future policy and Clinical Practice Guidelines as they relate to crisis response. For those personnel with a cough, a telehealth triage program was developed that included both active-duty Sailors, as well as contractors. The Undersea Community provided feedback on the utility of hyperbaric oxygen treatment for COVID-19 and provided recommendations for cleaning and disinfecting products suitable for the submarine environment.

Members from each of the Clinical Communities deployed in support of the USNS COMFORT, USNS MERCY, and Expeditionary Medical Facility missions, and are working on capturing lessons learned.

ii. Medical Force Structure Considerations

The following is a discussion on projected Navy medical force requirements and an assessment by the APHC on past COVID-19 requirements and how this may be used for future pandemic and infectious disease response planning.

Navy

Support of operations during the current COVID-19 pandemic has involved all types of Navy Medicine designators including Medical Corps, Dental Corps, Nurse Corps, Medical Service Corps, Hospital Corpsman of multiple subspecialties, as well as administrative staff. In total, from the beginning of the pandemic to April 16, 2021, Navy Medicine has supported across all COVID-19 operations with 6,018 active and reserve sailors. Missions include hospital ship deployments, support to the CCMDs and Navy component commands, and those in support of USNORTHCOM/DSCA efforts as requested by FEMA and approved by SecDef. As of August 2021, DSCA support involved 3,825 Active Component and 413 Reserve Component personnel totaling 4,238 sailors deployed, while global Fleet support involved 737 Active Component and 1,043 Reserve Component, totaling 1,780 sailors. The key to future pandemic response success will require leveraging a combination of COVID-19 military manpower deployment data to identify requirements for each Navy Medicine designator, subspecialties utilized, COVID-19 lessons learned from across MHS, and the evaluation of the effects on military platform/individual readiness and remaining organic mission capabilities.

As DSCA missions leveraged DoD heavily for both COVID-19 acute care response in 2020, and vaccination administration in 2021, Navy anticipates that future USNORTHCOM pandemic plans will be influenced by further DSCA expectations. Reshaping force structure to be as flexible as possible will be integral to Navy Medicine's success. During the current COVID-19 pandemic, Navy Medicine implemented emergency powers under the guidance of the Office of Personnel Management, Office of Management and Budget, and DoD to execute two mechanisms in reshaping force structure. The first allowed for civilian workers to be temporarily reassigned to mission critical tasks within their skillsets. The second mechanism accelerated the activation of reserve component members to backfill positions.

Tables 2 and 3 provide anticipated force generation requirement projections to ensure operational continuity during future pandemics. To align with the Joint Staff assessment in reference to Public Health shortfalls, Table 4 shows the additional requirements for Navy Medicine Acute Care Rapid Rural Response Teams.

Table 2: Navy Force Generation Requirements – Naval Medicine Manpower Requirements Program of Record FY 2026

NMMRR POR FY26		Medical Force Rqmt																	
		AC TOTAL									RC TOTAL								
		OFF REQ	ENL REQ	TOTAL REQ	OFF AUTH	OFF % AUTH	ENL AUTH	ENL % AUTH	TOTAL AUTH	TOTAL % AUTH	OFF REQ	ENL REQ	TOTAL REQ	OFF AUTH	OFF % AUTH	ENL AUTH	ENL % AUTH	TOTAL AUTH	TOTAL % AUTH
Operational	Sea Duty (Outside, Non-BUMED, BUMED)/OCONUS	2,073	5,613	7,686	1,782	86%	4,925	88%	6,707	87%	106	407	513	92	87%	361	89%	453	88%
	Sea Duty/OCONUS BSO-27	1,282	5,982	7,264	1,151	90%	5,585	93%	6,736	93%	343	1,227	1,570	333	97%	1,022	83%	1,355	86%
	NMAP/RC Homeland	2,347	3,073	5,420	2,027	86%	3,073	100%	5,100	94%	1,268	1,623	2,891	1,268	100%	1,623	100%	2,891	100%
	NMAP BSO-27	29	575	604	29	100%	575	100%	604	100%	0	0	0	0	-	0	-	0	-
Foundational	BUMED Non-Operational/Military Essential	1,572	2,917	4,489	1,195	76%	2,917	100%	4,112	92%	281	803	1,084	281	100%	803	100%	1,084	100%
	Non-BUMED Non-Op/Military Essential (CONUS shore & not BSO-18 nor BSO-27)	957	1,393	2,350	686	72%	1,002	72%	1,688	72%	107	583	690	85	79%	565	97%	650	94%
	Non-BUMED Non-Op/Military Essential (BSO-27 CONUS Shore)	130	573	703	108	83%	512	89%	620	88%	20	192	212	19	95%	173	90%	192	91%
	Shore Medical Support (NMRTC & NMRTU/OHSU)	343	621	964	250	73%	2,345	378%	2,595	269%	713	301	1,014	367	51%	102	34%	469	46%
	Training Faculty (Medical Graduate Education/Clinical)	341	0	341	152	45%	0	N/A	152	45%	0	0	0	0	N/A	0	N/A	0	N/A
Operational+Foundational Total		**9,074**	**20,747**	**29,821**	**7,380**	**81%**	**20,934**	**101%**	**28,314**	**95%**	**2,838**	**5,136**	**7,974**	**2,445**	**86%**	**4,649**	**91%**	**7,094**	**89%**
Force Generation	Training: Workload Producing (Residents/Interns and clinical students)	1,452	0	1,452	1,033	71%	0	N/A	1,033	71%	0	0	0	0	N/A	0	N/A	0	N/A
	Training: Non-Workload Producing (FTOS, A/C School, DUINS)	852	2,386	3,238	540	63%	2,398	101%	2,938	91%	1	179	180	0	0%	171	96%	171	95%
	Transients, Prisoners Patients and Holdees (TPPH)	233	871	1,104	123	53%	876	101%	999	90%	1	23	24	0	0%	23	100%	23	96%
Force Generation Requirement		**2,537**	**3,257**	**5,794**	**1,696**	**67%**	**3,274**	**101%**	**4,970**	**86%**	**2**	**202**	**204**	**0**	**0%**	**194**	**96%**	**194**	**95%**
Total Requirement		**11,611**	**24,004**	**35,615**	**9,076**	**78%**	**24,208**	**101%**	**33,284**	**93%**	**2,840**	**5,338**	**8,178**	**2,445**	**86%**	**4,843**	**91%**	**7,288**	**89%**
Force Generation Adj based on Auth		2,066	3,287	5,353	1,696	82%	3,274	100%	4,970	93%	2	202	204	0	0%	194	96%	194	95%
Total Requirement Adj based on Auth		11,140	24,034	35,174	9,076	81%	24,208	101%	33,284	95%	2,840	5,338	8,178	2,445	86%	4,843	91%	7,288	89%

*Requirement does not include ACT, RRRT or Vaccination teams.

Table 3: Navy Program of Record with Future Capabilities – Navy Medicine Augmentation Program

	CNOG	202	434	636	2			46	212	258	2		
	CNOG	185	221	406	5								
	CNOG	35	49	84	10								
	CNOG	1	0	1	10								
	CNOG	0	3	3	5								
	CNOG	29	575	604	1								
	CNOG	0	6	6	1								
	UONS/RET	6	1	7	1								
	UONS/RET	36	26	62	1								
	UONS/RET	10	6	16	1								
	UONS							1	2	3	8		
	UONS/RET	57	61	118	2								
	UONS/RET	46	48	94	7								
	UONS/RET	1	1	2	50								
	UONS/RET	5	2	7	24								
	TRANSCOM							613	520	1133	1		
	TRANSCOM							185	221	406	3		
	COA POR	**2376**	**3648**		**Total**	**6024**		**1268**	**1623**		**Total**	**2891**	

Table 4: Navy Manpower Requirements for Acute Care and Rapid Rural Response Teams by Officer and Enlisted

COVID-19 Support	Officer	Enlisted	Total
Acute Care Team X2	72	16	88
Rapid Rural Response Team X 4	24	4	28
Total	96	20	116

The following are specific examples on the Navy's response to COVID-19:

- Prior to the pandemic, MTFs performed proactive risk assessments on crisis bed capacity and their ability to expand their capacity to provide direct medical care. For example, in February 2019, an evaluation on disaster/emergency management capability reported that U.S. Naval Hospital Naples, Italy had the capability to expand bed numbers in times of crisis. This facility is a regional asset for the European theater, making it necessary to determine how to execute a bed expansion, or provide a more precise report as to the potential bed capacity in times crisis. The MTF team determined that U.S. Naval Hospital Naples could expand bed capacity in times of crisis and identified areas that would need to be closely monitored (e.g., pharmacy and consumable supplies) and other limiting factors that would impact expansion.

- At the onset of the pandemic, Preventive Medicine was asked to assist with support for base personnel returning from deployments and overseas. Preventive Medicine worked with PHEOs and the bases for guidance on how morale, welfare, and recreation; Navy Exchange; and childcare, could support active duty personnel and their families as much as possible while mitigating risks. Preventive Medicine provided consultation on menus and seating at food facilities, and on classroom sizes, cleaning products, and reopening plans at child youth programs.

- The Industrial Hygiene Department's mission is to evaluate exposures and recommend controls for chemical, physical, and biological agents for supported commands in accordance with Occupational Safety and Health Administration and Navy Occupational Safety and Health standards. The Industrial Hygiene Department's focus during the pandemic was on completing its core mission and providing consultation for COVID-19 exposure mitigation measures (e.g., assessments of ventilation and PPE). Initially, the most significant issue was obtaining access to the different areas on bases while commands were restricting entrance due to COVID-19 concerns.

Army

DoDI 6200.03 outlines the Department's policy in responding to public health emergencies. The issuance defines a PHE as "the occurrence or imminent threat of an illness or health condition that poses a high probability of a significant number of deaths, serious or long-term disabilities,

widespread exposure to an infectious or toxic agents, overwhelmed health care resources, or severe degradation of mission capabilities." The DoDI empowers various Army assets, such as MTF commanders or directors, PHEOs and alternate PHEOs, and MEMs and alternate MEMs to provide additional support required for effective installation preparedness, response, and recovery.

The public health capacity required to adequately support any future emergency responses to crisis or pandemics will be determined by a number of factors. The APHC response to the COVID-19 pandemic will help leadership make informed decisions for future contingencies. The systems and analytics developed by the APHC COVID-19 Task Force enabled the tracking of expenses, labor hours, requests for information and assistance tasks, social media and digital media content. The sections that follow summarize data representing APHC COVID-19 Task Force efforts for the period from January 2020 to March 2021.

- Operations:
  - Expenses. From January 2020 to March 2021, over $42 million was spent supporting APHC COVID-19 activities. Most of the funding was provided by the CARES Act enacted in FY 2020. The primary areas of expenditure were APHC labor, support to occupational health clinics, and public health laboratory activities.
  - Labor. From January 2020 to March 2021, over 100,000 man hours of APHC civilian and military personnel were utilized to support APHC COVID-19 activities. During each month, approximately 6,000 hours across APHC were dedicated to COVID-19 support. The Task Force itself accounted for approximately 3,000 hours monthly, on average. During this time frame, a total of 33 APHC staff members were assigned full-time to the Task Force for 23 weeks each, on average. Hours fluctuated greatly from April to September 2020 and then leveled off to 40 to 45 hours per week through March 2021.
- Products:
  - Requests for Information (RFI). The COVID-19 Task Force received a total of 1,088 RFIs between March 2020 and March 2021. RFI volume was highest upon initial formation of the Task Force (at the beginning of the pandemic), with 262 requests received in April 2020. After that, request volume gradually decreased and remained constant from September 2020 to March 2021 with an average of 53 requests per month. RFIs were received from a variety of organizations throughout the DoD, including DHA, the Office of the Army Surgeon General, and the Army Training and Doctrine Command, as well as internal requests from the APHC workforce. At the onset of the pandemic, most RFIs were related to occupational concerns (e.g., PPE, workplace sanitation, quarantine guidance) but, over time, the majority of RFIs were related to operational concerns.
  - Tasks. Time-intensive RFIs requiring original content development subsequently transitioned to Tasks. From March 2020 to March 2021, there were 437 Tasks, which

were related to Risk Assessment and Mission Planning (32 percent), followed by Surveillance and Screening (15 percent) and Public Health (14 percent).

- Social media. From February 2020 to March 2021, the APHC social media team, in coordination with the APHC COVID-19 Task Force, published over 1,400 content items that resulted in over 1 million impressions, over 160,000 engagements, and reached over 647,000 persons. Starting in October 2020, with expanded reach through use of Sprinklr, 83 APHC COVID-19 products were uploaded and used by other Army social media managers 567 times, the content reached 5,025,553 users, and was engaged 6,534 times.

- Digital content. On APHC websites, from March 2020 to March 2021, over 300,000 page views were recorded. Leading topics of interest were public health, PPE, and cleaning and sanitation. Products with the greatest number of downloads were related to cleaning requirements for prevention of COVID-19 transmission, materials providing general COVID-19 information, and risk assessment and mission planning.

c. Operational Support and Infrastructure Sustainment

During the pandemic, DoD MTFs experienced staffing shortfalls due to deployments to support health care delivery in private sector facilities. At the same time, MTFs identified a potential requirement for additional inpatient beds including intensive care and critical care capabilities. To address and mitigate any shortfalls, DHA implemented guidance to delay non-clinically urgent care and procedures, identified non-urgent product lines, and realigned staff to support deployments, expand inpatient beds, and maintain the required clinical capabilities and requisite infrastructure. DHA published comprehensive inpatient and outpatient guidance for providing medically necessary and readiness-related care while safely mitigating the negative impacts of COVID-19. This guidance focused on maintaining operational capabilities through prioritization of care to high-risk patients with deliberate postponement of routine and/or preventative care. Specific checklists were included for each HPCON level providing a framework for MTF leadership to implement DHA guidance. DHA also rapidly expanded virtual health capabilities across the direct care system, including virtual video visits and real-time provider-to-provider advice on infectious disease, pulmonary critical care, and other COVID-related morbidities. Specialty providers at large medical centers supported primary care providers at more remote MTFs worldwide with consultation support. DHA is codifying all lessons learned during the pandemic in permanent DHA guidance to maintain MTF capabilities in future pandemics and other contingencies.

Navy Medicine captured lessons learned throughout COVID-19 to aid in determining support and infrastructure sustainment gaps across personnel, equipment, supplies, and training pillars. In coordination with the Defense Security Cooperation Agency's Humanitarian Assistance Program and the U.S. Mission to Italy, the U.S. Navy provided donations of medical equipment and supplies to local Italian communities. A new ultrasound machine was donated to the city of Gaeta adding a new lifesaving capability to combat the coronavirus and improving health care delivery by enabling other medical procedures. The ultrasound machine was one of the contracts awarded by the Naples Contracting Shore Team in support of Naval Forces Europe-Africa

donation efforts in Italy. The contracts were worth approximately $1.3 million in equipment and supplies.

Both USEUCOM and USAFRICOM developed and executed plans to ensure all personnel engaged in operational activities were provided adequate medical support in response to COVID-19, including medical protective personal equipment, testing capabilities, and vaccine distribution/administration. Both coordinated with Department of State as required on these efforts.

17. References

A. Government Accountability Office Report to Congressional Addressees, GAO-21-321, "COVID-19 DoD Has Focused on Strategy and Oversight to Protect Military Servicemember Health," June 2021

B. Department of Defense Directive 5111.13, "Assistant Secretary of Defense for Homeland Defense and Hemispheric Affairs," October 31, 2024

C. Department of Defense Directive 3025.18, "Defense Support of Civil Authorities (DSCA)," December 29, 2010, as amended

D. Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," March 28, 2019

E. Department of Defense Instruction 6010.22, "National Disaster Medical System (NDMS)," April 14, 2016

F. Department of Defense Functional Campaign Plan for Pandemics and Infectious Diseases – 21, October 4, 2021

G. U.S. Northern Command Branch Plan for "Pandemic and Infectious Diseases Response," February 28, 2022

H. Defense Logistics Agency, "Warstopper Program," Information Paper prepared for the House Armed Services Committee, August 2021

18. Acronyms

ACS	Alternate Care Site
AFHSD	Armed Forces Health Surveillance Division
AFI	Air Force Instruction
AFRIMS	Armed Forces Research Institute of Medical Sciences
AMEDD	U.S. Army Medical Department
AMEM	Alternate Medical Emergency Manager
AOR	area of responsibility
APHC	U.S. Army Public Health Command
APHEO	alternate public health emergency officer
APORA	African Partnership Outbreak Response Alliance
ASBP	Armed Services Blood Program
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(HD&HA)	Assistant Secretary of Defense for Homeland Defense and Hemispheric Affairs
ASEAN	Association of Southeast Asian Nations
BARDA	Biomedical Advanced Research and Development Authority
BPC	building partnership capacity

BUMED	U.S. Navy Bureau of Medicine and Surgery
CCMD	Combatant Command
CCP	convalescent plasma
CDC	Centers for Disease Control and Prevention
CDRUSNORTHCOM	Commander, U.S. Northern Command
CJCS	Chairman of the Joint Chiefs of Staff
CONUS	continental United States
COVID-19	coronavirus disease 2019
D2D	Data-to-Decision
DCR	DOTmLPF-P Change Recommendation
DHA	Defense Health Agency
DHAPP	Department of Defense HIV/AIDS Prevention Program
DHP	Defense Health Program
DLA	Defense Logistics Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
DOTmLPF-P	Doctrine, Organization, Training, materiel, Leadership, Personnel, Facilities, and Policy
DSCA	Defense Support of Civil Authorities
DTRA	Defense Threat Reduction Agency
EM	emergency management
ESEP	Engineer and Scientist Exchange Program
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
FCC	Federal Coordinating Center
FCP	Functional Campaign Plan
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FHP	force health protection
FY	Fiscal Year
GCP	Global Campaign Plan
GEIS	Global Emerging Infections Surveillance
GHE	Global Health Engagement
GHSA	Global Health Security Agenda
GHSS	Global Health Security Strategy
HCW	health care worker
HHS	Department of Health and Human Services
HPCON	Health Protection Condition
IHS	International Health Specialist
JROCM	Joint Requirements Oversight Council Memorandum
MCM	medical countermeasures
MEM	Medical Emergency Manager
MERS-CoV	Middle East respiratory syndrome coronavirus
MHS	Military Health System
MILDEP	Military Department
MM-PM	Multi-Modal Patient Movement

MPEP	Military Personnel Exchange Program
MTF	military medical treatment facility
NAMRU	Naval Medical Research Unit
NATO	North Atlantic Treaty Organization
NCMI	National Center for Medical Intelligence
NDAA	National Defense Authorization Act
NDMS	National Disaster Medical System
NHRC	Naval Health Research Center
NMRC	Naval Medical Research Center
NMR&D	Navy Medicine Research and Development
NMRTC/U	Navy Medicine Readiness and Training Command and Units
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	outside the continental United States
OPNAV	Office of the Chief of Naval Operations
P&ID	Pandemics and Infectious Diseases
PAR	population at risk
PEPFAR	President's Emergency Plan for AIDS Relief
PI&ID	Pandemic Influenza and Infectious Disease
PHE	public health emergency
PHEM	public health emergency management
PHEO	public health emergency officer
PPE	personal protective equipment
R&D	research and development
ROM	restriction of movement
SARS	severe acute respiratory syndrome
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SecDef	Secretary of Defense
TSC	theater security cooperation
USAF	United States Air Force
USAFRICOM	U.S. Africa Command
USAID	U.S. Agency for International Development
USAMRDC	U.S. Army Medical Research and Development Command
USCENTCOM	U.S. Central Command
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USEUCOM	U.S. European Command
USG	U.S. Government
USINDOPACOM	U.S. Indo-Pacific Command
USNORTHCOM	U.S. Northern Command
USSOCOM	U.S. Special Operations Command
USSPACECOM	U.S. Space Command
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

19. Appendix A: Selected DoD Operational and Medical Officials Responsible for Pandemic Preparedness and Response Activities

OPERATIONAL

Under Secretary of Defense for Personnel and Readiness (USD(P&R)): Provides criteria, guidance, and instruction to incorporate public health emergency management requirements into appropriate DoD policy, program, and budget documents.

Assistant Secretary of Defense for Homeland Defense and Hemispheric Affairs: Coordinates with the ASD(HA) on public health emergency preparedness and management policy and guidance to ensure integration and consistency with policies and programs related to homeland defense, global security, mission assurance, and defense support of civil authorities among others. Serves as the DoD Domestic Crisis Manager.

Chairman of the Joint Chiefs of Staff (CJCS): Assesses force health protection as part of the overall planning of any force deployment decision. Periodically reassesses the force health protection posture of deployed forces. Reviews Combatant Commanders' joint plans, deployment orders, and other relevant documents for force health protection considerations.

Secretaries of the Military Departments (MILDEPS): Ensure execution of public health emergency management program requirements at installations. Ensure military commanders establish, at their discretion, a health protection condition level during an emergency to communicate specific health protection measures on installations. Reports metrics in accordance with ASD(HA) requirements.

Combatant Commanders with Physical Areas of Responsibility: Ensure unity of effort in the implementation of public health emergency management by DoD installations within the CCMD's area of responsibility (AOR). Establishes force health protection policies and programs for the protection of all forces assigned or attached to the command.

DoD Component heads: Implement public health emergency management guidance. Ensure component headquarters and installations identify appropriate public health and medical subject matter experts to advise on public health and medical issues.

Military commanders: Ensures an appropriate unit level response to public health emergencies by directing the public health emergency officer, military medical treatment facility (MTF) commander or director, and medical emergency manager to establish a framework of health protection measures for the installation population that are specific to the scope and severity of the current situation.

MEDICAL

Assistant Secretary of Defense for Health Affairs (ASD(HA)): Under the authority, direction, and control of the USD(P&R), oversees policy; plans and executes programs; and allocates use of public health, medical, and veterinary resources. Develops appropriate force health protection

guidance to achieve the greatest public health benefit while minimizing disruptions to DoD missions and deployments.

Director, Defense Health Agency: Supports the MILDEP Secretaries with their public health emergency management responsibilities and activities. Provides technical support to the Surgeons General of the MILDEPs, combatant commanders with physical areas of responsibility, appropriate joint force commanders, DoD agencies, and other DoD Components.

20. Appendix B: FHP Guidance Supplements in Support of COVID-19 Pandemic Response – by Topic Area (as of February 17, 2023)

CONSOLIDATED GUIDANCE

Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance *first issued* 4/4/2022. Consolidates, incorporates, and rescinds previous COVID-19 FHP documents and reissues them in one document with updates as necessary. Addresses the HPCON framework, masking, travel, testing, meetings, vaccination, and other guidance for DoD personnel. Revisions were issued on 6/29/2022, 4/4/2022, 8/29/2022, and 1/30/2023

INITIAL GUIDANCE

Force Health Protection (FHP) Guidance for the Novel Coronavirus Outbreak. 01/30/2020. Provides initial guidance for infection control measures and initial reporting measures. Rescinded by Consolidated DoD COVID-19 FHP Guidance (4/4/2022)

TRAVEL

FHP Guidance (Supplement 1) – *Department of Defense (DoD) Guidance for Monitoring Personnel Returning from China During the Novel Coronavirus Outbreak.* 2/7/2020. Directs evaluation and monitoring of DoD personnel (active duty, civilian employees, contractor personnel, and family members) returning from mainland China. Rescinded by FHP Supp. 14

FHP Guidance (Supplement 4) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Outbreak*. 3/11/2020. Pre- and post-travel guidance for Service members, DoD civilian employees, contractor personnel, and family members. Excludes air crews of military aircraft). Rescinded by FHP Supp. 12

FHP Guidance (Supplement 12) – *DoD Guidance for Personnel Traveling During the Coronavirus Disease 2019 Pandemic.* 8/6/2020. Updated guidance on pre- and post-travel guidance for DoD travelers. Rescinded by FHP Supp. 14

FHP Guidance (Supplement 14) – *DoD Guidance for Personnel Traveling During the Coronavirus Disease 2019 Pandemic.* 12/29/2020. Updates pre- and post-travel guidance for official, unofficial travel with travel-associated restriction of movement. Rescinded by FHP Supp. 20

FHP Guidance (Supplement 20) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Disease 2019 Pandemic.* 4/12/2021. Updates pre- and post-travel guidance for official and unofficial travel for Service members, family members, civilian employees, and contractors. Rescinded by FHP Supp. 20, Rev 1

FHP Guidance (Supplement 20, Revision 1) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Disease 2019 Pandemic.* 01/10/2022. Updates pre- and post-travel testing guidance to reflect changes to CDC guidance, and updates testing eligibility for DoD personnel. Rescinded by Consolidated DoD COVID-19 FHP Guidance

DEPLOYMENT/REDEPLOYMENT

FHP Guidance (Supplement 9) – *DoD Guidance for Deployment and Redeployment of Individuals and Units during the Novel Coronavirus Disease 2019 Pandemic.* 04/26/2020. Deployment & Redeployment of Individuals and Units During COVID-19. Rescinded by FHP Supp. 16

FHP Guidance (Supplement 16) – *DoD Guidance for Deployment and Redeployment of Individuals and Units during the Coronavirus Disease 2019 Pandemic.* 3/16/2021. Updates DoD deployment guidance to align with CDC Order 361 pertaining to domestic and international travel, and Executive Order 13998. Rescinded by FHP Supp. 16, Rev 1

FHP Guidance (Supplement 16, Revision 1) – *DoD Guidance for Deployment and Redeployment of Individuals and Units During the Novel Coronavirus Disease 2019 Pandemic.* 5/4/2021. Updated guidance on pre-deployment and redeployment, testing requirements, restriction of movement, and requirements for vaccinated persons. Rescinded by FHP Supp. 20, Rev 1

HEALTH PROTECTION CONDITION (HPCON)

FHP Guidance (Supplement 2) – *DoD Guidance for Military Installation Commanders' Risk-Based Measured Responses to the Novel Coronavirus Outbreak.* 2/25/2020. Provides Commanders with a risk-based framework to implement HPCON levels at installations/facilities. Rescinded by 4/29/2021 memo, *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*

PERSONAL PROTECTIVE EQUIPMENT (PPE) AND FACE COVERINGS

FHP Guidance (Supplement 3) – *DoD Guidance for the Use of Personal Protective Equipment and Non-Pharmaceutical Interventions during the Coronavirus Disease 2019 Outbreak.* 3/10/2020. Prioritization of personal protective equipment (PPE) and other non-pharmaceutical interventions to reduce risk to DoD-personnel and conserve PPE resources. Rescinded by FHP Supp. 7

FHP Guidance (Supplement 7) – *DoD Guidance for the Use of Cloth Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 4/8/2020. Updated guidance on mitigation measures; adds face coverings. Rescinded by FHP Supp17

FHP Guidance (Supplement 17) – *DoD Guidance for the Use of Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 3/17/2021. Clarifies SecDef policy on face coverings ("mask") use or masking in conjunction with other public health measures on Federal property, in accordance with Executive Order 13991 and OMB guidance. Rescinded by FHP Supp. 17, Rev 1

FHP Guidance (Supplement 17, Revision 1) – *DoD Guidance for the Use of Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 6/22/2021. Updated guidance for fully vaccinated persons per OMB guidance, "Integrating Planning for a Safe Increased Return of Federal Employees and Contractors to Physical Workplaces with Post-Reentry Personnel Policies and Work Environment," 6/10/2021 Rescinded by Consolidated DoD COVID-19 FHP Guidance

PATIENT MOVEMENT

FHP Guidance (Supplement 5) – *DoD Guidance for Movement and Medical Treatment of COVID-19 Patients, Symptomatic Persons Under Investigation, or Potentially Exposed COVID-19 Persons.* 4/7/2020. Movement and Treatment of confirmed or suspected COVID-19 Patients. Rescinded by FHP Supp. 21

FHP Guidance (Supplement 21) – *DoD Guidance for Movement and Medical Treatment of Coronavirus Disease 2019 Patients, Symptomatic Persons Under Investigation, or Persons Potentially Exposed to the Coronavirus Disease 2019.* 3/25/2021. Updates guidance on patient movement to provide DoD personnel with best practices for patient movement, protection of crew and other patients, and post-transport management of contaminated vehicles. Rescinded by Consolidated DoD COVID-19 FHP Guidance

LABORATORY DIAGNOSTICS, TESTING, AND SURVEILLANCE

FHP Guidance (Supplement 6) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Diagnostic Testing Services.* 4/7/2020. Provides guidance on laboratory testing for COVID-19 to incorporate guidance from the CDC to maximize critical testing capability. Rescinded by FHP Supp. 10

FHP Guidance (Supplement 10) – *DoD Guidance for Coronavirus Disease 2019 Clinical Laboratory Diagnostic Testing Services.* 6/11/2020. Updated guidance on clinical and diagnostic testing for eligible persons with a DoD connection suspected of having COVID-19. Rescinded by FHP Supp. 13

FHP Guidance (Supplement 11) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing.* 6/11/2020. Provides guidance for tier testing and risk-based surveillance testing. Names the COVID-19 Task Force Diagnostics & Testing Line of Effort (LOE) as execution lead. Rescinded by FHP Supp. 22

FHP Guidance (Supplement 13) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing.* 8/24/2020. Updated guidance on clinical and diagnostic testing for eligible persons with a DoD connection suspected of having COVID-19. Rescinded by FHP Supp. 15

FHP Guidance (Supplement 15) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 1/11/2021. DoD COVID-19 testing guidance incorporating updated CDC guidelines recommending options to reduce quarantine for close contacts, and addresses pooled and antigen testing. Rescinded by FHP Supp. 15, Rev 1

FHP Guidance (Supplement 15, Revision 1) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 3/15/2021, Updated guidance incorporating latest CDC guidelines and guidance on vaccinated persons. Rescinded by FHP Supp 15, Rev 2

FHP Guidance (Supplement 15, Revision 2) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 7/2/2021. Updated guidance incorporating latest CDC guidelines and additional revisions on testing vaccinated persons. Rescinded by FHP Supp. 15, Rev 3

FHP Guidance (Supplement 15, Revision 3) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 12/20/2021. Updated guidance incorporating latest CDC guidelines and additional revisions on testing vaccinated persons. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 22) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening Testing*. 7/21/2021. Provides updated guidance for DoD health surveillance activities, screening testing of asymptomatic persons, and sentinel surveillance. Provides supplemental information for FHP Supp. 15, Rev. 2. Rescinded by Consolidated DoD COVID-19 FHP Guidance

WORKPLACE SAFETY

FHP Guidance (Supplement 8) – *DoD Guidance for Protecting Personnel in Workplaces during the Response to the Coronavirus Disease 2019 Pandemic.* 4/13/2020. Provides guidance for FHP restriction of the workplace, return to work, and procedures for essential workers. Rescinded by FHP Supp. 18

FHP Guidance (Supplement 18) – *DoD Guidance for Protecting All Personnel in DoD Workplaces During the Coronavirus Disease 2019 Pandemic.* 3/17/2021. Provides updated guidance for FHP restriction of the workplace, return to work, access to workplaces, and information collection. Rescinded by FHP Supp. 18, Rev 1

FHP Guidance (Supplement 18, Revision 1) – *DoD Guidance for Protecting All Personnel in DoD Workplaces During the Coronavirus Disease 2019 Pandemic.* 1/6/2022. Provides updated workplace safety guidance. Rescinded by Consolidated DoD COVID-19 FHP Guidance

VACCINATION

FHP Guidance (Supplement 23) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 9/7/2021. Provides guidance for implementing additional FHP and workplace safety measures as directed by the White House Safer Federal Workforce Task Force. Rescinded by FHP Supp. 23, Rev 1

FHP Guidance (Supplement 23, Revision 1) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 10/18/2021. Expands procedures for implementing FHP and workplace safety, including vaccination attestation, screening testing, and vaccination verification. Rescinded by FHP Supp. 23, Rev 2

FHP Guidance (Supplement 23, Revision 2) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 11/1/2021. Updates the guidance in Revision 2 to provide additional information on the process for processing medical and religious exemptions including DoD forms. Rescinded by FHP Supp. 23, Rev 3

FHP Guidance (Supplement 23, Revision 3) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel***.** 12/20/2021. Updates the guidance in Revision 2 to better address the exemption process for vaccination and penalties for noncompliance. Rescinded by Consolidated DoD COVID-19 FHP Guidance

NOTE: The Department of Defense maintains a repository of signed guidance memoranda, press releases, fact sheets, and other publicly releasable documents related to the COVID-19 response on its website at the following address:

https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/

The documents in the repository are organized by subject matter. For example, "Force Health Protection Guidance" memoranda are grouped in their own section just as "Military Personnel Guidance" is maintained in its specific section. In each section, active documents are listed sequentially with the most recent documents presented first by default. Users may select to view older documents first by selecting "Oldest" in the display options. An additional display option ("Active Only" or "All") will allow users to view older documents that have expired or been rescinded by more recent guidance.

NOTE: Appendix B lists FHP Guidance Supplements in Support of the COVID-19 Pandemic Response in numerical order.

21. Appendix C: FHP Guidance Supplements in Support of COVID-19 Pandemic Response – Numerical Order (as of April, 4, 2022)

Force Health Protection (FHP) Guidance for the Novel Coronavirus Outbreak. 1/30/2020. Provides initial guidance for infection control measures and initial reporting measures. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 1) – *Department of Defense (DoD) Guidance for Monitoring Personnel Returning from China During the Novel Coronavirus Outbreak.* 2/7/2020. Directs evaluation and monitoring of DoD personnel (active duty, civilian employees, contractor personnel, and family members) returning from mainland China. Rescinded by FHP Supp. 14

FHP Guidance (Supplement 2) – *DoD Guidance for Military Installation Commanders' Risk-Based Measured Responses to the Novel Coronavirus Outbreak.* 2/25/2020. Provides Commanders with a risk-based framework to implement HPCON levels at installations/facilities. Rescinded by 4/29/2021 memo, *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*

FHP Guidance (Supplement 3) – *DoD Guidance for the Use of Personal Protective Equipment and Non-Pharmaceutical Interventions during the Coronavirus Disease 2019 Outbreak.* 3/10/2020. Prioritization of personal protective equipment (PPE) and other non-pharmaceutical interventions to reduce risk to DoD-personnel and conserve PPE resources. Rescinded by FHP Supp. 7

FHP Guidance (Supplement 4) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Outbreak*. 3/11/2020. Pre- and post-travel guidance for Service members, DoD civilian employees, contractor personnel, and family members. Excludes air crews of military aircraft). Rescinded by FHP Supp. 12

FHP Guidance (Supplement 5) – *DoD Guidance for Movement and Medical Treatment of COVID-19 Patients, Symptomatic Persons Under Investigation, or Potentially Exposed COVID-19 Persons.* 4/7/2020. Movement and Treatment of confirmed or suspected COVID-19 Patients. Rescinded by FHP Supp. 21

FHP Guidance (Supplement 6) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Diagnostic Testing Services.* 4/7/2020. Provides guidance on laboratory testing for COVID-19 to incorporate guidance from the CDC to maximize critical testing capability. Rescinded by FHP Supp. 10

FHP Guidance (Supplement 7) – *DoD Guidance for the Use of Cloth Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 4/8/2020. Updated guidance on mitigation measures; adds face coverings. Rescinded by FHP Supp.17

FHP Guidance (Supplement 8) – *DoD Guidance for Protecting Personnel in Workplaces during the Response to the Coronavirus Disease 2019 Pandemic.* 4/13/2020. Provides guidance for FHP restriction of the workplace, return to work, and procedures for essential workers. Rescinded by FHP Supp. 18

FHP Guidance (Supplement 9) – *DoD Guidance for Deployment and Redeployment of Individuals and Units during the Novel Coronavirus Disease 2019 Pandemic.* 04/26/2020. Deployment & Redeployment of Individuals and Units During COVID-19. Rescinded by FHP Supp. 16

FHP Guidance (Supplement 10) – *DoD Guidance for Coronavirus Disease 2019 Clinical Laboratory Diagnostic Testing Services.* 6/11/2020. Updated guidance on clinical and diagnostic testing for eligible persons with a DoD connection suspected of having COVID-19. Rescinded by FHP Supp. 13

FHP Guidance (Supplement 11) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing.* 6/11/2020. Provides guidance for tier testing and risk-based surveillance testing. Names the COVID-19 Task Force Diagnostics & Testing Line of Effort (LOE) as execution lead. Rescinded by FHP Supp. 22

FHP Guidance (Supplement 12) – *DoD Guidance for Personnel Traveling During the Coronavirus Disease 2019 Pandemic.* 8/6/2020. Updated guidance on pre- and post-travel guidance for DoD travelers. Rescinded by FHP Supp. 14

FHP Guidance (Supplement 13) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening with Testing.* 8/24/2020. Updated guidance on clinical and diagnostic testing for eligible persons with a DoD connection suspected of having COVID-19. Rescinded by FHP Supp. 15

FHP Guidance (Supplement 14) – *DoD Guidance for Personnel Traveling During the Coronavirus Disease 2019 Pandemic.* 12/29/2020. Updates pre- and post-travel guidance for official, unofficial travel with travel-associated restriction of movement. Rescinded by FHP Supp. 20

FHP Guidance (Supplement 15) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 1/11/2021. DoD COVID-19 testing guidance incorporating updated CDC guidelines recommending options to reduce quarantine for close contacts, and addresses pooled and antigen testing. Rescinded by FHP Supp. 15, Rev 1

FHP Guidance (Supplement 15, Revision 1) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 3/15/2021, Updated guidance incorporating latest CDC guidelines and guidance on vaccinated persons. Rescinded by FHP Supp 15, Rev 2

FHP Guidance (Supplement 15, Revision 2) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 7/2/2021. Updated guidance incorporating latest CDC guidelines and additional revisions on testing vaccinated persons. Rescinded by FHP Supp. 15, Rev 3

FHP Guidance (Supplement 15, Revision 3) – *DoD Guidance for Coronavirus Disease 2019 Laboratory Testing Services.* 12/20/2021. Updated guidance incorporating latest CDC guidelines and additional revisions on testing vaccinated persons. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 16) – *DoD Guidance for Deployment and Redeployment of Individuals and Units during the Coronavirus Disease 2019 Pandemic.* 3/16/2021. Updates DoD deployment guidance to align with CDC Order 361 pertaining to domestic and international travel, and Executive Order 13998. Rescinded by FHP Supp. 16, Rev 1

FHP Guidance (Supplement 16, Revision 1) – *DoD Guidance for Deployment and Redeployment of Individuals and Units During the Novel Coronavirus Disease 2019 Pandemic.* 5/4/2021. Updated guidance on pre-deployment and redeployment, testing requirements, restriction of movement, and requirements for vaccinated persons. Rescinded by FHP Supp. 20, Rev 1

FHP Guidance (Supplement 17) – *DoD Guidance for the Use of Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 3/17/2021. Clarifies SecDef policy on face coverings ("mask") use or masking in conjunction with other public health measures on Federal property, in accordance with Executive Order 13991 and OMB guidance. Rescinded by FHP Supp. 17, Rev 1

FHP Guidance (Supplement 17, Revision 1) – *DoD Guidance for the Use of Face Coverings, Personal Protective Equipment, and Non-Pharmaceutical Interventions During the Coronavirus Disease 2019 Pandemic.* 6/22/2021. Updated guidance for fully vaccinated persons per OMB guidance, "Integrating Planning for a Safe Increased Return of Federal Employees and Contractors to Physical Workplaces with Post-Reentry Personnel Policies and Work Environment," 6/10/2021 Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 18) – *DoD Guidance for Protecting All Personnel in DoD Workplaces During the Coronavirus Disease 2019 Pandemic.* 3/17/2021. Provides updated guidance for FHP restriction of the workplace, return to work, access to workplaces, and information collection. Rescinded by FHP Supp. 18, Rev 1

FHP Guidance (Supplement 18, Revision 1) – *DoD Guidance for Protecting All Personnel in DoD Workplaces During the Coronavirus Disease 2019 Pandemic.* 1/6/2022. Provides updated workplace safety guidance. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 19) –Not issued. Retitled and signed by SecDef as *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*. 4/29/2021**.** Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 20) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Disease 2019 Pandemic.* 4/12/2021. Updates pre- and post-travel guidance for official and unofficial travel for Service members, family members, civilian employees, and contractors. Rescinded by FHP Supp. 20, Rev 1

FHP Guidance (Supplement 20, Revision 1) – *DoD Guidance for Personnel Traveling During the Novel Coronavirus Disease 2019 Pandemic.* 01/10/2022. Updates pre- and post-travel testing guidance to reflect changes to CDC guidance, and updates testing eligibility for DoD personnel. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 21) – *DoD Guidance for Movement and Medical Treatment of Coronavirus Disease 2019 Patients, Symptomatic Persons Under Investigation, or Persons Potentially Exposed to the Coronavirus Disease 2019.* 3/25/2021. Updates guidance on patient movement to provide DoD personnel with best practices for patient movement, protection of crew and other patients, and post-transport management of contaminated vehicles. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 22) – *DoD Guidance for Coronavirus Disease 2019 Surveillance and Screening Testing*. 7/21/2021. Provides updated guidance for DoD health surveillance activities, screening testing of asymptomatic persons, and sentinel surveillance. Provides supplemental information for FHP Supp. 15, Rev. 2. Rescinded by Consolidated DoD COVID-19 FHP Guidance

FHP Guidance (Supplement 23) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 9/7/2021. Provides guidance for implementing additional FHP and workplace safety measures as directed by the White House Safer Federal Workforce Task Force. Rescinded by FHP Supp. 23, Rev 1

FHP Guidance (Supplement 23, Revision 1) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 10/18/2021. Expands procedures for implementing FHP and workplace safety, including vaccination attestation, screening testing, and vaccination verification. Rescinded by FHP Supp. 23, Rev 2

FHP Guidance (Supplement 23, Revision 2) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel.* 11/1/2021. Updates the guidance in Revision 2 to provide additional information on the process for processing medical and religious exemptions including DoD forms. Rescinded by FHP Supp. 23, Rev 3

FHP Guidance (Supplement 23, Revision 3) – *DoD Guidance for Coronavirus Disease 2019 Vaccination Attestation and Screening Testing for Unvaccinated Personnel***.** 12/20/2021. Updates the guidance in Revision 2 to better address the exemption process for vaccination and penalties for noncompliance. Rescinded by Consolidated DoD COVID-19 FHP Guidance

Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance*.* 4/4/2022. Consolidates, incorporates, and rescinds previous COVID-19 FHP documents and reissues them in one document with updates as necessary. Addresses the Health Protection Condition (HPCON) Framework, masking, travel, testing, meetings, vaccination, and other guidance for DoD civilian employees. Revisions issued 6/29/2022, 4/4/2022, 8/29/2022, and 1/30/2023.

NOTE: The Department of Defense maintains a repository of signed guidance memoranda, press releases, fact sheets, and other publicly releasable documents related to the COVID-19 response on its website at the following address:

https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/

The documents in the repository are organized by subject matter. For example, "Force Health Protection Guidance" memoranda are grouped in their own section just as "Military Personnel Guidance" is maintained in its specific section. In each section, active documents are listed sequentially with the most recent documents presented first by default. Users may select to view older documents first by selecting "Oldest" in the display options. An additional display option ("Active Only" or "All") will allow users to view older documents that have expired or been rescinded by more recent guidance.

22. Appendix D: FHP Measures by HPCON Level for the COVID-19 Pandemic

HPCON D Severe	**High COVID-19 Community Level* Risk, with degraded availability of medical countermeasures, and substantial loss of medical capability** **High COVID-19 Community Level* in the county in which the installation is located.** **AND any of the following** **Civilian health care capability and utilization (percent and trend)*:** >50% staffed of hospital beds filled with individuals who have COVID-19 as the primary admission criteria; or >70% of staffed intensive care unit (ICU) beds filled with individuals who have COVID-19 as the primary admission criteria; or Overall staffed hospitals and ICUs have limited to no capacity. **OR** **Military Health System (MHS) health care capability and utilization (percent and trend):** Degradation of MHS capabilities requiring Crisis Status operations; and >95% staffed bed occupancy; or >50% military medical treatment facility (MTF) staff in isolation or quarantine or unvaccinated; or >60% staff absent who provide urgent or emergent care; and Local emergency departments on divert or inability of civilian health care to absorb excess MHS patients; or Clinical or appointment capability reduced >60% in key departments. **OR**	**Utilize measures from HPCON A, B and C with the following modifications**: a. Less than 25 percent of normal occupancy in the workplace, or the minimum required on-site for essential operations that must be conducted in person. b. Strongly consider declaring a local Public Health Emergency. c. Consider limiting visitor access to the installation to only those required for mission essential activities. d. Cancel non-mission-essential activities. e. Close non-essential services (e.g., fitness centers, leisure and recreational facilities, beauty/barber shops, non-essential retail, dine-in eating establishments). f. Consider potential delay or cancelation of exercises. g. Restrict or suspend social gatherings to the greatest extent possible. h. Follow any other applicable force health protection guidance at: https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/.

	Other factors: Loss of vaccine effectiveness in available vaccines resulting in vaccinated individuals routinely experiencing severe disease, hospitalization or death; or Elevated case levels resulting in significant curtailment of essential services either on installation or in civilian communities immediately adjacent to the installation (e.g., emergency response, security, facility maintenance, and energy/communication). ***CDC COVID-19 Community Level (by county) can be found at:** https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html	
HPCON C High	**High COVID-19 Community Level* Risk** **High COVID-19 Community Level* in the county in which the installation is located.** ***CDC COVID-19 Community Level (by county) Civilian county level data can be found at: https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html.**	**Utilize measures from HPCON A and B with the following modifications**: a. Less than 50 percent of normal occupancy in the workplace. b. Consider limiting visitor access to the installation for non-essential mission-related/operational activities. c. Limit social gatherings to less than 50 percent facility/room occupancy. d. MTFs may limit elective surgeries in accordance with guidance from the Defense Health Agency and the Assistant Secretary of Defense for Health Affairs. e. Consider re-scoping, modifying, or potentially canceling exercises. f. Indoor common areas and large venues may be closed. Dining establishments may be limited to takeout. g. Gyms may be closed at this level or operate at diminished occupancy. h. Schools operated by the Department of Defense Education Activity (DoDEA) will operate remotely.

		i. Maximize telework to the greatest extent practical. j. Follow any other applicable force health protection guidance at: https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/.
HPCON B Moderate	**Medium COVID-19 Community level* Risk** **Medium COVID-19 Community Level* in the county in which the installation is located.** ***CDC COVID-19 Community Level (by county) Civilian county level data can be found at: https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html.**	**Utilize measures from HPCON A with the following modifications:** a. Less than 80 percent of normal occupancy in the workplace. b. Permit liberal telework where possible, especially for individuals who self-identify as immunocompromised or being at high risk for severe disease. c. Consider limiting occupancy of common areas where personnel are likely to congregate and interact by marking approved sitting areas or removing furniture to maintain physical distancing. d. Follow any other applicable Force Health Protection Guidance at: https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/.
HPCON A Low	**Low COVID-19 Community Level* Risk** **Low COVID-19 Community Level* in the county in which the installation is located.** ***CDC COVID-19 Community Level (by county) Civilian county level data can be found at: https://www.cdc.gov/coronavirus/2019**	a. Less than 100 percent of normal occupancy in the workplace, with telework as appropriate. b. Communicate to personnel how and when to report illness and seek care for potential influenza-like illness. c. Common areas and large venues (e.g., sit-down dining, movie theaters, gyms, sporting venues, and commissaries) should adhere to established cleaning and sanitation protocols

	-ncov/your-health/covid-by-county.html	d. DoDEA schools will operate following CDC recommendations and guidelines specific to schools as implemented in operational procedures and guidance from the Director, DoDEA. Children are not required to mask. Any DoD guidance that is more stringent than CDC guidance must be followed. e. Follow any other applicable Force Health Protection Guidance at: https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/Latest-DOD-Guidance/.
HPCON 0	**Normal Baseline**	a. Resume routine standard operations. b. Maintain standard precautions such as routine hand washing, cough on sleeve, good diet, exercise, vaccinations, education, routine health alerts, and regular preparedness activities.

23. Appendix E: HPCON Supplemental Guidance in Support of COVID-19 Pandemic Response (as of February, 17, 2023)

HPCON Guidance ISO COVID-19 Pandemic Response
Signed by SecDef, unless otherwise noted

FHP Guidance (Supplement 2) – *DoD Guidance for Military Installation Commanders' Risk-Based Measured Responses to the Novel Coronavirus Outbreak.* Signed by USD(P&R) 2/25/2020. Provides Commanders with a risk-based framework to implement HPCON levels at installations/facilities. Rescinded by 4/29/2021 memo, *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*

Guidance for Commanders on the Implementation of the Risk-Based Responses to the COVID-19 Pandemic. 4/1/2020. Supplemental guidance for Commanders on implementation of the risk-based responses to the COVID-19 pandemic. Rescinded by 4/29/2021 memo, *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*

Guidance for Commanders on Risk-Based Changing of Health Protection Condition (HPCON) Levels During the Coronavirus Disease 2019 Pandemic. 5/19/2020. HPCON level decision guidance for Commanders that supplements SecDef memorandum from 4/1/2020 and delegates authority to the Chief Management Office for HPCON level changes on the Pentagon Reservation and the Armed Forces Retirement Home. Updating to delegate to Washington Headquarters Service (WHS). Rescinded by 4/29/2021 memo, *Guidance for Commanders on Risk-based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic*

*Guidance for Commanders' Risk-Based Responses and Implementation of the Health Protection Condition Framework During the Coronavirus Disease 2019 Pandemic.*4/29/2021. Consolidates and updates DoD guidance on implementing the HPCON framework including recommended protective actions to be taken at each level, the incorporation of a Bravo Plus (B+) level, criteria to change levels, workplace occupancy levels, and a process for granting exemptions for national security and other critical missions. Rescinded by Consolidated DoD COVID-19 FHP Guidance

Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance. Signed by USD(P&R) 4/4/2022. Consolidates, incorporates, and rescinds previous COVID-19 FHP documents and reissues them in one document with updates as necessary. Addresses the Health Protection Condition (HPCON) Framework, masking, travel, testing, meetings, vaccination, and other guidance for DoD civilian employees. Revision 1 Issued 6/29/2022. Revision 2 Issued 4/4/2022. Revision 3 Issued 3 8/29/2022. **Revision 4 Issued 1/30/2023**

Extension of DoD-Declared Public Health Emergencies ISO COVID-19 Pandemic Response
Signed by ASD(HA)

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 4/7/2020. Enacts a policy waiver under DoDI 6200.03, "Public Health Emergency Management (PHEM) Within the DoD" to reduce the administrative burden on DoD installations of having to renew PHE declarations monthly. This memorandum temporarily extends the duration of DoD-declared PHE to up to 90 days (vs. the 30-day duration prescribed by DoDI 6200.03) until December 31, 2020. Extended

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 12/7/2020. This memorandum extends the 90-day duration for DoD-declared PHE until June 30, 2021. Expired

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 6/24/2021. This memorandum extends the 90-day duration for DoD-declared PHE until December 31, 2021. Expired

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 12/15/2021. This memorandum extends the 90-day duration for DoD-declared PHE until June 30, 2022. Expired

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 5/4/2022. This memorandum extends the 90-day duration for DoD-declared PHE until December 31, 2022. Expired

Extension of Department of Defense Public Health Emergency Declarations. ASD(HA) 1/19/2023. This memorandum extends the 90-day duration for DoD-declared PHE until June 30, 2023.

24. Appendix F: FY 2020 Navy DHAPP Expenditures

Direct HIV/AIDS prevention program: Total: $250K

- Civilian labor $220K
- Supplies: $15K
- Travel: $15K

Total HIV Testing Program (Separate from Prevention Program): $11.98M

- HIV Testing Contract: $10, 383K (average monthly bill $650K)
- HIV IT Support: Contract: $1.6 to $2.2M 1804/18TD DHP (average monthly bill $150K to $250K depending on vacancy rate)

25. Appendix G: FY 2021 DHAPP Achievements

Achievements with PEPFAR military to military funding in FY21 include:

- 570,296 individuals received testing and counseling services; 78,251 were pregnant women
- 406,345 individuals were reached with prevention interventions
- 208,027 individuals received antiretroviral therapy (ART). 30,374 were newly enrolled; 4,378 were pregnant women receiving ART to reduce risk of mother-to-child transmissions.
- 182,316 individuals were circumcised as part of the voluntary medical male circumcision for HIV prevention program.

Achievements with PEPFAR military-civilian funding in FY21 include:

- 970,509 individuals received testing and counseling services with 39,549 testing positive in screening programs
- 307,939 individuals received ART, and an additional 37,227 individuals initiated treatment on ART
- 207,266 individuals were circumcised as part of the voluntary medical male circumcision for HIV prevention program

Achievements with Defense Health Program mil-mil funding in FY21 include:

- 138,948 individuals received testing and counseling services; 19,234 were pregnant women.
- 157,025 individuals were reached with prevention interventions.
- 23,935 individuals received ART. 5,938 were newly enrolled; 371 were pregnant women receiving ART to reduce risk of mother-to-child transmissions.