



DEPARTMENT OF THE NAVY
HEADQUARTERS UNITED STATES MARINE CORPS
3000 MARINE CORPS PENTAGON
WASHINGTON DC 20350-3000

MCO 6220.2
PS
04 DEC 2017

MARINE CORPS ORDER 6220.2

From: Commandant of the Marine Corps
To: Distribution List

Subj: DISEASE CONTAINMENT PLANNING GUIDANCE

Ref: (a) DoD Directive 6200.3, "Emergency Health Powers on Military Installations," May 12, 2003
(b) DoD Directive 6200.04, "Force Health Protection (FHP)," April 23, 2007
(c) BUMEDINST 3440.10A, "Navy Medicine Force Health Protection (FHP) Emergency Management Program (EMP)," November 20, 2008
(d) BUMEDINST 6200.17A, "Public Health Emergency Officers (PHEO)," March 7, 2011
(e) CDRUSNORTHCOM Plan Review and Evaluation Matrix (NOTAL)
(f) SECNAV M-5210
(g) Under Secretary of Defense (Policy) Memorandum DTD June 16, 2009
(h) DoD Directive 6200.04, Force Health Protection, April 23, 2007
(i) DoD Instruction 6200.03 Public Health Emergency within the Department of Defense; Incorporated Change 2, Effective October 2, 2013
(j) MCO 3040.4
(k) Defense Production Act of 1950, Title 50, U.S. Code, sections 2061-2171
(l) DoD Instruction 6055.17 CH 1, Installation Emergency Management
(m) SECNAVINST 5211.5E
(n) 5 U.S.C. 552a, Privacy Act of 1974, As Amended
(o) DoD Directive 3025.18, "Defense Support of Civil Authorities (DSCA)," December 29, 2010

Encl: (1) Specific Diseases
(2) Disease Containment Plan Template
(3) Abbreviation and Acronyms
(4) Glossary

1. Situation

a. General

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(1) In accordance with the references (a) through (o), this policy provides guidance and aligns organizational roles and responsibilities within the Marine Corps for Disease Containment Planning (DCP) activities.

(2) This Marine Corps Order (MCO) incorporates existing Department of Defense (DoD) guidance from the Smallpox Response Plan, the Severe Acute Respiratory Syndrome (SARS) Medical Preparation and Response Guidance, Zika Virus and the Pandemic Influenza Preparation and Response Planning into a single document for DCP.

(3) The DCP prepares the Marine Corps to respond to and mitigate biological events of operational significance, whether naturally occurring or the result of a deliberate attack, while enabling mission recovery and sustainment. "The process of gathering, integrating, interpreting, and communicating essential information related to all-hazards threats or disease activity affecting human, animal, or plant health to achieve early detection and warning, contribute to overall situational awareness of the health aspects of an incident, and to enable better decision making at all levels."

(4) This MCO provides policy and guidance, outlines roles and responsibilities, and discusses planning consideration, including the basic assumptions that must be considered in order to understand the unique aspects of negating or mitigating the effects of a contagious disease outbreak. It also provides general background information on the characteristics of biological agents, modes of transmission, methods of protection, and incubation periods. This MCO also identifies preparatory actions that must be taken in advance of an outbreak to minimize the operational risk, and applies the concept of operations to disease containment principles.

(5) The Marine Corps response to a biological hazard event will focus on five major areas: 1) Force Health Protection (FHP); 2) Readiness; 3) Continuity of Operations (COOP); 4) Defense Support to Civil Authorities (DSCA); and 5) Support to U.S. Government (USG) efforts (both domestic and international). The focuses of the U.S. Marine Corps DCP is FHP, Readiness, and COOP. DSCA and support to USG efforts will be addressed separately in geographic combatant command (COCOM) plans.

(6) Commanders will continue updating directed plans and corresponding capability gaps for improved analysis of data and reporting generated by ongoing disease containment related activities.

(7) This policy is applicable to all Marine Corps activities and has been written to ensure the development of optimal Marine Corps capabilities and readiness for operations and tasks in support of missions involving disease containment activities.

(8) The U.S. Marine Corps executes measures to prepare for and prevent outbreaks and spread of biological hazards on its bases and

installations and among Marines and Sailors, assigned government/civilian workforce personnel, contractor personnel, and military family members to mitigate the effects of a potential biological event in order to preserve and maintain the operational readiness of the Marine Corps.

(9) The U.S. Marine Corps will prepare for potential outbreaks of biological hazards on its bases and installations and within forces through decentralized, synchronized, installation level DCPs. If a biological hazard event occurs, the Marine Corps must execute mitigation strategies of containment, interdiction and stabilization, recover in order to maintain force readiness and freedom of movement.

b. Strategic Guidance

(1) Preparing and responding infectious diseases require an active, layered defense. This active, layered defense is global, and integrates U.S. capabilities seamlessly in the forward regions of the world, the approaches to the U.S. territory, and within the United States. It is a defense in depth which includes assisting partner countries to prepare for and detect an outbreak, and to respond and manage the key second-order effects that could lead to an array of challenges. The top priorities are the protection of DoD forces (comprised of the military, DoD civilians, and contractors performing critical roles) as well as the associated resources necessary to maintain mission readiness and the ability to meet our strategic objectives. Priority consideration is given to protect the health of DoD beneficiaries and dependents.

c. Assumptions. Biological hazards are unpredictable. Nevertheless, we must make assumptions to facilitate planning efforts. Marine Corps planning efforts assume the following:

(1) Efficient and sustained person-to-person transmission signals are a potential indicator of an imminent outbreak.

(2) Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals may be able to transmit infection and develop immunity to subsequent infection.

(3) While the number of patients seeking medical care cannot be predicted with certainty, in previous deadly disease incidents, about half of those who became ill sought care. With the availability of effective antiviral medication for treatment, this proportion may be higher in the next deadly disease outbreak.

(4) Rates of serious illness, hospitalization, and deaths will depend on the virulence of the biological hazard and differ by order of magnitude between more and less severe scenarios. Risk groups cannot be predicted with certainty.

(5) Rates of absenteeism will depend on the severity of the biological hazard. In a severe disease outbreak, absenteeism attributable to illness, the need to care for ill family members and the fear of infection may reach 40 percent during the peak weeks with lower rates of absenteeism during the week(s) before and after the peak.

(6) Children will play a major role in the transmission of infection as their illness rates are likely to be higher.

(7) An efficient human-to-human outbreak will likely occur outside of the United States and may not be contained effectively.

(8) Not all parts of the world will be affected at the same time or to the same degree.

(9) Developed countries will be quicker in preparing for, detecting, and responding to outbreaks than less developed countries.

(10) If a biological incident starts outside the United States, it will enter the United States at multiple locations and spread quickly to other parts of the country.

(11) Some coalition partners, allies, and Host Nation (HN) governments will request military assistance and training from the USG for biological hazard preparedness, surveillance, detection, and response.

(12) HN support to U.S. Forces will be impacted by biological hazard incidents at a rate proportional to the impact of deadly disease on the HN's general population.

(13) DOD can expect requests from interagency partners to support civilian MA operations.

(14) Infected people, confirmed (when possible) or suspected, will not be transported to any facilities beyond the affected area unless their medical condition demands movement.

(15) International and interstate transportation will be restricted to contain the spread of the agent/virus.

(16) A layered mix of voluntary and mandatory individual, unit and installation-based public health measures, such as limiting public gatherings, closing schools, social distancing, protective sequestration, personal hygiene measures, and masking can limit transmission and reduce illness and death if implemented before or at the onset of the event. Quarantine, isolation and other movement restrictions are essential for a successful containment operation.

(17) The provision of routine security services for the protection of critical infrastructure will require Federal

augmentation.

(18) DoD will support security and possibly staffing of national critical infrastructure at all levels (e.g., air traffic control, security for national critical infrastructure, etc.).

(19) DoD Medical Treatment Facilities (MTF) will potentially be overwhelmed by patients, dependents, and beneficiaries, necessitating outsourcing and alternate care facilities. Treatment of military personnel and other beneficiaries may be prioritized at those outsourced facilities, with changes in priorities and altered standards of medical care during a deadly disease outbreak.

(20) Department of State (DOS) will request DoD support for selective Non-Combatant Evacuation (NEO) of designated non-infected individuals from areas abroad experiencing outbreaks. This will only be conducted after all other methods of extraction have been exhausted by DOS and only when directed by the Secretary of Defense (SecDef). As stated in the DoD Implementation Plan this will only cover areas experiencing outbreaks. Outbreaks are defined in the National Implementation Plan as an epidemic limited to a localized increase in the incidence of disease.

(21) Some military movements, basing, over flight as well as support to coalition operations, may be restricted by other countries. If DOS requests DoD support of NEO operations, DOS will obtain diplomatic clearances and country access required for military support of NEO operations.

(22) DoD will be called upon to assist in the transportation of American Citizens (AMCITS) living abroad if deemed necessary by public health officials or the DOS.

(23) In accordance with existing agreements, and in limited circumstances, under Immediate Response Authority, DoD will provide support to local communities' medical efforts with personnel, equipment, pharmaceuticals, supplies, and facilities within DOD capabilities, as requested.

(24) Under applicable authorities, DOD will assist civil authorities in the event of an outbreak.

(25) DOD reliance on "just-in-time" procurement will compete adversely with U.S. and foreign civilian businesses for availability of critical supplies.

(26) DoD Title 10 Reserve Component forces will need to be quickly mobilized to provide surge capabilities, especially in the areas of transportation, command and control, communications, engineering, logistics, force protection, maintenance, aviation and security.

(27) DOS Shelter-in-Place policy will be followed unless other conditions (e.g., civil disturbance or political instability force an evacuation). If a Shelter-in-Place policy is not feasible, DOD will be called upon to assist in the transportation of AMCITS living abroad if deemed necessary.

(28) DOS/United States Agency for International Development (USAID) will request support from DOD to provide Humanitarian Assistance/Disaster Relief support to the international community.

(30) National Guard Bureau forces, minus those subject to the needs of national security (e.g., CCMRF units called to Title 10 status), will remain in place to provide support to the Governors of the individual states.

(31) A surge in private demand for consumer goods (stockpiling) will cause DOD shortfalls.

(32) There will be a significant reduction in civilian transportation capacity that could affect DOD acquisition/distribution.

d. Friendly. The potential scope of a biological hazard incident is enormous, and the response to a deadly disease will involve many organizations. Accordingly, it is critical to establish communications linkages, liaison requirements, authorities, and agreements necessary to facilitate a rapid, coordinated interagency and international response to a biological hazard event. Further, these roles and coordination must be in effect in advance of a deadly disease event. Federal Departments and Agencies include:

(1) U.S. Department of Health and Human Services (HHS). The Secretary of HHS will be the primary agency coordinating the overall public health and medical response efforts across all federal departments and agencies and serve as the principal federal spokesperson for the U.S. Government on biological hazard health issues.

(2) U.S. Department of Homeland Security (DHS). The Secretary of Homeland Security, will coordinate the Federal response to save lives, maintain confidence in the government, sustain critical infrastructure, and recover from biological hazard incidents in the United States, its territories, commonwealths and possessions.

(3) U.S. Department of Agriculture (USDA). The Secretary of USDA is responsible for overall coordination of veterinary response to a domestic animal outbreak of biological hazards with deadly potential and ongoing surveillance of domestic animals and animal products.

(4) U.S. Department of State (DOS). The Secretary of State is responsible for the coordination of the international preparation

and response, including persuading other nations to join our efforts to contain or slow the spread of biological hazards, helping to limit the adverse impacts on trade and commerce, coordinating our efforts to assist other nations that are impacted by the biological hazard event, and interdiction with all official and non-official American Citizens (AMCITs) overseas.

e. Legal and Policy Considerations. Significant legal and policy issues could arise during operations in a biological hazard incident environment.

(1) Emergency Health Powers (EHP). To protect military and civilian personnel and DOD property, EHP enables the restriction of movement, the use of containment strategies (e.g., isolation, quarantine, social distancing) as well as medical evacuation and treatment. Installation Commanders are authorized upon consultation with their designated Public Health Emergency Officer (PHEO) to invoke these powers. Commanders at OCONUS locations may be restricted in the execution of these powers by HN laws and applicable international agreements. GCCs and the Marine Corps will ensure unity of effort in the implementation of EHP in the GCCs AORs and that the implementation of EHP does not violate applicable law and/or policy.

(2) Force Health Protection (FHP). Under existing FHP policy, a CCDR's responsibility/authority for FHP is limited to assigned or attached forces under the current forces for and to its subordinate commands/headquarters. COCOMs, Services, and DOD Agencies will ensure unity of effort in the implementation of FHP in the GCC's AOR. Under current FHP policy, Services retain existing FHP authorities and responsibilities. SecDef may, under extreme circumstances, choose to transfer to a CCDR authority for FHP over all DOD personnel within their AOR.

(3) Defense Support of Civil Authorities (DSCA). As directed by SecDef, CCDR will provide support to civil authorities. CCDRs in coordination with their Staff Judge Advocate will ensure that the support complies with applicable legal authorities and/or policy.

(4) International Support. COCOMs tasked to provide foreign humanitarian assistance or disaster relief to foreign countries within their AOR will, in coordination with their Staff Judge Advocate, ensure that it is done in accordance with applicable international agreements, laws and policies.

(5) Standing Rules of Engagement (SROE) and Standing Rules for the Use of Force (SRUF). SROE and SRUF will apply during a response to biological hazard incident. In addition, any COCOM theater specific ROE and SecDef approved mission specific RUF will remain in effect. GCCs may augment the as necessary by submitting a request for mission specific Rules of Engagement/Rules for the Use of Force

(ROE/RUF) to the CJCS. National Guard Forces performing in a non-federalized status are governed by their respective State's ROE/RUF.

(6) The Federal Government has legal authority to prioritize distribution of vaccines and antivirals.

(7) Defense Production Act authorizes the Federal Government to require manufacturers to give priority for goods and services necessary or appropriate to promote the national defense.

(8) Commander USNORTHCOM will provide assessments and recommendations to the SecDef through the Joint Staff on biological hazards related resource and policy decisions in other AORs that may impact Homeland Defense (HLD) and DSCA within the USNORTHCOM AOR.

2. Mission. The U.S. Marine Corps will prepare for potential outbreaks of biological hazards on its bases and installations and within forces through decentralized, synchronized, installation level DCPs. If a biological hazard event occurs, the Marine Corps, in partnership with Naval Bureau of Medicine, must execute mitigation strategies of containment, interdiction and stabilization and recovery in order to maintain force readiness.

3. Execution

a. Commander's Intent and Concept of Operations

(1) Commander's Intent. Minimize the effects of biological hazards against Marine Corps forces and their impact to operations and installation infrastructure; while simultaneously supporting, within capabilities, the USG domestic and international biological incident response.

(a) Essential Tasks

1. Medical surveillance, analysis, and reporting/dissemination.

2. Force Health Protection.

3. Assure capability to project and sustain combat power.

4. Support the USG biological incident response.

5. Assure capability to project & sustain combat power.

6. Coordinate and synchronize DCP.

(b) End State. Marine Corps Installations and Marine Forces (MARFORS) maintain operational effectiveness.

(c) Strategic Objectives. The effects of biological incidents are mitigated, forces maintain freedom of movement worldwide and U.S. partners have assurance of support.

(d) Desired Effects. The effects of biological incidents are mitigated and contained, and MARFORS are able to continue to operate in support of national interests.

(2) Concept of Operations. The center of gravity will be the installation. Installation Commanders will plan and execute in coordination with Bureau of Medicine and Surgery (BUMED), HN, State, local, tribal and private sector entities. Installations will initiate coordination with other military installations within a 100 mile radius.

b. Tasks

(1) Deputy Commandant, Plans Policies and Operations

(a) Serve as the lead office on DCP and response matters for the Marine Corps. Appoint a full-time planner to serve as the POC for all biological hazard event issues.

(b) Provide policy and planning guidance to enable the development of MARFOR and Marine Corps Installations Command DCP.

(c) Provide policy and planning guidance to enable the development and maintenance of a Disease Containment Plan annex to the Headquarters Marine Corps (HQMC) COOP Plan.

(d) In coordination with Health Services (HS), HQMC, provide policy and planning guidance for novel virus, pathogens and biological hazards.

(e) In coordination with Manpower and Reserve Affairs (M&RA), establish guidelines and procedures for the recall of Reserve personnel with critical skill sets in accordance with policy guidance from the Office of the Assistant Secretary of Defense Reserve Affairs (OSD(RA)).

(f) Assist Marine Forces North in coordinating with USNORTHCOM to ensure that policy and plans are developed and synchronized.

(g) Assist MARFORS, Marine Corps Recruiting Command, Marine Corps Systems Command, Marine Corps logistics Command, MCRC, MARCSYSCOM, MARCORLOGCOM and Installations in synchronizing their DCP with corresponding GCC biological hazard Contingency Plan (CONPLANS).

(2) Director of Health Services HQMC

(a) Advise the Commandant of the Marine Corps (CMC) and his operational and medical staff concerning FHP priorities necessary to ensure COOP throughout Disease Response Activities.

(b) Coordinate policies, plans, procedures, and guidelines with the BUMED to fully employ the resources of Navy Medicine and mitigate the biological hazard incident impact upon Marine Corps Installations and Operations. Specifically, coordination must address Marine Corps dependencies upon BUMED controlled assets, such as garrison MTF and public health support, to ensure:

1. PHEOs are properly allocated and trained to support Marine Corps Installation Commanders.

2. FHP program elements are consistent with FHP measures aligned by phase.

3. Community strategy guidance is provided to affected Marine Corps installations, including the procedures and guidelines for using Personal protective equipment, imposing quarantine or isolation, and screening and/or transporting patients.

4. Access to healthcare resources is provided for affected and eligible military/DoD personnel and family members at all Marine Corps installation MTFs.

5. MTFs that operate on Marine Corps installations perform daily surveillance and trend analysis in accordance with DoD policy, and report evidence of potentially emerging biological hazards to all affected installation commanders and higher headquarters.

6. Immunization of military units and key critical personnel is initiated once a licensed vaccine is available and supplies and distribution are adequate.

7. Occupational Environmental Health Survey assessments are conducted, as appropriate.

8. Theater distribution and tracking plans for antivirals, vaccines, ventilators, and other medical supplies/equipment for the GCCs is appropriately developed and executed.

9. Adequate stocks and sourcing of medical material are maintained.

10. Plans are in place to activate and deploy medical personnel to augment/support appropriate biological hazard related medical operations as directed by higher authority. Plans must

include provisions for mental health and screening criteria at aero-medical evacuation hubs and ports of debarkation.

11. In coordination with BUMED ensure antivirals and other essential medical supplies are pre-positioned at each installation MTF to support key populations.

12. Adverse events following a vaccine and/or antiviral administration are tracked and reported.

(3) Deputy Commandant, Manpower and Reserve Affairs

(a) Develop military/civilian personnel policy and guidance to address the following in the event of a biological hazard event:

1. Wounded, Ill and Injured care.
2. Telework.
3. Child care.
4. Financial assistance.
5. Educational needs.
6. Locator assistance.
7. Family employment.
8. Recall from TAD/Leave.
9. Retiree recall.
10. Stop Loss.
11. Stop Movement.
12. Implementation of Safe Haven.
13. Casualty Assistance

(b) Ensure screening of the Ready Reserve specifically addresses availability for activation during a biological hazard incident. Provide a report on impacts to Selected Reserve availability (due to the critical nature of their civilian occupations) to Deputy Commandant, Plans Policies and Operations no later than 180 days after ASD (MRA) releases its policy for

utilization of the National Guard and Reserves during a biological hazard event.

(c) In coordination with OSD and Office of Personnel Management, develop policy and advise Marine Corps leadership on civilian (appropriated funds and non-appropriated fund) personnel work flexibilities, limitations, and responsibilities during preparation for, response to, and recover from a biological hazard incident. Scope of task includes, but is not limited to; work hours, telework, social distancing, liberal leave (with or without pay), and other non-pharmaceutical FHP measures.

(d) In coordination with the Deputy Commandant, Installation and Logistics, authorize emergency hiring and contracting authorities to fill critical personnel shortages during and after a biological hazard incident.

(4) Director, Intelligence

(a) Develop and disseminate policies regarding intelligence support to a biological hazard incident across all phases of the event.

(b) Track global biological hazard spread.

(c) Provide threat indications, warning and assessments relating to biological hazard events.

1. Intelligence efforts will be focused by Priority Intelligence Requirements, and Commanders Critical Information Requirements (CCIR).

2. Assigned and attached units will submit information of intelligence value as soon as possible and pass critical information via the most expeditious means available.

(d) Monitor secondary and tertiary effects of biological hazard events on state and non-state actors.

(e) Develop and maintain interagency and international relationships to share biological hazard event information, including communications.

(5) Deputy Commandant, Installations and Logistics

(a) In coordination with Deputy Commandant, PP&O, operate as integral partners to define, develop, and implement appropriate DCP requirements.

(b) Analyze and provide support for critical infrastructure protection of critical maintenance, supply, and logistics process, facilities, and assets against biological hazards.

(c) In conjunction with Defense Logistics Agency, identify critical supplies, goods or services that require priority delivery from industry/suppliers to ensure COOP and sustainment of key population.

(d) Ensure MA plans address fatality management assistance in the collection of ante-mortem information and Deoxyribonucleic Acid samples in order to insure proper identification of remains, and advise personnel and families as needed regarding the process.

(e) Ensure guidance exists to address temporary housing during a biological hazard incident.

(f) In coordination with the Deputy Commandant, M&RA, authorize emergency hiring and contracting authorities to fill critical personnel shortages during and after a biological hazard incident.

(g) Be prepared to support HSS in conducting open or closed Points of Dispensing.

(6) Director, C4. Be prepared to provide Command, Control, Communication and Computers (C4) assets, personnel and expertise upon request to COCOMs, Joint Task Forces, Joint Communications Control Centers, MARFORs, and Installations in the event of a biological hazard incident.

(7) Deputy Commandant, Combat Development and Integration/Commanding General, Marine Corps Combat Development Command. Identify the roles and responsibilities regarding how studies, analysis, assessments and lessons learned for biological hazard incidents will be requested, the reporting format required and the appropriate recipients; as well as, how the information will be used to improve plans and response capabilities.

(8) Chaplain of the Marine Corps

(a) Provide religious activity support and guidance in the event of a biological hazard incident.

(b) Identify areas in the DCP that require or recommend Chaplain Service support, such as MA and Medical Services. Describe procedures to ensure religious support during emergency situations.

(c) Clearly identify the boundaries of service in the event of a biological hazard incident to avoid inadvertent spread of the disease.

(d) Within existing capabilities, surge pastoral care and religious support for both living and deceased Marine Corps personnel.

(9) Deputy Commandant, Program and Resources

(a) Identify resource shortfalls to OSD, as applicable, to ensure execution of Shape Phase (Phase 0) and Prevent Phase (Phase 1), and to begin preparation of remaining phases.

(b) Capture costs during all biological hazard phases for the ultimate reimbursement from the primary agency.

(10) Staff Judge Advocate to the CMC

(a) In coordination with GCCs, ensure unity of effort in the implementation of EHP in each GCC AOR and that the implementation of EHP does not violate applicable law and/or policy.

(b) Advise the CMC regarding policy and legislative issues and changes that will affect support to affected active and reserve component personnel and family members.

(11) Office of Marine Corps Communication

(a) Develop a comprehensive internal and external public affairs (PA) strategy (as directed) that supports DOD objectives.

(b) Ensure clear, effective and coordinated risk communication, before and during a biological hazard incident. Communicate/disseminate public health advisories, strategic communication themes and other messages consistent with Assistant SecDef for PA and Assistant SecDef for HLD and Global Security (ASD(HD&GS)) guidance, National and DOD policy and guidance.

(12) Commander, Training and Education Command. In coordination with HS HQMC, develop and disseminate specific training materials that stress preventive measures during a biological hazard incident. Ensure these training materials are used during Initial Entry Level Training for both officer and enlisted students.

(14) Commander, Marine Forces North

(a) Coordinate with USNORTHCOM in its execution of applicable USNORTHCOM CONPLANS.

(b) Synchronize staff actions with USMC Supporting Establishment Commands and all USMC attached and assigned forces to USNORTHCOM.

(15) Commander, Marine Corps Installations Command; Commanders, Marine Forces

(a) Utilize existing working groups to address DCP. Appoint appropriate core membership (to include tenant commands as applicable).

(b) Conduct situational assessment and gap analysis to identify mitigations, shortfalls and vulnerabilities.

(c) In coordination with supporting MTF (if applicable), develop a DCP with biological hazard incident Annexes' conforming in scope and format with enclosure (2).

(d) In coordination with DC PP&O, develop and maintain a disease containment plan within existing COOP plans to include:

1. Risk communications.
2. Alternative work schedules.
3. Telework.
4. Social distancing.
5. Isolation/quarantine.
6. Geographic dispersion.
7. Alternate operating locations.
8. PPE.
9. Delegations of authority.
10. Orders of succession.
11. Cross training of personnel.
12. Travel restrictions.
13. Personnel accountability.
14. Vaccinations/antivirals.

(e) Program and budget (to include Personnel Operations and Maintenance inputs) necessary resources to maintain and execute the DCP. Ensure funding is requested and allocated for external coordination consistent with desired external coordination effects and corresponding capabilities shortfalls.

(f) Establish and maintain appropriate Memorandums of Understanding (MOUs) and Mutual Aid Agreements (MAAs) with HN, local, State, tribal, Federal and HN civil authorities, private sector organizations and other federal facilities to address local support that either party might provide for immediate response to homeland emergencies. Ensure that Marine Corps commitments under MOUs/MAAs are

consistent with relevant regulatory and statutory requirements, including specific funding authorities. Coordinate all new or re-validated MOUs/MAAs with appropriate organizations.

(g) Develop and actively provide biological hazard preparedness information tailored to Key Population in the local area. Provide PHEO guidance for developing and implementing movement restrictions, individual protection, and social distancing strategies (including unit shielding, vessel sortie, cancellation of public gatherings, drill, ceremonies, training, etc.)

(h) When directed, receive, store, secure, maintain, and distribute PPE/vaccines and antivirals for a pandemic threat in coordination with GCC and Assistant SecDef for Health Affairs (ASD(HA)) prioritization guidance.

(i) Be prepared to conduct as situational appropriate, DSCA or Humanitarian Assistance/Disaster Relief. including but not limited to the following activities:

1. General Public Safety and Security, to include but not limited to:

a. Assist with the protection of emergency responder and other workers operating in a high-threat environment.

b. Conduct health surveillance to assist in public safety and security efforts, and provide technology support, as appropriate.

c. Execute security measures for quarantine and certain public health laws, including but not limited to isolation and other restriction of movement measures per approved ROE.

2. Security (food, water, pharmaceutical), to include but not limited to:

a. Assist in determining the location and status of suspected contaminated food and water supplies (may include conducting epidemiological investigations).

b. Assist in mobilization and staging of food supplies, including facilities and personnel to offload, store, allocate, and reload for shipment to food preparation/distribution sites within the disaster area.

c. Providing physical security for vaccines and antivirals in support of civil authorities.

3. Emergency Management, to include but not limited to:

a. Alert, notify, and assist with situation reports and assessments to regional and field components during a disaster/emergency.

b. Identify and implement compatible resource tracking systems when possible.

c. Provide Chemical, Biological, Radiological, Nuclear and Explosive subject matter experts and technical resources for planning and decision-making.

4. Mass Care Housing and Human Services, to include but not limited to:

a. Assist in establishing priorities and coordinating the transition of mass care operations with recovery activities.

b. Ensure water, ice, and other emergency commodities and services requirements are delivered to appropriate entities.

c. Provide assistance for the short and long-term housing needs of victims.

d. Provide assistance in constructing temporary shelter facilities in the affected area, as required.

e. Provide mass care functions including overall coordination, shelter, feeding, emergency first aid, disaster welfare information, bulk distribution, and other activities to support emergency needs of victims.

f. Support various services impacting individuals and households, including a coordinated system to address victims' incident related recovery efforts through crisis counseling and other supportive services.

5. Coordinate with Public Health and Medical Services, to include but not limited to:

a. Health Surveillance (Conduct field studies and investigations; Enhance surveillance systems to monitor the health of the general population and special high-risk populations; and identify diseases for which quarantine is appropriate).

b. Medical Care Personnel (Provide available personnel for support in hospital care and outpatient services to

victims who become seriously ill or injured; and Provide available personnel with immediate medical response capabilities).

c. Provide Health/Medical Equipment and Supplies and Behavioral Health Care.

d. Patient Evacuation and Patient Care Services (Provide available personnel to support inpatient hospital care and outpatient services to victims who become seriously ill or injured regardless of location and provide contagious casualty support, including isolation, quarantine, and restriction of movement).

6. Support mass fatality management

7. Support USDA animal eradication

(j) On order, restrict travel and personnel movement to areas experiencing a biological hazard outbreak. Ensure mission essential personnel entering such areas are provided with antiviral prophylaxis and vaccines, when available, and individual PPE. Personnel restriction is necessary to avoid moving unexposed personnel into an area experiencing an outbreak and/or to avoid allowing potentially infectious personnel to return to a biological hazard free area.

(k) On order, cancel or postpone all non-critical operations, exercises, or activities in areas with confirmed, sustained, human-to-human transmission of a biological hazard agent/virus.

(l) On order, implement policy and procedures for the Novel Influenza Vaccine Immunization Program.

(m) On order, implement policy and procedure for novel biological hazard Pre-Deployment Screening.

(16) Commander, Marine Forces Reserve

(a) Develop DCPs with biological hazard Annexes' conforming in scope and format to enclosure (2), to prevent, protect against, respond to and recover from a biological hazard incident affecting the Reserve Centers, Reserve Support Units their key population and critical infrastructures. Ensure DCP is coordinated and synchronized with USNORTHCOM and other GCCs, other geographically proximate (100 mile radius) service installations, and regional, State and local first responder emergency planning, and health authorities. Ensure plans prepare and exercise DCP, prevention, response and recovery with external partners.

(b) In coordination with DC PP&O, develop and maintain a disease containment plan within existing COOP plans to include:

1. Risk communications.
2. Alternative work schedules.
3. Telework.
4. Social distancing.
5. Isolation/quarantine.
6. Geographic dispersion.
7. Alternate operating locations.
8. PPE.
9. Delegations of authority.
10. Orders of succession.
11. Cross training of personnel.
12. Travel restrictions.
13. Personnel accountability.
14. Vaccinations/antivirals.

(c) Prepare for HQMC submission to USNORTHCOM, an assessment based upon OSD(RA) policy of which Marine Corps Reserve forces should not be available for activation given a biological hazard event, under appropriate authorities, due to the critical nature of their civilian occupations (first responders, health and medical professionals, transportation industry, critical infrastructure sustainment, etc.). At a minimum this study should be broken out by State, category of recall, skills set and specifically address the impact on anticipated DOD biological hazard incident response operations.

(d) Be prepared to provide Marine Corps Reserve forces to conduct the following types of operations within a biological hazard environment:

1. Transportation
2. Command and control

3. Communication
4. Engineer
5. Logistics
6. Force Protection
7. Maintenance
8. Aviation
9. Security
10. Mortuary Affairs (MA)

(e) On order, implement policy and procedure for Novel Influenza Pre-Deployment Screening.

(17) Commander Marine Corps Recruiting Command

(a) Develop DCPs with biological hazard Annexes' conforming in scope and format to Enclosure (2), to prevent, protect against, respond to and recover from a biological hazard incident affecting Marine Corps Recruiting Districts. Ensure DCP is coordinated and synchronized with USNORTHCOM and other GCCs, other geographically proximate (100 mile radius) service installations, and regional, State and local first responder emergency planning, and health authorities.

(b) In coordination with DC PP&O, develop and maintain a disease containment plan within existing COOP plans to include:

1. Risk communications.
2. Alternative work schedules.
3. Telework.
4. Social distancing.
5. Isolation/quarantine.
6. Geographic dispersion.
7. Alternate operating locations.
8. PPE.
9. Delegations of authority.

- 10. Orders of succession.
- 11. Cross training of personnel.
- 12. Travel restrictions.
- 13. Personnel accountability.
- 14. Vaccinations/antivirals.

c. Coordinating Instructions

(1) This plan is effective for planning upon receipt, and for execution on order.

(2) HQMC agencies COOP response roles and responsibilities are outlined in Annex E to HQMC COOP Plan.

(3) All biological hazard incidents, DSCA will be provided on a reimbursable basis unless the operation was ordered by the President of the United States or reimbursement is waived by the SecDef. Support provided under Immediate Response Authority should be on a cost-reimbursable basis, if possible. Marine Corps organizations will capture costs during all phases of the biological hazard incident for possible reimbursement from the Primary Agencies.

(4) CDRUSNORTHCOM and CDRUSPACOM shall be the coordinating authorities for any biological hazard event and DSCA operations in their respective Joint Operations Areas.

(5) Commanders responding under Immediate Response Authority will notify their appropriate service component command and Marine Corps Operations Center within 1 hour. For responses within the NORTHCOM JOA, Marine Corps Operations Center will, within 1 hour of receipt, notify the North American Aerospace Defense Command-USNORTHCOM Operations Center and the National Military Command Center (NMCC).

(6) Director, HQMC PA is the HQMC agent and delegating authority for the Marine Corps response to all media inquiries concerning Marine Corps biological hazard operations. Any Marine Corps response must take into account possible media contribution to GCCs mitigation efforts in support of the Primary Agencies.

(7) Direct Liaison Authority (DIRLAUTH). DIRLAUTH is authorized with Marine Corps organizations as listed in plan for the purposes of planning, synchronizing, and execution of this plan. Within USNORTHCOM JOA, Commanders, MARFORs are authorized DIRLAUTH with State, local, tribal and private sector planning partners. Outside of USNORTHCOM JOA, Marine Corps defer DIRLAUTH with HNs to CCDRs. In all cases, keep HQMC informed.

(8) Marine Corps installations will ensure that tenant units, Marine Corps and other Services, are incorporated into their Disease Containment Plan.

(9) Marine Corps organizations that are tenants or part of a joint base will ensure they are incorporated into the host installation's Disease Containment Plan, this can be accomplished through the installation Emergency Operations Center or through participation in the installations Emergency Management Working Group.

4. Administration and Logistics

a. Commanders/Commanding Officers shall ensure adequate staff and budget are provided to implement a comprehensive disease containment plan to meet the requirements of this Order.

b. Commanders shall publish local implementing guidance and appropriate supplemental policies. Such guidance must be consistent with this Order, but commanders may implement more detailed rules to meet their needs. CCDR Concept Plans and guidance shall be integrated into appropriate orders, training, educational programs, SOPs and deployment checklists.

c. Installations are the supported commands for biological incident preparation and planning. Tenant units and organizations are the supporting commands.

d. Installation DCP's are not authorized for destruction. Commanders/Commanding Officers shall maintain all plans until a records disposition is established.

e. Records created as a result of this Order shall be managed according to National Archives and Records Administration approved dispositions to ensure proper maintenance, use, accessibility and preservation, regardless of format or medium.

f. Privacy Act. Any misuse or unauthorized disclosure of Personally Identifiable Information (PII) may result in both civil and criminal penalties. The DON recognizes that the privacy of an individual is a personal and fundamental right that shall be respected and protected. The DON's need to collect, use, maintain, or disseminate PII about individuals for purposes of discharging its statutory responsibilities will be balanced against the individuals' right to be protected against unwarranted invasion of privacy. All collection, use, maintenance, or dissemination of PII will be in accordance with the Privacy Act of 1974, as amended and implemented.

5. Command and Signal

a. Command. This Order is applicable to the Marine Corps Total Force.

b. Signal. This Order is applicable the date signed.

A handwritten signature in black ink, appearing to read "B. D. Beaudreault", with a long horizontal stroke extending to the right.

B. D. BEAUDREULT
Deputy Commandant for
Plans, Policies and Operations

DISTRIBUTION: PCN 10209391200

Specific Diseases

1. Influenza (Flu). Influenza or the flu is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death. Some people, such as older people, young children, and people with certain health conditions, are at high risk for serious flu complications. Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes. There are many types of influenza viruses to include H1N1 (Swine Flu) and H7N9 (Bird Flu).

a. Symptoms. Fever or feeling feverish/chills, cough, sore throat, runny or stuffy nose, muscle or body aches, headaches, fatigue, some people may have vomiting and diarrhea, though this is more common in children than adults.

b. Incubation Period. You may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick. Most healthy adults may be able to infect others beginning one day before symptoms develop and up to five to seven days after becoming sick. Some people, especially young children and people with weakened immune systems, might be able to infect others for an even longer time.

c. Method of Transmission. Most experts believe that flu viruses spread mainly by droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby. Additionally, a person might also get flu by touching a surface or object that has flu virus on it and then touching their own mouth, eyes or possibly their nose.

d. Vaccination. The best way to prevent the flu is by getting vaccinated each year. All military personnel are required to receive their vaccination from the Naval Hospital Branch Clinic. Yearly flu vaccination should begin soon after flu vaccine is available, and ideally by October. However, getting vaccinated even later can be protective, as long as flu viruses are circulating. Since it takes about two weeks after vaccination for antibodies to develop in the body that protect against influenza virus infection, it is best that people get vaccinated as soon as vaccine is available so they are protected before influenza begins spreading in their community.

e. Treatment. Antiviral drugs and supportive care.

f. Specific PPE. No specific PPE recommendations; however, people help protect themselves from respiratory illnesses by taking everyday preventive actions:

- (1) Try to avoid close contact with sick people.

(2) If you are sick with flu-like illness, stay home for at least 24 hours after your fever is gone except to get medical care or for other necessities.

(3) While sick, limit contact with others as much as possible to keep from infecting them.

(4) Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.

(5) Wash your hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub.

(6) Avoid touching your eyes, nose and mouth. Germs spread this way.

(7) Clean and disinfect surfaces and objects that may be contaminated with germs like the flu.

2. Viral Hemorrhagic Fever (VHF). Viral hemorrhagic fevers (VHFs) refer to a group of illnesses that are caused by several distinct families of viruses to include Arenaviridae, Bunyaviridae, Filoviridae, Flaviviridae, and Paramyxoviridae. In general, the term "viral hemorrhagic fever" is used to describe a syndrome affecting multiple organs in the body in which the overall vascular system is damaged, and the body's ability to regulate itself is impaired. These symptoms are often accompanied by hemorrhage (bleeding); however, the bleeding is itself rarely life-threatening. While some types of hemorrhagic fever viruses can cause relatively mild illnesses, many of these viruses cause severe, life-threatening disease.

a. Symptoms. Specific signs and symptoms vary by the type of VHF, but initial signs and symptoms often include marked fever, fatigue, dizziness, muscle aches, loss of strength, and exhaustion.

b. Incubation Period. One to twenty-one days.

c. Method of Transmission. Rodents and arthropods are the natural reservoir of these viruses, although some hosts of the viruses remain unknown. Viruses causing hemorrhagic fever are initially transmitted to humans when the activities of infected reservoir hosts or vectors and humans overlap. The viruses carried in rodent reservoirs are transmitted when humans have contact with urine, fecal matter, saliva, or other body excretions from infected rodents. The viruses associated with arthropod vectors are spread most often when the vector mosquito or tick bites a human, or when a human crushes a tick. However, some of these vectors may spread virus to animals, livestock, for example. Humans then become infected when they care for or slaughter the animals. Some viruses that cause hemorrhagic fever, such as Ebola, Marburg, Lassa and Crimean-Congo hemorrhagic fever viruses can spread from one person to another, once an initial person has become infected. Human-to-human transmission of the virus

occurs via direct contact to droplets of body fluids from infected persons, or contact with equipment and other objects contaminated with infectious blood or tissues. Cases or outbreaks of hemorrhagic fevers caused by these viruses typically occur in parts of the world where both the virus and hosts co-exist. Outbreaks are sporadic and irregular. The occurrence of outbreaks cannot be easily predicted. Occasionally people become infected by a host that has been exported from its native habitat or by a person becoming infected in an area where the virus occurs naturally and then traveling elsewhere. If the virus is a type that can be transmitted further by person-to-person contact, the infected traveler could infect other people..

(1) Crimean-Congo hemorrhagic fever (CCHF) is caused by infection with a tick-borne virus (*Nairovirus*) in the family *Bunyaviridae*. Crimean-Congo hemorrhagic fever is found in Eastern Europe, particularly in the former Soviet Union, throughout the Mediterranean, in northwestern China, central Asia, southern Europe, Africa, the Middle East, and the Indian subcontinent. Transmission occurs from Ixodid (hard) ticks, especially those of the genus, *Hyalomma*. Numerous wild and domestic animals, such as cattle, goats, sheep and hares, serve as amplifying hosts for the virus. Transmission to humans occurs through contact with infected ticks or animal blood. CCHF can be transmitted from one infected human to another by contact with infectious blood or body fluids. Documented spread of CCHF has also occurred in hospitals due to improper sterilization of medical equipment, reuse of injection needles, and contamination of medical supplies.

(2) Marburg hemorrhagic fever (Marburg HF) is a rare but severe hemorrhagic fever which affects both humans and non-human primates. The reservoir host of Marburg virus is the African fruit bat. Infection may occur from unprotected contact with infected bat feces or aerosols or from contact with an infected person via direct contact with infectious droplets of body fluids, or contact with equipment and other objects contaminated with infectious blood or tissues.

(3) Because the natural reservoir host of Ebola viruses has not yet been identified, the way in which the virus first appears in a human at the start of an outbreak is unknown. However, scientists believe that the first patient becomes infected through contact with an infected animal, such as a fruit bat or primate (apes and monkeys). Person-to-person transmission follows and can lead to large numbers of affected people. When an infection occurs in humans, the virus can be spread to others through direct contact (through broken skin or mucous membranes in, for example, the eyes, nose, or mouth); with blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with or has died from Ebola, by objects (like needles and syringes) that have been contaminated with body fluids from a person who is sick with Ebola or the body of a person who has died from Ebola, from infected fruit

bats or primates (apes and monkeys), and possibly from contact with semen from a man who has recovered from Ebola (for example, by having oral, vaginal, or anal sex).

d. Vaccination. All vaccinations are in human trials at this time.

e. Treatment. With a few noteworthy exceptions, there is no cure or established drug treatment for VHFs.

f. Prevention. Avoid contact with host species (i.e. rodents, ticks, mosquitos). Disease prevention efforts include: controlling rodent populations; discouraging rodents from entering or living in homes or workplaces; encouraging safe cleanup of rodent nests and droppings, insect control, the use of insect repellent, proper clothing, bednets, window screens, proper clothing to minimize skin exposure, avoiding close physical contact with infected people and their body fluids is the most important way of controlling the spread of disease, isolation of infected persons.

g. Specific PPE. Maintain the minimum splash protection for the eyes and mouth. All other areas of the body must be covered with double glove protection on the hands. Default to current CDC guidance.

3. Middle East Respiratory Syndrome (MERS). Middle East Respiratory Syndrome (MERS) is novel viral respiratory illness first reported in Saudi Arabia in 2012. It is caused by a [coronavirus](#) called MERS-CoV. Most MERS patients develop severe acute respiratory illness.

a. Symptoms. Severe acute respiratory illness with symptoms including fever, cough, and shortness of breath. Some people also had gastrointestinal symptoms including diarrhea and nausea/vomiting. For many people with MERS, more severe complications followed, such as pneumonia and kidney failure.

b. Incubation Period. Ranges from 2 to 14 days.

c. Method of Transmission. This virus has spread from ill people to others through close contact, such as caring for or living with an infected person. However, there is no evidence of sustained spreading in community settings.

d. Vaccination. Currently, there is no vaccine available to protect against MERS.

e. Treatment. There is no specific antiviral treatment recommended for MERS. Individuals with MERS can seek medical care to help relieve symptoms.

f. Specific PPE. No specific PPE recommendations unless caring for an ill patient; however, people help protect themselves from

respiratory illnesses by taking everyday preventive actions such as those listed in para 1.f of this enclosure.

4. Severe Acute Respiratory Syndrome (SARS). SARS is a viral respiratory illness caused by a coronavirus, called SARS-associated coronavirus (SARS-CoV). SARS was first reported in Asia in February 2003. Over the next few months, the illness spread to more than two dozen countries in North America, South America, Europe, and Asia before the SARS global outbreak of 2003 was contained. There have been no further outbreaks since this initial outbreak.

a. Symptoms. In general, SARS begins with a high fever (temperature greater than 100.4°F [$>38.0^{\circ}\text{C}$]). Other symptoms may include headache, an overall feeling of discomfort, and body aches. The majority of patients with SARS have a clear history of exposure either to a SARS patient(s) or to a setting in which a SARS-CoV outbreak is occurring, and develop pneumonia. Suspicion for SARS-CoV disease is raised if the patient has a recent history of travel to mainland China, Hong Kong, or Taiwan or close contact with ill persons with a history of recent travel to such areas. In general, SARS begins with a high fever (temperature greater than 100.4°F [$>38.0^{\circ}\text{C}$]). Other symptoms may include headache, cough, shortness of breath, difficulty breathing, sore throat, runny nose, diarrhea, an overall feeling of discomfort, and body aches. Most patients develop pneumonia.

b. Incubation Period. The incubation period for SARS is typically 2 to 7 days, although in some cases it may be as long as 10 days.

c. Method of Transmission. The main way that SARS seems to spread is by close person-to-person contact. The virus that causes SARS is thought to be transmitted most readily by respiratory droplets (droplet spread) produced when an infected person coughs or sneezes. Droplet spread can happen when droplets from the cough or sneeze of an infected person are propelled a short distance (generally up to 3 feet) through the air and deposited on the mucous membranes of the mouth, nose, or eyes of persons who are nearby. The virus also can spread when a person touches a surface or object contaminated with infectious droplets and then touches his or her mouth, nose, or eye(s). In addition, the SARS virus may be spread by small-particle aerosols (airborne spread).

d. Vaccination. No vaccine available.

e. Treatment. Treatment consists of supportive care. Antiviral drugs have not been effective so far but continue to be are being tested for effectiveness in treating SARS.

f. Specific PPE. No specific PPE recommendations; however, people should protect themselves from respiratory illnesses by taking

everyday preventive actions such as those listed in paragraph 1.f of this enclosure.

5. Smallpox. Smallpox is a serious, contagious, and sometimes fatal infectious disease. There are two clinical forms of smallpox. Variola major is the severe and most common form of smallpox, with a more extensive rash and higher fever. The disease has been eradicated after a successful worldwide vaccination program but still remains a risk due to its potential use as a mechanism of bioterrorism.

a. Symptoms. The first symptoms of smallpox include fever, malaise, head and body aches, and sometimes vomiting. The fever is usually high, in the range of 101 to 104 degrees Fahrenheit. At this time, people are usually too sick to carry on their normal activities. A rash emerges first as small red spots on the tongue and in the mouth. These spots develop into sores that break open and spread large amounts of the virus into the mouth and throat. At this time, the person becomes most contagious. Around the time the sores in the mouth break down, a rash appears on the skin, starting on the face and spreading to the arms and legs and then to the hands and feet. Usually the rash spreads to all parts of the body within 24 hours. As the rash appears, the fever usually falls and the person may start to feel better. By the third day of the rash, the rash becomes raised bumps. By the fourth day, the bumps fill with a thick, opaque fluid and often have a depression in the center that looks like a bellybutton. Fever often will rise again at this time and remain high until scabs form over the bumps. The bumps become pustules—sharply raised, usually round and firm to the touch as if there's a small round object under the skin. People often say the bumps feel like BB pellets embedded in the skin. The pustules begin to form a crust and then scab. By the end of the second week after the rash appears most of the sores have scabbed over. The scabs begin to fall off; leaving marks on the skin that eventually becomes pitted scars. Most scabs will have fallen off three weeks after the rash appears. The person is contagious to others until all of the scabs have fallen off

b. Incubation Period. Exposure to the virus is followed by an incubation period during which people do not have any symptoms and may feel fine. This incubation period averages about 12 to 14 days but can range from seven to seventeen days. During this time, people are not contagious.

c. Method of Transmission. Principally spread, person-to-person by the respiratory route following fairly prolonged close contact. Less commonly, smallpox can be spread through direct contact with infected bodily fluids or contaminated objects such as bedding or clothing. Rarely, smallpox has been spread by virus carried in the air in enclosed settings such as buildings, buses, and trains. Humans are the only natural hosts of variola. Smallpox is not known to be transmitted by insects or animals. Smallpox may be contagious during the *prodrome* phase, but is most infectious during the first seven to

ten days following rash onset. The person is contagious to others until all of the scabs have fallen off.

d. Vaccination. Vaccination is required for military populations deploying to certain AORs; however, routine vaccination of the American public against smallpox stopped in 1972 after the disease was eradicated in the United States. There are stockpiles of the vaccine available in the event of military contingencies or national emergencies.

e. Treatment. There is no specific treatment for smallpox disease.

f. Specific PPE. Anyone caring for a smallpox patient should wear an N95 mask. Airborne and contact isolation precautions should be followed. Default to current CDC guidance. If working with a SARS patient, use standard Precautions (with eye protection to prevent droplet exposure) plus Contact and Airborne Isolation Precautions. Respiratory protection using respirators providing at least 95% filtering efficiency (e.g., NIOSH-certified N-95 or higher-level filtering face piece respirator) with appropriate fit-testing is recommended.

6. Anthrax. Anthrax is a serious infectious disease caused by bacteria known as *Bacillus anthracis*. Anthrax can be found naturally in soil and commonly affects domestic and wild animals around the world. Although it is rare, people can get sick with anthrax if they come in contact with infected animals or contaminated animal products. Anthrax poses a risk to the military population due to its potential use as a mechanism of bioterrorism.

a. Symptoms

(1) Cutaneous anthrax symptoms can include a group of small blisters or bumps that may itch. A painless skin sore (ulcer) with a black center appears after the small blisters or bumps. Most often the sore will be on the face, neck, arms, or hands. Swelling can occur around the sore.

(2) Inhalation anthrax symptoms can include fever and chills, chest discomfort, shortness of breath, confusion or dizziness, cough, nausea, vomiting, stomach pains, headache, sweats (often drenching), extreme tiredness, and body aches.

(3) Gastrointestinal anthrax symptoms can include fever and chills, swelling of neck or neck glands, sore throat, painful swallowing, hoarseness, nausea and vomiting, especially bloody vomiting, diarrhea or bloody diarrhea, headache, flushing (red face) and red eyes, stomach pain, fainting, and swelling of the abdomen.

b. Incubation Period. The symptoms of anthrax depend on the type of infection and can take anywhere from 1 day to more than 2 months to appear. All types of anthrax have the potential, if untreated, to spread throughout the body and cause severe illness and even death.

c. Method of Transmission. People get infected with anthrax when spores get into the body. This can happen when people breathe in spores, eat food or drink water that is contaminated with spores, or get spores in a cut or scrape in the skin. Although it is rare, people can get sick with anthrax if they come in contact with infected animals or contaminated animal products. Anthrax is not contagious in the way of transmitting the disease from one person to another. Anthrax can be weaponized and used as a biological weapon.

d. Vaccination. While there is a vaccine licensed to prevent anthrax, it is not typically available for the general public. Those with an occupational risk of exposure (including military personnel in certain environments) receive the vaccination to help prevent disease.

e. Treatment. Doctors have several options for treating patients with anthrax, including antibiotics and antitoxin. Patients with serious cases of anthrax will need to be hospitalized. They may require aggressive treatment, such as continuous fluid drainage and help breathing through mechanical ventilation.

f. Specific PPE. Default to current CDC guidance.

7. Zika Virus. Zika virus is an emerging viral disease that is transmitted through the bite of an infected mosquito, primarily *Aedes aegypti*, the same vector that transmits chikungunya, dengue and yellow fever. Zika has a similar epidemiology, clinical presentation and transmission cycle in urban environments as chikungunya and dengue, although it generally causes milder illness. Zika virus was first identified in 1947 in a monkey in the Zika forest of Uganda, and was first isolated in humans in 1952 in Uganda and the United Republic of Tanzania. Zika virus has been causing sporadic disease in Africa and Asia. Outbreaks were reported for the first time from the Pacific in 2007 and 2013 in Yap Island (Federated States of Micronesia) and French Polynesia, respectively. There was subsequent spread of the virus to other Pacific islands, including New Caledonia, Cook Islands, Easter Island (Chile), Fiji, Samoa, Solomon Islands and Vanuatu. The geographical range of Zika virus has been steadily increasing.

a. Symptoms. The Zika virus disease include fever, skin rash, conjunctivitis, muscle and joint pain, malaise and headache, which normally last for 2 to 7 days. About 1 in 5 people infected with the Zika virus have illness signs and symptoms. There is no specific treatment but symptoms are normally mild and can be treated with common pain and fever medicines, rest and drinking plenty of fluids. Other chronic health effects can include:

(1) Microcephaly, which is a neonatal malformation defined as a head size much smaller compared with other babies of the same age and sex. If this combines with poor brain growth, babies with microcephaly can develop developmental disabilities. The severity of microcephaly ranges from mild to severe.

(2) Guillain-Barré syndrome (GBS), the body's immune system attacks part of the peripheral nervous system. The syndrome can affect the nerves that control muscle movement as well as those that transmit feelings of pain, temperature and touch. This can result in muscle weakness and loss of sensation in the legs and/or arms. It is a rare condition, but people of all ages can be affected, however it is more common in adults and in males. Even in the best of settings, 3%-5% of GBS patients die from complications, which can include paralysis of the muscles that control breathing, blood infection, lung clots or cardiac arrest.

b. Incubation Period. The incubation period of Zika virus disease is not clear, but is likely to be a few days.

c. Method of Transmission. Zika virus is transmitted to people through the bite of an infected mosquito from the *Aedes* genus, mainly *Aedes aegypti* in tropical regions. This is the same mosquito that transmits dengue, chikungunya and yellow fever. However, sexual transmission of Zika virus is also possible. Other modes of transmission such as blood transfusion and perinatal transmission are currently being investigated.

d. Vaccination. There is currently no vaccine available for the Zika virus.

e. Treatment. Zika virus disease is usually relatively mild and requires no specific treatment. People sick with Zika virus should get plenty of rest, drink enough fluids, and treat pain and fever with doctor recommended medicines. If symptoms worsen, they should seek medical care and advice.

f. Specific PPE. No specific PPE recommendations; however, prevention of exposure means preventing mosquito bites; wearing long sleeved shirts; long pants and utilization of insect repellent.

Standard Format and Attachments for an Installation Disease
Containment Plan (DCP) in Support of the DoD Global Biological
Hazard Event Concept Plan (CONPLAN 3551)

1. General. The installation DCP should provide detailed procedures, information and guidance to prepare for and respond to disease outbreaks, whether naturally occurring or due to biological attacks, to protect installation personnel and critical resources. This DCP will support sustainment of mission operations during disease outbreaks, if required. The DCP should be maintained in an executable state via periodic updates. When available, lessons learned from exercises and real-world events, should be incorporated into the plan.

2. Plan Components. Three specific components are generally necessary for the DCP: the table of contents, the basic plan, and the attachments (annexes, appendices and/or tabs).

3. The Basic Plan. Installation plans will follow the format as outlined below. The basic plan will contain, at a minimum, nine sections: references, tasked organizations, situation, threat, key assumptions, mission, execution, administration and logistics, and command and control. Installation planners may add additional sections as required. Keep the basic plan brief; save the detailed information for the attachments. Where applicable, the DCP may reference other installation plans (e.g., installation security plan, medical contingency response plan) rather than restate the information.

a. References. List applicable DoD, Services, and installation-specific guidance, as well as any other references required to execute the plan.

b. Tasked Organizations. Identify installation organizations tasked to support this plan. Identify the size and breakout of the installation population. Include assigned Services units, tenant units, geographically-separated units, joint or coalition forces, military civilians, civilian contractors, military dependents, HN or third country civilians, and guests.

c. Supporting Forces. Identify military units or organizations outside of the installation that support this plan.

d. Supporting Organizations. Identify non-military organizations identified for support via memorandums of agreement (MOAs) or MAAs.

e. Situation. Describe the most probable conditions for implementing this plan. Identify other plans that are likely to be implemented concurrently with this plan.

(1) Threat. Identify the biological hazard threat to the installation. Consider enemy and terrorist use of biological

hazards agents/virus as well as naturally occurring disease outbreaks.

(2) Key Assumptions. Outline major planning assumptions used in DCP development.

f. Mission. Outline the basic purpose of the plan. Include the mission of the installation. Address the likelihood and circumstances that may require the installation to continue operations during a biological attack or disease outbreak. If assigned, attached, or transitioning forces must sustain mission operations, address impacts to the plan.

g. Execution. Identify the authority to execute the plan and the general process for implementation. Highlight the major tasks each installation organization and/or functional community must perform to carry out the plan.

(1) Phasing Structure. Identify distinct transition points in the plan where significant changes occur (e.g., threat, lead organization, level of effort). Include information as to how transitions will take place, to include reporting requirements.

(2) Limiting Factors (LIMFACs). Identify factors that may significantly impact execution of the plan. Specify how often LIMFACs will be reviewed and updated.

h. Administration and Logistics. Identify how key installation organizations are to be supported and what support they must provide for themselves, or to others. In general terms, outline the sources for equipment and supplies required for plan execution and sustainment. Address organic resources, those available via MOAs/MAAs, and those available via other means (e.g., Time Phase Force Deployment Data (TPFDD)). Additionally, identify local support conditions that adversely affect plan implementation. Resources required for plan execution but not currently available should be identified as LIMFACs.

i. Command and Control (C2). Identify command relationships both internal and external to the installation. List installation control centers used in the plan along with the individual or organization responsible for their operation. Outline the succession of command and provisions for continuity of command. Include provisions for C2 of supporting forces and organizations. Outline methods of communications to be used.

4. Annexes. The DCP will include, at a minimum, the following annexes. Installation planners may add additional annexes as required. Where applicable, annexes may reference other installation plans (e.g., installation security plan, medical contingency response plan) rather than restate the information.

a. Detection, Sampling and Identification of Biological Agents

(1) Identify detection, sampling and identification resources available on the installation as well as resources assumed to be available through MOA/MAAs. Identify vulnerabilities in the detection and identification capabilities based on the installation specific threat. Suggested areas of focus include:

(2) Create procedures for the revision of detector operations mode and sampling tempo IAW the force protection condition, trigger event, or outbreak.

(3) Create threat-specific environmental sampling plan.

(4) Create threat-specific water surveillance and testing plan.

(5) Create threat-specific food surveillance and testing plan.

(6) Identify laboratories (national, reference, and sentinel) available for presumptive and confirmatory analysis. Outline their capabilities and limitations. Include documentation requirements for identified labs, and the anticipated timeline between installation submission of sample(s) and receipt of results.

b. Medical Surveillance

(1) Outline installation medical surveillance procedures.

(2) Include generic templates for use during contact tracing and epidemiological investigations that address specific symptoms/diseases.

(3) Specify team composition for contact tracing and epidemiological investigation teams.

(4) Identify training requirements for non-Public Health personnel assisting with rapid contact tracing and epidemiological investigation teams.

(5) Outline procedures for conduct of epidemiological investigations.

(6) Outline the self-monitoring plan for installation personnel. Consider required supplies, educational materials or other types of aid necessary for personnel self-monitoring to determine onset of symptoms and guidance on when and how to use.

(7) Outline medical surveillance capabilities of local

laboratories and hospitals.

(8) Outline procedures and limitations on providing and/or requesting information from the local medical communities.

c. Medical Intervention and Treatment

(1) Identify the planning factors to estimate the number of installation personnel requiring medical intervention and/or treatment in the event of a biological incident.

(2) Describe the installation vaccination and prophylaxes distribution and administration plan. Include required stockpiles for vaccines and prophylaxes. Consider follow-on monitoring of the effects to personnel after administration.

(3) Identify PPE requirements for healthcare providers and patients in medical treatment facilities.

(4) Address the update of immunization records.

(5) Plan for behavioral casualty triage and management.

(6) Outline the biological triage plan.

d. Individual and Collective Protection

(1) Address Individual Protective Equipment (IPE) and PPE requirements and the distribution plan for installation population. Consider unique requirements for forces transiting the installation (TPFDD).

(2) Specify collective or shelter-in-place protection measures applicable to the biological threat(s).

(3) Identify tasked organizations to support shelter operations, to include roles and responsibilities, resources required, etc.

e. Security

(1) Identify the steps to enhance perimeter surveillance in response to biological intelligence warning or actual event.

(2) Outline contacts and procedures for conduct of investigation if outbreak is suspected to be the result of a terrorist attack. Address chain of custody requirements.

(3) Identify procedures to collaborate with local law enforcement/military authorities.

(4) Consider possible FPCON adjustments based on biological threats or events.

(5) Identify the procedures that will be used to secure and control access into and out of quarantine/isolation facilities.

(6) Specify the procedures that will be used to provide security for transfer of laboratory samples/specimens.

(7) Describe the steps to conduct an installation water and food vulnerability assessment. Develop associated plan for the protection of installation food and water supplies.

(8) Outline rules for the use of force for enforcement of security requirements during response to biological incidents.

f. Logistics and Supply

(1) Outline the steps taken to ensure availability of supplies and laboratory test kits for performing epidemiological investigations.

(2) Identify logistic requirements necessary to support each phase of a biological response and identify sources available to support taskings.

(3) Outline procedures for the expeditious access to the Strategic National Stockpile (SNS) or War Reserve Materiel (WRM) supplies.

g. Decontamination

(1) Provide decontamination capabilities and recommendations based on threat biological agents.

(2) Identify contamination avoidance and contamination control measures available to reduce the requirement for decontamination.

(3) Identify resources required to execute decontamination activities. Address decontamination requirements for patients, medical personnel, responders, mission equipment, and facilities.

(4) Outline contamination control procedures for the MTF and all identified quarantine/isolation facilities.

h. Restriction of Movement

(1) General

(a) Identify anticipated installation-specific application of ROM (i.e., use of facilities for quarantine and

isolation operations, lock down the installation and allow individuals to move freely within the fence, sector the installation and limit movement between sectors, etc.).

(b) Identify roles and responsibilities for implementing and maintaining ROM.

(2) Quarantine and Isolation

(a) Identify facilities for use in quarantine and isolation operations. Identify additional resources required once quarantine/isolation is initiated. Include procedures for initiating quarantine/isolation operations.

(b) Identify the steps to provide monitoring, medicine and medical care to personnel in isolation.

(c) Identify the steps to provide monitoring, medicine and medical care to personnel in quarantine.

(d) Outline a working quarantine plan for use when mission operations must continue. Address the active monitoring of personnel in working quarantine.

(e) Identify IPE/PPE requirements for occupants of quarantine/isolation facilities.

(f) Identify appropriate infection control measures within isolation facilities (Standard Precautions, Airborne Precautions, Contact Precautions, Droplet Precautions). For further guidance refer to the CDC Recommendations for Isolation Precautions in Hospitals.

(g) Describe the procedures to distribute basic needs materials and services during quarantine and/or isolation. Address food and water needs (consider unique nutritional requirements for ill personnel), shelter needs, social needs, religious requirements, and sanitary needs to include laundry, bathing, and waste management requirements. Consider special requirements for contaminated laundry and waste.

(h) Describe the plan to secure and control access into and out of quarantine/isolation facilities.

(3) Other

(a) Outline the steps required for dispersion of mission essential personnel to alternate housing facilities/shelters.

(b) Describe the procedure to implement social distancing measures to reduce risk of person-to-person transmission

of disease (e.g., minimize personal contact with others).

(c) Describe the process to limit ingress and/or egress to the installation or limit access to certain sectors of the installation. Consider who will be permitted access to and from the installation or sector.

(d) Identify non-essential installation facilities such as schools, commissary, exchange, gymnasiums, and movie theaters. Prioritize these facilities for closure or transition to quarantine/isolation facilities.

i. Emergency Communications. Both the medical community and PA have responsibilities in communicating biological hazard information to select audiences on an ongoing basis and during a biological crisis. Include both medical community and PA products in this attachment describing, at a minimum:

(1) Medical Community Emergency Communications. Medical community will coordinate emergency communications plans and procedures with installation functional experts, as required.

(a) Preparation and Pre-Event Communications

1. Include plan to produce, coordinate, and disseminate materials to inform installation population on biological threats, possible mitigation actions, and recommended readiness activities. Consider the following information:

a. Overview of medical support available in the event of a biological incident. Items to address include mass prophylaxis, triage, and referral for specialty care through TRICARE resources, clinic capabilities, and support from local community medical facilities.

b. Creation of flyers, trifold, website information, posters, and Command information materials that describe the health effects of biological weapons and agents and medical measures to mitigate risk.

c. Medical facility contact information and reporting procedures.

d. Biological-unique medical precautions that may occur including possible decontamination stations, quarantine, isolation, and restriction of movement options.

e. The need for all personnel and families to remain calm post-event and to not panic. Medical personnel will expand services on base to meet requirements. The Medical Community is here to serve and support them.

f. Psychological information regarding individuals' stress-related responses to biological incidents to include what people should expect and best practice recommendations for mitigation.

g. Importance of self-monitoring procedures during a biological incident.

h. Establish a telecommunications plan for hotlines and other services (Ref CDC SARS Appendix D5).

2. Coordinate with PA to ensure medical accuracy of counter-biological risk communications materials.

3. Support installation Unit Commander's Calls, as required, to provide general information on biological threats and anticipated installation response.

4. Create and maintain emergency notification rosters for appropriate national, state, and local medical agencies (FEMA, CDC, HN, USAMRIID, local hospitals, etc.).

(b) Trans-Event Communications

1. Outline plan to keep installation population informed throughout the biological event(s).

a. Biological agent of interest with associated symptoms, persons at risk, health impacts, and suggested actions.

b. Expected incident/outbreak duration.

c. Expected length of stay for quarantined/isolated personnel.

d. Disease containment principles and procedures.

e. Appropriate protective equipment and medical self-treatments options.

f. Mass prophylaxis plan execution.

g. Triage plan.

2. Include procedures to notify personnel subject to quarantine and/or isolation.

3. Include procedures to notify families of those subject to quarantine and/or isolation.

4. Include procedures for the expeditious contact and

notification of installation personnel. Consider the non- military base population (visitors, civilians, dependents, host- nationals).

5. Address unique communications requirements for forces transitioning through the installation.

6. Identify numbers and specialties of medical personnel required to support the installation PA effort.

7. Include procedures to coordinate with PA to ensure accuracy of medical information in risk communications.

(2) Public Affairs Emergency Communications. Attach the PA C-BW Risk Communication Plan that includes, at a minimum:

(a) Preparation and Pre-Event Communications

1. Address requirements and procedures to educate PA personnel on crisis communications fundamentals for biological emergencies.

2. Identify activities, with associated themes and messages, to build installation and community confidence that the installation is prepared for a biological attack or naturally occurring disease outbreak. Consider:

a. Media engagement activities.

b. Public briefings.

c. Commander's calls.

3. Establish a telecommunications plan for hotlines and other services.

(b) Trans-Event Communications

1. Include emergency PA biological templates/notices that can be tailored based on key audience and the specifics of the crisis. Consider:

a. Press releases.

b. Command Information products.

c. Public Service announcements.

d. Web content.

2. Outline procedures to coordinate information with installation medical experts to ensure accuracy of information.

3. Outline procedures to track public requests for information.

4. Include procedures for the stand up and sustainment of the PA Operations Center to support a biological crisis. Address number and expertise requirements for staffing.

5. Include installation procedures for public release of information during a biological event. Address expected media queries and releasable information and consider:

- a. Information regarding the cause of the event.
- b. Actions the installations is undertaking in response.
- c. Numbers of personnel affected.
- d. Potential impact to the local community.
- e. Recommended actions to mitigate the threat and reduce risk.

6. Include procedures for the stand up and sustainment of the Media Operations Center to support a biological crisis. Address numbers and expertise requirements for staffing. Address plan to inform affected population that the center is operational.

a. Include procedures to initiate the Services Hotline. Address information content for dissemination during a biological incident.

b. Provide talking points to Services spokespeople as necessary.

c. Refresh installation leadership on biological Risk Communication procedures.

j. Transportation Support

(1) Describe the plan for the transport of samples/specimens to appropriate laboratories for presumptive and confirmatory identification (Ref. CDC, Laboratory Network for Biological Terrorism). Include personnel protection and transportation security requirements. Address anticipated timeline requirements. Address laboratory documentation and handling requirements.

(2) Address the transport of those subject to quarantine/isolation, medical personnel providing care, security personnel, and resupply requirements. Consider special requirements for the transport of exposed, symptomatic, and contagious personnel.

(3) Describe procedures for the transport of contaminated waste.

(4) Identify transportation requirements associated with contamination avoidance and decontamination activities.

k. Casualty Assistance

(1) Describe procedures for the reporting of casualties, notification to next of kin and rendering of casualty assistance to survivors.

l. Mortuary Affairs

(1) Describe procedures for handling remains that were exposed to biological agents or contamination. Address potential requirements to inter biologically contaminated bodies using proper handling procedures.

(2) Identify agencies tasked to support MA such as chaplain, legal, etc.

m. Reporting Requirements. Identify requirements and procedures for the reporting of biological events. Consider development of pre-formatted or pre-addressed messages for OPREP-3 and NBC Warning and Reporting System (NBCWRS). Consider developing templates with agent-specific information for warning and notification messages in advance of an actual event. At a minimum, address:

(1) Higher headquarters.

(2) Lateral units.

(3) Local public health officials.

n. Mental Health

(1) Describe procedures to identify and manage individuals who are behavioral casualties.

(2) Identify the process to provide assistance to mitigate the psychological impact of quarantine/isolation on individuals.

o. Legal Considerations

(1) Address legal requirements for placing personnel in quarantine/isolation. Consider all installation population to include civilians, dependents, and visitors on the base.

(2) Identify areas of the plan that require or recommend legal be involved in decision making or plan execution. Include things such

as treatment of civilian casualties, notification to different populations, etc.

p. Personnel Augmentation

(1) Identify pool of medical augmentees (consider: vaccine support, contact tracing, active monitoring of quarantine, isolation support).

(2) Identify pool of security augmentees (consider: enforcement of quarantine and/or isolation, installation security).

(3) Develop procedures to request augmentation through DoD or local, state, or federal agencies, as necessary.

ABBREVIATIONS AND ACRONYMS

AMCITS	American Citizens
AOR	Area of Responsibility
ASD(HD&GS)	Assistant Secretary of Defense for Homeland Defense and Global Security
ASD(HA)	Assistant Secretary of Defense for Health Affairs
BUMED	Bureau of Medicine and Surgery
C4	Command, Control, Communication and Computers
CCDRS	Combatant Commanders
CMC	Commandant of the Marine Corps
COCOM	Combatant Command
CONPLAN	Contingency Plan
COOP	Continuity of Operations
DCP	Disease Containment Plan
DIRLAUTHDirect	Liaison Authority
DoD	Department of Defense
DOS	Department of State
DSCA	Defense Support to Civil Authorities
EHP	Emergency Health Powers
FHP	Force Health Protection
GBS	Guillain-Barré syndrome
GCC	Geographic Combatant Commander's
HLD	Homeland Defense
HQMC	Headquarters Marine Corps
HN	Host Nation
HHS	Health and Human Services
HS	Health Services
JOA	Joint Operations Areas
MA	Mortuary Affairs
MAA	Mutual Aid Agreements
MARFORS	Marine Forces
MCO	Marine Corps Order
MTF	Military Treatment Facility
NEO	Non-Combatant Evaluation
OSD	Office of the Secretary of Defense
OSD(RA)	Office of the Assistant Secretary for Defense Reserve Affairs
PA	Public Affairs
PHEO	Public Health Emergency Officers
ROE/RUF	Rules of Engagement/Rules for the Use of Force
SARS	Severe Acute Respiratory Syndrome
SecDef	Secretary of Defense
SROE/SRUF	Standing Rules of Engagement and Standing Rules for the Use of Force
TAD	Temporary Additional Duty
USAID	United States Agency for International Development
U.S.C.	United States Code
USDA	U.S. Department of Agriculture
USG	U. S. Government
USJFCOM	United States Joint Forces Command

USNORTHCOM	United States Northern Command
VA	Vulnerability Assessment
WG	Working Group
WHO	World Health Organization

Glossary

ASSET - Person, structure, facility, information, material, or process that has value.

EMERGENCY - Any incident, whether natural or manmade, that requires responsive action to protect life or property.

EMERGENCY MANAGEMENT - The managerial function charged with creating the framework within which communities reduce vulnerability to hazards and cope with disasters.

EMERGENCY OPERATIONS CENTER (EOC) - The distinctive location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An Emergency Operations Center may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. Emergency Operations Centers may be organized by major functional disciplines (e.g., fire, law enforcement, medical services), by jurisdiction (e.g., federal, state, local, tribal, other Services, private or HN), or by some combination thereof.

HAZARD - A condition with the potential to cause injury, illness, or death of personnel; damage to or loss of equipment or property; or mission degradation.

INCIDENT - An occurrence or event, natural or manmade that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wild land and urban fires, floods, HAZMAT spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, medical and public health emergencies, and other occurrences requiring an emergency response.

INCIDENT COMMAND SYSTEM (ICS) - A standardized on-scene emergency management construct specifically designed to aid in the management of resources during incidents. An appropriate ICS should provide an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

INSTALLATION - A base, camp, post, station, yard, center, or other activity under the jurisdiction of the Secretary of a Military Department, or, in the case of an activity in a foreign country, under the operational control of the Secretary of a Military Department or the SecDef. For the purpose of this Instruction, the term installation does not include leased facilities.

INTEROPERABILITY - The ability of EM and response personnel to operate in synergy in the execution of assigned tasks. In the context of communications technology, interoperability also refers to the condition achieved among communications-electronics systems or items of communications-electronics equipment when information or services can be exchanged directly and satisfactorily between them and/or their users. The EM system should allow the sharing of data with other jurisdictions and levels of government during planning and deployment.

JURISDICTION - A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., federal, state, local, tribal, other Services, private or HN partnerships boundary lines) or functional (e.g., law enforcement, public health).

MITIGATION - Activities providing a critical foundation in the effort to reduce injuries and the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster.

MUTUAL AID AGREEMENT (MAA) - A written agreement between and among agencies and organizations and/or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and other associated services. The primary objective is to facilitate rapid, short-term deployment of emergency support prior to, during, and/or after an incident.

NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) - A national crisis response system that provides a consistent, nationwide approach guiding government agencies at all levels, the private sector, and NGOs to work effectively and efficiently together to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.

NATIONAL RESPONSE FRAMEWORK (NRF) - Guides how the Nation conducts all-hazards response. The NRF documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. It describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It allows first responders,

decision-makers, and supporting entities to provide a unified national response.

PREPAREDNESS - The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and coordination among government, private-sector, and NGOs to identify threats, determine vulnerabilities, and identify required resources. Within NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning, training and exercises, personnel qualification and certification, equipment certification, and publication management.

PREVENTION - Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

RECOVERY - The development, coordination, and execution of service and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents.

RESOURCES - The forces, materiel, and other assets or capabilities apportioned or allocated to incident response operations. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an Emergency Operations Center.

RESPONSE - Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security

operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity, and apprehending actual perpetrators and bringing them to justice.

RISK ASSESSMENT - The identification and assessment of hazards.

RISK MANAGEMENT - The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits.

THREAT - Natural or manmade occurrence, individual, entity, or action that has or indicates the potential to harm life, information, operations, the environment, and/or property.

TRIBAL - Referring to any Indian tribe, band, nation, or other organized group or community as defined in section 450b of Title 25 of the U.S. Code, including any Alaskan Native Village as defined in or established pursuant to the Alaskan Native Claims Settlement Act (43 U.S.C.A. and 1601 et seq.), that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.