APPENDIX B TO ENCLOSURE B

MEDICAL READINESS REQUIREMENTS FOR DEPLOYMENT AND TRAVEL

1. MEDICAL READINESS FOR DEPLOYMENT AND TRAVEL INCLUDES:

a. Current periodic health assessment or physical examination IAW Service-specific policy that will remain current for the anticipated duration of deployment or travel.

b. All individual medical readiness deficiencies and deployment-specific health readiness deficiencies must be corrected before deployment and documented in the Service's electronic tracking system for individual medical readiness requirements IAW with reference d.

c. Mental health readiness assessment and baseline pre-deployment neurocognitive assessment IAW criteria outlined in references i and j.

d. No deployment limiting conditions as defined by Service-specific policy. Individuals with deployment limiting conditions may deploy or travel with a medical waiver as outlined in annex A of appendix B to enclosure B.

e. Dental Class I or II per current annual exam, which will remain current for the anticipated duration of deployment or travel.

f. Currency in Total Force/All Service Vaccinations IAW reference c.

(1) Hepatitis A

(2) Tetanus-Diphtheria (preferably with pertussis vaccine)

(3) Measles, Mumps, Rubella

(4) Poliovirus

(5) Influenza

g. Currency in Location Specific/Risk-based vaccinations IAW reference c.

(1) Hepatitis B

(2) Typhoid

(3) Meningococcal

(4) Yellow Fever

(5) Varicella (Documented Immunity or Vaccination)

(6) Anthrax vaccinations are required IAW current DoD policy for personnel deploying 15 or more days to the Combined Joint Task Force Horn of Africa (CJTF-HOA) AOR: Djibouti, Eritrea, Ethiopia, Kenya, Seychelles, Somalia, and Sudan.

(7) Smallpox vaccinations are required IAW current DoD policy for personnel deploying for 15 or more days to the CJTF-HOA AOR: Djibouti, Eritrea, Ethiopia, Kenya, Seychelles, Somalia, and Sudan.

(8) Rabies vaccine for personnel at high risk of exposure IAW Service-specific guidelines.

(9) Pneumococcal vaccine for personnel in a high risk category per Advisory Committee on Immunization Practice (ACIP) recommendations.

(10) TB screening test must be current IAW current Service-specific policy. Due to high risk of exposure, components and other subordinate activities are encouraged to consider annual screening programs for frequent deployers and travelers to the U.S. Africa Command AOR.

h. Deployment readiness lab studies:

(1) DNA on file.

(2) Human Immunodeficiency Virus (HIV) test within 24 months of deployment. Civilian screening will be accomplished IAW Service-specific policy.

(3) G6PD deficiency test status on file.

(4) Pre-deployment serum specimen for medical examination must be collected within 12 months of deployment IAW DoD policy at references g and h.

(5) Pregnancy testing will be accomplished IAW any Service-specific policy.

i. Pre deployment health assessment questionnaire, DD Form 2795, is required IAW references h and k and/or when risk assessment and/or commander's decision dictates use.

(1) For all deployments more than thirty days to locations without a fixed military treatment facility or whenever deemed necessary by commander decision, personnel must complete the mandatory Under Secretary of Defense for Health Affairs (USD/HA)-approved standardized pre-deployment health risk assessment questionnaire (DD Form 2795) within 60 days prior to travel or deployment date and update if health conditions change prior to travel/deployment.

(a) Medical personnel must review each questionnaire and ensure

appropriate medical follow-up as required.

(b) The original DD Form 2795 will be placed in the individual's permanent medical record, a paper copy in their deployment medical record (DD Form 2766), and an electronic copy is transmitted to the Deployment Medical Surveillance System (DMSS) at the Armed Force Health Surveillance Center (AFHSC).

(2) When risk assessment or commander's dictates use for DD Form 2795, personnel must complete the mandatory USD/HA-approved standardized pre-deployment health risk assessment questionnaire (DD Form 2795) prior to travel or deployment. The DD Form 2795 will be processed as indicated in paragraphs (a) and (b) above.

j. Immunization and deployment health record:

(1) Immunization record. A CDC 731, International Certificate for Vaccination or Prophylaxis, (yellow shot record, formerly PHS-731) that contains an official yellow fever certificate stamp (for yellow fever risk areas) is required for all personnel traveling or deploying to the African continent. While the DD Form 2766C, Vaccine Administration Record, is accepted by the World Health Organization, many African countries do not recognize the DD Form 2766C and may require re-vaccination or deny entry without a CDC 731 containing an official yellow fever certificate stamp.

(2) Deployment health record: a DD Form 2766, Adult Preventive and Chronic Care Flow Sheet, or equivalent must accompany the individual. The following health information must be documented or accessible via electronic record for all individuals:

(a) Blood type and Rh factor, G6PD, HIV, DNA.

(b) Known allergies.

(c) Current medications, including any force health prescription products prescribed and dispensed to individual.

(d) Corrective lens prescription.

(e) Special duty qualifications.

(f) Completed DD Form 2795, when required.

(g) Summary sheet of current and past medical and surgical problems.

(h) Documentation of dental Class I or II.

(i) Documentation of all medical and dental care received while deployed.

k. Individual medical readiness equipment. Individuals must deploy with:

(1) Prescription medications: personal prescription medication supplies to last the duration of deployment/travel plus 15 days or IAW Service-specific policy.

(2) Medical equipment: all required medical equipment (2 pairs of eyeglasses, orthodontic items, hearing aids and batteries, etc). Personal durable medical equipment for certain health conditions will be allowed IAW medical waiver.

(3) Any occupational health PPE (respiratory and hearing protection, dosimeters, etc).

(4) Medical Alert tags: individuals requiring medical alert tags will deploy with red medical alert tag worn in conjunction with their personal identification tags.

(5) Contact lenses: IAW Service-specific policy.

(6) IAW reference o, the DoD Insect Repellent System and other personal protective measures must be implemented in arthropod-borne disease endemic areas. Reference p provides detailed information about the DoD Insect Repellent System and other personal protective measures (PPMs). The requirement to utilize the DoD Insect Repellent System and other PPMs in arthropod-borne disease endemic areas must be included in all operational plans and orders.

(a) Insect repellent: all individuals deploying or traveling to arthropod-borne disease endemic areas, regardless of duration, will deploy/travel with enough personal use insect repellent with DEET to last through the deployment or travel. Commercial repellents are acceptable for use if they contain 24-35% DEET. Repellent should be applied directly to exposed skin and will protect against biting insects for up to 12 hours.

(b) Permethrin treated clothing/uniforms:

1. Individuals deploying or traveling to arthropod-borne disease endemic areas will deploy/travel with a minimum of two uniforms or enough uniforms, which have been pre-treated with permethrin to last the duration of deployment or travel whichever is greater. Uniform treatment with permethrin (Individual Dynamic Absorption (IDA) kit or aerosol spray) should follow the directions on the label and/or AFPMB recommendations at http://www.afpmb.org.

2. Individuals authorized to deploy or travel in civilian clothes will treat civilian outer/field clothing with the DoD permethrin aerosol spray IAW the label directions or with permethrin treatment products available commercially.

(c) Bed nets: individuals deploying or traveling to locations in arthropod-borne disease endemic areas will deploy/travel with a permethrin treated bed net and sleep under properly each night. Different bed net options may be found at http://www.afpmb.org/standardlist.htm.

ANNEX A TO APPENDIX B TO ENCLOSURE B

MEDICAL WAIVER PROCESS FOR DEPLOYMENT LIMITING CONDITIONS

1. GENERAL. If a component or subordinate activity wishes to deploy an individual (except Special Operations Forces (SOF) personnel), for more a 30 days, with a medical condition that could be disqualifying IAW enclosure 3 of reference rr and/or IAW Service medical standards, the component or subordinate activity will obtain a deployment medical waiver from the U.S. Africa Command Commander through the U.S. Africa Command Surgeon or U.S. Africa Command component surgeon IAW references f, kk, and rr.

a. Final medical waiver approval authority lies at the combatant command level. However, IAW 24 February 2009, U.S. Africa Command Surgeon policy at reference kk, medical waiver authority is delegated to the component surgeons for all deploying active duty individuals, except SOF, within their respective Service or sub-unified command for all non-behavioral health conditions. In making waiver determinations, component surgeons are encouraged to consult with the Special Operations Africa (SOCAF) Surgeon and CJTF-HOA Surgeon for individual seeking waiver for the OPERATION ENDURING FREEDOM-TRANS-SAHAL (OEF-TS) and the CJTF-HOA joint area of operations respectively.

b. The U.S. Africa Command Commander, through the U.S. Africa Command Surgeon, will retain waiver authority for all individuals, civilian and active duty, assigned to HQ U.S. Africa Command, for civilians unaffiliated with a Service (e.g., Defense Intelligence Agency, etc) and for Coast Guard personnel. The U.S. Africa Command Commander, through the U.S. Africa Command Surgeon, will also maintain waiver authority for all behavioral health waivers.

c. The U.S. Special Operations Command Commander may grant waivers for SOF personnel with conditions listed in enclosure 3 of reference rr, subject to the approval U.S. Africa Command Commander and Surgeon.

d. This medical waiver process does not apply to contingency contractor personnel, who shall comply with the guidance found in reference ff.

2. When a medical waiver is desired for a Service member, the waiver request shall be submitted to the component surgeon through the individual's servicing military medical unit, with medical input provided by the individual's medical provider. The component surgeon will review to make approval determination and forward request and approval determination to the HQ U.S. Africa FHP office for review and tracking by U.S. Africa Command Surgeon's office. In the case of a civilian employee, the waiver request shall be submitted though the individual's personnel office to the U.S. Africa Command for review, approval, and tracking.

a. The waiver request (items 1-5 below) is assembled electronically and will require the documentation to be scanned for transmission in encrypted, electronic format. Not all requests will require the items listed below; however, include as much information as possible as this will decrease follow-up questions and speed decision making. Include only medical information that is pertinent to the waiver request and on a need to know basis IAW Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(1) A Medical Waiver Request Form or like form, an example may be found in annex to appendix B to enclosure B.

(2) Completed DD 2795, Pre-Deployment Health Assessment , with a provisional deployment determination by trained DoD healthcare provider.

(3) DD 2766, Adult Preventive and Chronic Care Flow sheet with medical summary including all the following information (medical evaluation board, preventive health assessment, etc., all current within one year):

(a) History (Hx) of condition.

(b) Date of onset.

(c) Applied treatments.

(d) Current treatment.

(e) Limitations imposed by condition and/or medication.

(f) Prognosis.

(g) Required follow-up.

(4) Enclosures (include only if these have any bearing on deployability):

(a) Specialty consultations needed to establish diagnosis, treatment, monitoring plan, and prognosis.

(b) Operation reports that are pertinent and recent.

(c) Any needed lab reports, pathology reports, and tissue examinations.

(d) Reports of studies: x-rays, pictures, films, or procedures.

(e) Summaries and past medical documents (e.g. hospital summary, etc.).

(f) Reports of proceedings (e.g. tumor board, medically related boards, etc.).

(g) Job requirements (physical conditions, exertion level, etc.).

(5) Commander's Documentation: including request to deploy an individual with deployment limiting condition, individual's criticality to the mission, and other comments supportive of deployment.

b. The U.S. Africa Command FHP office and component surgeons will maintain a database to document, monitor, and archive medical waiver requests, approval, and disapprovals. At least bi-annually, the U.S. Africa FHP office will review waiver database with component surgeons to ensure all waiver requests have been captured.

3. The medical authority evaluating individuals for deployment or travel must bear in mind the following facts:

a. Medical care on the African continent is not as robust and available as that in the continental U.S. If maintaining an individual's health requires frequent or intense medical management and/or specialist care, laboratory testing, or ancillary services, she/he should not deploy.

b. The individual must take all personal medications and medical supplies with him or her to cover for the length of deployment. Replacements may not be available in theater.

c. Medical maintenance support for personal medical devices is not available. Common U.S. household electrical current (110V AC) is not usually available.

d. Environmental conditions may include extremes of temperature, physiologic demand (water, mineral, salt, and heat management), and poor air quality; while the operating conditions impose challenges of diet, discomfort, sleep deprivation, emotional stress and circadian rhythm disruption. If maintaining an individual's health requires avoidance of these extremes or excursions, she/he should not deploy.

4. Upon waiver decision, the component surgeon will return a signed waiver approval to the originator for inclusion in the individual's medical record and document the waiver approval in the component's medical waiver database.

5. Nothing in this document should be construed as authorizing use of defense health program or military health system resources for such evaluations if it is not elsewhere previously authorized. Generally, defense health program or military health system resources are not authorized for the purpose of pre-deployment or travel medicine evaluations for contractor employees. Local command, legal, and resource management authorities should be consulted for questions on this matter.

ANNEX B TO APPENDIX B TO ENCLOSURE B

MEDICAL WAIVER APPROVAL EXAMPLE
(include Privacy Act/HIPPA statement on all patient documents as needed)

Patient Name (Last, First) _____ SSN _____

Grade _____ Age _____ DOB_____ Sex _____

Skill Identifier/Job Description Home Station Unit _____

Service Yrs _____ Active Reserve Component Civilian Contractor (circle applicable)

Length of this Deployment _____ Destination _____

Previous Deployments _____

Profile - P___ U___ L ___ H___ E ___ S ___ Previous Waivers: YES NO (circle applicable)

Diagnosis (ICD 9) _____

Case Summary (include all of the following):

a. History (Hx) of condition
b. Date of onset
c. Applied treatments
d. Current treatment
e. Limitations imposed by condition and/or medication
f. Prognosis
g. Required follow-up

I have reviewed the case summary and hereby submit this request.

Signature_____
Unit Commander or Medical Representative

Surgeon Approval
(approval authority delegated to Component Surgeon/Commander)

Waiver Approval: Yes No Comments: _____

Signature _____

ANNEX C TO APPENDIX B TO ENCLOSURE B

FHP PRESCRIPTION PRODUCTS (FHPPP)

1. MALARIA CHEMOPROPHYLAXIS. Malaria risks and chemoprophylaxis requirements vary by location and season. Deploying units must review National Center for Medical Intelligence (NCMI) malaria risk assessments at www.intelink.gov/ncmi/index.php or http://www.afmic.dia.smil.mil/index.php (reference mm) and U.S. Centers for Disease Control and Prevention (CDC) traveler's health website at www.cdc.gov (reference nn) prior to deploying to ensure they have the most up-to-date malaria risk assessment information. Leaders at all levels must ensure FHP measures against malaria are enforced for all personnel deploying/traveling to the U.S. Africa Command AOR.

a. Primary malaria chemoprophylaxis is required for areas where NCMI assesses a small number of cases or more could occur in U.S. military members in the absence of countermeasures. Prior to medical personnel prescribing malaria chemoprophylaxis, NCMI malaria risk assessment should be reviewed. The use of directly observed therapy for primary malaria chemoprophylaxis is recommended to prevent malaria in personnel.

(1) Malaria occurs year round, chloroquine resistance has been reported throughout Africa, and the dominate form is *P.falciparum*. However, *P.vivax* and *P.ovale* do occur as well.

(2) As of March 2010, countries requiring malaria chemoprophylaxis include Angola, Benin, northern and central Botswana, Burkina Faso, Burundi, Cameroon, one island in Cape Verde, Central African Republic, southern Chad, Comoros, Cote d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, most of Madagascar, Malawi, southern Mali, southern third of Mauritania, rural areas of Mauritius, Mozambique, northern Namibia, southern Niger, Nigeria, Republic of the Congo, Rwanda, Sao Tome & Principe, Senegal, Sierra Leone, Somalia, northeastern tip of South Africa, central and southern Sudan, eastern central and eastern Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.

(3) As of March 2010, malaria chemoprophylaxis is not required for Algeria, Lesotho, Libya, Morocco, Seychelles, Tunisia, and Western Sahara.

b. Terminal malaria chemoprophylaxis is generally recommended for all individuals who were put on primary malaria chemoprophylaxis and had prolonged exposure to relapsing forms of malaria (*P. vivax* and/or *P. ovale*). Terminal chemoprophylaxis should begin once the potential for disease transmission ends, such as departure from the risk area or AOR.

c. Primary and terminal malaria chemoprophylaxis is an individual, tailored regimen to be prescribed in the context of a provider-patient relationship. Primary and terminal

malaria chemoprophylaxis use is determined by multiple factors, including operational situation, length of exposure, prevalence of drug resistance, and any Service-specific policy.

(1) IAW the Armed Force Epidemiological Board "Antimalarials and Current Practice in the Military 2003-13", 31 Jul 2003 report, the Centers for Disease Control and Preventions' (CDC) Health Information for International (the "Yellow Book") are appropriate national consensus guidelines for use by the DoD and may be found at www.cdc.gov.

(2) The Yellow Book does not recommend a single drug of choice, as different circumstances require different chemoprophylaxis choices.

(3) Some Yellow Book recommendations, including the indicated use of the drug or the dose of the drug, are off-label.

(4) Malaria chemoprophylaxis use in an off-label manner as recommended by the CDC may only be prescribed in the context of a provider-patient relationship or as part of an investigational new drug protocol.

d. As outlined above, in many parts of Africa risk of exposure to malaria is extremely high and prophylaxis is never 100% effective. Therefore, consideration of directly observed therapy, rapid diagnosis, management, and treatment of malaria cases must be included in any operational planning and orders. Medical personnel supporting operational activities will be trained in malaria diagnosis and treatment and will deploy/travel with FDA-approved rapid diagnostic kits and appropriate malaria treatment medications.

e. Malaria chemoprophylaxis use, screening prior to prescribing, and prescriptions documentation must be IAW FDA, DoD, and any Service-specific guidelines.

f. For the purpose of this policy, malaria transmission risk is classified as high-transmission, low-transmission, or non-endemic as determined by the National Center for Medical Intelligence (NCMI), accessible at https://www.intelink.gov/ncmi/index.php. High transmission refers to areas with an expected attack rate of 11% or more per month in the absence of countermeasures. Low transmission refers to areas with a potential monthly attack rate of <0.1%, <1%, or 1-10% in the absence of countermeasures. NCMI risk estimates for malaria transmission may not be as accurate as "on the ground" estimates of malaria transmission in specific deployment areas. In cases where local transmission is judged to exceed reported levels, chemoprophylaxis may be warranted regardless of NCMI estimates. When in doubt, assume higher risk of transmission. The U.S. Africa Command Surgeon's Office (J00-SG) will be adjudicating authority for questions regarding transmission risk.

Drug	Dose	Dosing Instructions
Atovaquoone-proguanil (Malarone)	250/100mg (1 tablet) Daily	Begin 1-2 days prior to entry into malarious area. Continue dosing 7 days after departure from malarious area.
Doxycycline	100mg daily	Begin 1-2 days prior to travel to malarious areas. Take daily with food. Continue until 28 days after leaving malarious areas.
Mefloquine	228mg (base) weekly	Begin 1-2 weeks prior to arrival in malarious area. Take weekly during travel and continue for 4 weeks after departure from malarious area.

Table B-B-C-1. Chemoprophylaxis Regimens for Africa

g. Chemoprophylaxis is administered as a force health protection measure under command authority as follows:

(1) High-transmission settings. Chemoprophylaxis is required for travel to high transmission areas in Africa. Atovaquone-proguanil (Malarone) is recommended as the drug of choice for the prevention of malaria in these areas. For individuals unable to receive atovaquone-proguanil due to intolerance or contraindication, doxycycline will be the preferred second-line therapy. Use of mefloquine prophylaxis is a third-line recommendation and should be restricted to individuals unable to receive either of the other regimens. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications.

(2) Low-transmission settings. In general, areas where potential rates are expected to be 0.1% per month or less do not require chemoprophylaxis in Africa. This is particularly true if there is little or no P. falciparum transmission and if the duration or nature of travel suggests a low likelihood of infection. For areas where monthly potential rates are assessed as >0.1% but <1% or 1-10%, chemoprophylaxis is generally indicated when night exposures are anticipated. When chemoprophylaxis is to be used, either doxycycline or atovaquone-proguanil (Malarone) are acceptable first-line prophylactic medications. Selection may be based on individual preference or tolerance, unit uniformity, side-effect profile, or desire for side benefits such as antibacterial activity of doxycycline. Individuals intolerant of the selected drug should receive the alternative first-line agent. Mefloquine should be reserved for individuals with intolerance or contraindications to both first-line medications. Before using mefloquine as prophylaxis, care should be taken to exclude the presence of contraindications. Atovaquone-proguanil (Malarone) should be considered for short-

term travel (2-3 weeks or less) or for frequent travelers due to increased compliance with a shorter dosing duration (7 days instead of 28 days) after departing Africa.

(3) Non-endemic settings. Chemoprophylaxis is not needed in non-endemic settings.

h. Monitoring compliance with chemoprophylaxis is the responsibility of unit commanders. Directly Observed Therapy (DOT) is strongly recommended when chemoprophylaxis is implemented and is critical in high-transmission areas of Africa. Once again, chemoprophylaxis should be viewed as the last component of a comprehensive malaria prevention program to supplement personal protective measures and vector control.

2. OCCUPATIONAL POST EXPOSURE PROPHYLAXIS. In many parts of Africa, HIV prevalence is extremely high. Individuals and units participating in activities that place them at high-risk for HIV exposure (e.g. dental/surgical/intravenous procedures with the local population) must deploy or travel with antiviral post exposure prophylaxis. Use of occupational post exposure prophylaxis will be IAW the most current CDC guidelines. Occupational HIV exposure incident and prophylaxis use must be reported and documented IAW Service-specific policy.

3. MANAGEMENT/TREATMENT OF VENOMOUS ARTHROPODS/SNAKE BITES. Personnel deployed to Africa are at a low to moderate risk for venomous arthropods and snake bites. The variety of arthropods and snakes, complexity of arthropod and snake identification and venom, and sporadic availability of FDA-approved antivenin in African countries makes it extremely difficult to provide single HQ U.S. Africa Command guidance. Units and medical personnel traveling or deploying to Africa must consider the possibility of snake bites and include the appropriate management and treatment of venomous bites in any operational planning and in medical personnel pre-deployment training.

a. The AFPMB has an excellent by-country summary of venomous arthropods and snakes called the Living Hazards Data at http://www.afpmb.org.

b. Information on antivenin products and producers or sources may be found at http://www.toxinology.com by searching the scientific or common name of the snake, spider, or scorpion.

c. Species of arthropods and snakes found in the U.S. Africa Command AOR are geographically different from species located within the U.S. and thus require antivenins not specifically approved by the FDA. The FDA classifies these antivenins are Investigational New Drugs (IND). Normally, IND classification requires development of an investigational protocol directing explicit conditions and manner of use of these agents in patient care. However, the FDA has granted a "blanket waiver" of the IND requirements of the use of non FDA approved antivenins and has placed unique requirements for their use. Information on these requirements may be obtained from the U.S. Army Medical Material Center Europe (USAMMCE) pharmacy officer.

(1) Non FDA approved antivenins must be ordered and stocked by a pharmacy officer or licensed provider who is trained in the management of INDs and proper preparation of doses. Antivenins require appropriate cold chain management. Three antivenins are stocked at the USAMMCE and may be ordered at phone DSN# 314-495-7230 or Comm# 011-49-6331-86-7230.

(2) Antivenin is generally indicated when there is a threat to limb or life and is a medical emergency best handled in a hospital setting. The risk and side effects of antivenin treatment versus the potential benefit must be considered. Not all personnel who are bitten will require antivenin treatment. Treatment with antivenin must be provided by an experienced health care provider who is trained in antivenin use.

ANNEX D TO APPENDIX B TO ENCLOSURE B

MEDICAL THREAT BRIEF

1. GENERAL. All deploying or traveling personnel must receive a pre-deployment health threat and countermeasures briefing within 30 days of expected date of arrival to Africa. African countries present a high level of overall health risk. Without adequate force health protection measures, mission effectiveness may be seriously jeopardized.

a. Qualified medical personnel must brief all deployers and travelers on anticipated location specific health threats and exposures, relevant countermeasures and their employment, planned health surveillance monitoring, and the overall operational risk management program.

b. At a minimum, content of brief will include endemic and communicable and vector-borne diseases, vector-borne disease countermeasures, food and water borne disease prevention, endemic plant, animal, reptile, and insect hazards, environmental conditions, occupational health and safety, personal/dental hygiene, operational and combat stress.

c. Detailed information for use in health threat and countermeasures briefings.

(1) Endemic diseases:

(a) Acute diarrheal diseases constitute the greatest immediate infectious disease threat to the force. Hepatitis A, cholera and typhoid are endemic; high level risk; and are primarily transmitted by ingestion of contaminated food or water. Drug resistant strains exist within Africa. To counter these threats: no food or water (including ice) should be consumed unless first approved by U.S. military medical authorities; however, deployers/travelers must be educated that if they do partake of local fare, eat only (piping or steaming) hot fully-cooked foods and avoid warm, cool, cold, and partially cooked or uncooked items; self-peeled fruits and vegetables are generally considered safe, but are safest when first sanitized; emphasize field sanitation and hygiene. If no U.S. military medical authorities are available to approve water sources, water or other beverages should only be consumed if they come from a sealed container (e.g. bottled water, soda, etc.). Do not consume unapproved, local milk even if it is in a sealed container.

(b) A significant risk of disease transmitted by insects and ticks exists year round in African countries. Vector-borne diseases are transmitted by mosquitoes, sand flies, ticks, lice, and fleas. Overall risk to U.S. forces is high. Many vector-borne diseases are present. Diseases include malaria, dengue, Rift Valley fever, typhus, African trypanosomiasis, leishmaniasis, tick-borne encephalitis, Lyme disease, typhus, Crimean-Congo hemorrhagic fever, sand fly and West Nile fevers, and alpha virus diseases. They can significantly impact force health unless preventive measures are enforced. Avoidance of vectors is key, including habitat awareness and proper wear of

uniform/other clothing. The DoD Insect Repellent System and other PPMs must be utilized in arthropod disease endemic areas.

(c) Tuberculosis is endemic. The risk may be elevated in those personnel with significant contact with local populations for example, personnel in support of humanitarian emergency relief efforts. As with many regions of the world, resistance to some or all of the current therapeutic regimens has been reported among African tuberculosis isolates. To mitigate the threat, avoid prolonged contact in crowded or enclosed areas and ensure TB testing is accomplished IAW appendix B to enclosure B and/or Service policy.

(d) Avoid animals. Do not keep mascots and pets. Animals are carriers and reservoirs for multiple diseases to include leishmaniasis, rabies, Q fever, leptospirosis, avian influenza, diarrheal disease, etc. Deployed personnel will avoid contact with local animals in the operational setting and will not attempt to feed, adopt or interact with them in any way.

(e) HIV, syphilis, gonorrhea, and other common sexually transmitted infections (STIs) are present at moderate to high levels. HIV is a major health concern in many African countries. Abstinence is the only way to ensure prevention of STIs. It is often impossible to detect a STI in a potential partner. Latex condoms should be made available and used by all unable to resist being sexually active. Proper use includes correct placement, use of non-petroleum lubricant to decrease breakage and use of a new condom with each sexual contact. Encourage personnel to seek prompt medical treatment for STI symptoms.

(f) Meningococcal meningitis is a bacterial disease found world-wide, especially throughout sub-Saharan Africa. Travelers and deployers to Africa may be at risk for meningococcal disease, particularly during the dry season. Risk is highest in those who will have prolonged contract with local populations, such as humanitarian relief operation participants. It is also of operational concern in many countries that fall outside the African meningitis belt (reference ll). Therefore, it is a required vaccination for travel or deployment to U.S. Africa Command AOR.

(g) Schistosomiasis (snail fever) larvae may be present in contaminated, snail infested bodies of fresh water - avoid wading or swimming to the extent possible.

1. Vigorous drying of the skin after exposure to schistome infested water, followed if possible by an alcohol wipe-down, can help prevent the larval penetration of the skin. Symptoms may not occur until 2-6 weeks after exposure and may be mild - physicians should be aware of possible exposures among redeploying troops.

2. When conducting diver or combat swimmer operations use contaminated diver decontamination protocols for cleaning and disinfection of personnel and equipment.

(h) Avian influenza, H1N1, or other novel influenza virus outbreaks have occurred in Africa. All personnel should avoid contact with sick or dead poultry and wild birds. Avoid poultry farms and live markets. Practice safe food handling and ensure all poultry products are thoroughly cooked. The most current NCMI influenza reports (reference dd) should be reviewed to ensure personnel are aware of the potential for pandemic influenza.

(i) Environmental health threats:

1. Heat injuries may be the greatest overall threat to military personnel deployed to warm climates. Acclimatization may take 10-14 days or more. Ensure proper work-rest cycles, adequate hydration, and command emphasis of heat injury prevention. Additionally, use sunscreen to protect against sunburn and skin cancer.

2. Risk of cold injury will depend on the specific region, but can occur in any environment. Hypothermia, a life-threatening condition, can occur at 55 degrees Fahrenheit (air temperature). The risk of cold injury is increased in persons who are in poor physical condition, dehydrated, or wet.

3. High altitude. High altitude medical threats include: acute mountain sickness, high altitude bronchitis, high altitude cerebral edema, and high altitude pulmonary edema. High altitude is defined as elevations greater than 8,000 ft (2,350 m). Ethiopia, Kenya, Tanzania, Rwanda, Uganda, Zambia, and Morocco have high altitude regions. Specialty equipment and medications may be necessary for personnel deploying or traveling to locations at high altitude.

4. Contamination of surface and ground water with raw sewage and industrial wastes, urban air pollution and vegetables contaminated with pesticides pose localized threats. Consult environmental assessment and medical food inspection personnel for location-specific information.

(j) Various species of poisonous animals, including reptiles and arthropods are present. A current list of venomous animals is available at http://www.afpmb.org/pubs/living_hazards/living_hazards.htm. Education/awareness and avoidance are required to prevent snakebite incidents.

(k) Assume that occupational hazards will not significantly differ from those at home station. If the job at home station requires use of personal protective equipment (PPE), so will the job while deployed.

(l) Commanders and all personnel should be aware of deployment-related stress and injuries, their signs/symptoms and how to seek final help for themselves or their buddy. Personnel should be cognizant of sleep discipline and the impact of alcohol misuse.

(m) Work-related injuries as well as sports and other recreational injuries are significant contributors to non-effectiveness. Command emphasis on safety awareness is important.

(n) Poor road conditions combined with varying driving experience of locals and of multinational forces significantly increase the risk of motor vehicle accidents. Drive defensively, always wear seat belts and ensure government and rental vehicles are in good working order. Travel during daylight hours and never drive alone.

(o) Hand washing is important to prevent transmission of disease. Good hygiene and sanitation of boots and other personal items, as well as items of unit equipment, is essential to prevent the importation of agriculturally important diseases.